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Q: What does the Louisiana healthcare climate look like through Lane RMC’s lens?

A: We see a health system in LA that does not work well. We are the only state in the country that has a Charity system. When it was started many years ago, it worked but it does not today. We hope that changes will be made to let the payments for services follow the patients. Today the Charity system gets the dollars and we take care of the patients. Our uncompensated care is rising every month to the point that our efficiencies are challenged to the point of breaking. Also, the state Medicaid system is woefully underfunded (a great deal of the issue is the Charity System again).

Q: What particular challenges does Louisiana healthcare face in achieving its goals?

A: The main challenges we have are:
1) Full payments for services we provide that will allow us to continue to provide high quality services.
2) Shortages in professional staff, such as nurses, technologists and other clinical healthcare workers.
3) The number of uninsured patients in Louisiana continues to rise, forcing us to become a safety net for primary care services.

Q: What is Lane RMC doing to meet these challenges?

A: To meet these challenges, we monitor our quality indicators with all appropriate benchmarks. Lane’s indicators compare favorably with others in the region. We feel strongly that in primary and secondary care we can do a better job than others in the area. We are smaller and can respond faster to any changes that are needed. We also are more efficient, due to our size and lower overhead. We have been talking to major employers to assist them in healthcare cost savings by referring to Lane. Also, we are making every effort to be the employer of choice for healthcare workers.
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Contents

Features

Letter from the Publisher 9

Local Hospitals are High Tech 10

Technology and Ethics 24

Louisiana a Leader: HIT 28

One on One 46
    Bill Cassidy, MD

Physician Availability 54
    in Greater New Orleans

Departments

Technology
    FDA Critical Path 30
    XLIF 32
    Deep Brain Stimulation 34
    Tech Bytes 38

Managed Care
    Examining Pay for Performance 50

Legal
    Medicare Will No Longer Pay 56
    For Hospital Errors

Administration
    Your Time is Unimportant 58
    To Me

Financial
    Game Plans 69

HJBR Resource Guide 81
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Classic Image

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Lee Michaels
It wasn’t too long ago if we wanted to research information it meant devoting hours to dealing with card catalogs and thumbing through library books and periodicals. I’m not sure who actually invented the internet but I am truly grateful to these people. Our lives will never be quite the same.

Technological advances are emerging so rapidly we are almost becoming numb to their impressiveness. In truth, we usually have far more capabilities in our current technological state than we can take advantage of. And, just by the time I think I’ve learned the newest software, a more advanced and user friendly version rolls out on its heels.

Despite our advancements, our healthcare system is in the infancy of exploring the possibilities available. An exciting opportunity of being in a post-hurricane position is the ability to institute information technologies on a broad scale as we design our new technological blueprint. Louisiana was recognized as one of the top 12 states in health information technology advancements. I’ve attended some encouraging conferences to discuss the possibilities here. DHH, LSU, and others are working with the providers and payers to gather data banks of information to better manage the health of all our residents. This information, managed securely and properly, can produce the kind of reports that public health experts and providers often crave.

It's too soon to congratulate ourselves. But, I'm optimistic that with continued support and collaboration, Louisiana will position itself as the leader in the nation for health information technology. To all you techies, keep up the good work. Those of us who know how to point and click are rooting for you.

640K ought to be enough for anybody.  
(1981) Bill Gates, Microsoft Founder
Local Hospitals are HIGH TECH

A Timeline of Technology
looking for the latest in state-of-the-art medical and information technology? Look no further. It’s right here in Baton Rouge. Recent interviews with area hospitals reveal that many are on the cutting edge of new technology – implementing electronic systems and utilizing diagnostic and treatment tools that are unparalleled elsewhere. Some are serving as prototypes for other medical centers around the country. Others are working at the design level on technology that isn’t available anywhere else. One thing we found in common with all of them is that they are very excited about their new technologies and welcomed the chance to share their experiences in selecting, designing, and implementing them. Here are a few highlights.

**Woman's Hospital**

At Woman's Hospital, the staff has been involved in the creation, integration, and adaptation of their electronic information systems. From bedside charting on mobile carts, to patient tracking, to electronic medication checks, the hospital is rapidly becoming very “wired.” “We always had electronic information,” said Paul Kirk, Director of Information Systems (IS), “but it was never interconnected before.” Now the information flows between departments and provides a “big picture” look at where the patients are and what they need. It has also enabled the hospital to provide the patient with an itinerary of their stay, allowing a better understanding of what is going to happen, and when. “We're most excited about the increased level of communication between departments and between nurses and patients,” said Lori Denstel, Director of Nursing Systems. “Now that we have this system we realize how much time we spent on the phone trying to find a room for a patient, discover if a specific task had been completed, or requesting that someone complete that task. Now we pull up the electronic bed board and all that information is there.”

The bed board actually was created at Woman's Hospital out of dire need, during Katrina. Swamped with patients, most of whom had no medical records, and fielding constant calls from outside the facility on availability of beds, patient status, and discharges, the old paper chart on the door method wasn’t working. In 48 hours, a crude version of today's bed board was up and running. Now, a doctor, nurse or administrator can access the web-based site and see at a glance, what rooms are available, what tasks have been completed, what tasks have not been completed in the anticipated time frame, whether labs have been done or results are available, and much more. Updated every minute, the bed board gives a very real time overview of the hospital. It can also be used to track efficiency, highlight problem areas, and forecast availability. It saves time and trouble for all stakeholders, eliminating the need to physically check or call for status. The hospital now gives patients a much better idea of when certain things are going to happen, such as a hearing test, baby pictures, even discharge, which helps them feel more involved with their care plan. “It also keeps us honest,” laughed Denstel, “because it is all right there on the screen.” With everything automated, with alerts and reminders built in, less information and fewer tasks fall through the cracks.

Kirk said that one of the unique things about the system is that it is designed specifically for their hospital and that the nurses who will use the system the most were integrally involved in its design, going so far as to “road test” the mobile carts. Even

**c. 10,000 BC:** Trepanning, or removing a section of skull to release pressure and bad spirits is likely the first surgical technique. It is performed without anesthesia.
now that it is up and running, nurses are encouraged to go online and post comments, suggestions, and questions, to continue to fine tune the system. That sense of ownership and the fact that it was not designed by IS and pushed out of that office onto the patient floors, but designed by the nurses themselves, has made the system a success, said Kirk. Now ancillary departments are clamoring to be part of the system, as it features information they feel would be helpful to their operations as well.

As the hospital continues to build on the system, a method to track patients rather than rooms will be accomplished through ultrasound readers and electronic tags attached to equipment that travels with the patient. Right now, the board will indicate if a room is assigned, but not necessarily that the patient is in the room. The ultrasound readers will indicate exactly where in the hospital the patient is at any given time. Medication administration will also be electronic, with the ability to scan both patient and medication information and confirm a match. The system will not only ensure that the right patient gets the right dose of the right medicine, but will also issue alerts for timing of the medication, contraindications, etc. “Every time we add a building block we go back and re-validate what we are doing already, to make sure it is a fit,” said Kirk. For example, when the electronic medical administration record was created, the staff realized that medications aren’t bar-coded by dosage, the hospital receives them in bulk. The hospital had to find a way to integrate the medicine into the system. Certain things like breast milk for NICU patients posed more complicated matching challenges as dosage and freshness issues came into play. In addition, medication matches required an electronic ID on the patient, but if the patient is a tiny premature infant, how do you attach the ID? That particular challenge became a quest, involving months of input, design changes, prototypes, and finally a specially crafted bracelet made just for Woman’s Hospital, which has since been picked up by other hospitals with the same challenges.

The hospital also worked on an electronic medical record system through a grant with the Department of Defense to design a high risk OB electronic military record for a military OB/GYN facility. Because of the similarities of that facility with Woman’s unique patient base, it also helped Woman’s develop their own. It will be launched this month and will offer local physicians with privileges at Woman’s Hospital access to the system. Under the system, physicians will be able to relay all pertinent medical, treatment, and prenatal records to Woman’s upon the patient presenting. By pre-populating the patients’ hospital record with this information,
the best possible care will be provided and staff will have all the pertinent information upon admission. In addition, after discharge, the original physician will be able to electronically access all of the additions to the patient's record made during her stay. These physicians will pay 15 percent of the system's cost, but excitement is high already because of the improved information flow and patient care it offers. Under guidelines laid out by the Office of the Inspector General and by the Stark Law, the hospital must walk the fine line between being required to offer physicians something they don't already have (meaning those with sophisticated EHR systems in place already can't participate) and not being seen to entice them to participate. “Ownership of the data is also a sticky question, on which the feds have failed to make a clear ruling thus far,” said Kirk. “Does the data belong to the patient? The physician? The hospital? Is there certain information in the health record that it would be better if the patient did not know at this particular time, such as a possible genetic predisposition to a disorder later in life? Are there liability issues in who sees this information?” For now hospitals implementing EHR must ensure their program follows HIPAA and that the data is kept secure.

Finally, the hospital plans to launch electronic check-in for the Breast Center early this year. Patients will be able to complete their own registration, fill out the appropriate paperwork, and even pay using an electronic tablet. The information is stored electronically, so it can be accessed by the registration desk while the patient is working on it, stored for future visits to avoid repeating the questionnaire each time, and tracked by administration to ensure quality care. This advance was actually spearheaded by CEO Teri Fontenot, who felt that asking patients to answer the same questions every time, especially on a return visit for a diagnostic mammogram, was not the most sensitive patient care. The Woman's Touch electronic check-in is very user friendly, allowing the patient to back out any time or summon a staff member for help. The program even allows patients to complete Medicare/Medicaid forms, permission forms, and complete payment by check or credit card on the electronic tablet. Best of all, the information

200s: First textbook on acupuncture written.

1249: Roger Bacon writes about convex lens spectacles for long-sightedness.
becomes part of the patient’s EHR and future visits will only require updates not a complete do-over.

Ochsner

Unlike most hospitals, the folks at Ochsner are not so excited about their electronic medical records system because it is new, but because it is not. “Ochsner has actually been storing patient information electronically for 20 years,” said Dr. Jay Brooks, Chairman of Hematology/Oncology. Lab tests, x-rays, and doctor’s notes were all kept in an electronic depository. One of the things that attracted Brooks to Ochsner years ago, was that all of the doctors worked out of a common record, making it easy to track all the care the patient had received. However in the last 5–7 years, great strides have been made in improving organization and access to that information. That put Ochsner ahead of the curve. Everyone is working on electronic health systems now, but Ochsner already had theirs in place before Hurricane Katrina. As evacuees sought treatment in other areas of the state and country, many people found that their physicians had evacuated and/or their records were lost due to flooding. However, nearly all of Ochsner Health System’s 300,000 patients found their medical records safe and easily accessible thanks to an electronic record system: Ochsner Clinical Workstation (OCW). OCW allows medical files to be retrieved from any Ochsner location throughout Southeast Louisiana. Physicians can also access the system essentially from anywhere that they have internet access.

“I think our electronic medical records really had their shining moment during and after Katrina,” said Dr. Brooks. “I treated many New Orleans patients who evacuated to Baton Rouge. One in particular could only describe her medications by color and size. I was able to pull up her profile on OCW. She was undergoing chemotherapy, radiation, and was a heart transplant recipient. Once I had all of the pertinent information I was able to treat her appropriately. Here was a woman who had left New Orleans with little more than her husband and her car intact. She wept when she found her medical records had survived as well.”

OCW is also unique in that it profiles the patient from birth to death, not by specific, episodic, medical events, such as stroke or heart attack. This format allows physicians to manage their patients longitudinally; looking back 20 to 30 years, to identify historical information to treat them more effectively. “With most systems in use in major hospitals, the information is event-oriented rather than patient-oriented,” said Brooks. “With ours, the data follows the patient not the specific event or admission.” The system required a learning curve for the doctors, nurses, and technicians, said Brooks. “If the information is not entered into the system or captured electronically, it for all intents and purposes never happened. Similarly, the information in the system is only as good as the person entering it, so incomplete or inaccurate data is unacceptable.”

Brooks attributes much of the success of Ochsner’s system to the fact that it is physician designed, tested, and critiqued. “What’s the use of having a great system if the docs won’t use it?” said Brooks. While inpatient doctor’s notes are still written in the chart, electronic charting at the bedside is coming soon. All dictated notes and all notes taken in the doctor's offices are captured electronically. Ochsner is also exploring ways to allow patients access to their records electronically. Certain outside physicians also have contractual agreements with Ochsner to access the database for their patient information. The system can also tell the doctors at a glance, how many patients they have, what beds are empty, etc. Patient names and diagnoses are never posted on these screens.

Despite these advances, Ochsner has found that the biggest nation-wide challenge in medical record technology is creating a universal language to allow major medical centers the ability to communicate with each other. For the most part, electronic medical records are limited to single hospital systems and there are no guarantees the databases can “talk to each other.” However Ochsner and M.D. Anderson Cancer Center are trying to address that by participating in a pilot program.
sharing electronic communication on patients that both centers currently treat. Ochsner is also participating in a Louisiana Department of Health and Hospitals project to develop electronic clinical information exchange between South Louisiana providers called LaHIE.

Outside of IT, Ochsner is also excited about some new treatment technologies. The hospital is the first facility in Baton Rouge to take advantage of a new technology called Navigation to perform total knee replacements. What makes this system unique is its similarity to GPS technology, using several mechanisms to transmit signals to the receiver to determine information. Navigation's mechanisms aren't GPS satellites, but instead, a computer, infrared camera, and wireless instruments that give the surgeon (the receiver) an exact view of his instruments in the patient's anatomy. These visuals allow surgeons to perform a more precise alignment of the knee than ever before. Without this technology, the traditional procedure relies on more invasive techniques and the surgeon for alignment. Navigation has also been used nationally in neurosurgery, spine, ENT, and trauma procedures.

Ochsner Medical Center-Baton Rouge is now also offering patients a minimally-invasive form of treatment that could eliminate the need for amputation. The new Excimer or “cool” laser produces pulsed bursts of ultraviolet light energy capable of vaporizing plaque and calcium into tiny particles that are easily absorbed into the blood stream. This new laser technology is a minimally-invasive method of eliminating the buildup in arteries and veins, thus reducing symptoms and possibly saving the limb from amputation. The energy in the laser is transmitted along flexible glass fibers encased in catheters, which can be passed through arteries and veins. The UV light energy is focused only on blockages that need to be treated. In contrast to the long recovery time required after bypass surgery, this procedure is performed within one or two hours with only minutes of laser use, followed by just one or two days of recovery.

Finally, Ochsner Medical Center-Baton Rouge reports that it is the only local facility with the latest high-definition endoscope. This new system provides sharper definition and clearer images of the body's internal organs and systems. This technology is able to produce such in-depth images by utilizing HDTV and narrow band imaging, a technique that manipulates tissue and light and improves visual contrast. This new technology allows doctors to detect smaller lesions and more accurately diagnose diseases of the upper and lower gastrointestinal tract, including colorectal cancer. In some cases, it can shorten procedure times.

Our Lady of the Lake Regional Medical Center

Our Lady of the Lake Regional Medical Center recently gained the distinction of achieving stage six of the HIMSS Analytics Electronic Medical Record Adoption Model. Attained by just .3 percent of hospitals nationwide, stage six indicates
that the facility has implemented all of the major EMR components used by physicians, nurses, and caretakers to order, document, interpret, and manage care delivery. Implementing this technology results in higher levels of patient safety and improved quality outcomes. Stage seven is the highest level awarded by HIMSS Analytics and no U.S. hospital has achieved this level.

As part of its journey to Stage Six, OLOL has implemented computerized practitioner order entry (CPOE), electronic physician documentation, and closed loop medication administration, which combines CPOE, pharmacy, nursing documentation, and the bar coding of the patients and medications to prevent medication errors.

OLOL's Chief Medical Information Officer, Dr. Paul Murphree indicated that OLOL has actually been using a partial form of electronic health records for many years, but it was in 1999 when the hospital teamed with a company called Cerner that it moved to the forefront of Health Information Technology (HIT). The company started off with a basic program and allowed OLOL to customize and grow the system and data to fit its particular needs. For a while, the hospital even operated as an “alpha site” where new manifestations were implemented on a trial basis to test, improve, and demonstrate them to other entities. Although this allowed OLOL to have access to state-of-the-art systems before anyone else, the hospital has since relinquished its alpha status to allow itself more flexibility to fit the program to the facility. The hospital remains the flagship of the Franciscan Missionaries of Our Lady (FMOL) health system in terms of HIT.

As the hospital continues to fine tune the system, Murphree admits there is a learning curve and that some practitioners have to be convinced of its benefits before they will jump on board. About 25 percent of the physicians practicing at OLOL currently use the system, but more are coming online every day. For the initial phases, the hospital targeted the high users, the doctors that are practicing at the hospital every day. Dr. Murphree has made increasing doctors' comfort levels and encouraging them to use CPOE his personal mission, constantly pointing out to the doctors the system's benefits, such as: instant feedback on your order entry or progress notes; Tallman lettering which emphasizes the differences in similar words, particularly drug names, eliminating the guesswork and errors associated with physician handwriting; and built-in order sets, reminders, and alerts. This was an area on which the hospital worked extensively with Cerner. “You can build in alerts for just about anything,” said Murphree, “But you don't want to have so many, that they are meaningless. We opted for the most vital notifications, such as a full page warning when ordering a medication that is contraindicated with previously ordered treatments, a pop-up allergy notification, an offer to review lab results when ordering any medications, etc.” The alerts are also constructed so that they can be overridden by the physician. “We never want to have a computer...
make a clinical decision,” said Murphree, “but it helps to have the resources and reminders right there on the screen. The computer does its job of letting you know there is a potential problem, and then the physician can use his/her experience and judgment to decide how to proceed.” OLOL also built in alerts and reminders related to the Five Million Lives initiative, a national campaign to dramatically reduce incidents of medical harm in U.S. hospitals. That way the electronic system helps implement and track quality of care tasks throughout the hospital. As opposed to desensitizing caretakers with alert overkill, the system will generate lists of treatment recommendations to ensure the best patient care.

Because the doctors, nurses, labs, pharmacy, etc. are all on the same system, it is easy to enter and check progress notes, file and check lab results, order and administer medication, even research a condition and access treatment recommendations—all from the computer. Not only does this ensure that everyone is on the same page, but it allows everyone involved in patient care to track what has been done. Doctors can even access the system from outside of the hospital so they can check on a patient's progress. A built-in messaging system, similar to e-mail, allows instantaneous communication with others involved in a patient's care.

The system also allows for closed loop medication administration. Medications can be ordered from the pharmacy online, and as mentioned before, the computer will notify the doctor of any contraindications. The pharmacist can also review this information and make suggestions. There are no handwriting issues because everything is entered electronically, with the additional security measure of Tallman lettering. The pharmacy will send up the correct dosage bar-coded exclusively for that patient. If the patient's barcode on their wristband and the barcode on the medication don't match, an alert will pop up on the hand held scanner used by the nurses. Murphree said some patients grumble that they are being scanned like an item at the checkout counter of Walmart, but once they realize it is for their protection, they approve. One of the features that is impressive about the closed loop system is that a doctor can impose an immediate stop on a medication, even if it has already been dispensed, bar-coded, and has made its way to the patient floor. As long as he enters that stop on his computer, before the nurse scans the patient, the system will not allow the nurse to continue. In the near future this closed loop of medication administration system will include a robot to mix medications and apply barcodes.

The electronic system also includes order sets for several diseases and conditions commonly treated in the hospital. These are guidelines and a standard of care agreed upon among the physicians in a particular service area. So, if a patient presents with pneumonia for example, the physician can access that order set and it will outline the treatment steps, available medications, precautions, reminders, etc. to provide an agreed upon standard of care. “The most amazing thing,” joked Murphree “is that we actually got doctors to agree.” Actually they have collaborated on about 300-400 order sets.

Although the hospital has kept electronic records for quite some time, new information entered on the current system
enters every piece of information as a discrete entity. This allows for tracking and graphing by just about any variable and will improve efficiency and performance. (Information that is still currently recorded on paper will be entered into the system through scanning, but does not have the advantage of being broken into discrete data.) This will also apply system-wide as the technology is implemented at each of the family of Franciscan Missionaries of Our Lady (FMOL) facilities and they gain the ability to share more and more data, such as patient histories between them. Estimates are that 40 percent of the Louisiana population seek treatment at one of the FMOL hospitals, so this ability to share information will improve patient care for a large portion of the state.

OLOL is currently exploring the possibility of creating a patient portal, where patients can access some aspects of their record themselves. Currently the information is accessible through physicians' computers, computers at nurse's stations, the hand-held scanners, and the workstations on wheels or WOWs that can travel between patient rooms. The system also includes an online medical reference site called Up To Date, as well as access to Google, which studies have proven useful for searching symptoms and studies for making diagnoses, said Murphree.

**Baton Rouge General**

Like many hospitals, Baton Rouge General's first experiences with information technology were piece-meal. As technology became available they might automate a system here, add an electronic version of a system there. And like many hospitals, they discovered that while each “latest, greatest” technology did improve efficiency, they didn't always work together. So, when the General decided its goal was a seamless, paperless, electronic approach to all systems, it sought out one vendor, McKesson, who could do it all, and in a limited timeframe of just two years. About the third of the way into full implementation now, the hospital will eventually have approximately 35 fully automated components which can “talk” back and forth, are accessible by all players in the treatment plan, include remote access by physicians, and seamlessly link the Bluebonnet and Mid-City campuses.

Some of the most important components of this system are already up and running, such as the Electronic Medical Record, the Medication Safety Program, and the Emergency Department Tracking Board. The Medication Safety Program is a completely automated system that follows the patient from admission through the hospital stay and back to their primary care physician. It tracks the medications they are on, allergies, medications they receive during their stay, and other patient information. The system provides administration safety checks and alerts for allergies and contraindications. In the pharmacy, medication is dispensed by a robot that follows the instructions in the electronic prescriptions ordered by the doctor. Not only does the robot increase efficiency and reduce errors, but it allows those who work in the pharmacy to spend more time in patient consultation to customize treatment.

In addition, the General recently launched its electronic Emergency Department Tracking Board, which replaces the traditional white board with a real-time way of tracking who's waiting, who's being treated for what, and by whom. In addition to the basic tracking information which appears on large plasma screens in the ED, the information is also accessible at desktop stations in the department and elsewhere in the hospital. The board includes triggers to other departments if their services are needed, such as a lab test or a consult. It even notifies housekeeping if an area needs cleaning. In addition it allows a quick view of what types of cases are waiting, and allows the staff to forecast what they will need in terms of treatment and admissions. Not only is efficiency improved, but

1656: First IV performed on a dog by Sir Christopher Wren who also experiments, unsuccessfully, with canine blood transfusions.
it means a shorter timeframe for the patients that present in the ED. Even after just two weeks of use, the doctors and nurses had submitted their own ideas of how to customize the system to their ED and the vendor was making those adjustments.

