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HEALTHCARE JOURNAL of Baton Rouge

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LETTER FROM THE PUBLISHER

Greetings,

With an issue that gives attention to minority health concerns, my original inclination was to opine on the topic of race relations. However, as a white male the social latitude we are normally given to explore any interesting angles is likely too narrow. So, I'll bottom line it for you – Racism is Dumb. Now, I think it is more prudent to simply explain a solution to the auto industry financial crisis.

We are facing a moral hazard in our country. Not to over simplify, but our basic political discussions used to be about taking from the rich and giving to the poor. Now government is much more interested in taking from the responsible and giving to the irresponsible.

Good news! We can use this new system of bailouts to actually solve the auto industry problem. This is how it works. Banks and individuals bought real estate thinking this asset class has to increase, or at a minimum, stay the same in value. Therefore, just "thinking" an asset has to increase in value justifies government bailing us out if it doesn't. So, the solution to the auto industry is simple. Let's all get together and "think" that if we buy a new automobile, it will increase in value.

Correspondence will commence as follows:

Dear federal government,

We, The Bank, have a customer who paid $24,500 for a new car. Apparently, a year later the car is only worth $17,300. We "thought" this asset would stay the same in value or increase. Our customer is shocked and will not repay the loan. We are also shocked. Please bail us out for the amount of $7,200 plus an additional $500 for our administrative costs. By graciously continuing this trend, you will save the auto industry the time of having to think about producing more marketable energy efficient cars, improving production, lowering executive pay, and basically trying to figure out how to be more competitive in the global markets. Thank you.

Sincerely yours,
The Bank

Dear The Bank,

Not a problem. Both parties support this great system. Taxpayers love it because, after all, who wants to live next to someone without a car? We'll just continue to tax or borrow from China. It will be great.

Hugs and BFF,
The federal government.

See! Now the auto industry will sell at least a million more cars because nobody can lose. Until this system implodes on itself, we will all be happy. On second thought, that system is really dumb. I think I should have talked about race relations.

Smith W. Hartley

Statistics and Disparities in Minority Health

by: Philip Gatto

As the first black president prepares to be sworn in, the United States embraces a level of equality unprecedented in its history. After all, if an African American man can be elected president those centuries of barriers must have finally been laid down. Unfortunately, that is not yet true when it comes to healthcare. Whatever the reasons, whether it is quality of care, access to care, lifestyle choices, cultural bias, lack of insurance, or a myriad of other socioeconomic factors, America's minority citizens are far from equal in the healthcare arena. Prevalence rates for most chronic health conditions tend to run double for African Americans as compared to non-Hispanic white Americans. More alarmingly, death rates for those same conditions skyrocket in many African American patients. Those national rates are mirrored here in Louisiana, which pre-Katrina was one of the top ten states in terms of African American population. Although Hispanics represent the largest minority in our coun-

try, and we do have a growing Hispanic population here in Louisiana, for the most part our minority population is African American so that will remain our primary focus.

According to recent census figures, 40.2 million people in the United States, or 13.4 percent of the civilian non-institutionalized population, are African American. The majority (54 percent) live in the South. In Louisiana, African Americans represent almost 32 percent of our population, while Hispanics represent less than 3 percent.

Recent figures indicate that 55 percent of African Americans in comparison to 78 percent non-Hispanic Caucasians used employer-sponsored health insurance. Nationally, 17.3 percent of African Americans in comparison to 12 percent of non-Hispanic Caucasians are uninsured. In Louisiana, 28.4 percent of African American adults are uninsured, compared to 17.6 percent of Caucasian adults. The numbers and the disparities are much smaller when children are considered because of the LaCHIP program. Only 5.2 percent of African American children in Louisiana are uninsured, compared to 3.9 percent of Caucasian children.

Across the nation, both the prevalence and the death rate for African Americans is higher than Caucasians for heart disease, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide. The ten leading causes of death for the African American population are heart disease, cancer, stroke, unintentional injury, diabetes, homicide, chronic lower respiratory disease, nephritis, nephrotic syndrome, HIV/AIDS, and septicemia. Similarly the leading causes of death for all Americans are heart disease, cancer, stroke, chronic lower respiratory disease, unintentional injury, diabetes, Alzheimer's disease, influenza and pneumonia, nephritis, nephrotic syndrome and nephrosis, and septicemia.

The leading causes of death for African Americans in Louisiana are cardiovascular diseases including heart disease, stroke, and cancer. African Americans in Louisiana also have a higher heart disease death rate and a higher stroke rate than whites. In addition, African Americans experience a disproportionate number of cancer incidence and deaths in our state. Cancer incidence for

Disparities Not Evident in Trauma Care

There is recent evidence of improvement in disparate treatment based on race and socioeconomic factors. A study highlighted in the November issue of Archives of Surgery, one of the *Journal of the American Medical Association (JAMA)* journals, found no significant differences between non-Hispanic white patients and African American and Hispanic patients in intensity of emergency department assessment, monitoring, treatment or release from the emergency department. There were also no considerable differences by region, hospital ownership or patient insurance status. In fact, the study authors found that the initial evaluation and management of injured patients from minority ethnic groups nationwide appears to be similar to that of non-Hispanic white patients.

Shahid Shafi, MD, MPH, and Larry M. Gentilello, MD, of the University of Texas Southwestern Medical School in Dallas, analyzed data obtained from 8,563 trauma patients in a 2003 national survey to determine if there were differences in the initial assessment and management of injuries based on patient ethnicity. Patients were divided into three groups: non-Hispanic white, African American, and Hispanic. The researchers noted patients' age, sex, insurance status, injury, and measures of injury severity. They did find that the minority patients were more likely to be younger, less likely to be insured, and more likely to have been treated at a public hospital, but were similar in sex, method of injury, and injury severity when compared with non-Hispanic white patients.

The authors concluded that their failure to find evidence of ethnic disparities in emergency department management suggested that other causes of ethnic disparities in functional outcomes of trauma patients should be sought. Among the suggested areas of study were quality of inpatient care, use of high-cost medications and procedures, access to acute and long-term rehabilitation services, and follow-up after discharge from acute care hospitalization. However the authors also surmised that the disparity in outcomes might have no basis in the healthcare received at all, but might be determined by factors "such as the socioeconomic status, educational level, employment and insurance status, rural vs. urban location, language barriers and cultural and religious beliefs and practices." (*Arch Surg.* 2008;143[11]:1057-1061.

African Americans in Louisiana is 520 per 100,000 compared to 482 per 100,000 for whites. The cancer death rate for African Americans is 250 per 100,000 compared to 197 per 100,000 in Caucasians. The good news is that the death rate has improved for both groups over the last few years. African American women also have a higher cancer death rate than white women. For some types of cancer, the disparities are more pronounced. For example, African American men have a prostate cancer death rate that is more than twice the rate for white men.

Here are some comparative statistics by disease that illustrate these disparities:

Heart Disease and related factors

• African American men are 30% more likely to die from heart disease, as compared to non-Hispanic white men.

• African Americans are 1.5 times as likely as non-Hispanic whites to have high blood pressure.

• African American women are 1.7 times as likely as non-Hispanic white women to be obese. Obesity rates in Louisiana are high across the board, with 68 percent of African Americans and 60 percent of whites reportedly overweight or obese.

• In Louisiana, the death rate from heart disease is 285 per 100,000 for African Americans and 241 per 100,000 for whites.

Stroke

• African American adults are 50% more likely than their white adult counterparts to have a stroke. Cerebrovascular death rates in Louisiana are almost twice as high for African Americans than for whites.

• African American males are 60% more likely to die from a stroke than their white adult counterparts.

• Analysis from a CDC health interview survey reveals that African American stroke survivors were more likely to become disabled and have difficulty with activities of daily living than their non-Hispanic white counterparts.

Cancer

• African American men are 1.4 times as likely to have new cases of lung and prostate cancer, compared to non-Hispanic white men.

• African American men are twice as likely to have new cases of stomach cancer as non-Hispanic white men.

• African American men had lower 5-year cancer survival rates for lung and pancreatic cancer, compared to non-Hispanic white men.

• African American men are 2.4 times as likely to die from prostate cancer, as compared to non-Hispanic white men.

• African American women are 10% less likely to have been diagnosed with breast cancer, however, they are 36% more likely to die from breast cancer, compared to non-Hispanic white women.

• African American women are 2.3 times as likely to have been diagnosed with stomach cancer, and they were 2.2 times as likely to die from stomach cancer, compared to non-Hispanic white women.

Diabetes

• African American adults are 1.8 times more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician.

• African American men are 2.1 times as likely to start treatment for end-stage renal disease related to diabetes, compared to non-Hispanic white men.

• Diabetic African Americans are 1.8 times as likely as diabetic whites to be hospitalized.

• African Americans are 2.2 times as likely as non-Hispanic whites to die from diabetes. Diabetes death rates in Louisiana are almost identical to national figures.

HIV/AIDS

• Although African Americans make up only 13% of the total U.S. population, they account for almost half of HIV/AIDS cases. In Louisiana, these numbers are higher, with the annual AIDS case rate five times higher for African Americans than whites.

• African American males have more than 8 times the AIDS rate of non-Hispanic white males.

• African American females have more than 23 times the AIDS rate of non-Hispanic white females.

• African American men are more than 9 times as likely to die from HIV/AIDS as non-Hispanic white men.

• African American women are more than 21 times as likely to die from HIV/AIDS as non-Hispanic white women.

Immunization

• African Americans aged 65 and older are 40% less likely to have received the influenza (flu) shot in the past 12 months, compared to non-Hispanic whites of the same age group.

• African American adults aged 65 and older are 30% less likely to have ever received the pneumonia shot, compared to non-Hispanic white adults of the same age group.

• Although African American children aged 19 to 35 months had comparable rates of immunization for hepatitis, influenza, MMR, and polio, they are slightly less likely to be fully immunized, when compared to non-Hispanic white children.

Infant Mortality

• African Americans have 2.4 times the infant mortality rate of non-Hispanic whites. This is also true in Louisiana, but our infant mortality rate across race is poor in general.

• African American infants are almost 4 times as likely to die from causes related to low birth weight, compared to non-Hispanic white infants.

• African Americans have 2.1 times the sudden infant death syndrome mortality rate as non-Hispanic whites.

• African American mothers are 2.6 times as likely as non-Hispanic white mothers to begin prenatal care in the 3rd trimester, or not receive prenatal care at all. In Louisiana about 92 percent of white women receive prenatal care as compared to 78 percent of African American women. African American babies are also almost twice as likely to be preterm and/or low birth weight.

The issue of minority health disparities is a major one. In 1985, the U.S. Department of Health and Human Services, (HHS) created the Office of Minority Health as a result of the "Report of the Secretary's Task Force on Black and Minority Health," which revealed large and persistent gaps in health status among Americans of different racial and ethnic groups.

The Centers for Disease Control and Prevention (CDC) created its own Office of Minority Health (OMH) in 1988 in response to the same report. Congress passed the "Disadvantaged Minority Health Act of 1990" in order to improve the health status of underserved populations, including racial and ethnic minorities. The Healthy People Initiative has been the Nation's prevention and health promotion agenda for the last two decades. Healthy People 2010 is designed to achieve two overarching goals: 1) Increase quality and years of healthy life; 2) Eliminate health disparities. Despite these major efforts, and considerable improvement, significant disparities remain. A 2006 National Health Disparity Report (NHDR) by the Agency for Healthcare Research and Quality found that disparities related to race, ethnicity, and socioeconomic status still pervade the American healthcare system. Although varying in magnitude by condition and population, disparities are observed in almost all aspects of healthcare, including:

• Across all dimensions of quality of healthcare including: effectiveness, patient safety, timeliness, and patient centeredness.

• Across all dimensions of access to care including: facilitators and barriers to care and healthcare utilization.

• Across many levels and types of care including: preventive care, treatment of acute conditions, and management of chronic disease.

• Across many clinical conditions including: cancer, diabetes, end stage renal disease (ESRD), heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.

• Across many care settings including: primary care, home health care, hospice care, emergency departments, hospitals, and nursing homes.

• Within many subpopulations including: women, children, elderly, residents of rural areas, and individuals with disabilities and other special healthcare needs.

For sizable proportions of measures, racial and ethnic minorities and the poor receive lower quality care:

• Blacks received poorer quality care than whites for 73% (16/22) of core measures. Blacks received better quality care than whites for 9% (2/22) of core measures.

• Asians received poorer quality care than whites for 32% (7/22) of core measures and better quality care for 36% (8/22) of core measures.

• American Indians and Alaska Natives received poorer quality care than whites for about 41% (9/22) of core measures and better quality care for 14% (3/22) of core measures.

• Hispanics received poorer quality of care than non-Hispanic whites for 77% of core measures (17/22) and better quality care for 18% (4/22) of core measures.

• Poor people received lower quality of care than high income people for 71% (12/17) of core measures and better quality care for 6% (1/17) of core measures.

The NHDR also indicated that for many measures, racial and ethnic minorities and the poor have worse access to care:

• Blacks and Asians had worse access to care than whites for a third (2/6) of core measures.

• AI/ANs had worse access to care than whites for 17% (1/6) of core measures.

• Hispanics had worse access than non-Hispanic whites for 83% (5/6) of core measures.

• Poor people had worse access to care than high income people for all 6 core measures.

For racial and ethnic minorities, some disparities in quality of care are improving and some are worsening. For the poor, most disparities are worsening:

• Of disparities in quality experienced by Blacks, Asians, AI/ANs, and Hispanics, about a quarter were improving and about a third were worsening.

• Two-thirds of disparities in quality experienced by poor people (8/12) were worsening.

For racial minorities, most disparities in access to care that could be tracked are improving; for Hispanics and the poor, most disparities are worsening. Of core measures of access that could be tracked over time:

• Most disparities experienced by Blacks (3/5), Asians (3/5), and AI/ANs (4/5) were improving.

• Most disparities experienced by Hispanics (4/5) and by poor people (3/5) were worsening. ❖

Sources: "About Minority Health," Centers for Disease Control and Prevention, www.cdc.gov/omhd/AMH/AMH.htm; "Key Themes and Highlights from the National Healthcare Disparities Report," January 2007, Agency for Healthcare Research & Quality, Rockville, MD, www.ahrq.gov/qual/nhdr06/highlights/nhdr06high.htm; Macklin, Durand "Rudy", "Minority Health in Louisiana: From Disparity to Parity 2003 Report," Louisiana Department of Health and Hospitals, Bureau of Minority Health, www.dhh.la.gov.

Access, Screening, Education
Weapons in the Battle Against Breast Cancer Disparities

by: Jamie Haeuser
Senior Vice President, Woman's Hospital

Understanding and eliminating racial disparities in breast cancer outcomes has proven to be a persistent and complex challenge. Efforts to increase breast cancer screening and promote early diagnosis continue to be a focus, but researchers across the country are seeking to understand other factors including more aggressive tumor biology, the effect of overall health status on outcomes, and differences in the effectiveness of some treatments.

According to the Louisiana Tumor Registry, the average annual rate of breast cancer per 100,000 women between 2002 and 2004 in Louisiana was 121.6 for white females and 123.7 for African American females. Average annual mortality rates between 2000 and 2004 were 25.7 for white females and 40.3 for black females. Cited factors related to these high death rates include Louisiana citizens' general lack of education, inadequate cancer screenings, and late-stage diagnosis. Researchers around the world are also examining factors such as differences in the use of radiation therapy, response to surgery, and co-morbidities such as diabetes and hypertension that appear to contribute to lower survival rates.

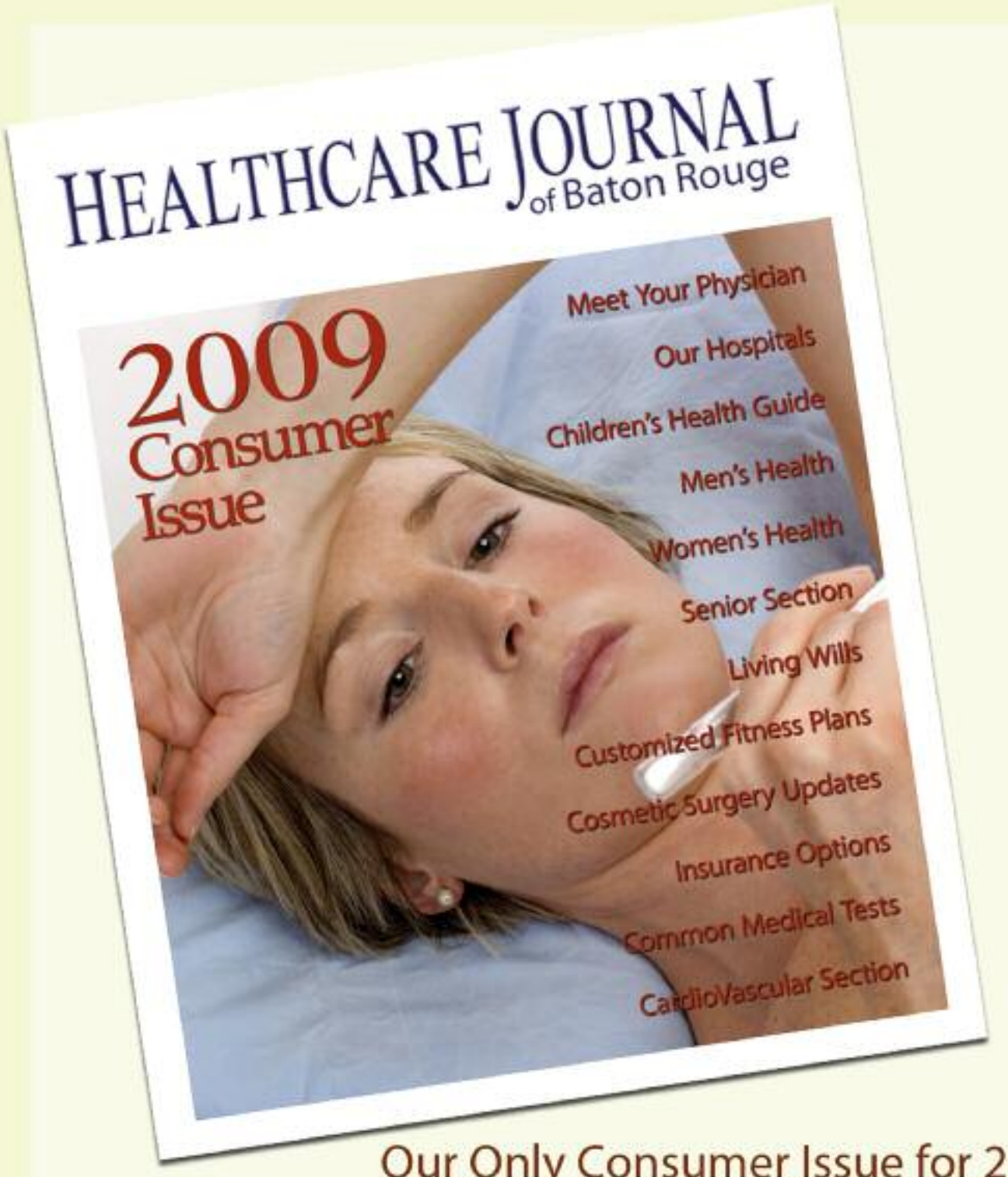
A study published in the September 15, 2007 issue of *CANCER*, a peer-reviewed journal of the American Cancer Society, revealed that racial differences in breast cancer survival increase according to stage of disease. A retrospective study of survival data showed that within each stage, African American women had larger tumors and more involvement of nearby lymph nodes. After controlling for those clinical factors the racial disparities in survival persisted. The finding suggests that non-clinical factors contributed to survival differences.

Even though the disparity issue is wider than access alone, screening mammography outreach continues to be a primary focus. Woman's Hospital works with the C.A.R.E. program of Mary Bird Perkins Cancer Center in conjunction with the YWCA's ENCOREplus program as well as the Louisiana Breast and Cervical Health Program (LBCHP), a cooperative agreement with LSU and the CDC, funded by a federal grant from the National Cancer Prevention and Control Program/National Breast and Cervical Cancer Early Detection Program.

As important as screening is ensuring access to diagnostic and treatment services following a suspicious finding, according to Woman's Hospital's Director of Imaging Services Cynthia Rabalais. "We consider it part of our mission to make sure that women have access to the services they need. Finding a problem through screening mammography is just the beginning." Help for uninsured women needing more complete work-ups is funded through the LBCHP program and other sources, including Foundation56 – a donor advised fund of the Baton Rouge Area Foundation, created by Dallas Cowboys linebacker Bradie James – and the Baton Rouge Affiliate of Susan G. Komen for the Cure.

