Federal Advisory Committee on Health Information Technology Policy

Local healthcare leaders help shape initiative

By Rick Chapman

The goal of assuring an electronic health record for every American is daunting. We at the Office of the National Coordinator for Health Information Technology do not pretend otherwise. We know this will be hard for some clinicians and hospitals, and we stand ready to help with resources provided by the Congress and the Administration.

— David Blumenthal, M.D., M.P.P., National Coordinator for Health Information Technology

In February of this year, the American Recovery and Reinvestment Act (ARRA), and its Health Information Technology (HITECH) component, was established by law. It will provide $20B+ in Economic Stimulus funds to ensure widespread adoption of electronic health records. Since then, Kathleen Sebelius was named Secretary of Health and Human Services (HHS) and Dr. David Blumenthal was named National Coordinator for Health Information Technology (HIT). Two Federal Advisory Committees have also been formed and will report to Dr. Blumenthal -- the HIT Policy Committee and the HIT Standards Committee -- and they will provide recommendations to the National Coordinator.

HIT Policy Committee

The HIT Policy Committee, of which I am honored to be a member, is charged with recommending to the National Coordinator a policy framework for the development and adoption of health information technology and the electronic exchange of health information, as well as the policy framework for the certification of HIT systems. The HIT Standards Committee takes the policy recommendations of the Policy Committee and further recommends specific standards, implementation specifications and certification criteria.

Three initiatives have set the agenda for the HIT Policy Committee’s first year: Incentives for “the meaningful use of certified electronic health records” by physicians and by acute-care hospitals; Establishment of a nationwide infrastructure for health information exchange; Overcoming barriers to adoption including use of the newly funded Extension Centers to offer technical assistance on best practices.

To address it’s work, the HIT Policy Committee has established three work groups: Meaningful Use, Certification and Adoption, and Health Information Exchange.
Letter from the Publisher

A New Look for the Business of Healthcare

We are pleased to issue the “new” Medical News in pursuit of our mission to help you stay informed, grow your business and build relationships around your most important issues.

I am sincerely grateful to Ben Keeton, our Editor-in-Chief, and Brendan Post of Brendan Post Graphic Design for their tireless efforts in creating our new editorial standards and graphic design themes. Integrating feedback from 150 of our readers, board members and community partners with our new mission statement is an intellectually challenging endeavor. You can see here that they have done an amazing job.

While business plans, mission statements and other good works are important, organizations truly thrive when, as Jim Collins says in Good to Great “the right people [are] on the bus.” I am privileged to work with a great team.

I hope the recent changes to the newspaper and to our web site generate even more thoughts and feedback. And, as always, I invite you to share your thoughts directly with me by email or phone at Tom@MedicalNews.md or 502-813-7401.

I also want to welcome Nik Heberlein to the Medical News team. Nik is our new account executive and he joins our team with a great attitude, a solid background in sales, and a top-notch education from Bellarmine University. Nik will help us extend our reach even more deeply in Kentucky and Southern Indiana. You can reach Nik at Nik@MedicalNews.md or 502-813-7404.

Very truly yours,

[Signature]

Editor-in-Chief
Ben Keeton
Ben@MedicalNews.md

Publisher
Advertising Sales
Tom McMahon
Nik Heberlein

Accounting
Design and Layout
Laura Craycroft
Brendan Post

Marketing Managers
Printing
Burcunc Arkun

Sally McMahon
Standard Publishing

Medical News is the leading source for the healthcare business community to stay informed, grow their businesses and build relationships around important issues. We are the community for the leaders of the region’s healthcare businesses.

Medical News is distributed throughout the healthcare industry in Kentucky and Southern Indiana.

Copyright Medical News, LLC, aka Medical News 2008. All rights reserved. All articles, columns, and other materials represent the view of the authors and not necessarily those of Medical News.

Advertising content does not signify endorsement of products or services by Medical News unless otherwise specified. Letters sent to Medical News are assumed available for publication.

[Contact Information]

Guidelines for submitting an article or other original work for inclusion in Medical News

Here’s what we ask: That the work you submit has not been, and will not be, published elsewhere or provided to a competitor of Medical News without our written permission. We also ask that the work not violate any existing copyright, either in whole or on part, that it contains no libelous or otherwise unlawful statements, that it will not infringe upon any trademark, patent, proprietary personal, or statutory right of others, and that you have all necessary permissions to use the materials that comprise the work.

Please note that Medical News may make any editorial changes to content or format of the work without the consent of author.

Here’s what we promise: After the work has been published, you may use, reproduce, and adapt the Work for use in personal presentations, speeches, client newsletters, or for similar “internal” purposes. However, for any of these uses, please include the following copyright notice on each copy:

Reproduced [or Adapted] with permission from Medical News, LLC
Vol. [Month, Year], Copyright © [Year Published]
www.medicalnews.md.
change. The initial focus of our work has been on the two components for incentive payment: meaningful use and certification of electronic health record systems. Privacy and security were seen as essential and as such are to be addressed by all the work groups.

**Meaningful Use**

The Meaningful Use work group has been the most active to-date and has proposed some bold improvements to overall population health during their initial presentation, such as reduction in heart disease and management of diabetes. These were coupled with a roadmap from now to 2015 that begins with ensuring that providers are using the technology as part of the care process, that they have the clinical information they need to make decisions (for example, lab results) and that the information systems collect the data needed to report on quality outcomes. Established outcomes measures may need to be modified so that they can be calculated directly from the electronic health records and not require a manual abstracting process.

The recommendations on meaningful use address priorities that include improving quality, safety, efficiency and reduction in health care disparities; engaging patients and families; improving care coordination; improving population health; and ensuring adequate privacy and security protections for personal health information.

The recommendations on meaningful use will be used by the National Coordinator as part of the rules making process for the standards to be used. CMS, the Centers for Medicare and Medicaid Services, another agency within HHS, has a representative on the Policy Committee. CMS has a separate rule making process that will define how the meaningful use criteria will be incorporated in the incentive payments.

The approach being taken by the Committee has been to start with current practices and work toward the goals in incremental steps. We hope this will be least disruptive to the existing care processes and will allow organizations to build on their existing investments in information technology. Nonetheless, we know that the meaningful use goals will be a stretch for almost all providers and will require additional work and investments. The incentive payments are intended to offset most if not all of that initial expense. Keep in mind that the payments are for use of the systems, not their acquisition. Once the information systems are in place, providers should be able to achieve operating efficiencies to cover the on-going costs of the systems. That has been the experience of providers who have implemented information systems in the past. The information systems will be certified that they are capable of supporting the intended use. Another key point is that while the recommendations focus on desired use, they do not say how the use will be achieved or what the care delivery will look like. This is intended to allow for flexibility in meeting the objectives and to allow for innovation.

**Timing of Incentives**

The meaningful use criteria are grouped by the year in which they first apply, 2011, 2013 and 2015. They set an initial level of use 2011 and then will be raising that level over the subsequent years. The providers then must demonstrate that they are using the system. The way in which that will have to do that is yet to be determined, but the ARRA funding requires that the regulations be issued by December of this year. The first incentive payments in 2011 will be paid through the Medicare program. Acute care hospitals will be eligible for payments beginning in October 2010. Individual physicians and other eligible providers will be eligible for incentives beginning January 2011. The details of how to receive these payments will be issued by CMS as an Interim Final Rule in December 2009.

**Covered Providers**

It’s interesting to note that the funding for incentives for meaningful use are, thus far, limited to (1) eligible providers (physicians and also dentists, podiatrists, optometrists and chiropractors) and (2) to acute care hospitals. Other providers may be covered in the future, such as Long Term Acute Care Hospitals and Nursing Centers. Many of the objectives are the same for both types. For example, both groups have requirements to maintain an active medication list for the physician or other licensed provider to use when ordering new medications and to have the information system check for potential drug-related interactions (drug-drug, drug-allergy). Other examples of meaningful use objectives include maintaining a problem list, recording vital signs and reporting established quality measures.

The acute care hospital criteria apply across the entire organization. For example, in the 2011 criteria, hospitals need 10% of all orders entered directly by the originating provider. That level of usage will be across all providers, all orders and all types of orders, not 10% in each grouping. This could be met by higher usage by some of the ordering providers and low or no use by other providers. Again, remember that at this time, these are recommendations of the Policy Committee and not CMS or ONC regulations.

A new area for most providers will be making the clinical information available to patients – both providing them access to their information and providing them with electronic copies of that information.

The Certification and Adoption Work Group is also well underway and I am an active participant of this committee. I will report on our progress in a future article.

Rick Chapman is Chief Administrative and Information Officer for Kindred Healthcare

---

**Clinic Innovation Day kicks off commercialization and economic development initiative at UK Hospital**

By Ben Keeton

University of Kentucky HealthCare clinicians can now turn their ideas into products thanks to a new commercialization initiative that will be unveiled August 4 during the 1st Annual Clinician Innovation Day. The morning workshop will also feature keynote speaker Dr. Thomas J. Fogarty, inventor of the world’s first balloon catheter that revolutionized vascular surgery overnight, and UK President Lee T. Todd Jr., founder of two technology companies, one of which was sold to IBM.

“I’m honored to speak to our clinicians not only as UK president, but also as a faculty entrepreneur,” said Todd. “This commercialization program creates a unique opportunity for our clinicians to make a direct impact on patient care and be involved in the development of their medical device or diagnostic without a substantial investment of their time or resources.”

“UK Chandler Hospital alone there are more than 550 clinical faculty; 500 interns/residents/fellows, 425 medical students and several hundred nurses and technicians, each potentially with an idea that would solve a clinical problem and make a difference in treating patients.”

“The University of Kentucky is one of a very few academic institutions to put a specialized commercialization program together for clinicians,” said UK Commercialization & Economic Development Vice President Len Heller. “This fits with our unique marketing position as one of the few universities in the country with both a complete medical center and all colleges including agriculture, pharmacy and engineering on one central campus.”

“Every day our clinicians have ideas that can help patients,” said Gurley. “Now we’re going to have a team of engineers and business people we can work with to develop our ideas into useful products.”
David’s story could have been heartbreaking. We gave it a happy ending.