One part of the hospital in particular has been a kind of pilot for the automated information technology at the General. The Pennington Cancer Center is already operating in a completely electronic, chartless, paperless mode. When the plan was first developed to build the Center, the staff wanted to be able to communicate patient and treatment information effectively between campuses and between the physicians. They decided a chartless and paperless format would be the most efficient and secure. In addition, they wanted to integrate that information system with their treatment systems, which were already on the cutting edge of technology. The mindset was basically the same as the hospital as a whole, but in a smaller, more controllable environment, so it was easier to implement. The Pennington Cancer Center is now the only chartless, paperless radiation oncology center in the region and the General is taking some of its cues from the Cancer Center as it implements its system-wide information technology.

The Cancer Center also applies the same innovative approach to its treatment technologies. The Center uses a linear accelerator, more affectionately known as LINAC, to deliver therapeutic levels of radiation very precisely to kill cancer cells with minimal collateral damage to healthy tissue. The technology has continuously developed to improve precision, accuracy, treatment delivery, and versatility, allowing treatment in a greater number of areas of the body. Alongside of this has developed a cutting edge imaging system that allows accurate views up to within a minute of treatment delivery to be sure the radiation is delivered as precisely as possible.

Zach Smith, Director of Radiation Oncology at the General’s Pennington Cancer Center compared the evolution of this treatment technology to the constant evolution in car manufacturing. “Think back to ten years ago and then consider all of the style, safety, engineering features that are offered on cars now,” said Smith. “Our technology is similar in terms of the leaps and bounds we have made in cancer treatment. Like the car manufacturers who are constantly working on the features of next year’s model, we are also working on the next generation of this technology.” The Center, which is a current flagship for top-of-the-line radiation therapy, has partnered with Siemens, the creator of the current technology, to develop the next generation. Not only will it be even more precise, but it will offer almost live imaging at times of treatment delivery for the most precise treatment possible. When this technology is ready, the Pennington Cancer Center will be the first facility in the United States, and one of only three in the world, to have it.

Smith said that Siemens is committed to its technology being accessible by everyone and is excited about making it available and practical for a community cancer treatment center rather than the usual academic centers, which tend to have more resources and fewer patients. “It makes sense,” said Smith, “because 85 percent of cancer patients receive treatment in community cancer programs like ours.” In order to sell this very expensive equipment, which costs $2-3 million, it has to be able to be used successfully in the community programs where the patients are. Siemens has declared Pennington one of its Centers for Excellence, and visitors often contact or visit the facility to learn about cancer treatment technology.

The Cancer Center is also fielding inquiries about its state-of-the-art computerized portal imaging technology. Smith recently was invited to the University of Texas M.D. Anderson Cancer Center to share his knowledge and experience about this highly successful technology.
advanced technology, which is based on a digital computer- 
ized radiograph (CR) platform and helps doctors to confirm 
that radiation treatment is accurately aimed at a cancer 
patient's tumor.

To replace their current imaging technology that is nearly 8 
years old, M.D. Anderson is now looking at the CR technology 
Pennington Cancer Center has been taking advantage of for 
more than a year. Because of his first-hand experience with 
the solution and his clinical expertise in radiation oncology, 
Smith was invited to advise M.D. Anderson's physics team 
about the implementation, interfacing, and workflow process 
es used in deploying this premier technology. Due to its superior image clarity, ability to be securely and 
remotely accessed by multiple users, durability, and unique design specific to oncology, FUJI-FILM's new Radiotherapy Portal Imaging technology continues the field's evolution to the 
new digital platform standard. In 2006, Pennington Cancer 
Center partnered with FUJI-FILM, a leader in imaging technol-

gy, to become the sole U.S. testing site for its latest CR Cassette for Portal Imaging solution. During the 15-month clini-
cal trial, Pennington Cancer Center's radiation team looked at 
clinical workflow processes and day-to-day use while imaging 
564 patients during their treatment course. “When we initially 
partnered with FUJI-FILM Medical Systems last year, it was 
because we were looking to upgrade our imaging technology 
and we knew we wanted the latest, most innovative solution 
for our patients,” Smith explained. “Because of our work at 
Pennington Cancer Center, other top cancer centers around 
the world will be able to utilize this amazing technology to ben-
efit their patients.”

Smith said part of the drive to implement the very latest and 
greatest technology is the feeling that as the capital city, Baton 
Rouge should start to be able to offer this level of treatment to 
its people right in their backyard. “Cancer treatment is tough 
enough without having to travel out of state to get it. We think 
it should be available here.”

**Lane Regional Medical Center**

Lane Regional Medical Center reports that it has a lot of new technology recently implemented or in the works. The big pic-
ture includes a multi-million dollar commitment to converting 
from analog to digital equipment throughout the organization, 
as part of Lane's broader commitment to electronic medical 
records and bedside charting. The system will include 
Electronic Medication Administration Record (E-MAR), 
Document Scanning, Mobile Carts for bedside charting, Status 
Board and Flow Sheet for Nursing, Bedside Medication 
Verification, a Physician Care Manager including Physician 
Order Entry, and wireless infrastructure for patients and visi-
tors. The hospital is also in the process of building a new state-
of-the-art cath lab as part of its recently launched Cardiology 
Services, which will offer world-class physicians and care in 
the heart (no pun intended) of Zachary. And, construction is 
underway on Lane's fourth medical office complex, which will 
be the first 3-story building in Zachary.

Despite the many technological updates the hospital is putting 
into place, they chose to focus on a few that are already being 
implemented. The first is the implementation of a new Synapse® PACS, Picture Archiving and Communication 
System, which is a state-of-the-art, radiology image and infor-
mation network system that will dramatically streamline hospit-
al operations and enhance patient care. Developed by FUJI-
FILM Medical Systems USA, Inc., the PACS gives radiologists the ability to electronically view, transmit and store diagnostic images, such as those generated by MRI, CT, Ultrasound, and Nuclear Medicine. With a PACS, both patients and hospital staff benefit from the digital upgrade, including: overall improved efficiency in the diagnostic and patient care cycles; nearly instant access to diagnostic images and results anywhere; and the elimination of overhead costs associated with managing film.

“The benefits we are experiencing with this technology are not only allowing us to do our jobs more effectively and efficiently, but are also allowing our patients to experience improved care and service,” said Greg Dickinson, director of Imaging at Lane Regional. Because diagnostic images are now being stored and viewed electronically, versus the traditional method of printing films which must be viewed on a light box, Lane Regional has been able to increase staff efficiency in relation to the retrieval and transportation of the images for diagnosis. Once a diagnostic image has been “captured,” the PACS technology enables radiologists to immediately and securely call up that image on any networked PC and make a diagnosis within seconds, thus eliminating the lengthy wait times previously necessitated by film development and the need to hand-carry images through the hospital for delivery to the radiologist’s office. This efficiency is a significant benefit to patients who now experience shorter waiting times, receive quicker diagnosis, and are on a faster path to necessary treatment.

“One of the most significant features of this technology is that it makes our records ‘storm-proof,’” stated Ginger Hunt, CEO of Primary Care Providers for a Healthy Feliciana (PCPHF). “That is especially attractive in this post-Katrina world.” She also stated that the program is extremely cost-effective and puts the participants on the cutting edge of the latest trends.

The purchase of the PACS was made possible by a two-year collaboration between PCPHF in Clinton and Lane Regional Medical Center, resulting in a $250,000 Rural Utilities Services Grant through the USDA. “It is wonderful to see that after two years of working together we can now provide the highest level of telemedicine and digital radiology available in the marketplace for our neighbors and patients,” stated Randall M. Olson, CEO at Lane Regional Medical Center.

Lane’s Special Procedures Department has also received a technological makeover. Literally overnight, all of the endoscopy equipment, from scopes, to monitors, to printers, was replaced with the most up-to-date equipment available. The $500,000 makeover included all new Olympus Video processors, light sources, flushing pumps, colonoscopes, gastroscopies, bronchoscopes, high definition flat-screen moni-
tors, and printers, all featuring digital technology. Laura Peel, Director of Endoscopy, said the makeover was essential to keep up with the amazing growth the community is experiencing and is great for both patient and physician satisfaction.

In another part of the hospital, Lane Home Health, the technology may not be as sophisticated, but it is making a significant difference in efficiency and patient care. Home Health Nurses are using the on-line patient education materials (Krames On-Demand) to develop an individualized teaching plan for each of their patients. The personalized teaching information stays in the home for the patient and family members to utilize. The Krames On-Demand system includes over 2,500 HealthSheets in 37 topic areas, in both English and Spanish. It also includes 10 HealthSheets covering the most critical issues in multiple languages. The peer-reviewed information is presented in clear, easy to read language targeted at a middle school reading level. It is enhanced with pictures and diagrams to help patients comprehend what is being discussed. Lane’s Home Health nurses can go online and create customized patient education depending on his/her condition or conditions. Special notes pertaining to that particular patient can be added. The program offers the nurses a competent, single source from which to compile the information and allows them to individualize the patient education. The nurses then can print out the information and bring it to the home so the patient and his/her family have access to it.

Trudie Meeks, Administrator of Lane Home Health said that after just a couple of months, the nurses were excited about what a simple and effective teaching tool the program has been. “We do a lot of home teaching,” said Meeks, “and this has really allowed us to improve that service.” Meeks also said the implementation of electronic health records and the purchase of laptops for the Home Health program have helped enormously. “Now, even when our nurses are on the road or at a patient's home, they can access the patient's records to answer a question, or check on something in the history. It's been a very useful tool for ensuring continuity of care.”

**Earl K. Long Medical Center**

LSU Healthcare Services Division-Earl K. Long Medical Center is also working to implement some of the latest technology to ensure safe, accurate, and continuous medical services. There's a lot going on, but some of the current projects include Telemedicine, Computerized Physician Order Entry (CPOE) for the Emergency Department, a Radiology Information System that includes a Picture Archiving and Communication System, and a seamless Clinical Inquiry System.

Telemedicine is being implemented at all LSU HCSD hospitals including Earl K. Long. The use of Telemedicine will allow...
hospitals to share resources in specialized areas via compressed video technology so that Louisiana citizens can take advantage of services offered across the state. For example, if a physician in Lake Charles specializes in a certain area and a patient in New Orleans needs to be seen by that physician, a Telemedicine appointment will be arranged and neither the physician nor the patient will have to travel. This method of patient care is not only economical, but it ensures continuity of care for all patients served.

A CPOE package is being implemented for the Emergency Department at Earl K. Long as well as all other hospitals in the LSU HCSD System. The CPOE package will automate the order entry process ensuring more accurate order processing and eliminating duplication of orders, thus providing a safer more effective avenue of patient care. The automation of order entry in the Emergency Department is only a small step toward LSU's goal to automate all order entry and move to a true Electronic Medical Record System. LSU HCSD has already received funding to move forward with Electronic Medical Records and Earl K. Long will be a large part of that project.

Another important project for Earl K. Long is the implementation of a Radiology Information System/Picture Archiving and Communication System (RIS/PACS). RIS/PACS will allow Earl K. Long to share vital Radiology tests with other physicians and hospitals within the LSU System as well as with independent practitioners and healthcare organizations. This system will also move Earl K. Long into a filmless environment, which is important in preserving the integrity of patient data and privacy.

Along with all of the new technology being implemented at Earl K. Long, a Clinical Inquiry System is constantly being upgraded to integrate with all systems. The Clinical Inquiry System (CLIQ) is a seamless access point for all patient information. CLIQ allows anytime, anywhere secure access to the Patient Health Information (PHI) so that physicians can provide effective continuity of care.

Earl K. Long Medical Center Computer Services is consistently researching new technology and upgrading existing hardware/software to ensure world class medical services are available to all Louisiana citizens.

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1818: First successful animal blood transfusion.
1842: Ether used as surgical anesthesia.
1853: Invention of the syringe.

1867: Joseph Lister develops antiseptic surgical procedures.
ne look at a timeline of technological advancements and it is easy to see that the latter part of the 20th century and the first part of the 21st have witnessed unprecedented technological advances in the healthcare field. Telemedicine, e-prescribing, robotic surgery, artificial hearts, electronic prosthetics, and genetic screening would have been fuel for science fiction just a few decades ago. Travel a little further back in time and these and many other technological advances

1895: Wilhelm Roentgen uses x-rays for medical imaging.

1901: ABO system of blood typing developed.
would be met, possible in equal measure, as “miracles” or “the devil's work.”

What is interesting is that while the way we practice medicine has changed so dramatically, the attitudes toward medical technology have remained fairly constant. While some hail each new advance as man's gradual dominion over disease, death, and disfigurement, others grow increasingly concerned that we are dabbling in areas that will lead to disaster.

Remember the outcry over the first in vitro fertilization? Hailed as a miracle technology for childless couples, others were scandalized that doctors were playing God. Now the technique is almost commonplace, but has led to other ethical questions. What do you do with the embryos you don't use? Is it okay to use them in research? If you screen embryos for genetic abnormalities or donor qualities, is it much of a leap to select sex, eye color, athletic ability? Do you destroy the ones that don't measure up? Is this better or worse than terminating a pregnancy based on a genetic screening? Though we appear to have avoided it thus far, nobody is ever quite sure which step will start us down the proverbial “slippery slope.” How far is too far?

That question is being raised in Israel where increased ability to test for genetic abnormalities in fetuses may be leading to unnecessary termination of viable pregnancies. A routine part of prenatal care, certain devastating conditions and diseases can be screened for early in the pregnancy, both as a way to prepare parents for the challenges they might face when a disabled child is born and, in more dire cases, to give them the option of terminating the pregnancy. A recent study that appeared in the September 19 issue of JAMA showed that when prenatal screenings indicated that the infant might have Gaucher's disease, in some cases the pregnancy was terminated, even when the likelihood was that it would be a mild and treatable form of the disease. This caused the researchers some concern. The screening test, while useful in the most severe cases for which it was designed, was probably responsible for the termination of viable fetuses. They did note that those couples who received a positive Gaucher screening, but also received medical counseling, were less likely to terminate the pregnancy.

But reproductive technology is far from being the only area of concern. Staying on the topic of genetic screening, we now have the ability to test women for the BRAC I and BRAC II gene indicating a higher risk of breast and ovarian cancer. This information can help them decide when to have children, whether or not to have a mastectomy, and whether to have their ovaries removed. What could possibly be wrong with that if it spares them getting cancer? Well, besides the obvious point that presence of the gene does not guarantee the cancer, so that information may in some cases be leading to unnecessary emotional trauma and surgery, this screening is also raising ethical questions about how to handle that information. Because the presence of the gene has a strong familial link, if one sibling has it, odds are the other might have it too. While one carrier wants this information so she can take action, the other “would rather not know” and is appalled at the thought that she may have already passed this gene to her 5-year-old daughter and now has this knowledge hanging over her head.

Genetic screenings for other things like Hodgkin's disease are causing information issues in other families, leading some doctors to embark on family covenants before a screening to ensure that the information is shared only with those who want it. While this may help, it is obvious that if one of your siblings at age 35 has a radical double mastectomy, she knows something you don't. Like the prenatal screenings designed to do good, they may still do harm.

So if we have a great technology that can save lives, should we not pursue it because it might also take away lives? Is ethics always about the greater good or is the ability to save one life worth it? These are questions meant for deeper thinkers than me, but doctors are still faced with ethical decisions daily. For instance when do you deny life-saving technology? When the patient is clinically dead or when no quality of life is possible? Who decides what quality of life is? While “First do no harm,” is a wonderful moral pillar it is a tad vague for today's scenarios. Highly publicized cases have pitted doctor's recommendations against parent's wishes and garnered the attention of the nation. If a parent still has hope, can they demand continuation of treatment when science says there is no hope? If continuing heroic measures in a hopeless situation is causing pain and loss of dignity, isn't that doing harm? What about when we have the technology to save someone and the family refuses? What if we have the ability to change or prolong life, but the cost is prohibitive and not covered by insurance? Unfortunately our ability to save and prolong life has also presented us with questions we never had to answer before. Throw in cultural and religious differences and a distraught parent or two and it can be a real mess.

Ethics has touched the vaccination issue too. Thanks to vaccinations, the world has managed to drastically reduce and eliminate most of the dread diseases that wiped out millions in years past. Yet, sometimes vacci-
tions are fatal or implicated in development-mental diseases such as autism. Clearly for the vast majority they are a good thing, saving millions of lives, but what is the correct number for determining there is an issue? What is an acceptable number of deaths and disorders to ensure the greater good is being served? As our understanding of the workings of genes, viruses, and disease grows, our ability to prevent illness and death through vaccination keeps pace. Ethical issues rise up single dad with three small children or the 7-year-old injured in a car accident that killed the rest of his family? For organ transplants and prosthetics, ethical discussions can veer off into the truly bizarre, with some critics claiming they dehumanize the person, as if the biological heart is any more responsible for human emotion than an artificial one, or a hug from a prosthetic arm any less heartfelt.

There are privacy and patient's rights issues with technology again however when these vaccinations start being mandated. Can I really be forced to have my 11-year-old vaccinated for a disease she is not susceptible to until she is sexually active (which according to her father won't be until she is 30)?

What about organ transplants? Once the stuff of Frankenstein, the development of better techniques, better anti-rejection drugs, and more accurate screening, has made this a much more viable option than anyone could have hoped. However, donated organs are still extremely hard to come by and the methods for determining who gets them are constantly scrutinized and criticized. Who is more deserving of a heart transplant, the chronic alcoholic who happens to be a chronic alcoholic who happens to be a

So if we have a great technology that can save lives, should we not pursue it because it might also take away lives? Is ethics always about the greater good or is the ability to save one life worth it?

The biggest fear in most ethical discussions about medical technology is that technology designed to heal could be abused to cause harm or to provoke decisions based on improving or enhancing humans rather than providing therapy. But is that a reason to not pursue the technology, which in all likelihood started as a therapeutic or life-saving endeavor? Most ethicists say no, the solution is to provide some level of oversight and regulation so we can keep tabs on where research is headed and how it is being used. An outright ban on certain uses of technology will probably not stop the research, but force controversial studies underground or overseas. The risks and advantages of each new technology should be considered as well as distribution of the burden, accessibility of the treatment, individual rights, etc. There will always be a possibility that technology created to do good may be used to do harm. One ethicist pointed out however, that just because we have the technology to do something, doesn't necessarily mean we will, so we should not allow visions of the "mad scientist" to have a chilling effect on research. Openness, oversight, and ongoing dialogue are each important during this technology boom.

1913: Hot cathode x-ray tube invented.

1927: Invention of the "iron lung," the first functional respirator. Mammography accepted as diagnostic tool.
Louisiana a Leader in Health Information Technology

by: Karen Stassi

ired of finding Louisiana at the bottom of all healthcare related statistics that are good, and the top of all that are bad? Well finally there's something to cheer about. A report by the Department of Health and Human Services Office of the Inspector General (OIG) found that Louisiana is among 12 states that are leading the country when it comes to adopting health information technology. It is also one of 25 with concrete plans in place to implement more health information technology and exchange initiatives. These states are hailed by the federal government as being at the forefront in a long-range national plan to improve the quality of healthcare and control spiraling costs by the year 2014. “We are positioned to take a leadership role in the implementation of Health Information Technology in this country,” said Christina Streb, Health Information Technology Strategist for the Louisiana Department of Health and Hospitals (DHH). “The fact that Louisiana can be placed at the top of the list for Health Information Technology is very exciting.”

In recent years, both the President and the Secretary of the Department of Health and Human Services (DHHS) have promoted the development of Health Information Technology (HIT) and Health Information Exchange (HIE), with the goal of electronic health records available to most Americans by 2014. The Department has called upon the state Medicaid and Medicare agencies to be leaders in this endeavor. In a recent study by the OIG to check on their progress, it was discovered that 12 State Medicaid agencies had implemented a total of 16 HIT initiatives, including claims-based electronic health records initiatives, electronic prescribing initiatives, remote disease monitoring initiatives, and personal health records initiatives. For most states, including Louisiana, implementation of an electronic health record (EHR) was the first priority. In fact nine State Medicaid Agencies have implemented claims-based EHRs. Louisiana’s Medicaid e-CDI (Electronic Clinical Data Inquiry), accessible through a web portal, contains descriptions of diagnosis and procedure codes as well as prescription histories. It also features clinical alerts for disease management of certain conditions, such as diabetes and asthma. Records are available for all Medicaid beneficiaries and are accessible to all enrolled Medicaid providers who prescribe medication in the state, including, doctors, dentists, pharmacists, and certain nurses. Louisiana was also mentioned for its planned Medicaid HIT initiatives, which include electronic prescribing.

The OIG report also noted that 25 states are involved in planning and developing statewide HIE networks to allow for the secure exchange of healthcare information. Again, Louisiana is at the head of the pack. The main goal of these networks is to develop a statewide infrastructure to support the widespread use of HIT and to allow most, if not all, healthcare providers and payers in a region or community to securely exchange clinical information. DHHS has been working on a prototype for a National Health Information Network (NHIN) under a contract from DHHS. Of course, what had always seemed like a good idea, became more of a priority after the chaos and destruction caused by hurricanes Katrina and Rita. The importance of secure electronic health records and the ability to communicate that information across the state became clear and fostered a partnership between DHH, healthcare providers, and others called the Louisiana Health Information Exchange (LaHIE). LaHIE is now a state-funded collaborative consortium of public and private healthcare organizations with a common goal of implementing and using technology to improve both access to health information and patient care across the state.

The way DHH sees it, LaHIE will eventually be the umbrella network consisting of multiple regional networks and exchanges, which can operate autonomously, but which will also be part of the larger statewide information exchange. The ultimate goal, said Streb, is to create an electronic master patient index which will include a minimum amount of information, such as name and address as well as medications, allergies, discharge notes, etc., on every Louisiana resident. “That way, should disaster strike again, wherever the Louisiana resident temporarily relocates and seeks medical care, the receiving doctor will be able to determine each person’s abbreviated medical history, ensure that each person has an adequate supply of the drugs they are taking, and that the physician will be alerted to any allergies,” said Streb. “This will expedite obtaining any immediate care needed for the person while helping to decrease or even eliminate treatment delays or errors.”
The rural parish of Pointe Coupee will soon have a more advanced electronic network of medical information than most other areas of the state because of funds awarded through the federal Department of Health and Human Services. The $1.5 million grant will link 11 rural healthcare providers serving the region. Network members include Pointe Coupee General Hospital, Our Lady of the Lake Regional Medical Center, four local rural health clinics managed by Our Lady of the Lake Regional Medical Center in New Roads, Innis Community Health Center, Better Access to Community Health, two private practice primary care clinics, and Pointe Coupee Homebound Health and Hospice.

- A $30 million award to LSU Health Care Services Division will allow for the first phase of an upgrade to their electronic medical record systems that will provide a common interface across its ten hospitals.

- In the near future, DHH, through Medicaid, will launch an aggressive project to assist Community Care physicians in obtaining and embracing Electronic Medical Record (EMR) software for use in their individual office practices, thereby enabling those primary care physicians to participate in this electronic exchange. Payment to assist physician adoption of EMR will be achieved through enhanced payments to the physicians by Medicaid.