The apparent link between outcomes and overall health status has led Woman's Hospital and Mary Bird Perkins Cancer Center to add elements of overall health education to outreach efforts. "We have an opportunity to provide basic health information on factors such as nutrition, control of hypertension and diabetes," said Rabalais. "We don't need to wait for research to give us a final answer. We are reaching hundreds of women a year with screening mammography, and have many 'teachable moments' at every screening event." The combined programs' goal is to reach 3,500 women in 2009.

Research continues on racial disparities across the world, but it has become clear that the complex and multidimensional nature of the problem will require responses that are just as diverse.❖



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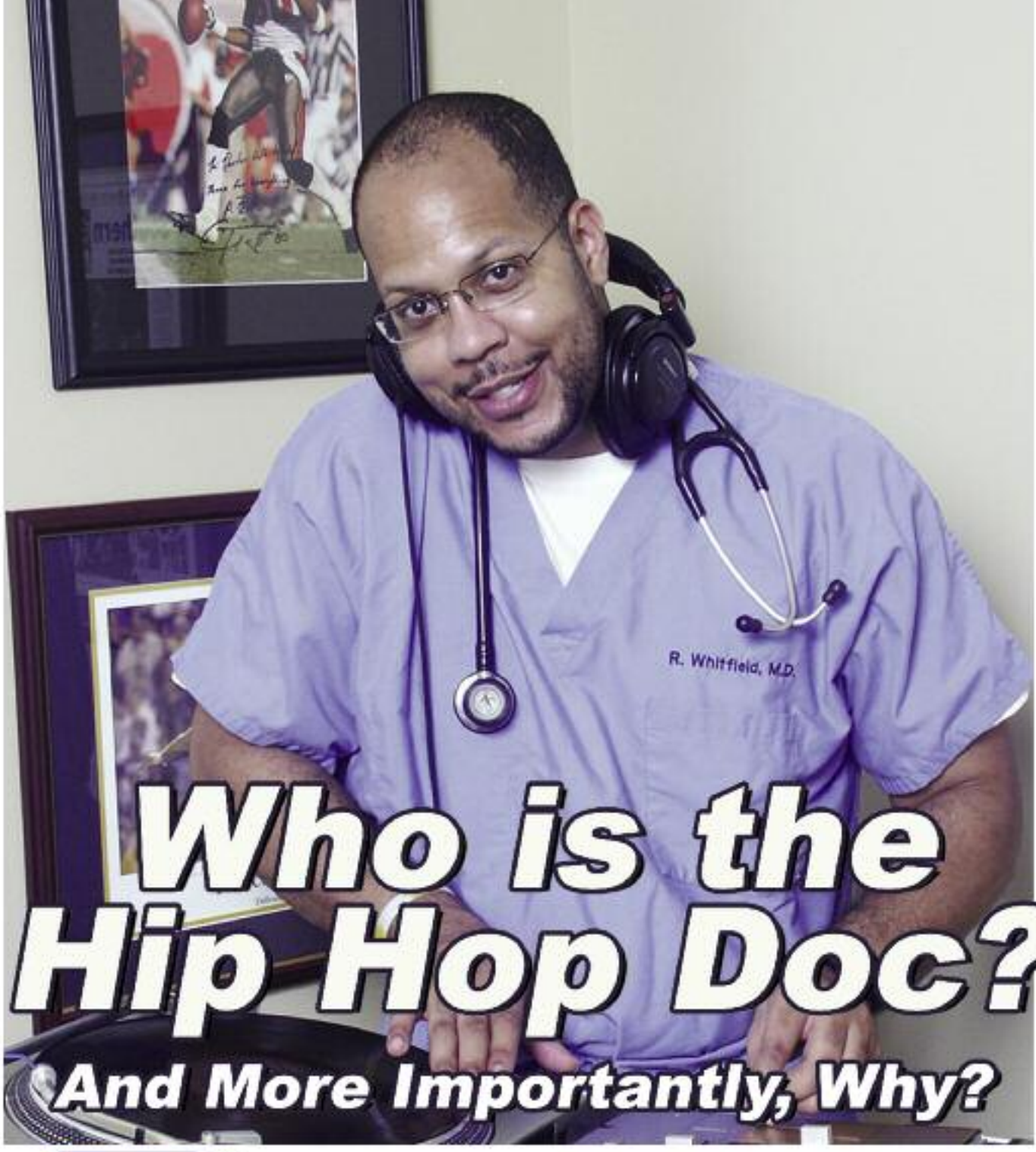


Who is the Hip Hop Doc?

And More Importantly, Why?

by: Karen Stassi

Dr. Rani Whitfield can't tell you whether it was his love of sports, his love of music, or his fascination with "Marcus Welby, MD" that got him where he is today. Perhaps that's because the three are inextricably intertwined in his role as the Hip Hop Doc, a title he is fairly certain will keep him out of the presidency should he ever decide to run. But that might be the only limitation for this local University High graduate who is building national acclaim for his unique approach to educating youth about healthy choices.

Like many starry-eyed teenagers, Whitfield saw his athletic skills and his music as a ticket out of town. He left on a basketball and vocal music scholarship to North Florida Junior College with dreams of the NBA. "That's when I realized that everyone I came into contact with was playing at the same level or better," said Whitfield. After just one year he returned to Baton Rouge, earned a Bachelor of Science degree from Southern University and decid-

ed to pursue medicine. Watching Marcus Welby practice "total healthcare" was not his only inspiration however. In addition to his parents' assumption that he would go to college and an innate passion for helping people, he recalled an incident in his youth where a doctor failed him for a prequalification physical even though he couldn't tell him what was wrong. "I didn't tell my parents, and I continued to play injury free," said Whitfield. "I wondered how many kids had the same problem and whether I could do a better job of helping them find the right answers." After earning his medical degree from Meharry Medical College in Nashville, Whitfield completed his internship and residency in family medicine at St Elizabeth's Medical Center in Dayton, Ohio, followed by a sports medicine fellowship at Ohio State.

Whitfield returned home and set up practice treating his family, friends, and neighbors. "I am very fortunate to be back here and serving my own community," he said. "I'm actually taking care of my parents, and my parents' friends, and friends of mine. They say one of the greatest honors for a doctor is to have a patient refer you, but for me, it's to have family and friends with enough confidence in me to allow me to take care of them." Although he does conduct a lot of sports physicals and volunteers as a team physician for several local teams, his primary focus is family practice where he sees everything from depression, to heart disease, to diabetes. "I like dealing with lots of things throughout the day. You never know what challenges you are going to walk into. It keeps things interesting."

It is his mission that necessitates the dual identity, however. While in med school he became aware of the many health disparities that exist for African Americans. "We are twice as likely to have diabetes, twice as likely to have a stroke, we have the highest incidence of HIV/AIDS," said Whitfield. "As an African American I wanted to address some of those disparities and the lifestyle issues that are behind them." So, in addition to his practice, he began using his love of hip hop as a hook to teach youth about health issues. "Our young people are dying from preventable and treatable illness today, and not just African Americans. I wanted to find a way to reach them. I wanted to incorporate my three passions—things that I have knowledge of and things that I love. I didn't want to do anything that I didn't know because it wouldn't have the same impact." Unfortunately hip hop is now associated with some negative images and messages and Whitfield is careful to separate himself from those, but it still lends him credibility with the kids when he knows their music. "With the music it's the messenger and not so much the message," said Whitfield. "Depending on my audience, I may hardly use the music at all. I come in as the Hip Hop Doc and that is intriguing enough alone to get their attention." He said the type of music may not be so important, but that kids want someone to talk to them at their level. "I am still going to talk about obesity, HIV, hypertension, diabetes, suicide, homicide, but I can't talk to them the way I talk to their parents." Whitfield says his mission involves coming outside of his comfort zone, coming out of the office, and going into their environment and utilizing things that they utilize or are familiar with. "I may use a jingle from my CD or show them pictures from the comic book, which really breaks ground and gets the questions going and gets the interaction going." He is not always sure it is working however. "I've had crowds that I thought weren't responding to me or didn't like me, but then I got lots of questions on the side. That's the older kids. The middle school kids don't know yet they have to be cool all the time."

Dr. Whitfield said he doesn't know of anybody in the world that has the exact mission and approach he has, but he thinks that one of the things that makes it work is his accessibility. "I'm putting out music, I'm putting out comic books, but you can see me. You can come to my office, you can call me, and you can see me talking at your school or on television." He also has to be careful to keep his work, whether it's the comics, the website or the music, to industry standards and present it in a way that will appeal to the high-tech, instant gratification world the kids live in. A heart with a happy face and arms and legs is not going to reach these kids on their level, he stressed. "The kids like that they can meet me and that the music and the comic books are of industry standard. It has to be done on their level. I have to fit in with what kids see and relate to."

One of his biggest challenges was to get people to accept the name Hip Hop Doc, said Whitfield, because the term is now associated with rap lyrics and degrading words and images. "It was really hard to get in the door initially, but now that people see that this guy speaks relatively intelligently, has a good message, really cares about the kids, and is practicing good medicine, I can't turn them away." He said the name has stuck so well some people can't remember his real name. "To be honest, I shied away from that other than in the environments where I really thrived,

like Big Brother, or the Lyrics Anonymous class I help with. Now it's a part of me, it's my label, it's my brand, and I'm very proud of it." The name reflects the disparities in healthcare he sees and his need to speak directly to those affected. "The mission is to get people healthy. It's all about helping folks and I don't think the label means that much other than a way to get people's attention."

And he is getting attention. Whitfield has been tapped by some very high profile entities to bring his unique approach to their message. He is a national spokesperson for the American Stroke Association's Power to End Stroke campaign. In 2006-2007, he travelled to major U.S. cities with Tavis Smiley on his "Road to Health Tour" sponsored by Kaiser Permanente. He was also featured with other prominent African Americans in the book, "Not in My Family," addressing HIV/AIDS in the African American community. Most recently, he was written into a grant by the Louisiana Highway Safety Commission along with the rap artist/middle school teacher David Augustine (Dee-1) who often accompanies him on his presentations. "He is 22 and I'm 39. He's a real rap artist that happens to be a middle school teacher and I'm a 39-year-old wannabe rapper that happens to be a real doctor. Together we make a pretty good team." The pair will be travelling around the state talking to kids about drinking and driving. While the celebrity circuit is not what he's about, participating with national organizations helps promote and expand his mission, too.

Whitfield may tailor his presentation to drinking and driving, safe sex, drugs, or stroke, depending on the audience, but his most important message is his Five Points to Healthy Living: know your doctor, know your number, know your family history, eat healthy, and exercise. It's a simple formula applicable to everyone. "People need to be more proactive about their health and we would have less people coming to us for sick care and more for health care. If we don't start taking better care of ourselves, who's going to take care of our family?"

Dr. Whitfield says he can tell his message is working by the increase in appointments and referrals, although making more money is not his goal. Instead his mission is awareness raising. "I can't take care of every patient and wouldn't want to. We have quality physicians in Baton Rouge that are doing a great job. I want people to go to the doctor, I don't care who they go to. I don't care if you say 'That dude's the hip hop doc and I don't like hip hop, so I am going to see somebody else.' I don't care…just go to the doctor." People are hearing the message and coming to see him saying, "I saw you at this health fair and realized I need to take better care of myself," or "I saw you at the church symposium and my sister has cancer; I need to get screened." Even individuals that don't have health problems are starting to tell their parents to go to the doctor. "Those are very cool and rewarding things that I hear from my patients. This has actually been a lot more powerful than I thought."

Demand for the Hip Hop Doc has grown outside of his practice, too. He is scheduled to speak at least once a week on the average, and his audiences are very diverse. "I love what I do. When I talk to kids at the schools, as tired as I might be when I get there, the lights just come on, the energy comes from nowhere—I'm loving it." His love for his daughter Raina is also a driving force. "Working at the parish prison, working at two substance abuse clinics, seeing the devastating effects of drugs, and realizing that she is just as susceptible as any other person—I want to know that at the end of the day I have done everything I could to make sure she lives in a safer, healthier place. I hope the world around her will take better care of her, because I am trying to take care of them."

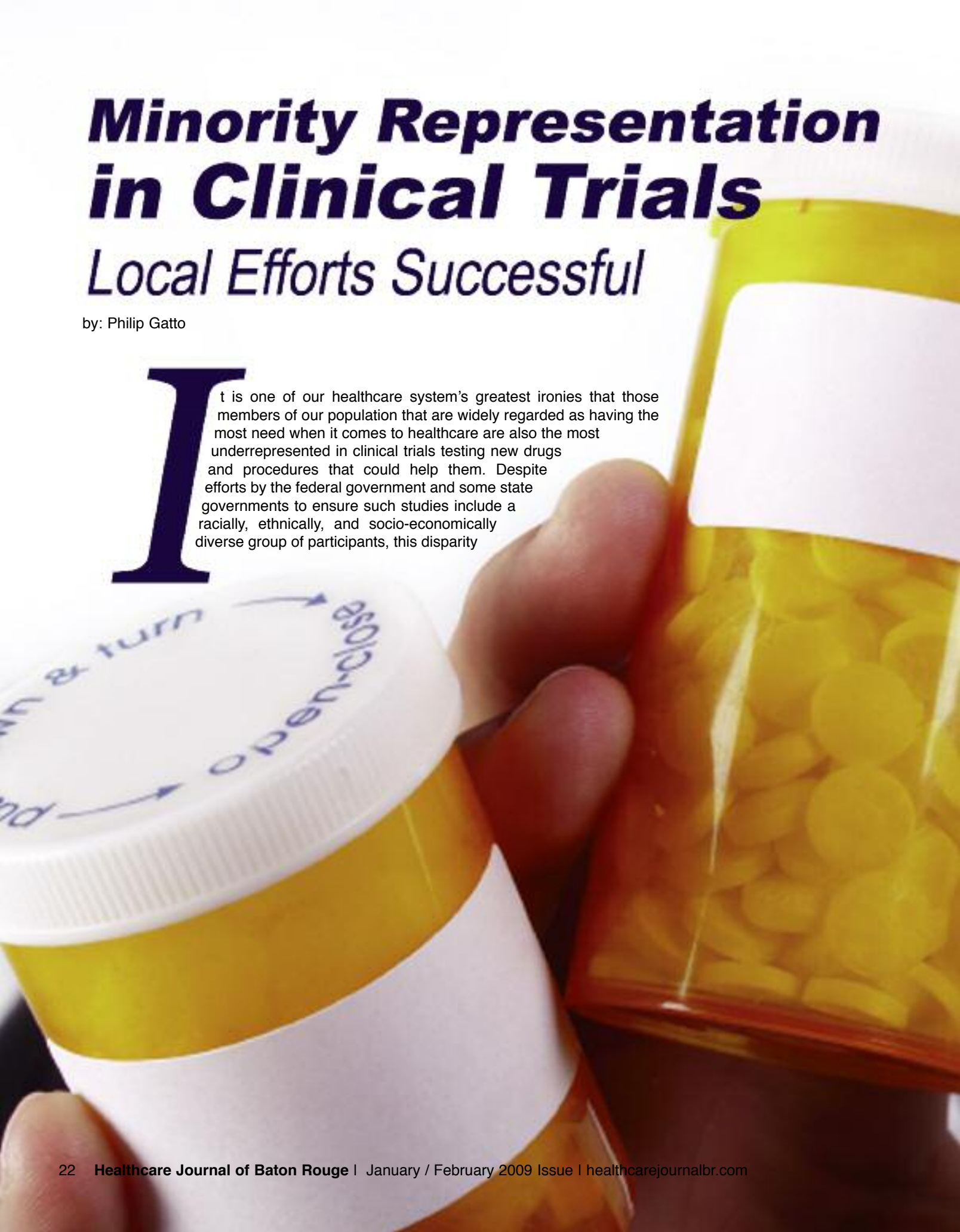
Somehow, Dr. Whitfield finds time to work out, play basketball, and to perform with two bands, Black Ice and Code Blue. He is also working on a book, plans another CD with Dee-1, hopes to expand the comic book series, and dreams of more sleep and more time with his daughter. That said, he questions whether he is doing enough and downplays his impact. "There's more to do and I have so many colleagues in this city that are probably doing greater things than me—they just don't choose to do it as vocally as I do," said Whitfield. "We have some of the best doctors in the country right here in this city and they are doing their thing. I am just grateful that I am welcome and that they haven't kicked me out of the society because I am choosing to call myself the Hip Hop Doc." ❖

Minority Representation in Clinical Trials

Local Efforts Successful

by: Philip Gatto

It is one of our healthcare system's greatest ironies that those members of our population that are widely regarded as having the most need when it comes to healthcare are also the most underrepresented in clinical trials testing new drugs and procedures that could help them. Despite efforts by the federal government and some state governments to ensure such studies include a racially, ethnically, and socio-economically diverse group of participants, this disparity



remains today. Some researchers have recommended and implemented strategies to ensure their trials are representative of the community at risk. Locally, these include the Clinical Research Department at Baton Rouge Vascular Associates and the Pennington Biomedical Research Center.

According to a paper on Eliminating Disparities in Clinical Trials from the Baylor College of Medicine and the Intercultural Cancer Center, the following populations are consistently underrepresented in U.S. clinical trials:

- The elderly
- Racial/ethnic groups
- Women
- Children
- Those with low income
- Those who live in rural areas.

This can mean unanticipated and sometimes dangerous side effects of drugs on populations who were not part of trials, most notably on women and children. It can also lead to a failure to recognize treatment benefits for certain populations if they do not participate.

There are a number of reasons for poor minority participation in clinical trials, ranging from access, to awareness, to plain distrust. It is hard after all to forget such experiments as the Tuskegee syphilis trials which amounted to withholding treatment from African American patients in order to learn about the natural progression of syphilis, or the lack of informed consent granted to Hispanic, particularly Puerto Rican, women in the studies of contraceptive methods in the 1960s. Those highly publicized examples offer the worst of the history of clinical trials and have a lingering effect particularly on the groups that were abused.

It is always a challenge to make sure that in research your subject population is reflective of the subject population that will actually be using the product or service or drug. It can be a challenge to recruit participants that accurately reflect that population.

—Wendy Frieberger, RN, BR Vascular Associates

"Historically minorities have been very underrepresented," said Wendy Frieberger, RN, Director of Clinical Research at Baton Rouge Vascular Associates. "It is always a challenge to make sure that in research your subject population is reflective of the subject population that will actually be using the product or service or drug. It can be a challenge to recruit participants that accurately reflect that population." While mistrust is an important factor it actually may be less damaging than lack of awareness and access to clinical trials. This problem is further exacerbated by the relatively small number of minority researchers and minority providers referring their patients to trials. "People are unfortunately hesitant when you say clinical trials because they are unaware of the safety measures and checks and balances that are now in place to keep participants safe and to minimize any adverse effects," said Ruben Rodarte, head of Pennington Biomedical Research Center's Recruiting Core. "Lack of awareness of how regulated the industry is now remains a major barrier." There may also be barriers such as lack of transportation, concerns about missed work, lack of insurance coverage, or overly rigorous participation criteria.

There has been a concerted effort nationally to overcome these disparities. In its National Revitalization Act of 1993, the National Institutes of Health (NIH) mandated that research trials seeking federal funding include women and demonstrate ethnic and racial diversity. The Centers for Medicare and Medicaid also tried to boost participation of the elderly in clinical trials by authorizing routine care costs for those in trials. The FDA Modernization Act of 1997 provided guidance for collection of research data on minorities but did not mandate their inclusion, a step many think the FDA should take. However, despite these efforts and despite some improvement, most studies do not include sufficient representation to ensure results can be extrapolated to the entire population.

Baton Rouge Vascular Associates has actually received national recognition by NIH as being one of the top enrollers of minorities in the country for participation in the CREST trial. Frieberger credits their success not to anything special they do to recruit minorities, but to their very transparent, compassionate, informed consent process. "I think that maybe establishing trust is one of the most important things that we can do. We don't real-

ly treat anyone any differently or say, 'Oh we have to get you in this study because you are a minority.' The most important thing we do is what we do with every patient—starting a very respectful dialogue, establishing trust, and really standing behind what we say." The doctors recruit patients for clinical research by discussing with them specific projects they might be qualified for. Frieberger then goes over the informed consent with the patients, explains the research, and answers any questions, in an effort to put them at ease and to ensure complete transparency. Patients are encouraged to bring their consent forms home so they can discuss the research with their personal physician or family members. "They know exactly what to expect during the research study and we know what to expect from them. Everything is on the table from the very beginning." Frieberger also said the clinic stresses that participation is voluntary and that patients can withdraw at any time. "We ensure they understand that their care will not be affected whatever their choice is."

