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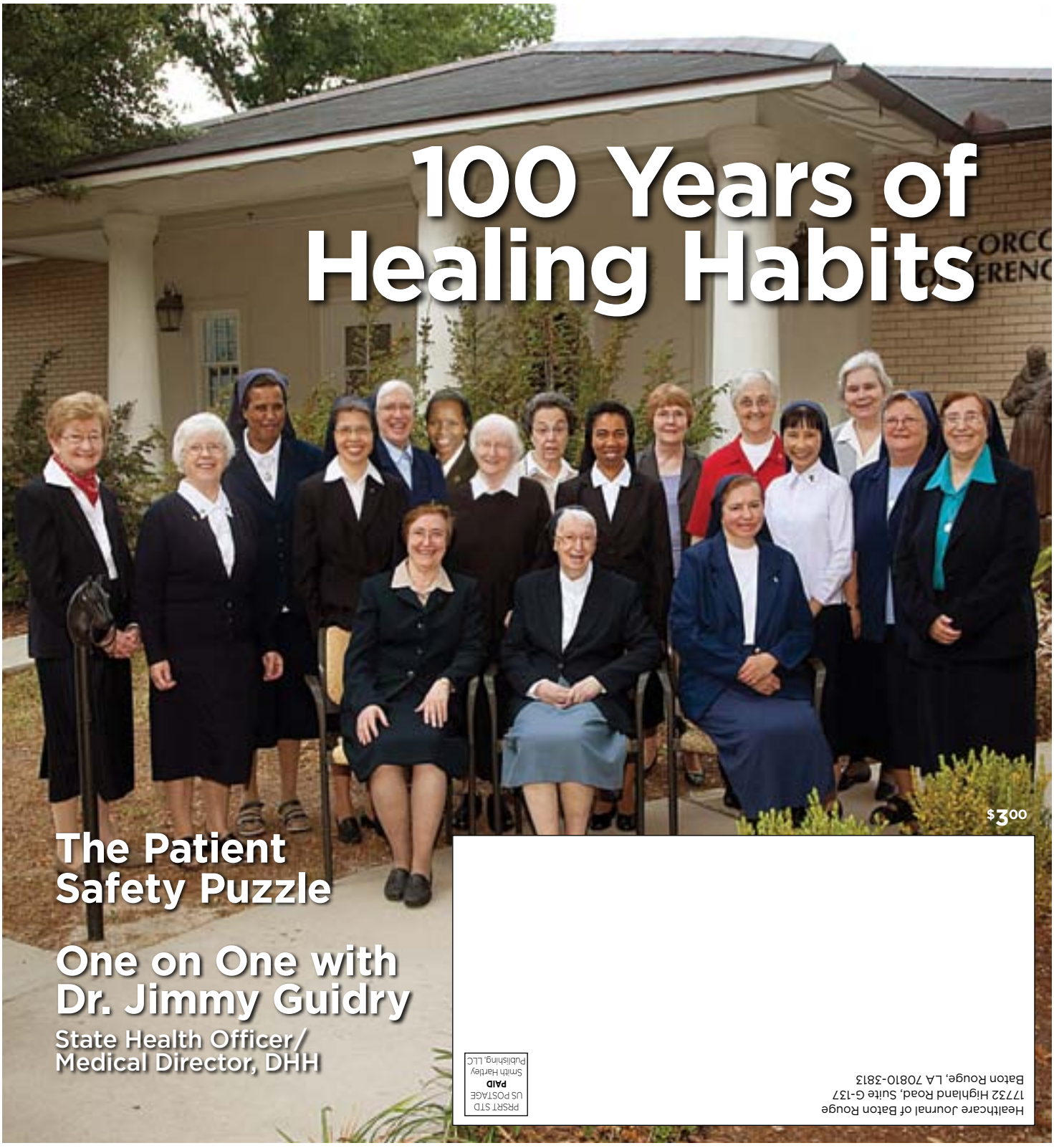

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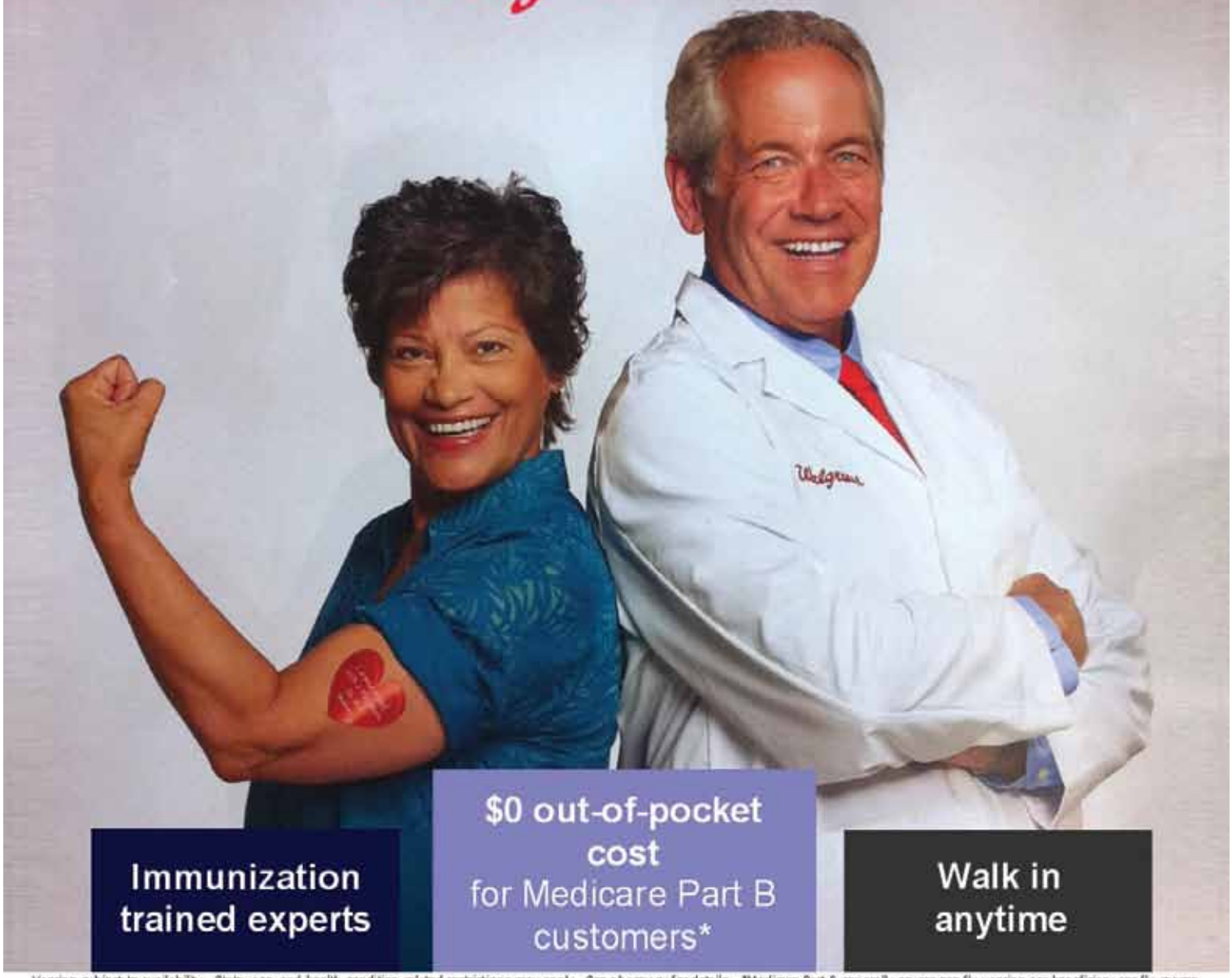

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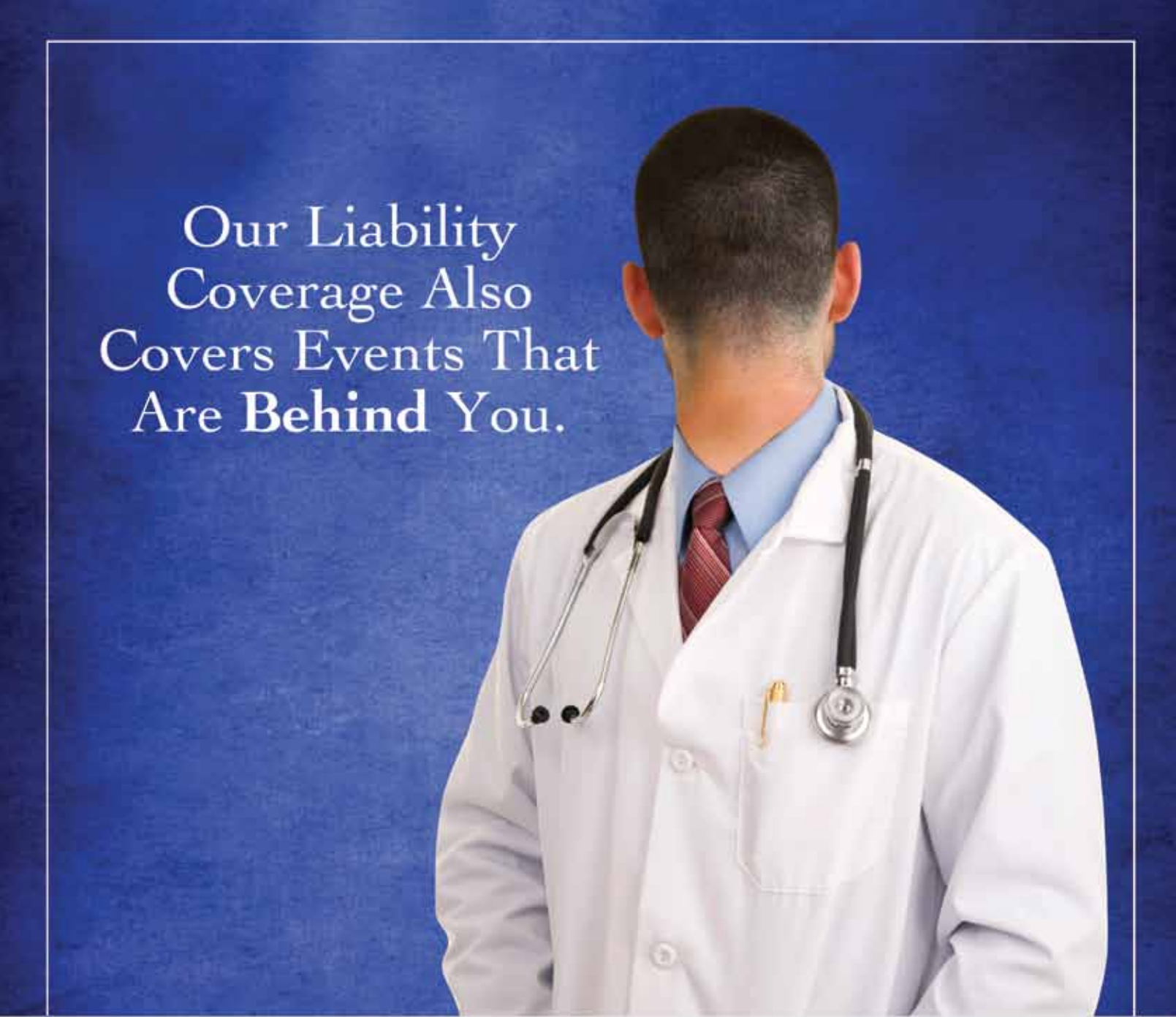

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SEPTEMBER / OCTOBER 2011

Inside

ON THE COVER:
SITTING FROM LEFT TO RIGHT: Sr. Kathleen Cain, Sr. Brendan Mary Ronayne, Sr. Mary Ann Sepulvado
1ST ROW STANDING FROM LEFT TO RIGHT: Sr. Betty Lyons, Sr. Helen Cahill, Sr. Ann Catherine Nguyen, Sr. Lilian Lynch, Sr. Getu Petros, Sr. Uyen Vu, Sr. Martha Ann Abshire, Sr. Margarida Vasques
2ND ROW STANDING FROM LEFT TO RIGHT: Sr. Margaret Abaga, Sr. Barbara Arceneaux, Sr. Mazgiya Ageto, Sr. Rita Lanie, Sr. Eileen Rowe, Sr. Vernola Lyons, Sr. Penny Prophit

> The patient does not care about **your science;** what he **wants to know** is can you **cure him?**
>
> –MARTIN H. FISCHER

Greetings,

Healthcare Journal of Baton Rouge has never made the claim of "medical journal." We've published some medical and scientific research, but I've always been optimistically skeptical about any research's scientific process. Apparently, I'm not alone in my concerns and these concerns are substantiated. A recent *Wall Street Journal* article provided an interesting account of the surge of mistakes in scientific studies reported in the usually credible medical journals.

To properly conduct scientific studies requires extensive peer-review. This peer-review process, however, needs to come under better scrutiny. According to Thompson Reuters Web of Science, an index of 11,600 peer-reviewed journals, the number of retracted published papers is up 15-fold since 2001.

England's *The Lancet* has come under notable fire for retractions ranging from the MMR vaccine and its link to autism to their well-publicized study called "Corporate" on combining ACE inhibitors with a drug called ARB to reduce blood pressure while minimizing kidney damage. Later the study was called "the result of fraud or incompetence" by Dr. Horton, *The Lancet's* editor.

With so much private and government money invested in research, the pressure to produce results is intense. Researchers know the prestige and perks that come from significant published findings. However, this pressure may have swung the pendulum too far, resulting in mistaken or manufactured findings published in the most respected journals.

The Lancet, New England Journal of Medicine, JAMA, etc. are all rightly considered excellent resources of scientific findings. But, as medical providers, one must always consider the real possibility that sometimes the studies are somewhat flawed or just outright wrong. These trusted sources, in my opinion, still remain trusted. I am just suggesting cautious consideration and keen judgment with your own instincts is a healthy approach to any research.

Insist that your scientific sources hold to the highest scientific standards of protocol and peer-review. As we all know, the information we have is often our patients' greatest asset.

