Washington Healthcare News

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In Touch and Inspired – Health Care Facility Design has a New Face

By Nora Haile
Contributing Editor
Washington Healthcare News

Health care facilities traditionally haven't been places people look forward to visiting. But lately, things are changing. Chances are small touches like soft music or a trickling fountain have made a recent appointment, and waiting for it, more pleasant. Clinics and ambulatory surgery centers are designing with the patient in mind, replacing cold impersonal décor with color, textures and sound that speak to the senses, pleasantly. Interviews with leading northwest organizations that design, build, lease and sell health care facility space corroborated on nearly all points related to design trends and shared what they're noticing in the market.

On the building side, George Constantine of Constantine Builders, Inc. (CBI) says, "Doctors are focused on the patient experience." Over 70% of the company's business is health care related, building, remodeling or implementing tenant improvements for specialty and medical clinics. Constantine pointed to a recent project with Northwest Weight Loss Surgery located in Lynnwood as a prime example of patient-centric building design. "Dr. Kevin Montgomery and his team did it right. The team included Pat Paulson, a member at the time of the national board for ASC, who specializes in design consultation for ASC and weight loss clinics and practices." He notes the simple but meaningful features of 48" doorways, wider seats in reception, water features and natural design elements including a separate waiting area for pre-surgery. All details focus on the patient – aiming to make a personally tough, highly sensitive process a relaxing and supportive experience.

"Health care is taking its lead from the hospitality industry now," agrees Kent Gregory, Taylor, Gregory, Butterfield Architect's founding principal. The firm has an impressive portfolio of Acute Care, Medical Buildings, Clinics and Ambulatory Surgery Centers as pleased clients. "We're designing health care facilities that create a sense of flow, a sense of calm." If not, patients may go elsewhere.

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Inside This Issue

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LETTERS TO THE EDITOR

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 recently made a major effort to increase our distribution in the Northwest. During April and May we added 1,300 readers in Idaho, Oregon, Montana, Alaska and Washington. Our distribution now totals 5,959. Our reader demographics remain the same: health care leaders from the manager level through the "C" level.

There were several reasons we decided to substantially increase our distribution.

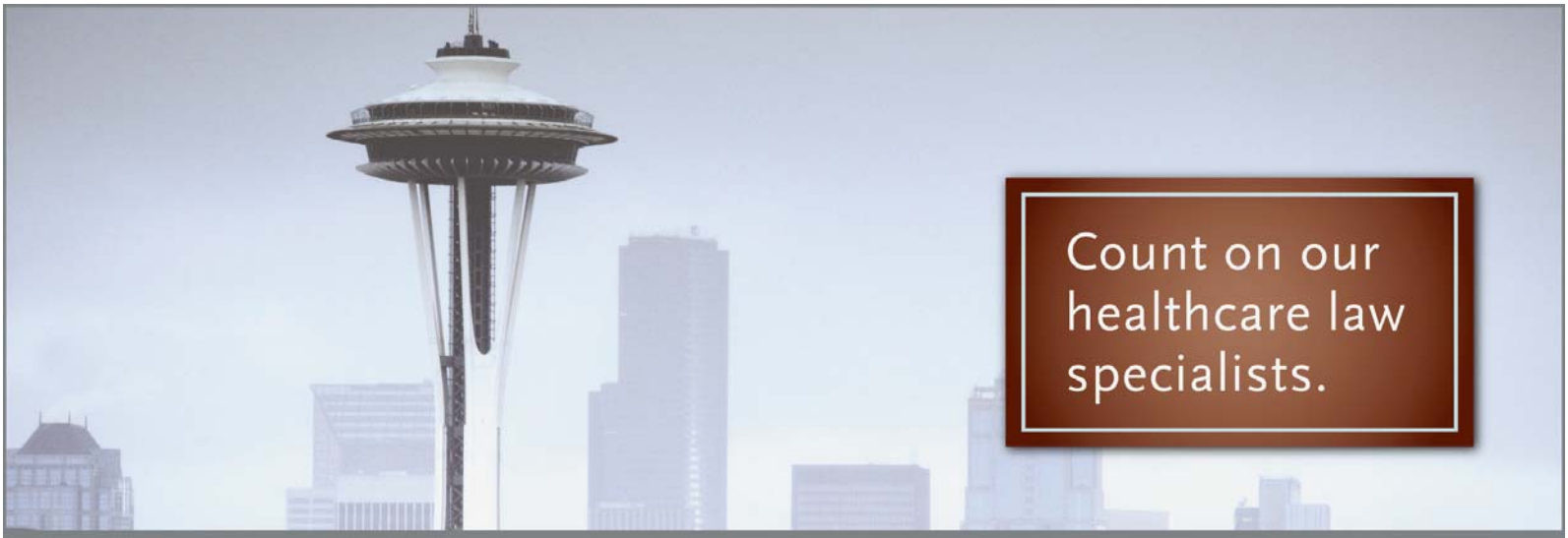
- Most of our editorial content transcends state boundaries. For example, this month's cover story on health care facility design should interest all people that own and/or manage facilities in the Northwest.
- The jobs we post on our web site and announce via e-mail require a high level of experience, education and training. Recruiters that post jobs with us should be able to reach the highest possible number of qualified candidates. Increasing our distribution, and number of qualified candidates, makes the News even more attractive as a recruiting resource.
- Most of our advertisers market to health care leaders in more than one northwest state. Advertisers receive better value when they can reach customers in multiple states through one source.

There's still room to grow and we'll do so as resources permit. We appreciate your support and hope you enjoy this issue.

