The business of healthcare

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students and cannabis oil proponents.

Victories for nurse practitioners, diabetic

By Kenny Colston

With the close of the 2014 session, only a handful of important issues to Kentucky's health community stand to become law this summer. While many other issues wait on the sidelines for their chance in future legislative session.

After weeks of committee hearings, speeches and legislative wrangling, the highlights of this year's session, from a health standpoint, deal with medicine and who can prescribe it.

Easy Victories

Senate Bill 7, signed into law by Governor Steve Beshear on February 13, gives more freedom to nurse practitioners when it comes to their own medical practices and prescriptions. Under previous law, the nurse practitioners had to have an agreement with a doctor to prescribe certain medicine. With Senate Bill 7, they will be able to opt out of such agreements after four years and be able to prescribe most medicines on their own.

The bill was a compromise from previous efforts for the issue and sailed through the General Assembly with only one “no” vote in either chamber.

Another easy legislative victory came from allowing diabetic students to give themselves insulin shots in school.

House Bill 98 allows diabetic students to give themselves insulin injections and other medical necessities without the help of a school nurse.

It also allows a trained professional in a school who's not a nurse to help administer an injection if necessary. The bill sailed through both chambers with little opposition and was signed into law by the governor March 5. Another bill allows a trained caregiver to administer an injection at any point, if given written consent of a diabetic patient.

Cannabis Oil Bill Passes

A third victory, depending on who's asked, comes from the passage of a bill allowing the use of cannabis oil for medical uses, especially for epilepsy. The Epilepsy Foundation of Kentuckiana pushed for the bill, which won passage in the final legislative days.

The bill allows the oil’s use for those in clinical trials with the U.S. Food and Drug Administration or at the University of Kentucky or University of Louisville Hospital. It does not allow full marijuana use for medical reasons, as some lawmakers had pushed for.

Unlikely Passage

But several other bills aren’t likely to get anywhere close to the governor’s desk for his signature. Those include a bill to allow for medical review panels in any cases of neglect or abuse and a statewide smoking ban.

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Stop or go?
The first rule of marketing is to make sure you have a clear message. For the American Medical Association (AMA) leadership, their position on the impending ICD-10 conversion could not be more straightforward. They want to see it stopped.

Read more on page 4

How to engineer your financial future

Financial resolutions can be the most difficult to keep. They can include minute detail, number crunching, plenty of files and discipline that can affect a person’s entire lifestyle.

Read more on page 24

Female CEOs can lead with impact

A record number of women are Fortune 500 CEOs. Women are launching businesses at 1.5 times the national average. There are now 8.2 million American women running their own companies. The numbers are notable.

Read more on page 25

Progress or capitulation?

According to the American Heart Association, cardiovascular disease affects 80 million Americans and the costs of care are exploding. It’s not surprising then that prevention of disease is more important than ever and that more aggressive approaches are clearly warranted.

Read more on page 25

ABOUT THIS ISSUE

Strategic Planning

In the ever-changing healthcare landscape, it is more important than ever to take a look at the here and now (what we are currently doing) and plan for the future. That’s why this month Medical News focuses on strategic planning.

Articles include in-depth looks at two local companies’ KentuckyOne Health and Seven Counties Services, strategic planning processes. We also explore trends in mergers and acquisitions and tap into why physicians are selling their practices. Further, we look at how recent tax code changes impact the bottom line at work and home and how to engineer your financial future through various wealth stages.

Articles begin on page 11
Letter from the publisher

Growing in the business of healthcare

Medical News is celebrating 22 years of bringing our readers the news and information they need about the business of healthcare in Kentucky and Southern Indiana. From our monthly publication, to the MediStar Awards, to our growing presence online and in your inbox, our aim is to bring you valuable and actionable information.

Over the course of the next few months, we will continue to expand our coverage of critical healthcare areas in our region, especially in Northern, Western and Central Kentucky. We have dedicated resources to covering these areas in more detail and are in the process of establishing editorial boards to help ensure we have the local, inside perspective that provides our readers with the most up-to-date, credible information.

With all of our growth, we want to make sure we remember that our readers are our number one priority. During the next several months, we will work to get to know you a little bit better through the newspaper and our web site. Your thoughts and opinions, from your unique point of view, will add diversity to our news. We want to make sure we are covering the topics that are important to you.

Keep an eye out for some more exciting projects coming from the Medical News team. In the coming months we will launch a new program with a focus on pharmacies and expand our coverage online. Our goal is to continue to help people build healthcare businesses and stay on top of the latest innovative practices to improve their practices.

Thank you for continuing to be a part of the Medical News community. We have enjoyed serving you over the past 22 years and look forward to many more.

Sincerely yours,

Ben Keeton
Publisher

Thoughts from the healthcare community

Ky Pharmacists Assoc @KyPharmAssoc
HB 125, which was amended in Senate committee to include med synch and CCA language, passes the Senate. Goes back to House for concurrence.

L&F Healthcare @LF_Healthcare
The health care jobs slowdown, graphed: dvbd.co/1bUTjol

McBrayer Law Firm @McBrayer_Law
#FTC: Don’t Limit #APRN’s Crucial Role in Health Care, bit.ly/1ruvqw2
#kya14 #HealthCareLaw

Steve Beshear @GovSteveBeshear
321K Kentuckians enrolled in health insurance thru @kynectky; that’s 1 in 13 people. Subsidies available if you sign up by 3/31 #getcovered

ARGI Financial Group @ARGIFinancial
Congrats! @KYOne_Health CEO Ruth Brinkley honored as @BFLOUISVILLE woman of influence. #BFW bit.ly/1o4ncvu pic.twitter.com/GsrcmWUaEc

KYYouth Advocates @KYYouth
House taking up consent orders, including SB 159 on oral health care and SB 176 on kinship care
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Stop or go?

With the deadline fast approaching, AMA campaigns against ICD-10 implementation.

By Cindy Sanders

The first rule of marketing is to make sure you have a clear message. For the American Medical Association (AMA) leadership, their position on the impending ICD-10 conversion could not be more straightforward. They want to see it stopped.

AMA president Ardis Dee Hoven, MD, pointed to a number of issues that have members worried about the health of their practices—and ultimately their patients. Concerns range from cost of implementation and software availability to worries over disruption in pay and a siphoning of resources away from other transformative changes that improve healthcare delivery.

In a recent letter to Kathleen Sebelius, secretary for the U.S. Department of Health and Human Services (HHS), the AMA acknowledges the position they have taken is at odds with some of their industry colleagues. Yet, AMA officials believe the timing of such a massive undertaking is ill advised and could prove disastrous for physicians.

“The challenge here is disruption — it’s a disruptive process that delivers no direct benefit to patient care,” Hoven asserted.

Many Codes Equals Much Room for Error

ICD-10 — the International Classification of Diseases, 10th Edition — was endorsed by the World Health Organization (WHO) in May 1990 and put into use by member states beginning in 1994. It is the tool used to capture mortality and morbidity data, track disease outbreaks, highlight research needs and provide a general snapshot of health among nations and populations.

There are two parts to the system in the United States. Clinical Modification (CM) is used for diagnosis coding in all healthcare settings. The Procedure Coding System (PCS) is for inpatient settings only.

According to the Centers for Medicare and Medicaid Services (CMS), anyone covered by HIPAA (not just those who submit Medicare and Medicaid claims) must convert to ICD-10 by the October 1, 2014 deadline.

“You’ve got to have an ICD-10 code for the disease signs and symptoms, abnormal findings, complaints, circumstances and external causes of injury or disease,” said Hoven. “The problem is the granularity of the ICD-10 codes.”

ICD-9-CM encompassed between 13,000 to 14,000 codes compared to ICD-10’s 68,000 options. “It’s about a five-fold increase,” Hoven continued and was quick to add the inflated number of codes in ICD-10 wasn’t set by the WHO but instead is a product of U.S. modifications to the system.

In addition to the CM codes, the PCS portion has 72,000 codes. Other countries
Preparing for ICD-10 Conversion

By Lynne Jeter

According to the latest Workgroup for Electronic Data Interchange (WEDI) ICD-10 readiness survey results, representing a mix of practices and hospitals, “it’s clear the industry continues to make slow progress, but not the amount of progress that’s needed for a smooth transition.”

“We’re finding that some practices have done absolutely nothing to prepare,” said Jennifer O’Brien, MSOD, a practice management consultant with KarenZupko & Associates Inc. O’Brien recommended eight steps for every physician provider to take.

1. Physician providers in a practice that allows them to control their own salary or draw should reduce that amount by 25 percent now.

By planning for little to no Q4 revenue while also reducing the draw in the first three quarters of 2014, you can pay yourself in Q4.

O’Brien explained: “Because the entire industry will make a change of such magnitude on the first day of Q4, the revenue cycle is going to be disrupted. Either the practice is going to make mistakes coding, payors are going to have difficulty processing the claims, or both. For practices that don’t adequately prepare, Q4 could be bone dry.”

2. Secure a substantial line of credit (LOC) with a bank to cover payroll and operating expenses in Q4.

“Like an insurance policy,” O’Brien said, “a LOC must be secured before needed.”


“This isn’t the year for capital expenditures, other purchasing and hiring that’s not absolutely necessary,” O’Brien said, noting the strategy applies to personal expenditures also. “2014 isn’t the year for physicians to build that dream vacation home.”

4. Because of increased expenses and decreased productivity, let employees know now that year-end bonuses are highly unlikely.

5. Order ICD-10-CM books, software or apps.

6. Depending on the practice, run a frequency report of the top 25 to 75 most commonly used ICD-9 codes with nomenclature.

“For specialty and subspecialty practices, the most common 25 diagnosis codes should be sufficient, but for internal medicine, emergency medicine, and other practices with a broader scope, there will likely be more than 25,” cautioned O’Brien.