Smith W. Hartley
Editor-in-Chief

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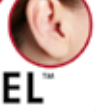
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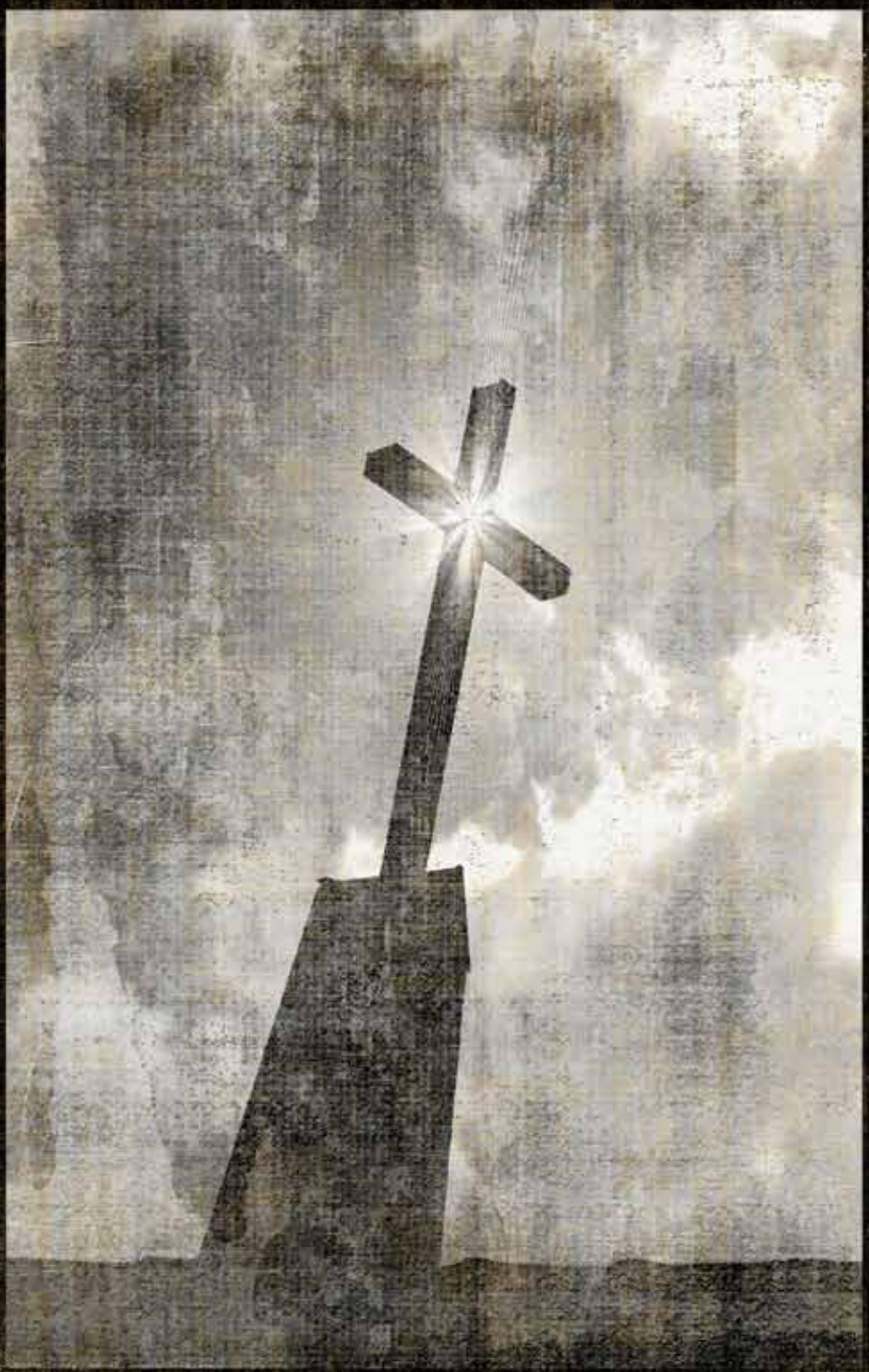


"At any one of those times when this nation was having difficulties we could have said enough is enough. We could fold up very easily and get out of healthcare today. We would be smart to do that, but 'no' is not part of our vocabulary."

FMOL: Six Sisters AND A Century OF Healing

BY KAREN STASSI

Precisely one hundred years ago, six nuns sailed from France toward a new life. At the request of the clergy in North Louisiana, the Sisters, members of the Franciscan Sisters of Calais congregation, had been assigned to provide healthcare to rural Pineville. While the assignment might seem unusual, the United States was, and still is, considered a mission for the French order, established in 1854 from an amalgamation of seven different Franciscan communities.

Other than modeling their lives after St. Francis, the congregation had no specific ministry. They simply responded to needs in their community and their missions around the world, operating orphanages, schools, clinics, and hospitals, or carrying out social work and other parish work. >>

So, speaking little English and possessing scant knowledge of the climate, landscape, and culture, these six brave Sisters, clad in wool habits, arrived in Monroe on September 30, 1911. A local priest, Father Enaut, bid them good luck in Pineville, but asked them to return to Monroe if all did not go as planned. Perhaps he knew something of the situation, because it did not. Although the original assignment was to work with a local physician to establish a hospital in Pineville, misunderstandings surfaced almost immediately and just a few weeks later the Sisters found themselves back in Monroe.

While French speaking Catholics might not have been an oddity in South Louisiana in 1911, they certainly were in North Louisiana, not to mention French-speaking nuns. However, need soon trumped curiosity and suspicion and the Sisters ministered to the sick through visits to patients' homes. "Even today, in the Baptist belt they might still believe that maybe we're using witchcraft, but if you are sick and someone's helping you and comforting you, you kind of overlook a lot of that," said Sr. Kathleen Cain, provincial of the Franciscan Missionaries of Our Lady. The nuns' pay, from those who could afford it, came in the form of chickens and eggs. True to the agreement that brought them there, the Sisters asked for nothing for themselves. Eventually, with a gift of land and $50,000, the Sisters were able to establish the St. Francis Medical Center in Monroe. For some, the mission would appear to be complete, but not for these ladies.

Not long after the Monroe hospital was up and running, an accident occurred in South Louisiana and the absence of a Catholic hospital in the area was noted. The Sisters were asked by Monsignor Francis Leon Gassler and area physicians to come and look at property and consider establishing a Catholic hospital in the state capital. Initially, the plan was to build on the spot currently occupied by Rabenhorst Funeral Home downtown. However, Mother Marie de Bethanie Crowley pointed instead to an old mule yard and briar patch near what is now Capitol Lake and declared that to be the spot. In 1923 the Sisters established a new four-story, 100 bed hospital there, appropriately dubbed Our Lady of the Lake Sanitarium. The facility, which cost just $250,000 to build, was greeted on opening day by more than half of the Baton Rouge population.

Over the next several years, the nuns at the hospital by the lake witnessed and were part of some of the most colorful days of Louisiana and American history. When Governor Huey Long was shot in the hallways of the new State Capitol in 1935 he was rushed to nearby Our Lady of the Lake, but he could not

LEFT: Mother Henrietta Didesse, the second administrator of Our Lady of the Lake. **AT RIGHT:** Nurse Pinning ceremony. Miss Margaret Casper receiving the Mother de Bethanie Award from Sister Rita.

"The Sisters knew they couldn't do everything themselves. There weren't enough of them and that's how we came to have a school of nursing."

be saved. Legend has it that one of the Sisters in the surgical suite pocketed the bullets removed from the Governor, but the secret of what Sr. St. Michael did with them died with her.

Sometime in the 1940s, a priest in Lafayette was involved in an accident. Wishing to be treated in a Catholic hospital he was brought to Our Lady of the Lake in Baton Rouge. Once again the Sisters answered the call, recognizing that Lafayette, too, could use a Catholic hospital. In 1949 Our Lady of Lourdes was built. "That's how we came," said Sister Kathleen. "It was always responding to a need."

The 1940s also brought changes to the Sisters' congregation, the Franciscan Sisters of Calais. The blitz bombing of World War II destroyed their home in Calais, eventually driving the Sisters to Paris. With the move came a name change to better reflect both their calling and their new home. "Obviously 'Franciscan' because we are following the role of St. Francis, but also 'Missionaries' because that's the spirit of the congregation. And then Our Lady of the Blessed Mother which was always very important in our life," said Sr. Kathleen. The new name, Franciscan Missionaries of Our Lady, is the one we now associate with Louisiana's largest health system.

As the Sisters built hospitals, they remained integrally involved in running them, but also recognized that they couldn't do it all. Schools to educate both nuns and lay people as nurses were established along with each hospital to keep them staffed. In 1919 one of the Sisters graduated from the school of nursing in Monroe. In 1926, Sister Marie Madeleine Lemoine was in the first graduating class of OLOL's nursing school. "The Sisters knew they couldn't do everything themselves. There weren't enough of them and that's how we came to have a school of nursing," said Sr. Kathleen. Now that commitment to medical education has grown to include not only nursing schools, but also allied health and expanding graduate medical education through a partnership with LSU.

By the 1970s, Our Lady of the Lake had outgrown its space and a decision was made to rebuild in a new location. Once again, Mother Gertrude Hennessy defied common wisdom and announced the new hospital would be built on a small road called

Essen Lane on the outskirts of town. "When we moved out here to Essen Lane, they told Mother Gertrude at that time, 'You're a foolish lady, there's no way OLOL is going to make it out in the boondocks. You're way too far out of town,'" said Sr. Kathleen. "But the women who first came here were very, very visionary. They knew what they wanted, they had great faith." Now, laughs Sr. Kathleen, people blame OLOL for the heavy traffic on Essen Lane, "But we were the first ones out here. It wasn't us." The new six-story Our Lady of the Lake Medical Center opened in 1977.

In the early years, it seemed the circumstances chose the Sisters, rather than the other way around, but each time FMOL responded and each time the communities rose up to support them. "I think religious communities who have been missionaries, in my experience, while they are active in the community, they really are there to serve and the people respect that," said Franciscan Missionaries of Our Lady Health System (FMOLHS) President and CEO John Finan. "They are not trying to influence politics or get engaged in local battles, they're really just there to serve the people. As a result, that generates a lot of community support and respect."

Some of that respect also comes from the fact that the Sisters, both then and now, are a formidable force. Stories are still told about Sr. Julie who had a degenerative eye condition. Despite her impaired sight, she could tell though hearing and touch when a patient in the nursery was in distress. "The pediatricians said when she called and said, 'you need to come,' they knew they needed to go," said Sr. Kathleen. Mother Gertrude worked in the operating room and not only kept the surgeons on their toes, but was known to make them blush. She was also said to begin directives to Finan with, "John, wouldn't it be nice if..." According to Sr. Cain, that really translated to, "John, figure it out and get it done." Then there was Sr. Liguori in Monroe who held an angry lynch mob at gunpoint to protect her patient. The sheriff had handed his gun to her and skipped town to avoid the confrontation. "Sr. Liguori once belonged to the Irish Republican Army," said Sr. Kathleen. "You didn't fool with her."

Then there was Sr. Liguori in Monroe who held an angry lynch mob at gunpoint to protect her patient. The sheriff had handed his gun to her and skipped town to avoid the confrontation.

She might deny it with a twinkle in her eye, but nobody fools with Sr. Kathleen either. With advanced degrees in business and law, she not only knows her stuff, but she knows her mind. Questions posed to the health system are sometimes simply answered with, "Because Sr. Kathleen wanted it that way." But the Sisters do not operate in isolation. Although FMOL and FMOLHS are two separate corporations, the congregation sponsors the health system. And, while the Sisters are for the most part, no longer engaged in the day-to-day operations of the hospitals, they remain very involved in the vision, planning, and discussions with the board and leadership about the strategies used to achieve their mission. "We've got this idea. Finan figures out how to do it," laughs Sr. Kathleen, sounding a lot like Mother Gertrude.

While FMOLHS is not the only health system sponsored by a religious order, it is perhaps unique in that the corporate headquarters are located within the provincial house or convent. Finan thinks the arrangement is key to keeping the health system's mission top of mind. "We are a ministry of the church first. We don't exist for the commercial reasons. We just have to live in the commercial world because that's where the ministry happens to be," said Finan. "The fact that we have more than 10,000 team members, and $1.4 billion in net revenue, 1900 physicians on our staffs, 25 joint ventures, we're in all these multiple markets, all that's interesting from an MBA standpoint, but it's not why we are here." OLOL CEO Scott Wester also believes the constant interaction of health system leadership with the Sisters keeps everyone on mission. "Through the stewardship of our Sisters and our partners on our boards they've educated us really on how we should act and behave in accordance with the mission and the values of what the Sisters want us to do."

ABOVE: Sisters on stairs at the original Our Lady of the Lake Sanitarium in the 1950s. **RIGHT:** Sister Julie O'Donovan, OSF, working on the pediatric unit at Our Lady of the Lake. Pediatrics was her main ministry.

Sr. Kathleen believes that's what makes patients feel different when they step into an FMOLHS facility. "It's not that the other hospitals aren't good, but hopefully you'll feel the difference because of who we are and who our team members are. I truly believe that they embrace what we are doing. They've accepted our way of life, not the vowed life, but our way of doing business. We are very Franciscan in how we operate our system, with an emphasis on caring for those most in need. We look at the bottom line, but we also look at how much community benefit are we providing, how much care to the poor are we actually giving? Are we doing services simply because they make money or is there really a need?" she explained. "I have a business background. The more money we make the better I feel, the more comfortable I feel, but the flipside is it's not the only

ABOVE: L-R: Sister Linda Constantin, OSF; Sister Edana Corcoran, OSF; Vivian Frey, OLOL employee.
TOP LEFT: Franciscan Missionaries of Our Lady North American Province, Provincial and Provincial Councilors. L-R: Sr. Barbara Arceneaux, OSF, Provincial Councilor; Sr. Kathleen Cain, OSF, Provincial; Sr. Margarida Vasques, OSF, Provincial Councilor; Sr. Martha Ann Abshire, OSF, Provincial Councilor.
BOTTOM LEFT: L-R: Sr. Vernola Lyons, OSF; Sr. Helen Cahill, OSF; Sr. Ann Catherine Nguyen, OSF.

scenario. That's a little bit different from some of the other entities out there."

The transition to a health system scenario began once Sister Brendan Mary Ronayne took over as provincial and FMOLHS was established in 1984. Our Lady of the Lake had become the largest of the institutions and Mother Gertrude had established the provincial house on Essen Lane, so Baton Rouge became the logical headquarters for the health system. In 1996, John Finan became the first lay CEO of FMOLHS, taking over from Sr. Brendan Mary. However, the Sisters were ahead of their time in hiring lay administrators for their hospitals. In 1967 Mother Gertrude Hennessy, provincial of the Franciscan Order and administrator of Our Lady of the Lake Medical Center handed over the reins of the hospital to J.B. Heroman. Most Catholic systems did not follow suit for another 10-20 years. "We were one of the first congregations in the country to bring lay leadership in," said Sr. Kathleen. "We knew, based on our size, that we needed to develop lay people."

The Sisters have had no problem recruiting lay people to buy into their mission, but recruiting young women to join their congregation has been much harder. The recruiting of priests and nuns has struggled in the era of smaller families and

increased options for women. It is even harder when you are limited to healthcare, said Sr. Kathleen. "Teaching congregations at least have contact with young women. With us, unless you are a student nurse, we just have incidental contact." The congregation has strengthened its ranks with international recruits; the last two Sisters came from Ethiopia. Within the Baton Rouge house they have Vietnamese, Ethiopian, Irish, and American Sisters. In the past they have also had French and Brazilian nuns. "And Cajun," added Finan, laughing. There are currently just 18 Sisters in the North American province of FMOL; thirteen in Baton Rouge, three in Monroe, and two in Lafayette. Over the years they have served the hospitals as nurses, finance people, administrators, pharmacy techs, pastoral care, and more. The province also operates a mission in Haiti. Internationally, the Franciscan Missionaries of Our Lady number fewer than 500 and can be found in 18 countries.

