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How Texting Patient Information Can Increase Risk

By Kimberly D. Baker
Member
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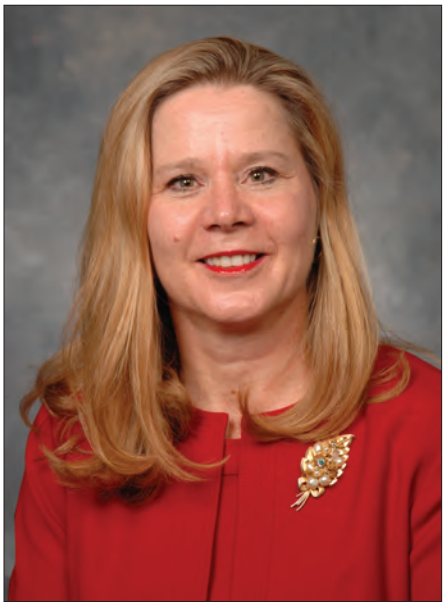

In some hospitals, some communications about a patient's health care have moved from the bedside or telephone to the exchange of health care information via text messages. Having ready electronic access to a provider has many virtues, but the exchange of patient information via texting has many risks associated with it. This article will review the potential risks that arise from the use of texting as a means of sharing patient information between health care providers.

Accuracy of Patient Information. High quality decisions about patient care are dependent upon accurate and complete information. Text messaging is designed for quick sharing of small bits of information. Since the number of characters that may be included in a text message are often limited, i.e. 160 characters, the ability to engage in complex decision making discussions, and explore options and alternatives is very limited. When the sender is seeking to shorten the message, critical information or options may be eliminated or there may be confusion about which patient is being discussed in the text message. Providers need to consider when it may be best to place a phone call or meet in person rather than texting so the parties can engage in an in depth discussion of the facts or care options, allowing the participants to hear, clarify, exchange ideas, reflect, contemplate and then make patient care recommendations.

Privacy of Health Care Information. Communication exchanged between a patient and her providers is statutorily protected from compelled disclosure. State and federal laws, including HIPAA, also protect against the disclosure of health care information. Texting patient related information creates a risk of unintended disclosure, especially when the text is unencrypted. The ability to maintain the confidentiality of the text messages and patient privacy is also often dictated by whether the texting is being done on devices whose services are privately purchased by a provider or on a device that is issued by a hospital and/or employer that pays for the services.

Similar issues of security, accessibility, and patient privacy arise when the device is provided by a healthcare employer but used for both professional and personal communication. Unless both sending and receiving devices use the

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Inside This Issue

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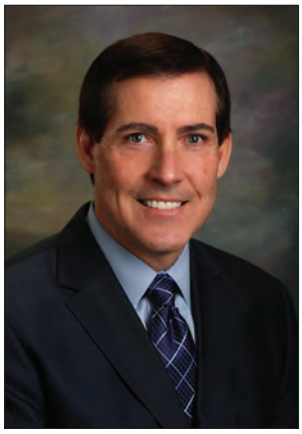
Letter from the Publisher and Editor



Dear Reader,

The Washington Healthcare News maintains a very active Facebook page. We scour the internet and post links to articles of interest to professionals in the Washington healthcare industry. We also post job openings and articles from the Washington Healthcare News web site.

Facebook users can "Like" our page and receive updates to their own pages as we make them to ours.

Many people have asked why we're so bullish on Facebook when our reader demographic is a "seasoned" one. After all, aren't Facebook and the other social networks for the young? Absolutely not!

According to iStrategyLabs.com, an organization that has been tracking Facebook growth since October 2007, from 01/04/09 to 01/04/10 more people in the 35-54 age range used U.S. Facebook than any other age range. The 29,917,640 U.S. Facebook users in this demographic represented a 328.1% increase over the prior year.

To see our page, visit www.wahcnews.com and click on the Facebook icon.

Until next month,

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same encryption software ***and*** the wireless service provider has certified that the wireless connection is secure (such as a hospital pager with text capacity used only in the hospital), it may be a HIPAA violation to send a text message that includes protected health information. For example, assume that a healthcare employer has contracted with one of the wireless service providers who advertise "HIPAA compliant" communication devices but the employer texts to a device that is unsecured. Healthcare providers must also be cautious about using the device in public, leaving the device unattended or sharing passwords.

Medical Records. A text message between two providers may allow for the exchange of pertinent patient information that leads to a change in patient care orders or recommended treatment. However, the content of the text and the decision making basis discussed in the text is only shared between the sender and recipient. The text message, in most circumstances is never made a part of the patient's medical record. Just as with phone calls, it is essential to chart the substance of the text messages in the patient record. One risk created by texting is that a record of the content of the communications, or that the communications occurred at all, is not created. If a lawsuit is filed even if the text exchange is accessible, the record is devoid of the content of the text. If the service provider for the privately used phone is no longer in existence, has a records destruction policy or can't be accessed without the device owner's permission, the ability to defend the case may be compromised. Similarly, even a facility that owned the device may have problems accessing the records because of the Stored Communications Act.

