Washington Healthcare News®

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Articles, Interviews and Statistics for the Healthcare Executive

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60 Minutes is Calling...
and News Helicopters are Overhead!

By Ronald B. Lahner
Partner, Health Group
Dorsey & Whitney, LLP

Such frenzied messages are the stuff of sleepless nights for hospital administrators. But, in spite of administrators' best efforts, these calls are a given hazard of the business, and this was indeed the call received several years ago by a startled Los Angeles hospital CEO.

As now seen in the rear-view mirror, the call was proceeded by an unfortunate series of events that started with a paraplegic homeless person presenting at the hospital's Emergency Department. Scrolling through the 24-hours following the patient's arrival at the ED, a series of triage, evaluation, discharge, and transportation glitches led to the media frenzy upon receiving surveillance camera views of the patient, still in his hospital gown, dragging himself in a Skid Row street gutter.

This was followed by expensive litigation posturing during which time the local media was pleased to revisit the event with each new filing. After a year, the fire was substantially doused by settlements of lawsuits brought by the City and the patient.

The effects, however, are still felt anytime a "patient dumping" (or, in the less incendiary terminology, "homeless discharge") case hits the press and reference is invariably made to this case, although the hospital staff chafes with the knowledge that for each problematic discharge, thousands are handled with care and utmost professionalism with the best result possible under the circumstances.

Disasters Happen

Disaster preparedness has been seminar fodder for some years. Hospitals have in place procedures for a variety of natural and man-made events, but not every event can be anticipated and protocols may prove ineffective if not properly stated and owned at all levels by those who may touch the problem.

Such was the case with this homeless discharge event. The hospital substantially followed its procedures, the principal bad actor being a contracted third party. But after-the-fact finger pointing may not rectify serious harm. A costly

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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,

Each year at this time we announce the next year's editorial calendar. Our 2011 editorial calendar, shown in the table below, communicates to our writers and advertisers each edition's theme, distribution date and advertising space reservation deadline.

Over the years we've made adjustments to align our editorial themes to the interests of our readers.

We will publish five editions with hospital themes in 2011. Over 2,000 of our 5,280 readers work at hospitals so this action matches our highest number of editions with our largest reader demographic. We will also publish three editions with a human resources theme and three editions with a clinic theme. Our 910 readers who work at clinics and 600 readers with human resource type job titles should appreciate this enhanced coverage.

Next year marks our sixth year publishing the Washington Healthcare News. Thanks for your historical support and see you next year!

David Peel, Publisher and Editor

Washington Healthcare News 2011 Editorial Calendar

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

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lesson is that finding avoidable error can prevent, as in this case, millions of lost dollars and largely undeserved negative press.

Find the Error and Eliminate It

Hospitals have been adopting procedures to assist generally in error reduction, in some cases taking lessons from other industries.

Error reduction methodologies, whether Six Sigma, Toyota Production or another, can empower staff, shine bright lights on improvement needs, and stop impending disaster in its tracks, assisting the development of best practices.

Also assisting the cause is the new found voice to admit errors swiftly, publicly, and appropriately celebrate them as learning opportunities.

So, Before Sixty Minutes Calls

The stars can line up in unfortunate ways at any place in a facility, but consider this actual case study of a homeless person presenting at an ED under circumstances that may sound familiar to you:

- An often frenetic level of activity in the ED
- An ED staff with a close knowledge of EMTALA requirements, but perhaps this knowledge is at the expense of failure to train in other areas because of limited training time
- A homeless patient presenting with the possibility of significant substance abuse and mental health issues
- ED staff pressure on throughput and admissions
- For some EDs, significant language and cultural barriers

Although this may appear to be an issue for larger metropolitan facilities, any facility having homeless people presenting at the ED cannot ignore the significant potential for problems that may arise should there be error in any step of the process in dealing with this special needs population.