Despite their small numbers, their accomplishments have been extraordinary and not without sacrifice. Most of the Sisters who came from other countries to minister to those in need have stayed here, often with limited visits to their own families and countries. "These were women that made incredible personal sacrifices to be here, especially the ones that came from Europe. They didn't go home for years," said Finan. Some, like Sr. Maggie spent 10-20 years here before returning to visit families that had sprouted a whole new generation in their absence. Eventually the nuns were granted permission to return home every three years.

"You look at 1911 with the original Sisters coming and opening a hospital in 1913, then World War I started. We come down here to Baton Rouge, we open up another hospital, and we go into the Depression. When we opened Our Lady of Lourdes we had the Korean War right afterwards," said Sr. Kathleen. "We could have folded at any one of these times and we didn't. We found ways to keep the doors open. We quit opening a lot of hospitals because we got tired of all these wars!" she joked. Yet, they didn't stop. In addition to building a new hospital on Essen Lane and numerous clinics and residences for those is need, FMOLHS acquired St. Elizabeth Hospital in Gonzales in 2000. "It was a great opportunity for the Sisters and for the health system to extend its ministry into the Ascension market," said Wester. "But I think more importantly, what we've received back from the people at St. Elizabeth was so contagious about how we should act and behave with each other and with our patients." Most recently, FMOLHS has been contracted to manage the hospital going up in St. Bernard Parish and selected to manage the old Methodist hospital in New Orleans East, which the city owns and will reopen as a Hospital Service District hospital. Both Finan and Sr. Kathleen acknowledged that it was never a plan to venture into the New Orleans market, but when they saw the need post-Katrina, they felt compelled to get involved.

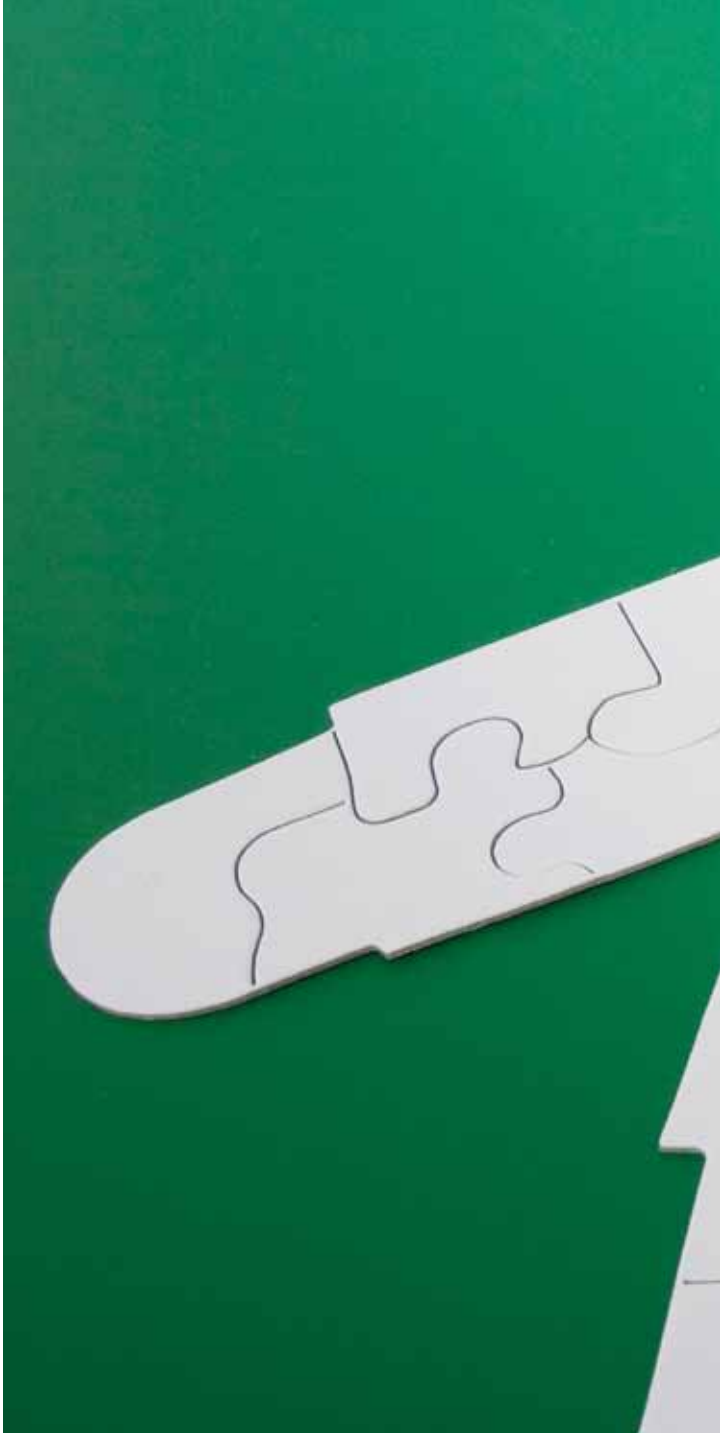
"At any one of those times when this nation was having difficulties we could have said enough is enough. We could fold up very easily and get out of healthcare today. We would be smart to do that, but 'no' is not part of our vocabulary," said Sr. Kathleen. "Our older sisters, the Gertrudes, the Corcorans, the O'Donovans, these women worked hard. They had an extremely deep spiritual faith life and 'no' was not in their vocabulary. When you look at our staffs, and our hospitals, and our leadership within our systems, it's the same thing today."

"We are very Franciscan in how we operate our system, with an emphasis on caring for those most in need."

Sr. Kathleen said the Sisters' plan is to continue to strengthen their foundation and the education of their lay counterparts. "We are 10,324 now. That's a lot of people when you realize we started with six Sisters who ran the whole hospital. We are at a totally different perspective but we believe in the ministry and we hope that's part of what the next 100 years is going to bring about: stronger and stronger lay commitment to our values," said Sr. Kathleen. "We don't have the same visionary women as we did in the past so we take what we have. We will be here a hundred years from now." **<<**

The Patient Safety Puzzle

BY KAREN STASSI



A little over a decade ago the Institute of Medicine (IOM) published a report called "To Err is Human: Building a Safer Health System." The report highlighted the shocking fact that 44,000-98,000 people died in the U.S. each year due to largely preventable medical errors; a number exceeding deaths by motor vehicle accident, breast cancer, and AIDS.

While quality improvement was already a hot topic in healthcare, the IOM report blew it out of the water, calling for a 50% reduction in medical errors in the ensuing five years. It was a catalyst for sweeping change and a myriad of initiatives tightening the focus on patient safety. Now it is hard to talk about quality without patient safety foremost in the discussion. It gets top billing over financial matters in hospital boardrooms across the country. Healthcare facilities have revamped their processes and thrown millions of dollars at the problem. Yet, according to some analysts, the improvements in patient safety are less than inspiring.

The number of wrong site surgeries appears to have risen. There are still hundreds of thousands of medication errors annually,

leading to more than 750,000 injuries and deaths. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days. The Centers for Disease Control (CDC) estimates that approximately 1.7 million healthcare-associated infections occur each year and lead to 99,000 deaths. According to the National Quality Forum (NQF), medical-related harm is now the third leading cause of death. In a recent Joint Commission podcast, Jerod Loeb, PhD, Executive Vice President, Division of Healthcare Quality Evaluation, said, "There is an epidemic yet of serious and predictable adverse events. In fact the risk of errors that lead to harm is increasing..."

Not only are the loss of life and disabilities resulting from adverse events intolerable, they are also costly. The NQF reports that costs associated with medical harm are estimated to range between $17 billion to $29 billion when healthcare expenses, lost productivity, income, and disability are all taken into account. "We spend $2.7 trillion in this country on healthcare," said Kenneth Phenow,

(FIGURE 1)

HOSPITAL VALUE-BASED PURCHASING PROGRAM FISCAL YEAR 2013

CLINICAL PROCESS OF CARE MEASURES

Acute Myocardial Infarction

- Aspirin Prescribed at Discharge
- Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
- Primary PCI Received Within 90 Minutes of Hospital Arrival

Heart Failure

- Discharge Instructions
- Evaluation of LVS Function
- ACEI or ARB for LVSD

Pneumonia

- Pneumococcal Vaccination
- Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
- Initial Antibiotic Selection for CAP in Immunocompetent Patient
- Influenza Vaccination

Healthcare-associated Infections

- Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
- Prophylactic Antibiotic Selection for Surgical Patients
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Surgical Care Improvement

- Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
- Surgery Patients Who Received Appropriate Venous Thromboembolism
- Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

PATIENT EXPERIENCE OF CARE MEASURES

HCAHPS - Hospital Consumer Assessment of Healthcare Providers & Systems Survey

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Pain Management
- Communication About Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital

MD, Chief Medical Officer at Blue Cross and Blue Shield of Louisiana (BCBSLA). "That's twice as much as any other developed country in the world and our quality does not reflect the amount of resource we put into healthcare." So what on earth is going on?

While the experts are still scratching their heads, theories include the fact that healthcare has gotten more complex and increasingly fragmented leading to more opportunities for miscommunication and dropped balls. Tighter time constraints and new technologies may make us prone to distraction. Others believe that with so many outpatient healthcare options available to us now, the patients who actually end up in the hospital are the ones who are seriously ill and sicker patients are more likely to experience adverse outcomes. Whatever the reason, the fact remains that we are failing. Not everyone of course. The Joint Commission acknowledges that there are pockets of excellence across the country. In Michigan, for example, central line associated blood stream infections (CLABSI) were reduced to almost zero in just a year and a half. Proof that it can be done with the right tools, the right focus, the right level of commitment.

Patient safety has long been a focus of the Joint Commission. In addition to providing patient safety measures required for accreditation, since 1995 the Joint Commission has required that hospitals report sentinel events, defined as an "unexpected occurrence involving death or serious physiological injury or the risk thereof." The Joint Commission also considers as sentinel events the 28 "never events" designated by the NQF. Those "unambiguous, preventable events that result in death or serious disability" include items such as wrong site surgery, use of contaminated equipment, medication errors, patient abduction, and falls. A complete list can be found at the National Quality Forum website at www.qualityforum.org. What is startling about both the never events and the patient safety goals provided by the Joint Commission and reinforced by other organizations and initiatives is that, for the most part, they seem so intuitive, so straightforward. And any given hospital will be quick to detail the changes they have made and continue to make to ensure their patients have a safe experience. Yet somehow it hasn't been enough and we are still tackling the same issues the IOM highlighted more than ten years ago.

It's not for lack of effort or desire, said Ken Alexander, Louisiana Hospital Association (LHA) Vice President of Quality &

Regulatory Activities. "Everybody is trying to give the best care possible, bottom line. Performance improvement isn't new to hospitals. It's been out there a long time. It's are we measuring, are we benchmarking, are we knowing how we are doing? I think that's where hospitals to a large extent were–maybe not looking and focusing and measuring the right things." The consensus seems to be that most adverse events stem from process and system breakdowns in hospitals, not from a lack of skill, education, or care by providers. However despite all the goals and checklists being implemented and all the focus on seemingly common sense practices, errors are still occurring. "The problem is a lot of those things are so routine that you take them for granted," said Alexander. "You just assume you are doing it until you stop and analyze." Patient safety goals need to be kept top of mind and in focus, he urged. "When we get busy with life and all of that stuff, you may not focus and attack it in that systematic, process-oriented way."

While the reasons medical errors have been so hard to eliminate may still elude us, the fact is, when the numbers of adverse events weren't dropping the way they had anticipated, the federal government started to take notice. In 2007 the Centers for Medicare and Medicaid (CMS) announced it would no longer pay for additional costs associated with many preventable errors including never events. As the largest payer, CMS tends to serve as a model for other payers, and true to form, many private insurers, like Blue Cross and Blue Shield of Louisiana, have followed suit and now do not pay for never events. "What has happened is without the government and payers being able to see the kind of widespread results they had been looking for, they have felt they need to incent or disincent this," said Richard Vath, MD, VP of Medical Affairs at Our Lady of the Lake Regional Medical Center (OLOL). "My personal belief is that will get the attention of the other players that weren't really on board with this idea. It will get them to begin playing hopefully at the level that we've been playing for some time. It's a little disappointing that that's what it took, but I think that's what we are seeing right now." Phenow thinks that while the initial call to improve patient safety came from academic circles like IOM, "Over the last ten years the siren has been sounded and there's been a lot of work done to try to reduce those medical errors at the hospital, driven to a large degree by payers," said Phenow. Not only are private payers like BCBSLA, United Healthcare, and Cigna pushing it, but also CMS, said Phenow.

"Over the last ten years the siren has been sounded and there's been a lot of work done to try to reduce those medical errors at the hospital, driven to a large degree by payers."

—KENNETH PHENOW, MD, BCBSLA

"And now, as we move into the era of managed care in Medicaid, we're going to see it in Medicaid as well."

"It's difficult to talk about which ones we shouldn't get reimbursed for and which ones we should," said Vath, who explained that OLOL adopted some best practices that called for contacting the patients and considering the financial impact when adverse events occurred. The hospital reviews events on a case by case basis, said Vath, but, "Now it's kind of taken out of our hands because CMS has pretty much laid the groundwork and all the payers are jumping on board in terms of Healthcare Associated Conditions." Phenow confirmed that BCBSLA followed CMS' lead in not paying for never events, and is beginning to tie reimbursement more closely to quality. Last year, said Phenow, BCBSLA instituted a type of pay for performance program where, when hospitals ask for increases, they are tied to quality improvement benchmarks. "We give the hospitals a choice of four different safety items to focus on: central line associated infections, using surgical checklists every time they operate, reducing the number of C-sections performed, and reducing the rate of pre-term inductions between 37-39 weeks," said Phenow. "Hospitals have a choice of which ones they want to take on and they are paid a certain amount if they are able to show improvement over time."

