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ICD-10 Readiness and Adoption

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The Department of Health and Human Services has issued a final rule on HIPAA electronic standards that would replace ICD-9 code sets with the greatly expanded ICD-10 code sets for claims, remittance advice, eligibility inquiries, referral authorizations, and other transactions.

This shift, effective October 1, 2013, represents a major change for the health care industry and without a solid upfront strategy in place prior to implementation, health care organizations could fall behind.

With ICD-10, all systems, tools, and interfaces—responsible for submitting claims, receiving remittances, exchanging claim status, or conducting eligibility inquiries and responses—must be analyzed to identify software and business process impacts.

Health care organizations should take inventory of their current systems and underlying IT infrastructure to determine each application's life cycle phase and then map out transitions to other systems and subsequent reporting processes.

If your organization intends to upgrade and maintain its current systems, the software vendor should be contacted now to find out what a transition plan looks like. It's important to determine whether current software licenses include regulation updates, and if they do, when the vendor will upgrade the respective systems.

Many health care organizations utilize systems that have been highly customized or have been developed internally from scratch. Customized systems may not have a simple upgrade path available.

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

Letter from the Publisher and Editor

Dear Reader,

We ask our hard copy recipients to confirm their contact information a few times a year. We want to be sure we're mailing the Washington Healthcare News to the right person at the right address. We ask for feedback at the same time.

We went through this process in July and the feedback received told me we're meeting our reader's needs. In fact, quite a few of our readers asked how they could help the Washington Healthcare News be successful.

Although we publish an attractive print publication, most of our work and effort goes to maintaining content on our web site. Our web site has articles, job postings, a library, Washington healthcare related articles from most major news outlets, and other high quality content.

All this said, the best way to help the Washington Healthcare News is to ask your webmaster to place a link from your web site to our home page at http://www.wahcnews.com. This helps us with our search engine results and allows people to find us easier. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2011 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2011	Hospitals	December 1, 2010	December 27, 2010
February 2011	ASCs	January 4, 2011	January 24, 2011
March 2011	Hospitals	February 1, 2011	February 21, 2011
April 2011	Insurance	March 1, 2011	March 21, 2011
May 2011	Clinics	April 1, 2011	April 18, 2011
June 2011	Human Resources	May 2, 2011	May 23, 2011
July 2011	Hospitals	June 1, 2011	June 20, 2011
August 2011	Hospitals	July 5, 2011	July 18, 2011
September 2011	Clinics	August 1, 2011	August 22, 2011
October 2011	Human Resources	September 1, 2011	September 19, 2011
November 2011	Hospitals	October 3, 2011	October 24, 2011
December 2011	Clinics	November 1, 2011	November 21, 2011

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Internally developed software systems will require substantial reengineering of applications, underlying databases, reports, and system interfaces to support the new ICD-10 codes.

Data conversion is another key consideration for ICD-10 adoption. The Centers for Medicare & Medicaid Services and the Centers for Disease Control have created General Equivalence Mappings (GEM) to ensure that consistency in national data is maintained. GEMs will be updated annually, as will ICD-10-CM and ICD-10-PCS during the transition period prior to ICD-10 implementation. While coding individual claims, it's important to remember that GEMs are simply helpful tools for converting larger system databases to ICD-10-CM and ICD-10-PCS.

In addition to operational system and data conversion considerations, many organizations have extensive processes for meeting both internal and external reporting needs. A data warehouse often supports these processes, which can require an extensive effort to extract, transform, load, and format information that's aggregated across multiple systems. With ICD-10, the aggregation, processing, and reporting of historical and active information will need to be accounted for.

While many C-level hospital executives have recently sought process improvement initiatives, typically only large hospitals can afford the implementation costs of lean methodology. Organizations that can implement a robust business intelligence strategy are well positioned to take advantage of additional metrics that ICD-10 provides.

Many organizations have projects already underway to support their ICD-10 adoption program. Organizations need to assess their current program and make sure all underlying projects have been properly defined and are on track. In addition, all project dependencies should be clearly defined, and each project should have its own risk tracking process. Finally, it's crucial to proactively communicate with vendors, partners, and other external entities to align project timelines, process and system changes, and test plans.

It's important to remember that technology isn't the only ICD-10 challenge. Coders will need refreshed biomedical training that includes medical terminology, anatomy, physiology, pathophysiology, and pharmacology. This can be done through online or classroom instruction, or independent study.

