Physician re-entry, recruitment issues pose practice obstacles.

Cindy Sanders

Typically, the phrase “barrier to care” calls to mind insurance coverage issues, but obstacles hampering the placement of the right physician in the right position equally compromises a patient’s ability to receive quality care.

At the end of January, the American Medical Association (AMA), in collaboration with other stakeholders, released re-entry recommendations to help boost the nation’s physician supply. The recommendations were geared toward adopting a coordinated approach for physicians who want to begin seeing patients again after an extended absence.

Susan Skochelak, M.D., MPH, vice president for medical education with the AMA, said there are many reasons why a physician might take time off ranging from raising a family to caring for elderly parents to personal health reasons to taking academic leave. She stressed the new re-entry recommendations are targeted only to physicians who have voluntarily left practice. “People that have disciplinary problems or people that have been identified as having knowledge deficits really require more intensive scrutiny and intervention,” she stated. “In our document, we make it clear that’s not the group we’re talking about.”

The AMA is reaching out to physicians who have been surprised to find there are few options for updating training. Instead, the AMA is reaching out to physicians who have been surprised to find there are few options for updating training. “These are not physicians in trouble. These are physicians who, on their own, are trying to make sure they’re well credentialed and ready to practice,” she said.

Skochelak, who is a board certified family physician, said one example that really hit home for her was a physician who took time away from practice to undergo treatment for breast cancer. When she was ready to return, the physician asked her certifying board about retraining options and was basically told the only recourse was to go back to residency. Skochelak was quick to say the board wasn’t really recommending this option, but the members were at a loss for other resources to help the physician update skills.

“This is kind of a hidden problem,” Skochelak pointed out. “Given the amount of challenge we have in this country in providing physicians in all places and in all specialties, this does become a small but important factor in our physician workforce.”

Re-entry Requirements

Currently, every state has different requirements for re-entry, and barriers include high costs and limited resources. Another

Continued on page 3

Barriers to care
The evolution of healthcare

The healthcare landscape is changing. The healthcare system of tomorrow will look dramatically different than what we are used to today. While evolution is good for the system, we must be careful about how the system evolves. This is especially true with the patient/provider relationship.

Last month, I had a conversation with my physician while in his office for a routine visit. After talking politics and general economic woes, he talked about the changes in his practice. One comment that he made really stood out to me. He said “I feel like there is always an accountant looking over my shoulder.”

Providers should have the freedom to care for their patients. We must trust providers have made educated decisions for the patient based on the data available and not necessarily on “cost-saving” mandates. While it is important to be conscious of costs and use healthcare dollars efficiently, that should not be the primary concern of our healthcare providers. Cost-savings practices can be a positive in the short-term but can lead to long-term serious unintended consequences for patients.

When I see my physician, I want to know that I am receiving the appropriate level of care that is best for my long-term well-being, not what will save a few bucks today.

Ben
issue is that re-entry programs, when they do exist, lack standardized curricula and an officially recognized accreditation process. The Federation of State Medical Boards, American Academy of Pediatrics, leaders in medical education and directors of re-entry programs all worked with theAMA to develop programming that could be implemented nationally. “The guidelines came from a very active process by a number of groups over time,” Skochelak noted. She added that the work group recognized there would not be a “one size fits all” solution to re-entry.

Physicians should be assessed,” she said. “See where they have solid knowledge and where the gaps are and tailor the program.”

A Sampling of Recommendations

The document (www.ama-assn.org/ama1/pub/upload/mm/40/physician-reentry-recommendations.pdf) contains 16 recommendations under five main headings:

• Regulatory Policies: Recommendations to ensure there is a comprehensive, transparent and feasible regulatory process for a physician to return to clinical practice.

• Physician Re-entry Program Policies: The group called for the development of policies that assure the quality of re-entry programs and the readiness of graduates to resume practice.

• Research and Evaluation: Information is needed to create an evidence base used to inform policymakers, educators, program developers and physicians.

• Program Funding: The recommendations account for the need to develop means to ensure a physician re-entry system is financially feasible.

• Collaboration and Communication: The group underscored the need of all stakeholders to have a voice in the process and for ongoing dialogue.

“Our reason for doing this and our excitement about it is to really help this issue move forward in ways that ultimately will make sure physicians provide the best care possible to their patients,” Skochelak concluded.

Recruitment Issues

Whereas re-entry poses problems in terms of skill sets, recruitment comes with myriad issues tied to regulatory mandates. Stark regulations and anti- kickback laws have been tweaked and refined to a point where a great deal of complexity and confusion exists. Entire seminars have been given on how to define geographic service areas and exemptions to the rule for hospitals attempting to recruit physicians and establish remuneration plans that satisfy federal statutes.

Curtis Pryor, CEO of national physician recruiting firm Arthur/Miller, Inc., noted the intent behind the regulations governing recruiting practices was to certify that the interest of patients in a geographic population were being served first … over and above the interests of the hospital or physician. However, he continued, the rules have become so complex that patients are done a disservice when the right doctor cannot be placed in the right location.

“Through the years, you’ve seen hospitals and clinics grapple with, ‘how do you deal with this … how do you recruit in this environment?’” Pryor observed. “It’s a constant grind to figure out how to balance all of this, and it has left a lasting legacy on the physician recruitment industry.”

Fear of regulatory miscue has changed the way facilities now approach recruitment. “We have seen a dramatic shift almost to the point where the decision-making process has shifted from the administrative area to the legal areas of a hospital,” Pryor said. “More often than not, we know the gateway to making a deal is through the attorney’s office. I do think there are many cases where the pendulum has swung so far that hospitals have gone too far the other way. Instead of doing things that are reasonable and customary, they have offloaded the process to their legal team, which ultimately inhibits their ability to be competitive.”

He added this trend does not bode well for a large swath of American communities when considering the current physician shortage, which is projected to worsen. Although Pryor doesn’t have any easy answers, he does hope to see balance return to the system where decisions are made based on what is truly best for patients.

Currently, every state has different requirements for re-entry, and barriers include high costs and limited resources. Another issue is that re-entry programs, when they do exist, lack standardized curricula and an officially recognized accreditation process.

For more information about the American Medical Association (AMA), re-entry recommendations to help boost the nation’s physician supply visit: www.ama-assn.org/ama1/pub/upload/mm/40/physician-reentry-recommendations.pdf.
**Floyd Memorial Medical Group**
Steve Manecke, CPA, joins Floyd Memorial Medical Group (FMMG) as its new Executive Director of Physician Network Operations.

Janet Streepey, M.D., MPH, General/Occupational Medicine Physician joins Floyd Memorial Medical Group-Palmyra.

**Jewish Hospital & St. Mary’s HealthCare**
Jewish Hospital & St. Mary’s HealthCare (JHSMH) has named Mark Milburn Vice President of Owsley Brown Frazier Cancer Care, Pharmacy Plus and VNA Nazareth Home Care Pharmacy.

Jewish Hospital & St. Mary’s HealthCare has named Brad Lincks Vice President and Chief Nursing Officer at Our Lady of Peace.

**Seven Counties Services, Inc.**
Reverend Wilbur Browning, Sr. has been elected to the Seven Counties Services, Inc.’s board of directors.

**University of Louisville**
Diane Partridge has been named vice president of marketing and communications for University of Louisville Physicians (ULP).

**WomenCare**
Nurse Midwife Damara Jenkins, RN, CNM has joined WomanCare, a Jeffersonville, Indiana OB/GYN practice.

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### Legislative Update

- **SB 40** was passed during the 2011 Legislative Session and signed into law by Gov. Steve Beshear. This bill authorizes pharmacists to administer flu vaccines only to individuals nine to 13 years old pursuant to a prescriber-approved protocol and with consent of parent or guardian. Upon request of the individual, parent or guardian, the pharmacist must provide notice to the primary care doctor.

- **SB 71** was passed during the 2011 Legislative Session and signed into law by Gov. Beshear. This bill establishes a licensure board for individuals providing diabetes education; however, it exempts pharmacists and some other licensed healthcare providers from being licensed by this new board.

- **HB 311** was passed during the 2011 Legislative Session and signed into law by Gov. Beshear. This bill updates Kentucky’s Controlled Substances Act to allow electronic prescribing of controlled substance prescriptions.