“Once you have the list of your most commonly used ICD-9-CM codes, use your new ICD-10-CM books to crosswalk them to correct, complete ICD-10-CM codes,” she said. “Don’t leave this up to the office staff. Do it on your own or with staff. The process of converting your most commonly used diagnoses to ICD-10-CM will likely demonstrate a need to change your documentation of diagnoses and may show a one-to-many crosswalk. That is, what used to be covered with one code will now require additional information to select the correct code from a list of many.”

7. Don’t plan on leaving the conversion up to internal billing staff or an external billing service.

“When asked, ‘What are you doing to prepare for ICD-10-CM?’ we’ve had physicians and managers respond, ‘Our billing service is going to take care of that.’ Guaranteed disaster! ICD-10-CM requires significant, documented input and details from the clinician for accurate, complete codes,” said O’Brien. “There’s no billing service or even computer program that can crosswalk ICD-9-CM codes to ICD-10-CM codes without additional details and input from the clinician.”

8. Research available ICD-10-CM training.

“Many national specialty societies, hospitals and practice management software companies and other organizations are offering ICD-10-CM training for physicians and their staff,” said O’Brien. “If your practice is large enough, it may be cost effective to hire the ICD-10-CM trainer to come to you and your staff. Plan to spend the next several months learning the ICD-10-CM coding system and changing your documentation. Don’t think you can cram for this by going to one or two seminars in the summer. This is like board examinations; only in this case, if you don’t study, prepare and perfect well in advance, the failure could mean financial ruin.”
Stop or go?

Needed to invest in new healthcare delivery models and well-developed technology that promotes care coordination with real value to patients,” Hoven said.

Balancing the Pluses and Minuses

ICD-10 certainly has many proponents who point to the benefit of having increased information through the detailed coding system to enhance data analysis, public health surveillance and research initiatives.

It isn’t an argument that sits particularly well with Hoven. “But at the end of the day it is going to improve patient care?” she questioned. “The answer is no.”

Those in favor of ICD-10 insist that’s exactly what the new system will do by providing greater opportunity for evidence-based practice and clinical decision support. The argument has even been made that the switch ultimately will lessen the burden on providers because they won’t be required to provide as much detailed clinical documentation since the codes are already so specific.

Hoven stressed physicians are strongly supportive of changing the way healthcare is delivered in terms of implementing evidence-based protocols, working collaboratively and adopting new models like the patient-centered medical home.

However, according to Hoven, too many new administrative and regulatory requirements that do little to improve outcomes have been thrust upon physicians to a point where it has become overwhelming.

“Over the last seven to eight years, the changes have been tumultuous in practices,” Hoven said.

On the way to implementing changes that improve patient care, physicians have been met time and again with administrative and financial hurdles mandated by CMS including new requirements for the physician quality reporting system (PQRS), value-based payment modifier program, and Meaningful Use.

Despite a national call for administrative simplification, Hoven pointed out, “Nothing seems to get simplified. It gets more complicated. The problem when you start dealing with rules at the federal level is it further complicates everything. It doesn’t improve healthcare, and it doesn’t improve health outcomes.”

What AMA Hopes to Achieve

In February, AMA launched a #StopICD-10 Twitter campaign in support of the organization’s continuing effort to urge HHS to make good on its commitment to improve the regulatory climate for physicians. However, after a number of delays, Hoven knows CMS officials have been adamant the ICD-10 implementation deadline will not move again. October 1 is coming—ready or not.

Hoven said she was delighted by the announcement in mid-February that CMS would conduct end-to-end testing for select providers. AMA, along with other industry groups including the Medical Group Management Association, have pushed hard for such testing. Hoven said the AMA believes end-to-end testing is essential to ensuring there won’t be massive disruptions in claims and payment processing. She noted it was critical that practices of different sizes and specialties be included in the test and called upon CMS to start as soon as possible considering the short window between now and October 1.

“If we see this end-to-end testing is a disaster, our hope is that they will, in fact, delay implementation until A. They can figure out how to fix it, or B. Replace it with something else that is more workable,” she said.

If ICD-10 goes into effect as planned, Hoven would advocate for policy changes to protect physician practices such as a two-year implementation period where there would not be payment denials around coding issues.

The Bottom Line

“ICD-10 is an unfunded mandate,” Hoven reiterated, adding it’s also one that comes with a high price tag at a time when physicians already are struggling to stay on top of other costly federal mandates.

“Adopting ICD-10, while it may provide benefits to others in the healthcare system, is unlikely to improve the care physicians provide their patients and takes valuable resources away from implementing delivery reforms and health information technology,” she concluded.

While the debate rages on over ICD-10, it should be noted work on developing ICD-11 has already begun and is expected to be ready for WHO approval in 2017.

Quick Definitions

ICD-10-CM: The clinical modification of the World Health Organization’s ICD-10, which consists of a diagnostics classification system. In the United States, ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity and provides code titles and language that complement accepted clinical practice. The system consists of more than 68,000 diagnosis codes.

ICD-10-PCS: Developed to capture procedure codes, this procedure coding system of 87,000 procedure codes is much more detailed and specific than the short volume of procedure codes included in ICD-9-CM.
University of Pikeville to start optometry college

The University of Pikeville, Pikeville, Ky., plans to open a college of optometry, the first in Kentucky, starting with 60 students in 2016.

Gov. Steve Beshear said the project will receive a $1.5 million grant from the Appalachian Regional Commission.

University president James Hurley said the university will build a new facility for the college.

“We will add 11,300 new optometrists by the year 2020 across the country, and there is not enough supply at the current pace to keep up with that demand,” Hurley said.

UK HealthCare nurses ranked No. 1 in national patient satisfaction survey

UK HealthCare nurses were ranked No. 1 out of 102 UHC (University Health Consortium) academic medical centers for the Nursing Care Aggregate HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) domain.

The HCAHPS survey is the first national, standardized, publicly reported survey of patients’ perspectives of hospital care.

UK Chandler Hospital demonstrated the greatest improvement in HCAHPS scores among the 41 academic medical centers that participated in the recent University HealthSystem Consortium (UHC) Patient Experience Improvement Collaborative. The hospital achieved an aggregate increase of 19.08 percent for the project’s focus areas of nursing communications, staff responsiveness, cleanliness and quietness.

To Submit to People In Brief

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

Please submit a brief description and high resolution color photo saved as jpeg, tif or eps (pdfs will not be accepted) via email to melanie@igemedia.com.
Lexington Clinic physician receives honorary membership

Dr. W. Ben Kibler, Lexington Clinic orthopedic surgeon and founder of the Shoulder Center of Kentucky, was selected to receive honorary membership in the National Athletic Training Association (NATA).

The honorary membership is awarded to those who show profound interest in and have made significant contributions to the profession of athletic training. Honorary members must be nominated and should show dedication toward advancing, promoting and championing the efforts of the NATA and its members.

UofL nursing school dean recognized at alma mater

Marcia Hern, dean and professor at the University of Louisville School of Nursing, was selected as one of 100 Alumni Transformers in Nursing & Healthcare by The Ohio State University College of Nursing during its centennial year.

This recognition commemorates alumni of the college who have deeply impacted the profession of nursing and the healthcare system. Since completing their education at the college, these alumni have excelled in their respective fields and succeeded in living out the mission of the college: transforming health, transforming lives.

Diversified Nurse Consultants receives Horseshoe Foundation Small Business Revolving Loan

Diversified Nurse Consultants received $50,000 for building improvements, working capital and the purchase of equipment.

Established in 2007 and granting its first loan in March 2009, the loan program was created to assist emerging private business enterprises based in Floyd County with expanding their operations and retaining or increasing employees.

Diversified Nurse Consultants is a nurse-owned business. Co-owners, Ginger Jones, RN, Tracy Book, RN, and Deana Hall, RN, currently employ more than 40 nurses and ancillary staff. They offer geriatric care management, catastrophic care management and MSA preparation services. In each of these areas, they provide a holistic approach treating every client as an individual.

Event calendar

2014 Health Equity Summit

Date: Thursday, April 10
Time: 7:30 a.m. - noon
Where: Muhammad Ali Center, 144 N. Sixth St., Louisville, Ky., 40202
Info: The Health Equity Summit brings together healthcare leaders, policymakers, social justice advocates and community leaders to review our progress in advancing health equity initiatives since the inaugural summit in 2007; examine challenges encountered in efforts to advance health equity; and explore how we might move our efforts forward in the future within the context of healthcare reform.

Meaningful Use Survival Seminar II

Date: Friday, April 11
Time: 7:45 a.m. - 12:30 p.m.
Where: Landmark Inn, 190 S. Mayo Trail, Pikeville, Ky., 41501
Info: Kentucky REC and KHIE offers continuing education programs to all healthcare professionals including information regarding: Meaningful Use (incentive payments, stage 2, 2014 changes, HIE updates); patient-centered medical home; HIPAA breaches and audits; and ICD-10.
To register: Registration is free to all Kentucky REC clients. For additional information and online registration visit cecentral.com/live/7876.

Hats for Hope

Date: Thursday, April 17
Time: 6:30 - 9 p.m.
Where: Ramada Inn, 9700 Bluegrass Pkwy., Louisville, Ky., 40299
Info: This signature pre-Derby event celebrates survivorship, friendship, fun and fashion, with 100 percent of event proceeds supporting breast cancer services for patients through the M. Krista Loyd Cancer Resource Center at the James Graham Brown Cancer Center at the University of Louisville.
To register: Tickets are $30 in advance or $40 the day of the event. To purchase tickets or to learn more about the event, visit hatsforhopelouisville.org.