Lessons Learned

It starts with the template hospital administrators have preached elsewhere in error reduction:

- Well-stated and frequently-updated **protocols**
- Continuous live and e-module **training**
- **Reassessments** from all who touch the issues

Other lessons learned include:

- Do not ignore ever-changing state and local laws on this subject, which may exact fines or criminalize certain actions
- ED training must go beyond EMTALA requirements
- Be mindful of the mental health issue – more jurisdictions are looking at possible exclusion zones for places where the mentally ill may not, under any circumstances, be transported, which of course places added burden on the psychosocial evaluation by the attending physician and social worker
- Get to know the capabilities and offerings of local social service agencies

Staff Protocols

These should include:

- Full-time and on-call social service staff (at a time of reductions in staff at many hospitals, a fairly modest move such as extending social service availability until 10 p.m. can greatly assist with reducing overnight admissions for homeless persons presenting in what is typically a spike between the hours of 7 pm and 10 pm, and provide the homeless with better service)
- Overall compliance responsibility with one person, perhaps a case manager
- Initial and periodic training, including shelter and service location, referral sources, cognitive intactness assessment, and post-discharge problems

Evaluation Protocols

These should include:

- Entering the patient name in a homeless person log maintained in the ED
- Documenting personal belongings and providing clothing, if inadequate
- Assessing and documenting mental or psychosocial status with participation by the treating physician and social worker, including cognitive intactment and ability to understand a discharge plan, to care for self, access shelter and medical care, determine current sleeping place, identify support systems, and evaluate orientation to person, time, and place
- Continuous pre-discharge mental assessment and treatment referral as appropriate

Discharge and Transportation Protocols

These should include:

- Applying for Medicaid, mental health services, and other financial assistance

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- Transfer, if medically appropriate and legally permissible
- The patient leaves with the correct DME for ambulatory assistance
- Assisting with outpatient referral
- Transportation expense approval by a supervisor and the patient's written consent to be transported
- Knowing the choices of facilities to assist with patient requests and verify a shelter meets the patient's needs
- Faxing or e-mailing information to the receiving shelter before transport, with proper identification of information required by the receiving facility
- Reviewing security and transportation contractor agreements regarding hospital policy compliance, including training
- Checking the ED waiting area for discharge compliance and re-engagement with social services, as needed

Ronald B. Lahner is a Partner in Dorsey's Health Group. His practice has involved representation of many segments of the healthcare industry, including managed care plans, providers, niche businesses, clinics, employer coalitions, and medical device developers, manufacturers and distributors. Ron has also counseled clients in a number of healthcare transactions, including joint ventures, mergers, and acquisitions. He can be reached at 206-903-2455 or lahner.ron@dorsey.com.

ICD-10 Transition: 2013 is Closer than it Seems

By Paul Goldberg
Principal
Paul Goldberg & Associates, LLC

Your healthcare organization is being constantly besieged with change and uncertainty: healthcare reform, patient safety, cost reductions, reimbursement changes, etc. There is one certain and mandated change, which if not completed, could bring many of your organization's activities to a grinding halt – the transition from ICD-9 to ICD-10. With a deadline of October 2013, this important project should be close to the top of today's priority list.

The International Classification of Diseases (ICD) code set is used for reporting healthcare diagnoses and procedures. The World Health Organization, which oversees the ICD system, updated version 9 (ICD-9) to version 10 (ICD-10) in 1990. Yes, two decades ago!! ICD-10 has been adopted by all developed countries in the world, except the United States. The U.S., which uses this code set more intensively in the administration of healthcare services than other countries, is still using ICD-9 due to the complexity and expense of the transition.

The ICD-9 code set is no longer sufficient because of expanded and more specific indicators added to disease classification and healthcare delivery in the past 2 decades. For this reason, DHHS has mandated that all HIPAA covered entities must convert to ICD-10 by October 1, 2013.

Your organization should be currently working on a prerequisite to ICD-10; the required upgrade of electronic healthcare transaction standards from version 4010a to version 5010. The new standards, mandated to be in effect January 1, 2012, include file structure and content changes necessary to accommodate ICD-10.

The transition to ICD-10 affects every organization along the healthcare value chain with processes and systems using diagnosis and procedure codes. This includes insurers, plan administrators, providers, clearinghouses and many vendors. It is not a simple version upgrade; it is a complete overhaul of the code set. ICD-9 has about 16,000 codes, where ICD-10 has over 155,000. Plus, the codes themselves are changing in length, character positions and meaning. The implications will ripple through the healthcare system to such an extent that, if not in compliance by the mandated date, organizations may not be able to perform daily activities such as billing, processing claims or managing clinical programs.

