Washington Healthcare News

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Inland Northwest Health Services Connects Washington – Grows Nationally

By David Peel
Publisher & Editor
Washington Healthcare News

When I first met Kalen Privatsky, President of the Washington State Medical Group Management Association, he told me that health care facilities in eastern Washington had a better infrastructure in place for information sharing with hospitals than health care facilities in western Washington. Living in Kirkland, three miles from the Microsoft campus, I was naturally skeptical but took him at his word because he recently managed a clinic in Spokane and now managed one in Renton. It wasn't until I learned more about Inland Northwest Health Services (INHS) that I understood what he meant.

Empire Health Services and Providence Health Care established INHS in 1994 on the premise that shared costs of certain services could reduce overall spiraling health care costs and increase the quality of care. Tom Fritz, CEO of INHS and driving force, has been with the company since 1998. Organized as a non-profit, INHS oversees a variety of health care companies and services including:

- St. Luke's Rehabilitation Institute, a freestanding hospital dedicated to medical rehabilitation.
- Northwest MedStar, an air ambulance service.
- Community Health Education and Resources (CHER), an organization that provides health education programs such as tobacco cessation and parenting classes to help improve the health of the community.
- Northwest TeleHealth, a videoconferencing network used for patient consults as well as education and business needs.
- Information Resource Management (IRM), an organization that provides integrated information systems that help hospitals and physicians improve patient care and lower costs.

Although all entities have had a major impact on the eastern Washington health care system, Northwest TeleHealth and Information Resource Management have dramatically improved information sharing between hospitals and clinics throughout the region and beyond.

Northwest TeleHealth

This video-conferencing network links nearly 150 end points to a variety of resources at more than 65 separate locations. The organization's technology permits

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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,

This edition has a health care technology theme which is fitting considering how we have recently used technology to help health care organizations recruit senior level positions.

In late 2006 we published our first Career Opportunities job advertisement. We had several loyal, regular advertisers work with us to assess the effectiveness of print media job advertisements.

We felt we could improve our results by applying technology and in mid 2007 enhanced our website to allow online job postings. The results were better but not superior to what was already available in the marketplace.

We thought we could obtain superior results by making widespread "announcements" via e-mail to people qualified for the jobs on the website. We thought the recipient should be able to view summaries of jobs by clicking on hyperlinks in each e-mail announcement. Compliance with anti-spam laws was necessary. In late 2007 we acquired the technology to do all of this and in early 2008 began announcing the jobs on the website via e-mail to our readers. We now see superior results and receive enthusiastic testimonials from our customers.

Does our past success with job posting technology mean the News will become an "e-newsletter"? No, because many people, like me, prefer reading the News in hard copy form. However, we now offer a lower resolution, web based version of the News we call our "green" edition and it's available upon request at no charge.

Until next month.

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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live interaction between two or more locations for patient consults, rural medicine, health education and medical training.

"Eleven of the 100 'Most Wired' hospitals in the country are participating in the INHS network."

INHS CEO Tom Fritz

Information Resource Management

In 1996, the INHS Board tasked INHS employees with implementing a common hospital information system in the six facilities belonging to the two sponsoring hospital systems. The end result was the formation of Information Resource Management (IRM) and the division has grown rapidly ever since. It now integrates 38 hospitals and health facilities with common data and technology standards, a single master patient index and supports the facilities with a centralized information technology staff. Though the majority of participating facilities are in eastern Washington and northern Idaho, IRM recently added four southern California hospitals to its network and has customers in western Washington, Alaska and other states.

IRM has provided great value to hospitals that join, as access to a common electronic medical record has made patient care more efficient. Each participating hospital gains clinical, financial and administrative functions as part of the system. Web-based tools in certain hospitals allow extraction of key information and display it as dashboards showing staff and administrators the real-time status of every facility unit. These technological tools, coupled with hospital policies that provide quick resolution to any resource problems which may arise, enabled one hospital to reduce its emergency room wait times by 90 minutes and to admit 1,000 more patients than in prior years, all without adding staff. In addition, the shared services model of IRM enables small, rural hospitals that would otherwise not be able to afford to implement these technologies to implement electronic medical records and other tools that improve their patient outcomes and communication with urban hospitals they refer to.

