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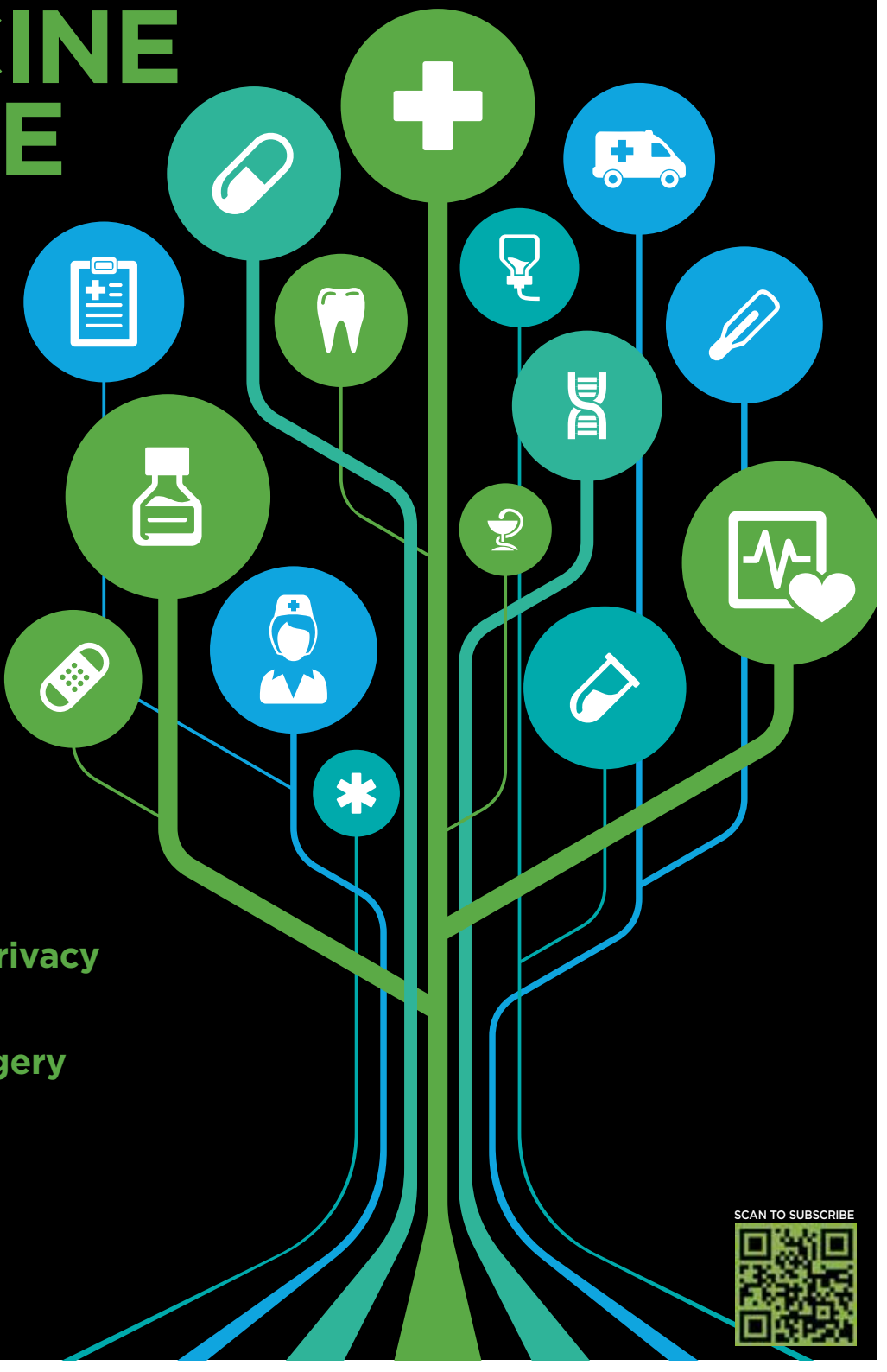
MEDICINE ON THE MIND



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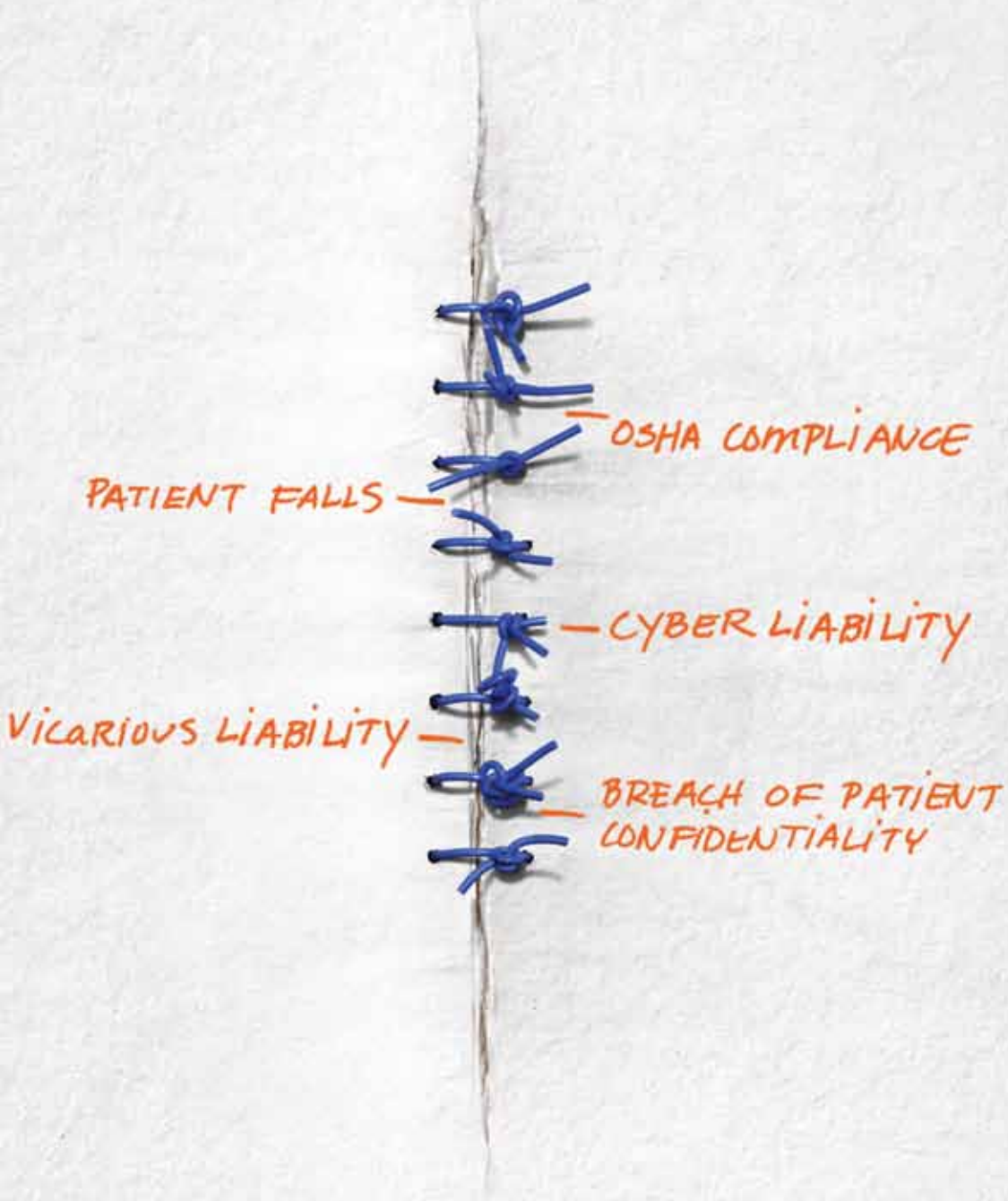

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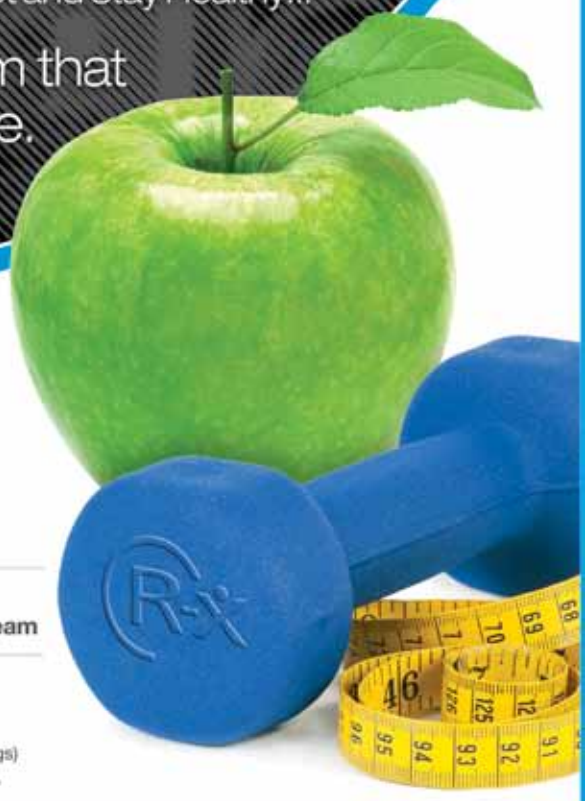

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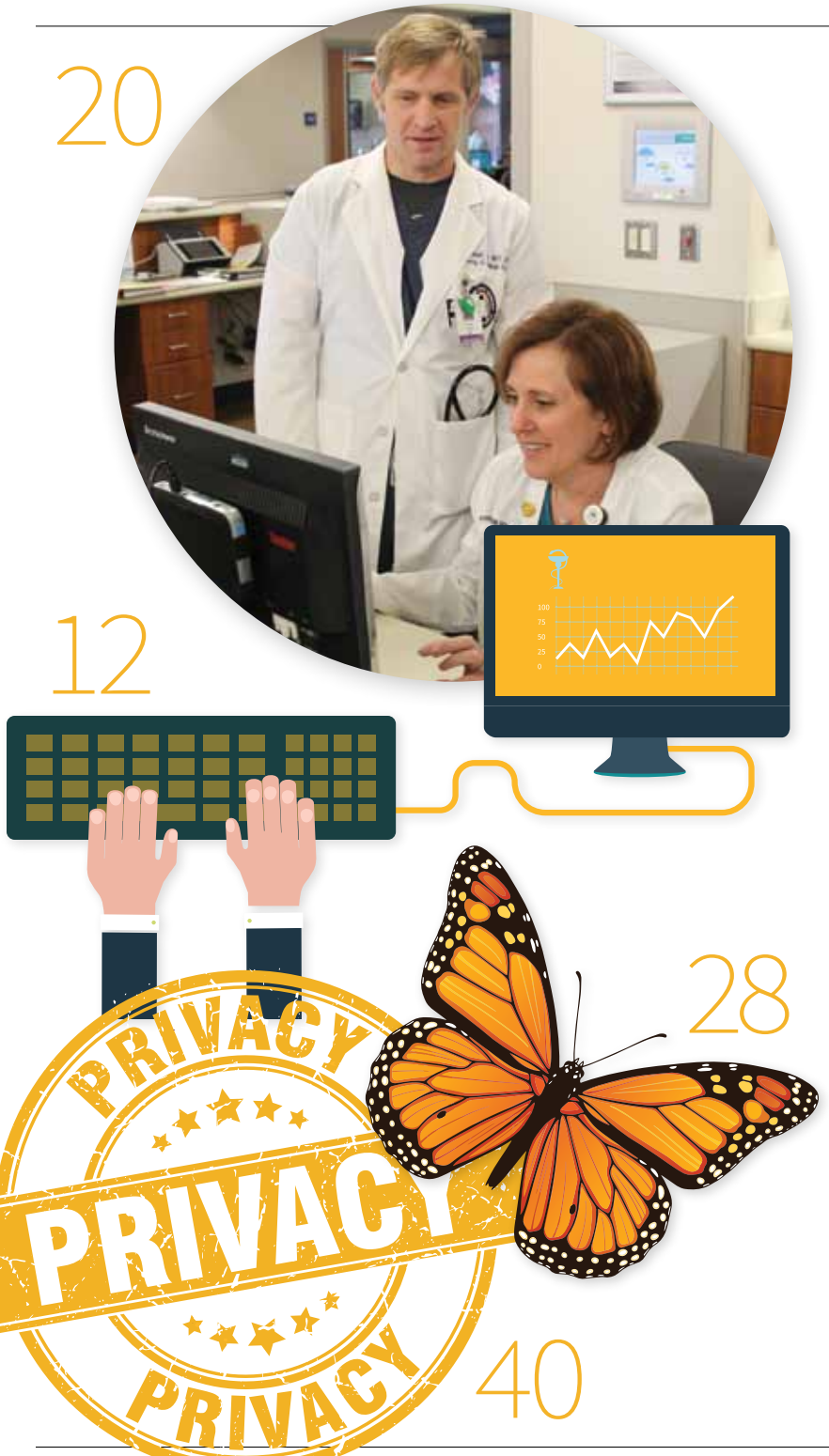

FEATURES

DEPARTMENTS

CORRESPONDENTS

The world population is at 7.5 billion people and growing. World health is a priority. The world is round.

DRAW YOUR OWN CONCLUSIONS about the future of human population, but I have to admit, this is an interesting dilemma; one I wrestle with as an advocate of world health.

It's estimated that at the end of the Great Famine and Black Death in the year 1350 that the world population was about 370 million. Some estimates predict over 11 billion people on earth within this century – perhaps over 25 billion people during the following century.

We're human beings, so we're human centric. We believe we are the most important living creatures. From our perspective, we're the center of the universe. If we were whales or butterflies, we would have an entirely different perspective, but we're not. So, let's just entertain our perspective as we normally do.

With an increased human population, we put a strain on natural resources. I don't think anyone denies this trend. We can likely, with enhanced planning, make modifications to our consumption and environmental influence. It's expected our foods will be much different in the future to account for consumption needs. A lifestyle on a crowded planet, will be different.

Population issues of the past have often sorted themselves out with disease, wars, etc. One obvious example is many of our European ancestors brought numerous diseases to populated lands which removed the large majority of native humans.

But, let's look at what's going on in the world with world news and the 24-hour news system. We are all watching each other. We are all chiming in.

Through the tool of fear, there will always be wars and rumors of wars. With increased international awareness, wars will become lessened due to an international community's resistance to war's justification.

Public health is being addressed in new and productive ways. There is a natural momentum to keep people alive and reduce death. We are living longer.

Please know that I'm not selling any idea or notions. I'm merely trying to resolve my own internal conflict with my own desire to solve world health issues. There are many great organizations working to minimize or eradicate communicable diseases throughout the world. I've worked with some talented folks on plans to improve health and improve opportunity. There is something that feels good and simple in this approach. The mantra becomes "all lives are important", "sustain life", "we're all God's children", etc.

I mention this in our local healthcare publication only to encourage some grassroots ideas. People are working on these issues, but most of us aren't invited into the room. It's good that we ask questions. It's good that we understand. Most of us wake up to provide good care to the patients we serve. Maybe that's good enough.

Smith Hartley
Chief Editor
editor@healthcarejournalbr.com

A TIMELINE OF surgery

For centuries upon centuries mankind has attempted to "fix what is broken" through a variety of often primitive surgical techniques. Taboos on investigating the bodies of those who had died meant that many methods relied on guesswork and theory as to the workings of the human body...a rather alarming prospect. Here are a few highlights of how surgery developed into the high-tech processes we use today.

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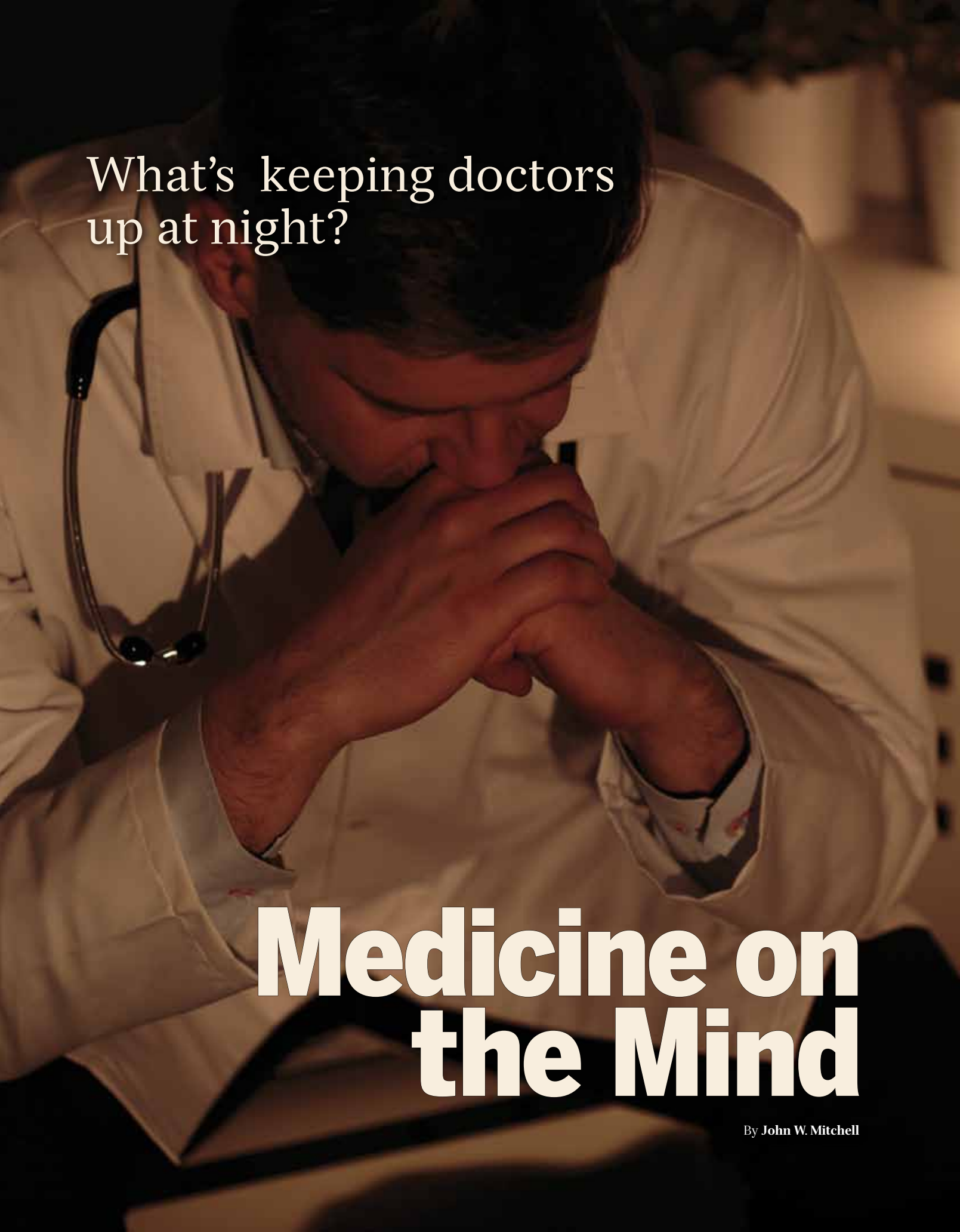


What's keeping doctors up at night?

Medicine on the Mind

By **John W. Mitchell**

Doctors have a lot on their minds these days.

The top nine medical concerns, according to the physician advocacy group the American Medical Association, include healthcare regulations (especially as delivery is being reshaped by the Affordable Care Act), issues such as health data security, and the evolving health insurance market (such as bundled payments).* To this list, the American Medical Management Group adds chronic care management and improving meaningful use in electronic health records.**

AND WITH MORE AND MORE DOCTORS being employed by hospitals, health systems are working to establish practice models that seek to make them more productive to help control costs. Louisiana currently ranks about in the middle nationally for the annual physician component of health expenditure costs, with doctor costs totaling $7.8 billion annually in the state.*** Nationally, physician expense runs about 27 percent of total healthcare costs.

