VIEWS & VISIONS
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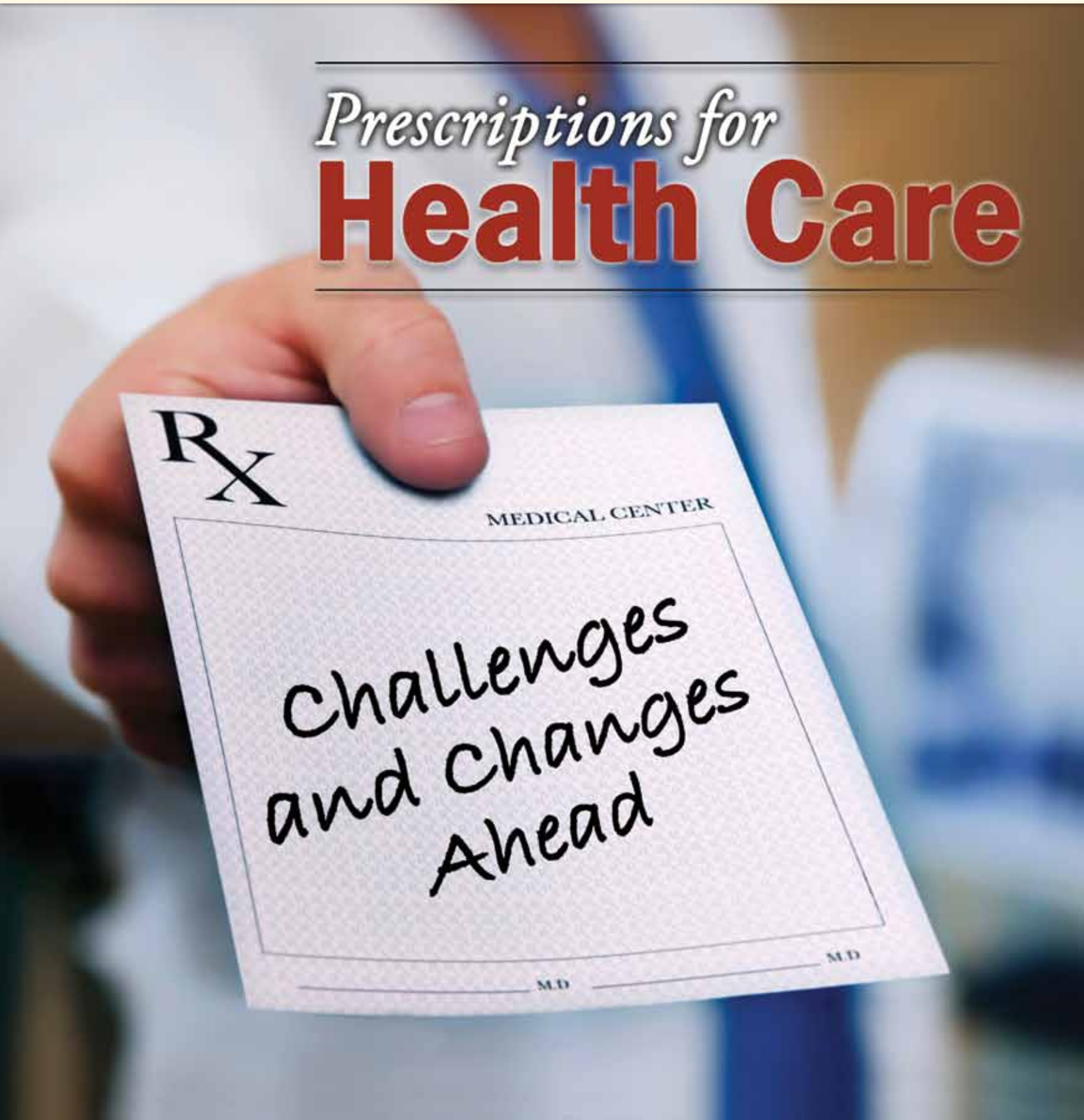
Prescriptions for Health Care



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Prescriptions for Health Care

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Thomas A. Heywood
Bowles Rice McDavid Graff & Love LLP

FROM OUR
MANAGING
PARTNER

Tom Heywood is Managing Partner of Bowles Rice and a former chief of staff to the Honorable Gaston Caperton, Governor of the State of West Virginia. He has significant experience in health care, corporate, finance and commercial law, and is recognized as one of the "Best Lawyers in America."

Earlier this year, Mr. Heywood was appointed by West Virginia Governor Joe Manchin to serve on the nine-member Independent Commission on Judicial Reform. The Commission, charged with evaluating West Virginia's judicial system and its current practices, will present its findings in November 2009.

Mr. Heywood is active in the community and in various West Virginia business and trade associations. He serves on the boards of many charitable organizations, including Vision Shared, Imagine West Virginia, Discover the Real West Virginia Foundation, Thomas Memorial Hospital, West Virginia University Hospitals, the Clay Center and the Kanawha County Library Foundation.

In a recent editorial in the *Wall Street Journal* Weekend Edition, Peggy Noonan wrote about the daunting challenge facing all who would attempt reform and improvement of our nation's health care system – the utter complexity of health care. I suspect we all would agree.

While the complexity of health care is indeed a deterrent to productive debate and discussion, it cannot prevent us from making progress. In this issue of *Views & Visions* we explore the many challenges facing our health care system. We hope that by doing so, each of us will better understand the issues, and better contribute to productive dialogue and solutions in our respective fields of endeavor.

A central figure in the national debate is Senator Jay Rockefeller, Chairman of the Senate Finance Subcommittee on Health Care, and a passionate advocate for health care reform since his days as a VISTA volunteer in Emmons, West Virginia. Inside this edition Senator Rockefeller shares his perspectives on President Obama's vision for health care reform, and his thoughts about the importance of health insurance reform in realizing that vision.

At the state level we also have talented and dedicated health care leaders. West Virginia Senator Roman Prezioso provides a succinct overview of the efforts of the West Virginia Legislature to position West Virginia for success – and be a reform leader – as federal policy changes are adopted. West Virginia Senator Evan Jenkins offers his observations and caution about the "public option" plan that is so actively debated at the federal level, in light of West Virginia's experience over many years with similar public programs.

At the heart of health care are providers – doctors, nurses, hospitals, clinics, nursing homes, retirement communities and others. In this edition we are delighted to present articles by many outstanding leaders from our region's provider community. I wish to thank each of these health care providers for their leadership on health care issues, and for their dedication and commitment to serving the citizens of our region, day in and day out.

We cannot overlook the importance of training and preparing our future health care providers. In this edition we also present articles by talented educators who are actively engaged in providing a world class education to those who will serve us all for years to come in the health care industry.

Technology and insurance are both key elements in any discussion related to health care reform. We are honored to feature insightful articles on both the pivotal role of technology in improving our health care system and health outcomes and the existing opportunities to expand and improve our health insurance system.

At Bowles Rice, we help many individuals and businesses in the health care industry achieve success and improve lives. Many of my colleagues who serve health care providers have authored thoughtful articles for this issue on a variety of topics that relate to health care challenges and complexity, from pandemic preparation to pharmaceutical research.

I extend sincere thanks to our many authors for their work, their leadership, and their views and visions. I hope you enjoy this edition, and I wish you good health as we work together for a better health care future for all.

Bringing Accountability to the Health Insurance Industry

The Honorable John D. (Jay) Rockefeller IV, United States Senator
West Virginia

Senator Jay Rockefeller is the chairman of the Senate Committee on Commerce, Science and Transportation and is the chairman of the Senate Finance Subcommittee on Health Care. He is also a member of the Senate Select Committee on Intelligence, and the Senate Committee on Veterans' Affairs.

Senator Rockefeller graduated from Harvard University in 1961. In 1964, he came to Emmons, West Virginia, where he began his public service career serving the people of West Virginia. In 1966, he was elected to the West Virginia House of Delegates and in 1968 to the office of West Virginia Secretary of State. He served as president of West Virginia Wesleyan College from 1973 to 1976. In 1976 he was elected Governor of West Virginia and re-elected in 1980. He was first elected to the United States Senate in 1984.

President Obama outlined a clear vision for health reform – a plan that will put families ahead of corporate profits, reduce skyrocketing health care costs and provide a strong pathway for more Americans to access meaningful and affordable care. With Congress back in session and back to work on health care reform, we must continue to build on the President's vision and capitalize on this profound opportunity to fix a broken system and make life better for millions of Americans.

Today it is an undeniable fact that millions of families carry the burden of failed health care policies and unmet promises. Too many feel as if they are walking a tightrope – just one serious illness threatens to throw them off balance and send them tumbling down.

Real protection for the American people means health coverage must be accountable – the insurance you buy today must be there when you need it tomorrow. Too many families who have paid their premiums faithfully every month for years, expecting to be covered, suddenly find themselves stuck with devastatingly high bills when they get sick and their plans don't actually provide coverage when they need it. It makes you wonder what the purpose of that health insurance is, in the first place, if it offers no protection against the ruin they hoped to avoid.

As chairman of the Senate Finance Subcommittee on Health Care, I believe we must continue to make tougher insurance regulation and greater transparency a top priority, and I will fight to protect families and businesses across the nation.

The Senate Finance Committee has laid out its framework, but at this point it simply does not go far enough to protect Americans from devastating insurance practices or outright loss of coverage.

Most Americans – 46 percent – get their health coverage through large employers in the self-insured market. Any new insurance market reforms, such as a prohibition on rescissions and benefit caps, should apply to this market as well. Otherwise, we will be doing very little to improve the coverage of a significant number of Americans.

Our goal is comprehensive reform that takes work, long hours, some disagreement, a lot of coming together and a deep commitment to bringing families real solutions once and for all.

In West Virginia, the example of a local garment company, Corbin Limited, is a sad reminder of the self-insured market's risks. When Corbin declared bankruptcy in April 2003, 444 former employees were left with $2 million in medical bills. With a self-funded plan, Corbin was subject only to the Department of Labor's inadequate regulation and had no licensing requirements or solvency standards. When the company went under, its employees had virtually no means of appeal.

Comprehensive health insurance reforms, like prohibiting rescissions, eliminating pre-existing condition exclusions and protecting employees in case of bankruptcy, must apply to all insurers and policies in every single market – including the self-insured.

In the Senate Commerce Committee, we recently heard testimony by Wendell Potter, who

worked in the insurance industry for more than 20 years. He explained very clearly the tactics insurance companies use to keep policyholders in the dark. He said they deceive consumers with incomprehensible explanations of their benefits, often leading people to simply ignore them or throw them away.

He also said that more and more consumers are falling victim to deceptive marketing practices – which essentially encourage them to purchase policies with high costs and limited benefits.

Consumers cannot make real choices because the insurance industry does not use standard terms or definitions. And consumers cannot challenge insurance companies' decisions because the companies do not explain the terms of coverage in clear, understandable language. When insurance companies fail to meet their obligations to these people, it literally becomes a matter of life and death.

That is why, since March, I have been holding a series of hearings in the Commerce Committee to get to the bottom of these misleading practices and demanding explanations from companies like CIGNA. And it is why I wholeheartedly believe that holding insurance companies – including self-insured plans – accountable for their actions has to be at the heart of any true health care reform.

Insurance companies have seen their profits soar over 400 percent since 2001, while premiums for consumers have doubled. Right now, the insurance industry is profit-driven when it should be patient-driven.

They are unfairly raising prices, cutting people out of coverage for pre-existing conditions, and as one report I released through the Committee revealed, systematically overcharging consumers who choose to see doctors outside of their networks.

To fight back, I have introduced the Consumers Health Care Act. In addition to creating a strong public health insurance option that would put competitive pressure on insurance companies and help drive down costs, my legislation also creates America's Health Insurance Trust – created *for* consumers and run *by* consumers.

The President's speech marked the first time the public option has been clearly explained to the American people. He reopened the door to a serious discussion about a public health insurance option – and the time to have that discussion is now.

Our goal is comprehensive reform and that takes work, long hours, some disagreement, a lot of coming together and a deep commitment to bringing families real solutions once and for all. I share the President's confidence and resolve that we will succeed.

West Virginia's Plan to Coordinate and Improve Health Care Delivery

The Honorable Roman W. Prezioso, Jr., State Senator
West Virginia

Roman W. Prezioso, Jr. has served in the West Virginia State Senate since 1996, and is a senior member of the finance committee and a member of the finance budget conferees. Besides his other committee assignments, he chairs the health and human resources committee and student intern interim committee. He also served four terms in the West Virginia House of Delegates, where he chaired the education committee.

During his chairmanships he was instrumental in the 2009 Roadmap to Health Project, which is the cornerstone for health care reform in West Virginia. He was awarded the Alzheimer's Association's Rockefeller Award for his contributions to that organization's mission, and received the Earl Ray Tomlin Award for Excellence in Legislative Leadership for his work with rural health legislation.

Senator Prezioso began his professional career as a teacher, principal and county director. He is currently employed as an administrative assistant for the Marion County Board of Education. He is active in many government, civic and community organizations, including the Southern Regional Education Board, the Southern Legislative Conference, the West Virginia University's Eberly College of Arts and Sciences Advisory Board and the Marion Regional Development Corporation.

Senator Prezioso received his undergraduate degree from Fairmont State University and his graduate degree from West Virginia University.

The challenge for West Virginia's health care system, in light of the state of flux in Washington, DC, is to maintain a watchful eye and a constant vigil on the proceedings. As Congress strives to craft meaningful legislation, one thing is certain: a speedy consensus is very unlikely, if it happens at all. The time frame for implementation of a national health care system is inherently hard to comprehend and logistically problematic to implement.

As legislators readily know, capturing the intent of legislation and drafting the true meaning of the law is only a part of the process. The debate during the amendment stage is a lengthy and arduous process. The implementation of the legislation will require even further scrutiny as it evolves through the drafting of the rules and regulations and the procurement of the funding necessary to set the plan in motion.

Congress will continue to struggle to overhaul a national health care plan, and states are left to second-guess the outcome. Prospectively, West Virginia should stay the course set by the major health care legislation passed during the 2009 regular session, and strive to provide quality, accessible and affordable health care in both the private and public health care delivery sectors. Although West Virginia's problems are not unique to the rest of the states, it does have its own anomalies. West Virginia ranks first in overall disability rate, hypertension and the rate of cancer-related deaths from colorectal cancer, and third in obesity, along with an aging population.

The Roadmap to Health/Health Care Reform Initiative in West Virginia, Senate Bill 414, was signed into law by Governor Joe Manchin III with the intent of developing a state-of-the-art health care delivery system. The legislation was passed with input and consensus from members of the Governor's office, the business community, the labor community, health care providers, special interest groups and the public sector. Participants in this collaboration made a concerted effort to bring sustainable change to our health care system in West Virginia.

Under the consultation and guidance of Kenneth E. Thorpe, Ph.D., Emory University, The Roadmap to Health Initiative was divided into four major workgroups: Administrative Simplification, headed by Carl Callison of Mountain State Blue Cross Blue Shield; Health Information Technology and Chronic Care, headed by Dr. James Comerci; Health Care System Redesign, headed by Tom Susman of TSG Solutions; and Wellness and Prevention, headed by Keri Kennedy of the West Virginia Department of Health and Human Resources. The working groups were provided these guidelines:

- Design solutions to reduce the growth in health care spending.
- Increase access to health care services among the uninsured.
- Improve the quality of care provided.

At the outset of the Roadmap to Health, it became apparent that for the plan to be successful, someone needed to be directing the course of action, and there must be a plan that outlines the goals and objectives. To address this, the legislation created the Governor's Office of Health Enhancement and Lifestyle Planning (GO HELP). This newly created office is under the supervision of a director who is appointed by the Governor with the advice and consent of the Senate. The director, a secretary-level position, has the responsibility for oversight of all health care reform initiatives. All state agencies which pertain to health care shall collaborate with the GO HELP office in coordinating health care delivery in the state.

Governor Manchin appointed former State Senator and Secretary of the Department of Health and Human Resources, Martha Y. Walker, as the director. Director Walker will be responsible for developing a five-year strategic plan on health care reform. Her duties include purchasing, entering into contracts and evaluating existing contracts, filing suit, negotiating pharmacy benefit contracts and advising the governor and the legislature on health care policy. The director will keep records, work with the governor to prepare a budget and any necessary appropriations, and has necessary rule-making authority. The office will replace the Interagency Health Council and inherit the existing duties of the Pharmaceutical Cost Management Council regarding prescription drugs, including advertising costs, reporting and the ability to participate in multi-state consortia.

The bill also creates an advisory council to assist the director with the goals and duties of the office. Members are made up of both governmental officials and public members. The public members serve four-year terms, and are appointed by the governor with the advice and consent of the Senate. The director serves as the chair of the advisory council.

This new office will work in collaboration with the other agencies that are responsible for the health care system, and validates that any agreement to proposed contract changes are cost effective and in the best interests of the state. The office oversees and facilitates the implementation of electronic medical records. Many of these projects are currently being evaluated under the federal stimulus package to ensure that the state is eligible for the most funding possible and that no barriers are created.

A key component of the redesign of the health care system is to move away from a model based primarily on treatment, and move to a model geared more to prevention. To accomplish this focus shift, the GO HELP director is to promote the concept of patient-centered medical homes. In a medical home, the patient develops a partnership with their health care provider and becomes an active participant in the delivery of their health care. The director is responsible for reviewing pilot projects underway at the Bureau for Medical Services and the Public Employees Insurance Agency. The goal is to extend beyond these pilots once successful projects can be evaluated and identified. This will move our health care delivery toward prevention of acute and chronic conditions through the collaborative efforts of the patient and their health care provider.

West Virginia's efforts to address growing health care concerns have put us at the forefront of this issue. As we keep a mindful eye on proceedings at the federal level to create a federal umbrella of health care reform, it becomes apparent that our efforts have given West Virginia a leg up on other states. We have keenly examined the problem on the state level and worked diligently to develop a strategy to address it. In doing so, we remained cognizant not to go too far afield so that we can easily fold our efforts into a federal solution. The focus now becomes implementation of our efforts. We must also be prepared to alter our course, should federal legislation require that. In short, we are just getting started.

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Evolution or Revolution?

David L. Ramsey, Chief Executive Officer
Charleston Area Medical Center

David L. Ramsey is president and chief executive officer of Charleston Area Medical Center, a not-for-profit, 913-bed regional tertiary referral hospital in Charleston, West Virginia. He also is president and CEO of CAMC's parent corporation, Charleston Area Medical Center Health System, Inc., which includes Braxton County Memorial Hospital, the CAMC Foundation, the CAMC Health Education and Research Institute, and Integrated Health Care Providers, Inc.

Mr. Ramsey joined CAMC in September 2000 from Methodist Healthcare-Memphis Hospitals, where he was president of a five-hospital regional system. He previously served as secretary of the Louisiana Department of Health and Hospitals under Governor Buddy Roemer; executive vice president and chief operating officer of the 405-bed Baton Rouge General Medical Center; and senior vice president of General Health, Inc. Previously, he was administrator of Montgomery County Medical Center, a 182-bed hospital in Conroe, Texas; and assistant vice president of 121-bed Methodist Hospital in Houston.

Born in Ohio and raised in Missouri, Mr. Ramsey holds a master's degree in health care administration and planning from Washington University School of Medicine in St. Louis, and a bachelor of arts degree in biology from the University of Missouri at St. Louis.

He is active in a number of civic and professional organizations, including the West Virginia Hospital Association, the American College of Healthcare Executives and the American Hospital Association.

With all the media attention and discussion occurring about health care reform, one recurring theme seems to be that Americans want health care insurance reform, not necessarily health care delivery reform. Very few would dispute that all citizens deserve access to health care. How that is managed, delivered and paid for is the dispute.

When you review the current reimbursement system for providers (hospitals and physicians), there is an obvious cost-shift to the private sector. For instance, when CAMC cares for a patient covered by Medicare, the hospital is reimbursed only 75 cents on the dollar of cost – not charges – simply cost. Other government reimbursement shortfalls hold true but are even more egregious, with Medicaid paying only 53 percent of cost and West Virginia Public Employees Insurance (PEIA) paying only 49

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percent. Of course, this requires that private insurers must pay substantially more than cost in order for hospitals and physicians to keep their doors open. With CAMC caring for more uninsured, Medicare, Medicaid and PEIA patients than any other hospital in the state, we are acutely aware of these shortfalls.

The consequence is that private insurance premiums have risen to a breaking point, as many smaller companies drop coverage for their employees. These same folks end up on

CAMC Health System

a government program, or in the ever-growing pool of the uninsured. And the cycle continues. One concern is that if reform involves modeling after current government programs, an unintended consequence very well may be that this cost-shifting cycle will actually worsen.

The ever-increasing cost of health care and the expense to individuals is somewhat a reflection of an aging population and accompanying increase in utilization. So will this impending legislation actually be health care reform, or a rationing of services through payment reform?