David Peel, Publisher and Editor

Washington Healthcare News 2008 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2008	Healthcare Public Policy	December 3, 2007	December 21, 2007
February 2008	Urban Medical Clinics	January 7, 2008	January 25, 2008
March 2008	Rural Hospitals	February 4, 2008	February 22, 2008
April 2008	Insurance Carriers	March 3, 2008	March 21, 2008
May 2008	Healthcare IT	April 7, 2008	April 25, 2008
June 2008	Rural Medical Clinics	May 5, 2008	May 23, 2008
July 2008	Healthcare Facilities	June 2, 2008	June 22, 2008
August 2008	Healthcare Human Resources	July 7, 2008	July 25, 2008
September 2008	Community Health Centers	August 4, 2008	August 22, 2008
October 2008	Third Party Administrators	September 8, 2008	September 26, 2008
November 2008	Insurance Brokers and Agents	October 6, 2008	October 24, 2008
December 2008	Urban Hospitals	November 3, 2008	November 21, 2008



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In Touch and Inspired – Health Care Facility Design has a New Face

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"Providers have to market their business as never before. Patients are doing what all good consumers do, comparison shopping. Image, appeal, service, cost – all become points of evaluation." His theory is that even as early as five years ago, selecting a health care provider or primary care doctor was one of the few decisions where patients didn't necessarily take cost into consideration, because insurance covered care. That's changing quickly. As insurance costs climb, more costs are transferred to the patient and the patient becomes more critical in evaluating the overall experience.

The Rainier Orthopedic Surgery Building

Photo courtesy of Taylor, Gregory, Butterfield Architects

The positive patient experience is tied to "flow" as well, according to Gregory. He explains that the concept of flow takes space planning to a different level; for instance, placing staff and nursing stations at integral points in the facility to ensure smooth workflow as well as clear, directional patient pathways. Bringing people through a clinic effectively and efficiently makes the experience much more pleasant not only for patients, but the staff as well. "Health care is high stress and typically sees a high turnover. When a clinic takes into account staff comfort and efficient flow, everyone benefits."

Major players in the Northwest's clinic market see the benefits of welcoming, efficient facilities. Mark Lewinski, Partner and President/COO of Kirtley-Cole, has worked with the Everett Clinic, the Polyclinic and others. He mentioned a completed project for Proliance Surgeons. "Their orthopedic surgery center went for a warmer, welcoming feel in the reception and waiting areas – a model similar to hospitality reception areas." The Polyclinic, another project, used a cool, clean design for their waiting area.

"Patient comfort is paramount in current design," says Charlie Hampton, Vice President, Transaction Services Group of Grubb & Ellis. The sales and leasing of health care facilities often includes implementation of tenant improvements or build outs. While physicians continue to balance cost with function and design, Hampton has noticed that clients consider the overall patient psychology when they look at space. "The old 'hospital-like' feel isn't conducive to what today's doctors are trying to do with their offices now."

There's added emphasis on the senses of sight, sound and touch, as well. Gone (or going) are the old plastic laminate counters, white walls and carpet. It's generally accepted that carpet is unhealthy, so with hard surface floors prevailing, how sound carries from hallways to treatment rooms has come into play. With clients like Group Health and

The Reception Area of Northwest Weight Loss Surgery

Photo courtesy of Constantine Builders

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Swedish Hospital, CB Richard Ellis is the world's largest provider of real estate services to the health care industry. Paul Carr is First Vice President representing CB's local health care team. Mr. Carr remarked, "I recently toured Swedish's new orthopedic hospital that CBRE is building. The project manager made sure to point out acoustics, finishes and natural lighting. He talked about creature comforts you'd expect to hear on a high end hotel tour." Less institutional, more spa – it makes sense. If you feel good about your experience, you're more likely to go back.

And what about the environment? In the socially conscious Northwest, it's not far-fetched to expect a prevalence of green-building. But natural lighting and healthy airflow aside, the environment takes a back seat in most situations.

"The economic drivers and incentives aren't in place here yet," TGBA's Gregory states. While the firm is seeing more interest in green design and building, it isn't yet an established trend. Lewinski of Kirtley-Cole said from a clinic standpoint and the doctors in those areas, it doesn't seem to be a focus, and isn't as meaningful for patients. Add to that the estimate that "going green" can cost between 2% and 5% more than traditional construction costs if going for LEED certification due to tracking of paper and processes. With a multi-million dollar project, this can be a significant consideration.

That doesn't mean there's no market for sustainable building. Constantine, who has completed LEED certified projects, sees some clients leaning that direction – typically when working on a "ground up" project where they expect to be in a building for the duration. Then it can make economic sense. "It comes down to the client's objectives. For instance, we had a project where we used recycled denim jeans for insulation. The doctor wanted to make a commitment to sustainability."

CBRE's Carr comments that while there's some limit to how far you can take green concepts in a pre-existing building, high energy usage health care facilities are proactively searching for ways to be more energy efficient. Plus from a marketing standpoint, there's the perception that a green building is a healthy building.

What about location? Is what Carr termed "adjacency" – when the medical facility locates according to referral sources – important? Most of the parties interviewed agree that with the shift from primarily inpatient to the outpatient services, there's more development concentrated on the cross referral community of providers. Gregory asserts that building to encourage that community is a "big deal."

Hampton notices a move to suburban areas, with doctors thinking more like retailers, getting close to the patient base. He points out cost is always an issue, as well. "The onus is still on practitioners and hospitals to pay for improvements." With that consideration, adjacency makes sense not only from the patient-centric perspective, but also economically.

On the other hand, it may depend on the procedure, says Constantine. "If your doctor says you need to see a particular orthopedic surgeon because they're the best for your condition, then you'll probably make the trek, for the simple reason that you trust your doctor." People are willing to travel for certain services, particularly for specialist care, if they feel it's in their best interest. Once again, it comes back to the patient.

Clearly, the consumer/patient continues to drive health care trends. In this era of spa popularity and holistic health, it seems obvious that patients would respond to treatment better if comfortable and relaxed. With that awareness permeating health care to the level of facility design, maybe going to the doctor won't be so onerous. Perhaps patients will even be more likely to schedule those preventive care visits.

