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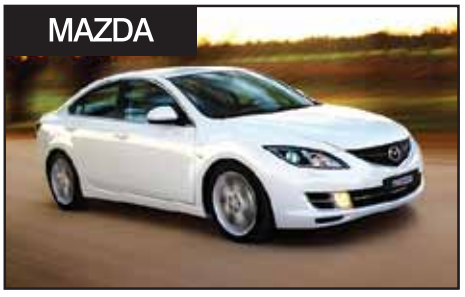

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> Remember there's no such thing as a small **act of kindness**. Every act creates a ripple with no logical end.
>
> — SCOTT ADAMS

IF YOU'RE A TRULY KIND PERSON, no need to read this column. This is a practice for the rest of us.

It was a day like any other normal day. I ventured out among my species. But, this time was a little harsher. People seemed angrier at every turn. We all know that feeling. Leaving your home cheerfully only to be met by an invisible venom at stores, offices, and on the roads. You want to look at yourself in the mirror and ask, "What do I look like to cause so much meanness?" But, you know, people just choose to be angry. I admit I've regrettably done it myself. I found this lack of kindness phenomenon to be fascinating considering we have so many better options. Knowing kindness is not directly associated with circumstances, but rather a conscious intellectual decision, I had to know, why do we choose not to be kind?

So I did a survey asking people about kindness. I asked, "Do you like it when people are kind to you?" The answer is 100% of people like it when others are kind to them with a 0% margin of error. Seriously, everybody likes when others are kind to them. So, I had to ask, "Are you always kind to others?" Now the answers vary widely. You can only imagine the excuses for not being kind. I then asked, "What do you think you will lose or give up by being kind to others?" The answer, through careful consideration, is nothing. In fact, almost every aspect of your life will improve by being kind. I know. I've been giving it a shot lately. It's awesome.

This is the great part. It's easy to do. It just takes practice. I'm not talking about the fake stuff. This is a method that I've found to be effective in pursuit of kindness. This practice really works!

Start with just five seconds. Look at a person, any person, and decide you will be kind to this person in thought, attitude, and words for five full seconds. Before you start you may have to roll your head like a boxer psyching himself up. Then go—five full seconds of kindness. Then practice again. Then practice again. Then practice again. Before you know it, you can be kind to another person for 15 seconds. Then, with more practice you will be able to be kind to a person for an hour. After a few weeks or months of practice, you may be able to truly be kind for almost an entire day. Once you reach mastery, you will then be a kind person. This practice will work for any characteristic you may like to have.

This is the beauty of it. Kindness is just a decision. Anybody can do it. We can all reap its joy. All we have to do is just decide to do it.

Smith W. Hartley
Chief Editor

P.S. I am so interested in understanding why one chooses anger over kindness, that I will give $100 to whoever can best explain why anger is more beneficial to our society than kindness. Please, send me that email, so at least I'll know.

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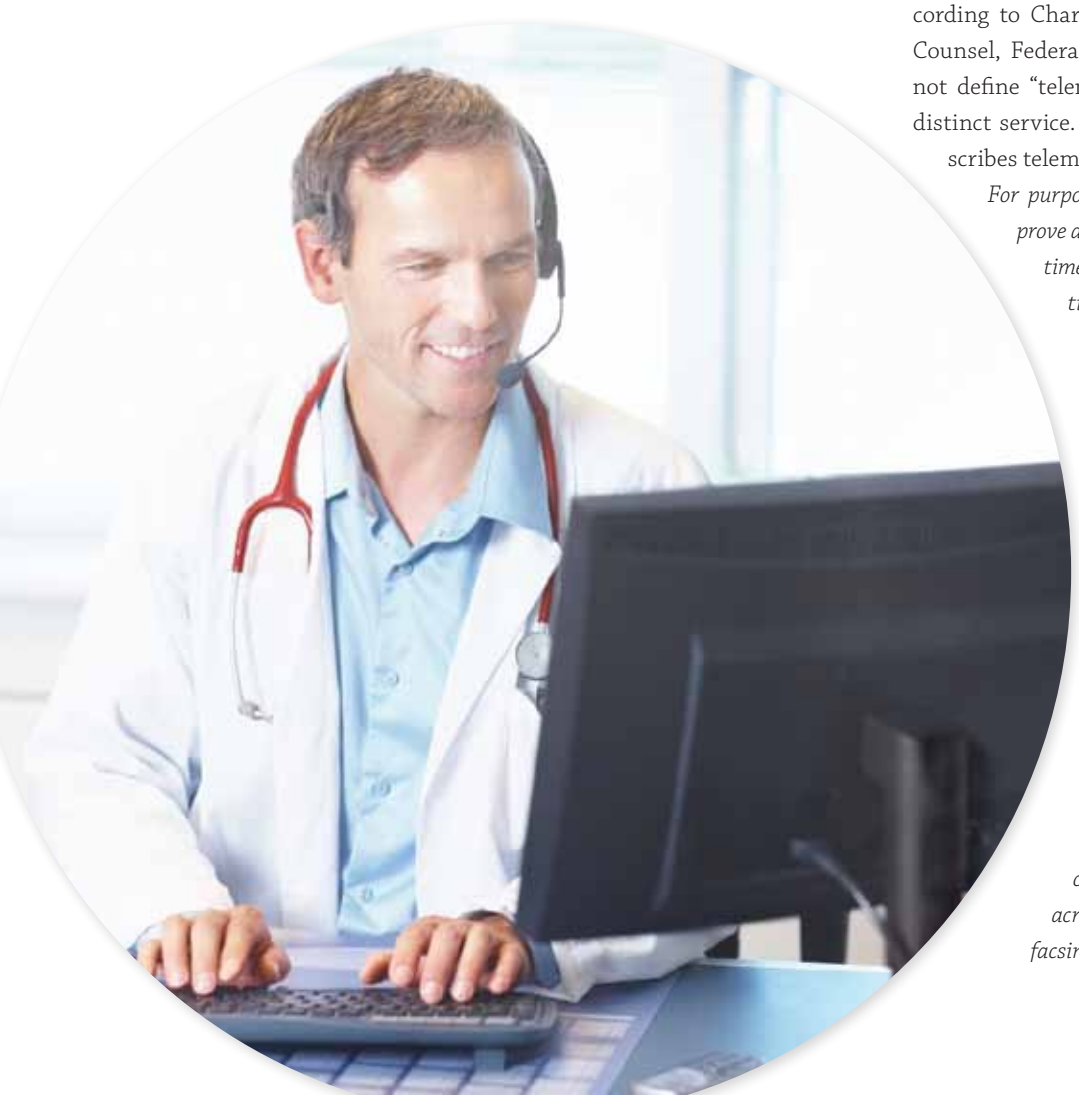
TUNING IN TO TeleHealth

Louisiana Explores Options to Expand Access, Reduce Costs

Video consultations, e-prescribing, home monitoring of vital signs, 24/7 access to providers. There is no doubt–the future is now. Increased costs, decreasing providers, scarce specialists, and other access issues have, by necessity, exploded the use of technology in the diagnosis and delivery of healthcare across the country. Now, the Louisiana Department of Health and Hospitals (DHH), under the direction of House Concurrent Resolution 96 (Simon), is discussing the merits and challenges of advancing high quality, low cost telehealth technology solutions for Louisiana. The goal is to seek and share creative innovations, challenges, and opportunities regarding telehealth technology in Louisiana from knowledgeable stakeholders and interested parties. >>

DHH's Director of the Center for Health Care Innovation and Technology, Carol H. Steckel, anticipates that the telehealth market will grow due to increased interest in technology as a tool to address increased demand for healthcare services at affordable costs. "Telehealth enables us to maximize those resources, particularly specialty care services, so people don't have to travel long distances for healthcare services and so we can better provide the full range of healthcare services for individuals in our rural communities and in our inner city communities," said Steckel. An initial stakeholder meeting and a separate telehealth vendor exhibition hosted by the department this summer revealed that not only is there a great deal of telemedicine already occurring in the state, but that there is enormous interest in exploring and expanding on this modern approach to medicine. Attendees included representatives from health insurance companies, hospitals, home health, and other providers. Vendors included national technology companies as well as existing Louisiana-based telehealth businesses.



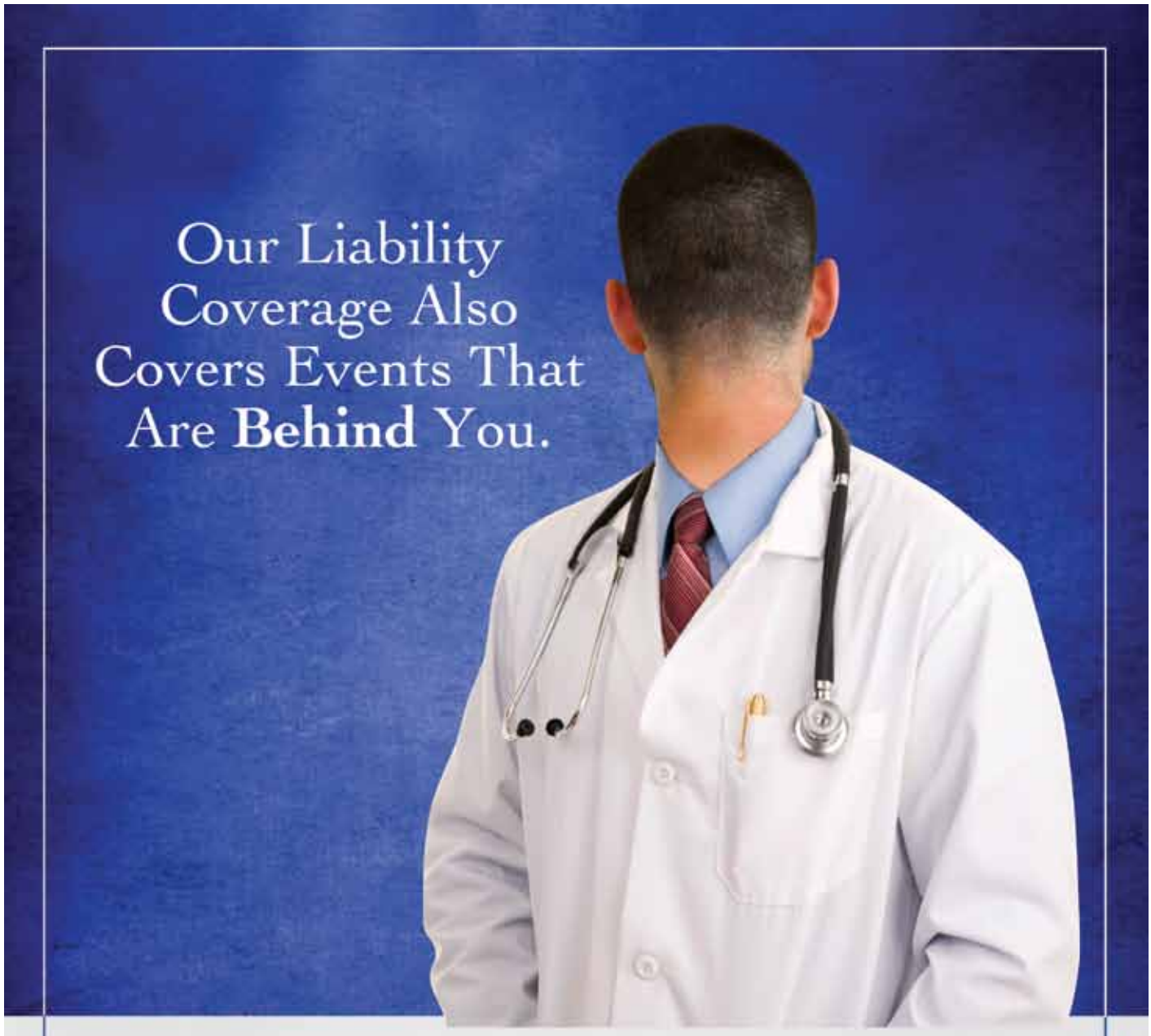
But before we go any further, let's clear up a vocabulary issue. While many people use "telemedicine" and "telehealth" interchangeably, for others there is a distinction, particularly when it comes to reimbursement. For those that make a distinction, telemedicine generally means a face to face encounter between provider and patient via a two-way audio-visual connection for the purpose of evaluation, diagnosis, and treatment. Telehealth, on the other hand, tends to include a broader array of technologies, including phone calls and emails between provider and patient, electronic monitoring of patient vital signs, blood sugar, etc., education via audio and/or visual means, and much more. Telehealth is generally considered to include activities that cover prevention and wellness, rather than just treatment of an illness or injury.

