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of Baton Rouge

JANUARY / FEBRUARY 2012

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SPOTLIGHT ON SERVICE: Jennifer Carter, Pharm D

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Q: What is the benefit of getting the Zostavax vaccine, and how has it helped your Walgreens patients that have already received it?

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The elusive

A photograph showing a row of dark blue, reflective cylindrical lids, possibly from containers like yogurt or ice cream, resting on a patch of green grass. The lids are arranged in a curve, receding towards the horizon. The background is a clear, bright blue sky.

ACO

Sightings in Baton Rouge?

Casting about for a solution to tackle the problem of rising healthcare costs, in March, 2011, the Centers for Medicare and Medicaid (CMS) released a proposed model for health-care delivery dubbed Accountable Care Organizations (ACOs). The concept was simple and undoubtedly on the right track, but the creature itself has proven to be chimerical at best.

“When they came out with the healthcare reform legislation it basically sent a message to the health-care delivery system that how they are going to get paid is going to change,” said Ed Silvey, Administrator and CEO of the Baton Rouge Clinic. “Unfortunately the federal government had written some guidelines that in reality didn’t work.” [>>](#)

THE ELUSIVE ACO

The CMS ACO is framed as a group of healthcare providers who are held jointly accountable for achieving measured quality benchmarks and reductions in the rate of spending growth while improving outcomes for a defined population. An ACO would typically include a strong primary care base, specialists, a hospital, long-term care, and ancillary services, all of which would share in savings realized by providing a more coordinated care approach.

To participate in the Medicare Shared Savings Program, ACOs would need to meet 33 quality standards in four key domains:

- Patient/caregiver experience
- Care coordination and patient safety
- Preventive health
- At risk population/frail elderly health.

Originally CMS had proposed 65 quality measures in five domains.

The idea of shared savings is an attractive one as nobody disputes that many healthcare costs can be reduced or eliminated through better coordinated care. In fact, CMS predicts Medicare savings of as much as \$960 million over three years. Tapping into a piece of that is certainly a carrot, but not if the cost of creating the infrastructure to deliver that coordinated care counteracts any potential savings. Ochsner Medical Center-Baton Rouge CEO Mitch Wasden said that CMS estimated it would cost Ochsner about a \$1.8 million investment to comply with the regulations and set up an ACO. Wasden said Ochsner's own estimates are closer to \$11 to \$26 million.

"The infrastructure that it's taking to do it doesn't justify the expense or the economic reward that the government has set up,"

agreed Silvey. It is also possible, since CMS has seemed to underestimate the costs of implementing an ACO, that they have also overreached on the projected savings. At the moment the savings are offered as a bonus above and beyond regular Medicare reimbursement. An ACO's performance would be measured against a series of benchmarks to determine if it was eligible for a share of the savings or would be held accountable for losses.

CMS has used all the right words: accountability, reduced spending, quality improvement, coordinated care, patient safety. In fact, no one disputes those factors are necessary parts of any real healthcare reform. However, CMS went on to define the structure, operation, and functions of ACOs in a 439-page regulation that had everyone a little bewildered. "I think if you look at the concept of accountable care organizations, as CMS defines it, they have a lot of great core concepts, but they had so many restrictions and regulations as they really got to finalizing the document that we are not pursuing an accountable care organization status as defined by CMS," said Baton Rouge General Executive Vice President & Chief Business Development Officer Dionne Viator.

After reviewing more than 1300 comments on its proposed rules, presumably many of them unflattering, CMS released final rules in October, 2011 that reduced some of the burden and increased some of the incentives for those creating ACOs. They also expanded the field of those qualified to form these types of organizations to include Federally Qualified Health Care Centers and Rural Health Clinics that provide primary care.

One of the biggest changes to the rules was to revise the two-track shared savings program to allow for one to be completely without risk. In the proposed rule, Track 1 included two years of one-sided shared savings with a mandatory shift in year three to performance-based risk or shared losses under a two-sided model. Track 2, which offered a higher percentage of shared savings (60%) as an incentive, called for three years under the riskier two-sided model where ACOs also share in losses. Under the final rules, Track 1 offers ACOs an opportunity to avoid the two-sided risk altogether for the first three years. CMS will also begin shared savings on the first dollar for all ACOs regardless of whether they choose the one-sided or two-sided model.

Another significant change removes the requirement that 50% of primary care physicians must be defined as meaningful users of electronic health records by the second year in order to participate. Despite incentives to implement EHRs, this requirement potentially posed a significant barrier for independent physicians, although, according to Silvey, defining meaningful use is a bigger challenge than achieving it. While the change reduces some of the burden, Silvey believes most people implementing EHRs will try to attain meaningful use regardless, as it "tracks so many of the quality metrics you need to hit anyway." To counteract the loss of the meaningful use requirement, CMS assigned much greater weight to EHR implementation as a quality measure—higher than any other, in fact.

A third change, aimed at addressing infrastructure concerns, was the introduction



of an Advanced Payment model under which physician-owned and rural ACOs, as well as some critical access hospitals, could be pre-paid a portion of future shared savings to help them get up and running more quickly and therefore providing greater access to coordinated care. Providers could receive the payments in one of three ways:

- Upfront fixed payment
- Upfront payment based on the number of Medicare patients served
- Monthly payment based on the number of Medicare patients

The advanced payments would be recovered from any future shared savings the providers incurred.

"Probably the biggest area where there were changes was that the anti-trust, anti-kickback, and Stark provisions were all relaxed substantially," said Silvey. Concerns about how these collaborations might inadvertently challenge those laws had many providers approaching the ACO concept with considerable caution. The final rules provide more guidance from CMS, the Federal Trade Commission, and the Department of Justice and make available an expedited review process to address antitrust concerns. "It's still fairly complicated," said Silvey. "You would obviously still want to get a lot of legal interpretation before you did anything."

Despite some attempts to reduce risk and make implementation less burdensome, the final rule still requires that each group of providers be held accountable for at least 5000 beneficiaries annually for a period of three years—a considerable commitment. The good news is that, for the moment,

participation in an ACO is voluntary, with shared savings as the incentive, but providers are rightfully watchful, with expectations that reimbursement will eventually be contingent on operating in an ACO-type delivery system. "Whether it be a government or a private payer they will incent this in whatever direction payment reform might take," said Silvey. "Then at some point they won't incent it any more; it will be an expectation." So, while few are trying to emulate the CMS model, most local hospitals, physician groups, and payers are exploring ways to work together to achieve some of the same goals. "I think people are trying baby steps to payment reform to see if it achieves some of the goals that the government's concept of an ACO does," said Silvey.

"The best explanation is there is the big 'ACO' which CMS adopted for their shared savings model and which is now an ugly word," said Richard Vath, MD, VP of Medical Affairs at Our Lady of the Lake Regional Medical Center (OLOL). "And then there's the little 'aco' which is a concept. I still like the little 'aco' concept." Wasden said Ochsner, too, agrees with the spirit of ACOs, noting that, "we need to get out of this model of getting more revenue for patient services just because people are doing more, because that's not necessarily the same thing as quality." However, Ochsner, like others, is finding the mechanics of it are going to be very costly and may not even work or be effective.

"If ACO regulations are created that are viable, then I think everybody's going to want to do it," said Wasden. "Until CMS is able to accomplish that, we will probably explore activities locally that accomplish



If ACO regulations are created that are viable, then I think everybody's going to want to do it. Until CMS is able to accomplish that, we will probably explore activities locally that accomplish the same thing.

—MITCH WASDEN

THE ELUSIVE ACO

the same thing. If they are able to improve the regulations I think you will see the ACO model and local efforts dovetail and become the same thing eventually."

Exploring local options is exactly what everyone seems to be doing. In fact, Silvey believes that's the critical factor CMS has failed to recognize—that models need to be tailored to the unique environment of each market and that a one-size-fits-all model is not a comfortable fit for anyone. In cities like Baton Rouge where large health systems have already explored partnerships with other entities, some form of ACO will potentially be easier to craft than in areas where there are a lot of independent practices.

"We, like many others, had been in conversation for a while before the CMS proposals came out," said Vath. About two years ago, OLOL started the conversation with independent physicians about clinical integration and accountable care as a concept. "We approached it as sort of a natural progression of what we have been able to achieve working with the independent physicians — getting around the table and improving inpatient quality of care," said Vath. OLOL has been working with physicians in the community on trying to develop what an accountable care model would look like. They have progressed far enough in that process to request an informal decision from the Federal Trade Commission (FTC) on how to model the finances. Included in the discussions are the Our Lady of the Lake Physician Group, St. Elizabeth Physicians, and the Baton Rouge Clinic. One of the keys to the integrated model is that all of them will be on the same EMR. Later, any other community physician that wants

to be on that record could join. "We're developing how that model could work now. How do we implement it, what would the cost be to join?" said Vath. "What I'll continue to push for is a little 'aco'. We've been very transparent about the journey for this whole quality outcome delivery model to be introduced into the community. We're really committed to this. The question is how many will be joining us?"

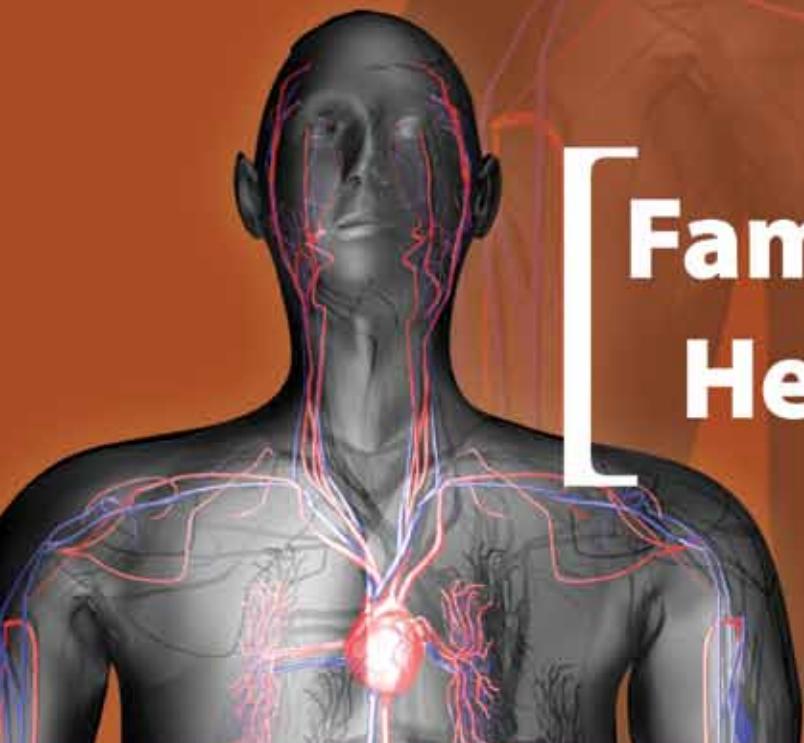
OLOL has also been working on a separate model as part of its collaboration with LSU and a commitment to take care of the population that health system serves. This model includes the OLOL Physician Group and St. Elizabeth Physicians, but also the LSU providers and some of the specialists in the community that weren't represented in those groups. OLOL also included Capital Area Human Services and Health Care Centers in Schools to discuss what an accountable care model for this population would look like. "With the help of consultants we really came up with a nice model and even some mechanisms for how to coordinate the care between the ambulatory environment and the inpatient arena," said Vath. "But then the decisions made by the state on coordinated care networks (CCNs) have to some extent put us on hold. If we apply for an ACO how does that work with the CCN or not work with the CCN?"

"ACO is kind of an amorphous term, but accountable care is what we are talking about...there's a lot of different ways you can package it," said Kenneth Phenow, MD, Chief Medical Officer at Blue Cross and Blue Shield of Louisiana (BCBSLA), which is primarily focusing on primary care as the accountable care providers. However, the payer will soon launch a new

product with Ochsner that is set up very similar to an ACO. "We're not calling it an ACO, but it really kind of is an ACO because they have the hospital, they have the specialists, they have the primary care, they have the ancillary," said Phenow. "They are taking risk with us as partners on actual premium dollars. There's going to be a quality piece where they are going to have to hit certain thresholds across all physicians. They would have to maintain or improve their quality index and then there would be distribution of funds based on the partnership agreement."

In addition, BCBSLA is forming narrow ACO-like networks, as part of a new product called Community Blue. The network includes Baton Rouge General as the key hospital, First Care Primary Care Physicians, the Baton Rouge Clinic, and various specialists. "It is an ACO; we are just not calling it that," said Phenow. "In a true ACO there is risk sharing going on between the components of the ACO. Here there is no risk sharing, but there are potential savings they'll share in. They reduce their rates a little bit, so we can reduce the overall rate from a premium standpoint, so we can attract more people that want to pay less for a little more narrow, high quality network."

However, said Phenow, BCBSLA believes sustaining primary care by transforming practices to deliver patient-centered medical home-type care is the way to go to reform healthcare delivery. To that end, BCBSLA is helping physician practices adopt the medical home model through funding certification by the National Committee for Quality Assurance (NCQA) and paying a per patient bonus based on the



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THE ELUSIVE ACO

level of certification attained. The payer is also helping primary care practices with the costs of implementing EMRs and is providing data through which providers can measure their performance against others in the market. In an ACO, said Phenow, everybody's accountable for improving cost, improving quality, and sharing potential savings, whereas in a medical home it's the primary care physicians who are doing it. "We're giving them information on how to improve their referral patterns—which hospitals to use, which ancillaries to use—it's very similar except they are just working within their group. They are being the accountable care organization."

Blue Cross also plans to start replacing fee for service with a per member, per month care coordination or care management fee based on the risk of the population. Then it will start to introduce a pay for performance bonus based on quality and cost savings. "As we move down the road to more integrated delivery models such as ACOs, whatever they are going to look like, there will be shared incentives," said Phenow. "We are not holding anybody at risk in the medical homes yet. But in the future we will."

Viator said the accountable care concept goes even beyond the hospital walls; it involves earlier coordination and reducing fragmentation in an effort to prevent hospital stays. "But if it happens, how we coordinate with home health agencies, rehab hospitals, nursing homes, and other systems of care is important. Communication is very important," she said. Baton Rouge General is exploring whether it can improve care by working with a small group of health partners with whom they have strong communication and expectations

of each other regarding quality of care. The idea is to improve the overall health status of that group, said Viator, who also noted that the only way to truly achieve those goals is for the patient to be an involved participant in their own care.

In the Community Blue partnership with BCBSLA, Baton Rouge General will be part of a narrow network of lower cost, high quality providers throughout the continuum of care, but will also include requirements like annual health assessments for the participants. "The intent is this very affordable health plan will be able to have savings passed back to the participants or priced at a premium. To me, that product has the underpinnings of a solid, accountable care approach," said Viator.

"In the old models of integration in the '90s hospitals just owned everything, owned the doctors, owned other hospitals," said Wasden. "We're trying to create some models where you don't have to own everything, but where you can partner and collaborate, such as sharing electronic medical records." Ochsner is also looking at collaborating with other entities to create councils around different disease states. For example, a cardiovascular council would meet to discuss and agree on what the best and most cost-effective ways are to take care of people with cardiovascular disease. The councils would hopefully reduce variation in care, and like the integrated EMR, help everyone to be on the same page. "Even if the ACO initiative is slow to be adopted or is changed dramatically you are going to see integration efforts in all communities across America," said Wasden. "People are realizing that we have to provide high quality healthcare at the lowest possible cost."