Biomedical education can be divided into "body systems." For example, coders from the cath lab should cover cardiovascular and pulmonary topics in depth, but they could skip or skim obstetrics.

Whenever possible, facilities and providers should work together developing and delivering this education. By offering this education to the provider community, a facility will hopefully gain cooperation in clinical documentation improvement projects.

Once biomedical education is completed, ICD-10 education can begin in earnest. The American Health Information Management Association estimates it takes about 16 hours to learn the ICD-10-CM system and 40 hours for the ICD-10-PCS system.

Health care organizations face numerous technical challenges and considerations as they contemplate ICD-10 adoption. Since ICD-10 transition planning has now started, the following outline represents a suggested timeline to follow:

1. June 2011—Assess current systems and processes and develop an implementation plan and impact assessment.
2. June 2013—Upgrade, replace, and implement operational and reporting systems.
3. January 2013 through September 2013—Conduct pilot testing, "go live" preparation, and systems cut-over.
4. January 2013 through September 2013—Ensure staff has received appropriate ICD-10 education and, most importantly, hands-on practice with ICD-10 code application.
5. October 2013 through December 2014—Perform post-implementation follow-up.

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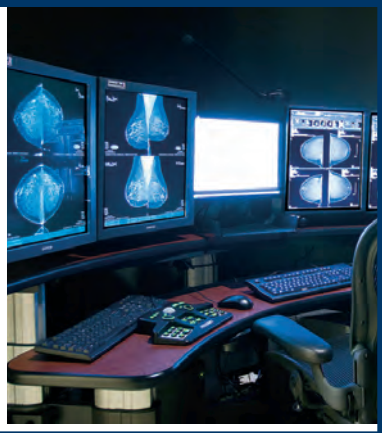

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Details and Bedevilment: New Data Validate Concerns & Raise More Questions About ACOs

By Anthony R. Miles
Partner
Stoel Rives LLP

New data available from both the Centers for Medicare and Medicaid Services (CMS)[i] and the Premier healthcare alliance[ii] offer health care providers their best opportunity yet to determine whether participating in an Accountable Care Organization (ACO) would be beneficial. While the theory of ACOs is that better care coordination and use of evidence-based practices by healthcare providers can both improve quality of and access to care for patients while generating substantial savings over current treatment and reimbursement practices, especially for high-cost patients, the new data suggest that more than the usual bedevilment is in the details of reimbursement for ACOs and that further refinement and flexibility than currently is in the models proposed by CMS will be necessary to realize this triple win and meaningfully reduce growth in the cost of care.

The initial model that CMS put forward this spring in its proposed regulations for the Medicare Shared Savings Program[iii] raised a number of questions and concerns for providers. For example, comments from the American Medical Group Association (AMGA) demonstrate that while the Shared Savings regulations resolved some issues (e.g., removing the restriction preventing physicians from participating in multiple ACO programs), many issues remain.[iv] Among the most significant of these are (1) retrospective attribution of patients; (2) increased administrative burden from reporting and care management requirements; and (3) insufficient rewards to support the investments.

Retrospective Attribution

Under the regulations, individuals will be assigned to ACO's after they have received care based on where they received the most primary care.[v] This means that primary care physicians will not know whose care they are responsible for managing until the end of the year. The Premier data suggest that organizations with high-cost patients can achieve greater savings with the prospective assignment approach under the Pioneer Program. Accordingly, the data indicate that by stipulating retrospective assignment of beneficiaries, the Shared Savings Program prevents the patient and physician from forming the care and care coordination contract necessary to effectively manage care. The absence of mutual accountability under the proposed regulations between the patient and his or her primary care physicians and among the various providers and practitioners of care undermines the potential for the Shared Savings Program to align interests among all parties to achieve lower utilization and higher quality in the delivery of healthcare services.

Administrative Burden

Reporting obligations and technology requirements necessitate too much investment given the

rewards to be realized under the Shared Savings Program. The proposed rules require ACO participants to make substantial investments in IT systems and internal processes to track data necessary to meet quality reporting requirements, implement evidence-based care and meet other administrative obligations, and also establish an unreasonably high confidence requirement for these data.[vi] Given the absence of ability to coordinate or manage care prospectively, variations among medical records associated with the assigned patients could vary substantially and potentially affect reimbursement significantly. For example, the Premier data assumes that an ACO meets all of the quality performance measurements but acknowledges doing so will be difficult for many organizations.

