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Cindy Nuesslein

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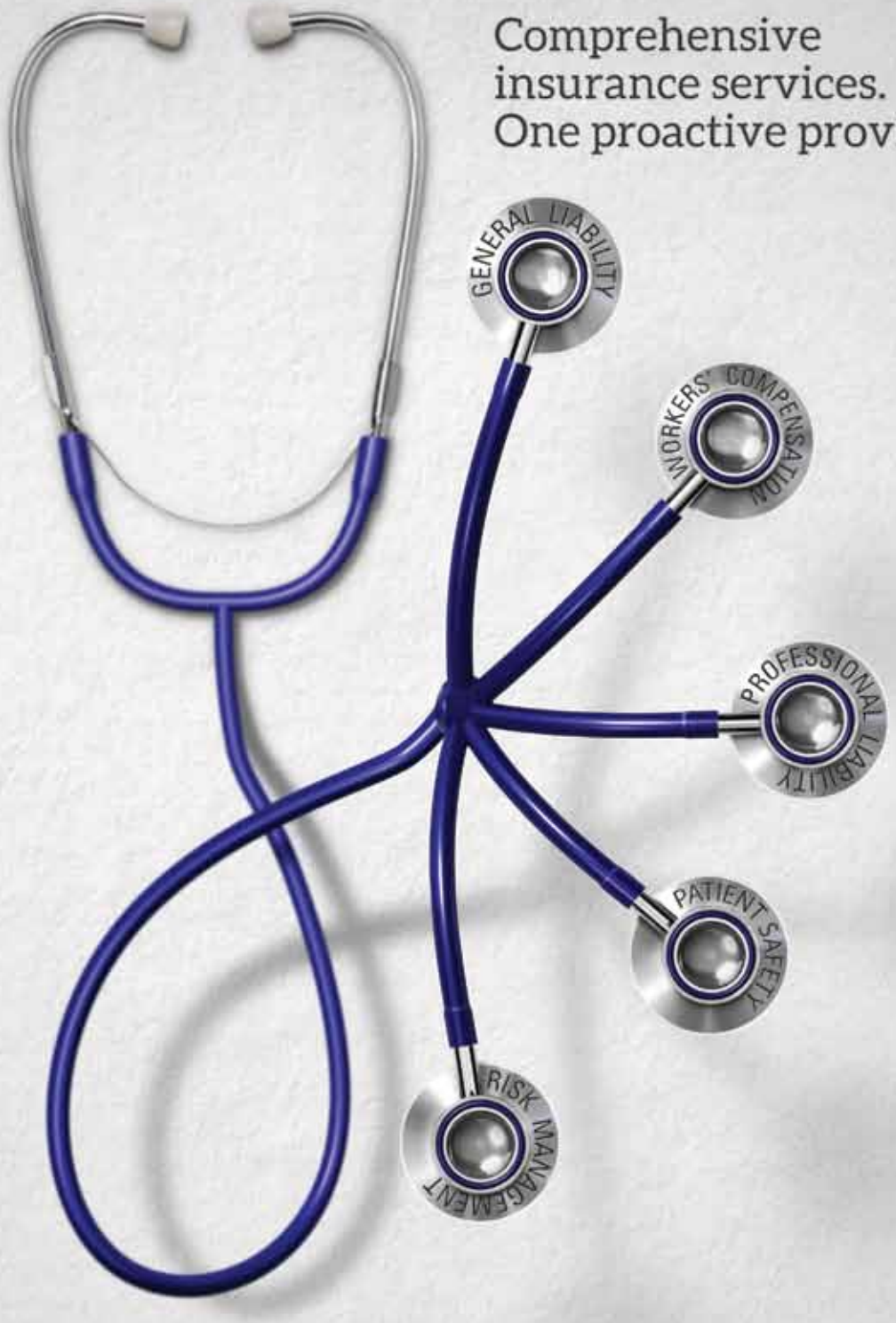

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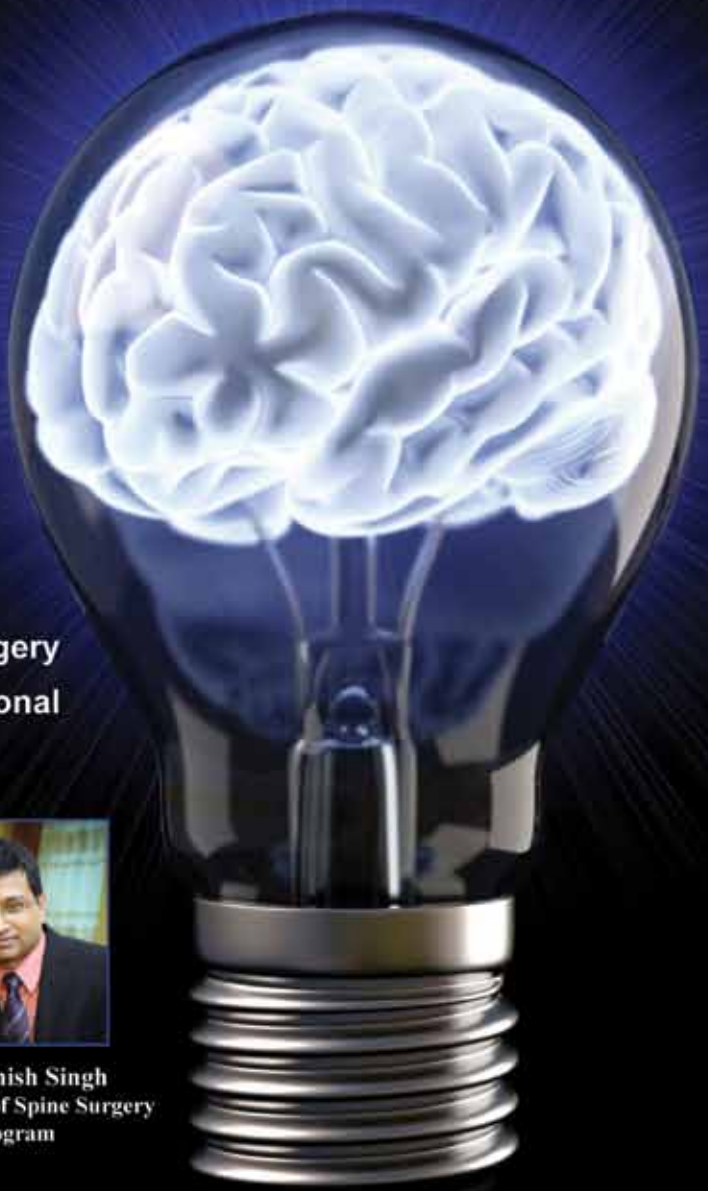

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CANON HOSPICE

"Making Every Moment Meaningful"

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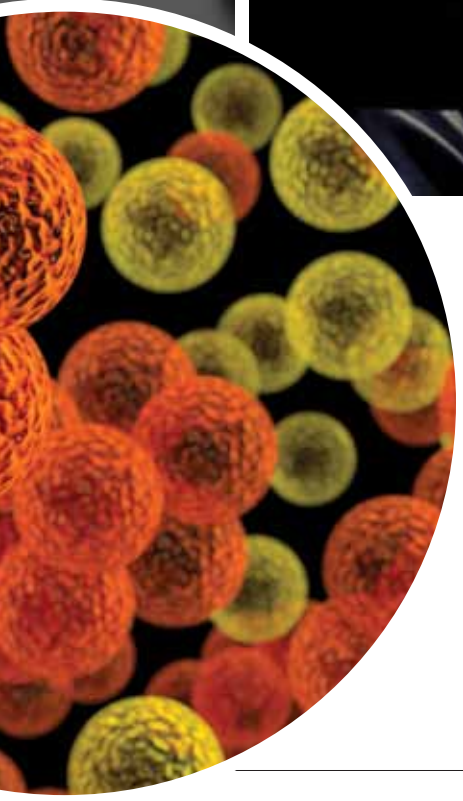

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Breathe Better for Better Health

There are many wonderful suggestions for entirely improving one's health that are rarely discussed, mostly because there isn't an economy to benefit from them.

For example, take the importance of the breath. Focusing on proper breathing provides many health benefits, but how often is it discussed or practiced? Just from a mental perspective, good breathing techniques help to calm the mind, reduce mental chatter, reduce fearful thoughts, and bring better mental awareness. The physical benefits are almost too many to mention.

I heard once that we should live as if we were given a certain number of breaths. No doubt there is likely a correlation between slower, deeper breathing and a longer life. The respiratory system is the gateway to purifying the body. It's often believed that because breathing is also involuntary, it's not meant to be controlled – not true. Regulating the breath is the means to train the lungs and nervous system to better serve our mental condition and physical actions on this earth.

Try this – Do you know of anyone who could stand to be less angry, depressed, frustrated, or anxious? Ask them for one minute of their time. It could change their lives forever and the lives of everyone they come in contact with. Have them try this simple exercise. Using a second hand clock, with the mouth closed, breathe in deeply for 6 seconds, then, breathe out deeply for 6 seconds. That's 5 full breaths in one minute. Is anything different? If you can breathe like this for a minute, you can do it for 5 minutes. Continue practicing until it becomes a habit, and you've changed your life.

We are always looking for better solutions, but some of the best and most basic notions are often simple and overlooked.

In a world that encourages a stressful existence, we still have some choices. We can live in the world, but we don't have to take the bait it offers us to join in its stress. We can ignore the world in this respect. We can breathe slower, we can be calmer, we can make clear decisions, we can be more aware. That's something the world can't take from us.

As health leaders, we always want to offer our patients and community better health options. With an evolving healthcare economy we are able to treat patients with a wide variety of economically based solutions. But, our greatest service is sometimes teaching us all to treat ourselves.

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Smith Hartley
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“I think if this had happened in some other rocking and rolling, well greased cosmopolitan city there wouldn’t be such a buzz, but it is a big buzz here. People are going to think of New Orleans as their destination for healthcare. They love the city and now they are going to love the healthcare.”

one on one

Cindy T. Nuesslein, RN, MBA, FACHE
CEO, Interim LSU Hospital

Cindy Nuesslein has served in various capacities at Louisiana Children's Medical Center Health since 1983. She served as Children's Hospital's Vice President of Operations from 1987 to 2013. While in that role she managed over $100 million in construction projects, directed the Community Benefits and Emergency Management Programs, as well as supervised several clinical and non-clinical departments.

In March of 2013, Nuesslein was promoted to the CEO of Interim LSU Hospital (ILH). As CEO she has lead the organization through a successful transition from a public hospital to a public-private partnership within a six month period, reopened inpatient beds, expanded capacity in the Emergency Room and outpatient clinics, improved throughput, and developed a management team to support future operations, including the relocation to the new University Medical Center in the summer of 2015.

Nuesslein graduated from Charity Hospital School of Nursing. She received a Bachelor of Science degree and a Master's of Business Administration from Loyola University, New Orleans, and is a Fellow of the American College of Healthcare Executives.

Because of her Emergency Management experience and leadership during and after Katrina, as well as her work in the Quality and Patient Safety arena, she has presented at a number of national and regional conferences and is often looked to as a guest speaker on a variety of topics.

As a lifelong resident of the New Orleans community, Nuesslein believes that giving back can and does make a difference. To that end, she donates her time in several leadership roles within the community. She was a founding member of the Greater New Orleans Women's Healthcare Executive Network and was President from 1994 – 1995. In 2006 she was recognized by *City Business* as one of the Women of the Year. In 2010, she was recognized by Dominican High School with the Sr. Mary Angela Mulherm, O.P. Service Award. She is the Chair of Board of Directors for the New Orleans Regional Leadership Institute and serves on the boards of the Miracle League, NORLI, and the Bricolage Academy.

Chief Editor Smith W. Hartley: In June, 2013, the Interim Louisiana Hospital (ILH) transitioned from a state-managed hospital facing deep budget cuts and layoffs to a privately managed hospital under LCMC Health. Tell us a little bit about the arrangement and the transition–how it affected you operationally and fiscally.

Cindy Nuesslein: Let me just explain at a high level. In 2009 the state created a 501c3 not for profit corporation called University Medical Center Management Corporation. It was never capitalized. It was in the news. There was a lot of discussion about who was going to sit on the board and how all these constituencies would be represented. We have a great board today. It's a little bit different from when it was originally confected, but what happened was, LCMC became the sole member of UMCMC so it was just a member substitution. So officially on June 24, the new UMCMC board governs this organization, but its parent company is LCMC Health. So that's kind of the technical arrangement.

As far as the transition in and of itself, it was five months of unbelievable feet on the ground, hands on the table, lots of desk time, tremendous engagement by the staff here, and the faculty. There was only one rule and that was, "Don't let anything affect patient care. If something doesn't work. Let's just make sure it's not about patient care. All hands on deck...we've got to take good care of these patients. The rest of it we can fix at some future point in time."

It seems easy to just jump across a two-lane, right? No, it's a big deal. Lots of engagement. Lots of hours of work. It is the most significant piece of work that we are doing right now.

It was a pretty difficult transition, I think, for the employees and the faculty. If you think about the cuts that they had to have suffered over the last two years. What was being considered would have devastated the medical schools in this community. So I think there was a lot of excitement about it, but at the same time, concern and trepidation. First of all you've got to go to the market and you've got to buy an entire employees benefits package, right? You don't do that in five months. So it's a month before transition and employees don't officially know that they have a job.

There were about 2000 individuals employed by ILH prior to the transition. We employed 1,800. The vast majority of the remaining 200, and those aren't exact numbers, but they are very close, decided to stay in state employment. So somehow, someway they have found employment in some other sector of the state.

And of course a private benefits package can't compete with a State benefits package. So a lot of these individuals had been vested at a certain level or were getting close to vesting at a certain level to receive these very lucrative retirement benefits and so it behooved them to stay in the State's employ. I can't compete with that, not in the private sector.

At any rate there was a lot of change in benefits, change in management style, change in culture, and I quite frankly think it's all been for the good. I think people feel good about where we are right now. They are just now getting over, "Is the other shoe going to drop?" because they were acclimated to that. They were getting over feeling like they had to operate in isolation and that they can really be free to speak as a team. I tell them a couple of things: One, we are all about patient-centered care and so, feel free to say anything as long as you feel like it's in the best interest of patient care, but too, you have to say it graciously. If you do those two things then we've got you covered, 24/7/365.

So that's kind of where we are. It was a big deal for the city. It was a big deal for the state. These cooperative endeavors have been under intense scrutiny. I am sure we have our detractors. I think overall the organization

I QUITE FRANKLY THINK IT'S ALL BEEN FOR THE GOOD. I THINK PEOPLE FEEL GOOD ABOUT WHERE WE ARE RIGHT NOW.

feels pretty good about where they are and I think they feel phenomenal about where we are going.

Editor: So the key issue was the employment transition. Did things change operationally in the hospital?

Cindy Nuesslein: Not initially. We are doing some fairly substantial reengineering. One of the big books of work we have to do is something called transition planning. That's developing a new owner/operator's manual for the new hospital. So we are looking at all our systems here and work flows, and figuring out which ones we want to take and which ones we want to leave behind. And at the same time correcting some of those because we had some real inefficiencies here and we didn't necessarily do everything as well as we want to. So we are improving this and at the same time designing best practices we can move across the street. It seems easy to just jump across a two-lane, right? No, it's a big deal. Lots of engagement. Lots of hours of work. It is the most significant piece of work that we are doing right now. We have a lot of other things that are happening, but this is the most significant piece of work we are doing right now.

Editor: Did the culture have to change to this process improvement or quality improvement focus?

Cindy Nuesslein: One of the things we deploy here in quality—and we use it for lots of different reasons other than its primary purpose—is a type of root cause analysis. And if you know anything about Joint Commission, they demand you do a root cause analysis if you have any serious safety event or sentinel event. But the process itself is exquisite and training people how to really look at issues that arise and designing systems that have a safety net so you prevent that issue from reoccurring. So as opposed to doing it just for any serious safety event, we say for any event we are going to do a root cause analysis.

What we've done is we've brought in staff from all levels—med students, residents, faculty, hospital staff. We sit them at a table and say, "Okay, here's what happened, how do we fix it?" and then engage them all in a conversation, because it's not about finding fault or blame, and then we use that environment and those individuals and we tell them, "You can't go back and talk about the incident, but go back and talk about the process." We really want to have a non-punitive approach to patient safety. It's critical if we want to improve our performance. It's really a very healthy process and the dialogue is really healthy. I think now that we've been doing it for nine months, people are really engaged in it and when they hear about it and they get invited and they come, even if they are not involved in the problem or maybe only tangentially, they recognize that the hospital is serious about patient safety.

The other thing we are doing is deploying something that we call 903-Safe and by May 31st everyone in our organization, regardless of whether you are employed by us or not, will know 903-Safe and you can dial 903-Safe and let somebody know that there's an issue. You can do it anonymously or leave your name and we will get back to you. So from, "I don't have a washcloth and it's 2 o'clock in the morning" to "I can't get this supply" to "I walk in the hospital every day and the same puddle of water is on the floor" to "We had a medication error." It's a collection tool that allows us to really get a handle on everything that's going on in our organization and everybody participates—from housekeeping to nursing to the faculty to the students. We are rolling out this initiative because on June 1st the Executive Management Team is going to walk through this hospital and stop everybody and say, "Okay if you've got a patient safety concern what do you do?" And we hope they say 903-Safe. I am pretty confident the vast majority will.

So I think those kinds of things are really starting to help all of us. All of the constituencies, all of the providers, all of the support services recognize that quality is job one. If we truly want to build a world class academic medical center with a national and international reputation, which is our vision, then we've got to provide awesome care, hands down. People around the country are going to have to say, "Wow, we're having this problem I wonder what we can do?" And I want them to think, "Call UMC, they'll have the answer." So that's where we're going but you've got to talk the talk every day. It's the first thing I say in the morning and the last thing I say before I leave at night so hopefully that's filtering down. I think it is. I think the faculty and the medical staff are on board. They want this. Who would not want this, right? So we are going to have this incredible new dress and she's gorgeous, stunningly, she's a very smart building, but it's more about what's inside and I think they know that. We need a new dress because we have a very tired and worn one, but it really is much more about people.

Editor: As far as patient care and safety issues, what specifically have you noticed has changed so far? You've got the process going, but have you noticed any difference in outcomes yet or are you still gathering that information?

Not only will you be able to get exceptional healthcare, but again faculty and students and residents from all over the country, the best and the brightest, are going to want to be here. This is going to be the best training program in the country.

Cindy Nuesslein: A little bit of both. We are a lot about what the photograph looks like today and then how to change that picture in the future, but we are also about what we have changed. So let me go to the ER specifically. And let me make clear I don't want to belittle what was done prior to LCMC taking over. The passion in this organization is beyond compare, people here have a real sense of care. We have been a safety net our entire life. I have been in a safety net organization my entire life, and it is really about taking care of people regardless of how resourced they are. But we had some struggles so we have to own up to those or we are not going to be able to fix them. One of those struggles was we made people wait an awful long time in our emergency room before we saw them. Part of that is capacity, part of that is system. So beginning in July we started an initiative saying we really want to look at this, we really want to make sure we are doing this significantly differently.

We used to have an urgent care center that was in this building so you had to come here to go to urgent care, but if you were sick, you had to go across the street, so it was hard to decide on one's own. We had a part of the building that wasn't being used that was tangential to the ER so we moved the capacity of our urgent care center to the emergency room and now have a fast track in the emergency room. The other thing we did was we started doctor triage. There is a lot of science behind that that says you can start initiating care. You come in, you see a physician, the physician asks ten questions, gets a brief picture of you, says you are going to need a CT and this kind of lab work, we can go and get that done for you and you can get into a room and have your definitive care sooner. So instead of waiting in the waiting room to be seen you are getting some of your work done during that wait time. We've noticed a significant drop in time from the time you hit our door to the time we see you. We would like that to be much better than it is, but it is dramatically different than it was.

That's something everybody touches and feels. The ER feels better about it. It's kind of a domino thing. We had to open up beds so we put more acute care beds on line. That's how we opened up more psychiatric beds, so we don't have to hold as many psychiatric patients in our emergency room. It's just a piece of a big puzzle, but we're changing it. I think people are excited about that; they recognize they have input and that they can make a difference, and we listen to what they say and respond to those things. It's not a pie in the sky or a perfect world, because we still have a lot we need to work on, but I think people are encouraged.

Editor: How do you handle the cost component with so much pressure on reducing hospital expenses? How do you handle that while at the same time trying to improve your services and quality?