Several other Louisiana parishes and communities are working to develop projects or have implemented health information technology on a smaller scale. Adding to these efforts are a coalition of state health officials and medical professionals who have come together to advance HIT implementation in Louisiana. The Health Information Security and Privacy Collaboration (HISPc) utilizes a multi-faceted approach including advocacy, education, and outreach to address issues of privacy and security in electronic medical records. HISPc is funded by the Louisiana Department of Health and Hospitals, the Agency for Healthcare Research and Quality, and the Office of the National Coordinator for Health Information Technology. It is administered by RTI International. In the coming months, members of the statewide HISPc collaboration will work to assist physicians with resources available to them to transition to EHRs and educate patients on how the new technology is underpinned by secure and private data storage and transfer. HISPc recently announced the launch of a website, www.ehrtoday.org, designed to educate Louisiana citizens and their caregivers on how security and privacy of personal health information can be managed to foster the adoption of electronic health records for all patients and providers.

Sources:

The original LaHIE Steering Committee was composed of one representative from each data publishing organization. These included:
- Baton Rouge General Medical Center
- Our Lady of the Lake Regional Medical Center
- Louisiana Health Care Review
- Baton Rouge Primary Care Collaborative
- Ochsner Health System
- Blue Cross and Blue Shield of Louisiana
- Medical Center of Louisiana/LSU Health Care Services Division
- Daughters of Charity Services of New Orleans.

Additional healthcare providers will join this list as LaHIE continues to develop and expand.

In addition to having the ability to receive appropriate data from the hospitals and other healthcare providers who participate in this Exchange, LaHIE will also receive data from both Blue Cross and Blue Shield and the Louisiana Medicaid Program. In the meantime, Louisiana can already boast some success stories with both information technology and information sharing:

- The Valentine Medical Center, a new family healthcare, urgent care, and occupational medical clinic in Gretna, opened two years after being destroyed by Hurricane Katrina. The center opened with electronic health record software and hardware donated by vendors who participated in the Katrina-Phoenix project sponsored by the Louisiana Healthcare Information and Management Systems Society (LaHIMSS) Foundation. LaHIMSS is a tax-exempt, non-profit corporation focused on providing leadership in healthcare for the management of systems, technology and information.

- A $13 million program targeting rural hospitals in North Louisiana will provide access to both electronic health records and information sharing. Over the next five years, 24 rural hospitals will be equipped with electronic health records that will link to LSU Medical Center at Shreveport. Not only will these hospitals be able to publish to a rural hospital information exchange hosted by LSU-Shreveport, but it will allow patients to receive better care both in Shreveport and at home in their own communities. The first seven will be fully connected early this year, with seven more to follow each year. In the meantime LSU-Shreveport is extending telemedicine capabilities to all 24 this year, allowing doctors to monitor their patients at the hospital and allowing patients to return to the care of their local physicians with fewer delays. Eventually, 900 area physicians will have real-time access to their patients’ electronic health records while they are in the hospital in Shreveport after they return home. Approximately 100 physicians will have that access this year.

- The rural parish of Pointe Coupee will soon have a more advanced...
It seems that every time you turn around, there is a new drug or medical device promising better, faster, smaller, less-invasive, more efficient solutions to the problems that ail us. Yet surprisingly, the federal Food & Drug Administration (FDA) says this “age of innovation” is somewhat lacking compared to years past. Despite important investments in basic biomedical research, the number of applications to the FDA for approval of new drugs and biologics has declined over the past decade. Of more concern to the agency, product development is not becoming more efficient over time. In fact, a drug entering Phase 1 trials in 2000 was not more likely to reach the market than one entering Phase 1 trials in 1985. The agency is concerned both about the scarcity of new technology and the “Critical Path,” defined as the scientific process through which a potential human drug, biological product, or medical device is transformed from a discovery or “proof of concept” into a medical product. The Critical Path consists of scientific tests and tools used to predict whether a product candidate will be safe and effective, to assess how prototypes interact with the human body, and to guide the sponsor in choosing an appropriate dose and regimen or device size and/or placement. It also consists of scientific tools to manufacture the product at commercial scale and assess the quality of the manufactured product.

The problem, says FDA, is that many of the tools used today to predict and evaluate product safety and efficacy, and to manufacture products, are badly outdated from a scientific perspective. To address this problem, FDA launched its Critical Path Initiative to stimulate and facilitate a national effort to modernize the scientific process of product development. The goal is to bring new scientific discoveries—in fields such as genomics and proteomics, tissue engineering, imaging, and bioinformatics—to bear on product development, to improve the accuracy of the tests we use to predict the safety and efficacy of investigational medical products.

With tools that can predict which product candidates do not hold promise early in the development process, product sponsors can redirect resources to more promising products. Early failures are efficient failures—they free up resources that would otherwise be invested in product candidates that will eventually fail. New Critical Path tools will help product sponsors devote those resources to new and better candidates, thus facilitating the availability of more new medical products for patients. In addition, modern evaluation tools will be more informative—we will learn more about products before they are approved. This will give doctors and patients the best available information about how to use the product to maximize its benefit and minimize side effects. In fact many of the tools being considered would help individualize therapy, by identifying who is likely to respond well to a treatment, and who should avoid it.

1938: Electroconvulsive therapy developed by Ugo Cerletti and Lucio Bini. Federal Food, Drug, and Cosmetic Act supersedes Food and Drugs Act of 1906 and extends coverage to medical devices, making it illegal to sell devices that are dangerous or marketed with false claims.
The FDA is not taking sole responsibility for improving the Critical Path, but because it oversees evaluation of all U.S. medical products, it can identify the key product development hurdles that commonly cause setbacks for companies industry-wide and ensure that new Critical Path tools become the new standards for proving efficacy, assessing safety, and manufacturing medical products. However, FDA has asked industry, academic researchers, patient advocacy groups, and others to do their part. The agency has published a Critical Path Challenges List at www.fda.gov/oc/initiatives/criticalpath/reports/opp_list.pdf. The purpose of the list is to provide concrete focus for public and private efforts and investments in new tools that could revolutionize product development. The list outlines an initial 76 "science projects" to bridge the gap between the quick pace of new biomedical discoveries and the slow pace at which those discoveries are currently translated into therapies for patients. The release of the list marks a starting point in identifying the essential development priorities to be accomplished under the agency's Critical Path Initiative.

One of the critical path opportunities on which FDA is currently working is the accelerated development of an artificial pancreas. FDA is collaborating with private organizations, researchers, and other government agencies to accelerate development of new technologies that are needed for an artificial pancreas. The goal of an artificial pancreas is to maintain blood glucose levels within normal ranges, with little to no patient involvement. It will monitor glucose levels in the body and automatically adjust the delivery of drugs that can either reduce or elevate blood glucose levels. The first generation of an artificial pancreas is likely to consist of three components: (1) an infusion pump to deliver the required drug, many of which are already available; (2) a continuous glucose monitor, several of which have been approved by the FDA for tracking and trending glucose levels; and (3) an algorithm to communicate between the pump(s) and glucose monitor. An algorithm will receive information from the glucose monitor and convert it to instructions for the infusion pump. FDA is advising independent clinical researchers as they develop new technologies that are needed to make an artificial pancreas a reality, and assisting them as they design studies to evaluate their safety and effectiveness. FDA is also collaborating with stakeholders to define a regulatory pathway for these new technologies.

Experts estimate that, if accomplished, the new tests and tools developed under the Critical Path Initiative will modernize the drug development process by 2010 and help to get new medical discoveries to Americans faster and at a lower cost.

**1945:** Willem Kolff invents a crude, yet effective kidney dialysis machine.
The Extreme Lateral Interbody Fusion (XLIF) is a technique that has been recently developed to allow an anterior spine fusion through a minimally invasive approach. This technique allows a fusion through a very small incision that is placed on the lateral abdominal wall, and as a result avoids much of the morbidity associated with traditional spine surgery. Commonly used posterior spinal fusion techniques often involve a large incision and extensive stripping of the musculature,
and this has been associated with significant post-operative pain and morbidity. Another commonly used technique, anterior lumbar interbody fusion (ALIF), is typically done using a retroperitoneal or transperitoneal abdominal approach. This approach often requires careful coordination with an approach surgeon and mobilization of the surrounding vasculature. This is done through a larger and less cosmetic incision and carries the risk of injury to the surrounding tissues.

The XLIF procedure is performed through a 2 cm incision that is placed on the lateral abdominal wall. The approach is performed using the retroperitoneal space and dissection is easily carried down to the psoas muscle which overlies the lateral lumbar spine. This technique has been avoided in the past due to fear of injury to the lumbar nerve plexus that overlies this muscle. However, recent advances in intraoperative neurological monitoring now allow the surgeon to carefully detect nerves and avoid injury to them during this dissection. The approach is continued through the psoas muscle with special monitored dilators that allow final access to the vertebrae and disc space. A specially designed monitored retractor system that attaches to the table is then used to maintain this exposure while the spinal fusion is performed.

There are several advantages to this approach over the traditional techniques. It allows the surgeon to place a larger graft in the interbody space. This improves the stability and increases the chance of fusion when compared to posterior techniques. It also avoids much of the approach related morbidity and risks associated with the typical anterior and posterior techniques. As a result, patients typically require less pain medication postoperative, have a significantly shorter hospital stay, and often enjoy an earlier return to activities. In addition, the postoperative scar is significantly more cosmetic than the larger incisions used for the traditional approaches.

The XLIF procedure is an excellent procedure for appropriate candidates. Patients that require interbody fusion and indirect decompression of the neural elements may elect this as an optional surgical treatment. However, fusion is only possible as caudal as the L4-L5 interspace secondary to the overlying iliac crest. In addition, some patients may require a more direct decompression of the spinal canal that is more amenable to a posterior approach.

Rattle off the words, “Extreme Lateral Interbody Fusion” and people are probably going to look at you sideways. As well they should, because XLIF is a new approach to spine surgery during which the surgeon accesses the vertebrae from the side, or laterally. XLIF, designed by Nuvasive®, may be used to address instability of the vertebrae due to degenerative disc disease, recurrent disc herniation, post laminectomy syndrome, degenerative spondylolisthesis, or degenerative scoliosis. XLIF allows for maximum access and is minimally invasive, reducing both surgery times and recovery times.

The XLIF procedure has been performed locally by Dr. Kevin McCarthy at the Bone and Joint Clinic, Dr. Jorge Isaza at Baton Rouge Orthopedic Clinic, and Dr. Stephen Gick at Ochsner. As mentioned by Dr. McCarthy, advances in nerve monitoring technology have made this approach possible. The Nuvasive system includes a high tech electromyography or nerve monitoring system, called NeuroVision, which provides real-time, surgeon-driven monitoring of the nerves in the surgical area to ensure they are not damaged. Adhesive electrodes are placed on the skin overlying the leg muscles for lumbar surgery (or arm muscles for cervical surgery) and provide instantaneous feedback to the surgeon on nerve health and function.

XLIF is not for everyone. The procedure is generally recommended for those who do not require direct access to the nerves for decompression. Placement of screws or rods for increased stability might also require a second procedure. Surgeons will generally consider patients for this type of surgery after they have explored other more conservative approaches to easing their discomfort.

- Karen Stassi
Deep Brain Stimulation (DBS) is a relatively simple, yet startlingly effective treatment for certain candidates with movement disorders caused by Parkinson's, Essential Tremor or Dystonia. Generally a measure of last resort for those whose tremors are radically interfering with normal life and for whom medication is no longer working, or in some cases even exacerbating symptoms, the treatment has shown great promise. Generally performed at major academic medical centers, DBS is available for the first time in Baton Rouge at the NeuroMedical Center.

Almost the stuff of science fiction, deep brain stimulation involves passing a wire fitted with four tiny electrical contacts deep into the area of the brain that is causing the tremors. The low amplitude, high-frequency electrical stimulation overrides normal function for the portion of the brain triggering the tremors or spasms. Performed by a neurologist and a neurosurgeon working together, the procedure involves drilling a 14 millimeter hole through the skull, under local anesthetic, and feeding the wire in through a catheter. Brain waves are measured to ensure proper placement as the pattern of the waves helps surgeons determine what part of the brain they are in. The patient remains conscious during the procedure so that the neurologist can also gauge proper placement and tremor control efficacy through patient reactions. Since the patient is awake, the electrode can be tested to ensure it has the desired effect and that the patient can tolerate it being in that spot with no side effects. The patients do not experience pain during the procedure as there are no pain receptors in the brain. “Patients don't complain of any pain,” said Dr. Paul J. Waguespack, the neurosurgeon on the team, “but they do complain that it is very loud when we are making the incision with the air drill.” Once the desired location and effect are confirmed, the temporary electrode is replaced with a permanent one. The opening in the skull is capped and a wire is run under the scalp to a spot behind the ear. There it connects to an extension which is also run under the skin to a small battery or pulse generator, similar to a pacemaker, implanted under the skin of the chest wall.
Prior to this technology, neurosurgeons could perform a thalamotomy or pallidotomy, which basically involved freezing or killing the part of the brain causing the tremors. The effect was almost like a miniature stroke. In fact, the idea for the surgery came after observers noted that patients with advanced Parkinson's would sometimes have improvements in their symptoms following a stroke in that part of the brain. One of the most famous patients to undergo this process was Michael J. Fox who suffers with Parkinson's. While the process works well, it has a few disadvantages. First, it is not reversible, so if by chance the wrong part of the brain is frozen, it can't be undone. Secondly, the human brain can be quite adept at overcoming an isolated “injury” and can sometimes work around the frozen area, with a return of symptoms, sometimes years down the road. Researchers began to look for something that would be reversible and also offer a little more control. With deep brain stimulation, the device can be programmed and manipulated externally with a sophisticated PDA-like device for optimum effect. For example, with Parkinson's patients, the stimulation parameters can be gradually increased as medication is gradually decreased until an acceptable balance is reached. Patients can also turn off the device if bothered by side effects from incorrect placement or improper settings. These can include tingling on one side, slurred speech or vision problems. The fact that DBS is reversible also means patients are able to try new treatments as they are developed. Researchers are exploring ways to use DBS to treat obsessive compulsive disorder, depression, and pain disorders.

The procedure, which has actually been approved by the FDA for several years, requires a multidisciplinary approach and specialized training. Dr. Gerald J. Calegan, II is a neurologist specializing in movement disorders while Dr. Waguespack is a neurosurgeon who actually performed the first deep brain stimulations in Louisiana in 1997 during his training at Tulane. The two are the first to offer the treatment in our area. Prior to Hurricane Katrina, the procedure was performed in New Orleans, but the specialists have dispersed and it is not currently available at Tulane or LSU. Although the treatment is fairly common, it generally occurs at major academic centers like the Mayo Clinic, Harvard, or Baylor. It is unusual to find it at an independent facility. The surgery has been performed for only a few months here, but the four patients treated at the NeuroMedical Center thus far are reportedly all doing well. For some the procedure has been life changing. One patient, a woman from Mississippi, had suffered with an essential tremor for decades, but in recent years the tremors had gotten so strong that she could not eat or drink in public, talk on the phone, write or type. When the device was implanted and activated, her tremors were almost 100 percent resolved instantaneously. “She was holding a cup of water and her tremors were so violent, we were all getting wet,” said Dr. Calegan. “When we turned the device on, her hand went perfectly still. She was crying, she was so happy.”

The procedure tends to be covered by insurance, with out-of-pocket expenses similar to any other surgery. At the NeuroMedical Center, the doctors like to break the procedure into small steps to ensure proper planning and less stress on the patient. Once the patient is declared a candidate for the treatment, they come in for an outpatient MRI. The planning for surgery is done well in advance. On the first day of the procedure, the patient comes in for the implantation of small screws which help with the accuracy of the procedure through computer imaging. This process takes about 30 minutes. A CAT scan is done to check placement and the patient is sent home. The next day the patient returns for the surgery, but by then everything is taken care of, so there is nothing but the procedure to focus on. Once the electrode is placed, then the patient is provided mild sedation for the rest of the procedure, which entails securing the electrode, capping the hole and running the wire. The patient spends one night in ICU for observation. The following week they return to have the pulse generator or battery implanted under the skin of the chest wall, which is completed as same-day surgery. Some require minimal follow-ups to ensure the settings are correct for them, but other than that, there are few issues. The battery life is three to seven years, depending on usage, and replacement involves a 30-minute outpatient procedure.

Once they receive the implant, just about the only stipulation is that patients must avoid having MRIs. The treatment carries a very low complication rate with marked improvement in quality of life. “They also leave with a very fine haircut,” quipped Dr. Calegan. ❖
Pelvic Congestion Syndrome (PCS) is a condition that is difficult to diagnose but causes distress to a significant number of women. Chronic pelvic pain accounts for up to 40 percent of outpatient gynecology office visits and is said to occur in 15 percent of women between the ages of 18 and 50. When physical and ultrasound exams are normal, many will get better without any intervention. Common causes of chronic pelvic pain include endometriosis or structural abnormalities of the fallopian tubes, bowel, or bladder. It is important that these significant diagnoses are excluded before a diagnosis of pelvic congestion syndrome is considered.

PCS is caused by a reflux of blood down the ovarian veins into the internal iliac veins within the pelvis, with swelling and engorgement of the veins causing pain, similar to varicose veins in the legs. This occurs most often in women who have had multiple births and is related to a lack of valves in the veins and the constant hormonal changes related to pregnancy. The pain is usually chronic and dull and presents with a post-coital ache that may last for hours or days and may be relieved by lying down. A family history of varicose veins and associated vulval varicosities is often present. Other features on exam include cervical motion tenderness and an engorged blue-looking...
PCS is caused by a reflux of blood down the ovarian veins into the internal iliac veins within the pelvis, with swelling and engorgement of the veins causing pain, similar to varicose veins in the legs.

cervix. These women are often anxious and very depressed, partly because they have very real symptoms for which the cause is often difficult to find. The stretching of the veins can also cause a release of neuro-peptide transmitters and neurokinins that are known to play a key role in the regulation of emotions.

Ultrasound, cat scans, and MRIs are not very sensitive for diagnosing this condition and ultimately a direct venogram is the procedure of choice for the definitive diagnosis. This is done by an interventional radiologist and is usually performed through a small needle puncture in the vein in the groin and a small catheter threaded into the veins of the ovaries. If the venogram demonstrates reflux, then these veins can be blocked off with coils and foam to prevent any further reflux. If the symptoms do not improve, then a repeat venogram will be performed about six weeks later and the internal iliac veins may have to be blocked off as well, as these can also cause the reflux. The procedure is performed as an outpatient procedure and the patient is sent home later that day. The success rate is similar to surgery with about 80 percent of patients describing relief of their symptoms after the procedure. The complication rate of this procedure is very low with significant pulmonary emboli posing no issue.

Patients with pelvic congestion syndrome are generally unhappy and have been through many procedures and exams to exclude other causes of pain. It is important that this diagnosis be considered and direct venography performed if no other causes have been found for the chronic pain. This disease can be successfully treated if diagnosed correctly and these patients can get significant relief of their symptoms.
MIT researchers have developed a new algorithm to help create prosthetic devices that convert brain signals into action in patients who have been paralyzed or had limbs amputated. The technique, described in a paper published in the October edition of the Journal of Neurophysiology, unifies seemingly disparate approaches taken by experimental groups that prototype these neural prosthetic devices in animals or humans.

Neural prosthetic devices represent an engineer's approach to treating paralysis and amputation. Here, electronics are used to monitor the neural signals that reflect an individual's intentions for the prosthesis or computer they are trying to use. Algorithms form the link between neural signals that are recorded and the user's intentions that are decoded to drive the prosthetic device.

Over the past decade, efforts at prototyping these devices have divided along various boundaries related to brain regions, recording modalities, and applications. The MIT technique provides a common framework that underlies all these various efforts.

Listening for Cancer

Researchers from the Georgia Institute of Technology have created an acoustic sensor that can report the presence of small amounts of mesothelin, a molecule associated with a number of cancers including mesothelioma, as they attach to the sensor's surface. According to the researchers, the technique might work for the detection of nearly any biomarker or molecular signal that denotes the presence of disease. They envision a relatively affordable, quick, and non-invasive diagnostic tool that could be used by physicians in detecting a wide variety of diseases.

The ACuRay™ chip, standing for ACoustic micro-arRay consists of a series of electrodes deposited on the surface of a thin film of zinc oxide, which allows the device to resonate or vibrate at a specific frequency when a current is applied. To turn this array into a sensor, the Georgia Tech researchers coated the zinc oxide surface with mesothelin-specific antibodies. These molecules are engineered versions of the antibodies the immune system creates to identify foreign intruders, such as microbial parasites. Mesothelin is a cell-surface protein that is highly expressed in mesothelioma, ovarian cancer, pancreatic cancer, and other malignancies. When the mesothelin binds to an antibody, the added mass changes the frequency at which the acoustic wave passes between the electrodes on the surface of the device. The device is able to "hear" the pitch change due to nanomolar concentrations of mesothelin (just a few molecules amid billions) binding to antibodies on the chip.

FDA Clears 'Computerized Medication Box' for U.S. Market

The U.S. Food and Drug Administration has cleared for marketing INRange Systems’ Electronic Medication Management Assistant (EMMA), a programmable device that stores and dispenses prescription medication for patients’ use in the home. Essentially a computerized medication box, EMMA was designed to be used under the supervision of a licensed healthcare provider. EMMA can reduce drug identification and dosing errors, and allow healthcare professionals to monitor patient adherence to medication regimens in an outpatient setting. It may be especially useful for aging patients, as well as those with complex medication regimens such as patients with HIV. A 2006 Institute of Medicine report estimated that medication errors harm at least 1.5 million people in the United States annually.

EMMA consists of a medication delivery unit and two-way communication software that allows a healthcare professional to remotely manage prescriptions stored and released by the patient-operated delivery unit. The delivery unit is about the size of a bread box and plugs into a standard power outlet. EMMA stores prescription medications, emits an audible alert to the patient when the prescribed medications are scheduled to be taken, and releases them onto a delivery tray when activated by the patient at the appropriate time. It uses a Web-based application for a healthcare professional, such as a doctor or pharmacist, to remotely schedule or adjust a patient's prescribed medications, and provides the healthcare professional with a history of each time patients access their medications.

FDA reviewed safety and effectiveness information for EMMA under the "de novo" classification process. The ability to petition for "de novo" initial classification was added under the Food and Drug Administration Modernization Act of 1997 to establish an additional way for novel, but less risky, devices to get to market.

Computer Check-in at the ER?

A few hospitals around the country are trying out a novel way of checking in to the ER or other clinics. Instead of standing in line or hoping to look worse than the guy next to you, patients can check in at computer kiosks, where all pertinent data are entered and a series of questions about symptoms are answered. Similar to electronic check-in at airports, not only does this get patients in the system faster at a busy ER, but it also helps with triage decisions. Plus, when the patient is admitted, they are already in the hospital's system, saving time on data entry and allowing immediate access by other departments. Although the kiosks are designed to be user-

1959: Ultrasound developed for use in obstetrical and gynecological diagnosis.