David Moore suffers from a congenital heart defect known as Hypoplastic Left Heart Syndrome. And, in the first three years of his life, he faced more surgeries than many do in a lifetime. Thankfully, David’s family turned to the hospital that offers specialized care for kids and their growing bodies – Kosair Children’s Hospital. Throughout all of his surgeries, David’s family was shown a level of expertise and compassion they’ll never forget.

As David’s father says, “Kids aren’t just patients to them, they become their babies.” Today, David Moore is leading a normal life as an energetic and happy preschooler. And that’s the kind of story we never get tired of telling.

Here’s your chance to help create even more happy endings. Visit HelpKosairChildrensHospital.com or call 629-KIDS to offer support through the Children’s Hospital Foundation.
Economic downtown provides practice owners time to prepare for a recovery of the M&A market

By Dave Zimmerman

The current recession and uncertainty about the future of healthcare has given all practice owners, quite literally, pause: pause in growth, pause in hiring, pause to reconsider exactly where their practices are heading — or need to head — if they are to meet their goals.

When times are good, most owners chug along with little guidance from advisors. Owners call their lawyers when they have a problem, their accountants when the taxable year-end approaches and their financial advisors when they realize that their daughter might not get that golf scholarship or is accepted to Medical School. In short, most owners expect their advisors to react quickly and effectively to whatever problem they pose.

Owners, who understand that selling/transfering their practice for top dollar can only be accomplished through careful planning, expect more. They look for advisors who approach them with specific strategies designed to increase the value of their personal wealth — both in and out of their practice.

Will you be ready to sell? If you have hired skilled and experienced Exit Planning advisors, they are already sharing strategies specific to your practice that you can employ today — in today’s economy and years in advance of your anticipated sale date — to increase the salability and value of your practice. If your advisors are not skilled in Exit Planning, they probably have been mute on the subject of your exit.

The Best Advisors are contacting the practice owners they work with about:

Increasing margins. Exit Planning advisors are helping owners to take advantage of today’s “pause” to increase margins so that if the recovery kicks in, their practices would enjoy higher profitability and cash flow potential.

Becoming the “Best of the Best.” Exit Planning advisors are working with owners to examine every aspect of their practice. They are asking, “What are tough times telling you about your employees, your vendors, your insurance contracts and your patients? How does your practice perform compared to your peer group in order to maximize its value at the time of sale?”

Reassessing a practice exit strategy. Nearly all owners have had to reassess their planned practice exits. Exit Planning advisors are helping owners to figure out exactly how postponing departure could affect:

➤ Post-retirement income goals.
➤ Choice of a successor.
➤ Dependence on other sources of income.
➤ Protecting assets. Exit Planning advisors employ numerous strategies to help owners to protect their assets. These include:
   ➤ Minimizing tax exposure.
   ➤ Minimizing liability exposure (by creating multiple entities).
   ➤ Reviewing any buy-sell agreement to make sure it includes provisions for a possible decrease in practice value.

Right now is the time to plan. Plan for your exit. Plan for your retirement. Plan for your future.

It is time to team up with your advisors to create a comprehensive plan of action that you can believe in. Many have already started and have a coach coordinating the work of all of their advisors toward their exit objectives. If you have not yet heard from your advisors or do not yet have a coach, it may be time to evaluate your needs for one.

Dave Zimmerman is an Exit Planning & Practice Management Specialist with ARG1 Business Services.

Beshear creates e-health information office

By Burcum Arkun

Kentucky Gov. Steve Beshear has created the Governor’s Office of Electronic Health Information within the Kentucky Cabinet for Health and Family Services. The state office will serve as a single point of contact for federal and state agencies involved with the initiative. It also will work with Kentucky’s three regional health information organizations, health care practitioners, consumers, insurers and other parties involved in the electronic exchange of health records, Beshear said.

“Many of our health care providers practice independently or in small groups and are located in rural areas,” Beshear said in the release. “Our challenge is to bring together Kentucky’s stakeholders to assure that the development and use of health information exchange meets federally defined standards for privacy and security and to assure stakeholders that health information exchange is interoperable, sustainable and dependable.”

Kentucky World Center sends medical delegation to Europe

By Ying Juan Rogers

The Kentucky World Center is pleased to announce the Medical Trade Mission to Germany and Belgium from November 14-21, 2009. Delegation members will be traveling to Brussels, Cologne and Düsseldorf. This trade mission will provide an excellent opportunity for US companies who wish to import and/or export their medical equipment and technologies and make valuable contacts.

During the trip, delegation members will have the opportunity to attend the MEDICA Trade Show in Düsseldorf. MEDICA is the world’s largest forum for in-patient and out-patient medicine: more than 135,000 visitors from over 100 countries attend yearly, gaining valuable information on current and future trends in in-patient and out-patient care. MEDICA regularly features around 4,300 exhibitors from around the world, who display their OEM products and services in an exhibit area consisting of 18 halls and spanning nearly 1.3 million square feet of exhibit space.

In addition, delegation members will be meeting with the various medical associations, Ministry of health, and also tour a Clinical Research cluster and medical technology center in the region. Briefings on most recent regulations on medical export will also be arranged.

The trade mission cost is $300 KWTC members, $500 KWTC future members. Fee includes all meeting arrangements, a ticket to the MEDICA trade show and transportation to group meetings.

The Kentucky World Trade Center (KWTC) is a non-profit organization whose mission is to help companies conduct business worldwide. In the last several years the KWTC has organized many overseas trade missions. With its association of 330 World Trade Centers around the world, the KWTC has extensive contacts with foreign government officials and business leaders in the coal industry and is experienced in arranging successful business meetings and travel itineraries.

For more information on the Medical Trade Mission, please contact Ying Juan Rogers at yingjuan@kwtc.org or 859-258-3139, or Lynn Cooper at lynn@bfwinc.com or 502-899-1808.
Kentucky among 43 states to settle with Pfizer

Kentucky, 42 other states and the federal government will share in a $2.3 billion settlement with Pfizer Inc. after the states alleged that the drugmaker and its subsidiaries paid kickbacks and improperly promoted Pfizer drugs for uses for which they had not been approved by the U.S. Food and Drug Administration.

Pfizer will pay Kentucky $5.4 million for alleged Medicaid fraud and consumer protection violations, Kentucky Attorney General Jack Conway’s office said in a news release.

Although it is not illegal for a doctor to prescribe a drug for a condition for which the FDA hasn’t approved the drug, it is illegal for drug companies to market drugs for treatment of conditions for which the FDA hasn’t approved the drugs, Conway’s office said in the release.

Under terms of the settlement, Pfizer will pay the states and the federal government a total of $1 billion in civil damages and penalties, according to the release. The money will be directed to Medicare and Medicaid programs and to federal health care programs that were deemed as being harmed by Pfizer’s actions.

Atria executive selected for council on active aging board

Kristine Rogers, vice president of active aging with Atria Senior Living Group in Louisville, has been appointed to the International Council on Active Aging’s advisory board.

The ICAs serves to unite professionals in the retirement, assisted-living, recreation, fitness, rehabilitation and wellness fields. It also provides education, information and resources to those professionals.

In her role, Rogers will help steer operations for the association, according to a news release from the council. She also will participate in ICAs 2020, an effort to create a vision for the future of the active-aging industry.

RecoverCare considers Louisville for headquarters

RecoverCare LLC, a Philadelphia-area company that recently merged with Louisville’s Medastat USA LLC, is considering plans to make its home base here.

The merged company, which retains the RecoverCare name, manufactures and supplies wound-care and bariatric-care products. It announced its potential relocation project during an Aug. 27 meeting of the Kentucky Economic Development Finance Authority in Frankfort.

If it follows through with its plans, RecoverCare could create jobs for 90 Kentuckians within seven years, according to plans filed with the state. The company would consolidate its corporate offices, administration, customer-service operations, call center and order-processing functions in Louisville.

In the first two years, RecoverCare would bring 45 new jobs to Kentucky with an annual payroll of nearly $4.4 million, its filing said. The new jobs would have an average hourly wage of $37.98.

The KEDFA board granted RecoverCare preliminary approval for $2.3 million in state tax incentives for up to 10 years if it expands in Louisville.
Our Lady of Peace unveils Children’s Peace Center program

New program name, logo emphasizes diverse children’s services

Our Lady of Peace – a service of Jewish Hospital & St. Mary’s HealthCare – unveiled its Children’s Peace Center programs during a ceremony at Our Lady of Peace.

The Children’s Peace Center will serve as the banner for the hospital’s children’s programs, which include free assessments by professional clinicians, inpatient care, day and evening outpatient programs and specialized services such as Peace Academy, a partnership with Jefferson County Public Schools that allows children to continue their classwork while receiving treatment.

While Our Lady of Peace has high success rates treating some of the most complex mental disorders, the hospital’s psychiatric physician staff treat many children with more common disorders such as Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), depression, anxiety, anger control and Obsessive Compulsive Disorder (OCD).

Western Baptist’s cardiac surgery recognized in top 20 percent of national project

Western Baptist Hospital’s cardiac surgery has earned a national quality improvement award, and four other clinical areas have been recognized for high quality care.

The recognition came from the Centers for Medicare & Medicaid Services (CMS) in the Premier healthcare alliance value-based purchasing project that rewards hospitals for delivering high quality care.

The hospital received the Top Improvement award in coronary artery bypass graft surgery. Of about 250 hospitals nationwide participating in the project, 110 were eligible for this award. The top 20 percent were recognized with the Top Improvement award for the greatest quality improvements.

Western Baptist also received an Attainment Performance award in coronary artery bypass graft surgery, as well as in the clinical areas of acute myocardial infarction, heart failure, hip and knee replacement and pneumonia. Attainment awards are given to the top 50 percent of participating hospitals that attain or exceed median level performance.

International Medical News • September 2009 • Page 7

UK College of Pharmacy welcomes class of 2013 during white coat ceremony

The University of Kentucky College of Pharmacy welcomed 125 new students in the Class of 2013 during a White Coat Ceremony held Aug. 21 at the UK Singletary Center for the Arts.

