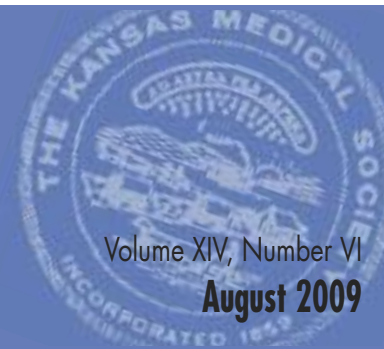


Kansas Physician

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Board of Healing Arts flip-flops again on “chiropractic physician” issue

In August 2008, the Kansas State Board of Healing Arts passed a resolution prohibiting chiropractors from advertising or representing themselves to the public as “chiropractic physician.” The policy was based upon a 1992 Shawnee County District Court decision which interpreted state law. Last Friday, the Board reversed itself once again, and voted to allow chiropractors to refer to themselves as “chiropractic physician.” The Board has a long history of being on both sides of this issue. Even though the statutes governing this issue haven’t been amended during that time, the Board has reversed its interpretation of the law four times in the last twenty years.

Board members voting to allow chiropractors to refer to themselves as physicians, and thereby reverse the policy from last August, were Board Vice-President M. Myron Leinwetter, DO (Rossville), Ronald Whitmer, DO (Ellsworth), Ray Conley, DC (Overland Park), Gary Counselman, DC (Topeka), Terry Webb, DC (Hutchinson), Frank Galbraith, DPM (Wichita), Sue Ice, Public Member (Newton) and Betty McBride, Public Member (Columbus).

Board members voting against allowing chiropractors to refer to themselves as physicians included Kimberly Templeton, MD (Leawood), Nancy Welsh, MD (Topeka) and Garold Minns, MD (Wichita).

Board President Michael Beezley, MD (Lenexa) abstained from the vote. M.J. “Boo” Hodges, MD (Salina), Carolina Soria, DO (Wichita) and Myra J. Christopher, Public Member (Fairway) were absent from the meeting.

In a letter to the Board prior to the meeting, KMS urged the Board to refrain from taking any action that could be construed as allowing chiropractors to use the term “chiropractic physician.” The KMS letter stated in part, “for the purposes of the Board’s discussion, this is not a question of whether the public is harmed or misled by the use of the term “physician” by chiropractors, nor of whether some chiropractors have been using the term for several years (in our opinion, in violation of the law), nor of whether other states allow the use of that terminology, nor of whether the federal Medicare law includes chiropractors in the definition of “physician” (under section 1861(r) of the Social Security Act, the term “physician” also includes doctors of medicine, dentistry and

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AG rules on Health Care Stabilization Fund reimbursements

Under state law, the state of Kansas pays the full cost of liability claims for KU residents, and partially covers costs associated with claims against KU medical school faculty. The Health Care Stabilization Fund manages the claims process for the state, pays all costs associated with liability claims, and then is reimbursed by the state for such expenditures.

Last legislative session, as a result of the severe state budget shortfall, then-Governor Sebelius directed the Kansas Secretary of Administration to suspend those reimbursements to the Health Care Stabilization Fund. That action resulted in the state not paying \$2.9 million of claims related expenses which is due the HCSF. Then last month, again as a result of deteriorating state finances, new Governor Mark Parkinson ordered a similar action, called “allotment”, for the coming fiscal year, which is expected to amount to another roughly \$3 million in unreimbursed funds.

Both the KMS and Kansas Hospital Association vigorously opposed the Governor’s action during the legislative session, believing that the suspension of the HCSF reimbursements constitutes an unfair tax on health care providers. Even though the legislature agreed and attempted to reinstate the funds, the Governor subsequently exercised his “allotment” authority and made the decision to suspend these reimbursements to the Fund.

