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Entrepreneurship and the Medical Profession

I hope your holidays were warm with love and overfilled with laughter. January always seems to be the time of new beginnings and revisions of old plans. One of the most important of our professional duties is creating something new and improving the “status quo” for the benefit of society. Whether you have thought of that or not, each of us in the Profession of Medicine, without regard to our work environment, must be an entrepreneur.

I would like you to meet another of my heroes, Dr. Will W. Ward. Dr. Ward is a noted internist and addiction medicine specialist whose service as a leader in the medical community of Jefferson County began in the middle half of the 20th century and continues to the present. When he completed his presidency of JCMS in 1980, he began looking around for some way to make improvements beyond bedside patient care. He had a professional relationship with Father John Morgan, who told him of his vision to create a shelter for the homeless. They made the shelters alcohol- and drug-free and started a program to help the visitors with their addiction.

Ward went to the JCMS Foundation. Although the foundation was not able to assist at that time, the then-president of JCMS, Dr. Joe Kutz, and president-elect, Dr. Ken Peters, saw merit in the project and the necessity in having physicians involved. The Mission House was included in the strategic planning of the society, and a committee of JCMS was created to oversee the project. Dr. L.G. Owen helped set up the initial committee, which included 16 members, 14 of whom were physicians. Dr. Don Mosley began a clinic offering medical care to the shelter residents. He and Rose Gardner, wife of AMA President Hoyt Gardiner, MD, managed the day-to-day operation as volunteers. Dr. Ward communicated the needs of the shelter to everyone. The shelter received a generous grant from Mary Bingham, and the committee was able to establish a fundraising program. The name was changed and Dr. Ward became the chairman of the board of the JCMS Outreach Program/The Healing Place from its inception in 1989 until 2001. The need for alcohol and drug treatment proved to be quite large. A staff was acquired, including a talented and newly minted Kent School of Social Work master’s degree holder, Jay Davidson, who eventually became president and CEO.

As the structure of The Healing Place developed, Dr. Ward realized that other skills would be required and he reached out to other professional associations. Members of the Bar Association offered legal services for setting up the corporation and members of the Kentucky Society of CPAs helped structure the financial aspects. Services were obtained from physicians, podiatrists, social workers, pharmacists, optometrists and others. Today, the organization has two main campuses, one each for men and women, and is an independent nonmedical model for corporations and governmental entities in the metropolitan area. The service provided by The Healing Place creates more than $21 million in medical and judicial savings for our society by allowing people to escape from being homeless, drug addicted, lost souls living on the streets. The Healing Place was created by physicians for the community to improve everyone’s quality of life.

Dr. Ward served as the entrepreneur to make this happen but constantly gives credit to individuals who offered service, expertise, finances and moral support to the project. He felt it was part of his role as a physician to improve something in the community. His conversations with Father Morgan opened a door to an opportunity that captured his imagination. From there, he used all the skills of an entrepreneur to help bring The Healing Place into existence. I asked him if he had any advice for physicians who might want to make something better in their environment. He said to be aware that change happens in everything, so see it, understand it and use it. Be aware that your projects can fail and plan against it, but do not accept failure as a possibility in your planning and enthusiasm. He also pointed out that people “like to be asked to do things” and that gives them a chance to help if they can. One aspect of his story stands out to me. Dr. Ward is a connector. As a physician, as well as in his life, he meets a great number of people and values their qualities and talents. He communicated his vision to his connections and extended “the invitation” that led to their involvement in The Healing Place story.

I believe that as a profession, Medicine is called upon not only to heal but to improve society. We will do this best when we think and act as entrepreneurs. Perhaps you will use the process to establish a first-rate practice to provide service for your patients and to increase your personal rewards. Perhaps, as Dr. Ward did, you will use the process to improve some aspect of our society’s health and well-being. Your work setting or choice of specialty does not matter; being an entrepreneur is a critical part of your professional life.

From my conversation with Dr. Ward I have gleaned seven principles: (1) Always try to see opportunities to make something better; (2) Develop the vision and make it big; (3) Have a plan but keep it flexible; (4) Make connections and keep them fresh; (5) Ask people for help; (6) Communicate continuously; (7) Remember that what you create is going to be bigger than you are, so share the credit and rewards.

Note: Dr. Bybee practices Endocrinology with Endocrine & Diabetes Associates.
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The Practice of Medicine: Earned Privilege of a Few or the Right of Many? Part 2

Tracy L. Ragland, MD

The future of nursing: leading change, advancing health, advocates for collaborative, multidisciplinary team-based care to improve health care quality and delivery in line with the goals of the Affordable Care Act of 2010. Although the IOM points to physician-led models as optimal, it formally recommends (with less compelling evidence) the continued trend toward nurses becoming “physician substitutes,” giving special praise to retail clinics’ use of APNs in the delivery of primary care services. Interestingly, one important IOM recommendation not mentioned much by nursing organizations is that along with this autonomy should come more accountability in the form of improved nursing education and residency training. Whether one agrees or disagrees with the IOM, it is important to note that, while it claims to be an independent body, it is funded primarily by the federal government and also takes disproportionately large donations from the pharmaceutical industry.

The Cost Control Argument

The White Paper also illustrates how NP groups focus on the potential for cost control as another driving force for nurse practitioner independence. As NP leaders ultimately do not expect nurse practitioners to be reimbursed less than physicians if they perform the “same work,” and indeed in some states third-party payer fee schedules are already very similar for physicians and nurse practitioners, it is difficult to see how this trend will lead to lower costs in the future. Pharmacists often talk about how nurse practitioners appear to prefer brand-name medicines over generics. Further, it is well-known that NPs generally order more diagnostic tests and referrals, leading to higher, not lower, costs.1 Everyday examples speak volumes. Shingles is a common problem primary care physicians deal with regularly. Recently, my partner saw a patient in follow-up who had been seen initially at a Wal-Mart clinic and then an affiliated local hospital emergency department for treatment of a straightforward case of shingles. When Dr. Karem asked the patient if he knew why he had been referred to the hospital, his response focused on the NP at Wal-Mart who made the call – “she was very caring and concerned and wanted further evaluation” for the patient. Soon after this, there was talk among U of L Medicine/Pediatrics residents about a bone marrow transplant patient who was unscrupulously given Zostavax (a live attenuated vaccine to prevent shingles, contraindicated in immunocompromised patients) by an NP working with no meaningful supervision at a similar type of retail clinic known to aggressively advertise immunization services. The patient had to be hospitalized and evaluated further to ensure no complications developed. These examples illustrate how lack of NP knowledge coupled with the “profit first” mentality of the corporations they sometimes work for can lead to both the potential for patient harm and obvious increased costs to our health care system. With Wal-Mart’s recent announcement that the corporation plans to be a key primary care provider in the future, improved NP-physician collaboration will be critical.
Murphy Pain Center provides its patients leading care as confirmed by being the region’s first and only practice to be awarded the distinction of: “Outpatient Comprehensive Multidisciplinary Pain Clinic” by the American Academy of Pain Management.
The Physician Shortage Argument

Finally, probably the most-lobbied justification for allowing expanded nurse practitioner autonomy involves the issue of inadequate access to physicians for people in rural and underserved areas, a problem that is directly linked to the overall primary care physician shortage in Kentucky and nationwide. It has been shown nationally, and we see it locally every day, that NPs generally choose to practice in urban or suburban areas over rural and underserved areas. So the NP claims that they are answering the call of the underserved are generally not true. With more and more specialties being offered in NP programs, surely will be expected that just as we see for medical students many NP students will be drawn to fields in which there is no true physician shortage. Even if they were joining existing practices and setting up primary care clinics in every rural county to the point that no patient ever had to travel or wait to be seen by a medical professional, the fundamental questions are: Does our society really want to try to solve this problem by giving partially trained nurses the right to practice medicine as physicians do? How long will it take for the physician shortage to worsen if this happens? Jonathan Hodes, MD, esteemed chair of the U of L Department of Neurological Surgery and Louisville Medicine Editorial Board member, shared about an eye-opening conversation he recently had with his teenager. When asked if he was considering medical school, his son echoed the eye-opening conversation he recently had with his teenager. When asked what he saw for medical students, his son thought that NPs were the way to go. What will be the impact of independent practice of medicine by NPs? What will be the impact of nurses taking over the place of physicians and there are no competent physicians available to fill the void, it will be a terrifying time. And, because people are human, someone will need to be blamed.