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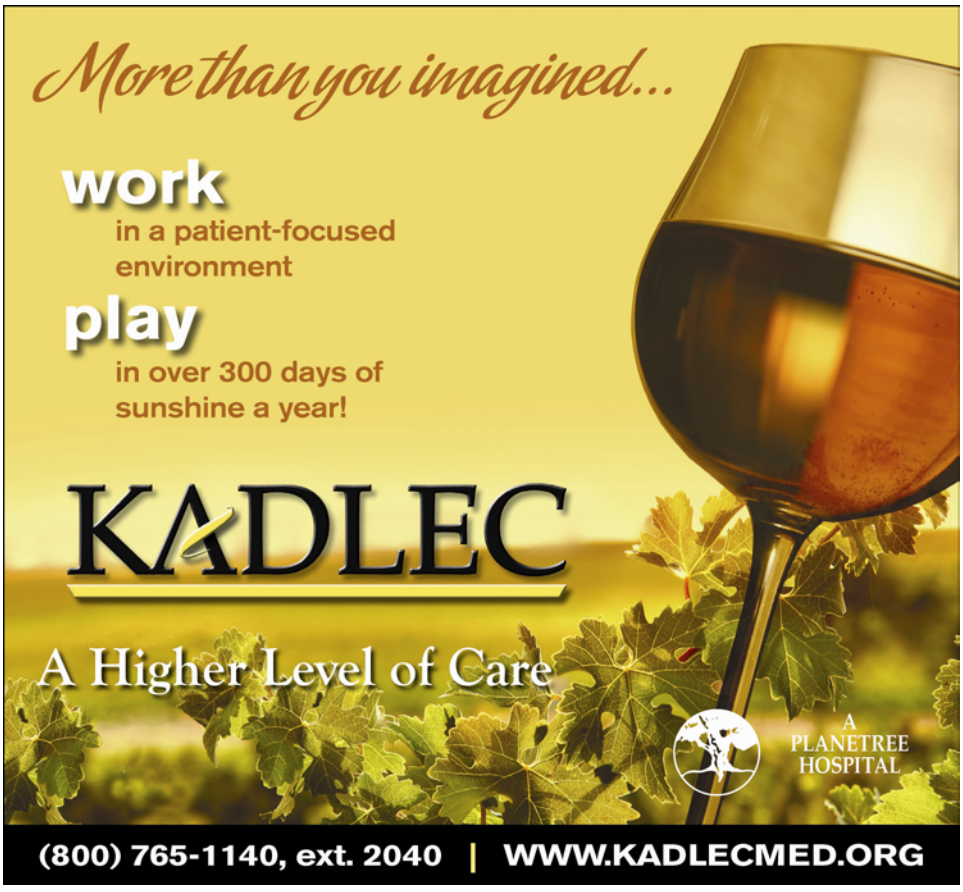

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A strategy of shared information

In February, I met with Fritz to gain a better understanding of INHS, as well as his vision to expand services to hospitals and clinics in western Washington and beyond our state's borders. I wanted to know if it was true that clinics and doctors in eastern Washington had easier access to patient information from hospitals, labs and imaging centers than western Washington.

According to Fritz, "The real difference is that what was created with the formation of INHS is that competing hospitals have agreed to share services for the community good whereas in the other hospital settings it's only their own system that shares the data within the system and with physicians with admitting privileges. In those situations, health information and data are seen as competitive assets." He continues, "We saw some of this infrastructure as strictly being a utility and should be a community asset rather than a competitive asset. That's a significant differentiator for us not only in the region but nationally."

INHS does integrate with several western Washington entities, including Enumclaw Community Hospital and Mason General Hospital, but it does not compare to the presence the company has on the east side of the state. INHS also works closely with the health plans in the state and works closely with Group Health Cooperative to ensure data exchange and access for physicians. During a February lunch conversation with an executive of a large western Washington hospital, I learned his organization was in the process of deciding between INHS and a competing health information system platform. He said INHS had put forth a compelling proposal but said his hospital felt there was great value in proprietary data. The final decision wasn't available to meet our publication date.

Fritz comments, "Our 38 participating hospitals have one major data center that reduces overhead cost for hospitals. In addition we support 50 clinics and about 6,700 individual physicians." That's a significant financial and operational benefit.

Combining a shared data center with telemedicine allows real-time, two way information exchanges between a physician and a patient who's in a remote location. For example, a neurosurgeon in Spokane can visually examine a patient in Colfax using real-time biometrics while simultaneously receiving access to medical records from the patient's prior services at any participating hospital, lab and imaging center.

Disaster recovery is another benefit of the INHS data center because it provides the capability to concentrate substantial assets into one entity, acquiring redundancy and security. INHS provides real-time back-up capability in a location not susceptible to earthquakes or flooding. This ensures patients' records stay safe in the event of a natural disaster.

Fritz explained the reason for the additional investment in system redundancies, "After Katrina, when hospitals lost all their data, we began to move to a real-time back-up data system so that if something happened to a health care facility on our network, it would automatically flip over to the back-up system and data would still be available."

The organization continues to offer new applications. INHS was just awarded a contract from the Centers for Disease Control to provide disease surveillance services. With so much data from so many entities in one location there are definite benefits to homeland security, public safety and public health.

Fritz summarized the success of INHS in one sentence, "Eleven of the 100 "Most Wired" hospitals in the country are participating in the INHS network. These hospitals have better clinical outcomes, less patient safety issues, shorter length of stays and lower costs per case."

Maybe the solution to some of our national health care system problems is right in our own backyard.