Derby Divas

Date: Thursday, April 17
Time: 6:30 - 9 p.m.
Where: Rodes for Him and for Her, 4928 Brownsboro Rd., Louisville, Ky., 40222
Info: A special night for shopping, fun and friendship to benefit the Norton Cancer Institute Breast Health program and support the cost of mammograms for underserved women in our community. The first 50 registrants to pay a special $125 admission price will receive an exclusive gift bag filled with beauty products and goodies.
To register: Call (502) 629-1234 or visit nortonhealthcarefoundation.com to purchase tickets. Tickets are $45 for pre-admission and $55 at the door.
Nazareth Home acquires Mercy Sacred Heart

Nazareth Home, Inc. entered into an exclusive agreement with Ohio-based Catholic Health Partners (CHP) with the intent to purchase Mercy Sacred Heart, Louisville, with its 146-licensed beds and other services. Once completed, it will bring two compatible organizations together in service to the community in new ways. Nazareth Home will grow to 317-licensed beds between the two campuses.

Baptist Health Foundation Paducah raises more than $17,000 for NICU

Baptist Health Foundation Paducah raised $17,090 for the hospital's Neonatal Intensive Care Unit at its annual luncheon. Information about the NICU's community impact was shared by neonatologist Edward O'Neill, MD, obstetrician-gynecologist Blair Tolar, MD, and Reidland Middle School teacher Stephanie Rathgeber, whose twin daughters spent six weeks in the NICU. The luncheon also included a fashion show by Nola's Boutique.

UofL Medical School put on accreditation probation

The University of Louisville School of Medicine has been placed on probation by its accrediting body.

The Liaison Committee on Medical Education, the body that issues accreditation to medical education programs in the United States and Canada, has expressed concern in nine areas of UofL's Medical School.

Some changes in curriculum and structures will be required. The school remains fully accredited at this time, meaning the school is still eligible for inclusion in federal grants and programs and graduates still qualify for the U.S. medical licensing examination.

The majority of the concern, UofL officials said, is clustered around two main things: the adequacy of the clinical instructional building and the pace of preclinical curricular change.

A $7.5 million renovation to the Health Sciences Center is already underway and curriculum reconfigurations are also being outlined, according to statement released by UofL.

There are 131 standards schools must meet to ensure they remain accredited.

UofL School of Medicine officials will submit a formal action plan to the accreditation body in the summer and anticipate a follow-up visit in the summer of 2015.

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

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Why did you decide to become a doctor? For me, it was love at first contact. My mother, who was a nurse for many years, piqued my interest in the field with her daily “war stories,” which were always dramatic and ended with her saving the day. Over time, I found myself being drawn to the mechanisms and physiology of it all. However, I have always been a gregarious extrovert and feared not having a constant, collegial interface had I limited myself to the science alone. The greatest joy in doing this is to hear a patient’s story and be a part of their extended family. The relationships that one forges on a daily basis are what drew me in. It was the perfect mix of head and heart, minus the terrible pun.

Is being a doctor different than what you thought? If so, how? So much of the time spent in patient care happens at a computer terminal or with paperwork. I never thought that face-to-face patient time was going to take up less of my time than those other activities.

What is the biggest misconception about your field? Most people think of cardiology as a hard science. There are a lot of unknowns and best guesses. We are guided by data generated by clinical trials and there is a lot of work to be done in this arena. Hence, we often use experience as a guide, which we hope leads us in the right direction.

What is the one thing you wish patients knew and/or understood about doctors? I wish patients knew how much we persevere about them. There are many times after a clinic where I will continue thinking about a particular patient having a particularly rough time. Often, I will call that patient days later because another thought or idea struck me.

What drew you to cardiology? The beauty of the cardiovascular system is awe-inspiring—the physiology of how the heart fibers contract to how the heart and blood vessels work in concert to work so efficiently. Moreover, some of the greatest advancements in medicine have come from this field. I wanted to contribute to this fund of knowledge.

If you had to pick your “theme song” what would it be? “You’ve Got a Friend” by James Taylor.

What’s one thing your colleagues would be surprised to learn about you?

When I’m in a funk, I look for old Don Rickles’ interviews on YouTube and watch them over and over again.

What’s the best advice you ever received? Who gave it to you? Dr. Roberto Boll, my divisional chief and mentor, always tells me to write/present my work using the time and patience one would use explaining it to a layperson. If you cannot make a layperson understand it, you probably don’t understand it yourself. That advice has yielded great results for me as a clinician, teacher, and as a researcher.

What’s the last good book you read? *Proof of Heaven*, a Neurosurgeon’s Journey into the Afterlife by Eben Alexander (Simon & Schuster, 2012). It is a fascinating read about his experiences in a near-death situation and his description of what he feels was an after-life.


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.

STAR offers undergraduates paid internships in STEM research labs

A grant from the National Institute of Alcohol Abuse and Alcoholism is funding a University of Kentucky program that will not only advance research of alcohol abuse, but also train tomorrow’s problem solvers.

Professor Mark Prendergast of the department of psychology and associate professor Kim Nixon of the department of pharmaceutical sciences turned their devotion to research and their commitment to mentoring students into the Summer Training in Alcohol Research (STAR) grant.

The $350,000 grant will make it possible for as many as 55 undergraduate students to earn a $4,000 stipend during a 10-week summer internship in one of 11 UK research projects focusing on alcohol and its effects. The program will reach out specifically for a diverse population of Kentuckians for this unique educational opportunity.

Due to the breadth of empirical approaches employed by UK’s alcohol research faculty, undergraduates will have a variety of research experiences to choose from, including impulsivity, fetal alcohol syndrome, addictive behavior, parental drinking and its effect on children, cancer, damage to the brain, thought processing, lost productivity and other adverse social and medical consequences of alcoholism. The students will perform independent STEM research under the supervision of alcohol research faculty, participate in weekly educational and professional development seminars, and be trained in responsible conduct of research.

At the conclusion of their internship, a summer alcohol research symposium will give the students the opportunity to professionally present their work through an academic research presentation to faculty, laboratory personnel and peers.
One (new) direction

Seven Counties Services plans for the future.

By Gwen Cooper

It’s hard to accomplish anything without a plan. Whether you are training for a half marathon, following a recipe or running a business, you must have a plan. According to Wikipedia, strategic planning is an organization’s process of defining its strategy, or direction and making decisions on allocating its resources to pursue this strategy.

In our constantly changing world of healthcare, it is more important than ever to take a look at the here and now (what we are currently doing) and plan for the future.

We spent time drilling down into each area of our multi-divisional organization to better understand the market value of every line of business. We’ve answered hard questions around the quality, competitiveness and sustainability of each service we offer.

Seven Counties is in the sixth month of an intensive strategic planning process. Often, there is much time and effort invested in writing the strategic plan with little time and effort invested in the implementation across all departments and divisions. Statistically between 70 to 80 percent of all plans fail. I am more than confident that ours will not.

We ask ourselves: What are we doing now that we must continue to do? What will we look like in the future? How can we continue to do more with less? Is the future one year away, three years or ten? What are we not doing now that we should or could be doing to help increase revenue and provide additional services?

Living, Fluid Documents

Strategic plans are living, fluid documents. They provide an opportunity to evaluate, discuss, plan and implement while providing the framework to self-check and alter plans as the future unfolds.

Seven Counties has had a challenging year. Kentucky implemented managed care in 2013, which resulted in a decrease in revenues of about 18 percent and increased our cost of billing by more than $1M; the 2015-2016 budget about to be passed by the General Assembly includes major cuts to our critical community care dollars, and the implementation of the Affordable Care Act is just getting started.

We spent time drilling down into each area of our multi-divisional organization to better understand the market value of every line of business. We’ve answered hard questions around the quality, competitiveness and sustainability of each service we offer. To date, this process has included a review of our mission and vision along with better defining our organizational mandates.

Concurrently, we spent time drilling down into each area of our multi-divisional organization to better understand the market value of every line of business. We’ve answered hard questions around the quality, competitiveness and sustainability of each service we offer.

Most importantly, we have involved our board and leadership group in conducting a broad SWOT analysis (strengths, weaknesses, opportunities and threats) of Seven Counties.

This information is currently being compared to an environmental survey to determine the most likely areas for success in the future.

Clearer Understanding of Service Delivery Model

The highlight for me, so far, has been the opportunity to learn about our service lines of business and to dissect them in a way that someone in external affairs would not normally have the opportunity to do.

This has given me a much clearer understanding of our service delivery model and has helped many of us in our discussions regarding what, in this delivery system is most critical and what we can change, improve or, in some cases, eliminate. It gives those of us who communicate our value and needs to the public a different way to talk about what we do and express our true impact in our community.

Our anticipated completion date for our strategic plan is mid-May. This gives us time to discuss and refine before beginning implementation in the next fiscal year. We remain well aware that our strategic plan has many facets and is truly a living document that we will breathe life into for the next several years.

Gwen Cooper is vice president, external affairs of Seven Counties Services.
Expanding options and access

KentuckyOne Health responds to changing healthcare landscape with focus on long-term primary care strategy.

By Damian P. “Pat” Alagia, III, MD, and Travis Burgett

With the changing landscape of healthcare in the United States, many organizations, including KentuckyOne Health, are actively working to fill the gaps in patient care. We are becoming focused not just on caring for the ill, but on improving the overall health of Kentuckians.

One way that we will do this is through the expansion of our primary care network. We believe that this is among the most important methods for improving the overall health of the community. To achieve this goal, we've identified several key initiatives, some of which are already underway. Other programs will be implemented in the next three to five years.

Leading these efforts is a multi-disciplinary team of employed primary care physicians, ambulatory care specialists, strategic business development team members, finance experts, physician liaisons and marketing experts. This team will develop our long-term strategic plan for primary care.

We recognize that our physicians are key to the success of our strategy, so we're working diligently to ensure that our efforts align with the needs and wants of the physicians who work with us.

Key Areas

The team has agreed that, first and foremost, patients need better access to primary care to improve their overall health. That means our strategy must be focused on providing more access points to the general population, especially those in underserved areas.

