Washington Healthcare News®

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Washington Health Plans Report Solid Profits Through September 30, 2011

However, Most Plans Show Lower Underwriting Gains than the Same Period in 2010

By David Peel
Publisher and Editor
Washington Healthcare News

Washington domestic health plans recently reported third quarter 2011 financial results and eleven of the fourteen plans were profitable. However, nine of the plans reported lower underwriting gains, and six reported an underwriting loss, suggesting premiums may rise more than usual in 2012. This becomes even more likely when the uncertainties of healthcare reform are considered.

Our report, shown on page four, shows total revenues, net underwriting gain (loss), investment gain (loss), income taxes and net income (loss) for the fourteen domestic health plans operating in Washington for the periods ending September 30, 2011 and September 30, 2010. We also present member months, the combined total of month ending membership for each nine month period. When the financial figures are divided by member months, a monthly average over the period is obtained that is valuable in comparing one plan to another. Financial statement users can then make apples to apples comparisons of health plans. All information in this report was obtained through publicly available reports on the Washington State Department of Insurance Commissioner (OIC) web site. Information not required to be filed with the OIC (self-insured and some Washington State insured business from non-domestic carriers) is not included in this report nor is it referenced in this article.

Comments from Industry Representatives

We asked representatives of the plans to give us insight into their fi-

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Plan and Hospital Financial Information Available at www.wahcnews.com

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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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nancial results. Some plans chose not to reply to our request.

Premera Blue Cross and LifeWise Health Plan of Washington spokesperson Amy Carter said, "For Premera, we have seen some growth in membership in 2011 in our Medicare Supplement and Federal Employee Plan business. However, I should note there has been some change to align our reporting practice with federal MLR (medical loss ratio) reporting, which contributes to the increase in member months as well."

Carter continued, "For LifeWise Health Plan of Washington, we have seen continued growth in 2011 after record-breaking growth in the closing months of 2010. LifeWise is now the leading individual carrier in the state, based on a very popular portfolio of products that offer the balance of benefits and costs that individual customers are looking for in a health plan."

Regence of Washington spokesperson Rachelle Cunningham described her company's results, "The decrease in membership was driven primarily by a drop in our Individual segment. In January 2011, we discontinued our product portfolio from our legacy systems and launched a new portfolio of products on our new administrative platform. As we expected, such a significant product change resulted in almost a 30 percent membership reduction (individual <age65) from Q4 2010 to Q4 2011."

She continued, "We remain committed to serving the individual market, but we also remain concerned about the implications of a marketplace in 2014 in which people may wait until they are diagnosed with a significant medical condition before purchasing insurance. In the meantime, we are developing new products to fulfill the market demand for lower prices. At the same time, we are very well positioned for growth in the large group market, as demonstrated by our winning the five-year contract to administer PPO benefits for King County employees beginning January 2012. We anticipate other large group growth in 2012 and 2013 fueled by the strength of our provider network collaboration."

The Group Health organization consists of Group Health Cooperative, Group Health Options and KPS Health Plans.

Group Health Cooperative and Group Health Options Chief Financial Officer Ric Magnuson told us, "We have seen higher than expected increases in medical care costs in 2011 that have had an impact on our margin. Some of this is in the nature of the insurance business, at times you can see cost spikes, such as those caused by a tough flu season earlier in the year. In some areas, we do see opportunities to improve our performance through better care coordination and other administrative changes. We have seen growth in 2011 and plan to continue to drive to make our plans an affordable value for purchasers."

Columbia United Providers Chief Executive Officer Ann Wheelock explained her organization's enrollment growth, "We picked up additional membership in January 2011 as we expanded into King and Pierce Counties. There were two IPA type groups that asked us to contract for Healthy Options with their networks."

KPS Health Plan President Jim Page commented on his company's dramatic financial turnaround, "We gave few concessions to retain ex-

isting business. As a consequence, we lost enrollment but also saw improved bottom line results. We benefited from a relatively positive turn in general industry claims trends and undertook several significant initiatives to control claims costs. We continued to manage our administrative costs effectively and our per capita administrative costs decreased as our enrollment decreased. This was no small task to accomplish."