"Personally, I think we could probably get very similar outcomes to ACOs by focusing on accountable, coordinated, collaborative care through some of the primary cares, some of the specialty cares," said Phenow. "I think we could get there and the hospital would not be part of it." He said that BCBSLA sees its role in the future as a type of collaborator, arming primary care physicians and specialists with the information they need to provide more coordinated care and improve referral patterns. The payer is also in a position to reward physicians for value. The plan is to eventually create virtual networks of medical homes by providing and funding a shared care coordinator to coordinate between patients, practices, and the health plan to manage that population in a more cost effective way. BCBSLA would also provide the data physicians need to make sure patients get the right care; provide information on preferred ancillary services; have them work with Blue Cross nurses in disease management; and work with other community resources. BCBSLA also plans to create an advance primary care ICU made up of primary care physicians that specialize in certain areas, who could co-manage difficult patients.

Blue Cross has already created a Blue Distinction hospital program that ranks hospitals for quality and will eventually rank them for cost effectiveness. The plan is to also rank specialists. These rankings would be provided to medical homes to change referral patterns. "Health plans have resources and informatics to drive high value care by rewarding for appropriate care and sharing info about good performers," said Phenow. He predicts that as primary care providers become more accountable for quality and cost effectiveness, the

patients will migrate to them. "Those losing business will probably start to lower their rates and that's how we will kind of recalibrate the entire market," said Phenow. "I think the same thing might happen with the specialists, but it's not going to happen overnight. I think it's going to be a slow, arduous, ugly process. But it's either that or the government is going to take over and decide how much each specialty is going to make a year and nobody wants that."

Contrary to Phenow's vision, area hospitals feel they are an important part of the mix in the ongoing reform of healthcare delivery. "There are a lot of models out there, but I think the strongest models are going to include as many pieces of the care continuum as possible," said Wasden. "I think a model that includes physicians, hospitals, home health, and the entire continuum is probably going to have a better opportunity to create quality and savings than one that focuses on just one piece of the delivery system, whether that's hospitals or whether that's physician groups." Silvey agreed that, "Some of it is just economies of scale—the larger the network is, the better able to implement things like EMRs or sophisticated chronic disease management programs."

One of the concerns physicians have had with forming ACOs is that the hospital is generally the largest, most powerful partner. "In the past, the way the collaboration worked, hospitals would buy physician groups because all they cared about was getting their volume. That was the old model of 'If I do more I make more money.' I think what we are looking for with these new models is how we collaborate on a population's health, which at times means not doing as much," said Wasden. "I think

when you look at some of these models where hospitals are partnering with independent physicians and where physicians remain independent, but have a more symbiotic relationship with the hospital, it can work." In addition, said Wasden, hospitals are more likely to have the capital for infrastructure changes like implementing high quality EMRs.

Hospitals, too, could be alarmed at a model geared toward reducing the number of people that have to be admitted. "It is counterintuitive for any hospital to be committed to this, but fortunately the leadership here has been able and willing to commit to this, realizing what the ramifications are," said Vath. He pointed out that hospitals have taken other actions prior to CMS requiring reporting or refusing to pay for those incidents. "We decreased things that we were being paid for then."

The carrot for some might be the shared savings, but, said Vath, "No one believes with the shared savings that they will be making as much as they are making today." The real incentives are to do the right thing for the population and the realization that something has to change, he said. "My idea is if you can get all the physicians around the table, and start talking about what's the best way to manage a hypertensive patient or diabetic patient, and then provide external resources that they can tap—all the same as the ones in a medical home, but shared—you can accomplish the same thing and share costs without trying to recreate the medical home in each practice. If you are going to approach it differently, then who better to capitalize to a great extent the formation of this external entity than hospitals?"



We approached it as sort of a natural progression of what we have been able to achieve working with the independent physicians — getting around the table and improving inpatient quality of care.

—RICHARD VATH, MD



THE ELUSIVE ACO

One oft heard criticism of the ACO model is, "Haven't we tried this before?" The answer is yes, and the memories are not generally fond. However, there is one major difference this time, noted Silvey, and that's the focus on quality and the fact that payment will eventually be tied to outcomes, ACOs or not. "It didn't work in the '90s because it was all about money," agreed Vath. "This at least has been approached a little differently. Yes, everyone is saying it's about the costs, but nobody is talking about the individual premium. It's still about how do we get the outcomes that we want?" Besides, noted Vath, "Everybody who has been around long enough and knows how it was in the '90s knows that they don't want to recreate that." Viator noted that there will be payment reform involved in all aspects of the pilot programs we are seeing locally. Instead of incentivizing providers to be paid per healthcare event, there will be reform that pays for the overall health of the population.

There is also general agreement that whether ACOs are the way to go or not, there has to be a change in the delivery system. "All of the stakeholders are getting frustrated, especially the employers; they want better value," said Phenow. "We spend a lot of money on healthcare, 17% of the GDP, but we are not showing good outcomes. That's not good value. Our healthcare system is not a system; it's a hodgepodge of financing, insurance, delivery, and payment mechanisms that are not standardized, not coordinated. A system is a network of integrated components that work together in a cohesive, coordinated, and collaborative fashion. That's what we need to get to and we have to start to develop a delivery model that

does that," he stressed. A coordinated delivery model that focuses on prevention of disease, avoiding hospitalization, and managing chronic illness rather than on specialty and procedural care is what's needed, said Phenow.

"I think the biggest challenge for this to work is whether the specialists are at the point, where they weren't in the 90s, to say, 'Look, I get it.' The reality is if I'm just a left ankle surgeon and that's all I do, I'm either going to have a boutique practice and take cash only, or I'm going to have to play with others in a different sandbox," said Vath. "It has to change and if it has to change this is the only way we can control it." He noted it is better to sit down with potential partners and design a model than to just wait to see what happens. "Even if it means groups come together, form a venture, and work with commercial payers or Medicare Advantage or anyone else to begin to move that model of making sure that everybody holds you accountable for the quality stuff."

One of the other reasons this approach is given more hope than the models of the past, is the focus on enhanced communication through electronic medical records. Interestingly, even if they are not officially exploring collaborations (although many are), most of the major providers in the area have chosen to implement the EPIC EMR. Among them are the Baton Rouge Clinic, St. Elizabeth Physicians, Our Lady of the Lake, OLOL Physicians, LSU Health System, Ochsner, and North Oaks. In addition, those entities can arrange to grant access to physicians outside of those networks. Ochsner is even helping to subsidize up to 85% of the cost of physicians



I hate to say you've got to get on board with an accountable care organization or be left behind, because that terminology is being thrown around to mean so many things. But I will say if you don't get on board with the concept of preventable care and the sharing of information technology so that decisions can be made by caregivers with a more complete set of information then I think you will be at a deficit to move forward.

—DIONNE VIATOR



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The infrastructure that it's taking to do it doesn't justify the expense or the economic reward that the government has set up.

-ED SILVEY

implementing EMRs that will be compatible with EPIC so they can be integrated. "It's not out of my thought process, that 80% of South Louisiana could soon be on this, which is really kind of 'Star Wars' for South Louisiana," said Silvey. "I'm excited about it." He should be excited. With EPIC, once a patient has a record in the system, that is his or her unique record. That means that anyone else using EPIC sees and adds to that record. The avoidance of confusion, miscommunication, lost data, and reproduction of work alone, has to not only improve the community's healthcare, but also create cost savings.

Whether they are pursuing a shared savings model or not, local healthcare leaders are in agreement that there are plenty of savings to be had through better care coordination. "According to some of the experts out there who study this stuff for a living there's an estimated 30-50% of waste,

duplication, unnecessary services, in the system already," said Phenow. "Employers, who are the ultimate payers, don't want to contribute any more into this very inefficient, ineffective system. They feel it's time for the doctors, the hospitals, the health plans to step up and do this stuff. There's so much waste out there that I think there's years of fruit to be taken off of the ground."

Some of the most commonly cited areas for potential savings with coordinated, accountable care include:

- Eliminating duplication of services
- Improving the generic prescribing rate
- Reducing readmission rates
- Reducing emergency room visits
- Reducing supply sensitive care
- Improving chronic disease management to avoid hospital admissions/readmissions
- Improving wellness and prevention

Although there is consensus on the ways ACOs could improve healthcare and generate cost savings, there remain concerns about their viability. The model basically requires binding agreements between parties that have historically been at odds, particularly where reimbursement comes in. "The shared savings discussion is where you get the tough conversations," said Vath. "What we've committed to do with our community physician group is to bring in an outside consultant. Because the doctors don't want to listen to what the Lake thinks is a good way to share savings and the Lake doesn't necessarily want to listen to what the physicians think is fair, the best thing is to bring in a neutral party to provide some options for shared savings." Phenow agreed that getting all these people to convene and work together when they don't

have business relationships could be the real bugaboo. "The other thing is who's going to be the keeper of the purse? Is it going to be the hospitals, is it going to be the specialists, is it going to be the primary care physicians?" said Phenow. Silvey said for this to work, the different entities are going to have to learn how to play in the sandbox together. "I think so long as that is clear on the front end with providers then I think that becomes non-contentious," agreed Wasden. "I think if you create an ACO or a clinic integrated network that says for all savings that are created this is how it splits and everybody understands that, then that eliminates potential conflict."

ACOs will also have to have some sort of board that holds everybody accountable, said Vath. "We have a whole structure—of quality committee and rules that they follow. We've developed the whole structure even down to the level of if you don't meet the expected targets what happens."

Silvey believes that funding issues will prevent ACOs from taking flight until the federal government finds a way to help pay for the infrastructure changes that are required. "It's hard to ask the providers to go out and spend all this money on infrastructure when they don't know how they are going to get their investment back." He compared it to the slow acceptance of EMRs until the government offered to help pay for implementation. "That's what's going to have to happen if they want a change in the delivery system," said Silvey. "If it can be made simple enough, if it makes clinical sense and truly benefits the patient, I haven't found a provider that's digging in their heels. They want to do what's right. When they get frustrated



is when they get a 500 page document that makes no sense." Despite the improvements made in the final rules, Silvey does not believe there will be an additional rush to implement the CMS ACO model. However, the rules do provide a frame of reference as to where the healthcare delivery system is moving in the future, he said.

"I think there is agreement among my peers that the core concepts are moving in the right direction, but I think the problem is with our current forms of reimbursement," said Viator. "I think we all have to look at partnering with the payers so that we can move forward in a way that does change our reimbursement to incentivize the objectives we have for care of the community. Unless we get together with payers and work on how to bridge from the current system and what it incentivizes to the future state then that will probably be one of the biggest barriers to moving forward."

ACOs are a moving target, said Vath, because every time you turn around either CMS releases a new model to play under or an insurance company comes up with another way they might approach physicians and physician groups. "For us it's still a concept and we are trying to take it from a concept down to the detailed part of actually sitting down and forming say, a physician hospital organization." Silvey agreed that "ACO" is a generic term, but said it sends a message that the country wants a change in the delivery system and the payment system. "If someone asked us are you developing yourselves to fit the CMS definition of an ACO, our answer would be no. But if you ask if we are preparing for the eventual payment reform that is coming, the answer would be yes. Whether enough cost and

reward can be wrung out of the existing system to make it work, nobody knows."

Vath said he doesn't really believe you can financially incent providers to do the right thing, nor can you regulate reform of the delivery system. "All they are going to do is meet some regulatory standard and that's not doing the right thing. Ultimately that's why the CMS thing is ridiculous. They had the right idea, the right concept, then they put 439 pages of things you had to do, to basically regulate doing the right thing," he said. "They are going to have to regroup."

"I hate to say you've got to get on board with an accountable care organization or be left behind," said Viator. "Because that terminology is being thrown around to mean so many things. But I will say if you don't get on board with the concept of preventable care and the sharing of information technology so that decisions can be made by caregivers with a more complete set of information, then I think you will be at a deficit to move forward. We also expect the CMS model to evolve over time, so as long as we just take some of the core concepts and what makes sense for the patients and this community, I think we will end up evolving into a better system of care, regardless of what label you put on it." ■■■



Personally I think we could probably get very similar outcomes to ACOs by focusing on accountable, coordinated, collaborative care through some of the primary cares, some of the specialty cares.

—KENNETH PHENOW, MD

Sources: "Accountable Care Organizations: Improving Care Coordination for People with Medicare," <http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html>; "Everything You Need to Know About Accountable Care Organizations, American Academy of Family Physicians and TransformMed," http://www.transformed.com/accountable_care_organizations.cfm; Evans, Melanie, "Forging the Way," *Modern Healthcare*, Aug. 29, 2011; "The Family Physician's ACO Blueprint for Success," American Academy of Family Physicians, www.aafp.org.



Electronic Medical Records

Meaningful Use & Usability

BACKGROUND

The story of Electronic Medical Records (EMRs) in healthcare over the last decade is one of lengthy demos, webinars, “the future,” and down payments. And though EMR platforms may vary in their bells, whistles, and targeted specialties, there seems to be an ever-present general theme of frustration and hope that it will get better among provider users, management, and their staff. >>



Much has already been written on the EMR topics of promised efficiency and cultural challenge. Still, not enough can be said about the practical effect of these software platforms on a care delivery system. This is now a care delivery environment going through rapid transition and protocol change in an attempt to be able to prove Meaningful Use of an EMR platform. So, what does that mean actually?

The answer is that it depends on who you are talking to and in what context. The buzz phrase of Meaningful Use means very different things to the government, software developer, patient, and provider, but, whether or not Meaningful Use will translate into Usability is the story and challenge of the decade ahead.

THE GOVERNMENT

There is a great deal of published information about why Washington (and the States) wants EMRs. Their expressed goal is good communication across care continuums. Cost reductions, improved quality of care, promotion of evidence-based medicine, and recordkeeping mobility are just a sample of the many topics touted as opportunities provided by EMRs; the proviso being that having a patient's entire healthcare experience in an electronic format facilitates ease of communication, information exchange, eventual efficiency, producing a better outcome at lower cost, yielding a better overall healthcare delivery system...kind of like a Windows OS for healthcare. No offense Mac users.

Whether or not you agree with the government's care coordination formula of Streamlined Communication = Efficiency = A

Better Healthcare System, it is public policy and a commercial sector at this point. With roots in the U.S. Military, coordinating care goes back several decades with the Department of Veterans Affairs (VA) Hospital System. In fact, the VA's VistA system is one of the largest enterprise level care coordinating EMR platforms in practical use to date.

To help steer the role of EMRs in care coordination and information exchange, the U.S. Department of Health and Hospitals created the U.S. Office of the National Coordinator for Health Information Technology, also known as the ONC, in 2004 via Executive Order. It was later legislatively mandated by the Health Information and Technology for Economic and Clinical Health Act in 2009 (HITECH Act). The most significant building project of the ONC is The Nationwide Health Information Network (NwHIN), a development that will essentially "tie together health information exchanges, integrated delivery networks, pharmacies, government, labs, providers, payors, and other stakeholders into a 'network of networks'"¹...kind of sounds a little 1984-ish. Physician and public health expert Farzad Mostashari serves as the National Coordinator for Health Information Technology.

To help bolster the commercial proliferation of EMRs domestically, the HITECH Act has earmarked incentive payments for eligible Medicaid and Medicare providers who prove Meaningful Use of an EMR platform. If certain thresholds are met with regard to a provider's total patient population, those who are significant Medicaid or Medicare providers may receive up to \$63,750 over six years and \$44,000 over five years, respectively. In order



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MEANINGFUL USE

Core Requirements:

- 1 Use computerized order entry for medication orders.
- 2 Implement drug-drug, drug-allergy checks.
- 3 Generate and transmit permissible prescriptions electronically.
- 4 Record demographics.
- 5 Maintain an up-to-date problem list of current and active diagnoses.
- 6 Maintain active medication list.
- 7 Maintain active medication allergy list.
- 8 Record and chart changes in vital signs.
- 9 Record smoking status for patients 13 years old or older.
- 10 Implement one clinical decision support rule.
- 11 Report ambulatory quality measures to CMS or the States.
- 12 Provide patients with an electronic copy of their health information upon request.
- 13 Provide clinical summaries to patients for each office visit.
- 14 Capability to exchange key clinical information electronically among providers and patient authorized entities.
- 15 Protect electronic health information (privacy & security).