Why Physicians Should Get Involved and Stay Informed

A substantial majority of patients prefers to see physicians for care and is not in favor of allowing nurses to substitute for physicians. A recent study showed that 80 percent of patients expect to see a physician in the emergency department, and most surveyed were willing to wait hours longer in order to be cared for by a physician. What matters most is what the legislators think, however, as they have ultimate control. We have learned the hard way that lawmakers tend to be convinced by lobbying and financial contributions. The NPs’ lobbyist, as mentioned earlier, is very active. All the legislators know him, as he also worked for the optometry bill that gave optometrists the right to practice medicine as ophthalmologists do. He helps organize NPs and supportive patients to communicate with legislators in Frankfort. Talking points are outlined and repeated passionately, over and over. “Nurse practitioners must have full autonomy so that they can reach the underserved and cut costs in our health care system” is the motto. This message, coupled with campaign contributions, is powerful—even though it is very deceptive. We have heard time and again that NPs are on track to be physician substitutes in Kentucky. Organized nursing and affiliated nursing lobbies are indeed very powerful, especially with “hidden” supporters like the pharmaceutical industry, the federal government and other big players in our health care system. The reality, however, is that the majority of states still require physician oversight in the areas of nurse practitioner diagnosis, treatment and prescription writing. For example, as of January 2011, most of our neighbors required more oversight than Kentucky law requires: Both Ohio and Indiana required NP-physician collaboration for practice including diagno-

sis, test ordering and referrals; Illinois required similar collaboration except in hospitals and ambulatory surgical treatment centers; Virginia required collaboration between state medical and nursing boards to authorize NP scope of practice; and Tennessee required physician supervision for NP practice. Further, the Kentucky Medical Association and our national medical societies are unanimously in both the support of supervision and/or collaboration and the opposition of independent practice of medicine by NPs. So it is not inevitable. Our legislators certainly don’t want to take credit for causing erosion and regression in the practice of medicine to the point it harms society. What if this process could be stopped before a bad ending is realized?

Physicians should care about this for several reasons. First and foremost, we care about patient safety and well-being. Secondly, we want the NP profession to continue to be respected. And last but not least, we believe the medical profession is sacred, allowing for the patient-physician relationship to stay at the heart of our health care system. There are several ways physicians can take action and make a difference for patients, the medical profession and our health care system. Being informed about existing laws and policy is important. In 2009, the AMA Scope of Practice Data Series was published as a resource for state medical associations and national medical specialty societies. In addition to explaining a great deal about NP training, licensure and regulation, the document’s section on NPs outlines AMA, ACP, AOA, AAP and AAFP policy regarding NP supervision. In September, the KMA House of Delegates adopted a resolution that endorses AMA guidelines regarding physician oversight of NP work. Resolution 2011-20, APRN Supervision, states that the KMA will oppose legislation seeking to authorize the independent practice of medicine by nurse practitioners. It also asserts that the KMA will support legislation that seeks to require meaningful physician collaboration with NPs in all settings. Key concepts of this resolution can be applied to any level of integration or collaboration between nurse practitioner and physician practices. Probably the most important guideline is that the physician must be immediately available (in person, by phone or by other means) at all times for consultation when needed by the NP. According to the resolution, appropriate collaboration should also require the nurse practitioner and physician to review and document, on a regular basis, the care of all patients with whom the NP is involved, allowing for both professionals to become fully conversant with each others’ practice patterns.

The Kentucky Board of Medical Licensure’s Board Opinion Regarding the Standards of Acceptable and Prevailing Medical Practice for Physicians Involved in Collaborative Agreements with ARNPs explains current Kentucky law that allows for collaborative agreements between NPs and physicians in the area of prescription writing. It is a resource for physicians, giving advice about the responsibilities of physicians in these agreements. Many legislators, the public and some physicians are not fully aware that prescription writing is the only area of practice that requires collaboration and that no supervision is required in these collaborative agreements. A bill that seeks to improve collaborative agreements between nurse practitioners and physicians will be introduced in the upcoming legislative session by concerned senators, in the interest of patient safety and welfare.

References

MAKE OUR VOICE HEARD

Physicians are obligated, in the public interest, to communicate with our lawmakers and other leaders in Kentucky’s government. State legislators and Gov. Steve Beshear will be directly involved in several important decisions impacting patients and the practice of medicine during early 2012. Will nurse practitioners be allowed to function as physician substitutes and practice medicine independently in Kentucky? Or will it be acknowledged that nurse practitioner work is complementary – not equivalent – to physician work and therefore must be supervised meaningfully by physician leaders?

Staying Informed About the Issues

- KMA’s Online Legislative Action Center (www.kmaactioncenter.org) enables physicians to follow the progress of important bills, read summaries and receive “talking points” about issues important to the practice of medicine. This site requires an ID and password, and physicians can call KMA at (502) 426-6200 to get these numbers.
- The Legislative Research Commission website, www.lrc.ky.gov, is another tool that can be used to read bills, track legislation and identify legislators.
- KMA Legislative Bulletins keep physicians up-to-date about legislation; by emailing legislativebulletin@kyma.org, physicians can request how they want to be notified – via email, fax or mail.
- MD ID, KMA’s public relations campaign that aims to educate the public about scope of practice issues in Kentucky, launched last summer and is receiving national attention. Very handsome brochures were sent to physicians’ offices across the state for sharing with patients. Television, newspapers, radio, Internet and other media are being used to deliver the message that physician education, training and preparation for practice is unequaled in our health care system.

Taking the Message to Frankfort

- The GLMS Annual Pictorial Roster 2011-2012 (pages 170-175) lists our legislators in the Kentucky General Assembly.
- To contact representatives and senators, you can go to www.kmaactioncenter.org or www.lrc.ky.gov. You can also identify and leave a message with appropriate legislators by calling the Legislative Message Line at (800) 372-7181. This message, called the “green slip” by legislators, is impersonal but important. Green slips in support of NPs and optometrists practicing medicine overwhelmingly outnumbered those in opposition during the last legislative session. All lawmakers can be contacted, not just your particular representative.
- The State Legislators’ Direct Line at (502) 564-8100 can be called to speak with your legislator directly by phone or to set up an appointment in Frankfort. Faxed messages will be delivered directly to legislators if physicians send them to the Fax Line at (502) 564-6543.
- Concerned patients, community and business leaders, hospital administrators and medical educators should be encouraged to call or write as well.

REFLECTIONS

Know Thyself

Teresita Bacani-Oropilla, MD

A colleague in his 80s broached the idea of asking for help in writing the story of his life. He thought sharing his childhood, the war years and his eventual settling into medical practice would make interesting reading. Although it is flattering to be privy to such personal and private matters, one has to ponder carefully the consequences of accepting such a task, such as being able to accurately portray the character of the person concerned.

To every person, the story of one’s life is a sacred trust, fraught with emotional undertones from beginning to end. Not surprisingly, these frame the values and motivations by which he lives. Don’t we all, to some degree, have the same desires, to leave a legacy of ourselves? We want to document and have our successes recognized, our motives understood, and our misgivings and mistakes justified.

As we grow older, we ourselves note that we tend to make an examination of our past, of our consciences, in regards to how we conducted our lives. We become unhappy if our performances fall short of our expectations, and pleased if we passed our life’s milestones as we envisioned them. In writing our memoirs, we show the world, as through a mirror, a version of ourselves that we want others to see. We judge others as well, perhaps more harshly, because they do not have the benefit of the internal counsel that we afforded ourselves.

The New Year is upon us. We have rituals galore for changing our wayward ways, making resolutions to better ourselves, physically, morally and spiritually. We expect and exhort others within our spheres to follow suit. Unrealistically, we even try to expect these of others over whom we have no control whatsoever.

It is to some degree a mini-judgment time, not final for sure, but instead with hopes for reprieve and redemption. My colleague’s idea of writing one’s life story might be, for him and likewise for others, the beginning of a probe into one’s life seen from the viewpoint of adulthood. It might give insights that one has missed, giving a better knowledge of oneself. After all, an old adage by Aristotle proclaims that, “Knowing yourself is the beginning of all wisdom.”

Note: Dr. Oropilla is a retired psychiatrist.
Dr. Masucci found a better way.

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there is a better way
Those of us who enjoyed our society's Wear the White Coat project last summer noticed that all participants, medical or not, liked hearing about how different doctors spent their days. The non-medical community leaders admired our work ethic, were dismayed by our long hours, but were intrigued by the complexity of our decisions.

Thus inspired, the Editorial Board has chosen “A Day in My Medical Life” as this year’s theme for the fifth annual Richard Spear, MD, Memorial Essay Contest. All GLMS members and University of Louisville medical students are invited to take a good look at a day of their professional trials and triumphs, and explain them to the rest of us. Some of us are retired, and memory lane will have to serve. Those of us in practice will have to sit up (if we get to sit) and take notice.

Dr. Richard Spear was a much-honored Louisville surgeon who loved to read. He established a generous bequest to our society expressly to promote good writing, by doctors, about medicine. Thanks to him, here’s your chance to take stock of your medical day, and to try to make sense of it for the rest of us.

The all-volunteer judges will consider excellence in expression, creativity, readability and clarity. We judge by category and reward accordingly: $1,500 to the practicing/life physician winner and $750 to the physician-in-training/medical student winner. The winning essays will be published in the July issue of Louisville Medicine. Many of the other entries will be published in subsequent issues as determined by the Editorial Board. At the judges’ discretion, an honorable mention gift card may also be awarded.

This year, for the first time, we have established a new award, for Medical Writing for the Public (as opposed to each other). The winner of this category will also receive an award (non-monetary) and recognition at the President’s Soiree in May.

GUIDELINES

You must be a GLMS physician member or GLMS student/in-training member to enter.