Follow-through is another factor, said Frieberger. Regardless of the patient's background, the research team communicates with them, helps them make appointments, and gives them a little extra attention to encourage them to actively participate. "You have to be compassionate and in tune to their limitations. If a person is in a wheelchair because they have lost a foot to diabetes, they can't just jump in the car. We try to be aware of it and work with them on issues like transportation."

A lot of people are hesitant, minority or not, about being involved in a clinical trial. We try to minimize that barrier as far as lack of information is concerned.

—Ruben Rodarte, PBRC

Pennington's Rodarte agreed that transportation and access can be a major factor hindering minority participation. "One of the things I've noticed is that Baton Rouge is starting to have big city problems and one of those is traffic. You have a lot of health disparities in certain areas, particularly among minorities, and it's really because of a lack of access to healthcare, which will also limit access to research opportunities." Rodarte said that Pennington is tackling this problem by setting up satellite centers not only throughout Baton Rouge, but throughout the state of Louisiana to get a more diverse population involved in clinical trials. Most recently they opened one at Baton Rouge General Mid City at the Family Health Medical Center.

Besides transportation and access issues, lack of awareness of clinical trials and the clinical process is probably the number one reason people don't volunteer, said Rodarte. Pennington's approach to counter that has worked. About 35 percent of participants enrolled in Pennington trials are minority participants. Federal guidelines recommend 25 percent. Rodarte said the center has worked tirelessly to overcome the difficulties of recruiting ethnic and racial minorities into clinical trials and has made significant progress. "One of the big things is just presence, just being present within the community. We've done a lot of outreach and held conferences that are open to the public. We also do a lot of speaking engagements throughout the community, not just for recruitment, but for the institute itself." Rodarte said Pennington has made a concerted effort to inform people what clinical trials entail, why they are useful, and what their overall purpose is. "That's a pretty big movement for us and the clinical trials industry as a whole. A lot of people are hesitant, minority or not, about being involved in a clinical trial. We try to minimize that barrier as far as lack of information is concerned." Rodarte said the size of the campus and trying to navigate it is intimidating in itself, and people wonder what's going on behind the walls. "We have quite a few open tours, we bring in local schools, we do some internships—all to demystify and dispel some of the aura that Pennington may have. We really have tried to become a good neighbor and a participating neighbor in the Baton Rouge area." ❖

Sources: Curley, Fia, "The Minority Role in Clinical Trials," Office of Minority Health, DHHS, www.omhrc.gov; "Eliminating Disparities in Clinical Trials," The EDICT Project, Baylor College of Medicine, http://www.bcm.edu/edict/; Hightower, Dorie, "Minority Participation in Clinical Trials," *Benchmarks*, 9/6/06, National Cancer Institute, www.cancer.gov/newscenter/benchmarks-vol6-issue4/page1; "Increasing Minority Participation in Clinical Research: White Paper for the Endocrine Society," Dec. 2007, www.endo-society.org/publicpolicy/health_disparities.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The Right Place, The Right Time
GBR Surgical Hospital Finds its Niche

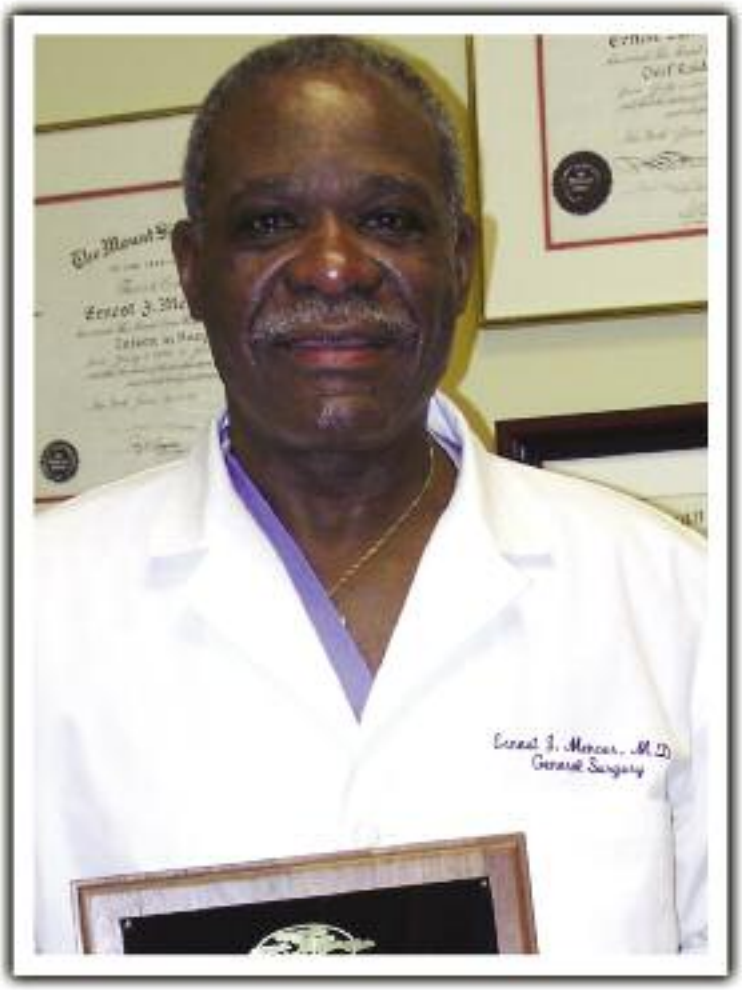
by: Karen Stassi

For many years it was an often unspoken, but deeply felt frustration. An inability to provide care the way they wanted to, the way they had promised themselves they would when they became doctors. An inability to wade through the bureaucracy, the politics, the lingering disparities, and emerge unscathed. When the opportunity arose to change all that, the parts seemed to fall together perfectly. A developer in north Baton Rouge was seeking a medical anchor for his new development. A group of African American doctors was exploring ways they could better serve their community. A casual conversation brought the two together and the idea of the Greater Baton Rouge Surgical Hospital was born. "Dr. Theodore Knapp, our chairman, was really the visionary for the facility," said CEO Rob Blair. The addition of a global partner, United Surgical Partners International, with ties to a medical facility contractor, Cambridge Healthcare Management Inc., made the dream a reality.

The Greater Baton Rouge Surgical Hospital is now in its fourth year of operation after opening its doors a month late courtesy of Hurricane Katrina, in October, 2005. "I will never forget the time, energy, and team effort this staff put forth to get the doors open amid those challenges," said Blair. "The doors opened with zero deficiencies, which is practically unheard of." The facility is owned and operated by a group of physician partners, the Intensive Care Group, many of whom are members of the Baton Rouge Chapter of the National Medical Association, a predominantly African American physician organization. In the planning stages, the Intensive Care Group invited other Baton Rouge physicians to come on board with the project, but at the time, the only taker was Vietnamese podiatrist, Dr. Qui Le. There are now 35 physician investors and 109 total credentialed physicians involved with the facility, but the ownership and leadership remains primarily African American. "That's extremely unique," said Blair. "We are members of both the state and national associations for physician-owned surgical hospitals, and I am not aware of any other facility like this."

The addition of a surgical hospital and medical office in this loca-

I think the reason these types of facilities started to evolve...doctors, in particular surgeons, started to become disenchanted with the lack of efficiency in big hospitals, the fight for time in ORs, a lot of bureaucracy to get new equipment or advance new ideas. *—E.J. Mencer, MD*



tion near the airport significantly improved healthcare access in north Baton Rouge, but the facility is also easily accessible from the interstate system, making it convenient to outlying areas as well. While the leadership and the location might suggest a primarily African American patient base, Blair estimates that close to 50 percent of the hospital's patients are not African American. The payer mix is equally diverse: 18% Medicare, 15% Medicaid, 44% Managed Care, 13% Commercial, 4% workers comp, and 6% other. GBR Surgical Hospital offers surgical services ranging from orthopedic surgery to gynecological surgery to comprehensive imaging, and the medical office offers primary care providers and other specialists in house. "I think the reason these types of facilities started to evolve…doctors, in particular surgeons, started to become disenchanted with the lack of efficiency in big hospitals, the fight for time in ORs, a lot of bureaucracy to get new equipment or advance new ideas," said Dr. E. J. Mencer, Medical Director of GBR Surgical Hospital and one of the primary investors. "I think what was perceived was an increasing inability to take care of patients in a personal way."

The full impact of a facility like this, minority-owned, minority run, in an area of town far from the "medical corridor," is even greater when you look at the history of African American healthcare in Baton Rouge. Dr. Mencer was born here at Our Lady of the Lake when it was still downtown. However, as a child, when his family needed emergency care, they had to travel to New Orleans to Charity Hospital because they were not white. Mencer said that back in the early days of the Baton Rouge Chapter of the NMA, the small group came together not only to represent the NMA but also to form a support system for professional advancement of African American doctors in Baton Rouge. "At every meeting for many years, they designed ways to advance the ability to get African Americans treated in local hospitals. Once that was accomplished, they worked to get African American doctors on staff." Mencer said that once the doctors were allowed on staff, they were only allowed to treat African American patients, and at the General, for example, that meant in the basement. As time went on, by the late 1940s and early 1950s some white physicians treated African Americans, but also in the basement, said Mencer. Eventually African American patients were moved to the fifth floor of the hospital, but could only be treated by African American doctors, who still could not treat white patients. "This is just some of the oppressive history that has led to the desire for the African American physician community to want to come together, to want to provide an opportunity to care for our people in a manner that is dignified and deserved," said Mencer. "By the time I came back to Baton Rouge in 1978, the ice had been broken, but even then, it was not unusual for the emergency room to inform me what race the patient was and to tell me they had informed the patient that I was African American." Mencer said it took a while to convince the staff they didn't need to pave the way for him. "It was a strange twist, as I had done my surgical training at Mt. Sinai Hospital in New York and learned to operate on white patients."

Mencer said that up until the early 1980s African American physicians were basically kept out of the hospital leadership arena in our area. "We were not chiefs of services, certainly not chiefs of staff." He thinks that many African American physicians have felt like their African American patients have not always been in the best position to receive sensitive care. "I think that has been one of the things that encouraged the development of ICG and the move to get a hospital where we would have some say in how it is operated and how people are treated. We have the expertise and we have the sensitivity." Mencer said the group has also had the opportunity to hand pick who works there and many of the staff members left other jobs to join the hospital because they were determined to be part of this project. "We knew we wanted sensitive, caring people who put the patients first and did not treat them as statistics, but as if they were their own family members." The less hectic environment, the patient-focused staff, and the opportunity for expansion have also been attractive features to physicians they have recruited, said Blair.

By the time I came back to Baton Rouge in 1978, the ice had been broken, but even then, it was not unusual for the emergency room to inform me what race the patient was and to tell me they had informed the patient that I was African American. —E.J. Mencer, MD

"From our standpoint as African Americans I think we've seen the positive and the negative of desegregation," said Mencer. "When we lived in a segregated society, we had in our communities our own insurance companies, restaurants, hotels, beauty parlors, morticians, physicians, and in some communities our own hospitals. When desegregation started, the concentrated support for those institutions became diluted because of interest in being part of the greater society and a lot of them failed." Now Mencer sees a need in the community for care people can trust and feel comfortable with. He said before he became involved with this project, he was frequently asked by patients why the African American doctors did not get together and form a clinic like the Baton Rouge Clinic. "They put their lives in your hands. They trust their doctors. I think that relationship has been tampered with quite a bit and we need to do everything we can do to help revive that relationship. We think we treat people like people here, and I don't mean to suggest we are the only ones, but it is important to be deliberate in taking care of people." Blair agreed, stating that the patient satisfaction ratings and positive feedback the doctors and staff receive at the hospital is like nowhere else he has ever worked. "Our mission is to provide a sound quality, friendly environment for our patients. Maybe the fact that we are smaller allows a more personal approach."

Our intention is to serve the whole community. We are not trying to be separatist, not trying to vindicate anything. We are just trying to be of service to people in a way that we think will be valuable.

—E.J. Mencer, MD

The idea of a physician-driven initiative also appealed to Mencer. "I felt like there's always been a lot of intrusion into medicine by people who know nothing about medicine but want to issue directives and so forth." When ICG first came together in 2001 to discuss a medical facility, it was ultimately decided it would have to be a hospital because everybody would have to be at risk. The challenge at the time, said Mencer, was the hospital business did not seem like a good business to be in. Emergency rooms were losing money, there were reimbursement issues, and there were increasingly regulatory and compliance issues. However, they noticed that specialty hospitals were cropping up with no ERs or ICUs, but with focused care in certain areas. The group developed the idea of starting a physician-owned surgical specialty hospital. When the plan came to fruition through their partnership with USPI and Cambridge, they were very deliberate in the naming of the facility. "Our intention is to serve the whole community. We are not trying to be separatist, not trying to vindicate anything. We are just trying to be of service to people in a way that we think will be valuable." Mencer also said all surgeons wish to have their own hospital, their own operating room, their own anesthesiologist, their own OR team. "This is about as good as it gets." ❖

Ozone, Asthma, and African Americans

Ozone reductions required by a new, stricter ozone standard implemented by the U.S. Environmental Protection Agency (EPA) may have pushed the five-parish Baton Rouge nonattainment area, which was close to meeting the old standard, a step backwards, but it may be great news for Baton Rouge's asthma sufferers. The new 8-hour, 0.075 parts per million (ppm) standard will mean more of our state will be in nonattainment, but it has prompted the Louisiana Department of Environmental Quality to step up its efforts to involve the entire community, industry, business, and individuals in reducing ozone in our area.

This is more than a quality of life or health issue; it is also a minority health issue. In the United States alone, 30.8 million people–more than ten percent of adults and twelve percent of children–have been diagnosed with asthma, a reversible lung disease caused by the narrowing or blocking of the lung's airways. An estimated 200,000 adults in Louisiana currently suffer from asthma and Louisiana falls within the top 25% of states for asthma related deaths. One in ten Louisiana households with children has at least one child with asthma. African Americans have higher rates of asthma than any other racial/ethnic group except Puerto Ricans. They are hospitalized for asthma at more than three times the rate of whites and account for 25 percent of all asthma deaths. While the triggers for asthma are most often allergens and indoor environmental factors such as dust, dander, and cigarette smoke, high ozone levels can also exacerbate symptoms, increase the number of asthma attacks, and boost usage of asthma medications. On days when ozone air pollution is highest, ozone has been associ-

ated with 10-20% of all respiratory hospital visits and admissions. Prolonged or repeated exposures can cause permanent lung damage particularly in at-risk groups such as children the elderly, and those with asthma.

A study conducted by the National Institute of Environmental Health Studies (NIEHS) found that the closer children live to a freeway, the greater their chances of being diagnosed with asthma. The researchers also found that children who had higher levels of nitrogen dioxide in the air around their homes were more likely to develop asthma symptoms. Nitrogen dioxide is one of many pollutants emitted from the tailpipes of motor vehicles and helps in the formation of ozone. When inhaled, outdoor pollutants can aggravate the lungs, and can lead to chest pain, coughing, shortness of breath and throat irritation. Outdoor air pollution may also worsen chronic respiratory diseases, like asthma. Despite continuing trends in air pollution reductions here, the American Lung Association listed Baton Rouge as the 10th most polluted city for ozone in 2008.

So what can you do?

• Maintain your vehicle properly

• Trip chain, combine errands, and limit daytime driving

• Ride public transportation or carpool to work

• Take your lunch to work

• Walk or ride a bicycle for short trips

• Refuel when it's cool -after 6 p.m. Don't top off your tank

• Avoid prolonged idling and jackrabbit starts -"Drive Emission-wise"

• Wait until the evening (6 p.m.) to mow your lawn or use gas powered lawn equipment

• Barbecue with electric starter or use a chimney, not fluid starter

• Conserve energy in your home

• Spread the word! Talk to your coworkers and neighbors about DEQ's Ozone Action Program. ❖

The EPA estimates that implementation of the lower ozone standard will, by 2020, prevent the following adverse health effects annually across the nation:

• 380 cases of chronic bronchitis

• 890 non-fatal heart attacks

• 1,900 hospital and emergency room visits

• 1,000 cases of acute bronchitis

• 11,600 cases of upper and lower respiratory symptoms

• 6,100 cases of aggravated asthma

• 243,000 days when people miss work or school

• 750,000 days when people must restrict their activities.

The associated savings in healthcare costs will help offset the anticipated costs of implementing the new standard, said EPA.

Sources: Louisiana Department of Environmental Quality, www.deq.state.la.us; U.S. Environmental Protection Agency, www.epa.gov; Louisiana Department of Health and Hospitals, www.dhh.la.gov; American Lung Association, www.lungusa.org; National Institute of Environmental Health Sciences, http://www.niehs.nih.gov/.

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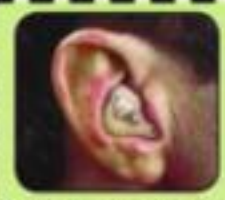

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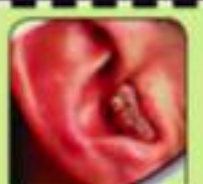

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One on One

with

Michael K. Butler, MD, MHA, CPE

CEO, LSU Health Care Services Division

Smith W. Hartley: We want to talk to you about some of the things going on with LSU in Baton Rouge, but first I'd like to ask you about the Charity Hospital in New Orleans and what's going on with the proposed changes in governance, etc.

Michael Butler: I have not been directly involved in the governance issue, that's been handled out of the LSU system office by Dr. Cerise, but primarily what is going on right now is that this project started as being part of the LSU/VA and the whole concept was rebuilding in the area where both hospitals were formerly in operation, with the plan that they would both share services to lower operating costs. Part of the decision that will have to be made, related to the VA, will be the site selection, the city survey, public comments and all of that. That period should come to an end very soon. The VA is planning on making an announcement about their location and the area they want to acquire. Once that process is done then LSU can probably make some statements about where we will be and whether that original vision of a joint project is going to be viable or not.

SWH: With regard to the proposed Medicaid changes, can you give us LSU's take on that?

Michael Butler: That's a fairly long plan and I have not completely read through it, but one of the things that concerns me about any reform effort is the notion somehow that it can be easily achieved by rearranging current dollars. That's a problem as I see it, because the dollars that we are already putting into healthcare from the state's perspective are already being strained. If we are not going to add dollars, but just spread them out differently, then what's the difference between two dimes and a nickel and a quarter? It still amounts to the same thing.

The other part that concerns me overall, and this is not specific to this plan, but health reform in general, is I think discussion of health reform has suffered in that people have conflated several things: health, healthcare, healthcare finance reform. Those are three different things. When we say Louisiana ranks poorly on health indices, there are things in there that have nothing to do with hospitals or healthcare such as firearm deaths, industrial accidents and injuries, drunk driving, high school graduation rates. All of those things will make Louisiana score poorly on those health indices. And the fact that we do poorly on those makes our health look poor. The number of uninsured is another part of that index. People need to recognize that we have made the argument that we need healthcare reform, but what some really mean is they feel we need healthcare finance reform. That may or may not be true, but if you look at the problem of healthcare, you have two other problems, even if you do the financing reform, that are not addressed. First, you are not addressing the quality problem. Louisiana has a significant quality problem. If you

Michael K. Butler, MD, MHA, CPE, is the acting Chief Executive Officer of the Louisiana State University Health Care Services Division where he designs and directs the patient care delivery and clinical information systems as well as the continuous improvement and care management programs. He is also responsible for the disease management programs and the appropriate medical staff training, yet continues to see patients. Dr. Butler has previously served as Chief of Surgery and Medical Director at the Leonard J. Chabert Medical Center, where he developed a disease management program. He also served as Chief Operating Officer and Medical Director for the Medical Center of LA at New Orleans and as CEO of South Louisiana Medical Associates.

look at the CMS Medicare data, for the last report about two years ago Louisiana ranked 51st in the country and had the highest expense for Medicare patients. We don't see very many Medicare patients in the LSU public hospital system, that's less than about ten percent. The vast majority of those patients are seen in the private sector. We're talking about reforming a system by taking patients in a cheaper system, perhaps putting them in a private system, which is more expensive and has less quality than what we are providing now. It may help in terms of financing, but it doesn't address any quality or access issues.