DHH has opted to use the broader, umbrella term of telehealth so as not to eliminate any potential opportunities for using technology to improve the health of Louisiana's citizens. However, there may be some legal ramifications to not only what term is used, but what technology. According to Charles Daspit, Esq., DHH Deputy General Counsel, Federal Medicaid statutes and regulations do not define "telemedicine" and do not recognize it as a distinct service. However, the Medicaid.gov website describes telemedicine this way:

For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

This description of "telemedicine" excludes services rendered via telephone or email. However, the website goes on to define and describe the related term "telehealth" as follows:

Telehealth (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth includes telephones, facsimile machines, electronic mail systems, and



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remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services.

In 2005, DHH promulgated a general Medicaid rule defining "telemedicine" as "the use of an interactive audio and video telecommunications system to permit real time communication between a distant site healthcare practitioner and the recipient." The definition's requirement of an interactive audio and video telecommunications system to permit real time communication would exclude services rendered via telephone or email.

The statutes and rules governing the licensing of physicians in Louisiana define "telemedicine" as "the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data by a physician using interactive telecommunication technology that enables a physician and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously." The rules specifically exclude the use of telephones from the definition of telemedicine.

These distinctions become important when seeking reimbursement for services and it is possible that some statutory changes may be necessary as the state explores the expansion of "telehealth." Some states have already broadened their definitions of what is covered under telemedicine or telehealth. Likewise, some payers, recognizing the potential cost-savings, network expansion, and patient wellness that can be achieved through telehealth, have broadened the range of services for which they are willing to pay. It is this type of issue that will be studied by four stakeholder workgroups assembled to discuss telehealth in Louisiana.

The **Legal, Regulatory and Governance Workgroup** is charged with exploring the pros/cons of creating a statewide public-private partnership to govern a telehealth system similar to a plan implemented in the state of Georgia (more on this later). In addition, this group will review the rules, regulations, and laws regarding telehealth and provide recommendations for changes.

A **Coverage/Policy/Services Workgroup** will develop recommendations regarding the types of services, providers, and policies required for an appropriate and high quality telehealth plan.

The **Reimbursement/Financial Opportunities Workgroup** will review reimbursement issues related to telehealth in the private and public sector. Any recommendations to DHH programs are required to be budget neutral.

Finally, the **Report/Cost Comparison Workgroup** is charged with drafting reports based on the recommendations of the first three groups. This workgroup will also be responsible for developing cost comparisons for the private and public sector. DHH is required by HCR 96 to submit a report to the Legislative health and welfare committees by the end of the year.

Steckel emphasized that DHH is not looking for a governance role in telehealth, but rather is trying to facilitate a public/private partnership like the Georgia Partnership

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for Telehealth (GPT). "GPT is a charitable, not-for-profit corporation, much like our Louisiana Health Care Quality Forum, but they are more finitely focused on telehealth and the development of telehealth services," said Steckel. "I think the reason why people have been attracted to that is you have fewer governance issues, because everybody gets to be part of the governance model, versus being a government function. The process for developing and contracting services is a little bit easier."

Carol H. Steckel

Georgia's program, which DHH hopes to emulate, initially began as an attempt to provide services for special needs children in rural areas, and was funded by a pair of federal grants. Expanding on that idea, GPT began as part of the Georgia State Insurance Office in 2005 and in 2008 became a private nonprofit foundation. GPT operates a web-based system that not only allows doctors and nurses to schedule and conduct visits, but also to share medical records and data electronically. It also provides marketing, education, and training on telehealth. As of last year, GPT encompassed 350 partners and 175 specialists and other healthcare providers and had handled approximately 40,000 patient encounters. The network includes school clinics and nursing homes, not only boosting access, but avoiding costly and potentially dangerous travel for fragile patients. Helping all of this succeed is the fact that the state of Georgia has mandated that payers cover telemedicine visits—another issue that must be addressed by the Louisiana workgroups.

"I can quantify a visit to a cardiologist," said Steckel. "There's usually an EKG, a series of things done, but how do we want to handle a patient calling her doctor and describing her symptoms and, based on those symptoms and medical history, having a prescription called in by the physician? Do we want to pay for that as a telehealth visit?"

Steckel hopes that payers in Louisiana will recognize the potential benefits and cost savings of telehealth. "This is just a different way of doing business and if we can show that it does reduce the cost or avoid a horrific outcome because someone does get in to see a specialist earlier, even if it's in a different way, then our Bayou Health providers, Magellan, Blue Cross & Blue Shield, and all of the private insurance companies will be able to benefit from the information we are gathering in this report." One of the concerns Steckel does have, as a former Medicaid commissioner, is finding a way to properly quantify telehealth services to (a) allow for appropriate reimbursement, and (b) prevent fraud in both federal programs and private insurance.

"I can quantify a visit to a cardiologist," said Steckel. "There's usually an EKG, a series of things done, but how do we want to handle a patient calling her doctor and describing her symptoms and, based on those symptoms and medical history, having a prescription called in by the physician? Do we want to pay for that as a telehealth visit?"

As for other funding sources to offset the cost of the hardware required for telehealth, Steckel said the department is always on the lookout for grants and opportunities to use resources to expand the program. They have already secured a grant to expand broadband communication through the FCC's Rural Health Care Pilot Program. That's a statewide program that will facilitate the creation of a nationwide broadband network. "In Louisiana we are working with providers in getting them connected to this broadband capacity to be able to do telemedicine," said Steckel.

The proposed breadth of a state telehealth network must also be discussed. In other states, for example, telehealth is providing better access and cost savings through integration of school clinics, nursing homes, psychiatric facilities, and even prisons. Angola Prison here in Louisiana is already conducting a significant number of telehealth/telemedicine visits, said Steckel. It makes sense. It can be quite an undertaking to get a maximum security prisoner into town to see a doctor. First you must find providers willing to treat prisoners, then there's the cost of specialized transportation, guards, etc. Now the hospital at Angola can link directly to a cardiologist or other specialist in New Orleans, for example. Similarly, transporting a rural nursing home resident to a major city to see a specialist generally requires an ambulance and can have a profound impact on his or her health. A robust telemedicine network could avoid both the stress to the patient and the additional cost.

But is telehealth really a substitute for in-person encounters or office visits? A recent study out of England purports to show how telemonitoring significantly reduced mortality rates (45%) and ER admissions (20%) among adults with chronic illness.[1] However, a much smaller study in the U.S. reported contradictory results, actually suggesting increased mortality for patients who were remotely monitored[2]. While the two studies cannot be compared back to back, they highlight the fact that we don't yet know with certainty if telehealth is effective.

Also at issue is the public's receptiveness to remote medicine, which DHH is currently researching in order to inform the workgroup. "I think it's a mixed bag," said Steckel. "Generally younger people tend to be more receptive and those of us who are a little older tend to be less receptive." It makes sense that if access is an issue due to transportation or distance, patients and their families might be grateful for an alternative. However, they might not have as much confidence in a long-distance diagnosis. It is important to note that in most telemedicine encounters there is also a healthcare professional on the patient end of the conversation who can perform a physical examination, describe or clarify symptoms, and answer questions to assist both the patient and the remote provider.

Angola Prison here in Louisiana is already conducting a significant number of telehealth/telemedicine visits, said Steckel. It makes sense. It can be quite an undertaking to get a maximum security prisoner into town to see a doctor.

As the cost of healthcare continues to be a primary focus for all stakeholders, DHH regards telehealth as one of the opportunities we have to provide healthcare better, faster, cheaper, but still maintain quality. "One of the things that we've been clear about, is that this is not just about Medicaid, it's not just about the Office of Public Health, but the system as a whole," said Steckel. "How do we look at telehealth the same way we looked at other services that we now consider routine? It has to be everybody looking at their piece of the puzzle. It can't be just the government."

[1]"Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial," *British Medical Journal*, *BMJ*; 2012; 344: e3874. Published online 2012 June 21, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381047/

[2]Paul Y. Takahashi, MD, MPH; Jennifer L. Pecina, MD; Benjavan Upatising, MSIE, PhD; Rajeev Chaudhry, MBBS, MPH; Nilay D. Shah, PhD; Holly Van Houten, BA; Steve Cha, MS; Ivana Croghan, PhD; James M. Naessens, ScD; Gregory J. Hanson, MD, "A Randomized Controlled Trial of Telemonitoring in Older Adults With Multiple Health Issues to Prevent Hospitalizations and Emergency Department Visits," *Archives of Internal Medicine, Arch Intern Med.* May 28, 2012;172(10):773-779, http://archinte.jamanetwork.com/article.aspx?articleid=1149633

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Obesity Remains a Big Problem

The most recent national data on obesity prevalence among U.S. adults, adolescents, and children show that more than one-third of adults and almost 17% of children and adolescents were obese in 2009–2010.

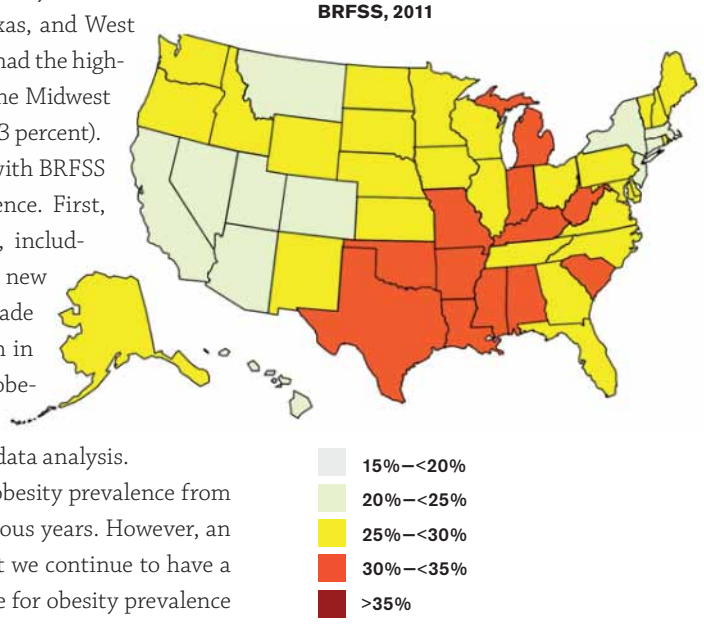
Differences in prevalence between men and women diminished between 1999–2000 and 2009–2010, with the prevalence of obesity among men reaching the same level as that among women. In light of this report from the Centers for Disease Control, the Healthy People 2010 goals of 15% obesity among adults and 5% obesity among children seem almost ridiculously far-fetched.

Although Louisiana did not claim the dubious honor of most obese state in the nation, the bayou region is definitely helping tip the scales in the wrong direction. In fact, more than thirty-three percent of Louisiana adults are reportedly obese. According to the most recent Behavioral Risk Factor Surveillance System (BRFSS) data, in 2011 state estimates ranged from 20.7 percent in Colorado to 34.9 percent in Mississippi. No state had a prevalence of adult obesity less than 20 percent, and 12 states (Alabama, Arkansas, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, South Carolina, Texas, and West Virginia) had a prevalence of 30 percent or more. The South had the highest prevalence of adult obesity (29.5 percent), followed by the Midwest (29 percent), the Northeast (25.3 percent) and the West (24.3 percent).

It must be noted that in 2011, several updates occurred with BRFSS that impact estimates of state-level adult obesity prevalence. First, there was an overall change in the BRFSS methodology, including the incorporation of cell-phone only households, and a new weighting process. These changes in methodology were made to ensure that the sample better represents the population in each state. Second, to generate more accurate estimates of obesity prevalence, small changes were made to the criteria used to determine which respondents are included in the data analysis.

Because of these changes in methodology, estimates of obesity prevalence from 2011 forward cannot be compared to estimates from previous years. However, an apples to apples comparison is hardly necessary to see that we continue to have a problem. Data collected in 2011 will provide a new baseline for obesity prevalence data collected in subsequent years. Hopefully those subsequent years will also bring some diminishing waistlines.

PREVALENCE OF SELF-REPORTED OBESITY AMONG U.S. ADULTS BRFSS, 2011



SOURCES: Centers for Disease Control, http://www.cdc.gov/media/releases/2012/a0810_2011_obesity_map.html; Ogden CL, Carroll MD, Kit BK, Flegal KM., Prevalence of obesity in the United States, 2009–2010. NCHS data brief, no 82., Hyattsville, MD: National Center for Health Statistics. 2012.

Freestanding facility opens in Livingston Parish

Closer to Home

Our Lady of the Lake Livingston, the state's first freestanding Emergency Room, opened in Walker this fall. The 170,000 square foot facility was built to address a perceived need for emergency services in the Livingston area and a coinciding need to relieve pressure on Our Lady of the Lake Regional Medical Center's main ER in Baton Rouge. According to OLOLRMC CEO Scott Wester, about ten percent of patients visiting the ER in Baton Rouge were traveling from the Livingston area and the facility on Essen Lane was operating at or close to capacity on any given day. >>

ABOVE Our Lady of the Lake Livingston, the state's first freestanding Emergency Room, opened for patients on September 12, 2012. **LEFT** A groundbreaking for OLOL Livingston was held January 31, 2011.