The class includes 96 Kentucky residents from 38 counties as well as students from 12 states and two different countries. The entering class members have an average overall GPA of 3.62. In addition, 48 percent of students have completed bachelor’s degrees and three have obtained master’s degrees; 13 percent completed the required pre-pharmacy curriculum in two years.

Participating in the coating ceremony were UK College of Pharmacy faculty members Markos Leggas, Ph.D., Ken Record, Pharm.D., Penni Black, Ph.D., and Jimmi Hatton, Pharm.D. Leading students in the reciting of the Pledge of Professionalism was Anne Policastri, Pharm.D., assistant director of experiential education and president-elect of the Kentucky Board of Pharmacy.

Currently, a new 286,000-square-foot College of Pharmacy building is under construction on the UK campus. The new state-of-the-art academic and research facility will open to students in January 2010.

Owensboro Medical Health System Community Benefit Program announces funding for 23 organizations

Partnership will include Owensboro Museum of Science & History and the Western Kentucky Botanical Garden

Owensboro Medical Health System has awarded over $272,000 in funding to 23 regional organizations as part of its Community Benefit Grant Program. An additional 15 organizations received over $8,000 as part of the OMHS Community Benefit Mini-Grant Program. The awards represent the first of two funding announcements planned by OMHS this year.

Included in funded projects is a grant to cover start-up expenses and initial sponsorship dollars for the Budding Biotech Program—a new venture to provide long-term educational and recruitment initiatives to increase student interest in science literacy and biotechnology. The initiative begins this fall, led by the Owensboro Museum of Science & History and the Western Kentucky Botanical Garden.

Bill Tyler, MD, a retired physician who practiced in Owensboro for many years, now serves on the board of directors for the Western Kentucky Botanical Garden. Tyler references the growing need to attract more students to health and science careers: “Educational deficiencies and lack of adequate numbers of health professionals represent major root causes of healthcare problems in Kentucky,” he says.

Jewish Hospital & St. Mary’s Foundation announces Doctors’ Ball honorees

The Jewish Hospital & St. Mary’s Foundation announced the 2009 Doctors’ Ball honorees. For 14 years, the Doctors’ Ball has recognized the accomplishments of physicians, nurses and community leaders who have made a difference through excellence in leadership, innovation and service.

This year’s categories and recipients are:

➤ Ephraim McDowell Physician of the Year: Charles C. Smith, Jr., M.D.
➤ Community Leader of the Year: Owsley Brown Frazier
➤ Compassionate Physician Award: Neurosurgeon Timir Banerjee, M.D.
➤ Excellence in Education Award: Mary G. Barry, M.D.
➤ Excellence in Community Service Award: David R. Watkins, M.D.
➤ Excellence in Nursing Award: Joanne Berryman, RN, MSN, FACHE

In brief

➤ Service.

➤ Difference through excellence in leadership, innovation and dedication of physicians, nurses and community leaders who have made a difference.

➤ The Doctors’ Ball has recognized the accomplishments of physician leaders.

➤ Attainment awards are given to the top 50 percent of participating hospitals that attain or exceed median level performance.

➤ The recognition came from the Centers for Medicare & Medicaid Services (CMS) in the Premier healthcare alliance value-based purchasing project that rewards hospitals for delivering high quality care.

➤ Owensboro Medical Health System has awarded over $272,000 in funding to 23 regional organizations as part of its Community Benefit Grant Program. Additional 15 organizations received over $8,000 as part of the OMHS Community Benefit Mini-Grant Program. The awards represent the first of two funding announcements planned by OMHS this year.

➤ Owensboro Medical Health System has awarded over $272,000 in funding to 23 regional organizations as part of its Community Benefit Grant Program. Additional 15 organizations received over $8,000 as part of the OMHS Community Benefit Mini-Grant Program. The awards represent the first of two funding announcements planned by OMHS this year.

➤ Owensboro Medical Health System has awarded over $272,000 in funding to 23 regional organizations as part of its Community Benefit Grant Program. Additional 15 organizations received over $8,000 as part of the OMHS Community Benefit Mini-Grant Program. The awards represent the first of two funding announcements planned by OMHS this year.
Local health IT initiative gains momentum

By Sheila Anderson

The Louisville Health Information Exchange (LouHIE) is a groundbreaking initiative in Louisville to improve the quality and safety of healthcare while lowering healthcare costs. LouHIE will accomplish this by creating an electronic health record banking system for the storage and exchange of patient medical information, as authorized by the patient.

Currently, medical information for individual patients exists in numerous paper and computer records, located in different places. The lack of immediate access to medical information can result in duplicative tests, avoidable hospitalizations, and adverse medical events, costing consumers, employers, insurers and the government millions of dollars each year.

LouHIE was formed in 2006 as a community collaboration including consumer groups, hospitals, insurers, employers, public health, healthcare providers, and other health related entities. LouHIE is a nonprofit entity and governed by a multi-stakeholder board of directors, making it uniquely positioned to address health care issues as a neutral and trusted entity.

LouHIE conducted research in 2007 to determine what residents of the greater Louisville area knew about electronic health records, if they would use a community health record bank, and what was important to them. Based on this research and the input of stakeholders, in 2008 LouHIE developed a sustainable business plan to implement a community health record bank.

After a thorough selection process, LouHIE chose a vendor team, consisting of 3M Health Information Systems and InterComponentWare, Inc. (ICW), to build the community health record bank. This bank

Continued on page 34

Getting Bogged Down?

Give us a call- we can help.

We realize that just because things get done, doesn’t mean they are done well.

From strategic planning to process improvement, we have individuals who are trained to help your company run more smoothly.

DEAN | DORTON | FORD

Lexington 859.255.2341 Louisville 502.244.7714

www.ddfky.com

To Submit

Each month, Medical News recognizes newly hired or promoted professionals who work in the business of healthcare in Kentucky and 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.
The Commonwealth of Kentucky offers a variety of innovative funding programs for start-up businesses, including life-science and healthcare companies, that can provide a return on the state’s investment by creating high-paying, high-tech jobs for Kentuckians.

One such state-funded program is the High-Tech Funding Pool, managed by the Kentucky Cabinet for Economic Development’s Department of Commercialization and Innovation (DCI). Awards generally range from $100,000 to $250,000 (typically provided as a forgivable loan), and are intended for companies or projects further along in the process of commercializing a product, technology or process. The funds can be used to up-fit a facility, license and certify a facility, protect intellectual property, as well as to purchase specialized equipment, computers, related peripherals, software, and for other uses deemed appropriate by DCI.

Some of the factors considered when making High-Tech Pool awards include the viability of the research and development; the generation of intellectual property; the potential for spin-off opportunities; the amount of matching funds from the company and other sources; company or project revenues (both past and projected); and the collateral provided where a forgivable loan or other loan is being proposed.

Typically, the high-tech company or project’s projected workforce will include jobs considered to be research and development-related, highly technical in nature, or management-level positions. New jobs are required to be created according to a negotiated schedule and offer an annual salary of more than $40,000, exclusive of benefits, bonuses and commissions.

Depending on the stage of growth and the type of high-tech company or project, businesses in Kentucky, or those willing to relocate here, can also apply for other Cabinet for Economic Development programs including: SBIR-STTR Matching Funds. The Kentucky Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) Matching Funds Program is designed to encourage small businesses to explore their technological potential and then commercialize their technologies. The program matches, on a competitive, peer-reviewed basis, Phase 1 and Phase 2 federal SBIR and STTR awards received by Kentucky-based high-tech businesses – or those willing to relocate to Kentucky. Phase 1 federal awards are matched up to $100,000 and Phase 2 federal awards up to $500,000 per year.

Kentucky New Energy Ventures Fund (KNEV). DCI manages the $5 million KNEV fund, which supports Kentucky-based companies that undertake the research, development, and commercialization of alternative fuels and renewable energy technologies.

Other state funding sources include the Commonwealth Seed Capital Fund, which invests public funds in seed-stage, high-tech companies and the Kentucky Commercialization Fund, which supports efforts made by Kentucky university faculty to commercialize a technology, product or process. Additionally, the Kentucky Enterprise Fund offers grants and investments to small and medium-sized Kentucky companies for business development and the Rural Innovation Fund provides grants and investments to small, rural companies working with a Kentucky postsecondary institution or third party.

Most of these funding sources were authorized by the 2000 Kentucky Innovation Act. Since that time, state funding has helped create nearly 600 new high-tech, start-up companies and over 3,000 high-tech, high-paying jobs. Links to more information about these sources and state tax incentives are available at www.ThinkKentucky.com.

Deborah Clayton is the Commissioner for Commercialization and Innovation at the Kentucky Cabinet for Economic Development.

Since the 2000 Kentucky Innovation Act, state funding has helped create nearly 600 new high-tech, start-up companies and over 3,000 high-tech, high-paying jobs.
Passionate. Entertaining. Anything but white bread.

The Kentucky Center for the Performing Arts

September 25, 8:00pm - 9:30pm
Anthony Bourdain
$35.00

Tickets at ideaevent.com

IDEAFESTIVAL
LOUISVILLE
Transparency tools
Consumer demand leads to innovative tools

Jim Freedman

Employers are changing their health benefits to require their employees to accept more personal responsibility for the cost of their healthcare. These new “healthcare consumers” are demanding transparency tools that enable them to make sense out of the mystery surrounding medical costs.

Health insurers and payors are rapidly jumping on board with transparency and are now willing to provide consumers more information. All of the large carriers are using their websites to increase transparency information to their members. While the information is specific only to their plans, it can help members gain a deeper insight into the true costs of their healthcare.

Nevertheless, consumers are still making healthcare inquiries using their favorite search engines, which offer’s them ease of use and familiarity. This is causing a parade of new social sites offering a variety of tools oriented toward healthcare information. Like most internet models you can obtain information, learn the experiences of others, as well as post your personal material, all in a relatively unregulated fashion.