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Medical textbook continues to sixth edition

James C. Reed, M.D., FACR, professor and vice chairman of radiology at the University of Louisville recently received the first copy of the sixth edition of his textbook Chest Radiology: Plain Film Patterns and Differential Diagnoses. Dr. Reed’s text was published by Elsevier Mosby and presented in advance of the publication date at the annual meeting of the Radiological Society of North America. Elsevier Mosby reports that it is very rare for a single authored medical textbook to continue to a sixth edition. Since the first edition, which was published in 1981, Dr. Reed’s book has become a standard part of the curriculum for radiology residents and is an internationally recognized reference textbook with translations in Spanish, Chinese, Japanese, and Hindi.

Area healthcare leaders receive ACHE Regent’s Award

Both Marty Bonick, president and chief executive officer of Jewish Hospital Medical Campus in Louisville, Ky., and Stephen A. Williams, president and chief executive officer, Norton Healthcare, Louisville, Ky., received awards from the American College of Healthcare Executives this past May. Williams received the Senior-Level Healthcare Executive Regent’s Award, which recognizes ACHE affiliates who have experienced in the field and have made significant contributions to the advancement of healthcare management excellence and the achievement of ACHE’s goals.

Bonick received the American College of Healthcare Executives Early Career Healthcare Executive Regent’s Award, which recognizes ACHE affiliates who have made significant contributions to the advancement of healthcare management excellence and the achievement of ACHE’s goals.

UofL physician named Emergency Department Director of the Year

Royce D. Coleman, M.D., FACEP, has been named Emergency Department Director of the Year by the Emergency Medicine Foundation (EMF) of the American College of Emergency Physicians (ACEP) and Blue Jay Consulting. Coleman is the Emergency Department medical director at University of Louisville Hospital and an associate professor of emergency medicine at the University of Louisville. He is a Fellow of ACEP and was honored at the ACEP Emergency Department Directors Academy in Dallas.

Baptist Healthcare System retains “AA-” and “Aa3” bond ratings

Baptist Healthcare System, Inc., Lexington, Ky., has received “AA-” and “Aa3” bond ratings from Fitch Ratings and Moody's Investor Service respectively. Baptist Healthcare System owns five acute-care hospitals throughout Kentucky, including Central Baptist Hospital in Lexington.

Fitch Ratings affirmed BHSI’s bond rating at “AA-” with a stable outlook May 10, and Moody's Investor Service affirmed BHSI's bond rating at "Aa3” with a stable outlook on March 25. Both agencies noted its strong ratings were due to Baptist’s statewide market presence and its strong balance sheet.

Bond ratings serve to allow existing and potential bond holders to assess the ability of a company or corporation to pay back the funds it borrows. The higher the rating, the lower the risk is to the bondholder.

Wound Care Center honored

The Wound Care Center, opened in January 2009, provides comprehensive wound care for people who suffer from non-healing wounds. The center provides full-time wound care, including hyperbaric oxygen therapy, where the patient is placed in a pressurized chamber and breathes 100 percent oxygen. This increases oxygen in the bloodstream and enhances the healing process. Since the Center opened, more than 2,300 hyperbaric treatments have been given.

Kentuckians identify cancer/childhood obesity as a top health concern

Cancer is the leading health concern identified by Kentuckians and the principal cause of death among women in the state, but men die more often of heart disease. This is according to results released from the Foundation for a Healthy Kentucky’s most recent Kentucky Health Issues Poll (KHIP). The report notes that, in general, Kentuckians have a lower average life expectancy than Americans (75.5 years compared to 78 years).

More than one-third of Kentucky adults (36 percent) identified cancer as the most important health issue for men, followed by heart disease (31 percent) and obesity (8 percent). According to the Commonwealth of Kentucky, heart disease was the leading cause of death for men in 2009, followed closely by cancer.

About six in 10 Kentucky adults (61 percent) said that cancer in general is the biggest health threat facing women, with five in 10 (52 percent) specifying breast cancer as the most important issue. While cancer was the leading cause of death among women in 2009, more than twice as many women die from lung cancer as breast cancer according to the Kentucky Cancer Registry. Heart disease nearly tied cancer in number of deaths among women two years ago, but only nine percent of adults listed heart disease as a leading concern for women. Six percent of Kentuckians identified obesity as the top health issue facing women.

Children's Top Health Concern

Obesity toppled the list of health issues when it comes to children, with 29 percent of Kentuckians indicating that obesity is of greatest concern. Respondents also identified diabetes (9 percent) and cancer (8 percent) as important healthcare issues facing children. While childhood mortality is rare, there are lifelong health implications that can be linked to struggling with obesity and diabetes at an early age.
UK HealthCare, Norton Healthcare advance collaboration

Louisville, Ky.-based UK HealthCare and Norton Healthcare announced plans to aggressively target Kentucky’s most pressing health problems. Specifically, officials from both health systems announced plans to establish:

- A statewide stroke and advocacy collaboration;
- A cancer program to share resources, research and clinical trials;
- An educational network to address obesity and weight management;
- Expanded teaching programs designed to increase the number of medical professionals with an educational residency rotation for UK medical students in Norton Healthcare hospitals, and Norton Healthcare physicians to join UK’s faculty; and
- A transplant and specialty clinic in Louisville.

Exemplifying the progress made in their collaboration, UK HealthCare and Norton Healthcare will be extending their original agreement — a Memorandum of Agreement signed on Nov. 8, 2010 — as initiatives in stroke, cancer, transplant, obesity, OB, heart and other areas are formalized. These areas were initially targeted because they are specific healthcare challenges where Kentucky is among the nation’s leaders in incidence of disease or illness.

Stroke

Statistics provide evidence that the stroke crisis continues to challenge the state. Kentucky ranks 15th among the 50 states in deaths per 100,000 caused by stroke or related diseases. Much of that is due to lack of exercise, hypertension, diabetes, smoking and other factors.

As a result, UK HealthCare and Norton Healthcare are creating a new education and consumer awareness collaboration that will partner with community hospitals to provide preventative education on healthy living and provide stroke screenings and training for emergency departments to be prepared for stroke patients. In addition, the collaboration will create Kentucky’s first statewide stroke registry to track the improvement of care provided by community and regional hospitals in the partnership.

Cancer

The opportunity to transform the state’s health status is significant. Kentucky is in the top five for cancer incidence nationwide and leads the nation in lung cancer incidence.

Physicians, researchers and staff from the Norton Cancer Institute and the UK Markey Cancer Center will be collaborating to share resources, research and clinical trials which span across the entire continuum of care. Special emphasis is on prevention and early diagnosis and screening and statewide treatment pathways. Several Norton Cancer Institute physicians will join UK’s faculty as community-based faculty members.

Obesity and Weight Management

Similarly, Kentucky has among the nation’s worst incidences of obesity and health problems associated with weight management. Kentucky’s 2009 obesity rate was the fourth highest in the country, costing the state an estimated $1.3 billion in direct health costs annually. If current trends continue, that number is projected to skyrocket to $4 billion annually.

In response, Norton Healthcare will expand its medical weight management services and educational programs to Lexington, offering community education programs on exercise and healthy eating, among other educational offerings. Access to pre-and-post surgical obesity management services — such as behavioral counseling and support groups — also will be expanded in Lexington. At the same time, Norton Healthcare facilities will adopt UK HealthCare’s protocols for diabetes at its hospitals. Also, Norton Healthcare patients will participate in clinical trials that expand the growing research program at UK’s Barnstable Brown Kentucky Diabetes and Obesity Center.

Obstetrics

In an effort to address the physician shortage and to create a more diverse training program, Norton Healthcare is opening its hospitals to UK OB/GYN residents. A quarter of the state’s obstetricians have either stopped practicing or have left the Commonwealth since 2001, leaving as many as 71 of the state’s 120 counties without an obstetrician.

UK HealthCare will begin implementing a clinical rotation this summer at Norton Hospital, one of Norton HealthCare’s five hospitals, which initially will involve senior residents in obstetrics and eventually be expanded to include other residents in various stages of training. This partnership will provide expanded training opportunities for UK residents while creating a residency obstetrics and gynecology program in Louisville. As part of this program, several Norton Healthcare physicians will be named to UK’s faculty.

Transplant & Specialty Clinic

Many families are currently leaving Kentucky for advanced-specialty care. As a result, a new transplant clinic will provide comprehensive pre-and-post transplant care for patients. Scheduled to open in June, the clinic will be housed at Norton Audubon Hospital in Louisville and staffed by UK HealthCare transplant specialists in kidney, liver, heart and lung diseases. The advanced Heart Failure clinic will be coupled with a pulmonary hypertension clinic.

