It is highly resistant to antibiotics and can pass antibiotic resistance to other types of similar bacteria. It can also exist in a carrier state, where patients may not exhibit symptoms but can spread the bacteria. And it can kill as many as half who get bloodstream infections from it. It's called CRE—and it's nearly unstoppable.

According to the Centers for Disease Control and Prevention (CDC), CRE—short for carbapenem-resistant Enterobacteriaceae—is a family of more than 70 bacteria that are a normal part of the digestive system, but it can cause infections when it gets into areas such as the bloodstream or bladder.

Most CRE infections occur in already-sick patients undergoing medical care in hospitals or long-term care facilities. Patients whose care requires devices such as ventilators, catheters, intravenous catheters or who are on long courses of antibiotics are at most risk. However, CRE can also spread to otherwise healthy people making them sick.

CRE infections are virtually un-treatable. “Collistin is the only antibiotic which has some effectiveness against CRE, but this antibiotic is seldom used because of the high rate of kidney toxicity,” said Kevin T. Kavanagh, MD, board chairman, Health Watch USA, Somerset, Ky.

The rise in CRE can be attributed to overuse in antibiotics, gaps in infection control in hospitals and long-term care facilities and from patients with CRE who are transferred between healthcare institutions.

Mandatory Reporting

The Courier-Journal reported that approximately 20 CRE cases have been treated in Louisville hospitals over the past two years. Yet, the Kentucky Department for Public Health has received only one report of an outbreak. (The hospital or county it was in was not released.) The Courier-Journal also recently reported that the Kentucky Department for Public Health and Kindred Healthcare are investigating the presence of CRE in about 40 patients since July at Kindred Hospital Louisville.

Currently, neither Kentucky nor the federal government tracks individual cases. Instead, hospitals are left on their own accord to interpret “outbreaks” and must only report greater-than-expected numbers of cases.

Kavanagh is trying to change this. He has the support of State Rep. Tom Burch, D-Louisville, who recently sent a letter to Gov. Steve Beshear seeking support for mandatory reporting of CRE bacteria. Burch plans to introduce a bill on mandatory public reporting in next year's General Assembly.

“This is a problem which affects the entire healthcare system, many different types of facilities and the community as a whole.”

— Kevin T. Kavanagh, MD, board chairman, Health Watch USA

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Staving off mental illness

Brain scans of those whose parents or siblings have schizophrenia reveal neural circuitry that is stressed by tasks their peers with no family history of the illness seem to manage with ease.

Read more on page 5

Special Legal Series:

HIPAA Final Rule

This is part three of our four-part series of updates summarizing the HIPAA Final Rules and addresses GINA definitions.

Read more on page 18

Pay or play?

No matter your political views or personal opinions on the legislation, it is certain that numerous changes have and will continue to impact everyone from healthcare consumers and providers to small businesses.

Read more on page 20

Obamacare’s broken promises to Kentucky

Senator Mitch McConnell’s editorial discusses how the costs of medical claims for Kentuckians next year would rise an average of 34 percent and how such premium increases will be devastating for middle-class families.

Read more on page 22

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ABOUT THIS ISSUE

Life Sciences & Pharmaceuticals

Our May issue takes a look at the life science and pharmaceutical industries. Articles delve into topics such as ways to rethink approaches to autoimmune disorders and the benefits of using genetic information to inform diagnosis and treatment. Understanding genetics is also the core of personalized medicine, one of the fastest-growing areas of medicine. We also explore Medicare Part D, the prescription drug benefit for seniors. Not only has the drug benefit managed to control costs, it has demonstrably improved seniors’ health. It has now become a target for cuts. We tell you why.

Articles begin on page 13
Letter from the editor

A Case for Expanding Medicaid

Each month, I am allowed a little bit of space in the paper to share what is on my mind. Sometimes I find it challenging to come up with just one topic to cover and sometimes the topics are obvious. This month falls into the latter column.

Over the course of the next 4-5 weeks, we expect that Governor Beshear will make an announcement about the expansion of Medicaid in Kentucky. The early money is on the Governor expanding Medicaid, but there has been some quiet pushback from some individuals and organizations that have suffered under the recent transition to managed care across the Commonwealth. While I recognize that there are challenges, I feel that it is for the benefit of the providers and the community for Kentucky to take advantage of this opportunity to expand Medicaid at little or no cost (at least in the immediate future) for tax payers.

It is undisputed that Kentucky has a poor overall health standing. The only way that we can improve the quality of lives for many Kentuckians is by providing better access to care. That means ensuring that each citizen has access to quality, affordable healthcare. Expanding Medicaid will enable us to cover the working poor; those that make too much to qualify for Medicaid, but do not receive benefits through their employer or cannot afford benefits on their own.

I also look at this from a purely economic standpoint. The more Kentuckians that have insurance, the less our emergency rooms will be used for primary care. It is no secret that regular well visits and preventive medicine are an effective way to reduce overall health costs. In addition, the more Kentuckians that have insurance, the more our physicians and hospitals will get paid for providing quality care.

While I fully endorse the expansion of Medicaid in Kentucky, I recognize that there are many challenges in the current Medicaid system. The healthcare community strongly encourages the Governor and the Cabinet for Health and Family Services to use this opportunity to create an environment that serves the healthcare consumer and allows the healthcare professionals to practice in a fair environment.

In my opinion, this is a decision that Kentucky simply cannot afford to pass up.

Sincerely yours,

Ben Keeton
Publisher

Thoughts from the healthcare community

Insider Louisville @insiderlou
Bucks for brains: Idea State U biz plan competition awards $100k including $5,500 to U of L’s PDM Pharmaceuticals - http://bit.ly/Yu7gq

EKU Public Relations @NewsEKU

Innovation Network @ginnovation
Kentucky awards $100K in grants to university students http://bit.ly/15m0G7p

McBrayer Law Firm @McBrayer_Law
“Why Does She Get To Do That?” Handling Questions about Employee ADA Accomodations http://wp.me/p1KIe0-7sr #ADA #EmploymentLaw

ARGI Financial Group @ARGIFinancial
ARGI is the 6th best place to work in ky for small-medium businesses. We’ll certainly take it but watch out for #1 next year! #bestplacesky

Health E. Network @HealthENetwork
Take our brief survey on the most urgent issues in 2013 on economic development in healthcare: http://bit.ly/ZYD3JD
“Transparency is the right thing to do in matters of public health,” said Linda Hummel, director of clinical quality and patient safety, University of Louisville Hospital (ULH). Hummel said ULH had two cases of CRE over the past year.

Baptist Health Louisville also tracks cases of multidrug-resistant organisms, including CRE. “We identified a total of eight cases in 2012,” said Connie Barker, MSN, vice president, quality and clinical effectiveness for Baptist Health Louisville.

Why the Resistance?

However, some healthcare facilities are resistant to the idea of mandatory reporting. “There is always a fear that reporting may cause patients not to enter a hospital,” said Kavanagh. “However, in facilities that know the source of the CRE and are taking active steps, reporting should reassure the public that the hospital is vigilant in their control efforts. Every hospital is faced with multi-resistant drug organisms. With proper control the incidence of these organisms can be decreased.”

Another argument is the cost and time mandatory reporting requires on the part of state health officials. But isn’t it more cost-effective for the patient, and

What Healthcare Providers Can Do

1) Know if patients in your facility have CRE.
   • Request immediate alerts when lab identifies CRE.
   • Alert receiving facility when a patient with CRE transfers, and find out when a patient with CRE transfers into your facility.
   • Ask if patients have received medical care somewhere else, including another country.

2) Protect your patients from CRE.
   • Follow contact precautions and hand hygiene recommendations when treating patients with CRE.
   • Dedicate rooms, staff and equipment to patients with CRE.
   • Remove temporary medical devices such as catheters and ventilators from patients as soon as possible.

