Washington Healthcare News

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Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 4, ISSUE 5 MAY 2009

Electronic Medical Records: Friend or Foe?

By Carol Sue Janes
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Hypothetical: A medical malpractice lawsuit alleges a failure to diagnose the aortic dissection that caused the sudden death of the patient. Two days before his death, the patient had visited a medical clinic, where the patient had shown normal vital signs except for a slight fever, and a mild shortness of breath. Based on the initial clinical presentation, the tentative diagnosis was pericardial rub or possible systolic murmur. The clinic's electronic medical records (EMR) showed that the clinic had promptly ordered blood work, a blood culture, and an echocardiogram, with a follow-up appointment in one week.

Benefits of EMR. EMR are becoming more and more common for health care providers. Providers are recognizing that EMR offer many advantages over handwritten records. They can be accessed quickly and easily by multiple providers at different locations. A provider can obtain all types of medical information (e.g., chart notes, test results, pharmacy records, and radiographs) from a single access point. Some EMR systems provide cross-checks for error reduction, such as notifying the provider regarding possible drug interactions. EMR systems may also prompt the provider and office staff to document follow-up after a patient appointment, such as documenting review of test results or radiographs, follow-up notification to the patient, and scheduling of any additional appointments. EMR are more legible and safer from destruction. EMR systems can protect confidentiality by password access and other appropriate safeguards quite well. EMR are searchable by content, both for use for patient care and for appropriate research purposes. They can result in cost reduction by reducing paperwork. Some systems also allow for patients to view their medical records directly via online access.

Litigation with EMR

Production of records. Certain features of EMR deserve special attention from a litigation perspective. As an initial matter, providers using EMR need to consider how records will be produced for litigation. Production of an EMR patient record takes more careful consideration than merely making a photocopy of the chart and duplicates of any radiographs. Legal counsel and the health care provider will likely work with in-house

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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,

In the summer of 2006 we published our first edition of the Washington Healthcare News. It contained an article on Pay-for-Performance, an interview with Sydney Smith Zvara, Executive Director of the Association of Washington Health Plans, and financial results for the largest hospitals and domestic health insurance companies in Washington.

In the summer of 2008 we increased our distribution to health care leaders in Alaska, Idaho, Montana and Oregon. In consideration of our larger service area, and the interests of our new readers, we added Idaho, Montana and Oregon health insurance companies and Oregon hospitals to our reporting. There are no domestic health insurance companies in Alaska and many hospitals in Idaho, Alaska and Montana don't make their financial information available to the public.

We changed the method used to present financial information this month. Now it is available on the home page of our web site at **www.wahcnews.com** instead of in our print edition. The primary reason we made this change was to reconcile the time between when the hospital and health insurance company financial information is available and the time we print our hard copy. By presenting it on our web site we can always provide the most currently available information.

So, if you want to review current financial information for northwest health insurance companies and hospitals visit **www.wahcnews.com** and click on the link to the report. A press quality PDF will open that can be printed or saved. Until next month.

David Peel, Publisher and Editor

Washington Healthcare News 2009 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2009	Urban Medical Clinics	December 1, 2008	December 22, 2008
February 2009	Human Resources	January 2, 2009	January 19, 2009
March 2009	Rural Hospitals	February 2, 2009	February 23, 2009
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October 2009	Community Health Centers	September 1, 2009	September 22, 2009
November 2009	Urban Medical Clinics	October 1, 2009	October 19, 2009
December 2009	Urban Hospitals	November 2, 2009	November 23, 2009

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IT staff or IT consultants to determine how to access and produce the EMR correctly.

User ID and time stamp features. The EMR likely contains information showing the "footprint" of when and how the provider and other staff created and accessed the EMR. The information may be visible to the provider, or may be invisible and stored in the form of "metadata" within the system. The metadata may be accessible and subject to disclosure in medical malpractice litigation. The existence of the electronic "footprint" makes it important for each individual to have a unique log-in credential rather than, for example, a physician and the physician's medical assistant sharing the same credential, so that it is clear after the fact which individual was accessing and making entries in the record. Disclosure of metadata should exclude the data showing when the provider reviewed the EMR with a risk manager or counsel for purposes of litigation.

Providers should pay careful attention to how any time stamp feature functions in the EMR systems they use. The timing of the provider's review of records may be important, particularly in the context of litigation. If a provider viewed a record twice, the software may only maintain a footprint record of one viewing and not the other. In addition, certain "preview" modes of review may not trigger the time stamp footprint, even though the provider in fact reviewed the information and took action on it. In the hypothetical case above, the EMR record only showed a time stamp for the physician's last review of the patient's lab work, after the patient's death, but did not document the physician's review of the lab work the day after the clinic visit because she had viewed it that day by looking at it in an e-mail in the "preview" mode. The time stamp feature was able, however, to accurately show when the physician had reviewed the patient's prior records, and when and who had promptly scheduled the patient's echocardiogram, lab tests, and follow-up appointment.