Local psychiatrist attended national leadership program

Dr. Scott T. Hedges, M.D., senior vice president for medical services at Seven Counties Services, Inc., joined his peers from community behavioral health organizations in 10 states last month in San Diego, Calif., to graduate from a year-long Psychiatric Leadership Program. The National Council for Community Behavioral Healthcare (National Council) conducted this leadership and training program as part of its wide-ranging efforts to improve the retention of psychiatrists in local community organizations and enhance the quality of care for people with mental illness and addictions.

The Psychiatric Leadership Program provided leadership training and mentoring to help psychiatrists lead clinical practice improvement efforts with the goal of improving the quality of care received in community behavioral health settings. The program also emphasized the need for psychiatric leaders to engage with their local communities and shape public policy.

Norton Healthcare receives award

Norton Healthcare, Louisville, Ky., was awarded the Kentucky Hospital Association (KHA) 2011 Quality Award, which is presented annually to honor hospital and healthcare leadership and innovation in quality, safety and commitment in patient care.

Norton’s KHA award application focused on the role of Norton Healthcare leadership in defining and promoting quality, and supporting staff and employee efforts to achieve quality goals; and on Norton Cancer Institute’s innovative Preventive and Early Detection Program, which is the region’s most comprehensive effort to prevent and detect cancer in its earliest stages through education, outreach, community cancer screenings and service, and evaluation of health outcomes.

Kosair Children’s Hospital ranked among top children’s hospitals nationwide

Louisville’s Kosair Children’s Hospital has been ranked among the top children’s hospitals nationwide in eight of 10 specialties in U.S. News Media Group’s Best Children’s Hospitals 2011-12 rankings.

Kosair Children’s Hospital ranked among the top 50 children’s hospitals in cancer, cardiology and heart surgery, gastroenterology, neonatology, nephrology, neurology and neurosurgery, orthopaedics, pulmonology, and urology. Seventy-six hospitals are ranked in at least one specialty.

For the full rankings and methodological visit www.usnews.com/childrenshospitals.
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For more information about Kindred Healthcare and how we Continue the Care every day, please visit www.kindredhealthcare.com.

CONTINUE THE CARE
Officials of three major Kentucky healthcare organizations announced this past June that their boards have formally approved plans to form a healthcare delivery system to meet the needs of all of the people of Kentucky and beyond.

The new system will include the University of Louisville Hospital/James Graham Brown Cancer Center, Jewish Hospital & St. Mary's HealthCare based in Louisville, and Saint Joseph Health System based in Lexington.

The partnership agreement still must receive regulatory and Church approvals before becoming effective, which could take 12 months.

The system will combine the faith-based and academic heritages of the partners, integrating medical research, education, technology and healthcare services wherever patients receive care. The network will collaborate with all healthcare providers, enhancing existing relationships and developing new partnerships.

Integration Benefits

One benefit of integration is the opportunity to efficiently move research from bench to bedside, improving healthcare outcomes, according to the partners. Plans call for expanding the academic medical center in Louisville to include the University of Louisville Hospital, James Graham Brown Cancer Center, Jewish Hospital and Frazier Rehab Institute, and extending the research and teaching programs of the University of Louisville statewide through an academic affiliation agreement with the University of Louisville School of Medicine.

The new system will bring together academic and community physicians, creating a medical staff of more than 3,000 physicians across the Commonwealth of Kentucky. The use of technology -- especially telemedicine -- will enable network physicians to expand access to specialty care that many communities have not had available before.

The sponsors of the health system are Jewish Hospital HealthCare Services, University of Louisville and Catholic Health Initiatives, a national nonprofit health organization based in Denver, Colo. Jewish Hospital & St. Mary's HealthCare was formed in 2005 through a joint venture between Jewish Hospital HealthCare Services and Catholic Health Initiatives. Saint Joseph Health System is also part of Catholic Health Initiatives.

Plans call for Catholic Health Initiatives to make an incremental capital infusion of $320 million in support of the system’s mission and healthcare services statewide. In addition, the new system will invest $200 million in capital to expand the academic medical center in Louisville and $100 million in statewide healthcare services.

The network will include hospitals, clinics, specialty institutions, home health agencies, satellite primary care centers and physician groups with 91 locations combined.

Until they have received regulatory approvals, the partners will continue to operate as separate organizations.
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Robotic Assisted Surgery lets doctors treat patients better than humanly possible.
Make the most of your reputation

Get expert marketing/PR guidance.

By Sue McNally

Far too often, healthcare companies decide to hire a marketing and public relations firm only after a business downturn or a crisis that threatens their reputation and financial health. A good reputation is the most valuable asset of any company, and a good marketing and PR agency can protect and even enhance it.

Making sure your company name is top-of-mind is more important than ever, due to increasing competition and consumer expectations. A good marketing/PR firm will make sure a positive message is created and distributed, drawing new business to you and reinforcing satisfaction in your current patients and clients. A powerful, differentiating brand for your healthcare business is the key to your success.

Here are three ways a good marketing/PR firm can enhance your brand.

1) Social Media

Navigating social media to protect your reputation and stay within HIPAA and CMS guidelines takes real expertise. Setting up a Facebook page is easy; making sure you are operating within regulations, and then posting relevant and interesting information, is difficult. An agency that specializes in healthcare will be familiar with the regulations and keep you out of trouble. If negative messages are posted, an all too regular occurrence these days, your agency can help you formulate an appropriate response that will not fan the controversy further. Having professionals guide you through this process means you won’t miss out on the rich opportunities for engagement that social media offers, while making sure your business is protected from the harsh repercussions of public mistakes.

2) Healthcare-related Advertising

Healthcare is subject to heavy regulatory requirements, and remaining compliant with all of the rules and regulations is challenging. Healthcare-related advertising is also subject to a number of compliance issues, and your marketing agency should create advertising to keep you in the good graces of the governing bodies pertinent to your business. Hiring a firm that specializes in healthcare marketing will help to ensure they have done their homework in regards to these complicated issues, and will keep your business free of fines and regulatory violations.

3) Outsource Events

Trying to figure out ways to free up your staff to plan special events can be a no-win situation. The staff is no doubt stressed by the additional workload asked of them and by doing something outside their area of expertise. When you outsource special events planning to an agency, the agency professionals utilize their experience and expertise to make sure the events are memorable and meet your goals.

Healthcare is driven and changed in fundamental ways by many factors well outside your areas of control. Governmental policy, pharmaceutical developments, new medical discoveries and changes in consumer health can have profound effects on your business. A good marketing and PR firm will help you interpret the trends and indicators to establish what effect the changes might have on your business, and to decide on the proper response to those developments.

Marketers look for opportunities in change and will point you in directions you were not able to envision. Public relations professionals will help to establish what, if any, response is appropriate to threats.

Advertising and marketing represent a significant investment in your future, and you want to make sure that you are spending those dollars wisely. Everyone has an opinion about advertising, creative initiatives, events and social media, but those opinions are based on nothing but the subjective evaluation of what an individual “likes.” When you are spending hard-earned money on outreach efforts meant to grow your business, make sure you are getting guidance from people who know what they are doing.

Just as you are an expert in your area of healthcare, a good marketing and PR agency will be an expert partner in how to “sell” your expertise. You would not come to the vimarce group to get a medical diagnosis on a bum knee, and you should not go to one of your employees for marketing advice. Hiring a reputable marketing and PR firm frees you up to do the things you do best, and positions your business for growth.

Today, reputations can be destroyed in hours, and taking the wrong posture can leave your reputation in tatters. An aggressive reputation enhancement program is the secret to achieving profitable growth.

Sue McNally is Director of Public Relations at the vimarce group, a full-service marketing, public relations, and advertising agency based in Louisville, Ky.
First things first: Prioritize your objectives

Proper practice planning includes setting financial goals and objectives for you including key actions for running—and exiting—a successful practice.

By David A Zimmerman, ChFC

“You’ve got to be very careful if you don’t know where you’re going, because you might not get there.” — Yogi Berra

It is not always easy to interpret Yogi. In this case, perhaps he is advising you to figure out just where you are headed in your practice. As you near the time when you will leave behind the daily worries and stresses of practice ownership, have you defined your successful exit? Do you know where “there” is, much less how to get there?

Unless you set and prioritize your exit goals or objectives, you may have too many, or they might conflict, but in either case you may not make much headway.

A Realistic Scenario

The clearest example of a failure to set objectives may be a doctor and practice owner who recently told us that he wanted:

• To retire within three years, but he was ready to leave today;
• Financial security, defined as a seamless continuation of his current lifestyle; and
• To transfer the practice to his other key doctors.