When Not At The Bedside. The art of personal communication is comprised of speech, verbal cues and physical surroundings. When a text is sent, the sender is removed from an environment of participatory communication where the listener hears and looks for physical expressions to accompany the words. Since texting is limited in the number of characters that can be used, text messages are often cryptic, include use of incomplete sentences, and contain symbols and abbreviations. If the text message is shown to a jury, the appearance of the message will often not be one of professionalism, but one of hasty, casual, incomplete consultation, and one that may be interpreted as unconcerned, flippant,

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< Texting, from P4

and/or disrespectful of the patient. Since texting is also a common means of exchanging casual communications with friends and family that include the use of abbreviations such as "LOL", providers need to be reminded that any use of texting in the health care context must NOT include the use of such casual abbreviations, informality and flippancy.

Providers should extend common courtesies to patients, family and other clinicians and avoid sending or reviewing texts while addressing patient care issues with them.

Take Your Criticism Elsewhere. One risk of texting is the removal of the face to face communications or verbal communications when a more professional demeanor can be maintained. When the sender does not have to look the recipient in the eye or does not believe that the message will be seen by others, the risk of exchanging demeaning or disparaging or otherwise inappropriate comments about the sender, the patient or the patient's family increases. Providers need to be reminded that text messages should not contain personal comments or opinions about the quality of care being provided, sentiments about other providers or the patient or patient's family (such as not being available when on call or passing off the tough patients or that the family is too stupid to understand the medical issues).

Policies Governing Texting In Health Care. Employers are encouraged to adopt and implement policies relating to texting. The policy should include guidance on when texting is appropriate, restrictions on disclosure of patient information, requirement of professional standards, a requirement to record the text's contents in the medical record and a statement advising the user that the communications are subject to disclosure and employees/users should not expect privacy in those communications.

Employer Access. One last concern is employer access to the text message sent or received by employees, including health care providers, whether on employer provided devices (particularly in the public sector) or privately owned devices. There are three issues: 1. Can the employer get access to the messages and what is the impact of the Stored Communications Act? 2. Does the employee have a reasonable expectation of privacy in the message? and; 3. Even if he or she does, does the employer have the legal right to access the messages? Risk management policies should also include consideration of the collection and preservation of text messages after a bad outcome to assist in future litigation and preempt spoliation claims. An employer should consult legal counsel to evaluate its access to its employee text messages, the need to audit, scope of the audit and restrictions on the disclosure and use of the text messages.

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Retirement Plan Management: Another Layer of Disclosure Required for Defined Contribution & Defined Benefit Plans

By William Small
Principal
Highland Capital Advisors

It is no surprise to healthcare employers that the operation of qualified retirement plans have become both more simple, and more complicated. Simplification has come through products, technologies and changes to regulations that support easier design, implementation and maintenance.

More complicated through increased demands on employers, plan sponsors and staff to measure and manage the direct and indirect expenses of the Plan. Some of these changes stem from regulation, some from new legislation and some from changed behaviors in the marketplace by decision makers and vendors.

2009 – Year of the Audit

For many retirement plan sponsors, 2009 was the "year of the audit" as most 403(b) plans with over 100 participants became subject to an annual plan audit and IRS tax filing for the first time. Concurrently, many such plans became subject to the provisions of ERISA, the watershed retirement plan law originally passed in 1974.

2010 – Year of Disclosure

Recently released final regulation under §408(b)(2) from the Department of Labor make 2010 the "year of disclosure" which layers an additional level of obligation upon plan sponsors and their management. The new regulation was released on July 15, 2010, with an effective date that will apply to existing service arrangements as of July 16, 2011. In other words, your current plan compensation must be accounted for beginning next July. The long lead time is reflective of the depth and detail of the new regulation and is intended to accommodate the costs and burden of transition to a new disclosure scheme.

Because the new regulation is interim as well as final, additional requirements may be added prior to the effective date.

The new regulation applies to both defined contribution and defined benefit plans, although some provisions only apply to those which provide participant direction of investment accounts. The new regulation focuses on the disclosure of direct and indirect compensation received by certain service providers that expect to receive at least $1,000 in compensation and that provide:

- Fiduciary or registered investment advisory services;
- Recordkeeping services;
- Brokerage services; or
- Certain other services for which indirect compensation is received.

Disclosure Requirements

Plan service providers are required to provide information in writing to the plan fiduciary (usually the plan sponsor). The rule does not require a written contract delineating the vendor's disclosure obligations, but we think best (or at least adequate) business practices suggest you require it of your providers.