And therein lies the central question. How do we provide access to quality, efficient care that, as a nation, we can afford? Expanding coverage and providing access is only part of the equation. The true challenge involves utilization review. This is clearly the more difficult part, which is why politicians (and others) are avoiding the subject. For a compelling case study on utilization, please read the article titled "The Cost Conundrum" by Atul Gawande in the June 1, 2009 edition of *The New Yorker* magazine.

Of course, this issue is not new. In the late 1980s, as the country faced similar difficulties with health care costs, a new model was born. Managed care was brought on by larger companies in an effort to control costs, and by 1996 health care premium growth was zero. However, physicians and patients rejected managed care. When the economy turned around in the 1990s, and there were funds to cover the rise in health care premiums, politicians responded to political pressure and

eliminated capitation options and ended the commercial Medicare-managed care plans. As the economy has tightened (and narrowly avoided a depression), the same discussions have been reborn on Capitol Hill and in state houses around the country.

So how do we address reform on the cost side of the equation? For starters, mandating that everyone carry some form of health insurance, which will help balance the risk pool. We must create incentives to drive appropriate provider behavior. Models for cooperation, and not competition, between physicians and hospitals should not only be allowed by law, but should be encouraged. The current legal and regulatory environments prohibit most cooperative agreements. Importantly, national tort reform is needed. When West Virginia passed tort reform in 2003, CAMC and other West Virginia hospitals saw a dramatic increase in our ability to recruit and retain physicians. In addition, malpractice insurance premium rates are decreasing. There needs to be a review of regulatory bodies and accompanying redundant regulations that cost hospitals millions of unnecessary dollars.

Finally, but perhaps most importantly, the American public must decide what we expect, and can afford, from our health care delivery system. Demanding every test, every time without following proven science or professional medical advice will continue to drive up utilization. Realistic dialog about managed care needs to take place. It has worked to manage utilization and slow the growth of health care costs for our country in the past – perhaps we should consider it as a part of our future solution.

One thing is certain about our health care system. As we look back in the weeks to come, we may see revolutionary change or evolutionary change – but we will see change. At this juncture, which direction and at what speed that change takes place is anyone's guess.

The new CAMC Heart and Vascular Center in Charleston, West Virginia

Hospital Systems Share Resources to Better Serve Patients

J. Thomas Jones, President and CEO
West Virginia United Health System

J. Thomas Jones has been president and CEO of West Virginia United Health System since 2002. Before joining WVUHS, Mr. Jones served as president and CEO of both Genesis Health System and St. Mary's Hospital in Huntington, West Virginia, and as associate administrator for Wheeling Hospital in Wheeling, West Virginia.

Mr. Jones earned a master's degree in hospital administration from the University of Minnesota and his undergraduate degree in business from West Virginia University. He is a board member of the American Hospital Association and chair of that organization's Region Policy Board 3; a member of the West Virginia Hospital Association Board of Trustees; and a fellow of the American College of Healthcare Executives.

He is a member of the boards of directors of the West Virginia Chamber of Commerce, Morgantown Chamber of Commerce, the West Virginia Roundtable, Vision Shared, Discover the Real West Virginia Foundation, and a member of the 21st Century Jobs Cabinet. He is a past board member and chair of the West Virginia Higher Education Policy Commission.

West Virginia United Health System (WVUHS) is the largest health care system in West Virginia, operating over 1,000 hospital beds with annual revenue of almost $1 billion annually.

WVUHS is the second largest private employer in West Virginia, with 7,500 full and part time employees. It is the only health organization in West Virginia to have an A+ bond rating from S&P.

The system was formed in 1997 through the merger of West Virginia University Hospitals (WVUH) in Morgantown and United Hospital Center (UHC) in Clarksburg. Leaders of the University and UHC agreed that while their hospitals served different functions, they shared basic values and had compatible missions. In 2005 West Virginia University Hospital-East (WVUH-East) was formed through the merger of City Hospital in Martinsburg and Jefferson Memorial Hospital in Ranson, and became part of WVUHS.

WVUHS is the second largest private employer in West Virginia, with 7,500 full and part time employees. It is the only health organization in West Virginia to have an A+ bond rating from S&P.

WVUHS believes that there will continue to be significant consolidation of hospitals over time, similar to what has occurred with banks, pharmacies, etc. Systems can offer many benefits that are simply not available to stand-alone facilities. The most significant business challenge hospitals will face in the future is access to capital. Facilities without an A bond rating or higher will not be able to finance debt or do so at a reasonable cost. It is imperative to keep costs down by operating efficiently, preserving cash and having a reasonable operating margin. Currently WVUHS interest cost on all debt is about four percent. This low cost allowed a completely new hospital to be built in Clarksburg, which will open in 2010, as well as major expansions in Morgantown and the Eastern Panhandle. Once complete, our facilities will be the most modern in West Virginia and among the most modern in the country.

WVUHS is also interested in having other hospitals with similar values and vision join the system. Expansion would allow some additional savings, as overhead is spread among more members and allow more cost saving opportunities that are size-dependent. Later this year, WVUHS will open a new centralized laundry that will provide laundry services to all system hospitals as well as a number of other hospitals. We also have been able to self-insure medical and liability insurance and workers' compensation, significantly reducing cost. Our centralized purchasing program also has reduced supply costs by about $2 million annually. Systems will either grow or be swallowed up by others. We need to grow to prosper.

Another challenge we will face is how to better integrate our hospitals and physicians. We are currently studying structures that would allow us to create a seamless system of care with both our medical school and private practice

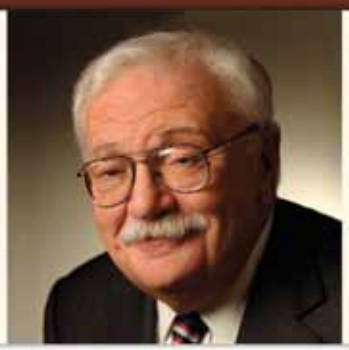
A rendering of the United Hospital Center in Clarksburg, West Virginia, scheduled to open in 2010

physicians. This integration will help reduce cost, improve quality and create an improved patient experience. We believe the future of medical care is a single organizational structure – such as Mayo, Cleveland Clinic or Geisinger – which has demonstrated lower costs and improved quality.

As important as these business practices are, the most vital activity from the patient's perspective is continuous improvement of the quality of care. Our hospitals work together with our physicians to identify best practices and implement them across our system. WVUH is working with UHC to provide state-of-the-art cardiac angioplasty and stroke care at UHC. Our hospitals participate in the Center for Medicare Services (CMS) Quality Demonstration Project and recently received high ratings in almost every category. As a system, our hospitals received an additional $190,000 in quality incentive payments, the most received by anyone in West Virginia.

Finally, WVUHS is working to provide an electronic health records system in all our facilities and for all our physicians. WVUH and the WVU School of Medicine physician practice plan have implemented a system in Morgantown and will offer it to private practice physicians throughout our system shortly. UHC and WVUH-East will have such systems within the next few years. These systems will allow access to a patient's records at any point in our system and reduce errors and cost while improving quality.

In conclusion, we face a number of challenges, just like all hospitals throughout our state and country, but we see a bright future as our system allows our member hospitals to share resources, reduce cost and improve quality to better serve patients.



UK Health Care: Becoming a Health Care Delivery System for Kentucky

Dr. Michael Karpf, Executive Vice President for Health Affairs
University of Kentucky Medical Center

In 2003 Michael Karpf joined the University of Kentucky as the executive vice president for health affairs to integrate clinical services. He is responsible for all clinical operations across the university hospital, Medical Center and practice organizations. He led UK HealthCare through a comprehensive planning review which included strategic, financial and capital planning processes as it created its vision for the future. Dr. Karpf has overseen a growth of over 72 percent in hospital discharges and an addition of over 2000 employees, creating an economic impact in the local economy of more than $550 million from salaries and benefits. He also oversees the planning and construction of the new UK Chandler Hospital, a 1.1 million square foot building with a scope, when complete, of more than $700 million.

Dr. Karpf received both his undergraduate and medical degrees from the University of Pennsylvania. After a year at the Miami Veteran's Administration Hospital, he was recruited to the University of Pittsburgh, where he later became vice chair of the Department of Medicine and was instrumental in restructuring the educational programs for medical students and housestaff, as well as the clinical programs of the Department of Medicine.

Later, as Vice Provost for Hospital Systems at UCLA, Dr. Karpf worked with leadership from the Medical Group and the Department of Medicine to develop a primary care network.

In 2004, responding to national pressures to reduce costs and improve health care access and outcomes – and local pressures to become a top 20 public research university – the leadership of the University of Kentucky Medical Center moved towards an integrated clinical enterprise, UK HealthCare. By creating a common vision and goals, the Medical Center then embarked upon a comprehensive and coordinated planning process that addressed financial, clinical, academic and operational issues.

These efforts led to a very broad consensus that UK HealthCare should support and strengthen the healthcare system of central, southern, northern and eastern Kentucky by both expanding and assuring access to advanced subspecialty care, while at the same time improving availability of, and access to, quality health care at rural hospitals and clinical sites. UK HealthCare's goal is to assure all Kentuckians that they will receive, in Kentucky, the best advanced subspecialty care and not have to worry whether their insurance will allow them to go to an out-of-state facility.

Small, rural hospitals are critical to their communities and counties. They represent the first line of care. Most individuals do not want to travel many miles for basic emergency care or other fundamental services. People in Kentucky want to stay close to home and family for health care for as long as possible. They are willing to go to a larger center for complex care, but only after appropriate options are exhausted locally. Furthermore, in many rural counties, small hospitals are one of the larger employers and are economically critical. Consequently, UK HealthCare came to the realization that good public policy dictated that we support these rural providers rather than compete with them.

Artist's rendering of the new 630- to 680-bed UK Chandler Hospital

Our approach is to engage rural hospitals and physicians in an analysis of unmet medical needs in their communities that they wanted UK HealthCare to fill. As an example, we developed outreach programs in oncology and sent our oncologists to several rural locations, working with the local hospitals' pharmacists and nurses to develop the capacity to provide chemotherapy at the local facility, while maintaining control over quality. Once certain that we could provide chemotherapy in a safe and careful environment, we were able to provide less complex chemotherapy treatments in these local communities. The community, the local medical staff and administrative leadership of these hospitals appreciated the commitment to expand local medical capabilities and to enhance their revenue.

These efforts led to a very broad consensus that UK HealthCare should support and strengthen the healthcare system of central, southern, northern and eastern Kentucky by both expanding and assuring access to advanced subspecialty care, while at the same time improving availability of, and access to, quality health care at rural hospitals and clinical sites.

With these outreach efforts and relationships, a significant number of patients have been able to remain in their communities for a much greater portion of their healthcare needs. This has translated into a strong economic boost to the local providers. We feel strongly that it is good public policy to keep patients close to home in a relatively low cost facility for as long as possible. It also is a good business practice for UK HealthCare, because of the relationships that evolve and the referral sources that develop for complex patients.

Our Medical Center came out of its tailspin in census very quickly after establishing our new strategic direction in 2004, and in the subsequent four years has grown dramatically. From a nadir of approximately 19,000 discharges in fiscal year 2003, we grew to nearly 32,000 discharges in fiscal year 2009. This dramatic growth in clinical activity, with its attendant increased cash flow, has been critical in moving us closer to our goal of being a top 20 public research academic medical center. At the end of fiscal year 2003, the Medical Center was a small, 25th percentile academic medical center in size, as measured by discharges per quarter. Similarly sized, small academic medical centers will struggle in trying to obtain top 20 public research status. By the end of fiscal year 2007 we were at the 50th percentile. In fiscal year 2009 and beyond, we will approach or exceed the 75th percentile in size, as measured by discharges. As a large academic medical center, the faculty truly believes and is emboldened to aspire to become an upper echelon academic medical center.

Because of our continued growth in volume, we also have adjusted our building project accordingly. Initially, we were planning a 473-bed replacement facility, but are now planning a 630- to 680-bed replacement facility. Opening in spring of 2011, the world-class UK Chandler Hospital will be uniquely Kentucky. It will welcome people from all parts of Kentucky and beyond and remind them of home, with references throughout of the richness of Kentucky's culture in the facility's art, music and landscaping. This beautiful and comfortable facility will house the most technologically advanced diagnostic and treatment spaces, and most importantly, it will be home to our world-class teams of physicians, nurses, pharmacists and other health care providers.

Rising Health Care Costs: A Focal Point for Reform

J. Fred Earley, II, President
Mountain State Blue Cross Blue Shield

Fred Earley is the president of Mountain State Blue Cross Blue Shield, based in Parkersburg, West Virginia. He joined the company in 1989. He has overall responsibility for sales and marketing, communications, government relations, public relations, corporate planning, legal and regulatory compliance, provider reimbursement and provider relations. He also serves as a member of the board of directors for Mountain State Blue Cross Blue Shield.

Mr. Earley is on the board of directors of the West Virginia High Risk Pool, the West Virginia Health Information Network, the Wood County Development Authority, the Boys and Girls Club of Parkersburg and the Parkersburg YMCA. Mr. Earley holds a bachelor of science degree in business administration from West Virginia University and a law degree from The Washington and Lee University School of Law. He is a member of the West Virginia State Bar.

As momentum for federal health care reform builds, one point has become increasingly clear: the rising cost of medical care is the root cause of the many problems with the health care system. Rising medical costs are the driving force behind higher private health insurance premiums and the growing number of uninsured and under-insured Americans.

Health care costs in the United States continue to increase at three times the rate of general inflation and have a profound effect on the ability of American business to compete internationally. Since 1980, national health care spending has increased by more than 750 percent, to $2.2 trillion. The specific causes of rising costs touch on many parts of our society and include advances in medical technology, chronic conditions, cost-shifting to the private sector, wasteful health care spending and consumer demand.

Higher Insurance Premiums: Where the Money Goes

The annual increases in health insurance premiums are a direct consequence of the higher cost of medical services and greater consumer demand for services. Among some of the general public, however, is a widely held belief that health insurance companies are raising premiums to cover high operating costs and to boost profits. The reality is that Mountain State Blue Cross Blue Shield uses nearly 89 cents of every premium dollar it receives to pay for the medical care of its members.

Technology's Role in Health Care

New technologies and new treatments, such as transplants, joint replacements, biologics and injectables, save lives and improve the quality of life. New imaging technologies, such as MRIs and PET tests, quickly diagnose medical conditions. The new frontiers of genetic and regenerative medicine hold open the possibility of people living longer, more productive lives.

But new technology comes at a steep price and is a major factor driving America's health care costs. Studies by the U.S. Congressional Budget Office and PriceWaterhouseCoopers estimate that medical technology contributes to higher health care costs by a range of 38 percent to 65 percent.

Technology drives costs higher in two ways. First, new technologies tend to increase costs because they are generally more expensive than the older technologies they replace. Second, while more advanced technologies can produce better outcomes for some patients, these technologies and diagnostic tests also can be used without scientific proof of better patient outcomes. As a result, some new technologies drive up costs without improving quality.

Chronic Disease: 75 Percent of U.S. Medical Costs

The growing prevalence of chronic medical conditions, such as diabetes, asthma, depression, high blood pressure, high cholesterol, cancer and heart disease, also are driving up the cost of health care. According to the Centers for Disease Control and Prevention (CDC), chronic diseases afflict almost half of all Americans and account for approximately three-fourths of the $2.2 trillion spent annually on health care in the United States. Obesity and physical inactivity cause many chronic ailments, including diabetes, and are driving up health care costs. The CDC has reported that, nationally, 33 percent of adults are obese, and nearly 20 percent of children ages

2 to 19 are overweight. Nationally, obesity has been estimated to generate $36 billion in annual health care costs.

According to the National Business Group on Health, scientific evidence shows that the three major contributors to chronic disease are tobacco use, poor diet and an inactive lifestyle. Eliminating these three determinants would prevent 80 percent of heart disease, 80 percent of type 2 diabetes cases and 40 percent of cancer cases. The steady increases over the past two decades in the use of hospital emergency rooms, hospital outpatient departments and physician office visits are primarily linked to the increased use of services for people with chronic medical conditions.

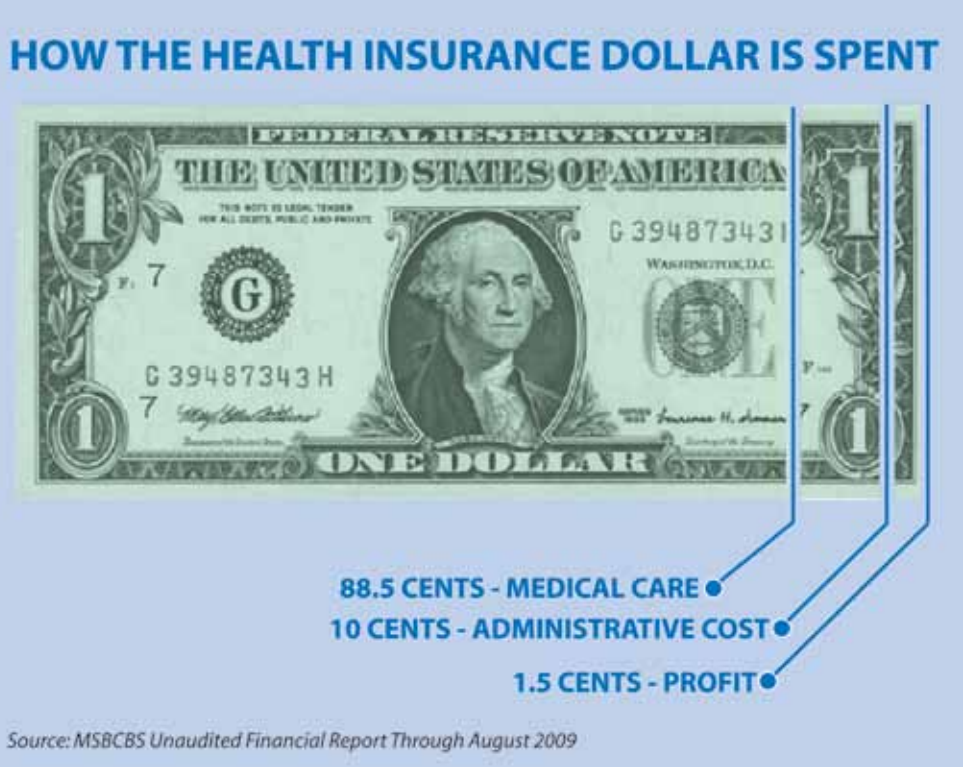
Cost-Shifting to the Private Sector

Inadequate reimbursement from state and federally sponsored healthcare programs to providers result in "cost-shifting" to private health insurance carriers. This underpayment of providers by public programs results in higher provider payment levels by private insurers, adding to the costs paid by privately insured employers and employees through higher premiums and cost-sharing levels.

Based on the 2007 fiscal year report from West Virginia Health Care Authority, its most recent report available, Medicare underfunds West Virginia hospitals by paying at 82 percent of the cost of care. State programs, including Medicaid and PEIA, pay only 73 percent of the cost of care. In total, private payors provided over $475 million to offset underfunding from these government programs.

Wasteful Health Care Spending

There also is ample evidence to show that too many health care dollars are wasted – going toward ineffective, repetitive or inappropriate medical care. Quality improvements should be built around trying to reduce the unwarranted variation in medical practice that cannot be explained by patient demographics or severity of illness. Improving the quality of care will result in improved patient outcomes and significant cost efficiencies by eliminating underuse errors, overuse errors and misuse errors.



Consumer Demand

Today, people are more informed about medical conditions and treatment options and, as a result, they are more likely to seek and demand the latest prescription drugs, diagnostic tests and treatments. Ironically, health insurance coverage also has played a part in fueling consumer demand for health services. Because health insurance historically has paid a large share of the bill for medical services, most consumers are insulated from the real costs of health care. As a result, they have had little incentive to consider the cost of medical services and often seek care that has minimal health benefit.

Conclusion

Rising health care costs should be a primary focus of the current debate about federal health care reform. In addition to expanding coverage for more Americans, President Obama and many others have highlighted controlling costs as a critical goal of comprehensive health care reform.

The multiple issues affecting health care costs are beyond the control of any single industry stakeholder and demand cooperation among all key participants – providers, health insurers, purchasers, unions, consumers and governments at federal, state and local levels. Initiatives to tackle the real drivers of increased health care costs must include the following:

- Changing hospital and physician payment incentives to promote better care.
- Managing and coordinating the care of people with chronic conditions.
- Encouraging healthy lifestyles to prevent disease and the onset of preventable chronic conditions.
- Encouraging research to determine which treatments work.
- Establishing sustainable long-term financing of public insurance programs to prevent cost-shifting to the private sector.