ABOVE Sisters of the Franciscan Missionaries of Our Lady join new OLOL Livingston team members for a tour as construction nears completion. **RIGHT** Scott Wester, Chief Executive Officer, Our Lady of the Lake, signs the final steel beam before it is installed at OLOL Livingston.

"Livingston was an obvious choice due to two major reasons," said Wester. "First, being one of the fastest growing communities in the state of Louisiana, but really without the level of infrastructure of healthcare needed, provided the right ingredients for the new facility to be successful in that parish." Perhaps more important, said Wester, "The residents of Livingston Parish have always looked at Lake as their access for care, whether it was for the emergency room on Essen Lane, inpatient care, or treatment at one of the multiple primary care facilities that see patients in Livingston."

That lack of medical infrastructure is also what prompted OLOL to opt for building a freestanding ER rather than an inpatient hospital in the area. "When you have a community such as Livingston that really doesn't have a robust medical infrastructure, the thing that parish lacks is specialty-based doctors such as orthopedic surgeons, cardiologists, urologists, ENT doctors, etc.," said Wester. "A hospital, to be successful, needs to have those types of physicians to be able to deliver that care in a hospital setting. Knowing that's such a void we landed on the freestanding emergency room." Wester pointed out that the facility also has

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WCA WOUND CARE ASSOCIATES

Dr. Shaun Carpenter, President and CEO of WCA, is a board-certified emergency physician and Fellow of the American Professional Wound Care Association. He is a graduate of Tulane University Medical School and completed his emergency medicine residency at Charity Hospital's trauma center in New Orleans.

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90,000 square feet of dedicated space for physician offices. "Over time, as we populate that office space, maybe at some point we'll be able to add inpatient capacity," suggested Wester. "But I don't see that happening for quite some time."

OLOL also explored the option of creating a full-service urgent care facility in the area, but was committed to providing 24/7 access for urgent and emergent conditions as well as the same medical personnel and diagnostic equipment available at the main campus ER. An urgent care facility would still have required trauma patients or others with serious or emergent situations to travel to a full-service ER in Baton Rouge or Hammond.

Wester dismissed the notion that building the ER was a strategic move to capture business from emergency rooms that might be closer for some Livingston residents, such as North Oaks or Ochsner. "We really didn't think about the competitive landscape or whether people access here or there for ER services. We just knew what our numbers were and our initial pro forma that we had developed was really about shifting that 10 percent volume from the main campus over to Livingston," he said.

OLOL Livingston is open 24 hours a day and staffed by emergency physicians and nurses. If a patient must be admitted to a hospital, OLOL has contracted with Acadian Ambulance to ensure an ambulance is on campus to immediately transport them. Air ambulance services are also available for trauma patients. While approximately 25 percent of patients presenting at the ER of OLOL's main facility are admitted, Wester anticipates that only about eight to ten percent of OLOL Livingston patients will require transport and subsequent admission to the hospital.

In addition to emergency services, Our Lady of the Lake Livingston's campus includes outpatient services including a lab; imaging services such as CT, ultrasound, X-ray and MRI; and a community pharmacy. A Community Health Education conference room provides space for health screenings, seminars, and other healthcare education events.

Wester described the freestanding ER as an emerging model particularly well-suited for fast growing, highly populated areas lacking sufficient medical infrastructure for a community hospital. According to the American Hospital Association, freestanding emergency rooms are located in only 16 other states, with about 250 across the country. When asked if OLOL had plans to recreate this model elsewhere, Wester answered, "If the right ingredients were there, absolutely. Early indicators are that this has been really well received. But it has to be that right fit."

"...being one of the fastest growing communities in the state of Louisiana, but really without the level of infrastructure of healthcare needed, provided the right ingredients for the new facility to be successful in that parish."

—SCOTT WESTER

All for One and

Unprecedented collaboration

Collaboration has fast become the latest buzzword in healthcare. Offered as one solution to rising costs and weighty reform, it is a path many healthcare facilities are increasingly exploring. In that spirit, eight major Louisiana institutions recently announced they would be collaborating on a new biomedical research initiative in our state. Funded by a first of its kind, $20 million, five year, National Institutes of Health (NIH) grant, the Louisiana Clinical Translational Science Center (LA CaTS) is anticipated to significantly support not only the conduct of biomedical research in our state, but also expand the number of researchers and expedite the path of research from bench to bedside. The LA CaTS Center will provide an infrastructure across the academic institutions of Louisiana to facilitate research in chronic disease prevention and improved healthcare in underserved populations. The new grant is one of the largest multi-institutional awards for health research in the state of Louisiana.

"This is a 'game changer' for Louisiana as it has created a new working network of medical research partners while putting best practices in medicine and preventive care into action."

William Cefalu, MD, Pennington Biomedical's Associate Executive Director for Clinical Research and principal investigator, LA CaTS Center.

One for All will boost biomedical research

BY PHILIP GATTO

The LA CaTS Center will be comprised of four primary collaborating institutions:

- Pennington Biomedical Research Center
- LSU Health Sciences Center New Orleans
- Tulane Health Sciences Center
- The seven public hospitals of the LSU Health Care Services Division.

Also participating are four research partners:

- LSU Health Sciences Center Shreveport
- Xavier University of Louisiana
- The Research Institute for Children at Children's Hospital
- LSU in Baton Rouge.

"Very few of the centers such as this in the country involve so many institutions," said William Cefalu, MD, Pennington Biomedical's Associate Executive Director for Clinical Research and principal investigator for the LA CaTS Center. "We essentially have three medical schools, a health care organization, a minority institution, a research center, an undergraduate campus, and a children's hospital involved. The fact that we have institutions with such diverse interests allows us to provide a very comprehensive infrastructure." It was this diversity coupled with the unique health challenges in Louisiana that played a major role in NIH's decision to award the grant.

The NIH Institutional Development Award Program for Clinical and Translational Research (IDeA-CTR) grant will provide clinical researchers and medical personnel in Louisiana greater access to the critical resources required to accelerate research aimed at reducing the burden of chronic diseases. The research infrastructure will facilitate collaborative goals, expand clinical trials among the academic institutions, and importantly, leverage vital resources contributed by each institution toward achieving the overall goal of the LA CaTS Center. "Each key component of the center is designed to provide specific support in designated areas so as to enhance overall research productivity and effectiveness," said Cefalu."This is a 'game changer' for Louisiana as it has created a new working network of medical research partners while putting best practices in medicine and preventive care into action."

Research facilitated by LA CaTS will focus on nutrition and chronic disease, health disparities, and expanded clinical trials, all ultimately designed to improve healthcare. The participating institutions will share clinical research facilities and support all aspects of the grant goals to:

- Promote the development of scientists, clinicians, and trained professional staff and leaders for continuation and growth of Louisiana's clinical and translational research base;
- Unify infrastructure consisting of clinical research units in Baton Rouge, New Orleans, and LSU Health Care Services Division clinical sites throughout the state;
- Facilitate health outcomes research and clinical research recruitment using the electronic health record system of the LSU hospitals and clinics;
- Provide training in community-based, participatory research and related topics;

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• Support collaborations among researchers in Louisiana who have been awarded NIH funding through Centers of Biomedical Research Excellence (COBRE) and IDeA Network of Biomedical Research Excellence (INBRE) programs.

"These programs are designed to use complementary research and clinical strengths in the Gulf Coast region to build a vital, growing enterprise with the ability and commitment to solve the region's unique health problems. The project will further our strategy to align the research pipeline coming from the academic centers of our state with our clinical and business priorities to improve health outcomes for the benefit of Louisiana's citizens," said Cefalu.

NIH's IDeA-CTR program encourages consortium applications to develop regional infrastructure and capacity to conduct clinical and translational research on diseases that affect medically underserved populations and/or diseases prevalent in IDeA states. It is a new program and LA CaTS is the first to receive one of these grants. LA CaTS will also be working in partnership with the state of South Carolina, through the Clinical Translational Science Award (CTSA) program based at Medical University of South Carolina in Charleston.

"What makes this application strong is the way so many of these institutions across the state are partnering and using a lot of the infrastructure that we put in place with the COBRE program and with the INBRE program," said Dr. Fred Taylor, program director for the Division of Training, Workforce Development, and Diversity in NIH's National Institute of General Medical Sciences (NIGMS). Taylor oversees the Institutional Development Award (IDeA) program. Also important, noted Taylor, is that they are proposing to really address the kinds of issues that are important in the Gulf state region. "The Louisiana Clinical and Translational Science Center Institutional Development Award will provide the environment for basic and clinical researchers to work collaboratively in addressing the health problems and needs of the Gulf Coast region," said Sidney A. McNairy, Jr., PhD, DSc, another IDeA program official. "This is particularly important because the region has a disproportionately high incidence of cardiovascular and other diseases, including some forms of cancer, especially in underserved and minority populations."

Louisiana ranks among the highest nationally in deaths from chronic diseases, with lifestyle as a major contributing factor. For example, Louisiana has the fourth highest age-adjusted mortality for cardiovascular disease and cancer rates are above the national average. More than half of Louisiana youth are overweight or obese and four out of 10 residents meet the national criteria for medically underserved. LA CaTS research will focus on nutrition, chronic diseases, health disparities, and preventive approaches to improving public health in Louisiana.

Why Louisiana?

- Louisiana routinely ranks in the most extreme decile for mortality from chronic disease, with lifestyle as a major contributing factor.
- Age-adjusted mortality from cardiovascular disease in Louisiana is 266 per 100,000 per year compared with US national averages of 262. The state ranks 46th nationally in this regard.
- Cancer deaths are notably higher in the state relative to national norms; 203 versus 178 per 100,000 per year.
- In Louisiana, 24% of the population lives at or below the poverty level (a component of the Index of Medical Underservice), compared with 18% nationally.
- In Louisiana, 41% met criteria of the Index of Medical Underservice, compared with the national average of 25%.

Using these criteria, all Louisiana parishes exhibit significant underservice. Overall, the quality of life in the state is heavily adversely impacted by the public health burdens of medical underservice and high rates of chronic disease. The simultaneously high incidence of poverty complicates these other factors and creates an environment of mutually reinforcing health deficits from which recovery is challenging.

Source: www.lacats.org

While the grant money is significant and designated toward "building research infrastructure" that infrastructure will be somewhat intangible to the outside viewer. "The grant does not build buildings; it's taking current resources and putting them under a virtual center," explained Cefalu. Instead of creating labs, the money will provide partial salary support to allow researchers to do their research. It will also pay for staff and coordinators to help facilitate resource sharing. "Each institution brings to this collaboration a unique strength. It allows all the researchers that formed this center to take advantage of that," said Cefalu. "No longer is the researcher within the walls of Tulane or LSU or Pennington. This now allows researchers to gain the expertise and resources across this particular grant." Cefalu stressed that while many researchers already collaborated between institutions, previously in Louisiana it was not occurring to this degree. This was due to any number of barriers, many of which were identified during the planning process for the center (see page 36). "A private institution has different regulations than a public medical school as compared to a research center. So we all operate within our own guidelines. This is really an agreement to work together collectively to reduce the hurdles, reduce the barriers, leverage our resources to facilitate research," said Cefalu. "This is really a major grant and is really going to change the way we do business here in Louisiana."

The LA CaTS Center has defined three specific aims:

Aim 1: Create a collaborative infrastructure for clinical and translational research both within and across participating institutions. Enhance and share clinical research facilities and support all aspects of the research, education, and community engagement infrastructure required to establish and sustain a state-wide culture supporting integrated translational and clinical research. A major emphasis will be on providing the research infrastructure and direct support to those investigators of the state's COBREs and INBRE.

Aim 2: Increase the critical mass of investigators performing clinical and translational research. This aim will be achieved by integrating existing faculty, coordinating new faculty recruitment across institutions, training faculty and pre- and post-doctoral trainees to expand their competence and comfort in clinical and translational team research, and by involving clinic-based physicians in the communities served.

Aim 3: Improve and sustain bi-directional relationships with communities. The approach includes assessing the needs of vulnerable populations, understanding those needs based on two-way communication, and promoting the appreciation for and involvement in clinical research among the population served.

The projected end result is a vastly more efficient clinical and translational research enterprise with foundational activities for sharing uniform and integrated approaches, which result in avoidance of duplication and a more productive research enterprise.

The endeavor will also assist healthcare providers through on-line tools from LA CaTS Center researchers. The center will help to streamline research from "bench to bedside" making available the latest discoveries for healthcare providers to use in their everyday practices. Also, healthcare providers will be able to provide feedback to LA CaTS Center Researchers ("bedside to bench") on the needs and health disparities of the communities they represent to support the aim of improving and sustaining bi-directional

"What makes this application strong is the way so many of these institutions across the state are partnering and using a lot of the infrastructure that we put in place with the COBRE program and with the INBRE program."

Dr. Fred Taylor, program director for the Division of Training, Workforce Development, and Diversity in NIH's National Institute of General Medical Sciences (NIGMS).

