Cannabis in the clinic

Lawmakers spark medical marijuana debate.

By Kenny Colston

After being laughed off for years, a push to legalize marijuana for medical purposes is gaining traction in Kentucky.

Both of Kentucky’s legislative chambers had committee hearings on the topic. And the chairman of the Kentucky House Health and Welfare committee, Tom Burch, a Democrat from Louisville, has said he strongly supports it.

But neither chamber has held a vote on a medical marijuana bill, and one hasn’t even been filed in the House to be voted on. Still, this is the first year the issue has been heard, legitimately, in Kentucky.

States Passing Laws

According to the Drug Policy Alliance (DPA), 20 states and the District of Columbia have passed laws allowing marijuana use for medical purposes. The DPA helped pass laws in nine of those states and advocates for ending the federal ban on medical marijuana. The alliance argues marijuana helps treat the symptoms of cancer, AIDS and other serious illnesses.

The debate in Kentucky comes on the heels of full legalization of marijuana by Washington and Colorado. The latter reportedly saw more than $5 million in sales for companies in five days of fully legalizing the drug. Washington’s legalization law has yet to go into effect.

Kentucky’s Argument

In Kentucky, parents of children with epilepsy have testified in both the House and Senate health committees in support of legalizing marijuana for medical use, saying the drug helps their children stop having frequent seizures.

Burch said he’s in favor of the drug after hearing from constituents who said marijuana helps with their arthritis.

A Kentucky Health Issues poll, funded by the Foundation for a Healthy Kentucky, found 78 percent of Kentucky adults favored legalization of marijuana for medical use in 2012. A 2013 Courier-Journal poll showed 60 percent favor it.

Opposition to Legalization

But several influential figures still remain opposed to legalization. Governor Steve Beshear, Attorney General Jack Conway and the Kentucky State Police oppose legalization, even for medical use.

A potential compromise has arisen in legalizing the use of cannabis oil in Kentucky, which apparently doesn’t have any of marijuana’s more psychotic side effects, but supporters of legalization have yet to resort to that compromise.

Gaining Traction With Neighbors

Many of Kentucky’s neighboring states are also strongly considering legalizing marijuana for medical use. Supporters in Illinois, Tennessee and Georgia remain optimistic of passage in their states.

Louisiana Governor Bobby Jindal also said legalization of marijuana for medical uses would be acceptable in his state.

And while the issue is gaining traction, it’s uncertain whether an actual bill, filed again by State Sen. Perry Clark, a Louisville Democrat, can advance, especially during a budget session in Kentucky.

While Clark’s bill did receive a hearing in the Senate’s health committee, the bill is actually assigned to the judiciary committee, giving it an uphill climb in the Republican-controlled Senate.

And House leaders, including Burch, have said they are unsure if a medical marijuana bill will be filed in the House.

Jobs for hire

Policy experts at the national level differ over whether there is a shortage of physicians in this country. Many fear that the need for physicians will become acute as more people obtain insurance, and baby boomer physicians like me hang up our stethoscopes and move into retirement.

Calling Kentucky home

This year, positive strides have been made to improve the provision of patient care that is rendered by PAs in Kentucky. And yet, young PAs continue to leave our state after being educated here because Kentucky’s practice laws are more restrictive than those in other states.

Six big changes shaking up healthcare

Working in healthcare today can feel like being adrift in uncharted, highly treacherous waters. Thanks to health reform and other disruptive forces, it’s hard to know what lies over the horizon. It’s tough to predict and plan for next month, let alone next year. Whether you’re a leader or a staff member, this uncertainty generates massive stress.

Workforce development

For the first time Medical News is taking a closer look at workforce development issues. First, we discover how Methodist Hospital tackled healthcare reform with cutting-edge patient education initiatives.

Then we show how using predictive analytics to forecast volume helps managers better align staff resources. We also look into the nation’s first BSN-to-DNP option, and what your employees need to know about preventing workplace violence.

Further, we take an in-depth look at why the U.S. workforce is projected to increase and healthcare jobs top the list of growing occupations. Locally, how does that effect our jobs? Read on and we’ll tell you.

Serving Kentucky and Southern Indiana

Articles begin on page 9
Ensuring an educated workforce

One of the many pleasures that I have with my job is talking with all of the healthcare companies and organizations in Kentucky. While it is always interesting to learn about projects they are working on, innovations they are exploring and ways they are working to improve the delivery of care, one constant negative is always expressed: the need for an improved workforce.

Covering workforce development in Medical News is always an important topic, especially as the healthcare industry continues to improve and evolve. It is no secret that healthcare delivery is only as good as the people providing the care. This covers the full spectrum of the healthcare system from techs to the most specialized physicians.

Our universities, colleges and technical institutions play an important role in ensuring we have the best trained personnel to provide quality care for our patients. These institutions not only provide the latest in training for those about to enter the workforce, but they also provide retraining opportunities for those interested in improving their skills. It is important that we continue to support these vital programs.

However, we must also remember that tomorrow’s workforce (and those that will be taking care of me when I am older) are today’s primary school students. It is equally important (if not more important) that we provide adequate support for our elementary, middle and high schools to provide a solid footing for the next generation of healthcare employees. Not only should we continue to push a STEM-focused curriculum, but we need to better help our students understand what career options are available to them as they progress.

Our aging population will only continue to grow and get more complex. I hope this issue of Medical News will help us start the conversation about how we ensure that our healthcare system and its workforce grow to support it.

Sincerely yours,

Letter from the publisher

Thoughts from the healthcare community

Kathie McClure @HITECHMcClure
Breach Notice Law intro’d in KY, one of handful of states w/o a consumer data breach notice law @WyattHITECHLaw bit.ly/1k8Gdr6.

Health E. Network @HealthENetwork
Welcome to our newest Base Investor, Centric Consulting!
To learn more, visit bit.ly/1exrtg1 @centric.

McBrayer Law Firm @McBrayer_Law
The Sun is Not Setting on the #EHR Safe Harbor, bit.ly/1k8Gdr6 #healthcare #EHRsystems.

Foundation4HealthyKy @healthky
New Ky Health Issues Poll (KHIP): awareness of kynect & support for Medicaid expansion: bit.ly/18r1876 #healthky @kynectky.

Adam Caswell @nkybachamheradam
And SB5 passes Committee. First step towards healing heroin epidemic. Thx to @kyoag @RepJohnTilley Sen Stine @hcooperNKY @StElizabethNKY.

Kindred Healthcare @kindredhealth
3 year medical school programs attracting students: bit.ly/ImH1IYX. Read more #HealthcareHeadlines: bit.ly/ImH1Iep.

NAMI Lexington (KY) @NAMLexington
#bipolardisorder #FACT Bipolar disorder is a real, treatable illness that affects the brain. There’s no “snapping out of it.”
We’ve got great news for your uninsured patients.

Now everyone can afford the healthcare coverage they need.

You know that covered patients are healthier patients. And now, kynect, Kentucky’s Healthcare Connection, is making that a reality for everyone. From now on, no one has to choose between medical care and other necessities. Even better, kynect will make wellness and preventive care a priority. So you can deliver the highest quality of care and better outcomes for all of us. Help your patients take the first step and let them know how easy it is to enroll.

Kynect.ky.gov  1-855-4kynect
AAMC releases new physician workforce state data

While there were small increases in the median number of active physicians and median number of students enrolled in medical school by state relative to the U.S. population between 2008 and 2012, the number of students enrolled in graduate medical education per 100,000 people has remained flat, according to new data released by the AAMC (Association of American Medical Colleges).

During this time period, the ratio of active physicians per 100,000 people in the United States increased from 254.5 to 260.5. Students enrolled in medical schools (MD and DO programs) grew from 91,474 to 102,498, but the number of students in graduate medical education positions remained relatively stagnant (moving from 35.7 to 36.6 per 100,000 people).

New conference highlights practice administrators

Practice administrators, executives, speakers and other visionaries will convene in Orlando, Fla., on March 23 with their eyes on the future of healthcare delivery at the MGMA Business of Care Delivery Conference.

The conference will be preceded by a one-day program for OB/GYN clinical and administrative teams as well as those interested in patient-centered medical homes (PCMHs). Other conference highlights include:

- “Utilizing Population Health Data,” with John Studebaker, MD, chief medical informatics officer, ForwardHealth Group, Madison, Wis.
- “Case Study in Transforming Your Practice to Improve Coordination and Access,” with Jennifer Savage, director of contracting, payer relations, and credentialing, Physician Associates LLC, Altamonte Springs, Fla.
- “Coloring Outside the Lines,” with Jeff Tobe, CSP, primary colorer, Coloring Outside the Lines.