Page continued, "While we feel fortunate to have experienced a bit of a financial turnaround, however, as a small plan a higher than average number of large claims would have an adverse impact on our bottom line."

Per Member Per Month Analysis

One of the more interesting ways to analyze health plan financial results is by reviewing per member per month statistics. As mentioned previously, this allows apples to apples comparisons of plan financial information.

For example, it can be learned how much a health plan takes to the bottom line for each person it insures through this type of analysis. If the federal government pays a Medicare Advantage plan $800 a month to provide health benefits for seniors then how much profit does the plan make on each insured?

In United Healthcare's case, its quite a bit. United Healthcare's domestic health plan focuses on senior health insurance through its Medicare Advantage products. They reported a profit of $41 per member per month through September 30, 2011, down from $46 during the same time period in 2010. That profit level can be contrasted with SoundPath Health, a Medicare Advantage plan, and their profit of $1 per member per month or Arcadian Health Plan, another Medicare Advantage plan, and their loss of $1 per member per month.

United Healthcare seems to be able to consistently wrangle more profit though economies of scale, experience, efficiencies and provider contracting strategies than other plans. While certainly consistent with American capitalism, and our notion of what makes a successful company, it doesn't bode well with physicians facing Medicare reimbursement cuts or seniors facing Medicare Advantage premium increases.

David Peel is the Publisher and Editor of the Washington Healthcare News. He has held executive positions at several health care organizations throughout his twenty five year career. David can be reached at dpeel@wahcnews.com or 425-577-1334.

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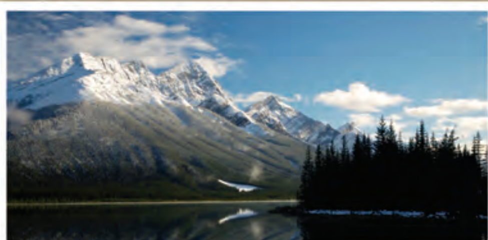

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Washington State Domestic Health Plan Financial Results[1]

For the Nine Months Ended 09/30/11 compared to the Nine Months Ended 09/30/10

Full Service Medical Plans Only - Sorted by Total Revenues - 000's Omitted[2]