Utilizing the expertise of this team, we've identified several key areas in which KentuckyOne Health can both expand and improve primary care for people across the state.

First, we're focused on expanding the number of traditional providers and their locations. We know that Kentucky is facing a significant physician shortage, and the need for healthcare providers will continue to grow in the coming years. We recognize that our physicians are key to the success of our strategy, so we're working diligently to ensure that our efforts align with the needs and wants of the physicians who work with us.

We're working toward a coordinated approach as we follow some new, non-traditional methods, but we want to ensure that we’re complementing our traditional provider base access points—not competing with them.

Second, we will examine opportunities for adding brick-and-mortar urgent care centers. We recognize that this service line will be important for expanding the continuum of care. We are also looking into opportunities to partner with retail pharmacies. We feel certain that the expertise of KentuckyOne Health Primary Care providers can greatly contribute to this growing area.

Anywhere Care

A third area of focus is the virtual component of primary care made available in our recently launched Anywhere Care service. This system provides convenient and cost-effective access to primary care for patients suffering from minor illnesses or injuries.

While Anywhere Care provides this urgent care access from anywhere in the state, we're also working to fill the gaps in care in the areas of Kentucky that need it most. In 2012, we opened a telehealth primary care clinic in Powell County, and another in Wolfe County. These two areas have some of the worst health statistics in the state.

Thanks to grants from the Foundation for a Healthy Kentucky and the federal government’s Social Innovation Fund, these facilities not only provide additional access to specialty care, but also minimize the need for a patient to travel to see a specialist, thereby reducing the costs of care.

Finally, we realize the need for a strong network of healthcare providers for non-emergency concerns. As the ACA is implemented, newly insured patients now have the access to primary care that wasn’t available to them before. We’ve always had a significant focus on providing indigent care, but now that many newly insured patients will enter the system, we need to make sure that we have enough access points to serve their needs by providing them with primary care physicians and by focusing emergency departments on emergency care.

The team has agreed that, first and foremost, patients need better access to primary care to improve their overall health.

Shifting from Illness to Wellness

Our focus is on the people we serve. We will continue to provide the highest level of care available to bring wellness, healing and hope to all, including the underserved.

Our strategy is directly aligned with recognizing the physician shortage and addressing that challenge in a way that works for our physicians, but also continues to expand options and access for our patients throughout the state.

Using this strategy, KentuckyOne Health hopes to improve the health of the communities we serve by providing reliable access to care. In this way, we will improve the overall level of health across the state.

This means a shift from illness to wellness; working to keep people healthy from the start. Creating a system of accessible primary care is at the root of our strategy.

Damian P. “Pat” Alagia, III, MD, is chief physician executive, KentuckyOne Health and Travis Burgett is director of strategy, KentuckyOne Health.
Study gains insights into nurses’ overall confidence and outlook towards retirement.

By Melanie Wolkoff Wachsman

When it comes to nurses and retirement there's both good news and bad news. The good news is that one quarter (26 percent) of all nurses with a workplace retirement savings plan have accumulated more than $100,000 in assets, up from 18 percent in 2011.

The bad news is that savings rates, especially among younger generations are less than optimal. For example, Fidelity Investments recommends employees save 10 to 15 percent of their salaries from both employer and employee savings. A new online study conducted by Versta Research on behalf of Fidelity Investments showed that Gen Y and Gen X nurses are saving a median of 5 percent and 6 percent, respectively, compared to Boomers who are saving 10 percent.

The 2013 Fidelity Investments Nurses Retirement Study, which was designed to gain insights into nurses’ overall financial confidence and outlook towards retirement, surveyed 536 practicing U.S. nurses. Most of the nurses surveyed (62 percent) were employed by not-for-profit organizations; 38 percent of nurses are employed by for-profit organizations. Four out of five (80 percent) were full-time. The average (median) tenure with their employers was seven years.

When it comes to tools and resources that nurses use to learn about and manage their workplace retirement plans, one-third (34 percent) say that they rely on educational resources from their employers.

No Participation

Despite the fact that nine in ten nurses report having a workplace retirement savings plan available to them, whether it is a 401 (K), 403 (b) or similar plan, 15 percent of nurses are not participating in workplace retirement plans. For those who have plans available to them, this represents a lost opportunity to save and qualify for the company match offered by many healthcare institutions.

Among those not participating in their workplace retirement savings plans, inertia and needing help figuring out how to begin are as important as not having enough money. Other reasons include:
- Don’t have enough funds to save (32 percent)
- Already save in other ways (29 percent)
- Have not gotten around to it (29 percent)
- Don’t know where or how to begin (22 percent)
- Overwhelmed by the amount needed (15 percent)

In addition to any workplace retirement benefits available to them, just more than half of the nurses surveyed are saving for retirement through an IRA—a number that has not changed significantly since the first nurses’ survey in 2007.

Further, less than one-half of nurses (44 percent) believe they will never fully retire. Six out of ten will continue to work, in part, because they need the health insurance.

Worries about Industry and Government Changes

The study also revealed that many nurses worry about industry and government changes that are outside of their control, including consolidation and reduced benefits. Four in ten nurses (42 percent) have experienced a consolidation (merger or acquisition of their employer), up from 29 percent two years ago. One-half anticipate more hospital consolidation over the next five to ten years (up from 39 percent) two years ago.

In regard to the impact on their jobs, nurses report negative outcomes caused by consolidation by a ratio of four to one. These include more stress, lower morale, fewer staff and cuts to benefits.

What do nurses anticipate as adjustments to their profession specifically from healthcare changes? Again, more than anything else, they see more work, more stress, fewer available nurses and lower levels of care. When it comes to changes that will most affect them personally, nurses focus on stress, reduced benefits and increased responsibilities.

Gen X Nurses Concerned About Retirement Security

Gen X nurses express the strongest concerns about their financial future in retirement, and Boomers express the least. More than half of Gen X (55 percent) and government changes that are outside of their control, including consolidation and reduced benefits. Four in ten nurses (42 percent) have experienced a consolidation (merger or acquisition of their employer), up from 29 percent two years ago. One-half anticipate more hospital consolidation over the next five to ten years (up from 39 percent) two years ago.

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Key Findings

- Retirement savings are up: one quarter (26 percent) of nurses with a workforce retirement savings plan have accumulated assets of more than $100,000, up 18 percent in 2011.
- Participation in workplace retirement plans remains steady at 85 percent. However, among those participating, saving rates are less than optimal especially among younger generations: Gen Y (5 percent), Gen X (6 percent) compared to 10 percent of Boomers.
- Gen X nurses (55 percent) and Gen Y nurses (48 percent) are not confident they will have enough money to retire, compared to 35 percent of Boomers. Gen X nurses (76 percent) are concerned they will never be able to retire compared to 53 percent of Boomers.
- Sixty-two percent of nurses report not saving enough for retirement. More than half (53 percent) feel retirement planning is overwhelming, and 79 percent are looking for guidance.
- Nurses are experiencing increased levels of stress as a result of industry consolidation from increased mergers and acquisitions.
Tackling taxes

Changes to tax code impact the bottom line at work—and home.

By Cindy Sanders

As the clock ran down on 2013, a number of deductions healthcare providers have depended upon to lessen their tax burden expired. Last year also saw an increase in federal tax rates, including higher taxes on investment income and capital gains. This combination has accountants nationwide bracing for a widespread outbreak of severe sticker shock come April 15.

Many of the changes in 2013 and 2014 will hit healthcare professionals and providers both as businesses and as individuals.

“Congress did not extend the favorable 179 deduction, which allows a taxpayer to expense immediately the cost of an otherwise capitalizable asset.”

— Scott Tomichek, senior tax manager, Carter Lankford CPAs PC

Key Business Changes

Beneficial depreciation options take a big hit in 2014. Changes to expensing qualified purchases, bonus depreciation, qualified leasehold improvements and a new IRS capitalization policy are all anticipated to impact many in the healthcare space.

“Congress did not extend the favorable 179 deduction, which allows a taxpayer to expense immediately the cost of an otherwise capitalizable asset,” said Scott Tomichek, senior tax manager for Carter Lankford CPAs PC, located in Tennessee. “The 2013 Section 179 deduction was $500,000 for purchases up to $2 million and set to be reduced to $250,000 for purchases up to $200,000 in 2014.”

Accelerated Depreciation Expired

Accelerated depreciation, which has been heavily used by healthcare providers and facilities to make equipment purchases more affordable on the front end was another incentive that expired at the end of 2013.

On the purchase of capitalizable assets in 2013, a taxpayer was allowed to deduct 50 percent of that asset in the year of purchase and then depreciate the remainder. The accelerated 50 percent goes away in 2014 and reverts to the regular rules of a more evenly-based depreciation schedule without Congressional intervention.

Another change is in the life of qualified leasehold improvements, which are defined as any improvement to an interior part of a building that is nonresidential property.

“Qualified leasehold improvements were able to be depreciated using a 15-year life and included in the previous Section 179 and bonus depreciation calculation in 2013,” Tomichek explained.

In 2014, those improvements return to a 39-year depreciable life, which means the expenditures are depreciated at a much smaller annual amount over nearly four decades and no longer qualify for the other depreciation benefits.

The new IRS capitalization policy that went into effect on January 1 is a bit of ying to the yang of losing the other deductions. The most important part of the rule is the de minimis safe harbors that apply to not only improvements but to certain tangible property purchased.

The de minimis safe harbor allows a taxpayer to deduct purchases under a certain threshold. For taxpayers with audited financial statements, the threshold is $5,000 per item as substantiated by invoice. For those without audited financial statements, the threshold is $500.

Previously, these qualified items had to be depreciated but now can be expensed, which is a tax benefit. However, to qualify, the taxpayer must have a written accounting policy in place at the beginning of the tax year.