System prompts and default entries. EMR systems often include prompts for documentation, which can provide helpful reminders to ask key ROS and diagnostic questions, can simplify the thorough documentation of pertinent findings and negative findings, diagnoses, and indications for treatment, and can facilitate complete documentation for billing purposes. In the hypothetical case, although the plaintiff's counsel had asserted that the patient had experienced prior episodes of syncope, which might have led to a different tentative diagnosis, the EMR demonstrated that the physician had asked about associated symptoms and the patient had revealed no relevant symptoms, and the ROS showed that the patient's systems were negative for syncope.

EMR systems can even make suggestions for diagnostic options, suggested treatment plans, and patient instructions for post-treatment. Many of these features, particularly for primary care providers, may be triggered by the documentation of the patient's initial presenting symptom, so the provider may need to be particularly thoughtful with this documentation in order to make the best use of the software's features. The provider should also be prepared to probe outside the software's templates and suggested chart entries.

Some EMR systems provide default field entries for certain automated fields. For example, a field might have three possible options for the provider to choose from: normal risk, low risk, or high risk. The system might default to the normal risk entry. But if the provider overlooks that field, and the system automatically generates a "normal risk" entry that is not accurate, then it may appear that the provider entered inaccurate data, or did not identify a risk level that should have been considered. The provider should become very familiar with what the software's default settings are, and develop documentation habits regarding these settings. This may require additional typewritten notes to provide more detailed explanations than the default settings may offer.

Effect on patient interactions. A provider may want to consider how the use of the EMR system affects their personal interactions with a patient during an appointment. If the system is designed for use during the patient appointment, it may provide many benefits, with prompts and automated entries. It can also distract from personal interaction with the patient, including eye contact and opportunities to make medical observations of the patient. The provider may want to develop new interaction habits around the use of EMR to prevent any loss of opportunity to build personal rapport with the patient.

Secured access. Those keeping EMR must also undertake appropriate safeguards to prevent loss of the EMR from computer failures

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or access by unauthorized users. Washington law allows juries to make an adverse inference against a health care provider whose health care records are no longer available. In addition to the federal HIPAA protections for the security of health information, state law requires notification to individuals whenever the keeper of "computerized data that includes personal information" reasonably believes that an unauthorized person has acquired access to the information. RCW 19.255.010.

Stark and anti-kickback considerations. Hospitals wanting to offer EMR access to outside physician clinics must also be aware of federal physician self-referral ("Stark") and anti-kickback laws under which the hospital's information sharing may be viewed as a benefit conferred in exchange for referrals. Hospitals should review such arrangements so that they fit under a Stark law exception or anti-kickback safe harbor.

EMR are an important development in providing medical care and documentation. They can provide valuable assistance with defense of a medical malpractice action, as they did in the hypothetical case. But providers must be aware of the challenges as well as the benefits of using EMR, in order to provide the best care for the patient and the best defense in any litigation.

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Personal Health Information: Compliance and Security

By Chris Kradjan
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Estimates indicate that close to 1 in 5 hospitals have experienced an information breach in the past six months, and surveys suggest that 1 in 23 individuals have been the victim of identity theft. Compromised personal health information (PHI) is indeed a real risk, and thanks to increased public scrutiny and media attention—as well as direct legal, monetary, and reputational implications—PHI compliance and security often top the list of IT projects for health care organizations.

Fortunately, administering an effective IT compliance program and enforcing PHI security do not have to be onerous when done in orchestration with other initiatives. The most progressive IT departments are working carefully to coordinate EMR implementations, routine security audits, HIPAA and PCI compliance, Red Flag Rules privacy programs, disaster recovery planning, quality control, and ITIL adoption, to name a few. By working on these various efforts in an organized manner, organizations can simultaneously address multiple risks, and do so in a more efficient and economical manner.

To address health information privacy, organizations should first consider the challenges. We can categorize these into three groups: consumer expectations, organizational and environmental factors, and technology.

Consumer expectations can come in many forms, such as interoperability, a high level of care, 24/7 coverage, and zero tolerance for PHI exposure.

Compounding factors from organizational and environmental causes include balancing a vast number of specialties with a wide array of internal and external parties, responding to similar yet disparate regulatory requirements, overcoming the absence of clear standards, staff resistance to change, and investing financial and staff resources wisely in light of restrictions.

Finally, technology constraints appear within fragmented and disparate systems, data housed in silos and data warehouses, lack of full integration, limitations on interoperability, and dissemination of data through mobile devices.

