Stephen Williams has devoted 39 years of his career providing service and leadership to Norton Healthcare — 23 of those years as chief executive officer. He stepped down from that position at the end of 2016 to enjoy a well-deserved retirement. Russell Cox, president of Norton Healthcare, assumed the role of president and CEO, effective Jan. 1, 2017.

Under Williams’ leadership, Norton healthcare has risen to be consistently rated as one of the nation’s top 100 integrated healthcare systems. More important, the organization has achieved tremendous growth and expansion of services throughout the system — more than doubling in size — during his time as CEO.

However, many of today’s healthcare industry quality standards and norms have their roots in work that we pioneered here in the mid-1980s.

That growth came through the expansion of services at Norton Hospital and Norton Children’s Hospital; the acquisition of Audubon Hospital and its expansion of services, including major renovations now underway; and the development of the Brownsboro campus, including construction of Norton Brownsboro Hospital, the children’s outpatient center, and two other outpatient medical services facilities, with more on the way.

I spoke with Williams about his long career at Norton Healthcare and his plans for the future. Highlights are below.

**Medical News:** How did you get started in healthcare, in general and in the Louisville area?

**Stephen Williams:** I grew up as a farm boy on a small farm in Livingston County, Kentucky, in a very caring family and I was always taking care of some farm animal. I was family physician was advising us on how to take care of some of our animals because we didn’t have a town vet. He knew my interest in science of medicine, but really loved the environment of healthcare and caring for individuals in need.

I went to Murray State University and worked as a scrub tech and in the emergency room at a local hospital. I loved both jobs, especially the environment. My first administrative job was in human resources. I thought it was so boring at the time because I wrote job descriptions for 160 jobs in the hospital. In retrospect, it was the perfect job because I learned what everyone did. Because of that experience, and my strong interest in the business curriculum at Murray, I went into healthcare administration.

Fast forward a couple of years, after graduating from Murray, I received a call from the physician at the county hospital where I had been an orderly. He asked if I’d like to be the new administrator. I was the youngest healthcare administrator in the state at the smallest hospital.

I then joined Norton Healthcare as an assistant to one of my mentors, executive vice president Jim Petersdorf. Even though I had run a small hospital, I didn’t want to simply be an assistant administrator to Jim. I wanted to see the whole picture. I soaked up everything from him, trying to learn as much as possible.

Two years later, I was appointed to the role of vice president of quality. In 1988, after Jim died, I was appointed executive vice president and chief operating officer and, in 1993, president and CEO. In 2013, my title changed to CEO when Russel Cox was named president, as part of a multiyear succession plan that began in 2007.

**Medical News:** What did you learn from these early healthcare careers and how did you apply them as you helped Norton grow?

**Stephen Williams:** Other industries had gotten ahead of the healthcare industry in measuring quality and trying to improve it. Jim asked me to develop programs to measure, report and continuously improve quality, safety and service in healthcare. I led this effort and I was fortunate to have people who worked with me who really wanted to help improve the outcomes for patients.

**Medical News:** We were the first hospital in the nation to publicly report all of our quality indicators, good or bad, on our web site. For 160 jobs in the hospital. In retrospect, it was the perfect job because I learned what everyone did. Because of that experience, and my strong interest in the business curriculum at Murray, I went into healthcare administration.

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**Stephen Williams:** We were the first hospital in the nation to publicly report all of our quality indicators, good or bad, on our web site.
Healthcare Asset Network secures $3M in financing

Healthcare Asset Network, a provider-to-provider platform for buying and selling surplus medical supplies and surgical equipment, has closed a $3 million round of financing. The company will use the growth capital to expand its technology and sales teams and to accelerate its relationships with enterprise customers.

The round included notable healthcare and technology founders such as Vencor/Kindred Healthcare founder Bruce Lunford, Genscape founder Sterling Lapinski, and iPay founder Mike Bowers. Prior investors who also participated in the round include Kentucky Science & Technology Corporation and Tamarind Hill. Healthcare Asset Network worked closely with Louisville-based Venture First to identify and secure the investors for this round of funding.

Healthcare Asset Network offers software that is professionalizing the healthcare secondary market and consolidating a disorganized, time-consuming customer experience into a single solution for buying and selling high-quality excess supplies and equipment. Its advanced, cloud-based technology simplifies critical buying and selling activities, significantly saving both time and money. Healthcare Asset Network has recently developed proprietary technology tailored specifically to large healthcare systems, with a particular focus on sustainability efforts. Current customers include healthcare systems (both large and small), ambulatory surgery centers, outpatient clinics, equipment refurbishing companies, distributors and humanitarian groups.

Longtime UK clinical lab employee leaves estate to Kentucky Children’s Hospital

Maquies Bentley was a dedicated, loyal and exemplary employee at the University of Kentucky College of Medicine for 27 years. When she passed away in 2015, she left her entire estate to the Kentucky Children’s Hospital.

Institute for Rural Health Policy reports geographic variations in health across state

The University of Kentucky Institute for Rural Health Policy has released a comprehensive report comparing and contrasting health behaviors and healthcare access in Kentucky’s rural and metropolitan areas.

The report serves as a resource for rural health researchers, policymakers and healthcare stakeholders interested in variations in health status and unmet healthcare needs in specific geographic regions.

By Elizabeth Adams

The University of Kentucky Institute for Rural Health Policy has released a comprehensive report comparing and contrasting health behaviors and healthcare access in Kentucky’s rural and metropolitan areas.

The researchers found poor overall health status and healthcare accessibility in rural counties and the Appalachian region. Appalachians were more likely to delay in medical care, avoiding medical care because of cost and health insurance coverage. Multiple statistical analysis of the data show variations in behavioral and access indicators in rural regions, with discrepancies most prominent in the Appalachian region.

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a small team to research what made the nation’s top companies successful, and then to translate that into a strategy for Norton.

We went to titans in the corporate world at the time such as IBM, Hewlett Packard, LL Bean and McDonalds, who were progressive in this area. We found an answer that we could relate to clinical care and safety, services and finances in healthcare: a relentless commitment to continuous improvement, transparent reporting and continuous improvement of quality.

I’m most proud of what’s hanging on our wall: our mission, vision and values.

This was a foreign concept at the time. However, many of today’s healthcare industry quality standards and norms have their roots in work that we pioneered here in the mid-1980s.

We were the first hospital in the nation to publicly report all of our quality indicators, good or bad, on our web site. We now publicly report our scores on over 800 clinical quality and safety indicators, as well as our scores on service and our financials.

This commitment to quality was recognized. Norton Healthcare was the first recipient of a national award for leadership in healthcare quality in 1987 and, nearly 25 years later, received the National Quality Healthcare Award from the National Quality Forum.

MN: What is your proudest moment?

SW: That is hard to answer because of my long career. I’m proud that our growth has been a result of our commitment to the constant pursuit of quality. It was meaningful to get the national leadership and quality award. I’m proud that we fundamentally rejected the notion that you can’t measure quality. It can be measured, although that certainly isn’t always simple.

We kept that in the forefront, not just to be recognized, but because it helped us provide better care. We held ourselves to a higher standard and it wasn’t a flash in the pan. It was a sustained initiative over decades that paid off for the patients we served, which is why we exist.

I’m most proud of what’s hanging on our wall: our statements of faith history, mission, vision and values. We wrote those in 1985 to guide the culture of Norton Healthcare. That goes hand in hand with the subject of quality.