3) Require and strictly enforce CDC guidance for CRE detection, prevention, tracking and reporting.
   • Make sure labs can accurately identify CRE and alert clinical and infection prevention staff when these germs are present.
   • Know CRE trends in your facility and in the facilities around you.
   • Join or start regional CRE prevention efforts, and promote wise antibiotic use.
   • When transferring a patient, require staff to notify the other facility about infections, including CRE.
   • Consider including CRE infections on your state’s Notifiable Diseases list.

Continued on page 4
society to control this superbug? Kavanagh thinks so.

“The State Health Department should consider requesting an increase in their budget to offset some of these expenses by providing rapid testing facilities around the state,” he said. “In addition, they could also consider having specialized equipment such as fogging units for use in hospitals with outbreaks where the source is not known.”

Where to Begin?

The Kentucky Department for Public Health educates healthcare providers about superbug prevention. However, Kavanagh feels that’s not enough.

“Hospitals have a responsibility to suspend admissions, at least on a unit level, and notify the public if they have an outbreak of CRE and have not identified the source. The public deserves no less,” he said.

“To be extra-vigilant we continue to implement immediate alerts when the lab identifies a CRE, alert receiving and transfer facilities when a patient has a CRE, and identify these patients at subsequent visits,” said Hummel. “In addition, we follow infection control recommendations such as the use of hand hygiene, dedicated rooms, dedicated staff if possible, dedicated equipment and require the use of gloves and gowns with these patients. Other ways we adhere to the prevention of the spread of CREs are by prescribing antibiotics wisely and the removal of temporary medical devices as soon as possible.”

Because preventing CRE from being transmitted from patient to patient is the same concept in every hospital, new infection-control measures are only needed if the means of implementing them is not working, said Hummel. For example, Hummel continued, “if staff are not wearing gowns and gloves to enter the room of a CRE patient, then it is not the practice of donning the protective equipment that needs changed; it is the enforcement of it.”

Likewise, Baptist Health Louisville is continuing their ongoing efforts related to infection prevention including education, hand hygiene and isolation precautions. In addition they are following recommendations from the CDC and are working closely with the state public health department as cases are identified.

“The is a problem which affects the entire healthcare system, many different types of facilities and the community as a whole,” Kavanagh said.
Staving off mental illness
UNC researchers discover mysterious links in two brain studies.

By Lynne Jeter

In a study to identify functional changes that may occur in the brains of adolescents at high risk of developing schizophrenia, Aysenil Belger, PhD, discovered that brain scans of those whose parents or siblings have schizophrenia reveal neural circuitry that is stressed by tasks their peers with no family history of the illness seem to manage with ease.

Belger, associate professor of psychiatry at the University of North Carolina (UNC) School of Medicine, performed functional magnetic resonance imaging (fMRI) on 42 children ages nine to 18. Half of the study subjects had relatives with schizophrenia; the other half didn’t.

Because there’s no way of knowing for certain who will become schizophrenic until symptoms arise and a diagnosis is reached, Belger became acutely interested in studying individuals who have a first-degree family member with schizophrenia, and therefore have an eight to 12-fold increased risk of developing the disease.

Researchers found that stimulating either brain cell pathway had opposing behavioral consequences.

Study participants each spent an hour and a half playing a game in which they had to identify a specific image – a simple circle – from a lineup of emotionally evocative images, such as cute or scary animals. At the same time, the MRI machine scanned for changes in brain activity associated with each target detection task.

Differences in Brain Functioning

Belger found the circuitry involved in emotion and higher order decision making was hyperactivated in children with a family history of schizophrenia, suggesting the task was stressing out these brain areas.

“This finding shows these regions aren’t activating normally,” she said. “This hyperactivation eventually damages these specific areas in the brain to the point that they become hypoactivated in patients, meaning that when the brain is asked to go into high gear, it no longer can.”

Because these differences in brain functioning surface before neuropsychiatric symptoms – trouble focusing, paranoid beliefs, or hallucinations – scientists believe the finding could point to early warning signs or “vulnerability markers” for schizophrenia.

“The downside is saying that anyone with a first-degree relative with schizophrenia is doomed,” said Belger. “Instead, we want to use our findings to identify those individuals with differences in brain function that indicate they’re particularly vulnerable, so we can intervene to minimize that risk.”

The UNC study, published online in *Psychiatry Research: Neuroimaging,* is among the first to look for alterations in brain activity associated with mental illness in individuals as young as nine.

“It may be as simple as understanding that people are different in how they cope with stress,” said Belger. “Teaching strategies to handle stress could make these individuals less vulnerable to not just schizophrenia, but other neuropsychiatric disorders, too.”

Potential New Mental Health Therapies

In a second UNC study, new research explains for the first time exactly how two brain regions interact to promote emotionally-motivated behaviors associated with anxiety and reward. The findings could lead to new mental health therapies for disorders such as addiction, anxiety and depression.

“For many years, it’s been known that dopamine neurons in the VTA (ventral tegmental area) are involved in reward processing and motivation,” said senior author Garrett Stuber, PhD, assistant professor in the departments of psychiatry and cell biology and physiology, and the UNC Neuroscience Center. “For example, they’re activated during exposure to drugs of abuse and naturally rewarding experiences. On the one hand, you have this area of the brain – the BNST – that’s associated with aversion and anxiety, but it’s in direct communication with a brain reward center. We wanted to figure out exactly how these two brain regions interact to promote different types of behavioral responses related to anxiety and reward.”

Previously, researchers tried to glimpse the inner workings of the brain using electrical stimulation or drugs, but those techniques couldn’t quickly and specifically change only one type of cell or connection. Optogenetics, a technique that emerged about seven years ago, can.

In the technique, scientists transfer light-sensitive proteins, opsins – derived from algae or bacteria that need light to grow – into the mammalian brain cells they want to study. Next, they shine laser beams onto the genetically manipulated brain cells, either exciting or blocking their activity with millisecond precision.

Initially, Stuber and colleagues used optogenetics for “photo-tagging,” to optically identify different types of neurons in vivo. This enabled them to identify a neuron in the BNST that’s projecting into the VTA. “So we know the neuron is directly interfacing with a reward-related brain region,” Stuber noted.

Foot Shock Experiment

They also exposed mice to a mild aversive stimulus, a carefully controlled but anxiety-provoking foot shock delivered repeatedly and unpredictably. The BNST neurons projecting into the VTA showed changes in their firing rate, “but some cells would increase their activity and others would suppress their firing,” said Stuber, adding that the results suggested functionally distinct populations of neurons within the BNST that are projecting to the VTA, therefore highlighting the complexity of this neural circuit.

Stuber and his team repeated the experiment, but this time optically identified BNST neurons that project to the VTA as either excitatory or inhibitory cells by integrating the approach they developed with the use of transgenic animals that allows for precise targeting of distinct neuronal cell types. The excitatory neurons were the cell population that increased their activity in response to the foot shocks; the GABAergic cells showed activity suppression during foot shock.

Finally, researchers found that stimulating either brain cell pathway had opposing behavioral consequences. The glutamate neurons provoked an aversive, avoidance behavioral response and promoted anxiety-like behavior in the mice.

In contrast, when Stuber’s team activated the GABAergic pathway projections from the BNST into the VTA, the animals showed reward-associated behaviors and less anxiety. They preferred that stimulation and would spend more time in the area of the cage where they had received it.

“When we exposed them to foot shock and at the same time activated this GABAergic pathway, it actually reduced the anxiety-associated behavioral consequences of that otherwise ‘aversive’ stimulation,” Stuber explained. “Because these cells are functionally and genetically distinct from each other, our findings also point to new potential targets for therapeutic interventions in neuropsychiatric disorders associated with alterations in motivated states such as addiction.”
Public health pays off

Public health is about creating conditions that make it easier for people to achieve a healthier life. The new dean of the University of Louisville School of Public Health and Information Sciences (SPHIS), Craig Blakely, PhD, underscores the value of prevention and the importance of well-supported public health systems in preventing disease, saving lives and curbing healthcare spending as the school promotes the concept of Return on Investment (ROI): Save Lives, Save Money, the theme of National Public Health Week.