The new healthcare delivery system reality is that doctors, hospitals, and even patients can no longer operate in a vacuum, independent of each other.

Of course, no healthcare gets delivered anywhere without a doctor's order. *U.S. Healthcare Journals* spoke to three Louisiana physician leaders and one national physician practice management expert about the challenges physicians face in this new order, as well as their strategies for dealing with epic shifts in healthcare delivery.

"Physicians control all the significant levers for costs – from what tests are ordered, if medications should be brand name or generic, and what kind of procedures need to be performed," said Floyd "Flip" Roberts, MD, Vice President of Clinical Affairs for the Louisiana Hospital Association. "From a physician standpoint there is a lot of frustration because payers are also trying to get their hands on the levers too. So there is always someone else in the room also trying to pull the right lever...this can be exhausting."

Dr. Roberts, a pulmonary and critical care specialist, noted that for physicians, practicing medicine has become more complicated as information sharing, quality reporting, and documentation standards become more vigorous. He supports the concept, as these requirements are intended to allow all physicians to care for any given patient anywhere, over time, but these new standards come with a price.

"The conversion from volume-based (taking care of ill patients) to value-based medicine (keeping patients healthy, also known as population health management) is a very difficult transition," he said. "There is a burden

"80 percent of doctors are in medicine because they have a calling, so they adjust to whatever practice models are necessary to care for patients. This includes the requirement to gather more quality data."

–Floyd "Flip" Roberts, MD, VP, Clinical Affairs, LHA

making sure all these measures are tracked and reported. But, the medical record plays a very important role in patient care."

For example, he said that when he started practice in 1982 it took about 2.5 employees in the "back" office handling paperwork. With the increase in reporting requirements, staffing has now more than doubled in order for the average medical practice to keep up. This is true for both private and hospital-employed physicians.

The switch from ICD-9 to the ICD-10, which uses more than five times the number of codes, has been a big issue for doctors since it was implemented in October.

Accurate coding is key for hospitals and doctors to get paid.

"These codes are a second language for physicians," Dr. Roberts said. "So learning the new codes has been kind of like learning in French, thinking in English, and then translating back into French."

Despite the challenges, the appeal of medicine is strong.

Floyd "Flip" Roberts, MD

Richard Vath, MD

"The really rewarding and fun part of medicine is the relationship with and taking care of the patient," said Dr. Roberts. "But we have to spend so much more time entering information into an electronic record now to tell the story of the patient, documenting for someone else (another doctor, insurance payer or the government)." But, he added, 80 percent of doctors are in medicine because they have a calling, so they adjust to whatever practice models are necessary to care for patients. This includes the requirement to gather more quality data.

"We have a lot fewer arguments about the data now," noted Richard Vath, MD, Senior Vice President and Chief Transformation Officer at Our Lady of the Lake Regional Medical Center. "We had to get past the individual physician view of 'in my experience' when it came to quality metrics. I have, on occasion, had to say to colleagues, 'Look I've

6,500 BC Ancient people use trepanation, the process of boring a hole, to relieve the skull of excess pressure.

c 1,500 BC The Ancient Egyptians have some knowledge of anatomy from mummification. They use clamps, saws, forceps, scalpels, and scissors. Egyptians use honey as an antiseptic.

2,700 BC The first known treatise on surgery was written by Imhotep, the vizier of Pharaoh Djoser. So famed was he for his medical skill that he became the Egyptian god of medicine.

known most of you for a long time and I have not read any peer-reviewed articles that say the quality data is controversial.' The data is not perfect, but we can accept it."

This buy-in on a common patient record platform, which includes quality measures, has been key at the Franciscan Missionaries of Our Lady Health System (FMOLHS). On January 1 they officially launched a clinical network, according to Dr. Vath. The network will facilitate the transition to the new healthcare delivery system by providing a common patient record network for physicians statewide.

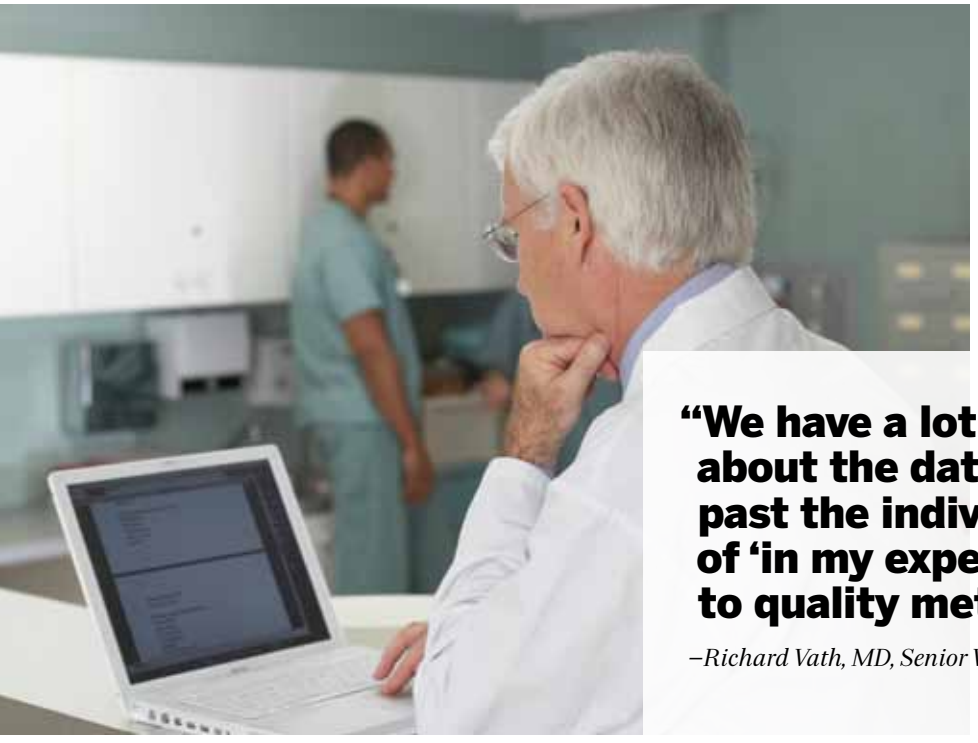
"The system has been laying the guide path for this clinical network for the past six or seven years," Dr. Vath explained. "This includes setting up a community-wide electronic ambulatory record and joint ventures with different community partners, including doctors throughout the state."

According to FMOLHS sources, the clinical network has 21 partnerships with various organizations. These include ambulatory surgical centers, specialty hospitals, outpatient physical therapy, cancer services, and after hours clinics. The statewide network also includes more than 600 providers, including physicians – and it's growing, said Dr. Vath.

While this network is key in helping the medical staff adjust to the new realities of healthcare delivery, it is also very much mission driven.

"We're fortunate to have a very strong mission in our healthcare system," said Dr. Vath. "The Sisters have never been shy or balked about taking care of the under- and uninsured. Expanding coverage for the uninsured has been accepted by our medical staff."

Mission helps – and is even a comfort, especially in Louisiana. The three Louisiana physicians interviewed all mentioned the state's decision not to participate in the Medicaid expansion option under the Affordable Care Plan. To one degree or another, all three noted that the state ranks near the bottom in the country for health and wellness, with high levels of obesity, diabetes,



"We have a lot fewer arguments about the data now. We had to get past the individual physician view of 'in my experience' when it came to quality metrics.

–Richard Vath, MD, Senior VP, CTO, OLOLRMC

MIPS

"MIPS adds a lot of transparency for quality and costs and penalizes some doctors. It's ominous, as it is not clear how it will operate."

and hypertension. These are all co-morbid, chronic diseases and among the most expensive to treat over time. When such realities are combined with the tough fact that the state still faces a nearly $2 billion budget shortfall,**** the truth is doctors not only have to juggle more balls faster, but do so while the ground is moving under their feet.

"What we have now is a fundamental switch in how to organize and pay for healthcare," noted Joseph Bisordi, MD, executive Vice President and Chief Medical Officer at Ochsner Health System.

He, too, said the transition from volume-based to value-based medicine as driven under federal mandate, including the Affordable Care Act, is a big change. But, he added, the Ochsner system has a good 74-year track record of aligning hospital and physician interests.

"We have some history working under these models. A third of our reimbursement is in capitation or shared-savings insurance models," said Dr. Bisordi.

As an example of how value-based medicine is replacing volume-based (or the old fee-for-service payment system) he cited the quality metric management approach that Ochsner deploys with its diabetes patients. This is historically one of the largest patient segments in the healthcare system. Ochsner has created a registry and reaches out to diabetics. Through a combination of mailers, emails, and phone calls, Ochsner was recently able to get 8,000 patients to reengage in their own care to help better manage their diabetes, such as having their A1C test updated.

"There is a lot of long term benefit for patients and the healthcare system. And by working with our medical staff, we are doing what we need to not just control costs, but improving the quality of care." He stressed that by aligning more than a thousand employed physicians and partnering with many other community-based doctors, it creates a shared approach to make the necessary transition under value-based healthcare delivery.

"We have excellent quality scores and we are controlling costs," added Dr. Bisordi. "We have not yet triggered all the Accountable Care Organizations (ACO) cost-sharing payments. But I think the next round of generation of ACOs will be tweaked to address problems. This is an important direction (in healthcare reimbursement) and we will be successful."

Dr. Vath also said that changing reimbursement models require doctors and hospitals to work together in new ways. Although CMS, which manages Medicare, just announced a pilot project to pay doctors and hospitals in about 70 major metropolitan markets a single lump sum – or bundled payments, the FMOL Health System has been operating under a

"What we have now is a fundamental switch in how to organize and pay for healthcare."

–Joseph Bisordi, MD, Executive VP and CMO, Ochsner Health System

c 600 BC Indian physician Sushruta, sometimes dubbed as the "founding father of surgery," composes the Sushruta Samhita, one of the oldest known surgical texts.

c 400 BC The Ancient Greeks perform minor surgical procedures with tools fashioned from iron, but do not perform procedures on the inner parts of the body.

c 300 BC The Greeks bathe wounds with wine to prevent them becoming infected.

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"Some entities have been doing value-based contracting for a while, but for most it's a new concept. It adds to the anxiety level of doctors because they don't know how it's going to affect their income."

–James Whitfill, MD

bundled open heart and total joint bundled model for nearly three years.

"The physicians endorsed this at both the quality and financial level," Dr. Vath said. "We've had good shared success on the total joint side and not as much yet on the CABG (open heart) side – but we're learning." He stressed that part of every contract with a physician to provide service is a performance-based metric to align the efforts of the hospital and medical staff.

All this change is likely to serve as a warm-up for one of the biggest looming changes for doctors–how they get paid. James Whitfill, MD, is a nationally recognized expert in health informatics, ACOs, and change transformation. He serves in several capacities that give him insight into this issue. Among other roles, he is Chief Medical Officer at Scottsdale Health Partners in Phoenix, Arizona; President of Lumetis, a consulting company that advises physicians on issues related to the transition from volume-based to value-based medical practices, including IT; and a Clinical Assistant Professor at the University of Arizona College of Medicine in the Department of Internal Medicine and Biomedical Informatics.

"We (physicians) are at a tough crossroads with the whole migration from fee-for-service to fee-for-value," he said. "We're not clear what that looks like for each specialty and physicians don't understand how to plan. Some entities have been doing value-based contracting for a while, but for most it's a new concept. It adds to the anxiety level of doctors because they don't know how it's going to affect their income."

In 2019, payment models for physicians will change dramatically. The model generating the biggest buzz is Merit-based Incentive Payment System, or MIPS. While other alternative payment models will be allowed (including ACOs and bundled care agreements), it's enough to know at this point that it will be a zero-sum gain system. CMS will, in one form or another, pay based on quality, performance, and cost metrics. This means taking money from lower performing physicians to pay higher performing physicians.

"MIPS adds a lot of transparency for quality and costs and penalizes some doctors," said Dr. Whitfill. "It's ominous, as it is not clear how it will operate."

Dr. Whitfill said the transition needs to be taken seriously and work needs to start now. His medical group operated the only MSSP (a type of ACO) in Arizona to receive performance pay in the last fiscal year.

Physicians also have an age-old demon to battle: striking the right balance between the passion of their career and their personal life. This is certainly not getting any easier with the tectonic shift under way in medicine.

"Doctors of my generation have always had a hard time saying enough is enough," said Dr. Roberts with the LHA. "It's an underlying challenge for physicians to try to achieve a decent quality of life, maintain their income, and struggle with the overhead of operating a small business."

His advice to fellow doctors?

"It's important to rely on family, friends, and faith...to cultivate another dimension in your life." ■

SOURCES

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** http://www.medpagetoday.com/Washington-Watch/Washington-Watch/55538?xid=nl_mpt_DHE_2016-01-07&eun=g918885d0r
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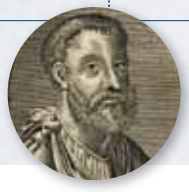
c 161 AD

Having practiced on animals and gladiators Greek-born physician Galen becomes surgeon to the Roman emperor. His ideas, although often wrong, dominate surgery for centuries.



476

With the fall of the Roman Empire many medical skills are lost in Europe but are kept alive in the Byzantine Empire and are later practiced by the Arabs.

c 1200

In Europe skilled craftsmen called barber-surgeons practice. They carry out amputations and set broken bones. However barber-surgeons are lower in status than university educated doctors.

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Medical Director of Research
Our Lady of the Lake Regional Medical Center

Hollis R. (Bud) O'Neal, MD, MSCI, is an Assistant Professor of Medicine and Medical Director of Research at Our Lady of the Lake Regional Medical Center's Office of Research.

Dr. O'Neal earned his MD from Louisiana State University School of Medicine in 2002. After completing his residency in Internal Medicine at the LSU-Earl. K. Long Internal Medicine Residency Program in 2005, he completed his fellowship in Pulmonary & Critical Care Medicine at Vanderbilt University in Nashville, Tenn. in 2009. He earned a Master's of Science in Clinical Investigation from the Vanderbilt University School of Medicine during his fellowship training.

Following training, Dr. O'Neal accepted a position at the Baton Rouge campus of the Louisiana State University Health Sciences Center with a joint research appointment that allowed him to utilize the skills he obtained through this program. In 2013 Louisiana State University, though a public-private partnership, merged its Baton Rouge training program with Our Lady of the Lake Regional Medical Center. Shortly afterward, Dr. O'Neal was appointed as the Medical Direct of Research. Since then, Our Lady of the Lake has seen a dramatic increase in academic output, from investigator-initiated studies to participation in large-scale industry-sponsored research.

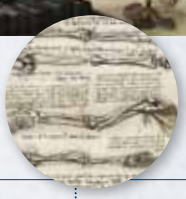
Additionally, through collaboration with the Our Lady of the Lake Department of Academic Affairs, Dr. O'Neal helped develop a program that provides residents with research exposure through case series, case reports, small cohorts, and participation in larger-scale studies. This program provides education and experience for the residents in conducting research (i.e., navigating human subjects protection, implementing the scientific method, responsible conduct of research, etc.) In this program, Dr. O'Neal has mentored several residents, assisting them and other faculty members in the development and execution of research projects and publications

Dr. O'Neal is also an active clinical investigator, serving as principal investigator for industry and investigator initiated clinical trials. He is a site Principal Investigator on a multi-centered NIH-sponsored trial, coordinated through Vanderbilt and its ICU Delirium and Cognitive Impairment Study Group, evaluating the effects of specific sedatives on long-term outcomes of ICU patients. Also, in addition to serving as the PI and/or co-investigator on pharmaceutic trials, Dr. O'Neal is currently working as the PI with a biotech company, CytoVale, INC (San Francisco, CA), in the development and evaluation of a novel diagnostic tool, using advanced microfluidic technology, for the early diagnosis of sepsis. He successfully completed a pilot project to evaluate the technology, and recently procured funding to generate a derivation cohort of 400 subjects to evaluate the diagnostic test characteristics of the assay.

RIGHT Dr. O'Neal and Christine Leboeuf, MSN, RN, Senior Clinical Research Manager, review research data.

“My long term vision is all about access to care for our patient population.”

c 1350 The Church allows some dissections of human bodies at medical schools, but the ideas of Galen continue to dominate.



c 1536 Ambrose Pare treats wounds with a mixture of egg yolk, rose oil, and turpentine rather than hot oil.

1452-1519 In his lifetime Leonardo Da Vinci dissects some human bodies and makes accurate drawings of them.

Chief Editor Smith W. Hartley Let's start with the "Why"—why does Our Lady of the Lake have an Office of Research?

Dr. O'Neal If you look at the history of research at Our Lady of the Lake, until a couple of years ago the Office of Research existed to support specific clinicians, typically private physicians in the community, who wanted to do research. Any time you do research there are a number of federal compliance issues and really a significant amount of effort that you go through to maintain compliance with federal regulations as far as maintaining ethics in the research that you are doing. So the Lake needed an office of research to manage those things and support those physicians.

In the last couple of years things have changed. The Lake now hosts LSU's training programs, the ones that were previously based at the now closed Earl K. Long Hospital, and has also grown in graduate medical education, by starting its own pediatric residency program and a joint psychiatry program with LSU. As the Lake has become an academic medical center part of that growth has been in the area of research.

Since I've been the Medical Director of Research for about two years, I've seen a lot of growth. It has moved from being just a support system for private physicians who want to participate in clinical research, often industry sponsored trials, into a viable piece of what an academic medical center is—to support not only trainees, but also academic physicians, physicians who have truly scientific questions that we want to answer to advance medicine from where we are today to where we think we should be tomorrow.

Editor How do you get physicians to participate? Is it communication from this department out to them or do they approach you with their ideas? What is the process?

O'Neal There's certainly some of both. There are those physicians who may have seen a trial or have been asked by a sponsor to participate in a study. An example might be a cardiologist—our cardiologists are very active in research and they want to participate—often a sponsor from a pharmaceutical company or somebody from the industry will ask them if they have a particular patient population that might benefit from participating in a trial and the physician will say, "Yes" and then come to us and say, "Can you help me facilitate the performance of this trial in our setting?" be it the inpatient setting or the outpatient setting.

It's not uncommon also that now, especially as we grow, physicians are curious and see problems in disease and areas where we really can advance the knowledge that we have. So sometimes those physicians come to us with what we call investigator initiated studies. They have a question and ask us to help them answer this question through research. That might be looking back retrospectively at the patient population that we've already treated using the medical record and the things we have to answer certain questions to see if maybe one thing we are doing has resulted in better outcomes than another. Or it might be prospective, saying, "Look we want to try doing this a different way now. We think we can do better, but we need to measure those outcomes to make sure we are indeed doing better." So we do get some of both.

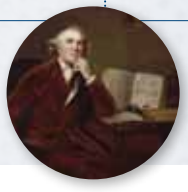
Again, we have training programs, we have residents and the various residency review committees have guidelines and requirements for residents to participate in research, be it either case reports or case series. It might be kind of looking at what happened to a specific patient or group of patients or even participation in more involved research. So the residents will often come to us and say, "Hey I have this question. Can you help me answer it?" So really there's a number of ways that physicians and principal investigators as we call them, get involved in research.

The Lake is a Catholic organization and we certainly want to make sure that anything we are doing falls within what's acceptable and what's appropriate by the religious directives that we have.