Information that must be disclosed in the vendor's written disclosure includes:

- A description of the services to be provided;
- All direct or indirect compensation to be received by the service provider, its affiliates or subcontractors;
- Detail on "bundled" arrangements where compensation is internal and not explicitly spelled out (as in the case of an insurance company or mutual fund with internal payments to funds, administrators, brokers, etc.);
- Service provider disclosure as to whether they are providing any services as a fiduciary to the plan; and

- Disclosure about plan investments. This obligation is placed upon both fiduciaries and on recordkeepers and brokers who facilitate the investment in plan options through administration platforms or other pooled mechanisms.

Impact & Action

There are significant differences between the New Schedule C to the Form 5500 Annual Report and supporting audit. First, there is no de minimis exemption for plans with fewer than 100 participants; second, the new regulation expands the obligations of plan sponsors dealing with vendor contract provisions and "reasonableness" of such provisions. The primary purpose of the regulation is to ensure that plan fiduciaries are provided with the information they need to prudently select and monitor service providers. This is part of a broader initiative by the DOL to increase the transparency of fee arrangements.

Noncompliance under the regulation may result in a violation of ERISA and an excise tax imposed under IRS code. Brokers, auditors and bundled service providers are scrambling to deal with this new regulation.

Stepping back from the tactical elements of these requirements, the net effect to most sponsors is a disruption of the mud at the bottom of the retirement plan pond. The time has come for every responsible sponsor to understand the nuanced issues surrounding fees, types of investment providers, etc. that have been ignored by many for far too long.

As consultants and advisors, Highland is helping plan sponsor clients deal with the new regulation. Key issues: a) how to gather and collate the required data; b) development of policy and process to determine what is "reasonable" compensation for services provided; and c) implementation procedures to conform with all requirements – driven by both ERISA and IRS regulations and by professional best practices.

For a complimentary analysis of your organization's risk profile and remediation options, give the author a call.

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Possible Stark Violation? What Providers Should Do Now

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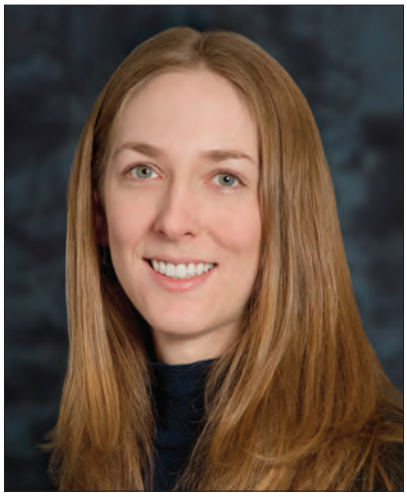

In recent years, hospitals, physicians and other providers have wrestled with the question of how to remedy violations of the dauntingly technical and complicated physician self-referral law, or "Stark Law."[1] The Stark Law prohibits accepting Medicare payments for services provided while a violation exists, but provides little guidance on the steps providers should take when they discover a violation and offers no mechanism to mitigate disproportionately harsh financial effects of minor, non-abusive violations. The Patient Protection and Affordable Care Act (PPACA)[2] and the Centers for Medicare and Medicaid Services' (CMS) new self-disclosure protocol have changed the landscape related to such situations.

PPACA Section 6402(d) mandates that a provider who identifies an "overpayment" must, within the later of 60 days after the overpayment is "identified" or any corresponding cost report is due: (1) report and return the overpayment to the government and (2) notify the relevant government agency of the reason for the overpayment.[3] PPACA further links retention of an overpayment, *i.e.*, "[Medicare or Medicaid] funds that a person receives or retains… to which the person, after applicable reconciliation, is not entitled," to the federal False Claims Act (FCA). The FCA imposes potential civil liability for knowingly concealing or knowingly and improperly avoiding an "obligation" to pay or transmit money to the government under the FCA (the "reverse false claims" provision).[4] Thus, overpayments retained beyond PPACA's 60-day "report and return" deadline could subject a provider to civil liability under the FCA,[5] as well as criminal liability under a separate statute.[6]

This mandate initially left providers in a difficult position, as it defined no procedure to "report and return" overpayments or to determine whether a violation led to an overpayment. On September 23, 2010, CMS unveiled its long-awaited Medicare Self-Referral Disclosure Protocol (SRDP), which describes how providers and suppliers should self-disclose actual or potential Stark Law violations, and offers some opportunity for providers to avoid excessive penalties.[7] The SDRP, like the Department of Health and Human Services Office of Inspector General protocol, requires the self-disclosure to describe the disclosing entity, the questionable conduct, the provider's investigation, potential causes of the disclosed conduct, and steps taken to ensure such conduct does not recur.

