Kentucky House Bill 1 Makes Sweeping Changes; Requires KASPER Registration

On April 24, 2012 Kentucky House Bill 1 (HB 1) was signed amending several existing provisions of Kentucky law and creating several new provisions relating to the prescribing and dispensing of controlled substances. The effective date of most provisions of HB 1 is July 20, 2012. The full text of the bill and a summary can be accessed through the Kentucky Board of Medical Licensure website.

In general, the bill makes changes to the KASPER reporting system, affects the operation of pain management facilities, requires certain actions by various State licensure boards, and places additional requirements on practitioners and pharmacists authorized to prescribe or dispense controlled substances.

The changes included in House Bill 1 will affect practitioners and pharmacists in the inpatient and outpatient setting by, among other things, requiring:

• A number of actions to be taken prior to prescribing or dispensing Schedule II controlled substances or Schedule III controlled substances containing hydrocodone, including the running of a KASPER report on the patient
• Specific documentation when a Schedule II controlled substance or Schedule III controlled substance containing hydrocodone is prescribed or dispensed
• The obtaining of patient consent for treatment with Schedule II controlled substances or Schedule III controlled substances containing hydrocodone
• A specific percentage of CME requirements relating to the operation of KASPER, pain management, or addiction disorders
• “Fast Track” KBML investigations related to improper, inappropriate, or illegal prescribing or dispensing of controlled substances
• Mandatory KASPER registration by practitioners or pharmacists authorized to prescribe or dispense controlled substances to humans

In the coming weeks, ARH staff will be working through operational issues related to the implementation of HB 1 and communicating additional information in that regard. In the meantime, practitioners are advised to visit the Kentucky Board of Medical Licensure website (which provides a link to the KASPER registration page) to complete their mandatory KASPER registration as soon as possible.

Judge grants injunction in ARH case against CoventryCares

United States Senior Judge Karl S. Forester ruled June 20th to grant in part, Appalachian Regional Healthcare’s request for a preliminary injunction against Medicaid Managed Care contractor CoventryCares. As part of Judge Forester’s ruling, the Coventry and ARH agreement will remain in effect and Coventry will continue to pay ARH at the rate initially agreed upon in its original Letter of Agreement with ARH from November 2011. Additionally, Judge Forester ruled that by August 1, Coventry must provide ARH a list of Coventry members who have used ARH services during the past five years so ARH can contact them to make them aware that ARH will continue to accept the Coventry plan through November 1.

With the threat of the contract between Coventry and ARH expiring on June 30 putting 25,000 Eastern Kentuckians at risk of no longer being able to utilize ARH facilities, ARH had begun an educational campaign to inform patients of how they could switch to an ARH-accepted Medicaid Managed Care provider. Due to the ruling, those with the Coventry plan are now under no pressure to switch providers unless they wish to do so and can wait until the August open enrollment period to make a change.
ARH Physicians are Servant Leaders

Harlan’s Jose Echeverria credits a successful and rewarding practice at the ARH Daniel Boone Clinic to dedication to professional principles built around three key ideas: embracing change, building trust and personal commitment.

Dr. Echeverria came to ARH and Harlan in the mid-1990s to open a new style of practice for the community, the Prime Time Clinic. His combination of quality care and engaging personality quickly built the practice into a major success.

“I enjoy the one-on-one approach to patient care,” he said. “I know all of my patients by name as well as my patients’ parents and their grandparents.”

This approach is not only good business; it is also good medicine, Echeverria noted.

“Because I make a point to keep up with them, I am able to understand the social and familial context for most of them when I provide care.”

Within a couple of years, Echeverria moved from an evening-hours, hospital-based clinic into a prime location in the adjacent clinic. Following the same strategy, his practice continued to grow and prosper.

“I always thought that the best way to be successful in the healthcare area was to put the patients first,” he said. “Common sense is prevalent in our community and my patients know that I care for them and their families. That is the reason I am blessed to have a very busy practice all these years and hope to continue the same way for years to come.”

The practice has also been on an upward trend over the years because of positive changes he has seen from his employer, Echeverria noted.

“I have been working for ARH for 17 years and I have been able to see a big change in the approach to medicine by ARH,” he said. “Mostly it is ARH’s belief in physicians’ opinions that have changed, not only in patient care areas but also in the administrative aspect of their respective disciplines.”

ARH has committed a growing number of resources and is giving much greater emphasis to preventive care activities in the community, which he strongly applauds.