1540 The United Barber-Surgeons Company specializes in blood-letting and tooth extractions.

1543 Andreas Veasalius publishes The Fabric of the Human Body, which contains accurate diagrams of the human body. Vesalius bases his ideas on observation not accepted lore.

1728-1793 Life of John Hunter who is known as the Father of Modern Surgery.



Dr. O'Neal and Terrie Thompkins.

Editor How do the research priorities get set? Do you consider all requests or is there a system for selecting them?

O'Neal The first thing that happens is we have a principal investigator or a potential principal investigator come to us. They need to develop a protocol, to develop the study so we can see if it answers the question they have. They submit it to the Office of Research and then we look through it and do what we call a feasibility review to make sure of a couple of things. Number one that we think this question and this methodology is scientifically sound. Number two to make sure that it's ethical and fits in the directive of the Church. The Lake is a Catholic organization and we certainly want to make sure that anything we are doing falls within what's acceptable and what's appropriate by the religious directives that we have.

And then we look at the patient population to make sure that we do have that population that we're studying. It would not make sense to try to perform a study in a hospital where we don't have enough or any of the disease we are treating. And so there are a number of things that we go through. Once a number of people look at it and vet the studies and we approve it for performance in our patient population within the confines of our institution, then it goes from there to the institutional review boards and then from there the study can be executed.

...RESEARCH IS NOT ONLY A PHYSICIAN-DRIVEN PROJECT. IT REQUIRES INPUT FROM EVERYBODY.

Editor Once the study is complete, how are the results communicated? Are they fed to medical journals? What's the process for getting the information out?

O'Neal From the investigator standpoint or academician standpoint, the end result of research and the tangible outcome is a publication. That's what we're after; the ability to convey our knowledge, what we have gained from the study, to the rest of the world. Usually the way it would work, at least for an investigator initiated study, the principal investigator sits down with sub-investigators and participants in the study and we write up the manuscript and an introduction, then what we did, what we found, and how we interpret what we found. Once that is complete we submit it to a journal. The journals are peer-reviewed and then usually after a couple of weeks we hear back from them and they either accept it, accept it with some revisions, or decline to accept it, at which point you can try to revise it and resubmit or send it to another journal.

So that's how we would do an investigator initiated study. Now when there's a large study, so often, especially with industry-sponsored studies, we might be one site of many performing the drug and we might enroll 10 or 20 patients out of 1000 or more across the country or across the world. When that happens, it's up to the sponsor or the primary investigator over the whole study to publish the results and get those out there. For any prospective study one of the things that always comes up is, "If this doesn't work is it going to get out there?" It's important to understand that any prospective study, any interventional trial of any medication or procedure that's being done in a population is published on a website called clinicaltrials.gov and so you can always search for the results of a trial on that website. So if you are a patient who has participated in a study and you are wondering what the outcome of that study was you can always look that up. That's publicly available.

So there are multiple avenues through which you can publish the results of a study.

Editor I understand that you do medical research, but then you also do some processes studies. It sounds like you have taken the traditional quality department and sort of made it into a laboratory of operations.

"From the investigator standpoint or academician standpoint, the end result of research and the tangible outcome is a publication. That's what we're after; the ability to convey our knowledge, what we have gained from the study, to the rest of the world."

O'Neal Yes, we have a very robust quality department here. There are a couple of fine lines between what would be called quality improvement and research. Quality improvement really is taking what we have learned through research and applying it systematically in the institution to try to improve the outcomes of the population that the institution sees. And we have that entire quality department that manages those projects and it's their job, they are kind of similar to our sister department, to come up the design and execution of what we would call quality improvement projects, which are actually not research.

Editor **Does hospital research change the culture of a hospital? Does it encourage a more scientific approach within the rank and file?**

O'Neal It does. The goal is, and I try to explain to people, when we're doing research we are trying to find out what the next best step is. We're trying to advance medicine and you can't take the next step from the back of the line. So when you are participating in research your standard of care has to be best practice. If it's not then you won't learn what you need to learn from the research. So as research programs develop, the standard of the care within the community should escalate to the point of best practice. And this is the reason why the best hospitals are usually large academic centers. When you want to go for advanced therapy you go to a place that participates in research because their standard of care should be the absolute best. Because they are always looking for that next step.

I tell patients when they consent to participate in research that is the ultimate "gift" that the patient can give us. Our job is to make sure they are receiving at least the very best practice that medicine has to offer today. We are using the experience that we will gain from that research, those studies, so that our best practice tomorrow will be even better. It really is something that can change the culture. It changes the culture of the nurses, it changes the culture of the respiratory therapists, of all the ancillary services that we see, because research is not only a physician-driven project. It requires input from everybody. It really is fun to watch people buy into it. It's fun to watch the nurses want to participate and it's fun to work with the dieticians and the respiratory therapists to work together as a team to make medicine better.

Editor **So what is the process for recruiting patients for research? Is it a challenge?**

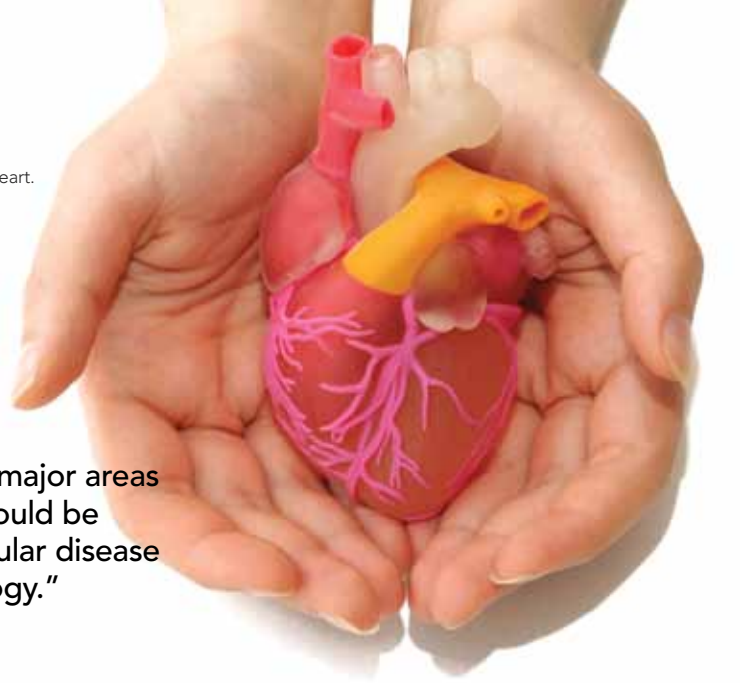
O'Neal I kind of talked about changing the culture of the nurses and the respiratory therapists and the ancillary services to want to participate. There is also, to a degree, a little bit of culture change with patients as well, because patients really are putting more trust in us. I think patients put a tremendous amount of trust in their physicians, but there's an added level of trust when you are talking about enrolling in research. There are places where you go where you know will be asked to participate in research, but it may not be expected in a place like Our Lady of the Lake, where research has not been a huge part of what has happened.

So what we do is—every study has a specific type of patient that it's looking for—we go to the physicians that may have a population of those patients. We educate the physicians on what we are looking for or what type of patient we are looking for and tell them, "If you think this patient might be appropriate and might gain some benefit from participating in this study then call us and we'll come talk to the patient." So at that point we approach the patient, explain to them what we're doing, what we're looking

1818 The first transfusion of human blood is performed by Dr. James Blundell.

1843 The first hysterectomy is performed in England.

1843-1844 Ether is introduced as a general anesthetic in surgery.



A 3-D printed heart.

for, and what the risks and benefits may be to the specific patient. Certainly the major benefit is that anybody that participates in research is helping to advance medicine for the next generation of patients. Then we tell them about the study, tell them what to expect, and ask them if they are interested. If they are interested then we get the consents together and go through that with them again, sign them up, and hopefully enter them into the study. No research is successful without patients enrolling. So the goal of the Office of Research is to provide a safe place so that patient can participate in research efficiently and really have a good experience with it.

Sometimes there is a bit of challenge. Patients don't always expect that they'll be asked to participate, but overwhelmingly patients appreciate it. They sometimes decline, but overwhelmingly they are curious and appreciative of the opportunity.

Editor **As of the beginning of 2016 what are some of the interesting projects you are working on?**

O'Neal We have a number of them. There are a couple of areas where we really are focusing our efforts in research because we think we have the resources to advance in those areas. One is cardiovascular research. We have a strong group of cardiologists. We have a strong group of nurses whose specialty is in cardiovascular research and so we have a number of interventional trials in the management of cardiovascular diseases like heart failure, managing cholesterol, and patients' risk factors for cardiovascular disease. We have Mary Bird Perkins with whom we participate in research. It's astounding the number of clinical trials they have access to for treating cancer. So those are two areas that we really try to focus on.

We've had recent publications from our residency programs in really just about every area you could imagine. It really is astounding the variety of things we have out there. Everything from experience with the use of certain medications all the way through diagnostic studies, and our experience with treating specific conditions in our community. So it's really a variety of things that we have, but our two major areas of focus would be cardiovascular disease and oncology.

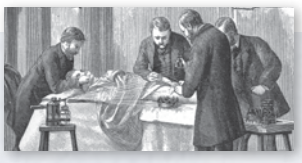
"...our two major areas of focus would be cardiovascular disease and oncology."

Editor **Can you touch a little bit on how this department is funded?**

O'Neal There are a number of ways through which we get funding. The Lake itself has been incredibly supportive and I think the administration sees the importance of advancing medicine through research. It has really helped us support the salaries of those involved in research. When a funded or sponsored study comes in the institution does receive some degree of support for enrolling patients for the study. The hope is that some of that goes to offset the cost of the research nurses and the regulatory and compliance people that we have to support the research endeavor of the institution.

There are also certain studies that are grant funded. So you receive a grant to

"We're trying to advance medicine and you can't take the next step from the back of the line. So when you are participating in research your standard of care has to be best practice."



1847 James Simpson begins using chloroform.

1867 British surgeon Joseph Lister publishes Antiseptic Principle in the Practice of Surgery, extolling the virtues of cleanliness in surgery and leading to an impressive reduction in surgical mortality.

1885 The first successful appendectomy is performed in Iowa.

participate in the research. But by and large our research department is supported by the institution itself.

Editor **I understand that some of your own research has focused on sepsis. What drew you to that area of study?**

O'Neal A couple of things. I am trained as an intensivist and so I did my fellowship training at Vanderbilt University which has a fairly large medical center. My mentors focused on this area. It's kind of forever the problem of the intensivist to figure out how to recognize, diagnose, and treat sepsis. And then, as a lot of things turn out, you end up in situations where you should probably take advantage of the opportunities in front of you, and I was offered an opportunity to participate with a relatively small biotechnology company out of San Francisco that is developing a new diagnostic study for the early diagnosis and early recognition of sepsis.

They are brilliant people—it's founded by a number of PhDs that graduated from MIT and they have developed this technology by which we can measure the physical properties of the individual cells on a scale that has never been done before, on the order of several thousand cells per second. We can look at their deformability and the idea is that cells that have been activated by sepsis are more deformable than cells that have not been activated. We might be able to use these properties of cells to recognize very early in the course of the disease who is septic from who is not.

We completed a small pilot study evaluating it, we had some good results, and those results were actually published as a poster at one of the international meetings called Critical Care, this past May. And then we are about to initiate the next phase of the study, which is going to enroll 400 patients looking to see the diagnostic utility of this test. So that's my current project and then a couple of other smaller studies, some NIH sponsored studies of which we we're one of several sites across the country, that we're participating in as well.

Editor **What's your long term vision for the Office of Research?**

O'Neal My long term vision is all about access to care for our patient population. I would hope that our research office in the next five to ten years can become a player in our state and our region as far as offering access to clinical trials, access to advanced treatment and care that patients don't otherwise have access to. I grew up in rural Louisiana and when I went off to fellowship I saw a side of medicine that I had never seen before—access to world class research and world class medicine. We have some of that here in Baton Rouge. Pennington is a world class center. There are some great things that happen here, but I think that bringing those things together and the Lake being the size it is, being the largest hospital in the state, and now truly an academic medical center, I would love to see the Office of Research play a role in advancing the Lake in that arena of becoming a truly legitimate viable academic medical center in our region to support the patient population that we have.

Editor **Do you work with Pennington or other research centers? Or are you isolated in your research?**

O'Neal Research is not at its best when done in isolation and I think it is best done through collaboration with whomever shares the same goals that you do. On an individual project level we do collaborate with Pennington and we do collaborate with some of the other institutions in the city, not on a systematic level by any means, but certainly on individual projects. And we certainly advocate for doing that when we can.

Editor **Does developing the research side of the Lake work as a recruitment tool for attracting new physicians?**

O'Neal It definitely does. To get top talent you have to have the top facility in whatever area it is. I think at the Lake we have a world class facility as far as taking care of patients. Some of the top talent wants to come and just take care of patients and not participate in research and we've never had an issue trying to recruit those physicians. But there are some physicians who want to be academicians and who want to be researchers and want the opportunity to do that. It's those clinicians and physician scientists who would now come because they do have the opportunity to have the career that they want. I think a couple of years ago it was not really a possibility really within the city or this area of the state. So it has certainly helped with recruiting physicians.

It also helps with recruiting residents. A residency program is only as good as the teachers and the trainees that we have and one of the things residents look for is the ability to participate in research either to learn for their own knowledge or that resident may want to go on to a fellowship or subspecialty training in some other institution and sometimes it's helpful to participate in research.

Editor **What do you personally want your legacy to be in terms of research and health?**

O'Neal I think for me, personally I don't want anything out of it, but I am an academician and at the end of the day it's about doing a couple of things. Number one it's about providing the best care I can to my patients. Number two, it's about teaching the doctors that come through, the student doctors, the residents, the doctors that will be taking care of me and my children. It's about teaching them to be the best doctors that they can be. And then it's about advancing knowledge. So I would hope that at the end of the day when I look back on my career I can say I was a very small piece of the puzzle that gave Louisiana something that I think has been missing which is a true academic medical center, something that would draw patients from where I grew up in DeRidder to come here to receive therapy and not have to leave the state or leave the region to go find what we don't have. I think that, ultimately at the end of the day, is what I would like to see. ■

Making Every Moment Meaningful

Canon Hospice is making a difference in our community by providing quality end of life care to those seeking comfort and dignity while dealing with a life limiting illness. Care is provided by skilled hospice professionals who specialize in pain and symptom management.

Canon's community involvement is extended even further through the non-profit Akula Foundation. The foundation sponsors:

- Camp Swan, a children's bereavement camp held three times a year, in Biloxi in the spring, Baton Rouge in the summer and the Northshore of New Orleans in the fall.
- The Canon Hospice Health Hour of New Orleans airs each Saturday from Noon – 1pm on WGSO 990 AM.
- The Grief Resource Center (GRC) offers educational inservices to health care professions, free of charge, throughout the year. In addition the GRC offers grief support to anyone in the community experiencing any type of loss.

All Foundation services are free and open to the public. For information about Canon Hospice, Camp Swan, The Canon Hospice Health Hour or Community Education and support, contact a Canon location in your area.

Northshore
985.626.3051

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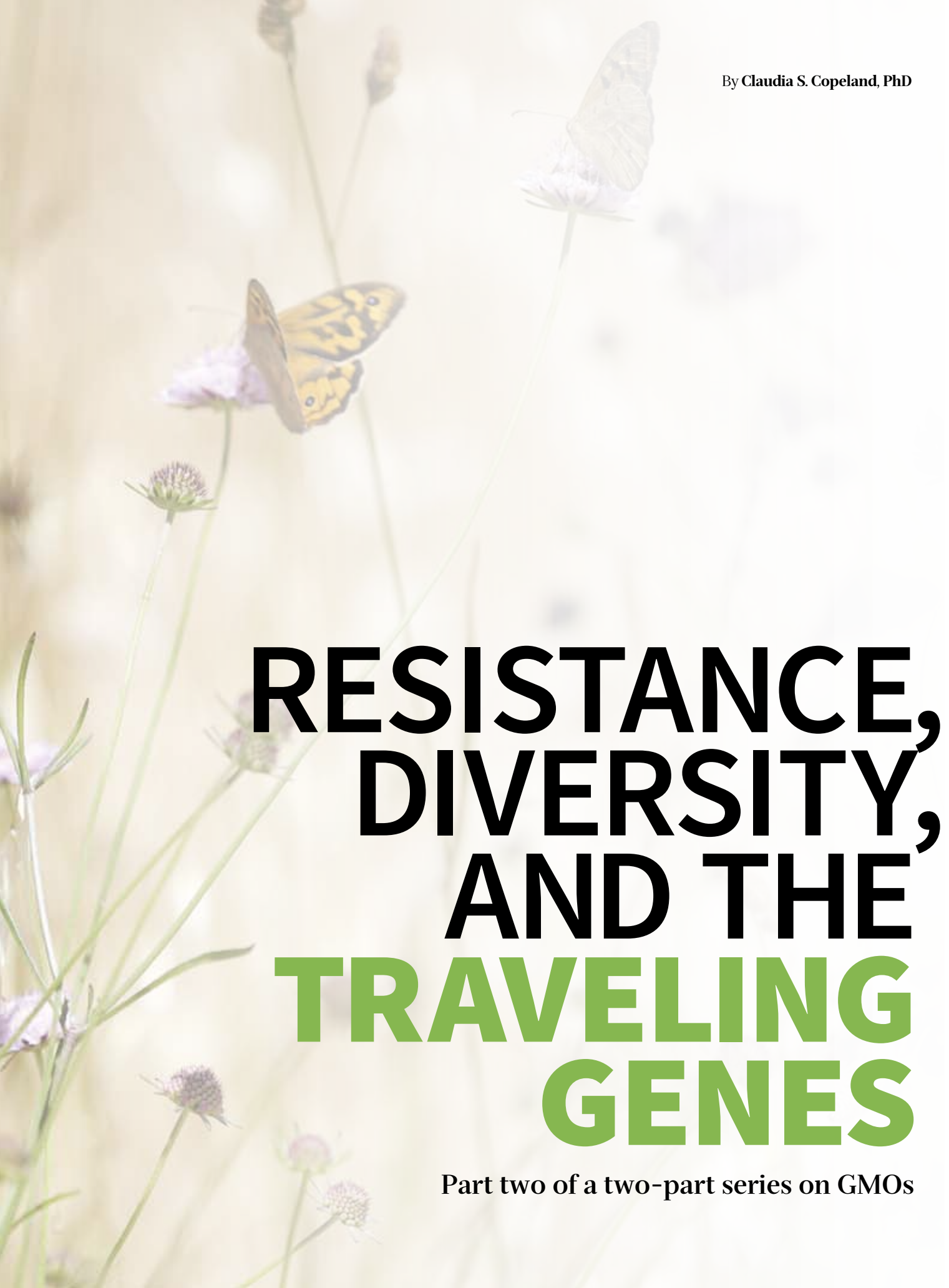
CANON HOSPICE

"Making Every Moment Meaningful"



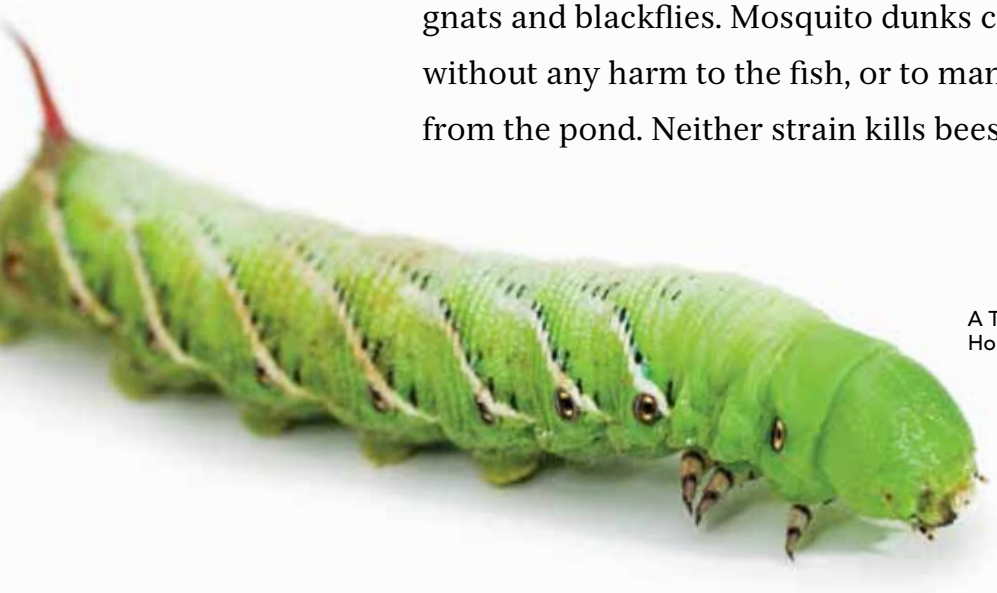
By **Claudia S. Copeland, PhD**

RESISTANCE, DIVERSITY, AND THE TRAVELING GENES

Part two of a two-part series on GMOs

To anyone trying to grow organic food, Bacillus thuringiensis is a natural wonder.