Under the SRDP, the disclosure must provide a legal analysis of the problematic conduct, and a financial analysis of the amount due and owing—but the SRDP provides no specific guidance on how to perform this analysis. Thus, providers should obtain legal advice from qualified counsel familiar with Stark issues to confirm the existence of a disclosable Stark issue and assist in drafting the disclosure. The SDRP does not provide guidance as to when an overpayment is "identified," but a provider who becomes aware of a potential Stark violation should act promptly to quantify the overpayment and should consult with

counsel about how to do so.

CMS will not accept repayments before it has reviewed the disclosure, so the repayment period is stayed pending review. CMS will require access to the provider's documentation related to the violation, and may refer a provider to law enforcement based on the disclosure. Importantly, CMS may, but is not required to, reduce any amount due resulting from a Stark violation.[8] The factors CMS may consider in reducing the amount owed include the: (1) nature and extent of the improper practice; (2) timeliness of self-disclosure; (3) cooperation in providing information; (4) litigation risk associated with the matter disclosed; and (5) financial position of the disclosing party. Providers who settle with CMS will lose the right to appeal a finding of a violation. If CMS does not settle with the provider, CMS may be able to reopen the disclosed claims.[9] Finally, providers should not disclose the same conduct under both the SRDP and the OIG's protocol, even if the conduct raises enforcement issues (such as civil monetary penalties) addressed by both protocols—leaving providers to decide which protocol to rely upon.

Unfortunately, the SRDP is silent as to how CMS will assess "technical" Stark violations, *e.g.*, a missing signature, that do not involve program abuse but nonetheless may result in significant overpayment liability. Therefore, providers and their counsel must carefully assess a possible violation and then seek a settlement by making a compelling case that the "nature and extent" of the conduct they self-disclose does not warrant significant repayment liability. More importantly, providers and suppliers have a continuing incentive to comply with the Stark Law and a new avenue to remedy compliance issues under the Stark Law.

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[1] 42 U.S.C. § 1395nn.

[2] Pub. L. No. 111-148, 124 Stat. 119 (2010).

[3] PPACA § 6402(d).

[4] 31 U.S.C. §§ 3729-3733.

[5] PPACA § 6402(d)(3).

[6] 42 USC § 1320a-7b(a)(3).

[7] A copy of the SRDP is available at http://www.cms.gov/PhysicianSelfReferral.

[8] PPACA, Section 6409(b).

[9] 42 C.F.R. §§ 405.980 - 405.986.

Picking Up Where UW Left Off: The 2011 State of Reform Health Policy Conference

By DJ Wilson
President & Founder
Wilson Strategic Communications

Understanding the implications of federal health reform is a big task. Gathering intelligence on what is coming next at the state level is a full time job. Few health care executives have the time to dig into the details on reform – at either level, federal or state. However, many of them should be concerned about the implications of reform to their health care organization.

I consult with an array of health providers and organizations helping them to better grasp the nuance and context of how policy is made. So, I hear about the level of anxiety that exists in the industry. Here is what they are saying.

From a physician leader: "The ground is shifting now 3x as fast as it was 12 months ago, but I'm not entirely sure if this is a mild tremor or a catastrophic earthquake."

From a health plan executive: "Politicians in DC have shot themselves in the foot, but I'm really scared about what Olympia plans to do next. I'm afraid they will end up doing the system even more harm."

On the policy side, state legislators are nervous, too. With general voter anxiety creating a topsy-turvy election cycle, and another $4.5 billion deficit looming, folks know "change" is coming but few know exactly what that looks like.

From a Democrat in the House: "We know we need to 'right size' government, and we now know that the first dollar in the door must go to education. But, without new revenue, that pretty much eliminates state funded health care as we know it."

From a Republican senator: "I used to think we needed to eliminate a bunch of this regulation in the health care marketplace, but I just don't think that's a reality anymore. So, how do we craft very limited but highly effective regulation to protect patients in the health care marketplace?"

From 1985 to 2008, the University of Washington Health Legislative Conference brought together stakeholders from across the state to network and discuss current and potential health legislation. Attendees included health care providers, payers, consumers, public officials, lobbyists, and researchers. If you are reading Washington Healthcare News, you probably attended this conference and know the value it provided.

However, with the closing of that conference, there is no longer an independent, objective forum for the gathering of stakeholders from across the political spectrum. Some groups continue to put on good events, but admit to a clear philosophical viewpoint on policy matters. The Washington Policy Center and Washington Health Foundation events are two which continue to provide thoughtful opinion and information, but which offer a different approach from that of the UW regarding objectivity and policy analysis.

For that reason, a group of more than 20 policy and industry leaders have come together as the Convening Panel for a new health policy conference picking up where the UW left off: the 2011 State of Reform Health Policy Conference.