Blakely points to several examples of public health’s potential ROI:
• Every dollar spent on childhood immunizations saves $18 on vaccine-preventable disease-related costs.
• If every state adopted comprehensive smoke-free policies, $2 billion over the course of several years would be saved in smoking-related deaths, lung cancer treatments and care for related health complications.
• Physician and nursing shortages could be substantially mitigated by creating a healthier community and population, reducing the need for clinical services.

Kathy Baumgartner, PhD, a professor in the department of epidemiology and population health, has taken part in public health research on the important link between physical activity and its protective association with breast cancer. This research has expanded to focus on how and why exercise works, and to determine answers to questions related to the type, frequency, duration and intensity of exercise when evaluating the benefits of physical activity. Public health research also is investigating how to modify environments to encourage exercise.

PMC expands cardiology services

Highlands Health System will expand their range of cardiology services in collaboration with Pikeville Medical Center (PMC). PMC will provide general cardiology and diagnostic services at the Highlands Medical Office Building on the Highlands Regional Medical Center main campus.

Highlands, which offers a full range of cardiology services, will now have more capabilities with the availability of PMC cardiologists on site. Pikeville and Highlands developed the arrangement in an effort to broaden health services within the community.

St. Claire Regional launched 50th anniversary fundraising campaign

Three respected fixtures in Morehead’s healthcare community are the honorary co-chairs of St. Claire Regional Medical Center’s 50th Anniversary Fundraising Campaign. Susie Halbleib, Sister Jeanne Frances Cleves and Ewell Scott, MD, are co-chairing the campaign with a theme of “50 Years of Amazing Medicine Close to Home.” As a nurse, Halbleib worked side-by-side with the late Dr. Claire Louise Caudill – after whom St. Claire Regional is named. Halbleib is still an SCR volunteer and an active member of the St. Claire Foundation board of directors. The Sisters of Notre Dame Covington Province is SCR’s sponsor, and Cleves was one of the original Sisters of Notre Dame who staffed the hospital. With the exception of a short stint overseas, she has remained a member of the SCR staff from day one.

Scott joined the staff of the Morehead Clinic (now Morehead Medical Specialists) in 1973.

Autumn Woods Health Campus expands

New Albany, Ind.-based Autumn Woods Health Campus celebrated its newly expanded Legacy Lane neighborhood for dementia residents during a ribbon cutting this past April. Autumn Woods recently added nearly 1,000 square feet of additional living space and six private suites.

Controlling norovirus outbreaks

Norovirus outbreaks account for more than 25 percent of all U.S. outbreaks according to a 2010 study in the American Journal of Infection Control. A recent study in the Journal of the American Medical Association reported that there are more than a 1,000 outbreaks of gastroenteritis reported by nursing homes each year. The study also found that norovirus outbreaks were associated with significant simultaneous increases in all-cause hospitalization and deaths in nursing homes.

To equip healthcare professionals with the educational tools they need to help prevent and contain norovirus outbreaks in their facilities Clorox Healthcare™ created the Norovirus Prevention Tool Kit. The kit includes:
• Key facts about norovirus, including the impact it has on healthcare facilities.
• Advice from leading infection preventionists.
• Prevention tips and protocols for different areas of the healthcare environment.
• An environmental cleaning checklist.

To sign up to receive a free hard copy of the Norovirus Prevention Tool Kit or to download a PDF version, visit www.cloroxhealthcare.com/norovirus.

UK professor inducted to John Hopkins Society of Scholars

Professor Natasha Kyprianou, the James F. Hardymon Chair in Urologic Research at the University of Kentucky College of Medicine, has been elected to the Johns Hopkins Society of Scholars.

Kyprianou is a professor of urology, molecular and cellular biochemistry, pathology and toxicology. A leading investigator in prostate cancer research, she is internationally recognized for her critical contributions to the identification of apoptosis as a mechanism underlying therapeutic response of breast and prostate tumors to hormone treatment.

There are currently 551 members of this society.

Murray-Calloway employees retire

After 24 years of service to Murray-Calloway County Hospital, Murray, Ky., Mary Conner retired in February 2013. Most recently she worked as a nursing assistant in post-partum.

In March, Faye Guthrie retired after nearly 22 years of work.
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A study published in the *Journal of Rural Health* reveals that people living in communities where mountaintop removal (MTR) mining occurs experience higher levels of illness compared to non-mining areas close by. MTR strips mountaintops to access coal seams using explosives. Fine dust, soot, and heavy metals are released into the air and waterways.

The study came from a community participatory health survey of residents in Floyd County, Ky., where MTR is taking place, compared with Elliott and Rowan counties with no MTR. Data shows higher reported incidences of asthma; chronic obstructive pulmonary disease; illnesses involving multiple organs; and general illness. MTR community residents also reported more serious illness and cancer deaths in family members, than residents in the non-MTR communities.

Kentucky Representative John Yarmuth and 26 other House members have introduced the Appalachian Communities Health Emergency Act (ACHE – H.R. 526) that places a moratorium on permitting for MTR removal (MTR) mining occurs in communities where mountaintop removal (MTR) mining occurs.

**Day appointed to national Expert Work Group**

Dr. Scottie Day, director of the Kentucky Children’s Hospital Transport and Outreach Program and assistant professor of pediatric critical care in the UK College of Medicine, has been appointed to a national Expert Work Group. The Expert Work Group is charged with developing and/or enhancing pediatric quality metrics for the Pediatric Intensive Care Unit (PICU) that will be proposed for national endorsement by the AHRQ-CMS Children’s Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Measurement Center of Excellence (PMCoE).

The long-term goal for this project is to advance and improve children’s healthcare quality measures that make a difference by both informing policy decisions and actual clinical performance in the inpatient and ambulatory settings.
Highlands holds orthopaedic surgeon open house

Highlands Health System hosted an open house to welcome orthopaedic surgeon and sports medicine physician, Robert Royalty, MD. Members of the community, Highlands’ employees, and medical staff greeted Dr. Royalty and his family in his office located in Prestonsburg, Ky., on the Highlands’ campus.

Baptist Health cardiac resuscitation earns award

Baptist Health received the Get with the Guidelines Resuscitation Silver Quality Achievement Award from the American Heart Association and American Stroke Association for reaching an aggressive goal in using guidelines-based care to improve patient outcomes from in-hospital cardiac arrest. The hospital received the Bronze Quality Award three months ago.

The silver award recognizes achieving a year or more of 85 percent or higher adherence based on four criteria to improve quality of care and outcome.

Baptist Health Paducah partners with March of Dimes

Baptist Health Paducah is partnering with the March of Dimes to lower the number of premature births. Baptist Health is among 100 hospitals nationwide working with the March of Dimes “Healthy Babies are Worth the Wait®” campaign, including the 39 weeks+ Quality Improvement Service Package to reduce medically-unnecessary (elective) inductions and Cesarean deliveries scheduled before 39 weeks of pregnancy.

ZirMed launches Patient Estimation solution

ZirMed, Inc., a leading provider of software-as-a-service (SaaS) revenue cycle management solutions, announced the availability of ZirMed Patient Estimation, a web-based solution that enables provider organizations to accurately determine a patient’s financial responsibility prior to providing service or care. Patient estimation is a critical best practice that enables provider organizations to get paid faster and more accurately, while reducing days in A/R and ultimately improving cash flow.