The HCSF Board of Governors recently requested an opinion from Kansas Attorney General Stephen N. Six, asking whether the Governor’s use of the “allotment” authority was legal as it relates to the HCSF reimbursements. At the end of July the AG released his legal opinion that the

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Reform reality show

Jerry Slaughter; KMS Executive Director



A man who carries a cat by the tail learns something he can learn in no other way. -Mark Twain

A curious thing is unfolding on the road to health care reform. Early on, presumably by promising them key seats at the bargaining table in exchange for their acquiescence, the Obama administration had shrewdly neutralized the expected opposition of much of organized medicine, hospitals, the insurance industry and drug companies. As an aside, the AMA's unqualified support for the House bill (HR 3200) has confused and angered quite a few physicians around the country, and here in Kansas.

With much of the health care industry silenced, the administration believed the way was clear for rapid enactment of sweeping, systemic change. Then, surprisingly, ordinary people started asking simple questions about the legislation being considered by congress. When reassuring, straightforward answers about the thousand page House bill weren't forthcoming, skepticism and fear about where this was all heading began to spread rapidly. That inconvenient reality has forced congress and the Obama administration to reluctantly throttle back their febrile dash to pass reform.

The odds are still pretty good that something will pass this year. It may not be as transforming as some would like, but it will be close enough, as they say, for government work. Failure to deliver on one of the cornerstones of his presidential campaign would be an embarrassment to the president, and it is not likely his party will allow that. However, the administration and congress have run into a speedbump that may prove to be more of an obstacle than they could have imagined. They were counting on ramming health reform through without much resistance, much like they did with the economic stimulus earlier this year. That obviously hasn't happened, and the longer it takes the more difficult it becomes.

The issue has been complicated by the car and bank bailouts, the stimulus bill, record budget deficits and a still-shaky economy, not to mention the estimated \$1 trillion-plus price tag for reform. The public is becoming weary of unrestrained government spending. And congress and the administration have created a serious credibility problem for themselves over the issue. The notion that health care reform, including providing new coverage to 47 million uninsured, will pay for itself while reducing costs, is just simply not believable.

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AMA seeks role in national health reform debate

Joe Davison, MD; KMS President



Physicians attending the AMA House of Delegates meeting this summer got a preview of the complicated, polarizing, oftentimes emotional, debate that has developed around health care reform. Would the nation's physicians support

the version of reform that was beginning to take shape in the Congress? How would such proposals affect competitive markets, the right to privately contract, and in the words of a past AMA President, our liberty? Many in attendance felt that at a time of great uncertainty, the AMA was surrendering its core values to an agenda that would commoditize the nation's physicians.

The most animated exchanges took place over Resolution 110 submitted by KMS that

asked the AMA to oppose the so-called "public option", the government operated alternative designed to provide competition to the larger private insurance market. Influential leaders, both past and present, provided compelling testimony, and even the President of the AMA interrupted debate twice to make pivotal comments. Amendments were made and rejected, and made again.

In the end, gone was Resolution 110's opposition to the "public option," and in its place was a benign policy to "support of health care system reform alternatives." A clear directive had become less clear. But by a narrow vote the AMA House of Delegates authorized its elected leadership to continue the conversations with the administration and congress and thereby maintain a "seat at the healthcare reform table." The AMA ultimately supported the House legislation because it felt the bill contained a core set of high-priority provisions the

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AMA has long supported, and because it believed that support was necessary to position the organization to be a key player in helping to shape the final product that makes it to the President's desk. For a more complete explanation of the AMA's position on the issue, you can read an open letter to the profession from AMA President, J. James Rohack, MD, at www.KMSonline.org.

KMS, by contrast, does not support HR 3200, even though we are supportive of some of the positive provisions in the reform legislation. In particular, KMS believes the public option feature is objectionable, and will ultimately lead to a single-payor, government controlled health system. The KMS statement (see page 5) cautions that the legislation "provides for a troubling and significantly greater degree of control by the federal government of the services, resources, financing and delivery of health care.

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AMA & health reform

(Continued from page 2)

As the issue has begun to unfold with more details, the nation has begun to speak. In towns large and small all across the nation citizens are asking questions. With the majority of Americans happy with their health insurance, they are questioning their legislators to explain the reason for such rapid and drastic change.

Physicians too, are becoming involved, as they question their ability under the proposed reform plan to care for their patients. They are skeptical of the dialogue about savings, when critical care decisions are allocated to bureaucratic entities.