Held January 5th, 2011, at the Hilton in SeaTac, the State of Reform Health Policy Conference will bring voices together from across the spectrum of politics, policy and providing care. The Convening Panel is a demonstration of

that diversity, which you can see from some of the organizations represented there:

- AARP
- Community Health Plan of Washington
- Group Health Cooperative
- Health Care Authority
- Eli Lilly
- Washington Budget and Policy Center
- University of Washington
- Swedish Medical Center
- Premera
- United Healthcare
- SEIU 775
- Puget Sound Family Physicians
- Seattle Children's Hospital
- Ryther Child Center

You can see the full list of Convening Panel participants at www.stateofreform.com.

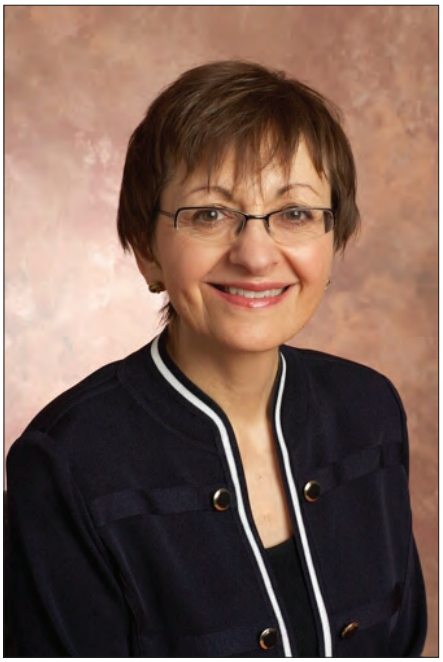
This conference has only one purpose: host an objective forum for the exchange of ideas and dialog around current and potential ideas for health policy. That will include policy leaders and political insiders. It will include health care providers, health care payers, and health care plans.

From administrators to researchers, the more diverse the set of conversation topics on health policy, the more likely you are to gather the business intelligence you need to lead your organization through reform.

Like the UW conference, this is the one health policy conference you must attend to really understand what's happening in health care and health policy today.

Ten Ways Outsourcing Medical Professional Liability Insurance Can Pay Off for Hospitals

By Susan Peskura
Associate Vice President, Marketing
Physicians Insurance
A Mutual Company



As more physicians become hospital employees, hospitals must face the challenges of integrating and managing physician practices. Many hospitals, for example, now outsource the risk exposures for medical professional liability to a specialty insurance company. A hospital's purchase of professional liability insurance for its employed physicians offers several key advantages.

1. **More Efficient Hospital Management.** Hospitals initially hired primary care physicians as employees, but as the hospital-employed physician mix moves from primary care to more specialists, some hospitals may no longer have the expertise to provide risk management and claims services for these specialists. When an insurance company manages a hospital's claims and risk management, hospital administrators can focus on what they do best: caring for patients. And a professionally managed liability insurance company provides specialized claims and risk management services for all unique exposures that employed physicians may present.
2. **Better Control of Claims and Settlements.** Professional liability insurance companies have decades of experience handling claims and controlling costs in every medical specialty. Keeping claim costs low is essential to a successful business, and established professional liability insurance companies have been helping physician practices and clinics stay successful for years. Professional liability insurers with experience in providing coverage to hospital-employed physicians can offer claims handling that minimizes conflicts with the hospital's self-insured exposures while maintaining protection for physicians.
3. **Lowered Risk.** Physician-specific and specialty-specific reports and loss analyses, along with risk management expertise, can help hospital administrators identify claim trends of specific physicians and within specialties. This information can help hospitals find more ways to improve procedures and systems, thus lowering risk within the organization.
4. **Detailed Tracking and Reporting.** With detailed tracking reports on claims losses, defense costs, legal expenses, and reporting to data banks, Washington State Medical Quality Assurance Commission, and CMS, hospital administrators can report data accurately and measure results and expenses separately from hospital-wide trends. The liability for these claims rests with the insurer, not the hospital, and costs can be allocated to the correct profit center.
5. **Specialized, Timely Risk Management Services.** Experts can advise physicians and staff on urgent matters and claim trends by phone, by e-mail, and in person, offering solutions on topics such as medical records, treatment of minors, HIPAA compliance,

team communications, dealing with a difficult patient, adverse outcomes, and much more.