Menu Requirements:

- 1 Implement drug-formulary checks.
- 2 Incorporate clinical lab-test results into certified EHR as structured data.
- 3 Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
- 4 Send reminders to patients per patient preference for preventive/follow-up care.
- 5 Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies).
- 6 Use certified EHR to identify patient-specific education resources and provide to patient if appropriate.
- 7 Perform medication reconciliation as relevant.
- 8 Provide summary care record for transitions in care or referrals.
- 9 Capability to submit electronic data to immunization registries and actual submission.
- 10 Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission.

to receive any of these incentives, eligible providers and hospitals must demonstrate Meaningful Use as defined by the 15 Core Requirements; eligible providers must meet all 15 Core Requirements and hospitals just 14.² The second list of 10 Menu Requirements are for both providers and hospitals, who must, in addition to meeting their Core Requirements, demonstrate Meaningful Use of at least 5 of the standards with their EMR. (see sidebar)

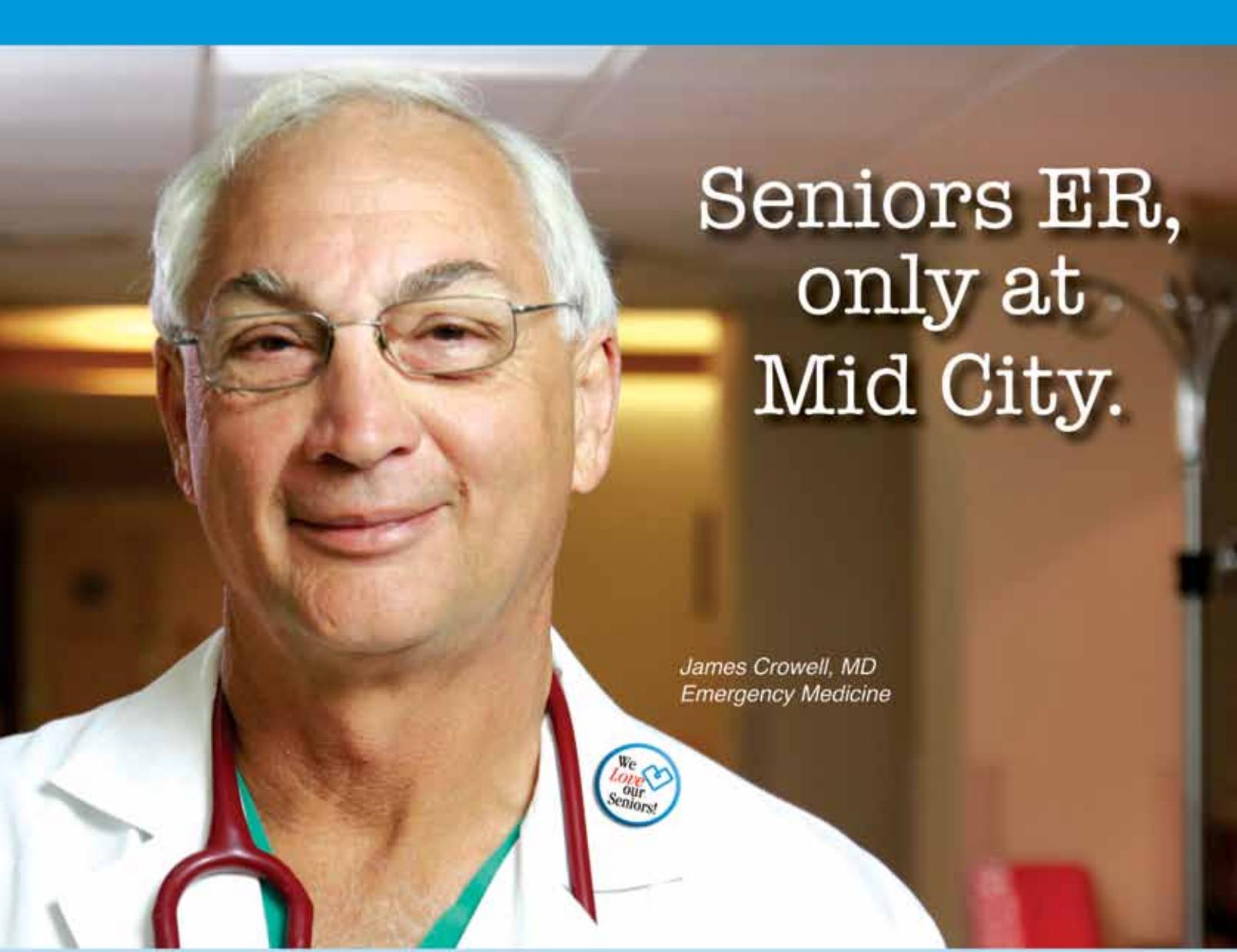
THE SOFTWARE DEVELOPER

What does Meaningful Use mean for the software developer in the context of their product? Really only two things: First, it is a guideline for the development of their platform (i.e., if their EMR app doesn't have the ability to deliver on all 25 measures, it's at a competitive disadvantage with other products); Second, Meaningful Use Certified has now become a slogan with which software companies market their platforms to providers, clinics, hospitals, etc. Most collateral marketing material contains emphatic statements about being CCHIT (Certification Commission for Health Information Technology) Certified and the bonus money available to those delivery systems that pull the trigger and purchase that EMR platform. In fact, if the software developer has any marketing ability whatsoever, one can usually find an amortized bonus schedule of the total incentive money available from the government directly underneath the Meaningful Use Certified and CCHIT marketing statements.

This is all fine and most credible software companies are deferring a substantial amount of their fees until providers or hospitals begin receiving their bonus money from the government. The only question is, what if the platform is so intrinsically difficult and cumbersome to the provider that, after they've signed a purchase agreement, developed an implementation team, jumped into training/using the EMR, experienced the initial culture shock, then listed out some of the dramatic changes that must take place in order for the thing to even work at a basic level, what happens then? The answer is that while the software company may have sold a Meaningful Use Certified platform with all the capabilities of meeting all Core and Menu requirements necessary to prove Meaningful Use, it doesn't mean the darn thing is Usable on a practical level. We'll revisit this later.

THE PATIENT

Let's say you're my doctor for a moment. How are you going to use my Electronic Medical Record in a way that's meaningful to



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me, the patient? I'm interested in customer service, outcomes, privacy, and portability. Does using an EMR PC, tablet, or iPad during the exam blow my hair back? Not really. It's cosmetic at best with the only lasting impression being that you, my doctor, are really, really, really, really tech savvy. Now, if I can get called back from the waiting room faster because I entered all my historical and demographic information into my EMR via a bank level secure web-portal, all of which gets consolidated to your iPad and throughout the course of the exam is used to visualize my progress (or lack thereof) in an attempt to demonstrate what's going on with me, then yes, it's awesome! If you're a specialist and I move to Seattle next week, it'll be meaningful if you can send the last four years of my care to my new doctor out West. Otherwise, it's not really super meaningful to me.

THE PROVIDER

So, now let's reverse it, let me play doctor for a moment with your EMR. Does using an EMR to assist in your care help me practice medicine in a way that's more meaningful? It all depends really, although, if a software program that's essentially medical chart centric drives medical decision making any more than a paper chart with the same history, maybe a little CME is in order for next year's budget. In truth, EMRs can be used meaningfully by providers, hospitals, and their staff to make a difference and provide better outcomes. Staff stop running around trying to find missing paper charts, physicians can pull up their schedules and review patient histories ahead of time, care coordination among specialists can occur in real time via desktop sharing applications, medical prescriptions can be emailed, and on and on.

The real issue at hand for the provider/hospital is different from the other three groups. It's not whether the EMR is Meaningful Use Certified, or whether I prove Meaningful Use by meeting all the requirements I have to, because all of that can be bought or done.

The status of things from a delivery system's point of view is undeniably how Usable is this EMR platform in clinic, on rounds, or any other circumstance that involves documenting care to a patient? Again, it all depends really.

Some providers are more facile with laptops, iPads, Galaxies (Samsung), PlayBooks (RIM), and TouchPads (HP) and can more quickly manipulate an EMR than other providers. I'm not

suggesting that usability of EMRs for providers is generationally correlated, but ask a 10-year-old today to go type a paper on a Tandy 1000 with 640K of memory and save it to a 3.5" floppy. It could be done, but it would be uncomfortable. The reverse is true for the provider today who's a couple years away from retirement. Give them an iPad and send them into an exam room. It could be done, but it wouldn't necessarily make that EMR more Usable for them.

CONCLUSION

Paper charts are about as done as Christmas lights on your neighbor's house in late May. They're over, finished! But, while an EMR platform can be proven to the government to be meaningful, sold by the vendor as certified, conceptualized by the patient as valuable, it doesn't necessarily mean Usable for the provider. In fact, sold as is with no change to paper chart protocols (i.e., entering histories, demographics, meds, etc., in the exam room), EMR hurts productivity while doing very little to improve outcomes.

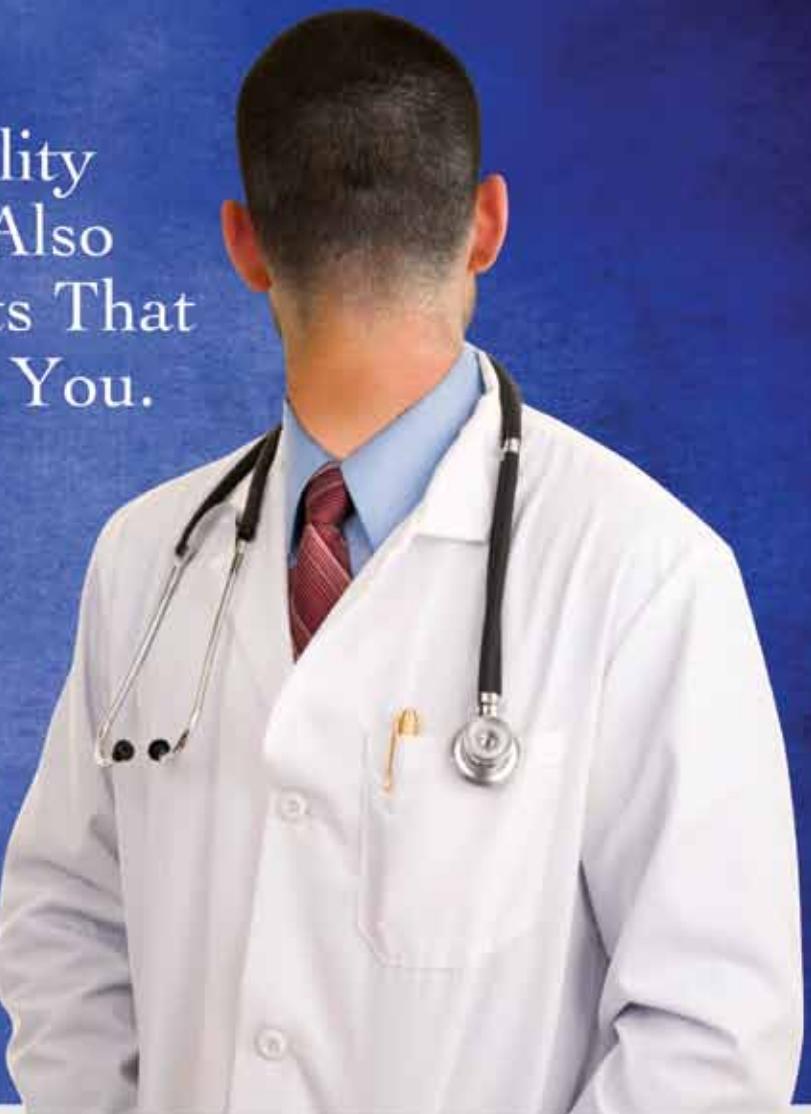
The future of medical charting has been legislated, developed, hyped, and sold, but using it to improve quality of care on a practical level is still a ways away. EMR Usability is an organic process that many delivery systems are working through. And by changing things like call center protocols, check-in procedures, and setting up waiting room terminals equipped with wizards for the patient to input some of their information, EMRs will become more and more Usable. Whether or not that translates into a better healthcare delivery system depends on who you are talking to and what "better" means to them.

BR

¹<http://www.nhinwatch.com/performSearch.cms?channelId=2>

²https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp

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IN HER ROLE as Assistant Vice President for Health Systems with the Louisiana State University System Dr. Townsend works with the system's 10 hospitals and their clinics in the development of operational strategies and system-wide policies. As part of this role, she is also serving in interim capacities as the CEO of the Interim LSU Public Hospital in New Orleans, Earl K. Long Medical Center in Baton Rouge, and as CEO of the LSU Health Care Services Division. Prior to joining LSU, in September of 2007, Dr. Townsend was appointed by Governor Blanco to serve as the Secretary for the Louisiana Department of Health and Hospitals (DHH). She also served DHH as the Medicaid Medical Director and Deputy Secretary, and Chief Operating Officer.

Dr. Townsend received a Bachelor of Science degree in Nursing from Duquesne University in Pittsburgh, Pennsylvania. Her nursing career was primarily spent in Humana Hospitals across the South. Prior to entering medical school, she was the Associate Executive Director/Nursing at Humana Hospital – Springhill, in Springhill, Louisiana. She received her medical degree from Louisiana State University School of Medicine in New Orleans. Upon completion of an Internal Medicine Residency at LSU/Earl K. Long Medical Center, Dr. Townsend remained at Earl K. Long as internal medicine faculty. Prior to moving to DHH, she became the Chief Operating Officer at Earl K. Long Medical Center and served as the Interim Chief Executive Officer. >>

One on One WITH **Roxane A. Townsend, MD**

CEO, LSU HEALTH CARE SERVICES DIVISION

It's been a journey.

SMITH W. HARTLEY: *First, can you clarify for us the status of this LSU facility?*

ROXANE TOWNSEND: This is the Interim LSU Public Hospital. Statutorily we are still funded under the Medical Center of Louisiana-New Orleans. We are the interim LSU Public Hospital really as a FEMA designation. A lot of that is because the whole reimbursement issue from FEMA was that they brought back an interim facility to serve us until we actually replaced Charity Hospital, which was destroyed. So the \$474 million that we received as an award from FEMA is to replace Charity Hospital, but by now they have probably spent upwards of \$100 million actually getting University Hospital campus up and ready for us to be able to run acute care services.

SWH: *How have LSU's services come back since Katrina?*

ROXANE TOWNSEND: It's been a journey. The sequence of events was we went from a ship, the USNS Comfort, to tents in the parking lot out here, to the Convention Center, to Lord & Taylor, actually running inpatient services with the trauma center at Elmwood. Finally in November, 2006, was when we were able to reopen this hospital. I think we started with about 60 beds. Today, between this hospital site and the DePaul campus, where we run 38 acute psych adult beds, we have 255 staffed beds. So all of our services that were going on pre-storm are actually back in some capacity, though not

necessarily full capacity. Before the storm we were running over 500 beds between the two campuses.

So services have come back, but we are not where we need to be. I'm running about 85 to 90% occupancy with a lot of overflow. Things that I am short of—my ICU beds are constantly short; we have 38 ICU beds. We have a beautiful trauma ICU that was replaced after the storm. FEMA helped us build that out. We have our medical ICU and we frequently have ICU patients holding either in the emergency room or in the recovery room. The other place I really don't have enough beds is Psych. Adult psych beds stay full all the time.

The other thing I think is exciting is that since we've been back we have re-established our Joint Commission accreditation. There were no significant findings. We were last accredited in February, 2010. Our Level 1 Trauma Center has been verified by the American College of Surgeons Committee on Trauma. We actually just went through another re-verification and we are just waiting on the letter for that. And we just went through a Joint Commission Stroke Certification and we are anticipating a positive outcome. So the services have come back and a lot of them have come back just as strong or even stronger. We are very proud of that. Essentially we put Humpty Dumpty back together again. That's really what it felt like.