Themed essay contest: all entries must be original, unpublished writing intended solely for publishing in LM. Essays must be pertinent to the theme: “A Day in My Medical Life.”

Length: 800 to 2,000 words.

Format: Do not put your name on your essay! Judges are blinded to authors. Instead, include a separate cover letter with name, entry category, essay title and contact information.

Medical Writing for the Public award: you may enter an article of any length, written on a medically related topic for nonphysician readers, published in a newspaper, magazine or book in 2011. The submission may not be a self-published work. Include a copy of the article along with a cover letter with the name and date of the publication and your contact information.

Deadline: Sunday, April 1.

Submission: Send via email as an attachment to Alecia Miller at alecia.miller@glms.org. Email submissions are highly preferred, but if not possible, send entry by fax to (502) 736-6363 or by mail to 101 W. Chestnut St., Louisville, KY 40202.
Passport Health Plan, a provider-sponsored Medicaid health plan serving more than 170,000 members in Kentucky, is ranked in the top 25 of all Medicaid health plans in the country and is the top-ranked Medicaid plan in Kentucky based on clinical quality, member satisfaction and NCQA Accreditation scores.

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"Sacred Air: Breath of Life" was the focus and title of the 2011 annual symposium of Louisville’s highly respected Festival of Faiths. The November 2-7 program addressed dimensions of air and breath through spiritual and artistic evocations, environmental effects, medical considerations and policy implications.

The medical and scientific aspects of Louisville’s air quality were presented by a panel of acclaimed national scientists and GLMS physicians. Warren Muir, PhD, from the National Academy of Sciences, and David Van Sickle, PhD, inventor and Asthmapolis founder, were joined by GLMS physicians Robert Powell, MD, Jesse Roman, MD, Matthew Zahn, MD, Michael Bousamra, MD, and Gordon Tobin, MD. Dr. Bousamra also introduced André Greene, founder of Help Clear the Air educational programs. The panelists gave a frank overview of Louisville’s and Kentucky’s exceptionally poor air quality and its disastrous effects on health. The following summary of their presentation conveys the severity of this health threat, some avenues to address the problems and a call to action.

Dr. Tobin began by broadly outlining the topic and citing 2011 data from Scientific American’s “Cities” issue and the American Lung Association’s State of the Air report card, which both showed Louisville among the 10 worst U.S. cities for air quality, especially fine particle pollution. In addition, the Environmental Protection Agency’s Toxics Release Inventory showed Kentucky among the five worst states for airborne toxins, including mercury and other heavy metals. He drew correlations to Kentucky’s exceptionally high pulmonary disease and cancer incidences, including the highest in the U.S. for lung cancer.

**FINE PARTICLE POLLUTION**

Dr. Powell, pulmonologist and chairman of the Louisville Metro Air Pollution Control District Board, reviewed the history of efforts to improve air quality in Louisville. In the 1940s, the city’s skies were often darkened in daytime by particulate air pollution in the form of soot, since homes and businesses were heated with coal. The Air Pollution Control District (APCD) was established in Louisville in 1952 through state legislation. After the federal Clean Air Act was adopted in 1970, the APCD became responsible for its implementation in Louisville. The Environmental Protection Agency has established maximum tolerable levels of the following pollutants: carbon monoxide, lead, sulfur dioxide, oxides of nitrogen, ozone and particulate matter.

Dr. Powell focused on fine particle pollution, a mixture of microscopic airborne particles that enter the airways and...
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- Nerve injury or other serious injury of the hand. Call your healthcare provider if you get numbness, tingling, or increased pain in your treated finger or hand after your injection or after your follow-up visit.

- Allergic Reactions. Allergic reactions can happen in people who have received an injection of XIAFLEX because it contains foreign proteins. Call your healthcare provider right away if you have any of these symptoms of an allergic reaction after an injection of XIAFLEX: hives; swollen face; breathing trouble; or chest pain.

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- **Nerve injury or other serious injury of the hand.** Call your healthcare provider if you get numbness, tingling, or increased pain in your treated finger or hand after your injection or after your follow-up visit.

- **Allergic Reactions.** Allergic reactions can happen in people who take XIAPLEX because it contains foreign proteins. Call your healthcare provider right away if you have any of these symptoms of an allergic reaction after an injection of XIAPLEX:
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XIAPLEX should be injected into a cord by a healthcare provider who is skilled in injection procedures of the hand and treating people with Dupuytren's contracture. The proteins in XIAPLEX help to "break" the cord of tissue that is causing the finger to be bent. It is not known if XIAPLEX is safe and effective in children under the age of 18.

What should I tell my healthcare provider before starting treatment with XIAPLEX?

XIAPLEX may not be right for you. Before receiving XIAPLEX, tell your healthcare provider if you:

- have had an allergic reaction to a previous XIAPLEX injection.
- have a bleeding problem.
- have any other medical conditions.
- are pregnant or plan to become pregnant. It is not known if XIAPLEX will harm your unborn baby.
- are breastfeeding. It is not known if XIAPLEX passes into your breast-milk.

Tell your healthcare provider about the best way to feed your baby if you receive XIAPLEX.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your healthcare provider if you use:

- a blood thinner medicine such as aspirin, clopidogrel (Plavix®), prasugrel (Effient®), or warfarin (Coumadin®). If you are told to stop taking a blood thinner before your XIAPLEX injection, your healthcare provider should tell you when to restart the blood thinner.

How will I receive XIAPLEX?

Your healthcare provider will inject XIAPLEX into the cord that is causing your finger to bend. After an injection of XIAPLEX, your affected hand will be wrapped with a dressing. You should limit moving and using the treated finger after the injection. Do not bend or straighten the fingers of the injected hand until your healthcare provider says it is okay. This will help prevent the medicine from leaking out of the cord. Do not try to straighten the treated finger yourself. Keep the injected hand elevated until bedtime. Call your healthcare provider right away if you have:

- signs of infection after your injection, such as fever, chills, increased redness, or swelling.
- numbness or tingling in the treated finger.
- trouble bending the injected finger after the swelling goes down.

Return to your healthcare provider's office as directed on the day after your injection. During this first follow-up visit, if you still have the cord, your healthcare provider may try to extend the treated finger to "break" the cord and try to straighten your finger. Your healthcare provider will provide you with a splint to wear on the treated finger. Wear the splint as instructed by your healthcare provider at bedtime to keep your finger straight.

Do finger exercises each day, as instructed by your healthcare provider.

Follow your healthcare provider's instructions about when you can start doing your normal activities with the injected hand.

What are the possible side effects of XIAPLEX?

XIAPLEX can cause serious side effects. See "What is the most important information I should know about XIAPLEX?" and "Common side effects with XIAPLEX include:

- swelling of the injection site or the hand
- bleeding or bruising at the injection site
- pain or tenderness of the injection site or the hand
- swelling of the lymph nodes (glands) in the elbow or underarm
- itching
- bruises in the skin
- redness or warmth of the skin
- pain in the untreated cord

These are not all of the possible side effects with XIAPLEX. Tell your healthcare provider about any side effect that bothers you or does not go away.

Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-FDA-1088.

General information about XIAPLEX

Medicines are sometimes prescribed for purposes other than those listed here. This is a summary of the most important information about XIAPLEX. If you would like more information, talk to your healthcare provider. You can ask your healthcare provider for information about XIAPLEX that is written for health professionals.

For more information visit www.XIAPLEX.com or call 1-877-663-0412.

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16 LOUISVILLE MEDICINE
come from coal-fired (electric power) plants, construction sites, residential fireplaces, industrial processes and diesel engines. He showed a map of regional air currents (pictured here), which transport particle pollution and toxins from nine surrounding states to the Louisville area. “They all end in and over Louisville,” Dr. Powell said. “The air currents may pass over several major cities, picking up air pollution as well as particles.”

Dr. Powell outlined the short-term effects of fine particle pollution as irritation of the lungs, coughing, difficulty breathing, asthma aggravation, lung infections, irregular heartbeat and heart attack. Long-term effects include chronic bronchitis, reduced lung function and premature death in people with heart and lung disease. He cited research in New York City and Indianapolis that showed more out-of-hospital sudden cardiac deaths occur on days when fine particulate pollution is higher.

Dr. Powell also highlighted the dangers for children. “The effects begin in utero,” Dr. Powell explained. “Mother breathes the particles, which results in low birth weight babies, increased infant mortality and morbidity, increased likelihood of wheezing in the first four years, slow lung development and decreased lung function.”

Individuals can reduce fine particle pollution, Dr. Powell said, by conserving energy, avoiding idling vehicle engines, maintaining diesel engines, driving less, avoiding open burning, reducing the use of fireplaces and woodstoves and using propane or electric grills instead of charcoal. Exposure to pollution can be limited by checking the Air Quality Index at www.airnow.gov and lowering outdoor activity levels on days with elevated levels.

“The fine particulate pollution in Louisville has decreased,” Dr. Powell said in conclusion. “There’s a problem with the fact that we still have as much as we do. We need to get them down to as low a level as we possibly can.”