Implementation of an effective compliance and security program that protects the privacy of PHI must encompass the following:

- Data and threat identification
- Policies and procedures
- Employee training
- System security
- Compliance documentation
- Detection and reporting methodologies

While the development of a privacy program to protect PHI may originate with a subcommittee of the organization's board, the ultimate responsibility needs to rest at the top of the organization. This will establish appropriate expectations when it comes to PHI security and compliance. The board should appoint a privacy officer who administers the compliance framework and remains accountable for results. The privacy officer should serve as the first line of defense for supervising, monitoring, and staying well-versed in the many disciplines affecting compliance.

To sufficiently identify relevant data and threats, the organization should brainstorm with other institutions, consider possible threat domains, perform a risk and readiness assessment, determine system limitations, institute system controls where possible, and develop compensating safeguards as needed. This process allows for the constructive development of policies and procedures that can

be cross-referenced to the various regulatory requirements, support meaningful employee orientation programs, and become the foundation for staff training content. With periodic updates, the documentation and training elements can be useful for developmental education and ongoing awareness—and for effectively communicating the board's expectations to the staff.

At the heart of protecting PHI is a thorough risk assessment. This entails isolating at-risk data elements and systems, implementing strong security settings for user roles, instituting logical structures of protection to system records, and using logging features within systems. When automated controls are not available, organizations should develop manual procedures and controls to compensate for inherent system limitations. Interaction with peers will prove critical in jump-starting this endeavor and avoiding having to reinvent the wheel.

Once effective compliance and security systems are in place, management must work collectively to provide sufficient staff awareness around the program as well as streamline and centralize reporting so that identified issues are captured, triaged, and appropriately addressed. In larger organizations, this is often best done through coordination between the IT, internal audit, and compliance teams. Given the need for transparency under many of the current regulations, organizations should ensure that identified breaches are properly addressed and reported through a controlled response plan, communicated to consumers for notification purposes, and meet external reporting requirements.

Chris Kradjan is a Partner with Moss Adams LLP and the Practice Leader for the Information Technology Auditing and Consulting Group. He has been with Moss Adams since 1994, and has been consulting since 1992. Chris specializes in providing service to health care organizations, not-for-profit, government and private businesses. His consulting engagements have involved the use of state-of-the-art methodologies and tools for analysis, planning, estimating costs, scheduling, and risk management for proposed solutions. Mr. Kradjan can be reached by phone at 206-302-6511 or by email at chris.kradjan@mossadams.com.

To learn more about Moss Adams LLP visit their web site at www.mossadams.com.

Retirement 2.0 - What Now?

By Ward M. Harris
Managing Director
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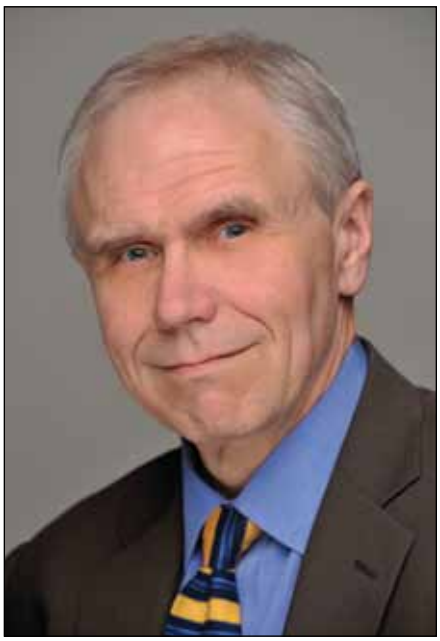

In golf, to "take a mulligan" is the act of driving a second ball off the tee after a failed first attempt, a.k.a. "a do-over".

Wouldn't it be nice to rewind our investment decisions of the last few years? Unfortunately, that's not an option in a world where in 2008 average 401(k) plans retirement plan assets were down by -27% and defined benefit plans did little better at a -25%.

With so much bad news about the economy, job losses and the markets, isn't it time for some good news?

While we can't grant you a mulligan on this course, there are ways to improve your odds of getting on the green. In coming months, this column will seek to inform, educate and equip its readers to help make better investment decisions, manage your organizations and your careers. Let's do the best with what we have.

Many Washington Healthcare News readers play a role in managing or influencing the retirement plans offered by your organizations.

Our mission is your personal and professional success. Our core constituents are general management (CEOs and legal staff), finance and HR/benefits leaders and members of investment and retirement committees – or anyone interested in the success of the retirement plans of health care organizations.

Market, regulatory and business challenges provide the backdrop for our analysis of challenges (and opportunities) facing health care retirement plans – their sponsors and participants.

The Bad News

Many health care retirement plans (403(b), 401(k) and defined benefit) under perform in terms of risk, return, expense and services to participants. Even in good times, many of us are paying too much for what we get. More recently, the results have been even more troubling.