In addition, a number of other general 2014 tax changes could impact medical practices and hospitals. One example is the transit benefit allowance. The amount of transit fringe benefits that employers can provide to employees on a pre-tax basis for using public transportation and van pooling will drop from $245 per month in 2013 to $130 per month for 2014.

Dozens of other extenders, or tax incentives, including the work opportunity tax credit for hiring targeted individuals and the research tax credit, as well as various energy credits, expired at the end of 2013.

For exempt organizations, which includes many hospitals, the IRS is focusing on compliance, using information reported on Form 990. Indicators of potential noncompliance that they have identified include the following relationships:

• Large fundraising revenues and small fundraising expenses;
• Large fundraising revenues and small charitable program services expense;
• Large unrelated business income but no income taxes due on the unrelated business income;
• Large total compensation to officers, directors, trustees and key employees and small annual gross receipts.

This Time It’s Personal

Much has been written about the continued on page 15
higher tax brackets and rates, but a lot of people will still be surprised at the cumulative effect.

“The top tax rate went from 35 to 39.6 percent and that happens starting at $450,000 married filing jointly or $400,000 for single filers,” said Tom McGuinness with Reimer, McGuinness & Associates, PC in Houston.

However, that’s just one of six tax changes that will impact high income taxpayers. A 5 percent increase (from 15 percent to 20 percent) in capital gains and dividends tax has also been instituted for those at the same income levels as the highest tax bracket. For individuals starting at $200,000 and married filing jointly at $250,000, the Affordable Care Act added a 0.9 percent additional FICA tax on wages and a 3.8 percent Medicare tax on investment income.

Itemized Deduction Phase-Out

Additionally in 2014, the sales tax deduction goes away, and for single wage earners beginning at $250,000 and married filing jointly at $300,000, itemized deductions and personal exemptions are being phased out. This itemized deduction phase-out could be quite costly, particularly to those who give large amounts to charity and have significant home mortgage interest they were used to deducting.

“The personal exemption is equal to $3,900 (in 2013) per exemption you claim, and all exemptions are lowered by 2 percent for each $2,500 of income above the numbers ($250,000 single, $300,000 married filing jointly),” McGuinness explained. “The larger your family, the larger the tax increase."

The net result is people are having to work much harder simply to make the same money.

Don’t Leave Money on the Table

Finally, too often money is left on the table due to poor revenue cycle management. “A lot of organizations and medical facilities have neglected their fee schedule payment from a lot of their third party payers,” Bourke said.

“While federal rates and large payers don’t typically offer much leeway, that doesn’t mean renegotiation is impossible with every payer. “If you can increase your fees even for a small percentage of your patients, it’s always a good thing to do,” he said.

Additionally, changes in health benefits have shifted more responsibility to consumers, resulting in rapidly rising bad debt. “Healthcare organizations have done a poor job in making that transition and holding people accountable,” Bourke said, adding that it isn’t about banging on people’s doors to demand money, but rather about making sure they’re accountable.

The Big Picture

“We are in an unprecedented atmosphere of confusion and uncertainty. It’s more important than ever that healthcare organizations do three things — minimize their tax burden while simultaneously optimizing their efficiency and minimizing costs,” said Brian Bourke, a healthcare consultant with Honkamp Kroeger & Co. PC, who works with both providers and purchasers of healthcare benefits.

Although admittedly easier said than done, Bourke noted it is possible for organizations to improve in one or all areas to strengthen the bottom line. It’s important for organizations to realize there is a cost inherent in complying with new laws and regulations.

“Although some employer provisions associated with ACA have been delayed, others—like allowing adult children through age 25 to remain on a parent’s plan—are already in effect. Now is the time to take a hard look at what it will cost to provide benefits and/or incur tax penalties."

Improving Efficiency

As for improving efficiency, enhancing the operational management function is critical and Bourke stressed the analytical process to ferret out inefficiencies isn’t a “one and done” proposition but an ongoing process.

“Over time, healthcare organizations have gotten very tolerant of inefficiency and revenue loss,” Bourke said, adding that often the management teams aren’t even aware of it. “To remain viable in this atmosphere is every cost needs to be looked at on a comprehensive basis.”

That means scrutinizing every expenditure from reviewing vendor contracts to pricing out office supplies. Another major area for review is the number of employees. Right-sizing isn’t always about laying off employees but might be achieved through strategic planning, realigning duties, early retirement incentives and natural attrition.

“That’s not always a popular thing to say,” Bourke admitted of reviewing human capital expenditures, “but it’s better than shutting down the practice.”

“We are in an unprecedented atmosphere of confusion and uncertainty. It’s more important than ever that healthcare organizations do three things — minimize their tax burden while simultaneously optimizing their efficiency and minimizing costs.”

— Brian Bourke, healthcare consultant

Resources

Link to list of expiring federal tax provisions: jct.gov/publications.html?func=startdown&id=4499
M&A trends in the reform era
Looking back at 2013 and ahead in the new year.

By Cindy Sanders

The Affordable Care Act, coupled with new models of reimbursement, has undoubtedly impacted the way the healthcare industry conducts business today and strategically plans for the future. For some industry sectors within healthcare services, a “strength in numbers” mentality has caused a marked uptick in mergers and acquisitions in comparison to a few years ago. For others, the strategy has been to take more of a “wait and see approach” while trying to figure out just how the new rules will impact their specific markets.

Frank Morgan, who serves as managing director for healthcare services and equity research with RBC Capital Markets, recently shared his thoughts with Medical News on the level of activity in 2013, and his expectations for the coming year. With more than two decades experience in equity research and investment banking, Morgan primarily focuses his research on facility-based healthcare services including hospitals, skilled nursing and assisted living facilities, long-term acute care (LTAC), behavioral health services and rehabilitation.

Overall, Morgan said there was a general uptick in activity in 2013 compared to 2012. That was particularly true within the hospital sector.

Not-for-Profit Side

From mergers to acquisitions to strategic joint ventures, there was a lot of movement on the not-for-profit side, which makes up about 80 percent of hospitals in America.

Dallas-based Baylor Health Care System and Temple, Texas-based Scott & White Healthcare completed their merger in late September to create the largest not-for-profit health system in Texas. Earlier in the year, Michigan-based Trinity Health merged with Pennsylvania-based Catholic Health Systems & Health Management Associates.

And some interesting partnerships occurred between not-for-profit hospitals and systems and publicly traded operators. LifePoint Hospitals and Duke continued to acquire hospitals for their joint venture. One of the largest mergers occurred between a nonprofit hospital system and a major insurer when the Pennsylvania Insurance Department approved the affiliation between Highmark (a BlueCross BlueShield subsidiary) and West Penn Allegheny Health System, both based in Pittsburgh. After closing that deal in April, Highmark went on to add two more Pennsylvania-based hospital systems to its integrated delivery system, Allegheny Health Network.

Publicly Traded Hospital Space

While a lot happened on the non-profit side, there were also major acquisitions within the publicly traded hospital space. On the for-profit side, there were two notable deals completed or announced in 2013 — Tenet Healthcare & Vanguard Health Systems and Community Health Systems & Health Management Associates.

In the first deal, Nashville-based Vanguard was the target of Dallas-based Tenet. The latter completed its acquisition of Vanguard at the beginning of October in a deal valued at approximately $4.3 billion ($1.8 billion purchase price plus assumption of $2.5 billion of Vanguard debt).

The second deal, Morgan said, was announced last year and is anticipated to close in the first quarter of 2014. In this case, Franklin, Tenn.-based Community Health Systems seeks to acquire HMA, which is headquartered in Naples, Fla. Just before Thanksgiving, CHS and HMA announced the companies’ proposed merger had been declared effective by the Securities and Exchange Commission (SEC), clearing the way for a vote by HMA stockholders for or against adoption of the merger agreement.

With a purchase price close to $4 billion plus assumption of debt, the overall value of the merger is anticipated to be in excess of $7.5 billion, making it the largest deal since the HCA buyout in 2006. Once the merger is executed, CHS will own and/or operate 206 facilities with more than 30,000 licensed beds.

“From an M&A perspective, I would expect to see a continued robust level of activity,” Morgan said of 2014. However, given the limited number of publicly traded companies and the amount of activity that has already occurred in that space, he said he expects much of the future activity to be in the not-for-profit world.
Behavioral Health

Behavioral health had a “decent” 2013, Morgan said. Franklin, Tenn.-based Acadia Healthcare began the year by completing previously announced deals acquiring Behavioral Centers of America and AmiCare Behavioral Centers and then acquired additional individual facilities during the remainder of the year. Morgan said he expected the company to continue to grow in 2014.

A behavioral health “marriage” announced in late 2013 will come to fruition in 2014. In November, the leadership of Centerstone, which has a major presence in Tennessee and Indiana, and the H Group, with facilities in Illinois and Kentucky, announced their intent to affiliate.

After a slow start, Morgan noted home health saw some movement by late 2013. “In home healthcare, we did see a little bit of pick up at the end of the year,” he said, noting Louisville, Ky.-based Almost Family acquired Nashville-based SunCrest Healthcare in December.

Going forward, Morgan said, “2014 could potentially be a year where you see more consolidation in the home health space.”

Quieter Sectors

Other sectors, said Morgan, were considerably quieter in 2013. Senior housing saw some limited activity, as did dialysis. Morgan said the latter was already pretty consolidated with the two big players being DaVita and Fresenius.

“Between the two, they already control about 55 percent of the domestic market,” he pointed out.

It was also a fairly quite year for labs, hospice, skilled nursing and LTACs as these sectors restructure and re-evaluate expectations under ACA and the impact of post-acute bundled payments.

In the lab space, Morgan noted, “They’re not redeploying capital for growth right now. They’re trying to pacify stockholders by buying back shares and paying dividends because of the weaker organic growth because of pricing and volume pressures.”

In general, Morgan concluded, there was good news in the equity markets for a number of healthcare sectors in 2013.