Cindy Nuesslein: We are a young system. Some things will go to the system level and we will gain efficiencies there. That will take us a little bit of a longer time. We do deploy things in our organization today that help us such as in the supply chain world where we have electronic ordering and electronic dispensing. We have a PIXUS system so it

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We look at it at a lot of levels. We are only just scratching the surface. If you think about it we're a ten-month-old hospital. We are still in our infancy. We are learning each other. We have a great executive team, but we are a new team. We are new to the organization. They are learning us. We are ten months old... we're almost walking.

Editor: Have things changed in your payer mix?

Cindy Nuesslein: It is really too early to see that. We are beginning to build some new programs here that will change that. That's not an overnight kind of thing. We are working on our managed care strategy so we can get on all the managed care plans so patients can come here. We are working on our referral systems so people can send us more patients. It was a somewhat closed system before—you had to be in the system to see patients in the system and we are trying to open that up so patients can come from anyplace to see us. We want to drive it more with, "We have this doc with this talent and there are only five of him in the country and if you really want exceptional care you need to be here." Of course our Level 1 Trauma Center is indiscriminate as to who gets in a car accident, so everything comes our way in regards to that. But the real financial issue for us is we have to be operationally efficient. If we are operationally efficient the finances will work for our system.

If you ever see what we call Room 4, that's where trauma patients go, it's like watching a symphony. It is really poetry in motion. It is so quiet and so calm...

Editor: You have another big transition coming up here in 2015. What will this mean to the existing staff? Other than the physical component what will it mean moving forward? How are you preparing for this transition?

Cindy Nuesslein: Just to give you a sense of scale, today we are operating about 222 beds. We can operate 251 beds in our organization and then we are at capacity. UMC is 444 beds, so about 200 more beds we can have online. If we think about strategy-wise—we're building an academic medical center, and we're going to have centers of excellence across all specialties. So what we are doing today is looking to see what do we look like? What do our centers look like today? What do we want them to look like? How do we build the rest of that? The challenge will be can we start building some of it now and move it over to UMC or do we have to wait until we have UMC to be able to do it? It's both of those things.

So, for example, today we don't have Radiation Oncology, but we have the facility to do RADONC across the street. There will be lots of those things. We are determining what

Editor: What is the general attitude? Is it a transitional weariness or are they looking forward to this with enthusiasm and optimism?

Cindy Nuesslein: Yes to the latter. We had our kickoff meetings for the actual operational planning of it and the staff all had to get together from different departments and what I hadn't quite recognized is that many of them hadn't really worked a lot with one another before. So it was an incredible opportunity for them to get to know the nitty gritty of these different departments. But the whole kickoff was about sitting down at different tables with different constituencies of people.

So respiratory had a table and transporters had to go there and communications had to go there and lab had to go there and say, "Okay, how are we impacting one another?" They got to write their highs and lows and they learned a lot, not only about the organization, but also about themselves. When you walked in the room, you know how you can feel energy? You could feel energy. I thought, "Wow, what a great tool, because we need to do this, because we have to figure out how to work across the street." But also, what a wonderful experience for all the directors to be able to, in an unthreatening, open, participatory, and contributory environment, learn one another. It's phenomenal.

THE TALENT AND SKILL THAT IS HERE IN THIS FACILITY—IF YOU GET HURT, YOU WANT TO BE HERE. IF I GOT HURT, I WOULD WANT TO BE HERE

We are pretty new into the planning; it's been since late December that we've really started to ramp up this planning. I don't know anybody that says, "I don't want to go," and it's a huge recruitment tool, not only for the hospital, but for the schools. We put up our website and we have a link to a virtual tour of the new facility and of course everybody thinks none of us who go through this will ever have the experience again. How often does this happen? I am a big fan of New Orleans and the region, and I think she's got warts, but she's a hell of a person, and I think that helps us immensely. I think if this had happened in some other rocking and rolling, well greased cosmopolitan city there wouldn't be such a buzz, but it is a big buzz here. People are going to think of New Orleans as their destination for healthcare. They love the city and now they are going to love the healthcare.

Editor: That was my next question—what does this mean for New Orleans?

Cindy Nuesslein: New Orleans is already on the map, sometimes for things we are not very proud of. I understand that, but it will be on the map for healthcare. Between the VA and UMC, you have two great medical schools, how many communities really have that that they can bring together to do something this incredible?

Editor: What's going on right now in the transition process? Where are you now?

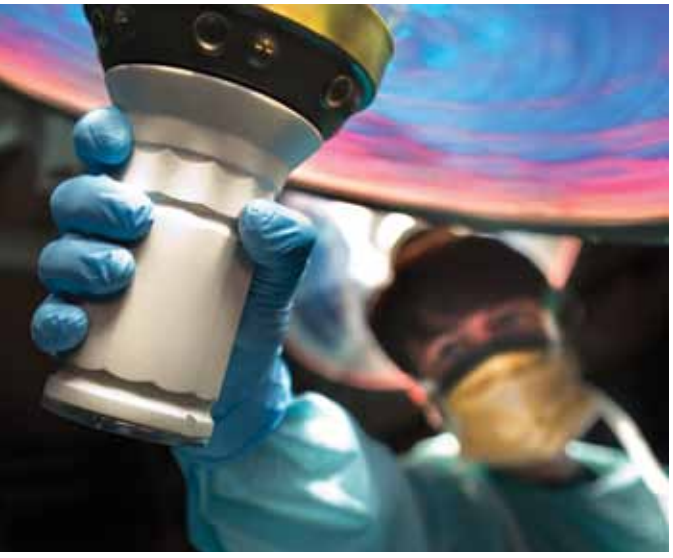
Cindy Nuesslein: We don't manage the construction project. The state manages the construction project. It is on a timeline to complete in December or January. Then it's got to get commissioned and then we've got to get in it and practice. We are down to the nitty gritty and the weeds looking at on Day One who's the first patient that goes in that hospital and how?

Editor: What do you call Day One then?

Cindy Nuesslein: We will practice for a while. We don't quite have our timeline in place yet. Our transitional planning company is helping us with that. Based on who we move and how we move will determine that timeline, but we suspect that by a year from this summer we will move in. We will not move July 1st because that's when every resident student changes. That's the academic year, so we are either going to move June or August, somewhere therein, but we haven't gotten far enough in our planning process to say this is the start date.

those service lines are. I went to school at Charity School of Nursing back in the late 70s so I started my career and I hope to gracefully end my career here, but you forget the hum of the science that's here. We get it first and we just need to deploy it first. And there's a lot of that that's happening. Unfortunately we don't necessarily always have the right support systems in play to be able to do that. We will at UMC, because the physical facility will no longer be our barrier. The only barrier we will have at that point is our imagination.

It's exciting. Who wouldn't want to do this? Even though you don't sleep at night. People ask me what's the one thing I can do for you? I say one of two things; teach the sun how not to come up or how not to go down. Neither one of those worked for me. It really is kind of a time crunch; it's a lot to do in a short period of time.



Editor: In terms of the academic portion, will it be an enhanced version of your current academic program?

Cindy Nuesslein: As an academic medical center we will maintain that tripartheid mission: excellent patient care, a robust learning environment for all of our students, and of course a big research mission, too. In collaboration with our partners, we'll be achieving all of those things. Not only will you be able to get exceptional healthcare, but again faculty and students and residents from all over the country, the best and the brightest, are going to want to be here. This is going to be the best training program in the country.

Again, you've got a beautiful new dress and it's a great building, but if you think about what we do here, our Level 1 Trauma Center is phenomenal. If you ever see what we call Room 4, that's where trauma patients go, it's like watching a symphony. It is really poetry in motion. It is so quiet and so calm and you have the sickest of sick and everyone knows exactly what their job is and they get the patients in, they get them assessed, and if they need to go to the OR we can do that in ten minutes. Where can you go and in ten minutes get in an emergency room and be in an operating room? It's just exquisite to see. Not that you want anybody hurt, but when you see the process in motion, it is utterly amazing. The talent and skill that is here in this facility—if you get hurt, you want to be here. If I got hurt, I would want to be here.

So we will still have a Level 1 Trauma Center there. We will have some other high end services we are working through all that right now. We don't quite know what our portfolio will look like. We are in a strategic planning process figuring that out, but I promise it will be something to behold.

Editor: And you come from the old Charity world too, so bringing all the perception of that, how do you strike that balance, bringing in something new, better, different, but it's still the same mission in some capacity?

Cindy Nuesslein: The mission doesn't change. We will honor our legacy and develop a single system of excellent care. It won't matter how resourced you are, when you enter our organization you will feel you have had respectful, exceptional care. We will all behave in that way. We will all be gracious and we will all treat people as they need to be treated. Appropriately and kindly, and with the quality that is unparalleled. It's not about the resource of the patient, it's about the delivery system of care. I think once you do that, the rest of those perceptions fall away.

Editor: So will you then also be competing for those patients covered by the commercial insurance market? Does it change the landscape?

Cindy Nuesslein: I never mind competing. To your point, and maybe with a little bit of a different spin, programmatically we are going to drive patients here. It doesn't matter how resourced they are. Because they are going to need our service and they are not going to be able to get it elsewhere. Or, it's going to be a service you might find in many tertiary care facilities, but they are going to want to come here because it is so much better. To us, as long as we have great care, a great training program, still have great medical schools, who's not going to want to be here? At the end of the day, it is what it is.

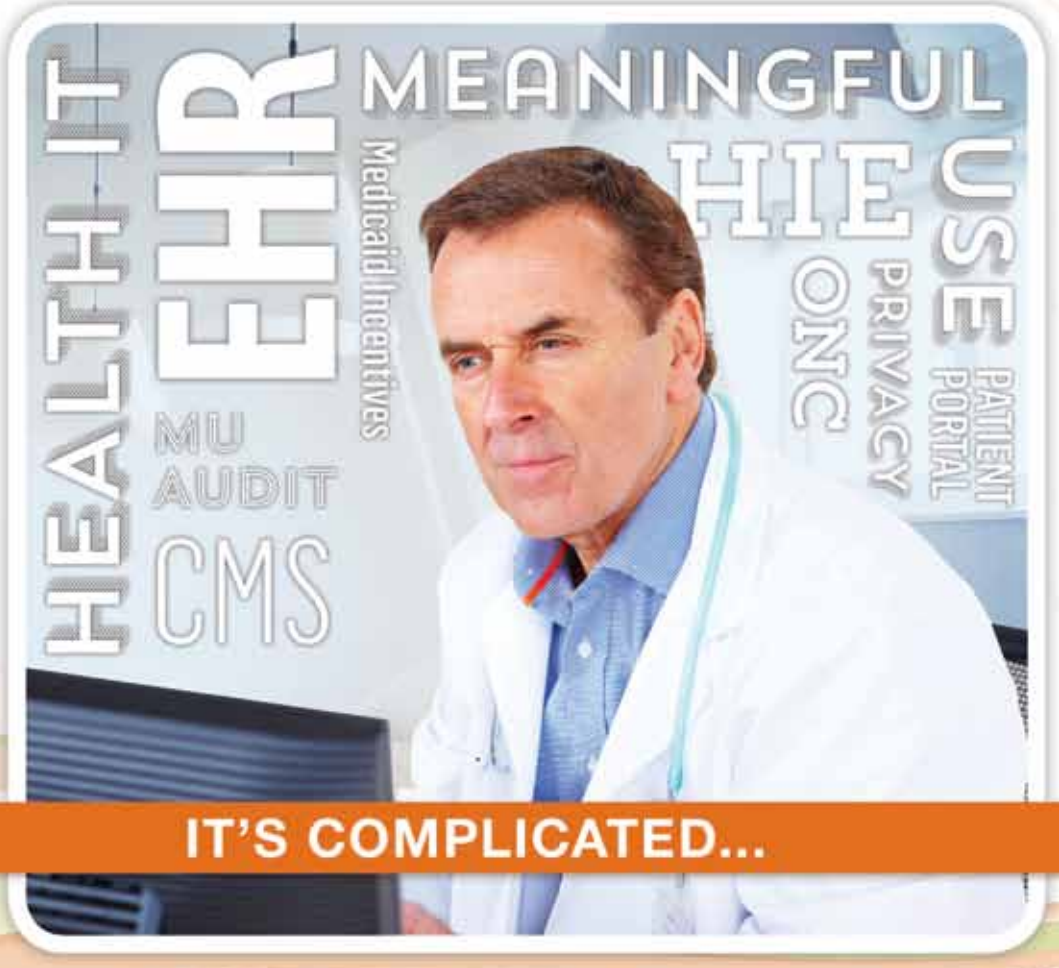
Editor: How will you know when you have succeeded?

Cindy Nuesslein: In order to learn the organization we've had lots of town hall meetings, and department meetings, and faculty and medical staff meetings, but one of the things I am doing is going to each department. It's critically important to me that all of the staff know who their leadership team is. We need to be out and about in the organization. In fact, on Wednesdays at lunchtime we are in the cafeteria, for people to walk up, ask us questions. Lots of people don't walk up so we just go and sit at tables and have conversations. Not all of us every week, but several of us go. The staff asks that, "How will we know when we have arrived?" I tell them these two things. Patients will want to come to UMC because they can't get better care. But that's not really it, when they leave they believe the same thing. But here's the real marker—every one of us in this room will want our healthcare and our families' healthcare here and that's how we'll know we've succeeded.

Editor: Are you going to be involved all the way through? Are you going to be the CEO of UMC and is that something you want?

Cindy Nuesslein: Well, I am going to get us across the street. It's really not a change at all. Today we call ourselves ILH. Tomorrow we will call ourselves UMC, so I am the CEO of the organization. It's just we'll be moving across the street and we will have a new name.

It is an incredible honor to be here. Who wouldn't want this job? I know I think I am the luckiest person in the world. Because it's just not going to happen again. You get to transform an organization and a city. Wow! I won't say the days aren't long and rough, but at the end of it, if you keep seeing the light at the end of the tunnel, my gosh, how to end a career, right? ■



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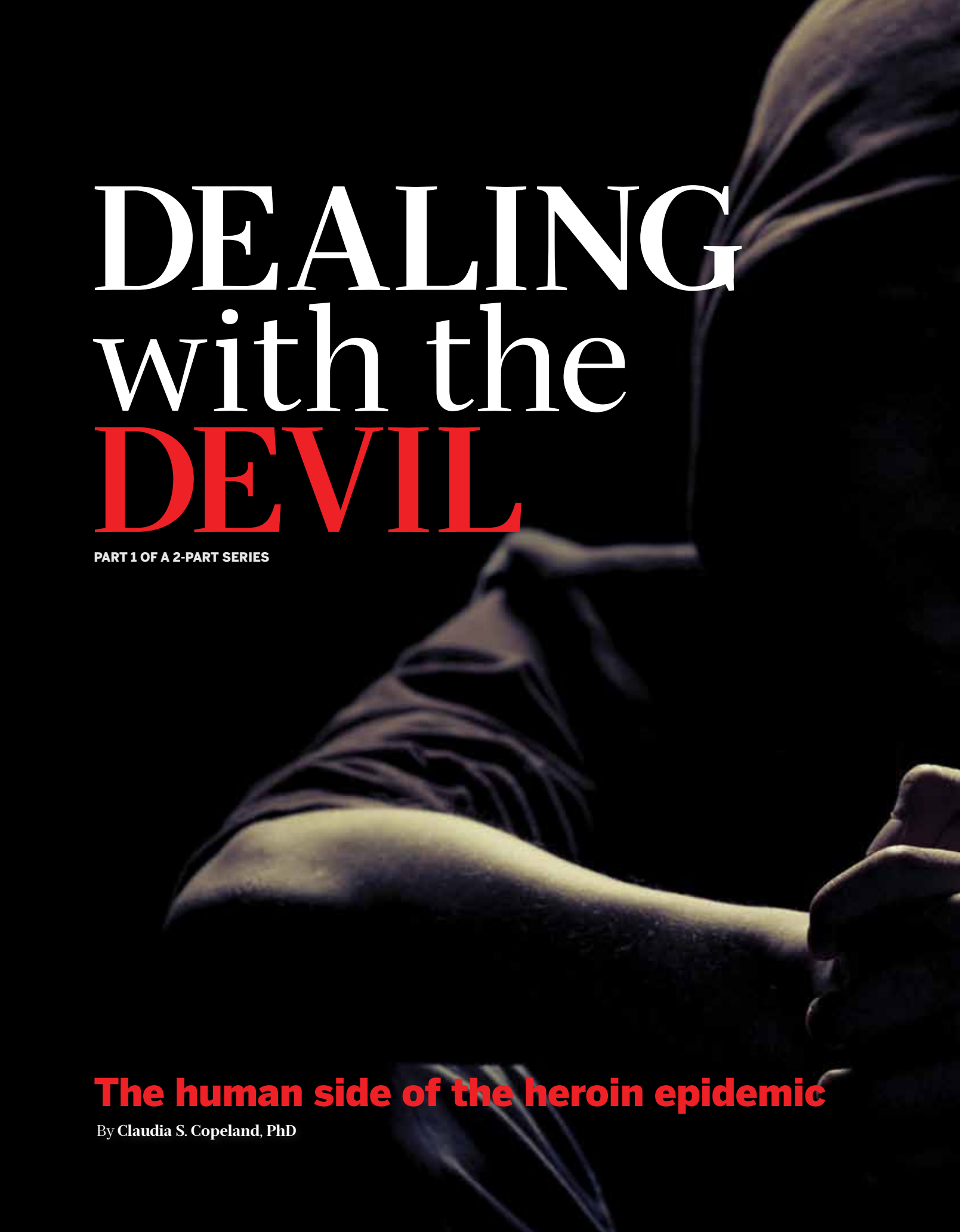

DEALING with the DEVIL

PART 1 OF A 2-PART SERIES

The human side of the heroin epidemic

By **Claudia S. Copeland, PhD**

On May 20th of this year, the Louisiana Legislature decided to get tough on heroin. Legislation sponsored by Sen. Dan Claitor, R-Baton Rouge, authorizes sentences of 99 years for a second heroin dealing offense (50 years for a first offense). Protests about the costs of this practice– the prisons are full; would murderers and rapists be released to make room for 90-year-olds who sold heroin decades earlier?–have been drowned out by a sense of panic at the scope of the heroin problem.

The drug has spread through the population, and overdoses have soared in recent years. With a number of serious associated health risks and alarming proliferation of users, heroin has become a major public health concern. At the same time, funding for behavioral health and substance abuse treatment has been cut amid budget concerns. Prisons are much more expensive than drug treatment centers, but the idea is that dealers will hear about the new legislation and this will stop them from selling the drug. In other words, the goal is deterrence to squelch the supply of the drug. To get an idea about whether this approach is likely to be effective, it is instructive to take a look at the history of heroin.

Heroin (the brand name for diacetylmorphine) is a synthetic drug that was created by Bayer in the late 1800s by adding acetyl groups to morphine. (Morphine, like codeine, is a natural component of opium.) Marketed alongside Bayer's other big commercial product, aspirin, it was largely touted as a replacement for morphine in treating serious respiratory illnesses. It was also marketed for a number of home health needs, including cold and cough treatment for children and a sleep aid. (One particularly disturbing 19th Century Spanish ad shows a child reaching for the heroin bottle as his mother holds it back—"No, no! Just one spoonful!" she seems to be saying.) While it was well-known that morphine was addictive, heroin was thought to be a non-addictive alternative, and was even touted as a treatment for morphine addiction.

IT WAS ALSO MARKETED FOR A NUMBER OF HOME HEALTH NEEDS, INCLUDING COLD AND COUGH TREATMENT FOR CHILDREN

Unlike aspirin, though, which was synthesized a year after heroin from white willow bark using a similar acetylation process, the "heroic" morphine derivative—so effective for pain treatment, sleep induction, and treating respiratory disease—had a very dark side. While the majority of heroin users did not become addicted, by the early 1900s, reports were being published that heroin was at least as dangerous as morphine, and it was banned from home use and eventually, in the U.S., from physician-supervised use as well. By the 1920s, doctors were no longer allowed to prescribe heroin. Unfortunately, though, this did not have the intended effect of stopping its distribution. Dealers were happy to step in and fill the void, and organized crime found in heroin an ideal money-making commodity. By the mid-1920s, heroin was more plentiful than ever, and the illicit heroin trade continues to thrive to this day.