Nora Haile is a contributing editor to the Washington Health care News, as well as principal and owner of NHaile Solutions, LLC, a communications services firm in Seattle, WA. She can be reached at nora@nhaile.com.

Cost Segregation: A Common Cure for Your Bottom Line

By Robert L. Grannum, CPA
Tax Senior Manager
Moss Adams LLP

Two common challenges that many businesses face in the health care industry are income taxes and the significant investment required for funding facility needs. Whether you own assisted living facilities, occupy medical office space, or operate ambulatory surgery centers, a significant portion of your bottom line is likely tied to your real estate investment and income tax obligations.

One way to improve the economic health of your bottom line is to accelerate the manner in which you recover the investment in your facility costs for income tax purposes. Cost segregation is a tax savings strategy that has become widely accepted and used by many across the health care industry in recent years to cut taxes and boost cash flow.

What is cost segregation and what are the benefits?

Cost segregation is simply a tax deferral strategy. It's the practice of segregating the cost components of a building and improvements into the proper asset classifications and recovery periods for federal income tax purposes. The end result is significantly shorter tax lives (5-, 7-, 15-year), rather than the standard 39-year for commercial properties and 27.5-year for residential properties. Depreciation deductions are effectively frontloaded into the early years of ownership, pushing income tax liabilities out into the later years and thus significantly increasing current cash flows and allowing owners to take advantage of the time value of money.

The financial impact from a cost segregation study would look something like this: a long-term care provider constructed an assisted living facility for $5,000,000 in the current year and is looking for ways to optimize depreciation deductions to save on taxes and increase cash flow. A cost segregation study is conducted for the facility, resulting in $1,500,000 in depreciation deductions over the first 5 years of ownership. This is in comparison with $800,000 in depreciation that would have been deducted over this same time period using the standard 27.5-year depreciation rate for most assisted living facilities. The cost segregation study allows the owner to depreciate an additional $700,000 over the same 5-year period, a tax savings of $245,000. Considering the time value of money, the study provides the owner with a present-value savings of up to $160,000 over the life of this facility.

What about the physician group that spends $1,000,000 building out their new medical office space? Regardless of whether the group owns the building, a cost segregation study on these improvements would provide $450,000 of additional depreciation deductions in the first 5 years with a corresponding tax savings of over $150,000.

In both cases a cost segregation study can have a substantial economic impact on the bottom line. But what if the improvements in both cases were completed and placed into service in a prior tax year and a cost segregation study had never been completed? Fortunately, the tax law allows owners to retroactively "catch up" previously missed depreciation all in the current tax period, often resulting in significant cash flow impacts in the current tax year. The procedure for truing up these depreciation deductions is done through a change in accounting method, an administratively friendly process, allowing for changes to be made to fixed assets

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"Give Me a Break!"

By Stacey Mark, Chair
Labor and Employment Group
Ater Wynne LLP

Everyone knows that employees can skip meals and breaks if they want to, right? Wrong. Lots of employees know that employers must not only provide meal and break periods to hourly employees, but ensure that employees take them. They also know that if they don't take the required meals and breaks, they can sue their employer. Don't believe it, you say? Ask employers like Sutter Health, Legacy Good Samaritan, and Tenet Healthcare, as well as Wal-Mart, Starbucks, Ann Taylor, and the countless others who have been targeted for wage and hour class action lawsuits over the last few years.

Although there is no federal law that requires employers to provide mandatory meal and break periods, many state laws do, including Washington and Oregon. Both states require that all employees *take* a paid rest break of 10 minutes for every four hours of work. Employers are responsible for ensuring that employees take the required breaks.

Washington employers must also provide an unpaid meal period of at least 30 minutes to employees who work more than five hours. In Oregon, meal periods are required for employees working more than six hours. The number and timing of the meal periods depends on the duration of the shift. If the employee is required to remain on premises for the employer's benefit, is on-call, or is otherwise engaged in any work duties during the meal period, then the entire meal period must be paid and, in Washington, an uninterrupted meal period of 30 minutes must be provided. If worked meal and break time result in an employee's total hours exceeding 40 in one work week, the employee is also entitled to overtime pay. Employees in Washington may choose to waive meal periods, but the Washington Department of Labor recommends that employers get that waiver in writing. Oregon does not allow employees to waive meal periods unless they are employed as a server in a restaurant, receive and report tips, and meet other specific requirements.

Unfortunately, many employers are under the misperception that employees may choose to waive their meal and break periods or trade them for a late arrival, long lunch, or early departure. That mistake can be a costly one.

In Washington, an employer's violation of the meal and rest period requirements may result in criminal and civil liability. Violators are subject to criminal prosecution as a misdemeanor and a fine of up to $1000. In addition, employees have a private right of action for unpaid wages for meal and rest break violations -- ten minutes pay for each break and 30 minutes of pay for each meal period missed. If the violation is "willful," the employee may recover twice the amount of any unpaid wages, plus costs, and attorney's fees.

An Oregon employer who fails to ensure that its employees receive the required meal and break periods is subject to a claim for unpaid wages of 30 minutes for each missed meal period, a wage penalty of up to 30 days' pay (plus a second penalty of the same amount if the wages were not paid upon termination of employment), attorneys fees and costs, a civil penalty and a fine of up to $1,000 *per violation*. This means an employer could be subject to fine of up to $9,000 per day for each employee, depending on the length of the shift. When you multiply these damages by multiple employees, you wind up with the kind of case that can bankrupt a business.

Health care facilities are prime targets for class action wage and hour suits. Health care workers who are busy caring for patients may lose track of time or not be able to get away for breaks and

meals. Even if they manage to steal away, many remain on-call during the break or meal period, and it is not unusual for them to get paged. Those in charge of supervising the hourly employees are often too busy themselves to monitor employee activities, and many employers do not want to monitor their employees this closely.

What can employers do to protect themselves?