During our research, we realized successful organizations had a common thread—they were clear about why they existed, what they were trying to do, where they were trying to go and what their values were. While we had that history and mission, we hadn’t articulated it well, which was a concern of mine as we were growing rapidly. We needed to discuss our roots, why we exist, what our purpose is. We needed to be more visible and redundant about it, starting internally so employees knew it.

Now we make sure it’s on the walls where decisions get made, conference rooms, offices and even waiting rooms. This writing on the wall is more than words and can far outlast any individual, such as myself. It’s a guiding light for generations to come.

MN: What are your plans for after retirement?

SW: After retirement, my wife, Kathy, and I plan to travel and enjoy our family. We also plan to spend more time with our two sons, David and Matt, and three grandchildren, Bailey, Zoe and Oaks. We also plan to travel and enjoy our family farm in western Kentucky.
Reita Jones, with the Kentucky Diabetes Network, will continue as secretary.

Centerstone
Rachita Agrawal, MD, was hired as an adult psychiatrist at Centerstone, formerly Seven Counties Services.

Nurse practitioner Amanda Marshall has joined Norton Children’s Health Primary Care Associates.

Norton Healthcare
Wafic ElMaari, MD, has joined Norton Cancer Institute as a gynecologic oncologist.

Kentuckiana Health Collaborative
Diana Han, MD, with GE Appliances, and Kenneth Wilson, MD, with Norton Healthcare, will remain as co-chairpersons on the executive committee.

KentuckyOne Health
Richard Blake, MD, has joined KentuckyOne Health Cardiology Associates.

Laila Agrawal, MD, has joined Norton Cancer Institute as a medical oncologist.

ResCare, Inc.
Laura Fowler was hired as director for talent acquisition.

Supplies Over Seas
Denise Sears was named president and CEO.

Stites & Harbison
Kelly White Bryant, member, has been named to the Rising Stars list of Kentucky Super Lawyers 2017.

University of Louisville
Gil Liu, MD, has been appointed as the new medical director for the Kentucky Department for Medicaid Services (DMS) in the Cabinet for Health and Family Services.

UofL Physicians
Rodolfo Zamora-Rendich, MD, has joined UofL Physicians Orthopedics.

CTEG
Joel Wallace has returned to the firm as a principal. Wallace had previously been an active member of the team while working on a variety of healthcare, commercial, municipal, educational and multi-use facilities.

University of Louisville
Jon Carlson, MD, has joined UofL Physicians Orthopedics.
Meet Joseph Flynn, DO, director and Chief Medical Officer at Norton Cancer Institute

Each month, Medical News catches up with a hospital or health system leader to learn about their organization, interests, and favorite pieces of advice and healthcare issues that ruffle their feathers most.

Medical News: How’d you end up being director and chief medical officer for Norton Cancer Institute?

Joseph Flynn: When I became a physician, my ultimate goal was to have a small practice somewhere and enjoy the uniqueness of being a cancer physician. Honestly, I never had the desire to be a leader in healthcare. While stationed in Germany for five years with the U.S. Army, I received the opportunity to lead a cancer program there and recognized a different level of satisfaction for being a cancer physician. Honestly, I never thought that I would ever be a hospital or health system leader to learn about their organization, interests, and favorite pieces of advice and healthcare issues that ruffle their feathers most.

From there my military, business and clinical experience offered me the opportunity to work at the Ohio State University (OSU) James Cancer Hospital. While there, I took on more and more leadership responsibilities as I maintained my clinical and research interests. A colleague at OSU actually saw the position at Norton and suggested it would be perfect for me.

JF: So, what’s it like?

MN: What were some early leadership lessons for you?

JF: Treat every person with respect. Not just patients, but every person across the organization. Treat every person with respect, not only in word, but in deed. Not to one, but to all. Some may think that this is unattainable, but it’s possible. Someone once asked me, “How do you keep your top people happy?” and I said, “It’s simple. Treat everyone with respect.”

JF: What’s most helpful in making it possible to do what you do?

MN: What was most helpful in making it possible to do what you do?

JF: My mother died of cancer and that had a profound impact on me. Still does. A day does not go by that I don’t think of her and remember the feeling I had when she was ill and ultimately died of cancer. That “gift” has always kept me focused on doing better and trying to shape the kind of care people receive. For every program I push forward, I conceptualize the answers to two questions. How would this have affected my mom when she was battling cancer? How would it affect my dad who now has cancer if that wasn’t good enough, I get to read mail from families whose lives have been forever changed by my colleagues. It is overwhelming! Believe me, there is truly nothing like it.

JF: What do you think is possible to do what you do?

MN: What was most helpful in making it possible to do what you do?

JF: What do you think is possible to do what you do?

Key Accomplishments

- Implemented same day cancer appointments.
- Developed revamped Comprehensive Lung Center.
- Initiated Adolescents and Young Adults cancer program and transition clinic.
- Initiated “Celebration of Courage” to honor all cancer survivors in the community.
- Launched Prompt Care Clinic to provide after-hours critical for cancer patients.

The Hosparus Inpatient Care Center (HICC) will undergo a $1.3 million expansion next year to better accommodate the needs of terminally ill patients and families, increasing total square footage to 18,390 from 13,582. The 25-bed hospice unit, established in 1995, is located on the sixth floor of Norton Healthcare Pavilion, 315 E. Broadway.

The center underwent a $2 million renovation in 2012 to increase capacity from 15 to 25 patient beds. The newest round of renovations, which will add a third wing to its two existing wings, is focused on expanding and reconfiguring space for the enhanced comfort of patients’ families. Expanding space for families became necessary due to an increase in the volume of patients at HICC — an average of about 108 per month. The center served 1,086 patients in 2015.

“Giving families more space to gather and share their feelings and concerns is important because a key component of a good end-of-life journey is having those difficult discussions,” said Terri Graham, senior vice president and chief clinical officer for Hosparus. “Families often come to us in turmoil with all sorts of disparate goals. Lack of privacy and space for families to convene adds stress to what is already an emotional time for them.”

Rather than transporting very ill patients to and from the hospital, a new procedure room is planned to allow for advanced clinical services such as tube insertions, as well as consultations for outpatient hospice and palliative care patients. Two transitional patient rooms will accommodate new patients, while allowing grieving families time to say goodbye to their loved ones after they have died without feeling hurried to leave.

New classroom and event space will allow Hosparus to offer nursing and students in other healthcare disciplines, as well as staff and the community, access to palliative and hospice care education. A new chapel will give families all religious backgrounds a place to seek spiritual comfort or hold memorial services for their loved ones. The center’s nurses’ station layout will be reconfigured to enable better customer service, more privacy and increased workflow efficiencies.

The expansion will be funded by private donations from estates, corporations, organizations and individuals. To date, Hosparus has raised $714,000 toward its $1.3 million goal. Construction is expected to begin in mid-2017.

“Families often come to us in turmoil with all sorts of disparate goals. Lack of privacy and space for families to convene adds stress to what is already an emotional time for them.”

Terri Graham

A Louisville-based, nonprofit organization, Hosparus provides quality hospice services wherever a patient calls home in its 33-county service area in Kentucky and Southern Indiana, regardless of their ability to pay. HICC provides short-term, inpatient hospice care to address symptoms associated with terminal illnesses that cannot be managed in other settings, or require special treatments such as frequent medication adjustments and advanced care or monitoring of open wounds. Admittance to the HICC is not determined by patient diagnosis. This special level of care is initiated when other efforts to manage symptoms are ineffective.