While diacetylmorphine is currently banned from all medical use in the United States, in the U.K. and other countries it is widely used in hospitals and palliative care settings. As with morphine, codeine, and other synthetic opiates, it is not the case that everyone who gets a dose of heroin becomes addicted to it. It is indisputable that opiates are highly addictive, but plenty of people use them without ever becoming addicted. So, why do some people become addicted while

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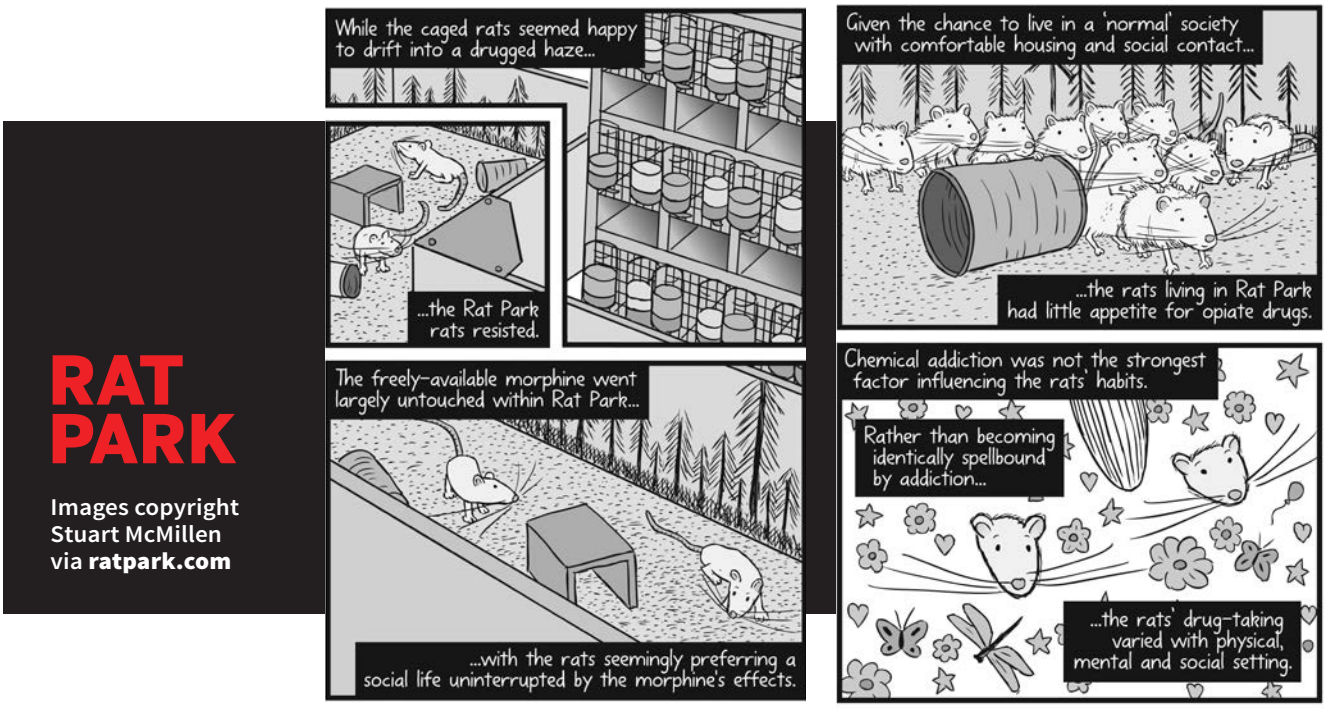

others may enjoy the experience but have no trouble walking away once the bottle's empty?

Research points to two factors that distinguish people who become addicted from people who don't: genetics and the general state of stress, quality of life, and mental health of the person. According to National Institute on Drug Abuse researchers Chandler, Fletcher, and Volkow, genetic factors are thought to contribute 40-60% of the vulnerability to addiction. Extracellular signal-regulated kinase (ERK), involved in neuroplasticity and learning as well as stress and reward circuitry, is one pathway that has been implicated, with numerous studies associating altered ERK signaling with opiate dependence. In addition, in April of this year, a team of American, Israeli, and Chinese researchers, Levan et al., reported a significant association between two polymorphisms of the FKBP5 gene and heroin addiction. FKBP5 has been shown in animal and fMRI studies to mediate stress-related responses and affective disorders. While these researchers were careful to acknowledge that "drug addictions are caused by genetic, environmental, and drug-induced factors," their results point to a clear and specific genetic component–that certain people are born predisposed to becoming addicted to heroin, and that this predisposition is rooted in the genetics of the stress response.

Research points to two factors that distinguish people who become addicted from people who don't: genetics and the general state of stress, quality of life, and mental health of the person.

If about half of addiction vulnerability is due to genetic factors, then that leaves the remaining half due to non-genetic factors. Chief among these is stress. While stress-related genes may be a genetic component of opiate addiction, a stressful or depressing environment appears to play a fundamental role in the non-genetic side of addiction. In the late 1970s, Vancouver biologist Dr. Bruce Alexander set up an experiment to test the idea that the environment or state of mind of the addict formed a more important component of addiction than the drug itself. Traditional animal addiction experiments had looked at isolated rats in small cages with essentially nothing to do but press levers to eat, drink, or receive a drug–these animals readily became addicted.

Dr. Alexander, reasoning that this is not a model of a "normal" animal, designed an experiment to test addiction under more realistic circumstances. He set up a "Rat Park", an enriched environment with 200 times the floor area of a standard laboratory cage and an abundance of food, toys, and wheels for exercise. There were 16–20

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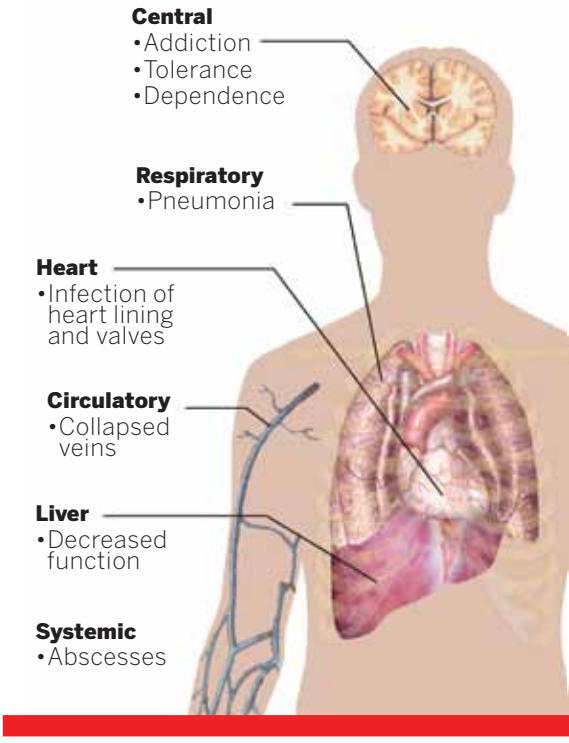
LONG-TERM effects of Heroin

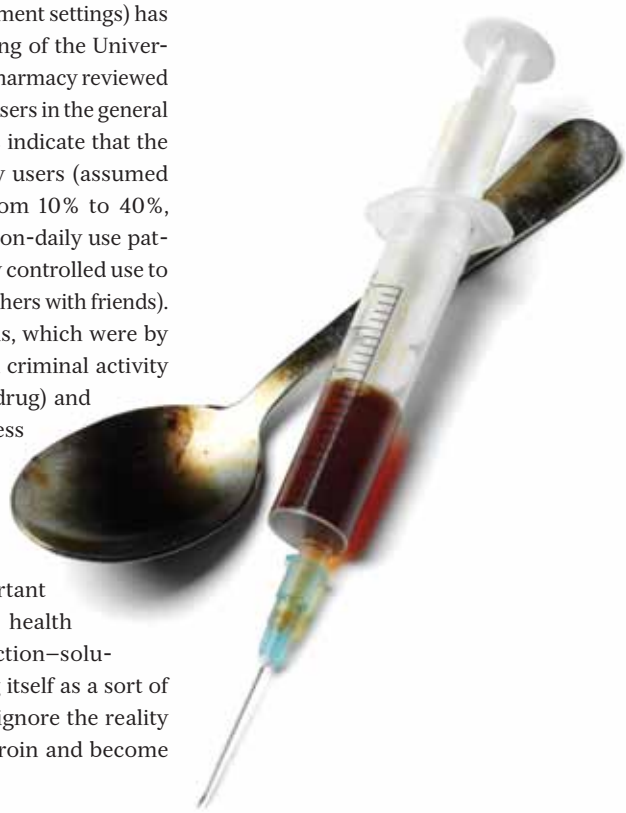


rats of both sexes in residence, and enough space for mating and raising litters. Comparing the rats in Rat Park with the rats in standard cages, he found that the rats in standard cages readily became addicted to morphine while the rats in Rat Park did not; they used morphine occasionally, but were significantly less likely to become addicted than rats in the standard cages. Moreover, rats that were forced to become addicted in standard cages stopped using morphine in an addictive way when they were moved to Rat Park, in spite of withdrawal symptoms. (Control rats kept in cages continued to use morphine compulsively.) Research in other species, such as the 2007 results of Chinese researchers Xu et al. in mice, have supported the Rat Park results. (Interestingly, some studies that created an enriched environment, but did not include running wheels, were not able to replicate the Rat Park results, implying that exercise may be an important component in resistance to addiction.)

While research on human heroin users (outside of addiction treatment settings) has been sparse, Dr. G. Harding of the University of London School of Pharmacy reviewed several studies on heroin users in the general population. These studies indicate that the percentage who are daily users (assumed to be addicts) ranges from 10% to 40%, with a wide variation in non-daily use patterns (from weekend-only controlled use to occasional use in get-togethers with friends). Even in these populations, which were by definition in contact with criminal activity (the only way to get the drug) and therefore expected to be less "stable" than the population at large, the majority of users were non-addicted users.

This is crucially important to addressing the public health problem of heroin addiction—solutions focused on the drug itself as a sort of infectious disease agent ignore the reality that some people use heroin and become addicted to it, while other people use it and do not become addicted. New Orleans psychiatrist "Dr. J" (who works with patients in severe crisis, and who spoke with me on condition of anonymity) has found that most heroin addicts did not, in fact, start with heroin, and often the opiate that started the addiction was prescribed: "People are often prescribed pain meds (opiate) for routine dental work, for orthopedic issues, back injury, and then stay on for ever. Tolerance develops, the habit increases, and they graduate to heroin; its often cheaper. One woman told me her primary care doc prescribed Vicodin for menstrual cramps when she was 15 and that started her. One [employed, but secretly a regular user] man told me that as a teen his parents were always fighting. His father gave him an OxyContin once for some injury and it made him feel so good, all worries about his family and stress at home didn't matter so much."

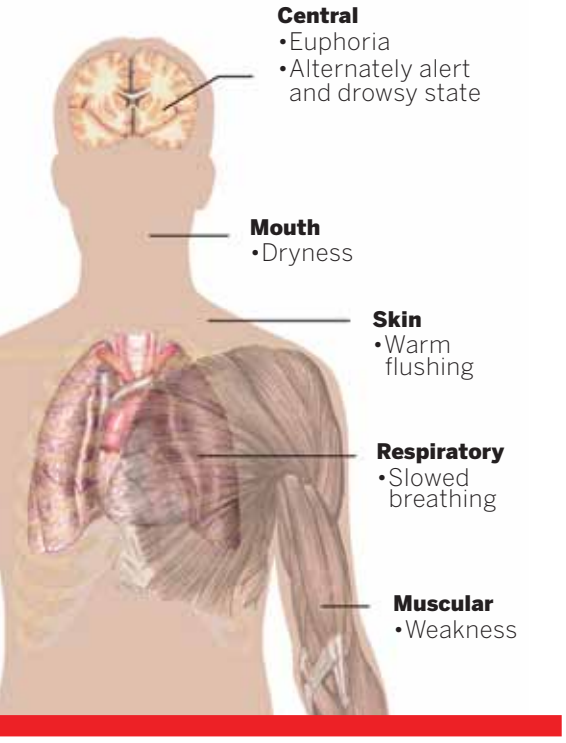
Successful treatment of the heroin epidemic must include a focus on the people who become addicted. Who are they and why do they become addicted? Are they suffering from mental health issues that can be treated? Stressful life circumstances that can be alleviated? Above all, what can be done to help these people?



Decades after his initial research, in a statement to the Canadian senate, Dr. Alexander generalized his results to humans, asserting that, "severely distressed animals, like severely distressed people, will relieve their distress pharmacologically if they can," and argued that drug policy should focus on the conditions that cause stress and suffering. It could be argued that parts of New Orleans and Baton Rouge have exceptionally large numbers of "severely distressed people." While not locked in solitary confinement in a small cage, circumstances such as poverty, lack of education, poor health, and lack of access to support might feel to humans like a cage feels to rats. New Orleans has an especially large population of people living in such stressful conditions.

Moreover, Dr. J pointed out that, as we grow older, we all must learn to deal with pain. In the process, we develop coping mechanisms, become stronger, and "grow up" to be wiser and more capable of dealing

SHORT-TERM effects of Heroin



with pain the next time it hits. If, on the other hand, a person finds out that they can take a drug that makes the pain go away, they do not go through this learning process. "I don't know the scientific basis for this," she relates, "but heroin addicts seem a gentler lot, who have a hard time getting into sobriety. I would guess it is because the heroin is such an amazing pain (psychic pain) reliever that it is hard to go back to dealing with the world in the raw. You have to learn about managing anxiety, frustration, loneliness, without chemical relief. If you started using in your late teens/twenties your emotional development is arrested at that point and now when you give up the opiate you have to learn how to handle all these emotions, have to grow."

This is an important consideration when thinking about drug treatment; to sustain recovery, former addicts must not only overcome the physical withdrawal from the drug, but must also develop alternative coping mechanisms so they do not turn to the drug the next time they find themselves in a crisis. This is an especially difficult problem, because whatever coping techniques are taught, they will probably be less effective than heroin, at least in the short term. If an especially stressful event takes place—not unlikely considering the circumstances of recovering addicts—there is a tremendous pull for former addicts to cope with the stress by using heroin.

Clearly, heroin addiction is a complex problem that goes far beyond the physical state of addiction. But, what if there is a simple solution to the problem—rather than trying to understand addicts and figure out how to help them, why not just get all the heroin off the streets? If there's no heroin, there can be no addicts. Setting aside the difficulty of actually accomplishing this, what would happen if the entire heroin supply was eliminated from the city? The research of Dr. Eloise Dunlap and colleagues from the nonprofit think tank NDRI, Tulane University, and the University of Houston sheds light on this approach.

Katrina was a very unique event in that it did something that no law enforcement agency has ever accomplished: it completely wiped out a thriving drug market. Almost overnight, the supply side of the New Orleans drug market was completely destroyed. However, demand for the drugs remained. In response, suppliers from Houston stepped in to serve exiled New Orleans users. New Orleanian suppliers, in turn, regrouped and established new networks to address the demand as well, and the drug market quickly re-established itself, albeit amid increased violence as the tumultuous new "freelance" market was much more chaotic than the established, more self-regulated "corporate" market that existed before Katrina. Several studies of New Orleans and Houston drug markets, spanning the years after Katrina, found that as long as pressure was exerted in the form of demand for drugs, suppliers stepped in to fill that demand. This has sobering implications for supply side drug solutions: the evidence indicates that no matter what is done to smash the supply side of a drug market, if demand is there, new drug markets will emerge to address that demand.

Demand, then, must be the focus of a successful public health program addressing the heroin epidemic. This is easier said than done, even with drug users who have been caught by law enforcement. Mandating substance abuse treatment for drug offenders has been notoriously unsuccessful, with less than a quarter of drug offenders completing mandated drug treatment programs. (As explained by Dr. J, coping with life's difficulties is hard, especially if your life is in ruins because of drug abuse; many convicted drug offenders prefer to keep taking heroin instead.)

There is, however, another justice-based solution that addresses demand: "drug courts." Rather than sending users to prison, they are put on probation, with regular drug testing. The programs generally include drug treatment, and some incorporate rewards for successfully attaining treatment milestones as well, but at the heart of the system is the

...A more comprehensive solution to the heroin addiction epidemic would address the underlying "disease" leading to heroin abuse, not just the symptoms...

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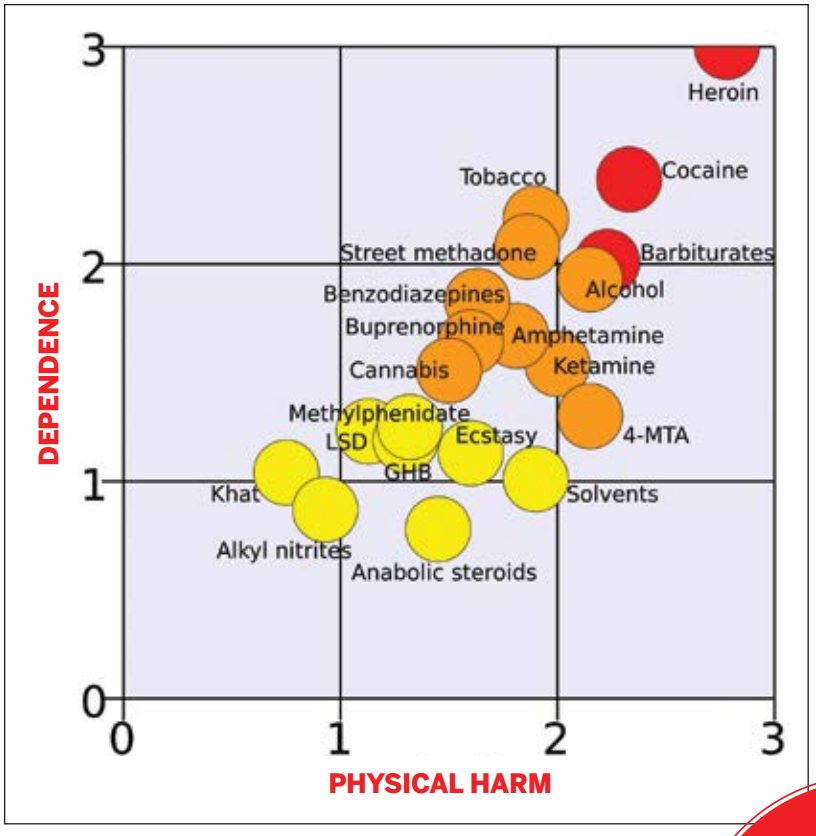


regular drug testing and checking in with the courts. Fundamentally, this sets up a "negative reinforcement" rather than a "punishment" scenario–the users know that they will be tested, and they know that they will go to jail if they fail the drug test. Unlike punishment after the fact, this is "before the fact" action, and from all indications, it seems to work very well. Multiple studies of drug courts have found that they significantly reduce recidivism, and have the side benefit of saving taxpayers over $2.00 for every $1.00 invested, compared with incarceration. (This does not take into account the fact that, whereas released prisoners face steep barriers to re-entry into law-abiding society, drug offenders who go through drug court can get their records expunged, and also exit the program with coping mechanisms learned as part of the substance abuse treatment component. Arguably, this would make drug offenders who went through drug court instead of prison more likely to stay off heroin and become productive taxpayers themselves after release from the program.)

Drug courts are a bona fide way to get drug offenders off drugs. Ideally, though, a more comprehensive solution to the heroin addiction epidemic would address the underlying "disease" leading to heroin abuse, not just the symptoms; addicts would be treated before being arrested and facing incarceration or drug court. First and foremost, this includes mental health care. According to Dr. J, psychiatric care services are available, free of charge: Metropolitan Human Services, http://www.mhsdla.org/, offers mental health and addiction treatment services to residents of Orleans, Plaquemines, and St Bernard parishes, Jefferson Parish Human Services Authority (about to be Jeff Care) provides similar services to residents in Jefferson Parish, and in Baton Rouge, mental health services are provided by Capital Area Human Services District. "Louisiana has provided free psychotropic medication to those who have no health insurance, and some of these services are now becoming more sliding scale based on income," says Dr. J. Do people in crisis realize this, though? And what if the nature of their crisis is just a pervasive sense of stress, isolation, and hopelessness? These people are probably more likely to attribute these feelings to the bleak nature of life rather than to a mental health condition that can be treated, and it may not occur to them that there is help out there for them.

DRUG COURTS ARE A BONA FIDE WAY TO GET DRUG OFFENDERS OFF DRUGS

Finally, while evidence points away from the belief that addiction is solely due to the inanimate drug, rather than the human addict, Dr. Alexander cautions that it may be beneficial for an addict to continue believing this misinformation, at least in the beginning of their treatment: "If they accept this belief, they can escape an enormous burden of guilt for their catastrophic lives, because the active agent is not themselves, but the drug. They made only one mistake and forgot to 'just say no': The rest was out of their control. Often such rationalisation provides a merciful relief for a suffering addict, at least for a time. Sometimes it is useful for drug abuse counselors to accept this belief during therapy."