Causes of this condition include poor alignment of client needs and vendor solutions along with a challenged sales/service paradigm, wrapped in an archaic business model. Add inattention due to other business priorities and it's no wonder that even well-crafted retirement programs may operate less efficiently and less effectively than we might desire.

The Good News

Resources are available to increase the probability of a favorable result. Through modern benchmarking tools and professional best practices, you can create effective, efficient and ethical processes to do the right things, in the right ways, for the right reasons.

This approach documents the efficacy and value of your efforts to boards, participants, regulators and – yes – even plaintiff's counsel should you ever be called to task.

These concepts, tools and techniques are equally valid whether you "do-it-yourself" or rely upon a trusted advisor.

This column's performance will be measured by your success. Please share your challenges, your aspirations, your successes and even your failures.

Our readers' perspectives and experiences will have great value for your professional community. Please tell us what you think.

Next Month: "Current Trends in Healthcare Defined Benefit Plans: Fund It, Fix It or Forget About It"

Coming in June: National Webinar on Health Care DB Plan Crisis Management

Ward Harris is Managing Director with McHenry Partners, a national investment consulting firm. A Seattle native with 30 years of experience in investments for corporate and not-for-profit organizations, Ward has served clients in consulting and management roles at Union Bank of California, Schwab Institutional and Rogerscasey, Inc. He can be reached at 1-800-638-8121 or ward.harris@mchenrypartners.com.

CIO Watch Words: Focus on the Basics, Integrate and Prepare for the Future

By Tom M. Martin
SVP Strategic & Support Services/CIO
Evergreen Healthcare

These are certainly unprecedented times for Healthcare IT. Irony and paradox seem to dominate the horizon for CIO's trying to navigate today's rough seas. Capital continues to tighten while demand for information technology ironically continues to grow. The paradox is that physician adoption of IT lags, while early adopters would never go back to paper. Here at Evergreen Healthcare, our response to these challenges can be summarized into the following watch words:

- **Focus on the basics**
- **Integrate**
- **Prepare for the future**

Evergreen Healthcare is a medium-sized integrated system centered on a 227 bed public hospital in Kirkland, Washington. Primary care is supported through seven clinics and two urgent care centers. Evergreen Neurosciences Institute provides care for Multiple Sclerosis, Parkinson's and stroke patients. In addition, Evergreen has an extensive home health and hospice practice.

In 2002, Evergreen Healthcare purchased the full Cerner suite of clinical applications and has implemented scheduling, registration, ADT, lab, pharmacy, order management, emergency room, surgery scheduling, surgery nursing documentation, medical records and document imaging. Nursing documentation is partially implemented and physicians have ubiquitous access to the system via a physician portal. Physicians still document and order on paper. Primary care and Home Health are fully electronic using McKesson products.

As we moved into 2009, the executive team made a conscious decision to evaluate all activities because of the continued economic deterioration. The goal was to preserve capital reserves and to avoid layoffs. For IT, that evaluation included not only the IT leadership team but also the IT steering committee that oversees all IT expenditures for Evergreen. This process generated the following results.

Focus on the Basics

1. *Provide a stable and responsive environment.* We consciously slowed the rate of change in the existing systems, creating fewer problems and overall increased stability. We also redoubled efforts at the help desk to ensure the phones were answered timely and that problems were solved on the first call. Our performance through the first quarter is a 5% abandon rate and an 80% first call resolution.
2. *Reduce the overall cost of operations.* We focused on travel and training initially. We also spent a lot of time evaluating our telecommunications budget, finding and cancelling data circuits, cell phones and pagers no longer being used. A consultant audited our phone bills, finding significant savings as well. Our next step is to go to major vendors and have a discussion regarding maintenance costs.
3. *Don't start new projects without evaluating capital availability.* We started 2009 with a capital budget of $1.6 million and a number of projects already started. The IT steering committee evaluated each project already started and those budgeted for 2009. While no active projects were cancelled, a commitment was made not to start any new projects without first evaluating the capital position of the hospital. These decisions were communicated to the key stakeholders.
4. *Focus on maintenance and enhancement tasks with a quick return.* We have been in an aggressive project mode over the last three years, with some maintenance and enhancements being deferred. With resources not going to projects, they were refocused to the de-

ferred maintenance activities with the highest returns.