ZirMed’s Patient Estimation solution reduces the time it takes a provider organization to collect revenue from the typical 120 days to an average of only 30 days. Patient Estimation features multiple payment collection options, automated workflow and ease of use and implementation.

Balancing healthcare issues can be complicated. Choosing a legal team shouldn’t be.

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More than 375,000 Kentuckians eligible for new health insurance premium tax credits

A report from the national health consumer organization Families USA said that in 2014 more than 375,000 Kentuckians will be eligible for premium tax credits that will help them pay for health coverage—a doorway to quality healthcare for individuals and families of all ages and of all racial and ethnic backgrounds across the state.

The report included county-by-county data, which reveal how many Kentucky families in different income brackets (ranging as high as $94,200 for a family of four) will soon be protected from having to spend more than a set percentage of their income for health coverage.

Under the terms of the Affordable Care Act, these premium tax credits take effect in January 2014, following an enrollment process that begins in October of this year. The tax credits will be determined on a sliding scale based on income. Those with the lowest incomes will receive the largest tax credits, ensuring that those who need it most will get the greatest financial assistance.

The tax credits will help Kentuckians purchase health insurance that meets their specific needs in the new health insurance marketplace, sometimes called the “exchange,” which is being set up in the state. The tax credits will flow directly to the health plans in which families or individuals enroll, offsetting the total cost of plan premiums.

**Report Findings**

- In terms of statewide eligibility for Kentuckians, the report, “Help Is at Hand: New Health Insurance Tax Credits in Kentucky,” says:
  - More than 375,000 Kentuckians will be eligible for new premium tax credits in 2014.
  - People with annual incomes between $47,100 and $94,200 for a family of four (incomes between 200 and 400 percent of the federal poverty level), will make up more than 55 percent of the Kentuckians eligible for the tax credits.
  - About 87 percent of the Kentuckians who will be eligible for the premium tax credits will be white and non-Hispanic, while about 6 percent of the eligible Kentuckians will be black and non-Hispanic and about 3.5 percent of the eligible Kentuckians will be Hispanic.
- **Across Kentucky**
  - The report provides the same data on eligibility for counties or county groupings, based on how data are presented by the U.S. Census Bureau, across the entire state of Kentucky. For example:
    - In Jefferson County, which includes the city of Louisville, approximately 53,600 Kentuckians will be eligible for the premium tax credit, and about 57 percent of those residents will be families with incomes between 200 and 400 percent of the federal poverty level. Approximately 70 percent of the eligible residents will be white, non-Hispanic, about 20 percent will be black, non-Hispanic, and about 5 percent will be Hispanic.
    - In Fayette County, which includes the city of Lexington, 22,000 people will be eligible, and about 55 percent of those residents will be families with incomes between 200 and 400 percent of the federal poverty level. Approximately 72 percent of the eligible residents will be white, non-Hispanic, about 12 percent will be black, non-Hispanic, and about 8.5 percent will be Hispanic.
    - In the Census Bureau county cluster which includes Bourbon, Franklin, Harrison, Nicholas, and Scott counties and the city of Frankfort, 12,410 Kentuckians will be eligible for the premium tax credit, and about 62 percent of those residents will be families with incomes between 200 and 400 percent of the federal poverty level. Approximately 88 percent of the eligible residents will be white, non-Hispanic, about 7 percent will be black, non-Hispanic, and about 4 percent will be Hispanic.
- The report also provides specific data on employment status and age of eligible Kentuckians, showing that an overwhelming number of those who will be eligible for tax credits will be in working families, and that young Kentuckians (ages 18-34) make up a large proportion of those who will be eligible for assistance.

Orofacial pain clinic opens

UK HealthCare opened a new Orofacial Pain Clinic, which is a diagnostic and treatment center established to provide care for patients suffering with temporomandibular disorders and orofacial pains. The clinic is home to one of the first orofacial pain programs in the United States.

The opening coincided with the 25th annual Orofacial Pain Alumni Continuing Education course for orofacial pain specialists led by Dr. Jeffrey P. Okeson, professor and chair of the Department of Oral Health Science at the UK College of Dentistry, and director of UK HealthCare’s Orofacial Pain Program.

The Orofacial Pain Program at UK is one of only two programs in the U.S. to be fully accredited by the Commission on Dental Accreditation during the first year of eligibility. The program takes a multidisciplinary approach to orofacial pain, utilizing dentists, psychologists and physical therapists and is one of the only programs offering psychology training applied to chronic orofacial pain.

Signature HealthCARE homes named among nation’s best

Several Signature HealthCARE homes were named on U.S. News & World Report’s fifth annual list of the nation’s Best Nursing Homes.

The report highlights top nursing homes in each state and nearly 100 major metropolitan areas, covering more than 15,000 nursing homes nationwide.

The list is compiled using data published in January by the Centers for Medicare & Medicaid Services (CMS), which sets and enforces standards for nursing homes. U.S. News has awarded the “Best Nursing Home” distinction to facilities that earned an overall rating of five stars, the highest rating CMS awards nursing homes. Under the five-star rating system, nursing homes are assessed in three main categories: health inspections, quality measures and staffing. The overall rating combines scores received in each of the three categories.

The news comes as more than half of Signature’s nursing facilities, a total of 37, have achieved four- or five-star rankings from CMS.

Baptist Health Louisville receives stroke award

Baptist Health Louisville received the American Heart Association/ American Stroke Association’s Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award. The award recognizes Baptist Health’s commitment and success in implementing excellent care for stroke patients, according to evidence-based guidelines.

In addition, Baptist Health Louisville also received the association’s Target: Stroke Honor Roll, for improving timeliness of stroke care.

Nazareth Home accepted into Working Group

The International Working Group on Compassionate Organizations announced that long-term care facility, Nazareth Home in Louisville, is the first nursing home in the world to be accepted as an organizational member of the Working Group.

Nazareth Home has met the Working Group membership requirements and strives to embody the seven values of the Working Group: compassionate action, effectiveness, connection, wisdom, integrity, responsiveness and responsibility.
The development of an anti-cocaine medication for the treatment of cocaine overdose has challenged the scientific community for years. In fact, there is no current FDA-approved anti-cocaine overdose medication on the market.

"According to federal data, cocaine is the No. 1 illicit drug responsible for drug overdose related emergency department visits," Zhan said. "More than
Meet Rodrigo Moreno, MD, partner at Kleinert Kutz and Associates/the Christine M. Kleinert Institute

Place of Employment: Christine M. Kleinert Institute

Why did you decide to become a doctor? My favorite class in high school was biology. I was born into a family where my father, my brother and one of my sisters were all doctors. Their influence on me was definitive. Seeing what my father did as a general surgeon and being able to work and help people in a small town or in a metropolitan helped me decide to choose this wonderful profession. My mother and one of my sisters are also in the medical field as clinical psychologists.

Is it different than you thought? How? It's different in the way that not only do you have to be involved in the medical decisions and patient care, but you also need to be involved in practice management. At medical school there is minimal instruction about management, so it's key to have a good administration to handle those issues.

What is the biggest misconception about your field? The biggest misconception that some patients have is that they use the emergency room for many medical problems that can be handled in an outpatient clinic or in an elective way.

What is your opinion of Managed Care and how will this affect you? Managed care locks the patients that are enrolled in the system to certain doctors or hospitals. What this does is restrict the options for patients, and they have to choose from the ones that are in their program.

It is designed to lower the cost of healthcare, but we don’t know if it will. I don’t know how it will affect our practice or our training program. It will cover more patients with insurance, but the quality of care will not be the same overall. The waiting time for surgeries, the waiting time for approval of diagnostic tests that already are questioned by other doctors or administrators not even in the same specialty, will delay treatment.