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	Member Months[3]			Total Revenues			Net Underwriting Gain (Loss)[4]			Investment Gain (Loss) & Miscellaneous			Income Taxes[5]			Net Income (Loss)		
Health Plan Name	**09/11**	**09/10**	**Change**	**09/11**	**09/10**	**Change**	**09/11**	**09/10**	**Change**	**09/11**	**09/10**	**Change**	**09/11**	**09/10**	**Change**	**09/11**	**09/10**	**Change**
Dollars																		
Premera Blue Cross	5,996	5,109	887	1,871,952	1,780,529	91,423	80,158	48,773	31,385	39,696	49,085	-9,389	-20,640	-21,722	1,082	99,214	76,137	23,077
Regence BlueShield	5,605	6,285	-680	1,657,219	1,746,148	-88,929	-35,401	15,391	-50,792	47,977	49,537	-1,560	12,585	-7,626	20,211	25,160	57,303	-32,143
Group Health Cooperative	3,323	3,232	91	1,544,901	1,413,511	131,390	-53,751	-16,204	-37,547	40,391	17,362	23,029	0	0	0	-13,360	1,158	-14,518
Group Health Options	2,113	1,918	195	760,262	627,665	132,597	1,846	6,080	-4,234	3,781	2,041	1,740	-2,257	-3,208	951	3,371	4,914	-1,543
Molina Healthcare of WA	3,103	3,080	23	619,936	561,760	58,176	22,585	27,641	-5,056	876	873	3	-8,864	-9,755	891	14,596	18,759	-4,163
Community HP of WA	2,523	2,414	109	529,400	455,468	73,932	3,944	10,774	-6,830	2,206	4,165	-1,959	0	0	0	6,150	14,939	-8,789
UnitedHealthcare of WA	492	411	81	388,136	333,304	54,832	33,699	27,008	6,691	1,859	1,630	229	-15,426	-9,902	-5,524	20,132	18,736	1,396
Arcadian Health Plan	378	356	22	308,548	282,255	26,293	-4,216	5,256	-9,472	3,947	1,968	1,979	0	-2,285	2,285	-269	4,940	-5,209
LifeWise HP of WA	904	736	168	212,181	161,629	50,552	-5,260	5,639	-10,899	3,527	3,633	-106	515	-3,134	3,649	-1,218	6,138	-7,356
Asuris NW Health	697	742	-45	196,616	183,794	12,822	-217	7,064	-7,281	1,876	962	914	442	-2,310	2,752	2,100	5,716	-3,616
Columbia United Providers	537	409	128	103,066	77,001	26,065	4,823	3,887	936	91	177	-86	-1,614	-1,422	-192	3,300	2,642	658
KPS Health Plans	270	317	-47	94,889	112,598	-17,709	2,093	-2,524	4,617	-157	255	-412	-69	0	-69	1,866	-2,269	4,135
SoundPath Health	102	63	39	37,968	44,164	-6,196	-10	639	-649	62	118	-56	0	0	0	51	757	-706
Timber Prod. Mfg. Trust	108	127	-19	18,960	19,993	-1,033	1,843	-252	2,095	71	222	-151	0	0	0	1,914	-30	1,944
Per Member Per Month[6]																		
Premera Blue Cross	5,996	5,109	887	312	349	-36	13	10	4	7	10	-3	-3	-4	1	17	15	2
Regence BlueShield	5,605	6,285	-680	296	278	18	-6	2	-9	9	8	1	2	-1	3	4	9	-5
Group Health Cooperative	3,323	3,232	91	465	437	28	-16	-5	-11	12	5	7	0	0	0	-4	0	-4
Group Health Options	2,113	1,918	195	360	327	33	1	3	-2	2	1	1	-1	-2	1	2	3	-1
Molina Healthcare of WA	3,103	3,080	23	200	182	17	7	9	-2	0	0	0	-3	-3	0	5	6	-1
Community HP of WA	2,523	2,414	109	210	189	21	2	4	-3	1	2	-1	0	0	0	2	6	-4
UnitedHealthcare of WA	492	411	81	789	811	-22	68	66	3	4	4	0	-31	-24	-7	41	46	-5
Arcadian Health Plan	378	356	22	816	793	23	-11	15	-26	10	6	5	0	-6	6	-1	14	-15
LifeWise HP of WA	904	736	168	235	220	15	-6	8	-13	4	5	-1	1	-4	5	-1	8	-10
Asuris NW Health	697	742	-45	282	248	34	0	10	-10	3	1	1	1	-3	4	3	8	-5
Columbia United Providers	537	409	128	192	188	4	9	10	-1	0	0	0	-3	-3	0	6	6	0
KPS Health Plans	270	317	-47	351	355	-4	8	-8	16	-1	1	-1	0	0	0	7	-7	14
SoundPath Health	102	63	39	372	701	-329	0	10	-10	1	2	-1	0	0	0	1	12	-12
Timber Prod. Mfg. Trust	108	127	-19	176	157	18	17	-2	19	1	2	-1	0	0	0	18	0	18

Notes:

1. All information from the State of Washington, Office of Insurance Commissioner web site.
2. 000's omitted means the last three digits of each figure is removed. For example, the number 1,000 becomes 1.
3. Member Months is the combined total of each month's ending membership. For example, to get Member Months through 09/11, monthly membership for January through September is added together to get a combined total.
4. Net Underwriting Gain (Loss) is Net Income prior to Income taxes, Investment Gains and Losses and Miscellaneous revenues and expenses. It is a thought to be an accurate measure of the adequacy of premium revenue and can be a good predictor of future premium increases or decreases.
5. A negative Income Taxes number means it was an expense.
6. Per Member Per Month is any of the financial figures divided by Member Months for the particular plan. For example, Premera Blue Cross Total Revenues at 09/11 of 1,871,952 divided by Member Months of 5,996 equals a Per Member Per Month Total Revenue figure of 312.