PHS

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FERRIDAY OFFICE - Natalie Quimby, RN; Leslie Jackson, Case Manager; Glenda Lewis, Co-Owner/President; Paula Dobson, Account Manager; Sandy Maroon, Office Administrator. BELOW: Al Clifton, Founder and Chairman of the Board.

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TEXAS OFFICE - from left, Chrystal Tabor, Manager of Business Operations; Kelly Mobley, PT, CEO of Texas and Louisiana; Susan Roberts, Director of Texas Sales and Marketing.

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relationships with communities. The approach includes assessing the needs of vulnerable populations, understanding those needs based on two-way communication, and promoting the appreciation for and involvement in clinical research among the population served.

NIH established the Institutional Development Award (IDeA) program in 1993 to enhance biomedical research activities in states that have had historically low NIH grant funding success rates, specifically COBRE and INBRE. Louisiana is currently home to seven COBREs and one INBRE. NIH will remain intimately involved with the LA CaTs program over the next five years.

"This is a cooperative agreement, so we are going to have input over the development of this award on an ongoing basis," said Taylor. "We'll be looking at, and participating in, and monitoring the progress, and working towards keeping everything on track, in attaining goals, and meeting milestones." To ensure they remain on track with NIH milestones, the principal investigators for each of the LA CaTS institutions meet weekly, said Cefalu, "So that at the end of five years we've done what we said we were going to do."

Overcoming Obstacles

As part of the planning process, the following key obstacles were identified to efficient clinical and translational research in Louisiana:

- Small critical mass of trained investigators, spread across multiple institutions;
- No clearly-defined training or certification paths in clinical research;
- Few enrichment activities for clinical translational researchers;
- Dispersed facilities and dispersed trained personnel who conduct clinical research;
- Institutional barriers to collaboration in regulatory policies and business practices;
- Lack of knowledge of how to traverse the regulatory landscape;
- Lack of funding to support pilot efforts or encourage collaboration;
- Barriers to access to Scientific Cores and special expertise across institutions(and lack of knowledge as to how to access these);
- Lack of an established web-based communication system to serve clinical and translational researchers;
- Lack of investigators trained in web-based resources;
- Lack of an integrated approach to maximizing the research potential of the electronic medical records, where Louisiana is making major investment, and the current fragmentary housing of clinical research records;
- Lack of good relations with communities and participants;
- Large number of low literacy patients with poor understanding of clinical research;
- Lack of established communication channels with disease management and quality improvement programs in LSU HCSD hospitals and clinics, so as to impact health improvement in that population; and
- A disconnect between the community perceptions of health problems and the academic research agenda.

Source: www.lacats.org

It took almost five years of planning and significant collaboration between institutions that would sometimes be considered competitors to develop LA CaTS and garner the NIH grant. "It's tangible evidence of what institutions can do when they really want to create a goal for the greater good—what can happen when people work together," said Cefalu. "The whole is greater than the sum of its parts." NIH is also enthusiastic about LA CaTS. "There are so many strengths to this application," said Taylor. "We have high hopes for what it can produce over the next five years."

For more information on how you can be a part of and benefit from this collaborative effort, visit lacats.org.

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SECRETARY'S CORNER

By Bruce D. Greenstein
Secretary
Louisiana Department
of Health and Hospitals

Hurricanes and Health Care: Highlights and Lessons from Isaac

Once again, our state has been tried and tested by the strength of Mother Nature. While perhaps not our most difficult challenge to date, it is important to remember that Hurricane Isaac left a path of destruction deep into our State, forcing thousands of our fellow residents from their homes and communities and leaving hundreds of thousands in the dark for days. Heartbreakingly, many watched their homes and belongings wash away in Isaac's floodwaters.

Having far too much experience responding to major disasters, including hurricanes, our state has provided many examples of incredible dedication to protecting the health of our residents during these extraordinary circumstances. We have learned much from Hurricanes Katrina and Rita and, more recently, Gustav. Those lessons were put into action during the response to Isaac, where our state demonstrated a level of interconnection across the health care system that has not been present in past storms. Nursing homes, hospitals, adult residential care providers, and other health care facilities across the state reported their status to us in real-time, allowing us to capture an accurate picture of power outages, generator capacity, and evacuation status. This was integral in allowing us to deploy resources where they were needed and protect the health and safety of some of our most vulnerable residents.

There were many success stories during Isaac. I want to first offer my deep appreciation for the sacrifice made by so many of our own DHH family. The state opened five medical special needs shelters during Hurricane Isaac, caring for more than 400 Louisiana residents with complex medical needs at the peak of the storm. The storm resulted in the evacuation of 21 nursing homes and hospitals, affecting nearly 1,100 patients. Whether

they manned phones late into the night at the Emergency Operations Center or provided nursing care to evacuees with medical challenges, public servants across the state showed tremendous resilience in the face of this storm. I know that the same can be said for those working in health care facilities that sheltered in place.

Isaac also gave us an opportunity to put our partner for behavioral health to test for the first time in a disaster. Magellan proved to be a tremendously beneficial partner as they maintained 24/7 operations throughout the event, fielding 539 storm related calls. Between August 27 and September 3, they facilitated 306 inpatient placements for people with immediate mental health needs. Providing ready access and fast placement kept emergency rooms in the impacted region from experiencing a backlog of patients.

As with each disaster, Isaac also exposed vulnerabilities in our plans and infrastructure. Successive years of continuing downward fiscal pressure are resulting in fundamental changes to the structure of state government, particularly in public health. Getting the state out of the business of being a direct provider of care is the right policy, but it also poses a challenge for our disaster response plans. With fewer clinical employees, staffing special needs shelters to provide needed care is difficult. That is why it is so important for us to build strong ties to our partners in the private provider community. It is also why it is important that our state's health care facilities take responsibility to be prepared for these events and not rely on the state for support. Having adequate generator capacity, plans to acquire fuel, resources to conduct an evacuation if needed and the protocols to ensure sufficient staffing are all essential to savings lives during a storm. Nearly all of our health care facilities demonstrated that level of preparation, but we are driving to reach 100 percent. I want to challenge the CEO or administrator of every hospital, nursing home, assisted living, or other type of health care facility to ensure that you are prepared to keep your patients or residents safe during a hurricane.

Similarly, DHH is constantly reevaluating our own plans, and we remain open to feedback on how to improve. We are examining the lessons learned from Isaac to determine where we can strengthen our response and improve communication. Part of that may include internal changes, but we will also examine our licensure regulations for different health care facilities to ensure that the proper safeguards are in place. While this hurricane season may be over, we must continue to look forward. It may be next year or it may be in 10 years before we are hit with another storm, but it will come. And it's our job to make sure that we are ready.

"With fewer clinical employees, staffing special needs shelters to provide needed care is difficult. That is why it is so important for us to build strong ties to our partners in the private provider community. It is also why it is important that our state's health care facilities take responsibility to be prepared for these events and not rely on the state for support."

Briefs

STATE & LOCAL HEALTHCARE NEWS





FROM LEFT Dr. David Carmouche, Wendy Bateman, Anh Tran, Roderic F. Teamer, Sr. and Jerry Abbruzzese.

STATE

BCBSLA Announces New Leadership

Blue Cross and Blue Shield of Louisiana announced several new leadership appointments. Dr. David Carmouche has been appointed as Senior Vice President and Chief Medical Officer, Wendy Bateman will fill the newly created position of vice president, consumer marketing, and Anh Tran has been named director of facility reimbursement and payment policies. In addition, Roderic F. Teamer, Sr. has been named as Director of Diversity and Business Development and Jerry Abbruzzese will head EDI Customer Relations.

Carmouche joins the state's largest health insurer after spending 15 years in internal medicine practice at the Baton Rouge Clinic. As the state's first board-certified clinical lipidologist, he directed the Center for Cardiovascular Disease Prevention and the Vascular Laboratory. He also directed a cardiovascular disease prevention program for women at the Woman's Hospital Wellness Center. Carmouche earned his bachelor's degree at Tulane University and his medical degree at LSU before serving his internship and residency in internal medicine at the University of Alabama at Birmingham. He is board-certified in internal medicine and a specialist in clinical hypertension as well as a diplomate of the American Board of Clinical Lipidology.

A Louisiana native and LSU graduate, Bateman most recently worked as the director of integrated marketing at Pepperidge Farm, Inc., in Norwalk, Conn. At Blue Cross, Bateman leads the company's overall consumer segmentation strategy and is responsible for developing and implementing marketing strategies and processes to sell individual products through the creation of new retail channels.

Tran began her career in data analysis and brings to her position more than 18 years of experience in managed care organization operations and strategies for large national health plans. She earned a bachelor's degree in mathematics and actuarial science from the University of California at Los Angeles and an MBA from the University of Southern California. In addition, she completed the Project Management Extension Program at UC Berkeley. Before joining Blue Cross, she was senior director of healthcare research and reporting with United Health Group.

In his new role Teamer will oversee Blue Cross' award-winning diversity and inclusion program. Teamer will also continue to build corporate presence and sales in the New Orleans region. Teamer joined Blue Cross in Aug. 2005 as Director, Metro Area Business Development. He has nearly 20 years of experience in resource development, marketing, project management, human resources, budget and finance, strategic planning, employee recruitment, training, and career development. He came to Blue Cross from INROADS/Louisiana, Inc., where he had been managing director since 1994.

Abbruzzese brought 30 years of experience to the position of manager of EDI Customer Relations when he arrived at Blue Cross and Blue Shield of Louisiana In October. He will be primarily responsible for supporting the Blue Cross provider electronic interface platform known as iLinkBlue. Abbruzzese most recently served as director of eServices for Emdeon Inc., the nation's largest EDI clearinghouse. He spent two years as an independent consultant before joining Blue Cross.

DHH Launches Living Well in Louisiana

The Louisiana Department of Health and Hospitals, through the Governor's Council on Physical Fitness and Sports, has launched Living Well in Louisiana, a three-month wellness challenge in which participants earn points for physical activity and healthy eating, compete on teams or individually, and track their progress at www.livingwellinlouisiana.org.

Louisiana is the fifth-most overweight state in the country and has the fourth-highest rate of childhood obesity, according to the 2011 "F is for Fat" report by the Robert Wood Johnson Foundation. Being overweight and out of shape leads to many chronic diseases, and also causes decreased quality of life says DHH. Living Well in Louisiana is designed to help people combat obesity and its related chronic illnesses by taking small but effective steps to eat right and exercise daily.

In addition to diet and exercise guidance, www.livingwellinlouisiana.org offers resources to help people quit smoking, focus on their mental health, and access preventive health screenings. The Living Well in Louisiana challenge is also available as a free mobile app that participants can use to track their progress on their smartphones.

LHCQF Announces New Officers, Board Members

The Louisiana Health Care Quality Forum has named new officers and five new board members to its Board of Directors for 2012-2013.

The new officers are: Ray Peters, President (Vice President of Human Resources and Marketing for RoyOMartin Lumber Company in Alexandria); B. Vindell Washington, MD, MHCM, FACEP, President-Elect (Vice President of Performance Excellence and Technology at Franciscan Missionaries of Our Lady Health System in Baton Rouge); Dionne Viator, CPA, FACHE, Secretary/Treasurer (Executive Vice President and Chief Business Development Officer at Baton Rouge General Medical Center in Baton Rouge); and Lynn Buggage, Member at Large (State Health Systems Director of the American Cancer Society in New Orleans).

In addition, five individuals have joined the Quality Forum board: Catherine Fairchild, JD (Attorney with the Louisiana Department of Transportation and Development in Baton Rouge); John E. Carroll, CFM, ARPC, CRPC, CSNA, AAMS (Vice President with Merrill Lynch Wealth Management in Alexandria); Sandra A. Kemmerly, MD, MACP, FIDSA (Medical Director for Quality and Safety at Ochsner Health System in New Orleans); Louis R. Minsky, MD (Private Practitioner with Minsky & Carver Medical Center for Personal Wellness in Baton Rouge); and Leonard Weather, Jr., MD (Gynecologist in Shreveport).

Boustany Receives Health Care Champion Award

In October the American Hospital Association (AHA) and the Louisiana Hospital Association (LHA) presented Rep. Charles Boustany, MD (R-LA), the Health Care Champion Award for his outstanding contributions to health care public policy.

During his tenure as a member of the House Ways and Means Committee and chairman of the Subcommittee on Oversight, Rep. Boustany has ensured that rural hospitals have the resources necessary to provide patients with the right care in the right setting. He supported and helped improve programs for the most isolated rural hospitals, whose size and census fluctuations make it hard for them to remain financially viable, and is currently working to continue the important Medicare Dependent Hospital program. Rep. Boustany also led the effort to ensure that hospitals are not inundated by burdensome federal tax regulations.