Despite the newness of healthcare transparency, you can bet consumer’s knowledge and demands for more sophisticated information will grow quickly. Just like with other industries and services, consumers want information that is personal to their situation. While quality is important, it is the “price” that consumers really want to know. Healthcare consumers view “charges” as virtually meaningless. They know that the prices paid by health plans to providers for the same procedure is not uniform. Retail businesses have known for decades that causing mistrust with consumers regarding money is a costly proposition, especially when they have options.

Consumers are seeking transparency to learn the specific aspects of having a medical procedure including their financial responsibilities. Consequently, they want actionable information, with little desire for social content. Transparency tools should be easy to use with quick access to specific information. The information needs to be up to date, accurate, and easy to understand.

Consumers know they cannot determine the clinical competency or quality of a provider, but they believe they have a right to expect it. They would rather refer to trusted national or industry authorities, just like they use when buying an appliance or a new car. However, consumers do want to know the experiences of other people. A quick glance at the internet demonstrates that people are quite willing to post and read about literally all of life’s experiences.

Healthcare is changing and even bigger changes are coming. Consumers are demanding information specific to their healthcare, because they are now directly paying for it. They want transparency tools that are convenient, feature understandable and actionable information specific to their situation. Consumers know and expect true transparency, anything less and they will see right through it.

Jim Freedman is the Chief Executive Officer of iF Technology, a Lexington based healthcare company.

This card is the only tool you need to solve your practice’s networking problems.

We have created a division that specializes in the IT needs of healthcare. Our IT specialists are experts in the field’s unique regulations and complexities, including DICOM, HL7 standards and HIPAA compliance, as well as the many technologies that need to work as a seamless unit. Call us for a consultation.

Problem solved.
New media and healthcare
An interview with Martin Bonick, president/CEO Jewish Hospital Medical Campus

Medical News: Why did you create the Hospital Life blog?
Bonick: As leaders, we are always looking for new ways to positively communicate and interact with our team members and our community. With the growing popularity of transparency and social media, I felt a blog would be a useful tool to reach out and connect with our team about current issues in a more real-time manner.

What type of topics do you cover?
I have covered a variety of topics centered around healthcare, work and life. My hope is to write about topics that will stimulate a response or comment. Over the months I have been writing, I am pleased to see that this type of interaction is starting to build. Sometimes I write about topics in attempts to build awareness on a program or service we offer and other times I have used it to celebrate and recognize an important achievement. The best topics though, seem to be focused on important relevant issues that the organization is grappling with, such as the effects of the economy and methods we are employing to deal with those challenges.

What audience do you hope to reach?
What started out as an experiment to improve communication amongst our team members has really blossomed into something much larger than I had really envisioned. In the eight months since I have been active in the blogosphere, there have been over 11,000 visits to the site including 5,000 unique visitors from 45 countries across the globe. While many of these may have just been passing through, there are currently over 500 readers that come back to visit on a routine basis. My hope is to develop a loyal following that will engage in a dialogue with me on the site to discuss and debate important issues for our hospital and healthcare in general.

What other forms of new media do you (or your hospital) use both internally and to reach the public?
Due to the creativity and drive of our marketing manager, Leslie Dorris, our hospital has become very active across many social media platforms. From fan pages on Facebook, to health tips on Twitter, to testimonials on YouTube, we have become very engaged with building our presence and reach through social media.

What opportunities do you see for blogs and other forms of new media in healthcare?
I think we have only seen the tip of the iceberg in where social media is headed in healthcare. The tools already exist for us to have virtual focus-groups with our customers, provide real-time service recovery with patients and family members, and promote services and health tips to a wide audience in a very cost-effective manner. Going forward, I predict we will see social media tools used to interact with our patients in everything from appointment scheduling and confirmations, to blood product and organ/tissue solicitation, to communicating important alerts or managing through emergency disaster situations.

How have you seen technology improve your facility (both internally and externally)?
Healthcare is a very technologically focused industry. Nearly everything we touch is influenced or improved by technology. Automation has had an impact on everything from the way in which we document in patient charts and process bills, to the way in which we monitor vital signs and communicate test results in critical situations. Even beyond computerization, we are seeing significant advances in technology that have allowed greater efficiencies to be gained across the hospital. As an example, with a severe shortage of skilled professionals needed to run the hospital, technology has helped us leverage our scarce talent by using robotics in the laboratory and pharmacy to help automate routines that once had to be done manually.

What do You want out of life?
- Traditional BSN 4 year program
- Second Degree BSN program (15 month program)
- Evening course offerings
- RN to BSN first class to begin Spring 2010
- Post BSN Nurse Educator Certificate

Master’s Degree Options:
- Family Nurse Practitioner
- Adult Nurse Practitioner
- Pediatric Nurse Practitioner
- Nurse Educator
- Nurse Leadership
- Post Master’s Certificate

SPALDING UNIVERSITY
75 Years of Nursing Excellence
502.585.7125 / www.spalding.edu
Looking at the present—and seeing into the future—of digital technology in physicians’ practice groups

By Tom Walker

Only a few years ago, digital technology and advanced services such as CT and MRI were almost exclusively the province of hospitals and large imaging centers. Today, however, there is a growing trend for physicians’ practice groups to offer digital imaging services in their offices. In addition, the potential of digital technology and the ability it offers physicians’ groups to interact and share health-related information with hospitals, clinics, research organizations, etc., is of increasing significance and only beginning to be tapped.

Both of these issues are of growing importance to physicians’ practice groups. So, Richard Whistine, Healthcare Information Technology Specialist, and Jeff Peterman, Medical IT Consultant, have offered to share their expert insights. Both are with Raynostix, a company based in Louisville, Kentucky that provides imaging equipment and services to hospitals, imaging centers and private physician practice groups across the country. It was also the first company of its kind to create a dedicated Healthcare Information Technology Group to deal specifically with the unique complexities of digital technology for the healthcare market.

Advanced digital imaging in the physician’s office

As Whistine explained, “We’re seeing a strong trend toward more noninvasive diagnostic imaging taking place outside of hospital outpatient facilities and in private physicians’ offices or imaging centers. According to a recent study reported in the February 2009 issue of the Journal of the American College of Radiology, private office imaging utilization rates between 1996 and 2006 grew by 71 percent among non-radiologist physicians, and 44 percent among radiologists.” The hospitals’ share of the market is slipping.

“There are a number of reasons for this shift,” said Whistine, “including the belief that many patients prefer having their imaging done in the convenience and familiarity of the physician’s office. But the primary reason is that the cost of the technology has moved to a price point that makes it more feasible for the private physicians’ to provide these services. It used to be that a basic PACS, or Picture Archiving and Communication System, product cost around $400,000. Now, technology has matured and is far more affordable to the physician market.” Physicians’ practices have moved...
Healthcare simulators using technology to test ideas

By Dr. Raymond L. Vigil

Through the launch of The Health Economy Simulator, Humana has embarked on a different approach to addressing the issues plaguing health care - one that leverages learning and creates collaboration among stakeholders in the health care system.

The use of a business simulator was introduced internally as a Leadership Development tool. The methodology continues to evolve and has since been adapted for external participants.

Simulator Design

This innovative two-day learning exercise brings hospital executives, employers, consumer advocates, community leaders, insurance brokers and insurance companies together to build a better health economy and establish collaborative relationships for the future.

Participants are invited based on their experience, expertise and knowledge of the health care system, as well as knowledge of the community and economy.

Through this learning experience, they shed their traditional professional roles and take on a new persona - doctors become insurers, advocates become employers, employees become providers, and so on.

Divided into teams, participants immerse themselves in a complex competition to build a health care system for four fictitious counties.

With access to an elaborate computer simulation, participants are able to see how a single decision can ripple through the delicate health care system – sometimes with dramatic effect and unintended consequences.

In a recent simulation in Salt Lake City, Utah, one group changed the way employers offered benefits, and the Simulator calculated the impact of that decision on everything from hospital profitability to population growth and business recruitment.

Similar ripples were recorded when participants raised taxes or hired more nurses. They also discovered how even small investments in health promotion translated into future cost savings.

The Result

At the end of the Utah simulation each team created a three-year plan that aimed to cut costs, increase preventive care, cover a population majority and enhance revenue.

They then received a quantitative, computer-generated assessment of the impact of their decisions on consumers and stakeholders, plus a qualitative comparison of each team’s performance.

While all participants left the session with new ideas to consider within their community, the real value came from the insight that through collaboration real change can take place within the health care system.

During the two days, participants laid the foundation for real change, real solutions and real reform.

Participants also gained powerful new insights into the roles, functions and unique challenges facing varied stakeholders.

The Future

Everyone is affected when a system like health care changes, even those who have been left out of the system. Humana believes all stakeholders must work together to share the challenge of finding a workable solution for our health care system and must make sure all Americans have quality, affordable health care coverage.

Raymond Vigil is Vice President and Chief Learning Officer, Human Resources, Humana Inc.
Norton Brownsboro Hospital is 298,000 square feet of everything our patients and their families could want. You see, before the first plans were drawn, we consulted Norton Healthcare patients, nurses, doctors and staff about their experiences at our existing hospitals, while researching and observing the most forward-thinking patient care models at hospitals nationwide. Our results enabled us to design the area’s first entirely patient- and family-focused hospital, so we could provide a better healing experience. For more information, visit NortonBrownsboroHospital.com.

Built with the help of our most expert consultants.

Now open at Old Brownsboro Crossing
Smoking should be extinguished

Each of us at one time or another has had a personal experience or the misfortune of having a patient, loved one or friend affected by cancer. Cancer comes in various forms and can be linked to a wide variety of causes. For example, smoking, according to the Centers for Disease Control and Prevention (CDC), is recognized as the primary causal factor for at least 30 percent of cancer deaths. Yet, according to a 2007 report by the Institute of Medicine (Ending The Tobacco Problem: A Blueprint for the Nation), about one out of five American adults still smokes – about 44.5 million people in the United States.