- Make sure there is adequate staffing to cover all required break and meal periods.
- Have a meal and break schedule.
- Have a written policy making meals and breaks mandatory for hourly employees that is communicated to all employees.
- If there isn't adequate supervision to ensure that employees are taking their required meals and breaks, require employees to clock in and out for meals and breaks, or require a signed daily record of their hours that includes meals and break periods.
- Discipline employees who fail to regularly take their meals and breaks.

If this sounds cumbersome, that's because it is. But it's better than the alternative.

Stacey Mark chairs both the Labor and Employment Group and the Sustainable Practice Advisory Group. She focuses her employment practice on developing strategies that enable employers to meet their legal obligations in ways that promote their overall business objectives.

Cost Segregation: A Common Cure for Your Bottom Line

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placed into service anytime after 1987, without the need for amending any prior tax returns. With the favorable rules and regulations currently available to taxpayers, it's often not too late to recoup those missed depreciation deductions.

Who performs cost segregation studies?

Although the benefits can be significant, the process is often complex, requiring the expertise of a qualified cost segregation provider. The IRS requires studies to be conducted by professionals with a thorough knowledge and understanding of the tax law, as well as in-depth experience in construction and engineering. These specialists work closely with the owners and the owners' tax accountants to ensure results are properly implemented and benefits fully realized.

Some additional benefits

The benefits of cost segregation can be enhanced dramatically when coupled with the favorable bonus depreciation provisions passed in the wake of 9/11, including 30% and 50% bonus depreciation and 15-year qualified leasehold improvement property. Most of these provisions expired at the end of 2004, but were recently resurrected with the Economic Stimulus Act of 2008. Taxpayers are again allowed to take a 50% bonus deduction on certain qualifying improvements in the first year. These provisions are set to expire at the end of 2008.

Most properties held for business use are eligible for cost segregation; however, the available benefits vary depending on the property type and an owner's particular tax situation. Many factors will need to be contemplated when considering whether a cost segregation study makes economic sense, including holding period, passive activity rules, like-kind exchanges, and recapture issues, among others.

Cost segregation continues to prove to be one of the most valuable tax savings strategies for owners of real estate and building improvements across the health care industry. So whether you acquired your skilled nursing facility 10 years ago or are in the midst of expanding your medical office space, cost segregation may be the perfect cure for improving your bottom line.

Robert L. Grannum is a licensed CPA and senior manager at Moss Adams LLP. He is chair of the firm's Cost Segregation Services Group and leads a team of tax and construction professionals providing cost segregation studies for clients across a number of industries in the Western States. For more information visit the website at www.mossadams.com.

Website Evolution for Generating More Business

By Matt McCormick
Web Developer/Principal
Barbarian Enterprises, LLC

It's time to take Charles Darwin's theory of evolution and apply it to your website. It's called A/B (or split) testing and it allows you to create a measurably better online presence. How does it work? You create two different versions of the same web page and let them compete against each other. You then let some fancy software watch the two pages and tell you which one is more fit for survival. Before we get started, there are a few terms you should know to understand this article:

- A/B Testing: A method of comparing two different versions of the same page to decide which is more effective. It's what this article is about.
- Google Analytics: A free product for analyzing a website's traffic. More info at: http://www.google.com/analytics
- Google Adwords: Google's pay-per-click online ad service. It also provides the main tool for running A/B tests. More info at: http://adwords.google.com
- Landing Page: The first page a user sees when they come to your website. This is frequently not your home page. And if you're using Google Adwords to drive traffic, it almost definitely shouldn't be your home page.
- Bounce Rate: The number of people that show up on your site, look at one page, and leave.
- Conversion: A measurable, desired action taken by a user on your website (buying something, signing up for a newsletter, etc).

To best understand the power of A/B testing, let's consider a real world example. One of my websites operates in a very small, niche market. At most this site gets a dozen hits a day. Fortunately, to end up on this site you almost certainly want the service being offered. But with so few visits, it's critical to get the most from each.

Using Google Analytics together with Google Adwords I was able to accurately measure the effectiveness of a commonly viewed page on the site. Here are the numbers from January 2008:

- Visits from Adwords: 357
- Bounce Rate: 56.31%
- Conversion Rate: 4.76%
- Cost / Conversion: $6.03

Starting in February, I created a second version of this page. It contained the same text but used a different layout, color scheme, and pictures. Using the Website Optimizer tool found on Google Adwords, I was able to setup a competition between this new page and the original. Approximately 50% of the people would see one version of the page and 50% would see the other version. Total time to setup this competition? Less than 30 minutes.

It took a month to declare a winner but the results were worth the wait. According to Google the new version showed a 251% improvement over the original! To be fair, the original was not a very good design but the results were still impressive. Obviously, I immediately replaced the original with the new version for all site visitors.

Here are the numbers for the month following the change:

- Visits from Adwords: 215 (ads were turned off for 1 week)
- Bounce Rate: 32.32%
- Conversion Rate: 9.30%
- Cost / Conversion: $2.90

As the numbers above show, taking the time to design an alternative page and then spending 30 minutes to setup the A/B test is completely worth the effort: Conversion rates doubled and cost/conversion were cut by more than half! Charles Darwin would be proud.

Matt McCormick is Principal of Barbarian Enterprises, LLC. The company specializes in building high quality web sites for small and medium sized businesses. Matt can be reached by at 206-406-5802.

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Using the '5 S' Technique to Improve Supply Chain Management

By Lynette Jones &
Desmond Scubi
Principals
Strategic Opportunity Solutions

At St. Joseph Medical Center in Tacoma, employee surveys showed growing dissatisfaction with the flow and organization of supplies. To delve into the problem, the hospital conducted a detailed employee survey around supply management and found that staff was spending increasingly more time searching for supplies. Many staff felt that the problem was delaying timely patient care. In Critical Care, timely patient care is paramount to success. As a result, the St. Joseph Critical Care Unit stepped up to the challenge of overhauling its supply organization.