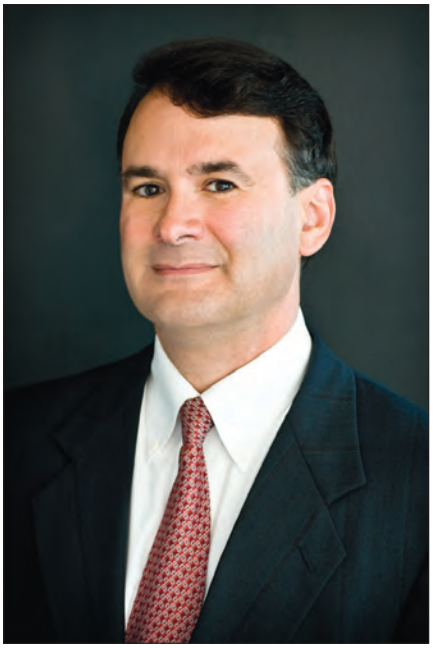
6. **Specialized Knowledge of Medical Professional Liability.** Navigating medical negligence claims can be a long, complex process. Experienced claims experts can handle the most difficult medical malpractice claims with skill and professionalism. They can also provide access to privileged communications with a psychiatrist who specializes in helping physicians understand and cope with the stresses of claims and lawsuits.
7. **Specialized Knowledge of Legal Venues and Attorneys.** In the event of a lawsuit, a defendant physician and the hospital can benefit from an insurance company's expertise and longevity in the marketplace. A local, experienced company will maintain strong relationships with top plaintiff and defense attorneys and possess in-depth knowledge of the strategies, expert witnesses, arbitrators and mediators, courts, and other participants in the medical professional liability field.
8. **Outside Review of Prospective Employees.** The insurance underwriting process offers a different look at a physician's risk exposures and can bring to light issues not addressed in the hospital's credential verification process.
9. **Organizational Teamwork Opportunities.** Using a professional liability insurance company creates additional opportunities for combined risk management efforts focusing on the entire hospital health care team.
10. **Better Allocation of Financial Resources.** A hospital that purchases professional liability insurance for its employed physicians does not need to tie up reserve capital for potential claims.

Hospital administrators should consider how outsourcing coverage of employed physicians aligns with patient safety initiatives, handling efficiencies, and budgets.

The Physicians Insurance marketing staff can answer any questions and discuss how these advantages apply to your institution. Please call 1-800-962-1399 (Western Washington & Oregon) or 1-800-962-1398 (Eastern Washington & Idaho), and ask to speak to the Marketing Department, or e-mail me at susan@phyins.com for assistance.

How Pharmacy Reimbursement Methods Have Evolved

By Dwight Johnson, FHFMA
Executive Director
of Provider Contracting
Coopersmith Health Law Group



Drug reimbursement from commercial insurance carriers changed considerably over the last decade. The old standard used to be Average Wholesale Price (AWP), which reflected the average prices of drugs sold to hospitals, physicians and pharmacies. Insurance companies often reimbursed drugs using AWP, or more likely a percentage above or below AWP, as agreed to by a carrier and provider. From the perspective of an insurance company, payment based on AWP was a positive event, reducing reimbursement, as prior to AWP, medications were often paid on a percent-of-charge basis.

Earlier this decade, however, interested parties began to notice problems with AWP as a standard for drug reimbursement. AWP was criticized as arbitrary, as it was not based on actual drug costs but on the prices charged by wholesalers and manufacturers for drugs. Manufacturers of course built a profit margin into their charges for medications, so the AWP standard could be established at an artificially high level. AWP was additionally self-reported by the drug manufacturers and did not take into account the discounts and rebates often agreed to in negotiations of drug reimbursement. By 2003 or so AWP was widely considered to be inaccurate at best, and a meaningless payment standard at worst.

As often happens in medical reimbursement (think DRGs and APCs), the federal government stepped forward to address the situation. In 2005, Congress changed the way Medicare handled drug reimbursement. AWP was replaced by Average Sales Price (ASP).

ASP was seen as a more accurate reflection of the actual cost of drugs, as it took into account the actual sales transaction information AWP did not, such as rebates and discounts.

A 2005 OIG study comparing over 2000 drugs determined that ASP was approximately 26% lower than AWP for branded drugs and 68% percent lower than AWP for generics. The commercial insurance carriers moved as swiftly as they could to negotiate new agreements that drove reimbursement for medications to the new ASP standard during the period from 2005 to 2010. These agreements were typically based on a percentage of ASP, or a percentage of the Medicare payment rate of ASP + 6%. The result was often a reduction in drug reimbursement to providers, in some cases dramatically so.

The evolution of drug reimbursement is not as simple as AWP being replaced by ASP, with the carriers now paying providers less for drugs. In the last few years another standard has been established for drug reimbursement, Wholesale Acquisition Cost, or WAC.

WACs are arguably even more precise than ASP. While ASP takes into account the transactional information AWP does not, WAC's are the actual costs wholesalers pay when they buy drugs from manufacturers. They are reported also directly by the distributors themselves, as opposed to ASP, which is typically reported by companies such as McKesson.

Some observers have pointed out that a weakness exists with WAC since like AWP, it fails to reflect rebates and discounts the way ASP does. WAC proponents have countered that one cannot get more precise than listing the actual costs of drugs, making rebate data in some

respects unnecessary. The debate continues and ASP continues to be the standard, but note that in our market at least one carrier is adapting the WAC methodology for certain medications.