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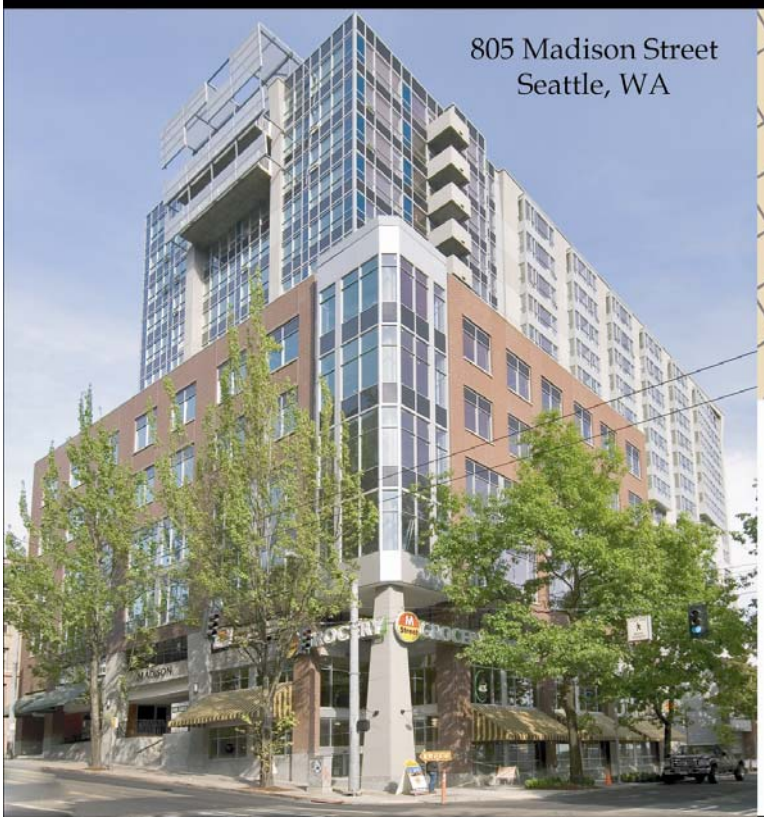

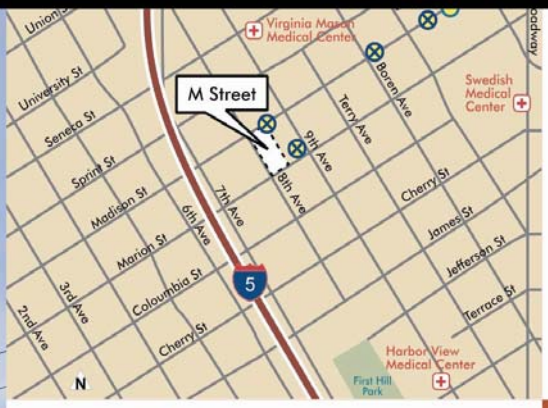

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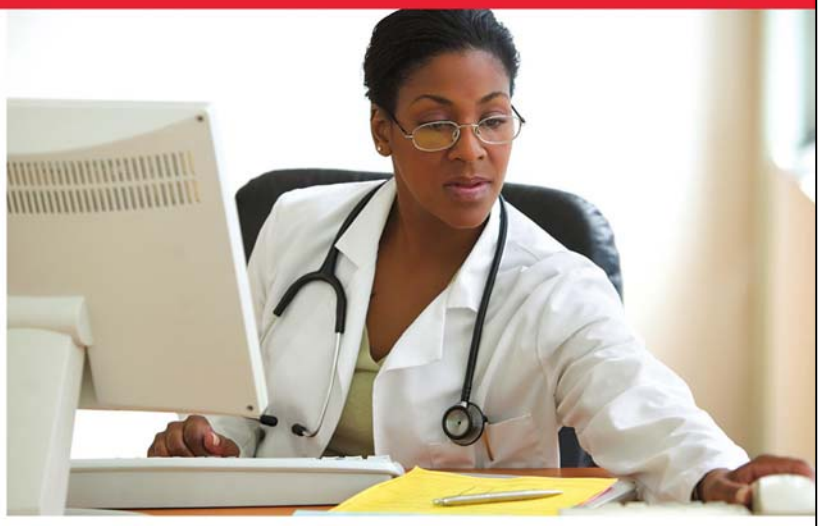

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New Opportunities to Promote Adoption of Electronic Health Records

By David Schoolcraft
Health Care Attorney
Miller Nash LLP

It's no secret that information technology holds the promise of improving the quality and efficiency of health care delivery. For most physicians, buying an electronic health record system can be overwhelming in terms of both cost and management of the implementation process. But hospitals and health systems now have the opportunity to help alleviate these worries and increase the technology adoption rates among the physician community.

Regulations adopted in October 2006 - specifically, an exception to the Stark law and safe harbor under the anti-kickback statute - now permit entities such as hospitals and health systems to assist with the financial burdens of implementing information technology infrastructure. While this is good news, the regulations are complex and require careful scrutiny when developing a permissible donation arrangement. Crafting an agreement between donor and recipient can be very challenging because of the numerous issues to document in order to provide each party with an adequate level of comfort regarding the transaction. Important considerations include the following:

> ***"Regulations...now permit entities such as hospitals and health systems to assist (physicians) with the financial burdens of implementing information technology infrastructure."***
>
> David Schoolcraft,
> Health Care Attorney
> Miller Nash LLP

- *Read the fine print*. There are separate rules for e-prescribing and electronic health record systems, with important distinctions between the two. For example, the rules for e-prescribing systems permit hardware to be included within the items donated, while the rules for electronic health records do not.

- *Seeing double*. A donor (a hospital, for example) may not provide e-prescribing or electronic health record technology to a recipient (a physician group, for example) if the recipient already possesses equivalent technology. A donor may, however, provide technology to update or enhance existing systems.

- *No free lunch*. Despite the fact that the new rules allow software systems to be donated, recipients are still required to pay 15 percent of the total cost. There must be a written agreement between donor and recipient documenting the cost split and additional terms related to the donation.