(FIGURE 2)

PROPOSED QUALITY MEASURES FOR FISCAL YEAR 2014

Mortality Measures:
- Acute Myocardial Infarction (AMI) 30-day Mortality Rate
- Heart Failure (HF) 30-day Mortality Rate
- Pneumonia (PN) 30-Day Mortality Rate

Hospital Acquired Condition Measures:
- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)
- Vascular Catheter-Associated Infections
- Catheter-Associated Urinary Tract Infection (UTI)
- Manifestations of Poor Glycemic Control

AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures:
- Iatrogenic pneumothorax, adult
- Post Operative Respiratory Failure
- Post Operative PE or DVT
- Post Operative wound dehiscence
- Accidental puncture or laceration
- Abdominal aortic aneurysm (AAA) repair mortality rate (with or without volume)
- Hip fracture mortality rate
- Complication/patient safety for selected indicators (composite)
- Mortality for selected medical conditions (composite)

While CMS has also tied reimbursement to quality through incentives and disincentives for reporting, implementing EHRs, reducing readmissions, etc., they will ramp up those efforts in 2013. Required by the Affordable Care Act of 2010, CMS' new value-based purchasing program for acute care hospitals will make incentive payments to hospitals based on their achievement or improvement on both clinical and patient experience measures. The intent is to transform Medicare from a passive payer of claims based on volume of care to a purchaser of care based on the quality of services beneficiaries receive. The quality measures CMS proposes to use for the FY 2013 hospital value-based purchasing program can be found in *Figure 1*. In 2014, CMS proposes to adopt three mortality outcome measures, eight Hospital Acquired Condition (HAC) measures, and nine Agency for Healthcare Research and Quality (AHRQ) measures for the Hospital VBP program (*Figure 2*).

When CMS first started with their core measurement program, they gave hospitals the option of reporting or not reporting data, said Phenow. Then they started paying hospitals for reporting. Now in 2014, hospitals will have to pay for not reporting. It's a typical regulatory cycle for CMS and private payers are following their example. "That's the way CMS has done it and frankly that's the way we're going to do it," said Phenow. "We've started by offering a little bit of a bump in their rates if they start reporting this data and showing improvement. Then over time that program will become more robust and there will be a greater percentage tied to performance. Eventually we won't reimburse them if they aren't performing to a certain degree." Hospitals are going to inherently listen to the people who write their checks so they can continue to be hospitals, said Alexander. "It's not their only focus, the only thing they're looking at, because there's all kinds of stuff they can involve themselves in, but they are going to make sure that whatever they are involving themselves in, it's targeted to whatever CMS says, because that involves their participation in Medicare, whatever the state Medicaid program says, because that's their participation in Medicaid, and it's whatever the Joint Commission says."

This April, with funding from the Affordable Care Act, the U.S. Department of Health and Human Services (HHS) launched the Partnership for Patients, a public/private partnership engaging all stakeholders to work on these common goals:

- Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Achieving these goals will not only save lives and prevent injuries to millions of Americans, it has the potential to save up to $35 billion dollars across the health care system, said HHS, including up to $10 billion in Medicare savings, over the next three years. HHS anticipates that over the next ten years, it could reduce costs to Medicare by about $50 billion and result in billions more in

Medicaid savings. While the Partnership for Patients is pursuing the reduction of all-cause harm, there are nine areas of focus:

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism (VTE)
- Ventilator-Associated Pneumonia (VAP)

At last count, 2000 hospitals and more than 4000 organizations had joined the initiative, including the Louisiana Hospital Association and area hospitals. Some were already working on areas targeted by the Partnership for Patients and are engaged in a variety of patient safety initiatives and strategies. One of the biggest, said Alexander, has been the CMS pilot that most Baton Rouge hospitals engaged in with eQHealth Solutions, the state's Medicare QIO. The project's goal was to reduce 30-day readmissions through a coaching program. The project saw substantive reductions in readmissions during the two-year pilot and won national acclaim. Now LHA has partnered with eQHealth Solutions to take the project statewide. In addition, in October, 2010, LHA started a collaborative to address central line associated blood stream infections (CLABSI). Now hospitals are starting to implement the tools and to see improvements. Alexander said they are seeing staff buy-in and excitement that he believes will spread to other areas of the hospitals. "That's going to follow through whether you are talking about a central line infection or hand washing across your facility. It kind of breeds itself," said Alexander.

In addition to working with LHA, hospitals are involved in a lot of patient safety initiatives on their own, said Alexander. For example, the LSU Health Care Services Division (LSUHCSD) is part of the National Association of Public Hospitals Patient Safety Initiative which provides them with resources for patient safety and allows public hospitals to learn from each other, said Michael Kaiser, MD, Chief Medical Officer for LSUHCSD. As part of this initiative each LSU hospital has established a Patient Safety Committee, implemented the Ask Me 3 campaign, participated in the annual Patient Safety Week and completed the AHRQ Hospital Survey on Patient Safety. And in July, 20 Louisiana hospitals agreed to participate in the Louisiana Department of Health and

"I can tell you that hospitals are light years ahead of where they were 20 years ago in focusing on quality and having it integrated into their culture."

—KEN ALEXANDER, LHA

Hospitals 39-week Initiative, a voluntary program in which hospitals agree to establish policies to end the practice of elective, non-medically necessary deliveries prior to 39 weeks gestation.

Because of their staggering numbers and devastating impact, an ongoing focus, both nationally and locally, remains on hospital acquired infections. In Louisiana alone, HAIs affect 29,000 patients annually and cause about 2,500 Louisianans to die basically needless deaths, said Phenow. They also increase hospital stays by 253,000 days and increase healthcare costs by over $400 million. Based on preliminary results from six sample hospitals, BCBSLA estimated that about 44% of hospital acquired infections are urinary tract based. Respiratory infections count for 18%, wound 16%, blood borne 12% and GI tract infections 10%. "Initially we thought hospitals would take care of their own house and figure this out" said Phenow. "But the data hasn't shown much movement, so I think there is a certain amount of concern that we need to tighten the focus." BCBSLA recognized that some hospitals may lack the resources to address their infection rates at the level of sophistication that is now required, so the insurer has partnered with an organization called Care Fusion to form the Louisiana Hospital Quality Initiative. Care Fusion provides a surveillance program called MedMined™ that identifies patterns in hospital data and shows where the processes are breaking down and allowing for infections to occur. BCBSLA is providing

grants to 27 hospitals to participate in a 21-month program using MedMined™ and participating in educational seminars to help prevent hospital acquired infections from occurring. "The problem is just identifying where in the system, because there are so many processes taking place in a hospital, where in the process the breakdown is occurring, where these issues of infection are being introduced, resulting in unnecessary mortality and morbidity, hospitals stays, and hospital costs," said Phenow. With MedMined™, hospitals can do this without the massive chart reviews and data analysis that were required in the past, he said. "I think CMS is going to get very involved in this," said Phenow. "I think Blue Cross is really one of the first to jump on board."

Technology has been an important patient safety tool for hospitals. Many have computerized and bar-coded medication systems to prevent errors. Most have incorporated prompts, safeguards, and reminders into their electronic health record and bedside monitors to force providers to stop, think, and focus. For example, in an effort to address foley catheter infections, OLOL put prompts into their system to help drive providers to review the circumstances. "They don't have to remember all these individual steps, but as they go about their day-to-day functions we remind them, is there a reason this device needs to stay in?" said Vath. An increased use of technology, particularly to ensure medication safety, is one half of the LSU Health System's two-pronged approach to patient safety, according to Kaiser. The other half is creating a "culture" of safety, one of the other buzzwords in the patient safety world.

In fact it is one of three things recently identified by Joint Commission President Mark R. Chassin, MD, FACP, MPP, MPH, and Dr. Loeb in their new approach to patient safety. Modeled after strategies used by other high risk industries like aviation and the chemical industry, the concept, called High Reliability, focuses on consistent excellence over long periods of time and requires three changes in healthcare:

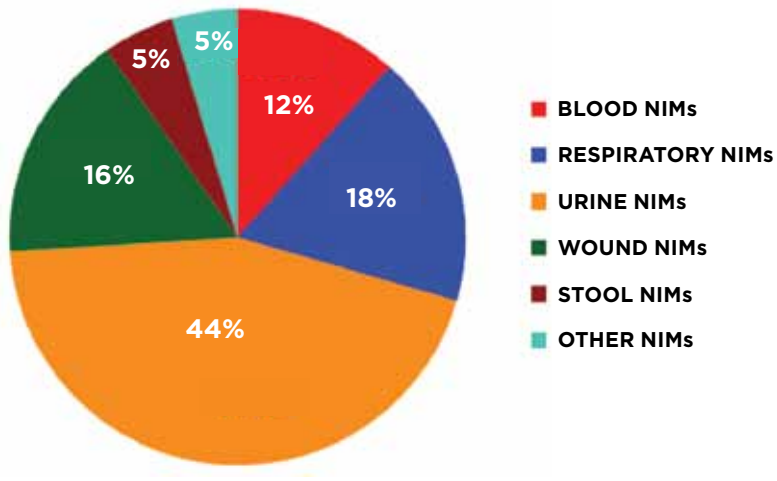
- Leadership buy-in. Top leadership must visibly make High Reliability the top priority.
- Culture of safety. Facilities must create a culture of safety that emphasizes trust, reporting, and improvement.
- Quality methods. Proven quality improvement tools such as Lean, Six Sigma, and Change Management must be implemented to systematically improve processes.

"High Reliability offers healthcare the best hope yet to achieve and sustain the elusive goal of consistent excellence in safety and quality," said Loeb.

For some, The Joint Commission may be preaching to the choir. Many local facilities have already incorporated those changes into their way of doing business. For example LSUHCSD has created a safety council where the seven hospital administrators meet on a monthly basis to educate themselves about safety tools, create an open environment, share issues that might be beneficial for other hospitals, discuss something unexpected, or address something a regulatory agency identified. At OLOL, the CEO participates in patient safety rounds with pharmacy heads, the patient safety

NOSOCOMIAL INFECTION MARKER (NIM*) DISTRIBUTION BY SOURCE

Preliminary Aggregate Results from 6 Louisiana Hospitals**



*The automated, peer-reviewed1 nosocomial infection marker (NIM) serves as an objective case-finding tool for quality improvement by identifying likely cases of healthcare-associated infections. Brossette, et al. American Journal of Clinical Pathology 2006; 125:34-39.

**The Louisiana aggregate analysis consists of preliminary results from 6 de-identified hospitals participating in the BlueCross BlueShield of Louisiana sponsored Healthcare-Associated Infection Prevention Initiative.

chief, medical directors, and other leadership. Patient safety is on the agenda at all board meetings and retreats. And almost every local hospital is already using principles of Lean and Six Sigma to improve their processes and chase the goal of zero errors. But there is always improvement to be made.

"I think that the patient safety goals in most instances, with most employees and most procedures, have been fully incorporated and implemented," said Dr. Kaiser. "But as with everything, getting the last little bit, from doing something 97% of the time to 100% of the time, that's the challenge." He said things that were once being done intermittently, like timeouts, are now the standard. "I think most of us who have done this work for a long time believe that if you continue to tweak these processes and you continue to have the focus of driving it to zero, I think you can get nearly there," said Vath. "There are so many variables including what the patient does in their own home after discharge that we haven't really even touched on," he explained. The key, says Alexander, is to focus attention on the details, to measure the right things, and track how you are doing, to take the subjectivity out of it. He does not believe we will ever be error free, but he thinks we can get very close. "I can tell you that hospitals are light years ahead of where they were 20 years ago in focusing on quality and having it integrated into their culture." He acknowledges that some of the cultural and funding issues that Louisiana deals with sets the state at a disadvantage in rankings, but, "I think as far as dedication to patient safety, the willingness to work to improve patient safety, and the desire to improve patient safety, we are on a par with anybody out there," he said.

What has been helpful about the patient safety movement in the last decade, explained Vath, is that it has made clinical quality a very personal thing. "I think it really became the catalyst to get all healthcare providers and all healthcare workers interested at a very personal level in improving the quality of the process to deliver the healthcare in a quality way and in a consistent fashion," said Vath. He said that the Institute for Health Improvement started 5-10 years ago focusing its efforts on very narrow areas like central line associated blood stream infections and gradually added more and more things to create a portfolio on defining patient safety within an institution. In the last five years that has evolved and "although we focus on all of these individual things, it has matured into looking at what happens overall in the institution." Vath thinks it's important to not get caught up in the weeds

"I think it is a reasonable goal that when a patient comes to one of our clinics or hospitals we've done everything 100% of the time to make that experience a safe one."

—MICHAEL KAISER, MD, LSUHCSD

of individual safety issues, but to take a broader view. One of his first roles at OLOL was to "build a foundation of patient safety as a literal trump card that trumps everything else in terms of clinical decisions within the organization," he said.

Another strategy both hospitals and insurers are using is to involve patients in their own safe care. Some insurers provide tips to patients before they go to the hospitals. Hospitals have implemented programs like LSUHCSD's Ask Me 3, to empower patients to speak up and question any aspect of their care such as whether a caregiver washed their hands or if the medication or dose is correct. However, there remains to some degree an innate hesitancy to question the doctor or the hospital. "We wouldn't think twice at a car repair shop about asking questions about what we are paying for," said Alexander. "Yet we often hesitate to question a doctor or nurse." He said that hospitals will be doing more and more to encourage that dialogue and to make patients feel they are a partner in their care, not only because it has been proven to help avoid errors, but because under value-based purchasing, hospitals will be measured not only on clinical indicators, but also the patient experience through the Hospital Consumer Assessment of Healthcare Providers & Systems Survey (HCAHPS). Vath agreed that it is important to continue to build a culture where patients

"What has happened is without the government and payers being able to see the kind of widespread results they had been looking for, they have felt they need to incent or disincent this."

—RICHARD VATH, MD, OLOL RMC

or their caregivers feel comfortable to ask questions or challenge something. "The patients or the patients' caregivers really need to be able to call the shots on a patient safety or quality issue so they can get the help they don't feel they are getting."

Enhanced communication between caregivers, departments, and healthcare facilities is also important. Whether it occurs on the floor or during a handoff, a gap in disclosure can have tragic consequences. Many hospitals have instituted team huddles at shift changes and focused renewed efforts on discharge processes to make sure all pertinent information is passed on. It is also important that all team members are heard and are empowered to "stop the line." Checklists and timeouts only work if they are used and there can be resistance, particularly among doctors, to follow them. Kaiser agreed that despite educational efforts to ensure everyone on the multidisciplinary team knows their role, some doctors can feel challenged if they are called out. Conversely, some team members may hesitate to call a timeout or enforce a checklist if they feel intimidated. Those breakdowns are something LSU explores in its root analyses of adverse events and reported near misses, said Kaiser. It's not always a conscious decision not to follow the steps, said Alexander, but it is human nature to become complacent about routine tasks. Often it is not until it is measured, that it becomes apparent that you are not following every step.