We as physicians can reduce the cost of healthcare also, but, many times we are also responsible for part of the problem. As an example, I got a phone call for a referral of a patient that was injured in a town near Louisville. I accepted the patient. The ER doctor referring the patient said he was sending the patient by helicopter. It was not a life-threatening condition, or limb loss situation, so it was not necessary to send the patient by air. Unfortunately, the patient was sent in a helicopter for an injury that was treated by us in the emergency room.

What’s one thing your colleagues would be surprised to learn about you? At some point in my life I considered being a graphic designer.

What’s the best advice you ever received? Who gave it to you? “No matter how many times you are knocked down, stand up and fight again for what you want.” My mother.


Favorite daytime beverage? Orange juice.

Call for Gold Standard Award for Optimal Aging nominations

The Department of Family and Geriatric Medicine at the University of Louisville is calling for nominations for the third annual Gold Standard Award for Optimal Aging.

The deadline to submit nominations is 5 p.m., July 15, and nominations can be made online. The award will be presented September 24, 2013, at the Gold Standard Award for Optimal Aging Luncheon at the Crowne Plaza Hotel in Louisville.

The Gold Standard Award for Optimal Aging is presented to someone who is an outstanding role model of optimal aging and who is 85 years old or older as of October 1, 2013.

The nomination process includes providing brief descriptions of five areas of the nominee’s life: physical activities, civic engagement, social life, spiritual life and creativity. Nominators also can include additional information about the nominee in a sixth category, “other.”

Winners of the 2012 awards were Benn Davis, 97, of Louisville and Betty and Irvin Thomas Sr., 88 and 89 respectively, of New Albany, Ind.

Wound Care Center receives honors

For the third consecutive year, Baptist Health Wound Care has been honored by Healogics™ – this time with the Robert A. Warriner III, MD, Center of Excellence Award and the Center of Distinction Award. These awards are given for meeting or exceeding certain quality standards for patient healing plus patient satisfaction at 92 percent or above.

The Baptist Health Louisville location was one of only three in Kentucky to receive the Warriner honor. The center, which opened in January 2009, provides comprehensive wound care for people who suffer from non-healing wounds.

A new study authored by University of Kentucky researcher Elaine Wittenberg-Lyles shows that more empathic communication is needed between caregivers and hospice team members.

The study, published in Patient Education and Counseling, was done in collaboration with Debra Parker Oliver, professor in the University of Missouri Department of Family and Community Medicine. The team enrolled hospice family caregivers and interdisciplinary team members at two hospice agencies in the Midwestern United States.

Researchers analyzed the bi-weekly web-based videoconferences between family caregivers and hospice team members. The authors coded the data using the Empathic Communication Coding System (ECCS) and identified themes within and among the coded data. The team reviewed 82 total meetings.

Overall, the researchers noted that members of the hospice team tended to react to caregiver empathic opportunities with a perfunctory response, implicit recognition or simple acknowledgement as defined by the ECCS scale. Most caregiver statements were met with biomedical or procedural talk from the hospice team.

Few responses went beyond to offer confirmation with a positive remark to the caregiver, and even fewer provided a shared experience to address the caregivers’ emotional needs.

Prior research shows that a physician’s expression of empathy positively influences the patient-physician relationship, but as this study shows, this is often not the norm.

Other research shows that physicians tend to respond more to informational cues from patients than emotional cues, and often respond to patient concerns by turning the conversation to biomedical information or medical explanation, nonspecific acknowledgement or reassurance.

Know a physician who deserves a chance in the spotlight?

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A role for personalized medicine

Medicare reimbursement policy helps physicians incorporate pharmacogenetics into practices.

By Tom Johnson

The use of genetic information to inform diagnosis and treatment is one of the fastest-growing areas of medicine. Understanding genetics is also the core of personalized medicine, making possible the development of treatments designed for the molecular make-up of specific, individual patients.

Personalized medicine has implications for virtually all medical disciplines, with theoretical applications from the prosaic to the fantastic. At the headline-making, visionary end of the spectrum are customized drugs designed and assembled by nanobots to precisely suit a particular patient. Drugs like that are years off, awaiting changes in technology that will make individualized drugs economically possible.

Not all use of personalized medicine lies so far in the future; there are techniques and technologies being broadly applied today. Pharmacogenetics – the use of genetic data to choose medications and set dosages – is, in certain medical specialties, close to becoming standard of care. The reason for that is the clarity of the correlation between genetic variations and the metabolism of drugs, coupled with the desperate need of patients and the healthcare system to lower costs and improve outcomes.

Picking up Traction

Where is personalized medicine getting the most traction? In the expensive or vague quadrants of a medical practice where it’s worth giving the unconventional a try:

- In oncology, where the cost of treating a single patient can run to six figures.
- In pain management, where physicians have never before had a way of knowing whether a patient seeking additional drugs is truly in pain or diverting their drugs to other uses.
- In psychiatry, where prescribed anti-depressants are as often ineffective as effective.

Despite the above, the eagerness to apply pharmacogenetics to intractable medical problems has been met with resistance. Until recently, single-gene tests cost thousands of dollars and were prescribed with little or no consistency. Pharmacogenetics has been called “evidence-based medicine for which there is no evidence.”

However true that may have been a few years ago, the evidence has begun to pile up, along with anecdotes about more effective care. That has convinced physicians to seek guidance in adopting personalized medicine into their own practice. That guidance has come primarily from small, specialized labs and academic institutions.

Medicare Revamps Billing Codes

With doctors ordering hundreds-of-thousands of tests so new they didn’t have CPT codes to identify them, payers needed to rationalize the prescription and reimbursement of pharmacogenetic tests. Taking the lead, naturally enough, has been Medicare.

In January 2013 Medicare announced a revamp of billing codes that, for the first time, recognized the value of pharmacogenetics. The revamp replaced the ad hoc stacking of CPT codes with codes specific to the most pharmacogenetically significant genes.

For example, a meaningful genetic result might require more than 50 discreet actions, each billed separately. Under the new system, the result itself has been given a single code paying a single rate.

Just what that rate might be, Medicare didn’t say. Without going into numbing detail, the traditional ways of pricing medical tests didn’t work for pharmacogenetics. For the first quarter of 2013, physicians could order the test, laboratories could perform the tests, but no one could get reimbursed for the tests.

Significant Threats

Going several months without payment posed a significant threat to the specialized labs that have been most effective at helping physicians incorporate pharmacogenetics into their medical practice. Worse still, when the rates finally did come out, the cuts were drastic. Reimbursement for CYP2D6, the gene most broadly applicable in the metabolism of drugs, dropped more than 75 percent, from $628 to $148. Others dropped just as precipitously, with regional variations caused by Medicare’s decision to leave reimbursement specifics to regional administrators.

The result was a chaotic, low-margin reimbursement structure that Forbes online said “has the potential to stymie one of the most important and potentially cost-saving technologies in the pipeline.”

It would have done that by making capital investment in the human and technological infrastructure of genetic testing less attractive, in effect penalizing the early-stage, specialized labs that take the time to work closely with physicians. Business would be driven instead to national labs focused on the performance of commodity medical tests that need little or no interpretation.

Where is personalized medicine getting the most traction? In the expensive or vague quadrants of a medical practice where it’s worth giving the unconventional a try.

Specialized Lab and Medical Practitioners Collaboration

There are rumblings that the previously announced rates are going to be modified to support, rather than hinder, the growth of pharmacogenetics. Medicare administrators realized that, in this formative period of personalized medicine, collaboration between a specialized lab and medical practitioners is essential to the adoption of personalized medicine and the resulting improvement of patient care. Pushing testing toward labs that have little or no interest in that collaboration will frustrate that adoption, impacting the people who need help most—patients who turn to personalized medicine because conventional care offers inadequate relief.

That was certainly not what Medicare had in mind, and their swift action in reversing the unintended consequences of their decision is worth acknowledging.