LAHIE Streamlines Public Health Reporting

The Louisiana Health Information Exchange (LaHIE) can now facilitate public health reporting in Louisiana, allowing enrolled healthcare providers and hospitals to submit immunization data, lab results, and syndromic surveillance information to be forwarded to the appropriate state offices for processing.

LaHIE provides authorized providers and organizations, such as the Louisiana Office of Public Health and the Louisiana Immunization Network for Kids Statewide (LINKS), the opportunity to electronically access and share health-related information through a secure and confidential network for the purpose of improving patient safety, quality of care, and health outcomes. The fusion of health information technology (HIT) with public health reporting also means the state can identify and address dangers to the health of its residents more quickly, according to DHH Office of Public Health Assistant Secretary J.T. Lane.

For more information about the exchange or public health reporting via LaHIE, please email lahie@lhcqf.org or contact the Louisiana Health Care Quality Forum at 225.334.9299.

Grant Pushes For Primary Care Nurse Practitioners

The School of Nursing at LSU Health Sciences Center New Orleans has been awarded a $700,000 grant over two years by the Health Resources Services Administration (HRSA) of the U.S. Department of Health and Human Services to help students pursuing advanced practice primary care nursing degrees meet educational expenses. The money can be used for tuition, books, fees, and reasonable living expenses.

Eligible full-time students in the LSUHSC Primary Care Family Nurse Practitioner Program may receive up to $22,000, and eligible part-time students up to $11,000. Students who receive awards will be appointed as trainees in HRSA's Advanced Education Nursing Traineeship (AENT). Trainees must remain in good academic standing, in accordance with the LSUHSC standards.

According to HRSA, the current primary care workforce in the United States is inadequate to meet the growing demand for primary care services. Moreover, the aging workforce, the increasing demand for preventative health services, and the

expansion of health care coverage from the Affordable Care Act will likely widen the gap between demand and the available primary care workforce. Programs such as this may help to increase access to primary care services and to expand the primary care workforce.

The LSUHSC School of Nursing Primary Care Family Nurse Practitioner Program is a Master's level program. In addition to a Master's Degree, a minimum of 500 clinical hours are required for certification. The LSUHSC program curriculum includes general core and advanced practice core courses as well as primary care family nurse practitioner courses that focus on the advanced nursing management of health conditions across the lifespan in primary care settings. The current plan of study provides opportunities for more than 700 hours of clinical experience.

DHH Adjusts Pharmacy Reimbursement Change

In response to feedback on its emergency rule, the Louisiana Department of Health and Hospitals (DHH) has announced adjustments to the Louisiana Medicaid program's pharmacy reimbursement methodology that will increase reimbursement for pharmacy services.

DHH promulgated an emergency rule in August that revised its reimbursement methodology for pharmacy services from an Average Wholesale Price (AWP) model to an Average Acquisition Cost (AAC) model. Effective Sept. 5, Medicaid began reimbursing pharmacists for their prescription services to Medicaid enrollees at the Average Acquisition Cost (AAC) plus a $10.13 dispensing fee.

In recent years, several national organizations have noted AWP-based reimbursement for Medicaid pharmacy is unreliable, subject to manipulation, and not representative of the actual purchase price for pharmaceutical products. A review of claims data showed when using the previous AWP reimbursement model Medicaid was consistently a top payer for pharmacy providers, paying more generously than commercial Pharmacy Benefit Management programs that serve patients with private insurance. As a result, a 2009 national Medicaid workgroup recommended state Medicaid programs shift their reimbursement methodology toward AAC to bring costs more in line with the actual cost of acquiring and dispensing prescription drugs to Medicaid recipients.

In order to incorporate feedback from pharmacists, DHH convened a workgroup of both independent and chain pharmacists to discuss the new reimbursement structure. After careful analysis DHH has made several enhancements to the reimbursement methodology that will increase reimbursement for pharmacy services. The new items are:

- Provide a markup of 10 percent above the AAC rate for generic drugs, and 1 percent for brand name generics.
- Increase the dispensing fee paid to pharmacy providers as part of their reimbursement from $10.13 to $10.51, based on a factor of consumer price index inflation.
- Reimburse certain classes of specialty drugs, which cost more and are more complex to stock and dispense than mass-market prescription drugs, at their Wholesale Average Cost (a more generous price index) plus 5 percent.
- Closely monitor drug-pricing updates that manufacturers make on product and pass along to pharmacists, to ensure Medicaid can adjust to the updated pricing quickly and accurately, which will limit instances where pharmacy reimbursement is below the cost of acquisition.

The Department is promulgating the new emergency rule, which will implement the updated reimbursement methodology changes for Medicaid fee-for-service pharmacy claims with dates of service Nov. 1, 2012 and beyond. These adjustments in methodology will be subject to federal approval by the Center for Medicaid and Medicare Services (CMS).

EHR/HIE Crucial In Disasters

The Office of the National Coordinator for Health Information Technology (ONC) and the U.S. Department of Health and Human Services have released a report detailing the findings of the Southeast Regional HIT-HIE Collaboration (SERCH) Project, in which the Louisiana Health Care Quality Forum participated. The project was designed to research how health information exchanges can be leveraged to provide timely access to clinical information during times of disaster. Its focus was to build on the lessons learned through major disasters over the years, including the evacuation of more than one million people in the aftermath of Hurricanes Katrina and Rita in 2005.

Nadine Robin, Health Information Technology Program Manager for the Quality Forum, said those disasters demonstrated the vulnerability of paper-based health information records and proved the need for electronic health records (EHRs) and a health information exchange through which those records can be accessed. "The findings of the SERCH Project illustrate the importance of both," said Robin.

The SERCH Project began in November 2010 and included six states – Alabama, Arkansas, Florida, Georgia, Louisiana, and Texas – that shared the goal of developing a strategic plan for sharing health information data among the Southeast and Gulf States during and following a declared national disaster.

The report, "Health Information Exchange in Disaster Preparedness and Response," includes five recommendations to be considered by HIEs in the sharing of electronic health information during a disaster. Those recommendations include:

- Understand the state's disaster response policies and align with the state agency designated for public health and medical services before a disaster occurs.
- Develop standard procedures approved by relevant public and private stakeholders to share electronic health information across state lines before a disaster occurs.
- Consider enacting the Mutual Aid Memorandum of Understanding to establish a waiver of liability for the release of records when an emergency is declared, and to default state privacy and security

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• Assess the state's availability of public and private health information sources and the ability to electronically share the data using HIEs and other health data-sharing entities.

• Consider a phased approach to establishing interstate electronic health information-sharing capabilities.

The project's findings indicate that combining disaster planning and HIE functions will help ensure that when a disaster occurs, patients and providers will have better access to information and be able to provide appropriate care.

To read the full report of the SERCH Project, visit www.healthit.gov. To learn more about LHIT Resource Center and LaHIE services, visit www.lhcqf.org.

eQHS Kicks Off Community Initiatives

A recent contract from the Centers for Medicare and Medicaid Services (CMS) will underwrite community healthcare initiatives in Shreveport and Monroe to improve health outcomes and reduce costs. The projects will build community collaboratives that include healthcare providers, community members and other groups interested in improving health outcomes in these north Louisiana communities.

The funding awarded to eQHealth Solutions is designed to identify and recommend sustainable interventions that improve patient outcomes. The initiatives will address specific chronic conditions, best practices that impact patient care, and resource utilization, including avoidable readmissions. eQHealth Solutions is seeking provider, as well as community participation, to build the collaborative groups that will make these projects successful. Over the next several months, eQHealth Solutions will partner with these providers and others to recommend and implement appropriate quality improvement initiatives.

Providers who are interested in participating or are seeking further information can call eQHealth Solutions at 225-248-7035.

Peoples Health Expands

Peoples Health announced the company is growing to serve a broader population of Medicare beneficiaries in the state, starting in 2013. Peoples Health will be accepting enrollments into its plans, including those offered in the new expansion areas, starting October 15 through December 7.

Currently, the company's Medicare Advantage health plans serve a 14-parish service area including New Orleans and Baton Rouge. With this new expansion, starting in January, Peoples Health will expand its plan offerings into 23 total parishes. This parish expansion includes: Assumption, East Feliciana, Iberville, Lafourche, Pointe Coupee, St. Helena, St. Mary, Terrebonne and West Feliciana.

LSU Grant to Improve Nursing Home Care

The LSU Health Sciences Center New Orleans School of Nursing has been awarded a $143,000 grant by the Centers for Medicare and Medicaid Services (CMS) to train nursing staff in Louisiana nursing homes in comprehensive skin care and wound management. The funding supports the training around the state. The state of Louisiana ranks 49 out of 50 in the prevalence of pressure sores, with an 11-13% prevalence, according to CMS.

"The need for this type of training around the state is vital as 97% of nurses administering wound care within nursing homes in Louisiana are Licensed Practical Nurses (LPNs) and LPNs do not receive this type of training during formal education," notes Jean Cefalu, MSN, ANP-C, GNP-C, CWOCN, CFCN, LSUHSC, Instructor of Nursing, and the grant's principal investigator.

The training will take place bimonthly at host facilities in New Orleans, Baton Rouge, Lafayette, and Shreveport. The training is a three-day course that includes lectures and hands-on practice, culminating in a certificate of completion from the LSUHSC School of Nursing. Those who have completed the training will in turn train RNs, LPNs, and Certified Nursing Assistants (CNAs) at their facilities.

LOCAL

LSU Health Women's Clinic Opens

The LSU Health Women's Clinic is now seeing patients in its new location at 500 Rue de la Vie, Suite 414, in the Physician's Office Building next to the new Woman's Hospital. The clinic is an important part of the LSU Health Sciences Center Baton Rouge OB/GYN Residency Program. Sixteen residents receive training at the clinic. Woman's Hospital cosponsors the program. Eight residents with the Baton Rouge General Hospital Family Practice Residency Program also receive training in the clinic. Residents will now have easy access to patients at Woman's Hospital.

With 6,980 square feet, the clinic has 12 exam rooms, two ultrasound rooms, treatment rooms, and an antenatal room for fetal non-stress tests, biophysical profiles, and preeclampsia evaluations. A conference room and offices for physicians and residents adjoin the clinic. The clinic has 14 staff physicians including specialists, five LPNs, four RNs, four nursing assistants, two hospital admissions technicians, an ultrasound technician, RN clinic supervisor, nurse practitioner, nurse mid-wife, medical assistant, and three clerical staff.

LSU will continue to provide GYN-oncology services at the LSU North Baton Rouge Clinic.

Davidge Among Those Recognized at OLOL College

Retired Our Lady of the Lake Regional Medical Center CEO Robert Davidge was recently recognized at the Our Lady of the Lake College Annual Luncheon. Davidge received the Franciscan Impact Award for his contributions to the health of south Louisiana.

Two outstanding alumnae were also honored at the luncheon: Sister Brendan Mary Ronayne, o.s.f., '66, who has made many contributions to the healthcare ministry both as a clinician and as a leader, and Alysha Bonvillain, BSRT (R)(T), '04, who received recognition as the College's

FROM LEFT Sister Kathleen Cain, Provincial for the Franciscan Missionaries of Our Lady, award recipients Alysha Bonvillain and Sr. Brendan Mary Ronayne, and OLOL College President Sandra Harper.

Distinguished Recent Alumni for her career achievements and community volunteer work.

This year's luncheon also included a special preview of future plans for the College as outlined in the College's 'Centennial Compass 2.0' which was presented by College President Sandra S. Harper, PhD.

Pennington Prof Named Obesity Society VP

Nikhil V. Dhurandhar, PhD, professor at the Pennington Biomedical Research Center, was named vice president of The Obesity Society for 2012-2013. He was elected to the four year term by the nominating committee, Fellows, and members of The Obesity Society for Council and will serve as president-elect (2013-2014), president (2014-2015), and immediate past president (2015-2016).

Dr. Dhurandhar is an internationally recognized investigator in obesity research. The focus of his research is to understand the causes of obesity, specifically obesity caused by certain viral infections. He is also investigating how some beneficial properties of certain viruses could be exploited for treating diabetes. Dr. Dhurandhar is a physician and received his PhD in biochemistry from the University of Bombay, India. He has been an active member of The Obesity Society since 1994.

Carville, Matalin to Speak at LAHP Conference

The Louisiana Association of Health Plans will hold its 2012 Annual Conference on Thursday, November 29 at the New Orleans Hilton-Airport in Kenner. The event will feature such distinguished speakers as James Carville and Mary Matalin, both highly-respected political commentators on the national stage.

The conference will also feature presentations by state leaders and experts on efforts to raise Louisiana's healthcare ranking from 49th to 35th within ten years. Additional segments include a demonstration on how telemedicine will change the future of healthcare, a special panel on diabetes, and a look back at the challenges and triumphs of Bayou Health's first year.

To register online for LAHP's 2012 Annual Conference, go to http://www.lahp.net/amc-the-event/.