A quick review of the doctor’s personal financial statement, however, revealed that most of the income required to maintain his lifestyle would have to come from the practice. Unfortunately, it wasn’t large enough to attract a cash buyer. And, since the doctor had done no exit planning, his employees had no funds with which to purchase his ownership interest. A long-term installment note seemed to be the only answer—a risk the doctor was unwilling to take.

Contrast this unpalatable solution with his objectives—objectives which could have been achieved had he taken the time (well before he wanted to leave) to establish and to prioritize his exit objectives.

If, for example, an owner’s need for financial security prevails, selling a practice to a third party for cash may be the best and quickest exit path.

If, however, attracting a qualified third party is unlikely, an owner may need more time to devise and to implement a transfer to an insider (child or employee) that provides the owner adequate cash.

Unless you set and prioritize your exit goals or objectives, you may have too many, or they might conflict, but in either case you may not make much headway.

On the other hand, if an owner’s desire to transfer the practice to a specific person or group trumps his or her need for financial security, and his or her deadline for departure draws near, financial security in the form of “up-front” cash must take a backseat.

Three Primary Exit Goals

As you can see, owners must consider—simultaneously—the three primary exit goals. Ask yourself which is your most important exit objective:

1) Financial security
2) Transferring the practice to the person of my choice (may include key employees, co-owner or child)
3) Leaving the practice when I want (could be immediately or never)

Prioritizing your objectives can be difficult, but meeting with a financial practice consultant can help offer fresh eyes and experience to make the right decisions for you, and provide a framework for decision-making. Proper practice planning first includes setting financial goals and objectives for you—the doctor and owner, and exit planning for you, which leads to key actions for running a successful practice with your goals in mind.

Exit Goals

Ask yourself which is your most important exit objective:

• Financial security
• Transferring the practice to the person of my choice (may include key employees, co-owner or child)
• Leaving the practice when I want (could be immediately or never)

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David A. Zimmerman is a Chartered Financial Consultant and Financial Practice Advisor with ARGI Business Services, a wholly owned subsidiary of ARGI Financial Group.
Creating a health-care culture that focuses on patient safety is not a new concept. However, it may seem that way since the drivers of healthcare reform keep increasing the speed and intensity of implementation. As old ways of thinking and acting are stripped away, one may notice fewer silos around the healthcare management table replaced with value driven reasoning emerging with each problem-solving concept. The key to providing safe, quality care starts with open communication, teambuilding strategies, and transparent communication throughout an organization. The question is who can lead such a change?

Cries from the “reformers” seem to get louder with demands of improved quality and safety while performing procedures and treatments. They want easier access to resources for the consumer and more cost-effective health programs for the nation. In return, many healthcare organizations are developing and using some version of enterprise risk management (ERM) principles for both value protection and value creation. There are four basic steps to ERM that include risk identification, prioritized options for resolution, prioritized intervention into the most costly risks, and monitored sustainability. To gain the most success with ERM, the organization has to educate all the staff in all the departments, as well as vendors who service the organization with the knowledge and support for the goals and mission of the organization. Collectively, they perform as a united risk management team in order to meet the ongoing challenges that increase with each passing day. This culture change cannot be a function of a single department.

As the required healthcare changes move into place, an organizations risk management team would be the obvious choice to lead the culture change since by nature they continually assess the care to identify potentially harmful practices and system failures. Overcoming challenges is a familiar routine for healthcare providers. But, since the passage of the Affordable Care Act of 2010, providers have had to run sprints just to stay in the game. The legislation has constituted the largest change to America’s healthcare system since the creation of Medicare and Medicaid. The new legislation expands coverage to 32 million people; builds on the employer-based insurance systems; initiates major insurance reforms; sets in motion future payment and delivery system reforms; and increases the focus on wellness and prevention rather than illness and recovery. The Affordable Care Act of 2010 realigns all healthcare provider incentives to emphasize quality of care rather than quantity of procedures. It celebrates consumer protections and establishes the Patient Bill of Rights as well as the National Patient Safety Goals as anchors of the reform. Over the next two months, the healthcare industry will be forming Medicare Accountable Care Organizations that present a totally new care delivery model that includes care coordination with shared savings and shared risk. The payment and delivery model tie the provider reimbursements to their quality and safety measures, as well as the reduction in cost of care for an assigned population of patients.

The Importance of the Risk Manager

The clinical risk manager position requires skills that relate well to achieving the health reform goals. A common function is to partner with others to project and eliminate potential risks before they affect the healthcare consumer. As the required healthcare changes move into place, an organizations risk management team would be the obvious choice to lead the culture change since by nature they continually assess the care to identify potentially harmful practices and system failures. A clinical risk manager is able to handle a lot of multiple tasks at the same time, is very organized and methodical in his/her work, has a working knowledge of the insurance market place, and is able to manage the risks and protect the assets.
in a healthcare environment. The risk manager is aware of hot issues that could lead to liability and increased cost, has the ability to collect and analyze data and identify the root cause of system failures, and generally works best in a team environment. Once a team solution has been implemented, the risk manager is skilled in developing tools to embed the change in the procedure or system and sustain the positive outcome.

An effective risk manager not only needs to work closely with the Quality and Safety Departments to identify system errors, they also need to partner with all other staff members to address prevention and avoidance strategies across all departments and the organization as a whole. When every department is part of the risk management team it allows them to search for new opportunities that improve the quality of care offered and efficiently delivered as well as the ways to manage an adverse event and avoid reoccurrence.

Adverse events are a reality for all organizations and have been managed for years by risk management staff members. However, having the risk team continue to work exclusively with loss prevention, claims management, and risk financing functions, the organization misses out on their skills in the proactive side of healthcare. The risk manager of 2011 has the opportunity to educate the team on transparency, effective disclosure, avoiding or reducing adverse events, early claims reporting, discovery responses that mitigate unnecessary healthcare litigation costs, and much more.

More than half of the activity of a risk manager needs to be spent in proactive reduction and/or prevention, safety, quality, and team building in order to meet the challenges and opportunities presented by healthcare reform. Going forward a successful risk management team will need to rely on all organization staff members taking responsibility. The only way to go forward is to go together.

Barbara Peterson is Business Development Director, Risk Management Consultant, for Risk Management Solutions in Columbus, Ohio.

Four Basic Steps to Enterprise Risk Management

1) Risk identification
2) Prioritized options for resolution
3) Prioritized intervention into the most costly risks
4) Monitored sustainability

Save the Date

Make plans to join the Cabinet for Health and Family Services and the Kentucky Health Information Exchange (KHIE) in Erlanger on Sept. 7 for the 2011 Kentucky eHealth Summit.

• Hear a report on the future of Health IT from the National Coordinator for Health Information Technology, Farzad Mostashari, MD, ScM.
• Find out how others are implementing electronic health record systems, the benefits to providers and consumers, and Stage II Meaningful Use.
• Get info on how the Kentucky Health Information Exchange (KHIE) is leading the nation in Health IT and how you can join the effort.

For more information on the 2011 Kentucky eHealth Summit, visit khie.ky.gov.
A Case for career colleges

Career colleges meet the needs of students who are underserved by public and non-profit colleges and universities.

By Candace Bensel

These days, career colleges, also known as private sector colleges and universities, are providing options for individuals seeking to continue their education. Studies have shown this option for college is growing due to the flexibility and fast paced nature of these programs.

A new study produced by Chmura Economics & Analytics has shed some light on the importance of career colleges to the educational landscape of the Commonwealth and brings a new perspective to cost effective ways of meeting Kentucky’s educational goals.

A major finding in the study is that career colleges are meeting the needs of students who are underserved by public and non-profit colleges and universities. Over half of career college students (65.4 percent) of all career college students are over the age of 25, double the rate of adult students attending public colleges. Referred to as “non-traditional students” these are often students who have been part of the workforce and may be currently working. This option also appeals to individuals supporting families because class schedules are designed with this lifestyle in mind.

Not only do career colleges serve more students who are traditionally under-represented at public institutions, but they also are graduating these students at a higher rate. Based on 2009-2010 academic year data, the average graduation rate for Kentucky’s two-year career colleges among first time students was 61.1 percent compared to community colleges at 24.7 percent. The graduation rate for four-year career colleges was 68.1 percent, also higher than the 46.4 percent rate for four-year public colleges.

Why Students Choose Career Colleges

Students choose to attend career colleges because they offer a focused education in a specific job field. The goal of private sector colleges is to educate toward employability. National accreditors ensure that these occupational goals are being met in the training they receive at career colleges. Based on survey results obtained during April 2011, almost seventy percent of graduates from Kentucky’s career colleges obtained employment within six months of graduation.