**ASTHMA PREVALENCE**

Dr. Zahn, University of Louisville pediatric infectious disease specialist and epidemiologist, turned to asthma as a public health problem. According to CDC data, about 13 percent of the population nationwide has asthma and 19 percent of Louisville residents have asthma. Children are particularly affected, with about 25 percent of hospital admissions for those under age 15 due to respiratory disease often triggered by asthma. “Asthma is not a static problem,” Dr. Zahn cautioned. “It’s getting worse ... for reasons that are not completely clear.”

Also of concern to him is the higher rate of hospitalizations due to asthma in West Louisville. He cited a survey of fifth- and sixth-graders at 13 schools in West Louisville conducted by the Louisville Metro Department of Public Health and Wellness. Of the 1,900 surveyed, 440 reported seeing a doctor for asthma and 130 reported being hospitalized overnight for asthma. “An awful lot of those kids are having their daily lives affected by asthma,” Dr. Zahn said.

“There is a health equity and disparity issue here. That community is being disproportionately affected. Can’t we try to aim as a community to make the kids in West Louisville as healthy in terms of asthma as the kids in East Louisville?”

While Dr. Zahn pointed out that pollution from Rubbertown is a factor, he considers crowding to be a larger contributor to the problem. Houses packed close together result in greater concentrations of vehicles and people living closer to roadways. He said lack of access to health care also adds to the disease burden, because people don’t get prevention and management for their asthma. This leads to absences at school and work due to asthma. The final leading factor is the city’s high smoking rate (31 percent in 2008, on the rise despite national trends to the contrary).

**INTERNATIONAL CONCERNS**

Discussion from a global perspective came from Dr. Roman, pulmonologist and chair of the Department of Medicine at the U of L School of Medicine. He described efforts by a colleague in Lima, Peru, Roberto Accinelli, MD, to reduce respiratory illness caused by indoor smoke. More than 50 percent of the world’s households cook and heat their homes by burning wood, leaves, straw, animal bones and other biological materials, Dr. Roman said. According to the World Health Organization, this causes more than 1.6 million deaths as well as high incidence of chronic obstructive pulmonary disease, emphysema, asthma, lung cancer and pneumonia in children. “Think about being exposed to this since you are born and until the day you die,” Dr. Roman said. “It’s not difficult to recognize that this is a tremendous problem for respiratory health.”

Dr. Accinelli led efforts to install improved stoves that incorporate a ventilation system to carry smoke outdoors for less than $200 per household. After this intervention, Dr. Accinelli documented fewer symptoms like cough and shortness of breath as well as incidences of pneumonia and acute bronchitis. In recognition of his work, Dr. Accinelli received the World Lung Health Award from the American...
Continued from page 17
Thoracic Society in May 2011.

“I think this is an extraordinary example of how communities can come together ... to address public health issues,” Dr. Roman told the festival attendees. “This is not about a prescription. I hope that you continue to participate in activities that help not only Louisville but spread this wealth of information of benefit to respiratory health outside the state, outside the country and into places that are truly suffering from this.”

YOUTH SMOKING

Dr. Bousamra, thoracic surgeon and associate professor at U of L’s Division of Thoracic and Cardiovascular Surgery, then focused on local youth. He told the story of how he created a program called Drive Cancer Out about five years ago to educate young people about the health consequences of smoking. Medical students took a Ford GT to schools and community events, and young people could have their photo taken in the car if they signed a no-smoking pledge. Drive Cancer Out collected about 10,000 pledges, Dr. Bousamra said.

“There’s nothing worse than taking organic compounds like tobacco, combusting and combining them with oxygen, producing scores of cancer-causing compounds and inhaling them right into your lungs and putting them back out,” Dr. Bousamra said. “About the only thing worse is to have someone else breathe the smoke that you produce.”

The chief causes of death in Louisville – heart disease, lung cancer, COPD and stroke – all have smoking as their principal etiology. He also believes that “the cancer epidemic of the 20th century is really just about smoking,” attributing the decrease in cancer incidence seen in the past 10 to 15 years to the decline in smoking. The five-year survival rate for lung cancer is up to 15.5 percent today from 13.8 percent in 1970, a change that Dr. Bousamra said is explained simply by earlier diagnosis of cases.

Dr. Bousamra announced that Drive Cancer Out has run its course and that he is handing over its resources to support Help Clear the Air, a Louisville-based smoking prevention campaign founded by Andrée Greene. Greene’s initiative uses rap music, cartoons, video and film in elementary school presentations to demonstrate to children the harm of smoking. Greene provided examples of his inspiring graphic campaign to prevent youth from taking up smoking, which can be accessed at www.helpcleartheair.com.

INNOVATIVE TECHNOLOGY
FOR ASTHMA EPIDEMIOLOGY

David Van Sickle, PhD, provided a fascinating example of innovative technology use for real-time monitoring of time, frequency and location of asthma attacks. His company, Asthmapolis, has developed his invention, which attaches a monitored GPS sensor to the rescue inhalers that nearly all asthmatics carry for urgent bronchodilation when severe attacks occur. This monitoring data improves daily management and will help identify sites or environments that pose particular threats. This might allow public health interventions and give new clues about attack causes.

In two previous clinical studies, Asthmapolis collected useful data that allowed significantly improved asthma control. This could help reduce the estimated $56 billion annual cost of asthma morbidity. Dr. Van Sickle announced launching of a Louisville-based trial next year to further test and apply this technology.

PUBLIC POLICY PROGRESS

Dr. Muir, currently executive director of the National Research Council’s Division on Earth and Life Studies, recalled the progress made during his 40-year career in various environmental posts in Washington.

“The outdoor air is not something we individually have a lot of control over. The Clean Air Act was passed and, in many respects, the outdoor air is cleaner than it was before,” Dr. Muir said. “I don’t want people to be so despairing ... that what we’ve been doing hasn’t been worthwhile.” Besides the Clean Air Act, he cited the Occupational Safety and Health Act for improving air quality in workplaces, the Toxics Release Inventory for providing data on chemical release incidents in communities, and protocols for reducing chlorofluorocarbons that deplete ozone.

Dr. Muir said the stabilization of carbon dioxide levels is one of the greatest current challenges because of global warming and climate change.

“In order to stabilize our carbon dioxide levels, the world is going to have to cut back carbon dioxide emissions from where we are now by 80 percent,” he said. “So it’s a very substantial amount of reduction. Carbon dioxide, because of the excesses in the atmosphere, will be with us for hundreds of years. I don’t know how we’re going to handle it.”

Dr. Muir views technology as a tool that will continue to equip individuals with information about the state of their local environment, even in their homes.

“As we seal up our homes and make them more energy efficient, the levels of contaminants are going to be higher,” he said. “That’s not going to lend itself to a Clean Air Act or EPA regulation. There is remarkable technology that is now in our pockets.”

CONCLUSION

The panel provided a succinct yet comprehensive insight into the health consequences of air pollution, as well as the history and present status of the very worrisome situation in Louisville and Kentucky. Hope was offered through continuing the achievements of the Louisville Metro Air Pollution Control District, the EPA, youth education on smoking prevention and innovative technology. In addition, vigilance toward public policy is needed from all of us. Two important issues require immediate attention. The first is to preserve and strengthen EPA regulations that protect Louisville and Kentucky by limiting emission levels of the most harmful pollutants, such as mercury, other heavy metals, acid gases and other toxins from coal-fired power plants. For example, the pending MACT rule (aka “toxics rule”) will keep 91 percent of the mercury and coal from being released. This is estimated to save $5-$13 in health costs for every dollar spent, and will prevent 17,000 premature deaths annually, according to the EPA. The second issue is to defend the Cross-State Air Pollution Rule. This limits cross-state emission transfers from poorly regulated, obsolete, coal-fired power plants whose emissions wind up in our air, and our lungs, when their home states fail to regulate them.

The panel’s presentations were well-received and evoked stimulating discussions. The message that our sacred air has been severely desecrated was inescapable, and that inaction would leave unacceptable health consequences for our neighbors, our children and the medically vulnerable.

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society. Dr. Tobin is a professor at the University of Louisville, Department of Surgery, Division of Plastic and Reconstructive Surgery. He practices with University Surgical Associates.
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James Patrick Murphy, MD

“DO YOU THINK IT IS BECOMING HARDER OR EASIER TO PRESCRIBE PAIN MEDICATIONS?”

This was the question I posed to an expert panel that included the White House’s drug “czar” Gil Kerlikowske at the November American Medical Association meeting in New Orleans. What I gleaned from their answer is that the way to do it right is becoming clearer, but the consequences of doing it wrong are greatly magnified by the prescription drug abuse “epidemic.” The statistics are sobering:

- In the U.S., prescription pain medications were involved in nearly 15,000 deaths in 2008 (more than triple the number from 1999).
- Deaths involving pain meds now outnumber the combined total of deaths due to heroin and cocaine.
- Kentucky is ranked in the top tier of both drug overdose death rates and amount of prescription pain medications sold per person.

As physicians on the front lines of “the war on drugs,” we can use all the help we can get. The Kentucky All Schedule Prescription Electronic Reporting program is one of the best weapons we have.