These activities hold the greatest promise to slow the growth of rising medical costs. V

Miles Ahead of the Curve…Minutes Away from Home

Louise Reese, FACHE, MS, Chief Executive Officer
West Virginia Primary Care Association

Louise Reese, FACHE, MS is the chief executive officer of the West Virginia Primary Care Association. She works closely with state and national health care leaders to support and advocate for the health centers in West Virginia.

Ms. Reese serves on the board of directors of the West Virginia Health Information Network, is a member of the West Virginia Behavioral Health Advisory Board and the Kidnitiative board of directors and is the president of the board of directors of the West Virginia chapter of the American College of Healthcare Executives.

Prior to assuming the leadership position at the West Virginia Primary Care Association, she was a consultant for Dixon Hughes PLLC, an accounting and consulting firm based in North Carolina. Ms. Reese also served as the assistant administrator for St. Joseph's Hospital in Buckhannon, West Virginia.

The West Virginia Primary Care Association is a membership organization comprised of 33 community health center members, 29 of which are federally qualified health centers (FQHCs). The Association members maintain more than 150 clinical sites, 48 school-based health centers, and many offer oral health services, behavioral health services, migrant health care and discounted pharmaceuticals. Health centers also often provide care management, health education and other supportive enabling services to meet the complex needs of their patients.

FQHCs have an extraordinary history, founded on the principle that all Americans should have access to medical care, regardless of their ability to pay. Arising more than 40 years ago, FQHCs now provide vital comprehensive health and medical care services to more than 18 million Americans, most of whom have significantly limited financial resources. FQHCs receive federal funding from the Health Resources and Services Administration to offset some of the loss associated with uncompensated care. Health centers must be located in (or serve) communities or populations that are considered medically underserved. FQHCs are unique in that they must be governed by a community board, with 51 percent of the board members utilizing the services of the center.

In West Virginia, federally qualified health centers serve one in six residents. As West Virginia health centers continue to expand, serving more patients each year, their expenditures and corresponding economic impact also continues to grow. By injecting over $172 million directly into their communities in 2007, the centers had an overall economic impact of $251 million and supported 3,212 jobs.

Federally qualified health centers have the potential to serve a pivotal role in health care reform both nationally as well as locally. The recent attention to the "patient-centered medical home" (PCMH) concept, which seeks to improve the quality and efficiency of primary care through better management of chronic conditions, highlights key characteristics of FQHCs. The PCMH incorporates the following principles:

- Facilitate partnerships between individual patients and their personal physicians
- Care is facilitated by registries, electronic health records
- Coordinated and integrated care
- Management of chronic conditions

Federally qualified health centers have implemented a patient care model that focuses on the collaboration between the patient and his or her care team in the ongoing management of the patient's overall health. Health centers utilize patient registries or electronic health records to assure that evidence-based standards of care are applied to all patients, including those with chronic illnesses. Care managers work with patients to improve self-care management techniques and assure coordination of care.

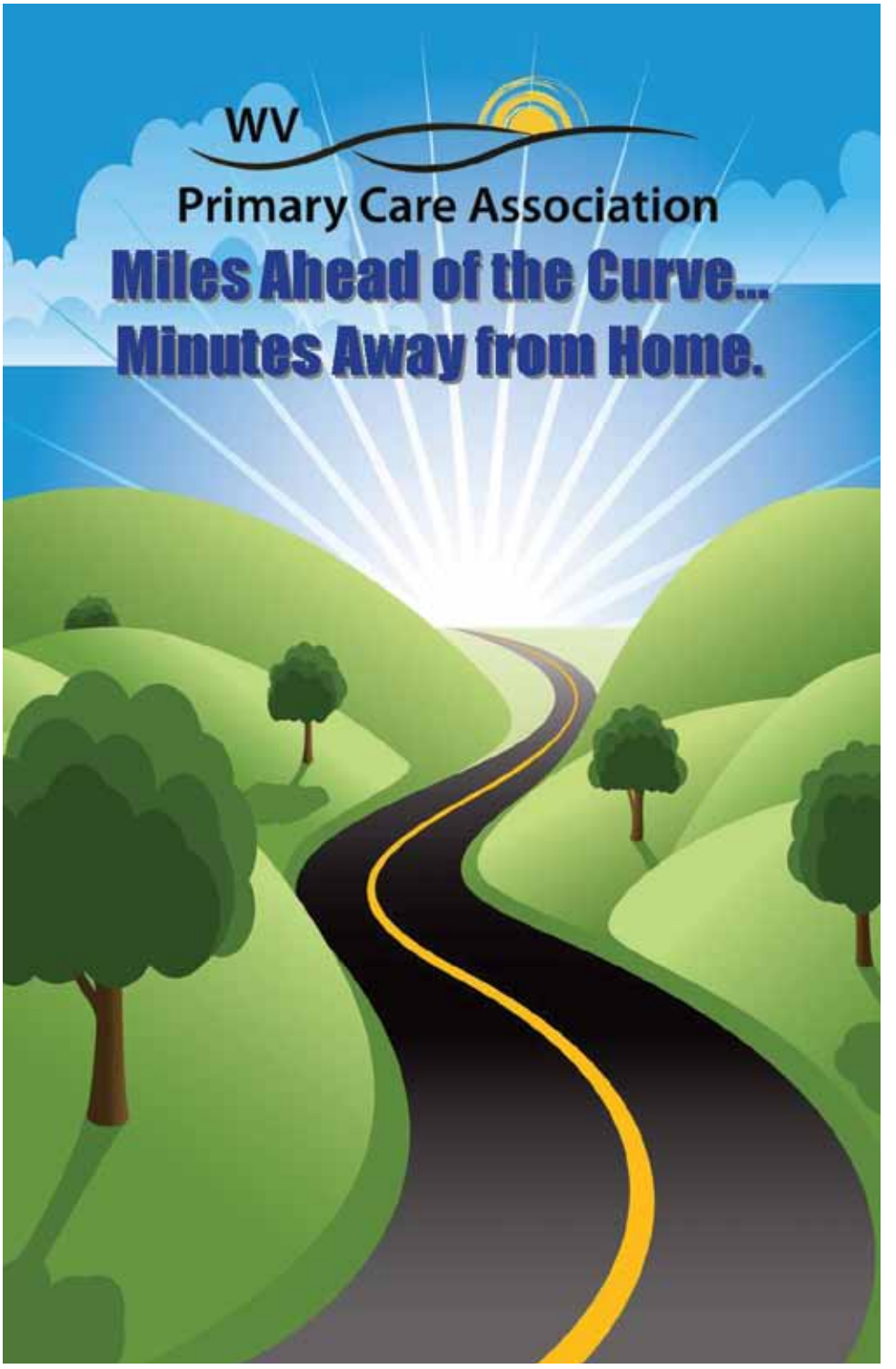
All current health care reform proposals seek to provide affordable health insurance to all Americans through greater investment in

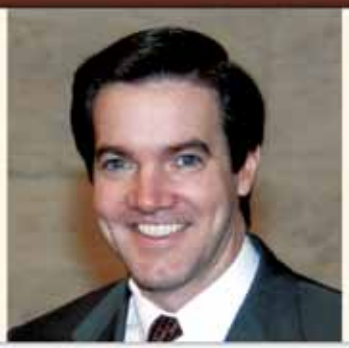
preventive and primary care as a means to assure access, improve quality and achieve measurable cost savings for the system. Research conducted by the Robert Graham Center revealed that medical expenses for patients seen in federally qualified health centers are 41 percent lower ($1810 per person annually) compared to patients seen elsewhere. This is the result of patient-centered care that reduces reliance on emergency rooms. Studies indicate that 50 to 70 percent of emergency room visits are non-urgent. Reasons for ER use for non-urgent care include false perception of severity of illness, 24-hour access of ERs and convenience.

While FQHCs have much to offer, financial reimbursement to health centers is complicated and does not adequately cover the cost to provide care to the growing number of uninsured people. The American Recovery and Reinvestment Act (Stimulus) funding to health centers will allow them to serve more patients, hire additional providers, enhance electronic infrastructure, modernize equipment and expand facilities. This funding will position the health centers to accommodate additional patients as health care reform efforts expand coverage, either through Medicaid or a public option. Stimulus funding does not address long-term financial sustainability. Cost-based reimbursement is vitally important to health centers.

With more than 40 years of experience providing patient-centered medical care, creating innovative ways to improve care to individuals with chronic conditions and serving as a leader in quality improvement efforts, federally qualified health centers hold a key to solving some of our most significant healthcare problems.

The value and potential for health centers was captured in a comment by the late Senator Ted Kennedy as he reflected on the marvelous history of this unique movement – *"if you didn't exist, we would have to invent you."*





West Virginia's "Public Option" Experience Might Suggest the "Co-Op" is a Better Approach

The Honorable Evan H. Jenkins
State Senator, West Virginia
Executive Director, West Virginia State Medical Association

Senator Evan Jenkins has served as Executive Director of the West Virginia State Medical Association (WVSMA) since 1999. Founded in 1867, the WVSMA is the state's largest physician organization dedicated to improving the health of West Virginia. Prior to joining the WVSMA, he served as General Counsel to the West Virginia Chamber of Commerce from 1992 to 1999.

He was first elected to the West Virginia House of Delegates in 1994, representing Cabell and Wayne counties, and re-elected in 1996 and 1998. He was elected to the West Virginia State Senate in 2002 and re-elected in 2006. He has held several legislative leadership positions during his 15 years of public service and championed many reform initiatives including medical liability reform and workers' compensation reform. Senator Jenkins' record earned him recognition as the most "Pro-Jobs" legislator two years in a row.

In 2006, he received the highest honor bestowed by the American Medical Association to a medical society executive for meritorious achievement. That same year, the U.S. Chamber of Commerce also rewarded his accomplishments by recognizing the WVSMA as the national grassroots organization of the year.

I'll admit I must be a policy geek to sit up until 3:30 a.m. watching a C-SPAN replay of the "public option" debate in the Senate Finance Committee. For most, I suspect this would be just as effective as a sustained-release Ambien sedative, but to me it was a one-stop-shop for the best arguments for and against inclusion of a government-run public option in the push for national health care reform.

With committees in the U.S. House of Representatives completing their work prior to the August recess, all eyes are now on the final committee hurdle in the U.S. Senate. Contrary to the firm House position that health care reform must include a public option, the legislation put before the Senate Finance Committee by its chairman, Max Baucus (D-Mont.), does not.

As I watched the four-hour public option debate, the philosophical battle lines were easy to see. The political left railed on the abuses of the insurance industry and strenuously argued that a robust public option was the only way to hold private health insurance carriers accountable. Senators on the opposite end of the political spectrum argued that the public option was nothing more than the proverbial camel's nose under the tent, and would put us well on the road to a single payor system, resulting in health care rationing as government bureaucrats come between patients and their physicians in medical decisions.

I was struck, however, to see unfold – just as I have seen in my own legislative experience at the Statehouse in Charleston – that the political will for the more extreme positions gave way to a less controversial middle ground. In the health care reform debate, the middle ground appears to be building around the concept of a "co-op" proposal that would be a statutorily-authorized, non-profit program, but *not* government run. The co-op would be owned and operated by its policyholders and expected to compete on a level playing field in the commercial insurance marketplace.

Our West Virginia experience can serve as a model. The important lessons we have learned suggest that the private market, properly structured, can outperform a public option through cost control, enhanced competition, reduced premiums, improved access and quality.

As Democrat and Republican committee members warmed to the co-op approach, I took notice when one Senator pointed out that the co-op concept is more accurately defined in insurance terms as a "mutual."

West Virginia has gone down a similar road of sorts over the past decade, and our experience offers several valuable lessons. In two notable areas, medical professional liability insurance and workers' compensation insurance, the government-run approach was not successful. In both cases, the legislature ultimately mandated an end to government-run insurance and instead created a mutual insurance program in an effort to improve coverage, enhance quality, reduce costs and restore competition.

Ten years ago, double-digit premium increases in medical liability insurance rates, year after year, caused an insurance "affordability" crisis for West Virginia physicians. The problem was compounded by an "availability" crisis when

the state's largest insurance carrier left the state. Both had a devastating impact on patients' access to care. Like today's health care reform debate, considerable public criticism was levied against the commercial insurance market, suggesting corporate profiteering and mismanagement were at the root of the crisis. Our policy makers' initial solution was strikingly similar to the course suggested by today's public option proponents: "let government run it."

Following a five-week special session, the West Virginia legislature in 2001 enacted legislation to open a public option within the Board of Risk and Insurance Management (BRIM), the state's existing government-run insurance program that covers primarily governmental entities. Despite a statutory requirement that BRIM charge premium rates higher than the commercial market, within a year it was clear that the public option was not on sound financial footing and actuarial losses began to mount. After less than two years in operation, West Virginia lawmakers reversed course and approved an exit strategy to cut their loss and close the program.

A key component of the legislative effort was to replace the public option with a mutual insurance program. With an initial subsidy from the state, the West Virginia Mutual Insurance Company was created as a private, policyholder-owned, non-profit organization. After five years in operation, by all accounts the company has succeeded in addressing both insurance availability and affordability. On average, premiums have been cut by over 30 percent and for some physician classifications, the premium reductions have been as high as 40 percent. The West Virginia Mutual also has fully repaid the state subsidy and new commercial carriers are starting to return to West Virginia, bringing competition.

It took 100 years to exit our state's other government-run insurance program, the Workers' Compensation Fund. Following the same policyholder-owned mutual structure that proved successful at insuring physicians, Governor Manchin and the legislature crafted legislation to get out of the government-run workers' compensation insurance business by creating a mutual. Our once government-run, monopolistic, multi-billion dollar, debt-ridden, high-cost program no longer exists and, BrickStreet Insurance Company, a policyholder-owned mutual, is competing with well over 100 other insurance carriers offering workers' compensation coverage to West Virginia employers. Robust competition and an average premium rate reduction of 30 percent in just the last few years (with an additional six percent cut coming in November), clearly demonstrate our policy decisions have hit the mark.

Our West Virginia experience can serve as a model. The important lessons we have learned suggest that the private market, properly structured, can outperform a public option through cost control, enhanced competition, reduced premiums, improved access and quality. As has been stated countless times throughout the health care debate, reforming one-sixth of our nation's economy is not easy, and it is important that we get it right. Universal access to high quality health care is critically important and, by following the right model, we can succeed. Then we can all get a better night's sleep. V

Integrated Health Care Systems

Dr. Judie Charlton, Chief of Staff
West Virginia University Hospitals

Judie Charlton, MD is chief of staff at WVU Hospitals and chair of the department of ophthalmology, where she holds the Jane McDermott Shott chair. She is a graduate of the WVU Schools of Pharmacy and Medicine. She is the recipient of the WVU School of Medicine Distinguished Teacher Award and the Dean's Award for Outstanding Clinician. She has served on the boards of directors for WVU Hospitals, WV United Health System and University Health Associates. She has held national positions with organizations that accredit ophthalmology education and board certification.

Dr. Charlton is a native of Fairmont, West Virginia, and a descendant of Morgan Morgan, the first white settler of West Virginia, and Francis Pierpont, the "Father of West Virginia." This year she was recognized by *The State Journal*, as "One of the 55 Best Things in West Virginia."

Your child is carried off the soccer field with a deformed forearm. A trip to the emergency room confirms a fracture. The diagnosis is followed by an orthopedic consult and trip to the operating room. Within 12 hours you are back home and feeling grateful for a seamless medical delivery team.

Two weeks later you catch a glimpse of the fractionated health care system as bills and insurance statements arrive. The hospital is reimbursed for use of the emergency and operating rooms, plus x-rays and lab results. Separate reimbursements go to the emergency physician, orthopedic surgeon, anesthesiologist and radiologist. Although the delivery of care took only 12 hours, it will take longer to deal with the aftermath.

Let's consider a different scenario to get a bigger picture. You experience chest pain and shortness of breath. Tests at your community emergency room are inconclusive and you need to be transferred to a tertiary care facility. Which facility will accept you? Will your test results travel with you, or will the tests be repeated, further delaying your treatment? Can you get records from your internist's office? You hope that the hospitals and physicians work together

West Virginia University Hospitals

like a well-oiled machine. Unfortunately, the current health care paradigm is that providers and facilities function independently (but with a cooperative spirit).

We also need to consider the health care needs of a population rather than a single patient. West Virginians are facing an epidemic of health problems from smoking, obesity and advanced age. The Centers for Disease Control epidemiologic maps (www.CDC.gov) show that West Virginia and Mississippi are in competition for the unhealthiest populace. The battle to improve health status as fought on the playing field of physician to patient, has been lost. We need something bigger to influence whole communities, and an integrated health care system is our best chance.

We need to plan for the future by training tomorrow's health care professionals and by making new discoveries. Academic health care centers (AHC), like the WVU Health Sciences Center, add the missions of education and research to clinical care. Successfully integrated AHCs have demonstrated a counterintuitive result. It would seem that taxing clinical dollars to pay for research and education would weaken the clinical enterprise. The surprising result is that the three missions feed synergistically from each other if correctly balanced. Physicians select academic careers to enjoy the privileges of educating the next generation and the

Aerial view of the Health Science Center, Morgantown, West Virginia

opportunity to make medical discoveries. Research is best done with a critical mass of collaborating investigators. AHCs that offer good support for research and education attract the best physicians, thus allowing the clinical practice to prosper, too.

Integration of clinical services recently was attempted between West Virginia University (WVU) School of Medicine, the physician practice plan, WVU Hospitals and WV United Health System. The governing boards of each entity endorsed the plan, but the proposal failed to achieve the necessary super-majority physician vote (57 percent supported the integration). The physicians were surveyed about strengths and weaknesses of the failed proposal. There was concern about the practice plan falling under the Health System reserve powers and the lack of an "easy out" clause. Proponents of the plan countered that all Health System members should have equal commitment, and that the commitment should be more like a marriage as opposed to "dating." Another concern was uncertainty as to who would fulfill key leadership positions. Proponents argued that the integration plan was about governance rather than management, and that the plan afforded checks and balances which would protect the enterprise. Much like the Constitution, drafted by our forefathers, which survived presidents of dubious character and capabilities, the hope was to create a model that would keep weak decisions or leaders from having undue influence.

Another significant concern was that the academic mission would become lost within a large clinical enterprise. Although the plan was intended to strengthen education and research, effective communication of this ideal became lost among discussions of board seats and lines of reporting authority. Some felt they were being asked to forsake the academic mission. Never ask a West Virginian to compromise a moral, a principle or a mission; just ask the WVU marching band. The WVU band once removed a Quaker hymn from its football pregame show. A loud public outcry resulted in its prompt reinstatement and continued place of honor for 30 years. Why would anyone want a Quaker hymn in a football pregame show? Well, the song was "Simple Gifts" (Joseph Baker, 1848), and West Virginians felt that it was important: "*Tis the gift to be simple, tis the gift to be free, tis the gift to come down where you ought to be… Tis the gift to be taught and a richer gift to learn…*"

With more work we can find an integration plan that embodies the spirit of "Simple Gifts." What will the West Virginia health care model look like? The model will be novel, effective, efficient and will be copied nationwide.

When George Washington was losing the Revolutionary War in the southern colonies, a group of civilian volunteers from what is now West Virginia reversed the British advancement. Traveling stealthily in camouflage buckskins and using sharpshooting skills, the mountaineers turned the tide of the war. Hence, the National Guard was born, along with a new style of military defense. Once more, West Virginians will show the nation how to do it right. V

Health Information Technology is a Critical Component of Health Care Vision

Sean Kenny, Vice President and General Manager
Business Process Outsourcing and Global Healthcare
HP Enterprise Services

Sean Kenny is vice president and general manager of business process outsourcing (BPO) and global health care for HP Enterprise Services. He is responsible for driving the business growth, strategy and investments required to support both the BPO and the health care business around the globe. He has more than 20 years of experience in the health care industry.

Previously, Mr. Kenny served as vice president of Business Transformation Outsourcing Services for EDS, now HP, where he led global efforts to grow the transformational applications and business process outsourcing business. Before joining EDS, he held various executive positions at Capgemini and was a partner at Ernst & Young.

Mr. Kenny is the author of *The Contemporary Dictator* and a contributing author of *The Managed Healthcare Handbook*, Fourth Edition. He is a frequent lecturer on health care matters and has been an annual lecturer at Washington University on business process transformation.

A collective sense of urgency to implement systematic changes that will provide sustainable benefits throughout the United States health care system never has been greater.

Given that real, sustainable health care transformation likely will not occur overnight, a suggested starting point is directional agreement among policymakers, payers, providers and consumers on a step-by-step change strategy.

With historic boundaries among stakeholder groups persisting, this is not a simple conversation. The path to success begins with a receptive environment. Single-mindedness has to give way to genuine, positive collaboration and fresh, innovative thinking. Further, a diverse set of social and economic relationships, business models, technology advancements and regulatory aspects has to be accommodated.