It is clear that this issue is far from decided. It is now, and it is here, that physicians can have their greatest influence. Our responsibility is to our patients and to that sacred bond between us and those we care for. Let your elected officials know how you feel about the reforms they are considering. ▲

Health Information Technology Task Force meets

At its May meeting the KMS House of Delegates adopted Substitute Resolution 09-15 which directed the Health Information Technology (HIT) Task Force to encourage physicians to take a strong leadership role in the design and implementation of health information technology, encourage physicians to become educated on issues related to adoption of electronic medical records, and to serve as a resource to physicians on HIT issues, including health information exchanges.

The KMS Executive Committee appointed the Task Force (members listed below) in July and the first meeting was held on August 12 at the KMS office. The members briefly reviewed the provisions of the American Recovery and Reinvestment Act of 2009 as it relates to increased Medicare and Medicaid reimbursement for the meaningful use of electronic health records by physicians. Also reviewed was a listing of developing clinical health information exchanges located in Kansas, as well as a listing of statewide health information exchange programs in Nebraska, Idaho, Utah and Colorado.

A major part of the meeting was devoted to a presentation on the Wichita Health Information Exchange (WHIE) that is being organized by the Medical Society of Sedgwick County. WHIE is a non-profit organization established to operate the health information exchange for the Wichita medical service area.

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Reform reality show, continued

Ominously for health care providers, statements by congressional leaders and the administration suggest that half the cost of reform will come from future savings in Medicare and Medicaid. The only realistic way you can wring significant savings out of these programs is to restrict access, cut provider reimbursements or benefits to patients, or more likely, all of the above. And when two-thirds of the population is eventually covered by Medicare, Medicaid or some iteration of the controversial public option program paying Medicare rates, your "voluntary" participation decision may be a Hobson's choice.

There are a number of good things in the reform bills that can be done without giving an unprecedented degree of control over the resources, financing and delivery of health care to the federal government. While the public supports health reform in general, there is an uneasy feeling that congress and the government are overreaching and grasping for too much control. That could fundamentally change the outcome of this issue, which until just a few weeks ago seemed a certainty. ▲

AG opines on HCSF, continued

allotment process can be used to suspend the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund for such claim costs.

The HCSF Board of Governors has indicated that unless the action by the two Governors is reversed, the HCSF will be required in July 2010 to increase the premium surcharges paid by health care providers to offset the losses resulting from the allotment orders. It is estimated that to fully recover the loss, the Stabilization Fund would need to raise surcharges on health care providers approximately 12% next July.

KMS is working closely with KHA and the Stabilization Fund to correct this situation, and prevent it from happening again. One possibility that is being carefully evaluated is a change in state law to protect the HCSF from such allotment orders in the future. Additionally, the possibility of recouping the unreimbursed amounts through the legislative appropriation process, or reversing the allotment orders, or through legal action, is also being considered. ▲

BOHA flip-flops again, continued

optometry, simply for statutory convenience). This issue is a matter purely of statutory interpretation - what is legally allowed under the Kansas Healing Arts Act."

KMS has long held that chiropractors may not legally utilize the term "physician" in conjunction with their name - either alone or in connection with any other term. The KMS position is supported by a ruling in 1992 by the Shawnee County District Court (Malmstrom, et al v. Kansas Board of Healing Arts, Case No. 91 CV 388) which found that chiropractors in Kansas are "prohibited from using the term "physician" either singly or in connection with any other term, phrase or description in a manner which in any way implies that such person is a physician of any type or nature." The court went on to state that it was "incumbent upon the Board of Healing Arts...to utilize the enforcement provisions of the Healing Arts Act to insure full compliance with this holding." Since then the Board has ignored the ruling by the district court and not disciplined any chiropractors for the unlawful use of the term. This last Board action was taken in spite of an admonition by the Board's legal counsel that it was contrary to the specific finding and order of the district court in this case.