- *The ties that bind*. Recipients of donated systems need to fully understand any requirements or limitations that may be imposed by the donor organization. For example, in contrast to a direct arrangement with the information technology vendor, the donor organization is likely to be restricted in its ability to assure the recipient regarding such items as system uptime and response time. In addition, if the donation is part of a communitywide patient record system, the donor may require all recipients to support common security technologies and procedures. It is important that the agreement documenting the terms of the donation clearly specify any such requirements or limitations.

The new Stark exception and anti-kickback safe harbor ease up some of the preexisting restrictions and

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Two Important Rules to Consider When Implementing Good IT Security

Christopher Crall
Vice President
Carris ProCare IT

Implementing good information security within a modern healthcare practice can easily become an overwhelming proposition. Practice managers are barraged with new technologies from hardware and software vendors designed to combat an ever increasing series of threats from inside and outside the organization. Add in regulatory requirements such as those from HIPAA and it can seem like a daunting task for practice management, owners and IT staff to stay on top of the issues.

It doesn't have to be that complicated. There are two important rules to consider regarding security. The first is that security is a process, not an end goal. You never get to be "finished". The second rule is that there is no completely secure organization. If more than one person works in the organization or your organization is connected to a network, then there are always going to be risks. The security management process is actually a risk management process. Practices need to put policies in place to deal with today's issues, and understand that continuous reviews are necessary to stay on top of emerging issues. The security management process should allow a practice to assess and plan, design, implement, and maintain good security practices.

1. **Assessment** – The first step is to identify the risks and threats, and combine those with regulatory requirements. This list provides the starting point of the issues which need to be addressed. These lists will include risks such as:
    a. Information disclosure – is patient or employee data in danger of being exposed.
    b. Unauthorized access – only authorized individuals should be able to access data. Everyone in the organization doesn't need to have access to all data.
    c. Destruction of data – how is patient and business data protected to keep it from being deleted?
    d. Business Continuity/ Disaster Recovery – how will the practice continue in the event of a disaster? Keep in mind that disasters can be major, regional events such as an earthquake or it could be as simple as a burst water pipe somewhere over the computer room. This is one of the most overlooked areas for small and medium business. The Gartner Group estimates that less than 50% of small and medium businesses have disaster recovery plans.

2. **Design** – Determine the policies, procedures and technologies that will be used to address the items identified in the assessment. It is important to note that your human processes and guidelines are just as important, if not more so, than the security technologies you use. Some of the mechanisms to mitigate the threats include:
    a. Security Awareness Programs – Training for staff members to understand their roles and responsibilities.
    b. Authentication – How should users be identified and what technology will be used to securely identify those users.
    c. Access control mechanisms – Identify which users should be able to access what data.

Continued on next page

Two Important Rules to Consider When Implementing Good IT Security

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d. Audit & Reporting – What kind of logs should be used to track actions by users and administrators? How will compliance reports be generated?

e. Data encryption – What data needs to be protected by encryption while stored (disk or tape) and while it is transmitted over networks?

f. Data backup – What data should be backed up and how should it be done?

g. Physical Access – Who should have physical access to the servers where patient and organizational data is maintained?

h. Disaster Recovery/ Business Continuity Plan – This plan should identify the critical applications, data and personnel as well as the plan for how those personnel are to bring the applications and data back online in priority order. HIPAA requires the organization have a backup plan, disaster recovery plan and emergency mode operation plan which are appropriate and reasonable for the size of the organization.

3. Implement – This stage of the process is about putting the new processes and technology in place. As mentioned above, this is as much about documented, consistent human processes as the technology. The organization needs to know how new users are added, old user accounts are removed, backups are run and tested and audit logs are reviewed.

The technology components should enforce the design and support the processes. All of the authentication, access control, encryption, patch, and audit components need to be tested and deployed.

4. Maintain – Processes should be put in place to continually monitor, maintain and review the security posture of the organization. The staff should verify that the authentication, authorization, audit logs, backups, etc. are all being maintained.

Another important step is to practice the disaster recovery process to verify the plan and make sure it will work if it is needed. Without the ongoing maintenance step, the effort and money invested in the first three steps is greatly reduced.

Only by implementing a continuous security management process can healthcare practices ensure that their practice remains safe and secure.

Christopher Crall is a Vice President with Carris ProCare IT. He holds the Certified Information Systems Security Professional (CISSP) certification. He can be reached by e-mail at chris.crall@procareit.com or by phone at 206.284.7154.

New Opportunities to Promote Adoption of Electronic Health Records

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may help promote the adoption of information technology in the health care setting. Health care providers looking to take advantage of these new rules should proceed with caution. The rules are complex, and the stakes for failing to meet their terms are high. Any proposed donation should be closely scrutinized to verify compliance with the new rules. In addition, it should be evaluated to ensure that the operational benefits of deploying a donated information system are sufficient to outweigh any burdens that may be imposed by dealing with a donor organization as opposed to having an arrangement directly with the underlying technology vendor.

David Schoolcraft is a health care attorney and partner of Miller Nash LLP, a multispecialty law firm with offices in Seattle and Vancouver, Washington, and Portland, Prineville, and Bend, Oregon. Mr. Schoolcraft can be reached at (206) 622-8484 or at david.schoolcraft@millernash.com.

When Projects Go Bad

By Paul Goldberg, MPH, PMP
Paul Goldberg & Associates, LLC

According to project management literature, a startling percent of projects fail; we're talking in the 50%-60% range!