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Critical Thinking in a Didactic World

By Teresa Pritchard
Vice President, Employee Services
Yakima Valley Memorial Hospital

Wouldn't it be great if all we needed to do in healthcare was follow protocol, process, and procedures? I'd love a world that was only black and white—in the form of checklists and algorithms. But that certainly isn't the reality--particularly in an industry where changes are happening at an increasingly rapid pace.

Even if you think that the Department of Labor, the EEOC, WACs and RCWs dictate what you do as an employer, that's only part of it. We as employers and managers need to think not only about how we implement policies, but why it is important. This is essential when explaining guidelines to employees, or when orienting new managers. Explaining why a policy or a standard is crucial takes critical thinking, and connects an individual's responsibilities to the organizational strategy built on its mission, vision and values. The why therefore becomes the essence—particularly when change imperatives are upon us.

When people ask human resources if a particular action or practice is "legal", they may be looking for the yes or no answer, or the black or white answer. As a longtime HR professional, I can attest that most HR professionals actually spend most of their time navigating in the "gray zone". The organization relies on this type of critical thinking to ensure a less chaotic, more consistent and constructive workplace culture. It's essential that executive leadership and management exercise critical thinking every minute of every day. I certainly find this to be true at Yakima Valley Memorial Hospital. Our most effective leaders navigate challenges and opportunities and count on their team members to demonstrate critical thinking no matter their position.

The Studer Group®, a trail blazer in developing strategies for achieving and sustaining exceptional clinical and operational outcomes, employs the AIDET© model: Acknowledge, Introduce, Duration, Explain and Thank you. When AIDET is present, it's been consistently proven that, "Patient perception of care is higher and quality clinical outcomes are more likely." I believe AIDET can also be an effective tool for employees. A model which ensures that an employee thoroughly understands exactly what is expected of them, and why. AIDET provides the critical picture of how their individual work not only directly affects patients and their families, but also can connect them to their co-workers throughout the organization. The understanding of the connection in turn produces an engaged workforce—a workforce fully cognizant of its mission, vision and values.

People often make the mistake of surrounding themselves with people who may think similarly. It's easier that way, isn't it? There's certainly less conflict. However, easier isn't always better and less critical thinking may result. The September 2011 issue of the Harvard Business Review focused on "Embracing Complexity". Gokce Sargut and Rita Gunther McGrath, authors of a fascinating article, Learning to Live with Complexity argue the difference between a complicated world and a complex world. "Complicated systems are

like machines; above all, you need to minimize friction. Complex systems are organic; you need to make sure your organization contains enough diverse thinkers to deal with the changes and variations that will inevitably occur." In a companion article, Embracing Complexity, Micheal J. Mauboussin makes a similar observation: "We try to put smart people on our teams. But we don't think enough about how much diversity can contribute. The key is to find smart people who think differently."

The lesson? We mustn't forget about diverse front-line employees and the role they play within the organization. Especially during this critical time when healthcare is transforming and care delivery systems are changing. One strategy Memorial offers its employees is a three day "Living Leadership" workshop. We introduce del Bueno's model which equally balances Interpersonal Relationships and Operational/Technical skills with Critical Thinking. Each is necessary for individual and organizational success. Often the most difficult to nurture is critical thinking. We witness people hired or promoted because of their solid technical skills in a particular area of expertise. And the mastery of a didactic learning environment doesn't always ensure success. We know the best care givers, providers and enablers are those which possess a balance in the three areas.