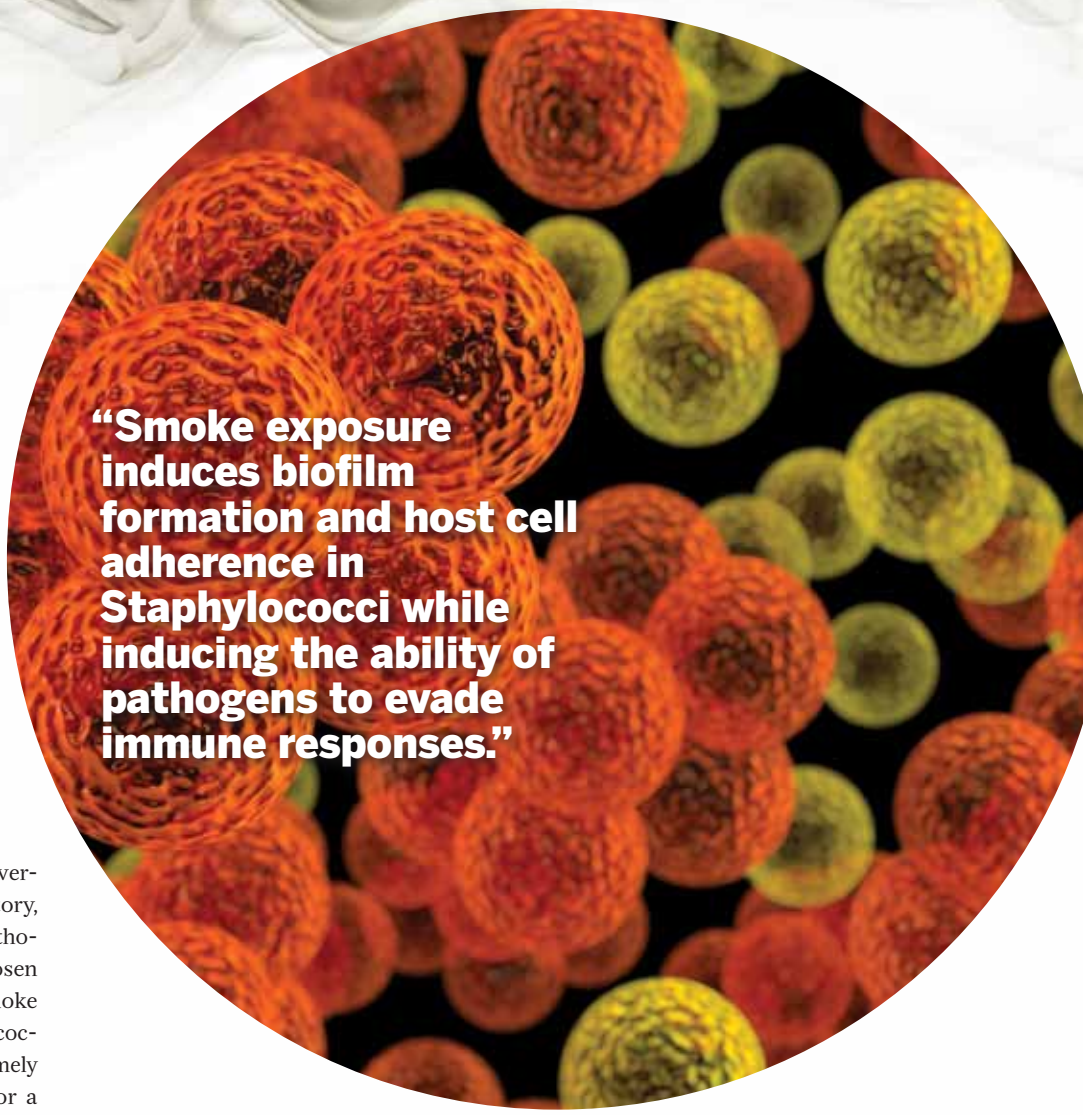
Eventually, though, addicts need to come to terms with the difficult task of learning non-drug based ways of coping with pain, including the pain of realizing how utterly their addiction has damaged their lives and the lives of those around them. The wider community must also realize that if we want to prevent or stop a heroin epidemic, we need to care for the health of our most vulnerable members, as difficult as facing that responsibility may be. ■

Smoke Gets in Your... What?

LSU RESEARCHERS SAY SECONDHAND SMOKE MAY BOOST BAD BACTERIA

By **Melina Druga**

What does cigarette smoke do to the bacteria that inhabits the respiratory tract? That's what Dr. Ritwij Kulkarni, MSc, PhD, along with Dr. Arthur Penn, PhD, and Dr. Samithamby Jeyaseelan, PhD, are hoping to discover at Louisiana State University School of Veterinary Medicine. The unique study is trying to identify an additional health risk associated with cigarette smoking.



"Smoke exposure induces biofilm formation and host cell adherence in Staphylococci while inducing the ability of pathogens to evade immune responses."

The team, working at the university's Lung Biology Laboratory, part of the Department of Pathobiological Sciences, has chosen to study the effects of secondhand smoke on Staphylococcus aureus, and Streptococcus pneumonia. Staphylococci are extremely common bacteria and responsible for a number of illnesses including skin infections, food poisoning, and toxic shock syndrome. They are found in the human body regardless of whether a person is healthy or sick. Staphylococci also cause a number of respiratory infections, and humans carry millions of bacteria in the mucus membranes, making Staphylococci the natural choice when studying the effects of secondhand smoke.

Dr. Kulkarni is a research assistant professor of the Department of Pathobiological Sciences; the department studies bacteria, viruses, and other causes of disease and their effects on humans and animals, thus its inclusion in the School of Veterinary Medicine. Kulkarni was drawn to pathobiological science because there is a fine balance in the body between normal flora and harmful pathogens. This delicate balance is interrupted when the body is exposed to pollutants, including tobacco smoke. In addition to studying the effects of smoke on the respiratory system, he has studied its effects on bacteria in the urinary tract. Dr.Penn is director of the university's Smoke Inhalation Facility and a professor of toxicology. His focus is on air pollution's effects on the respiratory and cardiovascular systems. Dr. Samithamby, an immunologist, studies the bacterial pathogens which cause tissue inflammation. His goal is to devise prevention strategies and treatments to eliminate inflammation.

Every organ of the body is affected by smoke, Dr. Kulkarni says, and everyone has been exposed to smoke at some point in his or her life. All forms of smoke–including smoke from burning wood, vehicular exhaust, and smoke from biofuels–are harmful. For those who are exposed to smoke for long periods of time, the effects are irreversible.

"The ill-effects of secondhand cigarette

Dr. Kulkarni and the Lung Biology Laboratory are funded by a grant provided by the Flight Attendant Medical Research Institute (FAMRI).

smoke exposure are not just limited to smokers," Says Dr. Kulkarni. "Smoking is bad for the health of smokers, without doubt. In addition, it is very important to consider that as a smoker you are putting the lives of your friends and family in peril."

Data show that individuals who have been exposed to smoke have higher rates of respiratory infections and have a harder time fighting off diseases. Smoke exposure puts a person at risk for lung cancer, emphysema, and Chronic Obstructive Pulmonary Disease (COPD).

Research began late last year and has been mainly in vitro, using components of the bacteria that have been isolated. So far, the team's research has shown smoke causes the Staphylococci to become more aggressive and more virulent.

THE TEAM'S RESEARCH HAS SHOWN SMOKE CAUSES THE STAPHYLOCOCCI TO BECOME MORE AGGRESSIVE...

"Staphylococcus aureusis is known to form biofilms, which are communities of bacteria contained within a protective membrane. The bacteria inside a biofilm are resistant to our immune defenses, as well as antibiotics, and smoke exposure increases biofilm production," says Dr. Kulkarni. "Smoke exposure induces biofilm formation and host cell adherence in Staphylococci while inducing the ability of pathogens to evade immune responses. This may explain why individuals exposed to cigarette smoke are predisposed to respiratory infections."

Dr. Kulkarni and the Lung Biology Laboratory are funded by a grant provided by the Flight Attendant Medical Research Institute (FAMRI). The grant, renewed in December, is for $108,000 annually for two years. The team will be providing FAMRI with annual progress reports and periodic benchmarks to measure the success of the team's work. Continued funding will be based on the progress reports and whether FAMRI is satisfied with the headway the team is making.

FAMRI has an invested interest in secondhand smoke. Founded in 2000 as a non-profit organization, FAMRI is the result of a class-action lawsuit filed in October 1991 in Dade County Circuit Court against the tobacco industry by Florida attorneys Susan and Stanley Rosenblatt on behalf of non-smoking flight attendants. The suit sought damages for diseases and deaths which resulted from non-smoking flight attendants being exposed to secondhand tobacco smoke while on the job. The case was settled in 1997. As part of the settlement, a medical and scientific research entity was required to be established with $300 million in funding from the tobacco industry.

Despite anti-smoking campaigns over the past several decades, Americans continue to smoke. According to the Centers for Disease Control, 18.1 percent of American adults, 42.1 million people, smoke. More than 16 million individuals suffer from diseases which are the direct result of smoking, and one out of every five deaths is attributed to smoking.

Rates of smoking vary by region and are higher in the Midwest and South than other parts of the country. In Louisiana, 20.5 percent of adults and 11 percent of minors smoke. The state ranks 37th among the states for overall smoking and ranks above the national average for youth smoking and smoking related deaths.

Over the next few months, the Lung Biology Laboratory plans to focus on experiments to determine the virulent characteristics of not only Staphylococci bacteria exposed to smoke, but Pneumococci bacteria, the cause of pneumonia and meningitis.

Since the study is in its early stages, there are no real conclusions as of yet. However, so far results seem promising and appear to indicate exactly what the team hypothesized–that smoke exposure is dangerous and causes toxic mutations to not only the cells in the human body, but also to the microorganisms that inhabit the body. The research has yet to be tested on humans. ■

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How To Analyze A

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent regulations have changed several aspects of compliance with HIPAA, including the way covered entities should think about misuses of Protected Health Information (PHI).

When a misuse of PHI occurs, the Health Insurance Portability and Accountability Act, (HIPAA) requires covered entities to conduct a thorough, good-faith analysis to determine whether the misuse rises to the level of a breach. A "breach" is the unauthorized acquisition, access, use, or disclosure of unsecured PHI which compromises the security or privacy of such information.

Depending on the severity of the breach, covered entities could face reporting and notification requirements that include notifying the Department of Health and Human Services (HHS), affected individuals, and

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Fisher & Phillips LLP

HIPAA Breach

A "breach" is the unauthorized acquisition, access, use, or disclosure of unsecured PHI which compromises the security or privacy of such information.

even the media. For this reason, whether a misuse rises to the level of a breach requires careful examination. In brief, a breach contains the following elements: 1) an unauthorized acquisition, access, use, or disclosure; 2) of unsecured PHI; 3) resulting in an impermissible disclosure under the privacy rule; 4) that compromises the security or privacy of such PHI; and 5) to which an exception does not apply.

Under the final regulations issued by HHS, which became effective on September 23, 2013, the concept of what "compromises" the security or privacy of PHI has changed. Previously, a breach occurred only if there was a significant risk of financial, reputational, or other harm to the individual. But the 2013 final regulations remove this "harm standard" and instead require a four-part risk assessment intended to focus on the risk that PHI has been compromised in a more objective way.

EFFECTIVE ON SEPTEMBER 23, 2013, THE CONCEPT OF WHAT "COMPROMISES" THE SECURITY OR PRIVACY OF PHI HAS CHANGED

The 2013 regulations provide that a covered entity must presume that an acquisition, access, use, or disclosure of PHI in violation of the privacy rule is a breach. This presumption holds unless the covered entity demonstrates that there is a "low probability" that the PHI has been compromised based on a risk assessment which considers at least the following factors: 1) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification, 2) the unauthorized person who used the PHI or to whom the disclosure was made, 3) whether the PHI was actually acquired or viewed, and 4) the extent to which the risk to the PHI has been mitigated.

Here's a closer look at how these are defined:

The nature and extent of the PHI involved
Based on HHS guidance, covered entities should consider whether the disclosure involved PHI that is of a sensitive nature, including the types of identifiers and the likelihood of re-identification. Social security numbers would be considered sensitive items, whereas a city or state identifier would not be as sensitive. Entities should consider the likelihood that someone could suffer financial or reputational harm based on the information to determine its level of sensitivity.

The unauthorized person who used, accessed, or received the PHI
Consider whether the unauthorized person is trained in HIPAA compliance, has obligations to protect the privacy and security of the information, has a track record of protecting similar information, and can be obligated to return it. HHS emphasizes that this factor should be considered in combination with the first factor regarding the risk of re-identification.

Whether the PHI was actually acquired or viewed
Analyze whether the PHI was actually acquired or viewed or, alternatively, if only the opportunity existed for the information to be acquired or viewed. Entities may have the technology to confirm that information was unviewed, or they may be able to lock a lost cell phone or destroy files remotely in order to protect themselves under this factor.

The extent to which the risk to the PHI has been mitigated
Finally, covered entities must evaluate the extent to which the risk to the PHI has been mitigated. If the PHI is no longer in the entity's possession, consider factors such as how easily it can be duplicated. ■

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LOUISIANA RANKS 12TH FOR SERVING DISABILITIES POPULATION

An independent analysis ranked Louisiana 12th in how it delivers care for individuals with intellectual and developmental disabilities (ID/DD). The 2014 Case for Inclusion rankings produced by the United Cerebral Palsy (UCP) is an annual ranking of how well state Medicaid programs serve Americans with intellectual and developmental disabilities. In addition to being ranked 12th, Louisiana was the second most improved state, jumping 36 spots, from 44 in 2007 to 12 in 2014.

Louisiana was noted for various achievements including the number of individuals served in the community and the resources allocated for community support. Louisiana was one of 15 states supporting a large share of families through family support. These support services provide assistance to families that are caring for children with disabilities at home, which keeps families together, and in a community setting. In the sub-ranking by major category, Louisiana ranked second for keeping families together. Louisiana was also recognized for promoting productivity due to the number of people with ID/DD working in competitive employment.

LOUISIANA WAS THE SECOND MOST IMPROVED STATE, JUMPING 36 SPOTS...

HEALTHCAREBRIEFS

STATE

Louisiana Senate Confirms DHH Appointments

The Louisiana Senate has confirmed three appointments of Department of Health and Hospitals (DHH) employees to top level positions.

DHH Secretary Kathy Kliebert appointed Jeff Reynolds as DHH undersecretary on February 2, 2014, and he assumed the role of undersecretary a month later on March 10, 2014. Prior to becoming undersecretary, Reynolds was Louisiana Medicaid Deputy Director.

Dr. Rochelle Head-Dunham was appointed Interim Assistant Secretary for the Office of Behavioral Health (OBH) on October 18, 2013. Dr. Head-Dunham, who served as the Medical Director and Chief of Adult Operations for OBH, assumed the role of Interim Assistant Secretary on October 30, 2013.

Mark Thomas was appointed Interim Assistant Secretary for the Office for Citizens with Developmental Disabilities (OCDD) on October, 18, 2013, and assumed the role on November 2, 2013. Thomas joined the Department as Executive Director of Community Services for OCDD in 2006 and has served as Deputy Assistant Secretary for OCDD since 2009.

LA CaTS Names Roadmap and Meritorious Scholars

The Louisiana Clinical and Translational Science (LA CaTS) Center, a statewide initiative funded by the National Institute of General Medical Sciences (NIGMS) of the National Institutes of Health (NIH), recently awarded the prestigious Roadmap Scholar distinction to three early career Louisiana scientists and the Meritorious Scholar distinction to a post-doctoral scientist.

2014 Roadmap Scholars:

- Dr. Christopher McGowin - LSU Health Sciences Center in New Orleans
- Dr. John Apolzan - LSU Pennington Biomedical Research Center in Baton Rouge
- Dr. Michael Hoerger - Tulane University School of Medicine in New Orleans

2014 Meritorious Post-Doctoral Scholar:

- Dr. Amir Al-Khami - LSU Health Sciences Center in New Orleans.

The LA CaTS Center Roadmap Scholar Program supports junior faculty who are entering the field of clinical and translational research. The Meritorious Post-Doctoral Scholar Program recognizes researchers who have at least two years of post-doctoral training and are being considered as potential faculty members. Both awards offer mentorship, tuition and salary support with the goal of providing a strong basis for a successful career in clinical/translational research.

Well-Ahead Louisiana Designates First WellSpots

The Department of Health and Hospitals (DHH) has designated its first three WellSpots—Mestizo Restaurant, Mid-City Market, and AmeriHealth Caritas Louisiana, all located in Baton Rouge. WellSpots are the healthy places around the state that voluntarily champion and embrace health and wellness.

WellSpots can be employers, schools, healthcare providers, universities, child care centers and restaurants. The Well-Ahead designation includes three levels of WellSpots, Level One, Level Two and Level Three. Level One is the highest level and indicates that the highest number of Well-Ahead criteria have been met, followed by Level Two and Level Three. All entities applying to become WellSpots must be 100 percent tobacco free. Mestizo, Mid-City Market and AmeriHealth Caritas Louisiana were designated Level Two WellSpots.

Organizations interested in becoming a WellSpot can visit www.WellAheadLA.com.

LSMS Announces Organized Medicine Award

The Louisiana State Medical Society Medical Student Section announced the 4th annual LSMS Organized Medicine Award. This award was presented during commencement ceremonies to a graduating senior at each of the three Louisiana medical schools who has demonstrated an extraordinary effort in advancing the field of organized medicine, whether on the local, state or national level.

Matthew R. Landrum, Louisiana State University Health Sciences Center, School of Medicine New Orleans, MD candidate 2014. Landrum was chairman of the Louisiana State Medical Society Student Section 2012-2013. He was also a member on the LSMS Council on Legislation and a LSMS Medical Student Section Delegate to the American Medical Association Medical Student Section.

Carol Shih, Tulane University School of Medicine. Shih was co-president of the Tulane Chapter of the American Medical Association, director of the Tulane Chapter of the Louisiana State Medical Society Student Section, and a member of the Tulane School of Medicine Admissions Committee.

Paulette Doiron, Louisiana State University Health Sciences Center Shreveport. Doiron has been an active member with Support for Humanitarianism through Intercontinental Projects since 2010, which includes a two-week medical trip to Kenya. She spearheaded medical student collaboration with the ArkLaTex Food System Council and other community organizations.

Healthy Communities Coalition Names Board

The Louisiana Healthy Communities Coalition, a statewide coalition designed to improve the health of Louisiana residents, announced that 20 members were elected to their advisory board. The new members, who will serve a two-year term starting May 2014, are:

- Annette Beuchler, Director of Programs and Communications, The Rapides Foundation
- Terry Birkhoff, Senior Manager, Primary Care Systems, American Cancer Society
- Stacie Bland, Medical Director, Baton Rouge Primary Care Collaborative
- Deborah Campbell, Business Development Representative/ Market Strategist, North Oaks Health System
- Jack Carrel, Director of Prevention, HIV/AIDS Alliance for Region Two
- Jonathan Chapman, Executive Director, Louisiana Primary Care Association
- Ivory Davis, RN Quality Management Coordinator, Department of Veteran Affairs
- Shannon Dosemagen, President, Public

Heart & Soul Gala Honors EMS

LSU Health Sciences Center Foundation was the signature sponsor for the American Heart Association's Heart & Soul Gala on June 7 at the Ernest N. Morial Convention Center. The event was chaired by Dr. Gerry Cvitanovich and honored EMS of Region 1.

One hundred percent of the funds raised through the Heart & Soul Gala are invested back into the New Orleans community through educational outreach programs, CPR training and certification, placement of automated external defibrillators, and funding for groundbreaking medical research. Additional money is invested in New Orleans beyond what is raised locally, by the national office of the American Heart Association. This year alone, the American Heart Association invested over $2 million into rebuilding research in New Orleans at such institutions as Louisiana State University, Ochsner, and Tulane.