If you are going to judge whether something is good in terms of reform well then, with any plan, you should judge its effectiveness based on several specific criteria: 1) Are more people going to get served by the new plan? 2) Are we going to reduce the per capita cost for the care delivered? 3) Are we going to get better quality outcomes? If you are addressing only one aspect of that then you are really not doing healthcare reform and you will have an incomplete solution. That is the lens by which I am going to look at any reform plan.

This reform stuff and taking care of people can't be reduced to sound bites. That's a disservice to the complexity of this issue. It's so important it can't be the result of political posturing and pandering. It has to be thoughtful reflection on things that are actually going to make things better for people. I've had family treated by this system and I take it very personally in that these are the things I would want to be done if it were my family. When people want to use LSU as a system as a stepping stone or some promotional tool for something they will get for themselves and ignore these people, that will make me very angry. We will not have done the citizens of Louisiana a service.

If there is anything that has hampered the LSU healthcare system it's many people want to use it for some other purpose, take the money, make a splash, do something other than make the care better. A lot of time is spent on talk about how to finance the care better, but when you ask about quality and access they say that's going to come. Well, I can

tell you, even with insurance, negotiating the healthcare system is a nightmare, particularly if you are not a medical professional. Somehow this notion that we are going to give people a little insurance card and all will be well in the land, that isn't happening. People in Louisiana lack healthcare. We have made it seem like the goal is to get people healthcare insurance. No, healthcare insurance is a means to get healthcare and let me tell you, if you have a kid and you have Medicaid, try to get your kid seen by a pediatric specialist with that card.

Part of the solution is that we have to start defining our terms, we have to have clear goals and expectations of what reform can do. We cannot neglect the other aspects of reform that are needed, the quality and the access. This silliness of let the dollar follow the patient—that works well on TV, but that's not in any way helpful to finding real solutions to what's going on because it is complex, it is detailed. You hear that we've been trying to get reform in Louisiana, but there hasn't been the will to do it. No, the reason those things died is because they were dumb. It wasn't lack of will; many of the proposals were impractical, impossible, and actually somewhat dangerous, and made by people who were ill-informed. They pushed it and it got killed, and rightfully so because it wasn't going to achieve the goals that we talked about. It's not going to improve access, it's not going to improve quality, and it's not going to lower the per capita costs. It might shift some money around, but if that's what you want to do then come out and say that. This notion that somehow with these other plans there was lack of political will, no, they died because they were dumb. But, as I said, I have not had a chance to fully review this current plan yet.

SWH: Can you tell us about the decision behind having an academic hospital in the Baton Rouge area and where you are in that process?

Michael Butler: As far as the goal of a university hospital, LSU as an academic institution has a responsibility for several things, all of which I would say are of almost equal importance. The first thing, whatever the arrangement in Baton Rouge, LSU is committed to preserving its mission of caring for the people who are most vulnerable. That's a given and must be part of any solution. Number two, LSU has a teaching mission. More than 70 percent of the workforce in healthcare in the state, primarily the doctors, train in LSU institutions, so from an academic point of view you want to have an appropriate venue so your trainees can get the best training. That means you need to be in an appropriate facility and you have to have an adequate patient population that will provide both the volume of experience and the breadth of experience. You are not going to be a good general surgeon if you do 100 hernias and no gall bladders.

The other aspect is to have something that is more financial-

ly viable than the current model. The vast majority of the patients we see primarily at Earl K. Long don't have a source of funds so we have been incredibly reliant on the state for DSH (Disproportionate Share) payments and some state general funds, and having to earn the rest. That makes for a very precarious, barely sustainable, and some would argue, unsustainable financial position going forward. The federal government has recognized that a hospital or institution that sees a disproportionate share of people with no coverage is particularly challenged. They recognize you are performing a societal good and you need to get compensated. The problem is while it is some monies, it is not the total cost or the total dollars needed to do that. One of the things that people can't imagine when they hear it is that UCC DSH money does not cover physician services. So I'm running the hospital and running the clinic system that's very large and for patients to get healthcare you need doctors, physician assistants, CRNAs, for different aspects of care, but federal DSH payments do not cover this. So you have to use some of your funding to cover that, which puts you almost in a negative position from the beginning. So part of the academic medical center would be to broaden the payor mix enough so that you can get some other patients with coverage that are able to more completely pay the total cost of service as opposed to just what's available through DSH or UCC.

the specific model of how that's going to be worked out in partnership with other providers in the community, that's yet to be determined.

SWH: What is your timeframe?

Michael Butler: We would have loved to have gotten it done yesterday. This is a need that's been there. It's a recognized need, but the appropriate institution and the appropriate support to do that is necessary.

SWH: In this issue we talk about racial disparities in healthcare. Can you tell us some of the things LSU is doing to deal with disparities?

Michael Butler: It's interesting. Disparities can be looked at in multiple ways. The way that I look at disparities is there are two aspects. There's the global picture or the community-wide picture that says here's the population of patients, they need a certain amount of access. If you look at groups, ethnic, racial, socioeconomic groups, there's a question as to whether they are getting the access they need based on fairly objective health standards. We have some difficulty with that because that's not under our control per se—how much access a racial group, an ethnic group, or a socioeconomic group gets to the facility. What LSU has chosen to focus on is that when people show up at our facilities, do they have equal access to the same sorts of treatment or for whatever reason, most of which are unclear, get guided into different paths? There's no apparent reason why one is offered surgery and one isn't. One of the things we've looked at here at LSU is the disparities you commonly see in other institutions do not exist in ours, not to the same degree. There are some, but they are relatively small and may not be clinically significant. We're able to close that gap. What does that mean? It does not mean that every ethnic group, every woman that needs a mammogram, every poor person that needs a service has access to those services anywhere. However it does mean that once you come here you get what you are supposed to get.

What LSU has chosen to focus on is that when people show up at our facilities, do they have equal access to the same sorts of treatment or for whatever reason, most of which are unclear, get guided into different paths?

The last part is about research. One of the things that has been very successful, and that we will continue to broaden, is our intra-institutional relationship with places like Pennington. We feel at LSU that the potential research and the population studies, service deliveries, and those kinds of things can only improve by fostering a more research/academic relationship with institutions like that. The relationship with a research arm like Pennington means that the translation of knowledge from basic research to the bedside can be compressed. You can have, because you come to an LSU facility, the most current thinking, the most current protocols, the most current drugs that are a potential benefit for you, quicker than you would if we were not participating with them.

One of the other things that's envisioned with this academic hospital is a level 1 trauma center. We have one in New Orleans and one in Shreveport. It's been clearly shown that if you're in an accident, going to a level 1 trauma center increases your likelihood of survival by 20-25 percent. It also takes the burden off the community when it's concentrated in a particular area at a specific place designed to handle it, so the cost of that care is also lower.

So that's the vision for what's going on in Baton Rouge. As for

Now the thing that's a little bit different about LSU is we focus on very specific disease conditions—we call it healthcare effectiveness disease management. Some of the high risk areas, the ones associated with chronic disease, asthma, diabetes, congestive heart failure, HIV, chronic kidney disease—those are people we feel are at particularly high risk, they're chronic, and by timely, appropriate interventions, engagement of those patients, with the proper protocols and evidence-

based guidelines, we can make a difference in their outcomes. If you come in and you are diabetic there's a host of things that you are supposed to get. We try to make sure that the diabetics that come to us get those things.

Here's what gets me in trouble with my national colleagues. Part of what has been thought of in terms of dealing with disparities is we need doctors to be more sensitive, we need people who can communicate better. It has, and this is somewhat disparaging on my part, too much of a "Kumbaya" feel to it for me. That's not the problem, because what that implies is the providers have to have some special insight into the population, they have to have some special empathy that translates into better care. I don't agree with that. What you need is an infrastructure to support the care. You can be the most conscientious doctor, the most racially sensitive person, the most forward thinking male feminist, but if it is hard for you with a chart four inches thick, to figure out diabetes because you've got about twelve things you've got to find in different places in the chart, to figure out all of the issues, you are going to have a problem. It's not a matter of being enlightened, it's just a matter of having an infrastructure that supports the work. How can I identify you as a person that needs or could benefit from one of our protocols? Our system does that. How do I know what things you have? Well, we have a prevention page so that if you are of a certain age and have one of our diseases, it immediately comes up with your background and your history of diabetes for example. It tells me these are the appropriate tests you should have, and I immediately know if you have had them or not and what the results were. If you didn't have them it will print out an order page that I can sign to make sure that you get them. I don't have to go through that entire chart looking for all of these things. I also immediately know your test scores and if the score is not acceptable or in range I can take action to fix that.

That's been LSU's unique approach to dealing with disparity. It works. We have a study looking at congestive heart failure where there was reduction in mortality and the group that did the best was a group of black women. That's not typical of other research in the industry. For me that's kind of validating our approach that you don't have to exhort physicians to really be sensitive, really be conscious, what you need to do is give physicians an infrastructure that supports the work they do, helps them identify people at risk, lets them know what aspects of care are needed, and facilitates them ordering and pursuing that care on behalf of that individual no matter what color they are, what socioeconomic status. That's what is different about what we do in general. ❖

Louisiana Medicaid Reform

A Work in Progress

by: Karen Stassi

With the election of a democratic candidate promising sweeping "change," including the way healthcare is delivered in the United States, came a renewed sense of urgency at the Louisiana Department of Health and Hospitals (DHH) in winning approval for Louisiana's Medicaid reform plan, dubbed Louisiana Health First. Not that the plan would be any less likely to succeed in an Obama administration, but there was a sense that the groundwork that had been laid with the current one might be lost, sending the state back to square one. However, that sense of urgency may also have been what prompted a sudden balking on the part of several healthcare groups in the state. "It has given people discomfort with the process because they felt that it was being pushed through without time for adequate input," said Roxane Townsend, MD, Assistant Vice President of Health Systems for LSU. "The original timeline was very aggressive and from LSU's perspective, we were concerned because of the procurement issues we face when trying to identify an administrative services partner so we may participate in this type of program." However, there is also concern said Gil Dupré, CEO, Louisiana Association of Health Plans, that a change in administration not only means shifting viewpoints, but significant delays related to transition, new leadership in departments, etc. He does not feel Louisiana can afford the wait with some deficit issues impending and a real need to deliver better quality care as soon as possible.

Despite assurances of transparency, open door meetings, meeting minutes posted on the website, and a multi-discipline technical advisory group (TAG), criticism of the plan and demands for more details emerged from those with the most at stake in a complete revamp of our healthcare system, most of whom had representation on the TAG. The Louisiana State Medical Society issued a statement actively opposing the plan due to a lack of transparency, and the Louisiana Chapter of the American Academy of Pediatrics and the Louisiana Hospital Association, separately submitted public records requests seeking more specific details of what was being proposed. "Quite frankly a number of us were taken aback by the negative comments by some TAG members," said Dupré who served on the TAG. "Here we have a process where all the major constituents are being represented and have a voice, and their opinions are obviously valued and influencing how DHH puts together this plan, and yet we have this criticism that it is not a transparent process," said Dupré. "Having spoken to folks in other states who have been through similar processes, they have told me it is one of the most transparent they've seen, so I have to believe a lot of this has nothing to do with transparency." Townsend also served on the TAG and agreed DHH had been open. "I don't think it is a lack of transparency from the Department," said Townsend. "Rather, I think it is a true lack of details in the plan. There

are still decisions that need to be made by the State and the Federal Government. A few of the issues had not been vetted with all of the key stakeholders and probably led to the Department's reluctance to broadly share all of the details. I'm certain that they would have preferred the chance to engage some of the constituents directly affected by the proposal before making it public." Townsend said it appears that the Department has taken the concerns voiced during the TAG meetings and incorporated them into the plan, however, CMS will make final decisions regarding what they will approve and the Department's final plan is dependent on those decisions.

Implementation Timeframe

Note: Many of the initiatives will require additional legislative involvement in terms of legal authority and policy details. Therefore, this timeframe for implementation is largely determined based upon what action, if any, is taken by the legislature during the regular session to authorize implementation. The state anticipates the following timeframe for implementation:

• December- January 2008: Submit Federal Authority (Waivers/ SPA) for Legislative Review

• December 2008 – January 2009: Submit Federal Authority (Waivers/ SPA) to CMS for the Coordinated Care Networks, the Statewide Expansion and the Access to Affordable Care Demonstration. CMS Review and Approval.

• January 2009 – July 2010: Implementation Preparation

• July 2009: Release Request for Proposals for CCNs in Region 1, 2, 5 & 7

• July 2009: Start enrollment of parents and caretaker relatives with income up to 50 percent of the FPL under the statewide expansion and providing coverage under a state-established benchmark benefits package. Region 5 expansion to 350 percent.

• November - December 2009: Evaluation of Responses to CCN RFPs

• July – December 2010: Phased in enrollment in coordinated care networks (Region 1, 2, 5 & 7) (Subject to Readiness Review and Enrollment Broker/Choice Counselor) implemented with rollout of CCN .

• December 2015: Statewide rollout of Coordinated Care Networks completed, subject to successful measurement and evaluation.

In response to the growing criticism and demands for details, Governor Bobby Jindal and DHH Secretary Alan Levine publicly rolled out the specifics of Louisiana Health First, "an initiative designed to improve the health of the people in our state and create a financially sustainable system of quality healthcare." The initiative focuses on expanding health insurance coverage for the working poor and offering Medicaid consumers choices on insurance coverage rather than a government-imposed, one-size-fits-all system. This initiative is also designed to reduce fraud and system abuse, ensure that providers are more involved in patient care, make the new charity hospital a competitive academic institution in New Orleans, reward providers for better health outcomes, and increase transparency in the Medicaid system by making performance measures available on the Internet.

In their public rollout of the plan, both Jindal and Levine stressed the urgency of our state's healthcare situation "We know the statistics, but behind these statistics there are real people," said Governor Jindal. "Louisiana is last in healthcare outcomes, we have far too many people with no health insurance at all, and this system will not improve on its own. We have to take action to improve our healthcare system, provide more access to health insurance for our people, and have a more transparent system where our system's performance can be accountable." He has a point. Louisiana ranked last in the nation in the 2008 United Health Foundation rankings. The state also ranked 47th in prevalence of obesity, 49th in infant death rates, 47th in cancer fatalities, and 49th in premature deaths. Additionally, there are many Louisianans currently outside the healthcare system altogether. Nearly one out of every four Louisiana citizens is uninsured.

Secretary Levine stressed that these poor outcomes cannot be blamed on Louisiana being a poor state. While Louisiana does rank 42nd in per capita income, Louisiana's total state spending on Medicaid and the uninsured is very high. The latest Kaiser Family Foundation State Health Facts ranks Louisiana 20th in Medicaid spending in 2006. In the two years since, the Medicaid budget has grown by more than $1.6 billion–a 28 percent growth. Medicaid spending has grown from 8.5 percent of the state general fund two years ago to more than 16 percent today, with the expectation it will consume nearly 22 percent of available discretionary dollars by 2011–potentially eclipsing funding for schools, economic/job development, roads, and law enforcement, according to Levine.

"When people talk about the standing that Louisiana has among other states, spending more than just about anybody else on Medicaid, and getting just about the worst results, some take that to mean our providers, hospitals, etc. are doing something wrong," said Dupré. "That's not the case; it is our system for delivering care that is not working, not just as a state, but as a country. The Governor with his background in healthcare promised us a plan and he has decided now's the time. We think it's past time, but we need to take advantage of this push and make some changes."

Levine said that the state has been working with the federal government to resolve the issue of $771 million potentially owed by the state for alleged overspending in Medicaid in the past so the state

can instead invest this money in what has become a state and national priority–expanding access to health insurance. He said the state has asked the federal government to freeze the interest on this money, which would allow Louisiana to invest this additional $100 million savings in expanded access to insurance, and to "stack" the repayment over a five-year period rather than pay it back over the traditional 15-21 months. Additionally, he said the state is also asking for the full amount owed from the federal government to build a replacement hospital for the Katrina-damaged Charity Hospital in New Orleans, and said that any difference between what FEMA pays and the $492 million the state is owed should be appropriated by Congress. Despite three independent studies declaring Charity more than 51 percent damaged and requiring replacement, FEMA has only offered to pay $23 million to restore the hospital. DHH would like to create a competitive, state-of-the art academic hospital to replace Charity. "It would be tragic for the taxpayers to be asked to fund a $1.2 billion enterprise only to re-create what we had before; a hospital that was poorly capitalized, unable to invest in its training programs and had no incentive to be efficient," said Levine. DHH is also requesting that the government lift limitations on how Disproportionate Share (DSH) funds are used and make them available for primary and outpatient care and access to affordable coverage. DHH is proposing demonstrating the benefits of using DSH funds this way in New Orleans and Lake Charles. The idea is that better primary and outpatient care will reduce the burden on emergency rooms and hospitals. More efficient use of DSH funds is essential as the state is nearing its cap.

The Louisiana Health First initiative will use many proven approaches to improving health outcomes and the healthcare system said Levine. "Rather than expand Medicaid as we know it, we are proposing to transform Medicaid into a system where its beneficiaries get the dignity of choice of insurance, a medical home, a system where the incentives are aligned for better health outcomes, and a more reasonable rate of growth in the cost." To improve poor health outcomes and create a sustainable system of quality healthcare in the state, the Louisiana Health First initiative includes a three-pronged approach.

First, the Louisiana Health First initiative focuses on expanding health insurance in the state. This would include:

• A statewide expansion of Medicaid financing for parents and caretakers of Medicaid-eligible children. The current eligibility level is 12 percent of the Federal Poverty Level (FPL), and the expansion would include those who live at or below 50 percent of the FPL, including roughly 60,000 more individuals statewide. Parents and caretakers were chosen because studies have proven that children in Medicaid whose parents or caretakers also have insurance coverage have better health outcomes than those who do not have coverage.

• A federally-supported demonstration program in Region 5 (Lake Charles area) that will offer full access to affordable coverage to virtually all residents of the region. This area of the state has the highest rate of uninsured people in Louisiana (approximately 28 percent of the population), making it the ideal place for implementation. First, Medicaid financing will be expanded to all who earn up to 200 percent of the FPL. Next, those who make over 200 percent and up to 350 percent of the FPL will be eligible to contribute

to a premium matched with federal matching dollars. As personal income goes up, the federal match goes down. This program should help relieve pressure on low-income families and employers resulting from rapidly increasing health insurance premiums.

The second element of improving the coordinated system of care focuses on ensuring that all individuals have a medical home to meet all of their healthcare needs. The Louisiana Legislature passed the Health Care Reform Act of 2007 directing DHH to develop and implement a healthcare delivery system providing a continuum of evidence-based, quality-driven healthcare services based on the medical home system of care and using successful managed care reimbursement principles. Medical home models have been effective at improving the quality of care in other states by creating systems of care that are patient-focused and rely on preventive care, management of chronic disease, and coordination of healthcare services.

One such model successfully implemented elsewhere is a Coordinated Care Network (CCN). CCNs are defined as organized health systems that offer an integrated system of care to Medicaid beneficiaries. The CCNs will also have substantial participating ownership by a hospital and/or provider group(s), creating a financial incentive for providers to invest in the long-term health of beneficiaries. DHH will require that each network move toward NCQA Medical Home Certification. At a minimum, CCN's will be required to offer all current services offered under our state Medicaid plan, but they will also be encouraged to offer enhanced services such as smoking cessation and weight loss programs. CCN's will also be required to offer disease management programs and work towards the medical home goal of 24/7 access to advice and services.

For the first year of the program a fee-for-service set-up will be available, but the state wants to move toward a pre-paid, per member, per month system. Levine disagrees with the notion that reimbursement will be the same or lower for physicians. He believes they will be able to negotiate reimbursement through the CCN's and in some cases, due to demand for specific services, may negotiate higher rates, since CCNs will be required to offer a full spectrum of services. They will also be financially incentivized to provide services that discourage use of emergency rooms for primary care services.

The third element of the Louisiana Health First initiative focuses on modernizing the health safety net by establishing a not-for-profit governance model for the Academic Medical Center in New Orleans, the facility that will replace Charity Hospital. Key elements of the new model include:

- Payments and conditions for the care for the uninsured and residency programs with LSU and Tulane would be negotiated through contracts between the state, LSU, Tulane, others, and the not-for-profit entity.
- The new not-for-profit entity would have the ability to issue debt separate from the state. The state would not guarantee this debt and therefore the debt would not affect the state's current debt cap.