Tom Johnson is the director of communications of PGXL Laboratories, a Louisville-based pharmacogenetics laboratory.
Unconventional wisdom

Rethinking the approach to some autoimmune disorders.

By Cindy Sanders

What if the standard treatment approach was the wrong one? In the case of several autoimmune disorders, it’s a theory that is gaining traction bolstered by recent research findings.

Stephen A. Paget, MD, physician-in-chief emeritus at the Hospital for Special Surgery in New York City, has spent his career researching and treating a range of inflammatory and autoimmune disorders. The rheumatologist, who is also a professor of medicine and Rheumatic disease at the Weill Medical College of Cornell University, said the potential exists for a paradigm shift in how clinicians view and treat some disorders including reactive arthritis, Whipple’s disease and persistent Lyme disease.

Paget said the accepted concept has been “that in a genetically predisposed person, with some type of environmental trigger—probably virus or bacteria—they develop disease.” Although the initiation was from a microorganism, he continued, the conventional wisdom has been that the self-perpetuation of symptoms is due to the body’s subsequent response.

Disease Effect on Predisposed Patients

“What you were left with was an inflammatory problem that was no longer tied to the previous organism,” Paget explained.

A good example would be persistent Lyme disease. The infectious trigger is the *Borrelia burgdorferi*, a bacterial species of the spirochete class, which is transmitted to humans through a tick bite. Skin rash in a bull’s-eye pattern (erythema migrans), fever, fatigue, chills and headaches are among early symptoms. Later symptoms could involve the joints, heart or central nervous system.

For most, a prescribed course of oral or intravenous antibiotics takes care of the infection and symptoms. However, in some patients, synovial inflammation persists even after the bacteria have been nearly or totally eradicated. This has given rise to the belief that in predisposed patients, the initial Lyme disease triggers an ongoing autoimmune disorder.

In his 2012 paper, “The Microbiome, Autoimmunity and Arthritis: Cause and Effect: An Historical Perspective,” which was published in Transactions of the American Clinical and Climatological Association, Paget noted that for more than 100 years, there has been “tantalizing but often inconclusive evidence” about the role of microorganisms in autoimmune diseases.

He wrote, “Current therapy focuses on the pathogenesis rather than the etiology of these disorders. In order to rein in the overactive immune system we believe to be causing the disease, we employ immunosuppressive drugs, an act that would be counterintuitive if infection were the root cause of the problem.”

Combination Antibiotic Regimen

A small but intriguing study out of the Division of Rheumatology at the University of South Florida College of Medicine published in the journal *Arthritis Rheum* in May 2010, found a six-month combination antibiotic regimen was effective in treating autoimmune disorders.
patients with the autoimmune condition Chlamydia-induced reactive arthritis.

In the nine-month, prospective, double-blind, triple-placebo trial, researchers assessed a six-month course of combination antibiotics with a primary end point of the number of patients who improved by 20 percent or more in at least four of six variables without worsening in any variable.

At month six, the authors found significantly more patients in the active treatment group became negative for C trachomatis or C pneumonia. The primary end point was achieved in 63 percent of patients in the active arm of the trial, with 22 percent of those patients believing their disease had gone into complete remission. No patient in the placebo group achieved remission.

**Improve Immunity Before Suppression**

Pointing to this study, Paget noted that one of the failures of antibiotic regimens in the past in treating autoimmune disorders might be the duration of the therapy.

“If you give long courses of antibodies, you may very well calm the problem down,” he said.

However, he noted, physicians currently switch to steroids, T-cell inhibitors, and other immunosuppressive drugs to ameliorate the ongoing inflammatory issue after treating the triggering microorganism with antibiotics or antivirals for a relatively short course.

“It may very well be we have to improve the immune system response instead of suppress it, and that’s the interesting twist,” Paget continued.

**Mounting evidence of the important connection between microorganisms and a number of autoimmune disorders provides “food for thought” when it comes to the best course of action for treating these conditions and could ultimately portend a paradigm shift in the delivery of care.**

If the root cause of an autoimmune condition is infection, “You’d want the army active,” he said of augmenting the immune system.

While much more research must be done, Paget said mounting evidence of the important connection between microorganisms and a number of autoimmune disorders provides “food for thought” when it comes to the best course of action for treating these conditions and could ultimately portend a paradigm shift in the delivery of care.

“In some of these, the organism is slow, smoldering but still there in a low-grade way that is triggering the inflammatory response. We have to be appreciative of the fact that we want to do the best thing for our patients, but what we’re doing (now) may be the worst thing,” he concluded.

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Improving seniors’ health and savings billions

Medicare’s Part D success story.

Lawmakers in Washington, D.C., are currently examining federal expenditures, searching for programs to trim and adjust. Medicare Part D, the prescription drug benefit for seniors, is one program that should serve as an inspiration to reformers—not a target for cuts. Not only has the drug benefit managed to control costs, it has demonstrably improved seniors’ health.

Under Medicare Part D, seniors shop for their insurance plans from each state’s approved list. The government sets the guidelines, but doesn’t actually provide the insurance. As a result, private insurance companies negotiate prices directly with drug companies and pharmacies, competing for seniors’ business by offering the lowest possible prices and the most possible options. When created, the idea was that competition would keep prices lower than government price controls could.

This structure has worked amazingly well. Part D is the rare entitlement program that has cost less than anticipated. Overall, costs have been about 45 percent below expectations, and seniors’ premiums are half what they were initially projected to be.

Part D’s success has been particularly beneficial to this region. Kentucky is home to 375,000 seniors on standalone Part D plans, and Indiana is home to 440,000. In both states, seniors can choose from among 31 different plans that cost an average of just $30 a month. Kentucky actually leads the nation in prescription-drug use by seniors.

Saving Money

Research shows that improved prescription drug adherence through Part D is saving money elsewhere in the healthcare system.

A study in the Journal of the American Medical Association, found that when Part D went into effect, non-drug medical spending fell by an average $1,200 per year for seniors who previously had limited access to prescription drugs. By improving seniors’ health, Part D helped save $13.4 billion in its first year.

Another study, conducted by researchers at Harvard, found that Part D significantly reduced hospitalizations for eight different conditions. Nationally, Part D eliminates the need for 77,000 hospital visits every year.

Part D Under Scrutiny

Despite these successes, Part D has come under scrutiny lately. In his budget, the President has proposed requiring drug manufacturers pay a rebate to the government on all Part D medicines sold to low-income seniors. But such a move could drive up premiums by as much as 40 percent for some beneficiaries, according to a former Congressional Budget Office (CBO) director.

The new Independent Payment Advisory Board, a powerful body charged with keeping Medicare costs in line, may also target Part D for spending cuts.

Part D is the rare entitlement program that has cost less than anticipated.

Further cuts will jeopardize seniors’ access to drugs and raise prices for other customers.

Part D is worth preserving. It is economically efficient, and most importantly, provides crucial medications to our seniors at affordable prices.

Robert B. Blancato is the executive director of the National Association of Nutrition and Aging Services Programs.
It’s budget season in Washington, D.C., and it seems like nearly everything is on the table as lawmakers discuss how to tackle the federal deficit. In particular, some legislators are considering proposals that would make big changes to the Medicare prescription drug program, Part D, that could raise out-of-pocket costs and potentially reduce the choices of prescription medicines available to beneficiaries.

If you aren’t familiar with Part D, here’s what you need to know: Part D is Medicare’s prescription drug program, which helps more than 31 million seniors afford the medicines they need to maintain their health. First implemented in 2006, it’s one of the rare government programs that is coming in under budget while exceeding expectations. Not only is Part D costing $334 billion (or 43 percent) less than originally estimated, but 90 percent of seniors say they’re happy with the coverage they receive. Further, three in five beneficiaries say they would not be able to afford their medications without Part D.