The success of employability upon graduation at career colleges is not by mistake. These schools work closely in advisory groups with employers in the communities they serve to not only offer programs with substantial need, but also to build state-of-the-art classrooms and labs preparing students with the hands on experience necessary for success.

When looking at the career college model, it is understandable why more students choose career colleges—the flexible class schedules, online program opportunities, workforce oriented focus, and expandable program availability encourage students with busy family and work lives to get an education directly applicable to the workforce. Whether they are parents, already working, or recently unemployed and seeking work, these schools are filling a gap in education not met by the public community colleges and universities.

Giving Back to the Commonwealth

Career colleges are returning a significant value back to the Commonwealth of Kentucky’s workforce training needs. These graduates go on to become a vital part of Kentucky’s workforce in high demand occupations in Kentucky’s local businesses:

- Fifty-five percent of medical assistants, 11 percent of registered nurses, 48 percent of radiologic technicians, 43 percent of surgical technicians, and 85 percent of pharmacy technicians who graduated last year were trained at a career college.
- Over three-fourths of Kentucky’s electrical and electronic engineering technicians were trained at career colleges.
- Over half of Kentucky’s paralegals or legal assistants graduated from a career college.
- Career colleges provide an opportunity to walk directly out of the classroom and into the workplace, with more than 65 percent of career colleges obtaining a job within the first six months of graduation.

— Source: Chmura Economics & Analytics

Continued on page 16
IF YOU NEED MORE PATIENTS WHO HAVE THE MEANS TO PAY, YOU NEED IDEALOGY.

With fewer insured patients and constant downward pressure on reimbursements, there’s one universal truth in health care right now: **every practice needs more patients with the means to pay for care.**

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The study also shows that not only are career colleges answering the students’ needs, they are returning a significant value back to the Commonwealth of Kentucky’s workforce training needs. These graduates go on to become a vital part of Kentucky’s workforce in high demand occupations in Kentucky’s local businesses:

• According to the Chmura report, 55 percent of medical assistants, 11 percent of registered nurses, 48 percent of radiologic technicians, 43 percent of surgical technicians, and 85 percent of pharmacy technicians who graduated last year were trained at a career college.

• Over three-fourths of Kentucky’s electrical and electronic engineering technicians were trained at career colleges.

• Over half of Kentucky’s paralegals or legal assistants graduated from a career college.

• Career colleges provide an opportunity to walk directly out of the classroom and into the workplace, with more than 65 percent of career colleges obtaining a job within the first six months of graduation.

Career colleges are producing valuable members of the workforce, and they’re doing it more cost efficiently than public colleges.

It is time to broaden the discussion on higher education from a “traditional” understanding. At a time when job creation and preparation are sorely needed and government funding limited, Kentucky’s career colleges are proud to provide services that meet the needs of students and contribute to the continued growth of this great Commonwealth.

Candace Bensel is Executive Director, Kentucky Association of Career Colleges and Schools.

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WINDSTREAM MEANS BUSINESS
Educat­ing stude­nts, build­ing a work­force

Stu­dent reflec­ts on UofL pro­gram to help increase Ken­tuck­y phys­i­cians.

By Jill Scog­gins

One of the first stu­dents to enroll in a pro­gram at the Uni­ver­sity of Louis­ville to help address Ken­tucky’s ac­ute short­age of phys­i­cians has com­pleted the pro­gram, put­ting her one step closer to her goal of be­com­ing a phys­i­cian. Mel­lis­sa “Mis­sy” Sul­li­van of Louis­ville en­rolled in the Post-Bac­ca­laureate Pre-Med Pro­gram (PBPM) at UofL in its ini­tial semes­ter, spring 2009. She will start classes at the UofL School of Med­i­cine in Au­gust.

“Pro­ba­bly the great­est asset of this pro­gram is the abil­ity to meet UofL med­i­cal school fac­ulty and ad­mis­sions com­mit­tee mem­bers.”
—Mel­lis­sa ‘Mis­sy’ Sul­li­van

The PBPM pro­gram ena­bles post-bac stu­dents who have min­i­mal pre-med sci­ence back­grounds to com­plete coursework nec­es­sary to qual­i­fy for med­i­cal school ad­mis­sion. It was imple­ment­ed to help in­cre­ase the health­care work­force in Ken­tucky. It is joint­ly admin­is­tered by the School of Medi­cine and the Col­lege of Arts and Sciences.

“The Com­mon­wealth of Ken­tucky needs more phys­i­cians to prac­tice in med­i­cally un­der­served ar­eas,” V. Faye Jones, M.D., Ph.D., as­so­ciate dean and head of the Of­fice of Min­or­ity and Rural Af­fairs, said. “To­day, 80 of Ken­tucky’s 120 coun­ties are fed­er­ally de­sign­ated as Health Pro­fes­sional Short­age Ar­eas. Our pro­gram ex­ists to serve as a po­ten­tial prob­lem re­medy by help­ing to en­able more stu­dents earn med­i­cal de­grees.”

Pro­gram De­tails

Stu­dents in the two-year pro­gram at­end pre-med classes and re­ceive ad­vis­ing and men­tor­ing spe­cially de­signed for post-bac stu­dents. They also bene­fit from other pro­grams and ser­vices that are geared to help them suc­ceed. Upon the suc­cess­ful com­ple­tion of the pro­gram, they are as­sured ad­mis­sion to the UofL med­i­cal school if they meet the nec­es­sary cri­teria.

Stu­dents can have a back­ground in any disci­pline, and the cur­rent group of 26 stu­dents en­rolled in the PBPM earned bach­e­lor’s or mas­ter’s de­grees in so­ci­ol­o­gy, en­gi­neer­ing, jour­nal­ism, phi­los­o­phy, busi­ness ad­min­is­tra­tion, art his­to­ry, and mus­ic, for ex­ample.

Mo­ther of Four Fees­led Com­pelled to Give Back

Mar­ried to Sean Sul­li­van and the moth­er of four chil­dren aged 4, 5, 7 and 10; Mis­s­ly Sul­li­van earned two bach­e­lor’s de­grees from Bellarmine Uni­ver­sity in 1993, one in eco­nomics and the other in psy­chol­o­gy. She said she was moti­vat­ed to en­ter the post-bac pre-med pro­gram by a de­sire to con­tribute to so­ci­ety.

“I have a good life and feel com­pelled to give back,” she said. “I also have looked back on my de­ci­sion to not pur­sue med­i­cine as a ca­reer with reg­ret. This pro­gram and the sup­port of my family en­abled me to re­turn to school.”

She re­com­mends the pro­gram to oth­ers. “It is ‘one-stop shop­ping’; in my very busy life, if I need­ed an­swers for some­thing re­lated to the pro­gram, just an e-mail or phone call to (pro­gram di­rec­tor) Tonia Thomas got me what I need­ed,” she said. “Pro­ba­bly the great­est asset of this pro­gram is the abil­ity to meet UofL med­i­cal school fac­ulty and ad­mis­sions com­mit­tee mem­bers.

“In ad­di­tion, since this is an ac­cept­ed cer­ti­fi­cate pro­gram, I have had ac­cess to stu­dent lo­ans that nor­mally are not avail­able to post-bac stu­dents. This has al­low­ed me to de­crease work hours and con­cen­trate more on stud­y­ing.”

She also cites the sup­port of her em­ploy­er, Day Spring, a Louis­ville pro­vider of ser­vices to adults with in­tel­lec­tual dis­abil­i­ties. “I’ve spent the past 15 years work­ing for Day Spring, which has been ex­trem­ely sup­port­ive of my de­ci­sion to make this ma­jor ca­reer change. Much of my work time was flex­ed to the third shift so my days were opened up for class work.”

As a wife, moth­er, em­ploy­ee and post-bac stu­dent, Sul­li­van said she went into the pro­gram with a rea­son­able view of balanc­ing her many roles. “I started this jour­ney with the atti­tude that I would con­tinue only if I could get the grades needed with the

Photo by To­nia Thom­as, UofL

Mis­s­ly Sul­li­van at the Post-Bac­ca­laureate Pre-Med Pro­gram com­mi­nua­tion held in May 2011.
David L. Dunn, M.D., Ph.D., vice president for health sciences and professor of surgery, microbiology and immunology at the University of Buffalo, is the new executive vice president for health affairs at the University of Louisville effective July 1.