Hospice inpatient unit to enhance accommodations for families of terminally ill patients.

"Giving families more space to gather and share their feelings and concerns is important because a key component of a good end-of-life journey is having those difficult discussions," said Terri Graham, senior vice president and chief clinical officer for Hosparus.

"Families often come to us in turmoil with all sorts of disparate goals. Lack of privacy and space for families to convene adds stress to what is already an emotional time for them."
Use of emergency departments for dental conditions increased after Medicaid expansion in Kentucky

According to a study published in Health Affairs, increased access to adult dental coverage through Medicaid exposed a largely unmet need for oral healthcare services in Kentucky and the potential implications when this care is sought in hospital emergency departments (EDs) instead of through a dental provider. Following the state’s expansion of Medicaid and addition of an adult dental benefit on Jan. 1, 2014, researchers found that the newly-eligible population was in poorer oral and general health compared to previously covered beneficiaries and faced challenges accessing the dental healthcare delivery system. The findings point to the need for educational outreach and other access improvements in addition to coverage.

In the study, “After Medicaid Expansion In Kentucky, Use Of Hospital Emergency Departments For Dental Conditions Increased,” authors Dr. Natalia Chalmers, director of analytics and publication at the DentaQuest Institute; Dr. Jane Grover, director of the Council on Advocacy for Access and Prevention at the American Dental Association (ADA); and Dr. Rob Compton, president of the DentaQuest Institute, explored the costly use of EDs for dental care. Among adult Medicaid enrollees, the proportion of discharges for conditions related to dental or oral health that could be classified as preventable with primary dental care rose from 22 percent in 2010 to 33 percent in 2014. The share of Medicaid enrollees discharged for a condition related to dental or oral health who also had a chronic comorbid condition—like tobacco use or diabetes—increased from 41 percent in 2010 to 51 percent in 2014. From 2013 to 2014, inflation-adjusted costs for ED discharges for adults with Medicaid and conditions related to dental or oral health increased by over $4.2 million or 219 percent.

Apellis gets FDA fast track designation for drug development

Apellis Pharmaceuticals, Inc., a clinical-stage biopharmaceutical company focused on inhibition of the complement system, announced today that the U.S. Food and Drug Administration (FDA) has granted Fast Track designation to the development program for APL-2, a complement C3 inhibitor, in the treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH), who continue to experience hemolysis and require RBC transfusions despite receiving therapy with eculizumab. PNH is a rare, acquired, potentially life-threatening disease characterized by complement-mediated hemolytic anemia.

Fast track is a program designed to facilitate the development, and expedite the review, of drugs to treat serious conditions and fill an unmet medical need. The purpose is to get important new drugs to the patient earlier. Fast Track designation offers various benefits, including more frequent meetings with FDA to discuss the drug’s development plan, eligibility for Accelerated Approval and Priority Review, if relevant criteria are met, and Rolling Review, which allows the company to submit completed sections of its New Drug Application (NDA), rather than waiting until every section of the NDA is completed before the entire application can be reviewed. Using data from the State Emergency Department Databases of the Healthcare Cost and Utilization Project, the Kentucky Cabinet for Health and Family Services, the Area Health Resource Files and the Commonwealth of Kentucky, the researchers found:

- From 2013 to 2014, the number of adult Medicaid discharges for conditions related to dental or oral health in Kentucky increased from 6,328 to 18,884, while the number of discharges for the uninsured decreased from 20,453 to 7,796.
- Among adult Medicaid enrollees, the proportion of discharges for conditions related to dental or oral health that could be classified as preventable with primary dental care rose from 22 percent in 2010 to 33 percent in 2014.
- The share of Medicaid enrollees discharged for a condition related to dental or oral health who also had a chronic comorbid condition—like tobacco use or diabetes—increased from 41 percent in 2010 to 51 percent in 2014.
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We all work **together** for a healthier Kentucky.

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First doctoral students graduate through UK Nursing-Norton Healthcare partnership

By Elizabeth Adams

The first cohort of nursing students to benefit from an academic-practice partnership between the UK College of Nursing and Norton Healthcare graduated with doctor of nursing practice (DNP) degrees on Dec. 16.

Through the partnership, introduced in 2014 by Norton Healthcare Institute for Nursing, as many as 150 advanced practice registered nurses employed by Norton Healthcare will receive their DNPs through the UK College of Nursing. The class of 2016 is the first of five cohorts scheduled to complete the program.

The UK College of Nursing established the first DNP program in the nation. The DNP program focuses on the development of advanced competencies for complex practice, and research utilization for the improvement of clinical care delivery, patient outcomes and system management. Graduates are experts in designing, implementing, managing and evaluating healthcare delivery systems and will be prepared to lead at the highest clinical and executive ranks.

Leaders at the UK College of Nursing and Norton Healthcare initiated the program in response to the Institute of Medicine’s proclamation that shifts in the healthcare system necessitated more members of the nursing profession achieving higher levels of academic and leadership training.

Tracy Williams, senior vice president and system chief nursing officer of Norton Healthcare, brought forth the original vision for the partnership, stating that growing the doctoral-prepared practitioner workforce internally is a strategic economic model for Norton.

University of Louisville/KentuckyOne Health relationship to enter next phase

The University of Louisville (UofL), University Medical Center (UMC) and KentuckyOne Health announced they have agreed to redesign their partnership with a vision to better support the future of health and wellness in Louisville and across Kentucky.

UofL and KentuckyOne Health will continue their academic affiliation, which includes decades-long Academic Affiliation Agreements with Jewish Hospital and Frazier Rehab Institute. The Joint Operating Agreement established in 2012 will be revised, bringing management of University of Louisville Hospital (ULH) and the James Graham Brown Cancer Center (JGBCC) to UMC. This decision was agreed upon by all parties as the most effective way to collaborate in care for the community, moving direct operations of the academic medical center to UMC and ensuring continuation of innovative and high-quality patient care and clinical training via KentuckyOne Health facilities.

The agreement, effective Dec. 14, 2016, establishes the framework for future partnerships between the organizations and resolves all disputes previously raised. Key aspects of the agreement include the following: KentuckyOne Health, UMC, and UofL, working together, will continue to implement projects involving up to $44.8 million in capital investments at ULH by July 1, 2017; KentuckyOne Health has agreed to complete the funding of the joint investment proposals as set forth in the Academic Affiliation Agreement; The University of Louisville will release its rights to three seats on the KentuckyOne Health board of directors; and the University Medical Center is expected to take over the management of the University of Louisville Hospital on July 1, 2017.

The University Medical Center, University of Louisville and KentuckyOne Health will work together over the next six months to facilitate a successful transition for both the management of ULH and JGBCC, and the Academic Affiliation Agreement between the organizations for programs at other locations. Ongoing information and details on the transition will be provided to patients, community partners, employees and physicians as the process evolves. Transition teams focused on key areas of patient care, employee engagement and infrastructure are being assembled, drawing from the shared expertise currently in place at ULH, JGBCC, KentuckyOne Health, UMC and UofL. These teams will guide the continuation of initiatives underway, including patient care quality and safety programs and recruitment and retention of top nursing talent, while also shaping the future operations and leadership structure.