In a related action, the Board also voted to introduce legislation in the 2010 legislative session to change the law to allow chiropractors to refer to themselves as physicians, which would seem to be an admission by the Board members that they know the use of the term is, at least at this point, not legally authorized. Of note, on at least two occasions in recent years (1991 and 1998), the Kansas legislature has specifically rejected attempts by chiropractors to amend the law to allow use of the term "chiropractic physician". In any case, based on the action by the Board, this issue will apparently be in front of the legislature once again. ▲

If you have questions or would like more information, please contact Jerry or Dan at the KMS office; both can be reached by phone at 785.235.2383 or by email at jslaughter@KMSonline.org and dmorin@KMSonline.org.

Federal health reform news

Dan Morin; KMS Director of Government Affairs



Congressional supporters and skeptics of overhauling the health care system have been visiting their respective home districts during the annual summer Congressional recess in an attempt to hear and shape public opinion at town-hall-style meetings. Public opinion on the issue is complex and diverse. Analysis of recent public opinion polls finds declining support for the version of health reform that is best represented by the bills awaiting action by the House of Representatives.

The House bill already has advanced through a series of committees and the full House is expected to vote in September on the bill. The three House versions must now be consolidated before a final vote on the House floor. The Senate Health, Education, Labor and Pensions Committee (HELP) has passed a bill, however, the Senate is now waiting on the Senate Finance Committee which isn't expected to pass a bill until September. Beyond that, the two bills—each as passed by the House and the Senate—will have to be negotiated in a joint conference committee. If a final bill is crafted in a conference committee, both the House and Senate must then approve an identical bill before they submit the single, final bill to President Obama for his approval.

The stated goals of reform when the debate started were to extend coverage to the nation's 47 million uninsured while also slowing the growth of health care spending. Unfortunately, while current plans seem to address the issue of those uninsured, the Congressional Budget Office has released comments that none of the plans currently discussed will do much to halt the steep upward trend of increased health care spending. President Obama recently has reiterated his intention to push and support a plan that would reduce the growth of health care costs, improve quality of care and regulate the insurance market.

In the Senate, the HELP committee's \$611 billion package includes a public health insurance option; a "play-or-pay" employer mandate; a requirement that every individual obtain health insurance while eliminating exclusions for pre-existing conditions; and government subsidies for those who have trouble affording coverage. It would also create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400 percent of the federal poverty level (\$73,240 for a family of three in 2009). The bill would also expand Medicaid to all individuals with incomes up to 150 percent of the federal poverty level.

The House bill would require individuals to have health insurance. It would also create a Health Insurance Exchange through which individuals and employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400 percent of the federal poverty level (\$73,240 for a family of three in 2009). It would require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage.

Sticking points in discussion from both chambers and with the public include:

- ▶ Should there be a government-run public plan as an option to compete with private insurance companies?
- ▶ Mandating businesses to provide insurance or otherwise pay taxes or penalties to contribute to the cost of the uninsured.
- ▶ Worries about the total cost of any health system reform plan: Current estimate place reform costs between \$600 billion and \$1 trillion. The Senate bill would add roughly \$597 billion to the federal budget deficit over 10 years, and one House bill would \$239 billion, according to the Congressional Budget Office.
- ▶ Holding down costs by revising the way Medicare pays hospitals, physicians and home health care providers.
- ▶ Immigration policy and "proof of citizenship" for those receiving health services in any public plan.

- ▶ The House bill proposes to fund reform via surtaxes on individuals whose annual adjusted gross incomes are higher than \$280,000 and small businesses.

Much of the delay in passing a bill from committee to a vote before the full House has been a result of an intra-party squabble between liberal and moderate Democrats (i.e., "Blue Dog Democrats) rather than the traditional Democrat versus Republican rhetoric. Many Blue Dogs oppose the idea of a government-run insurance option. Most Republicans in Congress are dead set against a public option, saying it would drive insurers out of business. The Senate Finance Committee is instead contemplating introducing insurance cooperatives, nonprofit groups owned by their members that are similar to rural utility co-ops. President Obama recently expressed openness to this alternative to a public plan option. Disagreement also exists on the topic of payment rates to providers under a prospective public plan. Blue Dog Democrats want to negotiate payment rates with health care providers under a public option rather than basing them on Medicare rates. A recent House bill amendment will require the Health and Human Services Secretary to negotiate reimbursement rates for any potential public plan with hospitals and physicians instead of basing rates on Medicare.