While it is acknowledged that most hospitals are making concerted efforts to ensure their patients' safety, there continues to be a push by some regulators and payers for increased public reporting. Some feel that until all adverse events are publicly reported, they will not get the public attention and outcry that could eliminate them once and for all. Only 28 states currently mandate public reporting although it is coming soon to a state near you, said Alexander. Some providers are still resistant, expressing fears about variability of data. "Conceptually I am a believer in public reporting and transparency, but as with all things, it's all in the details," said Kaiser. "The complexity of the patients, the different acuities, facility differences, different staffing ratios, all those make apples to apples comparisons very difficult." For example, he said, LSUHCSD's readmission rates may differ from other hospitals, but the numbers do not take into consideration the types of patients they treat and what happens when the patient goes home. "That may affect mortality and readmission more than anything we did while they were at the hospital. Public reporting doesn't cover those nuances very well," said Kaiser. Public reporting or no, Blue Cross plans to start providing its customers, brokers, and employers with more data on hospital performance. "They will, over time, begin to bring some pressure to bear on hospitals because nobody wants to pay good money for bad outcomes," said Phenow. BCBSLA has started to designate certain hospitals as Blue Distinction hospitals, meaning they have met very stringent criteria on certain quality outcomes. "We are going to be getting more and more information out to our members about what are the best hospitals when you need a certain procedure," said Phenow.

"I can tell you there's a lot of activity in quality these days in hospitals," said Alexander. "The majority of that is self-generated from the hospitals wanting to look for ways to improve how they are caring for their patients. Some of that is government induced with the CMS initiatives coming out–what we know as the 'thou shalts'. Some of it is financially induced. Nobody likes the regulatory stick," said Alexander. "But in a lot of ways it puts a broader attention on the area of patient safety." Phenow stressed that he thinks it's, "important to recognize that we are working with our providers and our patients on multiple fronts to try to drive better value in healthcare, better quality at better cost, and really enhance the patient's quality of life."

Whatever the incentives or disincentives or which initiatives or collaboratives hospitals choose to embark on, however, the numbers indicate that challenges remain. "The same big three areas have always remained and I think will always remain because of the complexity of healthcare and the number of people involved in healthcare delivery to an individual patient," said Vath. In his opinion, those are medication safety, reducing potential for healthcare associated infections, and handoff from one caregiver to another, whether it's a shift change, doctor change, discharge, etc. Dr. Kaiser feels the biggest challenge remains one of culture change, of every team member realizing they need to be aware every time something didn't go as it should, regardless of whether there was an adverse outcome. "When there's an adverse outcome, I think that's pretty well established, but when there's not, I think that's a harder challenge," said Kaiser. "We still need to work on the culture so people feel comfortable identifying potential problems." He added, "I think we will never be in an era where there are no adverse events, where things didn't go as one would have planned or hoped, but I think we can get to an era where we have all the safeguards in place to take the human element out of those adverse events. I think it is a reasonable goal that when a patient comes to one of our clinics or hospitals we've done everything 100% of the time to make that experience a safe one." **<<**

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One on One

With JIMMY GUIDRY, MD

State Health Officer and Medical Director, Louisiana Department of Health and Hospitals

Jimmy Guidry, MD, is the State Health Officer and Medical Director for the Louisiana Department of Health and Hospitals (DHH). As Medical Director, Dr. Guidry is responsible for medical consultation on a variety of health care policy issues, including health care programs and quality of care issues. He also serves as the Department's liaison with medical, nursing, pharmacy, and allied health professionals as well as with professional associations and organizations throughout the state. The Medical Director's Office also houses the Office of Emergency Preparedness for DHH.

Dr. Guidry chairs various task forces, including the DHH Obesity Task Force, the Child Death Review Panel, and the Governor's Task Force on Tuberculosis, and represents the state at medical and environmental engagements across the country. Prior to this position, Dr. Guidry served as the Assistant Secretary for the Office of Public Health and the Acadian Region's Medical Director. He has also served as Director of Adolescent Services at LSU School of Medicine, Pediatric Department, Earl K. Long Hospital.

Dr. Guidry received his Bachelor of Science degree from Southwestern University, earned his doctorate from the Louisiana State University School of Medicine and completed his residency at Earl K. Long Hospital. He has been Board Certified since 1984 and is a Fellow of the American Academy of Pediatrics. >>

SMITH W. HARTLEY: What are some of the current public health initiatives that DHH is working on?

DR. JIMMY GUIDRY: From the public health perspective there are a number of things and it depends on which arena we're talking about. It used to be when disease outbreaks were reported to the Office of Public Health they would send it by mail and it would get there days or weeks after an event occurred. It was a way of documenting what was going on in a community, but there wasn't a whole lot you could do about mitigating the spread of infection—you'd lost some valuable time. Now with the technology we have today, you actually have reporting of diseases in real time and literally can put the word out to providers to be on the lookout for an outbreak. We really got tested when H1N1 occurred. It was handled very differently than in the past because, one, of technology and then the fact that public health culture now is that we're available 24-7. It used to be it was a government job, 8:00-4:30. Now when people are hired they're told if something is happening they're literally going to be working around the clock. So our employees are aware that if there's a storm or an outbreak or whatever the issue is, whatever it's going to take to take care of that issue, they have to be available.

So H1N1. There were years of planning. What if there's this new virus that comes out and starts infecting people and what if it's virulent, what if it's going to kill people and if it is, how are you going to mitigate that? Well you have to be prepared to give antivirals, which is medication that has been stockpiled in case we need it. Well Public Health has a stockpile and has to get it out to the public if we have a real bad strain because it takes a while to develop any vaccine. So while you are waiting for the new vaccine development you have to be able to give these pills. During the H1N1 event, thank God it wasn't a real virulent strain, but when it came out of Mexico everybody thought there were a number of people dying so we were closing schools. Within one weekend we got antivirals out in hospitals, nursing homes, the entire state, with the help of our partners. What we've learned is that public health, which used to be more about the knowledge of the disease and working through the Centers for Disease Control, is now really having to deal with the public's health and so we deal with spread of infection, food-borne outbreak, bioterrorism events. It is just more and more varied. So your knowledge base now, the learning curve, is huge because you have to be able to deal with whatever the circumstance is to mitigate either infection, mortality or morbidity. So it takes people that are very knowledgeable, available, and working with all of our partners to make things happen. For instance, with the antiviral. A private company had to ship it, we had to store it, we got the National Guard to help us deliver it, we had State Police escorts to help us get the medicines. So you have numerous partners, private and public, for one event.

SWH: With regards to providers reporting, how do you characterize the challenges with that? Do you feel like you are capturing everything or most of what's out there?

JIMMY GUIDRY: It used to be that people reported it once they had made the diagnosis. As a result of 9-11, we now have what we call syndromic surveillance. If there are certain syndromes—cough, sneezing, sore throat—and there's a large number of them occurring, we are notified, before we even know what it is, that something's happening here that's different from normal. To show you how we use this, during the oil spill, people were being exposed to chemicals. The question was, was it impacting their health, was it creating problems towards their acute health? So we had reporting from hospitals and providers on what they were seeing out there. And we literally went back and looked at the past three years at what was the respiratory disease at that time of the year? How many people were coming in with pneumonias, bronchitis or sinusitis? And was there a difference now they were breathing in these chemicals because you would expect it to impact your lungs? It actually showed that the asthmatics weren't coming in any more than they had before and they would be very sensitive to fumes. So acutely we weren't seeing the illnesses as a result of this event, where before we just wouldn't have known. Now there's actually input and we have surveillance going on.

Not every provider out there is doing this, not every hospital

is doing this. You don't have to have them all doing it, but you need to have key places doing it so you can understand what's going on in that community. You just have to realize that something's happening that's very different and what the reason is for that. Obviously the earlier you find out something's happening the earlier you can mitigate the end result. So if there's a bioterrorism event and somebody has put anthrax out there then you are seeing a bunch of folks coming in with these symptoms, you're catching it early enough to give medicine to people. There's actually a public health plan that if we have some kind of anthrax event we will literally be handing out pills to whoever has possibly been exposed within the first 48 hours. They'll all get Cipro or Doxycycline quickly because once you get anthrax there's 98% mortality. You really have to be ahead of the game to prevent mortality. That's one of the more serious ones bioterrorism brought to our attention. Because of that we are more serious about surveillance and seeing what's out in the community, before we ever know what the diagnosis is.

74.9%

Percent of Louisiana children, age 19 – 35 months, who have completed immunizations for

MEASLES, MUMPS, RUBELLA, POLIO, DIPHTHERIA, TETANUS, PERTUSSIS, HEPATITIS B, AND VARICELLA BY

24 months of age according to the National Immunization Survey: Q1/2009-Q4/2009,

ranking Louisiana 10th in the nation.

National estimated vaccination coverage rate for the same period was 70.5%.

SWH: So you rely on immediate provider notification and then you have other systems behind that can mitigate?

JIMMY GUIDRY: The network is quite extensive. We have CDC with all their experts that are sharing with us what's going on at the national level and international level and we're sharing what we're finding at the local and state level. There's so much more communication and sharing of information. I literally, as State Health Officer, get reports every day from CDC on what are the infections and diseases that are out in the world and trying to figure out before it ever gets here that we are alerted that it's out there, it's near here, where is it? And to look for it. Because now that we have a global economy, some of these things we would never have seen before. So when they come in that medical provider may not recognize it. When CDC is telling us there's an outbreak of measles and where it is, we are sharing that with medical providers in the state through a health alert network, telling them to be aware. It makes people more aware of what they might be seeing that they may not recognize.

SWH: Let's shift gears a little bit. With regards to childhood obesity, what can a state agency do to improve that problem?

JIMMY GUIDRY: This is an interesting question for me because my background is as a pediatrician. I still see private patients to keep an idea of what's happening out there in the community, and what I'm seeing is children showing up with adult diseases. By that I mean, normally you have adult onset diabetes and usually that's much later in life. We are now seeing it in twelve-year-olds, fourteen-year-olds as a result of obesity. I am very concerned about what we are going to do to turn the tide because we have a huge issue of diabetes, end-stage renal disease, dialysis, hypertension, heart disease—very serious health conditions as a result of obesity that we are going to see at a much younger age if we don't do something to change behavior.

When it comes to obesity, it is multi-factorial. I have worked very closely with the Pennington Biomedical Research Center to try to figure out what are some of the things that would work to change what we're seeing with this trend, which is people getting heavier and heavier and heavier. We know that

what you eat and the amount you exercise are critical, but what's going to make a difference? We had a researcher come present at Pennington last year that had done research and pilot projects in schools where they changed the menus, increased the exercise, they did all these things that we know should make a difference in weight and obesity. In these multimillion dollar studies they didn't show much of a difference. You would predict that if you focused on all of this it would, so it doesn't make sense why doing all of these things doesn't make a difference. What it boils down to is that we are less active, we eat more, we drink more sweet drinks, sport drinks, a number of things that aren't good for us, so literally some of it is about behavioral choices, the amount of exercise you do, your choices in what you eat. If you curtail that in school it should help, but if you go home and continue the bad habits, you just make up for it. It has to be wholesale change. It literally has to be society deciding that we're going to make sure that the choices are limited. We are not going to have food with trans fats, or we're going to encourage bike paths, we are going to make sure every opportunity for exercise is available, we're going to encourage exercise and eating correctly.

But it's taken years for us to get this trend going the way it is and it's going to take years to possibly reverse the trend. It's not hopeless, but what it's taught us is that we've gone from being less of a society that works at hard labor to one that sits around and most of our work has to do with sitting and with availability of all kinds of foods. We are going to have to change our behavior in a way that it's so easy that you can't not do it. We're going to need the help of industry, fast food, everybody to make sure the things we are offering are better and better. People are not going to change easily. Fast food restaurants have tried selling salads alongside the fast food. People still eat the fast food.

The future doesn't look so bright. All you need to do is go on a plane and see people for whom the seats aren't big enough. I went to talk about obesity in New Orleans and the parents were upset that the desks weren't large enough to hold the children. The emphasis is in the wrong place. It should be how do we get our children smaller, not bigger desks. So it is worrisome from where I'm sitting that the whole country is looking at this and there aren't some very simple answers. It's very complex and it's going to take a lot of folks working at this to change behavior. In public health, when you want to change health outcomes, if you want people to live longer and healthier, they have to change their behavior. You

can't change genetics, but that represents about 20% of your health outcomes. Fifty percent of your health outcomes are impacted by personal choices. If you don't make the right choices you are going to end up with poor results. As providers we can tell people all the time, "Hey this is what you need to do to stay healthy," but at the same time when every function we do in Louisiana is around eating, you are fighting a really tough battle. It's very different to get together for a Fun Run than to get together for a jambalaya and that's the kind of behavior changes we are going to have to make.

Is it possible? We see it in California and New York, where people have paid attention to exercise and are eating healthier and they don't have some of the issues that we're dealing with. I think the education system plays a huge part in preparing people to make proper choices as they get older. It's been shown in public health that the higher your level of education, usually the higher your income, more access to healthcare, better choices. So literally the moment that child is born they need the most help they can get to be successful. And making sure from *in utero* on that the options are healthy ones so that the foundation is built and as they get older they can continue to make the right choices.

SWH: I guess with regard to health statistics, Louisiana generally falls behind. Would you characterize that as being "this is our culture" and maybe that's part of the problem of why we, in so many public health categories, seem to lag toward the bottom?

JIMMY GUIDRY: I've been asked that before. Why in Louisiana are we 49th or 50th when you look at health outcomes? Some of the answers are difficult to show, but what I've been able to show is that if you focus on those things that really make a difference, and you make changes, then you can change behavior. One of the best public health preventive medicine efforts is vaccination. Those diseases that can cause horrendous complications are totally preventable if children get vaccinated. So how do you change the fact that for the longest time we were 49th and 50th in vaccination of our children? It's provided at no charge or very little charge. It's provided in multiple places. How are you going to make sure that something so simple gets done? Well, we worked very diligently to put a plan together for making it readily available and sending out reminders to parents that their child is due for vaccination and making sure that at every opportunity that a child walks in a medical provider's office that they get vaccinated. We are in a poor state. When it comes to health outcomes we have poor numbers. Here's one that with changing behavior and making sure parents take their jobs seriously about getting their children vaccinated makes a difference. We worked with principals whose jobs with older kids are to say the child can't enter school unless they get vaccinated.

We got bioterrorism grant funds to practice mass vaccinations because if there was an event, how would we vaccinate everybody? We took that money and made a real drill out of it so that we would provide vaccines to kids right before school starts and we did it in the thousands to show we could do mass vaccinations. And we moved up from almost last to second in the country, in a poor state where you would think that's impossible. We've got all kinds of private partners, private providers, hospitals, after hour clinics giving vaccines on the weekends and after hours. We're just totally focused on every time you can give a vaccine you get it in the child and prevent a disease. For every dollar spent on that vaccine you save $20 in healthcare costs.