Multi-center study of adult stem cells now open at seven sites in six states

The first researcher to successfully demonstrate the safety and potential efficacy of a type of adult cardiac stem cells in patients with heart failure will now oversee an expansion of his work at seven new sites in six states.

Roberto Bolli, MD, director of the University of Louisville Institute of Molecular Cardiology, announced that a new research trial funded by NIH National Heart, Lung and Blood Institute, the CONCERT-HF Study, is now open to enroll patients. The study is a Phase II, randomized, placebo-controlled trial of the safety, feasibility and efficacy of two types of adult stem cells used alone and in combination in patients with heart failure.

In addition to UofL, the study centers are Stanford University, the University of Miami, Indiana University, the Texas Heart Institute, the University of Florida and the Minneapolis Heart Institute Foundation. The School of Public Health at the University of Texas Health Science Center at Houston will serve as the data coordinating center.

80 rural hospitals have closed since 2010, mainly in states that didn’t expand Medicaid

According to the Rural Blog, researchers at the University of North Carolina-Chapel Hill have charted the 80 rural hospitals that have closed since 2010. Many of them are in the South, largely in states that did not expand Medicaid under federal health reform. Texas leads the way with 13 rural hospital closures since 2010. Eight have closed in Tennessee, six in Georgia and five in Alabama and Mississippi. None of those states expanded Medicaid. Even though Medicaid was expanded in Kentucky, four have closed in Kentucky:
- New Horizons Medical Center in 2016
- Westlake Regional Hospital in 2016
- Parkview Regional Hospital in 2015
- Nicholas County Hospital in 2014

A UNC study published in September in the journal Health Affairs found that rural hospitals are more likely to turn a profit in states that expanded Medicaid. For example, rural hospitals in non-expansion states had mean operating margins of -0.18 percent, compared to 1.03 percent in states that expanded Medicaid. In contrast, urban hospitals in non-expansion states were, on average, more profitable than those in expansion states, with mean operating margins of 6.92 percent and 3.51 percent, respectively.

Report ranks Kentucky 49th in well-being for seniors

Kentucky held onto its 49th spot for the seventh year in a row in a new ranking of seniors’ well-being, with West Virginia following close behind.

The rankings are part of the Gallup-Healthways State of American Well-Being series that examines the well-being of Americans ages 55 and older. For the second year in a row, Hawaii had the best well-being score, at 67, compared with Kentucky’s score of 61.2. West Virginia, with a score of 59.9, ranked last for the second consecutive year.
Hospice of the Bluegrass changes name to reflect broader scope of services

By Cassandra Mitchell

Creating a name for a new business or rebranding an existing one is a challenging task. The new name should convey the company’s business as clearly and succinctly as possible, using language that potential customers easily understand. It also must reflect the company’s brand in a way that makes it stand out from competitors, and yet be broad enough to allow for future expansion.

For a healthcare brand, particularly a nonprofit, selecting a new name can be even trickier. Partners and customers have developed a strong attachment to the existing brand name, through perhaps decades of satisfactory encounters. However, healthcare organizations often grow by expanding their service lines. What if the existing name is overly specific, or constrains to one particular service or location?

Such was the recent challenge facing our leadership at Hospice of the Bluegrass, which had operated under the brand name anchored in hospice for over 30 years.

“Our organization was founded as Community Hospice of Lexington back in 1978,” said Liz Fowler, CEO. “As we expanded our service regions to other parts of the state, we changed our name to Hospice of the Bluegrass in 1986,” Fowler added. “And that name has served us well, until now.”

Our company grew to provide a wide range of services in addition to hospice care, including private duty nursing, case management, palliative care and grief care.

The name Hospice of the Bluegrass no longer reflected all of the services we provided, nor did it allow for the addition of other non-hospice services in the future. As our lines of service had evolved, our brand also needed to evolve. And yet, thousands in the community had grown to trust the name and the level of care we provided under the Hospice of the Bluegrass brand.

Market Research

We knew that changing a name after 30 years had to be done right, so we engaged with a nationally recognized firm that specializes in branding and marketing for hospice and palliative care. A series of surveys and focus groups with family healthcare decision makers showed our company’s brand awareness exceeded national averages. In fact, it scored so well that the marketing experts recommended that we keep “Bluegrass” as part of the new name, in order to help build a bridge from the existing name to the new one.

However, healthcare organizations often grow by expanding their service lines. What if the existing name is overly specific, or constrains to one particular service or location?

“However, healthcare organizations often grow by expanding their service lines. What if the existing name is overly specific, or constrains to one particular service or location?”

With our market research complete, several names were tested. In our initial tests, none of the names obtained consensus that gave us confidence it could be our new brand name. We went back to the drawing board twice, creating new naming conventions. Finally, with focus on the recurring themes heard in our market research, our new name was born: Bluegrass Care Navigators.

Our next step involved creating a short, concise tagline that would capture the essence of what we do each day. It needed to use as few words as possible to telegraph our mission statement to a wide audience – patients, payers and other healthcare partners – in a memorable way. We wanted it to reflect our identity, expertise, character and that we are a provider of care, without repeating any of the elements from our new brand name.

The solution? Expert. Connected. Care. Expert. From our board certified physicians to our skilled nursing and support staff, we wanted to underscore our experience and expertise in each of our service lines. We have a unique blend of knowledge, insights and talents gleaned from serving thousands of patients and families – and we wanted to highlight it in creating our new slogan.

Connected. The care teams deliver the right care at the right time in the right place by working as a cohesive team. They connect daily with their colleagues, other care providers, payers and suppliers.

Care. Every employee at Bluegrass Care Navigators is involved in one way or another with providing care, guiding people to care or supporting the care our patients and families receive. With Navigators as part of our name, we wanted to emphasize that we not only guide but provide care, too.

As we complete our transition to Bluegrass Care Navigators, we plan to co-brand with references to our old name during the first year. In this day of acquisitions and mergers, without the co-branding, some may assume that Hospice of the Bluegrass has gone away. Spreading the word about our new name must be done while letting the community know that we are the same company, with the same passion and expertise as they have come to know and trust.

— Cassandra Mitchell is vice president of Marketing & Business Development at Hospice of the Bluegrass, now Bluegrass Care Navigators.
Efforts to enhance prescription drug pricing transparency gaining traction

By Todd Nova and Julie Lappas

Driven in part by retroactive fees imposed upon pharmacies by pharmacy benefit managers (PBMs) and compounded by recent high profile cases of significant price increases for relatively common drugs, both retail and institutional pharmacies have continued to push for enhanced prescription drug pricing transparency.

Recent state and federal legislation, as well as lawsuits filed by coalitions of pharmacy providers and their representative affinity groups, suggests growing and significant inertia moving toward this goal. Not only should pharmacy stakeholders closely monitor these developments, they should carefully consider the underlying issues and their potential impact when contracting for pharmacy benefits coverage.

One of the most prominent examples of these developments is the legislation that was recently introduced in the U.S. Senate and House of Representatives that would prohibit Medicare Part D plan sponsors and their contracted PBMs from retroactively reducing payments to pharmacies for clean claims submitted at the point of sale. These retroactive fees are implemented via what are commonly referred to as direct and indirect remuneration (DIR) fees.