“The S&P was up almost 30 percent. Healthcare services was up more than 37 percent,” he said.

For some, the gains were even greater. Morgan said behavioral healthcare was up more than 100 percent and hospitals up more than 44 percent.

Looking ahead, he said, “I still think you can have really attractive returns for 2014 given valuations are still reasonable and the growth opportunities presented by the Affordable Care Act, but I think you need to pick your subsectors carefully.”
Physicians selling practices

Who's making the move now and why?

By Lynne Jeter

Since Congress passed the Affordable Care Act (ACA) in 2010, doctors have been bailing out of practices posthaste. Exasperated by surging expenses, shrinking reimbursements and costly-to-cover government mandates, frustrated physicians are citing healthcare reform-related spending as a major reason for selling practices as the rollout progresses.

According to a study by Jackson Healthcare, the nation’s third largest healthcare staffing agency, 12 percent of physicians who sold their practices before sweeping federal legislation became law made the change because they didn’t have appropriate resources to comply with the law and maintain a reasonable ROI. Within the last three years, the rate of physicians selling their practices for the same reason – especially now with dwindling ways to stay fiscally healthy – jumped to 30 percent.

Who’s Selling?

According to Jackson Healthcare’s report of those now considering selling their practices, 36 percent cite the complexity of the healthcare reform law as a reason; and 24 percent say they don’t have the resources necessary to comply with the law.

Who’s Buying?

In a companion survey released by Jackson & Coker, a subsidiary of Jackson Healthcare, a majority of doctors want to see ACA defunded or repealed. A scant 6 percent said it should remain unchanged.

“Physicians in private practice still outnumber those employed, but this could be shifting as less than half of the respondents with an ownership stake say they plan to remain in private practice,” according to the report.
The A.O. Sullivan Award for Excellence in Education

American Diabetes Association
Floyd Memorial Hospital and Health Services Association Education
Health Enterprises Network
Kentucky Regional Extension Center
Seven Counties Services
Norton Healthcare
Nucleus
UofL Dept. of Pediatrics, Office of Medical Education

The Hall Render Leadership in Healthcare Award

Rob Edwards, Kentucky Regional Extension Center
Mary Haynes, Nazareth Home
Keith Knapp, Christian Care Communities
Phil Marshall, Hosparux, Inc.
Helen Overfield, American Diabetes Association
Gregory Postel, MD, UofL Physicians
Gerard Rabalais, MD, UofL Dept. of Pediatrics
Suzanne Rinne, Masonic Home of Louisville
Carol Steltenkamp, MD, Kentucky Regional Extension Center
Sue Stout Tamme, Baptist Health

The Seven Counties Services Healthcare Advocacy Award

Stephanie Barnett, Choose Well-Louisville
Mark Birdwhistell, University of Kentucky Medical Center
Alice Bridges, KentuckyOne Health
Barbara DiMercurio, RN, University of Louisville Hospital
Gray Street Farmers Market
Healthier Communities Initiative,
Floyd Memorial Hospital and Health Services
Hope Health Clinic
Janice Johnston, Dept. for Behavioral Health,
Developmental and Intellectual Disabilities
Kentucky Regional Extension Center
Sheila Shuster, PhD, Advocacy Action Network
Anita Roper, KY Impact
Jean Wells, Wells Health Systems
Stephen Wright, MD, Kosair Children's Hospital

The Aging Care Award

Atria Senior Living
Creative Strategies
ElderServe
Greater Kentucky - So. Indiana Alzheimer's Association
Nazareth Home
Signature HealthCARE
UofL Physicians - Geriatrics
UofL School of Nursing and Greater Kentucky - So. Indiana Alzheimer's Association

The Facility Design Award

Arrasmith, Judd, Rapp, Chovan Architects and Planners, Nucleus Innovation
LMH Architecture, Suburban Hospital
Luckett & Farley, UofL School of Dentistry

The Healthcare Innovation Award

Bridgehaven Mental Health Services
InnovateLTC
Kentucky Regional Extension Center
Louisville Metro EMS
Nazareth Home
Norton Healthcare
UnitedHealthcare and the myHealthcare Cost Estimator tool
UofL Institute for Cellular Therapeutics
UofL Institute of Molecular Cardiology

The Nurse of the Year Award

Laura Crump, RN, Floyd Memorial Hospital and Health Services
Elizabeth Fitzgerald, EdD, Bellarmine University
Kim Hobson, RN, Nazareth Home
Stephanie Jensen, RN, UofL Physicians - Pediatrics
Barbara Polivka, PhD, RN, UofL School of Nursing
Frances "Libby" Smith, RN, University of Louisville Hospital
Thomas Steven Spalding, RN, Jewish Hospital, part of KentuckyOne Health
Carla Thompson, RN, Baptist Health La Grange
Theresa Watson, RN, Seven Counties Services
Tracy Williams, RN, Norton Healthcare

The XLerateHealth Physician of the Year

Deepak Azad, MD, Floyd Memorial Medical Group - Scottsburg
Toni Ganzel, MD, University of Louisville
Manoochehr Manshadi, MD, Seven Counties Services
Donald Miller, MD, PhD, JGBCG, part of KentuckyOne Health
Tad Seifert, MD, Norton Healthcare
Shiao Woo, MD, Louisville Cyberknife

The Sullivan University System
Sullivan University  Spencerian College  Sullivan College of Technology and Design

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MediStarAwards.com
Compliance is good business

Why you should move compliance into the top five issues in your organization’s strategic plan.

By Clay B. Wortham

Strategic planning is more important than ever before for today’s successful healthcare organizations of all sizes. Establishing a plan that addresses rising external costs, reduces internal costs and maintains an effective workforce is at the top of the list for many organizations.

Too often, however, strategic planning to ensure compliance with increasing regulatory pressures and to minimize compliance risk is a topic pushed to the back of the strategic plan or left off entirely because compliance is perceived as a risk-reduction effort and not directly tied to driving profitability.

And it’s no wonder that compliance can be overlooked; after all, management teams are busy, there are agreements to be made, complaints to be handled and products and services to be sold. In smaller organizations, organizational leaders may need to serve patients as well. Logically, however, compliance should be near the top of the list for every strategic plan. After all, what’s the point of a dynamite strategic plan if in the end the organization must repay the profits in fines and penalties? Like insurance, an effective compliance plan can help an organization capitalize on its success.

We all know that the “I’ll worry about compliance later” mentality can have grave consequences.

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We all know that the “I’ll worry about compliance later” mentality can have grave consequences. For example, in December 2013 Adult & Pediatric Dermatology, P.C. of Concord, Mass. was the first to reach a settlement with the U.S. Department of Health and Human Services Office of Civil Rights (OCR) for not having policies and procedures in place to address the breach notification provisions of the HITECH Act. The settlement resulted in a $150,000 penalty and a corrective action plan, not to mention the accompanying reputational harm to the business.

Five Key Areas

1. A HIPAA Risk Assessment

A HIPAA risk assessment is an investigation and analysis of potential risks of unauthorized use or disclosure of patient health information. There’s nothing magical about it. Identify areas where health information is stored. Who has access to it? What steps need to be addressed to ensure that keys, passcodes and other restrictions are in place and updated regularly so that only people who should have access to the information do? Do employees know about these rules?

A HIPAA risk assessment is not optional; covered entities, and now business associates, are required to conduct one and should update it annually.

The HIPAA Omnibus Rule, effective September 23, 2013, brought sweeping changes to the HIPAA rules. If your organization has yet to create or update its HIPAA risk assessment in the wake of the Omnibus Rule, here are two items that require immediate attention:

2. Notice of Privacy Practices

All Notice of Privacy Practices (NPPs) should be revised to include statements addressing the following:

• Uses and/or disclosures of patient information for marketing purposes, fundraising communications and the prohibition on the sale of such information without an authorization.
• Patients who pay out-of-pocket for a healthcare service have the right to restrict disclosures to their health plan.
• Breach notification policy.

Covered entities are required to post the revised NPP and make copies available at their office to all new patients and to anyone else on request. If the covered entity maintains a web site, the NPP should be posted there as well.

3. Business Associate Agreements

The Omnibus Rule expanded the definition of business associate (BA) to include subcontractors of existing business associates, and makes business associates directly responsible for compliance with HIPAA requirements. It also affirms that covered entities are liable for penalties for the failure of a business associate subcontractor to perform a function on the covered entity’s behalf. As a result, existing BA agreements should be reviewed and potentially revised to incorporate new requirements and impose those requirements on BA subcontractors.

2. Employee Trainings

Training for new employees is a must; in addition, there should be periodic refresher courses for current employees on policies and procedures and applicable regulations.

For instance, how will employees be compliant with the HIPAA Omnibus Rule mentioned above unless the organization sets aside time to make this a priority? It is the organization’s responsibility to educate and promote an atmosphere of learning. Effective employee training is time well spent; it not only helps to improve compliance, but can be an opportunity to discuss cost-reduction measures, personnel issues and patient service.

Employee training should always be documented. Record who attends trainings and keep a copy of the materials that were disseminated for the training. Regulatory agencies will consider what efforts have been made to train employees on best practices and the law in the event of an audit or investigation.

3. Using EHRs Effectively

The Medicare and Medicaid EHR Incentive Programs are proof that strategic planning and compliance efforts offer significant rewards. By using EHRs effectively, providers can receive valuable financial incentives. Compliance is important in the Meaningful Use context because the Centers for Medicare and Medicaid Services conduct Meaningful Use attestation audits to ensure compliance with the program’s requirements. Although only a small percentage of providers will be subject to a Meaningful Use attestation audit, the stakes are high — a single attestation misstep could be grounds for loss of the full incentive payment. Could your organization survive a Meaningful Use audit?