And it's one of the things where we often got criticized because several years ago our costs were so high and we had



so many employees, but we didn't know what it was going to take to do this and it certainly took tons and tons of people; way more than you could justify for the number of patients. Finally in 2009 we started to reach some equilibrium. That's when we brought Alvarez & Marsal in. We let them look at our operation, kind of to get a third party look from someone independent, and they really helped us say, "Yeah, this is how many people you probably need now to take care of these patients."

It took a long time for people in New Orleans to be willing to get out of crisis mode. With this event I think it is really unfair for the national media to take potshots at New Orleans because unless you've been through it...the people down here lived through some amazing times and I think have shown tremendous resiliency. So the fact that we are back and strong and getting better than ever is a real testimony to the people down here.

SWH: *What's the status of the University Medical Center since its groundbreaking in April?*



A glimpse of LSU's planned University Medical Center through architectural renderings.

ROXANE TOWNSEND: The exciting part is we have broken ground and actually started construction. In September we went to the Joint Budget Committee and got the approval to actually begin. Up until now our site preparation had been going on, but we couldn't get into any vertical construction. But they've driven test piles and if you look at the site today, it's essentially cleared. In November we moved the school off of this site, because it was actually in the footprint of the diagnostic treatment building. That was a huge undertaking. They used the same kind of technology that they used to move the shuttle. It took them about three days to move it from the center of the site to the corner of Galvez and Tulane.

If you look on the site you might see what looks like a thousand of these little orange flags and those are where the wicking is actually going to take place. They brought in about five feet of dirt to overlay the site and they are doing compression. That compression would normally take a couple of years, but they have this wicking process that they do where they literally stick wicks down and hundreds of gallons of water a day will be wicked off

the site and go into the sewage system to actually compress the area. They are expecting about 30 inches of compression on the site. Then they will be ready to drive upwards of 6000 pilings to circle the structure. So the construction is moving and we anticipate they will be finished in late November of 2014. We will actually start operating the new facility in spring, 2015.

SWH: *Can you clarify how the funding is going to work? Is there anything that is still in negotiation?*

ROXANE TOWNSEND: Well, we have the \$300 million commitment from the State. We have the \$474 million that was awarded from FEMA for the replacement of Charity Hospital. Right now there are some negotiations that aren't finalized yet for contents of some of the other buildings, because there were multiple buildings that were actually destroyed...not just Charity Hospital. And that could be upwards of another \$150 million that we may receive from FEMA for the contents that would go towards the construction. The balance of the funds for the ambulatory care building and the parking garage—that commitment is being made by the LSU Foundation. They are going to do a third party financing to complete that piece of the project.

SWH: *Could you characterize the joint venture with the VA and how the two entities are going to work in collaboration with each other?*

ROXANE TOWNSEND: Well, we are still working with the VA. Part of our issue with the VA has been the uncertainty of our timeline because the VA has had their money in place and had all their

approvals really for several years. With us just getting our approval in September they have had to move along because of their need to get services back online for the veterans. So some of the things we thought perhaps at the beginning we would be able to do with the VA we realize now that it's impossible for us to do.

The original thought was that we would actually build a joint facility. We would have a shared core and then perhaps have two patient towers—one for the VA and one for LSU. But what we have realized is that 9-11 really changed our world. So now it's necessary for the federal government to build really to terrorist specifications. While we're concerned about hurricane hardening and things like that, they have to think about terrorist threats. So their cost of construction is astronomic. For us to build to that same level of threat we wouldn't have been able to afford it. So that's why we are on two separate sites, but we do plan to share a lot of activity. They can't afford sometimes to do some things because of the cost of the specialists so they are going to be doing all their radiation oncology with us. Things like linear accelerators. We are working with them to try to jointly purchase them to put in our facility so that our specialists can take care of the veterans there. We will share women's services. We will share a lot of medical staff because it makes sense, since we are across the street from each other, that if you've got a doctor on call for ICU there's no reason they can't cover the ICU for the VA as well as our hospital. So we'll have a lot of physicians going back and forth—a lot of joint training going on with our Tulane and LSU residents being both at the UMC and at the VA.

SWH: *So the timeline for UMC is still on track?*

ROXANE TOWNSEND: In October they got the contract signed with Skanska/MAPP, the construction manager at risk. What they've done is come up with some pretty unique ways to try to keep things on track. If you are looking at the site on the corner of Canal and Galvez there is an old warehouse building and within that warehouse building they are going to build the mockups of the new ORs and all those things so we can use it for training and for physicians and staff to get in there and say, "Yeah this works, this doesn't work." And we will be using it for recruiting in the future. The other piece of that though, is they are actually going to do some of the construction in sections because the place is massive. I think at the end of the day it's about 2 million square feet. So they are breaking up the projects into much smaller contracts for multiple reasons: to allow more people locally to bid, because it would be very hard to be bonded on some of these really big contracts that could have gone

out; but they are also going to allow space so that things like the ductwork can be done in 20 foot sections. They'll build it there and then bring it over to the facility and just set it in. They'll do that with the bathrooms and things like that. It allows them to do things without the weather being a factor. So they are doing lots of things to make sure they stay on track. They are pushing.

SWH: *LSU is going to be relying significantly on private pay patients, which you haven't done in the past. Is this critical to LSU's success and how do you think that's going to impact some of the other local hospitals?*

ROXANE TOWNSEND: We certainly are planning for that. Our business plan calls for additional private pay patients. It's not a significant increase—perhaps about a 10% increase overall. As for the effect on other hospitals, we actually think because most of the programs we are talking about are destination programs, those patients don't necessarily come out of the population here. And as New Orleans continues to come back and the population continues to grow, and looking forward to 2014 if we actually have an expansion of Medicaid, if all that happens, there's going to be much more business in all of the hospitals. So there's no anticipation that there's going to be any sort of negative impact for the surrounding hospitals in this plan. It probably means that we would start to be looked at more like a Birmingham or a Houston and be a destination city for healthcare. So actually it's likely that everyone will benefit as we get better known, as the biomedical corridor grows, and you have more innovation and things happening.

LSU right now is unable to house their specialty programs in our current facility. It's simply too small...we can't get other patients in here. We can't get all of the population we are supposed to serve in. So when you expand beds and you allow the LSU physicians to actually practice in one area they are really excited about the opportunity. Because there are specialties, like our ENT program—they do skull-based surgery—they are world-renowned. They have patients from all over the country, all over the world, come in to have those special procedures done. They really like to be able to collaborate with the plastic surgeons, with the neurosurgeons, and it's more difficult whenever your neurosurgery program is in one place and your ENT program is in another and ortho is spread out. So all of them get very excited when you talk about, "You can all be in one place at one time. You can schedule these complicated surgeries and take care of those patients that are more of a challenge to take care of today." So it's a huge opportunity for us.



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“So the services have come back and a lot of them have come back just as strong or even stronger. We are very proud of that. **Essentially we put Humpty Dumpty back together again.**”

SWH: *One of the ongoing concerns is should the LSU system receive State funding for a hospital that's going to compete for private pay patients? But you don't anticipate an adverse effect on other facilities?*

ROXANE TOWNSEND: No. I don't think it's going to adversely affect them at all. I will say people like to make something out of LSU being paid by the State, but we don't get a subsidy from the State. There is not some pot of money that is sitting there supporting the hospitals. The State has chosen to pay LSU to take care of the uninsured citizens of Louisiana. So by statute, we have to provide free care to any Louisiana citizen who lives at less than 200% Federal poverty level. Well, as you know, free care is not free. Someone has to pay for the cost of that care because my employees at LSU hospitals, just like the employees at Ochsner and Tulane and everyplace else, expect to be paid every two weeks or every month.

So at the end of the day what the State has decided to do is pay for those services in the LSU hospitals and we are required to not bill patients who live at that level. The truth is, as you know, everyone receives state funding and federal funding, every healthcare institution. About 70% of healthcare in the country is actually paid for with taxpayer dollars. So as a state agency it is necessary for the State to cover the cost within the state agency. So we don't have the huge commercial population that is getting paid reserves. We don't hold reserves. We don't have the same situation; we are different. And as much as people would like to treat the LSU hospitals as

though they are exactly the same as the rest of the healthcare institutions, the truth is we are different and it's very difficult. None of the other hospitals in the state could survive if they had the same payer mix as we have. Fifty percent of the patients we take care of have no insurance. Thirty percent of them are Medicaid patients that are cost-based.

SWH: *Does the model change at all with reform if everybody's mandated to have insurance?*

ROXANE TOWNSEND: I think what's going to happen if everyone is mandated to have insurance is we may have some more patients that have Blue Cross or other third party payers, but I think the bulk of that expansion is going to be in the Medicaid world. And Medicaid basically for us covers the cost. If you are only covering the cost of that percent of the population even if that 50% that is currently uninsured gets Medicaid, for us it's still cost-based. Because with the 50% uninsured if you get paid with DSH (Disproportionate Share Hospital program funds) it only covers the cost. So there is not a profit to be made there. So if 80% of your business is cost-based today and 80% in the future is cost-based, the only difference and the advantage for us would be that the Disproportionate Share Hospital Program, which covers the uninsured today, doesn't cover physician costs, which is interesting. You don't get paid for physicians who are actually taking care of those patients, but the hospital costs get covered. But in Medicaid there is actually a physician portion that can be paid. So for us that will change the model a little bit.

SWH: *LSU-New Orleans doesn't do maternity services right now. Will you resume when the UMC opens?*

ROXANE TOWNSEND: No. We stopped doing obstetrics and nursery in August, 2010. It was for several reasons, but mainly that our volume was not high enough so that it really supported the residency training programs. So LSU moved their deliveries to Touro and Tulane already had Tulane Lakeside, where they were doing maternal child health, and they were able to move their program over there. The current plans for the University Medical Center are not to do obstetric services in that hospital. It's consistent with a model many university medical centers are using these days because often they will affiliate with a woman's hospital or do their maternal services someplace else. We will still do gynecological services, GYN oncology, and things like that.

SWH: *What's going to happen to the old Charity facility?*

ROXANE TOWNSEND: Well, we don't know. There is planning being done. Part of the programmatic agreement that we have identifies funding to help repurpose that facility. I understand that Facility Planning has had some meetings with developers so there will be a reuse for that facility, but it just won't be used as an acute health care hospital.

SWH: *Tell us about the New Orleans Biomedical District being created here. Can you characterize what that will look like?*

ROXANE TOWNSEND: I recently had a chance to tour the BioInnovation Center and it is a fantastic building. The Louisiana Economic Development group helped get it started. Apparently there was legislation passed in 2002 that actually enabled this. They had been open for about four months and they were about 40 percent occupied already. It's an incubator for bioinnovation. That's located on Canal on the other side of the interstate down toward the river.

But the concept is that this entire corridor will provide healthcare, but not just healthcare, but also be an area where research is encouraged, where folks that are selling medical equipment and things like that will have a place to be centered. Part of it is the new cancer research building that is very close to being occupied right down here on the corner of Tulane and close to South Roman. So this entire corridor right now is really looking great for kind of the broader scope of the healthcare industry from bench research, to taking medical devices to market, to being able to actually use those things and take care of patients.

SWH: *What is the UMC project going to mean economically to this area?*

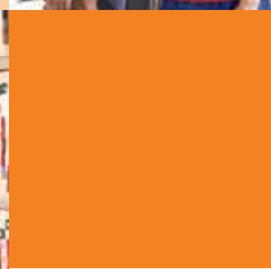
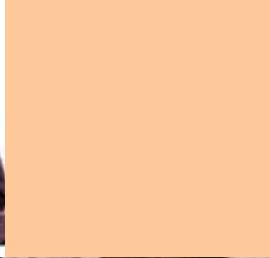
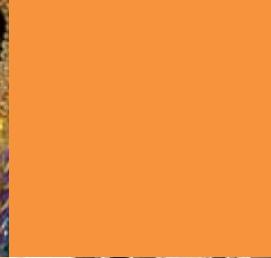
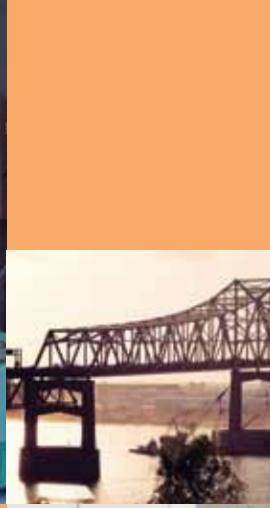
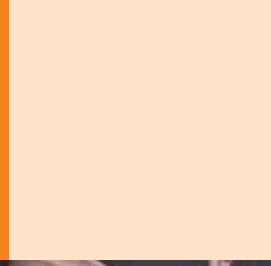
ROXANE TOWNSEND: Well even right now, I think Skanska is going to have at least 100 people in the project management office who are essentially going to be down here for the next several years, so they are occupying apartments, they are living in this city. Then you have all the construction jobs that are going on and one of the things I've seen is there are condos that have just gone up about a block away on Claiborne in the old Falstaff brewery in anticipation of the project. I think what you are going to see is now that we've gotten our go ahead from the State, I think there were a lot of people kind of sitting on property waiting to see if this was really going to happen. You know that there are going to be staff members, physicians, there are going to be all sorts of people that are going to need housing, that are going to be using restaurants, that are going to be buying goods. There actually has been an anticipated economic impact created. It's a tremendous impact to the city. It's about \$2 billion in construction between LSU and the VA.

It's huge for this city and it's big for the state. This is a big deal for Louisiana and I think one of the things people sometimes forget is that when you have a medical school that's training the physicians that work in your state and they stay close to home and you have access to that caliber of care, that's really important for our state. Then we provide a lot of the specialty services. We have ten LSU hospitals, but you can't have ten topnotch neurosurgery programs and you can't have ten topnotch ortho programs, but we are fortunate because we have Shreveport and New Orleans and we can refer people to those specialists so they don't have to go out of state. They do right now, but they don't have to.

SWH: *What about you personally? Are you going to be here overseeing this through the end?*

ROXANE TOWNSEND: I'm here as long as they need me.





HEALTHCARE BRIEFS

STATE

Bayou Health Kicks Off

In December Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein was joined in Mandeville by health care advocates and providers, Health Plan representatives, and Medicaid and LaCHIP recipients to kick off the first day of BAYOU HEALTH enrollment for Northshore and New Orleans Area residents. The four-parish New Orleans and five-parish Northshore areas known as Geographic Service Area A goes live on Feb. 1.

Earlier in the month, DHH announced that all five Health Plans contracted to manage care under the BAYOU HEALTH program had passed their operational and systems readiness review, and each has been certified as having an adequate provider network in the first region of the state to roll out BAYOU HEALTH. The reviews examined each Plan's ability to handle everything from case management and claims payments, where applicable, to member grievances and fraud prevention.

In addition, the Centers for Medicare and Medicaid Services (CMS) has given the green light to the state's program. Traditionally, the

federal government handles, on average, about two-thirds the cost of Medicaid, while the state picks up the rest. Any changes to the delivery system must be submitted as an amendment to the State Plan that outlines how it operates Medicaid.

To learn more about BAYOU HEALTH and see a Health Plan comparison chart, visit www.bayouhealth.com.

PAR: Increased Oversight for CCNs Needed

In December, the Public Affairs Research Council of Louisiana (PAR) released a report examining the state's new healthcare privatization initiative. The report, "Checkup on Bayou Health Reform: What Louisiana Needs to Know About Medicaid Managed Care Privatization," calls for increased legislative oversight of the program and recommends increased public education and discussion about the state's Coordinated Care Network (CCN) approach.