This humble soil-dwelling bacterium, discovered independently in Japan in 1901 and Germany in 1911, infects specific pest targets without any danger to people, since it is only pathogenic to insects. The kurstaki strain (in most garden-store organic pesticides, including Safer Brand Garden Dust, Monterey B.T., and Thuricide) is targeted specifically to Lepidoptera, including garden pest caterpillars such as army worms, cabbage loopers, tent caterpillars, and tomato hornworms, but also other lepidopterans, including stinging buckmoth caterpillars. Another strain, the israelensis strain (sold under brand names “Mosquito Dunks” and “AquaBac”) kills only mosquitoes and closely related insects, such as fungus gnats and blackflies. Mosquito dunks can be used in a fish pond without any harm to the fish, or to mammals or birds that drink from the pond. Neither strain kills bees.



A Tomato Hornworm.

Left: Lesser cornstalk borer larvae extensively damaged the leaves of this unprotected peanut plant. Right: After only a few bites of peanut leaves of this genetically engineered plant (containing the genes of the Bacillus thuringiensis (Bt) bacteria), this lesser cornstalk borer larva crawled off the leaf and died. *–Photo by Herb Pilcher.*

B. thuringiensis works so well, and is so safe, that it should come as no surprise that genetic engineers resolved to take genes from this natural bacterium and insert them into corn. Rather than spraying the bacteria on corn plants, the corn plants would make their own B. thuringiensis proteins. The first strains of such engineered corn, known as Bt corn, were introduced in 1996, providing effective control of the corn borer, which had caused vast infestations throughout the United States and Europe.

Non-target organisms

Not long after, though, questions arose about whether Bt corn might kill non-pest lepidopterans. In 1999, Cornell University entomologists Losey et al. published the results of laboratory experiments looking at whether pollen from Bt corn could harm monarch butterfly larvae. Monarch butterflies feed on milkweed, not corn, but corn is wind-pollinated, so it is plausible that the pollen could be blown to milkweed fields. Losey et al. dusted milkweed leaves with Bt corn pollen, unmodified corn pollen, and no pollen as an additional control group. Compared with monarchs in the two control groups, the monarchs that fed on leaves dusted with Bt corn pollen showed a number of health effects, including slower growth and higher mortality.

These results raised great concern among university biologists and the EPA. The USDA Agricultural Research Service provided funding for a consortium of biologists from universities in the United States and Canada to assess whether Bt corn posed a threat in the field to monarch butterflies. Their conclusions, in agreement with a separate study by the EPA, were that the threat to wild monarch butterflies in the field from Bt corn was negligible, for the following reasons: 1) the amount of pollen dusted on the milkweed leaves in the Losey lab experiment was much higher than would ever occur under real field conditions; 2) the toxin-encoding genes are not highly expressed in pollen,

In an effort to reduce corn stem-borer infestations, corporate and public researchers partner to develop local [transgenic] Bt (Bacillus thuringiensis) corn varieties suitable for Kenya.

BY DAVE HOISINGTON/CIMMYT [CC BY 2.5 (HTTP://CREATIVECOMMONS.ORG/LICENSES/BY/2.5)], VIA WIKIMEDIA COMMONS

further lowering the dose; 3) the seasonal overlap between the time of monarch larval feeding and pollen release in corn is limited, although the overlap is substantial in far northern regions; and 4) the only strain of corn that expresses enough toxin to measurably affect monarchs, called event 176 hybrids, constituted less than 2% of corn planted at the time of the study. Nevertheless, by 2004, event 176 hybrids had been phased out of commercial use in the United States.

Clearly, biologists at the EPA, USDA, and academia consider this a serious issue. The concerns raised by the Losey et al. study were not trivial—in laboratory studies, conditions are often artificial, designed to show proof-of-concept under very simplified conditions, and that is what Losey et al. did. While such findings do not necessarily reflect real-life field conditions, they do serve to emphasize the importance of careful risk assessment. Whenever a toxin-producing gene is expressed in a different organism, it substantially changes the way in which the dose of this toxin is delivered in the environment. B. thuringiensis is a soil-dwelling bacterium, and applying granules of the bacterium does not change the method of delivery nearly as much as having the gene expressed in cornfields of plants producing wind-dispersed pollen. For this reason, the EPA requires risk assessment of genetically modified plants that could impact the environment. (For specific studies underway or completed assessments, see http://www.epa.gov/regulation-biotechnology-under-tsca-and-fifra/overview-plant-incorporated-protectants.)

Assessment of plants that have been modified to express natural toxins includes risks to human health, risks to nontarget organisms and the environment, and potential for gene flow. (These toxins in their natural forms can also pose risks to nontarget organisms—while B. thuringiensis is safe for humans, if a vegetable garden is framed by butterfly garden plants, B. thuringiensis dusted on the vegetables could blow over, changing a sweet and helpful wildflower patch into an infectious butterfly deathtrap.)

Unhealthy agricultural practices enabled by transgenes

OK, so we need to be aware of the risk of transgenes to the environment and wild animals. But what about humans? As concluded in Part One of this series, GMO food products themselves don't pose any significant health risks to humans. However, there are agricultural practices enabled by transgenic crops that could affect human health. One of the biggest is the use of herbicide-resistant plants, most infamous among them, Monsanto's Roundup Ready line of crop plants.

Roundup is the brand name for glyphosate, a common weed-killer used in households and agriculture. Glyphosate is actually a relatively safe herbicide, compared with earlier herbicides such as paraquat/diquat and 2,4,5-T (Agent Orange), which contained the byproduct contaminant TCDD (dioxin).

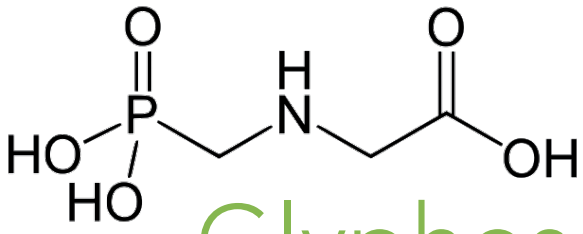
"butterfly deathtrap"

These toxins in their natural forms can also pose risks to nontarget organisms—while B. thuringiensis is safe for humans, if a vegetable garden is framed by butterfly garden plants, B. thuringiensis dusted on the vegetables could blow over, changing a sweet and helpful wildflower patch into an infectious butterfly deathtrap.

1890 Rubber gloves are first used in surgery.

1890-1895 Wilhelm Roentgen discovers x-rays.

1896 First successful heart surgery performed in Germany.



Glyphosate

Roundup works by inhibiting an enzyme, EPSPS, that is only found in plants, fungi, and bacteria, not animals. Further, it adsorbs (sticks) to soil quite strongly, reducing contamination of water, and its half-life in soil is about a month and a half. In some ways, it is environmentally beneficial, as it can be used to kill weeds before planting crops, which allows crops to be planted without tilling first. Tilling produces erosion and runoff, depositing fertilizers and residual insecticides into waterways.

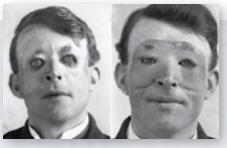
However, the fact remains that glyphosate residues have been found on vegetables several months after application, and while some sources, such as the EPA, consider it safe for humans, not all sources agree. Most notably, the International Agency for Research on Cancer (IARC) of the WHO has classified it as a probable carcinogen (class 2A), based on epidemiological evidence, particularly for non-Hodgkin's lymphoma in workers, animal studies, and in vitro mechanistic data. IARC classifications tend to favor caution—other examples of IARC class 2A carcinogens include yerba mate beverage, red meat, and emissions from high-temperature frying of food—so getting cancer from eating conventionally grown vegetables is highly unlikely at this point. (For comparison, processed meat is a much more dangerous carcinogen—Type 1, "carcinogenic to humans"—so eating hot dogs is much more risky than eating Roundup Ready crops exposed to glyphosate.)

That said, what if the amount of glyphosate sprayed on crops steadily increases? This is an issue because, while plants like Roundup Ready crops are engineered to withstand applications of glyphosate, evolution will also, inevitably, favor the development of resistance in weeds as well. It's a matter of selection, simple Darwinism. A 2015 USDA report found that a substantial number of farmers who encountered glyphosate-resistant weeds responded by increasing the amount of glyphosate applied (25 percent of corn acres with resistant weeds and 39 percent of soybean acres with resistant weeds).

One response is to engineer crops that are resistant not only to glyphosate but also to other herbicides, including 2,4-D and dicamba. Monsanto is, in fact, planning to release a new herbicide mix, Roundup Xtend, that contains both glyphosate and dicamba together, in concert with a new line of soybeans called Roundup Ready 2 Xtend soybeans. Evolution, however, favors the development of resistance, raising fears that crops will continue to be engineered with resistance to more herbicides, further increasing the amount and variety of herbicides sprayed.

It's important to remember that herbicide-resistant plants are not all GMOs.

"However, there are agricultural practices enabled by transgenic crops that could affect human health. One of the biggest is the use of herbicide-resistant plants, most infamous among them, Monsanto's Roundup Ready line of crop plants."



1905 Novocain is used as a local anesthetic.

1905-1914 The first non-direct blood transfusion is carried out.

1917 First documented plastic surgery performed on a burned English sailor.

1940 First metal hip replacement surgery performed.

"Biopharming"

While new, though, biopharming is just the reverse of a very old-fashioned practice—most medicines we have were either isolated from plants or are modified derivatives of compounds isolated from plants.

Triazine-tolerant plants began with strains of related plants that spontaneously evolved to be resistant, under conditions of triazine use in the field. These strains were bred with commercial crops, cultivated, and selected for the resistant trait, leading to triazine-resistant canola. These are traditional breeding techniques, not genetic modification, but they present the same type of health issue as engineered Roundup Ready crops. The risk is due not to the plants themselves but the increased use of herbicides enabled by these plants. Whether the plants have been produced through genetic engineering or traditional breeding is immaterial; it is the practice of increased pesticide use that is at issue.

Transgenic organisms on the loose

In general, transgenic crops are developed to express enhanced properties, and while the new organisms are tested for safety, the properties are not designed to affect human health, other than by enhancing nutrition. A somewhat different situation is that of biopharming, or the growing of pharmaceuticals in plants. This rather new practice of engineering plants to make medicines seems revolutionary, allowing a far lower cost of production than factory-produced pharmaceuticals and a more humane alternative to animal-grown ones (such as antibodies).

While new, though, biopharming is just the reverse of a very old-fashioned practice—most medicines we have were either isolated from plants or are modified derivatives of compounds isolated from plants. Genetic engineering, however, allows the development of specific products according to need, and targets have included not only the sorts of pharmaceuticals that natural plants produce, but also vaccines, antibodies, and even industrial enzymes.

A major difference between natural medicinal plants and biopharmed plants is that the latter are often farmed in food crops. Whereas aspirin was derived from salicylates found in willow bark, willow bark was never a major food source. Other medicinal plants that are also eaten as food, such as elderflowers and elderberries, are eaten in amounts culture and tradition have deemed to be healthy. In contrast, if a pharmaceutical is produced in corn, the plants will be engineered to produce a good yield to make the product economically viable. If such genes introgressed into food corn, people could unwittingly end up getting a dose of unwanted medicine along with their corn on the cob. One solution to this risk is to use non-food crops; the Ebola medicine ZMapp was biopharmed in a plant, Nicotiana benthamiana, that is closely related to, but different from, commercially produced smoking tobacco, Nicotiana tabacum. Duckweed has also been used in biopharming.

While non-food plants can be used, there are good reasons to use food plants instead. Food organisms are often very well-understood in terms of genetics, and therefore easier to genetically engineer. Also, since the infrastructure is in place for high yields, and there is familiarity with growth, harvesting, and storage, food crops are poised to have lower costs of production. Finally, their very edibility may be an advantage: Elizabeth Hood, a professor of plant biotechnology at Arkansas State University, explains that "if a pharmaceutical or vaccine is to be delivered orally, then having it in a food crop increases its safety." Further, when working with a known food crop, "all plants are completely free of animal pathogens, so [there's] no danger of transmitting a disease organism such as a virus."

So, what about the possibility of these plants breaking loose and consumers unwittingly getting vaccines along with their produce? According to Dr. Hood, "USDA APHIS has pretty strict regulations for growing biopharmaceutical crops in the out of doors. There are restrictions on how far the crop must be from similar crops, temporal differences for planting, and equipment cleaning." She continues, "An additional concept for containment is that the world market

"A major difference between natural medicinal plants and biopharmed plants is that the latter are often farmed in food crops."

"In the other incident, a biopharmed corn field was located too close to a food corn field, introducing the possibility that biopharmed corn pollen could cross breed with food corn."

for most pharmaceuticals is tiny compared to the market for food. Thus, the world demand for something like a HepB vaccine could be grown on a few hundred acres of corn—something easily accomplished in an isolated field away from the corn belt. Smaller market vaccines would take even fewer acres."

In 2002, two breaches in biopharming protocol occurred; whereas fields with biopharmed plants were to be left fallow for one year before planting any food crops, one farmer planted soybeans in a field that had just been used for biopharmed corn. Small "volunteer" corn plants grew in the field along with the soybeans, which would have contaminated soybean products with a small amount of biopharmed corn. In the other incident, a biopharmed corn field was located too close to a food corn field, introducing the possibility that biopharmed corn pollen could cross breed with food corn. Together, these incidents caused an outcry among groups concerned about the possible release of GM pharmaceutical plants. The USDA fined the company and ordered all of the crops destroyed. According to Dr. Hood, who had worked for the company but left before the incidents occurred, these events "involved a breach of compliance, no real danger to the environment or to people." Still, she says, "a breach of compliance implies a breach of safety and should never be done no matter what." No such breaches have occurred since then, so it does appear that protocols are being taken seriously by all farmers involved, but they serve to emphasize the importance of USDA vigilance and compliance with the regulations set forth. Importantly, even in these two worst-cases, the USDA's regulatory and enforcement arms did exactly what they were supposed to do; no contaminated products reached any consumers.

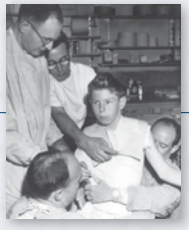
Since plants are stationary, with limits to how far pollen can move from the parent, they are relatively easy to contain. This is not true, however, with mobile organisms, and especially organisms that can move over long distances, like ocean fish. Fish have been engineered to grow several times as fast as their non-modified relatives, and could easily outcompete native fish if they escaped into the wild. The potential problem of invasive organisms is not limited to

"Fish have been engineered to grow several times as fast as their non-modified relatives, and could easily outcompete native fish if they escaped into the wild."

1953 First successful surgery using a heart-lung bypass machine.

1960 The first hip replacement surgery is performed.

1962 The first successful re-attachment surgery is performed.



Everett "Red" Knowles is seen here at the age of 12 with his MGH surgical replantation team, led by Dr. Ronald Malt, standing at left.

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transgenic ones; it is shared by all fish bred to express traits that may allow them to outcompete native fish. (Of course, most invasive organisms have been neither modified by engineering nor by traditional breeding techniques.) However, while the threat posed by conventionally bred fish may have the same nature as that posed by genetically engineered fish, the degree may be greater in engineered fish, which can express drastically different proteins that give rise to the potential for an "invasiveness on steroids" scenario. Of special concern are genes, such as those increasing cold tolerance, that could allow the new fish breeds to swiftly expand into different territories.

Further, as pointed out by Purdue professor William Muir in a 2004 EMBO Reports review, domesticated fish are bred (via traditional breeding or engineering) for growth in captivity, where predators are not present and food is ready available. They may very well have lost instincts vital for avoiding predators and obtaining food. If they interbreed with wild fish, there could be an overall loss of fitness. While this lack of fitness would very likely curb the expansion of escaped fish, Dr. Muir emphasizes the need for solid and careful risk assessment for new breeds of fish—whether conventionally bred or genetically engineered.

The same principle applies to insects or any other mobile organism that could escape into the wild. We have already seen the staggering ecological damage done by non-native species that become invasive, and while the bulk of the impact is on the environment, human health can also be affected, both indirectly and directly. For example, the introduced Solenopsis invicta fire ant, native to South America, is spreading through pastureland in the U.S., especially in the South. Control of the fire ants is expensive for farmers, perhaps discouraging free-range ranching and encouraging factory farming, with all its inherent problems for human health. At the same time, fire ant bites can be not only painful, but inflict serious injuries, especially on young children.

Transgenes on the loose

The last category of unintended effects, potential for gene flow, is one of the greatest concerns of anti-GMO groups. In 2001, UC Berkeley Environmental Science researchers Chapela and Quist published inverse PCR data that they claimed proved widespread infiltration of transgenes into Mexican corn, even though cultivation of genetically modified corn is illegal in Mexico. The report, however, was criticized as methodologically flawed—the data reported by Chapela and Quist did not constitute evidence of transgenes, but artefacts due to poor primer choices for a highly sensitive technique, said UC Berkeley and USDA biologists Kaplinsky et al.; what they probably detected was in fact an endogenous (natural) mobile genetic element in the corn. Subsequently, a team of Mexican and American researchers, Ortiz-Garcia et al., conducted a large-scale sampling of Mexican maize landraces, and found no evidence of any transgenes.

Then, in 2008, Piñeyro-Nelson et al., in a more methodologically careful study than the one reported in 2001, reported evidence of transgenic sequences in maize in some samples from the same localities identified

RIFA IMAGE BY THECOZ (OWN WORK) [CC BY-SA 4.0 (HTTP://CREATIVECOMMONS.ORG/LICENSES/BY-SA/4.0)], VIA WIKIMEDIA COMMONS

A floating "raft" of red imported fire ants (RIFA) in North Carolina over land that normally forms the bank of a pond. The land had become submerged due to excessive rain and resultant flooding which inundated the nest. The raft is anchored to some blades of grass extending above the water's surface.

1964 Lasers are first used for eye surgery.

1967 The first heart transplant is carried out by Christiaan Barnard.

1970 The nation's first ambulatory surgery center opens in Phoenix.

The abandonment of local crop varieties over the past several decades is staggering—the UN's Food and Agriculture Organization estimates that 75% of crop biodiversity has been lost from the world's fields. Among the best solutions to this potentially serious problem is the maintenance of seed banks, repositories of a diverse array of seeds from different varieties of plants.

by Chapela and Quist. However, in 2009, this was followed by a publication in the same journal, *Molecular Ecology*, by Schoel and Fagan, biologists at Genetic ID, a company Piñeyro-Nelson et al. used in their study, criticizing the methodology and asserting that sequences that were classified as positive should have been reported as negative. Piñeyro-Nelson et al., in turn, contested this assessment, again in the same journal.