When faced with a patient who has obtained or utilized more pain medications than prescribed, a physician must discern the cause for this aberrancy in order to properly respond. The reasons patients seek more medication than prescribed, the program is one of the best weapons we have.

Program is one of the best weapons we have.

In response to Kentucky’s prescription drug abuse problem, the January 2010 Journal of the KMA was devoted entirely to empowering physicians to combat the epidemic. In that issue, the “COMPLIANCE” aid was presented, which summarized documentation required to justify treatment with controlled substances (Table 1).

Review of a KASPER report can provide an early warning sign so that efforts can be made to determine into which group the aberrant patient resides, allowing intervention to commence.

In response to Kentucky’s prescription drug abuse problem, the January 2010 Journal of the KMA was devoted entirely to empowering physicians to combat the epidemic. In that issue, the “COMPLIANCE” aid was presented, which summarized documentation required to justify treatment with controlled substances (Table 1).

It is no coincidence that the first element of this guide pertains to compliance monitoring. There is no substitute for common sense and intuition in practicing the “art” of medicine, but also needed are as many objective measures as possible. Among the metrics available, KASPER is perhaps the most objective, prompt, inexpensive and valuable. Use of KASPER is also encouraged by the Kentucky Board of Medical Licensure.

KASPER is an electronic database administered by Kentucky’s Drug Enforcement and Professional Practices Branch. Pharmacies and other dispensers are required to submit data every seven days regarding prescriptions for controlled substances (schedule II–V) within Kentucky. Currently KASPER only monitors Kentucky prescribers and dispensers. However, excepting Missouri (which does not yet have a prescription monitoring program), KASPER expects to have access to the data from every Kentucky border state sometime in 2012.

Further enhancing the effectiveness of this valuable service:

KASPER reports are carefully and securely controlled and are available only to the entities and health care professionals listed below:

- Prescribers for medical treatment of a current or prospective patient
- Dispensers for pharmaceutical treatment for a patient
- Law enforcement officers for a bona fide drug-related investigation
- Licensure boards for an investigation of a licensee
- Medicaid for utilization review on a recipient
- A grand jury by subpoena
- A judge or probation or parole officer administering a drug diversion or probation program

Opening a KASPER account is straightforward. Log in at the KASPER website (www.chfs.ky.gov/os/oig/KASPER.htm) and follow the prompts. Both creating an account and obtaining the reports are free of charge. KASPER is fast too. The information can usually be downloaded in less than 10 minutes, which offers the practitioner the potential to use the information during a patient encounter. If assistance is needed, the number to call is (502) 564-7985.

KASPER may be useful, but it is not infallible. If the information is used in making clinical decisions, it must be verified by contacting the pharmacies. Other important standards of which to be cognizant are:

- It is a felony to release the report to someone unauthorized to receive it (e.g. other physicians, family members or even the patient).
- Do not place the reports in the patient record. Destroy them or keep a separate file.
- Do not release the reports to third parties (e.g. insurance companies).
- Reports must only be requested for a current or prospective patient, and only for clinical decision-making (i.e., NOT for staff, family, friends or self).
- A prescriber may NOT obtain a KASPER report in response to an investigation by the board or law enforcement agents (But a prescriber MAY seek a court order to obtain a KASPER report for use in one’s defense).

After obtaining a KASPER report:

- Document in the patient record that it was obtained.
- Document and discuss with the patient any aberrancies implied by the report.
- Document the consequences resulting from what was discovered (e.g. more frequent follow-ups, urine drug screens, pill counts, treatment agreements, prescription modifications, consults, addiction assessments and additional KASPER reports).

The most common use of KASPER is to determine if a patient has been obtaining controlled substances from multiple sources, or “doctor shopping,” which can imply intent to unlawfully divert or abuse medications. However, a subtle positive outcome is that patients, who might otherwise stray from the prescribed regimen, may opt for compliant behavior because they know they are being watched. Interventions that set boundaries, such as KASPER reports, urine drug screens, pill counts, treatment agreements, prescription modifications, consults, addiction assessments and additional KASPER reports).

Whether or not one feels it is getting easier or harder to prescribe pain medications, the need for pain care is only going to grow as the “baby boomer” generation continues to mature. More than ever, physicians need access to all appropriate means of providing pain care that are effective for our patients, safe for our community and do not place our medical licenses at risk. Surprisingly, only about 20 to 30 percent of Kentucky prescribers currently use KASPER, although this number is skewed somewhat by the inclusion of non-prescribers with Drug Enforcement Administration numbers in the calculation (e.g., radiologists, pathologists, anesthesiologists). Not using KASPER is akin to driving a car without a speedometer. The instantaneous information provided allows the person behind the wheel to:
• Drive within the boundaries of the law,
• Keep passengers (patients) on track,
• And protect the safety of the others on the road.

The police can use KASPER as their “radar gun.” They can tell when someone is prescribing too fast and furious. As “drivers” of their practices, physicians should use KASPER to access the same information.

Table 1
THE FOUR P’S

| P | The painful condition has worsened, or there is a new disease to consider. |
| P | Physiologic tolerance has developed, or the medications are not suited to the etiology of the pain (e.g. opioid resistant/neuropathic pain). |
| P | The patient is using the medications aberrantly to treat depression, anxiety or addiction. |
| P | The medications are being unlawfully diverted. |

Table 2
COMPLIANCE

| C | Compliance is monitored with findings leading to appropriate actions (e.g., drug screens, pill counts, family conferences, KASPER reports). |
| O | The patient is seen often enough to assess: analgesia level, activity level, adverse reactions and aberrant behavior. |
| M | Records are accurate, legible, complete and accessible. |
| P | Plan of treatment has objectives and goals to determine functional status. |
| L | Legitimate diagnosis of a recognized chronic painful condition. |
| I | Informed consent (Treatment Agreement). |
| A | Addiction risk assessment, past and current use, family history, psychological and social issues. |
| N | Non-addicting medications have proven inadequate or unacceptable (either through clinical trial or review of medical history). |
| C | Consultation(s) have been obtained when necessary and other health care concerns are addressed. |
| E | Evaluation is thorough (history and physical) reflecting the complexity. |

References
T'S WINTER IN THE BLUEGRASS STATE, and that means it's time for patients to come in with earaches. With ICD-10, no longer will the simple diagnosis of suppurative or nonsuppurative otitis media suffice. ICD-10 will require the physician to document which ear is affected, if it is a recurrent infection and if there are any additional environmental factors that are part of the cause. This seems like a simple step, but it takes additional time and physicians need to prepare for the additional time this type of documentation will take.

It’s a new year, so let's try to be proactive instead of reactive. By documenting more thoroughly now, come October 2013, ICD-10 will not be such a shock. Physicians are always touting the benefits of preventive medicine. Let's take our own advice to heart.

Below is a sample of the codes involved with nonsuppurative otitis media.

**Nonsuppurative otitis media H65-**

Use additional:

- Code for any associated perforated tympanic membrane (H72.-)
- Code to identify:
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

Includes:

- Nonsuppurative otitis media with myringitis

**H65 Nonsuppurative otitis media**

- **H65.0 Acute serous otitis media**
  - H65.00 Unspecified ear
  - H65.01 Right ear
  - H65.02 Left ear
  - H65.03 Bilateral
  - H65.04 Recurrent, right ear
  - H65.05 Recurrent, left ear
  - H65.06 Recurrent, bilateral
  - H65.07 Recurrent, unspecified ear
- **H65.1 Other acute nonsuppurative otitis media**
  - H65.11 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous)
    - H65.111 Right ear
    - H65.112 Left ear
- **H65.12 Recurrent, unspecified ear**
- **H65.13 Bilateral**
- **H65.14 Recurrent, right ear**
- **H65.15 Recurrent, left ear**
- **H65.16 Recurrent, bilateral**
- **H65.17 Recurrent, unspecified ear**
  - H65.19 Other acute nonsuppurative otitis media
    - H65.191 Right ear
    - H65.192 Left ear
    - H65.193 Bilateral
    - H65.194 Recurrent, right ear
    - H65.195 Recurrent, left ear
    - H65.196 Recurrent, bilateral
    - H65.197 Recurrent, unspecified ear
    - H65.199 Unspecified ear

- **H65.2 Chronic serous otitis media**
  - H65.20 Unspecified ear
  - H65.21 Right ear
  - H65.22 Left ear
  - H65.23 Bilateral
- **H65.3 Chronic mucoid otitis media**
  - H65.30 Unspecified ear
  - H65.31 Right ear
  - H65.32 Left ear
  - H65.33 Bilateral
- **H65.4 Other chronic nonsuppurative otitis media**
  - H65.41 Chronic allergic otitis media
    - H65.411 Right ear
    - H65.412 Left ear
    - H65.413 Bilateral
    - H65.419 Unspecified ear
  - H65.49 Other chronic nonsuppurative otitis media
    - H65.491 Right ear
    - H65.492 Left ear
    - H65.493 Bilateral
    - H65.499 Unspecified ear
- **H65.9 Unspecified nonsuppurative otitis media**
  - H65.90 Unspecified ear
  - H65.91 Right ear
  - H65.92 Left ear
  - H65.93 Bilateral

Can you hear me now?