Whether developing a new product or service, creating a strategic business plan, implementing a system, or improving a business process, projects just sometimes go bad. Often they aren't completed or if they are, they are late, over budget or short of the original scope. This is more than frustrating; it is expensive in terms of time, resources, missed opportunities and morale.

After years of managing complex projects, I have found there are many ways projects can get off track. Here are some of the common ones I watch for:

- The **sponsor** is not committed or involved. Or, worse, there is no executive level sponsor.
- The project is **not aligned** with the organizational vision, mission and goals.
- The **scope** is not managed and is either incomplete or "creeps" into unintended areas.
- There is no **work plan**, or the plan is incomplete or inaccurate.

> ***"Whether your world does or does not include formally trained project managers, there are some simple steps you can take to keep your project from going bad."***
>
> Paul Goldberg, MPH, PMP
> Paul Goldberg & Associates, LLC

- **Input** to what is required is vague, or **end-users** were not involved in developing requirements.
- Insufficient **resources** in terms of staff and/or funds are made available.
- There are no **project management** processes or tools.
- There is insufficient **communication** before and during the project.

Whether your world does or does not include formally trained project managers (yes, project management has become a fairly sophisticated discipline!), there are some simple steps you can take to keep your project from going bad:

Assign Appropriate Resources: Each project needs an Executive Sponsor to champion and guide it and a Project Manager to lead it on a daily basis. The Project Manager needs to be freed up to dedicate time for this work; for larger projects, this may require a half or full time commitment. Often, outside help needs to be brought in to play this role. The Project Team should include stakeholders from throughout the organization and include, in particular, those who are part of any process that is being created or changed. Be sure not to overwhelm team members who already have full time jobs. Reassignment of responsibilities may be necessary if a project is going to use more than 10% of a team member's time.

Write a Charter and Scope: These documents (I sometimes like to consolidate them to one document) identify the Executive Sponsor, Project Manager and the Project Team, and they describe the project objectives, desired outcomes, deliverables, key mile-

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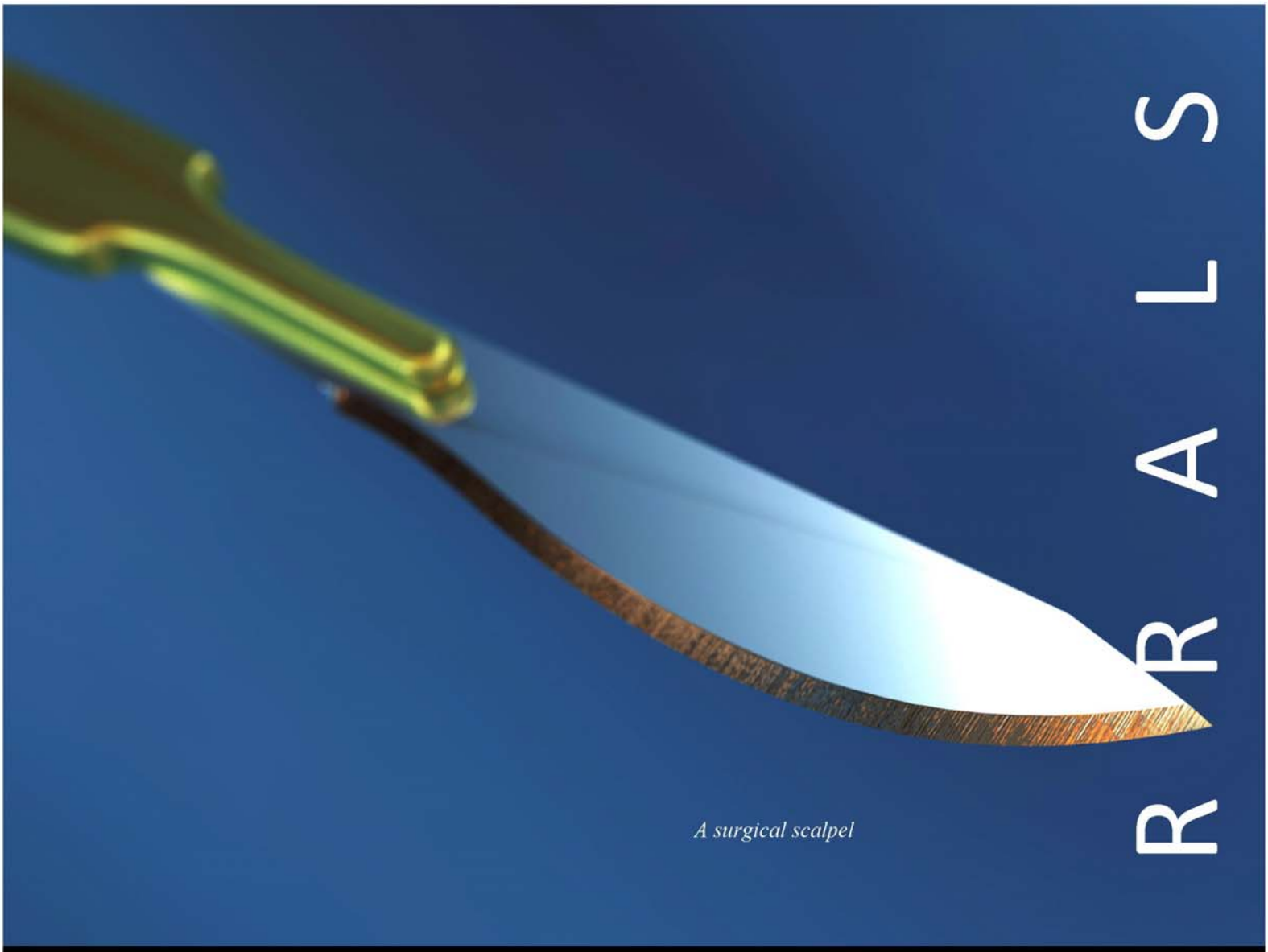

A surgical scalpel

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When Projects Go Bad

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stones, a high level timeline and resource needs.