1960: Cardiopulmonary resuscitation invented. First internal pacemaker succeeds.
friendly, staff members still need to be on hand to help if patients either get stuck or refuse to use it. Some systems even allow for consent forms and payment information to be handled though the kiosk, or in some cases an electronic tablet, with a built-in card swipe and signature pad.

**Medtronic Suspends Sprint Fidelis Defibrillator Leads**

Medtronic has voluntarily suspended distribution of its Sprint Fidelis defibrillation leads because a small number of fractures have been detected. As a result of Medtronic's action, no more Sprint Fidelis leads will be sold or manufactured and any remaining product should be pulled from inventory and returned to the company. Patients who are implanted with this lead are encouraged to contact their physicians for further information.

In the infrequent circumstance where a lead actually breaks, or "fractures," the lead may send false signals that cause inappropriate defibrillator shocks, or therapies such as pacing or shocks may not be delivered. Current adverse event information indicates that fractures have occurred in less than one percent of the approximately 268,000 of these leads implanted worldwide. Although the leads should no longer be implanted in patients, this recall does not imply that the leads should be surgically removed.

**Laser Blasts Viruses in Blood**

A father-son research team working in separate labs has discovered a new use for lasers—zapping viruses out of blood. The technique, which holds promise for disinfecting blood for transfusions, uses a low-power laser beam with a pulse lasting just fractions of a second.

Johns Hopkins University student Shaw-Wei David Tsen, an immunology researcher in the laboratory of T.C. Wu at Hopkins' Kimmel Cancer Center, sought a new method to rid isolated blood of dangerous pathogens, including the viruses HIV and hepatitis C. He says current techniques using UV irradiation and radioisotopes can leave a trail of mutated or damaged blood components. Using ultrasonic vibrations to destroy viruses was one possibility, but his father, Kong-Thon Tsen, a laser expert at Arizona State University, had a better idea: Lasers, unlike ultrasound, can penetrate energy-absorbing water surrounding the viruses and directly vibrate the pathogen itself.

The researchers aimed a low-power laser with a pulse lasting 100- to 1000-fold after the laser treatment. Instead of emitting a continuous beam of visible light like most lasers, this one repeatedly sends a rapid pulse of light and then relaxes, allowing the solution surrounding the virus to cool off, significantly reducing heat damage to normal blood components.

Building on the idea that vibration wrecks a virus' outer shell, the scientists found that their low-power laser selectively destroys viruses and spares normal human cells around them, while stronger beams kill almost everything. Father and son speculate that laser vibrations could destroy drug-resistant and -sensitive viruses alike. The scientists published their results in the July 13 issue of the Journal of Physics: Condensed Matter.

**Plain Soap as Effective as Antibacterial but Without the Risk**

Antibacterial soaps show no health benefits over plain soaps and, in fact, may render some common antibiotics less effective, says a University of Michigan public health professor. In the first known comprehensive analysis of whether antibacterial soaps work better than plain soaps, Allison Aiello of the U-M School of Public Health and her team found that washing hands with an antibacterial soap was no more effective in preventing infectious illness than plain soap. Moreover, antibacterial soaps at formulations sold to the public do not remove any more bacteria from the hands during washing than plain soaps.

Because of the way the main active ingredient in many antibacterial soaps—triclosan—reacts in the cells, it may cause some bacteria to become resistant to commonly used drugs such as amoxicillin, the researchers say. These changes have not been detected at the population level, but e-coli bacteria bugs adapted in lab experiments showed resistance when exposed to as much as 0.1 percent wt/vol triclosan soap. The study, "Consumer Antibacterial Soaps: Effective or Just Risky?" appears in the August edition of Clinical Infectious Diseases. The team looked at 27 studies conducted between 1980 and 2006, and found that soaps containing triclosan within the range of concentrations commonly used in the community setting (0.1 to 0.45 percent wt/vol) were no more effective than plain soaps. Triclosan is used in higher concentrations in hospitals and other clinical settings, and may be more effective at reducing illness and bacteria.
**MIT Researchers “Beam Up” Cells**

In a feat that seems like something out of a microscopic version of Star Trek, MIT researchers have found a way to use a “tractor beam” of light to pick up, hold, and move around individual cells and other objects on the surface of a microchip. The new technology could become an important tool for both biological research and materials research, say Matthew J. Lang and David C. Appleyard, whose work is being published in an upcoming issue of the journal Lab on a Chip. Lang is an assistant professor in the Department of Biological Engineering and the Department of Mechanical Engineering. Appleyard is a graduate student in Biological Engineering. The idea of using light beams as tweezers to manipulate cells and tiny objects has been around for at least 30 years. But the MIT researchers have found a way to combine this powerful tool for moving, controlling, and measuring objects with the highly versatile world of microchip design and manufacturing. Optical tweezers, as the technology is known, represent “one of the world's smallest microtools,” says Lang. “Now, we're applying it to building [things] on a chip.” As a demonstration of the system's versatility, Appleyard says, they set it up to collect and hold 16 tiny living E. coli cells at once on a microchip, forming them into the letters MIT.

**New Sensors Integrate Aerosol Technology, Microelectronics to Better Detect Asthma 'Triggers’**

Researchers at RTI International are developing a new generation of small wearable sensors as part of a National Institute of Environmental Health Sciences exposure-biology program to more clearly understand personal exposures to tiny airborne particles that trigger asthma attacks. The project is among the first to be funded as part of the Genes, Environment and Health Initiative of the National Institutes of Health, a unique collaboration between geneticists and environmental scientists. The research effort focuses on developing and miniaturizing RTI aerosol exposure measurement technologies to create a new generation of tiny devices that can easily be worn by both children and adults.

The devices will be designed to provide researchers with a record of real-time aerosol concentration levels, so that both peak and long-term exposure periods can be connected to undesirable health outcomes. These in turn can then be related to existing U.S. Environmental Protection Agency standards. The sensor system will
also characterize ozone and tobacco smoke exposures and their con-
 founding health effects for asthmatics.

**FDA Approves Continuous 7-Day Glucose Monitoring System**

The U.S. Food and Drug Administration has approved a device that measures glucose levels continuously for up to seven days in people with diabetes. While a standard fingerstick test records a person’s glucose level as a snapshot in time, the STS-7 Continuous Glucose Monitoring System (STS-7 System) measures glucose levels every five minutes throughout a seven-day period. This additional information can be used to detect trends and track patterns in glucose levels throughout the week that wouldn’t be captured by fingerstick measurements alone. However, diabetics must still rely on the fingerstick test to decide whether additional insulin is needed.

The STS-7 System uses a disposable sensor placed just below the skin in the abdomen to measure the level of glucose in the fluid found in the body’s tissues (interstitial fluid). Sensor placement causes minimal discomfort and can easily be done by patients themselves. The sensor must be replaced weekly. An alarm can be programmed to sound if a patient’s glucose level reaches pre-set lows or pre-set highs.

**Implantable Telescope May Help Severe Age-related Macular Degeneration**

Recent studies at the Joint Clinical Research Center at the Massachusetts Eye and Ear Infirmary have explored the use of a prosthetic device—an implantable miniature telescope—for end-stage age-related macular degeneration. While the device has not yet been approved by the Food and Drug Administration, physicians have described a recommended surgical technique to ensure proper product placement while minimizing damage to the eye. Their technique is published in the August issue of the *Archives of Ophthalmology*.

The implantable telescope has completed two years of follow-up in a pivotal multicenter trial. In this phase 2/3 clinical trial, 206 patients received the telescope prosthesis implant. One-year outcomes showed that 67 percent of eyes with the implant achieved a three line or greater improvement in best-corrected distance visual acuity, as indicated by reading an eye chart, compared with 13 percent of the fellow eyes in control patients. Meaningful improvements in quality of life measurements were also shown.

**Tumor Painting Revolutionizes Fight Against Cancer**

A tumor paint developed by researchers at Seattle Children’s Hospital Research Institute and Fred Hutchinson Cancer Research Center will help surgeons see where a tumor begins and ends more precisely by illuminating the cancerous cells. The study, published in the July 15, 2007 issue of *Cancer Research*, shows that the tumor paint can help surgeons distinguish between cancer cells and normal brain tissue in the operating room. The paint is a scorpion-derived peptide called chlorotoxin that is linked to the molecular beacon Cy5.5. Until now there has been no way to allow surgeons to see tumors "live" during surgery.

Chlorotoxin: Cy5.5 is a fluorescent molecular beacon that emits photons in the near infrared spectrum. This illumination gives surgeons a better chance of removing cancerous cells during surgery without injuring surrounding healthy tissue. This is particularly significant in the brain, where approximately 80% of malignant cancers recur at the edges of the surgical site. Current technology, such as magnetic resonance imaging (MRI) can distinguish tumors from healthy tissue only if more than 1 million cancer cells are present. But Cy5.5 can identify tumors with fewer than 2000 cancer cells, making it 500 times more sensitive than MRI under operating conditions.

**MIT Works Toward Zapping Cancer Cells**

MIT and University of Rochester researchers report important advances toward a therapeutic device that has the potential to capture cells as they flow through the blood stream and treat them. Among other applications, such a device could zap cancer cells spreading to other tissues, or signal stem cells to differentiate. The concept leverages cell rolling, a biological process that slows cells down as they flow through blood vessels. As the cells slow, they adhere to the vessel walls and roll, allowing them to sense signals from nearby tissues that may be calling them to work. Immune cells, for example, can be slowed and summoned to battle an infection.

In the body, P-selectin and other selectin proteins regulate cell rolling in blood vessels. When P-selectin is present on a vessel’s inner wall, cells that are sensitive to it will stick to that patch and begin to roll across it. To induce rolling in the laboratory, the original technology weakly adheres P-selectin to a glass surface and flows cells across it. This surface treatment remains stable for several hours then breaks down. To improve the technology, the team experimented with several chemical methods to immobilize P-selectin on a glass surface. They identified a polyethylene glycol (PEG) coating that strongly bonded to P-selectin. This coating is also “non-fouling,” meaning it does not react with or accumulate other proteins, so it is potentially safe for use in an implant.

To validate that this technology works with cells that are sensitive to P-selectin, the team flowed neutrophils (white blood cells) across the coated surface. They too slowed and rolled on surfaces treated with the new coating, and the effect lasted for at least four
weeks. The next step is translating these results to animal studies and using the technology to slow and capture stem cells and cancer cells circulating in the blood stream. Ultimately CellTraffic, Inc., a sponsor of this technology and its licensees, wants to apply the technique to a device that is either implanted into the blood stream or appended as a shunt. In addition to PEG and selectin molecules, the device would also include a therapeutic agent. Such an agent would interact only with certain cells for a specific purpose.

**Video-assisted Valve Surgery**

*Feasible as Additional Heart Operation*

Minimally invasive, video-assisted key-hole valve surgery is feasible in people who have had cardiac operations and significantly reduces risk of death during or after the procedure, according to a study reported in a cardiovascular surgery supplement of *Circulation: Journal of the American Heart Association*. Cardiac surgery, as well as older age and poor health, increases the risk of death in a person undergoing additional heart operations. However, in this study, patients undergoing video-assisted valve surgery had a death rate only one-quarter of that expected from open-chest valve surgery. In the minimally invasive procedure, a tiny camera and light are inserted into the chest cavity through a one-third-inch incision in the right armpit. Miniature surgical instruments are placed through a two-inch-long hole below the right nipple or breast. The camera projects an image of the heart on a computer screen through optic fibers (no specific software is needed). The surgeon watches the screen and uses instrument-like “joy sticks” to move instruments inside the chest.

**Microsoft’s HealthVault Goes Live**

In the continuing trend toward electronic medical records and e-prescribing, Microsoft has launched a site designed to help the consumer access, retrieve, and store health information online. Microsoft's HealthVault is a free, secure, web-based portal through which people can research their medical problems and store their own personal health history. It also can serve as a secure electronic link between patients and their doctors for lab results, shot records, prescriptions or patient education.

Microsoft also hopes that doctor’s offices, hospitals, insurance companies, and advocacy groups will find ways to link their health IT systems to HealthVault to improve access and flow of information between patients and providers. The American Heart Association and the American Lung Association have already created links on the site.

**New Imaging Technique May Offer Better Diagnosis for Heart Blockages**

A high-tech imaging technique might replace the more invasive standard coronary angiography as a way for doctors to look at blockages in heart arteries in some patients, according to clinical trial results presented at the American Heart Association's Scientific Sessions 2007.

In the Coronary Artery Evaluation Using 64-Row Multidetector Computed Tomography Angiography trial (CORE-64), researchers evaluated the diagnostic accuracy of multi-detector spiral CT angiography (MDCTA) compared with conventional coronary angiography (CCA) in detecting coronary artery disease. Coronary angiography is an X-ray examination of the blood vessels of the heart that requires that a very small catheter be inserted into a blood vessel in the groin or arm, positioned at the beginning of the coronary arteries, and used to inject a special fluid that is visible by X-ray. The MDCTA-64 also takes X-ray pictures of the coronary arteries in patients with suspected coronary artery disease, but it uses 64 detectors to take and combine multiple X-ray pictures and there is no need for catheter insertion.

The study included 291 patients in nine centers internationally: three in the United States and one each in Brazil, Germany, Japan, the Netherlands, Canada, and Singapore. Results showed that MDCTA had good diagnostic ability for detecting blockages and a similar diagnostic ability to CCA in its ability to identify patients who were felt to have severe enough disease to be referred for angioplasty or bypass surgery. It was less able however, to determine which specific vessel of the heart was blocked, compared with CCA.

**AAFP Joins with Payers and Employers to Improve Technology's Impact on Medication Safety**

SureScripts, founded by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA), has announced that it is collaborating with the American Academy of Family Physicians (AAFP), Blue Cross and Blue Shield Association (BCBSA), Humana Inc., Intel Corporation, and the Medical Group Management Association (MGMA) to launch The Center for Improving Medication Management.

1968: Electronic fetal monitor developed.

1969: President Nixon calls for minimum standards and premarket clearance on certain medical devices.
Physicians statewide have enrolled in an e-prescribing service designed to reduce errors and increase patient safety. The pilot program offered by Blue Cross and Blue Shield of Louisiana is the first of its kind in the state. Electronic prescribing enables a physician to transmit a prescription electronically to a patient's pharmacy of choice. It decreases prescription errors caused by hard-to-read handwriting and automates the process of checking for drug interactions and allergies. Blue Cross and Blue Shield of Louisiana is the first insurer in Louisiana to offer a statewide e-prescribing program.

Offering an e-prescribing pilot program is Blue Cross' second step toward encouraging the widespread adoption of electronic medical records. In 2005 the company began offering claims-based health histories to its customers. The health history is a three-year record of healthcare services, drawn from claims information submitted by doctors, hospitals, pharmacies, and laboratories, and it's available to almost all customers and healthcare providers through the company's secure web portal at www.bcbsla.com or by calling its customer service department.

**New Diabetes Tool Available on American Diabetes Association Web Site**

The American Diabetes Association has unveiled a new web-based diabetes tool that makes it easier for people with diabetes and their care providers to share and organize important health information to improve their diabetes care. The tool, My Diabetes Connector, is a diabetes management software application available by subscription at www.diabetes.org/mydiabetesconnector.

My Diabetes Connector enables people with diabetes to securely send blood glucose (sugar) readings from their glucose meter to the My Diabetes Connector Application. My Diabetes Connector's goal is to be compatible with other major, publicly available, web-enabled applications being introduced to the marketplace, such as Microsoft's HealthVault.

Data stored to My Diabetes Connector is accessible through the Internet, allowing care providers and family members—with the patient's permission—to monitor the information, regardless of location. For instance, a parent can monitor a child's glucose data while the child is away at college, and data for an elderly parent living in Florida can be easily monitored by a grown child who lives in Boston. Alternatively, people who do not wish to share online access with care providers can print reports and graphs and take them to appointments to review with their healthcare team.

**LOCAL**

**Physicians e-Prescribing for Better Patient Safety**

Physicians statewide have enrolled in an e-prescribing service designed to reduce errors and increase patient safety. The pilot program offered by Blue Cross and Blue Shield of Louisiana is...
through the accreditation process, while establishing a streamlined data gathering protocol that will ultimately help them run their facility more efficiently without incurring a heavy IT burden.

Surgisys is also one of the few national companies that take the accreditation process one step further. Rather than merely act as consultants to get a lab accredited then disappear, the Surgisys programs continue collecting critical data and procedure information for use in quality assurance, P4P, and streamlining operations. “Doctors need to be doctors, but they also need accessible, up-to-date information to ensure quality and efficiency,” added Albert D. Sam, II MD, MS, FACS, Surgisys chief medical officer.

Surgisys’ iMAP products incorporate practice management solutions in each vascular specialty area program. Without changing their current practice software, clients can increase their efficiency because Surgisys handles all data input and reporting as well as program upgrades, data backup, and security. The suite of interactive medical assessment programs physically resides at a managed hosting facility that is SAS 70 certified. This certification exceeds HIPAA compliance while providing 24/7 accessibility.

**New Online Application for Medicaid Now Available**

Enrolling in the Louisiana Medicaid program has become faster and more efficient thanks to an online application process now available through the Department of Health and Hospitals website. Louisiana citizens applying to enroll in any Medicaid program can use the online application process. This includes applying for Medicaid, LaCHIP (children’s healthcare coverage), LaMOMS (coverage for pregnant women), the Medicaid Purchase Plan (coverage for workers with disabilities), the Medicare Savings Program (premium assistance for Medicare recipients) and TAKE CHARGE (family planning services for women).

Once the online application is submitted, it is sent immediately to the office that will process the application. There is no delay for mailing or faxing, as might be experienced with a paper form. A paper application can still be used for enrollment; these are available at any Medicaid office or Medicaid application center, may be downloaded from the website, or requested from the toll free Medicaid hotline at 1-888-342-6207. The online application was launched on Oct. 10, 2007 and in the first ten days, 500 applications had already been filled out. The application is available at https://bhsweb.dhh.louisiana.gov/onlineapppublic/applyonline.aspx.
Smith Hartley: What do you think should be done with the charity hospital system?

Bill Cassidy: There’s no single answer as to what should be done with the charity hospital system. In some places like Washington-St. Tammany Parish Charity Hospital in Bogalusa, the hospital is an essential community hospital that functions basically like a private hospital. That’s very different from Huey P. Long which is an antiquated facility. So I think it is easier to come up with a general format as to why we need to have a public hospital system and then let each region figure out what works best for their region. As a general rule, the reason you want to have a public hospital is that it’s a safety net for the uninsured. It provides essential services, for example graduate medical education and workforce development. The doctors, nurses, and medical technologists train there and as part of that, the hospital is able to provide some services that are difficult to provide in the private sector, such as trauma centers. You have young surgeons working 24 hours, seven days a week, holidays included, and that lowers the cost of providing trauma care. Big cities like Baton Rouge, New Orleans, Shreveport, are big enough that their communities should have trauma centers like that. It’s also a conduit whereby federal funds can be used to care for uninsured patients. Federal funds cannot be used to treat outpatients, and there’s no way to funnel those dollars except through a public hospital. So having a public hospital allows you to provide those outpatient services. There are different roles for a public hospital, big or small, but it does have a role and that role will differ in each community.

SH: What direction should LSU take as bearer of the charity system?

BC: I think that LSU has to, and I know they want to, respond to what our state healthcare needs are. In a sense that has to be defined by the people. And I think those needs are again, to provide graduate medical education, workforce development, and a safety net. Now if you get distracted by saying we are going to use these dollars for economic development, you end up taking money that should be used to take care of an...
uninsured woman who has breast cancer and spending it on economic development. LSU or anybody else should absolutely not do that. They should not use that money to support a particular institution. Healthcare dollars are about taking care of people, not about taking care of an institution. So I think we as a people should come up with legislative policy and public policy, which demands that if there are dollars out there for healthcare, they are used for healthcare and not for something else, however noble those things are.

SH: What do you think LSU or the charity system can do to encourage preventive or primary care?

BC: The need to have more primary care providers will take an effort along several fronts. Right now, the medical schools are geared more toward tertiary care and providing specialists than they are toward developing a primary care workforce. As an example, there’s talk of creating a liver transplant program in Baton Rouge. Louisiana currently has three liver transplant programs. That would give us four in a state of two million people. We would have more liver transplant units per capita, I think, than any state in the nation. That is a misplaced priority. We should say we don’t need another liver transplant facility—the three we have currently are not operating at capacity. What we need is more primary care. And take the resources that we apply to that and the emphasis within the institution that would go there, and instead develop a center of excellence for primary care, or something like that. That's one idea we could use to improve primary care/preventive care. The state has moved toward creating medical homes in New Orleans, a linked information network. It’s very positive. They increased reimbursement to primary care providers, so now the patient with Medicaid is able to get in the door. Finally Medicaid payments approach the amount that it actually costs to see the patient. All that is very good. But you need to use that basis to then move into other areas such as doing a better job of educating our fellow Louisianans as to what a healthy lifestyle is, as well as making it possible to have that healthy lifestyle. Related to that, we need to think differently. Childhood obesity is a major public health problem. An obese child is more likely to have diabetes and hypertension at a younger age. Turns out, it isn’t the fast food or the Coca-cola or the Pepsi-cola, it’s that they don’t have bike paths, they don’t have places where they can go and play, and walk, and run. Cities that have more bike paths for example, have less childhood obesity. So we need to think differently about what healthcare is. Sometimes it's providing the avenue where people can exercise and by exercising lower the risk factors for things such as obesity.

SH: What are the important healthcare legislative issues coming up?

BC: The big issue is do we build New Orleans a $1.4 billion hospital? If we do, that will dictate healthcare spending in South Louisiana for our lifetime. Because the business plan basically states that 50 percent of the healthcare dollar for the uninsured in south Louisiana, will be spent in New Orleans even though at most, New Orleans is about 20 percent of the population of South Louisiana. That hospital doesn't fly, according to the business plan, unless we do that. That's going to be a big issue. Some people think we need to do it because of economic development. That goes back to what I said. Are healthcare dollars for economic development or for taking care of an uninsured woman that has breast cancer, that lost her husband, and can't get into the safety net hospital because the lines are too long in the emergency room? I think it's the latter, but there are other people who think it's the former.

SH: So, do you think continuing with the plans for the $1.4 billion hospital in New Orleans would be a mistake?

