Mental health pioneer

After 32 years at the helm of Seven Counties Services, Dr. Howard F. Brocco intends to retire, but not before he talks to Medical News about his experiences and the future state of mental healthcare in Kentucky.

By Ben Keaton

On August 1, 1978, Howard F. Brocco, Ph.D., CHIEF, assumed the leadership of a fledgling community mental health center with less than 300 employees, created out of the dust of a healthcare predecessor. The president and chief executive officer of Seven Counties Services, Inc., the community behavioral health and development services organization serving Kentucky's largest city - Louisville - and surrounding counties, Dr. Brocco holds the distinction of being Seven Counties' only president and CEO.

In his long tenure as a regional, state, and national leader in the field of behavioral healthcare, Dr. Brocco has been a champion for people who need, but cannot afford, behavioral health services. He has maintained an unwavering focus on creating access and high-quality services for all in need. Through both his leadership of Seven Counties and the private practice he maintains in clinical psychology, he effectively lives his motto of "improving the quality of life" for those he serves.

Dr. Brocco intends to retire from his position on April 30, 2011. Medical News recently sat down with Dr. Brocco, who shared his thoughts on the behavioral health system in Kentucky and reflected on his tenure.

MN: What did Seven Counties Services look like when it first emerged?
HB: It provided mostly outpatient mental health services and operated a state hospital. It had a budget of about $6 million dollars with 300 employees. Seven Counties today has a 95 million dollar budget with 1,400 employees.

MN: What was the perception of mental health then?
HB: Mental healthcare was mostly delivered through state hospitals. Independent practices and psychiatry were pretty limited. Mental healthcare was not very visible.

MN: What is significant is that we didn't identify behavioral healthcare as a part of healthcare.

MN: Behavioral healthcare was considered separate from physical healthcare?
HB: Right. One of the things that are coming to fruition is the integration of behavioral health into physical healthcare.

Special Section: Healthcare Innovation

An innovative and pioneering new program called "Pate of Saippu" aims to reduce high school dropouts with an operating theater at Louisa's White Oak Hospital in Louisa, via broadband internet link.

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Serving Kentucky and Southern Indiana
Avoiding delays
Tips for prescribing in the long-term care setting.

By Molly Nicol Lewis and Lisa English Hinkle

For a physician, treating a patient in a nursing home can be very different from treating a patient in a hospital. Because long-term-care facilities typically do not have their own pharmacy, are not eligible to become DEA registrants, and do not employ full-time physicians, providing medications in a timely manner to residents is not always easy. Even though state and federal regulations require quality and timeliness of medical and pharmaceutical care, obtaining the necessary authorization to satisfy DEA requirements for prescribing and dispensing drugs to nursing facility residents can cause lengthy delays. As a result of these delays, 93 percent of medical directors surveyed by the American Medical Directors Association ("AMDA") reported patients suffering uncontrolled pain due to the delays, 50 percent reported these delays as a daily occurrence, and 25 percent reported that their facility had to send patients to the hospital to obtain controlled substance medications because they could not obtain the necessary pain medication at the long-term-care facility in a timely manner. With this in mind, it is important that physicians know what is required to avoid these delays for their patients in nursing homes.

Traditionally, prescribing in the long-term-care setting involved a three-way communication—a nurse assessed a change in a resident’s condition, the nurse contacted the physician to describe the resident’s symptoms, the physician made a treatment decision that the nurse recorded in the resident’s clinical record, and the nurse implemented the orders by contacting the pharmacist on the physician’s behalf. Even though the physician remained responsible for patient care, the nursing facility nurse acted as the agent of the prescribing physician. In 2001, despite prior statements to the contrary, the DEA released a public statement announcing that its interpretation of the Controlled Substances Act did not recognize an agency relationship between a prescribing physi-

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cian and long-term-care nurse. Years later, in 2009, the DEA initiated vigorous enforcement actions assessing large fines against several long-term-care pharmacies in Ohio and North Carolina based on this 2001 interpretation. DEA audits have also been conducted in long-term-care pharmacies in Virginia and Wisconsin. Though the DEA stated that pharmacies, not long-term-care facilities, have been its target, the American Health Care Association reports that the DEA's enforcement actions have impacted long-term-care resident's access to pain medications.

**Tip Sheet**

In response to the DEA's aggressive enforcement action, the American Medical Association, AMDA, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, and the American Geriatrics Society have worked together to lobby Congress and the DEA to allow nursing facility nurses to act as agents of prescribing physicians. This coalition has also developed a "Tip Sheet" to help physicians, nursing homes and pharmacists comply with existing laws. The coalition recommends that physicians always carry a prescription pad, write prescriptions at the nursing facility and immediately fax the prescription to the pharmacy, and purchase a home fax machine for after-hour and weekend calls. The DEA also counsels that as long as the pharmacist contacts the physician after speaking with the nursing facility nurse, all requirements will be satisfied.

While the DEA allows physicians to call in prescriptions for Schedule III-V controlled substances to the pharmacy, Schedule II drugs may only be dispensed pursuant to an original, written prescription signed by a physician. In the nursing facility setting, a physician or his agent may fax (as opposed to hand-deliver) a prescription written and signed by the physician for the resident to a pharmacy. This exception for nursing facilities allows a nurse to call the physician to relay information about the resident's condition, and then the physician can fax a prescription directly to the pharmacy from his remote location. Under these circumstances, the fax serves as the original prescription. Kentucky, however, requires that the faxed Schedule II prescription be followed by an original written prescription to the pharmacy within seven calendar days.

In emergency situations, the DEA allows physicians to call in prescriptions to the pharmacy when followed by a written prescription within seven days. Under the pharmacy's DEA registration, a nursing facility may keep a secured "emergency kit" stocked with commonly dispensed controlled substances on-site. The DEA allows drugs from the kit to be dispensed by authorized nursing facility personnel when a physician is off-site so long as a physician first calls in or faxes an emergency prescription to the pharmacy. These exceptions to the general rule requiring written prescriptions permit residents to receive immediate pharmaceutical treatment.

**New Regulations Make e-prescribing More Effective**

The DEA has announced that its new regulations allowing e-prescribing will make physician prescribing of controlled substances to long term care residents more effective. On June 1, 2010, the DEA's Interim Final Rule became final and established a voluntary application process for practitioners to obtain the authority to issue electronic prescriptions. The rule allows credentialed practitioners to use a computer, laptop or PDA device to send a prescription to a pharmacy from a remote location instantaneously. The DEA's new process is extremely complicated and requires an applicant provider (pharmacy or other institution) to present evidence that its system is compliant with the DEA's requirements and requires physician prescribers to obtain complex authentication credentials. Since nursing facilities are not DEA-registered institutions and the DEA-registered physician is often off-site, several pharmacist associations have requested that the DEA clarify how e-prescribing will be implemented in the nursing facility setting. Whether e-prescribing will enhance a physician's ability to treat nursing facility patients is yet to be determined.

Providing timely care is important if nursing facility patients are to receive high quality and compassionate medical care. Physicians must be aware of the DEA's special requirements for prescribing controlled substances to nursing home residents and adapt their practices so unnecessary delays in delivering medical treatment can be avoided.

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