As a side note, various state Governors and other state officials are raising concerns about the respective health reform proposals to expand Medicaid and transfer more of the costs to states. Some are warning that many states will not be able to pay for expanded Medicaid programs when states are battling budget shortfalls and concurrently facing an increased demand for services and trouble maintaining services for existing enrollees.

Although much has transpired in a short time, there remains a long and surely intense political process ahead for significant health care reform. KMS is communicating with our congressional delegation and will continue to diligently monitor the reform process. In the meantime, please be on the lookout for health reform eConnect updates from KMS. ▲

For more information you may contact Dan at 785.235.2383/800.332.0156 or by email at dmorin@KMSONline.org.

Statement on HR 3200, "America's Affordable Health Care Choices Act of 2009"

The Kansas Medical Society supports reform of the health care system that promotes quality care, encourages individual responsibility, promotes pluralism and preserves the ability of patients and their physicians to make choices that meet their individual needs and circumstances. Although there are features in HR 3200, "America's Affordable Health Care Choices Act of 2009," which are consistent with KMS' health care reform principles, there are several important provisions in the legislation which we cannot support. The legislation contains over one thousand pages of new law and public policy that will significantly affect almost every aspect of the health care system. While there is much that can be supported, taken as a whole, the legislation provides for a troubling and unprecedented degree of control by the federal government of the resources, financing and delivery of health care.

HR 3200 does include positive health insurance reforms such as requiring health plans to demonstrate network adequacy, meet certain medical loss ratio minimums, adhere to timely internal grievance and appeals mechanisms and improves coverage for preventive services. Though it doesn't solve the problem in a permanent way, the bill takes a very positive first step towards eventually eliminating the flawed SGR (sustainable growth rate) payment methodology for physician services under Medicare. The bill also makes needed investments in the physician workforce and also provides needed payment incentives to strengthen primary care, particularly in the rural areas. We would prefer incentives rather than the mandates that individuals and employers purchase or provide health insurance. Unfortunately, the bill does little to promote a greater degree of individual responsibility in controlling one's own health care choices and costs.

We have serious concerns with the proposed public health insurance option contained in the legislation. In spite of assurances that the public option will not unfairly compete with private health plans, and that it will not compel physician participation at Medicare payment rates (providers would be paid 5 percent above Medicare, at least for the first three years), it is naïve to assume that it won't eventually face the same cost problems that have plagued Medicare and Medicaid, which will ultimately result in pressure to achieve savings on the backs of providers yet again. As provider reimbursement is cut to reduce costs, more employers and individuals will drop their private plans in favor of the less expensive, subsidized public plan, thereby inevitably moving us one step closer to a single payer, government controlled health system. Importantly, the bill does not alter the prohibition in law which prevents a patient and his or her physician from contracting privately for health care services outside the formal Medicare delivery and payment system.

We also have concerns about the limitations on physician investment in hospitals and health care facilities included in HR 3200. KMS supports responsible physician investment in health care facilities, technology, services and equipment, along with appropriate disclosure to patients so they can make informed care decisions. So long as such facilities, equipment and services improve access to high quality care, the fact that they have physician investment or ownership should not disqualify them from participation in public programs.

Finally, KMS is concerned that the legislation will do little to slow the growth of health care spending, which is one of the stated purposes of HR 3200. The Congressional Budget Office has warned that current reform proposals, including this legislation, would significantly expand the federal responsibility for health care costs and add to the federal budget deficit. While expanding the number of Americans covered by health insurance is certainly a laudable goal, this rapid expansion would appear to exacerbate the problem of rising health care expenditures, which will increase pressure to deny or delay services to patients, and to again cut reimbursement to providers.