These documents are used to authorize the project and attain agreement to and support of the project. They don't have to be incredibly detailed, but they do need sufficient information to guide the direction of the project.

Develop Detailed Requirements: This document provides detailed information on what the project is to deliver. It should be a collaborative effort to develop requirements and include extensive input from end-users.

Maintain a Work Plan: Projects can get complex fairly quickly. To keep activities from falling through the cracks, it is essential to keep track of specific tasks, dependencies, accountabilities, and start and end dates.

COMMUNICATE!! Make sure the entire organization knows what is being worked on, why, by whom and progress being made. Many staff are touched by these efforts, so make sure they know what is going on and that the work has Executive support.

Monitor and Adjust: Set up measurable milestones to check progress along the way. Review these regularly to see if the project is on target or if it is starting to go sideways.

If you find your project is off target, you must diagnose the problem and take action. It is important to identify the root cause of the problem. Some questions to consider are:

- Are you sticking to the project scope?
- Is there sufficient Executive Sponsor support, involvement and communication?
- Do team members understand their responsibilities?
- Are risks being identified and addressed?
- Are resources sufficient, and are they being used efficiently?

Once the problem is identified, action often comes in one of the following forms:

1. Change the project timeline. More time may be required to get things done. Or, in some cases, timelines can be reduced to create a sense of urgency and force efficiency (be careful, this can be tricky!).
2. Adjust the project resources. Consider not only the amount of resources, but whether they are the right resources. You may need to add funds to the budget, or staff to complete work on time. Team members may need coaching to increase their efficiency. Or, some may need to be replaced if they are not successful in completing their assignments.
3. Modify the project scope. It may be necessary to reduce the amount of what will be completed. (Be cautious, however, of saying things are going to be moved to a newly identified "phase 2", because I have found that, if not planned from the start, "phase 2" often doesn't happen). You also need to check for "scope creep" where new requirements have been added along the way. These may need to be taken out, or requirements re-prioritized.

Any of these actions can have a significant impact on the project's overall success. Such changes require good communication and buy-in from key stakeholders.

Even with perfect planning from the start, all projects are at risk of going bad. The key is to continuously monitor progress and be flexible enough to make adjustments along the way.

Paul Goldberg & Associates, LLC., focuses on business consulting, project management and project management training and coaching. For information, go to www.pgoldbergconsulting.com. Paul can be reached at 206.372.5158 or by email at paulg@pgoldbergconsulting.co.

Next Month in the Washington Healthcare News…

- We report on our March 2008 visit to Birch Street Medical Clinic in Grandview, WA.
- Op-eds from Mary Lou Misrahy of Physicians Insurance and State Senator Jerome Delvin (R)

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The Right Thing to Do: Honoring our Final Wishes

By Jim Moeller (D)
Washington State Representative
49th Legislative District

Yes, you bet ***it*** – our last day – could come way too soon. And when it comes, that day might well be way too late for us to have a say in decisions put off way too long. I'm talking about end-of-life decisions. Our final wishes. These are the highly personal decisions and wishes you will be in no position to express when your time comes.

But you know what? Unpleasant though the subject is, people should at least talk about it long enough to decide what they want done in the end.

A good start on this discussion is a POLST form, which is a "physician order for life-sustaining treatment." I've been working the past several months with a group of medical professionals, nursing-home directors, and hospital folks to find ways to make it easier to honor an individual's final wishes.

Our legislation (House Bill 2494) requires the state Department of Health (DOH) to create a template for a medical-treatment-preference form. Further, this legislative proposal would limit li-

> ***"Living wills are specified health-care declarations involving medical steps you either want taken or do not want taken at the end of your life."***
>
> Jim Moeller (D)
> Washington State Representative
> 49th Legislative District

ability for providers who act in accordance with such forms. State policy would provide protection from liability for all health-care personnel who in good faith are endeavoring to follow a valid POLST form. Right now, only emergency medical personnel are protected from liability.

Basically, this form documents your treatment-preference in a health care setting. The POLST might state "do not resuscitate." Or it might direct that only "comfort care" be provided. Or it might spell out your wishes for some other choice for emergency-medical treatment. Be assured that for such a form to be valid, it will need to be signed both by the patient and by the patient's doctor. You can see what this form looks like at *www.doh.wa.gov/livingwill/polst.htm* on the Internet.

Also involving end-of-life issues, I want to note that the Advanced Medical Directives Registry is up and running on the DOH Web site at *www.doh.wa.gov/livingwill*. This registry comes out of legislation I sponsored a couple legislative sessions ago. The idea in the statewide system is to protect a citizen's dignity and health-care wishes.