Even worse, in Kentucky, over 28 percent of the population age 18 or older smoke – about 8 percent more than the national average, according to 2007 data on the CDC’s Chronic Disease Indicators (CDI) Web site. Our children in Kentucky are not far behind the adults. Over 26 percent of youth in grades 9 through 12 have reported smoking cigarettes in comparison to 20 percent at the national level.

In sync with smoking in Kentucky, the incidence of cancer is also higher than nationally in most every category, and the mortality rate for cancer of the lung and bronchus is nearly 27 percent above the national average. Tobacco-related illnesses and death place a huge burden on our society. As reported in “Ending the Problem,” the financial costs add up to billions.

Health care community needs to recommend that physicians urge parents to keep a smoke-free home, advise their children that they expect them not to use tobacco and to monitor their children for tobacco use.

There are abundant free resources available to help smokers quit: smoking cessation programs, counseling programs, nicotine anonymous groups, Web sites with self-help tips and medications. There is no one cure. What works for one may not work for another.

The American Cancer Society Web site, www.cancer.org, always has helpful information and tools on this topic. Additionally, most states offer a free, statewide telephone-based tobacco cessation resource: 1-800-Quit-Now is a service of the National Cancer Institute, National Institutes of Health, and the U.S. Department of Health and Human Services.

Kentucky’s Tobacco Quit Line also has a coordinating Web site (http://chfs.ky.gov/dph/info/dpdo/quitline.htm) that offers “Quitter” materials, as well as educational materials physicians can share with their patients to assist them in their efforts to stop smoking.

Physicians can also find a practice guideline for patients with substance use disorders, including nicotine, on PsychiatryOnline, http://www.psychiatryonline.

In its report, the Institute of Medicine (IOM) outlines a two-part plan to reduce tobacco use, including recommendations to the health care industry. According to the IOM, the health care community needs to play a larger role in convincing youth to stay away from cigarettes.

One suggestion calls for physicians, dentists and other health care providers to screen and educate youth about tobacco use at their annual health care visit. Additionally, according to the IOM, physicians should refer youth smokers to counseling and/or available smoking cessation programs in the community.

The IOM goes farther to recommend that physicians urge parents to keep a smoke-free home, advise their children that they expect them not to use tobacco and to monitor their children for tobacco use.

There are abundant free resources available to help smokers quit: smoking cessation programs, counseling programs, nicotine anonymous groups, Web sites with self-help tips and medications. There is no one cure. What works for one may not work for another.

The American Cancer Society Web site, www.cancer.org, always has helpful information and tools on this topic. Additionally, most states offer a free, statewide telephone-based tobacco cessation resource: 1-800-Quit-Now is a service of the National Cancer Institute, National Institutes of Health, and the U.S. Department of Health and Human Services.

Kentucky’s Tobacco Quit Line also has a coordinating Web site (http://chfs.ky.gov/dph/info/dpdo/quitline.htm) that offers “Quitter” materials, as well as educational materials physicians can share with their patients to assist them in their efforts to stop smoking.

Physicians can also find a practice guideline for patients with substance use disorders, including nicotine, on PsychiatryOnline, http://www.psychiatryonline.

It is a matter of common knowledge that high quality cancer care relies on effective patient- oncologist communication (Pollak et al. 2007). Nevertheless, support for patients with advanced disease, where emotional suffering and end-of-life topics need to be addressed, has not gained the same attention as, for example, discussing treatment options in earlier stages of the illness. Oftentimes, these topics are not approached adequately due to feeling unprepared to deal with the intensity of upcoming emotions. Moreover, there are concerns that end-of-life discussions lead to patient’s desperation and might cause psychological harm.

Today, however, we know that patients generally desire frank and empathetic disclosure of their terminal diagnoses (Vandekieft, 2001). Beyond that, Wright et al. (2008) summarize their findings in a recent JAMA article by stating that end-of-life discussions have “casading benefits for patients and their caregivers”. They did not find any evidence that having end-of-life discussions increases emotional distress or psychiatric disorders. Instead, they found better quality of life near death, associated with less aggressive and more specialized care (e.g. hospice support), and even improvements in physical and mental health among surviving caregivers. In contrast, when no such conversations were reported, patients received significantly more burdensome aggressive medical care in their final week of life leading to a worse quality of life near death and caregivers showed a higher risk for developing a major depression 6.5 months later.

What can physicians do to become more effective and empathic communicators when addressing end-of-life issues and related emotions? In cancer patient's recol- lections, two behavioral factors are particularly important in addition to providing a comfortable environment: taking plenty of time with the patient and empathizing with the patient’s experience (Pra- cek & Pracek, 2001). It is rec- ognized that both factors pose challenges in clinical prac- tice where time is generally a scarce resource and training for these challenging empathic interactions is not provided in regular education. However, it can be said that providing empathic communications saves a significant amount of time in the long run because well-informed patients show better adherence to their treatments (Pollak et al., 2007), better emotional adjustment, and are less likely to sue their physicians (Pracek & Pracek, 2001). Moreover, cancer patients have less anxiety and depression when oncologists facilitate the expression of emotions (Pollak et al., 2007). Some basic strategies to support the expression of emotions in physician-patient interactions are stating the patient’s obvious emotion (“I can see this news comes as a shock to you”), legitimizing this emotion (“Many of my patients feel like this when they hear such news”), showing continuous support (“No matter what happens, I will always be here for you”), and elaborating on emotions (“Tell me more about what is upsetting for you right now”). In my expe- rience with teaching medical students, just knowing and practicing these basic communication strategies allows students to be more comfortable in addressing difficult discussion topics with patients. As these techniques can be utilized with limited training, they constitute a good foundation for adding further strategies that help to establish and maintain a trusting physician-patient relationship.
Without a doubt, the pharmaceutical and biotechnology industry is fast paced, exciting and a highly risky place to be where it can take 15 years (or more) from idea/discovery to commercialization of a novel therapeutic product addressing an unmet medical need. On top of the 15 years, add the fact that according to the Tufts University, the average cost to bring one therapeutic successfully to market can cost the lucky owner up to $1.2 billion or more; and that is before one dollar of revenue is generated from that product.

Considering the substantial risk, time and money involved in the biotechnology and pharmaceutical industries, how is it possible that one or more early stage companies are funded with such challenging odds up front? From a financial perspective, the return on investment from just one successful product can erase much of the pain associated with the large upfront investments and long development time horizon. For example, pharmaceutical products like Prilosec (proton pump inhibitor for gastro-esophageal reflux disease – GERD) generated over $6 billion in annual revenue in 2000 and was said to be the highest selling prescription drug during the year 2000. Fast forward to 2008, Pfizer’s blockbuster anti-cholesterol drug, Lipitor, is approaching $13 billion in annual revenues. Although it may be argued that these two blockbuster pharmaceutical drugs are more the exception than the rule, it is undeniably true that the significant value that can be achieved through innovative breakthrough pharmaceutical products is the key ingredient that continues to attract investors’ insatiable appetite for investing in this industry.

The graph below provides a general overview of the stages and other key parameters needed to simply have the “chance” (no guarantees) of successfully bringing a promising pharmaceutical discovery to the market.

Based on Graph 1 above, let’s assume I have now discovered a product we are ready to advance to the market and we want to gain a better idea of what each stage will entail to move the product forward. Below, I will breakdown each stage from Graph 1 and briefly describe what it will take to advance the product to market.

Steven Pursell, M.D., named medical director of Norton Cancer Institute

Steven Pursell, M.D., has been appointed medical director of Norton Cancer Institute. He succeeds Don Stevens, M.D., who has agreed to continue as medical director emeritus through the end of 2009 to assist Dr. Pursell during his transition.

Dr. Pursell has been practicing in Louisville since 1986 and joined Louisville Oncology in 1999. He brings experience in multiple settings, including private practice, academia, as well as the not-for-profit Norton Health system, which will serve as a great foundation for his new leadership role. His interests include expanding opportunities for the institute’s physicians to engage and provide leadership to streamline clinical operations.

“I am looking forward to my new position as the Medical Director of The Norton Cancer Institute,” Pursell said. “I have seen our group grow from four to twenty-six physicians. Norton Healthcare has made a significant commitment to the people in our community to provide excellent cancer care. We have a great opportunity during these exciting times to build on the foundation that we have as we prepare for healthcare reform, new technologies, and new drug therapies for cancer treatment.”

Dr. Pursell is a native of Kentucky and is board certified in obstetrics and gynecology. He earned his medical degree at the University of Kentucky and completed his gynecologic oncology fellowship at the University of Pennsylvania.

Drug discovery: Not for the timid or shy

By Randall Riggs
To us, the fourth time around is even more exciting than the first.

Our patient care speaks for itself. But over the last four years, it’s received a lot of help from *U.S. News & World Report*. Once again, the magazine has recognized us for excellence in the areas of gynecology and ear, nose and throat care. This great honor is given to hospitals that specialize in treating more than just a few conditions. It’s given to facilities that excel at treating a wide variety of them. That’s the kind of expertise our patients have come to expect from us – year after year. To learn more about this special recognition or any of our services, contact us today.
Should human genes be patentable?

By Robert Yang

Article I, section 8, clause 8 of the United States Constitution states the Congress has the power to "promote the Progress of Science and useful Arts, by securing for limited Times to Authors and Inventors the exclusive Right to their respective Writings and Discoveries."

The U.S. Congress provides a patent with a twenty year limited monopoly from the date of filing in exchange for teaching others how to use the patented invention. And granting a limited monopoly for a patent exists to encourage and reward such innovation.

But in a lawsuit that could change the patent landscape, the American Civil Liberties Union ("ACLU") filed suit on behalf of some researchers, women's health groups, and patients against the U.S. Patent Office and a company that owns a number of patents related to cancer screening.

The patents in dispute involve BRCA1 and BRCA2 genes, which relate to an increased risk of breast or ovarian cancer.

Myriad Genetics developed tests on the BRCA1 and BRCA2 genes that let women know whether they have increased risk factors for breast or ovarian cancer. Since Myriad owns the patent rights, it is the only company allowed to perform these lab tests and interpret the results.