For delivery systems, the more specific ICD-10 code set will require providers to complete more detailed documentation. Payers, in turn, will need to be able to receive and process claims with these new codes. Both provider and payer organizations will require remediation of processes and systems to accommodate the new code structure. If they are not ready to move to ICD-10 at the same time, it could lead to serious lags in billing and claims payments, even to outright claims denials.

To complicate matters, mapping between ICD-9 and ICD-10 is not direct. The relationships can be one-to-one, many-to-one and one-to-many. For some, there is no code to map to at all! There is currently no standard map or crosswalk available to be used by all entities. A mapping structure has been produced by the Centers for Medicare and Medicaid Services (CMS) and organizations are currently reviewing the CMS tool; additional mapping tools will likely be developed. While work is being done on mapping, each organization must understand their operations in sufficient detail to adopt a mapping methodology that fits

their business needs and processes.

If your organization has not started work on this transition, you could already be behind. This multi-year project can be very complex and require significant resources. Here is an approach to how it can be organized:

1. **Assess Organization-wide Impact:** A review of all business processes, systems, policies/procedures, reports, etc. to document use of the ICD code set, where changes are required, the nature of needed changes and resources needed for implementation. This assessment should be completed by early 2011.
2. **Develop an Implementation Work Plan:** An enterprise-wide work plan, which actually extends outside the organization to trading partners, must be developed. This should identify work activities, resources and time lines to implement changes to processes, systems, documentation etc. This work plan should be completed by early 2011.
3. **Implement and Test Changes:** This step will extend over multiple years and engage staff in making changes outlined in the work plan. It will include ongoing communication with external trading partners to ensure that their ICD-10 transition is on-track. Extensive testing, both internally and externally, is essential to ensure that business work flows, system processes and exchanges of information function without errors or unintended consequences.
4. **Go Live and Post-Implementation:** A transition period will be required for ongoing tracking of processes and outputs to ensure the implementation has been a success. During this period, payers may need the ability to receive claims that are in either ICD-9 or ICD-10 (because there will likely be providers and other organizations lagging in their implementation efforts).

The transition from ICD-9 to ICD-10 is a "mission critical" project that should already be underway. Healthcare organizations cannot afford to delay this work because of the confusion and flurry of other healthcare changes, or because 2013 seems far away; it is closer than you think.

Paul Goldberg & Associates, LLC is a management consulting firm focused on project management and the implementation of programs, services and systems in healthcare. For information, go to www.pgoldbergconsulting.com. Paul can be reached at 206.372.5158 or paulg@pgoldbergconsulting.com.

Healthcare Management Gains Ground with GIS Services

By Gareth Roe
Director of Planning
BCRA

and

By Derek Lunde
Director of Strategic Marketing
BCRA

In the healthcare field, we all use a number of different tools to assist us in effective management of our current facilities and sound strategy for future development and growth. We manage using dashboards, spreadsheets, charts, trends, and management reports, among many others. Working with C-level healthcare executives and administrators, we get to see first hand how disparate and disconnected these tools can become, making management less a visual tool and more an "in the numbers" process.