"The key public policy issue at this juncture is the need for effective oversight, accountability, and program authority, especially given the public dollars involved and the impact on citizens," states the report, noting the administration's decision to resist

a strong legislative oversight function and to proceed with statewide implementation without the benefit of a pilot program.

PAR notes that after 30 years of Medicaid managed care and despite repeated studies, there is no consensus on whether it saves money or improves quality. "The uncertainty surrounding managed care in general and CCNs in particular should alert the state to the need for strong oversight of every phase of the program."

You can read the full report at http://www.la-par.org/Publications/PDF/PAR_HealthcareReport.pdf.

LA Providers Committed to EHRs

At the ONC Annual Meeting in Washington, D.C., the Office of the National Coordinator for Health Information Technology (ONC) announced that the network of 62 Health IT Regional Extension Centers (RECs) achieved one of its first major milestones – gaining commitments from more than 100,000 primary care providers (PCPs) to adopt electronic health records in a meaningful way. As part of the network of RECs, the Louisiana Health Information Technology (LHIT) Resource Center has enrolled 1,072 primary care providers in Louisiana to date. Representing

roughly one-third of all PCPs in the U.S., these 100,000+ providers are building the foundation of a fully-electronic health care system.

The LHIT Resource Center, administered by the Louisiana Health Care Quality Forum, provides technical assistance, guidance, and information to support and accelerate health care providers' efforts to adopt and meaningfully use EHRs in our state.

For more information about the LHIT Resource Center services and the Quality Forum, please visit www.lhcqf.org.

Children's Hospital Earns CARF Accreditation

Children's Hospital in New Orleans announced that the Commission on Accreditation of Rehabilitation Facilities (CARF) has granted a three-year accreditation to the hospital's Rehabilitation Program. CARF officially recognizes health and human service providers as having met standards for quality of service. The accreditation process applies sets of standards to service areas and business practices during an on-site survey. Rehabilitation programs earning CARF accreditation are recognized for their ongoing innovation and continued conformance to the standards of performance.



HHS Expands Senior Medicare Patrol Funding

The U.S. Department of Health and Human Services (HHS) recently awarded \$9 million from the Centers for Medicare & Medicaid Services (CMS) to help Senior Medicare Patrol (SMP) programs across the nation continue their work fighting Medicare fraud. The Louisiana SMP, operated by eQHealth Solutions, was awarded \$350,000 to strengthen the effort in Louisiana.

The 2011 grants will provide additional funds for SMPs to increase awareness among Medicare beneficiaries about how to prevent, detect, and report health care fraud. Julie Mickles Agan, Louisiana SMP Manager for eQHealth Solutions, said her volunteers have already referred 81 cases to the CMS and the Office of the Inspector General for the Department of Health and Human Services.

For more information about fighting Medicare fraud in Louisiana, go to www.stopmedicarefraudla.org.

DHH Forecasts Medicaid Deficit

The Louisiana Department of Health and Hospitals' first forecast for Medicaid spending for SFY 2011-12 projected a \$126.7 million state funding deficit, the entirety of which will be addressed through a series of funding adjustments, management tools, and initiatives to slow the growth of certain programs. The plan does not include provider rate cuts or reductions in existing services. The funding shortfall represents about 5 percent of state funding in the Medicaid program. To address the deficit, Medicaid is implementing several measures:

- Recoup money from CommunityCare 2.0 providers who failed to make a good faith effort to attain national certification after receiving payment for doing so
- Implement strategies to manage prior authorizations in the Mental Health Rehab program as the Louisiana Behavioral Health Partnership is phased in

Linsey Rogers of Chauvin, La. works with Physical Therapist Lori Boyter at Children's Hospital.

- Employ means of financing adjustments related to expenditures of the Deficit Reduction Act and ARRA-related expenses
- Use funds associated with the LSU DSH audit rule as authorized by the Legislature
- Use federal match from cost reports as certified match.

Additionally, the Department will work with recipients, stakeholders, advocates and providers to identify an additional \$3.4 million (about 2.6 percent of the total deficit) of savings in the Waiver programs.

Ochsner CEO Named To HealthLeaders 20 List

Dr. Patrick J. Quinlan, CEO of Ochsner Health System, has been named one of 20 leaders identified by *HealthLeaders Magazine* as playing a crucial role in making the healthcare industry better. The magazine annually selects 20 individuals across the country as its "HealthLeaders 20."

Quinlan's profile highlights Ochsner's Change the Kids, Change the Future™ program which is an integrated approach in area schools that encompasses education and lifestyle changes for students, staff, and families to improve the health of the next generation. The program focuses on nutrition, exercise, and healthy eating habits, all of which set the stage for children's ongoing behavior.

Welch is New North Oaks VP/Clinical Services

Shelly Welch has joined North Oaks Health System as Vice President of Clinical Services and Director of Nursing for North Oaks Medical Center in Hammond. With more than 10 years of executive and administrative nursing leadership experience, Welch comes to North Oaks from CHRISTUS St. Patrick Hospital in Lake Charles, where she served as assistant administrator and, most recently, chief nursing officer.

Welch has earned Nursing Executive Advanced-Board Certification and is a member of the American Organization of Nurse Executives. She earned a master's degree in business administration with a health care management emphasis from Regis University in

Denver, Colo. and obtained a bachelor's degree in nursing from McNeese State University in Lake Charles.

LHCQF Calls For Subject Matter Experts

Since 2007, the Louisiana Health Care Quality Forum has drawn its strength from hundreds of volunteer stakeholders – providers, payers, purchasers, and consumers. As a result of this collaboration, the organization has emerged as the neutral convener, bringing people and organizations together for the shared purpose of improving individual health and the overall health of Louisiana's residents.

As the Quality Forum continues to mature, they are looking for individuals who would like to share their expertise to help the forum advance innovative and progressive health care initiatives in Louisiana. If you are interested, please visit the Quality Forum website and click the Subject Matter Experts button on the right side of the homepage. It will bring you to a sign-up page with a short form to complete and submit regarding your areas of interest.

If you need more information, please contact Linda Morgan, Marketing and Communications Director, at lmorgan@lhcf.org.

LA FQHCs Receive Funding

Under the Affordable Care Act, 500 community health centers in 44 states across the country will receive approximately \$42 million over three years to improve the coordination and quality of care they deliver to people with Medicare and other patients. Under this Advanced Primary Care Practice demonstration Medicare will pay community health centers based on the quality of care they deliver. Five centers in Louisiana, located in Abbeville, Clinton, Greenville, Shreveport, and Sicily Island, will be participating. This improved payment system will reward clinics for such things as helping patients manage chronic conditions like diabetes or high blood pressure. In addition, health centers will use this funding to expand their hours, make same day appointments and accommodate

patients with urgent care needs.

More information on the Advanced Primary Care Practice demonstration project, can be found at <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/fqhc/>.

New Leaf Psychiatry & Counseling Center Opens in Livingston

The New Leaf Psychiatry & Counseling Center at North Oaks-Livingston Parish Medical Complex opened to patient care in December. The center, located at 17199 Spring Ranch Road in Livingston at I-12 Exit 19, is staffed by Psychiatrist Michelle Barnum, MD, who is certified by the American Board of Psychiatry and Neurology and has more than 20 years of practice experience.

A second location of New Leaf Psychiatry & Counseling Center is expected to open in Hammond in early 2012 in the North Oaks Clinic Building on the North Oaks Medical Center campus.

Louisiana Citizens Challenged to Combat Obesity

Health care leaders from across the state gathered recently at the Pennington Biomedical Research Center to announce new health outcomes goals, steps being taken to address obesity in Louisiana, and to issue a challenge to the people of Louisiana to eat healthier and exercise more.

The announcement was made in conjunction with a release of the Pennington Biomedical Research Center's annual report, "Louisiana's Report Card on Physical Activity and Health for Children and Youth." Instead of releasing a letter grade, this year's report takes a new approach by establishing baseline data for each of the key 19 obesity indicators that Pennington tracks and then setting specific statewide targets for improvement in each indicator by 2020.

The data and targets in the 2011 "Louisiana's Report Card on Physical Activity and Health for Children and Youth" are specific to the population of children and youth in Louisiana and take a more aggressive approach



CLOCKWISE FROM TOP LEFT: Patrick J. Quinlan, MD; Shelly Welch; Tracy Randazzo; and Michelle Barnum, MD.

than the national objectives. The report calls for a 20 percent improvement in physical traits such as obesity and physical fitness, and a 40 percent improvement in modifiable behaviors such as physical activity and nutrition by 2020.

For a copy of the Report Card summary and the full research report, go to www.pbrc.edu or www.louisianareportcard.org.

Randazzo Joins North Oaks Health System

Tracy Randazzo has joined North Oaks Health System as Vice President of Business Development. She will lead the development, implementation, and management of all strategies to meet the communities' health care needs, communication plans to key audiences, and customer support strategies.

With more than 30 years of health care experience, Randazzo comes to North Oaks from Thomson Reuters, where she served as a consulting manager with the health care division's Strategy and Change consulting practice. Prior to her association with Thomson Reuters, she served as Director of Health Care Quality for the Texas Hospital Association, and also has held positions in the insurance and managed care industries.

Access to Oral Health Care Increased for At-Risk Kids

Effective Dec. 1st, the Louisiana Medicaid Program began reimbursing physicians for applying fluoride varnish twice each year to the teeth of Medicaid recipients between 6 months and 5 years of age. Previously, Medicaid only covered this service when performed by a dental provider. The aim is to apply the fluoride earlier in a child's life rather than wait until the first time he/she visits a dentist.

With the implementation of the updated fluoridation varnish policy, physicians, nurse practitioners, physician assistants, registered nurses, and licensed practical nurses will now be reimbursed for applying fluoride varnish.

LHCQF Selects Arcadia Solutions for Quality Project

The Louisiana Health Care Quality Forum has selected Arcadia Solutions, a leader in data-driven health IT services, to provide the organization with health care quality improvement support. The Forum will work with Arcadia to identify and define a statewide Quality Improvement and Quality Measurement methodology to accelerate implementation of these initiatives. This methodology will also integrate the accomplishments of the Forum's health IT initiatives: the Louisiana Health Information Technology Resource Center (regional extension center) and LaHIE (health information exchange). In addition, Arcadia will define the health IT tools necessary to improve the quality of health care safety and value to the state's residents.

Children's Hospital Receives Funding for Innovative Research

The Research Institute for Children at Children's Hospital has received funding through Grand Challenges Explorations, an initiative created by the Bill & Melinda Gates Foundation that enables researchers worldwide to test unorthodox ideas that address persistent health and development challenges. Principal Investigator Professor Seth Pincus, MD will pursue an innovative global health research project, titled Depletion of CD45RO+

Cells to Eliminate the Latent Reservoir of HIV.

Dr. Pincus proposes to eradicate HIV from patients by using antibodies to eliminate the memory lymphocytes that harbor the reservoir of latent HIV, which is resistant to antiretroviral therapy. The approach will be tested in a macaque model of latent HIV infection.

LSMS/LSU Study Details Lack of EMR Adoption

Despite potential incentives and penalties as dictated by the American Recovery and Reinvestment Act, or ARRA, which are dependent on a physician's willingness to use Electronic Medical Record (EMR) technology, the medical community is still hesitant to adopt EMRs, according to a newly published study by Drs. Andrew Schwarz, PhD, and Colleen Schwarz, PhD. Both are professors at Louisiana State University's E. J. Ourso College of Business and the Center for Computation and Technology. The report, a joint study between the Louisiana State Medical Society and LSU, is titled "Findings on the Non-Adoption of EMR Technology Among Physicians in Louisiana."

"In our review of the current discourse over EMR, we saw an alarming trend - an attempt to blame the doctors. In our research, we call this 'pro-innovation bias' - blaming the individual not adopting the technology instead of taking a critical view of the technology itself," said Andrew Schwarz. "We wanted to uncover what was really going on with EMR from the perspective of the doctor, with our approach being physician-centric. In the case of the medical community, we have a marketplace where the consumers of the EMR technology (i.e. the physicians) have little to no control over their pricing structure and are being forced to adopt a technology from vendors operating in a free market."

In phase one of the study, the researchers conducted 15 face-to-face interviews with physicians across the state who had not adopted an EMR. They also interviewed four other physicians who were either users of EMR or experts on the matter. From those interviews, they came up with 31 factors that were cited as reasons for the non-adoption of EMR technology. Those led to phase two

of the study, which was the development and distribution of a web-based survey that went to members of the Louisiana State Medical Society. The 594 physicians who completed the survey were practicing physicians, retired physicians, and medical students/residents from across the state and represented a variety of specialties. Respondents were almost split evenly, with 50.4 percent being adopters and 49.6 percent being nonadopters. Non-adopters of EMR technology had six over-arching concerns with EMRs:

- Negative views of EMR technology
- A lack of impact on their performance as a physician
- Negative views of the EMR marketplace
- Initial and long-term implementation concerns, i.e., cost and re-training
- Institutional distrust, including distrust of the federal and state government and insurance companies
- security and legal concerns.

"There is no demonstrable link between EMR deployments, meaningful use, and quality of care outcomes," concluded Shwarz. "Rather than taking our time and setting a national strategy, stimulus money and incentive pressure is being put on physicians to adopt questionable technology that is not proven to result in the outcomes that we hope to achieve."

To view the entire report, visit www.lsms.org/EMRstudy.

Ochsner Among Top Organ Transplant Centers

HealthGrades, a national independent ratings organization, has recognized Ochsner Clinic Foundation's liver transplant program as among the best in the nation. Of the 111 hospitals performing liver transplant procedures, Ochsner is one of only seven hospitals nationwide to receive the Liver Transplant Excellence Award, and the only hospital in Louisiana to receive this distinction for 2012.

Across the four transplant areas included in the HealthGrades assessment (heart, liver, kidney, and lung) Ochsner is one of only 20 hospitals nationwide to receive a 2012 HealthGrades Transplant Excellence Award.

Improving Health Care in Louisiana Through Health Information Technology

LaHIE enables health care providers and organizations to electronically access and share health-related information.

A secure and confidential network enhances quality of care, patient safety and health outcomes. Timely, safe and reliable access to information supports Patient-centered care. LaHIE resources can lead to improved coordination, quality and efficiency in health care for you and your patients.

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The Louisiana Health Care Quality Forum is a private, not-for-profit organization that is building and supporting the Louisiana Health Information Exchange, or LaHIE.

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The new Ochsner Health Center-Central opened in November.

LOCAL

Ochsner Opens New Central Clinic

In November Ochsner celebrated the opening of the \$2.2 million Ochsner Health Center - Central at 11424 Sullivan Road.

The expanded clinic, which is located in Central Park Professional Plaza, features:

- 7,500 square feet
- 12 exam rooms
- Laboratory services
- Imaging services including x-ray

With this expansion, Ochsner will now provide more specialty services and pediatric care in addition to adult primary care. The following Ochsner physicians will be available at Ochsner Health Center - Central: Keith Holmes, MD (Internal Medicine); Kenneth Gaddis, MD (Neurology); Lei Gao, MD (Cardiology); Gregory Gaspard, MD (Gastroenterology); Lois Gesn, MD (Pediatrics); Alicia Kober, MD (Pediatrics); and Salvador Velazquez, MD (Cardiology).

BCBSLA Joins Hero Health Hire

Blue Cross and Blue Shield of Louisiana has joined Hero Health Hire, a coalition of companies and other entities in the healthcare industry that are united with the goal of employing disabled veterans. Launched in Washington, D.C., Hero Health Hire includes companies, associations, and hospitals from across the spectrum of healthcare that collectively employ thousands of people. Each has committed to working to help veterans find and retain jobs in healthcare.