Note: Dr. Schrodt is chair of the GLMS Emerging Medical Concepts Committee. He practices Psychiatry with Integrative Psychiatry PLLC. The GLMS physician education and practice support staff of Dottie Hargett, Jessica Williams and Stephanie Woods and Sherry Thomas, CEO and director of education for the Professional Healthcare Institute of America, assisted with this article.
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IN PERSON, IN YOUR MAILBOX, ONLINE, NIA.
The first Wear the White Coat program took place in July 2011, with an invited group of 28 leading business and community leaders shadowing physicians in their offices. The Greater Louisville Medical Society created the program to give professionals insight into the world of health care through the eyes of physicians and to build relationships that result in improved health and wellness for Louisville. The next class will participate in Wear the White Coat in February. Here, two participants from the inaugural class share their experiences.

STEVE BARGER

Wear the White Coat was an interesting and informative experience, especially so as I was a participant in the GLMS Mini-Internship Program years ago. Both programs were well-done, with the mini-internship more procedure-oriented. I was in the operating room for numerous surgeries, spent time with a pediatric cardiologist as he performed an ultrasound on an expectant mother and finished by observing a colonoscopy. Wear the White Coat offered some of the same but with more of a big-picture view of the medical profession. The opportunity to engage in discussions on health care as opposed to medical care and to be presented with “where-the-rubber-meets-the-road practice concerns” by community physicians was invaluable.

As we entered the opening session, a real-time open heart surgery was showing on a large monitor. As we viewed the surgery, several medical instruments were passed around and, as a union carpenter who served an apprenticeship more than 40 years ago, I was struck by their similarity to the drill motors and templates used on construction projects. However, they were just a bit smaller and stainless instead of heavy plastic, and the sponge was a lot smaller than the ones used to clean tile grout.

During lunch, we had an opportunity to network with our fellow participants and meet our physician preceptor, scheduling time to experience a small flavor of their medical practice. Voice-Tribune Staff Writer Ashley Anderson and I were fortunate to have Dr. James Patrick Murphy as our physician preceptor. We were immediately impressed with his energy and enthusiasm for the practice of medicine coupled with his concern for people.

Several days later, we spent the morning with Dr. Murphy and his associates – starting the day with the administrator of Murphy Pain Center, who provided an overview of the impact that regulations, insurance and record retention have on the day-to-day operations of a medical practice.

Then we were on to join Dr. John Stocking and other associates of Murphy Pain Center as they counseled the day’s patients, performing medical procedures aimed at improving their patients’ quality of life. Dr. Murphy spent a good portion of our time together articulating the concerns of the medical profession, clearly showing his understanding of health care in our community.

The closing dinner was a real treat with Wear the White Coat participants and physicians commenting not only on the program, but how to better connect the medical community with the population it serves.

I’m glad the Greater Louisville Medical Society is continuing this type of community outreach and involvement. It is good for physicians, their patients and the community as a whole.

Note: Steve Barger is the managing member of Steve Barger Consulting LLC.
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Dedicated to Hope, Healing and Recovery
Continued from page 24

MARIA G. HAMPTON

Louisville is fortunate to be home to a vibrant health care sector. Institutions like the University of Louisville Hospital, Norton Healthcare, Jewish Hospital & St. Mary’s HealthCare, Baptist Healthcare System and Humana have been cornerstones of the regional economy for decades. This is not surprising when you look at broader trends. Nationally, the impact of the health care sector on the U.S. economy has grown over the years. Health expenditures have increased from about 14 percent of the nation’s total gross domestic product to about 17 percent over the past decade, according to estimates by the Organisation for Economic Co-operation and Development.

While we are familiar with the large medical facilities mentioned above, there exists a dynamic and thriving industry of small medical businesses in Louisville, too. Through the Wear the White Coat program, I had the opportunity to meet several of the entrepreneurial physicians who run these businesses. By participating in this program, I gained a new appreciation for the “small business” segment of the medical community and its approach to both the medical and economic bottom line.

The Louisville metropolitan statistical area (which includes parts of Southern Indiana) had more than 3,000 office-based physicians in 2009, according to a January 2011 report by the Lewin Group, a health care policy research and management consulting firm. The office-based physician practices supported more than 17,000 jobs and a total payroll of roughly $2.6 billion that year. They also generated about $176 million in taxes for the state and local economies, the Lewin Group says. As these figures show, the office-based physician industry has an important local presence in our community.

The medical professionals whom I met during the program possessed a variety of skill sets, technical expertise and educational backgrounds. Some of them were traditional MDs or RNs, while others were technical professionals who trained at a variety of institutions – universities, community colleges and technical schools.

As I soon came to realize, however, education for the physician entrepreneurs includes more than medical training. It also includes learning how to manage payroll and cash flows – “musts” for any successful small business. The learning continues every day, as these entrepreneurs find out about their patients’ socioeconomic environment and its impact on their overall health. These doctors must be more than physicians; they must also be business managers, counselors and experts at navigating the complex world of medical insurance and reimbursement.

During the program, I had the opportunity to wear my white coat and shadow Dr. Lara Fakunle with Endocrine & Diabetes Associates. I watched her balance the individual needs of her patients and the bottom line of the business. In many cases, her patients had cut their prescribed doses of medicine to save money, which certainly was not good for their health. Dr. Fakunle had to deal with these issues, provide appropriate care and maximize the number of patients served to earn the revenue needed by a volume-sensitive medical practice. She does all of this each day while adapting to the changing technology in the industry and a changing regulatory environment.

After spending the morning with Dr. Fakunle, I appreciated her intensity, her caring and her energy, and I was amazed at the productivity of all of the practice’s professionals who must operate in such a complex environment.

With the Wear the White Coat program, I expected to walk away with a deeper understanding of the medical side of the office-based physician enterprise. What I didn’t expect were the additional insights I gained, including an awareness of the vast skill sets required for a successful practice and how these types of businesses contribute to the overall health and economic vitality of the Louisville community.

At the Federal Reserve Bank of St. Louis, we seek to understand the many industries that drive the economies of the communities we serve. As the senior branch executive of the Louisville office, I have a particular interest in understanding the health care industry and other industries that operate within my branch zone.

To help us in this effort, the St. Louis Fed has created four industry councils. The councils represent industries that are critical to the Eighth Federal Reserve District – agribusiness, health care, real estate and transportation. Council members, who are industry representatives from throughout the district, share with Fed staff information on economic conditions in their specific industry.

As the facilitator of the health care industry council, which is based in Louisville, I look forward to sharing my Wear the White Coat experience with members of the council and with my colleagues at the Fed. I want to thank the Greater Louisville Medical Society for giving me this opportunity.

References

Note: Maria G. Hampton is the vice president and senior branch executive of the Louisville Branch of the Federal Reserve Bank of St. Louis. She serves on the Norton Healthcare Board of Trustees.
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Jeff Hilb died suddenly at his home on March 16, 2011. He was a general internist in the Louisville area, practicing for 27 years prior to his retirement in 2005. Jeff received his undergraduate degree from Washington and Jefferson College and an MS in chemistry from the University of Illinois. He served in the Army during the Vietnam era and then went to medical school at the University of Illinois at Chicago. Jeff opened his office in Louisville after his internship and training at the University of Louisville. He was a devoted and compassionate physician. He was a member of many professional societies and active on the staff of several area hospitals.

I met Jeff in the doctors’ lounge of Audubon Hospital in the spring of 1980, shortly after my arrival in Louisville. With Jeff’s outgoing personality, we soon learned that we had a lot in common including an interest in running and other sports. We enjoyed many long Saturday runs together, always with avid discussions about the practice of medicine, current events, books, etc., and ran numerous Louisville mini-marathons together.

Jeff was always looking for a challenge. He once ran two sub-four-hour marathons a few weeks apart – quite a feat for anyone, not to mention someone recovering from a stress fracture! He embraced the technology revolution and took advantage of the computer and photography options.

Jeff made the most of his retirement, staying true to one of his favorite phrases, “Carpe diem” (seize the day). Jeff developed an interest in cycling, taking part in biking tours in parts of Iowa, Ohio, Georgia, Virginia and Kentucky. His love of camping and hiking took him to numerous state and national parks. Jeff exhibited a zest for life and a lifelong love of learning. He and his wife of 36 years enjoyed many trips together, and Jeff was always eager to share photos of their travels. He was an avid reader of books, magazines and newspapers. He enjoyed books on tape as well as watching movies.

Jeff was a loyal and caring friend. He would never fail to inquire about the welfare of my wife and children and made the out-of-state journey, along with his wife, to the wedding of my younger son last year. Always glad to share his interests, he helped my older boy pick out a bike.

When someone you care about dies, a part of you dies with them.

Vaya con Dios, my friend.

—Max L. Irick, MD

Dr. Hilb and his wife, Francine, (standing) at the wedding of the son of Dr. Irick and his wife, Julia.
GLMS would like to welcome and congratulate the following physicians who have been elected by Judicial Council as provisional members. During the next 30 days, GLMS members have the right to submit written comments pertinent to these new members. All comments received will be forwarded to Judicial Council for review. Provisional membership shall last for a period of two years or until the member’s first hospital reappointment. Provisional members shall become full members upon completion of this time period and favorable review by Judicial Council.