Geographic Information System (GIS) was created to aid the

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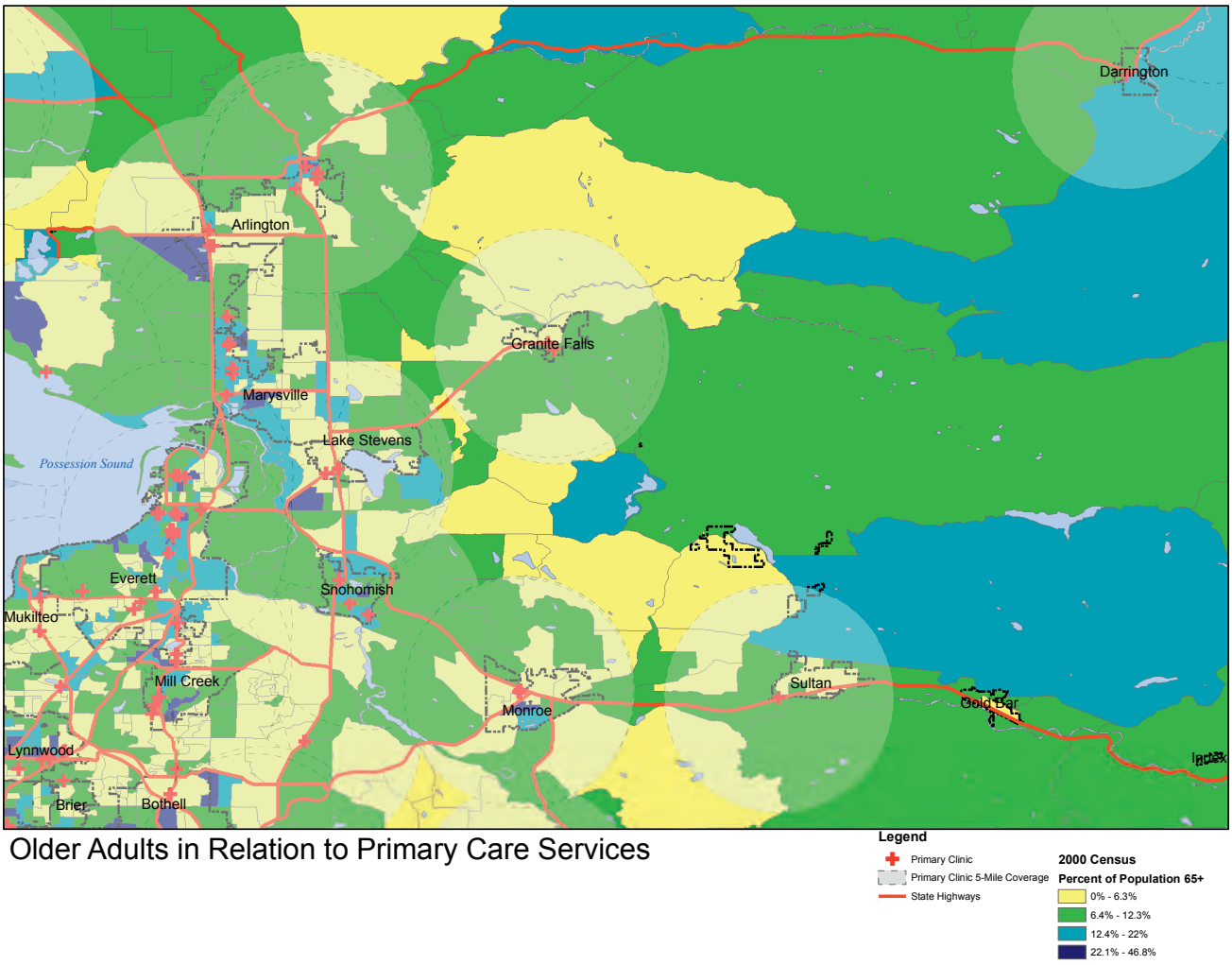

Older Adults in Relation to Primary Care Services

GIS can visually overlay unrelated information into one display for analysis and decision making. In this case, we show Census regions and their population of aging adults in relation to primary care clinics. Map courtesy of BCRA.

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leader, strategist, manager, and planner, with effective and visual decision making tools. Collating virtually infinite types of data sets and statistics – like demographics, geographics, zoning and infrastructure, and utilities – GIS can produce maps and reports that visually display pertinent and timely information.

Consider the following management and strategy scenarios that can be aided by GIS:

Examining the Spatial Distribution of Healthcare facilities and providers

Location intelligence is the key to a successful medical facility, and using mobile GPS mapping and routing equipment, healthcare providers can track and analyze the most favorable routes for emergency vehicles. Data obtained from this mobile equipment can be tied into the provider's GIS system to understand the quickest and most preferred routes from the location of the emergency to the nearest healthcare facility.

This healthcare coverage area evaluation could use GIS to map out the distances to the facility in 5-, 10-, and 15-minute drive-time increments to show the existing coverage area for a given facility. This type of analysis can also be used to show the spatial distribution of facilities and identify possible gaps in a particular market where a potential in-fill healthcare facility could be located to serve a population that may be too far from an existing healthcare facility and is therefore under served.