Integrate

1. *Complete migration of system phones to VOIP.* The hospital had recently completed a migration from a Centranet phone system to VOIP. The clinics and remote sites were the remaining locations still on Centranet. By completing their integration into the hospital VOIP system, we will save over $300,000 per year, as well as improve the diversity of the network of the hospital by having a second entry point to the main campus.
2. *Improve access of information across the continuum of care.* While Evergreen Healthcare has invested significantly in IT across hospital, clinic and home care settings, the data is not readily shared. With resources focused less on specific solutions, we are renewing our emphasis on having necessary clinical data from across the system available at the point of care. This includes additional interfaces and email notification of clinical events.
3. *Provide a safe place for physicians to share clinical data.* Using our physician portal, Microsoft exchange® and ZixMail®, we are providing a forum for community physicians to have encrypted email conversations.

Prepare for the Future

1. *Plan for Computerized Physician Order Entry (CPOE).* Evergreen Healthcare has not implemented CPOE. We are taking advantage of this capital slow down to prepare for CPOE as soon as capital resources are available. Physician committees have been formed, identifying key physician leaders. Pre-requisite activities are being outlined and teed up for execution. Budget planning is well under way.
2. *Prepare for sponsoring community physician Electronic Medical Records (EMR).* Evergreen Healthcare has begun developing business plans for how to best help physicians in our community to implement EMRs. This includes picking a limited set of EMR offerings, identifying implementation and integration requirements and determining funding limits and expectations.

It is easy to be disturbed by the realities of capital shortages or pressures to reduce cost. The CIO's role is to identify how to best adjust to these realities and deliver the maximum value for the resources entrusted to them.

Poliner v. Texas Health Systems: Confirming Peer Review Immunity

By Jennifer Gannon Crisera
Attorney
Williams Kastner

In 1986, Congress, concerned about "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care," sought to encourage good faith professional peer review activities and enacted the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. 11101 *et seq.* Congress found, among other things, that "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review" and granted limited immunity from suits for money damages to participants in professional peer review actions. Twenty years later, *Poliner v. Texas Health Systems*, 537 F.3d 368 (5th Cir. 2008) confirmed that immunity.

In August 2004, Lawrence Poliner, M.D., a board-certified physician in internal medicine and cardiovascular diseases, had certain hospital privileges suspended because of concerns over his care of several patients, including performing an angioplasty on the wrong artery. After a random review of 44 of Dr. Poliner's cases demonstrated substandard care, the peer review committee recommended summary suspension of his catheterization lab and echocardiography privileges.

Dr. Poliner objected to the suspension. After exhausting his procedural rights under the hospital's bylaws, he sued the hospital and several physicians involved in the peer review process, alleging defamation and other claims. The jury awarded Dr. Poliner $366 million in damages. The district court reduced the award to $33.5 million including pre-judgment interest. The defendants appealed, claiming immunity from monetary damages under HCQIA. The Fifth Circuit agreed and reversed the district court's judgment as noted below.

> Under HCQIA, a professional peer review action must be taken:
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary for [HCQIA immunity] unless the presumption is rebutted by a preponderance of evidence.

42 U.S.C. 11112(a).

The Fifth Circuit noted that "the HCQIA's 'reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard.'" 537 F.3d at 377. The focus is not on whether the peer review participants' beliefs as to the course of care were right, or even whether the participants had bad motives, but rather whether the peer review decision was objectively reasonable looking at the facts available to the participants at the time. 537 F.3d at 379-80. The peer review committee had found substandard care in more than half of the 44 of Dr. Poliner's cases it reviewed. Thus, the Fifth Circuit found it objectively reasonable for the peer review committee to conclude that restricting Dr. Poliner's privileges would further quality health care. Id. at 379.

Dr. Poliner argued that HCQIA immunity should not apply because the hospital failed to comply with its own bylaws. The court disagreed, holding that "HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards." 537 F.3d at 380-81. So long as the peer review action meets HCQIA's requirements, failure to comply with bylaws would not defeat immunity. Id.

The court made clear, however, that the HCQIA immunity is limited to money damages. Doctors who are subjected to unjustified or malicious peer review still may seek appropriate injunctive and declaratory relief in the courts. 537 F.3d at 381.

The Poliner decision is the result of 10 years of expensive litigation and likely a great personal toll on all involved. The U.S. Supreme Court declined review of the case on January 21, 2009, and denied Dr. Poliner's request for reconsideration on March 23, 2009.

Poliner should provide some comfort to participants in hospitals' professional peer review processes. As the Fifth Circuit noted:

> To allow an attack years later upon the ultimate "truth" of judgments made by peer reviewers supported by objective evidence would drain all meaning from the statute. The congressional grant of immunity accepts that few physicians would be willing to serve on peer review committees under such a threat; as our sister circuit explains, "'the intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.'" At the least, it is not our role to re-weigh this judgment and balancing of interests by Congress. [Citations omitted.]

537 F.3d at 384-85.

Ms. Crisera is a Senior Associate in the Seattle office of Williams Kastner where she advises clients on matters related to health care law, commercial litigation and product liability. She can be reached at jcrisera@williamskastner.com.