Better performers conduct patient-satisfaction surveys

Almost 80 percent of medical practices deemed “better-performers” by the Englewood, Colo.-based MGMA Performance and Practices of Successful Medical Groups: 2013 Report Based on 2012 Data indicated they used patient-satisfaction surveys. Compared with other practices, better-performers were more likely to assess patient satisfaction in their practice and did so more frequently.

Practices conducted satisfaction surveys to gauge, among other things, their patients’ overall experience, professionalism of the staff, availability of appointments and quality of care. More than half of better-performing medical practices indicated they used patient-satisfaction surveys to evaluate and improve practice operations and educate staff and physicians about behavior.

Almost 10 percent of better-performing practices cited using patient-satisfaction survey results as “part of physician compensation formula.”

In June, MGMA released the Physician Compensation Survey Report and results indicated that quality and patient-satisfaction measures appeared to be a small yet emerging component of total compensation for physicians.
UK College of Medicine establishes new laboratory

The University of Kentucky College of Medicine recently established a small molecule mass spectrometry facility. The addition of this facility to the analytical toolbox within the college provides analytical capabilities that are essential for research that will ultimately improve the understanding, diagnosis and treatment of human disease. The facility is directed by Andrew J. Morris and staffed by Manjula Sunkara and Sony Soman.

UofL one of nine pilot sites for pulmonary fibrosis research, treatment

The University of Louisville is one of nine pilot sites selected by the Pulmonary Fibrosis Foundation (PFF) for its newly established Care Center Network and the PFF Patient Registry program. Rafael Perez, MD, director of the UofL Intersitial Lung Disease (ILD) program in the division of pulmonary, critical care and sleep disorders medicine, will lead the UofL site.

Sites were selected because of their expertise in pulmonary fibrosis patient care and research. In the network with UofL are the University of California, San Francisco, University of Chicago, University of Michigan, National Jewish Health, University of Pittsburgh, Vanderbilt University, University of Washington and Yale University.

The PFF Care Center Network will provide a standardized, multidisciplinary approach to patient care. This model of comprehensive patient care will help identify and establish best practices, determine the impact of specific interventions and improve the quality of life of patients. The Care Center Network will expand to eventually include 40 medical centers by 2015.

The PFF Patient Registry is planned to be the largest database of PF patient records with the furthest demographic reach in the country. It will provide data essential for improving the understanding of the epidemiology, incidence, prevalence, natural history and other clinical characteristics of PF. The registry will use consistent data-gathering methodology so that the information obtained will be useful to all clinicians and researchers seeking to better understand the disease and develop new therapies for PF.

Passport Health Plan contracted with St. Elizabeth Healthcare, ARH

Passport Health Plan contracted with St. Elizabeth Healthcare in northern Kentucky to provide health-care services to members of Passport Health Plan. St. Elizabeth Healthcare, including more than 1,200 physicians with admitting privileges, provides care for approximately 300,000 residents in northern Kentucky.

In addition, Passport Health Plan has also contracted with Appalachian Regional Healthcare (ARH) to provide services to members of Passport Health Plan. Appalachian Regional Healthcare, includes eight hospitals in Kentucky, two hospitals in West Virginia, 600 physicians, home health agencies, HomeCare Stores and retail pharmacies, and provides care for approximately 350,000 residents. ARH is the largest private employer in southeastern Kentucky.

Passport Health Plan is a provider-sponsored, nonprofit, community-based Medicaid health plan that has been contracted with the Cabinet for Health and Family Services to administer Medicaid benefits for 128,500 people in 16 Kentucky counties since 1997.

Beginning in 2014, the Plan will expand its operations to administer Medicaid benefits throughout the Commonwealth of Kentucky.

Event calendar

Let’s Have a Ball
Younger Woman’s Club of Louisville Annual Ball

Date: Saturday, February 8
Time: 8 p.m. to 12 a.m.
Where: The Foundry at Glassworks, 815 West Market St., Suite 200 Louisville, Ky., 40202
Info: The YWC Charity Ball is the signature fundraiser for the YWC Charity Campaign. It includes heavy hors d’oeuvres, an open bar and a silent auction with all proceeds benefiting the YWC Charity Campaign. Last year, YWC raised more than $60,000 and allocated grants to 17 local nonprofits. Musical entertainment will be provided by KUDMANI.

One of the highlights of the ball includes the presentation of the Citizen Laureate Award, given to an individual who embodies the essence of volunteerism. The 2014 honoree is WAVE 3 News personality Dawne Gee.
To register: Tickets are $75 (individual), VIP tickets with exclusive seating are $1,250 per table of 10. For more information visit ywclouisville.org or contact Sarah Ritter Mitchell at (502) 741-1780 or srmitc03@louisville.edu.

Baptist Health Paducah Brunch Bunch

Date: Tuesday, February 25
Time: 11 a.m. to noon
Where: Baptist Health Paducah, 2501 Kentucky Ave., Paducah, Ky., 42003, Heart Center Auditorium
Info: Speakers will be cardiothoracic surgeon Nicholas Lopez, MD, and cardiologist Kenneth Ford, MD.
To register: Call (270) 575-2851 for more information.

An Evening with Martha Gulati, MD

Date: Wednesday, February 26
Time: 6 to 8 p.m.
Where: The Olmsted, 3701 Frankfort Ave., Louisville, Ky., 40205
Info: Dr. Gulati will speak about fitness, heart disease prevention and the effects of stress on the heart. She has been featured on Oprah, the Today show and in O, The Oprah Magazine and Fitness Magazine.
To register: Visit nortonhealthcare.com/goconfidently.

Recognizing Kentucky’s outstanding senior volunteers

Salute to Senior Service, sponsored by Home Instead, recognizes the invaluable contributions of adults age 65 and older who give at least 15 hours a month of volunteer service to their favorite causes.

Members of the community are asked to nominate and vote for these everyday heroes between January 15, 2014 and March 1, 2014. To complete and submit an online nomination form for a senior age 65 or older who volunteers at least 15 hours a month and to view the contest's official rules, visit salutetoseniorservice.com.
Meet: David M. Mannino, MD, chair, the department of preventive medicine and environmental health at the UK College of Public Health and professor of medicine in the division of pulmonary, critical care and sleep medicine

Place of Employment:
University of Kentucky, Lexington

Why did you become a doctor?
When I was 10, I fell off my bike and broke my arm. That was my first real interaction with a doctor in the emergency room. I thought it was really cool, and that experience put the idea in my brain. In junior high and high school I really enjoyed biology, physics and chemistry, and I gravitated toward the field of medicine.

Is being a doctor different than you thought? How?
Yes, things have changed a great deal over the past 35 years.

With the information explosion the entire world has changed. Now patients have more education on virtually every topic because of the Internet. They can plug in symptoms to find a possible diagnosis. But at the same time there is a lot of misinformation, which is a challenge.

What is the biggest misconception about your field?
Doctors today are working for someone else—a university or the government. We also face the challenge of dealing with insurers. In the old days if you wanted to order a prescription there was no problem. Now, you have to get permission. I can understand the rationale—some providers were abusing the system, which is inappropriate.

The flip-side, however, is that today decisions are being made by people who really have no qualifications when it comes to getting something certified. Someone with no more than a high school education is deciding that my patient doesn’t qualify for a CAT scan, for example. I then have to jump through hoops to reverse that decision.

It gobbles up my time, particularly in the respiratory world when dealing with pain management and drug formularies. I’ve had a patient who suddenly doesn’t qualify for a pain medication he’s been taking for years. This is happening more and more.

What is the one thing you wish patients knew and/or understood about doctors?
Like everyone, we work very hard, often with minimal reward. We have our good days and bad days. The bad days happen when working in a hospital, and old and young patients alike are dying, and you can’t do anything about it. That’s the reality of being a doctor—patients die.

As an outpatient physician there are days when you feel like there’s not a whole lot you can do to help patients. This can be frustrating. Also, there are frustrations of dealing with insurance companies, dealing with the hospital’s electronic medical record (EMR) system and miscommunications with the hospital employees.

When everything goes as planned, patients show up on time, everybody is doing what they’re supposed to be doing, and the EMR is working, making it easier to find things—those are the good days.

How did COPD become such an important part of your career?
My first patient as a med student in 1979 had a lung disease, which sparked my fascination with respiratory disease. I had an opportunity after doing my residency in internal medicine to do a fellowship in pulmonary. I was and still am interested in the whole gamut of respiratory disease.