Recall the tragedy of Terri Schiavo in which a doomed Florida woman lived her final anguished time in the opposite of privacy. It was heartbreaking to see what she and her family went through. But her ultimate death did bring national attention to the importance of end-of-life planning. People couldn't help but ask themselves: "What can I do to prevent this nightmare from visiting my own loved ones if I ever fall into such mental and physical helplessness?"

I worked with a large group of interested individuals and organizations to write state policy to strengthen an individual's personal dignity in his or her final days. We believe this policy re-

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Moving Beyond Cancer to Wellness: Cure is Not Enough

By Debra Friedman, MD
Director
The Fred Hutchinson Cancer Research Center Survivorship Program

Each year, more people benefit from early detection of cancer and effective medical treatments, leading to a remarkable increase in the number of cancer survivors. Roughly 10.8 million Americans are now living with a previous diagnosis of cancer. This large number of survivors has prompted studies of the long-term health consequences of cancer and its treatment. Although cured from their cancer, survivors may have increased risk for other cancers, problems with their heart and lungs, memory issues, sexual dysfunction, infertility and other health-related issues. Therefore, cure is not enough. Cancer survivors should be taught about the possible health-related risks of cancer and its treatment, and steps that they and their doctors can take to keep them healthy.

All cancer survivors should have a comprehensive evaluation after completing their cancer treatment so they can understand the long-term physical and emotional problems that they may face in the years to come. This begins with a careful health history, a comprehensive physical examination and a survivorship care plan that they share with their primary health care provider and their oncologist.

> ***"Cancer survivors should be taught about the possible health-related risks of cancer and its treatment, and steps that they and their doctors can take to keep them healthy."***
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> Debra Friedman, MD, Director
> The Fred Hutchinson Cancer Research Center
> Survivorship Program

What is a survivorship care plan?

A brief outline of the summary of care may consist of the following:

- Diagnostic tests and results related to the cancer diagnosis and treatment
- Tumor characteristics, including site(s), stage, grade, hormone status, biomarker results
- Details of treatment
  - Type of treatment (surgery, chemotherapy, radiation, transplantation, hormone therapy, gene therapy or other)
  - Agents used (regimen, total dosage)
  - Dates of treatment
  - Indicators of response
  - Side effects
- Support services provided (psychological, nutritional, other)
- Contact information for treating institutions and key individual providers
- Name of key point of contact and coordinator of continuing care

A brief outline of the evidence-based follow-up care may consist of the following:

- Likely course of recovery from treatment toxicities
- Need for ongoing health maintenance/related therapy
- Recommended cancer screening and other periodic testing/ examination
- Possible late and long-term effects of treatment and their symptoms

Continued on next page

Continued from prior page

- Possible psychological effects (marital/partner relationships, sexual functioning, work, parenting) and potential need for support
- Information on possible insurance, employment and financial consequences
- Specific recommendations for lifestyle changes to promote health
- Genetic counseling and testing
- Known effective preventive strategies
- Resources to assist in the management of health problems related to cancer and its therapy

By providing a summary of the type of cancer and treatments that were carried out, a survivorship care plan enables physicians to tailor care to the specific needs of each individual survivor. The components of the survivorship care plan clarify appropriate screening, prevention strategies for second cancers and potential long-term effects of treatment.

In addition to helping to enhance the quality of care, a survivorship care plan empowers patients in several ways. First, the information in the plan helps reassure survivors helping them to know what to expect. Also, cancer survivors – especially those who were treated for childhood cancers – often do not know exactly what treatments they have received.

Lastly, educating cancer survivors about healthy behaviors is an integral component of survivorship care, and the plan provides a convenient instrument to convey recommendations.

Where can patients get a specialized survivorship evaluation?

To improve care for cancer survivors, Fred Hutchinson Cancer Research Center launched a comprehensive Survivorship Program to address the unique needs of cancer survivors. The program works together with survivors' primary care providers and oncologists to provide additional clinical services.

Survivors receive detailed information on their cancer, its treatment, and recommendations for good health and supportive care. A clinical evaluation is performed and the patient is provided with a survivorship care plan.

For more information about the Fred Hutchinson Cancer Research Center Survivorship Program call (866) 543-4272, e-mail survivor@fhcrc.org or visit www.fhcrc.org/survivorship.

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lieves our family's anguish. What we've created is a statewide registry of living wills drawn up to reflect a person's final wishes.

This living will comes into play if we are either terminally ill or unable to speak for ourselves. Citizens can send their hard-copy health-care declaration to the Department of Health and it will be added to the registry in a digital format. You can change your living will whenever you want. The registry is published on the secure Web site noted above, and it's accessible only when appropriate by you, physicians, nurses, and health-care facilities. Our objective is to improve access to advance directives and mental-health advance directives. To be sure, the registry isn't intended to replace the current system for these documents. We simply want a health-care provider to be able to consult the registry when there is a question about the patient's wishes in periods of incapacity.

No, these end-of-life issues obviously aren't the most pleasant of topics. It's a very tough decision. But it's a decision that your loved ones might one day send you a silent "Thank you" for making.

Washington State Representative Jim Moeller represents the 49th Legislative District of Clark County. Moeller is Deputy House Speaker Pro Tempore, and he is a member of the House Health Care Committee, the House Judiciary Committee, and the House Commerce & Labor Committee. He is co-Chair of the Joint Committee on Veterans & Military Affairs.