**Candidates Elected to Provisional Active Membership**

- Archer, Johanna (19580) Springs Medical Center 6420 Dutchmans Parkway #395 40205 749-6420 Obstetrics Gynecology 06,10 Repro Endoc Infertility 10 Eastern Virginia Med School 97
- Bush, Matthew Lee (30800) Karyn Lynette Bush 800 Rose St Rm C236 Lexington KY 40536 859-257-5097 Otolaryngology 09 Marshall U 03
- Rothpletz, John (17836) Ann McKinley Rothpletz, PhD 702 Executive Park 40207 895-5405 Radiology 02 U of Texas Southwestern 97
- Vemuri, Venu (18971) Nadia Vemuri-Cataldi 210 E Gray St Ste 701 40202 584-7525 Orthopaedic Surgery Chicago College of Osteopathic Medicine 02

**WE WELCOME YOU**


**NOTE:** GLMS members’ names appear in boldface type. Most of the references have been obtained through the use of a MEDLINE computer search which is provided by Norton Healthcare Medical Library. If you have a recent reference that did not appear and would like to have it published in our next issue, please send it to Alecia Miller by fax (736-6363) or e-mail (alecia.miller@glms.org).
Happy New Year to All

The GLMS Alliance ended 2011 with busy hands and warm hearts.
In October, we enjoyed “Men’s Night Out” at Westport Village. The evening began at Westport Whiskey and Wine, where we sampled some really nice wines and bourbons. We strolled over to A.P. Crafters for dinner while listening to live music. Several of the businesses were having Christmas open houses, so we had lots to see. But most of all, we enjoyed the fellowship and getting to know each other better.

In November, I had a chance to drop by Lowe Elementary School to present Ms. Lisa Thurman’s kindergarten class with coloring books about health, nutrition, exercise and bullying. Ms. Lisa works hard every day to help the children make better choices when going through the lunch line. They also go outside and walk around the track during their recess breaks.

In December, we helped wrap more than 400 gifts for the School Choice children. The GLMS Alliance donated the money this year for a Mattel toy grant that helped supply the children with really nice toys for the holiday party. We got in the spirit of Christmas by helping wrap them on several days. The School Choice office started looking like the North Pole. The gifts were given out at the December 10 party. It was great to see all the smiling faces.

With the New Year ahead, we are excited about our February event. We will be going to 610 Magnolia for a cooking demonstration. Edward Lee is going to demonstrate a meal that we can cook for our special someone for Valentine’s Day. He is the winner of “Iron Chef” and was featured on “Top Chef” this fall.

I am going to close with a poem by William Arthur Ward:

“Another fresh new year is here ... Another year to live!
To banish worry, doubt and fear,
To love and laugh and give!

This bright new year is given me
To live each day with zest ... To daily grow and try to be
My highest and my best!

I have the opportunity
Once more to right some wrongs,
To pray for peace, to plant a tree,
And sing more joyful songs!”

Note: Email Rhonda Rhodes at rhoda40@hotmail.com.
Why I Decided to Become a Doctor

Sade Arinze, MD

I NEVER GOT TO KNOW MY GRANDFATHER. He was a farmer in Odogbolu, a small village in Western Nigeria without adequate health care facilities and personnel. At the time of his death, my family was living in Nairobi, Kenya. My father tells me that he died of an unknown illness at the age of 63. As young as I was, I did not understand why my grandfather passed away. However, I understood that a physician might have been able to save his life or perhaps identified his ailment. I made up my mind to become a physician. I wanted to help save lives. As I got older, I realized the need to be certain that this was the right choice for me. Determined to get as close with physicians.

During the summer of 2004, an opportunity arose. WellStar Health System selected me to participate in a 10-week physician shadowing program. During these 10 weeks, I worked in the following specialties – Obstetrics and Gynecology, Otolaryngology, Family Medicine and Pathology. For three hours a week, I observed each physician taking care of patients. Each physician was unique, but compassion for their patients was a trait they all shared. I was in awe of the work they did. I remember having the same feeling of awe at the foot of Mount Kilimanjaro in Kenya as a kid and at a Buddhist temple on top of a mountain in Chiang Mai, Thailand. At the end of the program, I had the confirmation that I needed to pursue a career in medicine.

At this point, all the experiences I had in medicine were life-sustaining. However, in the summer of 2005, I was faced with the reality that sometimes no matter how much compassion, expertise and zeal a physician possesses, some patients cannot be saved. My friend Vicky was admitted to the hospital for a cholecystectomy. Within a week of discharge, she developed acute pancreatitis and was readmitted. Her condition worsened daily. Eventually, she developed sepsis from a Staphylococcus infection. On July 21, 2005, she was moved to the intensive care unit. I stood by her bedside at the hospital and listened to all the beeps from the machines she was hooked up to. As a premedical student, I did not know what all the parameters on the machines meant. However, I did know that things did not look good. As grim as the situation seemed, her physicians were trying all they could to keep her alive. Vicky passed away that night.

I cried as I left the hospital. I was faced with the reality that although my primary reason to become a physician was to save lives, sometimes this goal might not be achievable. I must admit that it was a tough reality. With this in mind, I still decided to apply to medical school.

Questions about my grandfather’s early demise re-emerged during my first two years of medical school as I volunteered in local health fairs performing hypertension and diabetes screening in medically underserved areas. I wondered if the cause of his death was an acute or chronic process. Furthermore, would he still be alive if he had had the means to address his health issues? There were numerous individuals at these fairs with very high blood pressures and fasting glucose levels who had not visited physicians in years. Once we identified those at risk, we were able to set up follow-up appointments with local physicians. This marked the beginning of my interest in preventive medicine and an understanding of the need to go a step farther with management of the acute exacerbations of diseases. As I embarked on my clinical rotations, it became evident that Internal Medicine would afford me the greatest opportunity to do so.

These two important roles of an internist are best illustrated by two patients I encountered. I met FW, a 40-year-old man at the Wings specialty HIV clinic. He was a well-nourished male with no acute complaints and presented for his routine three-month visit. After reviewing his labs, which showed high CD4 counts, my attending spent the rest of the visit listening to how well his life was going. In contrast, LK was a patient I was assigned to during my month on medicine wards. She was a cachectic, bed-bound 33-year-old woman with HIV who had a history of poor follow-up care and presented with acute mental status changes. Her workup revealed low CD4 counts and Herpes Simplex encephalitis. Acyclovir was started and she gradually recovered. Through my encounters with FW and LK, I gained experience in preventive medicine and management of disease complications respectively. They represented a spectrum in the care of a single disease, and I became aware of the great variety in medicine. My interest in Internal Medicine as well as one of its subspecialties, Infectious Diseases, was solidified because of these patients.

Ultimately, I would like to practice both general Internal Medicine and Infectious Diseases. My goal is to provide health care to underserved populations both here in the United States and in developing countries. I am excited about my career path because there are endless opportunities to manage a variety of diseases. I hope to be able to help people like my grandfather, who did not have the benefit of access to a physician.

Note: Dr. Arinze is a 2011 graduate of the University of Louisville School of Medicine. She is an Internal Medicine resident at Vanderbilt University Medical Center.
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Medicare will begin financial rewards, percent of the usual Medicare hospital multiple performance measures. One and punishments, to hospitals based on scores for these measures. Through the Hospital Value-Based Purchasing Program, these “quality” measures, plus patient opinion surveys, will be reviewed and graded, beginning with a yearlong run-in period that started in July. Most of these quality measures make sense, and 70 percent of the pay-for-performance money will come (or remain withheld) from these. However, 30 percent of these monies will be based on patients’ opinion of their received care, as reported in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. This “Patient Experience of Care” measure is a looming minefield for hospitals, their staffs and physicians. If the patients fail to praise their caregivers, there literally will be hell to pay. Already stressed hospitals facing reduced government funding, with ever-increasing numbers of patients unable or unwilling to pay, could lose even more margin. Lower revenues could lead to lesser staffing, which could lead to worse survey outcomes, which could lead to lower revenues, etc. etc.

The killer question on the 27-item HCAHPS survey is No. 21: “Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?” Medicare will only reward a top score of 9 or 10, which brings to mind the old saw: for want of a smile, the 90 percent grade was lost; for want of a grade, the bonus was lost; for want of a bonus, the renovation funding was lost; for want of a renovation, the subsequent scores were lost; for want of subsequent scores, the CEO was lost; for want of a CEO, the hospital was lost.