A team was formed to investigate current processes and develop a solution. Two team champions were appointed: a staff nurse trained in process improvement, and the clinical supply support coordinator. Several senior-class nursing students from Pacific Lutheran University researched both nursing and business literature. Observation of existing supply areas demonstrated three causes: 1) no standardized, logical order for supply stocking; 2) like items were not grouped together; and 3) the actual storage of supplies was visually challenging.

To improve organizational efficiency and effectiveness, St. Joseph Medical Center had adopted the tenets of Lean, which is recognized by leading businesses as the optimal way for achieving production efficiency.

Since Lean is centered on the reduction of waste, it was the perfect approach for improving supply organization. The project team decided to utilize a specific technique from Lean called "5S" that involves sorting, simplifying, sweeping, standardizing and sustaining the work environment. The technique is foundational to organizational improvement. Without it, other types of improvements are very difficult to achieve and sustain.

Sorting is the removal of supplies that are not used; simplifying involves developing a logical system for categorizing supplies. While this sounds easy, there was considerable debate among staff since many items could be classified into more than one category.

In Lean, sweeping is defined as cleaning and/or the maintenance of the newly organized work environment. Staff members were assigned responsibility for this ongoing activity.

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Taylor Gregory Butterfield Announces Details of Cancer Center Expansion

Taylor Gregory Butterfield Architects recently announced details of the new Tri-Cities Cancer Center expansion in Kennewick, WA.

The expansion is the result of growing patient numbers and a growing community. Planners originally estimated the Center would treat 25 patients per day. However, last year an average of 41 radiation therapy patients were treated each day making the expansion critical and necessary.

The Center will feature expanded space to offer patients additional privacy during their treatments, increased comfort and an enhanced healing environment.

The addition will also allow for an expansion of the nurse case manager program, education programs, the beauty center and other programs to support the cancer treatment journey.

The expansion will include 25,087 square feet at a budget of $7 million. The Center is estimated to be completed in early 2009.

Funding will be provided through a loan. There will be naming and individual donation opportunities with all funds raised benefitting the Tri-Cities Cancer Center Foundation, supporting enhanced patient services, not construction costs.

Watercolor Portrait of the Tri-Cities Cancer Center

Illustration courtesy of Taylor Gregory Butterfield Architects

Taylor Gregory Butterfield Architects is a team of 33 design professionals whose talents are geared toward creating solutions for the complex needs of multi-faceted clients. TGB specializes in medical planning, health care design, church design and mixed-use projects, with a majority of the staff devoted to the area of health care projects.

TGB health care design work includes a wide spectrum of health care related projects, including community based hospitals, public district hospitals, medical office buildings, outpatient surgery centers, outpatient imaging centers and major medical institutions. The firm principals devoted to health care have over 50 years of experience in design and planning of complex medical projects. To learn more about the Tri-Cities Cancer Center expansion or Taylor Gregory Butterfield Architects contact Adora Maguire at 425-778-1530 or by e-mail at amaguire@TGBArchitects.com.

tgba | taylor gregory butterfield architects

Company Snapshot

Description	Company information
Key executives	Health Care Principals: Kent Gregory and Lois Broadway
Primary services	Architectural services for health care organizations
Service area	The Pacific Northwest
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Health Information Collaborative Requests Applications for 2008 Awards – $1 Million Dollars Available

The Washington Health Information Collaborative recently announced it was requesting applications from physician clinics and hospitals in Washington, Alaska, Idaho, and Oregon for awards of up to $20,000 each to support greater use of electronic medical record systems. Generally, preference will be given to smaller physician practices and hospitals. This is the third consecutive year that funds will be awarded by the Collaborative, a public-private partnership based in Seattle.

The awards are intended to promote enhanced patient safety and quality of care by helping doctors, other health practitioners and critical access hospitals transition away from old-fashioned, inefficient paper recordkeeping. Using electronic medical records and patient registry software within clinics and hospitals will benefit patients and providers. Examples include enabling doctors to instantly and securely access needed information in a patient's medical history. Such technology can also automatically send reminders and alerts to doctors and patients about preventive tests and other care important for effective management of chronic conditions like diabetes and heart disease. Clinics and hospitals also use such technology to look at aggregated data across all patients to improve overall quality and answer questions such as: "How consistently did we provide annual foot exams to our patients with diabetes?" or "What percentage of our female patients over 40 still need to get their annual mammogram?"

"The use of electronic medical record systems and other information technology has great potential for improving patient safety and the quality of care," First Choice Health Chief Medical Officer Ze'ev Young said in announcing the third annual awards program. "But the cost of these systems is too high for some health care providers, especially in smaller practices and in rural areas. We expect this program to grow, with additional employers and other purchasers, government agencies and others contributing to the improvement of our region's health technology infrastructure."

> ***"Inefficient paper recordkeeping in health care is wasteful and expensive, and adds to the cost of health care and to patient frustration."***
>
> Steve Hill
> Administrator
> Washington State
> Health Care Authority

Expanding the use of health information technology will reduce administrative duplication, while improving the patient experience. "Inefficient paper recordkeeping in health care is wasteful and expensive, and adds to the cost of health care and to patient frustration," said Steve Hill, administrator of the Washington State Health Care Authority.

The Washington Health Information Collaborative is sponsored by First Choice Health (www.fchn.com) and the Washington State Health Care Authority (www.hca.wa.gov), each of which provides $500,000 to the awards program, with consultative and administrative support from Qualis Health (www.qualishealth.org) and the Puget Sound Health Alliance (www.pugetsoundhealthalliance.org). This year, up to $200,000 of the Health Care Authority's funding is being reserved for larger grants of up to $50,000 to address Washington based community-wide provider engagement and connectivity efforts. Outside of Washington State, eligible applicants must be contracted participants in the First Choice Health Network. The mission of the Collaborative is to improve the quality of patient care through the use of health information technology.