The healthcare industry - including insurers,

health plans, pharmaceutical companies, device manufacturers, and hospital networks - is considered the fastest-growing industry in our economy, requiring talented individuals to help meet multi-generational healthcare needs. The industry is also uniquely positioned to understand and support the needs of the nation's wounded warriors. Hero Health Hire unites the healthcare industry with government agencies and the military to understand and eliminate the barriers to employment facing wounded warriors, as well as developing ways to support them in their transition.

For more information about the initiative, including resources for disabled veterans and information on joining the Hero Health Hire program, visit www.HeroHealthHire.com.

Newhauser to Head MBP-LSU Partnership

Kenneth R. Hogstrom, PhD, longtime leader of the medical physics partnership between LSU and Mary Bird Perkins Cancer Center, recently retired after playing a pivotal role in its development and expansion. Wayne Newhauser, PhD, one of the world's leading medical physics scholars in proton therapy physics, has been appointed as Hogstrom's successor.

The academic medical physics program is an applied physics program within the LSU College of Science. The partnership leverages Mary Bird Perkins' clinical team and facilities, treatment planning and dosimetry laboratories, and commitment to patients as well as LSU's expertise in imaging and medical physics within LSU's Department of

Physics and Astronomy. This combination of resources improves patient care, provides a rich arena for medical research, and provides much needed manpower in this highly-specialized field for Louisiana and the nation.

A board certified and licensed medical physicist, Newhauser earned degrees in nuclear engineering and medical physics from the University of Wisconsin. He worked at the German National Standards Laboratory (PTB), the Harvard Medical School and Massachusetts General Hospital, and The University of Texas MD Anderson Cancer Center at Houston. Dr. Newhauser has published more than 80 peer-reviewed journal articles, leads federal research grants, and mentors students and post-doctoral fellows. He also serves in leadership roles of the American Association of Physicists in Medicine and the American Nuclear Society.

OLOL College/BRCC Work on Transitions

Our Lady of the Lake College has entered into a formal articulation agreement with Baton Rouge Community College (BRCC) to allow graduates of BRCC who have received an Associate of Science in Nursing (ASN) to enroll seamlessly into the Bachelor of Science in Nursing (BSN) program at OLOL College.

Trends in healthcare show that medical facilities are increasingly interested in hiring RNs who hold a Bachelor of Science in Nursing. According to a 2008 Robert Wood Johnson Foundation/Institute of Medicine report "nurses should achieve higher levels of education and training to respond to increasing demands...patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care."

Peak Into Dutchtown

Peak Performance Physical Therapy recently completed construction and opened its newest Ascension Parish location just off Hwy 73, next door to Dutchtown High School. The

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ABOVE: Members of Go Red for Women's Red Tie Society and Circle of Red show their colors.

brand new building houses a large area for physical therapy, a special clinic for hand injury rehabilitation, and a 25,000 gallon Swim-Ex rehab pool for aquatic therapy. Peak Performance also has clinic locations in Baton Rouge, Denham Springs, Brusly, and Prairieville.

BCBSLA Launches New Health Plan

In the face of rising healthcare costs and increasing chronic illness statewide, HMO Louisiana, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana, has launched a new model of care in the Baton Rouge market. According to BCBSLA, the product is the first of its kind in Baton Rouge and is available to small businesses and individuals as of Jan 1, 2012.

The product, called Community Blue, offers comprehensive, coordinated, patient-centered care for people in the Baton Rouge market, including East Baton Rouge, West Baton Rouge, and Ascension parishes. Members have a select network of doctors and providers from within the Blue Cross network to choose from, and in exchange pay lower premiums.

The core of this product is a patient-

centered medical home model. Each patient is connected with a primary care physician who leads a team with shared medical service duties, providing for the patient's healthcare needs and working with other medical providers when more support is needed.

SBR Clinic Gains Medical Home Recognition

The National Committee for Quality Assurance (NCQA) has announced that the Earl K. Long Medical Center (EKLMC) South Baton Rouge Clinic at the Leo S. Butler Community Center has received Level 2 recognition from the Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) program for using evidence-based, patient-centered processes that focus on highly coordinated care and long-term patient-physician relationships.

Capital Area Go Red For Women Luncheon Promotes Heart Health

The American Heart Association hosts its annual Go Red for Women Luncheon on February 9 at the Crowne Plaza Baton Rouge beginning at 9:30 a.m. Chairpersons for the event are Vicki Brooks, long-time American Heart Association supporter, and Missy

Rockenbaugh of Kean's Fine Dry Cleaning. Also, this year's honorary chair is Louisiana First Lady, Supriya Jindal.

The luncheon, emceed by WBRZ-TV's Sylvia Weatherspoon, is part of the Go Red For Women movement that encourages local women to take charge of their heart health by making it a top priority so they can live stronger, longer lives. Guests can participate in free health screenings by Ochsner Health System, interactive health stations, group photo opportunities, and a silent auction from 9:30 a.m. to 11:30 a.m.

The ticketed heart-healthy luncheon program, beginning at 11:30 a.m., features food prepared using recipes by Holly Clegg. Three local women affected personally by heart disease will share their inspirational story of survival. Closing out the luncheon program is a fashion show featuring clothing from Macy's. Local heart disease survivors and other prominent Capital Area women will be modeling the clothing.

Tickets for the Capital Area Go Red For Women luncheon are \$100 payable in advance. To purchase tickets and for more information, please call 770-612-6180 or visit the local Go Red For Women website www.heart.org/batonrougegored and click on Your Event.



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Policy Must Address Challenges Posed by Longevity



A recent article in *The Advocate* featured a Baton Rouge woman. At first take, this woman sounds like a typical 53-year-old in the prime of her life. She is the stepmother of two teenage girls as well as a health care professional. What is not typical about this woman is that she was recently diagnosed with early onset Alzheimer's disease.

Alzheimer's disease is a dementia that progressively worsens—affecting memory, behavior, and thinking. More than 5 million people suffer from Alzheimer's today. There are over 200,000 Americans younger than 65 struggling with Alzheimer's disease. Currently, there are no known causes and no possibility of remission. While late onset Alzheimer's is more common, cases like this Baton Rouge woman demonstrate this disease does not solely affect the elderly.

One factor in the increase in Alzheimer's disease is that the number of Americans living into their eighties and nineties has grown dramatically. More than 10,000 baby boomers age into Medicare daily—this trend will continue for the next 19 years. One in eight Americans over 65 has Alzheimer's disease and the percentage jumps to 43% in the 85 years and older population. As the U.S. baby boomers age, the number of people affected by Alzheimer's is projected to triple.

Research into Alzheimer's causes, symptoms, and risk factors has gained traction in the last 30 years, but it remains the sixth leading cause of death in the U.S.—the only cause of death in the top ten that lacks prevention, cure, or even the ability to slow the effects as it progress-

es. There is no foreseeable timeline of how the stages will develop in each person. For example, an Alzheimer's patient may not need assistance with daily activities like using the restroom, eating or dressing for years after the diagnosis, but there is a chance an Alzheimer's patient could require around the clock assistance in less than a year. In the final stage of the disease, an Alzheimer's patient will lose the ability to communicate, fail to recognize family, and need constant care.

While the human toll is extraordinary, there are also associated economic costs. There are almost 15 million unpaid caregivers for Alzheimer's and dementia patients in the U.S., who in 2010 absorbed an additional \$7.9 billion in health care costs. In addition, those who take on this unpaid role deal with physical strain, competing demands, and the emotional toll of the disease. Specifically, one of the biggest hurdles facing individuals with younger-onset Alzheimer's is the cost of care. Just as older Americans require long term care and financial assistance, so do those diagnosed at a younger age. Younger individuals may also face additional burdens because they lose out on prime earning years and may not automatically qualify for Medicare. In 2011, Americans will spend an estimated \$183 billion on

caring for individuals with Alzheimer's disease.

The majority of the cost is covered by public programs like Medicare and Medicaid. Medicare costs are three times greater when a beneficiary is diagnosed with Alzheimer's and other dementias while Medicaid costs are nine times greater. As baby boomers age into Medicare, the cost of long term care and acute care expenditures will continue to increase significantly. Long term care comprises nearly one-third of all Medicaid spending. John Hood writes in *National Affairs* that "from 1960 to 1990, the fastest growing category of health-care

spending was long-term care." So why is there such a lack in the private insurance market for long-term care—only 7 million people are insured? The reason for this is so involved that it requires a future article.

The U.S. needs a strong, viable solution to address the financial pressures entering the public health care programs. Of the general population, 4% will be admitted to a nursing home by age 80. This percentage jumps to 75% for people with Alzheimer's disease. Currently, Medicaid encourages nursing homes, which is the most expensive type of long-term care. On average nursing home costs are double that of

home care. Most seniors prefer to live in their homes as long as possible. Community care should be encouraged over institutional care.

While Congress discusses long term care policy, we must remember the individuals impacted by policy. Greater life expectancy is the result of medical advancements, but it is a double-edged sword as it brings with it new medical challenges for our country to meet. Until research can catch up with diseases such as Alzheimer's, individuals must take an active role in health care and take on the task of planning for long term care needs.

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Launch of Louisiana's Health Information Exchange Marks Milestone



When the Louisiana Health Information Exchange (LaHIE) was launched November 4 at the state conference for the Louisiana Chapter of the Healthcare Information and Management Systems Society, it marked a milestone toward establishing a web-based medical records exchange that is designed to allow physicians, hospitals, pharmacists, and other health care providers to deliver coordinated, cost-effective patient care across the state.

Joining state health officials and industry leaders for the LaHIE launch and demonstration held in Kenner were David Callecod, Chief Executive Officer of Lafayette General Medical Center, and Jared Lormand, Vice President of Information Technology and Chief Information Officer at Opelousas General Health System, whose hospitals in the Acadiana region are piloting LaHIE.

LaHIE is the mechanism that will allow for the secure exchange of health information among authorized providers and across Louisiana's health care system to help improve patient safety, quality of care, and health outcomes. LaHIE is an initiative of the Louisiana Health Care Quality Forum. The Forum is dedicated to advancing evidence-based, collaborative initiatives to improve the health of Louisiana residents and serves as the state-designated, neutral entity to build and support a health information exchange in the state.

The Forum was created in response to recommendations made by the Louisiana Health Care Redesign Collaborative in 2006. This group was tasked with addressing the massive health care issues that existed in the state following Hurricanes Katrina and Rita in 2005. One of

the many casualties left behind by this powerful one-two punch was a shattered health care system.

Following Hurricane Katrina in August 2005, the New Orleans region faced a multitude of challenges in rebuilding its health care infrastructure and reconnecting physicians with their patients. Karen B. DeSalvo, MD, MPH, MSc, a founding member and Forum President, has experience dealing directly with post disaster challenges.

"The ability for health care providers to exchange information in a timely way is important in all situations," noted DeSalvo. "In the face of disaster, it is important for us to know people's medical information and what kind of medications they have to take. It becomes urgent for us if people need to evacuate. But really it is an everyday solution. It's a way that if you go to a doctor, the doctor has access to the health information that is important for your care – medications, the last diagnostic or lab test, so that he or she can make decisions and not delay care."

At the LaHIE launch Callecod said, "We certainly saw the vision of LaHIE and what it can do to improve the health of the community in Acadiana. It was important for us to be a first mover and an early adopter of this technology. And the hope certainly is we see such success in

Acadiana that this is replicated and quickly gets rolled out across the state. As we look at interfacing the technologies, one of the things that we all need to think about is meaningful use. Certainly the first step of it is relatively easy because you can control what you do inside your facility, but LaHIE gives you the ability to begin sharing information among providers and hit achieving meaningful use in those next stages."

When Opelousas General Health System was invited to be a pilot participant, Lormand noted, "We felt it was important to share data with our clinically affiliated hospital, Lafayette General. We are excited about the opportunity to share data between our ED (Emergency Department) facilities so that we can have more timely access to patient diagnostic results and the physicians at each end of the spectrum of care have immediate access to improve their patient care. This is very important, because as more hospitals join this program, the better patient care will be in Louisiana."

Brenda Ikerd, Forum Health Information Technology Director, described the LaHIE launch as a milestone event that was years in the making. "There has been extensive involvement with many stakeholders, and they are excited that it is now a reality," she shared. "We are one of the first states in the country to be doing it. The successful exchange between the two pilot hospitals will create secure, real-time access to information for high quality patient care. This launch was the next critical step in Louisiana's journey to advance health information technology and connectivity."

According to B. Vindell Washington,

MD, MCHM, FACEP, Vice President of Performance Excellence and Technology for the Franciscan Missionaries of Our Lady Health System and the Forum's Chair of the Health Information Technology Committee, the LaHIE launch signals a change in health care. "One of the things missing in health care is this linkage between providers. Health is about providing care across the community. We are not individuals providing individual care at individual hospitals, but the community providing care. Before the Health Information Exchange, we were unable to reach across and find out what care our brethren engaged in these efforts were doing and, therefore, were unable to give the kind of care that was coordinated and reached across the different areas of care provided in the state."

The Forum selected Orion Health as its primary technology provider. Orion Health is a national leader in state and federally funded HIEs. "It's extremely gratifying for us at Orion Health to see the Louisiana Health Care Quality Forum's vision for connected health care become reality," said Paul Viskovich, President of Orion Health North America. "We are proud to have been such an integral part of the project, bringing the HIE to launch in such a short time frame, and we look forward to seeing the ways in which LaHIE positively impacts the lives of residents and caregivers throughout the state of Louisiana."

Bruce Greenstein, Secretary of the Louisiana Department of Health and Hospitals, described the LaHIE launch as "... another feather in our cap in terms of Louisiana's accelerated pace as being one of the best states in the nation for health

information technology. This shows what our true potential is as a state in the world of health care and we can move forward from our low levels of health outcomes today to high levels, and we are showing our potential in what we can do in health information technology."

Following the pilot program in the Acadiana region, LaHIE will move forward to statewide implementation early this year. Core services available will include a master patient index, provider registry, record locator service, user identity management and authentication, audit trail, and consent management.

From January 2012 to June 2012 additional features will be developed: HIE to HIE transaction exchange; single sign on; direct secure messaging; additional data flowing through HIE (medications, procedures, claims); and facilitation of additional functionality with Louisiana Department of Health and Hospitals services (e.g., public health reporting on immunizations, electronic lab reporting, and syndromic surveillance). From July 2012 to December 2012 features to be developed include case management/analytics, patient access to LaHIE, quality reporting capabilities, and interstate exchange capabilities.

For more information about LaHIE, you can visit the Forum website at www.lhcqf.org or contact lahie@lhcf.org.



Cindy Munn is the Executive Director of the Louisiana Health Care Quality Forum.

Checkup on Bayou Health Reform



Enrollment for Bayou Health, the new Medicaid Coordinated Care Networks (CCN) program, is now underway, marking the start of perhaps the largest privatization ever of state-sponsored health services. The Public Affairs Research Council of Louisiana (PAR) published a report in December that describes the CCN model of care and its strengths and weaknesses.

Checkup on Bayou Health Reform: What Louisiana Needs to Know About Medicaid Managed Care Privatization examines the state's initiative to place more than two-thirds of the state's Medicaid population and more than \$2 billion in annual health care spending under the responsibility of privately managed Coordinated Care Networks. Similar Medicaid privatized managed care systems have been adopted by many states and rejected by some others.

PAR's report recommends the Legislature take the lead in providing oversight of this program by establishing a special committee or commission on oversight of state and federal health care reform. Oversight bodies for health care reforms have been created in most states. For Louisiana, the purpose would be to establish a year-round focus on the reforms and to verify their impacts on spending, health care service providers, and patient outcomes.

Over the next several months some 900,000 persons (70 percent of total Medicaid enrollment) will be transferred to five privately owned and operated managed care plans (CCNs). The transfer will include 750,000 persons currently enrolled in CommunityCARE, the state-operated managed care program for nearly a decade. Enrollees can choose from two types of CCN: (1) three of the five

plans will use the prepaid model (CCN-P) that receives monthly Medicaid risk-adjusted premium payments for each member and (2) two plans will introduce a shared savings model (CCN-S) which retains fee-for-service reimbursement but allows the plans and the state to divide any savings.