Another issue in public health is cancer in Louisiana. People say we live in "cancer alley." Not so. When you look at the cancer rates we are about average. We are about middle of the pack

In the 2010 Trust for America's Health report, LOUISIANA SCORED 9 OUT OF 10 in the "Ready or Not 2010 – Protecting the Public's Health FROM DISEASE, DISASTERS AND BIOTERRORISM."

for the states in cancer incidence. Somebody getting cancer in Louisiana is not as bad as people think it is and it's not due to cancer alley. Most of the cancer seen in Louisiana is a result of choices, like alcohol or tobacco. But in Louisiana, if you get cancer, we are first or second in the country for the likelihood you will die of it, because we diagnose it later. Because people don't go get checked for it. People don't get diagnosed early. If it's diagnosed later, the outcome is worse. So you are looking at a possible access issue, but you are also looking at a possible choice issue in that people won't seek the care, get an early diagnosis, get treatment early. As a result, our outcome is if you get it in Louisiana, the likelihood is you will die of it, more than anywhere else in the country. Because of an educational level, because of finances, because of choices—just a whole complex number of issues.

So we work diligently at the Department of Health to educate people on what you can do to diagnose cancer early, make screenings as available as possible, get the private sector to provide it free of charge. It's still not done near as much as it should be because people don't choose to go do that. And they don't choose to go do that because they don't realize that in this country one in three people will have cancer in their lifetime. So there's a high probability that we will all get cancer. Live long enough and it will get even higher. For screening and routine visits, you have to be able to afford it, it has to be readily available, you have to have access, and people have to choose to take advantage of those opportunities.

SWH: Do you think we are doing enough from an epidemiology standpoint, interpreting where these problems are coming from?

JIMMY GUIDRY: I think we are getting better now that we have the technology to monitor all of this information we can capture. I'll show you a study we did years ago in Baton Rouge. They did a study to find out where the mothers of premature babies lived, where were these infants coming from? Premature

births lead to increases in infant mortality, which is a measurement of health outcomes. And when they mapped out where these premature births were occurring, they found it was only certain areas of the city where most of these babies came from. It pointed to some very poor neighborhoods and young mothers. If you were going to spend your dollars wisely to address that issue, you would spend it in those areas that have the highest risk. If you are going to change behavior you need to change behavior where the highest risk is. So, literally, the ability to capture all this data and do epidemiological studies is available. What we perhaps don't have enough of are analysts. What does the data mean? What makes it useful information? How do you change behavior based on that information?

So if you look at Louisiana, with the grants we write and the studies we do, we have renowned Pennington Center that studies obesity, we have some cancer centers that are internationally known, we have a lot of things that are very, very good, but we have a lot of medical issues. The question then becomes how can you use limited dollars to have the most impact and that really becomes a challenge. If you are in a poor state and people don't have the wealth they need to do these things appropriately then how do you change it? You change it by making the information available to people, educating people, but you also have to focus on, as I said before, making sure that child's education is the best and enhance their ability for success. You also have to make sure that the kids we spend so much money and time on making sure they're successful, that we keep them here. If they leave the state it doesn't do us a whole lot of good and we're not benefitting from that investment. I'm sure that's one of the Governor's arguments all the time—how do we make sure we have the economy here to keep our kids here once they finish their education?

SWH: We've had a few secretaries over the past few years. I wonder if you would describe Bruce Greenstein's impact in the short time he's been here and comment on his leadership style and direction?

JIMMY GUIDRY: The reason I smile is that this is my fifteenth year and this is my fourth secretary and so I've got a wealth of knowledge from having worked with different personalities and different styles. What I find refreshing about Bruce is that he comes with a wealth of knowledge about economies and technology, which is such a need in Louisiana. To take this wealth of data we have and make sense of it and change the way we deliver healthcare. He's willing to

In 2010, the Cities Readiness Initiative (CRI) received scores ranging from 91% to 97% across metropolitan statistical areas in four regions of the state.

fight the fight, because the fight for change is incredible. People will put up every barrier possible so that you don't change the status quo because that's the way you normally get paid, because that's the way healthcare gets delivered and change threatens your livelihood and your future. But he can't threaten the fact that we are 49th and 50th, he can only take us up.

It's going to take making tough decisions using the best data available and fighting that upstream battle of making changes. What I've seen is energy and a willingness to do that. That's refreshing to me even though I'm getting older and I've been through many fights, because I've been through a number of disasters. I'm the lead for ESF-8, which is health and medical for disasters, so I've dealt with Katrina, Rita, Gustav, the oil spill. What I've learned is that you've got to fight the fight to make a difference. But you need a lot of folks, a lot of partners, and you have to be willing to give it everything you have and utilize those resources to the best of your ability. What I have seen in him so far has been very appealing because it's something different and I think Louisiana needs that, to bite the bullet and make these serious changes. Whether it works or not, we don't know, but it can't be worse. Let's make a change and see what happens. So far he has been very encouraging, he allows his experts to do what they need to do, he's very supportive, and he's willing to take the battles to make a better Louisiana. I've been working at it a number of years and I welcome a fresh, young person coming in with these capabilities. So far I've been very pleased about working with him. <<

What Does Our **Community** Need? Let's Start With **You.**

We've all seen the reports. In 2010 – Louisiana ranked 49th in America's Health Rankings by United Health Foundation, received a D rating from the National Alliance on Mental Illness, a D+ rating by the American College of Emergency Physicians, etc. In 2011 East Baton Rouge Parish ranked 19 out of 64 in parish health outcomes. You get the point. And this is not what we want for our community. In 2007, Mayor Holden said it's time to take corrective action, and created the Mayor's Healthy City Initiative (MHCI) – HealthyBR. The Initiative was launched as a movement to get the community engaged, involved, and at the table for taking responsibility for the outcomes of our city. Soon realizing that the task was more than just one committee could tackle, the Mayor divided the movement into 3 separate, but compatible and focused initiatives: HealthyBR – focused on healthier eating and more active lifestyle; MedBR – with a focus on access to care and health outcomes; and the Innovation Center – focused on community efforts to address Childhood Obesity.

The Innovation Center Childhood Obesity is an epidemic. According to the National Initiative for Children's Healthcare Quality and the Child Policy Research Center, almost 36% of Louisiana children are considered either overweight or obese. To assist with the development of a community based action plan, Mayor Holden applied for a technical assistance grant from the National League of Cities Institute for Youth, Education, and Families (YEF Institute). To his team's credit, Baton Rouge was selected as one of three cities to participate in the Municipal Leadership for Healthy Southern Cities technical assistance project. The three cities awarded the grants were Little Rock, Ark., Tupelo, Miss. and Baton Rouge, La. As part of the 18-month project, each city receives customized technical

BY COLETTA BARRETT

New pathway along Cane's Dog Park

Old Hammond Hwy. Park Trail

In 2007, Mayor Holden said it's time to take corrective action, and created the Mayor's Healthy City Initiative (MHCI) – **HealthyBR**.

PHOTOS COURTESY OF BREC

assistance from the YEF Institute and other national experts. The goal of the project is to advance local efforts to combat childhood obesity through the development and implementation of community wellness plans. The plans would include policies to expand access to fresh, healthy foods; land use protections for community gardens; incentives to mobile produce markets that locate in low income areas; grants and opportunities that encourage grocery stores to locate in underserved areas; government and/or school procurement policies that favor local healthy foods; etc. Policies to increase access to recreation include: joint use agreements for recreation facilities; mandated physical activity requirements for city-funded youth programs; conversion/rehabilitation of blighted areas into community gardens, parks or green spaces. Meanwhile work will continue on a city master plan that includes provisions to encourage walking and biking; a policy to ensure sidewalk continuity and direct routes for pedestrians and cyclists; streetscape design guidelines aimed at promoting walkability and bikeability; and our continued commitment to ensure that children live within walking distance of a playground, park or recreation center. While much has been done the past few years to raise awareness of childhood obesity, increase access to bike paths, walking paths, etc – there is much more work to be done. The Innovation Center of the MHCI continues to collaborate on effective community based strategies to bend the curve on childhood obesity.

HealthyBR In the beginning, HealthyBR was the overarching umbrella of the Mayor's Healthy City Initiative. In August of 2010, partners of HealthyBR agreed to conduct the Community Healthy Living Index (CHLI) assessment. Considered a best practice community assessment, CHLI was developed in partnership with experts from Stanford, Harvard, and St. Louis Universities

FROM LEFT: City Community Park, New Promenade under the Oaks; Alsen Park Trail; and Anna T. Jordan Community Park Walking Trail.

with support from the Center for Disease Control (CDC) and Robert Wood Johnson Foundation (RWJF). The YMCA of the USA created CHLI in response to our nation's rising chronic disease rates. The CHLI assessment of Baton Rouge identified gaps in community resources and helped identify opportunities for building strong partnerships aimed at improving the health of our community. For a copy of the CHLI Assessment, log on to www.HealthyBR.com. Recommendations for action as a result of the CHLI Assessment include transportation, city hall enacted policies, school based interventions, healthcare, business and community based programming. The chart below outlines specific tactics that are a part of the HealthyBR 3-year Action Plan.

The HealthyBR movement has certainly made inroads in educating the public on health issues facing Baton Rouge with the monthly production of Healthy Living in BR TV program. All previous 12 programs are now available on the HealthyBR website. Since the launch of HealthyBR, advocates for bike trails have increased the miles of bike paths from 23.4 miles to over 67.6 miles. There are now well over 1,000 miles of sidewalks to promote physical activity. The task of promoting healthier eating and more active lifestyles will take years of focus in order to impact Baton Rouge outcomes. Again, there is much work to be done.

MedBR MedBR was spun off of the HealthyBR work group when the Mayor's Healthy City Initiative deemed that the task

CHLI ASSESSMENT FOCUS AREAS FOR BATON ROUGE

1 Campaigns promoting healthy eating, nutrition, and physical activity.

2 Community healthy eating programs and physical activities make provisions for people with limited resources to gain access.

3 In addition to local food stores and supermarkets, vegetables and fruits are available from alternative sources in the community, such as farmers markets, and roadside vegetable stands.

4 Food stores and restaurants in the community offer healthy food and menu options, and are easily accessible by foot, bike, and/or public transportation.

5 School sites have walking and biking infrastructure so the majority of students can walk and/or bike to school agriculture programs for healthy eating (farm to school) as well as low-cost or free vegetable/fruit snack programs before/after school.

6 Community public transportation system provides access to major employer medical facilities, schools, recreation, and retail facilities. Public transportation stops are reached easily by walking or biking or park to ride stops.

7 The community public transportation system serves all areas of the community with sufficient frequency to make it a realistic option for regular commutes.

of broadly addressing community health was larger than what HealthyBR could focus on. MedBR's focus is on access to care and health outcomes. Who knew that President Obama's Patient Protection and Affordable Care Act (Affordable Care Act) enacted in March of 2010 would so eloquently lay out the path forward for MedBR. One of the new requirements of the ACA was for each hospital to participate in a Community Health Needs Assessments ("CHNA").While the CHNA requirements will not be effective until taxable years beginning after March 23, 2012, hospital leadership across the Greater Baton Rouge area felt compelled to begin the journey "sooner rather than later." In the Spring of 2011, hospital leaders invited other health care collaborators and partners to the table to begin a comprehensive community health assessment. The team evaluated processes and methods for conducting the assessment. Looking at Community Health Assessment best practices, open sources of healthcare related data, and other information publically available, the group began to identify community health needs, information gaps, and barriers to completing a comprehensive assessment. After reviewing publically reported and available data, the team validated those data with qualitative feedback from various stakeholders in the hospital and broader healthcare community.

The group priorities listed below are in alpha order and are not ranked for priority: Adolescent health (risky behaviors, abuse, culture of violence); Barriers (low health literacy, transportation, compliance, access to physicians, public policy); Cancer; Child Health (injury prevention, immunizations, abuse, vision, asthma, prenatal); Depression/mental health/substance abuse; Diabetes; Heart disease/high blood pressure/stroke; HIV/AIDS/STDs; Lifestyle issues (tobacco use, substance abuse, diet and exercise); and Obesity.

This list of top ten issues impacting health outcomes will be used to formulate the MedBR 3-year action plan. One best practice already implemented by MedBR has been the launch of MedLineBR – a nurse call, triage line that medically screens the caller and connects the "patient" with medical, dental, mental health, and other resources available in the community. The MedLineBR notices are in area hotel rooms to connect out of town visitors in need of medical advice – and billboards are up in North Baton Rouge and the Interstate promoting MedLineBR as a resource for access to care for the uninsured and underinsured.

Call to Action So what does all this mean for Baton Rouge? It means that ANYONE who wants to make a difference in our community can find a place in this Healthy City Initiative movement. Going online to see what HealthyBR is all about, making sure that your company is a committed partner of the Mayor's Healthy City Initiative, finding out how you can volunteer your time to support many of the programs and services of the MHCI – are but a few specific examples of how you can put your passion for a GREAT Baton Rouge into action. Sharing experiences and knowledge are not just something we do in addition to solving problems – in Baton Rouge it's the WAY we solve problems. Get involved, share your gifts and talents, make a difference in our community. Sir Francis Bacon said – Knowledge is Power. Coletta Barrett says – Shared Knowledge is Ultimate Power. Join us in the MHCI movement to make Baton Rouge, the next BEST city in America! <<

Government Healthcare Reform:

Grandfathered and Non-Grandfathered Health Plans

According to the United States Census Bureau, in 2009, fifty-six percent of insured Americans received their health insurance through their employers.[1] With the signing of the Patient Protection and Affordable Care Act (PPACA), it will be important for healthcare providers to understand the difference between grandfathered status and non-grandfathered status in group plans because private health plans pay, on average, thirty-five percent of hospitals' net revenue.[2] The PPACA, in October of 2012, will also bring about reform for hospitals. >>

WHAT ARE GRANDFATHERED HEALTH PLANS?

Grandfathered health plans were effective before the PPACA was signed on March 23rd, 2010, and are not subject to all of the reform's provisions. However, grandfathered plans must comply with specific guidelines in order to maintain grandfathered status.[3] In the business community, there is a strong push to remain grandfathered, because many employers fear that government healthcare reform may bring an end to their current group health plans. Therefore, many patients visiting healthcare providers will have grandfathered group plans.

As an employer, what are the pros and cons of remaining grandfathered? For the pros, grandfathered group plans: 1) cannot deny coverage to children less than 19 years of age because of pre-existing conditions; 2) must cover dependents up to 26 years of age; and 3) must eliminate lifetime maximums and annual benefit limits.[4] Although subject to the above pros, the point of remaining grandfathered is to reduce concerns that provisions of government healthcare reform may permanently change the way the United States' healthcare systems works. For the cons, grandfathered group plans: 1) are not required to provide first-dollar coverage for preventative care; 2) are not required to pay for emergency room visits if they were misdiagnosed; and 3) are not required to provide access to the external appeals process. Furthermore, in order for a grandfathered group plan to keep its status, the employer cannot increase their employees' out-of-pocket costs such as deductibles, copayments, and out-of-pocket maximums by more than 15 percent over medical inflation.[4] If an employer increases their employees' out-of-pocket costs above the specified amounts, then grandfathered status is lost.