Award recipients will be announced in October 2008. Inquiries and applications for funding are being accepted now and application information is available at www.WaHealthInfoCollaborative.org. The deadline for completed applications is July 31, 2008.

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How to Determine the Need for Physicians

By Sandy Champion, CMSR
President
The Champion Group, LLC

Hospitals and medical groups nationwide face significant challenges in physician recruitment and development. An adequate supply of physicians of all types is central to the overall health and stability of a health care delivery system and an issue of growing concern for many communities. Physicians are a hospital's most important asset in delivering patient care and protecting income. Physicians generate valuable revenue, provide outpatient and inpatient care, and are central to a successful planning and recruiting program.

Recruiting physicians has become increasingly difficult due to:

- The significant shortages in several key specialties including primary care, medical and surgical specialties.
- Older physicians becoming at risk for retiring.
- Declining reimbursement.
- Increasing malpractice costs.
- Physicians entering the workforce are making lifestyle choices including wanting more flexible hours, the stability of a large group rather than a solo practice, wanting to be employed, and having their education debt paid.
- Recent Federal regulations limiting a hospital's ability to offer financial assistance to medical groups that want to recruit additional physicians to their practice.

Hospitals and medical groups participating in physician recruitment must commit to more detailed analysis of physician need/demand for the communities they serve in order to ensure the "optimal number and type" of physicians/providers for the future.

Community-based physician need/demand analysis is a planning guide to meet your medical staff planning functions. There are a variety of physician demand measurements and market conditions that can impact the supply and demand for physicians. A comprehensive Community Physician Need/Demand Analysis (CPNDA) identifies current and forecasted need, gaps in various

specialties, additional succession needs and possible new growth opportunities within a given service area. The CPNDA is also an important input document as to a hospital's strategic plan.

When preparing a Community Physician Need Demand Analysis, it is recommended that a third party prepare the documentation in order to ensure an unbiased opinion. (IRS Private Letter Advisory Guideline to Auditors, 2001).

The analysis process must:

- Meet all Regulatory and Governmental Requirements and Guidelines
- Define and Profile the Service Area
- Profile the Medical Staff and Determine Physician and Provider Supply
- Determine Need/Demand by Specialty (Quantitative)
- Adjust for Market Factors Affecting Access (Qualitative). Because of the complicated challenges, hospitals and medical groups have to be more proactive by strategically planning for their current and future physician access to care.

Once your Community Physician Need/Demand Analysis is completed, it is then possible to identify specific needs. Based on the findings, you can launch a dedicated recruitment program and target key specialties. A successful physician recruitment program requires a highly professional and competitive process. Facilities that are not prepared to participate in physician recruiting are vulnerable and can experience dramatic shifts in market share to competitors.

Therefore, begin with a comprehensive Community Physician Need/Demand Analysis and Physician Development Plan, update the needs annually, and launch a professional and robust recruitment program.

Sandy Champion, CMSR, is president of The Champion Healthcare Consulting Group, LLC (The Champion Group), and provides comprehensive Community Physician Supply/ Demand Analysis and strategic planning services to hospitals and medical groups throughout the northwest and western regions. She can be reached at championgroup42@msn.com.

Our State Health Care System Needs Leadership and Vision

By Bill Hinkle
Washington State Senator
Eighth Legislative District

The average family health insurance policy has nearly tripled in cost since 2000. In that same time, nearly 200 health care-related bills have been passed by the Washington State Legislature.

This might lead one to conclude that Olympia is a bigger part of the problem than the solution.

One thing is clear: the current approach is not working. This includes a push toward a government-controlled health care system – a path leading to more costs and fewer choices for consumers.

As lead Republican on the House Health Care and Wellness Committee, my views stand in stark contrast to the status quo. I believe if we continue to address our health care problems the same way, we can expect the same poor results.

The 2008 legislative session was a hallmark example of the "business as usual" approach. Its biggest accomplishment was commissioning the state's 16th health care study since 2005.

It is time for more decisions and fewer commissions.

Our first problem is state leadership has no vision. A comprehensive health care system must have a vision based on guiding principles.

For example, our state should strive for a health care system with affordable coverage for everyone. People should be allowed to have health insurance policies that they own – not the government – and fit their specific needs. This means their coverage stays with them even if they change jobs.

Our second problem is the four primary groups central to the success of our health care system often distrust one another. These groups are the government, health care providers, insurers, and consumers – and they need to coalesce.

Our third problem is our health care system is not designed for 21st Century realities. We are not fully utilizing innovation and technology, or embracing the private sector. The entrenched bureaucracy in Olympia has resisted many of these necessary changes.

Finally, and most importantly, our state refuses to enact bold reforms. A lead House Democrat was quoted following the 2008 legislative session as saying: *"If you take too many bold steps, you'll no longer be in the majority."*

This is not leadership and underscores the need for change.

Olympia is not void of bold ideas – the majority party and governor simply refuse to take them off the shelf. I believe this is because they are married to a government-controlled health care system, and anything that deviates from this ultimate outcome is dismissed.

For example, I introduced health care legislation that would have provided assistance to the uninsured, small businesses and self-employed. House Bill 3384 would have provided a 50 percent business and occupation tax credit for the self-employed and reduced state mandates so those without health insurance could have access to affordable options.

The measure did not even receive a hearing.

Another piece of legislation, Senate Bill 6030, would have allowed insurance carriers to design plans to meet the specific needs of young adults ages 19 to 34. This group is generally healthy and represents 51 percent our state's uninsured.

The measure was not allowed to the Senate floor for a vote.

Again, there are bold ideas in Olympia – but they are being ignored. Here are some other solutions that would bring our health care system into the 21st Century:

- Increase access to health care cost and quality information so people can make the best decisions for themselves;
- Assist small employers and the self-employed with tax incentives on health insurance premiums (25 percent of uninsured adults);
- Increase access to Health Savings Accounts;
- Allow health policies that incentivize 19- to 34-year-olds to enter the market; and
- Reduce health insurance costs by limiting state mandates on policies.