Insufficient Rewards

Caps on shares of savings and minimum thresholds make it unlikely that providers can realize sufficient return on investments to achieve and maintain ACO status within the Shared Savings Program. Under the Shared Savings Program, an ACO that does not elect to put itself at risk for losses in the first year of the program arrangement can only realize a 50% share of savings.[vii] An ACO that elects to take on downside risk in the first program year can achieve at most a 60% share.[viii] However, the Premier data suggest a 54% probability that the gain or loss could be higher or lower than the minimum threshold due to random fluctuations. Combined with the absence of advance assignment of patients, the existence of the proposed minimum savings requirement in proposed 42 CFR 425.7(c) creates a real possibility that ACO participants could see no share of savings at all from their care management activities. Further, by limiting their protections to the Medicare shared savings amounts, the proposed waivers from the enforcement agency are too narrow to be helpful. Commercial insureds play too large a role in the financial viability of medical providers and practitioners practices to be left out of the incentives for entering into these types of arrangements.

Following the Shared Savings Program proposed rules, the Centers for Medicare and Medicaid Innovation (CMMI) issued a request for applications for an alternative program based on ACOs (the "Pioneer Program") which provides for prospective assignment of patients and potentially increased

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Capella Health Teams with Rush Companies on Capital Medical Center Expansion Facility

By Nora Haile
Contributing Editor
Washington Healthcare News

Through a collaborative effort, the Rush Companies and Capella Health have created an expansion to the Capital Medical Center (CMC) in Olympia, WA. The 110-bed full-service hospital needed more room. "They were looking for space to house their Diagnostic Imaging Center and Outpatient Clinic, as well as a Wound Care Center," explained Gordon Rush, partner and CEO of Rush Companies. "Plus, the right size lot would give them enough area for future expansion." The perfect 5.3-acre site was right across the street from CMC on Capital Mall Drive, but there was a catch – Educational Service District 113 occupied and owned the property. "We were able to bridge the gap – approaching the ESD about possibly selling the property." Timing was excellent. While the ESD, which used the buildings as an administrative facility, was willing to sell, it needed a facility that was still optimally located for their constituency.

The ESD wanted an improved and upgraded structure, so as part of the process, Rush found a former manufacturing facility in Tumwater that met the space and location needs of the school district. Once the ESD approved their potential new home, Rush purchased and renovated the site, then sold it to the ESD. Part of the purchase price was trading the property next to the hospital. "It was very complicated, very multi-layered," said Rush. "There were a lot of legs in the transaction, but the success all stemmed from need. Each participant had specific needs, and we were able to bridge the gaps, bringing expertise and

Artist's Rendering of Capital Medical Center Expansion

capital to the table."

To renovate the former ESD location, Rush and North Pacific Design worked together as the project team. "We needed to maximize the space while also updating systems – mechanical, electrical and plumbing," said Rush. "To further the 'campus' feel, we used CMC's colors and finishes where possible." The one-story building was well-suited to its future function, mostly needing cosmetic touches, such as an updated exterior facade. All interior and exterior modifications will offer better aesthetics to the medical community. It also will mean better flow for both patient and staff. The facility setting, a lush, mature Pacific Northwest landscape complete with flowering cherry trees and rhododendrons, further enhance the location.

Capital Medical Center's expanded campus will feature ample parking (146 spaces), immediate access to the full service Capital Medical Center, and a thoroughly updated facility complete with the latest technology. The clinic's two buildings, connected by a glass breezeway, together total 31,000 square feet. CMC will use the front building's 15,552 sf to provide physician office space for current and future CMC physicians.

CMC's Chief Operating Officer, Dana Rice, described the layout, "CMC will develop 8,477 sf of the rear 15,552 sf building into a diagnostic imaging center that will include a 64 slice CT, 1.5 large bore MRI, x-ray, and ultrasound." The imaging center will allow CMC to separate outpatient studies from inpatient and emergency department studies. "It's a model for increased efficiency," she added.

In the remaining 2,006 sf of the new Outpatient Clinic, Thurston County will gain another Wound Care Center. "Typically, WCC patients have chronic, non-healing wounds," explained Rice. "And right now, the only other WCC is in Aberdeen, 45 miles west of us." A highly trained multi-disciplinary team of physicians and healthcare professionals will provide advanced wound care, which uses debridement, bioengineered tissue, therapy and hyperbaric oxygen therapy.