WHAT ARE NON-GRANDFATHERED HEALTH PLANS? Non-grandfathered health plans went into effect after the signing of the PPACA on March 23rd, 2010. Non-grandfathered plans are subject to all effective provisions within the reform. Many employers choose non-grandfathered plans because they cannot remain grandfathered due

to the rising cost of premiums for group health plans. Many of those employers choose to increase their employees' out-of-pocket costs in order to offset insurance premium increases and subsequently lose their grandfathered status.

As an employer, what are the pros and cons of becoming non-grandfathered? Identical to the grandfathered plans, the pros of non-grandfathered plans include: 1) children less than 19 years of age cannot be denied coverage due to pre-existing conditions; 2) dependents up to 26 years of age must be covered; and 3) lifetime maximums and annual benefit limits must be eliminated.[5] Additionally, non-grandfathered plans: 1) are required to provide first-dollar coverage for preventative care; 2) are required to pay for emergency room visits even if they were misdiagnosed; and 3) are required to provide access to the external appeals process. With non-grandfathered plans, employers may increase employees' out-of-pocket costs above the earlier specified amounts in order to decrease premiums. For the cons, and this cannot be understated, non-grandfathered group plans are subject to all provisions within the government healthcare reform. These provisions may not bring about drastic changes for non-grandfathered plans until January 1st, 2014. At this time, provisions such as no discrimination based on health status, eliminating annual limits, ensuring coverage for individuals participating in clinical trials, and mandated cost-sharing limits will be put into effect.[6]

As for hospital reform, beginning on October 1st, 2012, the value-based purchasing program and the reducing avoidable hospital readmission provisions will bring about changes to Medicare's hospital reimbursement. The value-based purchasing program provision offers financial incentives to hospitals to improve the quality of care by reducing heart attacks, heart failure, pneumonia, surgical error, hospital acquired infections, and by improving patients' perception of care.[7] Under the reducing avoidable hospital readmission provision, Centers for Medicare and Medicaid Services (CMS) will track hospital readmission rates for certain high-volume or high-cost conditions such as heart disease, pneumonia, and stroke. With hospital readmissions accounting for roughly seventeen percent of Medicare's 2010 budget, PPACA's hospital reform has created financial incentives to encourage hospitals to reduce preventable readmissions, thereby reducing the financial burden on Medicare.[8]

WHY IS AN UNDERSTANDING OF THESE CHANGES SO IMPORTANT? First, like all businesses, healthcare providers have a reputation to uphold. Patients are customers, and customers want knowledgeable providers who charge fair rates for their services. Therefore, a patient's level of satisfaction with a hospital or a physician is likely to at least partially depend upon their perception of fair charges for the services rendered. As a result, healthcare providers must be able to explain such things as why the patient was charged a coinsurance on blood work during a preventative physical exam, or why the patient was charged for an emergency room visit that resulted from a misdiagnosis. "I don't know" is not an acceptable answer. Second, beginning on October 1st, 2012, hospitals must be in a position to take action on the two provisions that will directly affect their Medicare reimbursement rates. The incorporation of value-based care into their practices and the reduction of hospital readmissions will necessitate change at many levels. **<<**

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HEALTHCARE BRIEFS

STATE BRIEFS

UPL Programs to Expand

The Department of Health and Hospitals announced a series of programs being implemented or expanded this fiscal year that will help local governments, hospitals, and other health care providers maximize health care dollars and preserve access to care for Medicaid patients through a series of new programs being implemented or expanded this fiscal year. House Bill 1, which was signed by Governor Bobby Jindal, provides more than $102 million in expenditure authority for DHH to pay local public hospitals and ambulance services through the Upper Payment Limit (UPL) programs.

In addition to the budget authority provided for the UPL programs in HB1, Gov. Jindal signed Senate Bill 176 by Sen. David Heitmeier to authorize UPL programs and the payment methodology for the Public Hospital UPL. The Public Hospital UPL is expected to generate about $72.8 million for non-rural, non-state public hospitals throughout the state. In this program, local dollars from hospital districts are sent to the state and used as match to draw down federal UPL payments. Non-state, non-rural public hospitals that should benefit from the UPL payment include:

- East Jefferson General Hospital
- Iberia Parish Hospital
- Lane Memorial Hospital
- North Oaks Medical Center
- North Oaks Rehab Center
- Opelousas General Hospital
- Slidell Memorial Hospital
- St. Tammany Parish Hospital
- Terrebonne General Hospital
- Thibodaux General
- West Calcasieu-Cameron Hospital
- West Jefferson Medical Center

DHH submitted a State Plan Amendment on June 29 to the federal government outlining the Public Hospital UPL plan and expects approval by November with the first payments going out as early as December.

The second program provided for in House Bill 1 is the Hospital Based Physician UPL. Already in place, DHH is planning to make $15 million this fiscal year in payments to participating non-rural, non-state public hospitals for hospital-based physician services. There are 43 hospitals in the state eligible for the program. In this program, non-state, non-rural public hospitals send local or state general fund dollars to DHH to use as matching funds to access UPL payments. Those UPL payments are made back to the hospitals to ensure continued access to physicians, physician assistants, certified registered nurse practitioners, and certified registered nurse anesthetists at the hospitals for Medicaid recipients.

The final program is known as the Ambulance UPL, and DHH anticipates making about $14.5 million in payments to companies or government entities that provide ambulance services once the program is up and running later this fiscal year. The Department submitted a rule to the state Registrar in July outlining the Ambulance UPL, which will be followed in September by a State Plan Amendment to the federal government. Once approved, ambulance providers could see the additional dollars by March 2012. While the exact payment methodology is still being developed, it is expected that this UPL program will allow local governments (whether they run their own ambulance service or contract that service out) to send local dollars dedicated to emergency medical services to the state. The state can then use those dollars, which are currently unmatched, as match to access federal UPL dollars to pay to ambulance services to ensure continued access for Medicaid recipients.

Children's Hospital Telethon Raises $1.74 Million

The 28th annual Children's Hospital Telethon raised a record amount of more than $1.74 million. The final tote board at the two-day broadcast's conclusion showed $1,740,775; however, Children's Hospital received additional pledges that had yet to be tallied, said Brian T. Landry, the hospital's vice president of marketing.

The 2011 Telethon exceeded last year's total by $160,000. Since 1984, the annual event has brought in more than $20 million to Children's Hospital. Money raised through the annual event is used to ensure the most advanced medical and surgical equipment is always available.

Hospitals Recognized for Targeting Birth Outcomes

Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein, the Louisiana Hospital Association (LHA), the Louisiana State Medical Society (LSMS), the American College of Obstetricians and Gynecologists (ACOG), and other Louisiana health care leaders gathered recently at Woman's Hospital to celebrate the 20 Louisiana hospitals that have demonstrated a commitment to healthier moms and babies through their participation in DHH's 39-Week Initiative.

DHH introduced the 39-Week Initiative as a key component of the Birth Outcomes Project, which was established to combat Louisiana's historically poor birth outcomes. The 39-Week Initiative is a voluntary program in which hospitals agree to establish policies to end the practice of elective, non-medically necessary deliveries prior to 39 weeks gestation. DHH officials have been meeting with the state's largest birthing hospitals to teach them about the 39-week Initiative, encouraging them to adopt the initiative and providing support for its adoption.

Babies who are born premature have a greater chance of newborn health complications, such as breathing problems, and often must spend time in the NICU receiving costly specialized care. The National Center for Health Statistics ranks Louisiana 49th in infant mortality, preterm birth and in the percentage of low birth weight and very low birth weight babies. Additionally, Louisiana earned a failing grade on the 2010 March of Dimes Prematurity Report Card, and at 38 percent, has the second highest C-section rate in the country.

The following hospitals have signed on to implement the 39-Week Initiative:

- Baton Rouge General Medical Center, Baton Rouge
- CHRISTUS St. Frances Cabrini Hospital, Alexandria
- E. A. Conway Medical Center, Monroe
- East Jefferson General Hospital, Metairie
- Lake Charles Memorial Hospital, Lake Charles
- Lakeview Regional Medical Center, Mandeville
- Lafayette General Medical Center, Lafayette
- LSU Health Sciences Center Shreveport, Shreveport
- North Oaks Medical Center, Hammond
- Ochsner Foundation, New Orleans
- Ochsner Medical Center-West Bank, Gretna
- Rapides Regional Medical Center, Alexandria
- Tulane-Lakeside Hospital, Metairie
- Touro Infirmary, New Orleans
- West Jefferson Medical Center, Marrero
- Willis-Knighton Pierremont Health Center, Shreveport
- Willis-Knighton South & Center for Women's Health, Shreveport
- Woman's Hospital, Baton Rouge
- Women & Children's Hospital, Lake Charles
- Women's & Children's Hospital, Lafayette

Two hospitals that implemented the initiative prior to the department launching the statewide initiative have already seen the benefits firsthand. From 2007 to 2010, East Jefferson General Hospital reduced the number of elective inductions prior to 39 weeks from 503 to 16. Since implementing the initiative at Woman's Hospital in September 2007, neo-natal intensive care unit (NICU) admissions dropped 20 percent.

As an added incentive, LAMMICO, a mutual insurance company that provides malpractice insurance for most Louisiana doctors, has partnered with the Department to offer physicians who participate in a "39 Week" training course an hour of continuing medical education (CME) credit. LAMMICO-insured physicians also will receive an hour of credit toward the two-hour credit needed for a 10 percent premium reduction at the next renewal.

To learn more about the Birth Outcomes Initiative, visit the DHH website.

Our Lady of Lourdes Has a New Face

Our Lady of Lourdes Regional Medical Center recently opened its brand new 396,000 square foot hospital on Ambassador Caffery in Lafayette. Strategic planning and preparation for the move from the old St. Landry campus to the new facility has been underway for over a year, with several mock moves conducted to ensure patient safety.

The new Our Lady of Lourdes facility was built from the ground up at a cost of $211 Million and features the most progressive medical technology available in Acadiana. The 200 bed facility features larger patient rooms and smaller nursing pods located closer to patient rooms for more effective/efficient care. It also features innovative design and organization for better patient care, comfort, and privacy. The hospital was designed to be energy efficient and built with an eye for future expansion to a potential 332 beds.

DHH Narrows Field for Coordinated Care Networks

In August, the Louisiana Department of Health and Hospitals tentatively selected five entities to administer Coordinated Care Networks (CCNs) in the state's Making Medicaid Better initiative. The initial selection drew appeals from some of the entities that were not chosen, with calls for complete disclosure of the winning proposals and how they were selected.

The department chose from 12 submitted proposals for both prepaid and shared savings

networks, which would be implemented within three Geographic Service Areas (GSA). Entities were allowed to propose networks for a specific GSA, or multiple areas. All of the CCNs being recommended by the evaluation teams would serve all GSAs. The recommended CCNs are:

CCN-Prepaid

- Louisiana Healthcare Connections, Inc. (whose parent company is Centene)
- Amerihealth Mercy of Louisiana, Inc.
- AmeriGROUP Louisiana, Inc.

CCN-Shared Savings

- UnitedHealthcare of Louisiana, Inc.
- Community Health Solutions of America, Inc.

Under the prepaid model, CCNs will receive a monthly fee for each enrollee covered to provide core benefits and services, with prior authorizations and claims payment handled directly through the CCN. These networks also are responsible for establishing a robust provider network of primary care physicians, specialists, hospitals, and other providers. The CCN-Shared Savings is a managed fee-for-service model that is responsible for coordinating the care of its members. The entity shares in the savings generated by improving health outcomes and reducing costs. In this model, providers will continue being paid on a fee-for-service basis by the state Medicaid program.

Several steps remain before CCN contracts are final and the networks are ready to begin operations. The Division of Administration must approve the evaluation process and the final contracts. Additionally, CCNs will undergo a thorough readiness review before any network can begin providing services to Medicaid recipients. To ensure network adequacy, each CCN must demonstrate it has a robust network of primary care providers (and specialists, hospitals, and other provider types in the case of the prepaid CCNs) in place to treat patients, sufficient support staff to handle administrative processes and provider relations, and the ability to meet all the deliverables specified in its proposals. The Centers for Medicare and Medicaid Services will review each CCN's contract and network adequacy, and must approve these before recipient services can begin. Any CCN that cannot meet these rigorous readiness review requirements will not be allowed to operate in Louisiana.

For more information on Coordinated Care Networks, go to www.MakingMedicaidBetter.com.

Senate Honors Lemoine

John E. Lemoine, MD, a family physician from Bunkie, Louisiana, and a current member of the LAMMICO Board of Directors, was honored by the State Senate during the recent Legislative Session in Baton Rouge. The recognition came in the form of Senate Concurrent Resolution No. 83, sponsored by State Senator Eric LaFleur (D - Ville Platte). The resolution commends

John E. Lemoine, MD, a family physician from Bunkie, Louisiana, and a current member of the LAMMICO Board of Directors, was honored by the State Senate during the recent Legislative Session in Baton Rouge. Lemoine is pictured here with Insurance Commissioner Jim Donelon.

Dr. Lemoine "for his dedication in serving the healthcare needs of many patients, and as a tireless advocate for just and fair physician liability laws in the state."

Dr. Lemoine has been associated with LAMMICO since shortly after the company's founding in 1981. After serving as the Senior Vice President of LAMMICO's Underwriting Committee, Dr. Lemoine joined the Board of Directors in 1985 and became Chairman of the Board in 1996. From January 1, 2000 until December 31, 2007, Dr. Lemoine led LAMMICO as its Chairman of the Board/CEO/President. From January 1, 2008 until 2010, he remained on LAMMICO's Board of Directors as Chairman.

Increased Scrutiny Delays Payments

Due to a change in policy announced in July, Louisiana healthcare providers will now be paid later for Medicaid claims. The change comes as a result of an increase in review time for claims now being implemented by the Louisiana Department of Health and Hospitals. The goal of the increased scrutiny is to help root out fraud, waste, and abuse in the system. It is estimated that nationally as much as 10 percent of Medicaid and Medicare expenses are diverted by wasteful, fraudulent, and abusive activities.

Because of the additional review time automated payments in July hit bank accounts a day later than usual. In subsequent months, the payments will continue to be pushed out further in a similar manner until there is a full additional 14-day window for claims reviews. "We know this is going to be a transition for our health care community, so we are phasing in the additional time throughout the fiscal year to ensure they have time to adjust their businesses appropriately," DHH Undersecretary Jerry Phillips said.

LOCAL BRIEFS

Rushing to Lead Medicare Quality Improvement Contract

eQHealth Solutions' Vice President and Chief Operating Officer Edie Castello announced that Debra Rushing has been named the Executive Director for the company's Medicare quality improvement contract in Louisiana. She takes over for Scott Flowers, who recently accepted a vice-president position with Thibodaux Regional Medical Center.