KMS supports health system reform but that reform should build on the strengths of the current system. Reform should promote quality as determined by health professionals – not the government. It should preserve patient choice of physician and facility, promote delivery-model innovation and it should harness the power of individual responsibility and market forces as a superior approach to a government-controlled delivery system. KMS will continue to monitor the progress of the various reform bills under consideration by Congress, and will work with the Kansas delegation to identify those proposals which have the best chance of improving the system without adversely affecting the patient-physician relationship. ▲

Medicare private fee-for-service plans reviewing charts

KMS has received several calls from practices regarding Medicare Private Fee-For-Service (PFFS) plans. A PFFS plan is one of three plans provided under Medicare Advantage (MA). These plans, formerly called Medicare + Choice, were a provision of the Balanced Budget Act of 1997. One plan in particular, Humana Gold Choice, has been requesting a large volume of charts for review-as many as 500-which, for some, is the entire panel of patients for the plan. The request comes in the form of a phone call and/or letters explaining the need for the reviews. The request does not state that these audits are optional. Practices are asking "How did this happen" and "Must I comply?" Unfortunately, there is no straight answer, as there are several things that must be taken into consideration.

Medicare risk adjustment reviews are the most commonly requested reviews. These are plan-initiated audits that are typically post-payment audits. Providers are not required to submit records for these types of audits, unless under obligation by a signed contract, as is the case for a HMO or PPO plan, or in the case of PFFS plans terms and conditions of payment.

These reviews are not typically done to recoup payments, but to obtain data. Humana wants to ensure that physicians are documenting all chronic conditions of the member at least once a year-if not at every visit.

The correct coding guidelines for billing chronic conditions is: use the diagnosis for a chronic condition if you are actively treating (at that encounter) the condition. If you use the chronic condition as a factor in medical decision making you will reference it in your notes but not as a condition treated at that visit. Humana explains that gathering this data allows them to be proactive in setting premiums, benefit design, reimbursement to providers and referring members to disease management programs.

Humana has indicated that for large practices they try to schedule an on-site review to ease the administrative burden to practices, and for those that send records in, they will pay for records up to the state regulation of record requests, which for Kansas is \$18.18 for cost of supplies and labor, \$.60 for the first 250 pages and \$.43 for each additional page. Humana has shared with KMS that these reviews are not mandatory. ▲

If you have questions about one of these audits, please feel free contact Ruth for more information. Ruth can be reached by 785.235.2383 or by email at rcornwall@kmsonline.org.

Medicare proposed fee schedule for 2010

Ruth Cornwall; KMS Director of Health Care Finance



On July 1, 2009, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule to update the payment policies and rates for the 2010 Medicare Physician Fee Schedule (MPFS). The MPFS sets rates for more than 7,000 types of services in physician offices, hospitals and other settings.

CMS estimates a physician fee schedule decrease of 21.5 percent for 2010. MPFS rates are updated annually, based on a formula that compares actual Medicare expenditures to an allowed amount and includes the application of the sustainable growth rate (SGR)—something KMS has viewed as flawed. In fact, the formula has resulted in negative updates since 2002—relying on Congress to enact legislation to avoid negative updates.

Highlights of the proposed rule include removing the cost of physician-administered drugs from the definition of “physician services” for purposes of calculating the SGR. For years, organized medicine has expressed a strong opinion that drugs are supplies, not “services”, and should not be part of the formula. This change is not expected to materially impact the estimated decrease of 21.5 percent to the 2010 fee schedule, but that it would reduce the number of years in which physicians are expected to experience a negative update.

CMS also proposes to stop making payment for physician consults, which are typically billed by specialists, and are paid at a higher rate than equivalent evaluation and management (E/M) services. Physicians will instead use existing E/M service codes when providing these services. CMS proposes using the savings generated by this change in payment policy to increase payments for existing E/M services.

According to the 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes Table, which does not include the -21.5 percent conversion factor, in the proposed rule, general practitioners, family physicians, internists and geriatric specialists would see an increased payment from 6 to 8 percent. Hardest hit is diagnostic testing facilities at -24 percent, and radiation oncology at -19 percent. This information may be found on page 143 (33663) of the proposed rule by going to the link below.