Whether your current challenge is ARRA, CMS, EHR, PPACA, P4P or any other healthcare acronym, I believe that as our healthcare industry becomes more complex, we cannot afford to lose sight of the important balance between inherent skills and knowledge, and the didactic nature of clinical learning models and critical thought. Our world is not going to get easier—the boundaries between black and white will blur. Don't allow reform, a law or enactment to take away your ability to navigate in the gray zone. Put that on your checklist.

Teresa Pritchard is the Vice President, Employee Services of Yakima Valley Memorial Hospital in Yakima, WA.

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Instant Medication Dispensing is Now Available to Patients Before They Leave the Physician Office

By Gloria Calderon
Vice President of Clinic Operations
Molina Medical

Imagine this very common scenario: A child becomes ill and needs to see a doctor. A parent drives him or her to the doctor's office. The doctor examines the child and assures the parent they will be fine after a course of antibiotics. With prescription in hand, mom or dad gets in the car again to make their way to the drug store where there is a significant wait. By the time the sick child makes it home and is able to take the medicine they need to feel better, it has been hours.

Patients Using the Automated Medical Dispensing Equipment

Now imagine a different story. In this story, parents avoid the drive and subsequent wait at the drug store. Instead, they walk out of the doctor's office with the medication their child needs. No long drive to the drug store with a sick child. No long lines. No waiting for the medication.

At Molina Medical, our patients don't need to imagine anymore. In order to provide just this type of convenient access to prescription medications, Molina Medical is now offering patients instant medication fills before they leave the physician's office. A partnership with InstyMeds has enabled Molina to be the first medical group in the country to offer fully automated prescription drug services to Medicaid managed care patients.

Onsite prescription services are rarely available in single or solo physician practices. Even for commercial insurance patients this type of benefit is rare. Patients normally would only have access to instant medications in a pharmacy as part of a larger medical complex setting. When you or your children are ill, the last thing you want to think about is finding a pharmacy to fill a prescription.

In order to access the new program, Molina patients arrive for their physician appointment and are registered into the medication system where a sticker is affixed to their card. If the physician decides that the patient needs medicine for an acute condition, the physician is able to electronically

prescribe it and check for drug interactions. The patient is given a voucher with a unique security code and before the patient leaves the medical office, the robotic machine performs a triple bar code safety check, labels the drug, and dispenses the prescribed medication from the ATM-style machine for the patient.

Studies show that between 20-30% of prescriptions that physicians write go unfilled. The new system increases the likelihood that the patient will fill their prescription and undergo the physician's medical treatment plan. In a recent New England Journal of Medicine study, researchers reported that patients who fail to take their drugs result in hospital stays costing $100 billion a year – hospital stays that could have been averted.

A large portion of our physicians' time is spent educating the patient about an illness or disease and about the consequences of not taking prescribed medications. The new medication system will mean better patient compliance. In addition, our low income patients sometimes have difficulty finding reliable transportation to the pharmacy. Now, getting their medications here is easy and convenient. It will mean getting the first dose sooner and quicker improvement.

Molina has installed medication dispensers in its South Everett clinic in Washington state and in other clinics across the country. And over the next several months, Molina hopes to offer this option to cash patients too. The service is only available to Molina Healthcare of Washington members now and only covers medications for acute conditions.

Gloria Calderon is responsible for strengthening and growing the Molina Healthcare-owned and operated primary care clinics. She was with Molina Healthcare from 1989 to 1998 where in addition to working on the clinic development, she also was the director of provider services and contracting for the California health plan and assisted in the development of the Utah and Michigan health plans. She left Molina for a period to join Pacific Hospital in Long Beach. Before returning to Molina, Calderon held several positions at the hospital including vice president of contracting and clinic operations, chief operating officer of West Coast surgery centers, chief operations officer of Pacific Specialty Physician Management and vice president of business development.