The new center will be operated as a department of the hospital. Slated to open in October 2011, it will be a great asset to the medical community and the surrounding area's residents, as well as to CMC. Through their collaboration with Rush, as Rice said, "In a single transaction, CMC will be

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rewards over the Shared Savings Program.[ix] Unlike the Shared Savings Program, the Pioneer Program contemplates that participating organizations will have similar arrangements with private payers and actually requires that such arrangements constitute 50% of the participating providers' reimbursement by the close of the second program year. Another difference is that the Pioneer Program offers opportunities for individual organizations to make proposals in their applications for alternative reimbursement structures focused on improving population health that may better address the context in which they deliver care. CMMI will use the proposals to create an alternative reimbursement methodology that an ACO can elect upon choosing to participate. It seems likely that CMS also will attempt to use this alternative reimbursement method to address the issues raised by geographic instability in cost-trends that the new data also demonstrate create disincentives for some providers to participate in the Shared Savings Program depending upon their location. The Premier data indicate that the Pioneer ACO methodology will work best for ACOs with more high-cost beneficiaries or those located in high-cost areas.

By establishing ACOs and providing for payers and providers to share in the savings they achieve, the CMS hopes that this concept will improve the overall health of populations, leading to a win-win-win for providers, patients and payers. The program options proposed by CMS ask much of providers in terms of administrative infrastructure, capital and data sharing but do not require patients to make any commitment. The financial data now available suggest that more refinement and flexibility in CMS's models of ACO reimbursement will be necessary to meaningfully advance healthcare quality and access while reducing growth in expenditures.

Tony Miles is a Partner at Stoel Rives LLP who focuses his healthcare practice at the intersection of healthcare regulation and technology. He counsels providers and other health industry players in corporate matters, strategic affiliations, technology development and services transactions, and data privacy and security issues involving health information technology. Contact Tony at 206.386.7577 or armiles@stoel.com.

[i] CMS has made data available for Medicare Shared Savings Program applicants to calculate shares of services in Primary Service Areas. See, https://www.cms.gov/sharedsavingsprogram/35_Calculations.asp#TopOfPage

[ii] The Premier healthcare alliance (Premier, Inc.), a performance improvement affiliation of 2,500 U.S. hospitals and 75,000 other healthcare sites, commissioned an analysis from Milliman on the risks and opportunities of five different models of ACO participation under the Shared Savings Program options and the Pioneer Program. See, Milliman, Inc. The Two Medicare ACO Programs: Medicare Shared Savings and Pioneer – Risk/Actuarial Differences (July 8, 2011). http://www.premierinc.com/about/news/11-jul/newanalysis072711.jsp.

[iii] 76 Fed. Reg. 19528 (April 7, 2011)

[iv] See Letter to D. Berwick, MD from D. Fischer, Ph.D regarding Medicare Shared Savings Program: Accountable Care Organizations, CMS-1345-P (dated June 6, 2011), available at http://www.amga.org/Advocacy/ACO/ACOCommentsFINALJune6.pdf (last visited August 3, 2011).

[v] See, Proposed 42 CFR 425.6.

[vi] Under proposed 42 CFR 425.10, a discrepancy of greater than 10 percent between reported quality data and audited medical records eliminates credit for the ACO with respect to the quality measure.

[vii] See, Proposed 42 C.F.R. 425.7.

[viii] Realizing 60% of savings may not be adequate incentive for the necessary investments for several reasons, not least of which is the risk that CMS will adjust benchmarks annually without factoring in the aging of the assigned patient population along with other factors.

[ix] See Center for Medicare & Medicaid Innovation, U.S. Dept. of Health & Hum. Serv., Pioneer ACO Model, available at http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/ (last visited August 3, 2011).

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able to significantly grow outpatient imaging services and expand service lines, while also improving both patient and physician satisfaction with the Diagnostic Imaging center and Outpatient clinic, and providing increased Medical Office Building space."

The significant part of the deal was bringing all the parties together within the timeline needed, making it work efficiently for the various needs, and accomplishing the objectives of all concerned. Not many companies have the breadth, depth of knowledge and resources to complete such a complex process successfully, but Rush had the expertise and the client-oriented service to create a winning result for all involved.