Williams Kastner has been providing legal service to health care providers and other clients since 1929. It has offices in Seattle and Tacoma, Washington and Portland, Oregon.

An Interview with John Long, President of MultiCare Good Samaritan Hospital in Puyallup, WA

John Long is the President of MultiCare Good Samaritan Hospital in Puyallup, WA. Good Samaritan's primary service area is East Pierce County, WA. David Peel, Publisher of the Washington Healthcare News, asked Mr. Long a few questions in the March 2009 interview.

You have a long history as a Washington State health care executive. Describe your work history leading up to your position as President of Good Samaritan Hospital.

I first came to the area in 1986 to serve as President/CEO of St. Joseph Medical Center in Tacoma. During my tenure there, I served as Chair of the Board of the Washington State Hospital Association (WSHA). Later, I served as Vice President of External Development for Franciscan Health System, then served eight years in executive leadership as Chief Operating Officer with Group Health in both the Tacoma and Seattle locations, before moving to MultiCare Health System in Tacoma in 2004. At MultiCare, I was the Strategy Executive, a position primarily focused on major growth initiatives, including the eventual affiliation between MultiCare and Good Samaritan. At the conclusion of the affiliation in August 2006, I was asked to become the first affiliation President at MultiCare Good Samaritan.

Describe the services offered by Good Samaritan Hospital.

The hospital is recognized for a variety of services, including a Level III Trauma Center, a nationally-certified, comprehensive cancer care program, a Level 1 trauma physical medicine & rehabilitation center, state-of-the-art Family Birth Center, a top notch Orthopedics Program, and many others.

MultiCare Good Samaritan also offers a half dozen family care clinics throughout East Pierce County and several specialty services such as the Sleep Medicine Centers, the internationally known Children's Therapy Unit for children with neuromuscular disabilities, and the Good Samaritan Surgery Center.

"The affiliation with MultiCare was a turning point for Good Samaritan Hospital."

As a part of our outreach services, we provide comprehensive behavioral health services throughout East Pierce County, screenings and immunizations through our mobile health program, as well as home health and hospice programs and older adult services.

In 2006, Good Samaritan Hospital became affiliated with MultiCare Health System, the large Tacoma based health system. What is the nature of this affiliation and how has it helped Good Samaritan Hospital?

The affiliation with MultiCare was a turning point for Good Samaritan Hospital. Prior to the affiliation, we were not in a strong competitive or financial position. The support from MultiCare helped us overcome those hurdles and get us on the path to becoming the hospital that East Pierce County communities need and desire.

The influx of capital and expertise from throughout the extensive MultiCare system provided us the ability to grow, not just through expansion projects, but also through numerous clinical programs and services. For example, in January 2008, a 24-bed Cardiac Specialty Unit opened, focusing on serving patients with heart attack symptoms and related cardiac needs. Last fall Mary Bridge Pediatric Care at Good Samaritan opened, allowing young patients and their families the opportunity for specialized pe-

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Proliance Highlands Medical Center Opens to Serve Patients in Issaquah and Beyond

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

Located at 510 8th Avenue NE in the Issaquah Highlands, Proliance Highlands Medical Center is a striking three-story facility featuring over 43,000 square feet of space. While supporting primarily orthopedic services, the building also houses an ambulatory surgical center, imaging center and a physical therapy suite; future plans include an ear, nose and throat (ENT) practice and an administrative suite.

Situated on 2.5 acres of land in a pedestrian friendly zone, the medical center serves the burgeoning population of the eastern corridor and reduces the necessity of driving to Bellevue or Seattle to receive care. "Our provider group, Proliance Orthopaedic and Sports Medicine, recognized the value of not only 'owning the house they live in' but expanding their presence in the Issaquah area," explains Frank Gilbert, Executive Director. "Establishing their initial practice in Issaquah over twenty-five years ago, expanding to Bellevue and now opening our new building in Issaquah to serve a growing patient demand, these providers wanted a facility that would provide easy access and state-of-the-art technologies."

As part of Proliance Surgeons, Inc., the largest surgical medical group in Washington, Proliance Orthopaedic and Sports Medicine offers services which include surgical and non-surgical procedures for problems of the bones, joints and muscles at the Highlands location. The facility, 99% built to suit, was designed to be as flexible as possible and to effectively accommodate all specialties. Gilbert continues, "A multi-specialty group, our providers treat sports injuries, hand and arm problems, spinal injuries; they perform arthroscopic surgery and can even provide total joint replacements. Our goal is to maximize the efficiency of client visits and enhance our provider's capabilities."