It’s an area that covers so many things, tobacco as the number one cause of death in those with COPD, environmental health, infectious disease. As a sub-specialty it covers a wide range of different career opportunities than what you see in other fields.

What is the one thing your colleagues would be surprised to learn about you?
I still play racquetball two to three days a week.

What’s the best advice you ever received? Who gave it to you?
My father told me to “aim high.” He didn’t have a great deal of education, but he was street smart and always very supportive.

I have aimed high. At the same time my career has taken many twists and turns and to unexpected places. This has often been true in my career.

For instance, I was working as an epidemiologist in respiratory disease at the Center for Disease Control when interest in that topic got very hot in the early 1990s. And then interest in COPD took off in 2003.

What’s the last good book you read?
Good to Great: Why Some Companies Make the Leap...And Others Don’t (HarperBusiness, 2001) by Jim Collins.

Favorite daytime beverage?
Coffee

Know a physician who deserves a chance in the spotlight?
Email: melanie@igemedia.com and find out how you or someone you know can be considered for an upcoming Physician Spotlight profile.
Now do even more with Cash Flow Insight powered by PNC CFO – an innovative online financial management experience.

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- Manage and automate your invoicing and bill payments, all in one place
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Economic impact of Greater Cincinnati hospitals totals more than $17.5 billion

The daily operations of 31 of Greater Cincinnati's hospitals and their affiliated facilities resulted in a multi-billion dollar boost to the tristate economy in 2012. According to a study released by the Greater Cincinnati Health Council, the economic impact attributed to these hospitals in 2012 totaled $17.53 billion. This figure represents a 13.9 percent increase in inflation-adjusted dollars since 2007, the last time the study was commissioned.

The report, prepared by the University of Cincinnati's Economics Center, finds that tristate hospitals and their affiliated facilities contribute to the region's economy in a myriad of ways:

- Economic impacts from combined spending on operations (including employee wages) and capital expenditures amount to $17.53 billion annually.
- The total impact on employment in Greater Cincinnati is 137,596 jobs, representing an 8.1 percent increase from 127,229 jobs in 2007.
- The hospitals and their affiliated facilities employed a total of 62,875 people as of 2012, making it one of the largest industries in the region and representing a 21.4 percent increase from 51,802 jobs in 2007. Overall, this workforce represents about one out of every 17 jobs in Greater Cincinnati, and hospitals contributed to job growth in the tristate over the last five years despite the economic climate.
- Nearly nine percent of all patient healthcare revenue is generated from patients coming from outside of Greater Cincinnati, which translates to over $1 billion in economic impact generated from new money outside the tristate region. Those who come from a distance generally need a larger amount of healthcare, requiring larger proportions of surgery and inpatient care.
- The study also shows that hospitals continue to provide immense community benefits, both for its employees and also for the community as a whole.
- One new area highlighted in the study includes a recent effort by hospitals to increase the proportion of its purchases from vendors who are women or minority-owned business enterprises (W/MBEs). In total, hospitals reported $168 million in W/MBE purchases in 2012.

The full Economic Impact Report can be found online at: gchc.org/economic-impact-of-greater-cincinnati-hospitals-totals-more-than-17-5-billion/

Nursing professor recognized for research and service

Frances Hardin-Fanning, assistant professor at the University of Kentucky College of Nursing, received the 2013 American Public Health Association (APHA) New Investigator Award for Public Health Nursing at the association’s annual conference. Her research interests include behavioral and environmental strategies aimed at improving dietary habits among rural Appalachian residents who have difficulty accessing healthy food.

Hardin-Fanning also accepted the 2013 Spirit of Philanthropy Award for the Delta Phi Chapter of Sigma Theta Tau International Nursing Honor Society at the international conference in Indianapolis.

Test indicates cervical cancer

Researchers at the University of Louisville confirmed that using the heat profile from a person's blood, called a plasma thermogram, can serve as an indicator for the presence or absence of cervical cancer, including the stage of cancer.

The team, led by Nichola Garbett, PhD, published its findings online in PLOS ONE (dx.plos.org/10.1371/journal.pone.0084710).

To generate a plasma thermogram, a blood plasma sample is "melted" producing a unique signature indicating a person's health status. This signature represents the major proteins in blood plasma, measured by Differential Scanning Calorimetry (DSC). The team, which includes Brad Chaires, PhD, Ben Jenson, PhD, William Helm, MD, Michael Merchant, PhD, and Jon Klein, MD, PhD, from the University of Louisville School of Medicine, have demonstrated that the plasma thermogram profile varies when a person has or does not have the disease.

The team believes that molecules associated with the presence of disease, called biomarkers, can affect the thermogram of someone with cervical disease. They used mass spectrometry to show that biomarkers associated with cervical cancer existed in the plasma.

The University of Louisville researchers see great promise for their technique being able to detect and monitor in a range of other cancers and diseases.

The test is non-invasive and requires only a simple blood draw. The test has shown great promise as a prognostic indicator of disease, allowing physicians to monitor cancer patients more closely for remission, response-to-therapy and recurrence.

Passport Health Plan/AHA fights heart disease within religious communities

The American Heart Association and Passport Health Plan have partnered together to promote heart-healthy lifestyle changes among Kentucky's faith-based communities. Named "Have Faith in Heart," this program will raise awareness of heart disease and stroke in African American and Hispanic communities, which are at a higher risk of high blood pressure, heart disease and stroke.

Have Faith in Heart will launch at selected churches with one-day celebrations that will include free heart screenings, hands-only CPR training, and health insurance information assistance. Program participants will be matched with volunteer mentors and given resources to help them reach their blood pressure goals. As part of the free program, participants can check their blood pressure regularly and attend free monthly workshops to learn how to live a heart-healthy lifestyle. Mentors will monitor their results.
Healthcare dominates

The U.S. workforce is projected to increase and healthcare jobs top the list of fastest growing occupations.

By Melanie Wolkoff Wachsman

Job growth in the United States from 2013 through 2017 is projected to grow at a rate slightly faster than the preceding post-recession years. But for certain occupations and metropolitan areas, that outlook is much brighter. According to a report by CareerBuilder and Economic Modeling Specialists International (EMSI) the U.S. workforce is projected to grow 4.4 percent from 2013 to 2017.

The strongest projected growth is found in occupations supporting the healthcare industry. Of the 50 fastest growing occupations, 26 are in medical, allied health or health-related roles. The occupations range from low-skill personal care roles to high-skill jobs like occupational therapy or biomedical engineering.

The top five fastest growing occupations include personal care aides, home health aides, market research analysts and marketing specialists, medical secretaries and emergency medical techs and paramedics. The two list toppers—personal care aides and home health aides—are projected to add nearly a half million jobs through 2017 and are gaining prominence as the population ages.

Several fast-growing healthcare occupations fall within the medium-wage category. These include medical secretaries, emergency medical technicians, medical assistants and pharmacy technicians. The one high-wage exception is registered nurses, which expect to gain more than a quarter of a million jobs by 2017.

According to the report, looking only at the fastest-growing jobs requiring a bachelor’s degree or higher, it appears workers in allied health and other healthcare occupations are the clear winners. Topping the list is biomedical engineers, an occupation critical to the development of new medicines and the overall effectiveness of patient care. It is joined by medical scientists, biochemists and biophysicists, physical therapist and occupational therapists.

Local Outlooks

The projected job outlook looks favorable for Kentuckiana, thanks in part to the ACA.

“Occupational demand in healthcare is primarily driven by demand for services.”
— Jason Lovelace, president of CareerBuilder’s healthcare division

“We are also heavily recruiting nursing positions throughout the organization as well as surgical technicians.”
— Kayla Williams, allied health/nurse recruiter, human resources, Floyd Memorial Hospital and Health Service

Continued on page 10
Healthcare dominates

More good news for Louisville Metro is that CareerBuilder and EMSI’s analysis lists Louisville/Jefferson County eighth in terms of metros with the highest share of high-wage jobs at 47 percent.

Rounding out the top are Washington-Arlington-Alexandria (58 percent), Seattle-Tacoma-Bellevue (54 percent), Boston-Cambridge-Quincy (50 percent), Baltimore-Towson (50 percent), Kansas City (49 percent), San Jose-Sunnyvale-Santa Clara (49 percent) and Hartford-West Hartford-East Hartford (48 percent).

Where are the Jobs?

The top healthcare occupations at Floyd Memorial Hospital and Health Services range from entry-level to professional positions. “Some of the top healthcare occupations we are currently recruiting for are entry-level such as positions in food and nutrition and environmental services,” said Kayla Williams, allied health/nurse recruiter, human resources, Floyd Memorial Hospital and Health Services, New Albany, Ind. “We are also heavily recruiting nursing positions throughout the organization as well as surgical technicians.”