Healthcare Partner Named Lawyer of the Year

Breazeale, Sachse & Wilson, LLP announced that Corporate and Healthcare partner B. Troy Villa has been named as the "Baton Rouge Lawyer of the Year in Mergers & Acquisitions Law" by his peers for inclusion in The Best Lawyers in America® 2013 (Copyright 2012 by Woodward/White, Inc., of Aiken, S.C.).

Best Lawyers® began designating "Lawyers of the Year" in the U.S. in high-profile legal practice areas in 2009. Only a single lawyer in each practice area and designated metropolitan area is honored as the "Lawyer of the Year." Lawyers being honored as "Lawyer of the Year" are selected based on particularly impressive voting averages received during the exhaustive peer-review assessments conducted by thousands of leading lawyers each year.

AlwaysCare Names Kramer Senior VP, Head of Sales

Baton Rouge-based AlwaysCare Benefits, an insurance provider, has promoted R. William Kramer to Senior Vice President and Head of Sales. In his new role, Kramer will oversee sales of all employee benefit products and services, and continue the development of one of the industry's leading group benefits sales teams.

Kramer joined the company in 2011 and managed the Southern territory. Before joining AlwaysCare, Kramer held positions in sales and national accounts management with Unum, Reliance Standard Life Insurance Company, CIGNA Dental and Vision, and MetLife. He holds both a bachelor's and master's degree in business administration from Mercer University.

OLOL College Joins AGHE

Our Lady of the Lake College has been approved for membership in the Association for Gerontology in Higher Education (AGHE). OLOL College earned this membership as part of its ongoing efforts to establish programs that make regional, national, and international connections to build gerontological and healthy aging education and research.

The mission of AGHE, the educational division of the Gerontological Society of America, is to advance gerontology and geriatrics education and to provide leadership and support of gerontology and geriatric education faculty and students in educational institutions. The Association provides information about best practices and resources for gerontologists and gerontology/geriatrics educators.

AGHE is made up of 169 institutional members. As an approved member, Our Lady of the Lake College will have faculty and student representatives who will be notified of issues affecting gerontological and geriatrics education and will have voting privileges on decisions before the Association.

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QUALITY CORRESPONDENT

By Cindy Munn
Executive Director
Louisiana Health Care
Quality Forum

Baton Rouge Area Declared 'LaPOST READY'

The Louisiana Health Care Quality Forum and the LaPOST Coalition declared the Baton Rouge area as "LaPOST Ready" in November, completing a promotional campaign to raise awareness among health care professionals about the end-of-life-care document.

Created with input from health care and legal professionals across the state and approved by the Louisiana Legislature in 2010, the Louisiana Physician Orders for Scope of Treatment, or LaPOST, is a best-practice model for patients with life-limiting or irreversible conditions to state their preferences for end-of-life treatment in a physician's order.

"We want Baton Rouge providers to know what LaPOST is and how it works, but we also want them to be prepared for some poignant conversations with patients and their family members," said Susan Nelson, MD, head of the LaPOST Coalition, a network of Louisiana health care professionals promoting the document. LaPOST itself is an initiative of the Louisiana Health Care Quality Forum.

The coalition's awareness campaign began in mid-August. Weekly emails to area health care providers spelled out details about the document's function and purpose. Moreover, a series of five webinars took place in September and October.

"Awareness and education have been a work in progress, but we've taken some very important first steps over the past few months," says Nelson, medical director of senior services for the Franciscan Missionaries of Our Lady Health System.

LaPOST was modeled after Oregon's Physician Orders for Life Sustaining Treatment, known as the POLST Paradigm document, organized through Oregon Health Sciences University in the early 1990s. Louisiana is the latest in a growing number of states that have created similar measures based on POLST.

Studies in states with POLST documents available show that for patients who use them, treatment preferences were respected 98 percent of the time, and no one received unwanted CPR, intubation, intensive care or feeding tubes. As a result, POLST has helped bridge the gap between the treatments patients want and those they receive.

"LaPOST gives patients, doctors, and health care facilities the mechanism to express the desired medical care for patients with seriously advanced illnesses," says Nelson.

LaPOST is endorsed by the Louisiana State Medical Society and the National Physician Orders for Life-Sustaining Treatment Paradigm Task Force. It's also recommended by the Louisiana Health Care Redesign Collaborative's End-of-Life workgroup.

The document is completely voluntary and seeks to advocate neither for nor against treatment. It's publicly available but must be completed by a physician to be valid. It's printed on bright gold paper, making it easily recognizable for health care providers, patients and caregivers.

Moreover, LaPOST is completely portable, traveling with patients throughout the health care system – from their homes to hospitals to nursing homes – with clear and concise instructions. The original document stays with patients, and copies are

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considered valid and legal.

"The document is nonjudgmental – it's about respecting the choices of each human being," says Carla Brown, director of nursing for Ollie Steele Burden Manor nursing home, one of the early LaPOST adopters. "As nurses, we are educators. I would tell all fellow caregivers to educate themselves and assist patients and their family members with this document. We're not here just to administer medication. LaPOST is invaluable because it provides guidelines. You don't have to keep making phone calls and contacting the family. We need this in the medical field."

While most Americans believe death comes suddenly and at the end of a productive and full life, that's often not the case. For about 80 percent of the population, death comes after several weeks or even several years of progressive illness and debility.

"Studies have shown that patients and families who discuss advanced medical planning actually get better medical care that's patient centered and in a location they want – at home, in a hospital, a nursing home or elsewhere," Nelson says. "It's important for us as health care providers to be willing to help educate patients and their families about the types of care available, who provides it, who pays for it and all the related issues."

Nelson says that with LaPOST in place, providers should expect questions on advance care planning. Caregivers as well as patients with seriously advanced illnesses and their families should be prepared to discuss patients' goals, values and religious or cultural beliefs that affect those decisions.

The LaPOST document is also distinctly different from other existing forms of advance care planning. Living wills and advance directives, for example, are typically written well in advance of illness and describe the kind of care patients want if something occurs, particularly scenarios in which they don't want to receive aggressive medical care. Unfortunately, less than 25 percent of Americans have this level of planning. And even with them in place, those documents require interpretation and a physician order before being used.

A health care power of attorney document names the person who would make health care decisions if patients were unable to do so. Patients also must state the kinds of decisions such designees would make. In the absence of this document, state law stipulates who would make such decisions.

On the other hand, LaPOST is specifically for patients with seriously advanced illnesses, listing some of the medical treatments they would want or refuse. It becomes a binding medical order once completed and can be used independently from a living will or used to make a living will operational. Also, LaPOST documents can be modified or revoked at any time, based on new information or changes in a patient's condition or treatment preferences.

Nelson said that most importantly, LaPOST requires caregivers and patients to have real conversations in deciding treatment options for end-of-life care.

LaPOST Coalition guidelines recommend that health care providers talk with patients and families – preferably in an arranged meeting – about the kind of care available, measures that will help, those that might help, and those that will not help.

Among the recommendations, providers are encouraged to:

- Be attentive to patients' and families' emotional state and proceed at their pace as much as possible.
- Find out what the patient and family know about the illness or diagnosis, and then ask if they have questions.
- Talk about what can be done first, then emphasize there is always something that can be done, though it may not be curative.
- Keep the conversation moving with facts and empathy.
- Make sure patients and families understand the larger situation before going on to specific issues.

Other members of the health care team – nurses, social workers or chaplains – can be involved in the conversation, particularly to address the physical, psychosocial, and spiritual issues. LaPOST can also be initiated by other health care professionals under the direction of the patient's physician, although the physician and patient signatures are mandatory.

"I've found that LaPOST can relieve family members of a lot of guilt after a loved one dies because many decisions are already made," says Brown. "The document clearly explains everything in detail from medications to feeding, every aspect that caregivers wouldn't necessarily know the answers to."

For more information visit www.lapost.org, email Lapost@lhcqf.org. or call 225.334-9299.

"The document is nonjudgmental – it's about respecting the choices of each human being."

– CARLA BROWN, RN

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POLICY CORRESPONDENT

By David Hood
Senior Healthcare Analyst
Public Affairs Research
Council of Louisiana

The Plight of the Primary Care Provider

Are primary care physicians an endangered species? Many medical journals and healthcare publications make a strong case that PCPs are in decline while others report a resurgence in their numbers. Whatever the case with respect to total numbers of primary care physicians, there is general agreement that a shortage of PCPs exists to serve Medicaid and uninsured populations. The problem is that today's relatively minor deficiency could become a major shortage that could threaten delivery of healthcare for people who need it most.

The Association of American Medical Colleges (AAMC) warned of a physician shortage well before passage of the Affordable Care Act in 2010. Earlier projections had estimated a nationwide shortage (for all physicians) of 39,600 by 2015. That estimate has been revised upward to take into account a number of factors including ACA.

It is expected that 15 million persons will enroll in Medicare in coming years because of baby boomer retirement and 32 million uninsured persons will be enrolled in private insurance or Medicaid because of ACA. At the same time, large numbers of physicians who are over age 60 and still practicing will begin to retire, further exacerbating a growing shortage of doctors. Revised AAMC projections now show a shortage of 63,000 doctors by 2015, 91,500 by 2020 and 130,600 by 2025. AAMC has called for a 30 percent increase in medical school enrollment in 2015, an ambitious goal made much more difficult by current economic conditions.

At the core of the physician shortage problem is the primary care quandary. Primary care physicians are the foundation of every healthcare system. They must quickly assess all types of health problems, prescribe proper remedies, and direct traffic so patients are sent to the right specialist or tertiary care. Without these front-line managers the healthcare system would collapse in disarray. For this they are rewarded with the lowest compensation of any group of physicians. In fact, while physician income has in general declined, primary care specialties (Internal Medicine, Family Medicine, and Pediatrics) earn roughly half as much as the highest earning specialties. Another financial factor that medical students have to deal with is the debt load that they accumulate during their years of training. *American Medical News* (www.amednews.com) reports that the average debt for medical school graduates is about $161,000 and that 86% of students graduate with student loan debt. There is widespread belief that high education debt may be a factor when choosing a specialty. According to *American Medical News*, there is no research on this issue, but many believe that some graduates are selecting high-paying specialties to alleviate their heavy debt load and that may contribute to shortages in some areas, particularly the low-paying primary care specialties.

Healthcare in the U.S. is at a major turning point, mostly because of the passage of the Affordable Care Act. The major benefits of ACA include expansion of

POLICY CORRESPONDENT

coverage, either through private insurance or the Medicaid expansion. The concept of the Patient-Centered Medical Home was proven successful even before ACA and it is further strengthened by the reform act. Needless to say, more primary care providers will be needed to fully implement the intent of the act, not only to broaden coverage, but to reduce costs and improve quality. Primary care will be at the forefront in these efforts and that workforce must be up to the task. As mentioned earlier, AAMC projects the nationwide shortage of physicians (in all specialties) to reach 63,000 in 2015 and 130,600 by 2025. It is safe to say that at least half of those shortages will be in primary care.

What is Louisiana doing about the problem? Not nearly enough, but there are hopeful signs here and there, as well as disappointments. Here is a brief inventory of some of the state and federal efforts to resolve the primary care problem.

Primary care payments will be increased. The Affordable Care Act contains a mandatory provision that will use federal money to increase Medicaid primary care payments to the Medicare level. This is good news because Medicare payments are also increasing in accordance with ACA. The new payment rates will be in effect January 1, 2013, and will end December 31, 2014. Note that in 2008 Louisiana Medicaid paid primary care physicians at 90% of the Medicare level, ranking 15th in the nation. Current payment levels are not known.

A new medical school dedicated to primary care. Plans were being made by LSU to establish a medical school in Lafayette connected with the University Medical Center to train only primary care physicians. Several other states have successfully done this, partly to cope with the growing shortage of primary care doctors. Planning for the Lafayette school was mostly in the discussion stage and hopes faded recently when budgets for UMC and six other LSU hospitals were slashed by 35%. It is feared that all medical education programs could be negatively impacted by these unplanned budget cuts. In this counter-productive budget climate, a physician shortage will not be a high priority.

Assistance with medical school debts. The state has a program that pays a portion or all of medical school debt if the applicant agrees to practice in a healthcare shortage area. This is a long-standing program that has been successful, but limited. Now is the time to make it much more generous with broader criteria targeting more primary care physicians. Spending tax dollars to ensure primary care is available will actually save money. Having no physicians or only specialists to access for care will drive up the cost.

Utilize more nurse practitioners (NP) and physician assistants (PA). Numbers of nurse practitioners have been growing in Louisiana while the ranks of primary care physicians have been shrinking. The NP community across the country has been lobbying for recognition as full-fledged primary care providers. Their training is similar to that of a primary care physician, though not as lengthy. Many physician groups have spoken out against allowing NPs to replace doctors. It is hoped that this will evolve from a contentious issue to a mutual agreement as to how NPs, as well as PAs, can be utilized to help address a primary care shortage that could become a crisis. Note also that NPs have been used successfully in Medicaid to practice in underserved areas, but always under the supervision of a physician.