The survey is quite sensible overall. It asks: were doctors and nurses polite and respectful, were you listened to, did staff answer call lights promptly, did everyone explain things, were new meds taught to you, were you given detailed discharge instructions? It sounds so simple. But research in CHF patients shows that even with line-item medication detailing – what’s new, what’s old, what’s to stop – a full third of discharged patients go straight back to their previous pills. Sick people don’t pay attention. Sick people can’t concentrate well. Sick people take multiple new meds, many only temporary, several of which dull the brain so that recall of any accurate detail is faulty. Lots of my patients remember very little of an ICU stay (which I have always thought was merciful) but will they then recall that life-saving things were done on their behalf? Perhaps not. But they will recall bitterly that their room was not sunny and bright, and that the phlebotomist had to stick them three times, and that their supper, when it finally came, was not hot. All of these problems are common in hospitals, which are not resorts, not hotels, are not even quaint B&Bs tucked away in St. James Court. Hospitals are for healing, or at least helping, sick people. Such complaints flavor the perception of care, but are they important enough to lose a third of that allotment of money for such care?

For instance, we will be rated on question 14: “During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?” Gee – this is Kentucky, national leader in narcotic drug abuse and dependence. I foresee major demerits.

And question 9: “During this hospital stay, how often was the area around your room quiet at night?” Well, if the lady in Room 6 is demented and hollering, or the man in Room 4 is delirious and screaming, or the guy in Room 2 just crashed, whereupon 10 people showed up to do loud things in a hurry to get him breathing (possibly having overdosed him accidentally in an attempt to get good scores on No. 14), you just flunked that one. Even if your surveyed patient in Room 1 had just lived through meningitis, he’d give you a 2. Bye-bye bonus, hello repercussions.

In a related November New York Times article by Jordan Rau, Dr. James Merlino, Chief Experience Officer of the Cleveland Clinic (I believe we did not have one of those at Grady Hospital, and I am certain there was not one at Louisville General Hospital), said, “Hospitals are going to be punished financially for things they can’t control.” He also noted that the Cleveland Clinic’s own research showed that as length of stay increased, the less the patient felt he got attention, and the lower he scored the hospital. Depressed patients were significantly more negative in general.

Mr. Rau tells of hospitals that write detailed how-to-talk-to-people scripts

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I envision the heart patient: We continued his beta blocker (check), kept his 0600 blood glucose controlled (check), gave correct pre- and post-op antibiotics (check), prevented his blood clot (check). But did we send fresh flowers to his room and get-well cards to his dog and give crayons to his grandson? No? “Have a nice bypass,” we said. But it wasn’t enough. I

Note: Dr. Barry practices Internal Medicine with Norton Community Medical Associates-Barret. She is a clinical associate professor at the University of Louisville School of Medicine.

Where Are We Going in Quality Measurement?

The quality measurement activity in Washington is downright frenetic. Everyone recognizes the variations in care and disparities of clinical outcomes. In this country, we have superlative peaks of care as gauged by outcomes metrics and reports on patient experience with care. But we also have depths of medical care where patients receive inappropriate medications and inattention to recommended preventive services. Certainly, differences among patients who are active partners in care decisions, compared to patients who place medical recommendations as low priority (perhaps not affordable, not feasible or not wanted), play a significant role in these variations of care. But large population studies that control for variations in patient responses still demonstrate uneven care in this country. How do we raise the bar so that evidence-based, patient-centered care is the norm? To date, the response has been to generate measures as though by measuring a process or an outcome that the quality of care will suddenly be transformed. That is magical thinking!

A whole industry has developed in the generation of clinical measures. These measures have come from the federal government (Agency for Healthcare Research and Quality), from private organizations (Ingenix and National Committee for Quality Assurance) and from the American Medical Association with its Physician Consortium for Practice Improvement. These measures have been used in a variety of ways but all with the intention of becoming the catalyst for raising the quality bar.

Generally, sending “report card” results directly to individual physicians has not resulted in any significant change on re-measurement, according to Kevin Weiss, MD, CEO of the American Board of Medical Specialties. Such quality score data forwarded directly to physicians have been greeted with suspicion and doubt. Frequently, physicians have felt that such data are not credible or sufficient to warrant a change in clinical practice patterns. When either bonus or penalty have been tied to such measures, then often changes in practice can be found. That doesn’t imply that physicians find the data any more believable. They just know there are consequences or rewards from addressing those measures.

At a recent meeting of the AQA Alliance in Washington, I heard a presentation from a research organization in Wisconsin. A large group of doctors in that state had elected to participate in a pay-for-performance program (P4P) focused on diabetes. There were five standard measures of diabetes care included in the incentive program. The results for all five measures improved significantly. But the researchers also analyzed the results of several other accepted metrics for diabetic care (such as retinal eye examinations) for which there were no incentives or public reporting. The medical groups were unaware that they were being measured on these other parameters. The results from these “hidden” measures declined. The researchers’ conclusion was that the medical groups paid more attention to the measures for which there was an incentive, and devoted less energy to the measures for which there was no incentive. Another conclusion could be drawn: doctors are human!

New directions are moving within the Centers for Medicare and Medicaid Services to develop “measure sets,” i.e. groupings of measures that collectively get to the six basic elements of the National Quality Strategy:

a. Safer Care  b. Effective Care  c. More Affordable Care  d. Person/Family Centered Care  e. Better Care for Communities  f. Preventive Services Focus

Measure sets are intended to provide a broader view of quality than technical measures of clinical quality (the “effective care” measures such as monitoring LDL levels) or the preventive services measures (such as mammography or immunizations.) Examples of measures in these other categories would include:

<table>
<thead>
<tr>
<th>Safer Care Measures</th>
<th>Affordable Care (i.e. reducing complications and use of expensive procedures)</th>
<th>Person/Family Centered Care</th>
<th>Better Care for Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 30-day risk standardized readmission rate for AMI</td>
<td>• Elective delivery prior to 39 weeks gestation</td>
<td>• Hospital Consumer Assessment of Health Care Providers Survey data</td>
<td>• Initiation of alcohol and other drug dependence treatment</td>
</tr>
<tr>
<td>• Surgical site infections</td>
<td>• SCIP measure: Prophylactic antibiotics discontinued with 24 hours after surgery</td>
<td>• Assessing for rehabilitation services</td>
<td>• Pneumonia 30-day mortality rate</td>
</tr>
<tr>
<td>• Ischemic stroke patients discharged on antithrombotic</td>
<td>• Mortality for selected medical conditions including: CHF, stroke, hip fracture, AMI, pneumonia, GI hemorrhage</td>
<td>• Family evaluation of hospice care</td>
<td></td>
</tr>
</tbody>
</table>

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Tom James, MD

Continued from page 35

and teach their staffs to follow them, of hospitals that coach patients on how to answer the survey questions, and of hospitals that have started “happy hours” with chips and cookies as currency. What next, cheerleaders at the bedside?
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Continued from page 36

Of course many measures can reflect several of these characteristics. But current directions in Washington support drawing measures from each of the six areas to evaluate doctors, hospitals, nursing homes and health plans. Clearly, the ability of individual physicians, group practices, hospitals and nursing homes to impact these measures varies. Some of us have argued that while measuring more than technical and preventive aspects of care gets to a broader set of issues, it would be inappropriate to assign accountability to each entity equally. If measure sets are to be developed, there must be fair and appropriate identification of who bears greatest accountability for any given measure, and which measures must be judged only as team efforts. Ultimately, better ways to create evidence-based, patient-centered care, and how to finance them, must be found. With current measurement processes, we may be focused on the trees and forget the forest. Ultimately, it is the coordination of care among doctors that will cause the greater improvements in care.

Note: Dr. James is medical director of Humana’s National Network Operations and practices Internal Medicine and Pediatrics with Norton Community Medical Associates-Audubon West.

Coaching

My wife is an avid reader of The New Yorker and will often refer interesting articles to me. I am usually content to look at the cartoons and try to think of a title for the weekly cartoon caption contest. Recently, she suggested that I look into an article that appeared in the October 3, 2011, issue. It concerned physicians and issues that I found interesting.

The article is titled “Personal Best,” written by Dr. Atul Gawande, a surgeon at Boston’s Brigham and Women’s Hospital and associate professor of surgery at Harvard Medical School. He notes that having worked in his field for many years, he felt that he had hit a plateau as regards his skill and competency. One day, while at a medical meeting, he had some free time and decided to play tennis, at which he had excelled in his younger days. At the local tennis club he encountered the pro, a man in his 20s, who was able to give him some pointers, acting in the role of a coach, that improved his game immensely.

From that experience, he reasoned that many professionals, even at their prime in their careers, continue to have coaches who help keep them at the top of their abilities. He cites world tennis champions and outstanding musical instrumentalists and vocalists as examples. He asked himself why could not a surgeon, such as himself, have a coach and determine if there could be some improvement in his performance. Accordingly, he persuaded a retired surgeon under whom he had trained and whom he respected to serve as a coach, and observe him in the operating room.

The result was that he did indeed experience a benefit, not necessarily just in the surgical technique, but also in other aspects such as the placements of drapes and the positioning of the surgical assistants.

Dr. Gawande has become an advocate of coaching, wanting to make sure that the newer technologies are utilized beneficially for all concerned. He realizes that there is a natural resistance to this new concept of coaching. I, as a non-surgeon, doing mostly a “cognitive” type of practice, wonder how it might apply to my circumstances. I can think of many ways in which it might be appropriate. Does anyone care to discuss it?

Note: Dr. Goldin is a retired internist. Email him at eligershon@aol.com.
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