HEALTHCAREBRIEFS

Laboratory for Open Technology and Science

- Alsie Dunbar, Chemical Engineer/Chemist, Shell/Motiva Enterprises LLC
- Smith Hartley, Chief Editor, US Healthcare Journals
- Jerry Jones Jr., Economic and Community Developer, Imperial Calcasieu Regional Planning and Development Commission
- Jan Kasofsky, Executive Director, Capital Area Human Services District
- Ray Landry, CEO, Abbeville General Hospital
- Stephenie Marshall, Executive Director, Daughters of Charity Centers of New Orleans
- Evalyn Ormond, CEO, Union General Hospital
- Knesha Rose, Associate Director, Programs, Alzheimer's Association
- Jennifer Shoub, CEO, YWCA Greater Baton Rouge
- Cheryl Talbot, Executive Director, Louisiana Business Group on Health
- Rhiannon Traigle, Executive Director, Bayou Land Families Helping Families
- Lee Anne Venable, Development Director, Habitat for Humanity of Louisiana

The Louisiana Healthy Communities Coalition is led by an executive committee comprised of representatives from the Louisiana Department of Health and Hospitals, Louisiana Comprehensive Cancer Control Program, Louisiana Public Health Institute, and American Cancer Society.

For more information about the Louisiana Healthy Communities Coalition, please visit www.healthylouisiana.org.

WellCare Names Diaz Regional Medical Director

WellCare Health Plans, Inc. has named Dr. Victor A. Diaz medical director for its health plan operations in Arkansas, Louisiana, Mississippi, Tennessee, and Texas, effective May 12. He is responsible for overseeing the clinical direction of medical services and quality functions. He also provides medical leadership for the effective care integration of pharmacy operations, utilization/case/disease management activities and quality improvement activities. He reports to Frank Heyliger, WellCare's region president for Arkansas, Louisiana, Mississippi, Tennessee, and Texas.

Victor A. Diaz, MD

ENA Applauds LA for New Workplace Violence Law

As workplace violence increasingly threatens emergency departments across the country, the Emergency Nurses Association congratulated Louisiana for becoming the latest state to make it a felony to physically attack an emergency nurse and other emergency personnel. Gov. Bobby Jindal signed H.B. 1077 (LeBas) into law in June.

The new law, which goes into effect August 1st, creates the crime of battery of emergency room personnel, emergency services personnel, or a healthcare professional, and amends the crime of obstructing a fireman to include emergency services personnel.

"The unanimous approval of this bill shows there is bipartisan support in Louisiana in favor of addressing the growing problem of violence directed at healthcare workers," said ENA president Deena Brecher, MSN, RN, APN, ACNS-BC, CEN, CPEN. "The Louisiana Emergency Nurses Association successfully worked to bring this issue to the forefront, and we're thrilled with the outcome. We hope Louisiana law enforcement officials will rigorously enforce this important new law."

Research released earlier this year in the *Journal of Emergency Nursing* shows that more than 70 percent of emergency nurses encountered physical or verbal assault by patients or visitors while they were providing care in the emergency setting. Several factors such as long wait times, patient boarding, patients with a history of violence, and patients under the influence of drugs or alcohol significantly contributed to the violence.

Louisiana joins thirty other states that have enacted laws making it a felony to assault or batter an emergency nurse. Most recently, Ohio, Texas, Illinois and Idaho joined the list of states that have strengthened their laws protecting emergency nurses against violence. ENA says it is committed to making this crime a felony in all 50 states.

LOCAL

Local Startup Addresses Perforated Eardrums

Local startup Tympanogen LLC, whose new medical technology will provide a non-surgical treatment option for a condition affecting thousands of children each year, has won fifth place and $44,000 in the world's largest graduate-level student startup competition. The Rice University Business Plan Competition awarded startups nearly $3 million in cash, investment, and other prizes, and Tympanogen finished with three prizes totaling $44,000 after being named one of only six finalists. Over 500 startups from around the world applied for the event, and 42 startups from eight countries were selected to compete in this year's program in Houston, Texas.

Tympanogen is commercializing a gel patch the team developed at Tulane University called PerfFix™ for non-surgical repair of chronic tympanic membrane perforations, or holes in the eardrum. The startup pitched four times over the course of the weekend-long competition and earned $4,000 cash as the fifth place winner, along with two additional cash prizes. The team received a $20,000 award from the nCourage Entrepreneurs Investment Group for the top women-led startups at the competition, as well as the $20,000 NASA Earth/Space Human Health & Performance Innovation Cash Prize. This prize goes to the best life science startup whose technology has applications to NASA and the space program.

The company also won the $25,000 first prize in the Tulane University Business Model Competition in April, and the prizes from both events will help fund the startup's next phase of research. To prepare for these competitions, the team of biomedical engineers and physicians developed their business plan and pitch with free support from the New Orleans BioInnovation Center.

20 Arrested in Medicaid Fraud Roundup

The Louisiana Attorney General's Medicaid Fraud Control Unit (MFCU) arrested 20 personal care attendants as part of a crackdown on provider fraud in the New Orleans area.

MFCU agents initiated an investigation after receiving a citizen tip reporting potential personal care service fraud. Investigators learned that the personal care attendant being accused of fraudulent activity was servicing a Medicaid recipient living at a senior residential facility in New Orleans. Many other elderly residents living at the same housing complex are eligible for personal care services rendered through private provider agencies that bill the Louisiana Medicaid Program.

After comparing service logs submitted to the to the provider agencies by the personal care attendants to sign-in and sign-out sheets, MFCU investigators were able to identify numerous attendants from four different Medicaid provider agencies who cheated the Medicaid program by submitting fraudulent claims for payment to the Louisiana Medicaid Program for services that were never rendered. MFCU agents estimate the total fraud to the Medicaid Program at $150,000 over the span of about a year.

Sothern on 1st National Physical Activity Report Card Panel

Dr. Melinda Sothern, Professor and Director of Behavioral & Community Health Sciences at the LSUHSC School of Public Health, is one of 11 members of the Research Advisory Committee that produced the 2014 United States Report Card on Physical Activity for Children and Youth. The first-ever report card reveals that only about one in four young Americans meet the current guideline of 60 minutes of moderate physical activity a day.

Here are the grades:

- Overall Physical Activity D-
- Sedentary Behaviors D
- Active Transportation F
- Organized Sport Participation C-
- Active Play INCOMPLETE
- Health-Related Fitness INCOMPLETE
- Family and Peers INCOMPLETE
- School C-
- Community and the Built Environment B-
- Government Strategies and Investments INCOMPLETE

The report also indicates that children and youth spend more than seven hours a day in sedentary activities, and they become even more sedentary as they grow older.

The Report Card is the first in an historic series of national physical activity report cards in countries around the world that will be updated annually, providing an unprecedented global benchmark using a common methodology on this pivotal public health issue.

The full and summary reports are available online at www.physicalactivityplan.org.

LSUHSC Teaching Excellence Recognized

Six members of the faculty of LSU Health Sciences Center New Orleans have been awarded the 2014 Allen A. Copping Excellence in Teaching Awards. Chosen by their schools' leadership, their colleagues, and most importantly, by their students, the recipients are:

- School of Allied Health Professions: Elizabeth F. Williams, MHS, Associate Professor and Education Coordinator of Clinical Training in Clinical Laboratory Sciences
- School of Dentistry: Caroline F. Mason, RDH, Med, Professor and Director, Dental Hygiene Program
- School of Medicine: Murtuza Ali, MD, Associate Professor of Clinical Medicine
- School of Nursing: Gretchen Deeves, MSN, APRN, CNM, Instructor of Nursing
- School of Public Health: Melinda Sothern, PhD, CEP, Professor and Director of Behavioral & Community Health Sciences
- Basic Sciences: Hamilton Farris, PhD, Research Assistant Professor, LSUHSC Neuroscience Center of Excellence

Initiated at LSU Health Sciences Center New Orleans in 1995, the Allen A. Copping Excellence in Teaching Awards are awarded each year to one individual in each area of study. They also honor the legacy of the late Dr. Allen Copping, who served as Dean of the LSUHSC School of Dentistry, Chancellor of LSU Health Sciences Center, and President of the LSU System.

Med Students Select Recipients of Teaching Awards

The Aesculapian Society at the LSU Health Sciences Center New Orleans School of Medicine presented their 2014 Excellence in Teaching Awards at their annual banquet. Selected by each class of LSUHSC medical students, the recipients – LSUHSC faculty, interns and residents – are chosen for their leadership, quality of instruction, approachability, and overall excellence in teaching.

This year's recipients and their courses and specialties are:

- Class of 2017 Fall: Dr. Jason Mussell – Gross Anatomy
- Class of 2017 Spring: Dr. Michael Levitzky – Physiology
- Class of 2016 Fall: Dr. Richard DiCarlo – Science and Practice of Medicine
- Class of 2016 Spring: Dr. Grace Athas – Clinical Pathology
- Class of 2015 Intern: Dr. Lauren Green – Pediatrics
- Class of 2015 Resident: Dr. Drew Jones – Obstetrics/Gynecology
- Class of 2015 Faculty: Dr. Robin English – Pediatrics
- Class of 2014 Intern: Dr. Ross Thibodaux – Internal Medicine – Baton Rouge
- Class of 2014 Resident: Dr. Anthony DiGiorgio – Neurosurgery
- Class of 2014 Faculty: Dr. Tatiana Saavedra – Internal Medicine – Baton Rouge;
- Dr. Melissa Roy – Pediatrics.

Valentine Medical Center Earns Level 3 Designation

Valentine Medical Center recently received recognition from the National Committee of Quality Assurance (NCQA) as a Level 3 Patient-Centered Medical Home (PCMH) for individualized patient care, the highest level of the designation awarded.

The NCQA PCMH Recognition program identifies practices that promote partnerships between

HEALTHCAREBRIEFS

individual patients and their personal clinicians in the long-term, rather than treating patient care as a sum of episodic office visits. Each patient's care is delivered by clinician-led care teams that provide all healthcare needs and coordinate treatments across the healthcare system. Medical home clinicians demonstrate the benchmarks of patient-centered care, including open scheduling, expanded hours, and appropriate use of proven health information systems.

St. Tammany Quality Network Growing Rapidly

Since its launch in January, the St. Tammany Quality Network has added more than 160 member physicians to the organization focused on measuring and improving clinical quality and the patient experience throughout the North Shore.

STQN is a physician-led network operating under the clinical integration model sanctioned by the Federal Trade Commission, which requires the network to demonstrate a commitment to quality and outcomes by creating a medical community aligned around initiatives and payer engagement; using a common information technology platform to capture disease specific data throughout the network to assist in proactive patient care; and developing best practices.

The network's primary objective is to collaborate on patient-centric initiatives that enhance the quality and improve efficiency of healthcare delivery. That will be spearheaded by creating an information technology network that encourages sharing of patient clinical data and care coordination among participating providers. With regards to physician performance data, there is a focus on transparency so participating providers can learn best practices from one another and can also identify areas of opportunity.

STQN is led by Executive Director Jack Khashou and Medical Director Dr. Michael Hill, the Governing Board and three committees. The Governing Board consists of Drs. David Cressy, Mark Dominguez, Hill, James Lacour, David Powers, Sunhil Purohit, and Torcson. STPH Chief Medical Officer Dr. Bob Capitelli and STPH President and CEO Patti Ellish serve as ex officio, while Torcson serves as board chairman.

The committees include:

Performance Management, comprised of Drs. Pat Braly, Michael Carpenter, David Cressy, Rob Faucheaux, Hill, Roch Hontas, Michael Iverson, Joseph Landers, Merrill Laurent, Ralph Millet, Joseph Perdigao, Sunil Purohit, Hamid Salam and Torcson. Hill serves as committee chairman.

Network Operations, comprised of Drs. Pat McCaslin, Charles Baier, Chris Darcey, Dominguez, Celeste Lagarde and Jack Saux. Dominguez serves as committee chairman.

Finance and Contracting, comprised of Drs. Lacour, Cathy Quarls, Reiss Plauche, Michael Isabelle, Chris Foret and Vicki Steen, is responsible for joint contracting negotiations with payers and coordinating physician incentive distributions. Lacour serves as committee chairman.

For more information about how to join the St. Tammany Quality Network, contact Khashou at 985-898-4518 or jkhashou@stph.org.

Objective Medical Systems Earns "Stage 2" Certification

Objective Medical Systems, LLC, a local health information technology company, announced that its Electronic Health Record (EHR) system has earned Meaningful Use Stage 2 Certification from the Office of the National Coordinator for Health Information Technology.

The Electronic Health Records technology developed by Objective Medical Systems was designed from the ground up for cardiology practices to efficiently manage vital patient information. The company's diagnostic tools, part of its vendor-neutral Cardiovascular Information System for both private practices and hospitals, can instantly pull and analyze information from medical devices, reducing human error while also saving time and money.

DNP Program Earns Maximum Accreditation

The new Doctor of Nursing Practice (DNP) degree program at LSU Health Sciences Center New Orleans School of Nursing has been fully accredited by the Commission on Collegiate Nursing Education Board of Commissioners to June 30, 2019. LSUHSC Nursing's DNP program was awarded a five-year accreditation – the maximum a new program can earn.

The post-masters Doctor of Nursing Practice (DNP) is a practice-focused doctoral nursing degree designed for nurses seeking careers in advanced clinical nursing practice and nurse executive ranks. DNP education emphasizes research application and utilization in clinical practice settings as well as interdisciplinary team building skills, organizational leadership and management development, utilization of information technology and quality improvement techniques, and development and initiation of public policy.

LSUHSC Awarded NSF Grant for Undergrads

The National Science Foundation has awarded LSU Health Sciences Center New Orleans a Research Experiences for Undergraduates (REU) Site grant in the amount of $295,635. The funding will support the training of undergraduates from diverse social and educational backgrounds, underrepresented in the sciences, especially from the New Orleans area.

The project will provide students with training for 10 weeks during the summers of 2014-16. It will be led by Principal Investigator Dr. Fern Tsien, Assistant Professor of Genetics, along with Co-Investigators Dr. Alberto Musto, Assistant Professor of Research, Neurosurgery and Neuroscience, and Dr. Hamilton Farris, also a Research Assistant Professor in the LSUHSC Neuroscience Center.

Training will focus on research fields including genetics, microbiology, biochemistry, neurosciences, physiology, and pharmacology and will include one-on-one mentoring by faculty members from the LSUHSC Basic Sciences Departments and Centers on hypothesis development, experimental design, research methods, and scientific presentation skills.

Daughters of Charity Open Gentilly Clinic

Daughters of Charity Health Centers opened the doors to its newest location in Gentilly recently. This new facility, located at 100 Warrington

Drive on the campus of Dillard University, will increase access to health resources for Gentilly residents, offering a full-service primary and preventive care practice, including women's health (OB/GYN and prenatal services), primary care for children, adults, and seniors, pharmacy, behavioral health services, and more health resources under one roof.

Pegues Appointed Vice Chancellor

Dr. Larry Hollier, Chancellor of LSU Health Sciences Center New Orleans, has appointed J. R. Pegues, MBA, Vice Chancellor for Administration. He serves as the chief operating and administrative officer of LSU Health Sciences Center New Orleans.

Pegues has the lead responsibility for the university's successful business performance, including information technology, environmental health and safety, human resources, and auxiliary enterprises. He is responsible for developing campus master plans, acquisition and maintenance of property, as well as construction, renovation, maintenance and repair of facilities. His duties include establishing standards of personnel and institutional performance, defining broad institutional goals and objectives and coordinating the reporting and analysis of operating, capital and financial budgets.

Before joining LSUHSC, Pegues was President and Chief Executive Officer of Coventry Health Care's and Aetna's operations in Louisiana, Arkansas, Tennessee, and Mississippi. In that role, he had responsibility for all day-to-day operations and profitability of the organization.

New Orleans East to Receive Portion of BP Settlement

The Alliance Institute announced that New Orleans East will receive a portion of the $105 Million BP settlement awarded to coastal communities affected by the oil disaster. The Alliance Institute was instrumental in securing the BP funding for Eastern New Orleans, and 17 other counties and parishes along the Gulf Coast. The settlement is dedicated to increasing access to healthcare for Gulf Coast residents.

GRHOP's funding will also allow organizations like the Vietnamese Initiatives in Economic Training (VIET) and the New Orleans East Louisiana Community Health Center (NOELA CHC) to significantly increase its work in the New Orleans East community. More specifically, the Alliance Institute has charged VIET with leading the community engagement efforts as well as working with NOELA CHC to promote the transition into its brand new 9,000 square-foot state of the art facility, which is also partially funded by GRHOP. NOELA CHC is a federally qualified health center (FQHC) which has provided comprehensive, culturally competent, primary care services in the New Orleans East community since 2008.

For more information about the GRHOP Initiative, visit www.gulfregionhealthoutreach.com.

Essay Contest Winners Announced

The School of Medicine at LSU Health Sciences Center New Orleans has announced the winners of its first annual What Does Being Healthy Mean to Me? Essay Contest. They are:

9-12th Grade Category:

- 1st Place – Taylor Matthew, 12th grade, Baton Rouge Magnet Academy
- 2nd Place – Myles Poydras, 11th grade, St. Augustine High School
- 3rd Place – Justin Turner, 11th grade, John Curtis Christian School

6-8th Grade Category:

- 1st Place – Corrin Emmons, 7th grade, Patrick Taylor Academy
- 2nd Place – Johnell Marshall, 6th grade, Sophie B. Wright Elementary
- 3rd Place – Lucile Fonseca, 6th grade, Abita Springs School

1-5th Grade Category:

- 1st Place – Jannie Jones, 3rd grade, International School of Louisiana
- 2nd Place – Sydney Vander, 5th grade, Lake Castle Private School
- 3rd Place – Jordan Breaux, 2nd grade, Pittman Elementary School

"The first-place essay in each category was awarded $750," said Dr. Cathi Fontenot, Chief Executive Officer of the LSU Healthcare Network. "The second-place essay in each category received $500. The third-place entry in each category earned $250."

LSUHSC Gains Grant for Science Youth Initiative

LSU Health Sciences Center New Orleans has been awarded a $318,000 grant over three years by Baptist Community Ministries to support the LSUHSC Science Youth Initiative. The goals of this science education pipeline initiative are to promote K-12 students' interest and academic performance in the sciences and to prepare them for careers in the sciences. The initiative, led by principal investigator Fern Tsien, PhD, Assistant Professor of Genetics, along with co-investigator Martha Cuccia, Instructor of Public Health, will expand three existing programs.

The LSUHSC/New Orleans Schools Science Partnership supports 4th grade science education in New Orleans schools. Teachers report higher LEAP scores and grades in science since the program started in 2006.

The LSUHSC Hands-On Workshops maintain and increase interest created by the LSUHSC/New Orleans Schools Science Partnership. Since 2009, about 300 middle school and 1,400 high school students have conducted experiments on in high interest areas like forensics and cancer research at LSUHSC.

The Summer Internship Program for High School Students allows qualifying students to work in laboratory settings with an LSUHSC faculty member. This program helps students choose a college science career path, strengthen their resumes for college applications, and facilitate future careers in medicine or research. Since 2003, 117 high school students have been accepted into this program. The grant will expand the number of partnership schools, participating students, opportunities and resources for both students and teachers.

"The success of these programs is evidenced by the fact that some of the LSUHSC students and resident physicians now teaching in the programs were once high school student participants themselves," notes Dr. Fern Tsien, LSUHSC Science Youth Initiative principal investigator. ■

Reducing Costs and Improving Outcomes: DHH Addresses ED Utilization in Louisiana

Hospital Emergency Departments (EDs) are a critical, yet often over-utilized, component of the health care system in Louisiana, which, according to the Kaiser Family Foundation, ranks 45th in terms of ED visits. Additional data from the Louisiana Department of Health and Hospitals (DHH) puts the state at third in the nation in per capita ED utilization with 511 ED visits per 1,000 population at an average of cost of $1,000 per visit.

Those of us in health care know that a significant percentage of these ED visits are non-emergent in nature with patients presenting with conditions that could be more efficiently treated – and at lower costs – by Primary Care Physicians (PCPs) in other care settings. In our state, the financial impact of these visits is staggering, particularly in terms of Medicaid spending. In fiscal year 2013, the Louisiana Medicaid program spent approximately $176 million on hospital payments for ED visits, and DHH estimates that $73 million of that amount was for non-emergent conditions.

Recognizing the significant cost of providing primary care within an ED, Sen. David Heitmeier sponsored Senate Resolution 29 earlier this year, tasking DHH with creating and leading a multi-stakeholder workgroup to address the use of EDs for primary care. With members from organizations including the Louisiana Hospital Association (LHA), the Louisiana Association of Health Plans, health care providers, and other key stakeholders, the Emergency Room Reform Committee has already begun gathering and using data to identify trends that lead patients to the ED and developing strategies to reverse those trends.