Dunn fills the position left by Dr. Larry Cook, who announced his resignation last year. Cook returns to the faculty in the Department of Pediatrics on July 1 after serving since 2003 as the executive vice president for health affairs.

"Dr. Dunn brings to UofL a skill set that will help move us to the next level as a premiere academic medical center in very short order. He has experienced and resolved many of the issues associated with a rapidly growing research enterprise, and he has harnessed that energy so that it becomes very constructive and enables further expansion in the future," said Dr. James Ramsey, president of the University of Louisville. "We sought a national leader for this position and we have found one.

Prior Experience

As vice president for health sciences at the University at Buffalo (UB)/State University of New York (SUNY), a position he has held since 2005, Dunn was responsible for leading the strategic integration of teaching, research, service and clinical activities of UB’s five health sciences schools (Dental Medicine, Medicine and Biomedical Sciences, Nursing, Pharmacy and Pharmaceutical Sciences and Public Health and Health Professions), and their departments, programs, centers and hospital and clinical affiliates.

Prior to joining the University at Buffalo, Dunn was the Jay Phillips Professor and Chairman of Surgery at the University of Minnesota. He also was the division chief of General Surgery, head of Surgical Infectious Diseases, director of Graduate Studies and Residency Program director of the Department of Surgery. He was a full member of the faculty of the graduate programs in Surgery and the Biomedical Sciences. During his tenure in this position, clinical revenue and extramural grant support dramatically increased and a number of new clinical and research programs emerged, including the Lilliehi Heart Institute, the Diabetes Institute for Immunology and Transplantation (newly renamed as the Schulze Diabetes Institute) and the Center for Minimally Invasive Surgery.

Dunn has published more than 400 articles and book chapters in the areas of surgical infectious diseases and transplantation, and he is considered an authority nationwide and worldwide in the areas of endotoxin antagonist development and testing; immunomodulation during sepsis; intra-abdominal sepsis and host defenses of the peritoneal cavity; cytomegalovirus disease after solid organ transplantation; and pancreas transplantation.

"I am very impressed with the breadth and scope of the programs at the University of Louisville and the desire everyone has to enhance its national and international stature."—David L. Dunn, M.D., Ph.D.

Dunn earned a bachelor of science degree in zoology from the University of Michigan in 1973 and his M.D. degree from Michigan’s School of Medicine in 1977. From 1977-1985, he was a medical fellow in general surgery and from 1985-1986, he was a fellow in transplantation and transplantation immunology, both at the University of Minnesota. He received his Ph.D. in microbiology from the University of Minnesota Graduate School in 1985.

The executive vice president for health affairs at UofL provides leadership for the university’s Health Sciences Center. The Schools of Dentistry, Medicine, Nursing and Public Health and Information Sciences, as well as 14 centers and institutes, all fall under the oversight of the executive vice president for health affairs, who also serves as a key member of president James Ramsey's leadership team. The executive vice president also has principal responsibility for external affairs including hospital relations and other affiliated entities.
Dunn has either led or co-led the following initiatives at or on behalf of University at Buffalo:

- Segregated duties, intramural reporting and external relationships, as well as the financial structure of vice president for health sciences (VPHS) and dean, School of Medicine and Biomedical Science. Formerly, these positions were one in the same, and as part of his recruitment to UB, Dunn chose to separate them.

- Reconfigured UB’s five health science schools as the UB Academic Health Center (AHC), symbolic in principal, but tangible by initiation of strategic planning on the part of all AHC deans in concert and the creation of AHC-wide committees with highly focused missions and deliverables.

- Appointed to and chaired the Western New York Regional Advisory Committee of the Commission on Health Care Facilities in the 21st Century (known as the “Berger Commission”) by former New York Gov. George Pataki and drafted the report for the eight counties of western New York. These recommendations were included in large part in the final report and adopted into state law.

- As president and CEO of University at Buffalo Associates Inc., initiated and achieved widespread consensus among key stakeholders for the formation of a single clinical practice plan-UBMD-from 18 separate not-for-profit clinical practice plans.

- Finalized financial and oversight mechanisms and implemented IME/GME funds flow to School of Medicine and Biomedical Sciences and School of Dental Medicine faculty.

- Successfully recruited stellar candidates for the dean’s positions of the UB School of Medicine and Biomedical Sciences, UB School of Nursing, UB School of Public Health and Health Professions and UB School of Dental Medicine.

- Played key role in a number of major philanthropic initiatives including the $3 million Behling gift to support simulated learning in the AHC.

- Appointed by the New York state Commissioner of Health as a member of the newly formed Great Lakes Health System, and subsequently elected secretary/treasurer of this entity.

- Proposed concept and became chief academic officer for a $330 million capital project to create a joint venture with Kaleida Health to build a 10-story Global Vascular Institute/Translational Research Center/Biosciences Incubator (CTRC/BI).

- Principal investigator of a $7 million HEAL NY award from the New York state Department of Health to study prevention and prediction of disease progression and effective management of chronic renal disease using a patient-centered medical home model within UBMD practices.

- Spearheaded the creation of the UB Institute for Healthcare Informatics, funded through a $20 million HEAL NY 17 award and a partnership with Perot Systems/Dell Services that entails $15 million in support.
Vascular health issues can present in many different ways. Patients report leg pain or discomfort, toe and foot pain during the night, bluish extremities, or wounds that won’t heal after proper treatment. The symptoms vary from patient to patient.

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Dr. James Van Daalen can consult with your patients at three Kentuckiana locations. He performs vascular procedures including VNUS closure and laser surgery at Clark Memorial’s nationally-recognized Surgery Center in Jeffersonville, whose team consistently earns some of the highest patient and physician satisfaction scores in the region.

Find out more about all of the treatments available through the Thoracic and Vascular Surgery Center by calling (502) 894-0064.
UK receives $20 million NIH grant

The $20 million is thought to be one of the largest health grants in UK history.

By Melanie Wolkoff Wachsman

The University of Kentucky recently received $20 million from the National Institutes of Health for five years of specialized research.

The clinical and translational research financed by the award emphasizes linking research and medical practice so that laboratory advances become available to patients as treatment more quickly.

The $20 million is thought to be one of the largest health grants in UK history.

UK will become the only Kentucky organization with the NIH Clinical Translational Science Award designation.

“It’s more than money,” said Michael Karpf, UK’s executive vice president for health administration.

With the NIH emphasis on clinical translation, it is seeking opportunities to create centers of excellence, Karpf said.

“This grant is recognition by the NIH that we are one of the places” in the upper tier of medical institutions that can do clinical translation.

Kumble Subbaswamy, UK’s provost, said, “Without the NIH award, any notion that we would become an NIH top 20 university would simply ring hollow.”

Status Rising

Karpf and Subbaswamy said two other healthcare designations that UK is awaiting will boost UK’s status even further. An accreditation renewal is expected for the Sanders-Brown Center on Aging in July, and a review of the Markey Cancer Center for a National Cancer Institute designation is expected in November.

Having the three designations in hand, Karpf said, “puts us with the big boys.”

Such goals are not being pursued just for their prestige, Subbaswamy said. The distinctions are “not just for bragging rights, but for improving the lives of Kentuckians.”

Dr. Phillip Kern, associated provost for clinical and translational science, will be the principal investigator for the clinical translation program. The program will “break down the silos between scientists, clinicians and humans,” Kern said.

“It’s always astounding how we don’t deliver care … to those that need it the most,” he continued.

UK’s translational work integrates the school’s strengths in treating cancer, heart disease and diabetes with its research specialties in pharmaceutical sciences and biomedical engineering to develop new drugs and medical devices, Kern said.

Making Strides

Also in development is the Appalachian Translational Research Network along with Marshall University in Huntington, W.Va.; Ohio State University; the University of Cincinnati and regional academic institutions.

UK has also entered into a formal partnership with Marshall to finance research based on that university’s expertise in genomics (the study of gene structure and sequences), rural medicine and cancer research.

“Not every academic medical center is going to be a major player in the long haul,” said Karpf.

UK’s overall research budget topped $300 million for the first time in 2010, with $128 million in grants and contracts from the National Institutes of Health leading the way. Other major federal grants and contracts came from the National Science Foundation ($25.2 million), the Department of Energy ($13.3 million) and the Department of Commerce ($12.5 million).
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Navigating the complexities of 340B

For healthcare providers that have entered the waters of 340B pharmaceuticals, most will confess that the task is enough to have you running—frequently—for the extra-strength ibuprofen. After all, the benefits of operating a 340B pharmacy can be realized only if there is a perfect alignment of the healthcare provider, the practitioner, the patient, the drug, the service and the payor for a given claim. Yet there are benefits to operating a 340B pharmacy; and for some healthcare providers those benefits have been well worth the effort. The legal framework of 340B is complex, but understanding the fundamentals brings some clarity to achieving compliance.