Proliance Highlands Medical Center in Issaquah, Washington

In addition to the orthopedic clinics, the facility houses an imaging center on the first floor which features an MRI that doesn't require a separate computer room. According to Gilbert, this unique system means the unit uses significantly less power while producing the same quality of images in much less time. "Again, we increase the flexibility of our providers while improving the patient's experience – and this MRI enhances the "green" capacities of our facility," adds Gilbert.

Built in partnership with Marshall Erdman and Associates of Madison, Wisconsin (a Cogdell Spencer Company), the Proliance Highlands Medical Center was designed

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diatric physician and nursing care close to home.

The affiliation with MultiCare has helped us breathe life back into Good Samaritan and rallied its employees, physicians and the communities we serve around our dynamic and energizing vision: to be the trusted regional medical center of choice for every person in East Pierce County.

In early 2008 you broke ground on a new $400 million Patient Care Tower. What were the reasons behind this significant expansion?

This expansion has been something the community has needed and wanted for years. Many are not aware that Good Samaritan has one of the busiest Emergency Departments in the state. The original department, built in 1952, was designed to serve just 25,000 patient visits per year. We have far surpassed that number with over 61,000 visits last year.

It isn't just about the Emergency Department; the Patient Care Tower will provide expansive private rooms for our patients, with plenty of room for families, as well as an entirely new surgery department, imaging services and cardiac catheterization labs.

The tower will be technologically state-of-the-art and provide a beautiful, healing environment which will serve our growing communities for years to come. I am very proud to be a part of this renaissance and look forward to seeing our first patients in March 2011.

What else would be important for our readers to know about Good Samaritan Hospital?

One unique involvement for which we are very proud: for the past year and a half, MultiCare Good Samaritan has been partnering with the Ft. Lewis 5th Stryker Brigade Combat Team, 2nd Infantry Division, on an information sharing project. This partnership developed from the Brigade's interest in learning about hospital infrastructure in order to replicate similar services to communities overseas.

Each member of the Brigade was partnered with a member of Good Samaritan's staff in various departments such as physical medicine & rehabilitation, emergency department, campus development, and behavioral health. The partners met multiple times on Good Samaritan's campus to shadow our clinicians and share best practices.

This partnership has allowed the Brigade to understand the inside of a community hospital. When they are deployed this spring to Afghanistan, they will use what they learned here to help the local community there. We fully intend to continue our relationship with Ft. Lewis while they are overseas as they will be seeking advice and assistance in developing medical clinics.

This unique partnership between the military and our medical world has also benefited Good Samaritan.

For example, over the past 18 months we have welcomed soldiers from Ft. Lewis to participate in our internal disaster drills. Their experience and training in disaster preparedness has helped us streamline our processes.

The partnership has benefitted the two organizations beyond the initial expectation by building a relationship that will encourage best practices not only here in Puyallup but internationally.

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to reflect the environment which surrounds it. "Erdman is one of the top health care facility designers and builders in the country," says Gilbert. "They worked with our providers in an open and flexible manner – allowing our physicians to design the type of delivery system they needed."

With two sides of the building facing panoramic views of forested sections of land which will never be developed, the medical center was designed to convey a "lodge-type" look and feel. The exterior combines HardiePlank® siding with a stone façade and cedar beams. This feature is carried into the interior as well, with exterior stone used in the lobby and cedar beams utilized throughout the building. A combination of light and dark cherry laminates adds to the lush feel and a gas fireplace in the lobby is an attractive and functional centerpiece. "Matching our architecture to the physical setting was pivotal in the design of this building," adds Gilbert. "Designed and built with energy conservation in mind, we wanted it to be a pleasing addition to the Highlands area."

Featuring an open stairway to all three floors, the center favors collaboration and uses totally digital support services. Digital x-ray machines, digital MRI and other equipment provide optimum imaging quality in an environment without film. They no longer have to waste space and use toxic chemicals to produce and store x-ray film. Someday, in combination with their electronic medical record system, they hope to have a virtually paperless environment.

Individual suites are situated in the building to foster quick access and flexibility. Each "pod" is physically configured the same way and with minimal modifications can be quickly converted for use with any of their orthopedic specialties. This allows providers to utilize any pod available creating the most efficient and flexible scheduling environment. Warm, natural colors create an inviting space for clients and natural light floods the building, enhancing the lodge-like feel.

Designed to integrate with the surrounding forested areas and committed to providing excellent care to its patients, Proliance Highlands Medical Center combines state-of-the art technologies with compassionate and comprehensive care. The Highlands location, with its easy access off I-90 allows the entire Issaquah area to be served as well as parts of Redmond, Bellevue, Snoqualmie and North Bend.

Career Opportunities

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Manager - Health Information

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 650 staff members and 185 providers. The Clinic is one of the region's principal health care providers, offering extensive services to our patients.