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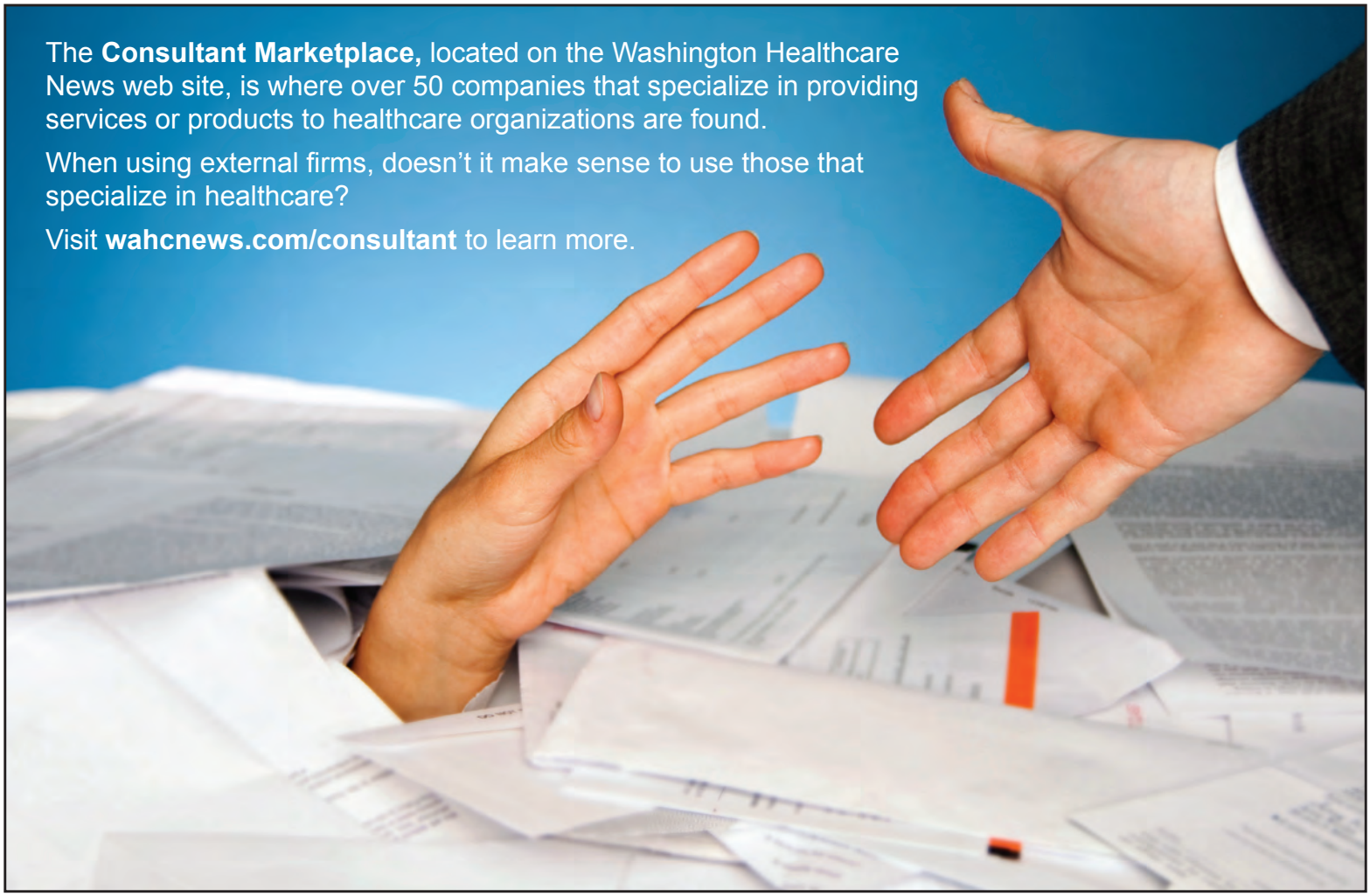

Creating a Patient/Family Centered Safety Culture

By Terri Wallin, RN, MHA
Owner,
Wallin Enterprises

It isn't uncommon to have the customer focus shift away from the patient. There are numerous business drivers that take our focus off the people we are trying to serve – rising costs of doing business, shrinking reimbursement and ultimately trying to do more with less. As healthcare leaders, every opportunity must be spent shifting the focus back to the reason for existing. Leadership drives culture change and having the leader unceasingly focused on the patient and family for experience and quality outcomes is the first step.