To complicate matters even further, the federal government began using another standard, Average Manufacturer Price (AMP), for the federal component of the Medicaid program. AMP excludes any prompt payment discounts, and drug manufacturers must report AMP information to CMS. The OIG issued a report stating that AMP is lower than AWP and WAC. Yet even here there is controversy as observers have noted that there is not much difference between AMP and ASP. A lawsuit was filed in 2007 which ultimately prevented CMS from publishing and using AMP for reimbursement. Currently AMP is used by the government on an internal Medicaid basis only.

What should you do about this complex issue? Generally, try to keep your drug reimbursement tied to AWP if at all possible. If you have to be on one of the other methodologies, consider seeking assistance from qualified negotiators or try other strategies such as negotiating as high a percentage above the base as you can.

Dwight Johnson is the Executive Director of Provider Contracting at Coopersmith Health Law Group. He can be reached at 206-343-1000 or dwight@coopersmithlaw.com.

Career Opportunities

Founded in 1936, The Vancouver Clinic is a multi-specialty clinic located in Vancouver Washington, just north of Portland Oregon. The Clinic is a privately held, physician-owned clinic, with over 700 staff members and 190 providers. The Clinic is one of the region's principal health care providers, offering extensive services to our patients. We are currently seeking the following key positions.

Clinic Manager

We are looking for an energetic, experienced professional to lead a team of staff providing compassionate medical care. Must have excellent communication and problem solving skills. The manager will work through supervisory staff to oversee the daily operations of specialty departments such as ENT, Orthopedics, Podiatry, Surgery, urology and our Special Procedures Suite. The successful candidate will have approximately 5 years of previous medical experience, preferably in an ambulatory care setting. Prefer those with a Bachelors degree or equivalent combination of education and experience.

Clinic Supervisor

We are looking for an experienced clinic supervisor with the ability to mentor staff and help them flourish. You will provide supervision of clinical and office staff, facilitate staff and patient workflow, and control expenditures. Requires demonstrated ability to interview, select, train, and develop qualified staff. Must be comfortable in a fast-paced environment, detail oriented, and self-directed. The successful candidate will have a min of 2 years supervisory experience in a medical setting.

RN Supervisor - Nurse Advise

The Vancouver Clinic

We are looking for a customer-service oriented RN with supervisory experience. Will be responsible for the daily supervision of advice nurse staff, assure compliance with all safety and regulatory bodies, train and develop nurse advice staff, and establish, implement, maintain and evaluate/improve patient care and quality service standards.

To apply for any of these positions visit www.tvc.org or call 360-397-3273 for information.

Career Opportunities

Director of Operations

(Seattle, WA)

As a member of the Management Team, this position is responsible for leadership and management in operations, including the planning, development and implementation of policies, procedures, programs and services in medical clinic operations; oversight for facilities, laboratory, staffing and workflow; and directing emergency preparedness, patient safety and health efforts; leads continuous improvement initiatives in meeting the needs of patients, clients and customers; ensures compliance with all applicable laws and regulations. Directs and supervises clinic operations, facilities, laboratory and emergency preparedness staff, programs and activities. This position carries a high degree of responsibility and judgment in overseeing the provision of high quality services on an ongoing basis, including in times of emergencies.

Minimum qualifications: Bachelor's degree, Master's degree in Nursing, Health Administration or related field. 10 years of progressively responsible experience in primary care, public health, clinic or related field, which includes 5 years of executive leadership. Work experience in a multicultural/multilingual setting. Valid Washington Driver's License.

For more information please visit our website: **www.ichs.com**.

Chief Operating Officer

Only 30 minutes from the heart of downtown Seattle and 15 minutes from the slopes of Snoqualmie Pass, Snoqualmie Valley Hospital overlooks the beautiful Snoqualmie Valley. The Hospital offers the opportunity to work with a successful organization built on collaboration and respect. Its employees take pride in providing exceptional patient care in a spectacular Northwest setting.

Snoqualmie Valley Hospital is seeking a highly qualified candidate for the position of Chief Operating Officer (COO).

The COO is responsible for the nursing, pharmacy, imaging, social work, rehabilitation and senior care departments and for insuring all hospital services provide high-quality care to patients while maintaining compliance with state, local and federal regulations. As a member of the Executive Management team the COO participates in strategic planning, budgeting, staff development and quality initiatives in all areas of the hospital.

Qualifications include a minimum of five years progressively responsible healthcare management experience, demonstrated leadership and team building and the ability to work with a diverse population. A bachelor's degree in a clinical field with an advanced degree in healthcare administration or business administration is desired, RN experience is preferred.

We offer competitive pay, medical and dental insurance, 403b and 457 retirement plans, paid vacations and holidays.