BC: I think it would be major mistake. It preserves, as much as people say differently, our current model of having a dual system. One for the uninsured and one for the insured, with all the inefficiencies associated with that. Inevitably, to make it work, you’d
have to go back to what we had before Katrina—if you wanted cardiac surgery and you lived in Lake Charles, you’d have to drive to New Orleans to get cardiac surgery. If you had complicated cancer treatment you’d have to drive to New Orleans to get that. Oftentimes the uninsured don’t have those resources and yet inevitably, I think you’d be forced to do that to make the system work financially. It is wrong. It is wrong. It is wrong. People in New Orleans didn’t like driving to Baton Rouge to get their care after the storm, and they can certainly understand that people from Baton Rouge, Lafayette, and Lake Charles don’t want to drive to New Orleans for their care. Care given locally is better care. So I’m not sure that we would be able to give care locally if we spend that much money on a hospital in New Orleans.

**SH:** Why do you think there’s a push for this hospital?

**BC:** I think LSU feels they need a teaching hospital in New Orleans, and I accept that, and there’s a big push to keep the medical school in New Orleans for economic development, and frankly folks fear that some want to move the medical center to Baton Rouge. Building that huge hospital there anchors the medical center. I don’t care if they move the medical school or not. Again go back to this, healthcare dollars should be used to treat patients not for economic development.

**SH:** How has the federal government’s role affected these decisions?

**BC:** The federal government pays 75 percent of the bill for taking care of the uninsured. The state pays 25 percent. That’s for adults. For children they pay 80 percent and the state pays 20 percent. So how we spend that money is greatly influenced by federal legislation. Part of the rationale for keeping public hospitals is that federal regulation requires a public hospital to funnel those dollars through to pay for outpatient care. One has to acknowledge that. If you have a strict system of buying everybody private health insurance, you don’t have a way to pay for the outpatient care dollars using some of those federal funds.

**SH:** Do you support Blueprint Louisiana?

**BC:** I do support Blueprint Louisiana. Right now we have a system in which dollars follow institutions, when broadly speaking, we need to have dollars follow patients. It doesn’t necessarily mean it has to be a private insurance policy, but I do think there should be some relationship between the
number of uninsured patients that appear in an area of the state and the amount of money the state devotes to treating the uninsured in that area. Right now we don't have that type of relationship. I think that Blueprint's broad outlines give us a better chance of that.

**SH:** Who did you support for governor?

**BC:** I supported Bobby Jindal. I think that Bobby's take on it is sophisticated and I think that he, as a past DHH secretary, understands the issues regarding charity hospital. That consumes so much of our healthcare budget; you've got to understand charity hospitals to make rational public policy decisions.

**SH:** What is your opinion on the future of Baton Rouge's Earl K. Long?

**BC:** There's broad support within Baton Rouge to build a new university hospital and one that wouldn't compete with the private hospitals so much as would complement them. And so, as an example, at a teaching hospital you can take care of all the trauma. Those patients have been going to the Lake and to Baton Rouge General as well as Earl K. If we could concentrate them in one hospital, we could provide better care, and relieve that financial burden on the private hospitals. Similarly, since New Orleans is so much smaller, a lot more graduate medical education is going to be performed in Baton Rouge. But it can be done in a way that complements each and doesn't compete. If you have cardiologists that need cardiology hours and cardiology training they can go to the Lake or the General and learn how to do cardiac caths, even treat the patients coming from the new university hospital. You don't need to build a cardiac center at the new university hospital. They complement each other, but don't necessarily compete. In the meantime everybody participates in graduate medical education. There are a lot of advantages and I think if it were done correctly it would be a tremendous thing for our community.

**SH:** Regarding trauma care, do you think Baton Rouge's capacity is sufficient?

**BC:** The Baton Rouge Area Foundation Report issued a report by PricewaterhouseCoopers, which said that Baton Rouge has now reached the size where it should have a level 1 trauma center. A level 1 trauma center is where you have 24/7 coverage with surgeons and have ready access to neurosurgeons, orthopedists, and thoracic surgeons. Baton Rouge doesn't have that. Statistically if you get in a wreck in a city with a trauma center you are more likely to live. So ideally, we build one and we bring that service to Baton Rouge. It should be part of the University hospital, because again it links so nicely with graduate medical education. If you have a surgery resident, he or she needs to be in the hospital anyway. So one of your main expenses, which is paying for a surgeon to be in the hospital, is lessened because you are paying a resident less money than a guy who's been in practice five years. So it gives you a low cost manpower pool to staff your trauma center.

**SH:** What are your priorities for healthcare?

**BC:** My healthcare priorities come with some rational sense of what our healthcare safety net should be like, to improve access to our safety net system, and while doing so make health insurance affordable for those who have the opportunity to purchase it. And also I think there are some simple things we could do regarding public health to decrease our long-term healthcare costs and improve our quality of life.

**SH:** Where do we waste the most money?

**BC:** I think what wastes most money is charity hospital in New Orleans. If you look at their budget they get $380 million dollars and provide no more care than Earl K. Long with $140 million. There's $240 million going somewhere that's not patient care. That's a huge amount of money to pay for other services. After that we can say that healthcare is an incredibly regulated industry and everybody's afraid to back off on the regulation. This is on a federal level and on a state level and that regulation costs money. Somebody will come out and measure the force that it takes to open a door to a doctor's office. And if it takes too much pull to get that door open then they've got to replace the door, adjust the springs or whatever. For the marginal benefits that we get, for that occasional case where it takes too much force to get that door open, it takes someone to come out there, someone to inspect, someone to make sure that the tape measure works, etc. Those things add up, so if we can begin cutting back on some of the regulation, that would be great. People are fearful to do so because of liability, but it just increases waste.

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1976: Medical Device Amendments are made to the Food, Drug and Cosmetic Act of 1938 to assure safety and effectiveness of medical devices.
Examining Pay for Performance

According to the 2003 study of Medicare quality and spending, Louisiana spent the most money per beneficiary, yet ranked worst among states in overall quality of care rankings.
Introduction
A fundamental premise of a successful business in a traditional capitalistic market is that superior performance resulting in either a superior product or service will determine the leaders in a particular industry. The U.S. healthcare system, despite consuming 15% of our national gross domestic product, has largely not operated under such a system. As a result, "pay for performance" (P4P) has been brought about as a response to evidence that the healthcare sector has significant shortcomings in patient safety, the quality of patient care, and efficiency in the delivery of said care.

The Problem
It has been estimated that medical errors result in the death of more than 100,000 patients annually. In addition, patients receive recommended care only roughly half of the time while untold numbers of Americans fail to receive the established and recommended care from which they would likely derive benefit. This lack of uniformity of healthcare delivery has resulted in a per capita health spending variation of nearly twofold across geographic regions in the U.S.—all without the benefit of improvement on outcome assessment measures of quality and safety. According to the 2003 study of Medicare quality and spending, Louisiana spent the most money per beneficiary, yet ranked worst among states in overall quality of care rankings. Particularly problematic is that this has all occurred in the context of increasing healthcare costs at double the rate of inflation.

Reducing medical errors, improving clinical outcomes, and improving affordability of healthcare are goals shared by the American public, health professionals, hospitals and health systems, and public and private purchasers.

The Solution?
"Payment is traditionally determined by what was done to a patient; P4P will allow payment to be determined by what is done for a patient."
-Centers for Medicare & Medicaid Services

Under pressure from the U.S. Congress, the Centers for Medicare & Medicaid Services (CMS) have attempted to find ways to reward quality associated with accepted, evidence-based medical care and have placed considerable time and energy in the adoption and execution of P4P. In theory, a shift to a balanced focus on “value” for healthcare dollars spent helps offset cost and high-quality clinical outcomes. Reducing medical errors, improving clinical outcomes, and improving affordability of healthcare are goals shared by the American public, health professionals, hospitals and health systems, and public and private purchasers. By paying differentially based on quality and efficiency, public and private payers seek to align payment incentives with the achievement of these goals.

CMS P4P programs are budget neutral implying that some providers will be “winners” and some will be “losers.” Resultantly, there will be a revenue distribution from poorer to better performers who meet the designated performance measures. The current voluntary P4P program relies on a limited set of performance measures. The dimensions of performance vary across P4P programs. For hospitals and physicians, the measure sets the focus on: 1) preventive services such as influenza and childhood vaccines, 2) selected care of common conditions like diabetes, heart attack, congestive heart failure, pregnancy, and newborns, and 3) complications such as surgical infections. Some P4P programs also include measures of patient perceptions derived from patient surveys. Future P4P initiatives will likely have more measures of the effectiveness and efficiency of clinical processes, and of patient outcomes. It is the outcome assessment of patient care that likely will result in the most challenging adaptation for hospitals and physicians as few institutional outcome measurement capabilities are in place in most U.S. practices, despite the improved performance traditionally seen in practices that have methods of outcome measurement in place.

The Controversy
The advent of P4P programs is not novel; P4P has been used
by businesses to improve quality and efficiency. Some programs include offering bonuses in addition to regular salary or withholding part of the salary and allowing the employee to earn it back as a reward for increased efficiency, quality, or productivity. To be effective, such reward should be of sufficient value to affect change in the intended behavior. Additionally, the implementation should be simplistic enough to be easily understood. In its current form, critics complain that neither of these criteria is met in the current voluntary P4P plan.

Another obstacle to compliance lies in the relative failure of most medical practices to have in place standardized methods of data collection, analysis, and outcome reporting. This more than any other factor may result in non-participation by practices in the current voluntary reporting P4P program. Failure to comply initially will likely have disastrous consequences as these practices may fail to be considered "high-performing" in later years. Also, it is highly likely that the results of reporting may eventually become public record and those practices either not participating or late to participate in P4P reporting may be viewed adverse-ly despite the quality of care rendered. The unintended consequence of P4P lies in the fact that if only efficiency is rewarded, quality may suffer. Similarly, in nonmedical fields, good performance may equate with improved profits, perhaps without emphasis on quality. When P4P models are used in the medical and surgical fields, however, most think of performance in terms of improved quality as represented by improved outcomes.

Naysayers—often skeptical physicians—point to the fact that very few peer-reviewed publications can be found to support this approach. A recently published article in JAMA that examined data on three performance outcome measures (cervical cancer screening, mammography, and hemoglobin A1c testing) concluded, "Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those with higher performance at baseline." Those above the target threshold feel that what they need to do is keep the status quo to get the performance bonus. In addition, the authors speculated that the performance bonus was too modest, at 5% annually, to result in a significant behavior change.

Despite the absence of appropriate research validating the merits of P4P, the process is not slowing down. In fact, the P4P movement has gained significant traction with the CMS announcement on October 28, 2005, that it would put in place a Physician Voluntary Reporting Program (PVRP) effective in 2006. In the notification it published on November 2, 2005, CMS stated that the PVRP is being instituted as a part of its overall quality-improvement efforts to "substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered." The notification went on to state that, "CMS is committed to the development of reporting and payment systems that will support and reward quality" and that "the quality initiatives aim to…ultimately support new payment systems that provide more financial resources to provide better care, rather than simply paying based on the volume of the service." This action has served notice that P4P is here to stay and will surely have a significant and permanent effect on healthcare providers and hospitals. Although initially established as a CMS program, past history strongly indicates that private third party payers will likely follow suit with similar initiatives.

P4P in Action: Carotid Stenting for Stroke Prevention

Stroke is the 3rd leading cause of death in the U.S. and a leading cause of disability resulting in billions in healthcare expenditures annually. One-third of all strokes are due to blockages that develop within the carotid arteries, the primary blood supply to the brain. Traditionally treated by surgical removal of these blockages, recently angioplasty and stenting has been shown to be an effective and safe alternative for a subset of individuals. In the attempt to regulate the performance of a procedure where adverse outcomes could be devastating not only to the individual but also to the healthcare economy, CMS introduced the first P4P program for a surgical specialty in its memorandum on specialists performing carotid artery stenting for the prevention of stroke. Not only did CMS require specific conditions for...
facility certification to perform carotid stenting, but they also set the exact preoperative and clinical conditions and anatomic criteria of disease that have to be met to satisfy their conditions for reimbursement. Failure to demonstrate these outlined criteria at best results in non-payment for services, and at worst could result in charges of and investigative efforts for Medicare fraud. To maintain credentialing, CMS mandated that either the facility or a contractor to the facility collect, analyze, and submit to CMS, on a 6-monthly basis, data on all carotid artery stenting procedures performed at the facility. The data must be made available upon CMS request; a facility will continue to be reimbursed and able to perform carotid stenting only if it maintains a level of performance acceptable to CMS. These actions have relegated the performance of this stroke-prevention procedure to only those clinicians and facilities that will provide the requisite data and proof of performance, thus P4P.

The Future
P4P has the capability and likelihood to fundamentally alter the nature of the healthcare marketplace. Performance measurement combined with public reporting promises to enable many different patient groups and 3rd party providers to make decisions informed by safety, quality, and efficiency considerations. The decisions that P4P data may heavily influence include: patient selection of a hospital to seek care; selection of a primary care physician or specialist; and selection by clinicians of referral sources. In addition, P4P data has a high likelihood of being used by organizations responsible for certification and accreditation purposes. Perhaps the most promising potential achievement of P4P programs may be the use of standardized performance measures enabling comparisons of practitioner performance within a community and between communities—or clinical “benchmarking.” Information gathered will allow comparisons of the safety, quality, and efficiency of care received by various demographics of patients thus identifying disparities in access and quality associated with gender, ethnicity, and/or socio-economic status.

Conclusion
Debate determining the future course of healthcare delivery to the U.S. has taken center stage in many discussions both locally and nationally. Whether regarding the wisdom of maintaining a charity system in Louisiana or the potential of national universal health insurance, there are significant issues yet to be determined. One certainty lies in the fact that P4P is here to stay and will only increase in relevance and importance. The prudent course of healthcare providers likely will be one that operates in the context of embracing rather than ignoring the inevitability of P4P. A failure to do so may have adverse consequences for those unwilling to participate in future P4P programs.
PHYSICIAN AVAILABILITY IN GREATER NEW ORLEANS:
TWO YEARS AFTER HURRICANE KATRINA
A white paper presented by Blue Cross and Blue Shield of Louisiana

Health claims show little change in New Orleans’ physician/population ratio

Two years after hurricanes Katrina and Rita struck Louisiana, media coverage and anecdotal evidence suggest a chronic healthcare shortage in the four parishes that make up Region 1.

Health claims submitted to Blue Cross and Blue Shield of Louisiana indicate that, in the aggregate, the total number of physicians practicing in the greater New Orleans area per 1,000 residents is near its pre-storm level.

“Three fourths of the population of greater New Orleans is back, according to the best available estimates,” says Blue Cross President and CEO Gery J. Barry. “Paralleling this repopulation trend, our claims data indicate that there are about three fourths of the pre-storm number of physicians now practicing in the region as well.”

The percentage of primary care physicians and specialists combined is about 74 percent of the pre-hurricane total – a figure that has remained relatively stable since March 2006. The data indicate that Region 1 as a whole has experienced little or no change in the total number of physicians per 1,000 residents. Both pre- and post-Katrina, the density ratio of 2.4 practicing physicians per 1,000 residents is on par with the national average.

The primary care physician ratio: still below national average
Region 1 as a whole also has experienced little change in primary care physician density. Before Hurricane Katrina, there were 0.64 primary care physicians in Region 1 per 1,000 residents. Post-Katrina, this number increased to 0.68 primary care physicians/1,000. Both pre- and post-hurricane numbers are well below the national average of 1.0 primary care physicians per 1,000 residents – and the U.S. average itself is low compared to the average among other developed countries.

“It should be noted that Louisiana’s primary care physician density has

1982: First permanent artificial heart (Jarvik-7) is implanted in Barney Clark who is able to live almost four months. Bureau of Radiological Health and Bureau of Medical Devices merge to become National Center for Devices and Radiological Health.
Slight decline in specialist density
Turning to the specialist population, the data show a slight decline in availability relative to the returning population. Our post-Katrina estimate shows a 3 percent decline for the entire region, from 1.78 specialists/1,000 people pre-Katrina to 1.72 specialists/1,000 post-Katrina.

While the percentage reduction in specialist density since the storms is greater than the percentage reduction in primary care physician density, the availability of specialists remains slightly higher than the national average of 1.40 specialists per 1,000 residents.

Commentary
“While this ‘big picture’ comparison of physician density pre-and post-Katrina is encouraging, access to care can still be an issue,” Barry cautions. “Primary care capacity remains limited, and there are other factors to be considered as well. For example, some of the doctors submitting claims may be spending only a part of their time in the region, or are seeing a number of patients from outside the region. Also, many individuals may not be able to locate the same doctors they saw before the 2005 hurricanes. Finally, long-standing professional relationships that doctors had with other doctors have been disrupted, and this can create problems in finding the right doctors for referring patients,” Barry says.

“This disruption means that patients have to adjust to a changing configuration of providers,” Barry says. “In addition, access to proper healthcare for the uninsured is particularly challenging. The safety net of the charity hospital system collapsed and has only been restored to a limited level. That’s why Blue Cross has been promoting the development of additional safety-net clinics and access by the uninsured to other facilities.”

The issues facing the greater New Orleans healthcare system are complex, but — as indicated by Blue Cross’ claims study — the news is not all bad. Another bright spot has been the stability of private insurance and the employer-sponsored market during and since the hurricanes. The percentage of residents participating in employer-sponsored health plans appears to have increased in Region 1, with some new start-up plans being offered and existing group customers adding more employees and dependents to their rolls.

“From day one, the private insurance market has provided a reliable base of financial support for the healthcare infrastructure that has remained to serve the people in the hurricane-affected areas,” Barry says.

Barry also stresses that — while this white paper cannot pinpoint all the gaps in healthcare facing the New Orleans community, such as inpatient and outpatient mental health services and the ongoing nursing shortage — it nevertheless provides a useful perspective on the broader picture of healthcare capacity in the area. “Part of that picture is that we have a solid base of healthcare capacity upon which to build, and it should be our first order of business from a public policy standpoint to continue doing what we can financially to stabilize it,” Barry says.

FDA mandated to register implanted pacemakers and leads paid for by Medicare.
Beginning on October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will no longer pay hospitals for Medicare treatment of certain health conditions that CMS believes the hospitals caused. CMS laid out its new policy on August 22, 2007 in the Federal Register which states that CMS will not pay hospitals for certain conditions which arise during the hospital stays of Medicare beneficiaries.

There are eight (8) “Hospital-Acquired Conditions” which meet the criteria for a non-reimbursable health condition, if the condition was not present when the Medicare patient was admitted to the hospital. The eight (8) Hospital-Acquired Conditions under the new CMS policy include:

- Objects Left During Surgery (a Never Event);
- Air Embolism (a Never Event);
- Blood Incompatibility (a Never Event);
- Catheter-Associated Urinary Tract Infections;
- Pressure Ulcers (Decubitus Ulcers);
- Vascular Catheter-Associated Infections;
- Surgical Site Infection (Mediastinitis) after Coronary Artery Bypass Graft (CABG) Surgery;
- Hospital-Acquired Injuries such as Fractures, Dislocations, and Burns.

CMS will not pay for healthcare related to any of the above Hospital-Acquired Conditions unless the patient had the condition when he or she was admitted to the hospital.

The CMS Acting Administrator stated that these Medicare payment reforms reflect CMS’ desire “to become a more active purchaser of high-quality care for Medicare beneficiaries.” However, some are concerned that the new changes set too high a standard for hospitals and create unrealistic expectations. For example, some conditions, such as infections and pressure ulcers, are not always preventable, even with the best of care. CMS reviewed many comments related to these concerns, but maintained that the standard to be applied was “reasonably preventable.” Thus, if the hospital can show the condition was not “reasonably preventable,” CMS would pay for care related to the Hospital-Acquired Condition.

One must also consider the practical effect of these changes. If Medicare refuses to pay for conditions that were not present on admission, who will end up paying the cost? Will the hospitals be required to absorb these costs or will the costs be passed on to other payers? In addition, will hospitals respond to this new rule by testing all Medicare beneficiaries for infection when they enter the hospital? This has been the result in Pennsylvania, where hospitals are mandated to report hospital-acquired infections. Such a practice of routinely testing every new patient for infection would result in higher costs to Medicare, an effect CMS is purportedly trying to avoid.

In addition, there will likely be more Hospital-Acquired Conditions to come. CMS has indicated that it will revise the list of conditions from time to time. In fact, CMS has already proposed consideration of the following Hospital-Acquired Conditions for 2009: Ventilator Associated Pneumonia, Staphylococcus Aureus Septicemia, and Deep Vein Thrombosis/Pulmonary Embolism. Hospitals will undoubtedly keep a watchful eye on future directives from CMS, as well as closely monitor the ramifications of the 2008 Final Rule. The Final Rule with Comment Period published in the Federal Register can be found at www.access.gpo.gov/su_docs/fedreg/a070822c.html.

by: Valerie A. Judice  
Kean, Miller, Hawthorne, D’Armond, McCowan & Jarman, LLP

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n 1993, while administrator of a group practice of 15 physicians in Houston, we decided it would be interesting to conduct a patient survey. For a week, each patient who arrived in our facility received a patient survey card to fill out throughout the course of their visit. Note: If you've ever conducted a patient survey, you know to expect a wide variety of comments, but the results will certainly create some sort of response by your group to change some aspect of behavior. I would advise conducting this exercise perhaps once a year.

The predominant issues that arose from our findings were in regards to waiting times. The patients didn't understand the need to wait, why some patients seemed to move through the system quicker, or expressed a general confusion about how long to wait. While reviewing the data, a pediatrician in the group made the statement, "Patients should just know they have to wait when they go to a doctor's office and be used to it by now." When I suggested perhaps she may be incorrect and we should concentrate on improving wait times, I instantly felt the glare all administrators dread when working for a physician-owned practice.

As I dodged that political bullet and we continued working on ways to improve patient flow, we came up with a number of good remedies, one of which was as startling in its simplicity as in its effectiveness.

The Goal:
Tell each patient who enters the facility the approximate wait time to see their physician.

As simple as this approach sounds, it is still seldom done in most physician waiting areas. Other service industries understand the need to keep the customer informed on waiting times. Can you imagine if a restaurant told you to just sit down and wait for a table? You would immediately
ask “How long?” In all likelihood, you would not be satisfied with the response of, “I don't know, the waiters are very busy with other customers.” In modern day society most people's time is important and should be respected. As our survey results demonstrated, most patients feel minimized during the waiting period. Although we may have every intention of getting to each patient as promptly as possible, circumstances do not always allow for this and we don't want to send the wrong message to our patients. Knowing you will wait about 20 minutes is much more satisfying than an unknown period of time where fears of hour waits begin swirling in your mind. Most people don't mind waiting for short periods of time. But we should always offer that information before being asked.

Method:
Keep the receptionists informed of each physician's approximate wait time.

We put in a board in the reception area. On one axis was the name of each physician. On the other axis was wait time in 10 minute increments. Example: on-time, 10 minutes, 20 minutes, etc. up to an hour or more. Each physician's nurse was responsible for knowing the approximate wait time for their respective physician and making the appropriate changes to the board. The receptionist could then quickly look at the board for each physician's wait time and notify each patient checking in. As long as the physician stayed in the 10-minute wait time, no adjustment to the board needed to be made. When the wait time was anticipated to change by the clinicians, a change to the board was made and each subsequent patient was notified accordingly.