We also need help at the federal level. Families would benefit greatly if their health care expenses could be tax deductible and if they could shop across state lines (portability) for health insurance. These concepts have met roadblocks in our nation's capital.

The bottom line is we must change from the mindset of "what is" to "what could be" for our health care system. This is going to require leadership and vision in Olympia.

Rep. Bill Hinkle, R-Cle Elum, serves as lead Republican on the House Health Care and Wellness Committee. He can be contacted at (360) 786-7808 or hinkle.bill@leg.wa.gov.

Opinions of Authors in this section do not necessarily reflect those of the Washington Healthcare News.

Using the '5 S' Technique to Improve Supply Chain Management

<Technique

From page 14

Standardizing means everyone is doing the work the same way.

This project used visual aids and other techniques to reinforce the new method in the work place. To achieve standardization and to aid visual identification of supplies, the project team developed a color-coding system for each supply type. A master color-coded list was attached to each supply cart and posted in supply rooms.

"Sustaining" involves organization-wide promotion of the new system and systematic evaluation of how the new system affects overall organizational performance. To sustain the new system, the hospital provides ongoing education to current staff and new hires. The contribution of the new system toward staff and patient satisfaction is being measured and monitored on an ongoing basis using the PDSA (Plan, Do, Study, Act) model.

St. Joseph has begun to realize a significant return on investment (ROI) from this project. Based on an employee survey, the Critical Care Unit calculated that the new system saved an average of 19 minutes per staff person for each 24-hour period. With 38 staff working on each 12-hour shift, 722 minutes are saved every 24 hours. Rolling out the system across the entire Franciscan organization could easily increase the ROI to millions of dollars, while simultaneously improving patient and staff satisfaction.

The project team must report the impact of the new system to the St. Joseph Lean Executive Steering Committee each quarter. The hospital plans to roll out the new system across the Franciscan Health System this year. In addition to St. Joseph, the Franciscan organization includes St. Clare Hospital in Lakewood, St. Francis Hospital in Federal Way; and Enumclaw Regional Hospital. St. Anthony Hospital, which will be the fifth acute-care hospital in the Franciscan Health System, opens in Gig Harbor in early 2009.

For more information about the project, contact St. Joseph Medical Center's performance improvement and compliance nurse, Alison Roberts, at alisonroberts@fhshealth.org.

Lynette Jones and Desmond Skubi are principals in the consulting firm Strategic Opportunity Solutions. Ms. Jones can be reached at lynettedjones@gmail.com and Mr. Skubi can be reached at dskubi@comcast.net.

New or Recently Promoted Health Care Leaders

First Name	Middle Name	Last Name	Title	Effective Date	Organization	New or Promoted Leader
Susan		Abolafya, RN	Manager, ACE Unit	04/08	Virginia Mason Medical Center	Promoted
Scott		Attridge	Chief Financial Officer	05/08	Ocean Beach Hospital	New
Karen		Anderson, MD, MPH	Medical Director	06/08	KPS Health Plans	New
Phillip		Baker	Chief Financial Officer	06/08	The Vancouver Clinic	New
Shelley		Brown	Office Manager	04/08	Urologic Consultants, P.C.	New
Elizabeth		Buckingham	Chief Executive Officer	06/08	Sophie Trettevick Indian Health Center	New
Maggie		Cable	VP of Operations	05/08	KPS Health Plans	New
Shari		Campbell	VP & Shareholder	04/08	JayRay, a Communications Consultancy	Promoted
James		Cannon, FACHE	ED, Health Information Program	02/08	Washington State Hospital Association	New
Tracy		Clark	Director of Pharmacy	04/08	Lourdes Health Network	Promoted
Mary		Clogston	Deputy Commissioner	04/08	WA State Office of the Insurance Commissioner	Promoted
Michelle		Curry	Director of Patient Care Services	03/08	Highline Medical Center	New
Joseph	A.	DiPalo	President & CEO	05/08	Ocean Beach Hospital	New
Jeremy		Evans	VP of Professional Services	05/08	Kootenai Health	New
Yuwei		Feng	Clinic Operations Director	03/08	International Community Health Services	Promoted
Roger	F.	Ferguson, JR	President and CEO	04/08	TIAA-CREF	New
Barbara		Flye	Health Care Advisor	01/07	WA State Office of the Insurance Commissioner	New
Toni		Fox-Corwin	Dir., Operations and Event Mgmt.	02/08	Washington State Hospital Association	New
Jaime		Garcia	ED, Health Work Force Institute	03/08	Washington State Hospital Association	New
Ginny		Gensler	Advertising and Events Manager	04/08	Valley Medical Center	New
Cindy		Hamming	Director of Surgical Services	03/08	United General Hospital	Promoted
Janet		Hanna	Director of Emergency Services	05/08	Kadlec Medical Center	New
Jim		Hicks	Director of Surgical Services	06/08	United General Hospital	New
Thom		Howson	Director, Human Resources	04/08	Presbyterian Retirement	New
Janelle		Jacobs	Quality Improvement Director	03/08	International Community Health Services	Promoted
Sue		Kent	System Vice President, HR	05/08	PeaceHealth	Promoted
Yogini		Kulkarni-Sharma	Director, Patient Safety Practices	03/08	Washington State Hospital Association	Promoted
Cheryl		Lee	Controller	03/08	International Community Health Service	Promoted
Amy		McElroy	Marketing and Web Manager	04/08	Valley Medical Center	New
Bentson	H.	McFarland, MD, PhD	EQRO Psychiatrist	06/08	Acumentra Health	New
Michael		McKee	Health Services Director	03/08	International Community Health Services	Promoted
Karen		Meek	Communications Manager	05/08	Physicians Insurance A Mutual Company	New
Lori		Moore	Inpatient Nurse Manager	04/08	Cascade Valley Hospital & Clinics	New
Indira		Paharia, MD	Asst. Dir. of Beh. Health & Wellness	05/08	Regence	New
Ken		Rudberg	Director, Clinical Analytics	04/08	Washington State Hospital Association	New
Rachel		Ruggeri	Chief Financial Officer	06/08	Presbyterian Retirement	New
Judy		Ruskell	Dir. of Comm. Outreach and Service	04/08	Virginia Mason Medical Center	New
Shelly		Schmucker, BSN	NW Regional Sales Manager	02/08	MED3000, Inc.	New
Michael		Soman, MD	President/Chief Medical Director	07/08	Group Health Permanente	Promoted
Vernon		Stoner	Chief Deputy	04/08	WA State Office of the Insurance Commissioner	New
Scott		Strandjord	Vice President of Finance	06/08	Northwest Kidney Centers	New
Llewellyn		Wynne	Director of Nursing	04/08	Highline West Seattle Mental Health	New
Beth		Zborowski	Director, Programs Communication	04/08	Washington State Hospital Association	New