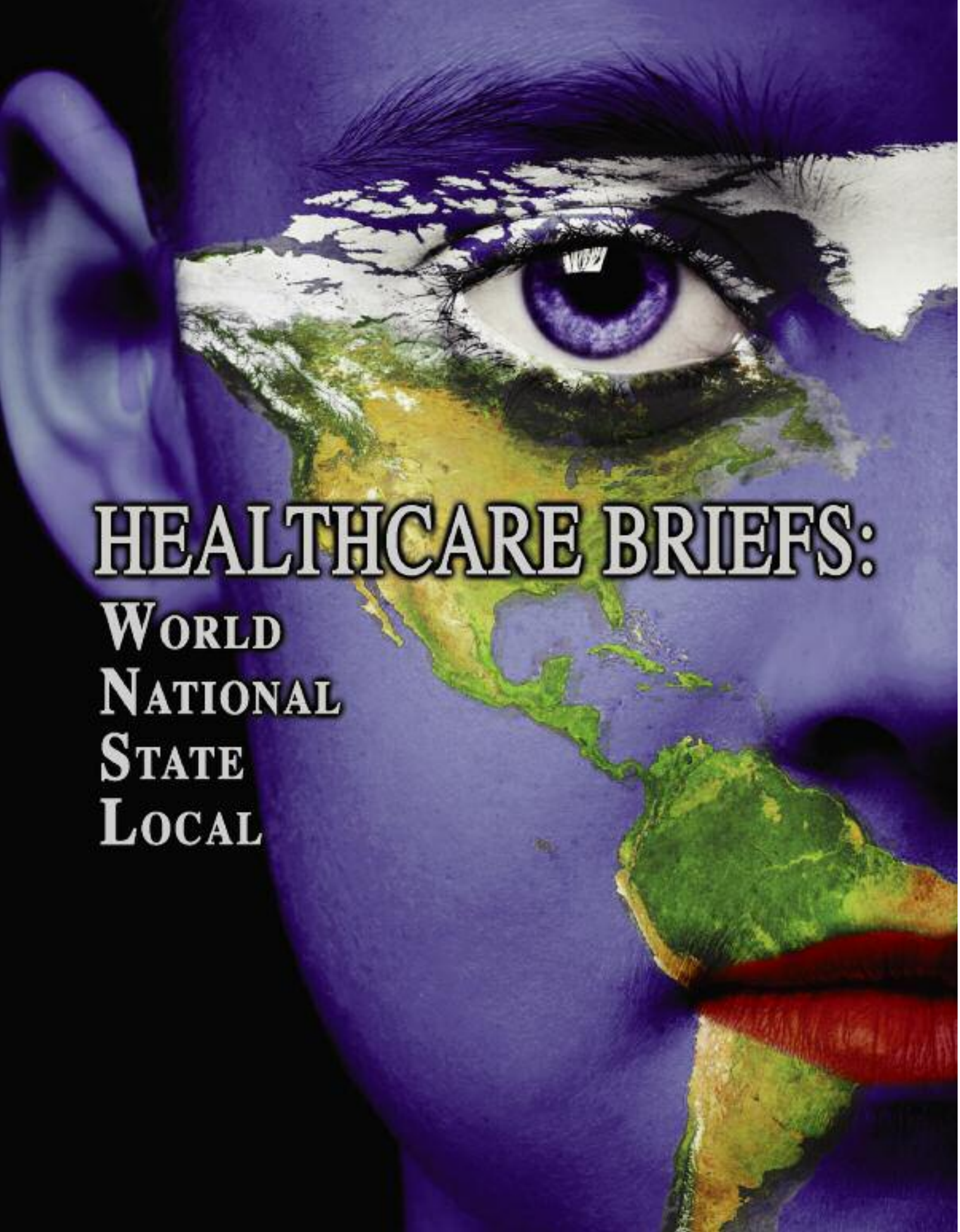
Dupré indicated that the health plans that have been involved with helping DHH with this process have a lot of confidence that the

plan will succeed. “It’s been done in the private sector–health plans partnering with the private sector to lower costs and improve care.” Dupré doesn’t see any indication of lower reimbursement rates or substantial unwarranted risk, but does understand why change is unnerving for some. When asked about the popularity with some stakeholders of the North Carolina plan, Dupré thinks it may have something to do with ease of implementation, less management of healthcare expenses, and the way healthcare is provided, but he also believes a plan specific to Louisiana is necessary, that there is no one-size-fits-all. “There are lots of examples out there that we’ve talked about and a lot of evidence that implementing these plans can significantly improve healthcare. There is no reason we can’t succeed.” Roger Smith, MD, LSMS President, agreed that insistence on a plan similar to the North Carolina one may be premature, but it was mentioned in LSMS’ initial statement because that state had gone through the same sort of trials, and had tried HMOs, which didn’t pan out. He said providers are concerned about participation, plurality, and choice, and LSMS is not sure a managed care plan is the way to go. “We’re not opposed to managed care, but our general policy is that we believe in a pluralistic medical environment, where patients have choice, and there’s not only one game in town,” said Smith.

Release of the plan documents, while they left some questions unanswered, did largely seem to allay the concerns of most stakeholders. Smith stressed that there is not an adversarial relationship and that he thinks Governor Bobby Jindal and Secretary Alan Levine are excellent people to have leading the reform. “We agree completely there needs to be improvement in access to care. That’s been a difficult situation and we have a large uninsured population,” said Smith, “But the way it was presented to us by the LSMS representative at the TAG meetings was that ‘this is how it’s going to happen,’ and it looked like it was going to be very much a managed care model with Medicaid recipients, and perhaps some expansion of the uninsured, being put into a primarily managed care box. We thought this was probably not the best way to do things from past experience.” Smith indicated that when DHH came out with its position paper, it was a very thorough document and covered a lot of bases. “We were pleased to finally see where DHH wants to go and they brought out several ideas. Some are really excellent, particularly the Region 5 one with vouchers to put Medicaid recipients and the uninsured in the insurance market. We support that project very strongly.”

Roxane Townsend agreed that the release of the concept paper and other documents helped. “The overarching principles in the plan are sound,” said Townsend, “but more detail will be required on financials, etc. The implementation timeframe outlined in the Concept Paper seems much more realistic and allows more time for the plan to be vetted with the Louisiana Legislature and other stakeholders.” Smith indicated that while LSMS still wants to discuss certain options with DHH and to ensure the plan offers plenty of choice, they are on board with DHH to enact some type of reform. “Feathers get ruffled pretty easily but they settle down quickly too. I think our governor and DHH secretary are very good people to have in place. We look forward to working with them.” ❖

Sources: Louisiana Health First, www.dhh.louisiana.gov/offices/349; America’s Health Ranking, www.americashealthrankings.org/2008/index.html.


HEALTHCARE BRIEFS:
WORLD
NATIONAL
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WORLD

New Study Presents State of the World's Health

The World Health Organization (WHO) has published a new assessment of the global burden of disease, a study that provides the reader with a comprehensive picture of the global and regional state of health. Drawing from extensive data across the organization, it features comparisons between deaths, diseases and injuries by region, age, sex, and country income for the year 2004. It also provides projections of deaths and burden of disease by cause and region to the year 2030. The study contains details of the top 10 causes of death and estimates for over 130 disease and injury causes. Striking findings include:

•Worldwide, Africa accounts for nine out of every 10 child deaths due to malaria, for nine out of every 10 child deaths due to AIDS, and for half of the world's child deaths due to diarrheal disease and pneumonia.

•The top five causes of death in low-income countries are: pneumonia, followed by heart disease, diarrhea, HIV/AIDS, and stroke. In high-income countries, the list is topped by heart disease and followed by stroke, lung cancer, pneumonia, and asthma/bronchitis.

•Men between the ages of 15 and 60 years have much higher risks of dying than women in the same age category in every region of the world. This is mainly due to injuries, including those caused in violence and conflict, and to higher levels of heart diseases. This difference is most pronounced in Latin America, the Caribbean, the Middle East, and the eastern European regions.

•Depression is the leading cause of years lost due to disability, the burden being 50% higher for females than males. In both low- and middle-income countries, and high-income countries, alcohol dependence and problem use are among the 10 leading causes of disability.

The production and dissemination of health information for action is one of WHO's core mandated activities. This study provides Member States with an important input for health decision making, planning and priority setting.

Impact of the Global Financial and Economic Crisis on Health

WHO Director-General **Dr. Margaret Chan** recently released a statement on the impact of the global economic crisis on the world's health. According to Chan the current financial crisis is rapidly becoming an economic crisis and threatens to become a social crisis in many countries at a time when commitment to global health has never been higher. Chan warned about mistakes made in previous efforts to overcome the fuel crisis, soaring oil prices, and the debt crisis of the early 1980s. "Mistakes were made when budgets were shifted away from investments in the social sectors, most notably health and education. Many countries are still suffering the legacy of these errors." Chan said it is essential to learn from past mistakes and counter this period of economic downturn by increasing investment in health and the social sector. There are several strong reasons supporting this line of action:

To protect the poor. Rising food and fuel prices along with employment insecurity are among the factors leading to increasing inequities during an economic downturn. In this context, impoverishing healthcare expenditures—that in "good" times push more than 100 million persons annually into poverty—are likely to increase dramatically. Inevitably, it is the most vulnerable who suffer the most; the poor, the marginalized, children, women, disabled, the elderly, and those with chronic illness. Stronger social safety nets are urgently needed to protect the most vulnerable in rich and poor countries.

To promote economic recovery. Investment in the social sectors is investment in human capital. Healthy human capital is the foundation of economic productivity and can accelerate recovery towards economic stability.

To promote social stability. Equitable distribution of healthcare is a critical contributor to social cohesion. Social cohesion is the best protection against social unrest, nationally and internationally. Healthy, productive, and stable populations are always an asset, but most especially in a time of crisis.

To generate efficiency. Pre-payment with pooling of resources is the most efficient way of financing health expenditure. Out-of-pocket expenditure at the point of service is the least efficient, and the most impoverishing—already pushing millions below the poverty line each year. A commitment to universal coverage not only protects the poor, it is the most affordable and efficient way of using limited resources.

To build security. A world that is greatly out of balance in health is neither stable nor secure. Robust health systems are essential to maintain surveillance and response capacity in the face of pandemic threats. The lack of investment in sub-Saharan African health systems in the 1980s meant they were tragically unprepared for the HIV/AIDS pandemic in the decade that followed.

Chan called on all governments and political leaders to maintain their efforts to strengthen and improve the performance of their health systems, to protect the health of the people of the world, and in particular of those most fragile, in face of the present financial and economic crisis.

World Health Report Calls for Return to Primary Healthcare Approach

The World Health Report 2008 critically assesses the way that healthcare is organized, financed, and delivered in rich and poor countries around the world. The **WHO** report documents a number of failures and shortcomings that have left the health status of different populations, both within and between countries, dangerously out of balance. The report, titled Primary Health Care–Now More Than Ever, commemorates the 30th anniversary of the Alma-Ata International Conference on Primary Health Care held in 1978. That event was the first to put health equity on the international political agenda.

The new report found striking inequities in health outcomes, in access to care, and in what people have to pay for care. Differences in life expectancy between the richest and poorest countries now exceed 40 years. Of the estimated 136 million women who will give birth this year, around 58 million will receive no medical assistance whatsoever during childbirth and the postpartum period, endangering their lives and that of their infants. Globally, annual government expenditure on health varies from as little as $20 per person to well over $6000. For 5.6 billion people in low- and middle-income countries, more than half of all healthcare expenditure is through out-of-pocket payments. With the costs of healthcare rising and systems for financial protection in disarray, personal expenditures on health now push more than 100 million people below the poverty line each year.

Vast differences in health occur within countries and sometimes within individual cities. In Nairobi, for example, the under-five mortality rate is below 15 per 1000 in the high-income area. In a slum in the same city, the rate is 254 per 1000.

To steer health systems towards better performance, the report calls for a return to primary healthcare, a holistic approach to healthcare formally launched 30 years ago. When countries at the same level of economic development are compared, those where healthcare is organized around the tenets of primary healthcare produce a higher level of health for the same investment.

WHO estimates that better use of existing preventive measures alone could reduce the global burden of disease by as much as 70%. Above all, healthcare is failing to respond to rising social expectations for healthcare that is people-centered, fair, affordable, and efficient. A primary healthcare approach, when properly implemented, protects against many of these problems. It promotes a holistic approach to health that makes prevention equally important as cure in a continuum of care that extends throughout the lifespan. As part of this holistic approach, it works to influence fundamental determinants of health that arise in multiple non-health sectors, offering an upstream attack on threats to health.

WHO and Health Partners Lead Massive Cholera Response

WHO and its health partners have launched an

intensive operation to prevent and control the increase in the number of cholera cases, which have tripled in some areas to 150 a week, amid the recent escalation of violence in the eastern part of the Democratic Republic of the Congo. Insecurity, massive population displacement (at least 250,000 people since early August), weak health services and a lack of safe water and proper sanitation facilities have caused a marked increase in the number of people with cholera in North and South Kivu. As yet no data is available on the number of deaths linked to the current outbreak, but generally in complex emergencies the case fatality rate can surpass 30%. In 1994, some 50,000 people died from a combined epidemic of cholera and dysentery linked to the Rwandan exodus into Goma, the main town of North Kivu.

WHO is leading the coordinated health response to the emergency. All concerned health providers and agencies coordinate their efforts through a group known as the Health Cluster. WHO is buying and delivering large quantities of medical supplies, including materials to treat cholera and other water-borne diseases, in the affected areas of the country. Supplies are being provided to **MSF Switzerland** in the northern town of Dungu, where separate fighting has impacted the health of the community. WHO has more than a dozen staff in the area, including epidemiologists, who are working to strengthen the reporting system for cholera and other potentially life-threatening diseases, including measles and malaria.

Ministerial Forum on Research for Health Begins

A unique blend of political, research, industry, and civil society leaders met recently in Bamako, Mali in an attempt to direct research to better meet the needs of poor countries. They discussed strategies for national and global research for health that addresses inequities in health, fosters greater health security, and strengthens health systems. Building on a ministerial summit held in Mexico in 2004, the **Global Ministerial Forum on Research for Health** reviewed progress on commitments, identified lessons learned, and issued a call to action reflecting priorities moving forward. The forum is the first such gathering to consider the perspective of 'research for health'—looking at how all kinds of research—not only health but also higher education, environment, security, and socio-economic research—can be harnessed to improve health. It provides a dialogue between policy makers, research leaders, and civil society representatives to encourage better cooperation on research that improves people's health. The six partners in the forum are:

•Council on Health Research for Development (COHRED)
•Global Forum for Health Research
•Republic of Mali
•United Nations Educational, Scientific and Cultural Organization (UNESCO)
•World Bank
•World Health Organization.

NATIONAL

Final Rule Issued for Patient Safety Organizations

The U.S. Department of Health and Human Services (HHS) has issued a final rule for Patient Safety Organizations (PSOs). The rule becomes effective on Jan. 19, 2009. It provides final requirements and procedures for PSOs, new entities with which clinicians and healthcare providers can work to collect, aggregate, and analyze data—within a legally secure environment of privilege and confidentiality protections—to identify and reduce patient care risks and hazards. Under interim guidance issued on Oct. 8, **AHRQ** has already listed 15 PSOs. During the remainder of the interim period, these organizations will maintain their status as PSOs. However, these and other PSOs listed throughout the interim period are expected to comply with the final rule once it takes effect.

The listing of PSOs is authorized by the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act). The Patient Safety Act is intended to encourage voluntary, provider-driven initiatives to improve the safety of healthcare through the establishment of legal protec-

tions to ensure that providers who report patient safety information do not incur new legal liability; to promote rapid learning about the underlying causes of risks and harms in the delivery of healthcare; and to share those findings widely, thus speeding the pace of improvement. The final rule is consistent with many of the provisions of the proposed rule issued on Feb. 12. However, it also includes new requirements for PSOs, such as:

•The requirement that a PSO notify providers if the patient safety work product it submits is inappropriately disclosed or its security is breached.

•Requirements for how a component PSO maintains separation between itself and its parent organization(s) have been made more flexible.

The final rule also makes several important changes from those in the proposed rule regarding the listing and delisting of PSOs and the ways in which PSOs must comply with statutory requirements, including:

• Expansion in the types of entities and organizations excluded from listing as PSOs.

• Revisions to how PSOs should disclose certain relationships with healthcare providers.

• Increased flexibility in how PSOs can store patient safety work product.

• Automatic expiration of Departmental listing after 3 years unless a PSO's listing is continued by the Secretary.

• An expedited delisting process for PSOs in a limited number of serious circumstances.

To read the final rule and access more information about PSOs, including background on the rulemaking process, visit AHRQ's PSO Web site at http://www.pso.ahrq.gov.

CDC Study Finds Community Physical Activity Programs Cost-Effective

Community-based physical activity interventions designed to promote more active lifestyles among adults are cost-effective in reducing heart disease, stroke, colorectal and breast cancers, and type 2 diabetes, according to a study by the **Centers for Disease Control and Prevention**, with support from the **Robert Wood Johnson Foundation**. Using a rigorous economic model developed to assess the cost-effectiveness of community-based physical activity interventions, the study found these interventions to be cost-effective; reducing new cases of many chronic diseases and improving quality of life. Researchers found that community-based physical activity programs appeared to reduce new cases of disease by: 5-15 cases per 100,000 people for colon cancer; 15-58 cases per 100,000 for breast cancer; 59-207 cases per 100,000 for type 2 diabetes, and 140-476 cases per 100,000 for heart disease.

Community-based physical activity interventions broadly fall under the following strategies:

•Community campaigns such as mass communication efforts (TV/radio, newspapers, billboards, advertisements).

•Social support networks such as exercise groups to encourage behavior change.

•Tailored behavior change to encourage people to set physical activity goals and monitor their individual progress.

•Enhanced access to services that support active lifestyles such as fitness centers, bike paths and walking trails.

The study, "Cost Effectiveness of Community-Based Physical Activity Intervention," was published online in the *American Journal of Preventive Medicine*.

Joint Commission Monograph to Offer Promising Strategies for Immunizing Healthcare Personnel

In an effort to help improve the rate of healthcare worker influenza immunization, **The Joint Commission** will produce a new monograph that includes examples of successful strategies and tools that have been used to improve immunization rates. The monograph, with funding from **sanofi pasteur**, will be produced in partnership with leaders in the fields of infection prevention and infectious disease from the **Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiology of America (SHEA), and the National Foundation for Infectious Diseases (NFID).** According to the CDC, vaccination coverage of healthcare personnel remains low despite the documented benefits on patient outcomes, staff absenteeism, and reducing infections among staff. In addition, increased vaccination rates can reduce costs within healthcare organizations. Healthcare personnel can acquire influenza from patients and can also spread the disease to vulnerable patients or other staff. In 2007, The Joint Commission implemented a new standard in hospitals and long term care facilities requiring that influenza vaccinations be offered to staff and practitioners.

The Joint Commission will use funding derived, in part, from an educational grant from sanofi pasteur, to gather and review real-world examples of successful initiatives for implementing influenza immunization programs for healthcare personnel. The free, educational monograph, planned for publication in mid-2009, will include:

• Information about the impact and prevalence of the acquisition and transmission of influenza in the health care workplace;

• An overview of barriers to successful influenza immunization programs and strategies for overcoming them; and

• A compilation of promising practices and effective strategies for implementing healthcare personnel influenza immunization programs.

Healthcare organizations are encouraged to submit examples of immunization programs that have successfully increased immunization rates among healthcare personnel. Submissions can be made online at http://www.jointcommission.org/PatientSafety/InfectionControl.

CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse

The **Centers for Medicare & Medicaid Services** (**CMS**) announced aggressive new steps to find and prevent waste, fraud, and abuse in Medicare. CMS is working more closely with beneficiaries and providers; consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program. As part of these enhanced efforts, CMS is consolidating its efforts with new program integrity contractors that will look at billing trends and patterns across Medicare. They will focus on companies and individuals whose billings for Medicare services are higher than the majority of providers and suppliers in the community. CMS is also shifting its traditional approach to fighting fraud by working directly with beneficiaries by ensuring they received the durable medical equipment or home health services for which Medicare was billed and that the items or services were medically necessary.

Furthermore, CMS will be taking additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in Florida, California, Texas, Illinois, Michigan, North Carolina, and New York. Those additional steps include:

• Conducting more stringent reviews of new DMEPOS suppliers' applications including background checks to ensure that a principal, owner or managing owner has not been suspended by Medicare;

• Making unannounced site visits to double check that suppliers and home health agencies are actually in business;

• Implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and ordering or referring physicians;

• Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;

• Verifying the relationship between physicians who order a large volume of DMEPOS equipment or supplies or home health visits and the beneficiaries for whom they ordered these services;

• Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the items and services for which Medicare is being billed.