DHH Secretary Kathy Kliebert, in a recent Q&A session with me, discussed some of the trends identified by the workgroup and shared details of the strategies currently under consideration.

To what do you attribute the high ED utilization rate in Louisiana?

"There are several factors in that – lack of education about available health care resources and lack of insurance, for example – but I really think it's primarily an issue of convenience. You have a mother whose child is running a fever in the middle of the night, and the mother can't miss work the next day, so the mother takes the child to the ED, even though it's really not an emergency situation," Kliebert said.

What are the most common reasons that patients are seeking care in Louisiana's EDs?

"The workgroup has been using claims data and data from LHA – basically all available data – to identify some of those reasons. What we've found is, for adults ages 18 and up, the top five reasons for ED visits are urinary tract infections; prenatal and post-partum care; abdominal pain; headaches; and lower back pain. For children, the most common conditions presented in the ED are upper respiratory infections, ear infections, fever, and sore throats," Kliebert said. "We've also identified the most commonly prescribed medications in the ED, and at the top of list is Hydrocodone, so there is concern about medication-seeking patients."

What's the impact of avoidable ED utilization?

"Cost is obviously an issue. A trip to the ED for a Medicaid patient costs five times as much as a visit to a PCP, and statistically, 56 percent of those ED visits could be avoided. That number has climbed fairly steadily over the years," Kliebert said. "But to me, the bigger issue is that patients who seek primary care in EDs are not receiving the benefits of an ongoing relationship with a PCP.

"If a patient goes to his primary care physician with a headache, for example, that patient may pay $75 for an office visit, but he's going to get comprehensive, personalized care – a diagnosis, medication, follow-up...If that patient goes to the ED with a headache, he's going

Cindy Munn
Executive Director
Louisiana Healthcare Quality Forum

I REALLY FEEL THAT IT'S IMPORTANT TO CHANGE THE CULTURE

to get an MRI at a cost of at least $1,000, and he's not going to get the ongoing care. That patient has no relationship with the ED doctor. So while cost is certainly a factor in efforts to reduce avoidable ED visits, the more important issue is that seeing a PCP will result in better outcomes for the patient. So our goal in reducing ED utilization is really two-fold."

Has the Emergency Room Reform Committee developed any potential strategies to decrease non-emergent ED utilization in Louisiana?

"We have identified eight possible solutions, with three to four of them considered to be the most feasible," said Kliebert. "The first of these is to focus on educating Medicaid patients and the general public about appropriate ED use. This is about changing behavior, and it won't happen overnight, but we want patients to focus on other options such as urgent care or after-hours clinics.

"Another plan is to use electronic health notifications for health plans to let them know when a member has gone to the ED. The goal there is to get that data to the health plan within a couple of days so they can ensure that the patient follows up with a PCP.

"We're also looking at developing a database for prescribed medications that would be similar to the disease registry used by the Office of Public Health to target outbreaks and provide public health response. This medication database would enable ED doctors to identify patients who may be seeking specific drugs. This will give the doctors more information before they dispense medications. Medication-seeking patients are a significant issue, and this will go a long way toward reducing the potential for abuse and gives the doctors the ability to refer patients to services such as substance abuse programs.

"We're looking at developing financial incentives for after-hours clinics, and we're considering the adoption of an information exchange system to identify 'super-users,' or patients who visit the ED three times or more during a 90-day period. We want to implement processes to assist those patients in getting appointments with PCPs within 72-96 hours.

"We've also discussed having designated hospital personnel to review utilization trends and training them to recognize surges, diagnosis trends, and so on. The idea is to give some of the responsibility to the hospitals and give them the ability to develop strategies to deter some of these visits.

"Of course, there is still much to do, but what we're working toward is a plan that can be in place and implemented in State Fiscal Year 2015."

What initial steps did the Committee take to identify these possible solutions?

"This has very much been a collaborative, comprehensive approach to the problem," Kliebert said. "We researched successful ED utilization projects in other states to see what's worked for them. We also looked closely at the managed care plans that have been implemented by the Bayou Health plans. They've developed performance improvement plans, such as using care managers to help patients monitor their care and to act as triage before the patients go to the ED and to ensure follow-up with PCPs. It's a focus on that relationship between the patient and the PCP, and it's working for them. In 2011, they recorded 54.3 ED visits per 1,000 members per month. That's down to 51.67 per 1,000 per month. It's not a major decrease, but it is significant. Their work has been a good start, and they've made it a major focus. They have the flexibility to do things differently."

What roles do data and technology play in the committee's plans?

"Obviously, the more data we have, the better the decisions that can be made," said Kliebert. "This is really about changing delivery models, and electronic data access will contribute to that. The data is really going to help us drive these efforts.

"We've also got to be creative in the use of technology. For example, DHH is utilizing geomapping technology in several areas, and we see the potential to use that technology in addressing ED utilization. It is clearly a great tool for identifying gaps in care and where the visits are occurring so we know what the issues are and how to apply the data to address the trends."

After working diligently with this committee and seeing the data and research, what do you feel is going to be the key factor in reducing avoidable ED visits?

"I believe very strongly in changing behavior through good support and coaching," Kliebert said. "Having strong resources in place to support patients can make a big difference. I really feel that it's important to change the culture if we're going to reduce ED use going forward. Everyone – patients, doctors, hospitals and health plans – needs to be involved and accept some of the responsibility because clearly, this is an important issue in reducing costs and improving outcomes." ■

U.S. HEALTHCARE: World's Biggest Spender Lacks Good Results

So, let me see if I've got this straight. The United States spends way more on healthcare than any other industrialized country in the world, right? So the reason that we spend so much is because we have top notch healthcare, right? Better than every other nation, right? That's why the U.S. is the biggest spender.....right?

Um, I think I have some flaws in my logic. Let me start over. First of all, the notion about first class healthcare providers is largely true. The U.S. has some of the finest doctors, hospitals, medical research, and medical education facilities in the world. But many other nations have medical personnel and resources that are equivalent to the U.S., though typically obtained at lower cost.

And although we often provide first class care to much of our population, we have to recognize the fact that about 50 million Americans have to settle for treatment in emergency rooms because they cannot afford health insurance. In addition to the 50 million who are uninsured, there are tens of millions who are under-insured with high deductible plans that don't cover routine visits with a doctor.

So where does all our money go? Good question. Luckily, a number of organizations have taken it upon themselves to do exhaustive research into why the U.S. spends so much and why our citizens are not as healthy or as long-lived on average as those living in other wealthy nations.

The Commonwealth Fund has been conducting studies and delivering reports for at least the past 10 years. As shown on the two tables at right, the U.S. spent $8,508 per capita (all amounts adjusted for purchasing power parity) which is significantly higher than any other nation.

Overall Ranking

The rankings in fig. 1 show that the U.S. does relatively well in quality care areas but has the lowest score for cost-related access problems, efficiency, equity and healthy lives. Those scores earn a last place overall for the U.S.

The historical rankings (fig. 2) are shown for each of the five editions of the Commonwealth Fund report since 2004. Note that the U.S. rank has declined in overall rank each year and has finished in last place for the 2014 report.

The Commonwealth Fund report comments on differences between the U.S. and other industrialized nations, particularly the absence of universal health insurance coverage.

"The most notable way the U.S. differs from other industrialized countries is the absence of universal health insurance coverage. Other nations ensure the accessibility of care through universal health systems and through better ties between patients and the physician practices that serve as their medical homes. The Affordable Care Act is increasing the number of Americans with coverage and improving access to care, though the data in this report are from years prior to the full implementation of the law. Thus, it is not surprising that the U.S. underperforms on measures of access and equity between populations with above average and below-average incomes.

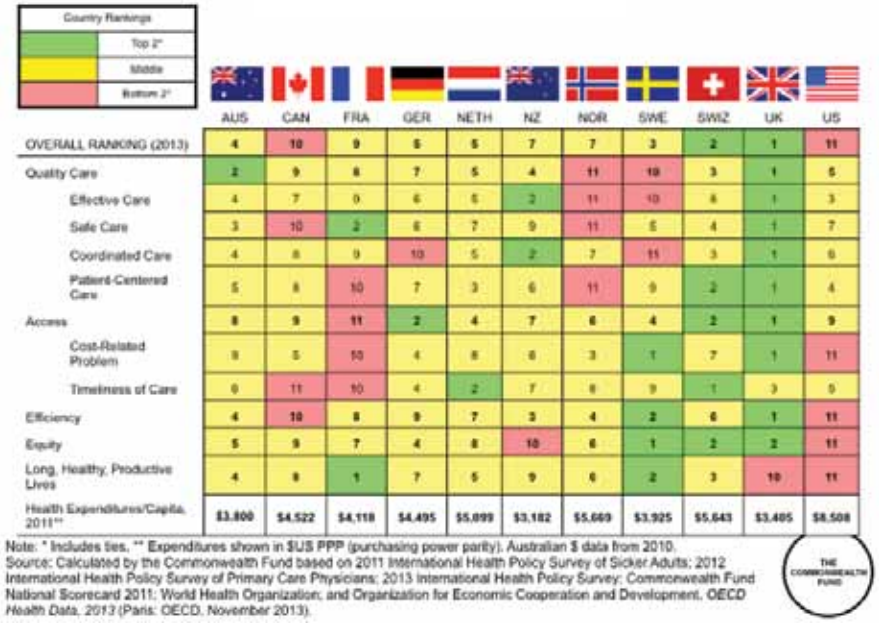
*"The U.S. also ranks behind most countries on many measures of health outcomes, quality, and efficiency. U.S. physicians face particular difficulties receiving timely information, coordinating care, and dealing with administrative hassles. Other countries have led in the adoption of modern health information systems, but U.S. physicians and hospitals are catching up as they respond to significant financial incentives to adopt and make meaningful use of health information technology systems. Additional provisions in the Affordable Care Act will further encourage the efficient organization and delivery of health care, as well as investment in important preventive and population health measures. For all countries, responses indicate room for improvement. Yet, the other 10 countries spend considerably less on health care per person and as a percent of gross domestic product than does the United States. These findings indicate that, from the perspectives of both physicians and patients, the U.S. health care system could do much better in achieving value for the nation's substantial investment in health."**

It should be noted that the data collected

**Source: Commonwealth Fund - Mirror, Mirror on the Wall—How Performance of U.S. Health Care System Compares Internationally - June 2014

David W. Hood
Former Secretary (1998-2004)
Louisiana Department
of Health and Hospitals

Overall Ranking (Fig. 1)



	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	6
Effective Care	4	7	9	6	6	2	11	10	5	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	8	5	10	4	6	6	3	1	7	1	11
Timeliness of Care	9	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	3	11
Long, Healthy, Productive Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Note: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity). Australian $ data from 2010.
Source: Calculated by the Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, November 2013).

for this report did not cover the time period for enrollment that occurred earlier this year in accordance with the Affordable Care Act. Therefore, the next report may show some improvement for the U.S. in terms of access to care and other related indicators.

The Commonwealth Fund is not the only organization studying the issue of high spending and relatively low performance in U.S. healthcare. Two other studies have been completed in the last few years. The most recent study was conducted by the Institute of Medicine and was published in a 421-page report in 2013: "U.S. Health in International Perspective - Shorter Lives, Poorer Health." Another study was done by the U.S. Burden of Disease Collaborators and published in the *Journal of the American Medical Association* (JAMA) under the title of "The State of US Health, 1990-2010 - Burden of Diseases, Injuries, and Risk Factors."

The studies done by these prestigious organizations generally agree that U.S. healthcare is needlessly expensive and yet fails to make the changes needed to improve performance and outcomes. Other organizations have also launched inquiries into the matter and more reports should be forthcoming.

Nevertheless, studies don't necessarily lead to progress in fixing the problem. Change in U.S. healthcare is slow in coming and often fails to proceed in the right direction. The Institute of Medicine report makes the following plea to avoid falling into the usual pattern of doing nothing, which will only result in higher mortality rates and worsening health:

"The consequences of not attending to the growing U.S. health disadvantage and reversing current trends are predictable: the United States will probably continue to fall further behind comparable countries on health outcomes and mortality. In addition to the personal toll this will take, the drain on life and health may ultimately affect the economy and the prosperity of the United States as other countries reap the benefits of healthier populations and more productive workforces. With so much at stake, especially for America's youth, the United States cannot afford to ignore its growing health disadvantage." ■

Source: "U.S. Health in International Perspective: Shorter Lives, Poorer Health," Steven H. Woolf and Laudan Aron, Editors; 2013, National Research Council and Institute of Medicine.

Historical Ranking (Fig. 2)

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2014 EDITION)	**4**	**10**	**9**	**5**	**5**	**7**	**7**	**3**	**2**	**1**	**11**
Overall Ranking (2010 edition)	3	6	n/a	4	1	5	n/a	n/a	n/a	2	7
Overall Ranking (2007 edition)	3	5	n/a	2	n/a	3	n/a	n/a	n/a	1	6
Overall Ranking (2006 edition)	4	5	n/a	1	n/a	2	n/a	n/a	n/a	3	6
Overall Ranking (2004 edition)	2	4	n/a	n/a	n/a	1	n/a	n/a	n/a	3	5
Health Expenditures per Capita, 2011*	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

* Expenditures shown in $US PPP (purchasing power parity); data for Australia from 2010.

Data: OECD, *OECD Health Data, 2013* (Nov. 2013).

Carnage in the Public Space: Managing the Epidemic of Societal Violence

By the time you read this, we will have engaged as a nation in the collective hand-wringing that follows every episode of public violence perpetrated upon the innocent. This time it surrounded the campus of the University of California, Santa Barbara. And the plethora of headlines read like a war story:

"Santa Barbara Shooting Suspect Emailed 140-page Hate Manifesto to Parents; Fatally Stabbed Roommates," *The Christian Post*, May 26, 2014

"Santa Barbara Shootings. Would a 'gun restraining order' have helped?" *The Christian Science Monitor*, May 28, 2014

"Dad of Santa Barbara Victim Sobs and Rails Against Son's Death," *ABC News*, May 24, 2014.

"7 Dead in Drive-by Shooting Near UC Santa Barbara," *Associated Press*, May 24, 2014.

This incident follows, of course, on similar tragedies that particularly target our nation's youth: Columbine High School in 1999, the Virginia Tech shootings in 2007, the Aurora Theater slaughter in 2012, and, most recently, Sandy Hook in 2013. While any type of violence randomly targeted at unsuspecting victims is abhorrent, these incidents are particularly concerning because they have a profound effect on children and adults, victims and survivors alike.

The World Health Organization defines violence as:

"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[1]

A simple definition of violence, however, does little to help us understand what societal or community violence is, how it affects us, what its multi-factorial determinants are, and, most importantly, how to intervene with the perpetrators. Former Attorney General Janet Reno recognized that "the most formative time of a person's life is in the age of zero to three when they learn the concept of reward and develop the sense of a conscience and punishment."[2] For that reason, policy recommendations to promote violence intervention strategies are usually reflected in federal and state initiatives such as Head Start or other early childhood development programs, legislative efforts to control media portrayals of violence, and proposals for gun control. The evidence would suggest that there is more to this violence epidemic than just the influence of early childhood development including parental support and training, television and video game viewing, early education, and child abuse. Additionally, it is essential that parents, school personnel, pediatric physicians and nurses, and other community workers who interact with children, adolescents, and young adults be cognizant of antisocial behaviors as predictors of future propensities toward violence. These include aggression, lying, stealing, cruelty to animals, and dishonesty.[3]

Kelly (2014) posits that nurses are not only uniquely qualified to recognize and intervene with individuals who are experiencing violence, but they practice in various settings including schools, community clinics, home health, shelters, and physicians' offices where they are likely to interact with potential perpetrators as well as victims.[4] In that regard, there exists for our profession an opportunity to promote preventive and interventional strategies for decreasing the occurrence of community violence and its significant sequelae including death, disability, mental suffering of victims and their families, impact on schools, businesses, and the community at large, and the legal and healthcare costs.

In order to be effective in treating and preventing societal violence, we need a three system approach: healthcare, legal, and public health. Our healthcare system has to care for all victims of violence in the emergency rooms, operating suites, and hospitals of our country. Violent trauma is particularly challenging because of the nature of injuries from gunshots, stabbings, or other mechanical trauma. Additionally, the emotional distress to families and treating physicians and nurses can be devastating. While healthcare workers deal with these issues, the legal system is charged with holding the perpetrators of violence accountable for their criminal acts.

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

NURSES CAN AND SHOULD TAKE LEADERSHIP IN THESE PREVENTION AND TREATMENT EFFORTS

From arrest through prosecution and incarceration, there are financial and emotional costs to society for keeping our neighborhoods and communities safe. While these two systems address the treatment aspects, it is the public health approach that holds the most hope for prevention of violence at the macro-system level. Simon and Hurvitz (2014) describe a public health philosophy that is multidisciplinary, joining healthcare experts with those from epidemiology, sociology, criminology, education, psychology, and economics to intervene at the population level to focus on prevention.[5] The authors go on to describe a system of prevention that includes defining the problem, identifying risk and protective factors, and the implementation of evidence-based approaches to enhance public health capacity through training and networking.[6]

Nurses are routinely involved in the treatment of violence after it occurs. They also have the broad skills and training to facilitate the public health approach to preventing societal violence. Home visiting programs are one example of a creative approach in which nurses can offer family-focused services in maternal health, child development, positive parenting, nutrition, school readiness, and economic self-sufficiency. School-based violence prevention programs are another strategy that nurses can organize to reduce aggression and violent behavior among students. These programs should focus on emotional self-awareness, self-esteem and self-control, positive social skills, conflict resolution, and teamwork. Finally, nurses need to be involved in educating the public about child developmental expectations, initiating parent education programs, and advocating for counseling services and community programs to improve family communication and to make treatment services available and accessible.

Societal violence is a preventable public health challenge, but one which requires the multidisciplinary cooperation of healthcare professionals, law enforcement and judicial professionals, and public health experts to intervene appropriately. Nurses can and should take leadership in these prevention and treatment efforts. From guidance with crisis intervention teams to coordinating violence disaster response initiatives to promoting community partnerships to develop violence prevention strategies, nurses are involved in trusted, caring relationships with their clients and community members that facilitate these types of efforts. It will take all of our sustained commitment to insure that another Santa Barbara doesn't happen on our watch. ■

[1] World Health Organization. (2002). "World report on violence and health." Retrieved from www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf.
[2] Reno, J. (1993) "Address to the Forty-third Meeting of the Seventh Circuit Bar Association," May 24, 1993. (As cited in Buka, S. and Earls, F. Determinants of Delinquency and Violence, *Health Affairs*, 12, (4) (1993): 46-64.)
[3] Buka, S. and Earls, F. (1993) "Determinants of Delinquency and Violence," *Health Affairs*, 12, (4), p. 50.
[4] Kelly, S.(2014) "Overview and Summary: Societal Violence: What is Our Response?" *OJIN: The Online Journal of Issues in Nursing*, 19 (1), Overview and summary.
[5] Simon, T.R. and Hurvitz, K. (2014) "Healthy People 2020 Objectives for Violence Prevention and the Role of Nursing," *OJIN: The Online Journal of Issues in Nursing*, 19 (1), Manuscript 1.
[6] *Ibid*

Birth Initiative Comes of Age

The health and wellness of mothers and their babies is a top priority at the Department of Health and Hospitals. Since August 2010, the DHH Birth Outcomes Initiative (BOI) has engaged community members and key stakeholders to develop evidence-based practices to improve women's and infant health. In April 2011, with heavy stakeholder input, BOI finalized its strategic plan, which included a paramount goal of ending elective non-medically indicated deliveries before 39 weeks.

To achieve this goal, DHH has forged a strong partnership with the Louisiana State Medical Society and the Louisiana Hospital Association. Together, these organizations have worked diligently to end this practice. Since 2012, every birthing hospital in Louisiana has signed a voluntary pledge that they will not perform elective deliveries prior to 39 weeks. In March 2012, the Office of Public Health began collecting new data from birthing hospitals on the LEERS Birth Record to provide insight regarding reasons for elective delivery prior to 39 weeks. The data collected assists DHH and providers to identify and monitor elective deliveries that occur prior to 39 weeks.

Thanks to the efforts of these partners, DHH has realized tremendous success in this endeavor. To continue the good work DHH will initiate the next phase of this initiative in FY 15 by implementing payment reforms to promote best practices for mothers and babies. Medicaid will no longer pay for services related to elective deliveries that occur prior to 39 weeks without a medical reason. DHH anticipates that this will reduce NICU admissions for the babies who would have been born early, reduce cesarean sections,52 and reduce complications for moms. This saves taxpayer money while improving the health outcomes of new moms and babies.