The lawsuit alleges Myriad aggressively enforces their patent rights by: 1) preventing clinicians from independently looking at or interpreting a person's BRCA1 and BRCA2 genes; 2) choosing not to license the patent broadly, resulting in women not able to get a second opinion on their test results; and 3) charging a high price for its lab tests.

The ACLU argues that human genes are either laws of nature, natural phenomena, or abstract ideas, none of which are patentable.

Certainly, ACLU's suit faces a difficult challenge as the U.S. Patent Office has granted similar biotechnology patents since 1980, when the U.S. Supreme Court held patent laws allowed a patent on a human-created bacterium. Ever since then, approximately twenty percent of human genes have been patented.

Patent owners such as Myriad argue patent laws must have an incentive to conduct costly research; otherwise no one would do it. Just as drug companies spend billions of dollars looking for the next blockbuster drug in the hopes of recouping their costs and making a profit while the drug enjoys patent protection.

So what is a fair way to encourage "Progress of Science" and reward innovation, yet ensure such life-saving innovation can be affordable and other researchers can perform further research?

In this case, the court could argue the patent system worked as intended in encouraging Myriad to innovate, so it should be rewarded. Or the court could invalidate Myriad's patents. Of course, the court could do something else; perhaps require a mandatory licensing agreement for a reasonable licensing fee to outside researchers and labs. And Congress could change whether genes or cancer testing can be patented in the first place.

Whatever the court decide could have a major impact on cancer research as nanotechnology promises to revolutionize cancer detection and treatment.

As reported in the August issue of the journal Genome Research, researchers from Johns Hopkins have developed a test that detects whether there are and how much of certain DNA changes that alert test subjects of a risk for developing cancer. This test could also indicate how well a particular cancer treatment is working.

This new DNA test uses quantum dots about 75,000 times smaller than the width of a human hair to detect the early signs of cancer. These quantum dots are mixed with and attach to isolated DNA strands associated with cancer. As a light shines on the quantum dots, the dots transfer energy from the light to a nearby fluorescent dye, causing the dye to light up or fluoresce.

The test appears to be quicker and more sensitive compared to current test methods, potentially allowing for personalized chemotherapy. The Johns Hopkins researchers are seeking patent protection on their cancer test. Will and should they be allowed to do so?

Stay tuned.

Robert Yang is a registered Patent Attorney with Stites & Harbison PLLC

11.3 million Humana members needing a physician.

25,000 Humana employees making it easy for you to treat them.

Join the Humana network and find out how easy we are to work with. We offer you:

• Electronic claims filing to help you get paid more quickly
• A national network with strong local, regional, and national resources
• Resources – like SmartSummary™ and Physician Finder Plus – to help members make informed health insurance choices
• Special clinical services and programs to support your treatment plan

Smarter consumers are easier to work with. So are smarter insurance companies.

To find out more, go to Humana.com/Providers.
It is truly an exciting time to be at the University of Kentucky and the Markey Cancer Center, a premier cancer research and patient care facility. Our nationally-acclaimed programs attract patients from every county in Kentucky and across the country. One of the main reasons for our excitement is the multidisciplinary approach that we employ to research and fight one of our Commonwealth’s most deadly diseases: cancer. Teams of physicians, scientists and dedicated staff in the Markey Cancer Center are working together not only to treat our patients with the care and compassion you and your loved ones deserve, but also to provide the cures for tomorrow.

The Markey Cancer Center has been recognized by the National Cancer Institute (NCI) as one of the premier locations in the nation that focuses on state-of-the-art research and advanced treatment for patients with gastrointestinal (GI) cancers which include cancers of the colon, rectum, pancreas, esophagus, stomach and liver. In fact, the NCI recently awarded the Markey Cancer Center a Specialized Programs of Research Excellence (SPORE) grant in gastrointestinal cancers, one of only six GI SPOREs in the nation, which allows for discoveries in the laboratories to reach the patients much more quickly than traditional scientific programs. A multidisciplinary team of specialists—including surgeons, medical oncologists, radiation oncologists, interventional radiologists, pathologists, basic researchers and genetic counselors—collaborate to deliver innovative multi-modality treatment techniques designed to improve patient outcomes and preserve quality-of-life.

In addition to GI cancers, other areas where specialized teams of physicians and investigators are working together in a multidisciplinary fashion to provide the most up-to-date and compassionate treatment plans for our patients include cancers of the lung, prostate, breast, head and neck, brain and ovaries just to name a few. Notable recent accomplishments and additions include a state-of-the-art gamma knife, which offers precise and focused treatment of difficult tumors of the brain, spine and head and neck, a nationally-recognized ovarian cancer screening program and renovated clinical facilities.

I also want to take this opportunity to recognize the exceptional work being done on a daily basis by our clinicians, nurses, scientists, and staff who help support our mission. Thank you to each and every one of you who is a part of the Markey Cancer Center team. We cannot continue to move our center forward without your valued and dedicated efforts. Together, we can help eliminate the pain, suffering and death due to cancer.

I invite you to learn more about the Markey Cancer Center by further perusing our website. Our excitement is measured by the teams who make discoveries in our research laboratories, by the teams who do exceptional work in our Cancer Control Program, by the number of Kentuckians we treat close to their homes via our Affiliate Network, by our generous donors who make our work possible and, most importantly, by the exceptional care and treatment our clinical teams provide to all our patients.

The Markey Cancer Center has been recognized by the National Cancer Institute (NCI) as one of the premier locations in the nation that focuses on state-of-the-art research and advanced treatment for patients with gastrointestinal (GI) cancers.
YOU DON'T GET A DOCTOR WORKING ON YOUR CANCER.  
You get six of them.

Multidisciplinary Lung Care Center  
at Baptist Hospital East.

The very prospect of cancer can be overwhelming. Fortunately,  
the process of coming to a diagnosis and deciding on a treat- 
ment doesn't have to be.

Baptist Hospital East’s multidisciplinary approach brings  
together several skilled surgeons and medical specialists to  
discuss your condition, share information, and proceed  
quickly to a diagnosis and treatment plan. This collaborative  
approach saves you the trouble of making appointments with  
each individual specialist, so that you can focus on healing.

A dedicated Nurse Navigator guides you through the process,  
coordinates appointments and alleviates that feeling of being  
overwhelmed with information by providing a personal touch  
and a consistent source of counsel through your journey from  
diagnosis to treatment.

For more information, call (502) 896-3008 to reach the Lung  
Care Center coordinator.
His last months are important. The care you recommend is critical.

For 30 years, Hospice of the Bluegrass has been a leader in end-of-life and palliative care and has the privilege of caring for over 1,000 patients and families daily throughout our 25-county service area. It is through the collaboration and partnership with community physicians that Hospice of the Bluegrass has been able to touch so many lives.

For more information on referring to Hospice of the Bluegrass, please contact us at (800) 876-6005.

www.hospicebg.org

Kentucky Roots. National Reach.

Barnett Benvenuti & Butler PLLC provides a vast range of legal, litigation and legislative services to select clients who appreciate value and substance. The firm dedicates itself to a wide range of complex health care matters and its health care experience is unequaled in Kentucky.

Our office is located in the heart of the Bluegrass — Lexington, Kentucky — but our body of work spans the Commonwealth and the nation. Whether your matter is big or small, BB&B has the experience and skill to meet your legal needs.

Find the help that you need at www.KyHealthLaw.com

Barnett Benvenuti & Butler PLLC

489 East Main Street, Suite 100 • Lexington, Kentucky 40507 • Phone: 859.226.6312

Drug Discovery

Continued from page 17

Drug Discovery

Phase III are pivotal trials

Drug Discovery

Copyright © 2009 by Ameba Media, LLC. All rights reserved. No part of this publication may be reproduced without written permission from the publisher.

Intellectual property, capital and management.

While ideas are great, if one does not have the appropriate intellectual property to protect the idea or product, then it will be very difficult obtain sufficient capital from investors to advance the idea to market, much less obtaining the right management skill to oversee and manage the product to market.

Drug Discovery to Investigational New Drug Application (IND)

Developing a promising product must be interrogated extensively at the preclinical stage to first and foremost ensure that any product discovery that enter into humans will not cause harm and is safe, which is the primary concern of the U.S. FDA. This stage can involve almost endless tests and experiments in search of whether this promising product merits moving forward into human clinical trials. And yes, this stage is far from commercialization, about 7-10 years, and can take up to 6 years and consume millions of dollars in capital.

Human Clinical Trials (Phase I-III)

Phase I. Human clinical trials involve a lot of uncertainty involving regulatory, clinical trial design, healthy subjects and, as always, substantial expenses. Phase I trials typically involves 20 – 80 healthy subjects and can easily approach $5 million or more in expenses depending on the number of clinical sites, number of healthy subjects treated, and the type of pharmaceutical product (e.g., small molecule, monoclonal antibody, protein therapeutics, gene therapy, etc.). Approximately 40% of the products completing Phase I will not make it to Phase II.

Phase II. Provided your product proves to be safe in Phase I, it may now proceed to Phase II trials, which typically involve 100 – 300 patients who have the disease the product is addressing. If Phase I is thought to be challenging with steep expenses, complexity of management of healthy subjects, etc., Phase II considerably amplifies Phase I considerably in terms of complexity and expenses, which such expenses can easily approach $15 million or more. Approximately 50% of the products completing Phase II trials will not make it to Phase III.

Phase III. Phase III are pivotal trials involving thousands of patients with at least two clinical Phase III trials in at least two countries (e.g., U.S. and Japan, Germany, etc.). With multiple clinical sites, type of clinical trial design, thousands of patients being treated with the disease of interest, the costs and complexity of Phase III trials dwarfs that of Phase I and Phase II trials combined. Approximately 30%-50% of the products completing Phase III will not be approved by the regulatory authorities as a new drug ready for commercialization. Moreover, expenses can easily approach $80 million or more for Phase III trials.

It should be noted that the estimated costs for the clinical trials described in this article is only for one discrete product that assumes it successfully reaches the market and does not include the cost associated with previous product failures. The Tufts University study referenced at the beginning of this article calculates the average cost of a pharmaceutical product reaching the market, plus it includes the cost of product failures.