Heirloom tomatoes

To say the least, the idea that transgenes have introgressed into non-engineered corn is controversial. Setting aside the science of whether or not this has actually happened, what would be the consequences if it had? Among the most important would be that the transgenic corn, through it's selective advantage, could push out native strains and thereby lower global diversity of these crop plants. Elimination of "heirloom" varieties could result in the loss of traits providing micronutrients of value to human health as well as other qualities a diverse population can bring.

As with other issues related to GMOs, this problem could occur whether the new strains were developed using genetic engineering or traditional plant breeding techniques. (In point of fact, in nature, genes do "horizontally transmit" on occasion—moving from one organism to another completely different organism, most often via elements like retroviruses.) This is a serious concern with bred or engineered strains because farmers like to use the "best" variety—that with the highest yield, most disease resistance, etc.—and therefore are not motivated, in terms of profit, to maintain a diverse population of strains.

The abandonment of local crop varieties over the past several decades is staggering—the UN's Food and Agriculture Organization estimates that 75% of crop biodiversity has been lost from the world's fields. Among the best solutions to this potentially serious problem is the maintenance of seed banks, repositories of a diverse array of seeds from different varieties of plants. Plant biotechnology companies themselves maintain seed banks, and use the stocks in developing new varieties. However, these banks are relatively small, and contain varieties likely to be helpful in the companies' for-profit missions. For this reason, national, government-maintained seed banks are crucial.

Besides seed banks, the encouragement of small-scale growth of heirloom varieties of vegetables is vital to the maintenance of both diversity and processes of natural evolution. Spontaneous evolution, after all, can create surprising new varieties that could have benefits not foreseen by engineers. When it comes down to it, while there's no reason to be paranoid about genetically engineered plants, traditional crop varieties most certainly are something to be cherished. After all, while GMO rice and beans (or corn tortillas and tofu) are healthy staples, a variety of herbs, spices, and diverse vegetables are key to long-term health and protection against diseases like cancer. So, while continued vigilance by USDA, EPA, and academic biologists is important, there's no need to worry if your budget requires you to buy mainly conventionally grown staples. Just save a little cash or gardening/foraging time to supplement those staples with some native blackberries, chanterelle mushrooms, or savory heirloom tomatoes—diversity is, after all, as delicious as it is healthy! ■

SEED BANK IMAGE BY R. C. JOHNSON [CC BY 2.5 (HTTP://CREATIVECOMMONS.ORG/LICENSES/BY/2.5)], VIA WIKIMEDIA COMMONS

RAMIN RAHIMIAN FOR PROPUBLICA

Small-Scale Violations of Medical Privacy Often Cause the Most Harm

Breaches that expose the health details of just a patient or two are proliferating nationwide. Regulators focus on larger privacy violations and rarely take action on small ones, despite the harm.

By **Charles Ornstein**, *ProPublica, Dec. 10, 2015*

"PPL WORLD WIDE," the Facebook post shouted, using text-speak for the word "people." "FRANCES ... IS HPV POSITIVE!"

The public missive from January 2014 gave Frances' full name, along with the revelation that she had human papillomavirus, a sexually transmitted disease that can cause genital warts and cancer. It also included her date of birth and ended with a plea to friends: "PLZ HELP EXPOSE THIS HOE!"

Within hours, a friend told Frances that a former high school pal who lived near her in northwest Indiana had shared a secret that only her family and a former boyfriend knew, she later said.

"My heart fell to my stomach," said Frances, a dental assistant in her late 20s who asked that her last name not be used. "I started crying immediately."

The Facebook poster was a patient care technician at the local hospital where Frances was treated, but the two were no longer friends.

Frances complained to a nursing supervisor at the hospital, which sent her a letter of apology in March 2014. "Please know that we take these types of situations very seriously," the letter said. "We did take action in accordance with our policies and procedures," although it did not specify what had been done.

Under the federal law known as HIPAA, it's illegal for health care providers to share patients' treatment information without their permission. The Office for Civil Rights, the arm of the Department of Health and Human Services responsible for enforcing the law, receives more than 30,000 reports about privacy violations each year.

The bulk of the government's enforcement – and the public's attention – has focused on a small number of splashy cases in which hackers or thieves have accessed the health data of large groups of people. But the damage done in these mass breaches has been mostly hypothetical, with much information exposed, but little exploited.

As Frances discovered, it's often little-noticed smaller-scale violations of medical privacy – the ones that affect only one or two people – that inflict the most harm.

Driven by personal animus, jealousy or a desire for retribution, small breaches involving sensitive health details are spurring disputes and legal battles across the country:

In Tampa, Florida, a nurse snooped in the medical records of

ProPublica is exploring how patient privacy violations are affecting patients and the medical care they receive. This story was co-produced with NPR.

Peter Brabeck at his home near Carmel, California.

her nephew's partner, learned that she had delivered a baby and had put the child up for adoption. She gave a printout to another family member, and the secret was announced at a family funeral in 2013, the *Tampa Bay Times* reported. The niece complained to the hospital; the nurse admitted what she did, was fired and relinquished her Florida nursing license.

A New Jersey woman sued a local hospital this fall, alleging that one of its employees shared details about her 11-year-old son's attempted suicide with people at his school. The boy was subsequently "bullied by his peers, called names and made fun of," her lawsuit says.

And in South Carolina, prosecutors allege that lawyers were illegally given information from the state's prescription drug monitoring program database to gain an edge in family court cases. A pharmacist and drug screener were indicted in August for conspiring to violate the rules governing the database; the pharmacist also was accused of disclosing data on prescriptions for controlled substances. The men have pleaded not guilty.

"...protecting your privacy, is part of what it is to be a doctor. It's part of your oath, it's part of your duty."

1975 First organ surgery performed using laparoscopic, or minimally invasive, technique.

1981 First open fetal operation performed.

1985 First robot-assisted surgical procedure performed.

Even when small privacy violations have real consequences, the federal Office for Civil Rights rarely punishes health care providers for them. Instead, it typically settles for pledges to fix any problems and issues reminders of what the Health Insurance Portability and Accountability Act requires. It doesn't even tell the public which health providers have reported small breaches – or how many.

Tami Matteson, a California high school teacher, complained to the agency in September 2013 after learning that her ex-husband's new wife, who worked as a medical records clerk at the local hospital, had looked at her records more than a dozen times over three years. It turned out the worker also snooped in other people's records, too.

But OCR decided not to sanction Northern Inyo Hospital after it terminated the clerk, sent privacy reminders to staff, increased its audits and instituted new policies. The hospital's compliance officer declined to comment to ProPublica but said in a court filing that the incident may have caused patients to lose confidence in the rural hospital.

Even though the clerk lost her job and pleaded guilty to a misdemeanor criminal charge, and even though the hospital paid Matteson $25,000 to resolve her legal claim, she said she still can't get over what happened. It has undermined her trust in doctors and the entire medical establishment, she said.

"HIPAA did nothing for me – not one thing," Matteson said. "I no longer can go to the doctor and feel safe or comfortable."

Asked about some of the privacy violations highlighted in this report, OCR Director Jocelyn Samuels called them "heartbreaking stories" and "the kinds of harm that HIPAA is intended to address."

She insisted her agency isn't afraid to pursue formal sanctions when they are warranted, but said its primary role is helping health providers to follow the law. "Our preference is always to promote voluntary compliance," Samuels said.

For patients, Samuels' agency is usually the only place they can seek vindication. HIPAA does not give people the right to sue for damages if their privacy is violated. Patients who seek legal redress must find another cause of action, which is easier in some states than others.

After being attacked on Facebook, Frances contacted Indianapolis lawyer Neal Eggeson. He had won jury verdicts for people whose medical information was improperly disclosed. Eggeson contacted the hospital and, without filing suit, secured a confidential settlement for Frances. (He asked that the facility not be named in this story.) Frances' former friend no longer works there, she said.

Frances said she still hasn't fully recovered. She sees a therapist and has a hard time trusting others.

"It's hard to even still deal with it," she said. "I'll spend that extra gas money to go into another city to do grocery shopping or stuff like that just so I don't have to see anybody from around the neighborhood."

A.J. MAST FOR PROPUBLICA

> "HIPAA DID NOTHING FOR ME - NOT ONE THING."

FROM INSURANCE DEFENSE TO PRIVACY OFFENSE

Eggeson, a litigator, was defending insurance companies in car accident cases when a "friend of a friend of a friend" referred a young man to him. The man, who is HIV positive, had been sued over a $326 debt by the medical group that had been treating him. The group's court filing gave the man's name, home address, Social Security number and date of birth – and included a

1987 The first heart and lung transplant is carried out.

2000 da Vinci robotic surgical system wins U.S. Food and Drug Administration approval.

2007 First natural orifice translumenal endoscopic surgery performed. This technique uses a natural body opening, such as the mouth, to insert instruments and minimize recovery times.

"The vast majority of people who come through my door honestly are upset that no one has stepped up to the plate and said that what happened to you was wrong. If the health care provider isn't going to give them that satisfaction, then maybe a jury will."

– NEAL EGGESON

billing statement containing the phrase "Last Diagnosis: HIV."

"His first concern was getting the court record sealed, more than anything else," Eggeson said. "I don't think he had any designs or visions beyond that."

A jury awarded the man $1.25 million.

After that victory, Eggeson represented Abigail Hinchy, who alleged that a Walgreens pharmacist had snooped in her prescription records and shared the information with the father of Hinchy's child (the man was dating and later married the pharmacist). Among the data shared: Hinchy had stopped taking birth control pills shortly before she became pregnant. A jury ordered Walgreens and the pharmacist to pay Hinchy $1.44 million.

A state appeals court upheld the award last year, saying trial evidence showed the man used Hinchy's information to berate her for "getting pregnant on purpose" and extorted her "by threatening to release the details of her prescription usage to her family unless she abandoned her paternity lawsuit." A copy of Walgreens' check is framed on the wall of Eggeson's home office, not far from his life-sized Batman costume and Star Wars lightsabers.

In 2008, Eggeson stopped handling insurance work altogether to devote himself to privacy cases.

"The vast majority of people who come through my door honestly are upset that no one has stepped up to the plate and said that what happened to you was wrong," he said. "If the health care provider isn't going to give them that satisfaction, then maybe a jury will."

Among Eggeson's current clients is a couple who claim that when their son was in an ATV accident this August, a hospital worker posted a comment on Facebook before the hospital had told them the teen had died. Panicked relatives who saw the post began calling his parents for updates, adding stress to an already wrenching time.

"It wouldn't have changed the outcome," said John Stuck, the boy's father, "but just the feeling of what in the heck, what do they know that we don't, that's what freaked me out I think the most."

Eggeson said he's handling about a dozen cases. He turns away far more, mostly because he's a solo practitioner with limited bandwidth and isn't licensed in other states.

He shared a 17-page list of the calls and emails he's received since mid-2013, including a sentence or two about each but no identifying information. Among them: A Massachusetts woman whose ex-sister-in-law accessed the patient's infectious disease records, told relatives and posted it on Twitter, and a whistleblower at the U.S. Department of Veterans Affairs who contends her own medical records were accessed hundreds of times in retaliation.

When Eggeson files lawsuits, he argues that privacy breaches amount to medical malpractice.

"My argument has been that protecting the confidentiality of your protected health information, protecting your privacy, is part of what it is to be a doctor," he said. "It's part of your oath, it's part of your duty."

While Indiana courts have been receptive to such arguments, courts in Ohio, Minnesota and other states have ruled that health providers are not liable for the actions of workers who snoop in medical records outside the scope of their jobs.

A federal court in New York rejected a claim against the Guthrie Clinic, where a nurse accessed records of a man being treated for an STD after recognizing him as her sister-in-law's boyfriend. While the man was awaiting treatment, the nurse sent at least six text messages to her sister-in-law informing her of his condition. The man, identified in court records as John Doe, complained to the clinic's administrator and the nurse was fired, but a judge ruled the clinic couldn't be held responsible for her actions.

"There is no evidence or allegation that [the nurse] took such steps on behalf of the clinic, or with the clinic's authorization," U.S. District Judge Michael Telesca wrote in 2012, dismissing the case. A federal appeals court

upheld the ruling.

This summer, a Los Angeles jury ruled against a patient who sued UCLA and the Regents of the University of California after a romantic rival accessed and shared her medical records. The rival was a temporary worker in the office of a private practice physician affiliated with UCLA's Santa Monica hospital. The doctor acknowledged improperly sharing his password and settled his part of the lawsuit.

UCLA maintained that it had taken adequate steps to protect patient privacy and that it should not be held liable for doctors and employees who break the rules. "We are pleased that the jury recognized that UCLA Health System's policies concerning electronic medical records strike the right balance between protecting patient privacy and providing our patients with world-class medical care," it said in a statement after the verdict. UCLA declined further comment.

J. Bernard Alexander III, the plaintiff's lawyer, said UCLA's privacy protections weren't enough to catch violators unless patients complained. "If you aren't checking to find out if there was a breach, you aren't going to find it."

Eggeson said it's distressing that more states aren't like Indiana.

"Privacy protections should be the same regardless of what state you're in," he said. "There is something wrong with an employer providing the means, providing the access, and providing the tools by which an employee can commit this crime and then being able to hold up their hands and say, 'It's not our fault.'"

The Medical Board of California accused Peter Brabeck's doctor in 2011 of overprescribing him controlled substances. Afterward, Brabeck learned the doctor had hired a private investigator to look into him and gave him Brabeck's medical records.
(Ramin Rahimian for ProPublica)

SMALL BREACHES GET LESS ATTENTION

The vast majority of the Office for Civil Rights' enforcement work has been directed at large-scale medical data breaches, whether or not they result in any demonstrable real-world harm.

Health providers are required to notify the office within 60 days of breaches affecting at least 500 people and also must share details with the media and contact those potentially affected. OCR's website makes public a list of these cases, highlighting them on what industry insiders dub the Wall of Shame.

Several massive breaches have come to light recently. Last February, Anthem Inc. disclosed that hackers had accessed records of nearly 80 million people. The following month, Premera Blue Cross, based in the Pacific Northwest, disclosed that a similar cyberattack had exposed the records of some 11 million people.

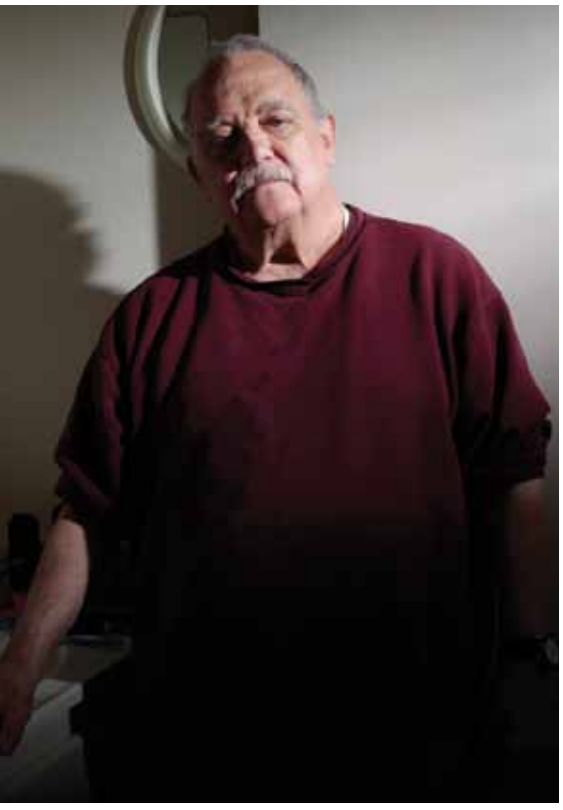
OCR is investigating these cases – and similar ones – though the companies say there's been no evidence that victims' data has been shared or exploited.

Rarely do small privacy breaches get

2008 A laser is used in keyhole surgery to treat brain cancer.

2010 First full face transplant is performed in Spain.

2011 The first leg transplant is carried out.



"Here we have not only a gross violation of [HIPAA] laws protecting the confidentiality of every patient's medical history, but in my mind far worse. Here is a deliberate attempt, born of vengeance, with malice aforethought to inflict great harm on his own patient."

– PETER BRABECK

anywhere near the same attention, except when they involve celebrities or high-profile individuals.

Organizations only have to report them to OCR once a year. Even then, the agency doesn't post them online and HHS has rejected requests under the Freedom of Information Act for information about them.

HHS is supposed to submit annual reports to Congress about the number and nature of medical privacy breaches and the actions it has taken in response. But the department actually submits such reports every two years and its most recent one covered 2011 and 2012. OCR says another report will be coming soon.

Since 2009, OCR has received information about 1,400 large breaches. During the same time, more than 181,000 breaches affecting fewer than 500 individuals have been reported.

The agency has levied only a few fines for HIPAA violations that involved a small numbers of people. Among them: In 2008, UCLA Health System agreed to pay $865,500 for failing to protect the privacy of two celebrity patients. And in 2013, Shasta Regional Medical Center in California paid $275,000 for sharing medical information with news organizations and employees about a patient who was featured in a news article alleging potential Medicare fraud.

In September, the HHS inspector general issued a pair of reports that criticized the Office for Civil Rights, including its handling of small breaches. The inspector general said OCR did not investigate the small breaches reported to it or log them in its tracking system.

"OCR does not record that information and therefore it's not available for staff to be able to look over time" for repeat offenders, said Blaine Collins, regional inspector general for evaluation and inspections in San Francisco. "Boy, that's critical for monitoring and oversight."

Samuels said that her agency is implementing the inspector general's recommendations to improve oversight. "We are constantly looking for ways to better serve the public and improve our operations," she said.

'AN ACT OF VENGEANCE AND RETALIATION'

Peter Brabeck, a 73-year-old retired petrophysicist who worked for the oil giant BP, turned to OCR in September 2011 when he found himself in the midst of a nightmare.

It began a year earlier when Brabeck's brother complained to the Medical Board of California that Dr. Steven Mangar, a pain doctor in Salinas, California, had overprescribed controlled substances to Peter. The medical board accused Mangar of prescribing drugs without examining Peter Brabeck and sought to take disciplinary action against his license.

Mangar reacted by hiring a private investigator to dig up dirt on Brabeck – and gave the investigator all of Brabeck's medical records. When Mangar refused to pay the investigator, he approached Brabeck's brother and showed him the records. The investigator then offered to sell the records to Peter Brabeck, who within days complained to the Office for Civil Rights.

"Here we have not only a gross violation of [HIPAA] laws protecting the confidentiality of every patient's medical history, but in my mind far worse," Brabeck wrote in his complaint. "Here is a deliberate attempt, born of vengeance, with malice aforethought to inflict great harm on his own patient."

Two years later, the Office for Civil Rights wrote back, saying it was "pleased to inform" Brabeck that his complaint has been resolved. It said it had provided Mangar's clinic, the Pacific Pain Care Institute, with guidance on how to comply with privacy rules. It said Mangar had acknowledged that he "impermissibly disclosed" Brabeck's personal health information to the private investigator.

OCR also said that Mangar had agreed to provide Brabeck with free credit monitoring.

"Based on the foregoing, OCR is closing this case without further action," the letter said.

Brabeck, who lives near Carmel, California, said he never actually received the credit monitoring. More importantly, he was left with a sense that the agency didn't take his case seriously.

"I made very clear in my letter that it was an act of vengeance and retaliation," he said. "That's why I was so surprised at how lightly they dismissed the whole thing."