For those claims not reviewed before payment is made, CMS is implementing further medical review of submitted DMEPOS claims by one of the new RACs. The RACs review paid claims for all Medicare Part A and B providers to ensure their claims meet Medicare statutory, regulatory and policy requirements and regulations. If the RACs find that any Medicare claim

was paid improperly it will then request repayment from the provider if an overpayment was found or request that the provider is repaid if the claim was underpaid. The new national RACs can be found at www.cms.hhs.gov/RAC.

Finally, CMS is consolidating the work of Medicare's program safeguard contractors (PSCs), and the Medicare Drug Integrity Contractors (MEDICs) with new Zone Program Integrity Contractors (ZPICs). The new contractors will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider, and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi).

CDC Announces Increased Rates in Diabetes

The rate of new cases of diagnosed diabetes rose by more than 90 percent among adults over the last 10 years, according to a study by the **Centers for Disease Control and Prevention** (CDC). The data, published in CDCs *Morbidity and Mortality Weekly Report*, show that in the past decade, the incidence (new cases) of diagnosed diabetes has increased from 4.8 per 1,000 people during 1995-1997 to 9.1 per 1,000 in 2005-2007 in 33 states. The study used data from CDCs Behavioral Risk Factor Surveillance System, and provides incidence rates of diabetes for 43 states and two U.S. territories. Only 33 states had data for both time periods, but 43 states collected data in 2005-2007.

State-specific, age-adjusted estimates of new cases of diabetes ranged from 5 per 1,000 people in Minnesota to 12.7 per 1,000 in West Virginia. The number of new cases was highest in Puerto Rico at 12.8 per 1,000. States with the highest age-adjusted incidence were predominately Southern states: Alabama, Florida, Georgia, Kentucky, **Louisiana**, South Carolina, Tennessee, Texas, and West Virginia.

Joint Commission Accreditation: Lab Decisions Will No Longer Affect Hospital Decisions

Beginning January 1, 2009, under new **Joint Commission** policy, laboratory accreditation decisions will no longer immediately impact hospital accreditation decisions. This policy establishes comparability in the way that a laboratory with an adverse accreditation decision rendered by The Joint Commission or one of its cooperative partners, **College of American Pathologists** (CAP) or **COLA**, impacts the hospital or other organization with which the laboratory is affiliated. Currently, a laboratory's accreditation has a direct impact on the accreditation status of its affiliated organization. Under the new policy, the accreditation of laboratories and hospitals accreditation will continue to be linked, due to the critical importance of laboratory services to the delivery of hospital care. An adverse laboratory accreditation decision, whether due to survey by The Joint Commission, CAP or COLA, will help prioritize the hospital's or other organization's next unannounced survey.

New Alliance Calls For Repeal of Provisions in 2003 Medicare Law

Eleven of the nation's leading professional, health advocacy, and other concerned organizations have formed a new alliance to secure Congressional support for the reversal of the harmful provisions of the 2003 Medicare Modernization Act (MMA). The **Alliance to Restore Medicare** (ARM) views the MMA as severely undermining traditional Medicare, endangering not only the survival of that program but also the political viability of a social insurance model for universal health coverage. ARM members have drafted "Stop the Assault on Medicare," a six-part plan that will be submitted to Congress

and the new President. According to members of the Alliance, the passage of the 2003 MMA launched a multi-pronged attack calculated to deplete Medicare's funds, erode the public's confidence in Medicare, and largely replace traditional Medicare with private insurance. ARM notes that although Part D, a much-needed prescription drug benefit, was included in the 2003 law, the benefit's private design has been inefficient, costly, and confusing for beneficiaries. Despite broad public support for allowing the government to negotiate drug costs directly, the MMA banned such negotiation. The Alliance seeks a repeal of that ban and calls for creation of a Medicare operated drug benefit.

Some of the other provisions of the 2003 law that ARM seeks to reverse are the Premium Support Demonstration Project set to begin in 2010 that would give many Medicare beneficiaries vouchers and force them to shop for insurance; and means testing of Medicare Part B (outpatient and physician services). The Alliance to Restore Medicare is also calling for a thorough study of (1) why the cost of the average patient's care is rising so quickly throughout the U.S. health system, and (2) ways to control costs so that Medicare's financial integrity is ensured and beneficiaries get the healthcare they need without undue financial stress. ARM has identified cost factors that the proposed study should consider.

Joint Commission Report Shows Gains in Safety, Quality

In some very critical areas, **Joint Commission**-accredited hospitals in America have steadily improved the quality of patient care over a six-year period, saving lives and improving the health of thousands of patients, according to a Joint Commission report. Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2008, an analysis of National Patient Safety Goal compliance and hospital quality measures related to heart attacks, heart failure, pneumonia, or surgical conditions, provides scientific evidence of improved patient care.

There were some dramatic improvements over the six-year period of data collection, especially in providing smoking cessation advice. For example, hospitals provided this advice to 98.2 percent of heart attack patients in 2007 compared with 66.6 percent in 2002. Hospitals greatly improved their results from 2002 to 2007 in providing this advice to heart failure patients (from 42.2 percent in 2002 to 95.7 percent in 2007) and patients with pneumonia (from 37.2 percent to 93.7 percent). Other strong improvements included providing discharge instructions to heart failure patients (from 30.9 percent to 77.5 percent) and providing pneumococcal screening and vaccination to pneumonia patients (from 30.2 percent to 83.9 percent).

However, the report does show that, for the third consecutive year, not all hospitals deliver the same level of quality and that some hospitals perform better than others in treating particular conditions. For example, hospitals provided discharge instructions to heart failure patients on average 92.1 percent of the time in the highest performing state, but provided discharge instructions 56.5 percent of the time in the lowest performing state. The performance difference among states is greater than 10 percentage points on 12 of the 24 quality measures tracked by The Joint Commission in 2007. There are exceptions to this variability. For example, virtually all—99.1 percent to 100 percent—accredited hospitals in the United States report that they measure oxygen in the bloodstream of patients with pneumonia.

The performance results released in the 2008 report reflect The Joint Commission's tracking of hospital performance on 25 individual quality measures reflecting the best evidence-based treatments. There are eight measures of care relating to heart attack, four to heart failure, eight to pneumonia, and five to surgical care. Data from more than 3,000 hospitals show:

• The heart attack care result improved from 86.9 percent in 2002 and from 94.4 percent in 2006 to 96 percent in 2007. (A 96 percent score means that hospitals provided an evidence-based treatment 96 times for every 100

opportunities to do so.)
• The heart failure care result improved from 59.7 percent in 2002 and from 84.1 percent in 2006 to 88 percent in 2007.
• The pneumonia care result improved from 72.3 percent in 2002 and from 87.3 percent in 2006 to 89 percent in 2007.
• On 11 of the 18 requirements of the 2007 National Patient Safety Goals, 90 percent or more of the 1,466 hospitals that received accreditation surveys during 2007 demonstrated compliance. National Patient Safety Goals provide strategies to prevent common healthcare errors such as medication mix-ups and surgery on the wrong body part.

Even with the improvements of the past six years, the report makes clear that more is needed. For example, treatments were still not being performed consistently in 2007 on some measures introduced in 2002:

STATE

Louisiana Health Care Quality Forum Unveils Quality MAP

The **Louisiana Health Care Quality Forum** (the Quality Forum), a private, not-for-profit organization whose mission is to lead evidence-based, collaborative initiatives to improve the health of Louisiana citizens, has unveiled a health care database on its Web site called the Quality Measurement Analysis Portal (Quality MAP). The Quality MAP is a data warehouse that contains de-identified claims information from 2005 for 2.3 million Louisiana residents, including Medicare and Medicaid recipients and those privately insured through **Blue Cross Blue Shield of Louisiana**. Through a grant from the Blue Cross Blue Shield Foundation of Louisiana and with support from **Tulane University, Health Dialog** created the data warehouse by aggregating 2005 data from the different payers and conducting analyses that provide the foundation for the data tables found in the Quality MAP. Health Dialog continues to support the Quality Forum in its effort to update and expand the data warehouse with more recent data from 2006 and 2007. For more information on the Quality MAP, go to www.lhcqf.org/project-overview.html.

Louisiana to Require Reporting of Carbon Monoxide Exposure or Poisoning

The **Department of Health and Hospitals** (DHH) is now requiring that cases of carbon monoxide exposure or poisoning must be reported to the **State Health Officer** within five business days. This illness was recently added to the state's list of Reportable Diseases and Conditions due to the high number of carbon monoxide related poisonings during the winter months and after hurricane-related power outages (State Sanitary Code, Title 51, Part II, Chapter 1). Reporting is required of every coroner, medical examiner, dentist, infection control practitioner, laboratory director, medical records director, nurse, nurse midwife, nurse practitioner, pharmacist, physician assistant, osteopath, homeopath, podiatrist, poison control center, social worker, veterinarian, and any other healthcare professional. This information will support the statewide health surveillance efforts of the DHH Office of Public Health.

Although few people in Louisiana are killed by carbon monoxide each year, during power outages and cold weather, many people unknowingly set the stage for dangerous conditions that could lead to poisonous levels. Carbon monoxide is a silent killer because it cannot be seen or smelled. Very tiny amounts of carbon monoxide can be lethal. The most recent statistics from Louisiana show an average of approximately 100 calls per year to Louisiana's Poison Control Center for carbon monoxide poisoning, and an average of approximately five deaths per year from unintentional non-fire-related carbon monoxide exposures. Nationwide, there are an estimated 480 deaths per year and 15,200 carbon monoxide emergencies each year. In the aftermath of Hurricanes Katrina, Rita and Gustav, carbon monoxide was responsible for the deaths of several people who improperly used generators.

Carbon monoxide poisoning can be difficult to immediately diagnose because the symptoms are similar to other illnesses. The most common symptoms are headache, dizziness, weakness, nausea, vomiting, chest pain and confusion. Anyone experiencing the symptoms should seek medical attention immediately. Some other tips to avoid carbon monoxide emissions include:
• Install a carbon monoxide detector in your home and replace its battery when you change the time on your clocks each spring and fall.
• Don't keep a car running inside a garage that is attached to a house, even if the garage door is open.
• Have your heating system, water heater and any other gas, oil, or coal burning appliances serviced by a qualified technician every year.
• Do not use kerosene or other fuel heaters inside. Carbon monoxide is given off when the fuel is burned.
• Even space heaters should be vented to the outside. If yellow flames are visible, carbon monoxide is being made.
• Have your chimney checked or cleaned every year. Chimneys can be blocked by debris. Never burn anything in a stove or fireplace that isn't vented.
• Never use a generator near a house or building. Carbon monoxide fumes can gain entry into living areas, especially through air conditioning intakes.

Reporting to the DHH Office of Public Health - Section of Environmental Epidemiology and Toxicology can occur via the Web, telephone or fax. Reports can be made by phone at (504) 219-4518 or by fax at (504) 219-4582. They can also be mailed to the Environmental Epidemiology and Toxicology Section, Department of Health & Hospitals, Office of Public Health, 1450 L&A Rd, 2nd Floor, Metairie, LA 70001.

Breast Cancer Screening for LSU Uninsured Among the Nation's Best

The **U.S. Surgeon General** and the **U.S. Department of Health and Human Services** set a goal of 70% of eligible women receiving a mammogram at least every two years in Healthy People 2010, a national health promotion and disease prevention initiative. This has been an especially difficult goal for patients who have no insurance coverage. Nationally, women without coverage get mammograms at a rate of 33% every two years. In the **LSU Health System Health Care Services Division** (HCSD), 72% of patients who are without coverage and classified as free care receive mammograms every two years. This rate is more than double the national rate for the uninsured. These patients have been a focus for HCSD because they have fewer options for obtaining screening. This disparity in care for patients without coverage and access must be addressed if we are to achieve optimal health outcomes in vulnerable populations. This 72% rate for the uninsured ranks among the nation's best and illustrates the tremendous commitment HCSD has made to preventative care and to an ongoing effort to enhance screening efforts.

HCSD has reached this milestone for these vulnerable women with a variety of mechanisms, including evidence-based provider guidelines, patient self-referrals, same-day mammography availability, technology upgrades, partnering with other community providers, flexible staffing schedules, and a staff commitment to quality healthcare. The LSU HCSD performs over 25,000 mammograms yearly.

Rural Hospitals Join with DHH to Become Tobacco Free

Keeping in mind the health concerns of both patients and their employees, Louisiana's Critical Access Hospitals have committed to becoming 100 percent tobacco free. Taking part in the **Louisiana Department of Health and Hospital's Project H.E.A.L.** (Help Empower All of Louisiana) campaign created by the **Louisiana Tobacco Control Program** (LTCP), seven Critical Access Hospitals across the state will develop or enhance current policies that prohibit tobacco use on hospital grounds or surrounding campuses effective in 2009. The new LTCP campaign, named Project H.E.A.L., is designed to help hospitals in rural Louisiana ease into becoming 100 percent tobacco free. Spread out over a twelve month period, Project H.E.A.L. details the transition and what a hospital can expect when going 100 percent tobacco free. Examples of the help that hospitals will receive with Project H.E.A.L. include:
• A month by month calendar outlining every stage of going tobacco free, from informing the board of directors to posting signage.
• Employee surveys to gauge the number of hospital employees who would need help with cessation.
• A patient consent form that insures that all visitors to the hospital are accommodating with the hospital's new tobacco policy.
• Information cards that can be passed out to

both employees and patients with information about cessation services provided by the state.

The targeting of rural hospitals by Project H.E.A.L. is part of the LTCP's ongoing commitment as part of the **Bureau of Primary Care and Rural Health** to help prevent new tobacco habits from forming, help current smokers with cessation, and to eliminate second-hand smoke exposure and disparities among tobacco users in Louisiana.

Leonard J. Chabert Medical Center Initiates New Internal Medicine Residency Training Program

Leonard J. Chabert Medical Center (LJCMC) in Houma has begun a new Internal Medicine Residency Training Program with full accreditation from the **Accreditation Council for Graduate Medical Education** (ACGME). Since 2000, the ACGME has accredited only four new programs in internal medicine in the South and 16 nationwide. ACGME has also given institutional accreditation to LJCMC, permitting it to form new residency programs in the future.

Studies have shown that a physician will likely remain within a 50 to 100 mile radius of where the physician completed residency training, providing healthcare and an economic stimulus to the region. The Terrebonne/Lafourche area anticipates a physician shortage, particularly in primary care and internal medicine. To receive accreditation for the program, LJCMC hired faculty including its program director, associate program director, residency and institutional coordinator, and others in key areas such as pulmonary critical care. **Dr. Dayton Daberkow II,** formerly the LSU program director in New Orleans for 12 years, is the LJCMC program director. Three residents were accepted for the first year of the three-year program, which began July 1, 2008. Next year eight will be accepted. Ultimately 24 residents will be in training simultaneously. Sixty percent of the time residents will see patients in the hospital; 40 percent of the time, they will practice in LJCMC ambulatory clinics. Residents have already gotten unique training: in the wake of Hurricane Gustav, they worked with the Disaster Medical Assistance Team and on strike teams going into the community to provide care.

First Lady Partners with Shots for Tots

First Lady **Supriya Jindal** has announced her partnership with the Shots for Tots outreach campaign. The effort, called "Every Child by Two," is an aggressive media campaign to raise awareness among caregivers on the benefits of immunizations and the dangers of leaving children unvaccinated. The ultimate goal is to make sure that 90 percent of Louisiana's kids are fully vaccinated by age two, which is also the national target. The program has four major components, including radio and television spots urging parents to vaccinate their children; a poster campaign featuring the First Lady and produced by **Wal-Mart**, one of the Shots for Tots partners; a **Hallmark** greeting card campaign, in which new parents receive a greeting card that congratulates them on their newborn and includes important vaccination information; and an upgrade of the Shots for Tots Web site, featuring all the First Lady's outreach material.

DHH Secretary **Alan Levine** said this campaign is just the latest step Louisiana has taken to improve childhood immunization rates. Louisiana now requires vaccinations for kids before they enter school and DHH has expanded immunization clinic hours to make it more convenient for parents. DHH also has a data system, called LINKS, a tool that optimizes the use of today's technology to help make its efforts more effective. Also, the Medicaid program can reward providers who use the state Immunization Registry to vaccinate their patients on time. All of these efforts have resulted in substantial improvements in the state's rate of vaccinated kids. The national **Centers for Disease Control and Prevention** ranks Louisiana 32nd in the country for children who are current on vaccines. This is 12 places better than the previous year.

Shots for Tots is a broad coalition of groups and individuals throughout our state who care about children. The coalition includes physicians, nurses, university officials, public health officials, volunteer agencies, political leaders, churches and community organizations. These diverse groups come together specifically to improve immunization coverage in Louisiana. It was formed in 1992 in Louisiana.

La. Rural and Underserved Areas Receive Healthcare Funds

The **Department of Health and Hospitals** awarded 14 grants of up to $75,000 to healthcare providers in rural and medically underserved areas in the state for community healthcare service expansion projects. Grantees include the **Allen Parish School Board**, **Bunkie General Hospital, Capitol City Family Health Center, Central Louisiana Area Health Education Center, Louisiana Rural Health Association, Morehouse Community Medical Center, Pointe Coupee Better Access Community Health, Richland Parish Hospital, St. Frances School-Based Health Center, South Cameron Memorial Hospital Foundation, Southeast Louisiana Area Health Education Center, Southwest Louisiana Area Center for Health Services**, **Tulane University School of Medicine, and Zenith Services.** The grants were awarded through the Bureau of Primary Care and Rural Health's Community-based and Rural Health Program. The $1 million program is funded through an appropriation from the Louisiana State Legislature. Public or non-profit healthcare organizations located in rural areas, health professional shortage areas or underserved areas identified through legislation were eligible to apply for grants to fund healthcare projects. Twenty-seven applications were received by the application deadline of July 30, 2008.

Bogalusa Medical Center Opens Special Beginnings Family Center

Bogalusa Medical Center (BMC) has opened its Special Beginnings Family Center, a new state-of-the-art labor and delivery unit. The new unit will have an estimated 300 births annually and OB/GYN admissions and surgery, filling a ten-year void in labor and delivery services for this area of the northshore. It will also fulfill requirements for the BMC Rural Family Medicine Residency Program, allowing residents to receive invaluable, high-quality OB/GYN training. With 10,782 square feet, the unit has six labor-delivery, recovery, post-partal (LDRP) suites, two dual-purpose rooms for obstetrics and LDRP when the unit is at capacity, and a state-of-the-art newborn nursery. In a completely renovated wing of BMC with the latest equipment and furnishings, the unit is designed so that a mother can labor, deliver, and recover in the same room and have nearly continuous contact with her family. The unit will also have a complete Cesarean-section suite.

The unit gives a triple boost to the Bogalusa area: it provides much-needed healthcare, residency training, and a significant economic stimulus. Besides construction spending, the $6 million dollar project will continue to infuse money into the local economy since it is responsible for 30 new jobs and will generate spending related to healthcare since women will not have to travel elsewhere.

DHH Proposes Licensure Rules for Pediatric Day Health Care Facilities

The **Department of Health and Hospitals** has proposed regulations for implementation of a new option for treatment of children with intensive special health care needs—Pediatric Day Health Care Facilities. Pediatric Day Health Care Facilities provide parents and caregivers with children under the age of 21 an option for intensive medical services and supervision while parents work. Besides nursing services, these facilities will offer physical, speech and occupational therapies. They also offer education and training to their clients, while also giving the medically fragile child or teenager the opportunity to interact with other children during these very important developmental years. In addition, these facilities offer respite for parents, and have been proven to actually save state Medicaid program dollars since parents would not only have to rely exclusively on home health services, but rather the services can be provided in a single setting.

Pediatric Day Health Facilities will be required to be part of any community Emergency Response Plan as well, and will be required to provide emergency power for children on ventilators. This requirement will help improve regional emergency options for parents when a hurricane or other event occurs. DHH Secretary Alan Levine said this approach provides an opportunity for parents to give their children an integrated setting for therapeutic services while also allowing the child to develop and interact with other children.

Insect Foggers Linked to Health Problems in Louisiana

A recent report from the **CDC** has highlighted Louisiana as a state with documented cases of illnesses and injuries resulting from the improper use of total release foggers, more commonly referred to as bug bombs or insect foggers. The **Department of Health and Hospitals Office of Public Health** is urging citizens to use caution when operating these foggers, as many people are unaware that these products pose a health risk, especially if label directions are not followed. Improper use may result in users developing respiratory problems from breathing the fog or entering too soon into a treated room. In addition to health risks, misusing foggers can cause fires or explosions.