Technology has a vital role in an inclusive, collaborative model for health care reform. Here are the basic technology-based concepts:

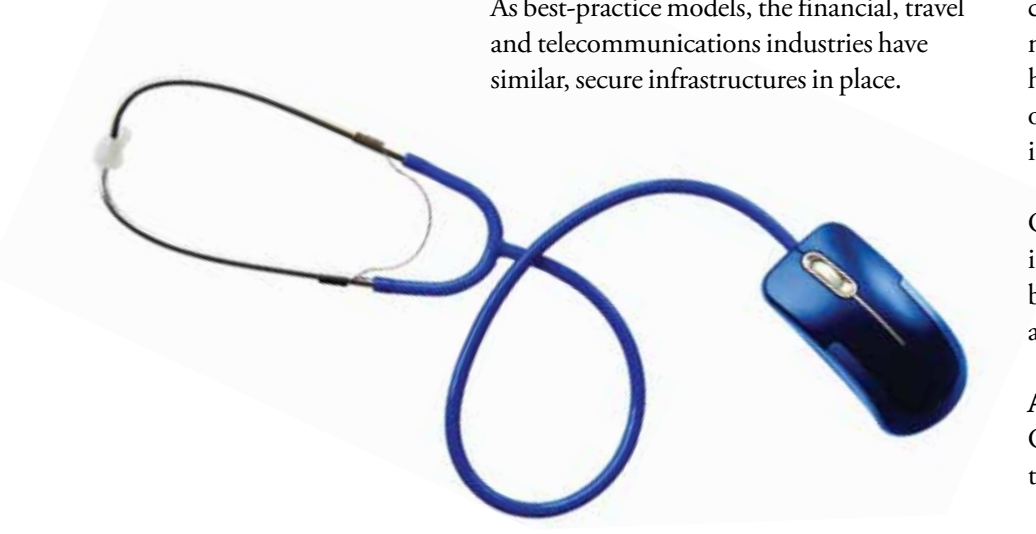
- Build a health information superhighway accessible to everybody. Health information exchange networks and regional health organizations are ready-made cornerstones. As best-practice models, the financial, travel and telecommunications industries have similar, secure infrastructures in place.
- Similar to driving directions available now on the Web, a health care superhighway would have well-marked on- and off-ramps, access roads and well-defined destination points to enable convenient, safe, secure access for users. Additionally, this information system would include "toll plazas," where information is collected, and "parking lots," where data and metadata can be sorted, catalogued, stored and analyzed.
- Digitization will be our vehicle. Health information needs to be captured and digitized, incorporating information security and data privacy safeguards. This includes having mechanisms and processes to ensure information is standardized, correct and trustworthy, timely, sufficiently detailed and sharable.

To reach this state, fundamental barriers need to be overcome. We must answer the fundamental questions of how health care is structured, where health care occurs and which choices should be made by the consumer, primary-care provider, specialist, third-party payer or government agency.

Currently, health care metrics focus on consumption of volumes – no coverage or too much coverage. To achieve measurable change, health care metrics need to focus on the actual outcomes, to drive quality and align our financial incentives and cultural expectations.

Given a more collaborative model and an information infrastructure, what should we begin to see on our health care road map? Here are some technology-enabled possibilities:

A Range of Choices for Health Care Insurance
Consumers will have a variety of options to help cover their health care costs



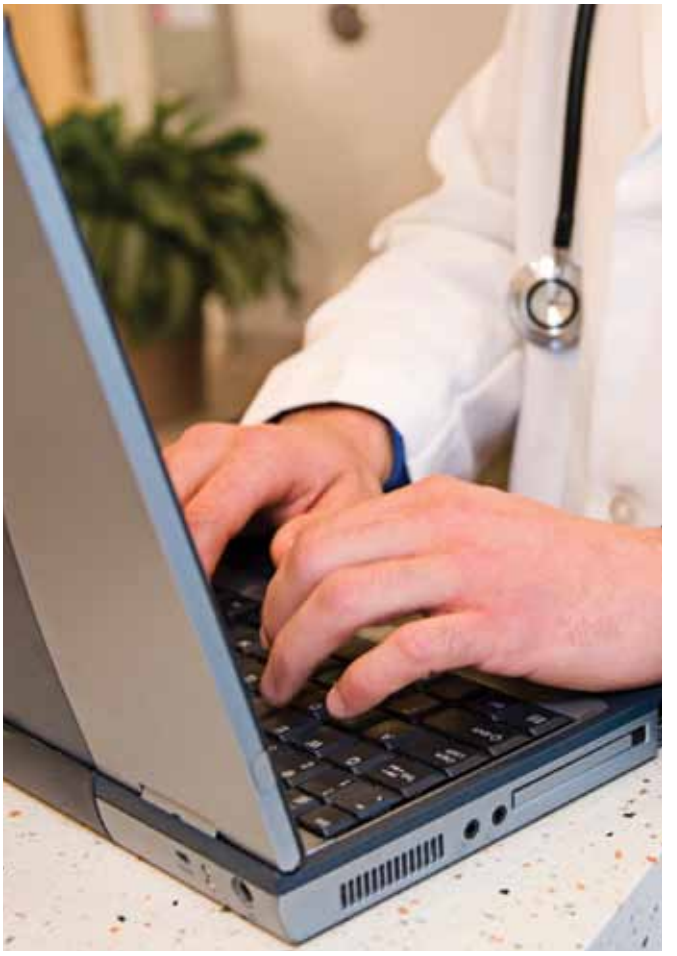
and minimize risk. Based on personal circumstances, users will have opportunities to customize benefits, cost sharing, provider networks and financial exposure.

Multiple Entry Points into Care and Consultation
Consumers already use a variety of entry-points – clinics in neighborhood retail stores and pharmacies, blood pressure kiosks, health screenings at churches, community centers, schools and job sites. Appointments are made online or through interactive voice response telephone systems. Customized information and instruction can be delivered, using technology-based personal identification and protection safeguards.

Electronic Practice Environments
Automation use will increase dramatically to manage appointments, communications and recordkeeping. Increasingly, physicians will have tools to input data automatically into work and documentation streams. They will enter menu-driven and free-form data, using both keyboard and image capture to record patient data. Automatic alerts will be sent on new treatment options, research findings and concerns affecting local and regional populations. Prescriptions will be transmitted electronically to the consumer's pharmacy of choice.

Virtualization of Care
Patients and providers will interact in a virtual environment to broaden access, speed information exchange and decrease dependence on physical presence. Patients will perform their own health checks, inputting results into their personal health records and transmitting to payers and providers. Alerts will be generated automatically if readings prompt concerns.

Personalization of Information, Care and Benefits
Patients who have not picked up prescriptions after 24 hours will receive automatic reminders that the medicines are ready. Patients will receive automatic notifications about new information relevant to their personal needs. More lifestyle programs (nutrition, weight-loss, smoking cessation, fitness regimens) will be available online or through automated kiosks.



Incentives for Better Health Decision-Making
Patients, payers and providers will share in the rewards of optimizing health care treatments and decisions. Providers and payers will share in the cost-savings from delivery of optimal care through pay-for-performance programs.

"Always Connected" Health Care Community
Information on health, wellness, treatment options and provider performance will be organized and accessible through social networking sites, Web portals and search engines.

Information Security and Data Privacy
Data protection and identity-theft safeguards are essential in developing and sustaining user confidence in Web-enabled solutions. Today, online banking and bill-payment are common practices in many households. Development and deployment of similar access and identity management technologies will promote consumer confidence for health care applications.

Integration of Clinical and Financial Systems
The electronic systems that capture all the clinical services, activities and results from an office visit will automatically convert those data points and generate an accurate payment request, to be posted and routed according to predefined preferences and coverage.

The vision for a patient-centered health care system that uses information technology to control costs and improve outcomes has been widely articulated. Providers and public and commercial payers must assume leadership in promoting and managing change for the benefit of all consumers. V

Issues Facing Long-Term Care as Baby Boomers Come of Age

John R. Elliot, President
AMFM, Inc.

John Elliot was born in Virginia, raised in Ohio, and after receiving a degree in architecture, began his own architectural firm in 1973. His firm has been primarily engaged in the design of nursing home facilities, which ultimately led to the development of AMFM, Inc., a West Virginia owned and operated nursing home company developed by John and his wife, Fonda, in 1982.

Mr. Elliot's commitment to education led him to earn his bachelor's degree in health care administration in 1991 and to become a licensed nursing home administrator in 1992. With his leadership, AMFM, Inc. continues to thrive in what can best be described as a turbulent health care environment.

Mr. Elliot applies his skills and experience in advocacy roles for patients, the long-term care profession and the many people employed and served by his company. He has held leadership positions on both the state and national level, including president of the West Virginia Health Care Association and secretary of the American Health Care Association. He has chaired political action committees at the state and national levels and represented long-term care issues on Capitol Hill and in grass-roots campaign activities at the state and local levels.

His volunteer service includes leadership positions in organizations such as the United Way of Central West Virginia, the Kanawha Valley YMCA, the West Virginia Symphony and the Clay Center for the Arts and Sciences.

AMFM, Inc., was founded in 1982, a West Virginia owned and operated nursing home company comprised of nine facilities and a home office. Since that time, the company has grown to 11 skilled nursing facilities, all within the state of West Virginia. Nearly three years ago, my family became long-term care consumers when my father-in-law required nursing home care due to post-surgical complications. Whether I look at our profession from a business or personal perspective, I believe the issues facing long-term care in the future will directly impact each of us, due to the aging of our parents, siblings and ultimately, ourselves.

The oldest of the 64 million baby boomers will reach the age of Medicare eligibility within the next five years. In the coming decades, the number of disabled elderly who cannot perform basic activities of daily living without assistance is predicted to rise exponentially. The baby boomers are expected to spend more time in retirement than any generation before them.

Combine this unprecedented demographic shift with the looming financial strain on federal and state budgets and an impending workforce shortage and you have the makings of a perfect storm, impacting the provision and financing of long-term care services.

Over the last three decades, America's long-term care system has developed into a continuum of professional services focused on meeting the medical and social needs of the mentally and physically disabled elderly. We provide not only supportive and rehabilitative health care for the aged and disabled, but also housing, transportation, nutrition and the social support needed to promote independence.

While advances in medical technology continue to drive up the cost of health care, the tax burden funding these increases falls on the shoulders of a relatively smaller workforce with an ever-declining worker-to-retiree ratio, resulting in an almost daily debate on Capitol Hill about the viability and sustainability of the Medicare, Medicaid and Social Security entitlement programs. Nearly half of all Americans will need long-term care at some point in their lives, with an average length of stay of 2.5 years. Public programs, primarily Medicare and Medicaid, fund 60 percent or more of that cost.

In a reimbursement system that is still based on the long-term health care delivery systems of the 1980s, state and federal rate-setting processes determine the majority of our revenue. In West Virginia, this accounts for as much as 90 percent of our income.

Medical advances and longer life expectancies have created the need for specialized units and facilities that can meet the needs of individuals with chronic conditions like Alzheimer's disease and AIDS. These multigenerational patients have become reliant on high-speed Internet and cell phones. They need support with complex psychosocial issues as wide-ranging as dealing with their own mortality to child custody and visitation issues. Because of changes in societal norms and an increase in lifelong stress, the baby boomers are anticipated to have the highest rates of aging-related dementia and cognitive impairments that our profession has ever seen. In younger members of the baby boom generation, a rising prevalence of diabetes and obesity, as well as other chronic lifestyle-related conditions, will only add to the number of disabled needing long-term care services.

Over the past decade we have seen the replacement of informal, unpaid healthcare providers with paid home care providers, as well as an increase in the utilization of assisted

living facilities, which promote longer independent living, and foster the concept of "aging in place." Demand for these types of services is expected to escalate in response to the diminishing availability of family caregivers because of rising divorce rates, increasing childlessness and declining family sizes. The rising labor force participation of women, traditionally the caregivers of extended family members, also may reduce their ability to provide informal care and lead seniors toward paid caregivers.

State and federally imposed staffing requirements dictate approximately 60 percent of our operating expenses. Yet we face significant competition from hospitals and other health care organizations for a declining pool of qualified nurses. Understaffed nursing schools, high turnover rates and diverse employment opportunities for women have increased the average age of a practicing registered nurse to 42.5, and created a significant shortfall in the number of qualified nurses that will be needed to fill 600,000 forecasted new nursing positions within the next ten years.

Long-term care providers are in the forefront for public reporting transparencies. Our inspection results, cost reports, policies and procedures, staffing information and clinical quality measures are all available for public inspection. In 2008, the Centers for Medicare and Medicaid Services instituted the 5-Star Rating System for Nursing Homes, which grades facilities based on inspection performance, clinical quality indicators and staffing. This information is all readily available on the Internet, and provides consumers the opportunity to make more educated decisions about the providers they choose.

Our primary mission is meeting the needs of those who entrust us with their care. Nearly half of the residents in our facilities today have no surviving family members to support and care for them. This tendency is expected to increase as the baby boomers reach our facilities. Our staff and community volunteers become the extended family they trust to accompany them through the end of their lives. We see the return of patients who stayed with us for short-term rehabilitation when the need for long-term placement arises. And our success is validated by the more than 85 percent of our customers who report overall satisfaction with their experience in long-term care settings and their recommendation of our facilities to others.

The good news for the baby boomers is that long-term care providers are committed to providing the highest quality of care throughout the course of their lives. Regardless of the challenges that face long-term care providers, we remain committed to honoring each of our customers by providing a meaningful life in a dignified and caring environment. We strive to meet the needs of each patient in our care today, and stand ready to meet the needs of the next generation of our nation's aged and disabled. V

Health Care in America: History in Transition

Kerry G. Gillihan, FACHE, President and CEO
Cardinal Hill Rehabilitation Hospital

Kerry Gillihan's healthcare career began as a combat medic and clinical specialist in the Army during the Vietnam era. For the past 16 years, he has been president and CEO of the Cardinal Hill Healthcare System, a multi-location, post acute care network that is the largest of its type in Kentucky.

Previously, Mr. Gillihan was president and CEO of Western Baptist Hospital in Paducah, Kentucky. His management experiences began with the Baptist Healthcare System, where he spent 17 years, and included building the Baptist Regional Hospital in Corbin, Kentucky.

Mr. Gillihan received his undergraduate degree from Murray State University and earned a master's degree in healthcare administration from the University of Alabama Medical Center in Birmingham.. He undertook postgraduate training at the Leonard Davis Institute of Health Economics at the Wharton School, University of Pennsylvania.

The evolution of health care in America is rich with courage, character and extreme innovation. Surprisingly, some of the thinking and treatments used as recent as the late 1700s date back to 400 BC and the ancient Greek physicians. Many of the surgical practices used during the Civil War had similarities to the ancient Romans and Egyptians. And then it began to change. The famous Kentucky surgeon, Ephraim McDowell, removed the first very large ovarian tumor on Christmas morning of 1809. Abdominal surgery at that time had never been successful. Dr. McDowell's patient lived 32 years beyond her surgery. And did I mention that this historic surgery was done without anesthesia or antisepsis? Neither were known during those times, but Dr. McDowell went on to perform 12 more ovarian tumor removals in his career. Of course, Dr. McDowell's surgeries were widely criticized by the English surgical literature. It seems most innovation in medicine and surgery is initially criticized and rejected.

Change in American medicine progressed slowly. For many, health care was concentrated in major metropolitan cities. Not until Senators Hill and Burton, did small rural communities get the opportunity to build hospitals. In the middle of the last century, I was born upstairs in the office of Dr. George C. McClain in Benton, Kentucky. That was considered progressive, as births a few years earlier were predominantly done at home.

That was 1950, and in the following few years, the Hill-Burton Act made funds available for rural communities, like Corbin, to build their own hospitals. Access to more comprehensive health care began in earnest. With such developments, came increasing cost and demand.

By 1964 and 1965, the federal and state government introduced the most significant stimulus to health care in our history… Medicare and Medicaid. For the first time, government funding was made available to benefit the elderly, Medicare, and the poor, Medicaid. These tremendous new programs created the platform for dramatic technological development in medical and surgical innovation and diagnostics. It also ushered in an environment of monetary reward for spending more money on new technology and expanded facilities. By the early 1980s, the administration of the Medicare trust fund "cried wolf," declaring it was going broke. So, in an attempt to curb government spending on health care, government changed the rules again. Enter a new Medicare reimbursement system, a "prospective payment system," based on a particular diagnosis. And for the first time, it allowed a hospital provider to make a profit on Medicare patients.

The entire health care world predicted doom and gloom as a result of these charges, and we all worried. These changes did, in fact, slow the expansion of many health care operations, just until we could figure it out and maximize returns under new reimbursement. Since the majority of a hospital's revenue comes from the federal and state government, it gets your attention when there is a dramatic change.

Meanwhile, as the doom and gloom gave way to modified systems that allowed the industry to thrive, so too did the steady progression of medical technology such as CAT scans, MRIs and minimally invasive surgeries. Managed care would not arrive until the mid 1990s, arising as a byproduct of the failed Clinton administration efforts to reform health care in 1993. Who would ever have believed, a few short years ago, that insurance companies – not

Cardinal Hill Rehabilition Hospital located in Lexington, Kentucky

doctors – would be directing where patients go, if they go, or how long they will be allowed to stay?

So despite the Medicare and Medicaid attempts to reduce expenditures for health care, insurance and managed care efforts to restrict payments, the ranks of the uninsured continue to swell, (more than 45 million people in the US), and demand grows unbounded. In the late 1990s and early 2000s, there was a slowdown of hospital and hospital system expansions, but if you look around now, it seems that everyone is building, including Cardinal Hill, UK, St. Joseph, and others throughout Kentucky and the region. We have to, in order to retool, improve accommodations and meet the demand that is building, like a tidal wave. Current expansions and increased debt service is in the face of the next volley of reimbursement changes.

Recently, United States Senator Max Baucus ushered his health care reform bill through the Senate Finance Committee. The bill did not contain the much-debated public option, which is a government sponsored insurance company. The Baucus bill calls for health care expenditures of $829 billion over the next 10 years. The other four bills circulating in Washington would each cost in excess of $1 trillion. The budget office says the Baucus bill's cost would be offset by new taxes on individuals and companies, fees and savings from the Medicare program itself. It has even been written that the Baucus Bill would actually reduce the federal deficit by $49 billion over 10 years.

So let me see if I understand this right. We have the largest number of people entering senior years (the baby boomers), with more expectations, more demand, more wealth and longevity. We have a growing unavailability of nursing home beds, a severe shortage of nurses and related health care personnel, a shortage of doctors, a growing number of hospitals with negative bottom lines, and increased numbers of uninsured sick patients accessing the health care system. So the hot health care reform bill getting air time now wants to provide coverage for a whole lot more people (but not everyone), spend another $800 billion to a trillion dollars, and make it budget-neutral by paying less for Medicare and taxing everything they can. I am reminded of the chorus in a popular country song – "God is great, beer is good…and people are crazy."

By the way, here is something else I find really troubling about health care in America. Even though we spend $2.5 trillion a year on health care, more than any other country, and we have the most technologically advanced system and the best access… the World Health Organization ranked the United States 37th. Guess what country ranked number one? France, where they eat luscious food, drink lots of wine and love to smoke! Oui! Oui!

Seriously, something must be done to address health care expenditure in America. Health insurance cost is the fastest rising expense for employers. Without reform, the employer-based cost for insurance on a family of four could reach $25,000 per year by 2018. The increase in national health care expenditures is expected to rise 6.2 percent per year between 2008 and 2018. Total expenditures during that time frame will rise from $2.5 trillion to $4.4 trillion.

The American health care system is the most vibrant dynamic sector of our economy. It is vital to us all, and must be preserved and enhanced to withstand the juggernaut of demand marching its way. This country has the intellect and, I believe, the will to meet those challenges. Good luck to us all. V

Defining Quality in Health Care

Dr. Niti Armistead, Vice President for Quality and Safety
West Virginia University Hospitals

After graduating from the University of Maryland School of Medicine, Dr. Niti Armistead completed her residency, as well as a year as chief medical resident, at Medical College of Virginia, Virginia Commonwealth University, in Richmond. She joined the faculty at West Virginia University School of Medicine as a hospitalist in 1998. She served as the medical director for care management for four years and served as vice chief of staff from July 2005 to July 2006.

In July 2006 she was named vice president for quality and patient safety at West Virginia University Hospitals. She has won numerous awards, including "best attending" for three consecutive years, was selected as a 2007 Generation Next winner by *The State Journal* and chosen as a member of the "Young Guns Class of 2009" by *West Virginia Executive* magazine. Her special interests include patient safety and medical education. She has been a speaker at several national meetings covering topics related to health care quality.

There is general agreement that Americans deserve the highest quality health care, that we should pay for quality, not quantity, and that our current system is riddled with inefficiencies and waste. The challenge is to get past the headlines and attempt to define what quality actually means.