Career Opportunities

Washington Healthcare News Expands to Alaska, Idaho and Montana

During April and May the Washington Healthcare News increased its distribution to northwest health care leaders and now totals 5,959. Much of the growth came from expansion in Alaska, Idaho and Montana.

David Peel, the Publisher of the News notes, "Most of our articles are of regional interest. For instance, we now publish regional financial information on plans and hospitals. We hope our new readers enjoy the publication as much as our current readers." The News is published monthly in Kirkland, Washington.

Career Opportunities

Next month in the News:

- *An interview with Kristen Fox, President of the Washington State Healthcare Human Resources Association*
- *A Healthcare Opinion article from Jonathan Ater, Partner of the health care law firm Ater Wynne, LLP and Vice-Chair of the Oregon Health Fund Board*
- *Our regular sections:*
  - *-Healthcare Law*
  - *-New or Recently Promoted Healthcare Leaders*
  - *-Career Opportunities*
  - *-Healthcare Agency*
  - *-Plan and Hospital Financial Statistics*

Plan and Hospital Financial Information

Financial Results for the 15 Largest Health Plans in the Pacific Northwest (Ranked by Total Revenues)[1]

Plan Name	State of Domicile	Total Revenues Qtr End 03-31-08	Net Income Qtr End 03-31-08	Statutory Capital As of 03-31-08	Enrollment As of 03-31-08
Regence BCBS of Oregon	Oregon	$664,297,147	$12,497,497	$548,550,374	1,011,613
Premera Blue Cross	Washington	$640,285,347	$17,391,917	$775,781,448	711,199
Group Health Cooperative	Washington	$587,664,637	$28,109,047	$726,108,841	397,763
Kaiser Foundation HP of the NW	Oregon	$582,850,617	$6,287,125	$499,062,450	471,903
Regence BlueShield	Washington	$568,759,264	$285,070	$888,050,920	822,735
Providence Health Plan	Oregon	$215,001,106	$2,891,546	$338,309,273	183,527
Molina Healthcare of Washington	Washington	$175,044,293	$8,318,143	$121,745,281	289,207
Blue Cross Blue Shield of Montana	Montana	$130,291,715	$1,111,145	$144,612,952	229,725
Community Health Plan of WA	Washington	$129,151,418	$1,422,070	$78,834,043	227,328
Regence BlueShield of Idaho	Idaho	$124,914,311	$931,619	$124,629,528	210,793
Pacificsource Health Plans	Oregon	$121,126,455	$785,151	$112,095,216	See note [1]
PacifiCare of Washington, Inc.	Washington	$117,194,761	$15,965,846	$244,986,575	45,835
Health Net Health Plan of Oregon	Oregon	$104,431,497	$1,575,659	$68,320,647	125,597
LifeWise Health Plan of Oregon	Oregon	$74,446,969	($2,740,257)	$67,511,870	105,236
Blue Cross of Idaho Health Service	Idaho	See note [1]	See note [1]	See note [1]	See note [1]

Financial Results for the 15 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]

Hospital Name	State	Total Charges CY 12-31-07	Total Margin CY 12-31-07	Total Discharges CY 12-31-07	Total Days CY 12-31-07
Swedish Medical Center-Seattle	Washington	$2,023,262,137	$101,027,578	34,208	143,492
Providence St. Vincent Medical Ctr.	Oregon	$1,190,848,000	$132,075,000	32,539	144,060
Sacred Heart Medical Ctr.-Spokane	Washington	$1,320,906,441	$69,153,314	29,503	149,640
OHSU Hospital	Oregon	$1,439,008,183	$39,511,642	27,744	144,235
Sacred Heart Medical Ctr.-Eugene	Oregon	$753,619,352	$51,346,157	26,036	114,067
Providence Everett Medical Center	Washington	$1,178,904,174	$30,321,510	24,674	100,545
Providence Portland Medical Center	Oregon	$919,017,000	$61,591,000	22,594	101,599
St. Joseph Medical Center—Tacoma	Washington	$1,438,379,738	$73,744,228	21,802	92,323
Southwest Washington Medical Ctr.	Washington	$974,184,166	$30,890,264	20,886	85,285
Salem Hospital	Oregon	$661,611,020	$19,685,011	20,492	91,132
University of Washington Med Ctr.	Washington	$948,997,861	$31,441,957	19,775	97,450
Legacy Emanuel Hosp. & Health Ctr.	Oregon	$889,675,890	$23,459,988	18,708	107,362
Harborview Medical Center	Washington	$1,156,062,000	$18,045,000	18,662	135,303
Providence St. Peter Hospital	Washington	$898,500,849	$24,444,980	18,162	83,281
Virginia Mason Medical Center	Washington	$1,149,485,689	$18,452,019	17,383	86,009

[1]Source: National Association of Insurance Commissioners. Blank cells indicate information wasn't available from the National Association of Insurance Commissions at press time. [2]Sources: Washington State Department of Health, Oregon Health Policy & Research.

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