Modeling demand for different services based on demographic data

Healthcare systems can use GIS to view characteristics about their patients and identify population trends over the regions which they serve. By syncing patient records databases with GIS software, decision makers can display a map showing where their patients reside. This analysis could demonstrate how patients are geographically concentrated, illustrate where new patient growth is occurring, or balance facility locations and service capacities with existing and future population densities.

Demographic information about patients from a particular hospital or medical facility, such as age, gender, race, income level, and education can be presented in map form. This can help determine level of service shortages or surpluses. For instance, by tracking common characteristics of heart attack and stroke patients using GIS, healthcare administrators can better evaluate how their system is able to care for these types of

ailments in certain geographic regions. In the end, institution decision makers can use GIS reports and findings to assist in their decision to construct additional facilities or augment their services to accommodate areas that are under served by existing providers.

In addition, patient data can be assigned consumer lifestyle profiles to determine if there are dominant lifestyle classifications within a particular service area. Lifestyle patterns and profiles are different among different patient groups. This information can be used by healthcare facilities to market specific services (cardiac, family birth centers, emergency medicine) to a particular patient group or demographic. Information gleaned from GIS services could also benefit marketing and advertising efforts aimed at target communities for specific services. GIS software and maps can also easily display specific ailments from a patient database, show the potential migration of a specific disease, and analyze the spatial association of infected persons.

Where to Begin

For most, investment in GIS as a long term management and strategy tool is not a logical first step. Many begin by exploring partnerships with firms that employ GIS technology and specially trained technicians with healthcare design backgrounds. Their guidance can assure you have effective visual tools rooted in data that can help healthcare administrators and C-level executives see new opportunities in new ways.

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Using Physician Noncompete Agreements in Washington

By James M. Shore
Partner
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To protect their valuable assets (patients, goodwill, and confidential information) and investments (recruiting, training and development costs), healthcare employers commonly require physicians to agree to restrictive covenants as a condition of employment. These restrictions typically provide that, upon termination, the physician will not: (1) work within a defined, surrounding geographical area for a prescribed time period; and/or (2) solicit or serve former patients for a prescribed time period. Both restrictions are frequently labeled "noncompete agreements," although the latter allows for competition while merely creating patient restrictions. Other common restrictions include non-solicitation of employees, confidentiality, and provisions to make clear who owns creations or inventions.

If a hospital provides any funding to induce a physician to relocate to the hospital's area, "Stark II" regulations may prohibit a medical practice from compelling that physician to sign a noncompete agreement. Some states prohibit or restrict physician noncompete agreements, and the American Medical Association considers them to be unethical in principle under many circumstances. However, a court applying Washington State law will enforce a "reasonable" noncompete agreement. Under Washington law, a noncompete agreement is reasonable if: (1) it is necessary to protect a legitimate business interest; (2) it is no greater than reasonably necessary to secure the employer's business or goodwill; and (3) the degree of injury to the public in the loss of the service and skill of the physician is so small as to warrant enforcement.

In analyzing element (1) above, courts tend to carefully examine factors such as the level of goodwill tied to the physician, status within the organization, level of compensation, training and patient access provided to the physician that the physician would otherwise not have obtained, the physician's tenure, whether the physician voluntarily quit or was terminated, whether severance was paid, access to sensitive business information or plans, whether the physician or new employer will gain an unfair advantage, and whether the physician engaged in bad acts while still employed (e.g., soliciting patients for the new business).

With regard to element (2), a noncompete agreement must be reasonable in both duration and geographic scope. The more restrictive the covenant, the more scrutiny and suspicion a court will exercise. As a general rule, time length should be limited to one to two years, although some courts have enforced three-year periods (especially in a sale of business context). Many judges disfavor going beyond one year. The geographic scope should correlate to the former practice area, not overreach. Washington courts can modify an unenforceable provision to make it enforceable to its maximum extent. However, some judges will not edit, choosing to instead strike entire paragraphs, which can gut a noncompete agreement. If a one-year non-solicitation agreement covering a particular county protects you, then strongly reconsider a longer, multi-county noncompetition agreement that might make a court question your motives. Courts ultimately rule in equity based on how they *feel* about the restraint under all of its circumstances. If it seems overly broad or punitive in black and white then you have hurt your case. A court will try to gain a clear sense of whether enforcement is more of an effort to squelch competition than

it is to protect goodwill.