“ARH is able to maintain and in most cases improve the quality of care that it provides to our patients,” he said. “This is evident when Harlan ARH was named to the Thompson Reuters 100 Top Hospitals Award in the nation for the 4th time in the last 10 years. That’s a tremendous honor and reflects a great accomplishment of all ARH employees who have dedicated themselves to improving the quality of life in this community.”

This level of success builds trust and belief that healthcare in southeastern Kentucky is headed in a positive direction and that ARH is leading the industry in its service area.

“I hope this represents a new trend in medicine,” he added, “when physicians, who put patients first, also believe and understand that an organization must have financial solvency in order to provide an adequate service. I strongly believe that we physicians have an obligation to protect our organization’s bottom line in order to be able to provide care for all those in need.”

We Want to Hear from You!

Feel free to share comments or ideas regarding the ARH Physician Newsletter by e-mailing

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Your Patients Can Now Access Faster Stroke Care –
With Stroke, Time Lost is Brain Lost

The Kentucky Appalachian Regional Healthcare System and UK HealthCare have announced that all eight ARH hospitals in Kentucky are now part of the UK HealthCare/Norton Healthcare Stroke Affiliate Network, providing stroke treatment and prevention to even more patients in Eastern Kentucky.

Stroke is the fourth leading cause of death and the number one leading cause of disability in the United States. With stroke, time lost is brain lost. As many as 32,000 neurons are subject to loss every one second that a stroke goes untreated/14 billion synapses every one minute. It is imperative that individuals seek immediate care when symptoms begin. The FDA approved time window is three-hours from the time the patient was “last known well” for administration of intravenous tissue plasminogen activator (tPA).

Kentucky, part of the stroke belt, has a higher incidence rate than other parts of the country. The rural nature of KY and other observed disparities add unique challenges in maximizing interventional opportunities with this disease. Transit times can be significant, even to local centers, making it all the more important that we are comfortable initiating care.

ARH has worked diligently to align its protocols with national evidence-based standards and the consistent approach shared by the Stroke Affiliate Network. Adherence to these standards of care can minimize concerns of risk management issues and possible litigation. Our affiliation not only provides the process resources and education, but also the support of the UK cerebrovascular neurologists in determining the most appropriate and safe approach with care decisions.

A Surgical Solution for Heartburn Without Incisions –
Now Being Performed at Beckley ARH Hospital

What may have seemed like science fiction, surgery without an incision, is now a reality that is making lives better for patients suffering from chronic acid reflux also known as gastroesophageal reflux disease (GERD). Dr. Maurice Smith at Beckley ARH is the first to offer the TIF (transoral incisionless fundoplication) procedure for the treatment of GERD in the area.

“The TIF procedure with the EsophyX device can significantly improve quality of life for our patients,” said Dr. Smith “Many patients take reflux medications which suppress acid production such as PPIs (proton pump inhibitors) to help relieve their heartburn symptoms and are still unable to eat the foods they want or have to sleep sitting up to reduce nighttime reflux. In addition recent studies have shown that long term use of PPIs can lead to inadequate absorption of minerals such as calcium leading to bone fractures. Studies have also shown that PPIs can interact with other prescription medications reducing their efficacy. Clinical studies show that at two years after the TIF procedure nearly 80% of patients are off their daily reflux medications and can eat and drink foods and beverages they avoided for many years. Reflux no longer impacts their life like it previously did.”

In a healthy patient, there is a natural valve between the esophagus and the stomach that forms a physical barrier preventing stomach fluids from backwashing, or “refluxing,” up into the esophagus. “In a patient with chronic GERD, this valve has become dysfunctional,” explained Dr. Smith.” The TIF procedure reconstructs the valve between the esophagus and the stomach to prevent reflux. It is based on the same well proven principles of conventional more invasive laparoscopic GERD surgery. TIF’s advantage is that it is ‘surgery from within’ performed transorally (through the mouth). Because the procedure is incisionless, there is reduced pain, no visible scar and most patients can get back to their normal activities within a few days.”

With millions of Americans diagnosed with GERD and not fully satisfied with their treatment options, the TIF procedure with the EsophyX device offers an excellent alternative.
New ARH Physicians (February 2012 - May 2012)
Patient Privacy

While ARH has only encountered minor problems with the use of social media as it relates to patient privacy, this is an area worth some added attention because of the ease of which patient privacy can be violated while using the many outlets available.

Here are a few tips on social media use provided by Dave Ekrem who manages web development and social media for MassGeneral Hospital for Children:

**Don’t talk about patients, even in general terms. It’s so difficult to anonymize [de-identify] patients, it’s not worth your time to attempt it.**

For example, it’s pretty obvious no thinking person would post this: “Dave Ekrem was in the ER last night with alcohol-induced liver disease.”