The CDC's *Morbidity and Mortality Weekly Report* examined 466 fogger exposure cases from eight states (including Louisiana) between 2001 and 2006. Roughly 20 percent of the cases had symptoms that were considered moderate or severe and five percent were hospitalized for one day or more. Twenty-two percent of the cases were from Louisiana. Most individuals had respiratory problems such as cough, shortness of breath and wheezing. In one case, a child was burned when a fogger exploded after it was placed under a stove with a lit pilot light.

DHH Program Trains Doctors to Help Patients Quit Smoking

The **Department of Health and Hospital's** Tobacco Control Program and the **Louisiana Campaign for Tobacco-Free Living** have developed a new online training and certification program for Fax-to-Quit Louisiana, a fax referral program for smoking cessation. The web-based training allows physicians to become certified in smoking cessation counseling in a convenient, accessible format. Fax-to-Quit Louisiana allows healthcare providers, with patient consent, to refer patients aged 13 years and older to counseling services offered through the Louisiana Tobacco Quitline, 1-800-QUIT-NOW. Once the fax referral is made, a Quitline counselor initiates first contact with the patient to begin counseling services. More than 150 physicians have been certified with the Fax-To-Quit Louisiana online training program since it was launched in September 2008.

According to a study by the **Centers for Disease Control and Prevention**, a smoker's chances of quitting improve by 41 percent when they use telephone counseling. Fax-to-Quit Louisiana was developed using the Public Health Service Clinical Guidelines for Treating Tobacco Use and Dependence. Physicians who participate in the program also receive a Certified Health Care Provider Tool Kit featuring a Fax-To-Quit Manual, Office Guide, Medicaid Brochure and Quit Referral Cards.

New Family Physician Joins Zachary Family Practice

Dr. Reagan E. Elkins, a family physician, has joined the staff of Zachary Family Practice located at 2335 Church Street, Suite E, in Zachary. He is board certified by the American Board of Family Medicine. Dr. Elkins was previously with the Medicine Clinic of Morgan City and is a

native of Alexandria, Dr. Elkins received his undergraduate degree and graduated summa cum laude from Louisiana College in Pineville and his medical education from LSU School of Medicine in New Orleans. He completed his residency training at LSU Family Medicine Residency in Alexandria.

CommCare Corporation Launches The Senior Care Kit

In its commitment to provide resources on long-term healthcare, **CommCare Corporation**, owner and operator of skilled nursing facilities throughout Louisiana and Mississippi, has designed a customized online Senior Care Kit. The 60 page kit is divided into eight sections covering every step of the way—from assessing the situation, to senior care options, and having the conversation with your loved one. The kit also provides information on what services to expect and how to plan for those services, to financial options, important documents and legal checklists and even a glossary of senior care terms. The entire kit can be downloaded or individual sections can be downloaded separately as needed.

LOCAL

Davis joins Futures Council

Nicole Davis, project manager for the **Louisiana Health Care Quality Forum**, recently

joined the **AARP Futures Council,** a group of social entrepreneurs from ages 25 to 45, focused on making positive changes in Louisiana for future generations. Davis also serves as the staff lead for the Quality Measurement and Medical Home committees of the Quality Forum.

Amedisys Pledges $150,000 to Healthy Student Initiative

Amedisys President **Larry Graham** recently presented a $150,000 Healthy Student Initiative investment pledge card to **Sue Catchings**, CEO of **Health Care Centers in Schools, Inc.** The receipt of this pledge of support acknowledges Amedisys as the first of sixteen potential corporate community investment partners in the expansion of Health Care Centers in Schools.

New Executive Director Takes Reins at Alzheimer's Services of the Capital Area

Barbara W. Auten, former **Alzheimer's Services** Development Director, has stepped up to the position of Alzheimer's Services

Executive Director. Auten has been with Alzheimer's Services for the past two years, starting with the organization as the Event Coordinator in 2006, then moving into the

Development Director position in 2007.

Louisiana Health Care Quality Forum Holds Summit on Health IT

The **Louisiana Health Care Quality Forum** held its Fall Summit on the topic "Transforming our Health System through Health Information Technology and Exchange." The summit's purpose was to emphasize health information technology and exchange (HIT/ HIE) as vehicles that support improved delivery systems and quality outcomes in Louisiana. The event brought local and national stakeholders together to look at innovative ways technology can support provision of evidence-based care, implementation of the medical home and Medicaid reform efforts. Topics included:

- An Integrated Approach to Improving Health Care
- The Louisiana Department of Health and Hospitals' Role in HIT/HIE Development
- Supporting Consumer-Centric Care
- The Intersection of Quality and Health IT: Opportunities for Louisiana
- Enhancing Coordination of Care
- Expanding Interoperability: Information Sharing/Exchange
- Quality Improvement and Clinical Measures Reporting
- EHR Demonstration: An Opportunity for Louisiana Physicians

Among the speakers were **Alan Levine**, Secretary, **Louisiana Department of Health and Hospitals; Janet Marchibroda**, CEO of the **eHealth Initiative; Sean Seerey**, Industry Strategist, **Health Solutions Group**, **Microsoft Corporation**; **Eva Powell**, Director, HIT Project, **National Partnership for Children and Families; Emily Welebob**, MS, RN, Vice President, Strategic Development, **Indiana Health Information Exchange**; and **Debbie Van Hoven**, Project Officer, Electronic Health Records Demonstration, Medicare Demonstrations Program Group, **Centers for Medicare and Medicaid Services**. ❖

HEALTHCARE JOURNAL of Baton Rouge
Legislative Correspondent

What Shape Will Reform Take?

by: Bill Cassidy, MD
U.S. Congressman

President Elect Obama and others in Washington have indicated that Health Care Reform will be a priority in the next administration. Washington policymakers, private healthcare providers, and independent reformers are laying out proposals for improving quality and accessibility while controlling the cost of healthcare in the United States.

The underlying problems with our healthcare system are widely agreed upon. The cost of healthcare has increased dramatically and is continuing upward. Tens of millions of Americans lack health insurance or are underinsured. When the uninsured need treatment, they often go to emergency rooms. The cost of this care is "shifted" to the privately insured. In effect, those paying for their insurance subsidize the uninsured. When the cost of subsidizing the uninsured becomes too expensive, businesses or individuals drop their insurance and there are fewer insured left to subsidize the uninsured, the number of which, by the way, just increased. So the problem worsens.

Escalating medical costs are a problem for families, businesses, and governments. As examples of each: There has been a 119% increase in cost of health insurance premiums between 1999 and 2008. Wages have remained roughly constant. Indeed, stagnating growth in workers' wages is blamed on more of the employee's compensation going towards paying for health insurance. General Motors blames many of its financial problems on healthcare costs for employees and retirees. It is not an exaggeration to say that healthcare costs may cause the bankruptcy of one of the largest manufacturing companies in the world. In the case of Government, it is projected that if the current rate of medical inflation continues, by 2050, healthcare spending will grow from 16.3% of Gross Domestic Product to 37%. Medicare and Medicaid will grow from 20.5% to 43% of the total Federal budget. This will clearly crowd out funding for infrastructure, education, and other vital needs.

Many states, including Louisiana, are working on their own health solutions, trying to decrease the impact on businesses and state budgets. The most prominent state reform is in Massachusetts. Massachusetts requires or mandates that all residents purchase health insurance. State government subsidizes health coverage for families and individuals with income below 300% of the federal poverty level. A bureaucracy, established by the state, determines the benefit package.

Although during his campaign, Obama opposed the Federal Government requiring or mandating people to purchase health insurance, many reform proposals being dis-

cussed at the national level employ an individual mandate as a way to end the shifting of costs from the uninsured to the insured. Individual mandates also have the effect of requiring the healthy to purchase insurance. A good example of this is a 25-year-old man who feels he is unlikely to get sick and therefore chooses to not buy insurance. Including folks such as this increases the number of healthy people who are unlikely to consume healthcare, but are still paying a share of the premiums. Like the Massachusetts plan, these national proposals requiring mandates would subsidize individuals and families earning less than three or four times the Federal Poverty Level (FPL).

There are problems with such mandates. For example, the cost of health insurance for a typical family of four may be $15,000 per year. If such a family earns 350% of the 2008 FPL, i.e. $73,900 a year, they may be mandated to spend $15,000 of that on a health insurance policy, the content of which is determined by a bureaucracy. In Massachusetts, subsidies stop at 300% of FPL. If, in this example, the Massachusetts model was followed, this family would not qualify for the subsidy.

Other potential problems are: (1) Many Americans will object to the Federal Government deciding what their family's spending priorities should be. (2) Well organized advocacy groups will lobby to have their services covered by the policy. At times, this would be appropriate. At other times it may increase expense without increasing value. (3) Once the Government mandates the purchase of insurance, the American citizen may demand in return that all medical services that are potentially available be provided even if marginally beneficial.

This is not to say that nothing should be done. The status quo as discussed above is unsustainable. At issue is how to provide for essential medical services such as cancer screening, immunizations, and care of chronic diseases without "breaking the bank." Other issues include how to preserve and build upon what is good about the current system.

As most readers know, I have recently been elected to Congress. It is reasonable that those whom I represent ask what I see as potential solutions. I will discuss this in a future issue. ❖

HEALTHCARE JOURNAL of Baton Rouge
Quality Correspondent

Louisiana Health Care Review Launches CMS *Every Diabetic Counts* Program

Program Addresses Need and Disparities in Diabetes

by: Samuel Leonard, MD, MBA
Associate Medical Director
Louisiana Health Care Review, Inc.

More than 60,000 Medicare beneficiaries in Louisiana are diagnosed with diabetes and a disproportionately large share of the population are African Americans aged 65 and older. African American Medicare beneficiaries are 2.4 times more likely than Caucasian Louisiana diabetics to die as a result of the disease.*

To assist Medicare beneficiaries in controlling their diabetes and improving their health, on August 1, 2008, the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) launched the *Every Diabetic Counts* (EDC) program. The EDC program offers free diabetes self-management (DSME) classes on health, nutrition, fitness, and medication monitoring. DSME is the ongoing process of facilitating the knowledge, skills, and abilities necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. Family members play an important role in encouraging people with diabetes to take good care of themselves. Family members, friends, and loved ones of Medicare beneficiaries with diabetes are welcomed to attend free classes in order to be educated in the plan of care and learn how to support the person with diabetes in their life.

The EDC program in Louisiana is currently available to patients from a group of forty physician practices with a high percentage of diabetic African American Medicare beneficiaries. Results from this pilot project will be used to develop programs available to physicians and beneficiaries statewide.

Physician offices in the Baton Rouge area that have already agreed to participate in the EDC program include:

Donnie Batie, MD (Primary Care Group-Mid City)
Jonathan Roberts, MD
Rani G. Whitfield, MD
James Hines, III, MD
Akwasi Sefa, MD (Physicians Care Center)
Janice Hudson, MD

Louisiana Health Care Review is also organizing additional support for Medicare diabetics through community health worker outreach efforts. These local volunteers will act as education extenders for the 40 physician offices chosen to partic-

ipate in the program. Community health workers will provide free training, reminders, and other important assistance for African Americans with diabetes who sign up for the self-management training through participating primary care physicians.

Free diabetes education training is also provided to all volunteers and applications are still being accepted for EDC Community Health Workers. For more information on how to register as a community volunteer, please call 1-888-321-3555.

United States Public Law #106-525 (2000), the Minority Health and Health Disparities Research and Education Act, provides a legal definition for health disparities:

"A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population."

(Source: Minority Health and Health Disparities Research and Education Act United States Public Law 106-525 (2000), p. 2498)

Resources for more information on diabetes management:

• Making Diabetes Self-Management Education (DSME) Classes Fun (Tuesday, Feb 26, 2008). This blog describes the nursing and leadership challenges from the staff nurse/nurse manager perspective. Composed of daily nursing practice insights and moments, it also provides perspectives derived from other disciplines such as business, communication, sociology, and adult education. http://novicetoexpert.blogspot.com/2008/02/making-diabetes-self-management.html

• Diabetic Care: 31:S97-S104; 2008 – DOI: 10.2337/dc08-S097 – Copyrighted 2008 by the ADA – Standards and Review Criteria, National Standards for Diabetes Self-Management Education. http://care.diabetesjournals.org/cgi/content/extract/31/Supplement_1/S97

• Implementing an Empowerment-Based Diabetes Self-Management Education Program, Martha M. Funnell, MS, RN, CDE, Robin Nwankwo, RD, MPH, CDE, Mary Lou Gillard, MS, RN, CDE, Robert M. Anderson, EdD and Tricia S. Tang, PhD: From the Michigan Diabetes Research and Training Center (Ms Funnell) and the Department of Medical Education, University of Michigan Medical School, Ann Arbor, Michigan (Ms Nwankwo, Ms Gillard, Dr Anderson, Dr Tang). http://tde.sagepub.com/cgi/content/abstract/31/1/53 ❖

**Data Source: Task 1D2 Statewide and Underserved Quarterly Rates. Item 6: 7/1/06 – 6/30/07 and CDC National Center for Health Statistics, Compressed Mortality File compiled from 1999-2003, Series 20, No. 21 2006 on CDC Wonder On-line Database, queried October 2006.*

This material was prepared, in part, by the Health Disparities Quality Improvement Organization Support Center (HDQIOSC) under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. LA9SoW4D108-O1882

Hospital Rounds

Baton Rouge General's Pediatric Unit Relocating
Baton Rouge General has relocated its Inpatient Pediatric Unit and Pediatric Intensive Care Unit (Pediatric ICU) to the General's Bluebonnet campus. The decision to move these units was based on the opportunity to create synergies between the Birth Center and Neonatal Intensive Care units located at the Bluebonnet campus. Baton Rouge General president and CEO Bill Holman said there was a consensus with the pediatric intensivists and hospitalists, and community pediatricians and pediatric specialists to relocate Inpatient Pediatrics and Pediatric ICU to Bluebonnet because of the complementary services for infants. Baton Rouge General will continue treating pediatric patients at both its Mid City and Bluebonnet emergency departments and the hospital will maintain the ability to do same-day pediatric surgeries at both campuses. Surgical cases and procedures requiring overnight stays will be scheduled at Bluebonnet and pediatric burn cases requiring hospital admission will be at the Pediatric ICU at the General's Bluebonnet campus. The General's Pediatric Rehabilitation program will remain at the Mid City campus, as will the General's adult Burn Center and outpatient adult and pediatric burn care.

Cutting-Edge Healthcare Technology Comes to Local Hospitals
In recognition of their commitment to healthcare technology, the Franciscan Missionaries of Our Lady Health System (FMOLHS) has been chosen by Cerner Corporation as a hosting site on an 85-stop, nationwide tour of the Cerner and Nuture Smart Semi. The Cerner and Nuture Smart Semi is an 18-wheel semi-truck showcasing interactive technology designed to improve patient experience and clinical outcome. Technology featured in this mobile showroom includes:
• MyStation–Delivers an innovative patient/hospital experience by transforming the standard patient room into an interactive healing environment. Patients can access their Personal Health Records (PHRs), learn about the doctors

and nurses providing their care, access the Internet, movies, and video games, and even order their meals at the touch of a button from the hospital bed.

• RxStation–Manages the medication dispensing process to help nurses reduce the chance of dangerous medical errors. This automated medication-dispensing cabinet features drawers that open automatically when a nurse clicks on a medication order entered in the patient's Electronic Medical Record (EMR).

• CareAware MDBus–Connects medical devices such as ventilators, monitors, and medication-infusion pumps to the electronic medical record (EMR). Nurses no longer have to write information on paper to be retyped into the EMR. CareAware MDBus allows information collected by medical devices to flow directly into the EMR, providing real-time access to patient status information and decreasing transcription-related documentation errors.

As part of clinical planning, hospital leaders and physicians toured the semi and attended demonstrations by Cerner experts. While elements of the technology showcased in the Smart Semi may be future projects, FMOLHS facilities already have much of the backbone in place. By mid-2007, FMOLHS had implemented a unified patient electronic health record (EHR) across all of its facilities. The EHR ties into a single database which means that patient information is easily accessible by nurses and doctors regardless of which facility they visit or where they are geographically located. Key medical information such as allergies, medications, and past medical history "follow" the patient throughout their episodes of care within Health System hospitals, providing a continuity of care and helping reduce the risk of providers not knowing about key medical information, should the patient be unable to speak for themselves. In addition to FMOLHS facilities, the EHR also integrates with many physician offices across the state allowing for a seamless flow of information from physician offices to hospitals and vice versa. The EHR is one of numerous steps FMOLHS facilities have taken to ensure safer, more efficient patient care.

Robert Hart, MD

Ochsner Announces Physician Leadership for Baton Rouge Region

Ochsner Health System recently announced that Robert Hart, MD has been named Regional Medical Director for Ochsner's Baton Rouge region and Ralph Dauterive, MD has been selected as the Vice President of Medical Affairs for Ochsner Medical Center–Baton Rouge.

Dr. Hart, who is a primary care physician, has been with Ochsner since 1994. He is board certified in both internal medicine and pediatrics. Dr. Hart received his undergraduate degree from Texas Tech University and earned his medical degree from the University of Texas Medical School at Houston. He completed his residency in internal medicine and pediatrics at the University of Texas. Prior to serving as Interim Regional Medical Director, Dr. Hart served as the Associate Medical Director for primary care in the Baton Rouge region.

Ralph Dauterive, MD

Dr. Dauterive, who has been with Ochsner since 1987, currently serves as the Head of the Department of Obstetrics and Gynecology at Ochsner Health Center. He earned his medical degree from LSU in New Orleans and completed his internship and residency at Ochsner. He is board certified in obstetrics and gynecology and is a fellow of the American College of Obstetricians and Gynecologists. Dauterive was one of the first physicians in the Baton Rouge area to perform gynecological surgeries using the da Vinci Surgical System and now trains physicians across the country on its use.

St. Elizabeth Hospital President and CEO Honored by Our Lady of the Lake College

Dee LeJeune, President and CEO of St. Elizabeth Hospital in Gonzales, was recently honored with the 2008 Distinguished Alumni Award by Our Lady of the Lake College. Our Lady of the Lake College President, Sandra Harper, PhD, presented LeJeune with this inaugural award at a banquet in November. Dr. Harper cited LeJeune's ability to "develop a stimulating, empowering work environment," as a factor in the award selection. LeJeune has remained very active with Our Lady of the Lake College since graduating from the School of Nursing. Most recently LeJeune sat on the Leadership Team of the Southern Association of Colleges and Schools, assisting the college in its Compliance Report preparations.

Dee LeJeune

Woman's Hospital Named One of the Nation's Top 100 Places to Work in Healthcare

Woman's Hospital was named by *Modern Healthcare* magazine as one of the 100 Best Places to Work in Healthcare. It is the only hospital in Louisiana to receive this honor. The rankings were a highly competitive process with over 5,000 hospitals eligible to apply. *Modern Healthcare* conducted this program to recognize outstanding employers in the healthcare industry on a national level. Woman's Hospital was selected on the basis of its application, survey results from a random sampling of employees, and information on its workplace practices, policies and employee benefits. Eight core areas were analyzed:

- Leadership and planning
- Culture and communications
- Role satisfaction
- Working environment
- Relationship with supervisor
- Training and development
- Pay and benefits
- Overall satisfaction

Woman's Hospital is recognized in the October 27 issue of *Modern Healthcare*, which is a widely-read, national journal for healthcare executives.

Nurse Named Honorary Mayor President of Baton Rouge

In recognition of her life-saving efforts during Hurricane Gustav, Ruth Turman, RN, EKLMC patient safety manager, was named Honorary Mayor-President by the Metropolitan Council of East Baton Rouge at its Metropolitan Medical Response Team Day. Mike Futrell, assistant chief administrative officer for the City of Baton Rouge recognized designated regional coordinators (DRCs) and the medical director for Region 2 at the September 24 council meeting. Honored with Turman were Allyn Whaley-Martin, RN, Our Lady of the Lake Medical Center (OLOLMC), Connie DeLeo, RN, Baton Rouge General Medical Center, and Dr. Louis Minsky, OLOLMC. As DRCs for Region 2, the three were based at the East Baton Rouge Parish Emergency Operations Center (EOC), Office of Homeland Security and Emergency Preparedness, under the direction of Dr. Minsky.