The Manager - Health Information is responsible for the operations of state-of-the-art Medical Records/ Health Information Department. This position may supervise up to thirty employees.

Requirements:

Bachelor's or technical degree in related field (computer science, information systems, Health Information Technology, etc.) or equivalent work experience. RHA certification or equivalent experience preferred. Minimum three (3) years supervising a Medical Records/Health Information Department. Familiarity with Electronic Medical Records required. A thorough knowledge of federal and State statutes pertaining to Health Information Management policies and procedures.

To Apply:

To apply and see additional requirements visit **www.thevancouverclinic.com**

Manager, Charge Capture Quality

Position Summary:

The Charge Capture Quality Manager will develop and maintain the education and quality review functions for Charge Capture coding staff.

Responsibilities:

Responsible for planning, preparation and presentation of on-going training for coding staff, new ProFee employee training, and other individual or departmental training as requested/approved by the Charge Capture Director. Develop and continuously update the Quality Review Program to meet UWP business excellence standards of 95% or better coding accuracy. Other reponsibilities available to review at www.uwphysicians.org.

Required Qualifications:

Bachelor's degree or an equivalent combination of education and experience. 5 years in a multi-specialty medical billing environment with at least 4 years supervisory experience. 3 years preparing and presenting coding training materials to provider and staff groups of various sizes; 7 years experience in medical terminology, CPT, ICD, and HCPCS, in addition to knowledge of payer coding, billing, documentation, and reimbursement standards. CCS-P or CPC required.

To apply and see other requirements: Visit our web site at www.uwphysicians.org, click on "Careers at UW Physicians" and submit cover letter and resume.

Contract Administrator

Community Health Plan was established in 1992 by a network of community health centers across Washington State. We provide coverage for people in 33 counties. Our members receive services from more than 1,000 primary care providers and 8,000 specialists at more than 250 primary care sites and over 80 hospitals. We're the fifth-largest health insurance company in Washington.

The **Contract Administrator** has accountability for developing the Provider Network (Hospitals, Facilities, Physicians, and Ancillary providers). Conducts negotiations and drafts individual contracts. Evaluates and negotiates contracts in compliance with company templates, reimbursement structure standards and other key process controls.

Requirements: Bachelor's degree and four year related experience and/or training; or equivalent combination of education and experience.

Please note that employment eligibility is contingent upon candidate not being sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

To learn more and apply visit http://tbe.taleo.net/NA8/ats/careers/jobSearch.jsp?org=CHPW&cws=1.

Business Intelligence Analyst

Community Health Plan was established in 1992 by a network of community health centers across Washington State. We provide coverage for people in 33 counties. Our members receive services from more than 1,000 primary care providers and 8,000 specialists at more than 250 primary care sites and over 80 hospitals. We're the fifth-largest health insurance company in Washington.

The **Business Intelligence Analyst** performs analytic work to measure or quantify the impact or effectiveness of projects, division-wide performance, or corporate programs.

Requirements: A Bachelor's degree in a quantitative discipline such as Mathematics, Statistics, or Economics is preferred. Two years of analytical experience within a healthcare environment is required as well as experience with software analytic and reporting packages.

Please note that employment eligibility is contingent upon candidate not being sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency.

To learn more and apply visit http://tbe.taleo.net/NA8/ats/careers/jobSearch.jsp?org=CHPW&cws=1.

Practice Administrator

Practice Administrator needed for Seattle Hand Surgery Group, a busy orthopedic practice with six physicians that includes ASC and hand therapy department. Responsibilities include general operations, employee and financial management. strong leadership skills, along with direct operational management experience in an outpatient medical department or physician practice setting.

Prior experience should include strong financial skills, commitment to both patient satisfaction and employee development. Ability to work well in a dynamic organization with a strong commitment to quality and excellence.

Administrator reports directly to physician board. Salary DOE with excellent benefits. Bachelor's Degree required.

Resume to Ginger Ryder at EMEDEX:

ginger@e-medex.com

Operations Supervisor - Ob-Gyn Department

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 650 staff members and 185 providers. The Clinic is one of the region's principal health care providers, offering extensive services to our patients.

Responsible for supervising minimum of 25 Medical Assistants, RN's, Patient Services Reps, Surgery Schedulers and Referral Coordinators.

Requirements:

Minimum 2-3 years supervisory experience in a medical office setting, medical business office setting, or insurance industry setting. Knowledge of clinic operational areas. Strong leadership skills. Strong interpersonal and problem solving skills, and the ability to confront and address issues with staff. PC utilization and software skills required. Ability to assess performance of employees. Ability to select, train, and develop qualified staff.

To Apply:

To apply and see additional requirements visit **www.thevancouverclinic.com**

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