Is it in the eye of the beholder?

Is it one of those things that is hard to define but you know it when you see it?

Are there fundamental, core elements that define this concept?

I believe there can be some basic agreement on what quality health care looks like. I have three vantages that define my perspective: I have been a physician for 16 years, a health care administrator for three years and, most recently, a family member of a health care "consumer."

A Physician's Perspective

One of the greatest privileges of my life is caring for patients who trust me with their heath and well-being. As a primary care provider, I try to focus on prevention and promote a healthy lifestyle. I hate paperwork and am not particularly interested in dealing with the "business" of medicine.

While I am a firm believer in following rules, I get frustrated when the logic behind the rules is not readily apparent. I also get frustrated when I am faced with obstacles in my pursuit to provide care to my patients. Obstacles can include insurance companies telling me what medication I can prescribe or what procedure I can perform; waiting for months for my patient to be able to see a sub-specialist; and the pressures of having to see more and more patients to keep my clinic afloat.

Despite these obstacles, I do not regret my career choice. In addition to the warm regards from my patients, I am in awe of my co-workers. The nurses, pharmacists, therapists and social workers help me navigate through the complex matrix of insurance formularies and admission/discharge criteria. My sub-specialist colleagues give me free advice on specific inquiries and frequently make time despite their busy schedules to see my patients. A wise teacher once told me that your patients do not care how much you know unless they know how much you care. These knowledgeable professionals practice this ideal every day despite the system obstacles.

Everyone involved needs to work together to build a system that delivers timely, safe, effective, efficient, patient-centered care.

So my definition of quality, from a physician's perspective, is the ability to provide timely and effective care to my patients in a respectful, caring manner with the least amount of hassle along the way.

An Administrator's Perspective

Three years ago, I was offered an opportunity to serve in a different way. I accepted a position as vice president for quality and patient safety at West Virginia University Hospitals. While I still maintain a small clinical practice, my prime focus has shifted to system improvement.

As a physician, I had a built-in skepticism about the motives of the "suits" and viewed their speeches and numbers with healthy suspicion. As an administrator, I now have a new-found respect for the challenges that management faces, such as garnering resources for investments,

like an electronic medical record system; meeting operating expenses; facing ever-growing cuts from insurers; and securing a positive bottom line.

From an administrator's perspective, quality is about building a culture that is focused on learning and growing – a culture where all workers understand the mission of the organization and clearly see how they can contribute to its success. Management and providers embrace change and work in partnership to continually improve their processes and outcomes as they strive to improve quality, safety and customer service.

A Family Member's Perspective

My younger sister, my only sibling, went for a routine medical exam in July. One month later, she was diagnosed with breast cancer. Our world has been rocked, to say the least. No woman at age 36 is prepared to hear the words, "you have cancer." She has gone through grief, anxiety, confusion and just an overall feeling of being overwhelmed. Her strength during this tough time has been truly inspiring to me.

While our family has rallied around her, it is at a time like this that you hope that the health care system can come through for you. It is so important to receive sound medical advice from a provider who sees you as a person, who considers your values and takes the time to answer your questions and who, most importantly, can get you healed.

My sister's experience thus far has been filled with simple blessings. Number one on that list has been compassionate providers who have spent time providing her with information, answering her questions, including her in the decision-making process and, most importantly, giving her hope. She is blessed with good insurance and has been fortunate enough to be able to get second opinions. She also has received much support from her family, friends and employer. Thanks to preventive care and early diagnosis, she has an excellent prognosis.

As a family member of a healthcare consumer, quality is easy for me to define. It involves receiving a timely diagnosis and successful treatment without suffering any harm related to the care. It involves receiving evidence-based, best practice care in a compassionate and caring manner, in line with the patient's values and beliefs.

Summary

As the national health care debate focuses on controlling costs, payment reform and even universal coverage, it is important to define what quality care means for all Americans. Everyone involved needs to work together to build a system that delivers timely, safe, effective, efficient, patient-centered care. The doctor, administrator and big sister in me can certainly live with that.

Dr. Christine Kincaid and staff at WVUH, using electronic medical record system

Dr. Niti Armistead and Robin Keyser, a WVUH Quality nurse

Real Health Care Reform

Michael A. King, Chief Executive Officer
Camden-Clark Memorial Hospital

Michael A. King is the president and chief executive officer of Camden-Clark Memorial Hospital in Parkersburg, West Virginia. He is a native West Virginian, a West Virginia University graduate and received his master's degree in health administration from Virginia Commonwealth University/Medical College of Virginia in 1978.

He has nearly 30 years of experience at a senior executive level of management, as the CEO of a 30-bed rural community hospital, to senior vice president for operations at the Charleston Area Medical Center, to his current position at Camden-Clark. Mr. King is a Fellow in the American College of Healthcare Executives.

Those of us who work in the health care industry find ourselves feeling like spectators on the sidelines as the health care reform debate rages on. When asked about my views on what health care reform means, it has been difficult to provide a concise, meaningful explanation.

The reason is that there is no concise explanation of what really is being proposed. Amid the shouting and political rhetoric, there are really three questions to consider with regard to this complicated, volatile issue. First of all, how many Americans will now have coverage that did not in the past? Second, how is the delivery of health care being reformed? Finally, what will be the method of paying for this reform? From our hospital's perspective there are other questions, e.g., who will pay us for providing health care services, what will they pay and what will the new system expect from us in quality and service?

Let's start with the public opinion. Most people would agree that health care needs reformed. However, recent surveys indicate that while only 44 percent of Americans are satisfied with the overall quality of the American medical system, a vast majority – 89 percent – are happy with their own personal medical care. This survey is backed by the findings of recent Gallup polling, that found 83.8 percent of Americans have health insurance and a majority of Americans feel that health reform legislation would not change or would worsen their medical care. These opinion surveys reflect the growing sentiment that most Americans are happy with their coverage and any reform should start with the guiding principle of "do no harm."

Support for reform comes from those of us who want all Americans to have access to health coverage and not face financial ruin by the health care system. It is a lofty and worthwhile goal to assist the 47 million Americans (many of whom are children) who do not have coverage, to gain health coverage. It is a goal that should unite us.

Sorely lacking in this debate is a vision of how the delivery of health care will change. There are discussions about paying for wellness and end-of-life treatment. Both are constructive ideas. The discussion of value-based payment to providers has many potential benefits as well, e.g., increased focus on quality and service. The issue for all of us is what role the government will play in this "new system." There is not a high level of trust that the government will administer a health care delivery system in an efficient manner that pays fairly for services rendered. Frankly, their track record is not good with hospitals or physicians. There have been too many promises of benefits with no plan to finance, other than reductions in payments to providers. Bundled payments need better evaluation until a credible methodology is developed. There really is no mention of health care planning, i.e., how the new system would allocate technology and other resources, or whether we individually will feel the effect of health delivery reform.

But instead, the financing – or how to pay for these additional insured – has fueled loud, rancorous debate. Will it be funded by reduction in payment to the providers, from increased taxes, or fundamental changes to how the delivery system delivers the service? It is not clear to any of us watching what the answer may be, but a combination of all of the above seems most likely.

Most current estimates of the cost of health reform arrive at nearly $1 trillion or more over a 10-year period and do not include coverage for the entire uninsured population. This figure comes on top of a crushing national debt. It is argued by supporters of health reform legislation that cuts in Medicare and Medicaid would be offset by providing coverage to the uninsured. At Camden-Clark Memorial Hospital, last year, we wrote off nearly $22 million in charity and bad debt. So, in theory, if coverage is expanded, our hospital should see fewer write-offs and less pressure to shift this cost to those that are able to pay. But if the plan does not provide coverage for all uninsured Americans, then hospitals and doctors will continue to provide large amounts of uncompensated care. And hospitals in states like West Virginia, that care for large numbers of Medicare and Medicaid patients, will be crippled by the proposed budget cuts.

Focusing on making health care more efficient is a good step and worth addressing. Most hospital administrators would tell you that realigning payment incentives for hospitals and doctors could identify waste within the system. It is not easy, and there are years of "this is the way we've always done it" to address. So, counting on the elimination of waste as a principal method of paying for health reform is viewed by many within the industry with skepticism.

Obviously, change is needed and change will come. But let's not make a blind and foolish leap before there is a careful and considerate exchange of ideas. Rather, let's tread thoughtfully and carefully with less rancor from all sides, making sure we get real reform and a way to actually pay for it. V

Seniors Launch New Chapters in Life

Diane Gouhin, Executive Director
Edgewood Summit

Diane Gouhin is a West Virginia native and an alumnus of Marshall University in Huntington, West Virginia. She is the executive director of Edgewood Summit, a retirement community in Charleston, West Virginia, a certified aging services professional and a licensed nursing home administrator.

Ms. Gouhin has more than 20 years' experience in senior health care and retirement housing and in the management and operations of nursing homes, assisted living facilities and retirement communities. She opened West Virginia's first retirement community in 1995 and was actively involved in the creation and passage of new legislation for residential care communities in 1997.

Ms. Gouhin has served on the board of directors of the West Virginia Health Care Association as president, vice president, secretary and chairperson of various committees. She is a member of the Charleston Rotary, the West Virginia Long Term Care Ombudsman Advisory Committee and has volunteered with various local organizations. Ms. Gouhin also is active with Greystone Communities, a developer and management firm for retirement communities across the country, and serves on task forces as well as being a regional advisor.

There is no question that retirement is bringing more to the lives of seniors today. They are learning that life is about your story, and retirement is just a new chapter. The residents of Edgewood Summit, Charleston's premier retirement community, are great examples of what is happening across the country. Seniors are no longer content just to retire and putter. They are launching themselves into new adventures.

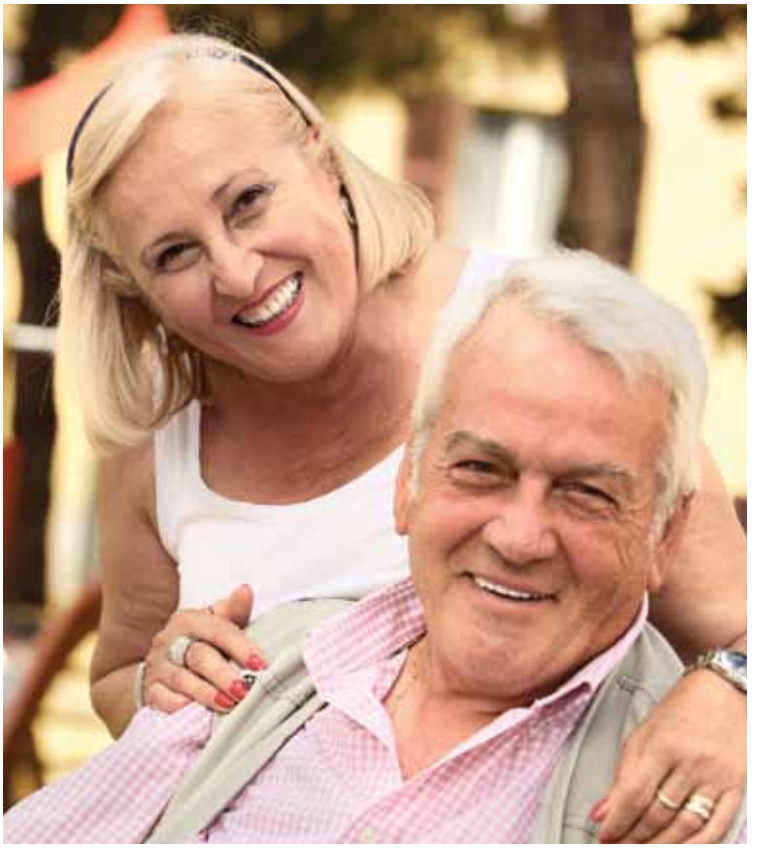
Seniors are creating the time of their lives and there is no limit to the things they want to do. We have never seen so much offered in the way of programs and services, and the excitement and enthusiasm are wonderful to witness. Seniors want to try "everything," while still remaining grounded in their local communities.

At Edgewood Summit, there are groups for poetry, bridge, the Red Hat Society, philosophy, theater, first time writers, new artists, classic movie buffs, current event debates and international travelers – as well as armchair travelers. Residents compete with each other in poker, bridge, Scrabble, golf-putting and the newest hit, Nintendo Wii. We see fun and laughter and the joy of new discoveries. The volume of activities being offered has more than doubled over the past decade.

Health is also a part of senior life. Wellness takes front and center stage, with equipment for cardiovascular health and strength training and classes for yoga, Tai Chi, balance and flexibility. The new fitness center at Edgewood Summit was designed with seniors in mind. All of the equipment was chosen with the help of experts in the field, and the building enlarged to accommodate their needs.

Residents are committed to aging well. Discussions about vitamins, nutrition and physical fitness are common. Chef-prepared menus feature healthy choices with a variety of

Edgewood Summit located in Charleston, West Virginia



fresh and lighter fare. The biggest benefits have been feeling good and having more energy.

Volunteerism is alive and well among seniors as they contribute their time and talents to local churches, Meals on Wheels, hospitals, schools, feeding the homeless, the arts and the community at large. If you are looking for reliable, enthusiastic volunteers, then look to seniors. Many of the senior volunteers have helped to create today's definition of social accountability, and they serve as great role models to all.

Technology-friendly seniors in retirement communities are on the upsurge. More residents are e-mailing, surfing the Web and using Facebook than ever before. Cell phones are commonplace, as well as computers. Those who are embracing new technologies do not just embrace it for technology's sake; they recognize that it can make their lives better. Some, using e-mail, have improved the frequency of their communications with families and friends. Others are using a computer to begin writing a book, or researching topics of interest.

The challenge for businesses providing services to seniors is probably obvious from a glimpse inside one retirement community like Edgewood Summit. We will all need to be on the top of our game to keep up with the changing wants and needs of senior citizens. They are discriminating customers who value quality, affordability, variety and flexibility. They educate themselves and compare many options before buying, and top-notch customer service is always expected.

As we look to the future, there is another challenge looming. The next generation of senior citizens who are coming through the "age wave" are baby boomers. The "boomers" represent the largest demographic of our population and have had a dramatic impact on our economy and culture with each phase of their lives since birth. Those in the retirement community industry have dubbed this new phenomenon as the "Silver Tsunami." So what can we expect as the boomers age, and become senior citizens? The senior baby boomer will most likely change everything about aging and retirement. It seems likely that they will continue to be focused on health and wellness, new technologies, volunteering and new fun adventures and opportunities. Although one can guess "what" will be the focus, only the imagination can capture "how" it will evolve. Make sure your seatbelt is fastened, because it will most likely be an exciting rollercoaster of a ride! V

Nursing Shortage Leads to Innovation and a Brighter Future

Georgia L. Narsavage, Ph.D., CRNP, FAAN, Dean
Laurie A. Badzek, JD, LLM, RN, Professor
West Virginia University School of Nursing

Georgia L. Narsavage, Ph.D., RN is dean and professor of nursing at West Virginia University School of Nursing in Morgantown, West Virginia. Dr. Narsavage is an administrator, educator, researcher and advanced practice nurse who works toward improving care for older patients with chronic lung disease and lung cancer. Through research and practice, she works with nurses and other health care providers to improve patients' quality of life and provide community-based care through education and research. She is committed to building the WVU School of Nursing's and university's mission to improve the health of West Virginians through strengthening partnerships between service, education and research.

Laurie A. Badzek, JD, LLM, RN is director and professor of nursing at West Virginia University School of Nursing Quality of Life Institute in Morgantown. Professor Badzek is also the director of the American Nurses Association Center for Ethics and Human Rights. She is an active scholar and researcher, investigating ethical and legal health care issues. Her research has been published in law, nursing, medical and communication studies journals. She is a graduate of the West Virginia University School of Nursing and the West Virginia University College of Law. In addition, she received her LLM in health care law from DePaul University in Chicago, Illinois.

Nurses are at the forefront of providing excellent health care. Responding to the revolutionary changes that occur in providing health care, nurses are leading the way to improving the health of our nation and our world. Over 2.9 million professional nurses are practicing in the United States. Last year 25,686 registered professional nurses held an active West Virginia license and comprised the largest group of health providers in the state.

Throughout West Virginia, professional nurses play a vital role in improving the health status of the individuals and communities they serve. Nurses are the most trusted and highly regarded professionals in the United States, having been voted again and again in the yearly Gallup Poll as the number one profession representing honesty and ethical standards. Nurses are uniquely positioned to make a positive impact on individual care and the local health care environment. The Joint Commission on Accreditation of Healthcare Organizations reported that a shortage of nurses put patients' lives at risk, and a growing body of research has shown that nursing care provided by registered professional nurses (RNs), with a higher proportion of nurses having baccalaureate degrees, results in better patient outcomes.

> **"There's never been a better time to be a nurse."**
>
> *– Slogan of Johnson and Johnson "Discover Nursing" Campaign*

The current challenge for nursing is not keeping pace with knowledge and best practices, but keeping pace with the growing need for professional nurses in a variety of expanding roles and nursing faculty to prepare them. An aging workforce, a demanding work environment and growing health care needs have contributed to an international nursing shortage. Unfortunately, the nursing shortage is expected to continue over the next decade and is predicted to be more severe and last longer than previously forecast (Nursing Shortage Study Commission, 2004).

Although the shortage presents challenges, it also has created a national spotlight for nursing and created new opportunities for growth and change within the profession. In West Virginia, the creation of the WV Center for Nursing (HB4143) has been a

Nurse Practitioner student Jennifer Westfall, RN with patient

Nurse Practitioner Sandra Cotton, RN, ANP-BC with patient

From left: Kayleigh Burner, Gail Van Voorhis, MSN, RN, CNNP, clinical instructor and coordinator of the Clinical Practice lab, Macy Miller, Susanna Dailey and Amanda Massie

proactive response to the nursing shortage in our state. The Center has developed recommendations and strategies for recruitment and retention of nurses, facilitated career advancement and leadership of nurses in West Virginia, and worked to create initiatives to support more nurses. Additionally, the Center has secured a large number of scholarships to help educate students and faculty in our state.

Additionally, schools of nursing throughout the state have strategized to increase nursing faculty and students. Currently, West Virginia has 10 associate degree nursing programs, 10 baccalaureate degree nursing programs, and five masters degree nursing programs. There are two doctoral degree nursing programs at West Virginia University: the doctor of philosophy in nursing and a doctor of nursing practice. Enrollment in advanced nursing programs has grown as the need for independent advanced practice nurses and doctorally-prepared nurses has increased. Advanced practice nurses (NPs, CNMs, CRNAs, CNSs) are well established in the state; their extended roles include diagnostic and prescriptive authority expanded by legislation. These masters- and doctorally-prepared nurses promote patient and community health through the integration of practice, education, research and management. These nurses *independently* provide health care, and their skill set includes advanced health assessment, decision making and diagnostic reasoning that provides access to health care for many state citizens, especially in rural areas where clinicians are not always readily available.

Enrollment in nursing programs is at an all time high, but additional increases in nurses and nursing educators, as well as retention of older nurses, will be necessary to avoid a serious nursing shortage in West Virginia. Two factors that limit the nursing student enrollment are the shortage of nursing faculty and often limited clinical placements for nursing students. Innovative teaching strategies include simulation mannequins capable of thousands of human reactions – a new but expensive alternative that addresses clinical placement shortages. Clinical simulation provides students with 21st century equipment with which to learn the analytic, diagnostic and intervention skills necessary to provide safe, quality care to patients and communities. Phase one of a new interdisciplinary state-of-the-art Clinical Simulation Center is now open in the Robert C. Byrd Health Sciences Center at West Virginia University. Information management technology for recording and viewing simulation encounters within the center is web-based and accessible to rural parts of West Virginia. More information on the simulation center can be viewed at www.hsc.wvu.edu/simlab/index.asp.

Truly, there has never been a better time to be a nurse. The increased need for nurses has led to larger, more innovative nursing programs, additional educational resources and grants, more collaborative inter-professional education programs and more leadership opportunities. You can feel the energy and excitement that exist in nursing today, as the voice of nursing becomes stronger and nurses take a more active role in guiding the health of our state, our nation and the world. Information on nursing, along with other information about nursing in West Virginia, can be located on the Center for Nursing website at http://www.wvcenterfornursing.org, at http://discovernursing.com, or on the American Nurses Association website at http://nursingworld.org.

Primary Care: A Growing Need for Physicians

Richard Rafes, J.D., Ph.D., President
West Virginia School of Osteopathic Medicine

Richard Rafes, J.D., Ph.D., is the fifth president of the West Virginia School of Osteopathic Medicine. Prior to coming to WVSOM, Dr. Rafes served as president of East Central University in Ada, Oklahoma.

He previously served in various capacities for 26 years in the University of North Texas System (University of North Texas, University of North Texas Health Science Center at Fort Worth, and University of North Texas at Dallas). His last position at UNT was senior vice president for administration. He was a faculty member at the University of North Texas and the UNT Health Science Center at Fort Worth.