But this could also identify your patient: “We had a fifty-year-old male in the ER last night with alcohol-induced liver disease.” (Somebody’s going to say “Really, In Boston? Hey – where was Dave last night? He’s fifty. Oh – I feel sorry for the kids.”)

And so could this: “Had a patient in the ER last night with alcohol-induced liver disease.” It takes only a couple of clues for the sleuths to piece something together. As little as time frame OR geography, coupled with condition, could be enough. [protected health information is virtually any information in which there is a reasonable basis to believe the information can be used to identify the individual]

**Do talk about conditions, treatments, research. You can write about conditions, treatment options, research, or other topics in general terms.**

Avoid: “I saw a patient last Tuesday with xyz condition…”

Okay: “Children with xyz condition typically present with these symptoms…”

If you wouldn’t say it in the elevator, don’t put it online. This is a famous test, probably repeated by compliance department training and hospitals all over the U.S. If you wouldn’t say it in the elevator, don’t put it online. You can try speaking your post out loud before hitting the enter key. Take particular care when replying to people in real-time venues like Twitter. You don’t have to respond right away and if you have any doubt at all, ask a friend or colleague for their reaction before you post.

Finally, here is the American Medical Association’s policy on the use of social media:

**AMA Policy: Professionalism in the Use of Social Media**

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians’ personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

(c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just, as they would in any other context.

(d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

If ARH physicians have any questions about HIPAA or patient privacy in general, they’re welcome to contact the ARH Office of Legal affairs located in the Hazard System Center.
Beware – CG-CAHPS is on the Way

Adapted from HealthStream

In early 2006, hospital leaders were beginning to deal with the new world of the Hospital-Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey – the CMS survey measuring the hospital experience of the inpatient. The implications for hospitals were not well understood at that time, but since the introduction of Value Based Purchasing, the impact of HCAHPS has become clear.

Shortly after the introduction of the HCAHPS survey, CMS released the first version of the CAHPS Clinician & Group Survey (CG-CAHPS) to allow patients to rate their experiences of their doctors’ visits. Late last year CMS introduced updated versions of the CG-CAHPS survey and changed “this doctor” to “this provider” to allow for the inclusion of advanced practice clinicians. In many ways, we are now at a similar point with CG-CAHPS that we were with HCAHPS in 2005, but on a much larger scale. Consider this: While there are fewer than 3,900 hospitals participating in the HCAHPS survey, there are more than 700,000 CG-CAHPS eligible physicians in over 200,000 physician offices. Healthcare leaders are just now beginning to become aware of this CAHPS instrument and the impact it will have on the future of the healthcare landscape.

Although the questions are many and the answers are few, it is important that physicians are aware of the coming changes as they will be significant. We may not have all the answers at this time, but ARH is busy preparing for CG-CAHPS. Be expecting more information to come!

Patient Testimonial

Datina Russell, OB patient

Dr. Nathan Mullins really cares about his patients. During my pregnancy, he never hurried through my appointments, he took the time to listen to my concerns and answer all my questions. This was my first baby, so I had lots of questions, and Dr. Mullins understood and helped me understand what was happening to my body.

When I arrived to the hospital to deliver my baby, the OB staff was very caring and attentive, making sure I was comfortable. Tracy Kelly gave me an epidural and never left my side, which I really appreciated since this was my first experience of giving birth. While Dr. Mullins was on his way to the hospital, the nursing staff was closely monitoring me and my baby. Later, when the baby's heart rate started dropping and my blood pressure started going up, I got scared; but both Dr. Williamson and Dr. Mullins, assured me that everything was going to be OK. They needed to do a C-section and take the baby quickly. Throughout the C-section I was awake, and Tracy explained what I was feeling and experiencing, which helped me so much.

Their response time was excellent, within 30 minutes my beautiful little boy was born. His father Charlie and I named our baby Shaun Darran Russell. Shaun weighed 5 pounds and 11 ounces and was 19 ½ inches long; and he is a healthy and happy baby.

I want to thank Dr. Nathan Mullins, Dr. John Williamson, Tracy Kelly, John Westbrook, Ed Morrison, Janice Patton and OB nurses Jerelicious Baker and Ann Hensley for the excellent care they gave me and my baby, especially during those critical minutes just before Shaun was born. I also want to thank Elaine Smith in Outpatient Pharmacy for having my medicine delivered to me at my discharge. This service was so helpful.

If I become pregnant again, I will choose Dr. Nathan Mullins at the ARH Women’s Health Center in Middlesboro.