Please submit your resume or C/V to: Human Resources
9575 Ethan Wade Way SE Snoqualmie, WA 98065,
telephone: 425-831-2300, fax: 425-831-2361
hr@snoqualmiehospital.org, **www.snoqualmiehospital.org**

Equal Opportunity Employer

Healthcare Risk Management Consultant

(Southwest Washington/Oregon)

Physicians Insurance A Mutual Company, a leader in medical professional liability insurance, is seeking an experienced Healthcare Risk Management Consultant to work in southwest Washington/Oregon. Requirements include a minimum of four years experience in technical work related to medical malpractice claims, underwriting, and risk management services. Clinical expertise is a plus. The position also requires leadership, presentation skills along with verbal and written communication skills, and a demonstrated ability to work effectively as a team member. This position will cover southwest Washington/Oregon. The consultant can either be based out of their home in the Portland area or from our Seattle office.

To apply for this position, send your resume to recruiter@phyins.com.

Learn more at:

http://www.phyins.com/about-us/careers.php

Provider Compensation Program Manager

(Portland, OR)

PeaceHealth Medical Group, a medical group with 500 + providers in Oregon, Washington and Alaska, is seeking a highly talented individual to lead our efforts to implement and manage a uniform compensation program across our healthcare ministry. This position will be located in Portland, Oregon.

The Program Manager is responsible for developing, organizing and implementing the resources needed to administer the uniform compensation program for PeaceHealth Medical Group. The primary responsibilities include the management and administration of compensation for all employed physicians and allied health of PeaceHealth. Additionally, this position is responsible for on-going development, enhancement and maintenance of the information infrastructure and reporting environment to support changing business needs through the management of data and information.

A bachelor's degree in Business, Accounting or Finance and three or more years experience in provider compensation is required.

PeaceHealth Medical Group is part of PeaceHealth, at which we carry on the healing mission of Jesus Christ by promoting personal and community health, relieving pain and suffering, and treating each person in a loving and caring way. The fulfillment of this Mission is our shared purpose. It drives all that we are and all that we do. To those who embrace the spirit of these words and our commitment to Exceptional Medicine and Compassionate Care, we offer the opportunity to learn and grow as a member of the PeaceHealth family.

TO APPLY ONLINE: **www.peacehealth.org**

Administrator

Olympic Peninsula Kidney Center

(Bremerton, WA)

HISTORY AND BACKGROUND

Olympic Peninsula Kidney Center (OPKC) is a community based, 501(c)3 non-profit dialysis organization established in 1980. Our mission is to provide high quality dialysis care for kidney patients in Kitsap and Jefferson counties on the Olympic Peninsula of Washington State.

POSITION OVERVIEW

The Administrator is responsible for ensuring the effective management of the OPKC facilities and provision of all dialysis services with twenty-four hour responsibility and accountability for dialysis operations. This responsibility includes oversight of staffing, scheduling, personnel performance appraisal and discipline, development and administration of fiscal budget, coordination and implementation of all patient care policies, safety and security of the building, grounds and equipment, support to Board of Directors and on-going collaboration with Medical Directors and medical staff.

QUALIFICATIONS

Education - BS or BA degree in healthcare related field. Masters degree in Business Administration, Health Care Administration or related fields preferred. May substitute relevant experience for degree requirement. Organizational management – At least five years of senior management experience. Dialysis experience preferred. Nonprofit experience a plus. Experience reporting to and working with Boards and committees. Demonstrated experience in dialysis operations management. Communication skills – verbal and written. Facility with Microsoft Office products, email and Internet usage.

APPLICATION PROCESS

To apply, please submit your resume and cover letter describing your interest and qualifications to **katrina.russell@dcgseattle.com**. You may send a hardcopy resume to Olympic Peninsula Kidney Center, attn: Katrina Russell, 2613 Wheaton Way Bremerton WA, 98310. All applications will be kept in strict confidence.

Director over Case Management and Utilization Review

(San Jose, CA)

EK Health Services is currently seeking a Director level employee to oversee the Case Management and Utilization Review departments for the company. A Nurse or other Medical professional with business acumen is welcomed but not required for this position. Workers Comp knowledge & experience preferred, but also not required. Some applicable healthcare experience strongly preferred.

Qualifications: BS degree required; MS / MBA Degree in related field preferred. Valid California Drivers license in good standing. 8-10 years of management experience, exceptional leadership and analytical abilities required. Experience in the insurance, workers compensation or related healthcare required. Strong interpersonal and communication skills; conflict resolution and mediation skills. Ability to foster a collaborative work environment. Must be self-directed and motivated; capable of managing operations independently on a day-to-day basis.

EK Health Services has built a reputation for superior, goal-oriented Workers' Compensation case management and utilization review services. Our emphasis on medical excellence, superior service, impartial reporting and case resolution is the driving force behind our consistent annual growth.

If interested, please submit a resume to Jenna Schrader at **jschrader@ekhealth.com**. Thank you.

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