In the first full year of operation (Fiscal Year 2012-13) more than \$2.2 billion will be spent for CCN activities, including almost \$1.9 billion for medical care of enrollees, \$260 million paid to plans for administrative costs and profit, and at least \$70 million in state administrative costs that will be allocated to CCN operations. Comparing these numbers to projections for the CommunityCARE program that will be replaced by CCNs shows there will be a net reduction in FY 2012-13 of \$373 million (16%) in spending for medical care of enrollees and an increase of \$263 million for CCN administrative costs and profit.

The underlying logic of the CCN initiative, like other forms of Medicaid managed care, is that improvements in coordination of care will result in lower costs and better health outcomes. The reality is that the reduction in medical spending is necessary to pay for administration and profit, as well as to generate a relatively small savings for



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the state. The central question is whether Louisiana, already a low-spending state on a per enrollee basis, can reduce spending further without threatening access to vital services (see table that compares spending on children).

Privatized managed care elsewhere has received mixed reviews. Some states have found savings and improved health outcomes for patients while other states have wrestled with fraud and unexpected demands by private companies for higher rates of compensation. Some states have tried the model only to bring care management back under state control. Many states use a hybrid approach of privatizing managed care for certain populations while letting government staff manage care for other populations.

The key public policy issue at this juncture is the need for effective oversight, accountability and program authority, espe-

cially given the public dollars involved and the impact on citizens, particularly those who will depend on the CCN program for vital health services and often life-saving care. The financial performance of the model should be closely monitored. Under the current system, Louisiana Medicaid spends among the least in the country on a per-enrollee basis, ranking 48th on spending per child and 41st on spending per person for all enrollees compared to other states. That relatively low rate of spending could be a potential impediment for CCN companies seeking to cut health care costs through efficiencies and lower expenditures on enrollees while also finding room to make a profit.

An additional factor is that implementation of the Affordable Care Act (federal health reform) will occur almost simultaneously with the effort to launch the CCN program. It comes as no surprise that Lou-

isiana has been judged as one of the states that has done very little to meet upcoming federal deadlines set forth in the ACA. The state CCN program and the federal ACA reform will have a major impact on each other and extensive planning is needed to assure coordination of efforts.

CCN planning so far has failed to include the looming provisions of federal law which call for a major expansion of Medicaid that will enroll 400,000 or more low-income adults. Actuarial studies for the CCN implementation have projected costs and savings as far as 2019, but do not include the impact of the federal expansion which starts on January 1, 2014. While federal funds will cover 100% of cost for new enrollees for the first four years of the expansion, there will be a major impact on provider capacity and other factors which should be taken into account to determine if state funds are needed.

Confronted with two colossal and concurrent tasks, Louisiana would be well advised to establish a single entity to assist with ensuring that all of these critical efforts are successful. The state would benefit from a public and transparent process with participation by the executive and legislative branches as co-equal partners and formal input by experts and stakeholders.

The report can be found at PAR's website at www.la-par.org/Publications/PDF/PAR_HealthcareReport.pdf.



David Hood is Senior Healthcare Policy Analyst,
Public Affairs Research Council of Louisiana

Medicaid Spending per Child in 16 Southern States FY 2008

STATE	CHILDREN COVERED	SPENDING PER CHILD	U.S. RANK	CHILDREN AS % OF MEDICAID ENROLLMENT	U.S. RANK
Missouri	566,300	\$3,046	7	55%	17
Maryland	395,600	\$2,643	13	51%	27
Texas	2,716,300	\$2,601	14	64%	2
North Carolina	900,000	\$2,531	15	53%	25
Kentucky	398,000	\$2,495	19	47%	39
Virginia	481,700	\$2,279	26	54%	21
West Virginia	191,200	\$2,246	27	48%	36
Oklahoma	440,200	\$2,245	28	59%	10
Alabama	439,900	\$2,177	30	48%	36
Tennessee	729,900	\$2,160	31	49%	34
South Carolina	440,800	\$2,099	35	51%	27
Mississippi	368,000	\$1,972	38	50%	31
Arkansas	378,400	\$1,948	41	54%	21
Georgia	979,200	\$1,837	46	58%	11
Florida	1,525,400	\$1,787	47	50%	31
Louisiana	601,300	\$1,687	48	55%	17
United States	29,239,700	\$2,171		49%	

Source: Kaiser State Health Facts

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HOSPITAL ROUNDS



Baton Rouge General Partners with Blue Cross

Baton Rouge General Physicians and Blue Cross and Blue Shield of Louisiana have signed a formal agreement to build a patient-centered medical home or PCMH—an innovative model of healthcare delivery that improves quality and lowers costs. The patient-centered medical home is an innovative concept of healthcare delivery centered on a primary care physician who manages a patient's healthcare needs. This physician is accountable for coordinating the patient's care and is reimbursed based on outcomes and patient satisfaction, not just volume of services.

The medical home model of care is designed to encourage and strengthen the doctor-patient relationship by replacing episodic and reactive disease-focused care with organized and proactive care focused on preventing disease and preserving health.

OLOL Recognized for Commitment to Excellence in Stroke

Our Lady of the Lake has earned the Get with the Guidelines Stroke Silver Plus Quality Achievement Award from The American

Heart Association and American Stroke Association. OLOL is recognized for its commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations.

"Our goal in this journey to Primary Stroke Center Certification has always been about best practice stroke care for our patients. Participating in Get With the Guidelines Stroke is our measure of that quality," said Liz Marcotte, RN, Neuroscience Program Coordinator. "This recognition speaks to the quality commitment we have throughout the continuum of care here at OLOL for stroke patients."

Facundus Joins Baton Rouge General Physicians

Edward Facundus, MD, FACS, has joined Drs. Dhaval Adhvaryu and Sidney Ross at Baton Rouge General Surgical Associates, part of Baton Rouge General Physicians. Dr. Facundus is Board Certified in general surgery and is distinguished as an American Society for Metabolic and Bariatric Surgery Center of Excellence surgeon.

Dr. Facundus is a graduate of Louisiana

State University School of Medicine in New Orleans. He completed his surgical residency at Alton Ochsner Medical Foundation in New Orleans. He is a fellow of the American College of Surgeons, the American Society for Bariatric and Metabolic Surgery, the Society for Surgery of the Alimentary Tract and the Southeastern Surgical Congress.

Woman's Nurses Honored

Woman's Hospital nurse Kristy Simmons, RN, CNOR was honored as national Nurse of the Year for Exemplary Professional Practice by the American Nurses Credentialing Center at the ANCC National Magnet Conference held in Baltimore, Maryland. In addition, April Morris, RN was named the Protector in Superheroes of Nursing by Mosby's Nursing.

ANCC is the world's largest and most prestigious nurse credentialing organization. This is the first time they have given the Nurse of the Year Awards and Simmons was one of only five recipients nationwide. Nominees were judged by a panel of nurse experts for innovation, consultation, leadership, and professional risk taking.

A perioperative surgical nurse at Woman's for 27 years, Simmons' professional excellence and passion as a patient advocate



Janie Martin, Executive Director of the LA-MCH Coalition presents Woman's Hospital's GIFT certification to Dana Vidrine, BSN, RNC-MNN; Leah Terrell, MSN, RNC-MNN; Karrie Delise, BSN, RNC-MNN; Tricia Johnson, MN, RN, CNEA-BC; and Wendy Singleton, MSN, APRN-BC, ANP.

emergency medicine, and palliative care and nurses trained in geriatric emergency care. In addition sensitivity training will be provided for other disciplines including physical therapists, pharmacists, social workers, and all staff who work with seniors.

Comprised of a special area dedicated to meet seniors' needs, the new Seniors ER features hand rails that line walls, anti-slip flooring, color-coded directions for ease of navigation as well as furniture and amenities made for senior use. Every bed area has a heated blanket, caregiver seating, and a comfortable mattress. Room lighting is softer, the colors are muted, and assistive tools are in place for easier reading of any medical paperwork.

LHA To Host Leadership Symposium

The Louisiana Hospital Association will host its annual Winter Healthcare Leadership symposium on January 31 and February 1, 2012 at the Hilton Capitol Center in Baton Rouge. Hospital leaders from across Louisiana will gather to learn about the latest developments in national and statewide healthcare reform, prepare for the upcoming legislative session, and gain useful knowledge that will help the hospital industry advocate for patients, healthcare workforce, and facilities.

Invited speakers include: Lt. General Russell Honoré USA (Ret.); Dave Willis, Managing Director, The Advisory Board Company; Dr. Loren Scott, President, Loren C. Scott & Associates, Inc.; Gov. Bobby Jindal; DHH Sec. Bruce Greenstein; and Stanley Hupfeld, Chairman, INTEGRIS Health Family of Foundations. In addition, an American Hospital Association representative has been invited to inform participants about the latest on national budget cuts and healthcare reform.

Registration is \$150/person for LHA

was noted through her many achievements including developing perioperative policies to improve patient care; being published about the proper care of non-English-speaking patients; encouraging nursing careers among local high school students and mentoring college students; working with the international community by organizing a medical clinic for underserved women in Mexico; and responding to the Japanese earthquake.

Morris, Charge Nurse in Neonatal Intensive Care at Woman's was named a winner in the Mosby's Nursing Superheroes of Nursing, a contest aimed to search and identify the real-life superheroes in the nursing profession. The contest was part of a nationwide Facebook campaign to recognize nurses who represent four key categories - The Validators, The Achievers, The Educators, and The Protectors - and identify how they address the issues they face daily. Morris was named the "Protector" and called "a real nurse and leader who can manage the most critical patient assignment," by Mosby's website.

Woman's Hospital Earns GIFT Certification

In December Woman's Hospital received a GIFT - the Guided Infant Feeding Techniques certification for its efforts in protecting, promoting, and supporting breastfeeding. The largest labor and delivery hospital in Louisiana, Woman's delivers more than 8,500 babies a year. The Louisiana Maternal and Child Health Coalition, the Louisiana

Perinatal Commission, and the Office of Public Health-Maternal and Child Health Program applauded Woman's for its programs to educate mothers on the benefits of breastfeeding and for providing ongoing breastfeeding support. The certification was presented to Woman's by Janie Martin, Executive Director of the Louisiana Maternal and Child Health Coalition.

Woman's full-time, board-certified lactation consultants visit new mothers throughout their hospital stay. Nurses also help women through prenatal classes, post-discharge consultations, private in-room visits and a 24/7 "Warmline" to answer any breastfeeding questions. Additionally, Woman's has designated lactation consultants for mothers of NICU babies. These consultants advise mothers on how to provide breast milk, whether it is through pumping or breastfeeding, to help their babies grow stronger and healthier.

Baton Rouge General Opens ER for Seniors

Baton Rouge General Mid City recently announced it has opened the region's first Seniors Emergency Room specially designated and designed for adults 65 and older. The Seniors ER is staffed with a team of medical professionals specializing in geriatric care and trained in administering screenings and assessments to identify patients who may need additional assistance or resources outside of the hospital. The team will include physicians specializing in geriatrics,

member hospital personnel and board members, LHA Associate members, and members of LHA societies (LONE, Attorneys, LSH-PRM) and \$250/person for LHA Corporate members and all others. The fee includes the seminar, printed materials, and refreshments. Lunch will be provided on Tuesday, January 31, 2012 only. For more information, go to www.lhaonline.org/.

Ochsner Men in Pink

In honor of October being National Breast Cancer Awareness Month several Ochsner Medical Center-Baton Rouge men donned pink scrubs to show their support. Ochsner-Baton Rouge held several events throughout the month of October to raise awareness and support of breast cancer research.

Dupont Named Pennington Cancer Center Medical Director

Joseph Benton Dupont, Jr., MD, FACS, has been named Medical Director of Baton Rouge General Medical Center's Pennington Cancer Center. He previously served as chief of Surgical Services and Chief of Staff at Baton Rouge General from 1998 to 2004.

Dr. Dupont is a graduate of the Louisiana State University School of Medicine in New Orleans. He completed his residency in general surgery at Charity Hospital in New Orleans where he served as Chief Administrative Surgical Resident. He completed a fellowship in surgical oncology at The University of Texas MD Anderson Cancer Center in Houston. Since 1997, Dr. Dupont has been a full-time member of LSU Health Science Center's Department of Surgery as a professor of Clinical Surgery.

Board Certified in general surgery and specializing in surgical oncology, Dr. Dupont has been an active member of Baton Rouge

General's medical staff since 1981. He is a fellow of the American College of Surgeons, the James D. Rives Surgical Society, and the Society of Surgical Oncology. Dr. Dupont helped guide the Certified Comprehensive Accreditation of Baton Rouge General's cancer program in 1987. He also served as Baton Rouge General's physician liaison for the Commission on Cancer, Chairman of the Commission on Cancer and the National Liaison Physician Program, and as Chairman of Baton Rouge General's Cancer Patient Service Group.

OLOL Named Consumer Choice Again

For the thirteenth 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. Consumer Choice award winners are determined by consumer perceptions on multiple quality and image ratings collected in NRC Ticker study. The 2011-2012 NRC Ticker study surveyed over 250,000 households representing 450,000 consumers in the contiguous 48 states and the District of Columbia.

Ochsner Nurses Recognized

Ochsner Medical Center-Baton Rouge announced that eight local nurses were among

those selected as the 2011 Great 100 Nurses of Louisiana. Honorees were chosen by their peers and patients based on their contributions to patients, the community, and the nursing profession. The Ochsner-Baton Rouge nurses recognized were:

- Theresa Chauncy, RN - Cardiac Catheterization Lab
- Dawn Pevey Mauk, RN - Chief Nursing Officer
- Jill Banker, RN - Endoscopy
- Cynthia Briody, RN - Women's Services
- Jill Baxter, RN - Women's Services
- Belinda Mounce, RN - Cardiac Catheterization Lab/CVRU
- Prentice Massey, RN - Critical Care
- Ruth Kirby, RN - Nurse Education

Tag! You're it!

Baton Rouge General's Pennington Cancer Center has launched a new breast cancer awareness campaign called, "Tag! You're It!" The campaign encourages women to remember the importance of a proper, annual evaluation of their breast health and monthly self breast exams with the help of short message system (SMS) text message reminders.

While signing up to receive the reminders, users have the ability to choose the exact day they would like to receive reminders, making the exams more clinically accurate. The anniversary of a woman's last mammogram can serve as the date chosen for the



Ochsner's Men in Pink: front row left to right: Teddy Thompson, RN; Wayne Register, RN and Bishoy Ramzey, PharmD. Back row left to right: Eric McMillen, Ochsner-Baton Rouge Chief Operating Officer; James Wade, LPN; Keith Streeter, RN; Mitch Wasden, Ochsner-Baton Rouge Chief Executive Officer; Kareem Neal, RN; Jason Despino, Vascular/Echo Sonographer; and Sam Carruthers, CPhT

HOSPITAL ROUNDS



CLOCKWISE FROM TOP LEFT: Karla Miller, RN, BSN; Charles W. Mason, MD, FACP; Kathy Pate, RN; and Mark Anderson.

annual text reminder.

Reminiscent of the children's game of tag, the campaign asks users not only to sign up for their own text message reminders, but to pass the information along to friends, family, neighbors, and co-workers to recruit as many women to sign-up as possible. Women interested in registering to receive personalized breast health text message reminders can sign-up at www.brgtagyoureit.org. Also available on the site is more information about breast cancer early detection and prevention, how-to videos, and wellness information for women of all ages.