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Project Access - a Local Solution

By Sallie Neillie
Executive Director and Founder
Project Access Northwest

Access to necessary health care is something many of us take for granted. We get sick - we go to the doctor. Tests are run, procedures are ordered and medications are prescribed. We get the care we need. However, over 835,000 uninsured Washington State residents don't have this option when they become ill. Community health clinics and other safety net clinics do an amazing job of meeting the primary care needs of low income patients, regardless of their insurance status. If a patient has a health care need beyond primary care, the uninsured patient faces many challenges in getting appropriate, timely and cost effective care.

Physicians and health system leaders in seven Washington counties have stepped forward to address this problem with an innovative program called Project Access which builds on the compassion of licensed clinicians and the health systems with which they work. This model makes good business sense. Project Access collaborates with physicians and health system leaders to build a distributed network of charity care. Project Access partners assume that if everyone does a little bit, and contributes what he/she does best, local communities can dramatically change the picture of access to needed health care services for our low income neighbors.

Based on a model initially developed in Asheville, North Carolina, the seven Washington State Project Accesses have common guiding principles, yet each is reflective of their local community's needs.

The Guiding Principles that are the foundation of each Project Access include:

- Health care for the uninsured will be organized and timely
- Physicians commit to participating, and each determines how many patients they will serve in a given time period
- Other services a physician needs will be organized and donated as well
- Patients will show up on time for their appointments and follow their physician's treatment plan – the local Project Access will help the patient understand his/her responsibility in being a good patient
- The local effort must be responsive to the physician's concerns
- Everyone does what they do best – laboratories, imaging centers, ambulatory centers, hospitals and a host of other critical partners support the physician's commitment and provide donated services that the physician needs to treat the patient
- Everyone does their fair share
- Project Access celebrates and recognizes the physician and health care delivery system's generosity

While a network of donated care isn't the long-term solution for the health care system's shortfalls, Project Accesses provide care to patients who can't wait for health care reform – in whatever form it ends up taking.

Project Accesses have been able

Please see> Access, P14

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Special to our Readers from the California Healthcare News (cahcnews.com)

Infection Prevention Goals Build Culture of Safety at Adventist's White Memorial Medical Center

By Nora Haile
Contributing Editor
Healthcare News

White Memorial Medical Center, a member of Adventist Health's not-for-profit, faith-based health system, has had notable success with safety initiatives. One of many California Hospitals that have taken on quality improvement measures focused on patient safety, the Los Angeles center uses a model adopted in 2008 from that of the Johns Hopkins Culture of Safety model. As part of that standard, White Memorial's hospital governing board established a subcommittee called "Clinical Quality and Patient Safety" which examines patient safety and clinical outcomes on a monthly basis, keeping everyone on their toes.

One of the safety and prevention initiatives White Memorial chose to tackle was the prevention of pressure ulcers (commonly known as bedsores). The painful condition, where tissue dies due to pressure against the skin, decreasing blood flow, can lead to serious complications such as sepsis, cellulitis, bone and joint infections, or even an aggressive form of cancer requiring surgical treatment. According to Lynne Whaley, White Memorial's CNO, "We joined CALNOC (Collaborative Alliance for Nursing Outcomes) in 2006, and began comparing our standing to their data. We realized we weren't stellar around pressure ulcer prevention." So began their corrective course.

"We went off-site for a full day of Lean work on pressure ulcers."

Lynne Whaley, CNO
White Memorial Medical Center

Though initial efforts brought some improvements, the traction wasn't there. Then came the light bulb. "We went to an IHI Conference," said Whaley. "There was a track particular to skin care and patient safety, with research around skin as an organ." The White Memorial and Adventist Health attendees took the information back and worked it into a plan, then scheduled a team retreat. "We went off-site for a full day of Lean work on pressure ulcers – representatives from nursing staff, physicians, Board and executive leadership – all came together with this specific prevention in mind." The team developed action plans that day and returned to engage the other caregivers as they implemented the plans.