Few cases actually turn on the "injury to the public" factor. If a physician has such unique and important skills that no one else in the relevant geographic area can serve the public, this weighs against enforcing a noncompete agreement. For example, if demand exists for oncologists and only two oncologists practice in the area, the restrictions could be construed to be against the public interest by restricting patients' access to treatment.

Valid "consideration" is also required to form an enforceable noncompete agreement. Signing a noncompete agreement at or very near to initial employment constitutes sufficient consideration. A "mid-stream" noncompete agreement with continued at-will employment alone does not provide consideration under Washington law. In such circumstances, a pay increase, bonus, or other significant remuneration that the employee would otherwise not be entitled to would satisfy the consideration requirement.

Many noncompete agreements permit physicians to continue practicing unfettered if they pay a specified amount (commonly known as a buyout or liquidated damages) upon termination. If the formula is reasonable and not a penalty, this can provide for an amicable departure, or it can alternatively help establish that you have an even fairer, more enforceable agreement. Finally, if you use noncompete agreements, you should enforce them consistently to avoid impairing or waiving your enforcement rights with future departing physicians.

Jim Shore is a partner of Stoel Rives LLP, where he represents healthcare providers in all aspects of employment law and labor relations. Contact Jim at jimshore@stoel.com or 206-386-7578.

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(Mammoth Lakes, CA)

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Qualifications:

Education: Must be a graduate from an accredited school of nursing, currently licensed to practice in the State of California. Three years experience and administrative knowledge, skills and abilities needed to perform the work; or an equivalent combination of education and experience. Flexible, mature individual who is capable of decision making and problem solving; well-informed in the principles of Performance Improvement. Membership and participation in a Quality based professional organization. Ability to work effectively with peers, physicians and ancillary departments. Maintains composure while recognizing the need for immediate response to true emergencies. Demonstrates maturity and creativity in problem solving. California RN license required. CPHQ preferred.

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(Seattle, WA)

Our Cardiothoracic Critical Care Unit has an outstanding opportunity for a Nurse Manager who will provide leadership for this busy area. This individual has 24-hour responsibility for managing this service area to provide effective and efficient patient care. Effectiveness and efficiency are achieved through operationalizing the Medical Center's and Patient Care Services' mission and objectives. To meet these responsibilities, the Nurse Manager selects and supervises staff, plans and implements programs to meet specific patient care needs, works to continually improve the quality of patient care and, with some exceptions, plans and manages the budget. The Nurse Manager provides leadership to achieve a culture of professional excellence in the service area, in the organization as a whole, and in the nursing profession.

Requirements:

WA RN licensure; BSN; prior management experience which must include a minimum of one year experience as RN3 or equivalent; critical care nursing experience.

Desired:

Master's degree; cardiac ICU nursing experience; prior Nurse Manager experience.

To apply and learn more visit:
www.washington.edu/admin/hr/jobs/apl/index.html
and search for Req #: 62794.
EOE

OLYMPIC MEDICAL CENTER

Technology Systems Administrator Cancer Center

(Sequim, WA)

Responsible for analysis, design, implementation, maintenance, and technical support of clinical and storage systems at the Sequim Cancer Center.

Bachelors/Masters in Computer Science, Network Administration or Database mgmt. Other degrees/backgrounds with experience in oncology systems considered. Three years experience operating or maintaining oncology/radiology IT Systems in an acute care setting required.

Work in a beautiful building set in a serene environment, and experience a wonderful quality of life. Located in sunny Sequim, we offer the dryer climate of the Olympic rainshadow, with magnificent views everywhere. Relocation Assistance.

Apply: **nbuckner@olympicmedical.org** or apply Online at **www.olympicmedical.org**

EOE

PeaceHealth

Director Human Resources

(Springfield/Eugene, OR)

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

We are seeking a dynamic leader for this key position. Manages the HRPO. Translates human resource strategies into operational reality. Develops and operationalizes business plans and strategies across all service lines and ensures alignment with organizational goals, vision, mission and values.