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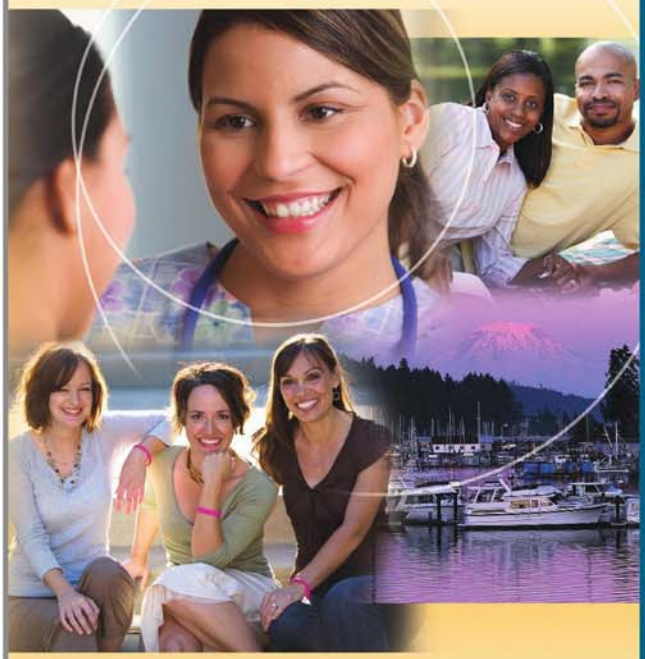

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In addition, please visit our website for a complete list of opportunities.

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Chief Executive Officer

The Regional Hospital for Respiratory and Complex Care has retained Deering and Associates to recruit their new Chief Executive Officer.

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If you or anyone you know might be interested in this opportunity please reply in the strictest confidence with a resume to Deering and Associates or by calling toll free (888) 321-6016 or email at george@deering-associates.com.

Plan and Hospital Financial Information

YTD Net Income and Members through 12/31/07 for the Largest Health Plans in Washington State[1]					
Plan Name	**Net Income**	**Members**	**Plan Name**	**Net Income**	**Members**
Health Plans:			LifeWise Health Plans of AZ.	($14,426,104)	29,247
Regence BlueShield	$66,598,417	884,409	Arcadian Health Plan	$4,598,287	19,157
Premera Blue Cross	$105,875,522	729,843	Timber Prod. Manuf. Trust	$633,552	17,541
Group Health Cooperative	$64,174,802	402,011	Washington Employers Trust	($1,149,392)	7,553
Molina Healthcare of WA	$45,477,166	283,485	Aetna Health, Inc.	$2,278,790	6,655
Community HP of WA	$5,548,137	231,673	Washington State Auto Ins. Trust	($904,993)	3,160
Group Health Options	$142,694	105,769	Puget Sound Health Partners	($3,619,579)	0
Asuris Northwest Health	$5,787,486	91,092	**Vision or Dental Plans:**		
LifeWise Health Plan of WA	$1,148,702	90,500	Washington Dental Service	$15,762,154	925,417
Pacificare of Washington	$54,015,908	51,465	Vision Service Plan	$6,945,130	552,312
KPS Health Plans	($2,556,888)	44,846	Willamette Dental	$661,905	72,461
Columbia United Providers	($2,281,141)	35,684	Dental Health Services	($1,412,266)	25,621
YTD Margin and Days through 12/31/07 for the Largest Hospitals in Washington State [2]					
Hospital Name	**Margin**	**Days**	**Hospital Name**	**Margin**	**Days**
Sacred Heart Medical Center	$69,153,314	149,640	St. Joseph Hospital Bellingham	$17,648,065	58,838
Swedish Medical Center	$101,027,578	143,492	Valley Medical Center	$29,143,036	53,265
Harborview Medical Center	$18,045,000	135,303	Yakima Valley Memorial	($834,838)	49,747
Providence Everett Med Ctr	$30,321,510	100,545	Highline Medical Center	$9,243,352	47,273
University of WA Med Center	$31,441,957	97,450	Northwest Hospital	$10,753,263	42,184
St. Joseph Medical Center	$73,744,228	92,323	Swedish Cherry Hill Campus	($11,255,381)	41,141
Virginia Mason Medical Ctr	$18,452,019	86,009	Kadlec Medical Center	$9,469,532	40,534
Southwest WA Med Center	$30,890,264	85,285	Central Washington Hospital	$9,999,359	40,116
Providence St. Peter Hospital	$24,444,980	83,281	Holy Family Hospital	$4,247,560	38,466
Tacoma General Hospital	$44,060,634	82,693	Saint John Medical Center	$25,177,258	37,689
Children's Hospital	$105,484,001	67,504	Stevens Hospital	$2,459,250	33,269
Deaconess Medical Center	($1,576,743)	65,362	Legacy Salmon Creek Hospital	($2,735,275)	32,896
Harrison Medical Center	$28,129,020	65,180	Auburn Regional Medical Center	($1,374,219)	31,856
Overlake Hospital Med. Center	$15,005,620	59,274	North Valley Hospital	$564,358	29,878

[1]Per filings with the WA State Office of Insurance Commissioner. [2]Per filings with the Washington State Department of Health. Evergreen Healthcare and Good Samaritan Healthcare were among the largest hospitals but their complete financial information wasn't available from the Washington State Department of Health at press time.

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