Drug Product Approval.

Obtaining marketing approval from the appropriate regulatory authority (e.g., USA FDA) can take up to two years because of the enormous data the agency must review, confirm and validate from the studies sponsored by the pharmaceutical product’s owner. If marketing approval is obtained, then the “discovery to market” journey is largely completed and a new, equally complicated journey starts with respect to the marketing and selling of the product. Sales of pharmaceutical products operate in a highly regulated, complex environment that, among many other questions, revolves around two important questions that may seem simple but are nothing more than a prelude to the many difficult challenges that lie ahead in the market. The two questions are: “Who will pay for the approved product (e.g., Medicaid, Medicare, health maintenance organizations (HMO’S), preferred provider plans (PPO’s), Veteran Administration, and so on)? What price(s) will the sponsor receive as reimbursement for the product? Fortunately for the reader, this article will stay within the confines of “drug discovery to market.” Discussion about selling the product and its challenges and rewards is out of the scope of this article and truly merits a separate article devoted entirely to this topic.

Indeed, drug discovery is not for the timid or shy, but if you thrive in fast-paced, high risk / high reward environments, then the pharmaceutical and biotechnology industry just might be in your future.

Randall B. Riggs is the President & CEO of Advanced Cancer Therapeutics (ACT).
Helping people in need

Medications are vital to helping people live longer, more productive lives. They also are generally less expensive than other forms of health care, such as surgery and hospitalizations.

Unfortunately, not everyone can afford the medications they need.

Lilly offers patient assistance programs to help people in need gain access to our growing portfolio of best-in-class and first-in-class medications.

For more information, call toll-free 1-877-785-4559 or visit lillyforbetterhealth.com, click on Health Resources for Consumers, then Patient Assistance Programs.
University of Kentucky Pharmacists develop diagnostic test

Process to personalize cancer therapy

By Andy Steen

A practical result of the Human Genome Project is the development of diagnostic tests that will personalize cancer therapy. TrackFive Diagnostics, Inc. is using the information contained in the DNA of the individual cancer patient to predict their response to EGFR inhibitors, a type of targeted cancer treatment. Knowing if a patient will respond to treatment in advance will both guide and improve a patient’s cancer care and reduce overall healthcare costs.

TrackFive Diagnostics was created in April 2009 by two researchers from the University of Kentucky College of Pharmacy, Penni Black, Ph.D. and Justin Balko, Pharm.D., Ph.D., and MetaCyte Business LLC.

“We felt like we could build a company around Penni and Justin,” said Steve Gaillar, President and CEO of MetaCyte, a veteran of the venture capital and life sciences industries. “They have the relevant expertise and a commitment to make their technology work.”

The technology is a novel methodology using both supervised learning methods and bioinformatics approaches to model sensitivity to EGFR inhibitors with gene expression data. TrackFive’s gene expression predictor of response to EGFR-targeted agents was built using lung cancer cell lines and sensitivity data to the small molecule EGFR inhibitor erlotinib (Tarceva®). The gene expression predictor of response to erlotinib also predicts response and disease control to the monoclonal antibody EGFR inhibitor cetuximab (Erbitux®), used to treat patients with metastatic colorectal cancer.

TrackFive’s first genomic-based test will be a valuable clinical tool in determining which patients should receive costly cetuximab therapy—about $71,120 per patient—for metastatic colorectal cancer, perhaps best used in combination with KRAS mutation analysis. In February 2009 the American Society of Clinical Oncology stated that, “based on systematic reviews of the relevant literature, all patients with metastatic colorectal cancer who are candidates for anti-EGFR antibody therapy should have their tumor tested for KRAS mutations in a CLIA-accredited laboratory.” Currently, the 60% of metastatic colorectal cancer patients who test KRAS normal are considered candidates for anti-EGFR therapy. Nevertheless, a significant number of KRAS normal patients do not benefit from treatment with cetuximab.

TrackFive’s gene expression predictor of response will stratify those KRAS normal patients that will or will not benefit from treatment with cetuximab.

For example, using TrackFive’s gene expression predictor of response to cetuximab in a cohort of actual patient data, KRAS normal patients that TrackFive predicted would respond to treatment had average progression free survival gains of approximately 5 months.

“We think that is meaningful and should have clinical utility,” said Dr. Black, “although it will need further validation.”

The U.S. cancer molecular diagnostics market in which TrackFive Diagnostics’ tests fit is expected to reach over $2 billion by 2013. Future tests may apply to lung cancer and pancreatic cancer.

Andy Steen is the Vice President for Business Development at MetaCyte Business Lab.

Help for cancer patients and families

UofL establishes Dr. Renato LaRocca Endowed Chair in Oncology Social Work

By Gary Mans

A diagnosis of cancer often will send a patient into a spiral of depression, pain and hopelessness. The University of Louisville hopes to prevent that from happening through the establishment of the Dr. Renato LaRocca Endowed Chair in Oncology Social Work.

“We don’t know of another program in the nation that focuses on cancer patients; we want to fill that void,” said Terry Singer, dean of the Raymond A. Kent School of Social Work at UofL. “Through this chair, we will create a state-of-the-art training and research program targeted at this very vulnerable population.”

Local cancer medicine specialist Dr. Renato LaRocca recognized the need for helping his patients navigating their way through the maze of emotions and health care systems associated with a cancer diagnosis. The result was his leading the effort to establish the nation’s first known endowed chair in oncology social work.

“A cancer diagnosis immediately impacts patients and generates a tremendous amount of emotional and technical needs,” LaRocca said. “I don’t know of any formal program in the United States, let alone the world, that researches the topic or that specifically educates and trains social workers in this arena. There is a tremendous need in our community and beyond and I can’t think of a better place than UofL to lead the way in this new specialty area.”

Oncology social workers serve as patient advocates, providing answers, guidance and support. They connect cancer patients and their families to community resources, including physicians, financial aid, local and government agencies and support groups.

The LaRocca Chair is part of the state’s Bucks for Brains program, where the state provides funds matched by private donations. This chair marks the first in the Kent School.

“At UofL, we strive to make a difference in people’s lives,” said Dr. James R. Ramsey, president of the university. “One way to accomplish this goal is to bring the best possible people to Louisville to examine the problems people face in their lives. Dr. LaRocca’s gift and Dean Singer’s leadership in establishing this program demonstrate how we work daily to improve the lives of people in Louisville, Kentucky, and beyond.”

Local Healthcare IT

Continued from page 18

will allow consumers to set up a free health record banking account to store their patient information in a private and secure bank. Each bank account will contain an electronic copy of an individual’s health records, consolidated from the various clinics, hospitals, and physician practices where the individual received care. Consumers will control their health record account information and can choose to make all or part of their record available to providers as they desire, or access their own record via the internet or cell phone.

LouHIE is currently initiating a campaign to educate the public and to secure funding to build the community health record bank. After sufficient funds are secured, LouHIE will implement the system with a pilot project, with full implementation expected by the end of 2010 or early 2011. After implementation, the operation of the system will be self sustaining with funds from consumer contributions, employer and health-plan contributions, government and non-government grants and contracts, and revenues from special services that can be provided to augment the health record banking system.

In addition to improving healthcare and lowering health care costs, LouHIE’s project will create economic growth in our region, particularly in the local technology and health sciences sectors. Technology and health sciences related businesses will prosper and more residents will receive training and find jobs in the technology and health sciences sectors.

For more information, you can visit their web site at http://www.louhie.org, send them an email at infor@louhie.org, or call 508-8443.
Health reform poses big challenge and HIT funds starting to flow

Congress is back from the August Recess and gearing up to address health reform legislation. Earlier this month, President Obama, spoke to a Joint Session of Congress to make his arguments for passing legislation. From a health IT perspective, the investments in a Nationwide Health Information Network (NHIN) can begin to enable cost avoidance and improvements in care delivery that can create a foundation for health reform. The American Recovery and Reinvestment Act (ARRA) funds are starting to flow to the states and communities. The foundation is being established quickly in order to achieve that foundation that non partisan AND critical to future success.

Legislative Branch

Congress returned from an impassioned August Recess ready to address health reform. Legislation has passed all House Committees and is awaiting floor action. In the Senate, the Health, Education, Labor, and Pensions (HELP) Committee completed action on legislation and is awaiting action from the Finance Committee. Finance Committee members are expected to move forward on a bill by the middle of the month that could include the establishment of regional cooperatives as an alternative to the public option that is favored in the House and Senate HELP Committee bills. A lot of work remains to be done before a single bill is completed in each chamber, and ultimately sent to President Obama for signature.

Health IT is addressed in the health reform legislation, but the majority of the legislative work was completed during the legislative activity associated with the passage of ARRA.

Executive Branch

The federal regulatory activities have been off the charts for the past seven weeks, as agency representatives continue to work to release program guidance and funding for the health IT initiatives in ARRA. The Obama Administration took steps to advance the health IT initiatives by releasing nearly $600 million for Regional Extension Center Grant opportunities and $564 million to support the ARRA legislative requirements that the Office of the National Coordinator for Health IT (ONC) fund state-level health information exchange activities.

The first program, entitled, the Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program is being designed as a three-phase funding opportunity aimed at establishing four-year cooperative agreements to support 70 or more regional centers. Dr. David Blumenthal and his team have identified this funding program as a high priority for helping providers achieve meaningful use before the start of the Medicare and Medicaid incentive payments. The result is a near doubling of funding over the ARRA requirement.

My understanding is the Regional Extension Center Grants will be awarded on a continual basis over the next 12 months, with 20 grants expected to be awarded in the first quarter of FY2010. The regional centers will be required to be affiliated with a U.S.-based nonprofit institution or organization, or an entity thereof. Each three-phase process for determining grants will include a preliminary application, a full application phase, followed by an awardee selection process. ONC encouraged organizations to stepping foot on the targeted provider’s doorstep for review and analysis of the practice’s Medicare and Medicaid utilization patterns. Therefore, to a large extent, RACs are RAC audits are expected to begin in Kentucky this fall. As Kentucky providers ready themselves for what many of their non-Kentucky counterparts are already dealing with it is important that providers appreciate the full potential of the RAC process.