To achieve a culture that is safe and patient/family centered requires a purposeful plan that truly transforms the organization. The executive leader must embrace the effort, own the culture change and sanction the focus in everything they do. Every leader in the organization must align with the executive leader and embrace the goal. This requires acting differently, using every opportunity to model and talk about why reaching the goals is important. It must be clear to and from each leader that it isn't an option not to achieve a culture that is safe and patient centered.

Achieving this culture requires building a safe environment where staff can do their best work. Trust must be present for people to begin acting differently. Employees must feel safe. And it is up to leadership to create the safe environment. Everyone needs to know that if something happens they will be guided through to learn and change. Leaders must model this learning. As a leader, talk about relevant mistakes you make and what you learn and change as a result. When others watch and hear you are unharmed, they will more likely jump on board.

In order for managers and staff to engage, they must understand the compelling reason for the change. Data analysis is a foundational element – creating the driving force behind the change includes benchmarking – internally and externally with a picture of current and future state. Data should readily be shared – at the beginning and throughout the process of transformation. Expect that initially there will be disbelief and attempts to discredit data, but over time with consistency the objections to data will lessen. With the analysis, select measures and measure them throughout the change process and over time to ensure there is no backsliding and that the cultural expectations are well imbedded into daily work.

Management staff must be equipped to manage and lead the transformation in their areas of responsibility. It is imperative that each leader buy into the vision in order to engage. They need to lead by example and to be skilled at coaching, teaching, and mentoring staff. If managers aren't equipped, they can create an unsafe environment and the goal will not be reached. It is important for leaders to be self-reflective and model constant improvement. When I began to look inside me and change, change became easier for others.

Communication is critical throughout any transformational change. Even though the leader may believe people are tired of hearing the message, each person learns differently

and may hear over time what you have articulated months earlier. Communicate progress, bumps in the plan, stories of success with patients, and where the organization is in terms of meeting goals.

Seek informal leaders and engage staff in the planning and execution. Over time, they will influence their peers. The people who can't seem to get on board will over time stand-out and that is one more opportunity for management to address the issue by helping the person engage or move to another work place that might better fit them. I learned as a leader that everyone is watching and if unacceptable behavior that is disruptive and non-compliant is allowed the willing and enthusiastic players will lose hope. The role of leadership throughout transformation can't be overstated – it is the most critical part to success. Consistency, transparency and hopefulness will encourage staff to move forward.

Involving patients and/or family members in your plans can be highly effective. Patients and families need to be heard and have trust that the problem will be addressed and resolved.

Celebrate successes along the way – inter and intra-departmentally. Be public about progress and involve teams to identify celebration techniques.

How do you create and sustain a patient/family centered safety culture? It is achieved through leadership commitment and guidance. Cultures can and do change. Keep the focus – forever. Your business depends on it. People are the reason healthcare businesses exist.

Wallin Enterprises formed because of Terri's drive to help organizations succeed with culture and system transformation. With extensive experience in clinical, administrative and executive operations, Terri is highly skilled in leading system design. Terri is sought out by leaders to speak to and coach others on improved business and system/process implementation.

Terri serves on Homecare Association of Washington's board and is president elect. She is a member of Visiting Nurse Association of America.

She is a published author on articles related to quality and business outcomes as a result of system transformation changes and can be reached at tntwallin@comcast.net

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REGIONAL MEDICAL DIRECTOR

Longview, Washington

PeaceHealth is a nonprofit, mission and values-oriented regional healthcare delivery system with operations in Washington, Oregon, and Alaska. Our core values are: respect for individual dignity and worth, collaboration, stewardship, and social justice. In Longview, WA, PeaceHealth consists of a 200-bed Level III Trauma and Medical Center, and a growing 120+ multi-specialty practice PeaceHealth Medical Group(PHMG). This is an exciting time to join PeaceHealth!

This is a new position that will have both system level and regional leadership responsibilities focused on system-wide standards, strategies, and objectives for operational, financial, and clinical performance aligning PHMG mission, vision, values, and strategic goals with needs of patients and caregivers in local markets and communities. This position reports dually to the PHMG CEO and the Regional CEO.

Requirements: MD or DO and a minimum of 7 years experience in healthcare, with at least 3 years progressive leadership experience in a large multi-specialty medical group; experience implementing evidence based protocols into clinical practice in multi-site, multi-specialty medical groups, and integrated delivery system.