Qualifications:

EDUCATION: Bachelor's degree; or equivalent knowledge and skills obtained through a combination of education, training and experience

EXPERIENCE/TRAINING: Eight years human resources leadership experience, with at least four in a leadership position, including extensive experience in negotiating collective bargaining agreements, preferably in the healthcare industry.

LICENSE/CERTIFICATION: SPHR preferred

To apply and learn more visit:
www.peacehealth.org

Contact Carolyn Murrow at 541-686-3898 or **cmurrow@peacehealth.org** with any questions.
AA/EOE

AHMC Healthcare Inc.

Human Resources Director

San Gabriel Valley Medical Center

(San Gabriel, CA)

Looking to find a place that fits just right? AHMC is expanding to become one of Southern California's premier healthcare systems. With over 200,000 total patients treated annually in our more than 1,100-bed health network in LA and Orange County, AHMC is the perfect place to maximize your career. While we have the flexibility and security of a large health system, we never compromise on patient care.

What you will do:

The Human Resources Director ensures the effective implementation of facility personnel and labor/employee relations plans and programs. The incumbent will plan, direct, and administer corporate and facility policies and procedures in areas of employment, salary administration, labor/employee relations, benefits, workers' compensation, and training and development. Will plan and recommend new programs and improvement of existing programs and initiate change or modification to existing policies to ensure compliance with laws, regulations, competitive practices and operational objectives. Other duties as necessary.

What you will need:

BS degree preferred or related experience. 5 years management experience. 3 years of hospital human resources experience as a generalist. Must have prior union experience. Must have knowledge of federal, state and local labor laws. The incumbent must have general mathematic skills. Must have general knowledge of budgeting. The incumbent must have TJC experience. The incumbent must have excellent human relation skills. The incumbent must have excellent written and oral communication skills.

For immediate consideration as the Human Resources Director, please send resume & salary requirements to:
lisa.loya@ahmchealth.com or Fax: 626-457-7459.

UNIVERSITY OF WASHINGTON MEDICAL CENTER
UW Medicine

Nurse Manager, Radiation/Oncology

(Seattle, WA)

Our Radiation Oncology Department has an outstanding opportunity for a Nurse Manager to provide leadership for the clinical, financial, operational and personnel activities of the Radiation Oncology Clinic. This Nurse Manager hires, supervises and mentors clinic staff to create effective teamwork, in collaboration with others implements new programs to ensure they meet specific patient care needs, and works to continually improve clinic operations and efficiency.

Requirements:

Washington State RN license. Bachelor's Degree in Nursing and three years management/supervisory experience required, preferably in a large academic medical setting. Ability to communicate in English, both verbally and in writing. Excellent communication skills and demonstrated interpersonal skills that enhance communication, promote conflict resolution and facilitate staff development. Ability to work with physicians, administrators, and staff members in a collaborative manner is required. Knowledge of JCAHO, DOH and other regulatory agency standards and requirements is required. Basic computer knowledge. (Word and Excel) is required – advanced skills preferred.

To apply and learn more visit:
www.washington.edu/admin/hr/jobs/apl/index.html
and search for Req #: 66798.
EOE

Marina Del Rey Hospital

Director of Health Information Management / Privacy Officer

(Marina Del Rey, CA)

Job Title: Director of Health Information Management /Privacy Officer

Reports to: Chief Financial Officer

Job Summary: Responsible for successful maintenance of patient records and organizational/administrative operation of the Health Information Management Department. Serves as resource for facility regarding medical record content and regulatory requirements. Assures availability of the medical records at all times. Oversees ongoing activities related to the development, implementation, maintenance of and adherence to the organization's policies and procedures pertaining to the privacy of and access to patient health information in compliance with federal and state laws.

Qualifications: Degree as a Registered Record Administrator / Technician from an accredited school. RHIT or RHIA required. Min 5 years of prior hospital experience in HIM management role. Knowledge of JCAHO, HIPAA, federal and state regulations for healthcare facilities.

To apply and learn more contact:

Margaret Morgan
Director of Human Resources
margaret.morgan@marinahospital.com

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