Even the private investigator who asked Brabeck's brother for money was surprised by the outcome of the case.

"In all my years in the business, I never experienced anything like that where a complete file was turned over," said Dan Taubman, who said he is still owed $6,800 by Mangar. "He didn't care who he hurt or burned."

Mangar did not return calls for comment. California's medical board placed his license on probation in 2012 and is now seeking to revoke it, saying he violated his probation and provided negligent care to other patients. Earlier this year, federal and state investigators served search warrants at Mangar's office and home. Monterey County Deputy District Attorney Amy Patterson said Brabeck's concerns are part of a much broader investigation that she could not discuss because it is ongoing.

OCR director Samuels said Brabeck's case pre-dated her arrival at the agency. But she said it was consistent with "our general principles" in terms of the nature of the injury, the number of individuals affected and a provider's lack of prior HIPAA violations. She also said the doctor agreed to apologize, which "can be very powerful in terms of remedying the damage that has been done."

Brabeck said he didn't get an apology: "No. Absolutely not."

WARNING EMPLOYEES BEFORE THEY SNOOP

Cedars-Sinai Medical Center in Los Angeles is trying to stop privacy breaches before they happen. Known for its celebrity clientele – its board of directors includes Barbra Streisand and Steven Spielberg – Cedars-Sinai has dealt repeatedly with employees trying to access records they have no business seeing.

In July 2013, the hospital fired six people who inappropriately accessed patient records, reportedly including those of reality TV star Kim Kardashian, who had given birth at the hospital to her daughter with rapper Kanye West.

The hospital fired three employees and took corrective action against three other people last year for inappropriately accessing patient information; it terminated two more workers this year, spokesman Richard Elbaum said.

Like other hospitals, Cedars-Sinai's electronic medical records system has a feature known as "break the glass." When an employee attempts to access information on high-profile patients, the system asks for a reason and requires the employee to re-enter his or her password.

That generally works, but such a warning isn't in place for every record, in part because officials in the information security world fear it would be ignored if it were seen merely as a second password requirement. For typical patients, it generally takes a complaint to trigger a review of the transaction log to see if anybody inappropriately accessed a record.

Cedars-Sinai is working with security specialists to augment its first layer of protection. Its goal: To create a warning system that generates automatic alerts based on pattern recognition, akin to what credit-card companies use to flag suspicious transactions.

The system will sift through the hospital network's traffic, looking for unusual activity. It might flag an obstetrician/gynecologist looking at the records of male patients or a staff member who looks at six medical records in quick succession. It might notice a staff member looking at the records of a neighbor. Or it might recognize that one staffer has looked at 20,000 records in a month when peers only viewed 3,000.

"Maybe they deserve a raise – or something is awry," said Darren Dworkin, chief information officer at Cedars-Sinai Health System.

Cedars-Sinai, the largest acute-care hospital in California, hopes to make the system live within the next six months. Cedars-Sinai and Dworkin have received a patent on the idea.

"Rather than have to report to a patient I'm sorry this happened, wouldn't it be better if we had real-time tools that asked you, 'Are you sure you want to do this?' Maybe sometimes that gentle reminder can stop something before it happens," Dworkin said.

One day, Dworkin said, such technology could become routine in health care – and organizations could be fined for not using it. "I can see a time when this stuff becomes the standard operating procedure," he said. "I hope it does." ■

NPR reporter Alison Kodjak contributed to this report.

2012 The first womb transplant is carried out.

2013 ACS NSQIP® releases Surgical Risk Calculator.

2012 Nerve transfer surgery enables quadriplegic to regain partial use of hand.

*FOR TIMELINE SOURCES PLEASE SEE PAGE 66

CIS CARDIOLOGISTS FIRST TO USE VENASEAL TECHNOLOGY

Drs. Satish Gadi and Deepak Thekkoott, cardiologists at Cardiovascular Institute of the South in Baton Rouge and Zachary, were the first to use new VenaSeal technology in the East Baton Rouge area to treat venous disease. This was also the second case in Louisiana.

The VenaSeal™ closure system is a cyanoacrylate-based medical adhesive (viscous, polymerizes quickly, and soft/elastic with a strong bond) for the closure of greater and lesser saphenous veins in the legs. This is the only non-tumescent, non-thermal, and non-sclerosant procedure where adhesive is delivered endovenously to close the vein. This unique approach eliminates the risk of nerve injury when treating the small saphenous vein.

The procedure is administered without the use of tumescent anesthesia, meaning only one needle stick is needed to numb the area, thus avoiding patient discomfort associated with multiple needle sticks. It also eliminates the need for post-procedure compression stockings, and post-procedure pain and bruising. The patient can return to normal activities rapidly.

TOP Pictured at the Zachary clinic are Lila Cox, Samantha Hasselbeck, Jennifer (Medtronic rep), Dr. Deepak Thekkoott, patient Joyce Palmer, Rachel Fontenot, and Mary Beth Clement, CIS vein clinic coordinator.

BOTTOM Pictured at the Baton Rouge clinic are Jessica Fogg, Dr. Satish Gadi, Jasmina Wilson, and Crystal Ned.

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STATE

Study Says Bayou Health Saved Millions in 2015

According to a new study released by the Louisiana Association of Health Plans (LAHP), the five Bayou Health Medicaid managed care organizations (MCOs) have saved Louisiana nearly $440 million in 2015 when compared with what the state would have paid under the old fee-for-service model.

The study, which was performed by Wakely Consulting Group, concludes that the managed care organizations are operating efficiently and producing significant savings when compared to the costs that DHH would have incurred under the old, fee-for-service program.

The Wakely study indicates a Bayou Health savings range from 6.7 percent, or $250 million, to 11.2 percent, or $437 million. The study was conducted by members of the American Academy of Actuaries and is actuarially sound.

GSQN and UnitedHealthcare Launch ACO

Gulf South Quality Network and UnitedHealthcare have launched an accountable care program to improve people's health and their satisfaction with their healthcare experience. The joint effort will focus largely on dedicating more resources to care coordination and making it easier to share important health information so that every doctor involved in a patient's care is supporting the same treatment plan.

Through this collaboration, UnitedHealthcare and Gulf South Quality Network will work closely to better coordinate patients' care, using shared technology, real-time data, and information about emergency room visits and hospital admissions, and services designed to help patients manage their chronic health conditions, and encourage healthy lifestyles.

LAC Releases Nursing Diversity Report

A new report details the current demographic makeup of Louisiana's nursing workforce, challenges faced in increasing minority representation, and actions that can be taken to recruit and retain minorities.

Embracing the Challenge: Enhancing Diversity in Louisiana's Nursing Workforce and an accompanying infographic were developed using data gathered and analyzed by the Louisiana Center for Nursing and discussions held during the August 2015 Nursing Workforce Diversity Think Tank hosted by the Louisiana Action Coalition (LAC).

The report and accompanying infographic are available at the Louisiana Action Coalition website: louisianafutureofnursing.org.

State Receives Grants for Workplace Safety, Drinking Water

The Louisiana Department of Health and Hospitals (DHH) has been awarded approximately $1.4 million through two competitive five-year grants funded by the Centers for Disease Control and Prevention (CDC) to improve worker safety and reduce water contamination.

The first of the two grants comes from the CDC's Occupational Health and Injury Surveillance Program, which aims to improve worker safety and health through continued identification and tracking of work-related injuries, fatalities, and hazards impacting Louisiana workers.

Tracking data will be used by DHH while identifying the State's priorities and inform decisions about injury prevention efforts performed in collaboration with state partners. This will help DHH improve the health of Louisiana's workers by supporting its work in:

- identifying worksites where workers are exposed to high levels of lead and other heavy metals,
- examining factors contributing to injuries and fatalities and using findings to improve worker training and promote changes in safety and health policies,
- educating employers and employees on how to protect themselves when working in hot and humid temperatures,
- training college students about occupational health through internship programs with local universities, and
- referring worksites with known hazards to the Occupational Safety and Health Administration (OSHA) for investigation.

DHH has also been awarded the CDC's Environmental Health Services Support for Public Health Drinking Water Programs to Reduce Drinking Water Exposures grant, which is implemented in Louisiana as the Louisiana Private Well Initiative. The grant will help Louisiana to identify and address drinking water program performance gaps, improve efficiency within and the effectiveness of drinking water programs, and identify and reduce exposures associated with drinking water contamination.

Partnerships Help Keep Costs Down

The first year's results from Blue Cross and Blue Shield of Louisiana's newest Quality Blue program show that it is increasing healthcare quality and lowering costs. The program, called Quality Blue Value Partnerships, offers incentives to physician groups for improving the quality and reducing the cost of the care they provide. Most participating physician groups successfully cut spending and improved healthcare quality. On average, they saved 1.7% in their total healthcare costs. The most successful groups saved 3.8% on average.

Even more promising, the physician groups with the best health outcomes for their patients had the highest total savings.

Blue Cross launched the Value Partnerships arm of Quality Blue in 2014. Five physician groups, called Accountable Care Organizations (ACOs), participated. The ACOs were Baton Rouge Clinic, Baton Rouge General Physicians Group, Gulf South Quality Network, Ochsner Health Network, and West Calcasieu Virtual Medical Home. These ACOs provide care for more than 130,000 Blue Cross customers.

Three more ACOs have signed on to participate in this part of the Quality Blue program for the second year: Health Leaders Network, which includes Our Lady of the Lake, St. Elizabeth, Our Lady of Lourdes, St. Francis and Our Lady of the Angels, The Family Doctors in Shreveport, and Willis Knighton Health System.

Department Kicks Off OYOH Challenge

The Louisiana Department of Health and Hospital's (DHH) Bureau of Minority Health Access and Promotions and the Governor's Council on Physical Fitness and Sports commenced the Own Your Own Health (OYOH) Challenge on Monday, January 25th.

OYOH is a comprehensive health program designed to empower Louisianans to become active participants in their own health and healthcare through healthy eating and activity and an overall healthy lifestyle. The OYOH 3-Month Wellness Challenge, which runs from January 25 - April 25, motivates participants to work individually or as a team to implement small changes that lead to living a healthier lifestyle. The challenge includes smaller fitness challenges such as counting steps.

Registration is open to the public. Incentives for participation in a challenge include spa packages, New Orleans Pelicans tickets, workout passes, gift cards, and Fit Bits.

To register for the challenge or for more information on the program, visit the OYOH website at www.oyohla.com, or call (225) 342-4886.

From left, Stephen W. Speeg, MD, and Juan J. Martinez, PhD.

Blue Cross Foundation Seeks Angels

The Blue Cross and Blue Shield of Louisiana Foundation is seeking nominations for the 2016 Angel Awards through Friday, April 8, 2016. Now in its twenty-first year, The Angel Award® program recognizes Louisiana volunteers who perform extraordinary work for children in need. The Foundation will also make a $20,000 grant to the Louisiana-based charity represented by each honoree.

If you know an Angel, you can find more information – including rules and guidelines –and a nomination form online at www.ourhomelouisiana.org. Nomination packets are also available by calling toll-free 1-888-219-BLUE (1-888-219-2583) or by emailing Angel.Award@bcbsla.com.

ABMS Approves LAMMICO Online CME Courses

LAMMICO announced that it is the first provider of Continuing Medical Education (CME) in Louisiana to be included in the Maintenance of Certification (MOC) list of CME approved by the American Board of Medical Specialties (ABMS).

Physicians are required to maintain their certifications through one of the 24 approved medical specialty boards of the ABMS through MOC-approved CME to demonstrate their medical specialty knowledge and commitment to lifelong learning.

Responding to the ABMS' call for MOC activities, LAMMICO submitted several online courses made available through a subsidiary, Medical Interactive (MI), this summer. As a result of this first phase of MOC directory development, more than a dozen medical specialty boards have approved nearly 70 LAMMICO courses.

LAMMICO is now providing ACCME-accredited CME that may also qualify for specialty-specific MOC certification needs. Scrolling down to the bottom of the white paper will help doctors determine the following:

- •CME credit value
- •State licensing requirements
- •Maintenance of Certification Approval Statement with a list of Member Board approval

MI further optimizes ease of navigation to help physicians find MOC-approved courses by featuring an orange button entitled "MOC Approved" in the right-hand navigation pane of their website. Physicians need only click the MOC button to access the most up-to-date list of board-approved courses.

LOCAL

Carpenter Health Network Names Chief Medical Officer

The Carpenter Health Network has named Dr. Stephen W. Speeg as chief medical officer. A certified hospice medical director, Speeg has more than 23 years of hospice, palliative, and post-acute care service.

Previously, he ran his own private internal medicine and pediatrics practice in Baker. He also has served as chief of staff and chairman of the quality assurance committee of Lane Memorial Hospital in Zachary, and clinical instructor of internal medicine at Earl K. Long Hospital.

Speeg is a member of the American Hospice Association, the American Academy of Pediatrics, the Southern Medical Association, and the American Academy of Hospice and Palliative Medicine. He is American Board of Internal Medicine eligible and has recertification pending with the American Board of Pediatrics.

Get Your Rear in Gear® Baton Rouge

Registration is now open for Get Your Rear in Gear – Baton Rouge, a 5K Run/Walk and Kids' Fun Run to help raise funds for colon cancer awareness efforts in the Baton Rouge-area. Money raised will stay in our community to encourage screening and education for the nation's No. 2 cancer killer. The race will be held Saturday, April 9, 2016 at Pennington Biomedical Research Center, 6400 Perkins Rd. in Baton Rouge.

Enjoy post-run refreshments, t-shirts for all participants, and marathon quality medals for age group winners. The day includes opportunity to honor survivors and remember those lost to colon cancer.

Through March 21, 2016 (midnight): Adult: $25; Youth (12 and under): $15

After March 21 until Race Day: Adult: $35; Youth (12 and under): $20

Please note: fees are non-refundable and race bibs are non-transferable. Survivors are free. Contact us christielockhart@getyourrearingear.com for the discount code.

Online Registration closes Sunday, April 3, 2016 at midnight. For more information, contact: Jared Broussard at jared@blinkjarmedia.com.

LSU Vet School Prof to Publish Research

Juan J. Martinez, PhD, associate professor in the Department of Pathobiological Sciences (PBS), has been accepted for publication in *Infection and Immunity*. The work is entitled "Non-selective Persistence of a Rickettsia conorii Extrachromosomal Plasmid during Mammalian Infection," and is published in the March 2016 issue. Dr. Martinez and his lab are interested in understanding the molecular basis by which certain obligate intracellular bacteria of the Spotted Fever Group (SFG) Rickettsiae, cause severe and often fatal disease in humans and companion animals.

In this current work, Dr. Martinez and senior author, Sean P. Riley, MS, PhD, assistant professor (research) in PBS, have demonstrated that introduction of an extrachromosomal DNA element called a plasmid into a pathogenic species of rickettsiae, Rickettsia conorii, does not lead to any defects in fitness in vitro nor in fatal outcomes in a murine model of disseminated rickettsial disease. The group's findings indicate that under non-selective antibiotic pressures, bacteria harboring this piece of DNA maintain the plasmid both in cell culture and when the bacteria are introduced into an animal. Plasmid is defined as a genetic structure in a cell that can replicate independently of the chromosomes, typically a small circular DNA strand in the cytoplasm of a bacterium or protozoan.

Parkinson's Research Gets Boost from Business

In February the staff at Baker Glass presented a $2,100 check to physicians at The NeuroMedical Center in support of local Parkinson's research and treatment efforts. The donation is the result of a months-long campaign, "Baker Glass Gives Back," launched in April of 2015 by family of the company's original owner and Parkinson's patient, William Mosley.

For every windshield Baker Glass replaced from April-August of 2015, the company donated $10 to a Parkinson's fund. Alongside Parkinson's

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specialists at The NeuroMedical Center, the Mosleys identified ways to keep the $2,100 raised in the Greater Baton Rouge area.

Voters Favor a Smoke-Free Ordinance

A coalition of local, state, and national public health groups released polling results showing 70 percent of East Baton Rouge Parish voters favor extending the statewide smoke-free policy, Act 815, to all workplaces, including bars and casinos.

The Healthier Air For All campaign (HAFA), the secondhand smoke campaign of the Louisiana Campaign for Tobacco-Free Living (TFL), and the American Cancer Society Cancer Action Network (ACS CAN), the advocacy affiliate of the American Cancer Society, commissioned the poll conducted by Public Opinion Strategies. The telephone survey was completed December 10-13, 2015, among 500 registered voters in East Baton Rouge Parish.

The survey indicated support is strong for a smoke-free ordinance that extends the current policy to include all workplaces, with 7 out of 10 voters favoring a move in this direction by the Council. Geographically, support by Metro Council District remains high at 69-70 percent. The proposal unites all voters in the city, regardless of ethnicity. Other strong polling results included little difference in support between conservatives and liberals; and more than half of those polled said they would be more likely to go out to bars and casinos if a comprehensive smoke-free policy were passed.

Little Earns Inaugural Sister Linda Constantin Award

Mary Bird Perkins – Our Lady of the Lake Cancer Center has named Kristina Little, a Licensed Clinical Social Worker and patient navigator, as the inaugural Sister Linda Constantin Courage and Compassion Award winner for 2015. The purpose of the award, named in honor of Constantin, a longtime nurse and member of the senior administrative team at Our Lady of the Lake Regional Medical Center, is to recognize a Cancer Center team member who exemplifies her deeply held values and beliefs. Constantin passed away in 2005 after battling colon cancer.

Pictured (l-r) are Kristina Little, LCSW, Mary Bird Perkins – Our Lady of the Lake Cancer Center; Sr. Barbara Arceneaux, provincial, Franciscan Missionaries of Our Lady; and Linda Lee, administrator, Mary Bird Perkins – Our Lady of the Lake Cancer Center.

Little, a member of the Cancer Center team for over four years, specializes in navigating head and neck cancer patients through their journey, beginning with diagnosis and continuing through treatment. Daniel Nuss, MD, chair of the Cancer Center's Head and Neck Cancer Multidisciplinary Care Team, praised Little for her work with an extremely complex patient population because of often disfiguring and life-changing surgeries and other treatments.

FertilityAnswers Plans Infertility Clinic

FertilityAnswers, a multi-clinic infertility center, is offering an "Infertility 101" Seminar open to the public and free of charge, Tuesday, March 22nd at 6 p.m. The seminar will be held in Conference Room 4 located on the first floor of Woman's Hospital in Baton Rouge. Reproductive endocrinologist Dr. Susan Conway will lead the discussion.

To register, please visit www.fertilityanswers.com.

NMC Physician Opens Clinic in Ascension

Interventional Pain Specialist, Dr. Samir K. Patel will now offer quick appointments to both new and existing patients seeking relief for low back, neck and post-surgery pain in Ascension Parish at The NeuroMedical Center's Gonzales satellite clinic located at 1004 W. Highway 30, Suite B.

Dr. Patel specializes in the non-surgical treatment of acute and chronic pain caused by neurological disease, disorder or trauma. Conservative treatment options include nerve blocks, spinal cord stimulators, trigger point injections, radiofrequency ablation (RFA), and botox.

From left, Samir K. Patel, MD, and Gregory J. Gelpi, MD

Dr. Patel is dual board certified in Pain Management and in Anesthesiology and along with specializing in treating low back and chronic neck pain he is also an expert in rehabilitating patients with failed back surgery syndrome.

Gelpi Joins OLOL Physician Group

Our Lady of the Lake Physician Group has welcomed Dr. Gregory J. Gelpi to the Pediatric Medical Center at 12525 Perkins Road in Baton Rouge.