Cost:
$30-$40 for a board – 1 hour to create the board – 10 minute in-service to train the staff.

Benefit:
A more satisfied patient who feels their time is as valued as the doctor's.

The board is certainly just one method of addressing waiting times. Your practice may have technology in place to offer similar information. The bottom line from our survey—patients want to know you care and managing their expectations of wait time is just another important aspect of achieving that goal.
HEALTH BRIEFS:
World
National
State
Local
WHO Stresses Need to Ensure the Safety of Children's Medicines

The World Health Organization (WHO) has released a report, promoting safety of medicines for children, to focus on the lack of thorough and reliable clinical data on the way medicines affect children. The publication gives an overview of the problem and offers solutions on how best to address side effects from medicines in children; namely, through improved reporting systems and collaboration between governments, regulatory authorities, research institutions and the pharmaceutical industry. The main challenge is the lack of clinical data. This results in fewer medicines being developed, produced, and marketed specifically for children. Often, children are given medicines that have only been tested in adults and are not officially approved for use in child populations. Non-availability of appropriate pediatric formulations forces healthcare providers to resort to administering portions of crushed or dissoluted tablets or the powder contained inside a capsule without any specific indication of the required dosage. For that reason, according to the report, potentially harmful medication errors may be three times more common in children than in adults.

New WHO Pocket-Charts Predict Heart Attack and Stroke

A new book of pocket-charts that will help health workers to identify people at risk of heart attacks and strokes and save lives by prescribing the most appropriate treatment has been published by WHO. The charts can be adapted for use in any setting, in any country, with any patient. The Pocket Guidelines for Assessment and Management of Cardiovascular Risk can be carried and used by any healthcare worker and is available in six languages. The guide contains easy-to-use charts that can predict the risk of a heart attack or a stroke and could help health workers to save and improve the lives of people in all countries.

Chinese Health Officials to Study U.S. Infection Prevention

A delegation of Chinese health officials recently compared their infection prevention and control practices with those in the U.S. when they met with the Association for Professionals in Infection Control and Epidemiology (APIC) in Washington, DC. APIC is the country’s largest infection prevention and control association, international in scope with 11,000 health professionals as members. Earlier this year APIC accepted a request to engage in talks aimed at assisting Chinese health officials with learning American techniques used to combat infections. Among the discussions planned were the United States’ experiences in dealing with emergency cases; advanced technology used by American infection prevention and control professionals; and this country’s experience with communicable disease prevention. The Chinese have also expressed a particular interest in U.S. efforts to combat AIDS.

New Guidelines to Improve Psychological and Social Assistance in Emergencies

International humanitarian agencies have agreed on a new set of guidelines to address the mental health and psychosocial needs of survivors as part of the response to conflict or disaster. The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings clearly state that protecting and promoting mental health and psychosocial well-being is the responsibility of all humanitarian agencies and workers. Until now, many people involved in emergency response have viewed mental health and psychosocial well-being as the sole responsibility of psychiatrists and psychologists. Recent conflicts and natural disasters in Afghanistan, Indonesia, Sri Lanka, and Sudan among others involve substantial psychological and social suffering in the short term, which if not adequately addressed can lead to long-term mental health and psychosocial problems. Yet, when communities and services provide protection and support, most individuals have been shown to be remarkably resilient.

UNITAID Celebrates a Year of Achievement

In the year since the international drug purchase facility UNITAID has managed to reduce the price of HIV treatments for children by almost 40%, and those for second-line antiretroviral (ARV) drugs by between 25% and 50%. In collaboration with the Clinton Foundation, UNITAID has also delivered more than 33,000 pediatric treatments against HIV/AIDS and is on course to meet the needs of 100,000 children by the end of 2007. Moreover, UNITAID has committed a total of US $45 million for second-line ARV drugs to fund the treatment of 65,000 patients by 2008. Four countries (Botswana, Cameroon, Uganda and Zambia) have already received a first supply of second-line ARV drugs through UNITAID and a further 13 countries are currently awaiting delivery. In partnership with the World Health Organization (WHO) and UNICEF, UNITAID has purchased and distributed 1.3 million Artemisin-in-based Combination Therapies (ACT) in Burundi and Liberia. In addition, UNITAID is supporting ACT procurement and delivery to eight countries through collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UNICEF. Delivery of the ACTs began in October 2007.

New Initiative to Address TB Drug Shortage

The Stop TB Partnership’s Global Drug Facility and UNITAID have announced a collaboration with 19 countries to address life-threatening shortages of anti-tuberculosis drugs. The initiative will provide these drugs to countries that are scaling up their TB control efforts and that have confirmed future support from the Global Fund to Fight AIDS, Tuberculosis and Malaria or another donor, but are not able to cover their full needs at present. The collaboration will deliver drugs to more than three-quarters of a million people who otherwise might not get treatment or could have their treatment interrupted because no drugs were available.

Call for More Research on Patient Safety

WHO and its partners have called for increased research to improve patient safety. WHO estimates that tens of millions of patients worldwide endure disabling injuries or death each year, directly attributed to unsafe medical practices and care. In Europe alone, an average of one in every 10 patients admitted to hospital suffers some form of preventable harm. But more research is needed to better understand the full impact of poor patient safety particularly in the areas of: Healthcare-associated infection Adverse drug event Surgery and anesthesia Unsafe injection practices Unsafe blood products Adverse medical device events.

Surgeons Remove Gallbladder With No Outer Incisions

French surgeons have successfully removed a woman’s gall bladder through her vagina, using natural orifice transluminal endoscopic surgery (NOTES) according to a report in the September issue of Archives of Surgery, one of the JAMA/Archives journals. Jacques Marescaux, MD, F.R.C.S., and colleagues at University Louis Pasteur, Strasbourg, France, performed a cholecystectomy (gall bladder removal) through the vagina in a 30-year-old woman. The surgical team was multidisciplinary and included a gynecologist experienced in trans-vaginal procedures, who made and closed the small incision in the back of the vagina. The procedure was performed with instruments inserted through this opening and the gallbladder was removed through the vagina. No bleeding or leakage of liver fluids occurred during the three-hour procedure.

1990: Human Genome Project jumpstarts biotechnology industry and sets the stage for discovery of genetic predispositions for diseases such as breast cancer. Safe Medical Devices Act requires reporting of devices causing injury, illness or death.
order for certain drug applications. For example, first generic products, for which there are no blocking patents or exclusivity protections on the reference listed drug, are identified at the time of submission for expedited review. This will mean that these products, for which there are currently no generic products on the market, may reach the consumer much faster. FDA now has about 215 full-time staff working on the review of generic drug applications. Under GIVE, FDA will hire and train new generic drug reviewers and focus on enhanced use of electronic programs for handling drug submissions and internal documents. FDA will also increase its communications with generic drug manufacturers and provide training on proper application submission to the industry in meetings and Webcasts.

FDA Takes Action to Stop Marketing of Unapproved Hydrocodone Products

The U.S. Food and Drug Administration plans to take enforce- ment action against companies marketing unapproved prescrip- tion drug products containing hydrocodone, a narcotic widely used to treat pain and suppress coughs. The action does not affect other hydrocodone formulations, which have FDA approval. Hydrocodone overdose can result in breathing problems or cardiac arrest, and its use may impair motor skills and judgment. The FDA has received reports of medication errors associated with formulation changes in unapproved hydrocodone products and reports of confusion over the similarity of the names of unapproved products to approved drug products.

Few Americans Aware of Dangerous Peripheral Arterial Disease

Three out of four people aren't aware of peripheral arterial disease (PAD), a common and dangerous vascular disease that affects approximately 8 million Americans, according to a new study published in Circulation: Journal of the American Heart Association. In a cross-sectional, population-based telephone survey of 2,501 adults over age 50, researchers found that public awareness of PAD (25 percent) is markedly lower than for other cardiovascular diseases such as stroke (74 percent), coronary artery disease (67 percent), and heart failure (67 percent). Yet, the risk for PAD is equal to or greater than the risk for these conditions. Survey respondents were much more aware of relatively rare diseases that affect far fewer people, including Lou Gehrig's disease (36 percent), multiple sclerosis (42 percent), and cystic fibrosis (29 percent).

FDA Approves Nasal Influenza Vaccine for Use in Younger Children

The U.S. Food and Drug Administration has approved expanding the population for use of the nasal influenza vaccine Flumist to include children between the ages of 2 and 5. Approval for the vaccine, which contains a weakened form of the live virus and is sprayed in the nose, was previously limited to healthy children 5 years of age and older and to adults up to age 49.

Radiologists Identify Early Brain Marker of Alzheimer's Disease

Researchers using functional magnetic resonance imaging (fMRI) have found a new marker which may aid in early diagno- sis of Alzheimer's disease, according to a study published in the October issue of Radiology. The findings of this study implicate a potential functional, rather than structural, brain marker—sepa- rate from atrophy—that may help enhance diagnosis and treat- ment monitoring of Alzheimer's patients, said the study's lead author, Jeffrey R. Petrella, MD, associate professor of radiology at Duke University Medical Center in Durham, N.C.

Among the earliest known changes to the brain in Alzheimer's disease are episodic memory deficits and structural changes in the medial temporal lobe (MTL). For the study, Dr. Petrella and colleagues set out to identify brain regions in which changes in activation took place during a memory task and to correlate these changes with the degree of memory impairment present in patients with Alzheimer's disease or mild cognitive impairment. While previous studies have suggested that MTL activation may be a possible marker of Alzheimer's, based on the findings, Dr. Petrella and colleagues concluded that, compared to activation in the MTL, deactivation in the postero medial cortices may repres- ent a more sensitive marker of early Alzheimer's disease.

FDA Clears First Rapid Test to Screen for Bacterial Contamination in Blood Platelets

The U.S. Food and Drug Administration has cleared for market- ing the first rapid test to detect bacterial contamination in blood platelets prior to transfusion. The Platelet Pan Genera Detection (PGD)-Test System is a disposable test strip for use in a hospital transfusion service setting. It is intended to supplement current quality control testing methods used by blood establishments fol- lowing collection of platelets using an automated instrument. Bacterial contamination of platelets is the leading infectious cause of transfusion-related patient fatalities. The risk of a patient receiving a transfusion contaminated with bacteria is 1 in 5,000–far greater than the risk of transmitting hepatitis C virus (1 in 1.6 million) or HIV (1 in 1.9 million).

Drug-Resistant Staph Infection Appears More Widespread Than Thought

Infections caused by methicillin-resistant Staphylococcus aureus (MRSA) appear to be more prevalent than previously believed, affecting certain populations disproportionately, and are being found more often outside of healthcare settings, according to a study in the October 17 issue of JAMA.

MRSA has become the most frequent cause of skin and soft tissue infections among patients presenting to emergency depart- ments in the United States, and can also cause severe, sometimes fatal invasive disease. R. Monina Klevens, DDS, MPH, of the Centers for Disease Control and Prevention and colleagues con- ducted a study to determine the incidence of invasive MRSA dis- ease in certain U.S. communities in 2005 and to use these results to estimate the prevalence of invasive MRSA infections in the U.S. The study consisted of a population-based surveillance for invasive MRSA in nine sites participating in the Active Bacterial Core surveillance (ABCs)/Emerging Infections Program Network from July 2004 through December 2005. Reports of MRSA were investigated and classified as either healthcare-asso- ciated (either hospital-onset or community-onset) or community- associated (patients without established healthcare risk factors for MRSA).

There were 8,987 observed cases of invasive MRSA reported during the surveillance period. Most were healthcare-associated, with 5,250 (58.4 percent) community-onset infections, 2,389 (26.6 percent) hospital-onset infections, 1,234 (13.7 percent) community-associated infections, and 114 (1.3 percent) that could not be classified. After adjusting for age, race and sex, the incidence rate of invasive MRSA for 2005 was 31.8 per 100,000
persons. Incidence rates overall were highest among persons 65 years and older (127.7 per 100,000), blacks (66.5 per 100,000), and males (37.5 per 100,000). Rates were lowest among persons age 5 to 17 years (1.4 per 100,000).

Multiresistant Bacterial Strain Emerges

A strain of the bacteria Streptococcus pneumoniae, which can cause ear infections in children, has been detected that is resistant to all FDA-approved antibiotics for treatment of ear infections and is not covered by the pneumococcal 7-valent conjugate vaccine, according to a study in the October 17 issue of JAMA. Antibiotic resistance to the bacteria pneumococci has been a focus in antibiotic development as pediatric medicine because it is the most frequent cause of bacterial respiratory infections, especially acute otitis media (AOM; middle ear infection), which is the most commonly treated bacterial infection in children. It was hoped that the introduction in 2000 of a pneumococcal 7-valent conjugate vaccine (PCV7) in the United States would curtail pneumococcal infections in children. In the early years following widespread use of PCV7, the incidence of AOM decreased by 20 percent and the frequency of persistent and recurrent AOM has been reduced by 24 percent, according to background information in the article. Because of overuse of antibiotics for children however, there has been concern that a bacterial strain could emerge that would be untreatable by FDA-approved antibiotics.

Vitamin E May Reduce Risk of Deep Vein Blood Clots In Women

Taking vitamin E might help women reduce their risk for life-threatening blood clots known as venous thromboembolism (VTE), researchers report in Circulation: Journal of the American Heart Association. However, authors acknowledge that the study results should be interpreted with caution until further research is done and that patients should not stop taking prescribed blood thinners.

FDA Clears Genetic Lab Test for Warfarin Sensitivity

The U.S. Food and Drug Administration has cleared for marketing a new genetic test that will help physicians assess whether a patient may be especially sensitive to the blood-thinning drug warfarin (Coumadin), which is used to prevent potentially fatal clots in blood vessels. One-third of patients receiving warfarin metabolize it quite differently than expected and experience a higher risk of bleeding. Research has shown that some of the unexpected response to warfarin depends on variants of two genes, CYP2C9 and VKORC1. The Nanosphere Verigene Warfarin Metabolism Nucleic Acid Test detects some variants of both genes.

New Report To Help Hospitals Improve Behavioral Health Services

As funding for behavioral health services remains inadequate, the American Hospital Association (AHA) has released a report to assist hospitals facing a growing demand for such services. The report, developed by the 18-member AHA Behavioral Health Task Force, offers recommendations on approaches to improve behavioral health services and examples of successful practices that can serve as models for implementing the recommendations.

The recommendations developed by the Task Force are present-
ed around six themes that address strategies hospitals can under-
take within their own organization and community. Those themes include:
Community needs assessment
Behavioral health planning
Community collaboration
Adaptive financing
Employer practices
Advocacy

Each theme includes several recommendations that hospitals should consider when determining the appropriate role for behavioral health services in the communities they serve. Following most recommendations is a brief case example.

FDA Approves New Uses for Evista

The U.S. Food and Drug Administration has approved Evista (raloxifene hydrochloride) for reducing the risk of invasive breast cancer in postmenopausal women with osteoporosis and in postmenopausal women at high risk for invasive breast cancer. Evista is only the second drug approved to reduce the risk of breast cancer. Evista is commonly referred to as a selective estrogen receptor modulator (SERM). In reducing the risk of invasive breast cancer, SERMs may act by blocking estrogen receptors in the breast. The benefits and risks of taking Evista, which carries significant side effects, should be carefully weighed in each individual woman.

Kids' Elevated Blood Pressure: Prevalence Linked to Rise in Obesity

After decades of decline, blood pressure levels in children and adolescents are increasing, according to an analysis of national health surveys published in Circulation: Journal of the American Heart Association. In a finding that links blood pressure increments to the recent jump in childhood obesity, researchers said each one-centimeter increase in waist circumference raised the likelihood of high blood pressure (HBP) by 10 percent and the likelihood of pre-hypertension by 5 percent.

Cancer Death Rate Decline Doubling


Among the general population, the report shows that long-term declines in cancer death rates continued through 2004 for both sexes and, despite overall higher death rates for men, the declines from 2002 through 2004 were 2.6 percent per year among men and 1.8 percent per year among women. Death rates decreased for the majority of the top 15 cancers in men and women. Important declines were noted for the three leading causes of cancer deaths in men: lung, prostate, and colorectal cancers. In women, death rates from colorectal cancer and breast cancer decreased, while the rate of increase for lung can-
cer deaths slowed substantially.

Overall cancer incidence rates (the rates at which new cancers are diagnosed) for both sexes and all races combined also declined slightly from 1992 through 2004. Incidence rates for female breast cancer dropped substantially from 2001 through 2004. This drop is possibly related to declining use of hormone replacement therapy as well as the recently reported decline in use of mammography. Also, lung cancer incidence rates in women stabilized from 1998 through 2004 after long term increases, and in men the rate declined 1.8 percent per year from the period 1991 through 2004. Colorectal cancer incidence rates decreased by more than 2.0 percent per year for men and women, likely due to prevention through the removal of precancerous polyps.

The authors report that earlier detection of disease through screening, improved prognosis through more effective treatment, tobacco control, and reduction in inequalities in cancer care all point to the success of the nation’s dedication and focus on reducing the burden of cancer in the U.S.
ADHD Study Planned

Two U.S. Department of Health and Human Services agencies will collaborate in the most comprehensive study to date of prescription medications used to treat attention deficit hyperactivity disorder (ADHD) and the potential for increased risk of heart attack, stroke, or other cardiovascular problems. Researchers supported by the Agency for Healthcare Research and Quality (AHRQ) and the U.S. Food and Drug Administration (FDA) will examine the clinical data of about 500,000 children and adults who have taken medications used to treat ADHD to determine whether those drugs increase cardiovascular risks.

The planned analysis follows an FDA-sponsored preliminary study that compiled information from large healthcare databases on prescription drug use, inpatient care, outpatient treatment, and health outcomes, including death. Based on that effort, researchers identified people who took ADHD drugs during a 7-year period ending in 2005. The analysis will take about two years to complete. Results are expected to be important not only to patients, their families and healthcare providers, but also to government insurance programs. Medicaid, Medicare, and the State Children's Health Insurance Program provide reimbursement for drugs prescribed for ADHD. This information could also be used to inform product labeling, which is used by healthcare providers when making treatment decisions.

Practical Guidance on Treating Patients with Bipolar Depression

Intensive psychotherapy, in addition to medication, significantly improves functioning in patients with bipolar disorder who are experiencing a depressive episode. However, for those patients experiencing a bipolar-depressive episode who also have symptoms of mania—sometimes referred to as a “mixed” episode—the addition of an antidepressant to their mood-stabilizing medication does not improve their chances of recovery and could lead to an increase in the severity of their manic symptoms. These findings are found in a pair of reports from the multi-site, federally funded Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Both reports appear in the September issue of The American Journal of Psychiatry, the official journal of the American Psychiatric Association. STEP-BD is supported by the National Institute of Mental Health and is the largest treatment study ever conducted for bipolar disorder, also referred to as manic-depression. Data on more than 4,000 participants were collected in real-world clinical settings over a period of five years. STEP-BD investigators are now working with the extensive database to learn about the natural course of bipolar disorder and the best approaches for its treatment and management over time.

FDA Licenses 15 New Blood Typing Tests

The U.S. Food and Drug Administration has licensed 15 new blood typing tests that were previously unavailable in the United States. These tests, known as blood grouping reagents, are used to determine the blood type of blood donors, and essential in ensuring safe blood transfusion for patients. The newly approved ALBAClone Blood Grouping Reagents include the common ABO and Rh tests, plus tests for rare blood types. The reagents are monoclonal antibodies, highly specific antibodies that ensure product uniformity and availability.

Routine Thyroid Screening

Not Recommended for Pregnant Women

In response to a debate over whether all pregnant women should be screened for subclinical hypothyroid disease, The American College of Obstetricians and Gynecologists (ACOG) recommended against routine screening in a Committee Opinion in the October issue of Obstetrics & Gynecology. ACOG says there is no evidence that identifying and treating pregnant women with subclinical hypothyroidism improves either maternal or infant outcomes.

A subset of women (estimated at 2%-5% of all women) have “subclinical” hypothyroidism. Subclinical hypothyroidism has no symptoms and while one test of thyroid function is mildly abnormal, the thyroid hormone level itself is still normal. Some studies have suggested a relationship between subclinical hypothyroidism and poor developmental outcomes in children, leading some to call for routine screening of pregnant women. However, the benefit of treatment to either mother or fetus has not yet been demonstrated in pregnant women with subclinical hypothyroidism.

CDC Awards $35 Million to Support HIV Testing and Early Diagnosis Among African Americans

The Centers for Disease Control and Prevention has awarded $35 million in funding to state and local health departments to increase HIV testing opportunities among populations disproportionately affected by HIV, primarily African Americans. Twenty-three states and major metropolitan areas will receive awards ranging from $69,000 to $5.4 million.

As part of CDC’s efforts to accelerate progress in reducing HIV among African Americans, the program is being targeted to areas of the nation in which African Americans have been most severely impacted. African Americans account for approximately half of the more than 1 million Americans currently estimated to be living with HIV, while comprising 13 percent of the U.S. population.

Eligibility and funding amounts were based upon the percentage of AIDS cases among African Americans in each jurisdiction. The states receiving funding are: California, Connecticut, Florida, Georgia, Louisiana, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and Washington, D.C. The cities receiving funding are Chicago, Houston, Los Angeles, Philadelphia, and New York City.

Quality Improvement Database Addresses Healthcare Gaps

An American Heart Association/American Stroke Association quality improvement initiative can identify disparities in health care and help patients get the care they need, as evidenced by a new study published in the Oct. 3 issue of the Journal of the American Medical Association.

Using the Get With The Guidelines–Heart Failure database, researchers found that only 35 percent of heart failure patients who may have benefited from receiving an implantable cardioverter defibrillator (ICD) actually received one. Additionally, women and black men were much less likely to receive the potentially life-saving device than white men. ICDs monitor heart rhythms and use small electric shocks to help control erratic rhythms that could stop the heart from beating.

The hospital-based quality improvement program provides information and tools on the latest guidelines and evidence-based treatments and therapies for healthcare professionals who treat people with heart disease and stroke. More than 1,400 hospitals across the country are applying GWTG practices in their patient care. Data shows that since the initiative was first launched in 2002, patients being cared for in GWTG-participating hospitals are getting more of the treatments and education they need to live healthier lives. There is significant improvement in the percentage of heart attack, heart failure, and stroke patients receiving indicated therapies upon admission, as well as those who are getting smoking cessation counseling, treatment to improve their cholesterol, and beta blockers and other medications known to improve their long-term health outcomes. The program also provides another valuable tool—a database now rich with more than one million patient records and the insight that information can give for improving patient care in the future.