Dr. Rafes holds a bachelor of arts degree in government from Lamar University. He earned a doctor of philosophy degree in higher education administration from the University of North Texas, and a doctor of jurisprudence degree from the University of Houston Law Center.

In just ten years there will be a shortage of 40,000 family physicians in the United States, according to the American Academy of Family Physicians. A factor listed in this increase is the 73 million baby boomers who will begin turning 65 in 2011. Family physicians, internists and pediatricians are included in the medical category called primary care physicians. They will be called upon increasingly to meet this growing need for medical services.

At the West Virginia School of Osteopathic Medicine (WVSOM), we are acutely aware of the growing need for physicians trained in primary care in rural areas, especially in West Virginia. In fact, WVSOM ranks #2 among all the medical schools in the nation, both allopathic (MDs) and osteopathic (DOs), in graduating primary care physicians, according to *U.S. News & World Report's 2010 Edition of "America's Best Graduate Schools."* WVSOM has also been ranked for 11 consecutive years among the nation's leading medical schools by *U.S. News & World Report* in the areas of primary care, rural medicine and/or family medicine.

Since becoming WVSOM's fifth president ten months ago, I have met numerous graduates who are committed to practicing in West Virginia, many in the area of primary care. WVSOM continues to strive to fulfill the ongoing need for primary care physicians. As we look to WVSOM's future, we are enhancing the essential components necessary to meet our current challenges and prepare us for the opportunities to come. Our vision for WVSOM is based on the following three priorities: education and student development, advancement of knowledge and service to West Virginia.

Our first priority is, and will continue to be, the education and success of our students. Our emphasis in education and student development will continue to be rooted in our dedication to the philosophy and practice of osteopathic medicine. We will educate students for all specialties in all locations, with emphasis on primary care in rural areas using the latest technology, medical library resources and the statewide campus experience. The WVSOM statewide campus (SWC), unique to West Virginia, will continue to offer the third- and fourth-year medical students the best possible clinical experience. WVSOM has partnered with clinical sites throughout the state. This collaboration brings together about 2,500 clinical faculty in diverse clinical settings to mentor and train our students in real world settings. We will continue to produce highly competent primary care physicians for West Virginia and beyond. Our students will learn patient-centered medicine and develop lifelong learning and leadership skills in our caring family atmosphere.

Second, we will continue to advance knowledge by focusing on academic, clinical and basic science research, engaging our students in that research and building partnerships with other

institutions. Examples of this focus are our new Center for Rural Health Research, Disease Prevention and Treatment, focusing on obesity and related diseases, and our collaborative work on grant proposals with WVU, Marshall, Concord and Shepherd universities.

Finally, we must promote and expand our dedication to service to West Virginia by continuing to provide primary care physicians to our state. There are 364 WVSOM graduates currently practicing primary care in West Virginia. We must grow our patient base and medical services through the Robert C. Byrd Clinic. These are traditional ways medical schools provide service. We should do more.

We will do this by utilizing our statewide campus sites and our new Clinical Evaluation Center to train medical providers in the use of electronic medical records. We will do so by focusing on research and outreach on the worst epidemic of our time, that of obesity and related diseases. This is an epidemic that costs the American health care system $147 billion each year – $54 billion more than all the cancers combined.

We will do so by purchasing and operating a mobile health unit to respond to disasters, like floods, in West Virginia; to educate children and adults in preventive health care; and to provide basic medical services to areas where there is no accessible health care for its citizens.

We will do so by continuing to promote to those within our medical school the importance of community service and involvement, modeled last year by WVSOM students who provided over 8,000 hours of community service.

And, we will do so by partnering with our city, our county, other universities and entities to jointly serve our community and state. We will do this not because it will enhance our reputation and status within West Virginia and beyond, but because service is a cornerstone of our mission and our existence.

I am convinced that our future will include the expansion of our reputation as a nationally renowned medical education institution, known for its outstanding graduates, many focusing in primary care; cutting edge research in obesity and other health disparities; and a compassionate response to the health care needs of our state and nation.

Medical education at WVSOM includes human patient simulators, or robots, the latest in hi-tech teaching tools. The robots have the ability to mimic live patients in a variety of ways, including heart failure

A WVSOM student doctor administers care at a volunteer clinic in an underserved region in the Dominican Republic

A WVSOM student visits a local Lewisburg elementary school to talk about health and the human body

Where Health Care Has Been and Where it May Go

David P. Cook, Senior Vice President
Wells Fargo Disability Management

Dave Cook is a senior vice president with Wells Fargo Disability Management and a member of the medical division executive committee. He has over 30 years of experience in employee benefit plan management for employers in the Mid-Atlantic region. One of the first Certified Employee Benefit Specialists in West Virginia, he has witnessed firsthand the change in health care while working with clients of Wells Fargo Third Party Administrator.

Mr. Cook is a lifelong resident of West Virginia, having grown up in Wellsburg and graduating from West Virginia University with a B.A. in political science in 1974 and a master of public administration degree in 1975.

With health care insurance being the dominant national issue this fall, health insurers and third party claims administrators are wondering what the landscape will look like for them, come 2010. Will it be business as usual, with employer-sponsored plans being the prevalent form of insurance for most Americans, or will the government step in with a competing plan? As they have done since the 1960s, health insurers and third party administrators (TPAs) must continue to be out front in adapting to the changing health insurance landscape. Just how have they adapted over the past 50 years?

The Golden Era of Health Insurance: 1951 through 1965

Medical inflation for the period from 1950 to 1965 was 67%. The Consumer Price Index (CPI) increased 35%.

Much of the growth in health care coverage came in the 1950s and early 1960s. Labor unions in large, national industries led the way and other employers followed. At the time, employers saw this as a rather inexpensive way to provide a benefit to employees. Through most of this period, benefits were mostly scheduled for hospital stays and related services (fees paid per hospital day and by type of surgery), with a major medical plan set up to cover a limited number of non-hospital expenses. Although medical care costs grew faster than consumer costs, the increase was a percentage of a much smaller number and something employers could sustain. All of this was about to change with the advent of ***The Great Society***.

The Great Society and the First Wave of Hyperinflation: 1966 through 1980

Medical inflation for the period from 1966 to 1980 was 197%. The CPI increased 171%.

With the election of Lyndon Johnson and solid Democrat majorities in both houses of Congress, the birth of The Great Society was upon us. It was time for government to step in and solve the lingering problems facing society at the time. One such problem was health insurance for retired Americans. Medicare and Medicaid were established in July of 1965. Coupled with the cost of other components of The Great Society, as well as the cost of the war in Viet Nam, inflation during this period was extreme. Employers, feeling the brunt of inflation in both materials and labor costs, began looking for unique ways to cut costs. One way that gained favor was self-insuring the health risk, and the rise of the TPAs was upon us.

The TPA offered an employer an avenue not readily available from health insurers at the time: self-insuring the health care risk. Advantages of self-insuring included a reduction in fixed costs (administrative fees, insurance premium tax, reinsurance premiums), as well as the employer holding the reserve for 'incurred but not reported' claims, which in some insurance plans was as much as 25 percent of plan-year costs. From the mid-1970s to the early 1980s, TPAs grew significantly, as more and more employers looked for ways to cut costs. Savings realized through self-insurance, however, were one-time events. The next wave of health inflation created a need for even greater change in the market over the next 15 years.

Hyperinflation Does not End in Health Care: 1981 through 1995

Medical inflation for the period from 1981 through 1995 was 194%. The CPI increased 77%.

As consumer prices settled during the 1980s, it was easy for employers, insurers and the government to see that health care inflation did

not follow suit. The government handled this problem as only the government can: by reducing reimbursements to medical providers. This reduction caused medical providers to begin shifting costs to the public and its representatives, insurers and TPAs. The response was predictable. If the government can control costs by setting reimbursement rates, we can do the same, and thus came the Preferred Provider Organizations (PPOs). PPOs set out to cut costs through negotiating lower reimbursements to providers in return for membership in their organization. The Blue Cross Blue Shield insurers led the way in this area, but other insurers were quick to catch up and build their own networks. TPAs took advantage of stand alone PPOs that offered their discounts to any group that would buy them. Cost reductions as high as 55 percent were not unusual during this period, as employers began to see some abatement in the cost of their plans. During this same period, benefits also were being cut for the first time through increases in deductibles, copayments and premium sharing. With the addition of utilization review, one would think the cost of medical care would be under control. What did the next 13 years bring?

Is There Any Way to Control Health Care Costs Left Undiscovered? 1996 to 2009

Medical inflation for the period from 1996 to 2009 was 65%. The CPI increased 37%.

PPOs, plan changes, utilization review and self insuring have all contributed to holding down the cost of medical plans over the last 43 years. Medical inflation for the past 13 years has dropped, when compared to the previous 30 years, but it is still nearly double the CPI, and the balloon is getting ready to pop. Insurers and TPAs see one undiscovered area to control costs: improving the health of the medical care consumer. A healthier consumer will use less medical care over his lifetime. The question is "how do we help consumers become healthier?"

Information and incentives are the keys. Consumers need to be able to easily obtain information about their health and determine what to do to manage their health. From there, benefit plans need to develop incentives to help move consumers along in pursuit of a healthier lifestyle. One such program is Wells Fargo Health Options and its Personal Health Record (PHR). The PHR is a powerful tool that allows the participant to gain control of his future health care. Features within the record will tell participants where they are in their management of health conditions, what they can do to improve this management, and the tools available to help. By giving participants the opportunity to improve their health, future health care costs can be greatly reduced. A good example is the annual cost of diabetes care, one of the leading ailments in West Virginia.

Normal Risk	$3,359
Low Risk	$7,388
Medium Risk	$25,182
High Risk	$85,777

The more a diabetic can manage care at normal or low risk levels, and avoid medium and high risk levels, the greater the savings for all. And the big bonus is that, in return for better management of the condition, the patient lives a healthier, longer life.

The Future

Where health care goes from here will ultimately be up to the consumer. Taking care of oneself is the only guarantee that the cost of health care will be less of a burden to all of us, whether through our own expenses or taxes. TPAs and insurers are offering programs to help the consumer measure how he or she is doing in the pursuit of a long, fruitful life. V

Community Health Centers Provide Thousands with Access to Care

Brian K. Crist, MSW, Chief Executive Officer
Lincoln County Primary Care Center

Brian Crist has been the chief executive officer of Lincoln Primary Care Center, Inc. since 2001. A West Virginia native, he received both an undergraduate and master's degree in social work from West Virginia University.

In 2007, Mr. Crist received the West Virginia Rural Health Education Partnership and AHEC Outstanding Alumni Award, the West Virginia Rural Health Association's Caperton Outstanding Community Program Award and the WV Primary Care Association's Outstanding Community Project award for his vision and for increasing access to community wellness programs.

He serves on the executive committee of the Community Health Network of West Virginia, is the former secretary of the West Virginia Primary Care Association executive committee, is the current president of the West Virginia School Based Health Assembly, and currently serves as the board president of the West Virginia Council for the Prevention of Suicide. Mr. Crist also serves as adjunct faculty for the West Virginia University Division of Social Work – Charleston campus.

Lincoln Primary Care Center (LPCC), founded in 1975 by a group of local businessmen in Hamlin, West Virginia, has grown to be one of the nation's premiere community health centers. LPCC began in a storefront that served at one time as the community's only grocery store. In 1990 the organization leveraged local dollars from private contributions with USDA funding to build a modern 18,000 square foot facility. In 2003 LPCC remodeled the interior of the building to expand to 32 patient examination rooms and added an additional 1,800 square feet to accommodate a new 340-B pharmacy, to serve those patients with no prescription coverage. Construction of a new 6,000 square foot wellness center followed in 2004 to address the community's fitness, health education and nutritional needs through programs designed to fight and prevent chronic diseases among local residents.

Throughout its storied history, LPCC has been recognized by many state and national organizations for quality care initiatives, education and training of health care students, innovative programs, a progressive approach to implementing advanced technology into its system of care and programs resulting in health care reform. In 1975 the center was recognized as the nation's first federally designated rural health center, and in 1990 was chosen as the nation's outstanding rural practice by the National Rural Health Association. In 2001 the center became a federally qualified health center (FQHC) under the Health Resources and Service Administration and since 2003 has received more than 10 awards from state health care organizations for its innovative programs dealing with children's immunizations, chronic disease prevention and wellness. In 2006 the center was honored by an unprecedented visit by then US Secretary of Health, Michael Leavitt, to observe the daily operation and impact of a community health center in rural Appalachia.

Community and Access

Community health centers have expanded their focus to become more integrated into the communities they serve. Lincoln Primary Care for instance, has become one of Lincoln County's largest employers, with 75 employees – 14 licensed medical providers and 16 nursing staff – resulting in

Lincoln County Primary Care Center located in Hamlin, West Virginia

The Lincoln County WELL (Wellness, Education, Lifestyle and Learning) Center, built in 2004

Lincoln Primary Care provides medical and ancillary services to nearly 10,000 individual users, provides over 33,000 billable encounters and services another 40,000 non-billable vists per year. The center continues to expand its programs to serve the needs of its 22,000 residents.

a substantial economic impact on the area. Lincoln Primary Care provides medical and ancillary services to nearly 10,000 individual users, provides over 33,000 billable encounters and services another 40,000 non-billable visits per year. The center continues to expand its programs to serve the needs of its 22,000 residents. Lack of access to care in rural areas has created a need for health care providers to offer more than just a traditional visit with a primary care physician. To address this issue, Lincoln Primary Care has developed innovative programs that address integrated mental health, preventive dental care, low cost prescriptions, social work, fitness, nutrition, prenatal care and access for children at four school-based health centers.

The Future

In preparation for the future, with or without national health care reform, LPCC and the other 28 community health centers in West Virginia continue to position themselves as the safety net provider for all, as a *medical home*. Access to quality care for the insured as well as the uninsured is the primary mission. Engrained in that mission is an effort to:

- Decrease long term health care costs associated with the ongoing symptoms of chronic diseases.
- Decrease emergency room utilization by providing expanded hours of access to care and health education.
- Provide a patient-centered care model to ensure patients are receiving necessary routine preventive care.

Additionally, LPCC has helped develop and implement an electronic health record that serves as a quality improvement tool, focusing on health outcomes. It allows a care team to have individual health care information readily available, as well as aggregate patient data, used to determine trends in care to modify treatment options. By the end of 2009 this same system will have been implemented in eight other community health center systems in West Virginia.

As the need for national health care continues to be debated, Lincoln Primary Care Center will continue its mission to be an innovative provider of care. The center's strategic plan enforces the need to expand services throughout its service area and create additional sites to ensure local communities have access to quality care. For nearly 40 years, rural centers like Lincoln Primary Care have been among the best kept secrets in health care but are now stepping forward to be leaders – and to make sure the secret is revealed. V

Rising to the Challenge: Southern Provides Nurses, Changes Lives

Pamela L. Alderman, RN, MSN, Dean for Careers and Technical Programs
Southern West Virginia Community and Technical College

Pamela Alderman, RN, MSN is the dean for career and technical programs at Southern West Virginia Community and Technical College. In September 2009, she was one of 50 nurses nationwide chosen to meet with President Barack Obama at the White House regarding health care reform. In addition to being a registered professional nurse, she is a primary care specialist and a medical rehabilitation consultant.

Ms. Alderman has served as a member of the West Virginia Board of Examiners for Registered Professional Nurses since 1999, and as the board president since 2003. She also is the vice chair of the West Virginia Center for Nursing board of directors.

She received her associate degree in nursing from Southern in 1977, followed by a bachelor of science degree in nursing and a master's degree in nursing administration and primary care from West Virginia University. She is currently pursuing a doctorate of education degree from Marshall University.

Southern West Virginia Community and Technical College (Southern) has been delivering nursing education to the citizens of the state for more than 37 years. During this time more than 1,500 graduates have become registered professional nurses, providing high quality health care throughout West Virginia and the nation. By providing students with an associate in applied science degree in nursing, Southern has changed lives and created a brighter future for those who have successfully completed the program.

The future of health care must include nurses, the backbone of the health care profession. Southern has become known for the outstanding nurses that graduate from its program. The demand for acceptance into Southern's nursing program, as well as for those who complete the program and enter the workforce, is phenomenal. Southern's graduates are among the first recruited by hospitals in southern West Virginia, the Kanawha Valley and the Potomac Highlands.

Acclaim and recognition did not come easily and, in fact, it took more than 20 years for the program to achieve the status and acknowledgement it enjoys today. Hard work, dedication, administrative support and an exceptional faculty and staff have brought Southern's nursing program to the pinnacle of

success. Without all these factors, the program would have continued to struggle. Nursing at Southern began in 1972 on the Logan and Williamson, West Virginia, campuses. The offerings were born from the need to educate nurses, as the hospital schools of nursing in each of those communities had closed in the late 1960s. Hospital administrators, physicians and community leaders approached Southern with a request to start a nursing program. As a new, freestanding community college, Southern rose to the occasion, and in accordance with the mission to serve the needs of the community, the program was established.

In 2001 Southern was again approached by another community that did not have an associate degree nursing program. Again responding to a need, Southern expanded its nursing program to Moorefield, West Virginia in the fall of 2003 and to the Kanawha Valley in the spring of 2004. Southern has since graduated three cohorts of students from the Kanawha Valley site and two cohorts of students from the Moorefield site. Although not an easy venture for Southern, programs at the two additional sites have provided nurses to another underserved rural region of the state as well as a large urban area in need of more registered professional nurses and students in both areas have been extremely successful.

Southern will graduate the last cohort of students from the Moorefield site in May 2010. Eastern West Virginia Community and Technical College (Eastern) will begin offering the associate in applied science in nursing degree in 2010. Eastern has elected to use Southern's curriculum as a basis for the new program, citing the quality of the program and the success of the graduates.

Many students within Southern's service district would never have the opportunity to pursue higher education, especially a degree in nursing, without the access to the college. Over the years, Southern has provided its students with a promising future and its graduates with a new quality of life, as well as providing exceptional health care to the citizens of the communities served by the program. Without Southern, many students would have been unable to fulfill their dream of becoming a registered professional nurse, and the shortage of nurses throughout the state would have been exponentially worse than it is at the present time.

The future of health care – and nursing – are going to depend in part on the responsiveness of colleges and universities throughout the region and the nation. Like many community colleges, Southern is poised to rise to the challenge, providing quality education in order to meet the health care needs of the people of West Virginia, the region and the nation. V

Pandemic Preparations for the Workplace

Mark H. Dellinger, Partner
Joy B. Mega, Associate
Bowles Rice McDavid Graff & Love LLP

Mark Dellinger is a partner in the Charleston office of Bowles Rice and is the leader of the firm's labor and employment practice group. He also serves as a member of the firm's human resources committee.

Mr. Dellinger represents private and public sector employers in matters of labor and employment law, including preventative counseling, employment litigation and traditional labor relations issues. A significant part of his practice is devoted to representing employers in employment law cases filed in federal and state courts where he has obtained numerous summary judgment rulings, and successfully handled trials and appeals.

Based on his work in the area of labor and employment law, Mr. Dellinger has been recognized as an "Up and Coming" Lawyer by *Chambers USA: America's Leading Business Lawyers* and selected for inclusion in *West Virginia Super Lawyers*. He received his undergraduate degree in business administration from Lenoir-Rhyne University and his J.D. degree from West Virginia University College of Law.

Joy Mega is an associate in the Charleston office of Bowles Rice and a member of the labor and employment practice group. A significant part of her practice is devoted to representing employers in employment law cases filed in federal and state courts. She also advises employers on personnel matters and human resource issues.

A graduate of the West Virginia University College of Law, Ms. Mega was inducted in Order of the Barristers and was a member of the national moot court team. She received her bachelor of arts, *cum laude*, from Marshall University.

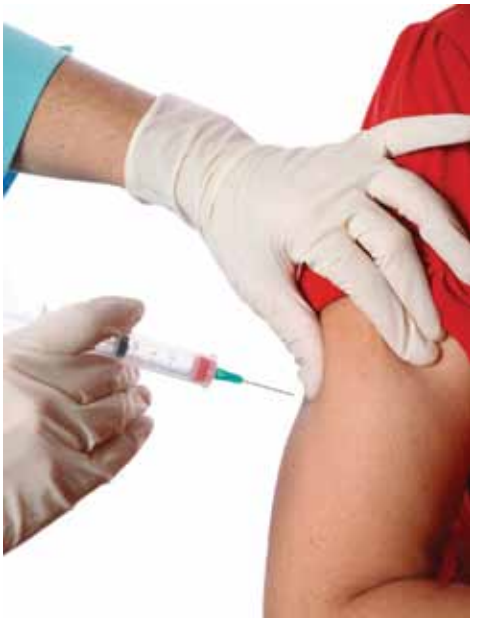
She is a member of the West Virginia State Bar, the Defense Trial Counsel of West Virginia, the Defense Research Institute and is a 2008 graduate of Leadership Kanawha Valley.