Additionally, approximately 31 states now have laws requiring transparency surrounding maximum allowable cost (MAC) pricing caps commonly utilized in PBM contracts with more development. These examples, in addition to increased scrutiny of PBM practices by various state and federal agencies, serve as a reminder to pharmacy network participants to carefully consider the terms of their PBM contracts since enhanced price transparency protections, while beneficial, may not sufficiently protect the interests of participating pharmacies.

DIR and Increased Transparency

With the implementation of Medicare Part D, the Centers for Medicare & Medicaid Services (CMS) coined the term DIR to refer to price concessions and fees impacting the price of a drug that are not captured at the point of sale. These include any number of fees charged to pharmacies by prescription benefit plans and PBMs after the point of sale, such as fees for network participation, periodic reimbursement reconciliations and to incentivize compliance with certain quality measures.

Each year, CMS requires Part D plan sponsors to report drug costs and DIR associated with the Medicare prescription drug benefit, though the wide ranging nature of DIR fees often results in ambiguity about the detail behind the components of DIR charges to pharmacies. This has served to obscure true reimbursement amounts for drugs and to create uncertainty regarding anticipated reimbursement for pharmacies during the payor contracting process.

To counteract this uncertainty that can make it difficult for pharmacies to prepare reliable budget assumptions in conjunction with the commencement of a new plan or PBM contract, CMS and Congress have indicated a willingness to bring about more transparency related to DIR via statutory mandates. These efforts were in part initiated as a result of the fact that in 2014 CMS proposed guidance that would have required Part D sponsors to publish all DIR fees that could reasonably be determined at the point of sale for the contract year 2016. However, despite support from Congress and network pharmacies, CMS ultimately decided not to finalize the guidance.

In part due to CMS’s decision not to require enhanced reporting of DIR fees, bipartisan support in both the Senate and the House of Representatives in September of this year resulted in parallel bills (S. 3508 and H.R. 5951) that would prohibit Medicare Part D plan sponsors and PBMs from retroactively reducing claim payments submitted by pharmacies under Medicare Part D.

More specifically, this legislation would require contracts between a Part D sponsor (or the sponsor’s agent or PBM) and a pharmacy to include language prohibiting the Part D plan sponsor or agent from retroactively reducing payments to the pharmacy (either directly or indirectly) for clean pharmacy claims. Retroactive increases in payment to a pharmacy by a sponsor (or the sponsor’s agent) would be permitted.

Beyond the obvious benefits to participating network pharmacies, the National Community Pharmacists Association has stated that it believes that the proposed legislation would also serve to lower cost-sharing for consumers since the DIR fees would be reported to CMS as pharmacy price concessions at the point of sale.

Perhaps adding additional inertia to legislative efforts to mandate DIR fee transparency, the recently released 2017 Office of Inspector General (OIG) Work Plan notes that prices for the most commonly used brand name drugs have risen substantially since 2002. OIG announces in the Work Plan that it will evaluate the extent to which corresponding pharmacy reimbursement for brand name drugs under Part D changed between 2011 and 2015 in light of the rate of inflation for the same period.

Increased Transparency from PBMs

PBMs provide various pharmacy benefit management services to payors. These include claims processing, pharmacy network development and maintenance, drug formulary development and manufacturer discount and rebate agreement development. Since PBMs manage prescription drug benefits for the majority of Americans, this serves to aggregate their bargaining power.

While this consolidated approach has resulted in enhanced bargaining power for PBMs generally, it has also invited scrutiny from consumers, legislators, insurers and pharmacies seeking to understand the exact nature of the relationships cultivated by PBMs and virtually every participant in the pharmaceutical supply chain.

For example, Express Scripts, the largest PBM in the United States, recently received subpoenas from U.S. Attorney’s Offices in New York and Massachusetts. In New York, the government requested information about Express Scripts’ relationships with pharmaceutical manufacturers and prescription drug plan clients, including payments made to and from those entities. In Massachusetts, the government sought information about the relationships between Express Scripts, pharmaceutical manufacturers, independent 501(c)3 charities providing cost-sharing assistance to federal healthcare program beneficiaries and specialty pharmacies.

These examples further illustrate the increased national focus on transparency in prescription drug pricing and the critical role that PBMs play in such arrangements. As key players in policy-making and law enforcement seek reasons behind spiking drug prices and introduce more transparency into the system, PBMs like Express Scripts...
can expect heightened scrutiny from legislators and investigators.

**MAC Legislation**

The MAC refers to the maximum amount that a health plan will reimburse a pharmacy for a given strength and dosage of a generic drug or brand name drug that has a generic version available. Currently, there is no singular standard regarding the inclusion of drugs on a PBM or plan’s MAC list or for the methodology as to how exactly a PBM or plan will determine or update the MAC for a particular drug. As a result, PBMs and plans have historically enjoyed discretion in determining pricing for drugs on a MAC list. This latitude resulted in frustration that in turn led to relatively widespread state and federal legislative and regulatory efforts to increase MAC transparency.

At the federal level, CMS issued a Final Rule in 2014 that functionally requires disclosure by Part D plan sponsors of various pricing standards, including MAC standards and other publicly or non-publicly available costs. The Final Rule requires Part D plan sponsors to “update any prescription drug pricing standard . . . based on the cost of the drug used for reimbursement of network pharmacies by the Part D sponsor on January 1 of each contract year and not less frequently than once every seven days thereafter.” Additionally, Part D plan sponsors must indicate the sources used for making any updates to their prescription drug pricing standard. At the state level, approximately 31 states passed MAC laws requiring PBMs to disclose and update their MAC sources and pricing information. For example, Wisconsin now requires PBMs to update MAC pricing information at least every seven business days, reimburse for prescribed drugs or devices subject to this updated MAC information, and eliminate drugs from the MAC list or modify MAC in a timely fashion consistent with prescribed drug or device availability and pricing changes in the marketplace.

Furthermore, laws in states like Minnesota include additional provisions requiring contracts between PBMs and pharmacies to include appeal, investigation and dispute resolution provisions related to MAC pricing.

**Practical Takeaways**

Recent legislative and investigatory actions on both the state and federal levels reflect an increasing desire for transparency in prescription drug pricing. Therefore, healthcare entities such as pharmaceutical manufacturers, PBMs, pharmacies, payors and other healthcare providers responsible for or affected by drug pricing should carefully design, implement and monitor their contracts, programs and policies to acknowledge pricing transparency trends and to ensure compliance with the changing environment. This should include efforts to ensure careful attention is paid to contract terms and to ensure both state and federal legislators consider the practical implications of any proposed changes in the law.

Given the increased state and federal legislative interest in DIR fees and MAC transparency, for example, pharmacy stakeholders should consider reaching out to their legislative advocacy teams to monitor updates or changes in laws affecting topics such as DIR fees, MAC pricing standards and pharmacy appeal rights and deadlines (among others). Additionally, stakeholders should work with their contracting teams to ensure that applicable laws are appropriately incorporated into their pharmacy, PBM and payor agreements.

— Todd Nova and Julie Lappas are attorneys with Hall, Render, Killian, Heath & Lyman.
21st Century Cures Act

A legislative remedy for mid-build off-campus provider-based departments.

By Charise Frazier

On December 7, 2016, the Senate passed the 21st Century Cures Act (HR 34) (Cures Act), which, among many other changes, revises Section 603 of the Bipartisan Budget Act of 2015 (Section 603) to provide an exception for off-campus provider-based departments (PBDs) that were mid-build or under development prior to November 2, 2015. The Cures Act was signed into law by President Obama on December 13.