Dr. Gelpi provides diagnoses and treatment for children of all ages, from newborns to adolescents. He is Board Certified in Pediatrics and is a Fellow of the American Academy of Pediatrics. He currently serves as Chief of Pediatrics at Woman's Hospital and is a member of the Academy of Breastfeeding Medicine and the Louisiana Breastfeeding Steering Committee.

LSO Foundation Hosts Hat Run in April

The Lauren Savoy Olinde Foundation is holding its 4th annual 5K and 1 Mile Hat Run on Saturday, April 16, 2016 at 8:00 a.m. behind Pennington Biomedical Research Center, 6400 Perkins Road, to promote skin cancer awareness. Join the fun at the Hat Run and learn how to protect the skin you're in.

The Hat Run will include a 5K Run, 1 Mile Fun Run, free skin cancer screening by local dermatologists, and a Finish Festival. The Finish Festival features a children's activity tent, skin cancer survivor area, community vendor expo, and a food tent serving jambalaya. In addition to the Finish Festival, this year's Hat Run is going to the circus and will feature a clown, carnival treats, and carnival games for the public to enjoy.

The Hat Run encourages all participants to wear hats during the race and a hat contest will award the best team and individual hat. For more information on the race and to register please visit thehatrun.com or purchase tickets at the race.

Tickets are $30 for Adults and $15 for Kids (15 and under) until Wednesday, April 13. After April 13, Adult Tickets will increase to $35. ■

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Since Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, most states, not unlike our own, have worked to develop robust health IT infrastructures that support the secure, timely, and efficient exchange of patient data to ensure coordinated, quality care for patients.

Data Blocking: Disrupting The Data Flow

THESE EFFORTS HAVE YIELDED tremendous increases in health IT adoption and implementation across the country: the Office of the National Coordinator of Health Information Technology (ONC) reports that as of April 2015, more than 75 percent of eligible providers and nine out of 10 eligible hospitals have received incentive payments for the meaningful use of certified health IT, and that more than 60 percent of hospitals have electronically exchanged patient data with providers outside their organization.

Here in Louisiana, as of October 2015, 92 percent of Primary Care Providers (PCPs) and 90 percent of the state's Critical Access and rural hospitals enrolled with the Regional Extension Center (REC) for EHR implementation services have demonstrated Meaningful Use – well above the national average. The statewide health information exchange (HIE) now boasts more than 300 participants - including more than 60 percent of the state's hospitals - across the spectrum of care, touches more than four million patient lives, and features unique analytical functions that allow providers to mine their data to drive quality outcomes.

Unfortunately, the incredible infrastructure we've built across the nation and here in Louisiana remains somewhat hindered by "data blocking." ONC describes data blocking as a practice in which "persons or entities knowingly and unreasonably interfere with the exchange or use of electronic health information," and reports that it is an issue that "frustrates the national information sharing goal."

It is also frustrating to Louisiana's statewide information sharing goal.

THE DATA BLOCKING EQUATION

In a 2015 report to Congress about data blocking, ONC noted that it is a nebulous concept that occurs for a variety of reasons. Essentially, reports ONC, there are two sides to the data blocking equation – one side is provider-based, and the other is vendor-based.

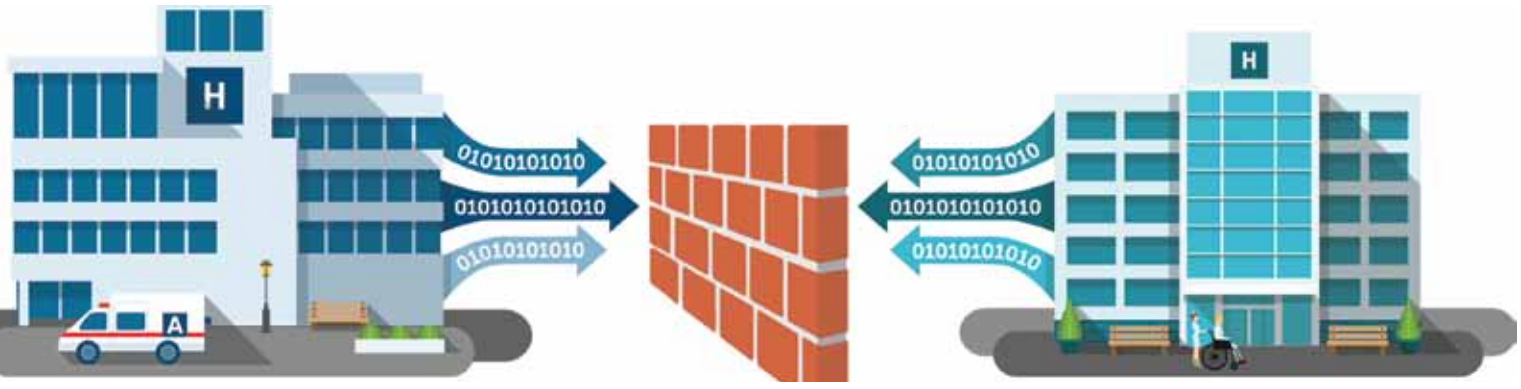
On the provider side, privacy-based concerns are often cited as a reason for declining to share data. ONC reports that while some of these "privacy-based refusals" are based on legitimate concerns about data privacy, there are others in which providers use HIPAA to refuse to share data even when they know it is not a prohibitive factor. However, according to ONC, it is often difficult to prove intent to block data in those cases.

Further, data blocking on the provider side may also be rooted in the increasing value of health data. As the nation moves toward a quality-focused and value-based payment system, the economic value of health data continues to climb, and without any strong financial incentives in place to spur the sharing of that data, some providers remain unwilling to share it.

Even greater challenges exist on the health IT vendor side of the data blocking issue. Across the nation and here in Louisiana, there are providers who report that pricing practices remain an issue. These providers argue that some vendors charge different prices for the same kinds of connections and interfaces, often with rural providers being required to pay more for the same level of connectivity than providers in larger markets.

In addition, some providers, often located

Cindy Munn
Chief Executive Officer
Louisiana Health Care Quality Forum



in rural markets, note that they have purchased interfaces that would enable data sharing, only to eventually learn that their vendors do not have the resources available to complete those interfaces in a timely manner. Also, according to these providers, the vendor may tack on additional costs for ongoing support and hourly rates for interface maintenance. These practices are strong deterrents for providers in the purchase of such interfaces.

THE IMPACT

Providers need timely access to valuable, actionable health data in order to make informed decisions about care plans, follow-up care, and care management. Similarly, patients need access to their health information to make critical decisions about their health and health care. The unavailability of that data leads to poor decision-making, which negatively impacts the safety, quality, and effectiveness of the care delivered to patients as well as patients' confidence in their providers.

Here in Louisiana, data blocking is a challenge particularly for smaller providers and hospitals. Some of these providers and hospitals report that although they are sharing data with larger health systems, the larger systems are not always as willing to share data with them, which negatively affects care coordination efforts.

On a larger scale, data blocking slows the nation's progress in reforming care delivery and payment models toward a patient-centric, quality-focused system, which is centered on the ability of providers to seamlessly and securely share health information across the continuum of care and disparate systems.

Further, in more global terms, when data is blocked, it detrimentally affects advances in public health and biomedical research. This research is founded on the availability of valuable health data for analysis to identify public health risks and new treatments and cures. Without the data to advance those efforts, the evolution of precision medicine is delayed, if not ended completely.

THE SOLUTION

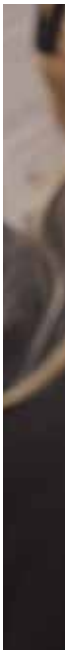
At the national level, efforts are underway to address the data blocking issue. For providers, increased HIPAA education will be available to reduce privacy-related data sharing denials and to ensure that consumer rights to data access are met. In addition, opportunities are being explored to move health payment in a direction that will encourage providers to demand interoperability from vendors and product developers.

Also, a new complaint form will be released to address data blocking among providers. This form will ensure the collaboration among multiple federal agencies to identify and address data blocking occurrences.

On the vendor side, the certification criteria will be expanded to aggressively survey field engagements of health IT products. Vendors will also be required to submit to greater disclosure of pricing models to ensure pricing transparency.

These national efforts will have a positive impact on data sharing issues within our own state, but Louisiana is doing its part, too. With specific data sharing and storage standards in place through the statewide HIE, and with tailored EHR adoption and Meaningful Use assistance available through the REC, Louisiana is well positioned to overcome the challenges related to data blocking.

We are fortunate to have health care providers and organizations in our state that share a commitment to improved health and health care delivery through health IT advancements for the residents of Louisiana, and through continued collaboration with health care stakeholders across Louisiana, we anticipate that we will be successful in developing and implementing strong data sharing strategies. ■



MANAGING HEALTHCARE AT A DISTANCE:

Facilitating Telehealth in Louisiana

House Concurrent Resolution 88 of the 2014 Regular Session created the Telehealth Access Task Force (TATF) as an advisory group to the Legislature and Department of Health and Hospitals on policies and practices to expand telehealth services. The Louisiana State Board of Nursing is a designated member of the Task Force. As such, we are intricately involved in the functions of TATF, which include:

- Serve as an advisory body to the Louisiana Legislature and the Department of Health and Hospitals on policies and practices that expand access to and coverage for telehealth services in a manner that ensures quality of care and patient safety.
- Serve as a coordinating forum on telehealth-related matters between and among state agencies, local government, and other nongovernmental groups.
- Study technical aspects of delivery systems utilized in telehealth, and develop basic standards based upon such study to recommend to the governor, the legislature, and the secretary of the Department of Health and Hospitals concerning modalities and features of telehealth delivery systems.
- On a regular basis, research and review state regulations, guidelines, policies, and procedures that pertain in any way to telehealth and make policy recommendations to the governor, the legislature, and the secretary of the Department of Health and Hospitals.

BACKGROUND

Act 442 of the 2014 Regular Session expanded the narrow Telemedicine definition with that of the more comprehensive definition of Telehealth. Telehealth can include innovative methods to deliver health services through home monitoring, synchronous (real-time) or asynchronous[1] interactions. Specifically, Act 442 defines telehealth as a mode of delivering healthcare services that utilizes information and communication technologies to enable treatment, education, and care management of patients at a distance from their providers. In terms of nursing care, telenursing would mean using those same technologies to deliver nursing care to patients. Telenursing doesn't in any way change nursing care or nursing process – it is simply a different delivery scheme. From the standpoint of the Louisiana State Board of Nursing (LSBN), telenursing also does not change the standard of care that nurses are expected to use in the delivery of nursing care. The standard of nursing care in a telenursing visit must be the same as that provided in a face-to-face visit. That means nurses still are expected to assess, plan, intervene, and evaluate nursing care. Particularly for nurses, telehealth and telenursing facilitate patient self-management and care support using the Internet, computers, hand-held digital devices, and telemonitoring.

PRACTICE IMPLICATIONS

Patient safety, improved access to care, and decreased costs are the primary foci of the TATF for 2016. For all providers, including nurses, we want to facilitate the delivery of healthcare services through technology that promotes the appropriate development of a patient-provider relationship, facilitates appropriate assessment, and meets all

Karen C. Lyon, PhD APRN, NEA
Executive Director, Louisiana State Board of Nursing

ACT 442

Specifically, Act 442 defines telehealth as a mode of delivering healthcare services that utilizes information and communication technologies to enable treatment, education, and care management of patients at a distance from their providers

standards of care for patient health outcomes. Specifically, TATF will focus on:

- Defining recommendations for when and how provider-patient relationships are established;
- Establishing recommendations for reimbursement standards for telehealth services provided; and
- Outlining recommendations for prescribing through telehealth that focuses on appropriateness and safety of prescribing; increases access to care; is consistent with standards of practice; and is consistent with prescribing in the face-to-face encounter (this last recommendation has significant implications for APRNs).[1]

Since the landmark publication of the Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century*[2] in 2004, information technology has been recognized as essential in helping us to improve quality healthcare outcomes. Telehealth and, by extension, telemedicine and telenursing have the potential to reduce stressors on an already overburdened healthcare system by streamlining delivery within regions, nations, and the world. The focus should be on population health specific to the identified needs of the region's residents. In Louisiana, consistently ranked in the bottom 5 in terms of health status of states, this would include using telehealth technology to focus on reducing obesity and its comorbid conditions of cardiovascular disease and diabetes, decreasing the high incidence of infectious diseases, and lessening the high prevalence of low birth weight infants. TATF will explore specific opportunities to use the American Telemedicine Association's recommendations to improve health outcomes in the areas of school-based care, high-risk pregnancies, home-based care, diabetes care, and mental and behavioral health.[1]

Provider shortages, health reform, and an aging population are the overwhelming drivers of change in the delivery of health services. Innovations in technology are helping providers to manage those changes in the delivery of care to populations facing lifelong management of chronic illnesses. Telehealth allows both providers and patients to be more engaged in decisions about and management of healthcare. Through home-based technology and mobile applications, care delivery will be facilitated, access will be improved and costs will decrease. These are win-win solutions for nurses, physicians, allied health providers, and, most importantly, our patients. ■

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[2]Committee on Quality of Health Care in America, Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press, 2004.
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Advances in Health Research from **Pennington Biomedical Research Center**

March 22 is Diabetes Alert Day, described by the American Diabetes Association as a one-day wakeup call to inform the American public about the seriousness of diabetes and to encourage people to take the Diabetes Risk Test to find out if they are at risk for type 2 diabetes – a disease with which Louisianians are all too familiar.

LSU'S PENNINGTON BIOMEDICAL IS WORKING TO ADVANCE TREATMENTS FOR DIABETES

DO YOU HAVE A FAMILY HISTORY of the disease? Are you are overweight or inactive? Do you have high blood pressure or abnormal cholesterol levels? The answers to these questions, often along with a simple blood test, can provide you and your doctor with a better idea of your risk for developing the disease.

Unfortunately, many parts of our state are 50 percent above the national average for prevalence of diabetes. Fifty percent! The monetary cost of diabetes in Louisiana exceeds $4 billion a year.

At LSU's Pennington Biomedical Research Center, scientists are working to uncover the triggers of chronic diseases such as diabetes, heart disease, obesity, and Alzheimer's. Researchers understand that these diseases are interconnected and are harnessing the power of research to bring us toward better treatments and eventual cures.

Did you know that Pennington Biomedical has been involved in the development of all approved obesity medications on the market today, as well as key diabetes medications? The work of the world-renowned researchers is focused on providing better prevention methods and treatments so that the 30 million Americans living with diabetes, and the 86 million affected by prediabetes, can live a better life.

Through landmark clinical trials, Pennington Biomedical's researchers right here in Baton Rouge are finding meaningful results that translate into real-world approaches to battle diabetes:

The Diabetes Prevention Program proved that people can reduce their risk of being diagnosed with diabetes by 58 percent through the loss of seven percent of body weight and 150 minutes of exercise each week.

The HART-D Study showed that diabetics can improve their glycemic control by combining strength training and aerobic activities versus either type of exercise alone.

The Look Ahead Study demonstrated that people with type 2 diabetes can achieve and maintain weight loss for more than four years, reducing the amount of medicine they need and improving cardiovascular risk factors and diabetes control.

Progress is being made in the fight against diabetes, but there is still ground to be covered. Right now, Pennington Biomedical's scientists are participating in a national study to determine whether vitamin D3 can slow the progression from pre-diabetes to diabetes. They are also looking into the health benefits of botanicals such as cranberries for people at risk for diabetes and heart problems.

People who have already been diagnosed with diabetes can participate in a variety of research as well.

In the landmark GRADE study, researchers are working to determine which combination of two medications is best for glycemic control, has the fewest side effects, and is the most beneficial for overall health.

The Sleep Diabetes research study is looking at how sleeping at a "simulated" altitude will influence blood glucose levels in individuals with type 2 diabetes. It is expected that blood glucose levels and the body's response to insulin will improve following 14 nights of sleeping at a simulated altitude.

Participants in these studies have access to lab work and study related medications at no cost, as well as additional compensation for their time. To find out more about how you can join Pennington Biomedical to move science forward, check out www.pbrc.edu/healthierLA.

More than 8 million people, or nearly 28 percent of people with diabetes, don't know they have it. If left undiagnosed or untreated, diabetes can lead to serious health problems such as heart disease, blindness, kidney disease, stroke, amputation, and even death. With early diagnosis and treatment, people with diabetes may prevent the development of these health problems. Diabetes Alert Day is a great time to get involved in the fight against this deadly disease.

For more information on diabetes visit ndep.nih.gov or www.diabetes.org. ■

COLUMN
SECRETARY'S CORNER

Rebekah E. Gee, MD, MPH
Secretary, Louisiana DHH

Expanding Medicaid will create better health outcomes for Louisiana's citizens, save lives, and protect livelihoods. While implementing expansion will be a challenge, we know from our own experiences with Bayou Health that Medicaid expansion can and will work for Louisiana. I am calling on you to support Medicaid expansion and to do what you can to make it as successful as possible.

Medicaid Expansion Challenging But Promising

WHILE ALMOST EVERYONE AGREES that giving more working Louisianans health care coverage is a good thing, I still hear concerns that, with so many new Medicaid enrollees, we will not have enough doctors, nurses, and hospital beds to care for the hundreds of thousands of new health care consumers throughout Louisiana.

The reality is that these patients won't be new at all. Those lacking insurance today already seek and receive care, only they seek it after their ailments and injuries have progressed to the point at which they are unbearable. Then, often visiting emergency departments rather than primary or urgent care clinics, they receive costly, reactive care. Besides being significantly more expensive, seeking care this way provides the worst chances at lasting recovery and long-term health. It also prevents patients from establishing relationships with primary care providers, which are essential for successful long-term health management. By expanding Medicaid, we can place these individuals in coverage through Bayou Health, granting them access to both case management and preventative medicine in a primary care setting.

Louisiana's Bayou Health plan has a proven history of increasing access to primary care for Medicaid enrollees and building expanded provider networks from medical practitioners and facilities that are already here, ready and waiting. For example, Bayou Health has already increased the number of primary care physicians available to current Medicaid enrollees by 68 percent. Other successes include increasing the number of current enrollees who receive primary and preventive care, including both nearly doubling access to primary care for Medicaid children and adolescents and increasing adult access to primary care from 78 percent to 82 percent. These improvements didn't come from having more doctors in Louisiana; they come from the fact that the doctors we do have are able to deliver care more efficiently and more profitably as part of a managed care organization's network.

I HOPE EACH OF YOU JOINS ME IN WORKING TOWARD SUCCESSFUL EXPANSION IN OUR STATE...

One example of how Bayou Health accomplished these improvements is found in its use of value-based contracts. With such contracts, providers are rewarded for producing better outcomes by the private managed care organizations, which have a vested interest in keeping their members as healthy as possible over the course of their lifetimes. In the past six months alone, $3.3 million in performance payments have been disbursed by the various managed care organizations under Bayou Health. The value-based contracts are so popular, one Bayou Health plan has signed over 80 percent of its providers onto them.

Yes, expansion will mean redesigning our care delivery system, and everyone in the health care community knows that it will require significant work. However, in my own experience as a doctor, I have seen firsthand the consequences that come when patients in desperate need are unable to afford care and the health system of Louisiana fails to provide it to them. These firsthand experiences on the front line of caring for the uninsured are perhaps the strongest reason why I'm personally committed to making Louisiana's health programs work more effectively and efficiently for everyone, especially the hard-working families that will be newly eligible for Medicaid coverage when expansion takes effect later this year.