Occupations Williams expects to see in high demand over the next few years will include nursing positions as well as medical technologists since, Williams said, “A large percentage of our associates in these positions plan to retire or are thinking about retirement.”

Steven Rudolf, vice president, human resources, Baptist Health Louisville, has also seen a rise in retirements and, consequently, projects an increasing need for hiring staff within areas such as laboratory (med techs), nursing (staff RNs) and surgery (OR nurses) as employees begin to retire.

= John Elliott, vice president of human resources, University of Louisville Physicians

“We also anticipate hiring more mid-level practitioners (APRNs/NPs/PAs) as we move to serve the increasing needs of our patient population and to help offset potential shortages in the availability of primary care physicians.”

— Steven Rudolf, vice president, human resources, Baptist Health Louisville

Why the need for workers?

Whether there exists immediate positions to fill or positions on the horizon for human resource professionals, putting the right healthcare worker in the right role is paramount.

“The shortage of healthcare workers has been an issue, is currently an issue and is expected to continue to be an issue. This is true for physicians, nurse practitioners, physician assistants, pharmacists and many other jobs,” said John Elliott, vice president of human resources, University of Louisville Physicians.

“That is because there has been a static production of highly skilled healthcare workers, while demand for healthcare services continues to escalate. We have a growing aging population, plus we as an overall population often don’t take good care of our health, and that helps drive the demand for more healthcare services.”

Lovace views the prospective job increase as a positive. “This a great time to enter the industry. With so many jobs in the field growing exponentially faster than average, there’s a real opportunity for students and workers of all ages to develop a high-paying career in healthcare — whether it’s in a support role, a specialty, nursing or general practice,” he said.

Only time will tell if Kentucky has the manpower to fill the projected healthcare jobs. It looks like the jobs will be there, waiting, and so will the patients.

**Kentucky Healthcare Projections**

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<th>Position</th>
<th>New Jobs</th>
<th>% Change</th>
<th>Avg. Hourly Earnings</th>
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<td>Physical Therapists</td>
<td>403</td>
<td>16%</td>
<td>$39.24</td>
</tr>
<tr>
<td>Family and General Practitioners</td>
<td>206</td>
<td>16%</td>
<td>$83.72</td>
</tr>
<tr>
<td>Skincare Specialists</td>
<td>78</td>
<td>15%</td>
<td>$11.08</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>134</td>
<td>15%</td>
<td>$48.34</td>
</tr>
<tr>
<td>Medical Scientists, Except Epidemiologists</td>
<td>119</td>
<td>15%</td>
<td>$24.81</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>1,077</td>
<td>14%</td>
<td>$13.06</td>
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<tr>
<td>Healthcare Social Workers</td>
<td>208</td>
<td>14%</td>
<td>$21.50</td>
</tr>
<tr>
<td>Pediatricians, General</td>
<td>65</td>
<td>14%</td>
<td>$80.43</td>
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<tr>
<td>Health Educators</td>
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<td>14%</td>
<td>$20.94</td>
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<tr>
<td>Nurse Practitioners</td>
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<td>14%</td>
<td>$40.85</td>
</tr>
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<td>Pharmacy Technicians</td>
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</tr>
<tr>
<td>Internists, General</td>
<td>95</td>
<td>13%</td>
<td>$93.12</td>
</tr>
</tbody>
</table>

EMSI occupation employment data are based on final EMSI industry data and final EMSI staffing patterns. Wage estimates are based on Occupational Employment Statistics (QCEW and Non-QCEW Employees classes of worker) and the American Community Survey (Self-Employed and Extended Proprietors). Occupational wage estimates also affected by county-level EMSI earnings by industry.

**Special Note:**

At a growth rate of 10%, Registered Nurses will add the most jobs of any occupation in Kentucky over this timeframe (4,222).
BSN-to-DNP

Nation’s first DNP option takes nursing development another step forward.

By Maggie Roetker

In a world of medical provider shortages and shifts in care delivery, a new program between Norton Healthcare in Louisville, and the University of Kentucky College of Nursing in Lexington, Ky., is offering a solution. The bachelor of science in nursing to doctor of nursing practice (BSN-to-DNP) option offered by the Norton Healthcare Institute for Nursing through the University of Kentucky College of Nursing allows nurses with a bachelor’s degree in nursing the opportunity to earn their doctor of nursing practice (DNP) degree and sit for certification as an advanced practice registered nurse (APRN), also called a nurse practitioner, in three years.

“The nation’s first DNP program will begin studies in January 2014. Those who apply for the program must have a BSN and three years of service at Norton Healthcare. They will be selected through a rigorous interview process. Once selected, they will need to work full time at a Norton Healthcare location while attending school full time.

“In an ever-changing world of healthcare, there is a shortage of providers to deliver care to patients,” said Kim Tharp-Barrie, DNP, SANE, system vice president, Norton Healthcare Institute for Nursing and Outreach. “Providers with a DNP will be able to help support our physicians and provide extended care to patients.”

— Maggie Roetker is director of public relations, Norton Healthcare.

Advancement of Nurse Education Needed

A 2010 report from the Institute of Medicine urged the advancement of nurse education to assist with increased demand for healthcare services, specifically with primary care providers, which will come as a result of the Affordable Care Act (ACA).

The Norton Healthcare program calls for 150 DNP-prepared APRNs to be added in the next few years to serve Norton Healthcare patients through new opportunities in its facilities and physician practices.

“This program is part of our vision for nursing and is an important component for the National League for Nursing guidelines and our designation as a Center of Excellence in nursing education,” said Tracy E. Williams, DNP, senior vice president and system chief nursing officer at Norton Healthcare. “I know from experience that it can be very difficult for a nurse to go out on his or her own and attain this advanced degree. With this new program, Norton Healthcare will provide support to program participants through tuition assistance, mentors, clinical rotation within the system and classes offered on-site and online.”

First Cohort

The first cohort will begin studies in January 2014. Those who apply for the program must have a BSN and three years of service at Norton Healthcare. They will be selected through a rigorous interview process. Once selected, they will need to work full time at a Norton Healthcare location while attending school full time.

“In an ever-changing world of healthcare, there is a shortage of providers to deliver care to patients,” said Kim Tharp-Barrie, DNP, SANE, system vice president, Norton Healthcare Institute for Nursing and Outreach. “Providers with a DNP will be able to help support our physicians and provide extended care to patients.”

— Maggie Roetker is director of public relations, Norton Healthcare.
Six big changes shaking up healthcare

And four “constants” that will help us weather the storm.

By Quint Studer

Working in healthcare today can feel like being adrift in uncharted, highly treacherous waters. Thanks to health reform and other disruptive forces, it’s hard to know what lies over the horizon. It’s tough to predict and plan for next month, let alone next year. Whether you’re a leader or a staff member, this uncertainty generates massive stress.

We have to get better at providing quality care, but the good news is healthcare professionals already want to do that. The solution is to create organizational cultures that harness and maximize that hunger for continuous improvement. When people have the right structure and the right tactics, they can create miracles.

But first let’s identify six big changes that are shaking up our industry—as well as four “constants” that will bring us safely through to the other side.

The Six Big Changes

CHANGE #1: The nature of change itself has changed. The most profound challenge healthcare organizations have had to deal with—and the one that’s requiring the biggest adjustment—is the industry’s move from episodic change to continuous change.

Think about the annual budget process. This has always been a tedious and grueling process. But in the past, when the budget was done, the organization had a good, solid 12-month game plan in place. Today that 12-month game plan can actually change very early in the new fiscal year. Payments may change, volume may not be what was projected or expected, or supply costs may be higher than what was anticipated. In essence, a budget is now just a guideline that requires continuous monitoring and change.

Another great example is how Joint Commission visits are handled. In the past, The Joint Commission would tell a hospital or health system that they were coming to visit. To ready themselves for the visit, the organization would prepare rigorously by testing knowledge, auditing processes, checking records, and so forth to ensure compliance. This is episodic change. Now, The Joint Commission will show up unannounced, so an organization is expected to be ready. We’ve been forced to move to a state of continuous readiness. This is a good change, but it is stressful and hard to accomplish.

CHANGE #2: New rules are disrupting the external environment. Although uncomfortable, disruption is a very effective way to force change. One can disrupt the environment—via a new invention, a new technique, a new tool—in a way that completely challenges the status quo and causes us to rethink and start over.