STATE

Regents Approve Plan to Increase Number of Nurses, Healthcare Workers in Louisiana

The Louisiana Board of Regents recently approved a 2007-08 Health Workforce development plan to use more than $12.4 million in new state funding to address the shortage of nurses and allied health-care professionals working in the state. The plan aims to help the state’s public and private nursing and allied health programs employ more faculty, enroll more students, and produce more graduates. The plan allocates new funding for the state’s nursing and allied health educational programs. One important use of that funding will be to hire new faculty, which will help increase program capacity at institutions by an additional 772 nursing students and 202 allied health students in critical shortage areas. In addition, the plan provides for an increase of 500 students in Licensed Practical Nursing (LPN) programs in Louisiana. To help meet future faculty needs, the budget plan provides stipends for 86 graduate students in healthcare disciplines. Upon receipt of their graduate degrees, recipients benefiting from the stipends are committed to teach in Louisiana nursing programs.

Blue Cross and Blue Shield of Louisiana Receives New Accreditation

Blue Cross and Blue Shield of Louisiana has been awarded Health Network, Case Management, and Health Utilization Management Accreditation from URAC, a Washington, D.C.-based healthcare accrediting organization that establishes quality standards for the healthcare industry. URAC’s Health Network Accreditation standards include key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement, and consumer protection. Case Management Accreditation standards require companies to establish a process to assess, plan, and implement case management interventions. Health Utilization Management Accreditation standards provide assurance to patients, providers, purchasers, regulators, and employers that the practices of the organization performing these services are fair and equitable for all parties.

Louisiana Moves Out of Last Place in Health Rankings

The overall health of Louisiana improved over the last year, inching Louisiana up one spot in America’s Health Rankings 2007 from 50 to 49. In fact, the United Health Foundation identifies Louisiana as successfully making strides in one area of health care where the rest of the nation is lagging behind, said the Louisiana Department of Health & Hospitals (DHH). According to the report, the prevalence of obesity in Louisiana has dropped by 12 percent over the past year, while many states showed increases. Louisiana was the only state to see a decline over three percent.

Two additional factors that contributed to Louisiana’s improved ranking include the state’s continued accessiblility to prenatal care and a significant increase in high school graduation rates. Some improvement in access to prenatal care can be attributed to a program that expands coverage to unborn children through the Louisiana Children’s Health Insurance Program (LaCHIP). This provides coverage for expectant mothers who are not eligible for...
the LaMOMS program where nearly 1,000 additional expectant mothers are enrolled. Louisiana maintained its ranking of 6 in this area from 2006 to 2007.

Louisiana also had the biggest improvement of any state in the percentage of high school students who graduate within four years, with an increase from 64.1 percent to 69.4 percent. The state's ranking in this category improved from 44 in 2006 to currently 39 in the country.

After showing significant improvement for the past three years, Louisiana did see a decrease in the rate of childhood immunizations following Hurricane Katrina. Immunization experts with the state say the loss of doctors and the displacement of young families were significant enough to impact these rates. The state's ranking dropped from 43 to 49. DHHS Secretary Dr. Roxane Townsend stated that the increased rate of uninsured citizens for which Louisiana and Mississippi were noted in the report could also be attributed to the hurricanes. Louisiana's ranking dropped from 43 to 48 in rate of uninsured.

Another category affected by the 2005 storm season is the number of primary care physicians in the state. DHHS has been working through the use of grant funding to replace the doctors who left Louisiana after Katrina and Rita, but despite recent successes in recruitment, the period covered by the United Health Foundation's report showed numbers below previous estimates. Louisiana dropped from 22 to 26 in this category.

America's Health Rankings 2007 measures the overall healthiness of states and the nation by using a set of related health determinants and health outcomes. The full report can be viewed at http://www.unitedhealthfoundation.org/ahr2007/index.html.

LSU Leaders Praise VA Hospital Site Decision

Louisiana State University officials praised the U.S. Department of Veterans Affairs for announcing it wants to build its new hospital adjacent to a planned LSU teaching hospital in downtown New Orleans. The VA's preferred site is on 34 acres of land bounded by Tulane Avenue, Canal, South Galvez and South Rocheblave streets and is about five blocks from the VA's hospital that was knocked out of action by Hurricane Katrina. The property adjoins 37 acres of land on the east side of South Galvez Street being purchased for the LSU hospital. An environmental assessment team is also evaluating the LSU site. LSU Health Sciences Center Chancellor Dr. Larry Hollier praised the VA move saying that the collaboration will save more than $400 million for taxpayers over the next 25 years and the two hospitals will serve as the main anchors for the development of the downtown biomedical district, which will be critical for the future of the New Orleans area. When completed, the nearly $2 billion total LSU/VA Medical Center will include a state-of-the-art Level One Trauma Center and encompass more than 1 million square feet of treatment and research space.

University Medical Center Receives Funds to Reduce Overcrowding

University Medical Center (UMC) in Lafayette is receiving $2,045,000 for expansion and renovation of its emergency department. The State Bond Commission approved the UMC Emergency Department Expansion Project, with $340,000 available immediately and $1,705,000 available for future expenses. Studies indicate that the current area of the emergency department, about 5,000 square feet, is not adequate for its 42,000 patients a year. Instead, for that number of patients, the emergency department should be at least 16,000 square feet, which is the amount of space that the expansion will provide.

The expansion will occur in segments, permitting the ongoing provision of emergency care, and will meet regulatory standards. Once completed, the space will include examination rooms; trauma rooms; orthopedic rooms; holding and observation areas; triage; registration and isolation rooms; radiology; minor-procedure, and ophthalmology; a nurses station; waiting room; patient conference room; physician work station; supply room; common areas; and an ambulance ramp.

Design Team Selected for LSU Hospital

One of the world's leading design firms is partnering with Louisiana architects known for their healthcare expertise to form the architectural team for the new Louisiana State University Hospital in New Orleans. A joint venture of Bitch Knevel Architects of New Orleans and NBBJ of Seattle was selected by the Division of Administration to plan the 484-bed hospital to be built on a 37-acre tract of land in downtown New Orleans. The project's $12 billion facility is part of a joint medical center project under development by LSU and the United States Department of Veterans Affairs, which is planning an adjacent 200-bed hospital. LSU System President Dr. William Jenkins praised the selection as a “major step forward” in building the university-run hospital that will replace the 68-year-old Medical Center of Louisiana at New Orleans (MCLNO), which includes the Avery C. Alexander Charity Campus and the Interim University Hospital Campus, both of which were heavily damaged by Hurricane Katrina two years ago and were declared obsolete prior to the storm.

Before Katrina struck, the LSU and VA hospitals served as primary training venues for more than 500 LSU and Tulane University medical residents along with more than 2,000 third and fourth-year medical, nursing, pharmaceutical, and allied health students such as physical therapists and medical technologists; students, not only from LSU and Tulane, but also Xavier, Delgado, and Dillard universities. NBBJ is the second largest architectural firm in the U.S. and fourth largest in the world. It has a long history of designing academic medical centers and other healthcare facilities both in the United States and overseas. The firm has collaborated on seven of the Top Ten U.S. News and World Report Honor Roll hospitals. Land acquisition for the new 1.1 million-square-foot LSU hospital is underway. Planners say design begins in September and will be completed by March 2009. Construction is scheduled to begin in June 2009 with the first patients admitted in December 2012. The LSU hospital will include 68 psychiatric beds, long-term care beds, ambulatory care space, along with an energy plant, dietary, and lab facilities that will serve both the LSU and VA hospitals.

Ochsner Named “Consumer Choice Award” Winner for 12th Year in a Row

New Orleans residents have named Ochsner Health System a “Consumer Choice Award” winner for the 12th straight year. The Consumer Choice Award reflects the growing role consumer choice plays in the healthcare field. Dr. Patrick Quinlan, Chief Executive Officer of Ochsner Health System, received the award from National Research Corporation representatives. NRC provides annual Consumer Choice Awards for the most-preferred hospitals in more than 190 U.S. markets. The award honors hospitals that area consumers feel have the highest quality and image in their market based on multiple consumer ratings. In the largest study of its kind, NRC surveyed more than 200,000 households nationwide. Winners, named in Modern Healthcare magazine, are selected from the nation-wide consumer healthcare profile, the NRC Healthcare Market Guide. NRC is a recognized industry leader, with two decades of specialization in healthcare performance measurement.

LSU Receives Nearly $400,000 for Vulnerable and Hard to Reach HIV Populations

The U.S. Department of Health and Human Services Health Resources and Services Administration has awarded the LSU Health Care Services Division (LSU HCSD) a Special Project of National Significance (SPNS) grant of nearly $400,000 a year to develop an electronic network for medical access for vulnerable and hard-to-reach populations of persons living with HIV (PLWH). The four-year demonstration project will implement and evaluate a model using health information technology (HIT) to share patient information across healthcare providers so that providers can offer appropriate HIV care.

Near and real-time electronic data sharing among network partners can increase the ability of all partners to identify newly diagnosed persons and to reach out to PLWH who may be unaware of their diagnosis or lost to HIV care. In Louisiana, an estimated 40 percent of PLWH are not in care, including an estimated 6,000 adults with confirmed infection. Also, an estimated 600 HIV-exposed infants have an unconfirmed serostatus, meaning that their mothers are HIV-infected and it is unknown if the infant became infected from the mother. Many of these, or the parents of these infants, are not aware of their HIV status, may not understand or value the benefits of treatment, or may be unable to access care.

At some point, nearly 80 percent of these PLWH have been in a public hospital or clinic since their HIV diagnosis, but medical staff were unaware of the diagnosis. Most received diagnoses outside of the public hospital system. In Louisiana, nearly 40 percent of those newly identified with HIV develop AIDS within one year, indicating late entry to care. Over 51 percent of PLWH have AIDS diagnoses, and 42 percent of the total number of persons living with HIV/AIDS did not access primary medical care in 2005. Information sharing can afford the patient early access to and continuity of care, it can reduce for the state costs associated with morbidity and mortality due to delayed entry into care, and it can prevent HIV transmissions in both the pediatric and adult populations.

LSU HCSD has collaborated with the Louisiana Office of Public Health (OPH) HIV/AIDS Program, the OPH Sexually Transmitted Disease Program, the OPH Tuberculosis Control Program, and the Louisiana Public Health Institute (LPHI) to develop an electronic information exchange network, the Louisiana Public Health Information Exchange (LaPHIE), for timely interventions for PLWH and/or syphilis, tuberculosis or co-morbid conditions. Louisiana ranks second in syphilis, 6th in HIV/AIDS, and tenth in tuberculosis. Silent symptomology characterizes all three. Timely care can delay or halt HIV progression and cure TB and syphilis. Without treatment, the PLWH can experience rapid progression of TB and/or syphilis. The SPNS network will consist of the seven LSU HCSD hospitals, the OPH HIV/AIDS, sexually transmitted disease and tuberculosis programs, and the LPHI. The LSU HCSD LaPHIE project team implemented a previous SPNS information technology evaluation of its Lab Tracker HIV Clinical Management and Reporting System. The team showed its ability to evaluate HIT, to document the process, and to disseminate its findings.

increased demand for obstetrical care, and the lack of newborn care in Kenner, prompted us to bring these services back to Ochsner Health System, Chairman of Obstetrics and Gynecology.

OMC-Kenner also welcomed the following community obstetricians to the Labor and Delivery unit:

- Dr. Stuart Schultz, OB
- Dr. Vadim Gelman, OB
- Dr. Louise Collins, OB
- Dr. Antoine Faucheaux, OB
- Dr. Adrian Coleman, OB
- Dr. Cynthia Williams, OB

Prior to Hurricane Katrina and Ochsner ownership, the Kenner hospital offered both obstetrical care and a Level II-NICU. This opening is a return of services with an increased safety net of care. The OMC-Kenner Labor and Delivery suites, Nursery, and NICU feature fully renovated, private rooms and the latest birthing techniques, including birthing tubs. All new mothers and babies will receive individualized care designating one nurse for each new family. The community will also now have access to educational classes and breastfeeding services closer to home.

The Kenner Nursery has installed an infant security system called Hugs & Kisses that helps guard against infant abduction and transfer errors. The Hugs & Kisses system works through two security bands: one on mom and one on baby. The “Hugs” band is placed on the infant’s ankle at birth and if the infant is moved into an unauthorized zone, the band is cut or does not provide a signal, an alarm alerts the staff. The “Hugs” band is programmed to a matching “Kisses” wristband worn by the mother. When mom and baby are brought together with a correct match, a lullaby will sound. An incorrect match generates a buzzing tone, alerting the staff.

Additionally, in response to the growing Hispanic population in the Kenner area, Ochsner’s Obstetrics nursing staff has a basic understanding of relaying medical terminology in Spanish. Additionally, two RNs at Ochsner Medical Center-Kenner are fluent in Spanish.

**LSU Interim Hospital Opens Inpatient Psychiatric Care Unit on DePaul Campus**

The LSU Interim Hospital has opened a temporary 33-bed inpatient psychiatric care unit in the Seaton Building on the campus of the former DePaul Hospital in New Orleans. LSU Interim Hospital will use the building for inpatient mental health services only. It will not offer a crisis intervention unit in the building. As staffing increases, the number of staffed beds will increase up to the planned 33 beds. All patients will be medically screened, and those patients needing admission will be admitted to the Seaton Building.

Previously used as an inpatient mental health facility, the Seaton Building has the required features for psychiatric care. LSU Interim Hospital has updated the building for its use as its psychiatric care unit and will provide security for patient and public safety. On May 31, 2007, the LSU Board of Supervisors approved a temporary five-year lease of the Seaton Building. LSU will not establish a permanent facility in this building.

**LSU Lallie Kemp Medical Center Offers New Geriatric Services**

The LSU Lallie Kemp Medical Center now offers geriatric services staffed by Dr. Asif Sheikh, a board-certified geriatrician. The program provides comprehensive care for this age group: Besides medical care, the geriatrics staff reviews the patient’s support system at home, transportation issues, meal preparation, home medical equipment, and other factors that impact quality of life. To meet the specific needs of the geriatric population, the Geriatric Services Program provides this broad approach to best serve the patient. Typical diagnoses seen in this population are dementia, delirium, osteoporosis, fall and gait problems, malnutrition, dizziness, syncope, pressure ulcers, sleep problems, mood problems, polypharmacy, urinary incontinence, hearing loss, vision problems, and dysphagia.

**Ochsner Supports New Orleans Elderly Population with PACE Program**

In September, the site of the former St. Cecilia Church in the Bywater district of New Orleans opened as a revolutionary day care center for the elderly. Ochsner Health System has committed to serving as the program’s healthcare partner providing specialty medical services and hospitalization at Ochsner Medical Center on Jefferson Highway.

New Orleans’ Program of All-Inclusive Care for the Elderly, or PACE, is the only program of its kind that allows nursing home-eligible individuals to continue living at home in the evening, but receive nursing-home-level care during the day. Louisiana’s PACE program is named The Shirley Landry Benton PACE Center at St. Cecilia, located at 1015 France St., corner of N. Rampart, and operated by the Catholic Charities Archdiocese of New Orleans. The facility is named as a memorial to the first wife of New Orleans Saints owner Tom Benson, who contributed $2 million to renovate the facility. This site marks the first time that a former church has been retro-fitted for the PACE program in the U.S. PACE is available in 25 other states. To be considered for PACE, a person must be at least 55 years old and eligible for Medicaid. The program is available to all New Orleans residents and six zip codes in Jefferson Parish. The center will be licensed for 92 people on any single day. But because of flexible scheduling, it will serve about 150 people in all.

**Bogalusa Medical Center Receives $11 Million for Expansion**

Bogalusa Medical Center (BMC) is receiving $11 million from the State Bond Commission for expansion and renovation of its Family Medicine Clinic and for construction of a new OB/GYN unit. The plans for the expansion and new OB/GYN unit meet the requirements of the Accreditation Council of Graduate Medical Education (ACGME). As a result, the ACGME gave full accreditation to the LSU Rural Family Medicine Residency Program.

Construction of the new OB/GYN unit began in early November and is scheduled for completion by August 2008. The new unit will feature spacious, modern labor-delivery-and-recovery (LDR) rooms, exam rooms, conference rooms, and waiting areas. The LDR rooms are designed so that a mother can labor, deliver, and recover in the same room and have nearly continuous contact with her family. The unit will also have a complete C-section room with...
anesthesia. The Family Practice clinic addition, slated to begin construction early this year, will increase by 125% the size of the clinic from 7,500 square feet to 18,000 square feet.

In its May 2007 site visit, the ACGME Residency Review Committee (RRC) indicated that BMC rural family medicine resi-
dents needed delivery and obstetric continuity-of-care experi-
ence and that the program needed more clinical space and a
birthing center. The expansion and new OB/GYN unit will allow
the program to meet these criteria. The RRC will again visit
BMC in September 2008 to inspect the new facility.

Smart Bodies Wellness Program for
Louisiana Children Earns National Recognition

Smart Bodies, a Louisiana school-based program designed to
combat obesity, is gaining nationwide recognition in only its
third year. Smart Bodies was developed by the Blue Cross and
Blue Shield of Louisiana Foundation and the LSU AgCenter to
provide people seeking drug and alcohol treatment with
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Blue Cross and Blue Shield of Louisiana Introduces Portable Personal Health Record

More than half a million Louisianans can now create a free, secure online personal health record (PHR) that they can print out or access from any computer at home or on the road. Blue Cross and Blue Shield of Louisiana is giving many of its customers free access to its new personal health record service, where they can store and organize important health information in a secure, password-protected online record. Unlike many competing PHRs, the record will remain accessible to the customer even if he or she leaves Blue Cross.

Powered by WebMD, Blue Cross’ personal health record stores essential health history, current treatments, and personal health habits. Customers can use the PHR to track lab test results and other measurements such as weight, blood pressure, and cholesterol levels. The service also identifies potentially harmful interactions among medications, herbal supplements, and vitamins.

The personal health record is the latest addition to a variety of online health tools offered by the insurer. Through AccessBlue, the company’s secure, self-service web portal, customers can view a payee-based health record based on Blue Cross claims data. They can also review the status of current claims, order replacement ID cards, and handle many other routine requests. Other health tools allow customers to research health conditions and view detailed cost and quality information on most of the state’s hospitals.

Dr. William Clark Named Medical Director for Emergency Medical Services

Dr. William Roger Clark has been named Medical Director for the Department of Health and Hospital’s Emergency Medical Services. The appointment was effective October 1, 2007. As Medical Director, Clark will provide medical direction for the DHH Bureau of Emergency Medical Services. The mission of the Bureau is to ensure optimum pre-hospital emergency care through effective education and certification of EMS providers throughout the state according to national standards.

Clark is a reserve Deputy Medical Director of the East Baton Rouge Sheriff’s Office SWAT Team and is the President of the Louisiana Chapter of the American College of Emergency Physicians. He received his undergraduate degree from Louisiana Tech University, Ruston and his medical degree from Louisiana State University School of Medicine in New Orleans. Clark completed his residency in emergency medicine at Earl K. Long Medical Center in Baton Rouge.

HHS Recognizes Hospitals With Highest Organ Donation Rates

The U.S. Department of Health and Human Services (HHS) presented awards to 392 of the nation’s largest hospitals for their success in increasing organ donation rates at their facilities. Among these were two Louisiana hospitals, West Jefferson Medical Center in Marrero and Ochsner Foundation Hospital in New Orleans.

Hospital executives, together with their partners in 57 federal-ally designated organ procurement organizations (OPOs), received the Department’s Medal of Honor for Organ Donation for achieving and sustaining a donation rate of 75 percent or more of eligible donors. They were recognized during the Third National Learning Congress on Organ Donation and Transplantation held in Nashville, Tenn., on October 9-10.

The 392 winning hospitals come from a pool of 716 hospitals that met eligibility criteria. This represented 30-year-old core operating system with a state-of-the-art packaged system—all while managing a staff of more than 530. The Women Looking Ahead 100s List is compiled by the magazine’s nominating committee and members of the board of directors. Women are selected for the list based on their perseverance in the face of career challenges, commitment to professional excellence, promotion of diversity in the workplace, and involvement in community service. Those named to the list are ordinary women with extraordinary talents.

Mary Bird Perkins Cancer Center Doc Named Chair in Medical Physics at LSU

Dr. Kenneth R. Hogstrom has been appointed as the Dr. Charles M. Smith Chair of Medical Physics at LSU—a $1 million endowed chair to support cancer research. This is the first endowed chair in medical physics at LSU and one of just a few in the nation. Hogstrom is director of LSU’s medical physics program, a tenured professor in the university’s Department of Physics and Astronomy, and chief of physics at Mary Bird Perkins Cancer Center. The creation of the endowed chair is one of several initiatives that are part of the academic and research partnership between MBPCC and LSU.

Blue Cross VP Honored by Women Looking Ahead Magazine

Women Looking Ahead magazine has chosen Allison Young as a member of the 100s List for 2007. The Atlanta-based magazine annually creates the 100s List to honor the most powerful and influential women in the country. Young, Blue Cross and Blue Shield of Louisiana’s vice president of benefits administration, was honored in a ceremony September 26 in Atlanta along with the other honorees. Since arriving at Blue Cross and Blue Shield of Louisiana in 2003, Young has led the company through a massive business transformation—the replacement of its 30-year-old core operating system with a state-of-the-art packaged system—all while managing a staff of more than 530.

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CEO Recognized at Oncology Conference

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With football season moving into bowl season and tailgating and touchdowns on so many people’s minds, I’d like to take you on a “sneak peek” into a couple of very different locker rooms.

In one room, there has been meticulous preparation and planning. The hours spent on the practice field were preceded by three times as many hours studying game films, discussing offensive and defensive strategies, and thinking through the game in advance, play-by-play, quarter-by-quarter. Behind closed doors, the coaches hemmed and hawed, passionately discussed their opinions about what the game plan should be and argued over which players should take the field to give their team the best chance of winning. But, they emerged with a game plan, unified in their effort to implement it to the best of their collective abilities. It should not be a shocker to you that these guys score a lot of touchdowns and do not get scored on very often.

In the other room, there is also a lot going on but they sort of “go with the flow.” The coaches are tugged on in a lot of different directions and between public appearances, shooting commercials, signing autographs, attending their kids’ soccer games, it’s just tough to cram in all those hours watching film. In fact, because of their busy schedules, the coaches study game film separately on their own time. The head coach, being the superstar that he is, is so overwhelmed that he just blindly delegates many of the pre-game decisions to the assistants who...
he thinks have prepared the best. He has often been overheard saying to different assistant coaches, “Just go with whoever you think is the best and run the plays you think will work.” When they leave the locker room, it’s a pretty good bet that the right hand will not know what the left hand is doing since they did not build the game plan together. Is it a shocker that this team’s punter plays more minutes than anyone on the squad?

Now, you can use your imagination to guess what would likely happen if these two teams played against each other. One has a well thought out plan and the other has no plan at all. In sports, the teams that prepare better usually win.

When you look at planning, or rather the lack thereof, in this context, it seems silly or even unthinkable. In fact, it would be downright despicable, given the salaries, the resources, and the perks that football coaches are accustomed to these days. Can you imagine what the radio talk shows and newspaper reporters would have to say about such an incompetent staff?