Background

Section 603 effectively reduces Medicare reimbursement for certain off-campus PBDs, as defined in 42 CFR § 413.65 (the Medicare provider-based rule), by eliminating eligibility for payment under OPPS effective January 1, 2017 but grandfathered (except) any off-campus departments of a hospital that billed Medicare under the OPPS for services furnished prior to November 2, 2015. Beginning January 1, 2017, services at non-excepted locations will be paid based on a reduced payment amount that is generally equal to 50 percent of the OPPS rate.

Section 603 became problematic for many hospitals with off-campus PBDs under construction as these mid-build facilities would not be grandfathered (i.e., would not be eligible to receive higher reimbursement under the OPPS). In the CY 2017 OPPS Final Rule (Final Rule), CMS’s position was that it could not create an under development exception based on the statute. Section 16001 of the Cures Act, as further described below, extends Section 603’s grandfathered protection to some of these mid-build facilities.

Cures Act Section 16001

Under Section 16001, an off-campus PBD would be eligible to receive the full OPPS payment rate beginning January 1, 2017 if it furnished services prior to November 2, 2015 and the main hospital submitted a voluntary attestation in accordance with 42 CFR § 413.65(b)(3) prior to December 2, 2015 (2017 Exception). The intent of this provision was to assist those hospitals that had furnished services but not yet billed for those services prior to the date of enactment of Section 603.

However, in the Final Rule, CMS adopted a policy whereby off-campus PBDs would be eligible for grandfather status (i.e., eligible to receive full OPPS payments) as long as services were furnished prior to November 2, 2015 and billed under OPPS in accordance with timely filing limits. Therefore, this portion of Section 16001 will likely have little, if any, impact.

Alternatively, off-campus PBDs may be eligible to receive the full OPPS payment rate beginning January 1, 2018 if all of the following requirements are met (2018 Exception).

- The hospital files a provider-based attestation (pursuant to 42 CFR § 413.65(b)(3)) within 60 days after the date of enactment of the Cures Act legislation.
- The hospital reports the off-campus PBD of the hospital by submitting a change to its 855A enrollment form adding the location of the hospital.
- The off-campus PBD meets the definition of mid-build, which requires that the hospital had a binding written agreement with an outside unrelated party for the actual construction of such department before November 2, 2015. Additionally, to qualify as mid-build, each off-campus PBD will be required to submit a certification from the provider’s Chief Executive Officer/Chief Operating Officer prior to 60 days after the date of enactment of the Cures Act legislation. The certification must state that the off-campus PDB meets the definition of mid-build.
- Section 16001 also instructs CMS to audit compliance with the 2018 Exception. If CMS finds that a PBD does not meet the applicable requirements, the location will not be treated as grandfathered and will receive the lower payment for non-excepted facilities.

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“Since CMS extended grandfathered status to PBDs that furnished services prior to November 2, 2015 and billed under OPPS in accordance with timely filing limits, the 2017 Exception should not impact hospitals.
- Off-campus PBDs that meet the 2018 Exception would not be eligible for full OPPS payments during 2017 and instead would be subject to lower modified payments until January 1, 2018.
- Hospitals that wish to take advantage of this mid-build exception should mobilize quickly in order to meet the attestation and certification deadlines.

—Charise Frazier is with Hall, Rendar, Killian, Heath & Lyman in Indianapolis, Ind.
Preserving community health centers

Uncertain future of Medicaid program, substantial losses to the CHC federal grant funding program are real threats.

By Melissa Mather

Like many healthcare organizations across the nation, community health centers (CHC) are facing an uncertain future as our elected officials try to reshape healthcare legislation and policy under the new administration. For more than 50 years, community health centers (sometimes called Federally Qualified Health Centers or FQHCs) have been a stable presence in Kentucky’s most underserved communities. Our stability rests on two essential pillars: community health center federal grant funding and a strong Medicaid program. Unfortunately, both of these pillars are at risk in 2017.

The 115th Congress will convene on January 3, and the first order of business will be to repeal key portions of the Affordable Care Act, namely eliminating expanded Medicaid, subsidies for purchasing health insurance and the individual and employer mandates. This change alone will put 486,000 Kentuckians’ health coverage at risk. While the devil is in the details for what comes next, proposals are being made for structural changes to the Medicaid program, including block granting or per capita allotments, which have the risk to severely diminish community health centers’ ability to serve its communities.

Additionally, CHCs are facing a potential loss of 70 percent of their federal grant funding if the mandatory portion of the CHC grant program is not reauthorized by October 1, 2017. This funding cliff will hit all community health centers, and equates to more than $37 million disappearing from Kentucky’s 23 community health centers overnight.

Safety Net Cut
Hundreds of thousands of Kentuckians rely upon community health centers for healthcare, and they are the backbone of the Commonwealth’s safety net system. An uncertain future of the Medicaid program and substantial losses to the CHC federal grant funding program will erode the foundation of community health centers.

“The CHC funding cliff alone would be devastating to our health centers,” said Joseph Smith, executive director of the Kentucky Primary Care Association. “This cliff, combined with the potential changes to the Medicaid program, are the greatest threat to community health centers in more than 20 years.”

At Stake
The mission of community health centers is to provide affordable, quality healthcare to anyone in need. CHCs deliver real value to the health system; undermining their existence would have a ripple effect across healthcare providers:

- Access: 23 Kentucky CHC organizations are the medical home to more than 378,000 Kentuckians, while four CHCs in neighboring states also serve Kentucky residents. Approximately 60,000 patients in Kentucky could lose access to care if the funding cliff is realized.
- Integrated Care: In addition to primary care across the lifespan, many CHCs also provide dental, behavioral health, case management, pharmacy services and other support services that enhance care.
- Cost Savings: A recent study of CHCs’ patients with Medicaid found that patients who received the majority of their care at health centers saved an average of $2,371 in total healthcare spending compared to non-health center patients. Kentucky CHCs serve roughly one in five Medicaid patients.
- Economic Impact: CHCs in Kentucky generate positive economic impacts, including more than 2,000 full time jobs, $49 million in tax revenue, and an estimated $396 million economic impact in some of our poorest communities.
- Front Lines: In 2016, five CHCs expanded substance abuse services to help address the opioid epidemic in Kentucky.

Call to Action
As leaders within our industry, we have an obligation to help shape the outcome of legislation and policies that affect our work and our patients. In the coming year, advocacy will be essential to preserving community health centers and other health programs that have become vital to our organizations and our patients.

Commit to speaking up! Contacting your legislators to express your concerns about the threats to CHCs can have a real impact on the outcomes of legislation.
Modernizing healthcare

Telehealth and opportunities for value in the community mental health space.

By Lauren McGrath

From initial research and exploratory planning, we believe appropriate use of telehealth applied to severe and persistent mentally ill and co-occurring populations could reduce admissions and re-admissions emergency rooms and corrections facilities in our service area.

Obstacles aside, we are still seeing growth in this sector. The private market place (i.e., on-demand and direct-to-consumer products that can be purchased by consumers) is in the lead, followed by growth within value-based arenas, that are operating under bundled or capitated payment models (Kaiser Permanente’s growth was under a capitated model).

From a provider perspective, the value-based landscape (driven by bundled and capitated payments) is of particular interest. This shifts the market from one based on volume, to one based on value. The success in the value-based models lies, in part, in its ability to shift some of the risk from the payers to the providers to deliver on performance and outcomes; while also allowing for provider flexibility in appropriately determining the service delivery interventions that best serve their populations.