Louisiana also has an extremely high rate of cesarean deliveries. According to the March of Dimes, between 2002 and 2012, the percent of live births delivered by cesarean section increased more than 32 percent in Louisiana. Across the state, 28 hospitals are participating in the DHH and LHA sponsored "Perinatal Improvement Collaborative" led by the Institute for Healthcare Improvement (IHI). This program teaches quality improvement practices to the labor and delivery units to implement structures and processes that will lead

Kathy Kliebert
Secretary, Louisiana DHH

DHH RECENTLY IMPLEMENTED MEDICAID POLICY CHANGES TO COVER VAGINAL PROGESTERONE AND MAKENA

to improved outcomes on the Perinatal Core Measure Set, elective inductions, and reversing the trend of rising cesarean rates. Louisiana is engaging providers and hospitals to reduce C-sections through reducing the number of elective inductions before the due date and encouraging them to go for a full 40 weeks.

DHH is also taking steps to increase access to medical therapies proven to lower the instance of preterm birth. In particular, DHH recently implemented Medicaid policy changes to cover Vaginal Progesterone and Makena. We are in the process of putting together a state-wide Vaginal Progesterone strategy in partnership with March of Dimes and other stakeholders. The focus will be on provider education and engagement with the OB/GYN and the Maternal-Fetal Medicine community around the state to increase the utilization of progesterone.

DHH is also working to update its perinatal care guidelines, which were last revised in 2007. This is being done as part of a national movement to look at regionalization criteria and NICU levels of care and Louisiana wants to be at the forefront of that effort. In 2012, the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) released Guidelines for Perinatal Care, 7th Edition which expanded the classification system from three levels of care to four.

As we began to look at how to best bring Louisiana Medicaid in line with current best practices, DHH developed a collaborative approach by forming the Perinatal Clinical Guidelines Committee in 2013. Committee members include hospital executives, perinatology and neonatology physicians, and quality improvement registered nurses from around the state. The purpose of this committee is to inform and develop recommendations for contemporary levels of neonatal care, including identifying national best practices for newborn tiered provisions of care and to standardize definitions for facility requirements providing neonatal care. The committee will suggest a process for ensuring the guidelines for perinatal care are updated on an annual basis as well as appropriately enforced.

Through each of these initiatives, I am confident that Louisiana will see better health outcomes for women and children across our state. Education coupled with action will further our goals to reduce preterm births, prevent birth defects, decrease the number of unnecessary C-sections and increase care in the NICU. Those interested in learning more about the goals and initiatives are welcome to contact the Department. ■

Across the state, 28 hospitals are participating in the DHH and LHA sponsored "Perinatal Improvement Collaborative" led by the Institute for Healthcare Improvement (IHI).

2014 Grand Rounds Classic

Thurs. Oct. 23, 2014

Santa Maria Golf Course Baton Rouge, LA

1 p.m. Shotgun Start

For more information or to register online, visit lsms.org/2014GrandRoundsClassic.

Louisiana State Medical Society
6767 Perkins Road, Suite 100 • Baton Rouge • LA 70808 • 800-375-9508

TRANSPLANT RECIPIENTS PREPARE FOR TRANSPLANT GAMES

Recently, Ochsner Medical Center, Louisiana Organ Procurement Agency (LOPA), and Team Louisiana, a group comprised of nearly 30 post-transplant recipients, living donors, and donor families from across the state and surrounding areas, celebrated the countdown to the 2014 Transplant Games®. This biennial, Olympic-style, national competition, held in Houston, Texas, July 11-15, recognizes the tremendous accomplishments of individuals whose lives have been affected by organ donation in some way.

Led by The Gentilly Brass Band, over a hundred people second lined around the hospital to the official "Games" flag signing ceremony. Similar to the passing of the Olympic torch, the flag arrived in Louisiana for the team to sign and will continue its journey across the country for signatures from the more than 40 participating teams. The flag will return to Houston, Texas where it will fly over BBVA Compass Stadium during the Opening Ceremonies of the Games.

Local athletes include:

- Amy Austin Kinler - heart transplant, Covington
- Jack Badinger - kidney/pancreas transplant, Pearl River
- Roy Blain - heart transplant, Metairie
- Tyrone Cooper - heart transplant, Luling and Donor Mom - Marion Duplantis, Houma
- Louis Danflous - liver transplant, Metairie
- Michael Davidson - heart transplant, New Orleans
- Isiah Douglas - heart transplant, Hammond
- Britney Dugas - heart transplant, Metairie
- Jamie Napolitano - heart transplant, Destrehan
- Bruce Pinsonat - kidney transplant, Mandeville
- Tina Pitre - kidney transplant, Luling
- Blake Babin - heart transplant, Slidell
- Randy Zell - kidney/pancreas transplant, New Orleans.

TOP Gentilly Brass Band leads second line through Ochsner Medical Center-Jefferson Highway.
MIDDLE Tyrone Cooper, heart transplant recipient, hugs his donor mother, Marion Duplantis.
BOTTOM Team Louisiana transplant athletes gather around the official Transplant Games flag after the signing ceremony.

PHOTO CREDIT STEPHEN LEGENDRE, OCHSNER HEALTH SYSTEM

HOSPITAL ROUNDS

Stephen Robinson, Jr.

Abdul Majid Khan, MD

STPH and Ochsner Partner for Access

St. Tammany Parish Hospital (STPH) and Ochsner Health System announced the signing of a Letter of Intent to form a strategic partnership which will focus on delivering the Northshore greater access to quality healthcare in the most cost-effective manner.

The partnership between Ochsner and STPH provides strategic benefits for both organizations, their physicians, and most importantly, their patients. It provides an opportunity for both organizations to realize future growth opportunities through appropriate expansion of services, improved coordination of resources, sharing of best practices, a continued focus on quality, and implementation of advanced technology. These advances will result in more integrated care and better value for patients.

Lakeview Recognizes Volunteers, Installs Officers

Lakeview Regional Medical Center recently hosted its Annual Volunteer Appreciation Luncheon. Along with presenting the volunteers with pins for service hours served, each volunteer received a gift from LRMC. Installation of the new auxiliary officers was conducted by Bret Kolman, CEO of Lakeview Regional Medical Center. New board members for the LRMC Volunteer Auxiliary include: Jerry Lambert, President; Marie Mauer, Vice President; Karen Callaway, Treasurer; Beverly J. Smith, Secretary; June Selzer, Past President, and Henry E. Markel, Parliamentarian.

At the luncheon, $26,551.45 in donations was presented to various charities within St. Tammany Parish voted on by the volunteer auxiliary. Donations were funded by the volunteer auxiliary's various fundraisers throughout the year and profits from "The Duck's Nest" gift shop, which is operated by the volunteer auxiliary.

Robinson to Lead Ochsner Medical Center-Kenner

Stephen Robinson, Jr. is the new CEO for Ochsner Medical Center-Kenner. Robinson joins Ochsner with over 14 years of healthcare leadership. His prior experience includes Vice President of Operations/Administrator for Tulane-Lakeside Hospital and AVP of Operations for Tulane Medical Center. Most recently, he served as the Chief Operating Officer at Lakeview Regional Medical Center in Covington.

EJGH Completes 100th Convergent Procedure

East Jefferson General Hospital, led by Cardiovascular Surgeon, Dr. Michael Brothers and Cardiac Electrophysiologists, Drs. James McKinnie and Zhen Jiao, has completed the 100th Convergent Procedure for the treatment and cure of atrial fibrillation (A-Fib). EJGH has been placed in the top five in the United States for this procedure.

During a Convergent Procedure, the surgeon first enters into the chest through a small, single port and uses an ablation technique to burn a pattern of lesions into the beating heart through radio frequencies, eliminating the need for a heart lung machine. The electrophysiologist follows by placing a catheter in the femoral vein in the groin and leading it inside the heart to ablate the areas that the surgeon could not access. This procedure allows for shorter hospital stays and recovery time.

Khan Joins Lakeview Behavioral Health Center as Medical Director

Dr. Abdul Majid Khan is the Medical Director of the new location of the Lakeview Regional Behavioral Health Center. Dr. Khan has served as Medical Director of Acute Inpatient Psychiatric facilities, Partial Hospitalization, and Intensive Outpatient Programs in the private sector. He has also provided consulting for the Department of Corrections for more than two years. He has been on faculty as

LHH Awarded Advanced Stroke Certification L-R, Kevin Hopkins, EMS Acadian Ambulance; Brenda Ashley, RN, BSN, Stroke Coordinator; Fredro Knight, MD, FACEP, Emergency Department Medical Director; Matthew Primeaux, EMS Acadian Ambulance.

St. Charles Parish Hospital Breaks Ground on Clinic

an Assistant Professor of Psychiatry with the LSU Department of Psychiatry in New Orleans and was most recently a Unit Director at Greenbrier Hospital in Covington.

Located on the hospital campus in Covington the new Lakeview Regional Behavioral Health Center will offer more comprehensive and efficient care for patients, and their families, in need of mental and medical healthcare.

LHH Awarded Advanced Stroke Certification

The Joint Commission, in conjunction with The American Heart Association and American Stroke Association, has awarded Louisiana Heart Hospital Advanced Certification as a Primary Stroke Center. Achievement of Primary Stroke Center Certification signifies an organization's dedication to fostering better outcomes for patients. LHH's Primary Stroke Center Certification has demonstrated that their program meets critical elements of performance to achieve long-term success in improving outcomes for stroke patients.

Ochsner's Telestroke Program Reaches 3,000th Consult

Ochsner Medical Center was the first hospital in Louisiana to use telemedicine to treat stroke. In the four and a half years since its implementation, Ochsner has become one of the fastest growing networks in the country with 20 active spoke hospitals. Its 3,000th patient consultation was performed at Minden Medical Center in March.

With Ochsner Medical Center in New Orleans functioning as the "hub," TeleStroke links specially-trained vascular neurologists to "spoke" hospitals 24/7 for collaborative care. Via the TeleStroke program, Ochsner stroke neurologists are present virtually at more than 20 hospitals around the state. Through secure wireless data and video communication, Ochsner's stroke team partners with on-site clinicians to evaluate, diagnose, and direct care for patients, as well as to ensure timely thrombolytic therapy is administered when appropriate.

STPH Welcomes New Physician Associations

The St. Tammany Parish Hospital recently welcomed the following physicians to its medical staff:

- Dominick Alongi DDS, Endodontics
- Michele Cooper MD, Plastic Surgery
- Artemus Flagg MD, Pain Management
- Julian Foreman MD, Radiology
- Saurabh Gupta MD, Nephrology
- Ara Kassarjian MD, Teleradiology
- Steve Lee MD, Pain Management
- Erik Soine MD, Dermatology.

St. Charles Parish Hospital Breaks Ground on Clinic

St. Charles Parish Hospital has officially broken ground on its Plantation View Medical Offices located on the East Bank of the Mississippi.

Filling the need for quality healthcare services on the East Bank of St. Charles Parish, the 62,000 square foot complex will contain a number of services deemed important by the residents of St. Charles Parish, including internal medicine, gastroenterology, orthopedics, ophthalmology and optometry, urology, neurology, and general surgery. The facility will also host the most asked for service by residents on the East Bank, an urgent care clinic.

The facility is estimated to create nearly 50 new jobs in the parish and will play an integral part in expanding healthcare options for not only residents of St. Charles Parish, but also the surrounding communities.

Three Cardiologists Sign on with LHH

The Louisiana Heart Hospital (LHH) announced that it has completed agreements for clinical integration with three cardiologists, Ali M. Amkieh, MD, FACC, Barry A. Kusnick, MD, and Pramod V. Menon, MD, FACC. These agreements represent another important step in the growth of the Louisiana Heart Hospital integrated delivery system.

Dr. Amkieh has practiced on the Northshore since 1997 and holds Board Certifications in Internal Medicine, Interventional Cardiology, Cardiovascular Diseases, and Nuclear Cardiology.

Dr. Kusnick has practiced cardiology on the Northshore since 1998. Dr. Kusnick received his

HOSPITAL ROUNDS

6 graduate from STPH nursing residency program: Clockwise from bottom right: Quiana Dorsey, Christine Fields, Alex Schell, Rachel Lukinovich, Amanda Jarrell, and Denise Hurstall.

Lisa Napier

medical doctorate from The American University of the Caribbean and completed his internship and residency in Internal Medicine at Grace Hospital.

Dr. Menon has practiced on the Northshore since 2006 and holds Board Certifications in Internal Medicine and Cardiovascular Disease.

Lakeview Announces New Hires

Lakeview Regional Medical Center recently added the following physicians to its medical staff:

- Carla Rider, MD – Emergency Medicine
- Paul Stahls, MD – Cardiac Electrophysiology
- Brandt Zimmer, MD – Radiology
- John Flatt, MD – Child Neurology
- Saurabh Gupta, MD – Nephrology
- Kristina Lafaye, MD – Neurology
- Frank Arena, MD – Cardiology

EJGH Scores "A" in Hospital Safety Score

Designed to rate how well hospitals protect patients from accidents, errors, injuries, and infections, the latest Hospital Safety Score honored East Jefferson General Hospital with an "A" – its top grade in patient safety. The Hospital Safety Score is compiled under the guidance of patient safety experts and is administered by The Leapfrog Group, an independent industry watchdog.

Calculated under the guidance of Leapfrog›s Blue Ribbon Expert Panel, the Hospital Safety Score uses 28 measures of publicly available hospital safety data to produce a single "A," "B," "C," "D," or "F" score representing a hospital's overall capacity to keep patients safe from preventable harm. More than 2,500 U.S. general hospitals were assigned scores in spring 2014, with about 32-percent receiving an "A" grade. Hospital Safety Score is fully transparent, and its website offers a full analysis of the data and methodology used in determining grades.

6 Graduate From STPH Nursing Residency Program

St. Tammany Parish Hospital has recognized six registered nurses who recently completed the Nursing Residency Program: Quiana Dorsey, Christine Fields, Denise Hurstall, Amanda Jarrell, Rachel Lukinovich, and Alex Schell.

The Nursing Residency Program was created in 2011 to offer recently graduated nurses the opportunity to build a solid professional foundation through mentoring in the area of skills development, clinical decision making and teamwork. Since its inception, 33 nurses have completed the program.

Napier joins ILH as Chief Financial Officer

Lisa Napier has been named Chief Financial Officer for Interim LSU Hospital. Napier has more than 25 years of hospital financial management experience. Prior to joining ILH, she served as Chief Financial Officer of Tenet Healthcare Corporation's Atlanta Medical Center, a two-campus, 762-bed, major tertiary care Level I Trauma Center; and at Spalding Regional Medical Center in Griffin, Ga. Earlier in her career, she spent eight years in the New Orleans area where she worked as CFO of Lakeside Hospital in Metairie and New Orleans' Lakeland Medical Center.

STPH Outpatient Rehab Adds Location

St. Tammany Parish Hospital Outpatient Rehabilitation Services has opened a satellite rehab clinic at the West St. Tammany YMCA in Covington, to better serve the needs of the community.

STPH Physical Therapist Kevin Mizell now sees patients at the YMCA for orthopedic diagnoses and will also will lead sessions on body mechanics and core strengthening, among other topics, for YMCA members.

Ochsner St. Anne Honors Employees of the Month

At Ochsner St. Anne General Hospital the following employees have been honored as Employees of the Month and Employees of the Quarter for the first quarter of 2014. These individuals were nominated and selected by their peers:

January Clinical Employee of the Month: Ann Savoie, Infusion Center Manager, has worked as a Registered Nurse at Ochsner St. Anne since 1999.

January Non-Clinical Employee of the Month: Tiffany Hunter, a team member for the past seven years, serves as the Supervisor of Primary Care Clinics.


EJGH Opens New Infusion Center

February Clinical Employee of the Month: Cassandra Gray has been a Patient Care Technician since 1997.

February Non-Clinical Employee of the Month: Daniel Guidry is a 20-year veteran on the Plant Maintenance Team.

March Clinical Employee of the Month: Marcie Champagne Richoux, a Registered Nurse, joined the Ochsner St. Anne team in 2004.

March Non-Clinical Employee of the Month: Torrie Carpenter is a Supervisor in Health Information Management.

Leader of the Quarter: Mae Hitt, Community Outreach Director, has served the community and hospital since 1974.

Physician of the Quarter: Dr. Michael Marcello has served the hospital and the Central Lafourche community for 36 years.

STPH Receives Women's Choice Awards

St. Tammany Parish Hospital has received Women's Choice Awards as one of America's Best Hospitals for Heart Care, Obstetrics, and Orthopedics, while Mary Bird Perkins was recognized as a Best Hospital for Cancer Care.

Awards are based on surveys of thousands of women, as well as research conducted in partnership with the Wharton School of the University of Pennsylvania on what drives the consumer experience for women versus men.

West Jefferson's EMS Receives AHA Award

West Jefferson Medical Center's Emergency Medical Service (EMS) is the only New Orleans area hospital-based EMS to receive the American Heart Association's Mission: Lifeline® EMS Silver Award. The honor recognizes West Jefferson's commitment and success in implementing specific quality improvement measures for the treatment of patients who suffer a severe heart attack known as a STEMI (ST Elevation Myocardial Infarction).

Mission: Lifeline's new EMS recognition program recognizes those emergency responders for their efforts in improving STEMI systems of care and improving the quality of life for these patients. Agencies that receive the Mission: Lifeline Silver award have demonstrated at least 75 percent compliance for each required achievement measure for the entire year, and treat at least eight STEMI patients for the year.

EJGH Opens New Infusion Center

East Jefferson General Hospital and The Foundation recently announced the opening of the new Outpatient Infusion Center. This expansion triples the space and capacity to treat cancer patients and is the result of a successful $3 million capital campaign to add a third floor Infusion Center, completely renovate second floor physician and clinic offices, and improve the first floor radiation therapy departments.

The completed Outpatient Oncology Infusion Center includes the following enhancements:

- Outpatient Infusion Center capacity and footprint tripled from our former site.
- Increased number of infusion stations from 8 to 22. Each infusion station is an individual, more private treatment area complete with a specialized recliner and all necessary clinical equipment.
- Increased number of patient rooms with beds from 3 to 7.
- Expanded infusion Fast Track area to more quickly serve patients.
- Incorporated a multi-media conference room for physicians and care team to host video conferencing, presentations, and educational offerings.
- Expanded Cancer Resource Library to offer patients and their support system access to computer stations and the most up-to-date research and educational material.
- Expanded patient access and registration area to welcome and register patients more efficiently.
- A serenity area for relaxation with specially designed massage chairs and therapeutic music.

Ochsner Implants Leadless Cardiac Pacemaker

The John Ochsner Heart & Vascular Institute (JOHVI) at Ochsner Medical Center is the first facility in the Gulf South region to implant the Nanostim™ leadless pacemaker. Developed for patients with bradycardia the Nanostim™ device is placed directly in a patient's heart via catheter without the visible lump, scar and insulated wires (called leads) required for conventional pacemakers. This is the world's first retrievable, non-surgical pacing technology and is part of the LEADLESS II Clinical Trial.

In Louisiana and Mississippi, Ochsner is currently the only provider to offer this technology and is one of handful of sites in the United States certified to implant this device. Ochsner's first implant procedure was performed by Michael Bernard, MD,

HOSPITAL ROUNDS

Juan C. Duchesne, MD

Christopher J. White, MD

PhD and Sammy Khatib, MD, electrophysiology and pacing, at John Ochsner Heart & Vascular Institute and lead principal investigators for the study.

Thomas Appointed to MedPAC

Gene L. Dodaro, Comptroller General of the United States and head of the U.S. Government Accountability Office (GAO), announced the appointment of three new members to the Medicare Payment Advisory Commission (MedPAC), as well as the reappointment of two existing members and the designation of the Commission's Vice Chair. Warner Thomas, MBA, President and CEO of the Ochsner Health System, was one of the three new appointees. Joining him were Kathy Buto, MPA and Francis "Jay" Crosson, MD, Group Vice President, American Medical Association in Chicago. Their terms will expire in April 2017.

Congress established MedPAC in 1997 to analyze access to care, cost, and quality of care, and other key issues affecting Medicare. MedPAC advises Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for- service programs. The Comptroller General is responsible for naming new commission members.