Lane Names Telemetry Unit Director

Karla Miller, RN, BSN has been named Director of the Telemetry Unit at Lane Regional Medical Center. A lifelong resident of Central, Miller is responsible for coordinating all aspects of nursing care for the unit, including patient satisfaction, staffing, and

Pictured at Ochsner Medical Center-Baton Rouge's recent GIFT certification award presentation are: Jessica Evins, BSN, RN, IBCLC; Amanda Edwards, BSN, RN, IBCLC; Leslie H. Lewis, MPH, LDN, RD, CLC; and Cindy Briody, RNC-NIC

physician relations.

Miller has more than 14 years of health care experience. Prior to this position she was the Pathway to Excellence Coordinator at Lane. She is currently a member of the Nursing Shared Governance Council and Congestive Heart Failure team and is a former Lane Employee of the Month.

the American College of Physicians and a member of several professional organizations including the American Academy of Hospice and Palliative Medicine and the Louisiana State Medical Society.

Ochsner-Baton Rouge Earns GIFT

Ochsner Medical Center-Baton Rouge's Family Birthing Center received the Golden GIFT Breastfeeding Award in recognition of its recent GIFT certification. The Louisiana Maternal and Child Health Coalition and the Louisiana Office of Public Health-Maternal and Child Health Program awards GIFT certification to those birthing centers that demonstrate a commitment to breastfeeding through hospital-wide policies that support, promote, and protect breastfeeding as the preferred and normal method of infant feeding.

Ochsner Medical Center-Baton Rouge employs three International Board Certified Lactation Consultants (IBCLC's) to assist new moms with breastfeeding before, during, and after baby's arrival. The hospital's Family Birthing Center was also designed to allow babies to room in with moms throughout their hospital stay in order to make breastfeeding easier.

Lane Names New Nursing Home Director

Kathy Pate, RN has been named Director of the Nursing Home at Lane Regional Medical





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HOSPITAL ROUNDS

Center. She replaces Pam Haley, RN, who is retiring in January after 20+ years of service at Lane. Pate will be responsible for coordinating all aspects of nursing care for the facility, including patient satisfaction, staffing, and physician relations. Prior to being named director, she was Director of the Telemetry and Skilled Nursing Units at Lane.

Pate has more than 21 years of health care experience. A graduate of the University of Georgia, she is certified in Advanced Cardiac Life Support (ACLS) and is a Certified Basic Life Support Instructor and a Safe Sitter Instructor.

Anderson is New Lane CFO

Mark Anderson has been named Chief Financial Officer for Lane Regional Medical Center. Anderson is responsible for overseeing all finance and accounting functions, including strategic planning and capital budgets. He will work with various departments to grow volume, control costs, and improve operations.

A native of Bossier City, Anderson has more than 15 years of experience in healthcare financial management. Prior to joining Lane, he was Chief Financial Officer for Danville Regional Medical Center, a 290 bed hospital in Danville, Virginia with 1,300 employees and net revenues in excess of \$170 million. He is a graduate of Louisiana Tech University in Ruston, received his MBA from Regis University in Denver, and is a Fellow Graduate of The Advisory Board Academy in Washington, D.C.

Pre-Schoolers Warm Woman's Preemies

In December, fifteen Parkview Baptist pre-schoolers warmed Woman's Hospital's tiniest babies, and the hearts of many grown-ups, with hundreds of donated blankets for the Neonatal Intensive Care Unit (NICU). In the spirit of the holiday season, the four- and five-year-old students hopped in a school bus to visit Woman's as the culmination of their lesson plan about the importance of giving to those in need. The little philanthropists collected hundreds of blankets and

Parkview pre-schoolers look on with excitement as Barbara Zeigler, Parkview Baptist preschool curriculum coordinator, points out a tiny NICU baby held by Woman's NICU nurse Ashley Hobson, RN.

hand-delivered them to Woman's Special Care Nursery.

As Woman's NICU nurse Ashley Hobson, RN gave the children a short lesson about babies, the children were excited to play with baby bottles and baby clothes. But the true excitement came when a real baby was brought to the nursery window. The children were convinced that the weeks-old infant waved "hello" to them. The children were then treated to milk and cookies in the cafeteria.

Baton Rouge General Announces New Board Members

Baton Rouge General/General Health System recently announced three new members to be appointed to its Board of Trustees: James L. Llorens, PhD, Patricia J. Tyson, and Rev. Ronnie L. Williams. They join current members of the Baton Rouge General Board of Trustees: David Pitts, Chairman; Evelyn Hayes, MD, Vice Chairman; Venkat Banda, MD; Peter J. Bostick, MD; Gregory Bowser; Sue Anne Cox; Perry Franklin; Gary Graphia; Leslie Herpin Marx; Margaret Hart; William R. Holman; Roy Kadair, MD; Nanette Noland; Andrew Olinde, MD; Janice Pellar; Charles "Buddy" Roemer; and Ed Starns, CPA.

Dr. James L. Llorens is Chancellor of Southern University and A&M College in Baton Rouge. Llorens previously served as Dean of Southern University's Graduate School, Chair of the University's Political Science Department, and Associate Professor of Public Administration. Llorens also worked in various governmental positions in East Baton Rouge Parish, including Assistant Chief Administrative Officer to Mayor-President Melvin "Kip" Holden as well as Personnel Coordinator, Director of Human Services, and Federal Aid Coordinator for East Baton Rouge. In addition to receiving a doctorate in political science from Louisiana State University, Llorens was named a post-doctorate



Fellow in Public Policy and Minority Communities at the University of Minnesota's Hubert H. Humphrey Institute of Public Policy and is an American Council on Education Fellow.

Patricia J. Tyson is a teacher with the East Baton Rouge Parish School System and has served public schools throughout the Greater Baton Rouge Area for more than 10 years. Certified in elementary education, she currently teaches at University Terrace Elementary in Baton Rouge. Tyson is a graduate of both Louisiana State University and Southern University A&M College.

Reverend Ronnie L. Williams is the founder and President of Camelot College in Baton Rouge. Nationally accredited by the Accrediting Council for Independent Colleges and Schools (ACICS) and certified by the U.S. Department of Education, Camelot College is one of the largest privately owned colleges in Louisiana to provide short-term, job-specific training. Williams, a licensed and ordained pastor, has presided over the Power in The Word, World Ministries, located on Camelot College's campus, since 2002. Rev. Williams served in the U.S. Air Force during the Vietnam era and was discharged with honors. He is a graduate of Louisiana State University.



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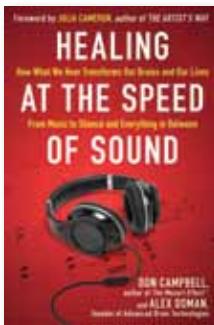
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Book Corner

>> Reviews by **THE BOOKWORM**



Healing at the Speed of Sound

**by Don Campbell and Alex Doman,
foreword by Julia Cameron**

c.2011, Hudson Street Press

\$25.95 / \$30.00 Canada

263 pages, includes index

For about four days now, you've been carrying a happy tune.

And you're not happy about it.

The song you've whistled, hummed, and sung could've been something you heard on-hold, on TV, or on a speaker - you don't remember and you don't care. You fall asleep with it and wake with it. You don't know the title of it or who performed it and you don't know all the words - which is driving you crazy.

That, and you can't get the blasted thing out of your head.

It's called an "earworm" and though it's maddening, it's actually good for your brain. Learn why and more in the new book "Healing at the Speed of Sound" by Don Campbell and Alex Doman.

So you woke up this morning grumpy, feeling like you just couldn't get going? Chances are, Campbell and Doman say, you need to change your first-thing-in-the-morning sound. If you wake to an alarm, for instance, soothing chimes or bird sounds might be

gentler. If you need energy to face your day, Calypso music might be the wake-up ticket.

That's because your gray matter "mirrors what it has perceived."

Sound, tone, and pitch cause different parts of your brain to interact in a "more intense" way, which affects mood, wakefulness, and health: studies show that music played in pediatric ICUs enhances the growth rate of preemies. Research indicates that exercise can be improved with music, enhancing performance and challenging athletes. Alzheimer's and dementia caregivers have noticed that music and movement can boost their patients' well-being. Even pets' moods are lifted by song.

But, of course, not all sound is good.

Exposure to loud music can weaken muscles, worsen some health issues, and cause hearing loss. Annoying noises cause productivity to plummet in business, and it can drive away clients.

So what can you do to best utilize sound?

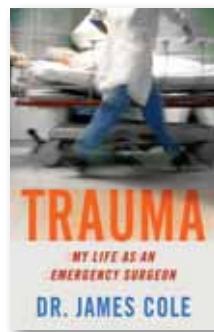
Start by making your home a haven, and use music to match your needs. Know what kind of listener you are, put yourself on a "sound diet," and ask your family to respect that. Tactfully approach neighbors for a "sound curfew" and look for support within your community's noise laws.

Oh, and those earworms? Keep them. You may need them someday...

With contagious enthusiasm, some personal anecdotes, and a wealth of study results, authors Don Campbell and Alex Doman prove that pleasant sound - particularly music - isn't just something in the background. That's fascinating information, with implications not only for physicians, but for parents, caregivers, business owners, athletes, and casual readers. I was also glad to see research on the disadvantages of cacophony;

without those results, this book would have been incomplete.

For best results, this book requires patience (because there's plenty to absorb here), a nearby computer (to utilize interactive website links, see demonstrations, and hear recordings), and a desire to take easy steps to maximize your well-being. Whether you love or hate music, welcome noise or abhor it, if you care what goes into your ears, "Healing at the Speed of Sound" could be music to your eyes.



Trauma: My Life as an Emergency Surgeon

by Dr. James Cole

c.2011, St. Martin's Press

\$25.99 / \$29.99 Canada

336 pages

Don't run in the house.

It's one of the first rules you learned when you were young, right along with "No playing ball in the living room."

You could run on the playground. You could run in the school gym. You could get your little legs going on the sidewalk, the street, ball field, or track.

But in the house?

Nope. No running, and the rule was in effect for school hallways, too. But, as you'll

see in the new book "Trauma: My Life as an Emergency Surgeon" by Dr. James Cole, running is allowed in hospitals, as a matter of life or death.

Even before he was through high school, James Cole knew he wanted to be a surgeon. It was a long-time dream, and he was doing it differently: following his internship, Cole took a two-year "hiatus" to work as a military General Medical Officer assigned to an elite Marine Corps unit.

It was a great opportunity, but it involved sacrifice: Cole was away from his family for long stretches at a time; on rotation thousands of miles away, training with his military team, or deployed at an overseas camp hospital.

During and between his military duties, Cole worked in stateside hospitals and trauma centers. In Texas, he worked with burn patients and gang members. In the Midwest, he tended to accident victims whose lives he could save but whose limbs he could not. He cared for mentally ill patients, on behalf of

whom he takes colleagues to task. And he writes about differences.

In America, a man can lose a leg to a motorcycle accident. At war, a soldier can lose an arm to a bomb.

Drugs, anger, knives, abductions, and street violence can rob a mother of her child in America. In Afghanistan, a land mine can do the same thing.

Here at home, an abusive husband, a drunk driver, or a seven-story fall can send pieces of metal deep into body cavities, and do damage. In Iraq, it takes one suicidal person and an explosive...

There's a lot to like about "Trauma: My Life as an Emergency Surgeon," starting with the humility of its author.

Dr. James Cole repeatedly chastises himself for his arrogance, which is often followed by fervent expressions of thankfulness to have been sent down paths that allowed him to achieve his goals. He gives credit to those who taught him - colleagues and patients alike.

Add to this some exciting stories of life (and death) in the ER, a hint of danger and secret military ops, and a not-so-subtle warning for anyone who wants to be a doctor and thinks it would be just like on TV, and you've got a memoir that's first-rate.

Be aware that, because of the real-life OR pictures (which are, thankfully, in black-and-white) this book isn't for the weak of stomach. If you want a unique peek behind the bedside curtain, though, "Trauma: My Life as an Emergency Surgeon" is a book to run for.



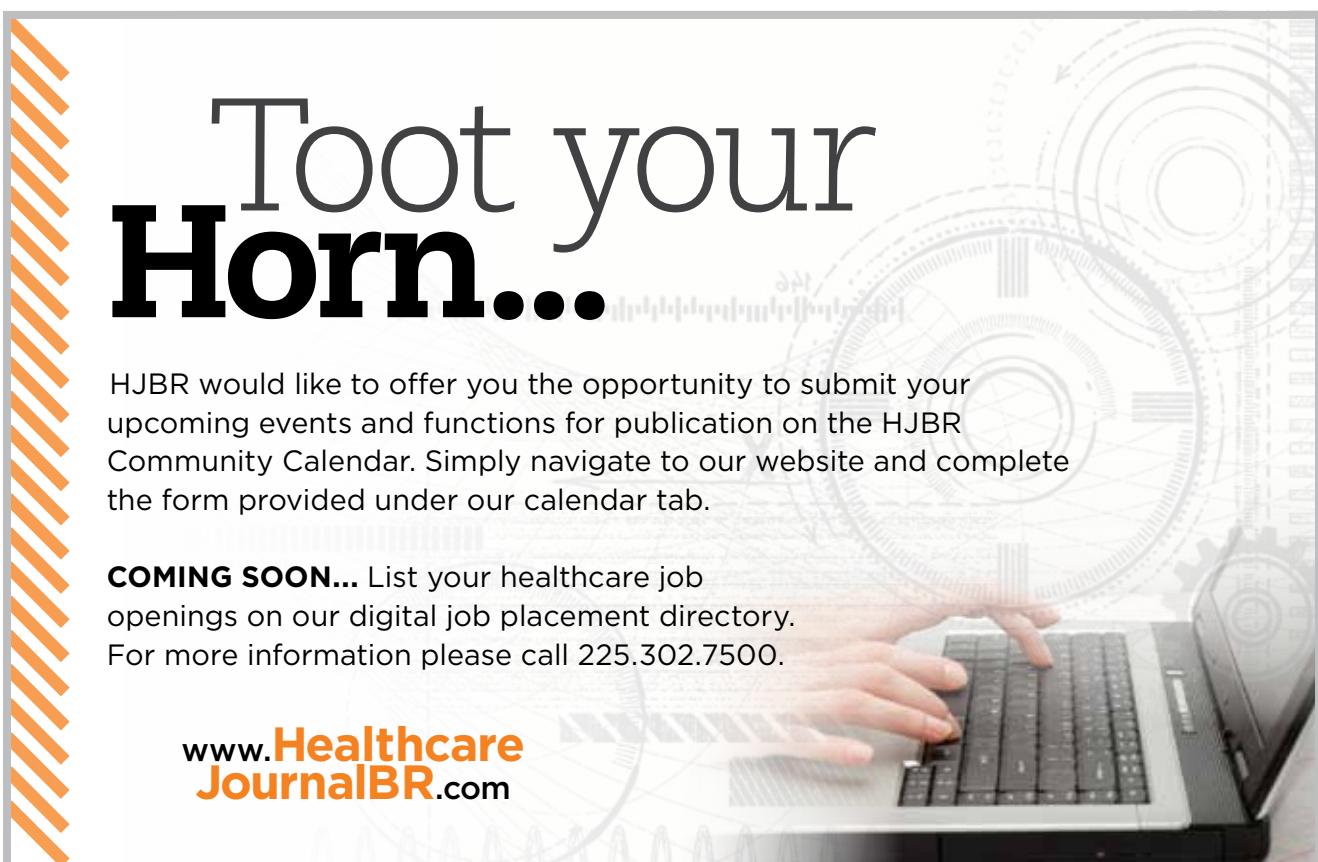
The Bookworm is Terri Schlichenmeyer. Terri has been reading since she was 3 years old and she never goes anywhere without a book. She lives on a hill in Wisconsin with two dogs and 12,000 books.

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Mary Ann Anzalone,
Peoples Health plan member

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