A Maze of Options

In the community mental health space, we largely work within Medicaid sphere of reimbursement models, following a maze of both state and federal policies with limited options for telehealth reimbursement. As a community-based provider, we support safeguards to preserve quality and privacy, but also believe it is time to assess efficient means to expand patient-centered care options.

From initial research and exploratory planning, we believe appropriate use of telehealth applied to severe and persistent mentally ill and co-occurring populations could reduce admissions and re-admissions emergency rooms and corrections facilities in our service area by providing timely, medically necessary interventions to clients in crisis.

For example, telehealth services could be wrapped into a mobile, community-based, crisis response protocol administered by our Assertive Community Treatment (ACT) teams and delivered to adult consumers experiencing a psychiatric crisis in order to divert in-patient treatment.

A second example of a direct-to-consumer crisis intervention would be establishing a warm hand off linkage between community mental health centers and emergency rooms for persons who have experienced an opioid-related overdose. In this scenario, the patient recovering from an overdose could engage in pre-discharge teleconsult with a case worker or peer support specialist, and schedule immediate/next day follow-up services.

By keeping people in their communities, with appropriate services and supports, community-based providers are able to more efficiently utilize public resources while increasing clinical outcomes. Additionally, well-planned implementation of telehealth interventions for high acuity populations has opportunity to advance access to underserved populations while more efficiently utilizing our behavioral health workforce, thus addressing some aspects of our state’s workforce shortage.

In conclusion, we endorse on-going, rigorous clinical research to ensure the maximum clinical efficacy of expanding telehealth, balancing utilization, costs, and patient privacy with opportunities to expand access, innovate, and more effectively extend quality care at the right time, to the right person, in the right place.

— Lauren McGrath is the government affairs director at Centerstone Kentucky, formerly Seven Counties Services.

Barriers to Expanding Role of Telehealth

- Vast inconsistencies in payment delivery formularies.
- Licensure questions.
- Concerns with parity.
- Large variances in state-based policies that continue to hinder the scaling of telehealth.

Assertive Community Treatment (ACT) Teams

Assertive community treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental healthcare providers work together. ACT team members help the person address every aspect of their life, whether it be medication, therapy, social support, employment or housing.
KMA sets advocacy priorities

Priorities include improved public health, increased patient safety and a fairer legal system for healthcare providers.

By Cory Meadows

A new look to the Kentucky House of Representatives offers new opportunities for legislation important to physicians in the 2017 session of the Kentucky General Assembly. In order to capitalize on those opportunities, the Kentucky Medical Association (KMA) has established a set of priorities that emphasize improved public health, increased patient safety and a fairer legal system for healthcare providers.

Tort Reform: KMA has long supported efforts to improve Kentucky’s medical liability climate. During the 2017 legislative session, meaningful and comprehensive tort reform will continue to be a top priority for the KMA. Other stakeholders, such as the Kentucky Hospital Association and the Kentucky Chamber of Commerce, through a group known as the Partnership for Commonsense Justice (PCJ), have also advocated for comprehensive tort reform in order to create a more fair and consistent climate for both business and medical providers. States that have become business friendly included as a main pillar to that label passage of tort reform.

Smoking Cessation: Kentucky still has one of the nation’s highest smoking rates and, as a result, the state spends $1.92 billion annually in smoking-related healthcare expenditures. KMA is committed to addressing this serious public health issue. Specifically, KMA will continue its successful smoking cessation campaign called Commit to Quit, started last year in order to encourage individuals to talk to their physicians about quitting smoking.

KMA also will support legislation designed to ensure comprehensive smoking cessation coverage for both the private insurance and Medicaid populations that is free of any barriers (e.g. pre-authorizations) to patient access. If adopted, the legislation would reduce tobacco use rates, remedy confusion among providers and patients regarding the specific components of covered tobacco cessation benefits, decrease costs to the healthcare system from tobacco-related illnesses and improve health outcomes for the state.

KMA urges Medicaid managed care organizations, and commercial insurers generally, to work with KMA and other healthcare advocacy groups to place greater emphasis on managing the care of our population rather than simply managing money.

Prescription Drug Abuse: KMA and the Kentucky Foundation for Medical Care have launched a new public health campaign targeting the prescription drug abuse

Continued on page 17
Reconsider SB 205

Kentucky General Assembly should pass legislation to level the playing field for nursing facilities in Kentucky.

By Elizabeth “Betsy” Johnson

Today, we are bombarded with information through television, newspapers, radio and social media and often, we do not question what we read or hear. Albert Einstein challenged us to question everything, a concept I believe in wholeheartedly. I especially question what I read or hear when the message being delivered is motivated by simple profit or self-interest, rather than the common good.

In Kentucky, it is very difficult not to see negative advertisements against nursing facilities because they are everywhere. Many advertisements against nursing facilities come in the form of full-page advertisements in newspapers that mislead the public by utilizing out-of-date and out-of-context government survey information. Simply put, these types of advertisements are false and misleading and, therefore, are not protected forms of commercial speech.

Many advertisements against nursing facilities come in the form of full-page advertisements in newspapers that mislead the public by utilizing out-of-date and out-of-context government survey information. As the president of the primary association representing nursing facilities in Kentucky, I pay attention to these advertisements. I know first-hand how misleading they can be. I often wonder if people who are being subjected to these advertisements question the veracity of the written or spoken word. When an advertisement uses government nursing facility inspection or survey information without context, the reader is led to believe that the government sanctions the advertisement, or that the nursing facility is not currently in good standing.

Some of the questions we should ask when we see these types of advertisements:
- When did the violation occur?
- Is the facility currently in good standing with the government?
- Did the violation cause actual harm?
- Was it wide-spread or isolated?

The advertisements make viewers believe the worst case scenario and clearly, we cannot rely on the advertisers to provide clarifying information to the public. Simply put, these types of advertisements are false and misleading and, therefore, are not protected forms of commercial speech.

During the 2016 legislative session, Senator Danny Carroll championed Senate Bill (SB) 205, which would have ensured that the public continues to be informed about the quality of services that are provided within a Kentucky licensed nursing facility. After passing the Senate, SB 205 was not given a hearing in the House of Representatives and, therefore, was not given the opportunity to be signed into law.

Reconsider SB 205

The Kentucky Association of Health Care Facilities will again ask the Kentucky General Assembly to consider this legislation during the 2017 legislative session. Without this legislation, trial attorneys – mostly from out-of-state law firms – will continue to mislead Kentuckians as to the quality of services being provided in nursing facilities, using advertisements that include outdated survey information and do not indicate if and when the provider returned to regulatory compliance.

Several other states have passed laws addressing the problem of misleading advertisements – Arkansas, Tennessee, Georgia and Ohio to name a few. It is time for Kentucky to act on this issue.

Critics of truth in advertisement legislation surround their objections with myth and misleading rhetoric. This type of legislation does not limit anyone’s right to advertise or the right to use public survey information in advertisements. It simply ensures that when survey information is used in an advertisement, it is provided in such a way as to not be false and misleading to the public. Commercial speech should be truthful.