Gloria Bancarz, CNO for Adventist Health Corporation, talked about the experience, "We realized that we needed to focus on this as a health system. White Memorial and several other facilities had done so individually. We decided that as a collaborative group we could more effectively assist each other in the prevention process." Each facility identified a point person, or Wound Care Champion. Working together, the facilities developed standards and policies. Through the corporate IT department, they

built in screening tools, including a risk assessment based on the Braden Skin Assessment Scale, a nationally known, evidence-based assessment. An all-facilities mattress fair looked at appropriate mattresses and proper overlays for various levels of care and at-risk patients. As the new practices were implemented, the system's hospitals shared which initiatives worked, discovering obstacles together and sharing lessons learned. The network made significant safety strides, as Bancarz related, "Within a two-year period, we saw a 65% improvement in our rate. Engagement across the system and within the staff built that success."

Accolades are much deserved. White Memorial and the larger Adventist Health organization have changed the way every medical team member looks at a wound. Treating the skin as an organ means understanding how it is affected by nutrition, hydration, treatment, hygiene – and realizing how much depends on correctly recognizing risk at the outset. "We have nurses who are wound care specialists," said Whaley. "So if the admitting nurse conducting the Stage assessment sees anomalies or is unsure at what level to Stage

"We realized that we needed to focus on this as a health system"

Gloria Bancarz, CNO
Adventist Health Corporation

the patient, they have an expert to go to for those complexities." Then there's the Wound Care Committee, made up of physicians from all areas. They look at every skin care issue and work the prevention program to keep patients safe. Plus, the technology tools provide constant feedback, as Whaley points out, "We know right away if we're tracking to success or not, thanks to real-time data."

"Our infection prevention achievements are team triumphs," added Bancarz. "The physicians make sure the evidence-based orders on their side link with what's happening on the nursing side." That includes other safety and infection prevention programs, such as central line infection prevention, ventilator associated pneumonia and catheter related UTIs – all of which the Adventist and White Memorial have addressed successfully.

And always, the teams focus on the positive outcomes. At White Memorial, where the outcomes include an 85% reduction in pressure ulcers since 2009, there's good cause. In 2008, the Southern California Patient Safety Collab-

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Time to bring in outside help?

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< **Access, from P10**

to work with patients and health care systems to use limited and valuable charity care effectively and efficiently. As there are no dollars changing hands, Project Accesses have had the opportunity to effect change without consideration of impacting a revenue source for any of our partners. Our goal is to assure that needed labs, imaging and other pre-visit work-up information is available at the time of the initial exam. As an example, Project Access Northwest (serving King and Snohomish counties) interviewed multiple specialists in our highest demand specialties. Through this process, we determined that the community standard of obtaining an MRI for a patient with a problematic knee doesn't meet the need of the orthopedic physician. Weight bearing, plain films are preferred by the physician to make an appropriate diagnosis and provide treatment – and this type of imaging is much less expensive. Not doing unnecessary MRIs created tremendous savings to hospitals that were absorbing the cost of these tests.

Project Accesses are also providing a learning lab for some of the challenges facing all health care systems; using physicians' time effectively, assuring appropriate utilization and managing transitions of care. The typical low income uninsured patient population has a no-show rate of 30% - close to 1/3 of the time, a patient does not show up for a scheduled appointment. Not only does the patient forgo necessary care, the appointment slot goes unused wasting the provider's time, the office's time and potentially turning away a commercially insured patient. With the attention to case management and patient education related to a patient's responsibility in his/her health care, Project Accesses have a no-show rate that ranges from 1% – 6%. If a physician's practice is willing to donate time and services, it is critical that the appointed patient show up for the appointment.

Project Access makes sure all information is available to the treating clinician, supports the clinician by making necessary follow-up appointments, scheduling procedures, providing interpreters as needed and seeing that documentation on treatment rendered is available to the initial referring clinician. This reduces the burden of uncompensated care on the hospital systems, decreases the amount of charity care that gets mistakenly charged to bad debt and makes it easy for the physician or other local clinicians to provide a discrete amount of charity care in the comfort of his or her own practice.