The proposed rule may be viewed at: <http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf>; the comment period has closed but KMS will continue to follow this issue and keep you updated on the final decision. ▲

KaMMCO gears up for Fall Loss Prevention programs

Mark your calendar and plan to attend one of the fall loss prevention programs. The program, “That Will Never Happen to Me...Understanding Medical Professional Liability Litigation Through Real Claims and Case Studies,” is designed for physician and clinic administrators, hospital administrators and risk managers, and other health care professionals. The program will be presented by David O’Neal, JD, Vice President-Claims & Corporate Counsel, KaMMCO; and Cristy Anderson, JD, Claims Manager-Wichita office, KaMMCO, and will explore and analyze many of the complex issues that go into the successful (and sometimes unsuccessful) defense of medical professional liability claims.

Using actual KaMMCO files, this program will identify many of the strengths and weaknesses that impact the outcome of claims in Kansas and offer loss prevention and claim tips that can lead to the successful defense of a case.

For the first time, this year KaMMCO will offer on-site website registration to our members. Eligible members will also receive a premium credit for their attendance, as well as continuing education credit for physicians and nurses.

If you would like more details about the programs including dates and cities, please visit the “Loss Prevention” section at www.KaMMCO.com. ▲

Alliance seeks to evolve

Michelle Grindel; KMS Alliance President

I had a terrific year of preparation to lead the Kansas Medical Society Alliance. I attended AMAA meetings in Chicago & in March I attended the National Advocacy Conference in Washington DC. A great deal of the talk was focused on changing health care. Change, in some form, is coming to the world of health care whether we like it or not. It is more essential than ever that we as the family of medicine come together and become active to affect this change for the better.

Change is also coming to the ranks of the medical alliance. Membership numbers are dropping across the country. We are experiencing this in Kansas as well. We must evolve to accommodate the changing population of our Alliance-eligible members. Members are men and women, professionals and stay-at-home spouses who want to see the value of time and money given to an organization. The KMSA board is addressing these issues. Our Planning and Development Committee plans to begin work on a strategic task force this year to develop short range and long range goals. We choose to make change.

As a member of KMSA I feel the choice to be a member benefits the health of the citizens of Kansas. Our purpose as a volunteer in the Medical Alliance is to work towards improving the health and quality of life for all people; promote health education; encourage participation of volunteers in activities that meet health needs; and to support health-related charitable endeavors. How do we actually “DO” this? Suffice it to say, the activities across the state of Kansas encompass a wide range of activities. We have programs that engage students in anti-bullying role play; puppeteers in classrooms teaching children about leukemia, bullying and healthy eating; a student “I Can Be Health” poster contest which culminates in a downtown billboard; Healthy Kidz Kan project to fight childhood obesity. Walking Teams which raise money for health funds; a fashion show to raise money for at risk youth and a free clinic; collaborating with the Meals on Wheels program to deliver lunches to shut-ins.

You will not find any other organization that will offer you the support of fellow members that are engaged in the medical family world. We hope you will consider becoming a part of KMSA. ▲

I’m available via email for any questions you may have about our organization, projects and membership at mgrindel@cox.net. I’d enjoy hearing your suggestions or comments.

Revised regulations impact supervision of ARNPs

Catherine Walberg, JD; KaMMCO Vice President & General Counsel



The Kansas Board of Nursing has made regulatory changes to the regulations that will affect physicians' supervision of advanced registered nurse practitioners (ARNPs). The Kansas Board of Nursing has approved revisions to existing regulations that will be effective September 4, 2009. Under these revisions, each ARNP will be "authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients, and medical decisions based on an "Authorization for Collaborative Practice" with one or more physicians."

The revised regulations define the "Authorization for Collaborative Practice" as a medical plan of care for patients and clients developed by and managed by an ARNP based upon an agreement developed jointly by an ARNP and one or more physicians. The Authorization for Collaborative Practice (Authorization) must be reviewed annually by the ARNP and physician(s) and signed by the ARNP and physician(s). Furthermore, each Authorization must include a cover page containing the names and telephone numbers of the ARNP and the physician(s), their signatures, and the date of review by the ARNP and physician(s). The Authorization must be maintained at the ARNP's principal place of practice. K.A.R. 60-11-101(b). The regulations make clear that the immediate and physical presence of a physician is not required when care is given by an ARNP.