Utilize more International Medical Graduates (IMGs). Table 1 shows that almost one in five active physicians in Louisiana happens to be an IMG. The state ranks 24th in the U.S. in the percentage of physicians that are IMGs. This is another supply that can be tapped if necessary.

TABLE 1

Louisiana Physician Workforce	LA	LA RANK
• Total active patient care physicians per 100,000 pop., 2010	201.1	31
• Active patient care primary care physicians per 100,000 pop. 2010	68.3	42
• Percentage of active physicians who are age 60 or older, 2010	27.5%	12
• Percentage of active physicians who are International Medical Graduates	18.9%	24
• Residents/fellows in primary care ACGME per 100,000 pop. on Dec 1, 2010	15.3	13
• Percentage of physicians retained in state from GME, 2010	47.1%	20

Source: AAMC State Physician Data Book 2011

Louisiana

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Dr. Thomas Kinstrey • Family Medical Clinic, Shreveport, LA
Practitioners, Kelly Toups, APRN, CFNP and Jessica Smith, APRN, FNP-C

QUALITY BLUE
PHYSICIAN RECOGNITION PROGRAM

LEGISLATIVE CORRESPONDENT

By **Congressman Bill Cassidy, MD**

THE MEDICARE MUDDLE

A CASE FOR PREMIUM SUPPORT

Medicare is a contract between seniors and the government. However, if major reforms don't occur, that trust will be broken in the coming decades. Medicare's own Chief Actuary acknowledges that, if we do nothing to reform the program, it will run out of money by 2024. A number of non-partisan health economists have pointed out that this might actually be an optimistic number. Taking into account the double counting in Obamacare, the Medicare trust fund could run out of money as soon as 2016.

Structural changes in Medicare and other entitlements are needed to incentivize quality care while redirecting public funds to those who need it most. Despite the election rhetoric, both Democrats and Republicans acknowledge this. For example, according to news reports and Bob Woodward's much acclaimed new bestseller, *The Price of Politics*, President Obama proposed raising the Medicare eligibility age from 65 to 67 during the budget negotiations last year.

Additionally, Obama's plan would significantly increase means-testing benefits in Medicare. Premiums, fees, deductibles, and out-of-pocket costs, such as co-payments, would increase for upper income seniors. Within 20 years, about 25 percent of seniors would be paying higher, income-based premiums. These premiums would increase as much as 15 percent. President Obama would be changing Medicare as we know it even while he criticizes others who propose reform.

However, the changes proposed by the President would still not guarantee Medicare's solvency. More substantial restructuring is necessary to put Medicare on a stable financial footing.

Vice Presidential nominee Paul Ryan has most recently led the effort for such reform in Congress. He sparked a serious conversation about entitlement reform with his FY2012 and FY2013 budget proposals, and has since worked across the aisle towards a serious solution. In conjunction with liberal Democratic Senator Ron Wyden (D-OR), Congressman Ryan generated a serious premium support proposal that would significantly alter the incentive structure toward higher quality and lower costs. The plan does this by increasing competition in Medicare and forcing greater efficiency. Presidential nominee Mitt Romney has endorsed the general movement toward premium support.

Premium support has a long history of bipartisanship. In 1998, Democratic Senator John Breaux (D-LA) worked with Congressman Bill Thomas (R-CA) on a very similar proposal to the Wyden-Ryan plan as part of President Clinton's National Bipartisan Commission on the Future of Medicare. More recently, former Congressional Budget Office (CBO) Director and President Clinton's Office of Management and Budget (OMB) Director, Alice Rivlin, presented a similar proposal with former Senator Pete Domenici (R-NM). The Domenici-Rivlin plan

In conjunction with liberal Democratic Senator Ron Wyden (D-OR), Congressman Ryan generated a serious premium support proposal that would significantly alter the incentive structure toward higher quality and lower costs. The plan does this by increasing competition in Medicare and forcing greater efficiency.

comes out of the Bipartisan Policy Center (BPC). Both Dr. Rivlin and Senator Breaux testified in Congress in support of the Wyden-Ryan plan.

Competition such as this has worked with Medicare Part D, the well-liked drug insurance program for senior citizens. Due to competition, costs are 40 percent lower than projected while providing seniors the power to choose the plan they like.

Moreover, bipartisan policy leaders have formed consensus towards premium support in specific, and entitlement reform in general. The only thing missing is presidential leadership. It's time to be frank with the American people about the problems with the status quo. The good news is that entitlement reform presents an opportunity to transform Medicare toward a much more dynamic system that uses the power of competition to reward quality and decrease costs.

Rounds

REGIONAL HOSPITAL NEWS

ABOVE Leaders and representatives from Baton Rouge General Medical Center and the Louisiana Department of Veterans Affairs cut the ribbon at the new facility. From left to right are: Edgardo Tenreiro; Venugopal Vatsavayi, MD; Denise Dugas; Navin P. Patel, MD; Terry LeBourgeois, MD; Dionne Viator; Lane Carson; and Jon Salter.

BR General Expands Behavioral Health to Jackson

Baton Rouge General Medical Center held a ribbon cutting ceremony in October to celebrate the opening of the Behavioral Wellness Center at Jackson. Working together, Baton Rouge General and the Louisiana Department of Veterans Affairs partnered to expand behavioral health services to serve residents in Jackson and surrounding communities. The center, which is located at the Louisiana War Veterans Home on Highway 10 in Jackson, will provide outpatient behavioral health and wellness services for the community.

LSU Recognized for EMR

The Interim LSU Public Hospital (ILH) in New Orleans has received national recognition for its sophisticated electronic health record system and its use throughout ILH. LSU Health is implementing PELICAN, with its single, integrated database, in all ten of its hospitals, giving providers throughout the LSU Health system immediate access to patient records whenever a patient receives care from LSU or its affiliated clinics.

HIMSS Analytics announced that ILH achieved Stage 6 on its Electronic Medical Record Adoption Model, placing ILH in an elite group for modern healthcare delivery. Stage 6 hospitals have the following attributes:

- Have made significant executive commitments and investments to reach this stage;
- Appear to have a significant advantage over competitors for patient safety, clinician support, clinician recruitment, and competitive marketing for both consumers and nurse recruitment;
- Have almost fully automated/paperless medical records when they have implemented their IT applications across most of the inpatient care settings;
- Are either starting to evaluate data for care-delivery process improvements or have already documented significant improvements in this area;
- Have made investments that are within reach of most hospitals and recognize the strategic value of improving patient care with the electronic medical record;
- Have begun to create strategic alignments with their medical staff to effectively use information technology to improve the patient safety environment;
- Are well positioned to provide data to key stakeholders, such as payers, the government, physicians, consumers and employers to support electronic health record environments and health information exchanges.

By June 2013, all LSU hospitals and 500 physician clinics will be linked and using PELICAN for the coordinated care of the more than 500,000 patients LSU Health sees each year.

Pennington Cancer Center Earns Re-Accreditation

Baton Rouge General's Pennington Cancer Center has been awarded a three-year term of accreditation in radiation oncology as the result of a recent review by the American College of Radiology (ACR). Radiation oncology is the careful use of high-energy radiation to treat cancer. A radiation






FROM LEFT Jason Bennett, MD; Daniela Cardozo, MD; O. Joseph Dean, Jr., MD; Vivek R. Huilgol, MD; Randy Lamartiniere, MD; and Teri Fontenot.

oncologist may use radiation to cure cancer or to relieve a cancer patient's pain.

ACR accreditation represents the highest level of quality and patient safety. It is awarded only to facilities meeting specific Practice Guidelines and Technical Standards developed by ACR after a peer-review evaluation by board-certified radiation oncologists and medical physicists who are experts in the field. Patient care and treatment, patient safety, personnel qualifications, adequacy of facility equipment, quality control procedures, and quality assurance programs are assessed.

Ochsner Welcomes New Physicians

Ochsner recently welcomed the following new physicians to the Baton Rouge region:

• Jason Bennett, MD joins Ochsner's Pathology Department. Dr. Bennett earned his degree from West Virginia School of Medicine in Morgantown, West Virginia. He later completed his internship in internal medicine at West Virginia University Hospitals followed by a pathology residency at West Virginia University Hospitals, Charlestown Area Medical Center, and Virginia Hospital. Dr. Bennett is board certified by the American Board of Pathology.

• Daniela Cardozo, MD joins Ochsner's Family Medicine Department in Denham Springs. Dr. Cardozo earned her degree from La Universidad del Zulia in Maracaibo in Venezuela. She later completed her residency at the University of Nebraska in the Department of Family Medicine.

• O. Joseph Dean, Jr., MD joins Ochsner's Urology Department. Dr. Dean earned his undergraduate degree in physics at Howard University in Washington, D.C. He then attended Louisiana State University School of Medicine in New Orleans. Dr. Dean completed his residency in general surgery at St. Elizabeth Medical Center in Youngstown, Ohio. He completed fellowships at both Howard University and Tulane University schools of surgery and urology. Dr. Dean is board certified in urology and trained in robotic surgery.

• Vivek R. Huilgol, MD joins Ochsner's Gastroenterology Department. Dr. Huilgol earned his bachelor of medicine and bachelor of surgery degrees at Flinder's University of South Australia. He then completed his internal medicine residency at the Aurora-Sinai Program in Milwaukee, Wisconsin. Dr. Huilgol completed two fellowships in gastroenterology and hepatology at Aurora-Sinai Program and Medical College Wisconsin. He completed his final fellowship of Advanced Gastroenterology Training at the LSU Health Sciences Center in Shreveport. He is board certified in gastroenterology and internal medicine.

• Randy Lamartiniere, MD joins Ochsner's Internal Medicine Department. Dr. Lamartiniere earned his medical degree and completed his internship and residency at Louisiana State University Medical Center in Shreveport. He is board certified in internal medicine.

Fontenot One of "Most Influential People in Healthcare"

Teri Fontenot, Woman's President and CEO, has once again been named to the "100 Most Influential People in Healthcare" ranking by *Modern Healthcare* magazine. This is her second year in a row on the list, ranking at #61. Fontenot is the only Louisiana leader to be named. She shares this elite status with President Obama (#4), Chief Justice of the United States John Roberts (#1), presidential nominee and former Massachusetts governor Mitt Romney (#13) and other prominent figures, including CEOs of well-known healthcare organizations.

This is *Modern Healthcare* magazine's 11th annual ranking. The complete list can be found at modernhealthcare.com and in the August 27 edition of the magazine.

Bone Marrow Registration Offered at Screenings

Mary Bird Perkins-Our Lady of the Lake Cancer Center is taking a step to help increase the number of registered bone marrow donors in the Baton Rouge area, especially those belonging to minority populations. By partnering with Be the Match, a nonprofit organization that matches patients with donors, the Cancer Center is offering bone marrow registration at its free cancer screenings in Baton Rouge.

Thousands of patients with blood cancers like leukemia and lymphoma, sickle cell, and other life-threatening diseases depend on finding a bone marrow match to save their life. The chance of finding a match on the national registry is as low as 66 percent for African Americans and other minorities, compared with 93 percent for Caucasians, reports Be the Match.

Baton Rouge Mayor Kip Holden was also concerned with the bone marrow registration issue and contacted the Cancer Center, asking for help in making bone marrow registration a more visible priority in the

community. He recommended the Cancer Center use its free community cancer screenings as a mechanism to help increase donors so that more people have a chance for a match.

Baton Rouge General Named Top Performer

The Joint Commission recently released a list of hospitals that are Top Performers on Key Quality Measures™. Of the 620 hospitals nationwide and 15 statewide that were listed, Baton Rouge General Medical Center was the only Baton Rouge area hospital recognized. Top Performers have achieved exemplary performance in using evidence-based clinical processes that are shown to improve care for certain conditions. Baton Rouge General was recognized for its achievement on quality measure sets in the areas of Heart Attack, Heart Failure, Pneumonia, and Surgical Care.

The Top Performers ratings are based on an aggregation of accountability measure data reported to The Joint Commission during the 2011 calendar year. Top-performing hospitals met two 95 percent performance thresholds. First, they achieved performance of 95 percent or above on the composite score that includes all the accountability measures for which data were reported to The Joint Commission for calendar year 2011. Second, recognized hospitals met or exceeded a 95 percent performance target for each and every accountability measure for which they reported data.

Also recognized in Louisiana were:

- Rapides Regional Medical Center, Alexandria
- Oceans Behavioral Hospital of Lafayette, Broussard
- Lakeview Medical Center, LLC, Covington
- Bayne-Jones Army Community Hospital, Fort Polk
- Leonard J. Chabert Medical Center, Houma
- Women & Children's Hospital, LLC, Lake Charles
- Byrd Regional Hospital, Leesville
- Minden Medical Center, Minden
- Dauterive Hospital Corporation, New Iberia
- Oceans Behavioral Hospital of Opelousas, Opelousas
- Huey P. Long Medical Center, Pineville
- Ruston Louisiana Hospital Company, LLC, Ruston
- West Calcasieu Cameron Hospital, Sulphur
- Mercy Regional Medical Center, Ville Platte.