Strategic planning for Meaningful Use compliance involves documented staff training on the appropriate use of the EHR technology and working closely with your EHR vendor to ensure
that the tool you are using satisfies legal requirements and can be used effectively day-to-day.

4. Vendor and Provider Arrangements
Service agreements, supply agreements and other vendor agreements are essential for any healthcare business. Agreements should be reviewed periodically to determine whether the agreements are current and comply with applicable laws, including fraud and abuse requirements such as anti-kickback safe harbors and Stark law exceptions. Business Associate Agreements should be evaluated as discussed above. The exclusion database should be monitored periodically to ensure that vendors are not on the excluded provider list.

5. Billing Compliance
From patient check-in to final bill collection, billing compliance is a team effort. Billing technology has improved the process greatly, but there is always room for error—or worse—fraud and abuse. Noncompliance with billing regulations can lead to nonpayment (not good for business), overpayments, and prosecution under the False Claims Act (which can all mean the end of a business).

Strategic planning for billing compliance means documented employee training and fostering an environment that encourages employees to identify issues and report problems. Establishing a billing audit program to periodically double-check a sampling of claims for billing errors can help to identify errors before they result in significant liability.

Protect your business and position the organization to capitalize on its success. Move compliance into the top five issues for your organization’s strategic plan.

Clay B. Wortham is an associate in the health law group of McBrayer, McGinnis, Leslie & Kirkland, PLLC.

All Notice of Privacy Practices Should Include Statements Addressing the Following:

- Uses and/or disclosures of patient information for marketing purposes, fundraising communications and the prohibition on the sale of such information without an authorization.

- Patients who pay out-of-pocket for a healthcare service have the right to restrict disclosures to their health plan.

- Breach notification policy.
A new state-of-the-art procedure to treat pain and numbness caused by pinched nerves in the neck, also known as cervical radiculopathy, as a result of degenerative disc disease was introduced recently at Clark Memorial Hospital in Jeffersonville, Ind.

Robert Blok, DO, recently completed the first posterior cervical stabilization procedure with DTRAX technology in the greater Louisville area and the state of Indiana.

“We are very excited to offer this procedure to our patients,” said Blok, who first became aware of the technology after reading an article in the Journal of Neurosurgery last year. “It is an alternative to anterior fusion that is less invasive and could be performed earlier in the continuum of care.”

Faster Recovery, Less Invasive

Blok further explained why the technique has significant advantages over previous surgeries for treatment of degenerative changes of the cervical (neck) spine.

“Traditional approaches to fusing the neck involve an incision in the front of the neck to remove the spinal disc and replace it with a spacer and spinal hardware. While successful, this traditional procedure can cause swallowing and speaking problems for years after surgery. However, this new approach avoids these issues completely, while also getting rid of the scar in the front of the neck,” he explained.

Pressure on the patient’s spinal nerve is relieved by opening the joints and stabilizing with two implants and graft material so that the irritated nerve is no longer pinched by the abnormal disc or bone spurs. The implants enable healing and fusion of the joints, providing a more stable spinal column so that the relief is long lasting.

Patients who receive cervical fusion with DTRAX technology do not have any bone or tissue removed from their bodies, enjoy a fast recovery time; and avoid visible scars in the front of their necks.

“Clinical outcomes revealed a significant decrease in neck and arm pain at the two-to-four week post-operative follow-up,” said Blok. “Our patients are very satisfied overall, and we are excited to now offer a less disruptive approach to neck surgery, as well,” said Blok.

Another bonus: The DTRAX system is a disposable kit; the hospital does not need to purchase any special equipment.
Should opioids for spinal pain be banned?
Recent research supports this limitation.

By Robert Kimberlain, DC

Several national guidelines, including one by the U.S. Department of Health and Human Services, have made recommendations regarding the appropriate use of opioids (e.g., oxycodone, fentanyl, morphine) for the management of acute low back pain. These recommendations suggest that opioid analgesics could be an option for symptom control, but only for a short course due to their side effects.

Recent research supports this limitation. A scientific study published in Spine, the leading international orthopedic journal, found a negative association between patient results and the early use of opioids for acute low back pain. In other words, the more opioids a patient used, the worse their results.

Relationship Between Early Use and Pain Onset

The research team investigated the relationship between early opioid use for acute low back pain and results in a two-year period following low back pain onset with 8,443 participants. Their analysis took into account such items as low back injury severity, age, gender and job tenure.

The findings are important. Patients with an early use of high morphine equivalent amounts were, on average, disabled 69 days longer, the risk for surgery was three times greater, the risk of receiving late opioids was six times greater, and medical expenses were more than $15,000 greater than those who received no early opioids.

The researchers concluded that the use of opioids for the management of acute low back pain is counterproductive to recovery.

Why the Increase in Opioid Analgesics?

It is interesting to note that before the 1980s, treatment with oral opioid analgesics was limited to terminal cancer patients experiencing chronic pain. During the late 1980s, pharmaceutical companies conducted a large-scale media campaign aimed at increasing the use of opioids for acute pain management. The marketing succeeded in increasing opioid prescribing.

In 2002, opioid analgesics were the most frequently prescribed controlled substance.

Robert Kimberlain, DC, is a chiropractor located in Louisville.
How to engineer your financial future

Four tips for all wealth stages.

By Paul Taylor

Financial resolutions can be the most difficult to keep. They can include minute detail, number crunching, plenty of files and discipline that can affect a person’s entire lifestyle.

Many folks simply are not predisposed to combing through the details of their financial situation; for them, the financial world is abstract and filled with arbitrary rules, constantly changing interest rates and other complexities, but being more involved in your own money is well worth the investment.

**Taking Control**

There are four things you can specifically do to take control of your financial life.

1. For your cash flow, keep in mind the four A’s: accounting, analysis, allocation and adjustment. The four A’s describe a systematic and disciplined approach to your daily, weekly, monthly and yearly spending habits.

2. **Utilize estate planning tools such as wills and trusts; make sure the details are accurate.** Wills and trusts allow you to spell out how you would like your property to be distributed and much more. A will gives you the opportunity to nominate your executor and guardians for your minor children. If you fail to make such designations through your will, the decisions will probably be left to the courts. Bear in mind that property distributed through your will is subject to probate, which can be a time-consuming and costly process.

3. Start planning your retirement sooner rather than later. There are a variety of retirement planning options that can meet your needs. Your employer funds some; you fund some. In most cases, early withdrawals before age 59½ may be subject to a 10 percent federal income tax penalty. The latest date to begin required minimum distributions is usually April 1 of the year after you turn age 70½. Withdrawals from tax-deferred plans are taxed as ordinary income.

The top planning options include defined benefit pension; money purchase pension; profit-sharing plan; savings plan; employee stock ownership plan; tax-sheltered annuities; individual retirement accounts; self-employed plans; simplified employee pensions; and savings incentive match plans for employees.

4. Remember the first commandment in safe investment: diversification. Virtually every investment has some type of risk associated with it. Don’t put all your eggs in one basket. Diversification is one of the main reasons why mutual funds may be so attractive for both experienced and novice investors. Many non-institutional investors have a limited investment budget and may find it challenging to construct a portfolio that is sufficiently diversified. For a modest initial investment, you can purchase shares in a diversified portfolio of securities. Depending on the objectives of the fund, it may contain a variety of stocks, bonds and cash vehicles, or a combination of them.

Paul Taylor is the founder and owner of Capital Advisory Group & Tax Planners of Lake Norman and Capital Investment Advisors, Inc.
Female CEOs can lead with impact

Three ways to set yourself apart from the competition.

By Debora McLaughlin

A record number of women are Fortune 500 CEOs. Women are launching businesses at 1.5 times the national average. There are now 8.2 million American women running their own companies. The numbers are notable. From 1997 to 2011, the number of U.S. women-owned businesses increased by 50 percent. According to Catalyst, a nonprofit organization, as of January 1, there were 21 women running Fortune 500 companies, including IBM and PepsiCo. That's up from seven in 2002-2003. Among the Fortune 1,000 companies, there are twice as many, including the CEOs of Neiman Marcus Group, Cracker Barrel and Dun & Bradstreet.

Transparency encourages greater communication, team building and leadership.

Nonetheless, business women still face hurdles. Keep in mind, while 21 are Fortune 500 CEOs—a record high—that's only 4.25 percent of the total. The figures hold for Fortune 1,000 companies, less than 5 percent have a female at the helm.

Upward Climb

While women are launching more businesses, they have an upward climb; studies show that women-owned companies are less likely to hit the $1 million mark and are more likely to fail. While women are launching more businesses, they have an upward climb; studies show that women-owned companies are less likely to hit the $1 million mark and are more likely to fail.

Female CEOs can lead with impact

1. Develop your personal brand. Let people get to know you, your core story of experiences and how they relate to your drive and vision. As Steve Jobs said, “connect the dots,” then use transparent communication to share your story. People make better connections with people who tell a great story, and they’re most interested in the story behind the person at the top. Transparency encourages greater communication, team building and leadership.

2. Develop and use your personal network. Find a mentor and be a mentor; seek out other women at your level; and accept the strength, ideas and energy your connections have to offer. It is no longer necessary to blaze trails alone, and women have more power than they may realize.

According to a Dow Jones report, startups with five or more female executives have a 61 percent success rate. It goes further and says that odds of success “increase with more female executives at the vice president and director levels.”

3. Stand for something: position yourself as a strong thought leader. It’s not easy being at the top. Women tend to distrust powerful women, and men may view women as weak or too collaborative and sensitive.

Take a firm stand on something you care about deeply and rally the organization around that objective. You will gain the respect of your peers, customers and stakeholders.

As the numbers clearly demonstrate, business is changing. Women account for 21 percent of all full-time employees in the United States and over 40 percent of all college graduates. More women than ever before are entering the workforce and achieving greater influence and impact.