On June 11, 2009, the World Health Organization (WHO) declared the first global flu pandemic in 41 years, raising the threat for the new H1N1 flu virus (swine flu) from phase five to phase six, the highest level. Documented outbreaks of the swine flu have occurred across the county and it is clear that the risk of pandemic illness is serious enough to require a sufficient commitment of time and resources to maintain efficient and viable business operations. This article briefly examines the nature of a pandemic, effective pandemic preparations for the workplace, and an overview of some of the important legal issues that employers must navigate as part of those preparations.

Now that the threat of a new pandemic has been realized, it is important for employers to develop and activate response plans to avoid business disruption. Prudent employers will want to consider a wide range of issues as part of their pandemic preparations. These considerations range from dealing with employees who are sick in the workplace to the development of health and hygiene protocol. From a practical perspective, employers will want to develop crisis management measures, such as contingency plans in the event a large segment of their workforce is absent because of a pandemic.

Developing a Communicable Disease Policy

There are several basic measures employers may choose to implement as part of their pandemic preparations. First, employers should consider developing and implementing a communicable disease policy. Under such a policy, employers may require employees to disclose when they have been diagnosed with a



communicable illness, exposed to a person with such an illness, or visited a place where there is an outbreak of this type of illness. This type of policy also should include language promising to protect individual privacy, to the extent possible, and prohibiting harassment and retaliation.

Second, employers may want to consider implementing a travel and quarantine policy. This type of policy should provide that foreign travel must comply with advisories issued by the U.S. Centers for Disease Control and Prevention (CDC) and other select agencies, as well as require employees, who are traveling to areas with current outbreaks of a communicable disease, to have all recommended vaccinations and to follow recommended health precautions.

Third, employers should review their current leave policies. While employers are typically concerned with ensuring employees' good attendance, they may want sick employees to remain at home in a pandemic situation. Accordingly, leave policies should address matters such as how employees should request leave and whether the leave is paid or unpaid. Lastly, employers need to make sure that their workers' compensation premiums are paid so that they maintain their statutory workers' compensation immunity to various types of common law tort claims.

Consider Existing Federal and State Laws

As with any type of workplace policy, employers need to analyze various federal and state employment laws when drafting and applying pandemic response plans. For instance, there are existing federal regulations and guidelines issued by the Occupational Safety and Health Administration and the CDC that may apply to a pandemic situation. Furthermore, there are an assortment of statutes that employers need to consider in drafting or revising leave policies as part of pandemic planning. Influenza-related leave could constitute a "serious health condition" triggering protections under the Family and Medical Leave Act of 1993.

Similarly, disability and reasonable accommodation issues may surface under the Americans with Disabilities Act of 1990, as recently amended by the Americans with Disabilities Amendments Act of 2008. Indeed, the U.S. Equal Employment Opportunity Commission has already developed a technical assistance document entitled "ADA-Compliant Employer Preparedness For the H1N1 Flu Virus" (www.eeoc.gov/facts/h1n1_flu.html).

Prior to requesting health information from an employee or before using such information, employers will also need to determine the applicability of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Employee Retirement Income Security Act of 1974, which applies to certain types of employee benefit plans, may apply to any plan changes that are made. Employers will also need to examine their pay and telecommuting policies. Employees may want to work, or be asked to work, from home during a pandemic to promote social distancing. Those telecommuting employees who are classified as non-exempt employees under the Fair Labor Standards Act present potential overtime issues for employers. Employers can act to prevent these types of problems by preparing policies requiring employees to perform work only during specified hours, accurately and timely recording their hours of work, and receiving prior authorization before working overtime.

In the context of a pandemic, employers need to be prepared to respond with a flexible approach which transcends the traditional notions of employment law in order to preserve a continuity of business operations. Based on recent developments, employers are becoming acutely aware of the serious risks that pandemics pose to their workplaces and of the necessity of preparing adequate response plans. V

More Thought and Less Care

Dr. Mark Cucuzzella, FAAFP, Associate Professor of Family Medicine
West Virginia School of Medicine

Mark Cucuzzella, MD, FAAFP is a family physician in Harpers Ferry, West Virginia and an associate professor at West Virginia University School of Medicine. He has been a competitive runner for nearly 30 years, completing over 50 marathons and ultras, and continues to compete as a national level masters (age 40 plus) runner. He has a string of 21 consecutive years running a marathon in under 2:35, except for the year of his medical internship.

Dr. Cucuzzella is the lead recipient of a large Robert Wood Johnson Foundation "Healthy Kids Healthy Communities" grant which aims to halt the current national epidemic of childhood obesity. He has been awarded the US Air Force Athlete of the Year in 1997, the Family Physician Teacher of the Year for the state of Colorado in 2000, and was recently named as the Harpers Ferry National Park Volunteer of the Month.

In his daily practice, Dr. Cucuzzella encourages walkers and runners at all levels of ability. He teaches classes on "Exercise is Medicine" and healthier and pain-free running. He received his undergraduate and medical degrees at the University of Virginia and spent 10 years as an active duty family physician and flight surgeon in the US Air Force before entering civilian academic practice. As a Lieutenant Colonel in the Air Force Reserves, he is coach and captain of their marathon team and designs programs to reduce running injuries in military personnel.

Nearly 20 years ago I entered family medicine with a vision of shaping healthier individuals and communities. Over this period, our disease-based health care has devolved into a complex, disjointed, horribly expensive and, by current evidence, an often dangerous mix of medications, tests, specialists, shifting payers and complex rules. Even the often-used term *preventive care* being discussed in think tanks implies that the ticket to better health is dependant on the *care*, e.g., screening and exams, which a health provider gives to an individual. This style of *preventive care* is, at best, early detection of something that may or may not cause you problems later; it is not true *prevention*.

What is often surprising to the public is that the ritual annual "physical" has not been shown to save lives or decrease costs and that accepted screening tests, e.g., cholesterol, colonoscopy, PSA, pap smears and even mammograms, unfortunately are blunt tools at best and, at worst, lead to costly and painful interventions and treatments when applied broadly to well populations.

Without debate are the benefits of a comprehensive healthy lifestyle in many societies throughout the world that share common practices. This is true prevention. Massive longitudinal studies have been carried out in thousands of patients over decades, such as the Okinawa Centenarian Study, the HALE Project, the EPIC/Norfolk UK Study, the MacArthur Study of Successful Aging, revolutionary studies performed by Ralph Paffenbarger (Harvard Alumni Study) and studies of the Cooper Institute.

A recent book called ***The Blue Zones*** (http://www.bluezones.com) highlights several healthy populations throughout the world. There is nothing new and innovative in their traditional healthy lifestyles. They do moderate physical activity their entire life, eat a plant-based diet, do not smoke, maintain their weight, some have a drink a day and provide lifelong care to their fellow citizens. There is something magical about the elderly being woven into their culture in a valuable and serving way, not left forgotten and at the mercy of a corps of medical providers. A perfect example is Clarice Morant, who recently died at 104. She took care of two, similarly-aged family members in her own home after she reached the age of 100. In *giving* care, Clarice *received* life and health.

So as the health care policy makers and interest groups debate over who will pay for the inefficient and costly *care*, maybe we need to give more *thought* into how we live, and promote policies and programs that support an active and healthy lifestyle for all generations. Current health care reimbursement is compensated by *how much care* (i.e. tests, procedures, drugs, devices) we deliver; not by the thought, effort and outcomes achieved.

In our rural county of West Virginia, we are a finalist in a Robert Wood Johnson Foundation initiative called "Healthy Kids Healthy Communities." The first phase of our project, titled "Wild and Wonderful Trails for Every Child," involves building a fitness trail and community garden at every school and park in the county. We have a four-year plan to reshape the built environment and nutritional policies to align with the principles of healthy living. Our focus extends the *medical home* into the *medical home's backyard*, with a collaboration of over 30 community partners, all with common interest in preserving the health of our families and the environment we live in.

The grant activities will support accessible, after school programs on the local trails, to build

Dr. Cucuzzella runs with community children during a weekly fun run

family fitness; teach nutrition through "edible" gardens; and hopefully reestablish the connection between children and nature. The initiative will designate safe routes to school for walking and biking, gather and distribute donor bikes to area kids so they can use these routes and, over time, hopefully change the culture of how the community lives. The vision is for a ring of trails, initially focused around the schools, eventually expanding and connecting as the community sees the value not just in health, but also in the aesthetic and economic impact provided by a pedestrian- and bike-friendly community.

In line with changing the culture, we also planned a large event focused on community fitness for all – Freedom's Run (www.freedomsrun.org). We hold weekly fun runs and teach classes to help all abilities succeed in their individual goals. This idea of all-inclusive family jogs was first born in New Zealand, under the legendary coach and mentor, Author Lydiard (http://www.lydiardfoundation.org). Lydiard started the Auckland Joggers Club in the 1950s, mostly out of a desire to rehabilitate heart attack victims (a wildly controversial concept at the time, now a standard of care). His Sunday morning gatherings of young, old, walkers, joggers and a few serious runners became a weekly party. If you visit New Zealand today, similar groups gather in small towns throughout the country, and the health of the nation benefits in this active, social play.

In 1962 the legendary University of Oregon coach (and Nike founder), Bill Bowerman, traveled to New Zealand to observe Lydiard's coaching technique for Olympic-level athletes. What Bill really discovered was the *jogging* movement of the citizens, inspiring him to write "*Jogging*," a 60-page pamphlet which quickly became a bestseller – and gave birth to a new word and lifestyle. Bill himself could barely cover a half-mile the first day, but after several months of easy and fun running, he was 30 pounds lighter, renewed and able to jog for miles. Bowerman began hosting Friday evening jogs in his Eugene community. At first, only a few gathered, but soon hundreds appeared at the Oregon track to head out on the local routes. Eugene is now recognized around the world for its trails, recreation and community health. Bowerman started a culture change simply, with the Friday jogs and this call to action: "If you have a body, you are an athlete."

Our small county's plan can be a model for any community, urban or rural. Perhaps the *thought* we put into this local initiative could be translated into a larger national forum … and maybe in the future we will be providing less *care*, like they do in Okinawa. V

Changes in the Pharmaceutical Industry

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Gardiner Smith is of counsel in the Charleston office of Bowles Rice and practices in the areas of intellectual property, biotechnology and licensing.

Mr. Smith is a graduate of North Carolina Central University School of Law and received his bachelor of arts from the University of North Carolina, Chapel Hill. He joined Bowles Rice from Aspreva Pharmaceuticals, where he was the senior vice-president of business development and licensing.

Mr. Smith previously served as in-house intellectual property attorney at GlaxoSmithKline, a research-based pharmaceutical company. His role with GSK focused on compound licensing in oncology, research and development alliances and acquisitions. He also was a patent attorney and a scientist at Glaxo Research Institute. Additionally, Mr. Smith served in senior transactional roles at Human Genome Sciences and Memory Pharmaceuticals, two publicly traded biotechnology companies.

Prescription drugs have improved our health as a society, and saved many lives over the past 100 years. Starting with compounds like aspirin, progressing to vaccines and antibiotics, drugs are now treating conditions like blood pressure maintenance and cancer – and some diseases can be slowed or even eliminated. As part of our health care system, pharmaceuticals play a key role, helping to keep overall costs down, improve quality of life and frequently preventing the need for more intensive care.

Based on this success in medicine, pharmaceutical companies have grown to be large, multinational manufacturing and marketing corporations. Additionally, through co-funding arrangements with venture capitalists and academic-sponsored research, the industry has created a subsector in biotech for the discovery and testing of new drug compounds. The drug development process is time consuming and expensive, and these companies spend tens of billions of dollars every year on research and development in the U.S. and in other major markets.

Despite this successful record, scientifically and financially, the biopharmaceutical industry is now under increasing economic and political pressure, perhaps beyond that of other sectors during this current economic slowdown. These pressures have resulted in flat stock prices and a static valuation in the industry as a whole over the last 10 years. Although successful drugs remain profitable, the companies who make them must overcome several challenges.

The biggest hurdle to new drug products is the underlying complexity of human disease. Many of our greatest remaining health challenges are conditions involving the breakdown of more than one biochemical system in the body, particularly those associated with aging. Cardiovascular disease involves blood vessels, digestion, metabolism and the heart. Alzheimer's and dementia affect the most complicated system that we are aware of, the human brain, and the blood biochemistry which supports it. While the drug industry has been successful with products which are effective and relatively safe against a single biological target, such as the blocking of acid-secreting cells in the stomach to alleviate ulcers, the likelihood of a single agent solving multifactorial disease is low. The trend of needing multiple medicines, taken together, is one with which most of us are familiar, either for ourselves or for a relative. Discovering new medicines and how they work in combination is exponentially more difficult than a single drug therapy.

Biopharmaceutical companies have been criticized, particularly recently. Some criticisms are not directly attributable to the industry, like out-of-pocket payments not covered by insurance being disproportionately attached to prescriptions, as opposed to other health care expenditures which may be more fully covered. However, the industry bears responsibility for an increasing expenditure and focus on marketing and advertising for modestly improved products, at the expense of developing more novel medicines for unmet medical need. In the context of consistently high profit margins over time, biopharmaceutical companies and the investors who support them need to take a long-term view to adding value through innovation.

Another challenge to the biopharma industry is the increase in political process and burden at the federal level. Few doubt the wisdom of oversight for distribution of chemicals which we ingest, under the Food and Drug Administration. Every drug has some benefit, as well as some adverse consequences. When we multiply the number of doses one takes by the number of patients on a given prescription, it becomes a massive statistical task to try and understand the cost/benefit for a given medicine across a patient group, that is whether the drug should be prescribed broadly, and to what patients. Add in the effect of other drugs on the drug at hand, and the decisions the FDA must make are difficult. They also are subject to review by Congress, often as a result of publicity around side effects for a drug, usually relatively rare for approved products. Increased education of the public and our representatives on the public policy considerations around the benefits and risks of pharmaceuticals is critical.

Adding to pressures on the biopharmaceutical sector is an aging U.S. population, which is requiring a larger share of health care spending, including pharmaceuticals. As we face budget pressures, choices will have to be made about what we can afford to provide for all of our citizens, and how we allocate resources that, although vast, do have limits.

Fortunately, tens of thousands of scientists and business professionals in developed countries around the world commit their working hours to advancing the understanding of pharmaceutical treatments. An example of how scientific and medical leadership is paying off can be seen in the increased understanding of how individual patients manifest disease, and how their responses to drug therapies vary. Over the past 15 years we have deciphered subtle variations in the structure of the biological molecules, for example, proteins, which make up the composition of each of our bodies. Through detailed medical records comparing these structural variations and the differences they have on drug effects, done under confidentiality and with patient privacy, we can begin to predict with greater accuracy what drugs work well in certain people, whereas in others an alternative medicine is a better choice. This combination of diagnostics and therapeutics also will allow us to use the lowest effective dose of a drug, minimizing costs and limiting side effects. The opportunities in this area, called pharmacogenomics, are just beginning.

The U.S. has strong governmental and non-profit support of basic pharmacological research, and substantial resources from the private sector are going into biotech and pharmaceutical research and development, manufacturing, education and distribution. West Virginia plays an important role in these efforts through our universities, non-profit centers and industry. The cycle of invention, hard work, investment and production is something we excel at, and our efforts in biopharmaceuticals are justified by the improved quality of life to which good health contributes. The biopharmaceutical industry, one of our greatest accomplishments to date, will continue to benefit all of us over the long term as we find ways to adjust to the new challenges ahead. V

Is Health Care Reform Going to Cost You More?

John S. Moore, Partner
Bowles Rice McDavid Graff & Love LLP

John Moore is a partner in the Charleston office of Bowles Rice and serves the firm's health care clients. He has more than 20 years' experience in insurance, managed care and hospital and physician business matters.

Mr. Moore's prior experience includes 10 years in a major hospital system, working with health care business issues including physician employment and compensation, acquisitions, practice management, fee analysis, fraud and abuse, IS and payor contract negotiations. He built and managed one of the largest physician management service organizations (MSO) in the East.

Mr. Moore played key roles in managed care contracting, PHO and HMO implementation, system integration, market analysis and strategic planning. He also has taught insurance at the college level and has run TPA operations. He frequently lectures hospital and physician audiences on a wide variety of health care law and business issues.

He earned his law degree in 1973 from the West Virginia University College of Law and was a member of Mountain, West Virginia University's ranking honorary. He is active in community initiatives, including serving two terms as chairman of the board for Goodwill Industries; long-term participation in Read Aloud WV; chairman of the West Virginia chapter of the Multiple Sclerosis Association; and volunteering for educational and community fund raising.

Yes. Here's why.

Some say that the cost of health care and health insurance would be less "if only we had real competition among the commercial insurers."

News Flash:
There is competition now and health insurance companies are not dummies.

Insurance company profits are not "causing" the high cost of healthcare. Nor is socializing their industry or introducing government "competition" going to reverse increasing health care costs.

Much of my practice is spent negotiating contracts opposite folks at United, Aetna, Carelink and Blue Cross Blue Shield After 30 years in the business of health care, I have acquired a healthy respect for health insurers' systems and expertise. They are good at what they do: seeking efficient and quality medical care solutions for their beneficiaries.[1] The notion that a government third option can do it better than them, or offer real competition is, I believe, mistaken.

Health care insurers and claims administrators already compete fiercely to deliver networks of providers and care protocols which result in the lowest possible cost to their customers. Adding a government "competitor" is not going to materially change costs or options.

However, the way a government third option could save itself money is by paying doctors and hospitals at lower than market rates. If this sounds good to you as an employer or as an employee buying health insurance, then we need to talk about cost-shifting.

Cost-shifting is a hidden tax imposed upon businesses offering health insurance coverage. It occurs because the government … Medicare, Medicaid, PEIA and now, maybe, the government third option … pay hospitals and doctors less than market rates and, often, less than cost. Can your business survive when customers pay you less than your production costs? Neither can hospitals or doctors.

Those government payment rates are not negotiated. The government simply tells providers how much they are going to pay. The providers, in turn, have no choice but to ask commercial payors (your business or your insurance company) to pay more. So, the cost of government's under-payments are shifted to you. At a guess, your current commercial hospital bills are about twice what they would otherwise be if government and commercial insurors all paid equal fair shares.

Think about what will happen if you, or other employees or businesses, choose to buy government third option insurance (if it ever becomes available). You will save some dollars. For awhile. Hospitals and doctors will be paid less. In turn, they will be forced to raise rates even further to those remaining in self-insured or commercially insured programs. Health insurance premiums and costs for those folks will go up. Eventually, those remaining customers will abandon their relatively high-cost commercial insurance plans. Some hospitals will go out of business. Many health insurance companies will melt away. There will be no one left to whom to shift the cost of government underpayments Your taxes will then have to go up to keep remaining health care providers in business.

There is No Free Lunch.

How is that government third option working now? Fewer hospitals. Maybe fewer doctors. No insurance competition to the government. Hello, socialization. That may cheer some. Just don't believe that this will result in lower costs. Pay it in insurance premiums, or pay it in taxes.

To be intellectually honest, however, it should be noted that if a government third option program intervenes to pay hospitals and doctors for providing care to uninsured or indigent populations, that would help relieve cost-shifting pressures. Of course, payment for that care would likely be derived from increased taxes. Pay the bill now, or pay it later.

Ever heard of "Burning House" Fire Insurance?

Imagine that fire insurance was readily available for homeowners at any time, including when a house had smoke billowing from the windows. Guess what? Lots of people owning burning houses would quickly arrange for fire insurance if they didn't already have it. And, if the insurance company was precluded from denying applications from those with pre-existing conditions, e.g. burning

houses, you can readily imagine that the price of fire insurance would go up. Way up. This is an example of, and the consequences of, adverse selection.

The same principle exists in health insurance. While I support people being able to have access to affordable health insurance, there is peril in opening the access doors wide even for those who are on the way to the hospital, that is, providing coverage to those previously without insurance who suddenly find they have a significant diagnosis needing treatment.

Could we require that everyone have and pay for health insurance? Sure. Except, maybe, those who can't afford it. Presumably, for those, the taxpayers will foot the cost of their coverage. Pay the bill now, or pay it later.

None of the foregoing is intended as an attempt to persuade you that as a society we should not pursue expanded health care coverage for all of our citizens. That is a worthwhile cause worthy of debate. The message here is limited to:

- The high cost of health care is not the insurance companies' fault.
- Faux competition from a government third option is not the answer.
- Unconstrained access to insured health care has its costs.

We should pragmatically assess the potential increased costs of helping vulnerable and disadvantaged members of our society. We need to weigh the human merit in providing insurance coverage for all. But the notion that we can provide more at less cost is not well founded. Health care reform is going to cost you more. V

Notes
[1] And squeezing doctors' and hospitals' bottom lines.