Reimbursement has been—and remains—the biggest change. As healthcare expenditures grow, they consume an ever-increasing portion of the U.S. gross national product. In fact, if they continue to escalate, healthcare costs would eventually become the entire GNP. This cannot be allowed to happen—thus, we are seeing disruption through a drastic change in what Centers for Medicare and Medicaid Services (CMS) will pay for as well as the amount it will reimburse healthcare providers.

Healthcare providers now have a more complete understanding of reimbursement changes and an understanding of what must happen. We now know that winning healthcare organizations are able to achieve higher quality with lower costs.

CHANGE #3: Healthcare technology is making what was once impossible possible. The healthcare industry is a hornet of innovation. Right now reimbursement changes are driving an explosion of technology and applications that will help us manage our own health, as well as allow others to look at the state of our health, even from a distance.

CHANGE #4: Transparency is driving accountability. Today, I can get on my computer and go to the medicare.gov or cms.gov web sites to find out how well a hospital manages pain or what core clinical outcomes look like.

Anyone can go to the Hospital Compare web site (medicare.gov/hospitalcompare) to look at the metrics of various hospitals. Within minutes one can find a “snapshot” of the quality of hospitals in an area and across the nation by looking at how they rate on timely and effective care, re-admissions, complications and deaths, use of medical imaging, survey of patients’ experiences, number of Medicare patients, and information about how much Medicare pays hospitals. This is transparency.

The more engaged the employee is, the better the patient safety and the better the success in process improvement. This means less rework and fewer work-arounds. Other research shows the more objective a leader evaluation tool, the better the patient experience. In the past we wouldn’t have been able to prove many of these connections.

CHANGE #6: There’s a big push for integration. In this case, integration means efforts to put as many providers on a single asset sheet as possible. Trying to get everyone on the same page and the same team, either through an employment contract or some type of agreement, is a drastic change and one that takes time.

...and the Four Core Constants

CONSTANT #1: Passion. Passion is demonstrated and lived out each and every day by healthcare providers. You see it in the nurse who clocks out but stays to sit with an ill patient. You see it in the physician who carefully and caring explains to a family their father’s deteriorating condition. You see it in the hospital staff who pull together to bring a Christmas tree and presents to a sick patient’s family.

Passion is no different today than it was in the beginning, and it continues...
every day in healthcare. As an industry, we are blessed with an abundance of great people filled with passion.

**CONSTANT #2:**

**Fortitude.** Working in healthcare has always been challenging, but with all the change happening, it's even more complex today. It takes great fortitude to thrive in the midst of these changes.

Change is difficult all around. It is hard for the people experiencing it. It's hard for the people on the receiving end (the patients). But it may be hardest of all for the people tasked with managing it. The good news is that the healthcare industry is taking steps to help leaders channel their fortitude in ways proven to lead to successful change.

As an industry, we are blessed with an abundance of great people filled with passion.

**CONSTANT #3:**

**A willingness to learn.** Every day in healthcare people save lives, handle disease with dignity and help family members cope with death. Yet in the middle of all the intense emotions that come with their jobs, people continue to learn. Whether it is mastering a new technology, learning a new procedure, or studying what’s happening with a disease or illness, healthcare people consistently exhibit that a desire to learn is in their DNA and that quality patient care is their ultimate goal.

**CONSTANT #4:**

A desire to do work that has purpose, is worthwhile and makes a difference. While people may initially feel their work meets these criteria, this feeling can be fragile. That is why it’s so important, when asking them to make significant changes in their day-to-day work, leaders explain the why behind the changes (rather than just giving orders). And the real why is never just saving money or complying with government regulations—it’s improving the well-being of the patients we serve and saving lives.

What may be helpful to realize is that healthcare professionals are not being asked to reinvent the proverbial wheel. Yes, we need new skill sets, but they build on the skill sets we needed in the past. We’re not being asked to learn different behaviors and techniques—we’re being asked to improve the existing ones. Not different. Better.

The good news is the timeless values we possess—passion, fortitude, willingness to learn, and the desire to do worthwhile work and make a difference in the lives of others—will drive us to master the skills we need. It’s those values that will pull us through the tough changes with our passion and dedication intact.

Quint Studer is the author of A Culture of High Performance: Achieving Higher Quality at a Lower Cost (Fire Starter Publishing, October 201) and the founder of Studer Group.
Two-night minimum

Observation, inpatient and the two-midnight rule.

By Cindy Sanders

If being quite specific while leaving plenty of room for interpretation was an art form, the Centers for Medicare and Medicaid Services surely would have achieved master class status by now. The two-midnight rule, the recent compliance mandate that went into effect on October 1, is an example of this dichotomy and has left physicians and hospital administrators scrambling to understand what it means for patients—and the bottom line.

Boiled down, the new rule sets “two midnights” as a benchmark for inpatient admission, but there are exceptions. Meant to clarify the difference between appropriate observation status and inpatient admission, the IPPS final rule caused enough confusion that CMS offered a three-month amnesty period. During this last quarter of the year, hospitals will not face financial penalties even if deemed out of compliance.

Going forward, one-night inpatient stays will probably serve as a red flag for auditors to dig deeper to ascertain whether Part A reimbursement was appropriate.

During this period, the Recovery Audit Contractors (RACs) have not conducted medical necessity reviews. At year’s end, CMS has said it will assess the findings to see if additional guidance is needed.

Brian Contos, executive director overseeing the clinical research and insights programs at The Advisory Board Company, spoke with Medical News to shed light on the confusing and controversial rule.

The Backstory

“There are probably two storylines behind why they have implemented the two-midnight rule,” Contos said of CMS. “On the one hand, they’re instituting this policy to address concerns surrounding extended observation stays. I think the other reason is the simple fact that there are a tremendous number of very short stay inpatient admissions.”

Looking to the first motivating factor, Contos said, “Between 2006 and 2011, there was a dramatic increase in observation stays—a 65 percent increase.”

In addition, he continued, there was a 176 percent increase for those kept in observation for an extended period — 48 hours or longer. As for the second issue, Contos said, “Of the roughly 15 million Medicare admissions in 2012, about 2 million of those were admitted with a one-day stay.”

Since the cost to Medicare is far greater under Part A than under Part B (outpatient or observation status), the federal payer has a vested interest in how patients are classified, but CMS made it clear the goal is neither to keep patients in observation limbo when inpatient admission is warranted nor to pay Part A rates when services could be rendered in a more cost effective manner.

“From CMS’ perspective, there’s a yin and yang here. We don’t want a really long observation period nor do we want to pay for these really short inpatient stays,” said Contos. “It’s all about finding equilibrium.”

Red Flags

Going forward, one-night inpatient stays will probably serve as a red flag for auditors to dig deeper to ascertain whether Part A reimbursement was appropriate. While two midnights is the benchmark for inpatient status, there certainly are exceptions. First and foremost, any procedure that appears on the inpatient-only list is exempt from the rule.

Second, there are other conceivable situations where a patient could have reasonably been expected to meet the benchmark but only stayed one night, including self-discharge against medical advice, death or transfer. However, Contos stressed the documentation must clearly show the physician admitted the individual to inpatient status with an expectation that the patient’s condition warranted a stay of at least two midnights.

In addition to the marked increase in observation cases, Contos said the issue of post-acute care was another catalyst for the rule. For Medicare to pick up the tab for a stay in a skilled nursing facility or rehab unit, a patient has to stay in the acute care facility for three days, and observation days don’t count. Pressure has mounted on CMS—both by patient advocacy groups and through legal challenges—to “do something.”

A report based on Medicare data from 2012 and released July 2013 by the Office of Inspector General found there were more than 600,000 hospital stays last year that lasted at least three nights but didn’t qualify for inpatient payment, which means those stays would not have satisfied the three-day rule if needed.

Contos noted, “I would say the three-day rule is universally hated. Hospitals and advocacy groups want time in observation to count if a patient ultimately is admitted.”

While CMS did not opt for that route, the two-midnight rule could be seen...
Prepping for Post-Amnesty

With the grace period granted by CMS rapidly coming to an end, Brian Contos, executive director overseeing the clinical research and insights programs at The Advisory Board Company, offered four observations about steps hospital administrators could take to optimize compliance.

1) Emphasize physician education. “You don’t want to dictate, but you do want to make sure everyone understands the rule and documentation requirements,” Contos said.

   In the eyes of CMS, he added, “admit” and “admit to inpatient care” are different. No one wants to lose out on reimbursement because of incorrect terminology. Hospitals also don’t want to present RAC auditors with widely divergent case documentation.

   “As a hospital, you do want to try to establish some norms here so it’s not a total crapshoot if audited,” Contos said. “If you’re all over the map, it becomes really difficult to right-size your program.”