During an emergency, the team is the community's lifeline. For the hurricane, they responded to all calls for medical assistance from the public except 911 calls, working nonstop for several weeks on end, including 20-hour days just prior to and just after the storm. "This was exactly what my counterparts at EKLMC were doing," Turman said, quick to note that she accepted the honor on behalf of all at EKLMC. Turman is also part of the EKLMC disaster management team. Sometimes the best assistance the DRCs provided to callers was listening and offering comfort. Besides taking calls, the DRCs for Region 2, which includes the

Charlotte Placide

parishes of East and West Baton Rouge, Point Coupee, East and West Feliciana, Iberville, and Ascension, served as liaisons between hospitals and the EOC to ensure hospitals had vital resources for their continued operation. DRCs managed staffing from outside the region, including credentialing issues, and tracked surge capacity and patient movement and placement. They worked with the coroner's office, arranged for dialysis and patient exchanges of oxygen tanks, and coordinated with the Office of Public Health patient placement in the PMAC.

Our Lady of the Lake College Celebrates 85th Anniversary

Our Lady of the Lake College recently celebrated its 85th anniversary as an institution of higher learning with a mass at St. Joseph's Cathedral and dinner at De la Ronde Hall on November 15, 2008. In addition, Mayor Kip Holden declared November 15, 2008 "Our Lady of the Lake College Day."

The OLOL College has grown from its modest beginning in 1923, as a small nursing college with only nine students, to a student-centered academic community with nearly 2,000 students. Today, OLOL College is a four year college offering students masters, bachelors, associate degrees, and certificates in nursing and various healthcare professions, the liberal arts, and the humanities. It is the only Catholic college in Baton Rouge. During the anniversary celebration and dinner, three annual awards were presented:

• 2008 Franciscan Impact Award was awarded to Charlotte Placide, Superintendent for the East Baton Rouge Parish School System. Her efforts impact thousands of children each school year, as she strives to provide a strong education base for our community leaders of tomorrow.
• 2008 Distinguished Alumni Award was presented to Dolores "Dee" LeJeune, President and CEO of St. Elizabeth's Hospital in Gonzales, Louisiana. Under her leadership, St. Elizabeth's has been recognized nationally for its outstanding work environment and has been awarded a Louisiana Performance Excellence Award Level III.
• 2008 Distinguished Young Alumni Award was given to Christine Blanchard who graduated from Our Lady of the Lake College in 2007 with an ASN in Nursing.

LSU Hospitals Score High In Patient Satisfaction Ratings

LSU teaching hospitals exceeded national norms for patient satisfaction, communication with doctors, pain management, and cleanliness in a new survey conducted for the federal government. The results contained in a *New England Journal of Medicine* article included data for seven hospitals operated by LSU's Health Care Service Division (LSU HCSD). The surveys, which covered six areas, including communication with doctors and nurses as well as explanations about medication, the helpfulness of hospital staff, and whether patients received discharge information, were part of an ongoing assessment of patient satisfaction at all U.S. hospitals that receive Medicare payments.

Overall, the study found moderately high levels of satisfaction with care. Nationally, 67.4 percent of respondents said they would definitely recommend the hospitals, but for LSU hospitals, an average of more than 77 percent of patients said they would recommend LSU hospitals to friends and family. The single highest scores for LSU hospitals were in doctor-patient communications. Asked how often doctors communicated well, 89 percent of LSU patients gave high marks to their physicians, 10 points higher than the national average. The study's lead author, Dr. Ashish Jha, assistant pro-

fessor of health policy at the Harvard School of Public Health, noted that teaching hospitals were rated higher than all other hospitals.

OLOL Announces Special Gift to the Baton Rouge Community
In recognition of receiving the Consumer Choice Award ten times in ten years, Our Lady of the Lake announced a gift of 100 trees to be planted in ten locations throughout the Baton Rouge area. OLOL will be working with Baton Rouge Green to plant the 100 trees. For the tenth consecutive year, Our Lady of the Lake Regional Medical Center has been selected by the National Research Corporation (NRC) as the Consumer Choice Award winner for the hospital with the highest overall quality and image in the Baton Rouge metropolitan area. This gift is considered a thank you to the community for their confidence in our quality and clinical excellence.

"The trees represent not only recovery from Hurricane Gustav, but are a symbol of our ongoing commitment. Just like OLOL has planted roots and will continue to grow with this community, the trees will do the same and serve as a reminder of how grateful we are to the community who supports us," said Scott Wester, Chief Executive Officer. OLOL has been working with Baton Rouge Green to help coordinate this multi-part gift. Ten trees will be planted in each of the following ten locations:

• Capitol Lake area, now site of the Poydras Building and the 1st Circuit Court, these buildings sit on the original site of Our Lady of the Lake.
• State Capitol grounds, acknowledging OLOL's support of the State of Louisiana and the ongoing efforts to improve healthcare across the state.
• Downtown Baton Rouge, representing revitalization and progress.
• East Baton Rouge Schools, representing OLOL's commitment to education and commitment to the future generations they will serve.
• BREC Parks, a fitting symbol of the importance of physical fitness and activity as key components of a healthy lifestyle.
• Baton Rouge Zoo, St. Francis of Assisi, OLOL's patron saint, is well known for his love of nature and animals recognizing all as God's creation.
• Bon Carre area, a focus of OLOL's outreach ministries and neighbor to its Elderly Housing complex and St. Clare Manor nursing home.
• The Rural Life Museum, the hospital's neighbor on Essen Lane as well as to Ollie Steele Burden Manor and the Maryville Convent, home to the Franciscan Missionaries of Our Lady, OLOL's sponsoring Sisters.
• Livingston Parish, OLOL's healthcare ministry is growing and they are excited about the future in this dynamic parish.
• Ascension Parish, it is OLOL's privilege to join with its sister facility, St. Elizabeth Hospital, in serving the families of Ascension.

Todd Daniel

Lane Providing Healthcare Solutions to Local Employees
Lane Regional Medical Center is now offering a new program designed to work hand-in-hand helping local business and industry with their many employee health needs, especially controlling costs associated with worker's compensation. The free program is called WellnessWorks. The four basic components that make up the Lane WellnessWorks program are:
1) Prevention Services—Provides employers with easy access to healthcare information and healthcare services, including on-site safety talks, health events and flu shots, pre-employment/post exit/injury related and random drug screenings, and physicals.
2) Injury Intervention—Offers cost-effective and efficient return-to-work

strategies and helps minimize treatment time and lost work days.
3) Service Coordination—Provides a centralized communication hub within the healthcare system to assist employers with scheduling and tracking worker's compensation cases.
4) Wellness Promotion—Helps employers educate their workforce regarding general health policies and plans, and helps employees utilize the benefits provided.

Robert M. Moukarzel, MD

Baton Rouge General Names Daniel Director of Materials Management

Baton Rouge General has announced that Todd Daniel, MSM, has been named as director of the hospital's Materials Management Department. He was previously director of the General's Respiratory Care Department. Before joining Baton Rouge General, Daniel was employed by an international leading manufacturer of medical equipment and Marshall Regional Medical Center as Cardiopulmonary Department Director. Daniel obtained a Bachelor of Science degree in Cardiopulmonary Science from Louisiana State University Medical Center in Shreveport and a Master of Science in Management degree from Letourneau University in Longview, Texas.

Lake After Hours Now Open on Lee Dr. at Highland Rd.

Lake After Hours has opened a new clinic at 123 Lee Drive in Baton Rouge at the corner of Lee Drive/Highland Road. Lake After Hours provides urgent care medical treatment without appointments or long wait times and is open during hours in which most doctors' offices are closed. The new clinic will operate from 3 pm–11 pm, Monday–Friday and from 9 am–6 pm on Saturdays and Sundays. Lake After Hours treats ear or eye infections, fever, minor cuts needing stitches, possible broken bones or simple fractures, severe sore throat, sprains or strains and vomiting/diarrhea. Lake After Hours is affiliated with Our Lady of the Lake Regional Medical Center and has five locations around Baton Rouge: Perkins Road, O'Neal Lane, Drusilla Lane and Shoe Creek Drive in Central. Additionally, Lake After Hours has a location on LA Highway 16 in Denham Springs and Veterans Avenue in Hammond.

William J. Hubbard, MD

Women's Victory Open a Success

Benefiting breast cancer outreach, education, and research at Woman's Hospital, the tenth annual Women's Victory Open golf tournament at the Country Club of Louisiana, grossed more than $135,000. Since its inception, funds raised have exceeded $700,000, which benefit the women in the Baton Rouge community and surrounding communities affected by this disease. Capital One and Saia Electric were the presenting sponsors for the Women's Victory Open. Proceeds from the tournament helped to purchase a mobile mammography coach for Woman's Hospital which provides screenings in high risk, underserved areas.

Baton Rouge General Adds Ortho Surgeons to Staff

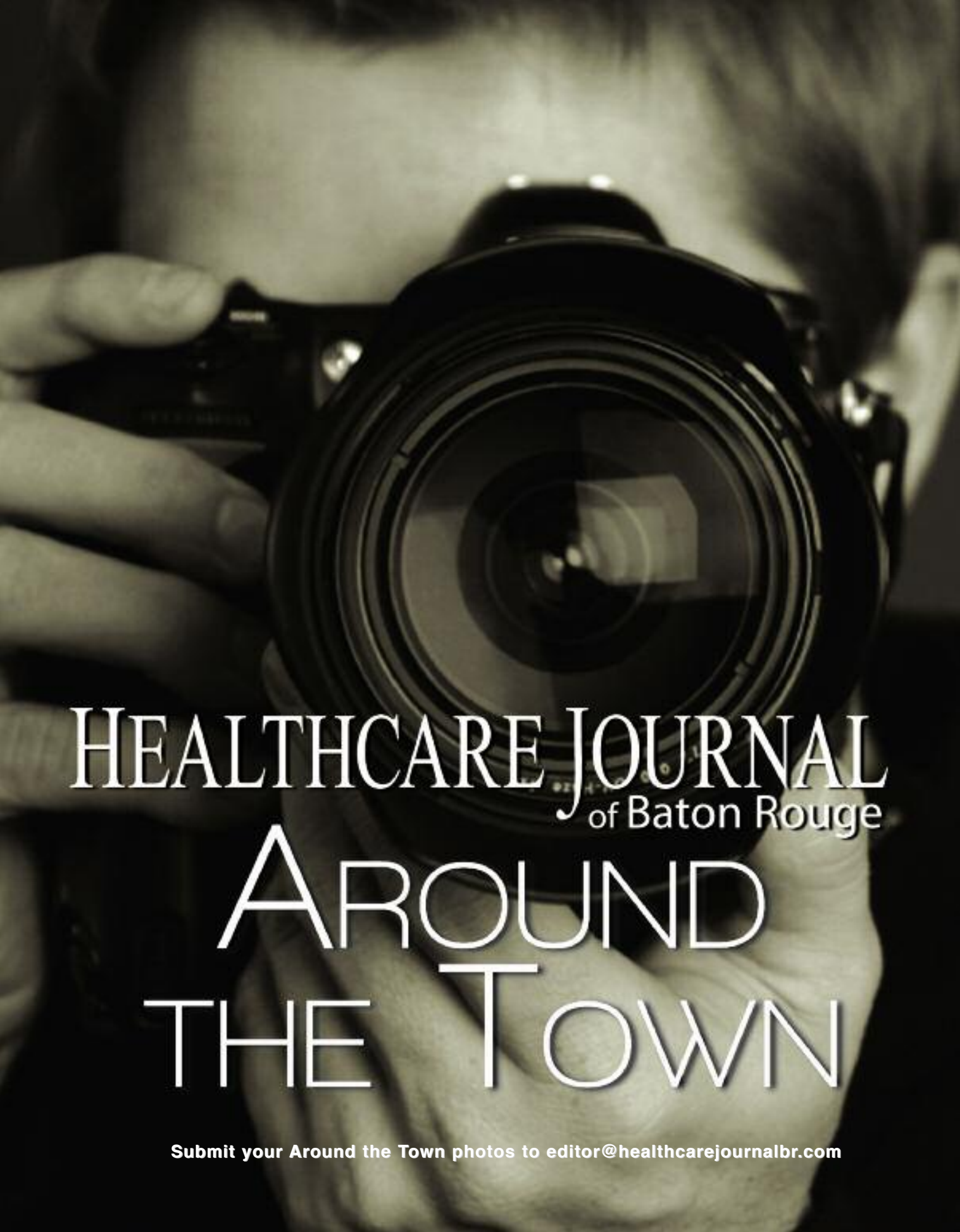
Two well known orthopedic surgeons, Dr. Robert N. Moukarzel and Dr. William J. Hubbard, have joined Baton Rouge General Medical Center. Dr. Moukarzel is a Board Certified orthopedic surgeon with special medical interests in total joint replacement and sports medicine. He earned his medical degree from Albany Medical College in Albany, New York, and completed his residencies at Albany Medical Center Hospital. Dr. Hubbard is a Board Certified orthopedic surgeon with special medical interests in hand surgery and surgery of the peripheral nerves. He received his medical

degree from the University of Mississippi School of Medicine in Jackson and completed his residencies at Gorgas Hospital in the Panama Canal Zone and at the Maricopa Medical Center in Phoenix, Arizona.

LSU and OLOL Explore Partnership

The LSU Health System and Our Lady of the Lake Regional Medical Center (OLOL) have been in discussions to explore a possible partnership aimed at supporting graduate medical education and improving access to care in the Baton Rouge area. The proposed partnership was offered by LSU as an alternative to their previous plan for building a new academic hospital in the Baton Rouge area.

The proposed partnership would meet OLOL's desire to expand its role in graduate medical education and fulfill LSU's academic and patient care mission. The plan would likely involve closure of Earl K. Long hospital, but LSU would continue to serve patients in that part of town through clinics. OLOL and LSU Health System administrators have agreed to continue more detailed discussions for OLOL to become the teaching hospital site for LSU in Baton Rouge. If both parties reach an agreement, the change will likely occur in about two years. ❖



HEALTHCARE JOURNAL of Baton Rouge

AROUND THE TOWN

Submit your Around the Town photos to editor@healthcarejournalbr.com

Pictured at the dedication of the new Claude Kirkpatrick Chapel at Baton Rouge General's Bluebonnet location are Bill Holman, president and chief executive officer of Baton Rouge General and Mrs. Edith Kirkpatrick.

Pictured at Baton Rouge General's 16th Annual Eucharistic Ministers and Volunteer Chaplains Banquet are: Pat Davis, Ava Maria Celestin-Langlois, Theresa Celestin, Father Michael Jung, Betsy Gosserand, and K. Thomas.

A Kickoff Celebration for the American Heart Association's Go Red for Women campaign was held October 29th at the home of Renee Furr. Go Red for Women increases awareness of heart disease and inspires women to take charge of their heart health. The annual Go Red for Women Luncheon, chaired by Renee Furr and vice-chaired by Terrie Sterling, is scheduled for Thursday, February 12, 2009 at the Holiday Inn Select.

Enjoying the dedication of Ochsner Medical Center-Baton Rouge's new wellness path are Eric McMillen, chief operating officer; Barry Chambers, chief financial officer; Bob Breaux, chairman, Board of Councilors; Mitch Wasden, chief executive officer; Dawn Pevey, chief nursing officer and Steve Childers, vice president Philanthropy, Ochsner Health System.

RESOURCE GUIDE

Airport

Baton Rouge Metropolitan Airport
9430 Jackie Cochran Dr.
Baton Rouge, LA 70807
225.355.0333
www.flybtr.com

Audio Visual

Woofers Home Theater
14241 Airline Hwy.
Ste. 108, Baton Rouge, LA 70817
225.757.6615
www.WoofersHomeTheater.com

Automotive (Tire and Care)

Treads & Care
1312 W. Hwy. 30
Gonzales, LA 70737
225.647.9631

Treads & Care
10711 Coursey Blvd.
Baton Rouge, LA 70716
225.368.1234

Cancer Services

The Total Woman Boutique
9244 Florida Blvd.
Baton Rouge, LA 70815
225.924.4531
www.thetotalwomanboutique.net

Catering

Southern Belle Catering
1969 N. Lobdell Ave.
Baton Rouge, LA 70806
225.927.4670
www.southernbellesandwich.com

Chiropractor

Capitol Spine
& Rehabilitation
429 E. Airport, Ste. 1
Baton Rouge, LA 70806
225.926.1900

Cleaners

Sunshine Cleaners
16645-A Highland Rd.
Baton Rouge, LA 70810
225.753.4060
www.sunshinecleaners.net

Consulting

HealthCare + Business
Consulting, Phillip H. Rees
7474 Highland Rd.
Baton Rouge, LA 70808
225.767.9577
www.HCBconsulting.com

Healthworks:
A Management Services Group
8017 Jefferson Hwy, Ste. A2
Baton Rouge, LA 70809
225.383.1180
www.healthworks-llc.com

Florist

Peregrin's Florist &
Decorative Services, Inc.
8883 Highland Rd.
Baton Rouge, LA 70808
225.761.0888
www.peregrinsflorist.com

Hearing Aids

Audibel Hearing Healthcare
8754 Goodwood Blvd.
Baton Rouge, LA 70806
225.928.1490
www.audibel.com

Home Health

Personal Homecare Services
6869 Hwy. 84 W.
Ferriday, LA 71334
877.336.8045
www.personalhomecare.net

Hospitals

Baton Rouge General
Medical Center
8585 Picardy Ave.
3600 Florida Blvd.
Baton Rouge, LA

225.387.7000
www.brgeneral.org

Promise Hospital
of Ascension
615 East Worthey Rd.
Gonzales, LA 70737
225.621.1242
www.promisehealthcare.com

Promise Hospital of Baton Rouge
Baton Rouge General
(Mid-City Campus)
3600 Florida Blvd., 4th Floor
Baton Rouge, LA 70806
225.381.2682

Promise Hospital
of Baton Rouge
Ochsner Campus
17000 Medical Center Dr.
3rd Floor
Baton Rouge, LA 70816
225.381.2682

St. Elizabeth Hospital
1125 W. Hwy. 30
Gonzales, LA 70737
225.647.5090
www.steh.com

Insurance

Employees Insurance
2645 O'Neal Ln.
Bldg. B, Ste. A
Baton Rouge, LA 70816
225.273.1471
www.employeesinsurance.com

LAMMICO
1 Galleria Blvd., Ste. 700
Metairie, LA 70001
800.452.2120
www.lammico.com

Louisiana Health Plan
P.O. Drawer 83880
Baton Rouge, LA 70884
225.926.6245
www.lahealthplan.org

Jeweler

Robert Roth Jewelers
7513 Jefferson Hwy.
Baton Rouge, LA 70806
225.927.9444

Medical Uniforms

Uniforms Etc. USA
9490 Airline Hwy.
Baton Rouge, LA 70815
225.248.1333
www.uniformsetcusa.com

Menopausal Clinic

Baton Rouge Climactric-
Menopausal Clinic
429 E. Airport Ave.
Baton Rouge, LA 70806
225.928.1791

Non-Profit

American
Heart Association
4962 Florida Blvd. #402
Baton Rouge, LA 70806
225.248.7700

Nursing Home

CommCare
Corporation
5550 Thomas Rd.
Baton Rouge, LA 70811
877.277.3859
www.commcare.com

Orthopedics

Bone & Joint Clinic
of Baton Rouge
7301 Hennessy Blvd.
Ste. 200
Baton Rouge, LA 70808
225.766.0050
www.bjcbr.com

Pediatrics

Pediatric Surgery
of Louisiana
7777 Hennessy Blvd.
Ste. 212, Baton Rouge, LA 70816
225.769.2295

Pharmaceuticals

Gulfcoast Pharmaceutical
Specialty
1039 E. Hwy. 30
Gonzales, LA 70737
800.498.5220
www.gpspharmacy.biz

Physical Therapy

Peak Performance
Physical Therapy
11320 Industriplex Blvd.
Baton Rouge, LA 70809
225.295.8184
www.peakphysicaltherapy.com

Quality Improvement

Louisiana Health
Care Review
8591 United Plaza Blvd.
Ste. 270
Baton Rouge, LA 70809
225.926.6353
www.LHCR.com

RESOURCE GUIDE

Skilled Nursing Facility

CommCare Corporation
5550 Thomas Rd.
Baton Rouge, LA 70811
877.277.3859
www.commcare.com

Wines and Spirits

Calandro's
Select Cellars
4142 Government St.
Baton Rouge, LA 70806
225.383.7815

Calandro's
Select Cellars
12732 Perkins Rd.
Baton Rouge, LA 70810
225.767.6659
www.calandros.com

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