“340B” stands for the multiple provisions of Section 340B of the federal Public Health Services Act, located at 42 U.S.C. § 256b, but like Elvis, Cher and Pele, practitioners commonly reference it singularly as “340B.” Section 340B is administered and overseen by the Office of Pharmacy Affairs, which is an office buried within the Health Resources and Services Administration, an agency within the Department of Health and Human Services (HHS). As statutes go, Section 340B is not particularly lengthy or complicated to read. Though cliché to write, the devil truly is in the details.

340B Fundamentals

In general terms Section 340B requires pharmaceutical manufacturers to enter into an agreement with HHS that obligates the manufacturer to offer certain outpatient drugs (“Covered Drugs”) at no more than a certain price (“Average Manufacturer Price”) to certain healthcare providers (“Covered Entities”). The 340B program is, effectively, a price control program aimed at alleviating safety-net healthcare providers from the escalating costs of purchasing certain drugs. Section 340B is not viewed as reimbursement legislation and has no direct effect on the level of reimbursement healthcare providers receive for dispensing Covered Drugs. However, Covered Entities generally receive a greater margin when dispensing and seeking reimbursement for 340B Covered Drugs because of the drug’s cheaper acquisition cost, at least as compared to drugs using non-340B prices. On average, a 340B Covered Drug may be purchased at approximately 50 percent of the drug’s average wholesale price.

Not all healthcare providers are eligible to become a Covered Entity. There are benefits to operating a 340B pharmacy; and for some healthcare providers those benefits have been well worth the effort.

By Wesley R. Butler
Member
Barnett Benvenuti & Butler, PLLC

Legal Matters

There are benefits to operating a 340B pharmacy; and for some healthcare providers those benefits have been well worth the effort.

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Navigating the complexities of 340B

Covered Drugs that are dispensed. Only outpatient drugs are covered by Section 340B. Covered Drugs purchased at 340B pricing may not be diverted for use in an inpatient setting. Covered Drugs purchased under 340B pricing may not also be reimbursed through Medicaid if the Covered Drug is subject to a Medicaid rebate. Section 340B prohibits Covered Entities from reselling or diverting 340B Covered Drugs to a person who is not a patient of the Covered Entity. The Covered Entity must have a defined relationship with a patient for the Covered Entity to be able to dispense to the patient drugs purchased under 340B pricing. HHS and the pharmaceutical manufacturers have the right to audit a Covered Entity’s records if there is evidence that the Covered Entity is dispensing 340B Covered Drugs in a manner that is contrary to 340B program rules.

The 340B program is, effectively, a price control program aimed at alleviating safety-net healthcare providers from the escalating costs of purchasing certain drugs.

More recently, changes in the 340B program have slightly expanded the types of healthcare providers who may be eligible as a Covered Entity. The 340B program has also expanded the opportunity for Covered Entities to dispense and seek reimbursement for 340B Covered Drugs through multiple contract pharmacies, rather than solely through the Covered Entity’s in-house pharmacy. As pharmaceutical prices continue to rise, the 340B program may continue to expand.

Section 340B provides a meaningful opportunity for certain healthcare providers to better manage their drug purchasing expenditures, but the opportunity requires a commitment to complying with the program’s rules and requirements—and sometimes an adequate supply of ibuprofen.

Covered Entity Defined

The definition of “Covered Entity” specifically identifies about 16 different types of healthcare providers. The common trait among all the eligible healthcare providers is a focus on those that provide a significant level of service to indigent patients or receive federal grants for treating patients with particular medical conditions. Those healthcare provider types listed include:

- Federally qualified health centers;
- Disproportionate share hospitals;
- Children’s hospitals;
- Critical access hospitals;
- Rural Referral Centers; and
- Sole Community Hospitals.

A healthcare provider’s eligibility as a 340B Covered Entity may not always be readily apparent simply by reviewing the list of eligible entities.

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VRT enhances vision lost to neurological impairment

Vision loss, particularly in the central 10 percent of the visual field, has an impact on quality of life and safety. That may change.

By Cindy Sanders

After suffering a neurological injury, it is common for patients to work to regain function through speech, occupational and physical therapy. However, “adjustment” and “compensation” have been the watchwords when it comes to the vision loss that often accompanies these neurological insults.

Treatment of vision loss due to stroke, traumatic brain injury (TBI), tumors or other neurological damage largely has focused on therapy to help patients compensate for their acquired vision deficits rather than to improve the field of vision. However, vision restoration therapy (VRT) appears to offer the opportunity for measurable improvement in sight. In a number of studies, FDA-cleared NovaVision VRT™ has demonstrated functional improvement for neurologically impaired patients.

Vision loss, particularly in the central 10 percent of the visual field, has an impact on quality of life and safety. Often, such loss impacts mobility and makes tasks such as driving, reading, writing, or even walking extremely difficult—if not impossible.

Tom Bridges, vice president of sales and marketing for NovaVision, said patients suffering vision impairment from neurological injuries could lose up to half of their vision. “Put your left hand over your left eye and imagine that’s your visual world,” he said to demonstrate the limitations patients often feel.

Improving the Visual Field

To mitigate those limitations, NovaVision, which is based in Boca Raton, Fla., has focused on stroke and TBI patients using light stimuli therapy delivered through a non-invasive computer device. One study showed approximately 88 percent of patients had some demonstrable improvement in at least one of their daily functional activities with 75 percent of patients experiencing improved mobility. Additionally, 75 percent of the study subjects had “substantial” visual field improvement.

A small study out of Columbia University Medical Center used functional MRI (fMRI) to track a patient’s brain activity while undergoing VRT. The fMRI showed increased activity in the visual cortex one month after patients began receiving therapy. “It shows the increased activity in the ocular center doesn’t just happen simultaneously,” Bridges said. He added that while science has not yet completely answered the “how” and “why” VRT works, those behind the company believe the therapy induces neuroplasticity.

The therapy is an option for the millions of people worldwide who have experienced interference in the neurological pathways between the eyeball and ocular center.

Interestingly, clinical studies have shown the time lapse between the onset of neurological injury and the initiation of treatment was not relevant. A patient’s age also appears to be a non-factor in achieving successful outcomes. “The only contraindication is if someone has a light sensitive seizure disorder,” noted Bridges. He did add that the therapy also wouldn’t be appropriate for someone who had suffered such significant cognitive impairment that they were unable to perform functions or if the actual structure of the eyeball was so badly damaged that it couldn’t receive stimuli.

The therapy is, however, an option for the millions of people worldwide that have experienced interference in the neurological pathways between the eyeball and ocular center. For this group, explained Bridges, “The eye still takes in the information. But if that information doesn’t get back to the processing center, then you don’t see. The eye isn’t damaged, it’s the brain.”

After Therapy

After therapy, Bridges said, “On average, VRT patients permanently recover 5º of central vision, a critical gain for conducting many daily activities.” He added that patients with significant improvement gain up to 8º. While this might seem like a small difference, he explained this improvement is in the central 10 percent of the eye and actually has exceptional impact on daily life.

The home-based therapy, which typically lasts six months, requires patients to twice daily spend 20-30 minutes with the computer device that uses light stimulation on the borders of sight and non-sight. Each patient’s plan is customized and reformatted as vision improves. “In the initial stage, we identify where the patient can see and where they can’t see, and there is always a fine borderline between the two,” said Bridges. “We develop an algorithm of light stimulation that marches between that borderline.”

The computer device is connected to the NovaVision office via phone line. Once a month, a patient’s data is downloaded, and the therapy plan is adjusted as warranted.

The best part, according to Bridges, is hearing the individual success stories of patients who can once again read, play tennis or golf, paint, go to movies and just take part in daily life. “We’ve given them their self esteem back —their ability to be more social and to be able to be out in public.”

It is estimated that between one and two million TBI and stroke patients in the United States alone suffer from visual field limitations. Patients with surgical trauma, tumors and amblyopia are also among the candidates who might benefit from VRT, which could be prescribed by an ophthalmologist, neurologist or physiatrist.
Priorities and Meaningful Use attestation highlight summer fun

As we head into July, the level of activity around health IT is reaching a fever pitch on both ends of Pennsylvania Avenue in Washington, D.C. Legislation is being introduced to counter the effects of the Stimulus Package and the Healthcare Reform law, while agencies are working on Meaningful Use, implementing healthcare reform requirements, and thinking big thoughts about how health data can change patient involvement in their care delivery. It’s enough to make your head spin.