2) Hospitals should look at the processes in place to assess and reassess observation cases. While it’s critically important to document how, when and why a decision was made to admit to inpatient status, it’s also important to expedite that process. “It’s something every hospital is going to have to push on — timely decision-making,” Contos said.

3) Hospitals should also review their internal auditing process. “You want to develop a self-review process to identify cases that were inappropriately admitted so you can rebill under Part B within the one-year filing window,” Contos noted.

4) In addition to educating staff about the two-midnight rule, hospitals also need to remember to explain it to patients. “It’s very important the patients understand that just being in a bed in a hospital doesn’t mean you are admitted. Patients pay more out-of-pocket for Part B so they must understand the nuances about payment for inpatient and observation,” Contos stated.

continued from page 14

The Problem for Hospitals

“It’s a judgment call at the end of the day,” Contos said of whether or not a physician admits a patient.

Therein lies part of the problem for hospitals. The two-midnight rule is specific in that it is a judgment call and simultaneously very loose because, by its very nature, a judgment has many shades of gray.

The two-midnight rule is specific in that it is a judgment call and simultaneously very loose because, by its very nature, a judgment has many shades of gray.

Patient Burden

Exacerbating the financial concern is the increased out-of-pocket burden on patients. Moving from Part A inpatient to Part B observation status typically means the patient will shoulder more of the costs, adding strain to the collection process and potentially increasing the hospital’s bad debt ratio.

So what is to keep a hospital from skewing the numbers in their favor—keeping short stays longer and admitting more observation patients? Contos said some hospitals certainly might opt to roll the dice, but there are inherent risks in this plan.

First, demanding a patient be admitted contrary to a doctor’s medical opinion is never optimal.

“Physician judgment should really be held almost sacred,” Contos said. “There is nothing more disruptive to hospital/physician relationships than for a hospital administrator to tell a physician how to assess or judge a particular patient’s care.”

The second risk is that a hospital could ultimately wind up taking an even bigger hit to the bottom line. Although CMS offers a rebilling process to move claims incorrectly filed as Part A to Part B, hospitals only have one year to do so. By the time an auditor comes in to review inpatient claims, there is a good chance many would be past the one-year mark. In those cases, a claim deemed inappropriate by the auditor wouldn’t be eligible for rebilling. Instead, the hospital would be liable to CMS for the full amount of those claims plus any fines.

as a step toward ensuring a more timely determination of whether or not a patient should be admitted.

400,000 observation cases to become inpatient, and 360,000 inpatient cases to move out, many hospitals don’t believe the rule will help the bottom line. First, the inpatient payment rate is being adjusted down slightly to achieve budget neutrality.

The other concern is that for some hospitals, the number of inpatients gained from extended observation will be considerably less than the number lost from shorter stays, which will negatively impact margins that are already tight.

“I don’t think we can assume what happens in one hospital will happen in all. It will be institution by institution. Every hospital looks differently,” Contos said.

Certain service lines will probably be disproportionately impacted. For example, about one-third of hypertension cases and approximately 40 percent of Medicare chest pain cases result in a one-day admission. Presumably, those patients will wind up as observation patients in the future. Contos encouraged hospital administrators to work closely with their analytics team to get a better sense of the anticipated effect of the rule on their specific hospital.
How Methodist tackled the ACA head on

Hospital implements healthcare reform with cutting-edge patient/employee education initiatives.

By Freida Campbell

For Kentucky, healthcare reform is more than just a statewide transition—it’s a matter of national attention. The state’s transition to the new regulations within the Affordable Care Act (ACA) remains in the national spotlight, since Kentucky smoothly planned its Medicaid expansion and successfully launched the state’s health insurance marketplace, kynect, offering both private and Medicaid insurance.

With industry-wide change comes great responsibility, both statewide and at the local level. The changing landscape of healthcare has left many Kentucky citizens confused about the future of their benefits coverage. While state officials have worked hard to educate consumers on their options, providing crucial information and resources also lies in the hands of local hospitals.

In 2011, Kentucky faced a budget crisis and increasing cases of costly health issues, including morbid obesity, diabetes and respiratory illnesses. As a result, the state undertook a complete overhaul of its state-run Medicaid program and made the transition to a managed care delivery system. This forward-looking approach allowed hospitals across the state, including Methodist Hospital in Henderson, Ky., to work with managed care organizations to coordinate healthcare for Medicaid patients. Methodist was able to successfully adapt to this transition while staying committed to providing quality healthcare to all patients, paving the way for tackling healthcare reform.

Facing the ACA

To face healthcare reform head-on, Methodist needed first to look inward to streamline processes and procedures that would be impacted by rollout of the ACA. Working in partnership with Accretive Health, a market leader in revenue cycle management, Methodist planned to leverage its existing resources and personnel to better serve its patient communities.

The first step was hosting an October 2013 Kaizen event that focused on interdepartmental awareness and operational preparations for the ACA, and creating a unified, lean process for the launch of the kynect state exchange and Medicaid expansion, launching January 1, 2014. (Kaizen refers to the philosophy of continuous improvement of processes.)

More than 20 Methodist Hospital leaders participated in the week-long event, which developed a set of best practices for the development of organizational resources and aligned staff with the mission of leading patients through the ACA transition. This is one of a number of programs that have engaged Methodist as a leader in the implementation of the ACA within the region.

Effectively implementing the ACA at Methodist Hospital meant not only educating staff, but also ensuring that patients were equipped with the information and tools they need to make smart benefits decisions.

In 2011, Kentucky faced a budget crisis and increasing cases of costly health issues, including morbid obesity, diabetes and respiratory illnesses. As a result, the state undertook a complete overhaul of its state-run Medicaid program and made the transition to a managed care delivery system. This forward-looking approach allowed hospitals across the state, including Methodist Hospital in Henderson, Ky., to work with managed care organizations to coordinate healthcare for Medicaid patients. Methodist was able to

Many patients now have access to health insurance for the first time. In fact, a recent patient sent a thank-you note to express her gratitude.

Navigating the ACA

Navigating complex benefits options or the application process through kynect.

The response to the hospital’s initiatives has been tremendous. In fact, a recent patient sent a thank-you note to express her gratitude. She began by explaining that her mother has not had healthcare coverage for years. After navigating her options and applying through a kynect kiosk, her mother called her, and in joyful tears, shared that she is now covered. After continued stress over her mother lacking insurance, this patient was grateful that her mother was finally able to secure the coverage she needed thanks to the support of Methodist staff.

Moving Forward

As the ACA rollout continues across the nation, Methodist will continue its marketing campaign, which focuses on community awareness and the services and support that Methodist offers. Initiatives include the launch of a Methodist Hospital Facebook page with regular activity and policy updates, as well as sharing news and materials with the community through local organizations, health fairs and more. Methodist also added language on the ACA transition to the hospital’s written communications to patients.

Looking ahead, Methodist will further its mission of providing access to outstanding care by focusing on patient-centered initiatives and advocacy. The hospital plans to continue calling upon its strategic partnership with Accretive Health throughout the ACA rollout and beyond to navigate the ongoing transitions that are required as national healthcare reform trickles down to local markets.

Through forward-thinking initiatives and strategic partnerships, Methodist Hospital is positioned to remain at the cutting edge of patient care for generations to come.

Freida Campbell is director of Data/Process at Methodist Hospital in Henderson, Ky.
Preventing workplace violence

Healthcare workplaces have become vulnerable to incidents of threatening and violent behavior. They don’t have to be.

By Samuel H. DeShazer

Several recent mass shootings in schools and workplaces have, tragically, served as grim reminders that we live in times where none can be confident they will be immune from violence at work. Ironically, healthcare workplaces, which are dedicated to providing compassion and healing, can be especially vulnerable to incidents of threatening and violent behavior.

Workplace violence continues to be a serious issue that covers a broad spectrum of conduct and activity—from threatening statements or behavior (e.g., workplace “bullying”) to the presence of weapons or physical assault, to even mass killings.

Because of these realities, and because healthcare employers may be confronted with a progression of threatening and violent behavior, healthcare employers should evaluate whether to adopt policies that strictly prohibit any form of threatening or violent behavior in the workplace. Further, healthcare employers should engage in planning activities that address the organization’s preparedness to effectively respond to, and recover from, serious violent incidents.

The following checklist suggests steps employers should consider implementing in their organizations to provide a safe environment.

Samuel H. DeShazer is a shareholder with Hall, Renden, Killian, Heath & Lyman PSC.