We are just beginning the journey to help all Louisianans live healthy, productive lives. I hope each of you joins me in working toward successful expansion in our state, not just for our friends, families, and neighbors, but also for our children and the generations to come after them. ■

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GROUNDBREAKING HELD FOR OLOL CHILDREN'S HOSPITAL

IN FEBRUARY, OUR LADY OF THE LAKE CHILDREN'S HOSPITAL BROKE ground on a new, state-of-the-art, freestanding hospital that will serve as a premier destination for high-quality, advanced medical care for children within a statewide network of pediatric healthcare excellence. Local dignitaries and former patients joined hospital leadership for the ceremonial groundbreaking witnessed by a standing room only crowd of hospital staff and supporters.

Each year Our Lady of the Lake Children's Hospital provides care to approximately 100,000 patients from all across Louisiana, parts of Mississippi, Texas, and beyond and is committed to healthcare education and keeping children healthy. The new facility will allow for expanded and even more specialized care in a building that was designed exclusively for children and their families.

The new 350,000 square-foot hospital will feature six floors and include inpatient beds, a pediatric emergency room, surgical unit, a dedicated hematology/oncology unit that will serve both inpatients and outpatients, playrooms on every floor, and room to grow. Plans also include a four-story, 95,000 square foot medical office building primarily for pediatric medical specialists.

In addition to Baton Rouge, Our Lady of the Lake Children's Hospital Pediatric Specialty clinics are located in Hammond, Gonzales, Lafayette, and Monroe. Virtual groundbreakings at each of these facilities were displayed on-screen before the signal to "dig" was given in Baton Rouge amid flurries of confetti and a balloon release.

Currently Our Lady of the Lake Children's Hospital operates as a hospital within a hospital model inside Our Lady of the Lake Regional Medical Center. The new, freestanding Our Lady of the Lake Children's Hospital will be built on 66 acres of property that runs parallel to I-10 in between Essen and Bluebonnet near Our Lady of the Lake's main campus in Baton Rouge. Estimated construction cost for the hospital and medical office building is $230 million. The project is expected to be complete in late 2018.

HospitalRounds

Home Raffle to Benefit Woman's Hospital

One hundred dollars could buy a nice dinner, a new pair of shoes, or even a night on the town, but for one lucky winner, it will buy a brand-new house.

The "$100 Home for Good" is a 2,483 square foot, four-bedroom, three-bathroom home valued at more than $400,000. It is located at 2854 Grand Way Avenue in Lexington Estates subdivision, which is off Nicholson Drive near S. Bluebonnet Boulevard. It features stainless appliances, an outdoor kitchen and living area with a fireplace, a landscaped yard, and more.

The Capital Region Builders Foundation will raffle the home on Friday, July 22, 2016. Ticket sales benefit Woman's programs and services that improve the health of women and infants in the community, such as Woman's Newborn and Infant Intensive Care Unit (NICU) and Mammography Coach.

See the home's construction progress at facebook.com/100DollarHomeforGood. To purchase a $100 ticket, visit womans.org/win.

Lane Launches Substance Abuse Treatment Program

Lane Regional Medical Center has announced the opening of its newest program, Lane Recovery Solutions, a substance abuse treatment program located at 4801 McHugh Road, Suite A, in Zachary.

Lane Recovery Solutions is a structured program of outpatient addictionology and psychiatric services provided to adults over the age of 18 who are impaired by one or more addictive substances, such as alcohol, prescription medications or other drugs.

It is a medically-directed, comprehensive, and highly-structured treatment program designed for those who still need direct medical supervision, but do not yet require overnight stays in a hospital setting. Treatment is more intense than the care provided in a doctor's or therapist's office and is often an alternative to inpatient care. Typically, patients receive six hours of care per day, five days a week, for approximately six weeks.

A board certified addictionologist, licensed addiction counselors, registered nurses, and additional staff members provide the highest quality therapy available to address the physical, psychological, social, and spiritual aspects of recovery. After successful completion of the program, the patient and their family members may continue their recovery journeys in an aftercare program and/or transition to a less intensive level of outpatient treatment.

Physician referrals are not required. Most commercial insurance plans and Medicare are accepted.

Assurance Financial Donates to Burn Center

Assurance Financial recently donated $15,000 to the Baton Rouge General Regional Burn Center. Offering care for both children and adults, the Regional Burn Center was the first designated burn facility in Louisiana, 14th in the nation, and is one of fewer than 70 verified burn centers in the nation, according to the American Burn Association. Being the only burn center in a 300-mile radius, patients come from all over the south. Of the 600-700 patients the Regional Burn Center sees a year, 100-200 of them are children.

The Regional Burn Center sends pediatric burn survivors to the "I'm Still Me" Summer Burn Camp in Scottsville, Texas. During the week-long camp, participants enjoy swimming, fishing, arts and crafts, and many other fun activities. The donation of $15,000 from Assurance Financial could help as many as 15 children attend the camp free of charge.

The donation was funded in part by proceeds from an annual "Jeans Fund" in which Assurance Financial team members contribute money throughout the year in exchange for the opportunity to wear jeans or casual dress attire to work. The Jeans Fund contribution, along with a corporate match, is made to a charity each year.

Pictured, from left: Beth Barback, Regional Burn Center; Dr. Tracee Short, Regional Burn Center; Crystal Curtin, Underwriter for Assurance Financial; Lindsay Anders, Servicing Coordinator for Assurance Financial; Kenny Hodges, Managing Partner for Assurance Financial; Chad Hebert, Controller for Assurance Financial; Danielle Hall, Underwriter and Jeans Fund Committee Chairperson for Assurance Financial; Steve Ward, Chief Operating Officer for Assurance Financial; and Robin Comeaux, Regional Burn Center.

Dubrovsky Joins St. Jude Affiliate Clinic at OLOL

Leonid Dubrovsky, MD, a specialist in pediatric hematology/oncology, has joined the St. Jude Affiliate Clinic at Our Lady of the Lake Children's Hospital where he provides specialized care to children with a variety of blood disorders and cancers.

Dr. Dubrovsky is Board Certified in pediatrics and pediatric hematology/oncology, and is an active member of the American Society of Pediatric Hematology Oncology and the Children's Oncology Group.

School of Nursing Announces 2015 Graduates

Baton Rouge now has 36 new nurses. Three dozen registered nursing candidates recently received their degrees from Baton Rouge General's School of Nursing (SON).

The Class of 2015 joins a group of more than 875 talented nurses who have graduated from BRG's School of Nursing. The School has been recognized by the La. State Board of Nursing (LSBN) for its 100% first-time pass rate on the registered nurse license exam (NCLEX-RN).

Most of BRG's new graduates will begin their careers at Baton Rouge General in the Emergency Department, Telemetry, Oncology, and on medical and surgical units. After entering nursing, many graduates have gone on to earn bachelor's, master's, and doctorate degrees, and many work in management or leadership positions, or as nurse practitioners and educators.

OLOL Announces New Vice Presidents

Our Lady of the Lake Regional Medical Center recently announced new members of its leadership team.

Nicole Telhiard, DNP, CPN, NE-BC, has been named Vice President of Patient Care Services. Telhiard joined Our Lady of the Lake in 1993 and has held a variety of nursing and nurse leadership positions during her tenure. She is a Board Certified Nurse Executive and Certified Pediatric Nurse. She also currently serves on the Board of

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the Our Lady of the Lake Children's Hospital subsidiary Health Centers in Schools.

Frank Canova, Jr. has been named Vice President of Finance. Canova joins Our Lady of the Lake from Aiken, South Carolina where he served as Chief Financial Officer for Aiken Regional Medical Centers for the last four years. Previously he served as Chief Financial Officer for the CHRISTUS Schumpert Health System in Shreveport, Louisiana.

Family Offers Comfort to Bereaved Parents

Woman's Hospital recently received a CuddleCot, which was designed to help parents who suffer the loss of a baby. In a situation when every moment counts, the CuddleCot gives families extra time to spend with their baby for bonding, pictures, footprints, and visits from other family members. The CuddleCot system uses a cooling pad to allow the baby to remain with his or her family.

The CuddleCot was made possible through a donation by the Brown family, who lost their newborn daughter – a twin – 18 months ago. Because of the incredible care they received in Woman's NICU, they chose to give back in a very unique and special way.

Ochsner Renews Commitment to Federal Initiative

Ochsner Accountable Care Network (OACN) was selected as one of nearly 150 renewing Medicare Shared Savings Program Accountable Care Organizations (ACOs), providing Medicare beneficiaries with access to high-quality, coordinated care across the United States, the Centers for Medicare & Medicaid Services (CMS) announced. That brings the total to 434 Shared Savings Program ACOs serving over 7.7 million beneficiaries.

Ochsner Accountable Care Network (OACN) will be one of 434 ACOs participating in the Shared Savings Program as of January 1, 2016.

Cleft and Craniofacial Team Earns National Designation

The Cleft and Craniofacial Team at Our Lady of the Lake Children's Hospital has been recognized with full approval by the American Cleft Palate-Craniofacial Association. They are now the only ACPA-designated team in the Baton Rouge area.

The Cleft and Craniofacial Team is a multidisciplinary network of experienced and qualified physicians and healthcare professionals coordinated through a partnership between the LSU Department of Otolaryngology-Head and Neck Surgery, the LSU Department of Oral and Maxillofacial Surgery and Our Lady of the Lake Children's Hospital. This team works together to coordinate the care of children with cleft and craniofacial disorders, and thoroughly evaluates and supports patients both physically, emotionally and socially.

FAMILY OFFERS COMFORT TO BEREAVED PARENTS
Left to Right: Amye Reeves, Laurel Kitto, and Cheri Johnson of Woman's; LaTerrica and Brandon Brown with their son, Corbin; and Beverly Brooks Thompson of Woman's.

Baton Rouge General Honors Medical Staff

Physicians at Baton Rouge General were honored at the hospital's annual Medical Staff Gala.

The Leadership honoree was Dr. Floyd "Flip" Roberts, who practiced at Baton Rouge General for 34 years, and served as Chief Medical Officer from 2002 through 2015. Dr. Roberts was recognized for his contributions to the hospital's culture of quality and safety, and the establishment of Tulane School of Medicine's Baton Rouge campus.

Several retiring physicians were also honored, including Dr. Charles Gruenwald, Jr., Dr. Joe Morgan, Dr. Jane Peek, Dr. Barry Rills, Dr. Carlton Sheely II, and Dr. Stephen Wilson.

Gremillion Named CMO, VP of Medical Affairs

Steven Gremillion, MD has been named Chief Medical Officer and Vice President of Medical Affairs at Our Lady of the Lake Regional Medical Center. Previously, Dr. Gremillion had served the organization as Associate Chief Medical Officer and Chief of Staff.

In these roles, Dr. Gremillion will work with the organized medical staff of over 1,100 physicians, the Board of Directors, and hospital administration to ensure the delivery of high quality care to patients at Our Lady of the Lake. He will also work closely with the CEO, Chief of Staff, Medical Executive Committee, and other physician leaders to prioritize physician partnerships while leading best practice delivery models within the enterprise. Dr. Gremillion will also continue to treat patients as a cardiologist with Louisiana Cardiology Associates.

Dr. Gremillion has been practicing as a cardiac electrophysiologist in Baton Rouge since joining Louisiana Cardiology Associates in 1993. Dr. Gremillion is Board Certified in internal medicine, cardiology, and electrophysiology.

Woman's Receives Grant for Mammography Coach

The Foundation for Woman's recently received a $100,000 grant from The Hearst Foundations for a new Mammography Coach.

In 2015, the Mammography Coach provided more than 4,700 screening mammograms and yielded 26 cancer diagnoses. The grant will assist Woman's in adding a second coach to its fleet, increasing the number of patients served to nearly 10,000 annually. With an additional coach, service will expand to Iberia, Jefferson, Lafourche, Orleans, Plaquemines, and St. Bernard parishes for a total of 21 parishes.

The grant will also help Woman's upgrade its current coach from 2D technology to 3D, which assists in diagnosing cancer as early as possible, when it is most treatable.

Ochsner Joins Excelera Pharmacy Network

Ochsner Health System has joined the Excelera national specialty pharmacy network. The Excelera® network consists of point-of-care specialty pharmacies owned by health systems and academic medical centers.

The Excelera organization will partner with Ochsner Health System to develop key specialty pharmacy capabilities including training, operations, data aggregation, reporting for drug manufacturers and payers, revenue cycle management, and pharmacy business office.

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HospitalRounds

Inaugural Gala to Benefit Local Cancer Patients

The Ascension Parish community helped take the fight against cancer forward recently by raising more than $125,000 to benefit local patients being treated at Mary Bird Perkins Cancer Center in Gonzales over the coming year. At the inaugural gala at Houmas House Plantation and Gardens, a sold-out crowd enjoyed a festive evening that included dinner, a live auction, and musical entertainment. Speakers provided an update on the Cancer Center's progress and how funds raised will directly impact patient care locally moving forward.

The Gonzales Gala was spearheaded by co-chairs DeEtte DeArmond and Ronnie Daigle, along with a group of other dedicated community volunteers representing various industries and geographic areas of the parish.

Ochsner - Iberville Offers 3D Mammography

Ochsner Health System recently announced a new location for 3D mammography in Louisiana. The technology, which has been found to identify up to 41 percent more invasive cancers than conventional 2D mammography, is now available to patients at Ochsner Medical Complex - Iberville. Ochsner now offers 3D mammography across 13 locations.

Baton Rouge ACO Joins Federal Initiative

The Centers for Medicare & Medicaid Services (CMS) recently announced 121 new participants representing 49 states and the District of Columbia in an innovative initiative, Medicare Accountable Care Organizations (ACOs), designed to improve the care patients receive in the health care system and lowers costs.

In Baton Rouge, Health Leaders Medicare ACO Network, which includes several Franciscan Missionaries of Our Lady facilities, was selected as one of 100 new Medicare Shared Savings Program Accountable Care Organizations (ACOs), providing Medicare beneficiaries with access to high-quality, coordinated care across the United States. That brings the total to 434 Shared Savings Program ACOs serving over 7.7 million beneficiaries.

Babies at BR General Go Red for Women

Babies born at Baton Rouge General Medical Center in February wore red hats in support of the fight against heart disease. By wearing red, the babies are sending a lifesaving message to their mothers and all of the women in their lives: Love Your Heart.

Babies Go Red is an effort designed to bring awareness and is a part of Baton Rouge General's partnership with the American Heart Association's larger Go Red For Women campaign, celebrated in February each year. The campaign encourages women to improve their heart health while taking action to fight heart disease.

BCBSLA Recognizes Hospitals for Maternity Care

In an effort to help prospective parents find hospitals that deliver quality, affordable maternity care, Blue Cross and Blue Shield of Louisiana announced the first hospitals in Louisiana to receive the national Blue Distinction® Center and Blue Distinction Center+ for Maternity Care designations under the Blue Distinction Specialty Care program.

This new maternity care program evaluates hospitals on several quality measures, including the percentage of newborns that fall into the category of early elective delivery, an ongoing concern in the medical community. In addition, hospitals that receive a Blue Distinction Center for Maternity Care designation agreed to meet requirements that align with principles that support evidence-based practices of care, as well as having initiated programs to promote successful breastfeeding, as described in the Baby-Friendly Hospital Initiative by Baby-Friendly USA or the Mother-Friendly Hospital program by the Coalition for Improving Maternity Services (CIMS) through its "Ten Steps of Mother-Friendly Care." The program also evaluates hospitals on overall patient satisfaction, including a willingness to recommend the hospital to others.

Blue Distinction Center Maternity Care:

Abbeville General Hospital, Acadian Medical Center, Baton Rouge General Medical Center, Brfhh Monroe, Byrd Regional Hospital, Ochsner Medical Center Northshore, St. Francis Medical Center, West Calcasieu-Cameron Hospital.

To receive a Blue Distinction Centers+ for Maternity Care designation, a hospital must meet the same quality criteria as Blue Distinction Centers while also meeting requirements for cost efficiency. Hospitals recognized for these designations were assessed using a combination of publicly available quality information and cost measures derived from BCBS companies' medical claims.

Blue Distinction Center + Maternity Care:

East Jefferson General Hospital, Jennings American Legion Hospital, Lafayette General Medical Center, Lake Area Medical Center, Lake Charles Memorial Hospital, Lakeview Regional Medical Center, Lane Regional Medical Center, Minden Medical Center, Natchitoches Regional Medical Center, North Oaks Medical Center LLC, Ochsner Medical Center, Ochsner Medical Center Kenner, Ochsner Medical Center at Baton Rouge, Ochsner St. Anne General Hospital, Opelousas General Health System, Rapides Regional Medical Center, St. Tammany Parish Hospital, Terrebonne General Medical Center, Touro Infirmary, Tulane University Hospital & Clinic, West Jefferson Medical Center, Women's and Children's Hospital.

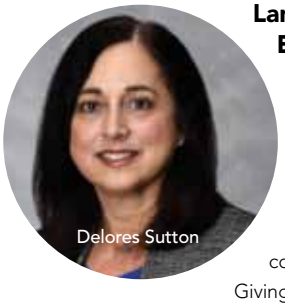
Tonya Davis holds her newborn daughter, Grace Anjanette, who was born Tuesday, February 2 in BRG's Birth Center.

The Gonzales Gala steering committee: Back row, l-r: Randy Haddad, Randall Aldridge, Simone Henry, Debbie Babin, Sheriff Jeff Wiley, Penny Saucier, Karen Braud, Melanie Boudreaux, DeEtte DeArmond, Ronnie Daigle, Mayor Barney Arceneaux, Shannon Templet, Tonya Brown, Paula Berthelot, State Representative Johnny Berthelot, and Sheree Gauthier. Front row, l-r: Sherrie Despino, Tiffany Shelton, Sheila Savoy, Betty Arceneaux, Clerk of Court Bridget Hanna, Tracie Waguespack, Wendy Daigle, and Darla Rye (not pictured)

(L to R) Erica Link, Edwin Link, Jr., Erin Link, and Brittney Guess.

Former NICU Patient Gives Back

Erica Link was born weighing two pounds and spent time in Woman's NICU. Now in the 8th grade, she wanted to do something special. She and her family members made diaper cakes for Woman's patients, which were brought to Woman's NICU as well as Woman's first baby of the new year.



Delores Sutton

Lane Regional Names Sutton Employee of the Year

Delores Sutton was recently named Lane Regional's 2015 Employee of the Year. Sutton is the Marketing Coordinator for the medical center. Sutton serves on several hospital committees including the STAR committee, Blood Drive committee, Keep the Beat committee, Employee Wellness committee, and the Lane Foundation's Employee Giving committee.

Sutton has worked at Lane for more than 20 years and was recognized for her dedication and outstanding work. She was named Employee of the Month in May 2015 and was selected as Employee of the Year from the twelve monthly honorees of 2015.

Woman's Hospital Recognized for Breastfeeding Efforts

Woman's Hospital recently received another "gift" from the state for its breastfeeding efforts. The hospital received re-designation of its GIFT (Guided Infant Feeding Techniques) initiative to improve the health of mothers and babies. GIFT recognizes facilities for protecting, promoting and supporting breastfeeding.

GIFT facilities must implement policies aligned with the "Ten Steps to a Healthy, Breastfed Baby," which are internationally recognized, evidence-based maternity care practices that have been shown to increase breastfeeding initiation and duration.

Woman's offers many resources to educate mothers on the benefits of breastfeeding as well as ongoing breastfeeding support.

BR General and LHC Group Announce Joint Venture

Baton Rouge General and LHC Group (NASDAQ: LHCG) have announced a new joint venture agreement that will enhance home care service in Baton Rouge and help to seamlessly transition patients from the hospital to the home.

Under the agreement, LHC Group will serve as the preferred home health partner for all Baton Rouge General patients. It also creates a Baton Rouge office for LHC Group – a national healthcare provider headquartered in Lafayette. The Baton Rouge office will be based on Baton Rouge General's Mid City campus. ■

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