Future Barriers

However, some proposals would place new taxes, or rebates, on drug manufacturers in the Part D program. This could raise premiums by as much as 40 percent, an estimated increase in out-of-pocket costs for all Medicare beneficiaries of $1.5 billion to $3.7 billion. Applying rebates threatens to turn Medicare Part D into a Medicaid-style program, potentially resulting in barriers to access and restricting seniors’ choice of medicines.

Part D works. Any changes or cuts that would make medicines raise costs and reduce choices for seniors must be avoided if the program is to remain successful and continue to provide seniors with affordable access to prescription drugs.

Amy O’Connor is the director of digital government affairs at Eli Lilly and Company, and manager of the Campaign for Modern Medicines.

Not only is Part D costing $334 billion (or 43 percent) less than originally estimated, but 90 percent of seniors say they’re happy with the coverage they receive.
Incorporating GINA definitions into the HIPAA Privacy Rule

Final Rule includes certain definitions, terminology relating to genetic health information.

By Christina Anderson, Thomas Anthony, Chad Eckhardt, Charles Johnson

The Final Rule expands the Privacy Rule to ensure the definition of “health information” includes genetic information. Under the Rule, “genetic information” includes information relating to an individual’s genetic tests, genetic tests of family members (including a fetus or embryo), and the manifestation of a disease or disorder in family members of an individual. The Rule excludes information about an individual’s sex or age from its definition of “genetic information.”

In addition, the Rule expounds on what constitutes “genetic information” by adding definitions for other GINA-related terms, including: “family member,” “genetic services,” “genetic test,” and “manifestation” or “manifested.” In the Rule, “genetic tests” refer to tests which analyze human DNA, RNA, chromosomes, proteins or metabolites, and which detect genotypes, mutations or chromosomal changes. Moreover, the Rule points out that tests such as HIV, blood counts, cholesterol and liver function, or tests for drugs and alcohol are not considered genetic tests. Further, the Rule defines “manifestation” to include a disease or disorder that could be reasonably diagnosed by a healthcare professional with knowledge in a given field. According to HHS, this definition was drafted to prevent genetic information embedded in their records in making underwriting decisions, including segregating, if necessary, certain reports or records containing genetic information.

Exception for Long-Term Care Plans

Despite the intended broad scope of this prohibition, the Final Rule creates an exception for issuers of long-term care plans. In issuing the Final Rule, HHS took particular note of the importance in maintaining a strong market for the issuance of long-term care insurance.

The Final Rule also prohibits group health plans, health insurance issuers or issuers of Medicare supplemental policies from using or disclosing genetic information for underwriting purposes.

As a result, the Final Rule strikes a balance by permitting long-term care issuers to utilize genetic information in an underwriting capacity, while requiring them to be bound by the Privacy Rule such that genetic information will be protected from unauthorized and improper disclosures and uses.

Next month, our final part will focus on HIPAA Final Rule’s impact on business associates and those doing business with business associates.

Christina Anderson is an associate at Frost Brown Todd LLC in Columbus, Ohio. Thomas Anthony is a member at Frost Brown Todd LLC in Cincinnati, Ohio. Chad Eckhardt is an associate at Frost Brown Todd LLC in Cincinnati, Ohio. Charles Johnson is a member at Frost Brown Todd LLC in Charleston, WV.
The birth of BPAN

International team identifies new neurodegenerative disease.

By Cindy Sanders

“The more we learn, the more we realize how little we know.”
— R. Buckminster Fuller

While that particular version of the quote is attributed to American architect, systems engineer and poet Bucky Fuller, the sentiment behind it is one that has been expressed by men and women of discovery for centuries. Certainly that holds true for an international team that has identified a new neurodegenerative disease associated with iron accumulation in the basal ganglia located deep in the brain’s cerebral hemispheres.

“We are just scratching the surface here—we have a new disease,” said Sami I. Harik, MD, who was one of the researchers involved in identifying BPAN (beta-propeller protein associated neurodegeneration).

“We are just scratching the surface here—we have a new disease.”
— Sami I. Harik, former chairman, Department of Neurology, University of Arkansas for Medical Sciences

New Mutation

Neurodegeneration with brain iron accumulation (NBIA) has been recognized since the 1920s. Originally called Hallervorden-Spatz disease, it was later tied to a gene mutation affecting the protein pantothenate kinase 2 (PANK2). Other mutated genes were subsequently identified, most notably C19orf12 and PLA2G6. The common tie among the three is the accumulation of iron in the brain, hence NBIA, which results in developmental delays and neurological deterioration in movement and cognitive functions.

Now a newly discovered mutation in the WDR45 gene, located on the X chromosome, has been identified as a distinct entity of NBIA.

Harik, who served as chairman of the Department of Neurology at the University of Arkansas for Medical Sciences and continued on as a professor until his retirement in 2012, said the discovery came from studying MRI scans of patients, particularly pediatric patients, who were not achieving normal developmental milestones.

“Iron happens to give a characteristic appearance to the head MRI,” explained Harik. “You look and you see dark areas in the basal ganglia.”

With PKAN (pantothenate kinase-associated degeneration), he continued, “You get the so-called ‘eye of the tiger’ sign on the MRI. The dark area and in the center there’s a white area that is compatible with tissue necrosis.” In other entities of NBIA, he noted, “there is tissue iron accumulation but without necrosis.”

Female Predominance

Harik and other physician-scientists in Europe and America who were studying NBIA under the leadership of Susan J. Hayflick, MD, chair of the Department of Molecular and Medical Genetics at Oregon Health & Science University, would send blood samples from patients with NBIA to Hayflick.

She performed genetic and other biochemical studies on the samples and found a considerable fraction —30 to 40 patients—did not fit the known diagnostic gene abnormalities.

“In collaboration with the Institute of Human Genetics at the University of Munich in Germany, who performed exome sequencing on samples from these patients, in 20 of them, they described a definite gene mutation in the WDR45 gene located on the X chromosome,” said Harik.

Interestingly, of the 20 patients, 18 were women and two were men. Harik said there are various explanations as to why there is a female predominance in this form of NBIA.

“One reason might be that more pregnancies carrying a male fetus with the XY chromosome spontaneously abort if the WDR45 gene is defective. In the XX female fetus, it’s possible the healthy X chromosome provides some protection against fetal loss.

“In those born with BPAN, Harik explained, “This gene that is defective — WDR45 — encodes for the beta propeller protein.”

However, at this time researchers do not know of a link between this protein deficiency and brain iron accumulation. What is known so far is that the mutation doesn’t seem to be hereditary. Blood studies were run on siblings and parents without finding evidence of WDR45 gene mutations.

Neurological Symptoms

Those who present with BPAN have a number of neurological symptoms, often from very early childhood.

“Many believe this abnormality has a high penetrance, which means it is unlikely it will go unnoticed by an astute clinician,” Harik said.

However, there may be a major selection bias in those identified with BPAN by the researchers. All of them exhibited clear signs of developmental delay in childhood, with progression in adulthood with Parkinsonism, dystonia and dementia.

“These patients have hallmarks of neurodegeneration,” said Harik. “They don’t attain developmental milestones. Some of them did relatively well until...
Pay or play?

Healthcare insurance reform and the potential penalties to employers.

By Adam Shewmaker

On March 23, 2010, President Barack Obama signed into law The Patient Protection and Affordable Care Act (The Affordable Care Act), which put into place comprehensive reforms aimed at holding insurance companies more accountable, lowering healthcare costs, guaranteeing more healthcare choices and enhancing the quality of healthcare for all Americans. No matter your political views or personal opinions on the legislation, it is certain that numerous changes to impact the nation is scheduled to take effect in a matter of months. By January 1, 2014, all states are required to create Health Benefit Exchanges (HBEs) or utilize the HBE being developed by the federal government. These HBEs will serve as online market places where employers and individuals can compare health insurance policies, purchase health insurance coverage and determine if they qualify for certain subsidies and/or tax credits.