Workplace Violence Policy Checklist

- Develop a workplace violence policy. Develop a handbook (or equivalent) policy, addressing threats and workplace violence. Topics should include:
  1. A statement of “zero tolerance” to workplace conduct that is construed as threatening, confrontational or violent. (Prohibited conduct should include anything that is harassing, intimidating, presents a challenge to fight, veiled or direct threats, confinement, assaults or sabotage.)
  2. A statement reflecting the employer’s expectation that employees report any incident(s) they experience or witness, whether the actor is a co-worker, supervisor, customer, vendor, visitor, etc. (The policy should set out options/channels for reporting, and indicate that employees will not be retaliated against in any manner for making good faith reports.)
  3. A statement encouraging employees to report circumstances (at or away from work) where they are in violent or potentially violent relationships and when they have been recipients of threats or victims of violence. (In policy and practice, employers should provide assurances to employees that their privacy will be protected to the extent reasonably possible and that they will not suffer any adverse job consequences by making a report.)
  4. A statement about the employer’s policy on weapons on and around its premises.
- Disseminate the policy. All employees should be aware of policy terms and definitions, the rationale behind adopting the policies, and its strong commitment to maintain a safe workplace environment.
  1. The policy should be clearly communicated to all employees, and management should periodically reinforce the policy’s importance.
  2. The policy should be in the Employee Handbook, and, if appropriate, posted within the organization’s facilities/locations.
  3. Employers may disseminate the policy to persons and organizations outside the workplace such as with vendors or law enforcement.
- Train supervisors. Supervisors will be responsible for implementing policies and ensuring policies are understood and taken seriously by their direct reports. Supervisors often are “first responders” to threats/violence incidents, and it is critical that they understand their roles.
- Address incidents promptly. Decisions on how to respond to workplace threats/violent incidents, including employee discipline or termination, should be made promptly, but only following an investigation, and in a calm and deliberative atmosphere. This may require the development of policies and procedures designed to maintain the status quo until the incident has been dealt with and the workplace returns to normalcy.
- Coordinate policy and responses with outside resources, including professional law enforcement, medical and legal professionals. How and when these resources should be utilized should be an important component of the planning and implementation process.
- Plan for organizational recovery. Experience teaches that healthcare environments are typically required to continue operations during crisis events. Healthcare workplaces must recover quickly from such incidents, so that services provided can be continued and sustained at a high rate of efficiency and competency. An important component of training should involve how organizations operate effectively during an incident/crisis, and how the workplace can return to normalcy following an incident/crisis event.
Staffing headaches
Two ways hospital can prepare for flu season.

By Chris Fox

According to flu.gov, five to 20 percent of all U.S. residents get the flu each year. As there are an estimated 314 million people in the United States, that’s roughly 47 million people. The flu, as we know, does not hit everywhere the same time. Some areas of the country can be hit hard while other areas experience much less impact, and this varies year-to-year.

With all of this uncertainty how can a hospital prepare? There are two ways.

1. Develop the right layering of staff to be able to adjust to spikes and dips in census.
2. Employ predictive analytics to develop a forecast of patient demand to create more accurate schedules.

Layering Staff
Core staff, those individuals who hold an ongoing FTE (full-time equivalent) commitment within a department, are the backbone of a hospital. How many core staff a unit needs to function efficiently varies from unit-to-unit. A fair amount of census analysis is required to discover the right size for each unit/department. The point is to hire the number of core staff needed to keep them working without the need for excessive floating or overtime (which can be staff dissatisfiers that will lead to turnover).

Contingency staff are the individuals who flex their hours up and down to respond to fluctuations in census or fill in when core staff members are not available to work. There are as many as seven different types or layers of contingency staff that should be part of your resource mix, depending on the size of the hospital or health system. These can include:

- **Enterprise float pool**: For systems with two or more facilities within 30 minutes normal driving time, an enterprise float pool is a wise strategy. These individuals are highly skilled and extremely flexible, with the ability to work on various units in different facilities.

Using predictive analytics to forecast volume helps managers better align staff resources and eases the strains and anxiety managers often face in the few hours leading up to the shift.

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THIS IS AN ADVERTISEMENT
By Cindy Sanders

What if gathering critical heart health information from around the world was as simple as entering a few keystrokes on a laptop or smartphone? Turns out there is an app for that—actually several apps—and researchers with the Health eHeart Study hope to turn those rich data sources into powerful tools to predict, prevent and treat heart disease and stroke.

“In my 30-year career as a researcher and physician, I’ve never seen a study as innovative as the Health eHeart Study,” said Elliott Antman, MD, president-elect of the American Heart Association (AHA) and co-chair of the study’s scientific advisory board. “This is a seamless way to participate in a research study while going about your daily activities.”

Rather than having to make an appointment to see a physician to submit or update health and activity information for the study, participants can log info on the go and at their convenience via computer or mobile device.

Launched last year, the AHA has joined forces with the University of California, San Francisco (UCSF) to support this long-term, large-scale health research project. The goal is to enroll one million adults from around the globe, and the only inclusion criteria are that participants be over 18 and have access to the Internet.

Participants Across the Spectrum

Researchers are seeking individuals across the spectrum from the very healthy to those diagnosed with cardiovascular disease or other chronic conditions. Rather than having to make an appointment to see a physician to submit or update health and activity information for the study, participants can log info on the go and at their convenience via computer or mobile device.

Antman noted the immediacy of the media also opens up possibilities to test the efficacy of various treatments and behavioral modifications.

“This is nimble and has the potential to change the way we study health behaviors and test interventions to modify those behaviors,” he explained.

For example, Antman noted a subgroup of participants who identified themselves as regular smokers on the baseline questionnaire could be pulled from the larger study. From that subset, one group could be randomized to receive a weekly email from a health coach reminding them not to smoke, while another group might receive a link to a web site with information on how to make behavioral changes. Subsequent follow-ups could show one method to be more effective than the other.

That, noted Antman, is where the nimbleness of the technology comes into play by allowing researchers to quickly switch all participants to the more effective intervention.

Get Involved

Antman said physicians and other providers could be major allies in helping get patients signed up for the study. He encouraged physicians to go online to learn more about the project and to share the web site information with their adult patients. The AHA has brochures available for distribution at clinic and office sites, as well.

Again, he stressed, the goal is to include everyone across the health spectrum from young, active adults to those with multiple comorbid conditions. Antman noted that while this is a long-term commitment, participation is extremely easy.

“This is a study that doesn’t impose on a person’s time the way other research studies do,” he said.
Jobs for hire

Three issues combine to make it more difficult to recruit new physicians to our state.

By Fred A. Williams, Jr., MD

Policy experts at the national level differ over whether there is a shortage of physicians in this country. Many fear that the need for physicians will become acute as more people obtain insurance, and baby boomer physicians like me hang up our stethoscopes and move into retirement.

In Kentucky, a recent study indicates that while most areas of our state have an adequate number of physicians, this situation could change as more people become insured. A recent survey of physicians in rural areas of Kentucky conducted by the Rural Kentucky Medical Scholarship Fund found that most believe they can see a patient within one day of the patient calling for an appointment, although they also believe there is a need for physicians of every specialty.

Whatever surveys and data might show, if you have called a physician’s office and it takes days, weeks or even months to be seen, you are experiencing firsthand the need for more physicians.

It stands to reason this situation may become more severe as our population ages (that baby boomer issue again) and suffers from bad health, an unfortunate combination of factors, which is especially pronounced in Kentucky.

Three Recruitment Challenges

There should be more physicians, or at least more physician time devoted to treating those in need. Physicians are licensed by their respective states, and each state vies for the chance to recruit the small number of available physicians. Three issues combine to make it more difficult to recruit new physicians to our state.

First is the problem of educating enough physicians. Generally, physician education is a two-step process that includes graduation from medical school and then completion of a residency training program that can last from three to nine years depending on the specialty. While Kentucky medical schools have stepped up to increase the number of graduates, residency training slots have not increased, which left some 528 medical graduates from obtaining a slot for residency training in this country last year. This is a funding issue and unfortunately some in Congress, as well as the President, have proposed cutting this funding. This situation significantly limits the pool of physicians available to practice here.

Adding to the shortage is the regulatory environment for physicians, as evidenced by a recent RAND study. This issue has become dire over the past few years and has left many physicians staggered by the amount of regulation placed on how we treat our patients.

Addressing Immediate Needs

Lawmakers, health plans and others need to recognize that something must be done to address the need for more physicians in our state. Without physicians, there can be no hospitals. Without hospitals and other clinics, businesses are less inclined to move into an area. As has been said many times before, “Jobs follow physicians.”