And yet, when it comes to families in the medical profession developing their personal financial “game plan,” I tend to see a lot more households that look like team #2 than team #1. Being on call, work schedules at odd hours, kids’ activities, active social lives, and other distractions keep medical professionals from even developing an overall financial plan in the first place, much less keeping it updated as things change. Being in a profession that produces its fair share of financial rewards, as one’s wealth grows, so does the complexity and responsibility of managing it.

As time marches on, you end up with a lot of moving parts and relationships to manage, as well. Your medical practice manager, insurance agent, stockbroker, private banker, CPA, attorney, real estate agent, and others are all offering advice in their respective areas of expertise. The problem is, they end up like the coaching staff on team #2, all studying the game film by themselves and rendering their advice in a vacuum. That leaves you, the head coach, with the task of sorting it all out for yourself. That is not an easy task, and sometimes you get conflicting advice because they don’t always agree, do they? So many times, because of your lack of time and expertise in those matters, you just end up saying what our disorganized coach said to each assistant, “Just do whatever you think is best.”

Just like teams with a game plan are more likely to win, families with a game plan are more likely to achieve their financial goals. They’ll accumulate the money for their kids’ educations, they’ll save plenty to create an income stream they’ll never outlive in a 30+ year retirement, they’ll put away the money for that “wedding fund,” and they’ll make sure Uncle Sam does not deplete their sizeable estate when they pass it to the next generation. These are genuine and worthy financial goals for a family to pursue and they are accomplished by having a plan for accomplishing them. And just like team #1 wrestled over the details of the strategies, yet emerged unified at game time, if both spouses have not had input into the plan or have not communicated the plan between each other, then there is no plan. Carrying “the plan” around in your head only works until your head stops working!

Note that I did not say, nor will I ever say, that owning an investment or a group of investments that outperforms your neighbor’s investments, your co-worker’s investments, or the “market” for that matter, is a financial goal. That’s like the coach saying, “I just want to rack up more passing yards than my opponent.” The goal is to win the game. The same is true in reaching a financial goal, and what someone else’s investments did or did not do is irrelevant to your plan.

You can benefit from having multiple qualified, competent advisors who all have your best interests at heart. But you can’t have multiple plans. You can only have one financial plan that everyone works from in order to reach your financial goals. Make everyone sing off of the same choir page.

By coordinating your advisors and the advice they give you, you can avoid some of these common financial mistakes that I have seen medical professionals make over the years:
Problem/Mistake and Solution/Advice

Not making the time to stay on top of things
Build your own board of advisors with your important professional relationships and hold meetings at least annually.

Chasing the new “drug stock”
By the time you get the tip, the market has probably priced in the prospects. Let your plan tell you how much or even whether you should do it.

Managing your tax liability
Many deductions and credits get left on the table when the clock strikes midnight on Dec. 31st.

Poor use of leverage
Not all debt is bad debt, but debt to fund a certain lifestyle can be bad! Be smart about the things you finance.

Not wanting to be left out of “the deal”
Everyone has an ego and no one wants to be the village idiot, but many of the complicated schemes and investments that get pitched to you are only good for the guy pitching them.

Money sitting idle
High incomes lead to high cash accumulation. Have a plan to get it working as you earn it.

So how do you get your arms around all of these moving parts and relationships? With the account aggregation technology available today at almost every financial firm worth its salt, it's easy for you to get organized and stay organized by having all of your financial accounts and assets pulled into a consolidated report. These web-based Wealth Management Systems pull in all of your financial accounts no matter where they are located, they make it easy to check your asset allocation, alert you when things get out of balance, and help you keep your plan updated as your life and the markets change. Heck, some of them even track your frequent flier miles and hotel points! When it comes time to put together those financial statements your bankers are always asking for, it can usually be done with the click of a button. Most systems will even allow you to give your other professional advisors access to the system if you want them to have it, making it easier to keep everyone on the same page. Ask the firm you're working with if you have access to an account aggregation system, or visit www.horizonfg.com to see a demo of the one our firm uses.

Real financial goals require a real financial game plan. Not the one you carry in your head but the one you huddle together and develop with the other important people in your life. Commit it to paper and update it at least annually. Make an appointment and put it on the calendar. Invite all of your important advisors to the table to help you hash it out.

The time to develop your family's financial game plan is now! You don't want to get to retirement, or to your daughter's first year of college, and find out you are only on the 40-yard line when you thought you'd be in the end zone.
Juan Michelle Lewis, RNC
Earl K. Long Medical Center

“Michelle is a graduate of Our Lady of the Lake College and began working for the Labor & Delivery Department of EKLMC in June of 2001. She is an outstanding individual with extremely high personal and professional standards. While exhibiting genuine concern, caring, and compassion, she regularly promotes excellence in patient care and service. She has the uncanny ability to comfort and place her patients at ease with her calm voice, sparkling smile, and warm embrace.

Additionally, Michelle serves as a preceptor and mentor for the unit’s new nurses and area nursing students during their clinical rotations on L&D. As well as being a team player, she functions as a strong team leader. Michelle’s ability to be everywhere at once and being capable of multi-tasking is legend. Never satisfied with the status quo, she is at the forefront of suggesting ways of “doing it better, faster or less expensively.” Michelle’s greatest strengths lie in her internal motivation, her love of nursing, and a personal commitment to continued professional growth. In December 2006, she demonstrated one aspect of that commitment by successfully achieving her certification as an Inpatient Obstetric Nurse through the NCC. In anyone’s estimation, she is certainly a Nurse of Excellence.”

Lori Miley, RN
Lane Regional Medical Center

“Lori Miley works at Lane Regional Medical Center as Unit Manager for our eight bed LDRP/Nursery unit. Over the past two years, I have seen her focus her attention on the delivery of quality care to our patients. She oversees the operation of the units as well as "pitches in" and provides direct patient care when our unpredictable census dictates. In the past two years, she has been instrumental in upgrading our infant security system and facilitating the coordination of a major upgrade in our Central Monitoring System for our laboring patients. The upgrade will include a major revision in our documentation, which will facilitate bedside charting, increasing the amount of time we, as nurses, spend with our patients. I have taken part in interdepartmental meetings which Lori has facilitated that had direct, positive results either in reducing redundant tasks for the nursing staff or providing a direct, tangible improvement in the delivery of care to our patients.”
“Lori is a caring person who works very hard to be fair to her employees while balancing the needs of her children and family. She brings a lot of positive energy wherever she goes. She is gifted in problem solving and negotiations. I consider it a privilege to work with her.”

Irene Watson, RN
Our Lady of the Lake Regional Medical Center

“Irene is a Certified Neurology Registered Nurse. She has practiced in multiple areas associated with Neurology for more than 30 years. Irene is instrumental in researching and compiling new policies and procedures for her team members that will affect OLOL’s patients. She is truly a patient advocate, putting her patients first and encouraging others to do the same. She promotes professionalism and contributes to enhancing the practice of nurses by maintaining integrity, striving for excellence, and expecting the very best from all involved. Irene makes it a point to go out and speak to her patients’ families in person while they are in surgery, instead of calling on the phone. Her familiar face and expansive knowledge in her field brings them comfort.

“By compiling knowledge, research, and data for her team members to use in the role of patient care, Irene has contributed to improving the competence and knowledge base of other nurses who are fortunate enough to work with her. Her standard of care is exceptionally high. Irene has collaborated with physicians, physician assistants, nurses from other hospitals, and her own team members to come up with better protocols to ensure patient safety and continuity of care. Irene is also actively participating in developing a process for the new Pre-op Surgery holding area.”
St. Elizabeth Hospital Establishes Hospital Medicine Program
On October 15, 2007, St. Elizabeth Hospital began its Hospital Medicine Program. The program involves the use of physicians, called Hospitalists, who are the primary physicians in charge of patients' care during their stay in the hospital. Daria Muzychka, MD, a Hospitalist at St. Elizabeth Hospital said that, while patients initially tend to be cautious of placing their trust in a Hospitalist as opposed to their primary care physicians, most acclimate quickly to the concept. “Patients enjoy and benefit from the increased amount of time that Hospitalists are able to spend with them in the hospital.”

Since Hospitalists do not have office hours, they have more time to spend with patients, and answer questions that patients and their family members may have. Just as primary care or specialists consult with other specialists when they follow patients in the hospital, Hospitalists may consult other doctors in the same manner. The Hospitalist works closely with the primary care physician who provides information about past health history and significant findings or events. In turn, Hospitalists send the primary care physician information about the patient’s hospital stay, thereby providing continuity of care.

The Hospital Medicine Program at St. Elizabeth Hospital is staffed by Srivalli Donthineni, MD; Daria Muzychka, MD; and Linda Prempeh, MD. They are employed by St. Elizabeth Physicians, a wholly-owned subsidiary of St. Elizabeth Hospital. All are board certified in Family Practice or Internal Medicine and have many years experience in the clinical and hospital settings.

New Study Finds Baton Rouge General Patient Outcomes Superior
The quality of hospital-based care in America is improving, but the gap between top-performing and poor-performing hospitals persists according to a study released by HealthGrades, the nation’s leading independent healthcare ratings company. The study ranks Baton Rouge General best in the state for overall critical care and among the top 5% of hospitals nationwide for Critical Care. For the seventh year in a row, HealthGrades also recognized the General as Best in Baton Rouge for Cardiology (2002-2008).

The Tenth Annual HealthGrades Hospital Quality in America Study identifies key trends in the quality of care provided by approximately 5,000 hospitals nationwide. HealthGrades researchers analyzed Medicare discharges from every U.S. hospital between 2004 and 2006. Risk-adjusted mortality and complication rates were calculated and hospitals were assigned a 1-star (poor), 3-star (as expected), or 5-star (best) quality rating for 28 diagnoses and procedures from heart failure to hip replacement to pneumonia. Individual hospital quality results from this study are available at www.healthgrades.com. Baton Rouge General is recognized in the following areas:
• #1 in Louisiana for Critical Care
• Ranked Among the Top 5% in the Nation for Critical Care
• Recipient of the 2008 Health Grades Critical Care Excellence Award™
• Best Rated in Baton Rouge for Cardiology 7 Years in a Row (2002-2008)
• Five-Star Rated for the Treatment of Heart Attack 7 Years in a Row (2002-2008).

$1.5 Million Grant to Establish Health Information Network in Pointe Coupee Parish
The rural parish of Pointe Coupee will soon have a more advanced electronic network of medical information than most other areas of the state. That’s because funds awarded through the federal Department of Health and Human Services are being used to establish a health information technology network in the Pointe Coupee Parish area. The goals of this effort are to improve coordination of care, increase quality of care and provide cost savings to the system. The $1.5 million grant will link 11 hospitals.
Designated as a healthcare shortage area for primary, mental health, and dental care, Pointe Coupee Parish has many health challenges. The parish is also considered a medically underserved area. While there are nine private providers locally, 50 percent of these are near retirement and have significantly reduced their hours of operation. Also, Pointe Coupee General Hospital is the only hospital in the parish and has a total of 25 beds. Establishing an electronic health information network within this system is expected to improve the overall healthcare system and, more importantly, improve patient care.

31 Ochsner Nurses Named In "100 Great Nurses of Louisiana"

Once a year, 100 of Louisiana's brightest registered nurses are singled out for their outstanding contributions to the profession at the Great 100 Nurses Celebration. This year a record number of Ochsner Health System nurses were named with 31 receiving the Great Nurse designation. The 100 Great Nurses of Louisiana was founded in 1986 as a way to recognize outstanding nurses and their accomplishments and successes. The honorees are selected by their peers and patients, based on their humanity, as well as their contribution to the community and the nursing profession. Below are the 31 Ochsner Health System nurses that are honored in The 100 Great Nurses of Louisiana:

- Melissa Adams, RN
- Joelle Bourgeois, RN
- David Brennan, RN
- Jennifer Buquoi, RN
- Susan Foret, RN
- Georgia Gafeney, RN
- Maureen K. Gomez, RN
- Janice Marie Johnson, RN
- Janet M. Kaleher, RN
- Michelle K. Blow, RN
- Melissa Brack, RN
- Leslie Brown, RN
- Mary Kay Ford, RN
- Aimee G'sell, APRN
- Janie P. Gilberti, RN
- Cherie L. Hippler, RN
- Rosa Judd, RN
- Melissa McDougle, RN

- Cheri Oser, RN
- Carsten A. Pennier, RN
- Margaret Pizzitola, RN
- Debra W. Rushing, RN
- Patti G. Terrebonne, RN
- Penny Tomb, RN
- Mary Kay Woodruff, RN
- Lisa F. Pellerin, RN
- Anthony F. Pichon, Jr., RN
- Karen Rowden, RN
- Kristine F. Strecker, RN
- Shelley B. Thibeau, RN
- Heather B. Webre, RN

OLOL Named Consumer Choice Award Winner for the Ninth Consecutive Year

For the ninth 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 the NRC Healthcare Market Guide study. The 2007-2008 NRC Healthcare Market Guide study surveyed over 200,000 households by phone representing 450,000 consumers in the contiguous 48 states and the District of Columbia. The 2007-2008 Healthcare Market Guide is the nation's largest and most comprehensive study of its kind.

St. Elizabeth Hospital Welcomes New AVP of Quality

Leslie Norman, St. Elizabeth Hospital Vice President of Patient Care Services, recently named Caroline Conerly, MS, HCM, RN, CNA-BC, as Assistant Vice President of Quality and Risk. Conerly holds a Master of Science in Health Care Management from the University of New Orleans and a Bachelor of Science in Nursing from the University of Mississippi Medical Center School of Nursing, Jackson, Mississippi. She has been a registered nurse since 1981. Before joining St. Elizabeth Hospital, Conerly was employed as Patient Safety Officer at Woman's Hospital, Baton Rouge. During her tenure at Woman's, she also served as the Director of the Magnet Project with successful achievement of magnet status in nursing excellence in 2006. Prior to her employment at Woman's, she worked for Keystone Health Plan Central, a Pennsylvania HMO, as Manager of Performance Improvement. Conerly is also certi-
Healthcare Journal of Baton Rouge

Woman's Hospital Files Lawsuit

Woman's Hospital along with a number of concerned beneficiaries have filed suit in federal court, seeking to secure crucial funding for medical care for the neediest women and infants of Louisiana. “The refusal of the Department of Health and Hospitals and the governor to adequately fund the care for which the state is responsible has reached such proportions as to threaten access to many services that we provide to the community at large,” said Teri G. Fontenot, President/CEO.

The state has repeatedly underfunded the Medicaid program, refusing to pay the actual costs of care while increasing Medicaid eligibility, said Woman's Hospital. “We have attempted to work with state officials, especially over the past six years, to secure reasonable Medicaid reimbursement through an appropriate adjustment of Medicaid payment rates, to no avail,” said Fontenot. “At this point, we are faced with the remedy of last resort—filing a lawsuit to secure reasonable reimbursement as required under federal and state law.” The lawsuit specifically requests that the state be held accountable to follow the federal regulations in place that govern the Medicaid program and to comply with a 2003 state law designed to protect providers who care for large numbers of Medicaid patients.

Ochsner Expands Services in O'Neal Area

In its continuing efforts to expand services in the O'Neal Lane area, 32 Ochsner physicians will now serve patients at the O'Neal Lane Health Center at 16777 Medical Center Drive, Physician's Plaza I, I-12 at O'Neal Lane. The move, which involved a six month renovation of the center's facilities, brings the center's total physicians from the previous 10 to 32. In addition, nine new specialties will now be available at the health center.

DHH Responds

The Department of Health and Hospitals immediately issued a response to the lawsuit filed by Woman's Hospital, stating that it will pay millions more to Woman's for extra care. DHH stated that for the past four years, the Blanco administration and the Department of Health and Hospitals have worked to increase the reimbursements made to all hospitals throughout Louisiana, including Woman's Hospital in Baton Rouge. DHH took issue not only with the suit, but also with the way the hospital characterized its dealings with DHH. The department said that this year alone, it will:
- Pay Woman's Hospital $4.5 million more this fiscal year than last year.
- Increase the hospital's payments for treating uninsured patients.
- Increase funding to hospitals (such as Woman's) that provide care to a high number of Medicaid patients.
- Make extra payments to Woman's for their home healthcare program.
- Increase the rates paid to Woman's for the care they provide to babies that require complex medical care.

The new services are:
Allergy  Cardiology
Nephrology  Neurology
Ophthalmology  Optometry
Podiatry  Pulmonary
Surgery, General

Services already at the health center include: Gastroenterology, General Internal Medicine, Geriatrics, Laboratory, Orthopedics, Pediatrics, Radiology, and Urology.

Lane Regional Medical Center Breaks Ground on Zachary's First Three-Story Building

Lane Regional Medical Center hosted a groundbreaking ceremony recently to celebrate its new Medical Office Building IV. Zachary Mayor Henry Martinez, Metro Councilman District #1 Wayne Carter, Chief of Staff Dr. Clayton Brown, Lane Board Chairman Dell Guerra and CEO Randy Olson presided. Lane Regional Medical Center’s administration selected the construction management team of Arkel Constructors, General Contractor, through a bid process. They will work with architectural corporation Bradley-Blewster & Associates to build Lane’s new three-story, $9 million Medical Office Building IV on 2.9 acres of land located adjacent to the hospital on Hwy 64, 6550 Main St. This frontage property is just a portion of the land purchased last November for future expansion projects.

The new building will be a first for Zachary. Due to previous city ordinance height limitations, Lane’s will be the first three-story structure ever to be built in the city of Zachary. With 63,000 square feet, it will house up to 16 physician medical offices and feature a new outpatient center for imaging and lab referrals. The new medical office building is expected to take approximately 14 months to build.

The new building is the latest achievement in a busy year during which Lane has:
• launched Cardiology services
• opened a new Cath Lab and Intermediate Care Unit
• put into operation the Picture Archival System making x-rays and images digital
• expanded the Diabetes, Sleep Studies, OB/GYN, Orthopaedic, Outpatient Surgery, and Scale Down weight management programs
• built a third Medical Office Complex
• partnered with Zachary High to offer the Z-Med Certified Nursing Assistant program
• created a Nurse Tech Internship program
• purchased additional property for future expansion efforts
• received numerous Awards for Quality.

In the near future, Lane plans to:
• open FastLane—an After Hours Walk-in Clinic for minor illness and injury
• begin Bedside Registration in the Emergency Room
• establish hospital-wide Electronic Medical Records
• begin construction on a permanent Cath Lab
• open offices in Central.

Our Lady of the Lake
Purchases Land in Livingston Parish
Our Lady of the Lake (OLOL) Regional Medical Center recently completed the purchase of approximately 200 acres of land near Walker, with the anticipation of expanding services in Livingston Parish. The parcel was purchased for approximately $9.6 million. In the coming months, OLOL leaders will work with the Parish President and the mayors of the individual towns in Livingston Parish to get feedback from the community about healthcare needs of the area.

Vista to Serve as EKL Satellite
According to The Advocate (Nov. 9, 2007), LSU Health Care Services Division has purchased the 35-bed Vista Hospital on Perkins Road with the intent of creating a satellite surgical center for Earl K. Long Medical Center. The additional surgical space will help relieve a surgical backlog at EKL and provide additional physician-in-training opportunities. The $20 million purchase was funded by a $15 million appropriation by the 2007 Legislature and $5 million from LSU’s budget. The property includes 50,000 square feet of existing surgical space, 6,900 square feet in office space, some medical equipment, and 20 acres within the Essen-Bluebonnet medical corridor.
Excellence in General Gala for the Baton Rouge General Foundation. David Pitts, Chairman of the BRG Board of Trustees; Amy Howe, Committee Co-Chair; Bill Holman, BRG CEO; Bob Rainer, Chairman of the BRG Foundation; Nancy Breitenbach, Penny Miller, Committee Co-Chair; Cynthia Michael, Baton Rouge General Foundation; and Lonnie Stockwell, Co Chair.

Participants walking at the annual Alzheimer’s Services Walk/Run to Remember on LSU’s campus Saturday, October 22.
This month will be Bob Davidge's last as CEO of Our Lady of the Lake Regional Medical Center, having announced his retirement last summer. A sprightly 66, Davidge decided to step down to spend more time with his family, engage in more travel, and hopefully fit in some time for fishing. With close ties to the community, Davidge plans to stay in Baton Rouge. He will also serve as a consultant with the Franciscan Missionaries of Our Lady Health System for one year to ensure a smooth transition.

Robert C. Davidge, Jr. joined Our Lady of the Lake Regional Medical Center in 1979 shortly after the hospital moved to Essen Lane from its original downtown location. During his tenure as the hospital's top official, Davidge's vision and leadership have propelled OLOL to its position as one of the largest and most highly regarded hospitals in Louisiana and the southern United States. Davidge has also served on numerous civic and professional organizations, continuously working on behalf of both his community and the healthcare profession.

Davidge also served his country. Following 36 years in the United States Air Force Active Reserves, Davidge retired in 1995 as a Colonel 0–6. While in the Reserves, Davidge served on active duty during Operation Desert Storm. Davidge also served on Active Duty in the Air Force from 1959-1963, receiving decorations for meritorious service. He holds both a Bachelor of Science and Master of Business Administration degree from the University of Florida.

We wish Bob and his family the very best in their future endeavors.
The individuals and companies listed in the **HJBR Resource Guide** are supporting the *Healthcare Journal of Baton Rouge* and are committed to supporting those in the Baton Rouge area healthcare field.

To be listed in the HJBR Resource Guide, call 225.302.7500.

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Baton Rouge Symphony Orchestra 225.383.0500
P.O. Box 14209, Baton Rouge, LA 70898
www.brso.org

**Airports**

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

**Attorneys**

Breazeale, Sachse & Wilson LLP 225.387.4000
One American Place, Suite 2300, Baton Rouge, LA 70825
www.bswllp.com

Taylor, Porter, Brooks & Phillips LLP 225.387.3221
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www.taylorporter.com

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www.dhcla.com

**Home Health**

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6869 Highway 84 W., Ferriday, LA 71334
www.personalhomecare.net

**Hospitals**

Baton Rouge General Medical Center 225.387.7000
8585 Picardy Avenue
3600 Florida Blvd., Baton Rouge, LA
www.brgeneral.org

Lane Regional Medical Center 225.658.4000
6300 Main St., Zachary, LA 70791
www.lanermc.org

**Imaging**

Imaging Center of Louisiana 225.761.8988
8338 Summa Avenue, Suite 302, Baton Rouge, LA 70809
www.imagingcenterofla.com

**Insurance**

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

Louisiana Health Plan 225.926.6245
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www.lahealthplan.org

**Medical Equipment**

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Baton Rouge, LA 70809
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www.uniformsbybayou.com

Uniforms Etc. USA
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NeuroTherapy Specialists, Inc.
11140 North Harrells Ferry Rd.
Baton Rouge, LA 70816
www.neurotherapyspecialists.com

Orthopaedics
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www.bjcbr.com

Gulfcoast Pharmaceutical Specialty
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11320 Industriplex Blvd., Baton Rouge, LA 70809
www.peakphysicaltherapy.com

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Mansurs on the Boulevard
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