Finally, the description of the functions of ARNPs, other than certified registered nurse anesthetists, has been revised. Consequently, ARNPs acting in the categories of nurse practitioners, clinical nurse specialists, and nurse midwives, as well as their supervising physician(s), should take a moment to review the revised description of the functions of these types of ARNPs. These descriptions are found in the revised regulations, K.A.R. 60-11-104; 60-11-105; and 60-11-107, issued by the Kansas Board of Nursing. They can be accessed by going to the website of the Kansas Board of Nursing at www.ksbn.org/approvedregs.htm. ▲

HIT Task Force, continued

The software and hardware for operation of the Exchange are being provided by the Axolotl Company located in California. Axolotl has been in the health information exchange business since 1995 and is the provider for the statewide HIE's in Nebraska, Idaho and Utah.

The Task Force determined that additional research should be conducted on the possible development of a statewide health information exchange, and believed that such an effort should be led by physicians, hospitals and other key stakeholders. Members of the task force are:

Debra Doubek, MD; Manhattan (Chair)
James Appelbaum, MD; Kansas City
Ronald C. Brown, MD; Wichita
Jennifer Brull, MD; Plainville
Dennis Cooley, MD; Topeka
Robert Cox, MD; Hays
Joe Davison, MD; Wichita
Eric Huerter, MD; Lawrence
Bradley Marples, MD; Topeka
Steen Mortensen, MD; Wichita
Robert Moser, Jr, MD; Tribune
Jay Murphy, MD; Shawnee Mission
Charles Porter, MD; Kansas City
David Ross, MD; Topeka
Mark Synovec, MD; Topeka
DeAnna Vaughn, MD; Neodesha ▲

Collaborative selects focus area & plans for first Summit on Quality

Kendra Tinsley; Kansas Healthcare Collaborative Program Director

The KMS and Kansas Hospital Association's joint effort to engage physicians and hospitals around issues related to clinical improvement in our state continues to take shape. Led by representatives from both organizations, the Kansas Healthcare Collaborative's Steering Committee has recently formalized the group's organizational structure, hired KHC's first full-time staff member and identified upcoming programming opportunities.

Readers may recall that KHC is a provider-led organization whose newly adopted mission is to transform health care through patient-centered initiatives that improve quality, safety and value. The organization was founded by KMS and KHA last year; it embodies the commitment of two of the state's leading health care provider groups to act as a resource and continuously enhance the quality of care provided to Kansans. Both organizations envision KHC will play a unique role in placing health care providers (physicians, nurses, hospital executives) in leadership positions to drive clinical improvements directly to the patient's bedside.

Quality initiatives

KHC intends to be supportive and complementary of already ongoing local, state and national quality improvement and patient safety initiatives. The KHC Steering Committee has identified as its first priority the implementation of a comprehensive effort to reduce Healthcare Acquired Infections (HAIs). One initiative within that goal is a program to reduce influenza infection through immunization of health care workers. KHC's goal is to immunize all hospital-based health care workers including medical staff. We know improved immunization rates will benefit patients and reduce health care worker absenteeism. This is just one example of initiatives aimed at reducing infections in the healthcare environment that we will use to drive quality and safety directly to the patient's bedside.

Summit on Quality

On October 16, 2009 at the Topeka Capitol Plaza Hotel's Maner Conference Center, KHC will host its inaugural Summit on Quality that will bring together providers from across Kansas to ac-

tively engage and take the lead in implementing initiatives geared toward quality and patient safety in their own hometowns. We hope to have every hospital in Kansas send representatives to our Summit; registration information will be mailed soon.

The KHC Summit is uniquely provider driven—the breakout sessions will feature Kansas providers sharing experiences and successes in implementing quality improvement and patient safety efforts. One of the event's keynote speakers will be Michael Leonard, MD who serves as the Physician Lead

for Patient Safety at Kaiser Permanente and is a faculty member at the Institute for Healthcare Improvement. Health and Human Services Secretary Kathleen Sebelius has also been invited to speak about national issues effecting health care. ▲

We look forward to including KMS members in the Collaborative's work; please feel free to give us a call if you'd like more information or have questions. You may contact Kendra Tinsley, KHC's Program Director, at 785.235.2383 or by email at ktinsley@kmsonline.org.

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