And the population of this state has become dire over the past few years and has left many physicians staggered by the amount of regulation placed on how we treat our patients. It is a major concern when trying to recruit new physicians, and has little to do with the feeling that physicians lack protections from what many believe is a legal industry that sometimes does not provide us with a fair process. Legal cases can also drag on for years and if you have ever been sued, you know the emotional toll it can take. Without tort reform, we face an uphill battle recruiting and retaining those we need in our state.

By Fred A. Williams, Jr., MD, president of the Kentucky Medical Association.
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Can PAs call Kentucky home?

Nearly half of PAs educated here leave after graduation. Here’s what Kentucky is doing to get them to stay.

By Virginia Valentin

I am proud to say that America’s physician assistants (PAs) are on the front lines of medicine, especially here in Kentucky. PAs practice medicine and are educated in a very similar way to physicians, via an intense graduate-level medical program wherein we are trained to diagnose, treat and prescribe. In rural areas, a PA may be the only healthcare provider-on-site, working with a physician elsewhere through telecommunication.

PAs not only treat disease, but also promote health education and disease prevention, which can potentially decrease demand on the healthcare system over time. PAs conduct physical examinations, diagnose and treat illnesses, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling and make rounds in hospitals and nursing homes.

This year, positive strides have been made to improve the provision of patient care that is rendered by PAs in Kentucky.

And yet, young PAs continue to leave our state after being educated here because Kentucky’s practice laws are more restrictive than those in other states.

According to the Kentucky Academy of Physician Assistants (KAPA), nearly half of PAs educated at the three excellent PA programs at the University of Kentucky, University of the Cumberlands and Sullivan University leave after graduation.

PAs enter the workforce quicker than physicians and are rigorously educated in a master’s program modeled on the medical school curriculum. In addition to classroom instruction, PA students complete a minimum of 2,000 hours of clinical rotations with an emphasis on primary care in ambulatory clinics, physician offices and acute or long-term care facilities. Once in the workforce, PAs complete 100 hours of continuing medical education every two years and pass a national recertification examination every 10 years.

Steps Forward

If Kentucky can continue to modernize practice laws, we can expect more PAs who are educated here to practice here and increase access to care for Kentucky’s patients.

In March, Gov. Steve Beshear approved a law that removes a requirement that physicians be on-site with PAs during their first 18 months of medical practice. Kentucky was the only state with such a lengthy on-site requirement and one of only three states in the country with any such requirement.

Through May 2014, physicians will be required to be on-site as newly graduated PAs provide care for their first three months of practice. Beginning in June 2014, this requirement will be eliminated entirely.

Additionally, the Kentucky Board of Medical Licensure updated its definition of “on-site” to embrace emerging technology and telemedicine.

These were tremendous steps forward to allowing PAs to practice to the fullest extent of their experience and education. Yet there are other steps that our legislators can take to ensure PAs are able to care for new and existing patients.

No Signature Needed

Currently, physicians must approve every chart that a PA generates. This not only creates additional paperwork to handle when physicians and PAs could be seeing patients, but also limits the effectiveness of a physician-PA team.

Kentucky PAs support legislation that would eliminate this mandate for physician signature: Requiring a physician to sign routine chart entries is a poor use of the physician’s time. The legislation KAPA supports will allow each practice to determine the best way to handle chart entries.

Deaf workers helped our company grow

Blending hearing, non-hearing workforce.

By Sean Belanger

There are myriad benefits to companies that hire disabled people, from gaining excellent problem-solvers with above-average attendance and productivity records, to earning federal tax credits.

Unfortunately, too many companies worry that the benefits will be offset by the costs to accommodate those employees—not true, by the way.

While unemployment is just more than 7 percent nationally, it was 13.5 percent as of September for disabled workers, according to the Bureau of Labor Statistics.

At Stratus Video, 68 percent of our employees who don’t work as interpreters are deaf or hard of hearing. All of our 250-plus contractors across the country are deaf, and three of our eight company vice presidents are deaf. We’ve grown to more than $50 million in revenue, and we were recently named to the Inc. 5000 list of top Tampa-metro area businesses. Thanks in large part to our diverse workforce.

Ways to Integrate

Integrating Stratus Video’s hearing and non-hearing employees involved facilitating communication, which wasn’t difficult, given that’s the company’s specialty:

• In-house trainers teach the hearing employees American Sign Language.
• Each employee has access to a video phone and video software so all can communicate both visually and vocally.
• The company’s human resources department found coverage for hearing aids and cochlear implants, not covered by insurance, to ease communication for hard-of-hearing employees.

Benefits to the company have been numerous. Our deaf employees are committed, engaged and come up with solutions to problems based on insights unique to their experience.

Federal Tax Benefits

If that’s not enough, companies that hire disabled people can also qualify for federal tax benefits. According to the Americans with Disabilities Act, a disabled person is defined for work purposes as someone who is deaf or has serious difficulty hearing; blind or has serious difficulty seeing even when wearing glasses; has serious difficulty concentrating, making decisions or doing errands alone because of a physical or mental condition; serious difficulty walking or climbing stairs; or difficulty dressing.

Among the tax incentives are the Work Opportunity Credit; the Disabled Access Credit; and the Architectural Barrier Removal Credit. In addition, the Wounded Warrior Tax Credit offers incentives for hiring vets with service-connected disabilities. You can find out how much your company may qualify by using the Hire Gauge, a free tool at ThinkBeyondTheLabel.com.

Sean Belanger is chief executive officer of CSDVRS and Stratus Video, in Clearwater, Fla.
Can PAs call Kentucky home?

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method to assure excellence in practice for physician-PA teams.

By design, physicians and PAs work together. This collaboration allows patients to have more interaction and exposure with healthcare providers and extends the reach of medical care to more people. The most effective PA laws are written in ways that allow flexibility for healthcare teams to determine how best to collaborate and meet their patients’ needs.

Improving how PAs practice medicine enhances the care that Kentucky patients receive. There are more than 93,000 PAs in the workforce today, and the profession will only continue to grow as more than 7,000 PAs graduate from 181 programs in the country every year.

Properly modernized practice laws that allow teams of physicians and PAs to determine the best care patients can receive are an excellent way to ensure our patients have access to the best care possible.

Virginia Valentin, PA-C, is president of the Kentucky Academy of Physician Assistants.

Staffing headaches

Continued from page 18

- Site-based scheduled float pool: This small segment of nursing generalists typically carry an FTE and can function on a variety of units dependent on a facility’s emerging needs.
- Site-based PRN pool: Typically, this is the largest segment of your contingency resources. These individuals work a fluctuating schedule based upon the match between your organization’s needs and the individual’s availability.
- Unit-based PRN pool: For heavily specialized units (e.g., neonatal and burn units) to be able to manage spikes in census or staff absences, they need a small number of PRN staff who can fill in. Unit-based PRN pool can do that.
- Core staff in extra shifts and overtime: While there is no getting around the use of overtime, it should be rarely used. Only employ during times of extraordinary need, like an intense flu season. In addition to being expensive, overutilization of overtime can lead to burnout and negatively affect morale and quality.
- The “right” agency partnership: Carefully choosing and nurturing relationships with one or two high-quality local agencies is a sensible strategy that could end up saving the day in times of high need. And, the right contract stipulations can prevent them from hiring away your staff.
- Travelers: When a comprehensive, multi-layered contingency plan is in place, carefully planned, well-timed traveler assignments can complete a contingency staffing strategy.

Forecasting Patient Demand

The key to this layering strategy’s effectiveness is having an accurate predication of staffing needs.

Typically, hospital units staff to a budgeted average, and staffing plans are made against this average. However, as anyone who has worked on a unit knows, no day is average. That said, there are discernible patterns that can be uncovered and deciphered through the use of sophisticated mathematical modeling, even during flu season.

This insight helps better align staff schedules with the trends in patient volumes on a weekly and seasonal basis. For example, if a department typically experiences its peak volumes on Wednesdays and Thursdays, the number of staff on those days should be higher than the number of staff scheduled on the days with lower volumes. This would also apply seasonally; therefore, a Wednesday during flu season should have a higher number of staff than a Wednesday during other times of the year.

Using predictive analytics to forecast volume helps managers better align staff resources and eases the strains and anxiety managers often face in the few hours leading up to the shift. What is key to this is having the prediction more than thirty days in advance of the shift, when schedules are being built. The development of more accurate initial schedules creates a framework for better staffing throughout the schedule period.

An accurate forecast complemented by robust layers of contingency staffing to fill in the cracks caused by staff absences or spikes in census results in less overtime, less floating, and considerably less time spent by managers sorting through the chaos during the scheduling and staffing process throughout flu season.

Chris Fox is CEO of Avantas.
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