Partnership to Increase Access for St. Charles

St. Charles Parish Hospital (STCH) and Ochsner Health System have announced an intent to expand their strategic relationship and build upon existing relations, expand services, and increase access to medical care. Working closely together since 2008, Ochsner and STCH will fully align to strengthen resources, enhance existing clinical services, and lower costs for the patients for whom they provide care.

Current services between the two entities include Ochsner's Telestroke program, Neurology services, and Primary Care services. Under the expanded affiliation Ochsner would provide management services to St. Charles Hospital and assist the local management team. However, the St. Charles Hospital Service District will continue to own the hospital and the Hospital Service District Board will continue to serve as the board of the hospital with all the same responsibilities for oversight.

Duchesne Appointed to LERN Regional Commission

North Oaks Medical Center Trauma Surgeon Juan C. Duchesne, MD, has been appointed to the Regional Commission of the Louisiana Emergency Response Network (LERN) for Region 9, effective May 15. Region 9 is comprised of five parishes, including Tangipahoa, Livingston, St. Helena, St. Tammany, and Washington.

Dr. Duchesne, who is certified by the American Board of Surgery in General and Critical Care Surgery, was nominated by the Louisiana Hospital Association and will represent hospitals with greater than 100 beds on the Commission.

The Regional Commission for Region 9 is comprised of 16 participating providers, including 11 hospitals and five EMS providers.

Ochsner Physician Receives Top Designation

Dr. Christopher J. White, Professor and Chairman of Medicine at the Ochsner Clinical School and System Chair of Cardiovascular Disease at Ochsner Medical Center, has been named to the inaugural class of Master Fellows of the Society for Cardiovascular Angiography and Interventions (MSCAI). SCAI is the professional medical society for adult and pediatric invasive/interventional cardiologists.

MSCAI is recognized worldwide for its commitment to quality and education for enhancing the care of patients who suffer from all forms of congenital and acquired cardiovascular disease. The MSCAI recognition acknowledges outstanding SCAI members for a career achievement of excellence in patient care, teaching, research, and innovation.

STPH Honors 5-Year Employees

St. Tammany Parish Hospital recently recognized employees who have been with the hospital for five years. Those recognized for the second quarter include:

Katherine Bulloch, Franklinton Family Practice; Wendy Castillo, Newborn Nursery; Clifford Darby Jr., Security; Christine Dugas, 2 East; Stephen Dupont, Building Services; James Fussell, Infusion Services; Shannon Jackson, Surgery; Tami Knight, Ambulatory Care; Nick Kohler, Environmental Services; Rachel Litchliter, Laboratory; Christin Morgan, Laboratory; Lori Northcutt, Surgery; Paul Owens, Security; Sonja Powell, Patient Financial Services; Melanie Solis; Home Health Care Services; Kenny Stockstill, Cath Lab; and Vicki Summerlin, Patient Financial Services.

Touro Celebrates Inaugural Leadership Series Class

The Paul S. Rosenblum Series, hosted by Touro Tomorrow, is an interactive six-week series that provides participants the opportunity to learn about Touro Infirmary and the Louisiana Children's Medical Center (LCMC). Participants interact with Touro Infirmary Administrators and LCMC leaders as well as staff, doctors, and supporters, about current healthcare issues and future hospital and system growth.

The inaugural class included 20 participants from various professional backgrounds and industries.

Rehab Hospital Outcomes Rank Near Top

North Oaks Rehabilitation Hospital has been nationally recognized as a 2014 Top Performer by the Uniform Data System for Medical Rehabilitation

Ochsner Presents 2014 Research Day Awards

On Ochsner's annual Research Day awards are presented for outstanding submissions from four groups of researchers. The Ochsner Alumni Association presents awards to the top three presentations by residents or fellows. The System Nursing Professional Development and Research present the Nursing Research Award, a rotating plaque that is engraved each year with the winner's name. Pharmacy leaders acknowledge the outstanding pharmacy submission. Faculty of The University of Queensland Ochsner Clinical School selects first, second, and third place winners from the medical student submissions.

Left: Karen Rice, DNS, APRN, ACNS-BC, ANP, (left) presented the Nursing Research Award to Anne Pirrone, BSN, CCRN for An Evidence-Based Approach to Creating a Restraint-Free Environment in the Pediatric Intensive Care Unit. Also acknowledged were Cynthia Boudreaux, MS, APRN, IBCLC (2nd place for Early Skin-to-Skin Contact and Exclusive Breastfeeding Rates), Jean Shiber, MN, RN-BC, OCN (3rd place for Reducing Central Line–Associated Bloodstream Infections Through the Addition of Disinfecting Port Protectors to the Central Line Bundle), and Raymond Egger, BSN, RN, CNRN (honorable mention for Stroke Central: An Innovative Approach to Coordinated Comprehensive Stroke Care).

Right: From left, Sohail Rao, MD, MA, DPhil, and Daniel Morin, MD congratulate the winners of the Ochsner Alumni Association Resident Research Award. First place was presented to Saima Karim, MD for Correlation Between Positron Emission Tomography Stress Myocardial Blood Flow and Ventricular Tachyarrhythmia or Death in Patients with Cardiomyopathy. The 2nd place winner was Kaustubh Shiralkar, MD (Improved Methodology for Calculating Hepatorenal Index), and 3rd place was awarded to Tariq Javed, MD (Repair and Regeneration of the Diabetic Kidney).

Presenting the Pharmacy Research Award to Ushma Patel, PharmD (center) for Cytomegalovirus Infection in Liver Transplant Recipients after Protocol Change to Universal Prophylaxis were Nicole Lacoste, PharmD (left) and Debbie Simonson, PharmD (right).

Ochsner Research Day 2014 Awards: University of Queensland, Ochsner Clinical School students recognized at Research Day for outstanding abstract/poster submissions were 1st place winner Asia Downing, MBBS (fourth from left) for Missed Opportunities for HIV Diagnosis in a New Orleans Area Health System, 2nd place winner Brian Reuter for Combination Therapy for Colorectal Cancer Metastasis Using an Orthotopic Xenograft Model, 3rd place winner Matthew Clark for Exclusion Criteria in Prehospital Stroke Screens Contribute to Their Insensitivity, and honorable mention for John Patrick Sisney for Enhanced Nanoparticle Delivery to in vivo Pig Skin. Also pictured (from left) are Jawed Alam, PhD; William Pinsky, MD; Sohail Rao, MD, MA, DPhil; and Murray Mitchell, DPhil, DSc (far left).

HOSPITAL ROUNDS

The Inaugural Paul S. Rosenblum Series Class of 2014 included: L to R front row: Samantha Wolf, Erica J. Washington, Dria Abramson, Arianna Baseman, Whitney Evans, Adrian Cohn, Clay Smith, Paul S. Rosenblum. L to R back row: Katy Mallios, Andrew Yaspan, Zach Kupperman, Sarah Bates, Renita Montegut, Keith Stenhouse, and Jon Brouk. Not pictured: Rebecca Atkinson, Samuel Berman, Eric Greenberg, MD, Jamelle Lacey, Stew Krane, and Harlan Schwartz.

(UDSMR), performing better than 90% of the hospitals in the U.S.

North Oaks Rehabilitation Hospital patients were found to make greater improvements faster, according to UDSMR 2013 data. The study looks at how patients improve in activities like memory; caring for one's self; eating, bathing and dressing; toileting and bladder control; and mobility, locomotion, navigating stairs, and transfers (e.g. moving from bed-to-chair, tub-to-shower and wheelchair-to-toilet.) The facility was compared to other hospitals in our region and across the nation.

Funds for Safety Grants Awarded to Hospitals

The 2014 Funds for Safety Grant Program awarded $300,000 in grants to 14 hospitals in Louisiana in May. The grant program is sponsored and funded by the Louisiana Hospital Association Trust Funds. The grants are given to hospitals for initiatives to improve patient safety or visitor safety.

The grant recipients were: Abbeville General Hospital, Allen Parish Hospital, Beauregard Memorial Hospital, Central Louisiana Surgical Hospital, Hardtner Medical Center, Lady of the Sea General Hospital, Lane Regional Medical Center, Natchitoches Regional Medical Center, Reeves Memorial Medical Center, Slidell Memorial Hospital, St. Helena Parish Hospital, St. James Parish Hospital, Union General Hospital, and Woman's Hospital.

New Ultrasound Machine at STPH Women's Pavilion

The St. Tammany Parish Hospital Women's Pavilion now has leading technology that can provide a supplementary scan for cancer in women with dense breast tissue. Automated whole-breast ultrasound does not replace the need for screening mammography, which is a highly effective cancer-screening tool, says Dr. Eva Lizer, STPH breast specialist. But painless, radiation-free whole-breast ultrasound can be used in tandem with screening mammography as an additional tool to find cancer in dense breast tissue, she says.

Breast density is determined by the amount of white that appears on a mammogram, not by the look or feel of the breast. Dense breast tissue shows up white on a mammogram. Cancer also appears white, lowering the sensitivity of mammography in women with dense breasts, Lizer explained.

West Jefferson Recognized for Interactive Patient Care

GetWellNetwork®, Inc., the leader in Interactive Patient Care™ (IPC) solutions, has announced West Jefferson Medical Center as one of the recipients of this year's IPC Awards, which recognizes healthcare leaders and organizations that have demonstrated improved clinical care and outcomes through the use of IPC technology. West Jefferson received the following IPC Awards:

World Class Service and Support

West Jefferson Medical Center received the World Class Service and Support award for implementing a collaborative support team to address hardware, software and configuration issues within four hours of being notified to help reduce patient disruptions.

IPC Champion

This award recognizes leaders within their organization and the IPC community, who, through their vision and commitment to patient-centered care, are having a profound impact on outcomes and the evolution of IPC technology. This year's IPC Champion is Michael Adcock, FACHE, senior vice president of Operational Support Services at West Jefferson Medical Center in Marrero.

River Parishes Introduces New PT Technique

River Parishes Hospital has announced a new, innovative technique that is now being performed in the Physical Therapy Department. The Graston Technique® uses instruments to allow the


Cynthia Polt


Greg Barker


Stephen Baldwin

clinician to isolate adhesions and restrictions, and treat them very precisely. Since the metal surface of the instruments does not compress as do the fat pads of the finger, deeper restrictions can be accessed and treated.

Benefits to the patient include: decreased overall time of treatment, faster rehabilitation/recovery, reduced need for anti-inflammatory medication, and resolved chronic conditions that were previously thought to be permanent.

Ochsner Achieves Top Honors from Healthgrades

Ochsner Medical Center and Ochsner Medical Center – West Bank* have received the Healthgrades 2014 Women's Health Excellence Award™ and the 2014 Patient Safety Excellence Award™, according to Healthgrades.

Healthgrades 2014 Women's Health Excellence Award™

This recognition distinguishes Ochsner Medical Center and Ochsner Medical Center – West Bank* as a top performing hospital in women's health for their outcomes for care provided to women for common conditions and procedures treated in the hospital. Ochsner, which has received this honor three years in a row, is one of only 178 hospitals recognized nationally and remains the only recipient of the Women's Health award in Louisiana for the second year in a row.

Healthgrades 2014 Patient Safety Excellence Award™

This distinction places Ochsner Medical Center and Ochsner Medical Center – West Bank* within the top 5% of all hospitals for its excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays. Only seven hospitals in the state of Louisiana were recognized; Ochsner's facilities in New Orleans and Baton Rouge were two of them.

**Ochsner's quality metrics include data from both Ochsner Medical Center and Ochsner Medical Center - West Bank Campus.


Dr. Eva Lizer with the new ultrasound machine at STPH Women's Pavilion

Lakeview Performs Robotic Gastric Sleeve Surgery

Lakeview Regional Medical Center announced it is the first and only hospital on the Northshore to perform robotic assisted gastric sleeve surgery. On June 6, 2014, Dr. Ruary O'Connell completed three robotic assisted sleeve gastrectomies. The gastric sleeve procedure is a surgical weight-loss procedure in which the stomach is reduced to about 25% of its original size by surgical removal of a large portion of the stomach along the greater curvature. The result is a sleeve or tube like structure. The procedure permanently reduces the size of the stomach.

Gastric sleeve surgery is generally performed laparoscopically, but Dr. O'Connell now uses the most advanced technology available to a surgeon by performing the procedures on Lakeview Regional Medical Center's da Vinci® Si System.

Touro Announces New Administrators

Touro Infirmary recently announced three administrative changes. New members of the Touro team include:

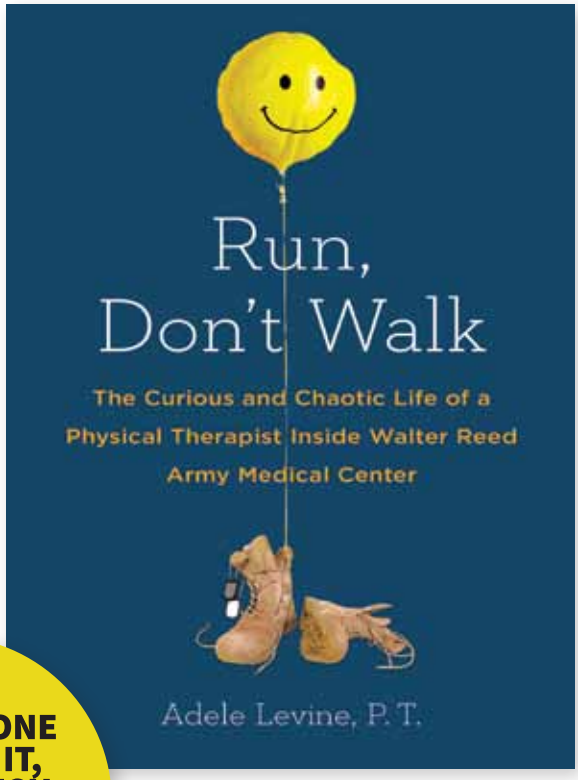
- Cynthia Polt, CPA, Chief Financial Officer at Touro Infirmary
- Greg Barker, Vice President, Operations
- Stephen Baldwin, Vice President, Operations. ■

bookcorner

REVIEWS BY THE BOOKWORM

It all starts with baby steps.

Baby steps, with arm-waving balance and shaky testing of foot on floor. You held onto the fingers of someone bigger and more experienced at that sort of thing, one foot in front of the other before you finally got the hang of it all.



by **Adele Levine, PT**
c.2014, Avery

You probably don't remember your first steps – unless it's your second chance to learn how to make them. In the new book "Run, Don't Walk" by Adele Levine, PT, you'll see how that can happen.

The call came at 0600. Sure that someone was dead (isn't it always the case with calls like that?) Adele Levine answered the phone and learned that she was being granted an interview for a job as a physical therapist in the amputee clinic at Walter Reed Army Medical Center.

Levine had gone to PT school because of "several depressing rounds of unemployment." PT had never been her "calling," and she didn't have big plans, other than to find a job close to her apartment. She figured that Walter Reed would be a temporary gig.

As it turned out, she loved the amputee clinic, and stayed for several years.

WHEN YOU'RE DONE READING IT, YOU'LL WISH YOU COULD READ IT AGAIN FOR THE FIRST TIME

Surrounded by glass walls "The Fishbowl" was complete chaos, a "nonstop party" with visitors, cookies, and bent rules. Double- and triple-amputees worked with therapists to learn to be ambulatory with new prosthetic devices, and other patients hung around as support. Because of the glass, visitors could see what went on but Levine says that the soldiers barely noticed. They were too busy meeting new challenges.

Sometimes, the challenges were Levine's.

Patients occasionally didn't cooperate with their treatment, and needed warnings, encouragement, or just more understanding. Others really didn't want to get better, finding the role of victim more appealing. Like most of her co-workers, Levine tried to create unusual ways to keep everyone – staff and patients alike – occupied, to keep them working on getting better, to keep them healthy in mind and body.

They did this, through personality clashes. They did it, while the injured never stopped coming. And they did it, though their clinic was closing in less than a year...

With a sense of irony, a dose of humor, and beaming pride, author Adele Levine gives readers entertainment and lessons that are both sweet and sad. Her anecdotes are peopled by soldiers whose lives have been forever altered, therapists who show them that those lives aren't over yet, and officers who offer support to both sides. This isn't necessarily some sunny, feel-good book, though: Levine is plain about pain, roadside bombs, f-bombs, frustrations, injury, and death.

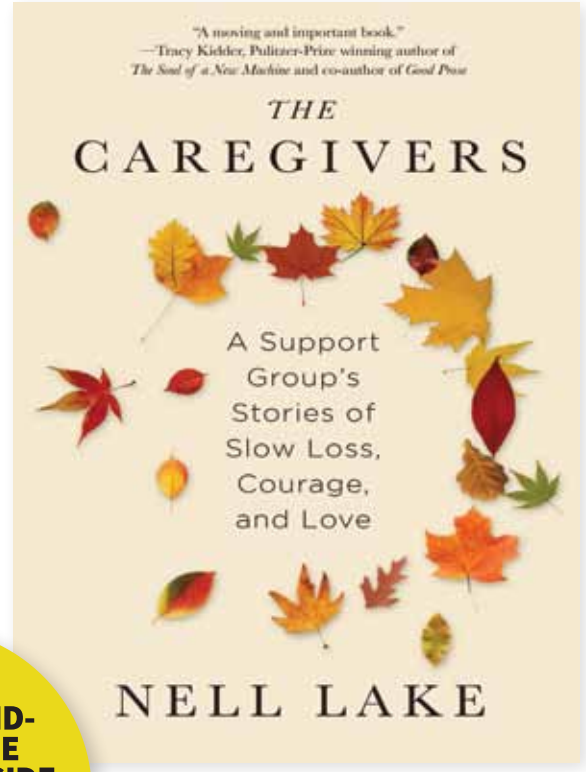
This is one of those true stories that, when you're done reading, you'll wish you could read it again for the first time. And how could you resist a book like that?

Really – you can't, so "Run, Don't Walk" is a book you should take steps to find. ■

For better, for worse.

You promised that once, and you meant it. For richer, for poorer was okay, too; you'd do it together. And over the years, that's how it happened... until you got to the last part.

In sickness and in health.



by **Nell Lake**
c.2014, Scribner

You hoped it would be more of the last part, less of the first, but life doesn't turn out like that. And in the new book "The Caregivers" by Nell Lake, you'll see how one group of spouses (and children) dealt with it.

Though her grandmother had never been demonstrative, Nell Lake knew the woman loved her. Hildegard was "elegant, German, unadorned, restrained," independent, strong-willed, and active. And when she found out that some pain she was having "could mean" cancer, she committed suicide.

Hildegard possessed dignity and grace while alive, Lake says, but she missed "the intimacy that may come with tending and being tended to" while dying. Fear of "the shadow part of life" followed Lake, too, so she decided to immerse herself in a "group of people living in that shadow." She joined a support group for caregivers of those with dementia and Alzheimer's.

ADVICE THAT'S SOLID-BUT-SUBTLE WRAPPED INSIDE ONE OF THE MORE POWERFUL STORIES YOU'LL EVER READ

Eighty-eight-year-old Daniel suffered from recurring cancer while caring for his much younger wife; she was depressed, bi-polar, and had myriad other severe health issues. William married the love of his life shortly after World War II, then watched as she was overtaken by dementia. Liz struggled with guilt for putting her abusive husband in a veteran's home due to his Alzheimer's. Inga, who'd cared for and lost a daughter, aunts, and both parents, was caretaker for her partner, Louise, who was recovering from multiple surgeries. Rufus tended a friend who'd died, but kept returning to the group anyhow. And Penny, who's featured most in this book, cared for her mother with humor, good-natured teasing, frustration, and the sometimes-surprising support of her siblings.

Throughout the year, there was sadness and loss but "Moments of loveliness arise," too. Taboo subjects were tackled, and friendships formed. And through it all, group members learned to grieve someone who was gone, but who was still around...

I struggle with what to say about "The Caregivers" because, truthfully, it made me so profoundly sad.

And yet, I know there's comfort in what author Nell Lake has to say, as well as advice that's solid-but-subtle wrapped inside one of the more powerful stories you'll ever read. Lake brings each of her pseudonymous subjects alive so well that when they're stricken, we're also stricken - and there's a lot of that in this book.

What made me stick with it, though, I think, is the compassionately wistful sweetness mixed with resigned, gotta-keep-moving outrage that's here. Lake's ability to repeatedly remind us of the former is like a gentle slap. The latter, however, is why you'll keep reading.

For Boomers who are squinting into the future, or anyone who's already in a caregiving position, bring tissues and find this book. I'm not sure I'd call it light reading, but "The Caregivers" might make you feel better. ■

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