Pushing for Truth

Our Association is not alone in pushing for truth in advertisements legislation. Recently, support of this measure came from two unlikely sources – a newspaper and an attorney. On December 28, 2015, the Danville Advocate Messenger, in an opinion piece, questioned the motives of a Florida-based law firm for publishing advertisements “fishing for clients who may have been mistreated” by a nursing facility. The newspaper correctly printed the telephone number for the Office of Inspector General (OIG) and recommended to its readership that they call the OIG, as the regulatory agency overseeing nursing facilities, if they have a question or law enforcement if they believe that a crime has been committed.

Our Association agrees with this approach. In April of 2016, an attorney wrote a letter to the editor of the Elliott County News apologizing, as a 50-year member of the Kentucky Bar, to the readership of the Elliott County News and Licking Valley Courier for “the full page ambulance chasing ads.” He recognized that these advertisements are being used for one simple goal – to line the pockets of trial attorneys.

— Elizabeth “Betsy” Johnson is president of the Kentucky Association of Health Care Facilities.
problem in the Commonwealth. The Know Your Meds KY campaign encourages physi-
cians and patients to work together through knowledge and education about prescription
drugs. Information about the campaign can be found on the KMA web site at kyma.org/
know-your-meds-ky.

Regulatory Reform: Access to care, which is the ultimate goal of any health-
care system, requires regulatory relief for physicians and all medical providers. The
more administrative burdens imposed on physicians and patients, the less time there is
for physicians to treat patients’ underly-
ing conditions. Today’s healthcare system
includes various layers of paperwork and
documentation that adds little to the overall
care of patients.

While it is desirable to measure quality, every insurer and government agency has a
different definition of quality that involves different administrative requirements, lead-
ing to confusion. We should instead focus on making Kentuckians healthier by having
systems that support smoking cessation and other health factors that could improve the
overall health of our population. The cur-
rent system simply leaves patients frustrated by imposing needless administrative work.

In 2016, KMA experienced one of its
best legislative sessions in years. Four major
priorities – issues ranging from maintenance
of certification to fair contracting – were
adopted by the General Assembly. KMA
was able to meet these legislative objectives
by maintaining a focus on issues important
to physicians and the patients they serve.

— Cory Meadows is director of Advocacy
and Legal Affairs at the Kentucky Medical Ar-
sociation.

KMA sets advocacy priorities

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Six protections Kentuckians will lose if ACA is repealed

As lawmakers in Washington make decisions about healthcare, the protections afforded in the ACA should be built on, not rolled back.

By Dustin Pugel

The patient protections provided by the Affordable Care Act (ACA) have enabled as many as 1.9 million Kentuckians to receive needed health coverage and care without falling victim to harmful insurance company practices.

If these vital protections end through a repeal of the ACA, the effects would be widespread and dangerous, particularly for children, seniors and those with disabilities and chronic diseases.

If these vital protections end through a repeal of the ACA, the effects would be widespread and dangerous, particularly for children, seniors and those with disabilities and chronic diseases. According to a state-by-state analysis by Families USA, here is what is at stake in Kentucky:

- 1.9 million Kentuckians with conditions like asthma, diabetes and cancer could be denied insurance coverage.
- 1.9 million privately insured Kentuckians (including 397,000 children) as well as 863,000 seniors on Medicare could lose free preventative care like immunizations, blood pressure screenings and cancer screenings.
- 1.4 million Kentuckians, 362,000 of whom are children, could see caps placed on the amount an insurer would spend over each person’s lifetime — cutting off coverage for the sickest individuals when they most need it.
- Women could be charged premiums as high as 57 percent more than men.
- All insured Kentuckians could lose protection from being overcharged by insurance companies. Since the ACA was passed, companies have refunded Kentuckians $33.3 million that wasn’t needed for administration or care.
- The ACA included a provision that closed the so-called donut hole (a glitch in Medicare prescription coverage that led to some prescription drugs being out of reach). But an ACA repeal would mean disabled and older Kentuckians would pay more for prescription drugs. These vulnerable Kentuckians have saved $405 million in prescription drug costs. The average savings for affected Kentuckians was $1,108 in 2015 alone.
- It is widely expected that the ACA will be partially repealed through a legislative procedure known as Budget Reconciliation in January. Although it is not clear which protections Congress would roll back specifically, at this point all are at risk, especially since they were designed to be inter-related.

It is widely expected that the ACA will be partially repealed through a legislative procedure known as Budget Reconciliation in January.

Loss of these important patient protections would contribute to and compound the massive rise in the number of Kentuckians without insurance that would happen with ACA repeal, and otherwise decrease access to needed care. As lawmakers in Washington begin to make decisions about the future of healthcare in America, the protections afforded in the ACA should be built on, not rolled back.

— Dustin Pugel is with the Kentucky Center for Economic Policy.

Know Your Meds

Statewide campaign encourages patients to look to their physicians for prescription education.

By Nancy Swikert, MD

Tremendous advancements in science and medicine have revolutionized the treatment of conditions and diseases that were once unmanageable. Prescription medicines have become an essential lifeline for many Kentuckians, helping them to better treat their pain, seizures, mental illnesses and other serious ailments.

This statewide campaign will encourage patients to look to their physicians for education about how best to use, store and dispose of their medicines in the safest way possible.

When patients adhere to the treatments prescribed by physicians, their health outcomes and quality of life can often be improved. But the dangers of misuse and abuse are always present, particularly when dealing with powerful opioids to manage pain.

Nearly one in four Kentucky adults report that a family member or friend has experienced problems as a result of abusing prescription pain relievers.

Prescription drug abuse has become one of Kentucky’s most pressing and publicized public health epidemics. In recent months, there has been no shortage of news stories about the tragic, often deadly, consequences of drug abuse and addiction.

That’s why the Kentucky Foundation for Medical Care and the Kentucky Medical Association are launching Know Your Meds KY. This statewide campaign will encourage patients to look to their physicians for education about how best to use, store and dispose of their medicines in the safest way possible. It will also encourage physicians throughout the Commonwealth to take an active role in educating their patients about the importance of adhering to prescription schedules and how to safely dispose of unused medicines.

A simple conversation with your physician can go a long way in equipping you with the knowledge you need to use, store and dispose of your medicines in the safest way possible.

Prescription medicines save lives. But if used improperly, they can also be dangerous ― especially if they get into the wrong hands.

Studies have shown that 75 percent of teens say they can access prescription pills at home, and a quarter of them will go on to abuse prescription medicines. Many accidental overdoses occur when individuals abuse medications prescribed to other family members in their households.

Safely storing your prescription drugs will help to prevent abuse and accidental overdose. Proper disposal of unused medications is also critical to keeping prescription drugs away from anyone who might misuse or abuse them. Kentuckians can dispose of their expired or unwanted medications at one of the state’s many prescription drop boxes. There are now 190 locations in 116 counties, with new sites being added daily. You can visit the Office of Drug Control Policy web site.

If you cannot make it to a drop box, you should take the correct and necessary steps to properly dispose of your medications at home. You can learn more at myoldmeds.com.

Studies have shown that 75 percent of teens say they can access prescription pills at home, and a quarter of them will go on to abuse prescription medicines.

Kentucky doctors are on the frontlines of the prescription drug abuse epidemic, and consequently, play an important role in addressing this statewide problem. Know Your Meds KY encourages physicians and patients to work together to prevent prescription drug abuse through knowledge and education. For more information on safe drug use, storage and disposal, visit kyma.org/know-your-meds-ky.

— Nancy Swikert, MD, is president of the Kentucky Medical Association.
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