The Congressional Budget Office (CBO) recently forecasted that as many as 7 million Americans will receive their health insurance benefits through an exchange by the year 2022. The reason? Many employers may choose to pay the penalty and not continue to subsidize health insurance for its employees. This looming decision for employers is being characterized as either “pay or play” or “shared responsibility.”

Under this provision, large employers (defined as 50 or more full-time employees working an average of 30 hours per week) must decide whether they will offer healthcare coverage to their employees or pay the mandated penalty for not offering coverage. If the large employer decides not to offer coverage to its employees, and any of the employees receive a premium or cost-sharing credit through either the federal or applicable state exchange, the employer must pay a $2,000 penalty per year for each full-time employee, exclusive of the first 30 employees. This penalty is calculated on a monthly basis and is non-deductible to the employer on its applicable federal income tax return(s).

The penalty will be the lesser of the $340,000 calculated above OR $3,000 x 120 (subsidized employees) = $360,000, thus a $340,000 penalty.

Employer contribution: ($250/month x 12) x 80 full-time employees covered by the employer’s plan = $240,000

Total cost to employer not considering tax impacts = $340,000 + $240,000 = $580,000

As you can see, there are key strategic decisions that face many employers in the coming months.

As Kentucky’s Health Benefit Exchange progresses towards an open enrollment start date of October 1, 2013, employers will be crunching the numbers and assessing its competitive position in the market to determine which way it will turn at the “pay or play” fork in the road.

Adam Shewmaker is the associate director of healthcare consulting services at Dean Dorton Allen Ford.
CONGRATULATIONS!

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John Roberts, MD, University of Louisville School of Medicine
Kim Tharp-Barrie, DNP, Norton Healthcare
Louisville Water Company – The Louisville pure tap® program

The Hall Render Leadership in Healthcare Award
Diane Hague, Seven Counties Services
Dr. LaQuandra Nesbitt, Louisville Metro Public Health and Wellness
INCAPS (InterNational Center for Advanced Pharmacy Services) at Sullivan University College of Pharmacy

The Crowe Horwath Innovation Award
Asthmapolis
Cardiovascular Innovation Institute
John Carroll, Creative Strategies

The Seven Counties Services Healthcare Advocacy Award
Dr. Brooke Sweeney, UofL Physicians Healthy for Life! Pediatric Obesity Program
Dr. Goetz Kloecker with patient Nancy Alvey, James Graham Brown Cancer Center
Dr. Tad Seifert, Norton Healthcare

The Governor’s Dignity of Humanity Award
Hope Health Clinic
Hosparus, Inc.
Jewish Hospital & St. Mary’s Foundation and the Center for Health Equity
Virtual Primary Care Clinics in Powell and Wolfe Counties, Saint Joseph Health System, part of KentuckyOne Health

The Physician of the Year Award
Emma Birks, MD, Jewish Hospital
Dr. Anthony Dragun, James Graham Brown Cancer Center
Michael Marvin, MD, Jewish Hospital
Steven Hester, Norton Healthcare

The Consumer First Award
Crime Victim’s Services at ElderServe
Kosair Children’s Medical Center – Brownsboro
UK Arts in Healthcare

The Facility Design Award
The Cardiovascular Innovation Institute
Norton Hospital-Brownsboro
Renovation of Emergency Psychiatric Services Unit at University of Louisville Hospital
Obamacare’s broken promises to Kentucky

By Senator Mitch McConnell

A recent study published by the Society of Actuaries—the nation’s leading group of financial risk analysts, and as non-partisan a group as you will find—revealed that thanks to Obamacare, the costs of medical claims for Kentuckians next year would rise an average of 34 percent. With wages stagnant and gas and tuition prices skyrocketing, these premium increases will be especially devastating for middle-class families.

Liberal Democrats in Washington act as if this is surprising news. Three years after pushing the law through, Secretary of Health and Human Services Kathleen Sebelius grudgingly admitted that now, “there may be a higher cost associated with getting into that healthcare market.”

But Kentuckians aren’t surprised at all. It’s been obvious all along Obamacare would raise costs, cut jobs, grow the government and slow the economy. This new report is more proof that this law is failing to deliver on its promises—and that those of us who opposed it were right to be skeptical.

Kentuckians React

I’ve held 35 town halls at Kentucky hospitals and medical facilities over the past few years, and heard from thousands of Kentuckians about how this law will adversely affect them, their families and their livelihoods.

Jack, a small-business owner in Owensboro, wrote to me: “It is almost certain that my company that has an annual payroll in excess of $3 million and 212 employees in western Kentucky will surely close because we cannot afford the mandated insurance penalty.”

Bradford, the administrator of a nursing and rehabilitation center in Louisville, wrote that Obamacare, “will leave me no choice but to lay off additional workers so that I will be able to either purchase insurance for my remaining employees, or pay the penalty for not having a health insurance plan...[Obamacare] is a significant obstacle to maintaining the level of service to which our residents have been accustomed.”

And Junior Bridgeman, the former University of Louisville basketball player and current owner of more than 160 restaurant franchises across the country, wrote: “The law does not consider our ability to afford the mandate. Under our current labor model, [it] will increase labor costs whether we offer healthcare or pay the tax penalties... This creates, in essence, a disincentive to hire low income employees.”

How did so many Kentuckians grasp the simple truth that Obamacare would be disastrous to our economy, when the so-called experts in Washington did not? I think the difference is the common sense that comes from working in a business—as opposed to working in a bureaucracy.

No one thought our healthcare system was perfect, but many were concerned that Obamacare would undermine the things they did like about our healthcare system. No one thought our healthcare system was perfect, but many were concerned that Obamacare would undermine the things they did like about our healthcare system. These Kentuckians wanted reform, but they wanted the right reforms, not some grand scheme that increased our debt, expanded the government, raised premiums, killed jobs, and forced Americans off the plans they currently have and like. As predicted, however, the latter is just what they got.

The more we learn about Obamacare, the clearer it becomes that there is just no way to fix it. It costs way too much, and it’s not working the way its proponents said it would. If we have any hope of fixing the country’s healthcare system without crippling our economy in the process, Obamacare must be pulled out by its roots.

We only raise them to point out that there is still a better way.

Mitch McConnell (R) is a United States Senator from Kentucky and Senate Minority Leader.
The birth of BPAN

Continued from page 19

they were older and then because the basal ganglia is involved, they had basal ganglia dysfunction which manifests as a movement disorder.”

What isn’t known is whether or not there might be those with a mutated WDR45 gene who have a milder form of the disease or even no visible symptoms.

Next Steps

The next step is to catalogue the clinical manifestations of the disease. There seems to be considerable variations amongst patients. Particularly with women who have two X chromosomes.

“There is a process in the body where one X chromosome is activated and the other is suppressed. There may be variations in how much the diseased X is expressed,” said Harik.

Ultimately, of course, researchers will hope to one day understand the mutation and find a way to reverse its effects.

Harik concluded, “There’s a lot of work to be done. Every time you discover a new thing, you discover just how much you didn’t know.”
Qualified personnel are available in these fields:
• Clinical Assistant
• Clinical Laboratory Assistant
• Health Unit Coordinator*
• Healthcare Reimbursement Specialist
• Invasive Cardiovascular Technology*
• Limited Medical Radiography
• Massage Therapy
• Medical Administrative Assistant*
• Medical Administrative Management
• Medical Assistant
• Medical Clinical Specialties
• Medical Coding Specialist
• Medical Laboratory Technician
• Medical Massage Therapy
• Medical Transcriptionist
• Nursing*
• Ophthalmic Assistant*
• Personal Trainer
• Phlebotomy
• Radiologic Technology
• Respiratory Therapy*
• Surgical Technology*

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