Apply online at: **www.peacehealth.org/careers**
Inquiries to: **dtroyer@peacehealth.org**

Forks Community Hospital

"Pioneers in Rural Health Care"

Chief Financial Officer/ Chief Operating Officer

(Forks, WA)

Forks Community Hospital is a Critical Access Hospital with a service area of 2200 square miles. We are located on the western edge of Washington, near the Olympic National Park and the Pacific Ocean. It rains a lot and the air is wonderful to breathe. And if you're stopped in traffic, you just wait for our light to turn green.

FCH seeks an experienced Chief Financial Officer/ Chief Operating Officer to provide administrative leadership and supervision of designated internal functions of the organization. This individual will direct departments and financial functions connected with overall Hospital operations. Position is also responsible for Hospital leadership in the Administrator/CEO's absence.

Requires at least ten (10) years financial/administrative leadership in healthcare (preferably rural). Bachelors Degree in Finance/Management field required. Master degree in related field is preferred.

To learn more and apply visit:

www.forkshospital.org/employment

Fresno Surgical Hospital

Clinical Nurse Educator

(Fresno, CA)

Job Summary: Responsible for developing, implementing conducting and evaluating inservice programs, orientation and continuing education for nurses, and other staff; establishes educational policies and procedures; acts as a resource person to staff and management; participates in CQI performance improvement activities; serves on special committees.

Job Roles:

Develops and directs orientation programs, inservices and continuing education for the nursing and auxiliary staff in multiple clinical departments. See additional job roles for this position on our web site.

Education and/or Experience:

Completion of an accredited nursing program. BSN required. MSN preferred. Five years of acute care experience preferred within the last 10 years in varied areas Medical Surgical, Orthopedics, Surgery, PACU, Preop, ER, ICU.

License and/or Certification:

Current California nursing license. BLS Certificate. ACLS Certificate preferred.

To learn more, see other requirements and apply visit

www.fresnosurgicalhospital.com

HMA Healthcare Management Administrators

Healthcare Sales Executive - Office Leader

(Portland, OR)

This position has a two-fold responsibility - Sales Executive and Office Leader of HMA's Portland office. The Sales Executive must demonstrate a consistent focus on achieving or surpassing sales goals, and be experienced building and executing tactical and strategy sales plans. He or She must show a passion for continuous improvement, and demonstrate personal motivation, energy, creativity and adaptability while pursuing goals. The Sales Executive will be expected to motivate others by communicating a compelling vision and translating that vision into clear, actionable goals and objectives. This position will work closely and collaboratively with several other departments within HMA. As the Office Leader, this position will have responsibility for the resolution of client issues for existing clients serviced out of our Portland office, whileunderstanding the need to escalate to Senior Management for advice when necessary. The Office Leader will drive the culture and achievement of corporate objectives in the Portland office, and will be responsible for ensuring that both customer needs and HMA operational requirements are met.

Successful Candidate will have: Bachelor's degree in Business Administration or an industry-related field or a combination of education and experience. 5 years experience working with TPA, carrier or broker agency. 2 years leadership or supervisory experience. Extensive knowledge of ERISA, Stop Loss, Self-Funded Benefits Plans, and underwriting of insurance products. OR State Agent's License, Life & Disability. Additional requirements apply.

Healthcare Management Administrators (HMA) believes in delivering superior value to our many self-funded Northwest clients by combining competitive rates with superior service. If you would like to learn more about our organization, please E-mail your resume, cover letter and salary history to: **recruiter@accesstpa.com** Faxed resumes are welcome at 305/574-0443. Be sure to visit our website at **www.accesshma.com**.

CMA California Medical Association

Research Associate

(Sacramento, CA)

The California Medical Association (CMA), a non-profit advocacy organization representing physicians and patients, is looking for a staff member for the policy and regulatory advocacy team. The ideal candidate will have a college degree (advanced degree in public health or public policy preferred) and background in health policy issues.

Reporting to the Vice President of Medical and Regulatory Policy, the Research Associate is responsible for research and advocacy on a range of health care issues, which may include public health, health care disparities, workforce diversity, pharmaceutical issues and scope of practice. The position also requires coordinating regulatory response and nominations processes, as well as providing staff support for physician committees. Candidate will have strong analytical ability, organizational skills, writing and communication skills.

Salary is dependent on experience. We offer a comprehensive benefits package.

To learn more about CMA, please visit our website at **www.cmanet.org**

Send resume, along with cover letter and writing sample to **hr@cmanet.org**

The California Medical Association is an equal opportunity employer.

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