At their core, RACs are data miners. Once collected, the data is reviewed and analyzed, often along with medical record information, by a stable of auditors and clinicians that are trained to hunt for potential overpayments. RAC audits result from claims submitted and reimburrsed under the Medicare program for medical care and Medicaid incentive overpayments. Identified overpayments result from claims submitted and reinserted under the Medicare program for medical care and Medicaid incentive payments which, upon review, appear to have been inappropriately paid based on non-compliance with Medicare payment rules. Examples include claims submitted and paid for non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services.

RACs certainly have some unique features, and are intended to protect the integrity of the Medicare program by detecting (and subsequently recovering) overpayments through the use of technology. For example, it is data mining technology that permits claims information to be easily analyzed in a variety of formats such as comparing similarly situated providers (both institutional and individual) to one another to identify questionable utilization patterns. Therefore, to a large extent, RACs are yet another example, albeit a highly significant one, in a ever growing list of private contractors (such as Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC)) that mine claims data in an effort to effectively, efficiently and covertly identify aberrant billing practices.

As many Kentucky providers have come to learn, state and federal enforcement agencies have become particularly astute at evaluating potential investigative targets (and in many cases beginning criminal and/or civil investigations) prior to stepping foot on the targeted provider’s property. Accordingly, providers should not be lulled into believing that the information collected and evaluated by RACs will be used for the sole purpose of identifying and recovering overpayments un

‘RAC’ing up false claims?

Overpayment demands likely to be only one of the issues providers will face once RAC audits begin in Kentucky

As most Kentucky providers know, the Tax Relief and Health Care Act of 2006 required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The national RAC program resulted from a successful demonstration program authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration was, at least from the government’s perspective, overwhelmingly successful. Specifically, it resulted in over $900 million in overpayments being collected from hospitals, physicians, laboratories, DME suppliers, home health companies, ambulance providers, inpatient rehabilitation and skilled nursing facilities and returning the same to the Medicare Trust Fund between 2005 and 2008.

RAC audits are expected to begin in Kentucky this fall. As Kentucky providers ready themselves for what many of their non-Kentucky counterparts are already dealing with it is important that providers appreciate the full potential of the RAC process.

At their core, RACs are data miners. Once collected, the data is reviewed and analyzed, often along with medical record information, by a stable of auditors and clinicians that are trained to hunt for potential overpayments. Identified overpayments result from claims submitted and reimbursed under the Medicare program for medical care and Medicaid incentive payments which, upon review, appear to have been inappropriately paid based on non-compliance with Medicare payment rules. Examples include claims submitted and paid for non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services.

RACs certainly have some unique features, and are intended to protect the integrity of the Medicare program by detecting (and subsequently recovering) overpayments through the use of technology. For example, it is data mining technology that permits claims information to be easily analyzed in a variety of formats such as comparing similarly situated providers (both institutional and individual) to one another to identify questionable utilization patterns. Therefore, to a large extent, RACs are yet another example, albeit a highly significant one, in a ever growing list of private contractors (such as Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC)) that mine claims data in an effort to effectively, efficiently and covertly identify aberrant billing practices.

As many Kentucky providers have come to learn, state and federal enforcement agencies have become particularly astute at evaluating potential investigative targets (and in many cases beginning criminal and/or civil investigations) prior to stepping foot on the targeted provider’s property. Accordingly, providers should not be lulled into believing that the information collected and evaluated by RACs will be used for the sole purpose of identifying and recovering overpayments un

 Continued on next page
False claims Continued from previous page

False claims

Under the RAC program, rather, providers must be cognizant of the fact that there are no prohibitions on how RAC-generated information can be otherwise used to enhance integrity in the Medicare program. Accordingly, RACs are not only expected, but obligated to fully cooperate with the United States Department of Justice (DOJJ) and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) as well as fellow contracts such as Fiscal Intermediaries (FI), Medicare Administrative Contractors (MAC), PSCs and ZPICs in their efforts to eliminate fraud, waste and abuse from the program.

Therefore, if in the course of identifying overpayments, a RAC believes it has discovered information that is indicative of a fraudulent or abusive practice, providers should fully anticipate that appropriate referrals will be made. With this in mind, providers and their counsel would be well served by carefully evaluating the issues of non-compliance that form the basis of demands for overpayment made by the RAC. This is especially true of demands involving large amounts as they are typically more likely to be the subject of a referral. However, even issues that result in smaller overpayments could be problematic if the underlying non-compliance related to a service is related to a significant portion of the provider’s operations and/or if the issue appears to be indicative of a more systemic failure to comply with a general reimbursement principle such as medical necessity.

The RAC program places limitations on the RAC’s ability to identify past overpayments. The so-called look back period is limited to three (3) years and in no case can a RAC review claims paid prior to October 1, 2007. However, it is important that providers understand that this limitation applies only to the RACs’ identification and recovery process. In no way limits other contractors or enforcement agencies from identifying similar claims wrongfully submitted for payment. Thus, it would be possible for a non-RAC contractor or enforcement agencies to investigate a provider based on an issue that for RAC purposes could not be subject to an overpayment recovery prior to October 1, 2007. As the RAC process proceeds, providers will likely be left to grapple with the issue of to what extent a substantiated overpayment demand by a RAC has put the provider on notice that similar claims may have not been submitted in compliance with Medicare rules. This evaluation process should, among other things, take into account the significant exposure that a provider would incur should the government take the position that the provider improperly retained or concealed the corresponding overpayments. This seems especially true given the recent passage of the Fraud Enforcement and Recovery Act (“FERA”) of 2009 which redefined the term “obligation” as used in the federal False Claims Act to include “the retention of any overpayment.”

There can be little doubt that the RAC program will further increase the inherent risks (including criminal, civil, and administrative liability) currently faced by health care providers that submit claims for payment to the Medicare and Medicaid programs. Accordingly, RACs should act as further justification and motivation for health care provider to ensure compliance with applicable laws, regulations and program rules and standards with a particular focus on developing and implementing processes aimed at preventing and detecting potential coding and billing issues.

Digital technology Continued from page 13

Digital technology

In-house digital imaging offers many advantages. “Rather than having to wait while images are developed, physicians can view the high resolution digital images immediately,” said Whistine. “They can also be securely shared for outside consultation.” He added that digital technology simplifies the transmission of data back and forth from hospitals. “We are really just now bringing doctors’ technology to the point where hospitals have been for a few years. They can now share and compare images and information in a similar format.”

Redundant storage is essential to any medical practice as well as for HIPAA compliance. Losing a patient’s records could be disastrous and leave providers with nothing to use for comparison or patient history in the future. PACS, much like an electronic medical record, enables physicians to share digital imaging within the office or with specialists anywhere. As Peterman explained, “A PACS system allows you to transmit images digitally into your network, where they can be archived and retrieved at workstations throughout the practice or securely accessed from outside the practice. They can also be securely transmitted for review, going directly to radiologists’ or other specialists’ imaging systems. A PACS system makes image retrieval much simpler than if your images were stored on film, CDs or DVDs.”

What’s the next step?

If a physician’s group is considering moving to digital technology, Peterman recommends working with someone who specializes in its installation and application in the healthcare arena. “The needs of health-care are unique,” said Peterman. “HIPAA regulations, for example, require networks to be secure and firewalled. Data must be encrypted when sending it from one system to another. In addition, a lot of software and certain languages, such as HL7 and DICOM, are specific to healthcare. For a successful conversion to or expansion of digital technology, you need someone who has in-depth experience in healthcare, interfacing one system to another, and creating gateways to move data from one point to another. It is the best way to ensure that your technology meets your needs, remains compliant with changing regulations and gives you access to information that will help you provide leading-edge patient care.”

Tom Walker is President of Raynorsix.

Physician-patient communication Continued from page 16

Physician-patient communication

It is understood that physicians cannot provide specialized treatments for patients and family members who develop mental disorders or complicated grief issues during their battle with cancer and referrals to licensed psychologists or specialized counselors should be made in these situations. However, research assures that even when there is no curative treatment left to offer, physicians still play a crucial role in the care of patients with advanced cancers, when they are not afraid to provide adequate information and address upcoming emotions. A first step towards increasing these communication behaviors is to make the cognitive shift that allowing end-of-life discussions does not take away patients’ hope and happiness but rather offers the opportunity to keep control over their lives, make informed decisions, and get specialized support in this challenging time of life. A second step is to define effective communication as a core clinical skill and provide physicians with specialized training to give them confidence in having these important discussions.


Changing the Experience of Prostate Surgery

www.SaintJosephDaVinci.org

Kentucky’s FIRST HIGH DEFINITION da Vinci® Surgical Robot System was installed at Saint Joseph Hospital in 2007.

Surgeons at Saint Joseph Hospital have more experience with robotic surgery than any other facility in Lexington.

Learn more about the benefits of robotic-assisted, minimally invasive surgery at SaintJosephDaVinci.org or by calling 859.313.4746 or 1.877.313.4746.

Catholic Health Initiatives®

Saint Joseph Hospital
Providing Qualified Personnel in the Following Fields:

- Phlebotomy
- Clinical Assistant
- Medical Assistant
- Medical Coding Specialist
- Medical Transcriptionist
- Healthcare Reimbursement Specialist
- Medical Administrative Management
- Medical Clinical Specialties
- Clinical Laboratory Assistant
- Medical Laboratory Technician
- Limited Medical Radiography
- Radiologic Technology
- Massage Therapy
- Medical Massage Therapy

LOUISVILLE CAMPUS ONLY:
- Ophthalmic Assistant
- Health Unit Coordinator
- Medical Administrative Assistant
- Nursing
- Surgical Technology
- Invasive Cardiovascular Technology

Call Today to Find Your Next Great Employee

LOUISVILLE CAMPUS  502-449-7828  LEXINGTON CAMPUS  859-977-5406

Spencerian College is accredited by the Accrediting Council for Independent Colleges and Schools