According to Catalyst, a nonprofit organization, as of January 1, there were 21 women running Fortune 500 companies, including IBM and PepsiCo. That's up from seven in 2002-2003. Among the Fortune 1,000 companies, there are twice as many, including the CEOs of Neiman Marcus Group, Cracker Barrel and Dun & Bradstreet.

Progress or capitulation?

New cholesterol guidelines significantly increase the number of statin-eligible patients, but does this truly represent advancement in care?

Elizabeth Klodas, MD

According to the American Heart Association (AHA), cardiovascular disease (CVD) affects 80 million Americans and the costs of care are exploding. The AHA projects that by 2030 we will spend more than $800 billion per year on CVD management. Put in context, that's equivalent to the one-time massive economic stimulus used to save the entire U.S. economy after the Great Recession. It's not surprising, then, that prevention of disease is more important than ever and that more aggressive approaches are clearly warranted.

And, indeed, the latest cholesterol guidelines are clearly more holistic, attempting to address cardiovascular risk above and beyond lipid levels. However, they also surrender on lifestyle, by not including weight, activity or eating habits in the new risk calculator — and by tacitly abandoning the mandate to try lifestyle intervention first before placing an individual on medications. Getting rid of LDL as numerically significant has also eliminated a measurable indicator of lifestyle improvement that patients could easily follow and strive towards.

Why not try to utilize every meal as an opportunity for a therapeutic intervention? Why not make food the cornerstone of reducing risk?

In practice, the risk calculator can mandate statin therapy in individuals clinically at low risk, while seemingly ignoring red flags in others. For example, a fit 53-year-old normal-weight African American male who religiously follows a DASH diet [a plant-focused diet, rich in fruits and vegetables, nuts, with low-fat and non-fat dairy, lean meats, fish, and poultry, mostly whole grains, and heart healthy fats] and maintains his systolic readings around 120 mmHg with low-dose ACE inhibitors alone qualifies for statin therapy — despite a total cholesterol of 190 and HDL of 80. Meanwhile, a massively overweight 53-year-old white male who eats primarily fast food, who has the same total cholesterol but an HDL of 34 has a calculated 10-year risk below 5 percent. No statin required.

Cardiovascular Disease, a Food-borne Illness

Clearly no calculator ever substitutes for clinical judgment, but the above examples illustrate that some of the most salient factors that contribute to the development of heart disease are not being addressed in the cholesterol guideline.

Cardiovascular disease is a food-borne illness. To not include nutrition status in any way within the newly designed risk calculator is a travesty — because it essentially lets patients off the hook. We cannot capitulate on lifestyle in this way — when lifestyle is a primary cause of the disease.

Increasing the number of statin-eligibles is not without consequences.
Pharmacists should take a second (and third) look before filling prescriptions for large quantities of controlled substances. Recent criminal prosecutions demonstrate that law enforcement officials are now expanding the scope of their investigations beyond those who prescribe these substances, to include pharmacists and pharmacy technicians as well.

When is it a “legitimate medical purpose?”
The Controlled Substances Act (CSA) makes it unlawful, except under certain circumstances, to distribute controlled substances. Physicians, pharmacists, and those assisting them may nevertheless distribute controlled substances so long as the prescriptions are “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” Two questions arise: first, what is meant by the phrase “legitimate medical purpose,” and second, when is a practitioner “acting in the usual course of his professional practice?”

For a pharmacist or pharmacy technician, the second question may be easier to answer. Although not defined by statute, a pharmacist acting in the usual course of practice does so when abiding by generally accepted standards of pharmaceutical practice. These would include following state rules and regulations governing the operation of the pharmacy and the dispensing of controlled substances. The more difficult question concerns the meaning of a “legitimate medical purpose.” Because even after verifying the license of the prescribing physician, and calling the physician’s office to confirm the accuracy of the script, filling a prescription for controlled substances may nonetheless subject the pharmacist to liability under the CSA.

What is a pharmacist to do?
As a precaution, some pharmacies have begun refusing to fill all out-of-state scripts. Others have taken less drastic measures and rely on their own observations in their dealings with customers. Is the script written for an unusually large quantity of controlled substances? Is the customer paying in cash or is the medication covered by insurance? Is the customer requesting refills of the substance before the scheduled refill date? Is there some reason the customer must travel to another state to see a physician for the particular ailment? These questions may help a pharmacist decide whether the script was issued for a legitimate medical purpose.

Pharmacy technicians: Consult with the boss.
Of course, making the “legitimate medical purpose” determination is considerably more difficult for pharmacy techs lacking the skill and training of registered pharmacists. For this reason, pharmacy technicians should never fill a script for a controlled substance without obtaining the approval of the pharmacist-on-duty. In the end, taking multiple looks at that questionable script may help pharmacists and pharmacy technicians avoid prosecution.

Is there more you need to know? Call DBL.

Female CEOs can lead with impact

Continued from page 25

for 73 percent to 85 percent of consumer decisions in the United States, which gives female CEOs yet another advantage—insight into their customers’ values.


Progress or capitulation?

Continued from page 25

In clinical practice up to 20 percent of outpatients receiving statins experience treatment intolerance, and the guidelines do nothing to address this issue. It is conceivable that at least some of these individuals could achieve lower risk levels through specific dietary changes. On a broader scale, nearly as many, if not more, of the statin-eligibles are actually statin-unwilling. It’s not just fine and good to recommend a treatment if people won’t actually take it. But everyone has to eat. Why not try to utilize every meal as an opportunity for a therapeutic intervention? Why not make food the cornerstone of reducing risk?

Impact of Dietary Patterns

The impact of dietary patterns on the incidence of heart disease and heart disease risk factors has been extensively documented in the literature. Indeed, nutrition intervention trials have even demonstrated cholesterol lowering effects commensurate with those achieved with statin therapy. So why are the lifestyle guidelines relatively generic and milquetoast, relegating food to a mere supporting role?

Are we just more comfortable and confident focusing on statins? There’s no question that drugs are easy, but food is hard (and time/resource consuming) to affect. But perceived difficulties around dietary interventions should not relegate dietary advice to a separate guideline and essentially “background” therapy.

Food is central to health and disease. Food has to be emphasized as clearly and emphatically as statins if we are ever going to curb the tsunami of cardiovascular disease. Capitulating on diet is not progress. It’s a giant step backwards.

Elizabeth Klodas, MD, FACC, is a cardiologist in Minneapolis, Minn., and the co-founder of Truhealth MD.
Nurses’ –now and future—financial needs

Continued from page 13

48 percent of Gen Y are not confident they will have enough money to retire, compared to 55 percent of Boomers. Further, more 76 percent of Gen X nurses are concerned they will never be able to retire compared to 53 percent of Boomers.

Roughly one in five (19 percent) nurses expect Social Security to be their primary source of retirement income. Gen Y and Gen X nurses put less faith in the program, with only 8 percent and 16 percent, respectively citing Social Security as primary source.

The number of nurses who report having a defined benefit pension plan has dropped from 48 percent in 2011 to 39 percent in 2013. Among Boomer nurses, 44 percent have access to a defined benefit plan. Similarly, the numbers who expect to rely primarily on a defined benefit pension plan for retirement income is down from 18 percent six years ago to 7 percent in 2013.

Relying on Employer Resources

Bottom-line 62 percent of nurses acknowledge that they are not saving enough for retirement. A majority of nurses admit needing more help planning financially for retirement, especially Gen Y and Gen X nurses.

However, needing help does not always lead to action. Among those who say they are not saving enough, just one in four (27 percent) will seek retirement planning and guidance over the next 12 months to help them save more.

When it comes to tools and resources that nurses use to learn about and manage their workplace retirement plans, one-third (34 percent) say that they rely on educational resources from their employers. Among the employer resources that nurses find most helpful are individual in-person meetings and mailed materials. Individual consultations, either in-person or by phone, are increasingly important.

Beyond one-on-one employer resources, nurses increasingly look to general online resources and family for help:

- **Online tools** (relied on by 40 percent, up from 31 percent in 2011).
- **Family and friends** (relied on by 41 percent, up from 31 percent in 2011).
- **Online educational sites** (relied on by 32 percent, up from 23 percent in 2011).
- **Financial publications** (relied on by 16 percent).

Further, less than one-half of nurses (44 percent) believe they will never fully retire. Six out of ten will continue to work, in part, because they need the health insurance.

Legislative wrap-up

Continued from cover

Act and the kynect exchanges are also up in the air, with both the governor and the state House including funding in their budgets, while the Senate stripped such funding out.

At press time, lawmakers were still arguing over a final budget, leaving the funding up in the air.
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LEXINGTON, Ky. (Jan. 24, 2014) — Chang-Guo Zhan, professor in the University of Kentucky College of Pharmacy's Department of Pharmaceutical Sciences, received a three-year, $1.8 million National Institutes of Health (NIH) grant to develop a therapeutic treatment for cocaine overdose.

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 half a million people visit emergency rooms across the country each year due to cocaine overdose."

This new grant is the fourth in a series of investigator-initiated research project (R01) awards that Zhan has received from the NIH to continue to discover and develop a cocaine abuse therapy. In previous work, Zhan has developed unique computational design approaches to generate of high activity variants of butyrylcholinesterase (BChE), a naturally occurring human enzyme that rapidly transforms cocaine into biologically inactive metabolites.

Zhan and his collaborators have improved BChE catalytic activity specifically against cocaine by 4,000 times. The focus of this new grant is to optimize and stabilize these high-activity BChE variants. The hope is that at the end of this grant, this therapy will be ready for clinical development.

"Dr. Zhan's lab is at the leading-edge of cocaine overdose therapy," said Linda Dwoskin, associate dean for research at the UK College of Pharmacy. "This grant is the culmination of the pre-clinical, innovative and groundbreaking work that has been taking place in Dr. Zhan's laboratory for many years. The next step will be to move this potential therapy into clinical use and make it available to those who need it."