Project Access was first introduced in Washington State in Spokane, under the auspices of the Spokane County Medical Society. Since then, other Project Accesses have opened in Whatcom, Thurston, Clark, Pierce, King and Snohomish counties. Each has a structure that makes sense in the particular community, either as part of a local medical society, an independent 501(c)3 or a department in a social service non-profit. Combined, over 2,000 physicians or other licensed clinicians have committed to participating in their local Project Access. By year end 2010 (the year of the most recent data), these dedicated clinicians donated close to one hundred million dollars in care for the low income uninsured in our state. While it may not seem like much for our physicians, hospitals, labs, imaging centers and a myriad of other partners to see one or two new patients per month, thanks to the number of partners that have stepped forward, Project Access is making a huge difference in the health of our local communities.

Sallie Neillie is the Executive Director and Founder of Project Access Northwest which was founded in early 2006 with the help and support of a committed group of individuals. Since its inception, Project Access Northwest has served approximately 12,000 patients from all over King County – and beginning in late 2010, Snohomish County. The specialty care services they received are valued at over $30 million dollars. Sallie can be reached at sallien@projectaccessnw.org or 206-788-4204. The organization's web-site is www.projectaccessnw.org and contains contact information for all the Project Accesses in Washington State.

< **Prevention, from P13**

orative recognized them for completely eliminating severe (Stage 3 and 4) bedsores. Then in a 2008 on-site, unannounced accreditation survey, the Joint Commission granted the Gold Seal of Approval. "We celebrate the successes," Whaley said. "For our patients and families, and the good nursing care they've been given. It's a constant journey."

Nora Haile can be reached at nhaile@healthcarenewssite.com.

Career Opportunities

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Medical Director

(Bellingham, WA)

Interfaith CHC is a private, non-profit, federally qualified health center that has been proudly and successfully serving the greater Bellingham area since 1982. We offer primary care medical, behavioral health, dental, and pharmacy services at 3 locations in Whatcom County where we assure access to high quality, affordable health care for all.

Our main site is located in beautiful downtown Bellingham, which is consistently rated as one of the most desirable communities to live in the United States. It's a popular university & retirement community nestled on Bellingham Bay at the foot of the Cascade Mountains that's just a short distance from Seattle, Vancouver BC, and the San Juan Islands. This area offers mountains, lakes, Puget Sound, skiing, snow boarding, fishing, hiking, sailing, biking, kayaking, and more.

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(Hermiston, OR)

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B. Experience. Required: Charge nurse or supervisory experience. Desired: Previous manager experience.

C. Licenses, Certificates. Required: Current RN license in the State of Oregon, ACLS, PALS. Desired: Certification in specialty area preferred.

Compensation: Compensation for this salaried exempt position is based on experience with a salary range from $85,000 to $116,000 per year plus benefits including: medical insurance, dental insurance, Vision insurance, Life insurance, Disability insurance, Liability insurance, Pension, paid vacation, holiday and sick leave. Other benefits include discounts and paid continuing education.

For more information please contact and send resume to:

Kelly Sanders
VP Human Resources
Good Shepherd Medical Center
610 NW Eleventh
Hermiston, OR 97838
(541) 667-3413
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(Brewster, WA)

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Interested Candidates may apply in person or by mailing their resume to:

Okanogan Douglas District Hospital
Anita Fisk, Director of Human Resources
PO Box 577
Brewster, WA 98812
(509) 689-2517 x 3343

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Send resume to: **afisk@oddh.org**
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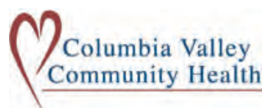

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(Wenatchee, WA)

Columbia Valley Community Health (CVCH), in Wenatchee, WA, is seeking a Dental Director to provide leadership for all dental services at CVCH sites. This senior level position provides direct patient care and is responsible for all aspects of dental care delivery, regulatory compliance, quality, efficiency, and the supervision of all dental providers.

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To apply, contact Sarah Wilkinson, HR, @ 509-664-3587 or **swilkinson@cvch.org**

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(Beverly Hills, CA)

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