The HITECH Act and the Future of Health Information Technology

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Lenna Chambers is an associate in the Charleston office of Bowles Rice. She focuses her practice on employee benefits, executive compensation and ERISA matters.

Ms. Chambers graduated from The George Washington University Law School in 2006. While at George Washington, she was a member of the moot court board and served at the Vaccine Injury Clinic. A 2002 *cum laude* graduate of Marshall University, She received her bachelor of science degree in biological sciences. Her studies at Marshall included minors in history, chemistry and Spanish.

Ms. Chambers is a member of the American Bar Association, the West Virginia Bar Association and the Kanawha County Bar Association.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), takes relatively small steps toward the development of a national health information exchange network, but suggests that much more in the way of reform and regulation is to come. Although efforts to create a national health information network are hardly new, the HITECH Act attempts to overcome some of the obstacles that have plagued previous attempts.

The biggest obstacle to the establishment of a national information system is creating a system that works for everyone. Interoperability, or the ability of providers to share and exchange information despite the use of different systems, is key to a workable and efficient system. Over the years, various private-public partnerships have been established to study, create and harmonize health information technology standards, but a patchwork of systems still exists, and most often they cannot communicate with one another. The HITECH Act consolidates the efforts of predecessor entities within the Office of the National Coordinator for Health Information Technology (ONCHIT), which was originally created in 2004 by executive order and has always been charged with developing and implementing a nationwide interoperable system for use in the public and private sectors. Committees to create health information technology policy and standards also have been established, and work to develop a national health information network is well underway. It remains to be seen whether the product of these efforts will be one network, built from the ground up, or a network of networks, similar to the system used by the banking industry, but interoperability is one of the primary requirements.

Another significant challenge is getting facilities and providers to use health information technology *at all*. A study published last year in the *New England Journal of Medicine* found that only about four percent of physicians who responded to a national survey reported having a fully functional electronic records system, and another 13 percent reporting having only a basic system.[1] Although survey respondents overwhelmingly reported benefits of using such systems, and there seems to be a consensus that using health information technology is beneficial in terms of quality of care and efficiency, the cost to providers of creating an electronic records system remains a significant barrier to universal use.

The HITECH Act pushes the use of electronic health records systems by federal agencies, by requiring them to transition to systems meeting standards approved by ONCHIT as the agencies upgrade or acquire health information technology systems. The HITECH Act indirectly pushes the use of these systems in the private sector as well, as federal agencies must now contractually require health care providers, plans or health insurance issuers to adopt ONCHIT-approved technologies and products as they upgrade or acquire health information technology systems. ARRA authorizes incentive payments to providers and hospitals for the adoption and meaningful use of electronic health records to accelerate the adoption of health information technology as well.

The duties of the national coordinator, set forth in the HITECH Act, give a glimpse into the future for health information technology reform. The national coordinator is charged with identifying specific objectives, milestones and metrics to promote the use of an electronic health record for every person in the United

States by 2014, and estimating the public and private resources needed to achieve this goal. The national coordinator also is charged with establishing a national governance mechanism for the national health information network. Thus, while the use of electronic health records remains optional under the HITECH Act, the assignment of these duties suggest that they will be required and regulated in the not-so-distant future.

Regulatory focus will undoubtedly be placed on the privacy and security of patients' health records. A significant number of ONCHIT's duties in creating a national network, as laid out in the HITECH Act, consist of evaluating and implementing protections of the privacy and security of electronic health records and information. The HITECH Act also expanded the privacy and security rules of the Health Information Portability and Accountability Act (HIPAA) by making many of the standards directly applicable to more entities, creating new obligations with respect to notification of confidentiality breaches, boosted enforcement of these rules by authorizing state attorneys general to prosecute HIPAA violations and significantly increasing monetary penalties for violations.

ONCHIT and the federal government are not working alone. State-based partnerships have been assisting providers in establishing these systems for years, and are now moving to take advantage of HITECH Act grants to promote the use of health information technology. For example, the West Virginia Health Information Network, a public-private partnership created in 2006 to study and create an interoperable and affordable system for the state, is well-positioned to help make West Virginia a leader in the health information technology field.

The future holds many unknowns for the health care industry; however, the assessment that health care reform will require the use of health information technology and electronic health records is a safe bet. This is sure to have a significant impact on the operations of industry stakeholders – hopefully, the impact will be a positive one. Take advantage of financial and other incentives to adopt these systems, if you are not already using them, lend your voice and be involved in the discussions that will create a new system that is developing as we speak. V

Notes
[1]Des Roches, Catherine M., et al., Electronic Health Records in Ambulatory Care – A National Survey of Physicians, N Engl J Med 2008 359:50-60.

The Importance of Advance Directives

Paul L. Hicks, Partner
Emily R. Lambright, Associate
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Paul Hicks is a partner in the Parkersburg office of Bowles Rice and a member of the firm's tax team. He focuses his practice in the areas of tax, estate planning and administration, asset protection planning, elder law and Medicaid planning, guardianship and conservatorship proceedings, with additional experience in general business, real estate and natural resources law. He is licensed to practice law in the states of West Virginia, Ohio and Kentucky.

Mr. Hicks is a member of the Board of Directors for the Good Samaritan Clinic and President of the Mid-Ohio Valley Estate Planning Council. He is a member of the National Academy of Elder Law Attorneys and the Professional Advisors Committee of the Parkersburg Area Community Foundation. He is an ordained priest and trustee of the Episcopal Diocese of West Virginia. He also is a retired surface warfare officer in the United States Navy, where he held the rank of Lieutenant Commander.

Mr. Hicks received his law degree from the West Virginia University College of Law and earned his bachelor of science degree in business administration, with an emphasis in accounting, from West Virginia University.

Emily Ralston Lambright is an associate in the Charleston office of Bowles Rice and also a member of the firm's tax team. A certified public account (CPA), she received her undergraduate degree in 1998 and a master's of business administration degree (MBA) the following year from West Virginia University. She later entered West Virginia University College of Law, where she was Order of the Barristers and a member of the national moot court team.

She is a member of the West Virginia Society of CPAs, the Charleston Estate Planning Council and the West Virginia State Bar.

As a result of the media attention paid to the Terri Schiavo case in Florida, there has been a renewed interest in advance directives. While sometimes known by different names, the term "advance directives" generally refers to documents in three categories: living wills, medical powers of attorney and financial powers of attorney. These days we often combine the living will and medical power of attorney into one document. The combined medical power of attorney/living will and financial power of attorney are important documents that allow you to better determine who will handle your affairs, should you become incapacitated.

These advance directives extend your individual autonomy. Further, without these written directives, you (and your family) may face prolonged, painful and invasive therapies that might not be what you really wanted, or you could be denied treatment that could have otherwise relieved your pain and provided you comfort. The following will describe how each type of advance directive can help you and your family plan for the future.

Advance Directives

Living Will

A living will is your written expression of how you want to be treated in certain medical conditions. Depending on state law, this document also may permit you to express whether you wish to be given life-sustaining treatments in the event you are terminally ill or injured. You have the ability to decide in advance whether you wish certain treatment, such as being provided food and water via intravenous devices ("tube feeding"), analgesia (pain relief) and the use of ventilators, and give other medical directions that impact the end of life, such as a do not resuscitate (DNR) order.

A living will applies in situations where the decision to use such treatments may prolong your life for a limited period (with no realistic medical hope of recovery) and not obtaining such treatment would result in death. Unlike the medical power of attorney, the living will does not name someone to make decisions on your behalf; it is a statement of your wishes in regard to end of life treatment. Not only is this important for the treating physician, but it also can be very helpful and comforting to your family when faced with an important decision about your continued care.

Medical Power of Attorney
A medical power of attorney (also sometimes known as a durable power of attorney for health care) allows you to designate someone you trust to make health care decisions on your behalf if you are unable to do so yourself.

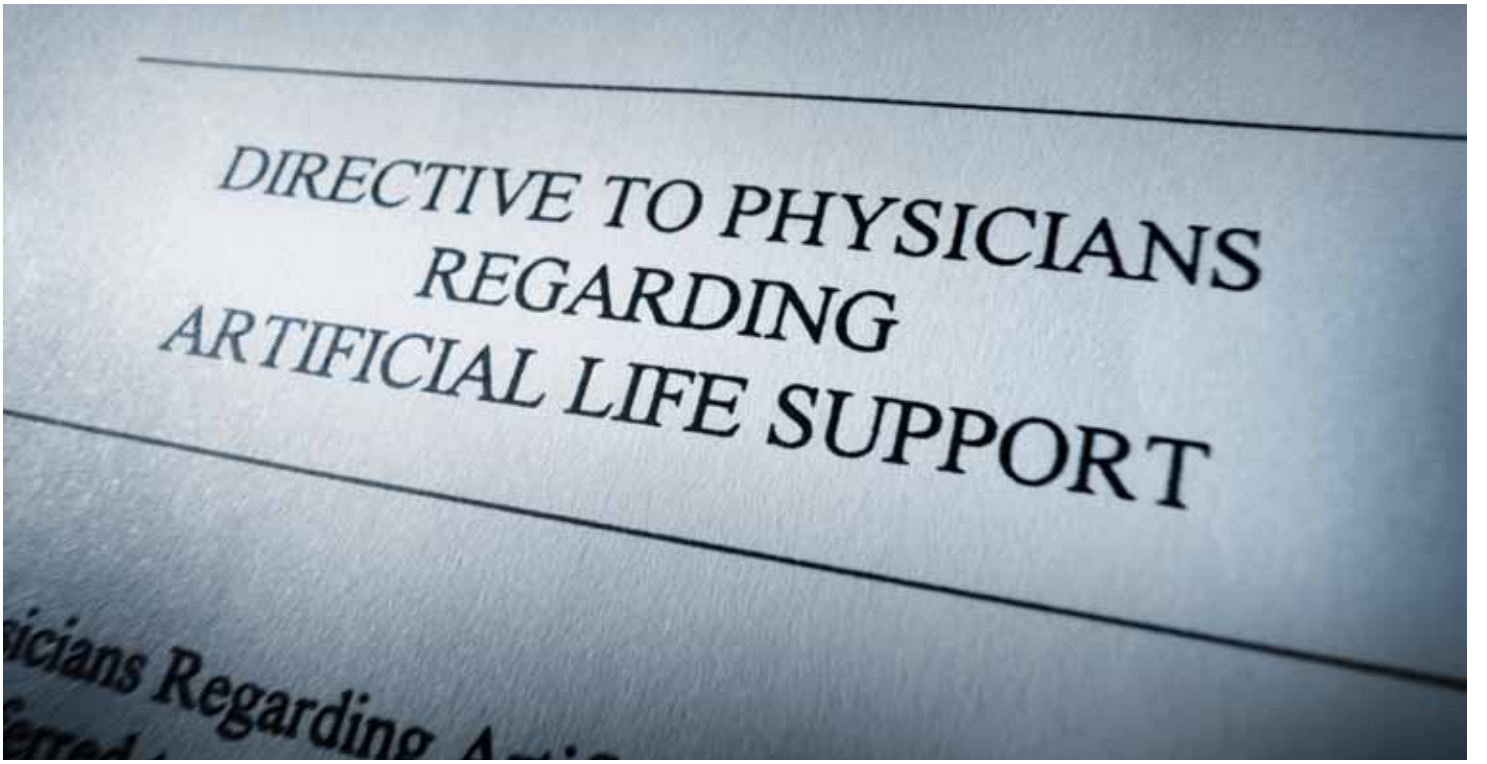
The individual named as your medical power of attorney helps your doctors determine if or when life-supporting measures should be stopped. If your wish is to not use life-sustaining measures, you should convey this to the person you have selected, so that they may be able to express and fulfill your wishes. The person named as your medical power of attorney only has responsibility for your health care decisions, and cannot make financial or other decisions on your behalf.

Durable Power of Attorney
A durable power of attorney allows the designee to act on a person's behalf who is somehow incapacitated (such as suffering from dementia or senility) and who is no longer competent to make their own decisions. These persons need to have someone they trust to make financial decisions on their behalf when they are unable and/or have lost the capacity to do so. A durable power of attorney appoints a trusted individual to make those decisions, and avoids the costly and sometimes painful experience of a guardianship process, sometimes referred to as "living probate." These financial powers of attorney should be very detailed and explicit because courts will construe them to be exclusive, not inclusive. In other words, if the power is not specifically listed, do not assume your designee has that power.

In conclusion, whenever we meet with estate planning clients, we make a point to discuss their advance directives. In our opinion, these documents are just as important, if not more important, than a will or trust. A will and a trust are important, of course, but they do not take effect until one's death. It is the advance directives that can come into play during one's lifetime and have the greatest effect.

For instance, without a medical power of attorney, the law will decide who makes medical decisions for you. This is increasingly important for individuals in non-traditional relationships or without close family. Without a financial power of attorney, your loved ones, including your spouse, cannot make decisions on your behalf without going to court and having you legally declared incompetent. This is a costly process, causing families significant emotional strain in guardian and conservator hearings.

Frequently, the first time many people are approached about needing advance directives is in a hospital emergency room, which is not the best time or place to make these important decisions. We urge you to plan ahead, and consult your legal advisor to discuss these important issues yourself.



Health Care Reform: To Be or Not to Be?

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Lesley Russo is a partner in the Charleston office of Bowles Rice and the leader of the benefits group. She is a member of the firm's retirement plan investment committee and also administers the firm's retirement plans.

Ms. Russo has extensive experience in the qualified retirement and employee benefits area, representing numerous clients in all aspects of qualified and non-qualified retirement plan design, implementation and administration.

She devotes a substantial part of her practice to advising clients on the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), the rules necessary to maintain the qualified status of retirement plans under Internal Revenue Code § 401 et. seq. and issues arising in the day-to-day administration of such plans. In addition to assistance in the qualified retirement plan area, she counsels clients in connection with the establishment and administration of non-qualified retirement plan arrangements and other executive compensation alternatives.

A *cum laude* graduate of Harvard Law School, Ms. Russo practiced law in Boston, Massachusetts, specializing in employee benefits and tax-exempt organizations, before joining Bowles Rice. She received her undergraduate degree in 1983 from the University of New Hampshire, where she graduated *summa cum laude* with a bachelor of arts degree.

Health care reform is a topic on everyone's mind and in the news daily. As this edition of *Views & Visions* goes to press, President Obama's goal of rehauling the American health care system remains far from certain. Questions continue to loom about the feasibility of health care reform, the scope of such reform, the types of changes needed, the consensus required to obtain legislative passage and the price tag and sources of revenue to pay for reform.

In an effort to move beyond the juggernaut that has stalled Congressional action, on October 13, 2009 the Senate Finance Committee approved an $829 billion health care reform bill (commonly referred to as the "Baucus Bill"). The Senate Finance vote was 14-9, with Sen. Olympia Snow (R-Me.) being the sole Republican to vote in favor.

Highlights from the Senate Finance Committee-approved Baucus Bill include the following:

- Subsidies for working families to buy health insurance (subject to income caps)
- Expansion of Medicaid
- Numerous Medicare changes, including changes to the prescription drug program
- Mandated coverage by insurers without regard to pre-existing conditions
- Additional workplace wellness regulations
- Creation of insurance cooperative to help consumers find insurance
- No federally created public health plan option
- No employer-mandated coverage provision
- Complicated employer "free rider" penalty provisions requiring certain employers to pay a penalty if qualifying employees claim the federal subsidy
- Automatic enrollment in large employer group health plans, subject to employee opt-out opportunity
- Required W-2 reporting to disclose value of employer-provided health insurance
- Changes to flexible spending account limits and cafeteria plan rules
- Changes to individual itemized deduction limits for high-income taxpayers
- Federally-imposed fees on certain industries, including health insurance issuers, pharmaceutical companies and medical device manufacturers

The Senate Finance Committee's action in no way means that health care reform is guaranteed. Before the full Senate votes on the Baucus Bill, Senate Majority Leader Harry Reid (D-Nev) will meet with both Senator Baucus, Chairman of the Senate Finance Committee, and Senator Christopher Dodd (D-Conn), Chairman of the Senate Health Committee, to work out differences between the Baucus Bill and another health care bill approved by the Senate Health Committee. Some key Senate Democrats are

pushing for the two bills to be reconciled before the end of October. If that happens and the Senate passes a health care reform bill, it would head to the U.S. House of Representatives, which has its own bill that differs significantly from the Baucus Bill.

A major difference in the House bill is its inclusion of a publicly-sponsored health care option. In addition, financing of the health bills differs. The House bill would finance its price tag in large part through anticipated future health cost savings in the Medicare and Medicaid systems, as well as a new "millionaire's tax" on high-income families. The Baucus Bill anticipates Medicare and Medicaid cost savings to account for almost half of its price tag, with the remainder to be financed in large part by a new excise tax on high-value health insurance plans, dubbed "Cadillac plans." The source of funding health care reform remains a hotly contested issue that continues to draw ire from various factions, some contesting increased tax provisions to fund health care reform and others questioning whether it is realistic to rely on future cost savings that may never materialize.

With the proponents and opponents of the Baucus Bill stepping forward to contest the merits of its provisions and the mechanisms for financing its costs, the future of health care reform remains uncertain and faces many hurdles in the days and months to come. Many Democrats insist that any health reform bill include a government-sponsored insurance option to compete with private insurers, while more conservative Democrats and most Republicans generally oppose such a provision, as well as imposing new taxes to finance its costs. Meanwhile, Senator Baucus, the lead sponsor of the Senate Finance-approved bill, remains optimistic, stating that health care reform will pass this year. Whether that will be the case remains an open question. V

Extraordinary.

It takes an extraordinary professional to be named among "The Best Lawyers in America," and each of these recognized attorneys help to make Bowles Rice an exemplary full-service law firm. In addition to the selection of these 41 distinguished attorneys from our offices in Charleston, Martinsburg, Morgantown and Parkersburg, West Virginia, and Lexington, Kentucky, Bowles Rice was ranked #1 nationally in Ethics and Professional Responsibility Law, as well as #1 in 52 different practice areas and/or locations.

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Gregory W. Bailey	Education Law
Robert L. Bays	Eminent Domain and Condemnation Law
Ricklin Brown	Labor & Employment Law
Michael E. Caryl	Corporate Law, Mergers & Acquisitions Law, Tax Law and Trusts & Estates Law
Julia A. Chincheck	Bankruptcy & Creditor-Debtor Rights Law
Mark B. D'Antoni	Corporate Law and Real Estate Law
David A. DeJarnett	Corporate Law and Trusts & Estates Law
Robert W. Dinsmore	Natural Resources Law and Real Estate Law
Richard M. Francis	Bankruptcy & Creditor-Debtor Rights Law and Government Relations Law
Andrew G. Fusco	Antitrust Law and Mergers & Acquisitions Law
F. Thomas Graff, Jr.	Administrative Law, Corporate Law, Energy Law, Mergers & Acquisitions Law, Natural Resources Law and Oil & Gas Law
Steven R. Hardman	Real Estate Law
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Michael B. Keller	Corporate Law
Robert S. Kiss	Tax Law and Trusts & Estates Law
Leonard B. Knee	Energy Law and Environmental Law
J. Thomas Lane	Energy Law, Mining Law, Natural Resources Law, Oil & Gas Law and Real Estate Law
Charles M. Love, III	Bet-the-Company Litigation, Commercial Litigation and Mass Tort Litigation
Ellen Maxwell-Hoffman	Ethics and Professional Responsibility Law
Stephen M. Mathias	Real Estate Law
Edward D. McDevitt	International Arbitration, Public Finance Law and Securities Law
Stuart A. McMillan	Media Law
Marc A. Monteleone	Construction Law, Corporate Law, Tax Law and Trusts & Estates Law
John S. Moore	Health Care Law
Sandra M. Murphy	Banking Law, Corporate Governance & Compliance Law and Corporate Law
George A. Patterson, III	Oil & Gas Law
P. Michael Pleska	Bankruptcy and Creditor-Debtor Rights Law
Phyllis M. Potterfield	Workers' Compensation Law
Charles F. Printz, Jr.	Bet-the-Company Litigation, Commercial Litigation and Labor & Employment Law
Lesley A. Russo	Employee Benefits Law, Non-Profit/ Charities Law and Tax Law
Howard E. Seufer, Jr.	Education Law
Camden P. Siegrist	Corporate Law and Public Finance Law
Melody A. Simpson	Employee Benefits Law and Non-Profit/ Charities Law
Sarah E. Smith	Workers' Compensation Law
Gerard R. Stowers	Bet-the-Company Litigation, Commercial Litigation, Legal Malpractice Law and Personal Injury Litigation
Elizabeth D. Walker	Labor and Employment Law
Kenneth E. Webb, Jr.	Construction Law
Timothy C. Wills	Construction Law, Labor & Employment Law and Professional Malpractice Law

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