Legislative Update

A lot of time is being spent on the National Debt Ceiling and positioning for victories to tout during the 2012 Presidential Campaign. We have seen a jump in proposed health IT legislation after two quiet years following passage of theHITECH provisions of the American Recovery and Reinvestment Act (ARRA). The four most notable legislative proposals attempt to address consequences of ARRA and other health IT-related laws.

First, Representative Mary Bono Mack (R-CA) is sponsoring the Secure and Fortify Electronic Data Act—affectively known as the SAFE Data Act—to address privacy concerns generated by the recent data breaches at Sony and Lockheed Martin. As a long-time proponent of data privacy, Senator Patrick Leahy (D-VT) has developed similar legislation in the Senate. Based on the fact that there is bipartisan and bicameral interest in clarifying privacy and security requirements, these pieces of legislation may “have some legs” on Capitol Hill. I’ll monitor their progress and keep you posted on developments.

Second, Rep. Renee Ellmers (R-NC) introduced the Strippling the E-Prescribe Arbitrary Mandates Act (STEAM Act) legislation to eliminate disincentives associated with deductions in Medicare reimbursement rates starting in 2015 for those who do not adopt e-prescribing as part of EHRs. Rep. Ellmers is among a group of legislators who believe the disincentive will have a greater negative impact on healthcare delivery in the U.S.

Third, Senator Kent Conrad (D-ND), an original chairperson of the Capitol Hill Steering Committee on Telehealth and Healthcare Informatics (now part of the HIMSS Foundation’s Institute for e-Health Policy, http://www.e-healthpolicy.org/) has sponsored legislation to improve the utilization of teleconsultation, telerehab, telemedicine and telehealth coordination services for the provision of healthcare to U.S. veterans. As Chairman of the Senate Budget Committee and longtime proponent of the Senate Budget Committee, Conrad’s push for this legislation may set the groundwork for future Medicare and Medicaid reimbursement for telehealth services.

We’ll have to wait to see what happens with any of these initiatives before Congress heads out of town on its August 2011 recess.

Executive Branch Update

Meaningful Use in Full Swing

The big push in federal agencies this month is to make sure hospitals that plan to attest to Meaningful Use in 2011 are on their way to meet the September 2011 deadline for having a 90-day attestation period. Officially, the Centers for Medicare and Medicaid Services reports that more than 54,000 eligible professionals and 1,700 eligible hospitals are preparing for Meaningful Use in 2011. Among these Meaningful Medicare and Medicaid reimbursement for telehealth services.

If disaster strikes, are you ready? Mother Nature has proven recently that disasters will happen. Tornado season has been particularly active this year and you can add windstorms, ice storms, disgruntled employees, fire, leaking pipes, etc., to the list. Unless you’ve prepared in advance, the consequences can be devastating.

During times of disaster, first and foremost on our minds are the things we value the most. Thus, escape routes and meeting places are established to make sure your family and co-workers are safe. But have you given the same thoughts to the things most valuable to your business? If the office were destroyed, does your data have an escape plan or an offsite location where it is safe?

Your organization probably couldn’t survive if you lost your accounting system, practice management system, customer data files, etc. You could probably go as long as three to 10 business days recovering, but if you can’t return to “normal” computer operations in less than two weeks, then studies predict you’ll be out of business within a year.

Good backups are essential for ensuring that if disaster strikes, your data is safe and available for you to get back to “business as usual” in just a few days.

Prepared by: By Thomas Leary
HIMSS Senior Director of Federal Affairs

Based on the fact that there is bi-partisan and bicameral interest in clarifying privacy and security requirements, these pieces of legislation may “have some legs” on Capitol Hill.

If the office were destroyed, does your data have an escape plan or an offsite location where it is safe?

Protective Measures

Here’s some of the essentials you must ensure are in-place before there’s a fire, flood, tornado, water leak, data theft or corruption, etc. I suggest you review the list with your IT staff or vendor so they can give you a solid comfort level that if “disaster” strikes, the long term effect is minimal.

• Back up your computer systems every weeknight. The backup routines should include all of the files your systems need to be restored and functional on a different server, in case your server is completely destroyed. For the majority of organizations, nightly backups are mandatory.

• Monday through Thursday backups should run each night, and the media used for these “days of the week” backups can be re-used each week. Replace the media every 12 months.

• Friday’s backup should go to an offsite location each week. You should keep at least six weeks of these backups offsite. After six weeks, you can re-use the oldest copy. This process provides up to six copies of your data so if your office is completely destroyed, and the Monday-Thursday backups were destroyed along with the office, you have several full copies you can use to restore your operations.

• The “offsite” location should be at least 10 miles from your office, and the backups should be stored in a fireproof safe at both locations. If no suitable offsite location can be found, consider using one of the storage services who will come by your office each week and maintain your offsite backups in secure storage for a reasonable fee each month.

• “Trust but verify” is a good motto to live by. At least once a year, run a full test of your backup process to validate that if you need to recover from a loss of your server and data, you can be back to normal, with all your files, software, and data fully recovered, in just a few days.

There are many options for backups and what is best for you will be determined by the criticality and sensitivity of the data. An audit of your current backup system and needs will assist in determining the best solution for your organization.

Continued on page 27
UofL Geriatrics calls for nominations for optimal aging award

UofL Geriatrics, a division of the Department of Family and Geriatric Medicine at the University of Louisville, is calling for nominations for the first annual Gold Standard for Optimal Aging Award. The Gold Standard for Optimal Aging Award is presented to someone 80 years old or older as of October 1 who is an outstanding model for optimal aging in all areas of life.

The nomination process includes submitting a short paragraph on the nomination form that briefly describes why the nominee qualifies for the award. Nomination forms can be obtained from UofL Geriatrics by calling (502) 852-1998 or emailing UofLGeriatrics@louisville.edu.

The deadline to submit nominations is 5 p.m., July 22. The award will be presented October 4 at the Annual UofL Geriatrics Luncheon at The Olmsted in Louisville.

To Submit to People in Brief

Each month, *Medical News* recognizes newly hired or promoted professionals who work in the business of healthcare in Kentucky or Southern Indiana. To be considered, the employee must work in or directly support a healthcare business. Listings will be published in order of receipt as space allows and not all photos will be published.

Please submit a brief description and high resolution color photo saved as jpeg, tif or eps (pdfs will not be accepted) via email to Melanie@igemedia.com.

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Users, over $75 million in first payments were released to Medicare eligible professionals and eligible hospitals in May 2011 alone. To join the group of Meaningful Users for 2011, eligible hospitals had to start their 90-day attestation by July 3. Eligible professionals need to begin by Labor Day to receive an incentive payment this year.

As the Stage 1 Meaningful Use program continues to move forward, the Health IT Policy Committee has completed its review of Objectives for Meaningful Use Stage 2. There was considerable discussion among the committee members over whether the core requirements should increase or remain in a steady state for Stage 2. The more “progressive approach” (read as adding to the list) won out in the recommendations. Another important recommendation is the decision by the Policy Committee to recommend a delay of 18 months on the start of Stage 2, therefore proposing that Stage 1 requirements remain in effect through 2013. All the recommendations will be forwarded to HHS for consideration by the end of this month.

HHS Health Data Initiative—Innovation Waiting to Happen

The Department of Health and Human Services is joining the federal government’s push to get more data into the hands of individuals and companies to see what consumer-oriented applications can be developed. HHS Chief Technology Officer, Todd Park, has seized on the initiative to provide de-identified health information to “innovators” around the country to see what new apps for smart phones and other devices can be developed to help patients become more engaged consumers in their healthcare. The HHS Health Data Initiative was launched in June, and will join the Department of Veterans Affairs Innovations 2 initiative to leverage grant and prize monies to foster innovation. I look forward to learning more about this initiative in the coming weeks as applications are received and prizes awarded.

Conclusion

The legislative and regulatory wheels keep moving us toward greater health IT involvement in the delivery and quality framework of healthcare transformation in the U.S. The agencies are starting to see results after laboring to create programs these past few years. Meaningful Users are coming on line and funds are rolling out. On the flip side, we are starting to see a legislative backlash to the structural changes that are occurring in healthcare delivery. The trick is going to be whether we can sustain the movement toward transformation, or if the change is “too much.” More fun before August Recess!

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