View the complete list of 2012 Top Performers at www.jointcommission.org.

Lane to Add Radiation Oncology Center

Lane Regional Medical Center and Baton Rouge General have announced a joint venture to build a multi-million dollar, state-of-the-art Radiation Oncology Center, located on Lane's campus in Zachary.

The American Cancer Society estimates about 23,480 new cancer diagnoses in Louisiana this year, with prostate, lung, female breast, and colo-rectal among the most common. The CDC notes that about 50% of all cancer patients receive some type of radiation therapy during the course of their treatment.

Groundbreaking of the new facility was scheduled for late Fall 2012 with a 12-month construction schedule.

MBPCC and OLOL Unify Cancer Services

Mary Bird Perkins Cancer Center (MBPCC) and Our Lady of the Lake Regional Medical Center (OLOL) have entered into an agreement signifying an even closer, integrated alliance in providing cancer care to the surrounding communities. Jointly branded as Mary Bird Perkins-Our Lady of the Lake Cancer Center, the two organizations will move forward together in creating a more unified experience for patients, which will include a phased-in integration of the two organizations' cancer services, processes, and interactions.

MBPCC and OLOL have been accredited together since 1992 by The American College of Surgeons, which is the gold-standard for community-based cancer care. However, the National Cancer Institute's (NCI) competitive selection of the Cancer Center as a National Community Cancer Centers Program (NCCCP) site in 2007 quickly accelerated the partnership's progress. NCI recently selected the Cancer Center for continued participation in NCCCP for the next two years. Together with 20 other centers across the United States, Mary Bird Perkins-Our Lady of the Lake Cancer Center will continue its focus on the accessibility of high quality cancer care across the entire cancer care continuum, including best practice survivorship services, leading-edge clinical trials, and multidisciplinary cancer care teams dedicated to expertise with specific disease sites.

Despite their unified cancer care efforts, the two organizations will remain separate entities with individual board leadership. The overall governance structure of the unified Cancer Center will be provided by the Cancer Center Leadership Team, consisting of MBPCC and OLOL executives and medical staff leaders who will oversee its strategic direction. Cancer Center staff will continue to work for their respective organizations, and physicians will retain their current status as members of the MBPCC or OLOL medical staffs. MBPCC will continue serving its other established markets and partners.

Ochsner Physician Earns Board Certification

Ochsner Baton Rouge Orthopaedic Surgeon Catherine Petty, MD has earned her board certification in orthopaedics. Dr. Petty joined Ochsner in June 2010 and sees patients at Ochsner Health Center–Summa. Dr. Petty earned her medical degree from Medical University of South Carolina and completed her orthopaedic surgery residency at Harvard. Additionally, Dr. Petty completed a fellowship in orthopaedic sports medicine at Taos Orthopaedic Institute as well as an orthopaedic

peripheral arterial disease

Pain in your legs or feet?

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FROM LEFT Catherine Petty, MD; Stephen M. Graham, MD; Brad M. Lake, MD; and Sue Knight.

trauma fellowship in Portland, Maine. Dr. Petty is a member of the Arthroscopy Association of North America, the Orthopaedic Trauma Association and the American Orthopaedic Society of Sports Medicine. Her special interests include arthroscopy and fracture care.

North Oaks Opens Urological Associates

North Oaks Physician Group announced it has opened Northshore Urological Associates in Hammond and Livingston. Urologists Stephen M. Graham, MD, and Brad M. Lake, MD, staff the clinics.

Both Drs. Graham and Lake specialize in the treatment of disorders of the male and female urinary tract, including blood in the urine, recurrent urinary tract infections, overactive bladder, kidney stones, and trouble with urination. They also specialize in care of the male reproductive system, including vasectomy and infertility. They diagnose and treat several cancers of the urinary tract including the prostate, kidney, and bladder and are trained to perform minimally invasive surgical procedures using the da Vinci® robotic surgery system at North Oaks Medical Center.

Dr. Lake earned his medical degree from Louisiana State University Health Sciences Center in New Orleans. He went on to complete an internship in general surgery at Baylor University Medical Center in Dallas and a residency in urology through Washington University/Barnes-Jewish Hospital in St. Louis. Dr. Lake also earned a bachelor's degree in microbiology with a minor in chemistry from Louisiana State University in Baton Rouge.

Dr. Graham earned his medical degree at Louisiana State University Health Sciences Center in Shreveport and completed his internship in general surgery and residency in urology at the University of Kansas Medical Center. In addition to his medical degree, Dr. Graham also earned a bachelor's degree in kinesiology from Louisiana State University in Baton Rouge.

The Hammond practice of Northshore Urological Associates is located in Suite 201 on the second floor of the North Oaks Clinic Building at 15813 Paul Vega, MD, Drive on the North Oaks Medical Center campus. The Livingston practice is located within North Oaks-Livingston Parish Medical Complex at 17199 Spring Ranch Road.

Knight Earns Fellow of HFMA

The Healthcare Financial Management Association (HFMA) has awarded Sue Knight of St. Elizabeth Hospital the certification of Fellow (FHFMA). Knight, an HFMA member since 1997 and HFMA Louisiana Chapter participant, earned this prominent designation by demonstrating a significant level of expertise, service, and commitment to transforming the healthcare finance industry.

Knight is the Chief Operating Officer for St. Elizabeth Hospital and St. Elizabeth Physicians. She has been employed with St. Elizabeth Hospital since August 1, 2000. Knight is a Certified Public Accountant and has also been recognized as a Chartered Global Management Accountant.

To be awarded the FHFMA distinction, applicants must be credentialed as a certified healthcare financial professional; be an HFMA member for at least five years; complete a bachelor's degree or 120 semester hours from an accredited college or university; and volunteer in HFMA or the industry. Fewer than 1,200 individuals have received this honor in the organization's 65 year history.

Lane Expands Hours at Urgent Care Clinic

Lane Regional Medical Center announced that its after hours urgent care clinic, FASTLane, is now open: Monday – Friday from 7 a.m.-10 p.m., and Saturday – Sunday from 9 a.m. – 6 p.m.

With on-site x-ray, lab, and drug screening services, FASTLane is designed to take care of things like routine physicals, fevers and coughs, sprains and strains, eye and ear infections, stomach viruses, cuts and bruises, and everything else that is not a true emergency. FASTLane is located at 19900 Old Scenic Highway in Lake Pointe Centre.

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PHYSICIANS ARE YOU PREPARED FOR YOUR "RAC" VISIT?

The Tax Relief and Health Care Act of 2006 made permanent the Medicare Recovery Audit Contractor (RAC) program to identify improper Medicare payments - both overpayments and underpayments-in all 50 states (currently approximately 96% of mistakes have been overpayments). RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers.

RACs may review the last three years of provider claims for the following types of services: hospital in-patient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. The RACs use proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding. RACs also conduct medical record reviews.

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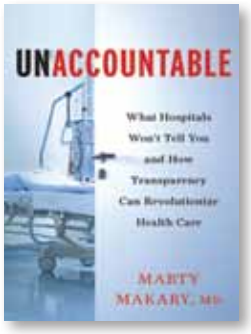


Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care
by Marty Makary, MD
c.2012, Bloomsbury Press
$26.00 / $27.50 Canada
246 pages

You're trying hard not to be scared.

You really weren't surprised when the doctor said you needed an operation. It was kind of expected, but let's face it – you're nervous, even though you know you're in good hands.

But are you? How does your hospital rate for safety and employee satisfaction?

Believe it or not, the hospital doesn't want you to have that information, but in the new book "Unaccountable" by Marty Makary, MD, you'll see how transparency could make a difference in your health.

When you chose your personal physician, you probably had many reasons for settling on that one person. Maybe he came with a good recommendation from friends. She might have been a referral from another doctor. But how do you know you got the right doctor for you?

The truth is, you may never know. Hospitals, says Makary, pay good money to ensure that internal surveys on teamwork, safety, adherence to policy, mortality, infections, and more never become public. What's more, doctors are loath to sound the alarm on a colleague's incompetence because doing so is career suicide. Honesty and outspokenness can get a doctor "run out of town," and though it's assumed that the State Board will handle an issue, Makary says it's not always what happens.

What he recommends is transparency.

If hospitals allow the public to know where internal problems lie and where money is invested, that knowledge gives prospective patients the power to change the system for the better by patronizing institutions that are doing things right. Hospitals with poor performance scores will be forced to rise to the challenge and improve.

Transparency, he says, worked in New York's heart centers. It could work everywhere.

In the meantime, there are things you can do to help yourself when you need medical care.

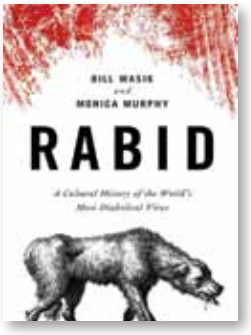
Be aware of clever marketing and don't let a flashy website keep you from asking questions. Use your right to a second (or third) opinion, even if you have to pay for it yourself. Know what kind of doctor you need and pick one who's done a lot of the kind of care you require. And finally, before you settle on a surgeon, ask other healthcare workers who they'd choose for their healthcare.

That, says Makary, "...tells you everything."

Sobering, thought-provoking, and wonderfully entertaining, "Unaccountable" is also very controversial. And, according to author Marty Makary, it's something many of his fellow physicians thanked him for writing.

Using his own experiences and observations as examples for his ideas, Makary sharply illustrates how bad medicine can have tragic outcomes and what can be done about it. Readers will surely be shocked—and frustrated because of the code of silence that Makary describes in dismaying detail and because he offers ample reasons behind why the cost of getting you healthy will make you absolutely sick.

If healthcare is on your mind in this politically-divisive year, then "Unaccountable" will give you more food for thought. This book on medical transparency is clearly something you'll want to read.



Rabid: A Cultural History of the World's Most Diabolical Virus
by Bill Wasik and Monica Murphy
c.2012, Viking
$25.95 / $27.50 Canada
275 pages, includes index

You've been robbed.

Robbed of a clean yard because you put your trash out last night, and when you woke up, it was strewn all over. You were robbed of a good mood, too. Thing is, you could easily pick the culprit out of a line-up, even though he always wears a mask.

You'd go out and shoo that raccoon away if you could, but you doubt you'd ever catch him. And after reading *Rabid: A Cultural History of the World's Most Diabolical Virus* by Bill Wasik and Monica Murphy, you'll be glad for that.

Hidden inside some of history's oldest, most important writings are clues that a scourge has plagued mankind for eons: "lyssa" is casually mentioned in The Iliad. The Code of Hammurabi proscribes punishment for the owner of an animal with it. Ancient Indian texts describe rabies and its symptoms and, perhaps not surprisingly, most sources blame the virus on the dog.

The rabies virus itself is shaped like a bullet, the tip of which carries "a malevolent payload of...RNA." Once the virus enters the body, it does what very few other viruses do: it avoids the bloodstream, instead "creeping" up the nervous system at an average of two centimeters a day, on its way to the brain. It moves so slowly, in fact, that it could take months for symptoms to appear. By that time, sufferers may not remember having been bitten by the animal that transmitted the virus.

Throughout history, various methods have been used in the "cure" of rabies. Ancient Sumerians proscribed magical water for the patient to drink; an interesting treatment, in light of the infection's most infamous (hydrophobic) hallmark.

Fifteenth-century English literature recommended using a rooster's hind-end to "suck forth the poison." Bleeding was once considered curative, as was more sex, but it wasn't until Louis Pasteur's then-risky vaccine that rabies was treatable and not until this century that full-blown, totally symptomatic cases have been survivable by humans. Today, the WHO estimates that 55,000 people – mostly in Asia and Africa - die from rabies each year.

...Fifteenth-century English literature recommended using a rooster's hind-end to "suck forth the poison."

And the poor dog? Since the virus is "perfectly matched to the dog as host," he's definitely a carrier, but probably not the most dangerous one. On this continent, bats, raccoons, and other wild animals give Fido a run for his money...

With a good mix of history and science, blended with literature and myth-busting, authors Bill Wasik and Monica Murphy give readers a chilling look at a disease that Westerners only think about when it's time to take pets to the vets.

That's good. What you'll want to remember, however, is that when they say "Rabid" is "not for the squeamish or weak-kneed," they're not exaggerating. Pet lovers, especially, need to know that while there's great information here, there are also parts that will turn your stomach.

Still, "Rabid" is lively, often borders on amusing, and is otherwise enjoyable, despite truly cringe-worthy parts. If you're feeling brave and want to read something unusual, it's a book to steal away with. HJBR

The Bookworm is Terri Schlichenmeyer.

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