Since joining eQHealth in 2009, Rushing has served as a Quality Improvement Director on the Louisiana Medicare contract. She received her nursing degree from Southeastern Louisiana, and her MBA from the University of Phoenix.

Pennington Hosts Obesity Conference

On September 14, 2011, the Pennington Biomedical Research Center will host its fourth annual childhood obesity and public health conference, Reducing Childhood Obesity in Louisiana: Charting the Course for 2020. The conference is designed for professionals engaged in public health efforts, including: physicians, nutritionists, physical activity specialists, registered dietitians, nurses, health educators, psychologists, and counselors, healthcare policy makers, researchers, media, business and civic leaders, parks and recreation personnel, and early childhood and school-age educators and decision-makers. Participants in this conference will be able to:

- Comprehend the extent of the problem of childhood obesity in both the nation and in Louisiana
- Identify national public health objectives as detailed in Healthy People 2020
- Suggest public health goals for childhood obesity for the State of Louisiana
- Identify strategies to achieve demonstrable improvements in obesity-related behaviors.

Among the featured presentations are an introduction by Bruce D. Greenstein, Secretary, Louisiana Dept. of Health & Hospitals; a presentation on National Goals for Improving Diet & Health by Deborah Galuska, MPH, PhD, U.S. Centers for Disease Control and Prevention; a discussion of The National Physical Activity Plan by James R. Whitehead, American College of Sports Medicine; and Lessons Learned from Physical Activity Promotion in Brazil, a presentation by Pedro Hallal, PhD, Federal University of Pelotas, Brazil.

The free conference will take place from 9 a.m. to 3:30 p.m. on September 14th. You can register at https://www.pbrc.edu/childhood_obesity_conference/registration.aspx.

Dupuy Named Outstanding Nursing Instructor

Keeley Dupuy, MSN, RN, Assistant Professor of Nursing at Our Lady of the Lake College, was recognized by Our Lady of the Lake Regional Medical Center as the Outstanding Nursing Instructor of the Year. The award nomination describes Dupuy as caring and compassionate with her students, yet holding them to a high standard.

Dupuy contributes in significant ways to academic development at Our Lady of the Lake College, where she has worked for over six years. She currently serves as chair of the College's curriculum committee, leading the development of a groundbreaking foundational BSN curriculum. Not only has she championed an interdisciplinary approach to curriculum, but she has involved

faculty across the campus in the development of case studies for campus-wide use.

Dupuy is currently on the Board of Directors for the Louisiana State Nurses Association and Chair of the Membership Committee for the Baton Rouge District Nurses Association. She is also a member of the American Nurses Association, Sigma Theta Tau International Honor Society of Nursing, and the Phi Kappa Phi Honor Society.

LEFT: Steven P. Sellars, CEO of Convenient Care, LLC, has been named to the Urgent Care Association of America (UCAOA) Board of Directors. **RIGHT:** Keeley Dupuy, MSN, RN, Assistant Professor of Nursing at Our Lady of the Lake College, was recognized by Our Lady of the Lake Regional Medical Center as the Outstanding Nursing Instructor of the Year.

HHS Invests in Local Health Centers

The Department of Health and Human Services recently announced awards of $95 million to 278 school-based health center programs across the country. Among them was Baton Rouge's own Health Care Centers in Schools along with 13 other entities across the state.

Provided by the Affordable Care Act, the awards will help clinics expand and provide more health care services at schools nationwide. HHS estimates an additional 440,000 patients will be served thanks to the new funds awarded. The awardees are currently serving approximately 790,000 patients.

Lake After Hours Locates to Coursey

Lake After Hours has opened a new location at 13702 Coursey Boulevard. The clinic is open seven days a week from 9 a.m. to 6 p.m. A nearby location on O'Neal will maintain evening and night hours so the Coursey clinic with day-time hours will provide greater access to those who may not be able to make a same day appointment with their primary care physician, or travel across town to see their physician.

Sellars Named to UCAOA Board of Directors

Steven P. Sellars, CEO of Convenient Care, LLC, which owns Lake After Hours and Total Occupational Medicine, has been named to the Urgent Care Association of America (UCAOA) Board of Directors. Sellars serves as a board member for a multi-site rehabilitation company and the Baton Rouge Primary Care Collaborative, is an active member of UCAOA's Certification Committee, and is a member of the Medical Group Management Association.

UCAOA provides educational programs in clinical care and practice management, sponsors urgent care Fellowship Programs, funds groundbreaking industry research, has a monthly *Journal of Urgent Care Medicine* and maintains an active website and online forum for daily exchange of best practices. UCAOA provides leadership, education and resources for the successful practice of urgent care for its members.

Two Medical Equipment Suppliers Sentenced

Two local business owners have been sentenced for defrauding the federal government with claims relating to their durable medical equipment supply companies. In the first case, Samuel B. Johnson of Baton Rouge was sentenced by the U.S. District Court to serve 60 months in federal prison for his role in a multi-year health care fraud scheme that he perpetrated in the Baton Rouge area. Johnson was also ordered to pay $878,280 in restitution, and ordered to forfeit an additional $928,280 in proceeds from his crimes. Following his release from imprisonment, he will be required to serve a 2-year term of supervised release.

Johnson was one of the owners of a company known as Medical Supplies of Baton Rouge, Inc., which was engaged in the business of providing power wheelchairs, orthotics and other durable medical equipment to Medicare beneficiaries. In connection with his guilty plea, Johnson admitted that from November 2005 through about June 2009, he conspired to use the company to defraud the Medicare Program and commit health care fraud. Specifically, Johnson and his co-conspirators routinely submitted claims to Medicare seeking reimbursement for a set of expensive braces (including a back brace, knee braces, and other items), knowing that the braces were not medically necessary and had not been prescribed for the beneficiaries by their physicians.

In the second case, Veronica Ann Lewis Green, of Gonzales, was sentenced to thirty months in prison, restitution of $1,128,308, and two years supervised release after imprisonment. Green was also ordered to pay restitution to Medicare, Blue Cross, and the Social Security Administration. From April 2006 through August 2009, Green submitted false and fraudulent claims to Medicare. The false claims led to Medicare and Blue Cross of Louisiana issuing payments to her medical supply business, AYS Medical Supplies, in Gonzales. Green defrauded Medicare by submitting claims for durable medical equipment which was neither medically necessary nor actually provided to Medicare beneficiaries. In the course of investigating the false claims to Medicare and Blue Cross, investigators also discovered that Green submitted false information to the Social Security Administration.

DOE: OLOL College Among Most Affordable

Our Lady of the Lake College in Baton Rouge is among four-year, private, non-profit institutions providing undergraduate education at the lowest net price according to a Department

of Education report released in June. Each year, the Department of Education compiles College Affordability and Transparency Lists which name institutions at the extremes of tuition rates in a variety of categories. Our Lady of the Lake College is among 121 institutions in its class recognized as charging the lowest total cost of attendance.

Each year, all institutions of higher education are required to submit data to the U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS). The average net price is calculated using this IPEDS data by subtracting the average amount of federal, state/local, government or institutional grant or scholarship aid from the total cost of attendance. Total cost of attendance is the sum of published tuition and required fees, books and supplies and the weighted average for room and board and other expenses. Based on IPEDS data, the net price at Our Lady of the Lake College is $9,125. The national average for similar type institutions is $19,009.

Elliott wins NRHA's Outstanding Researcher Award

The National Rural Health Association (NRHA) named Robert Elliott, MD, PhD, the 2011 recipient for the Outstanding Researcher Award during NRHA's 34th Annual Rural Health Conference in Austin, Texas. The premise for the NRHA Outstanding Researcher Award lies in the notion that health services research and basic scientific inquiry specific to rural health needs have the potential to make long-lasting contributions by guiding public policy and health care planning toward a rural focus. Dr. Elliott was chosen for the honor based on more than 20 years of research and contributions in advancing treatment of breast cancer.

In addition to his work with breast cancer, Elliott has made tremendous strides in other types of cancer as well. When the U.S. Navy Cancer Vaccine Program was established to develop a new prostate cancer vaccine, the Department of Defense built the program around Elliott's pioneering cancer research.

OLOL College Makes Honor Roll

The Corporation for National and Community Service (CNCS) recently honored Our Lady of the Lake College as a leader among institutions of higher education for their support of volunteering, service-learning, and civic engagement. OLOL College was admitted to the 2010 President's Higher Education Community Service Honor Roll for engaging its students, faculty, and staff in meaningful service that achieves measurable results in the community.

OLOL College has been named to the President's Higher Education Community Service

Honor Roll for the years 2006, 2008, 2009 and 2010. The Corporation for National and Community Service, which has administered the Honor Roll since 2006, chooses institutions for recognition based on a series of selection factors including the scope and innovation of service projects, percentage of student participation in service activities, incentives for service, and the extent to which the school offers academic service-learning courses. A full list of Honor Roll recipients can be found at www.nationalservice.gov/honorroll.

PBRC Study Suggests Sedentary Work Contributing to Obesity

In a new study conducted at the Pennington Biomedical Research Center, scientists have found that the decrease in workplace physical activity over the past fifty years is a significant contributor to the obesity epidemic. The study suggests that changes in caloric intake cannot solely account for observed trends in weight gain increases for men and women in the United States. The study, entitled "Trends Over 5 Decades in U.S. Occupation-Related Physical Activity and their Associations with Obesity," was published by the *Public Library of Science* (PLoS), an international peer-reviewed journal in science and medicine.

In the 1960s, more than one half of jobs included moderate physical activity in contrast to today's less than 20 percent, according to the new study. "In the last fifty years, we estimate that daily occupation-related energy expenditure has decreased by more than 100 calories per day, and this reduction accounts for a significant portion of the increase in mean U.S. body weights for women and men," said lead study Pennington Biomedical scientist Timothy Church, MD, MPH, PhD.

The study examined the trends in occupational physical activities over the past five decades, comparing how the trends compare to concurrent changes in body weight in men and women in the United States. In 2008, federal physical activity recommendations were released suggesting 150 minutes per week of moderate intensity or 75 minutes of vigorous intensity physical activity per week. However, only 1 in 20 Americans are meeting these guidelines. If men and women were meeting these recommendations, this would make up for the decreased activity levels in the labor work force.

In addition to Dr. Church, six of the study's authors are from the Pennington Biomedical Research Center: Catrine Tudor-Locke, PhD, Peter T. Katzmarzyk, PhD, Conrad P. Earnest, PhD, Ruben Rodarte, MS, Corby K. Martin, PhD, and Claude Bouchard, PhD. Other authors are Diana M. Thomas, PhD, of Montclair State University, and Steven N. Blair, PED, of the University of South Carolina. <<

Cindy Munn
Executive Director, Louisiana
Health Care Quality Forum

LAPOST: An Achievement for Providers, Patients, and Families

My mother was a vibrant, fiercely independent, Cajun woman who lived alone and looked after herself for 30 years after my father died.

In 2005 and at the age of 78, she needed emergency surgery. While the procedure was successful, a series of complications began eroding her health and self-sufficiency over the next three, sometimes-grueling years until she passed away in 2008.

Watching her health fade was painful enough. To see her cherished independence spiral away, however, was almost too much to bear. She had no, or very little, control in fundamental decisions on her medical care and, ultimately, how her life would end.

That left my two sisters and me to make countless difficult decisions about our mother's life. Would we keep taking her back to the emergency room? Should she be resuscitated if she stopped breathing? At what point do we say no more?

When I joined the Louisiana Health Care Quality Forum (LHCQF) and learned it was involved in creating the end-of-life care document that would eventually become LaPOST, no one had to convince me it was a worthwhile effort.

Composed with input from health care and legal professionals throughout the state and given final approval by the Legislature in June 2011, the Louisiana Physician Order for Scope of Treatment, or LaPOST, is a document that empowers terminally ill patients to decide for themselves the type of care they would like to receive when cure is not possible.

LaPOST was created as a best-practice model through the efforts of the LaPOST Coalition, a statewide network of Louisiana health care professionals that operates through LHCQF. Endorsed by the Louisiana State Medical Society, the Coalition is led by the capable hands of Dr. Susan Nelson, medical director of senior services for the Franciscan Missionaries of Our Lady Health System.

Dr. Nelson will be very visible in the coming months as she takes part in LaPOST outreach programs planned around the state. "We want the medical community to know that LaPOST is here and the change it represents," she said. "Most of all, we want to help prepare physicians for patients who ask about LaPOST."

The document allows terminally ill patients to state their preferences for end-of-life treatment in a physician's order. It is modeled after the Physician Order for Life Sustaining Treatment, also known as the POLST Paradigm document, organized through the Oregon Health Sciences University beginning in the early 1990s. Louisiana is the latest of several states nationwide that have developed similar documents modeled after POLST.

"Medical advancements allow doctors in some cases to significantly prolong patients' lives. While some patients might benefit from that, it may not be the ideal treatment for everyone," Dr. Nelson explained. "LaPOST gives patients who face terminal illness more control in deciding the point where active curative treatment is no longer attempted and the focus is on comfort and symptom management."

LaPOST is completely voluntary and neither for nor against treatment. The document is publicly available, but must be completed by a doctor to become valid. It's printed on bright gold paper, making it easily recognizable for patients and caregivers.

Moreover, LaPOST travels with patients throughout the health care system – from their homes to hospitals to nursing homes – with clear and concise instructions. The original document stays with patients, and copies are considered valid and legal.

LaPOST's portability is a crucial benefit for patients' families. As my mother moved among various health facilities during her illness, we were forced to constantly repeat and reinforce her treatment preferences.

LaPOST should be distinguished from two other end-of-life documents – a living will and health care power of attorney.

A living will, sometimes referred to as an advance directive, also helps individuals plan and declare their end-of-life

preferences but usually in advance of any illness. A health care power of attorney document allows an individual to designate a proxy to make health care decisions. Both documents become effective if a patient is incapable of making decisions.

LaPOST, meanwhile, is a physician order recommended specifically for patients with a terminal illness and a life expectancy of less than a year. It takes effect if the patient is unable to communicate and is honored by health care providers throughout the state.

While all three measures play important roles, LaPOST was designed to eliminate much of the confusion and heart-rending decisions families often face during a terminally ill loved one's last moments of life. As others who've faced similar experiences can attest, this is perhaps the hardest part. Your head knows what is happening, but your heart struggles to make a decision.

"In the absence of stated preferences or a clear plan, routine questions and second-guessing among family members sometimes balloon into personal and bitter disputes."

We agonized, for example, about whether my mother should continue receiving antibiotics, knowing the medication wouldn't change an outcome that was inevitable.

My sisters and I were a united front throughout the

process, reaching consensus on all decisions. We were fortunate in that respect.

Physicians and providers know all too well that emotions run very high when loved ones, especially those unable to communicate or make decisions for themselves, are faced with terminal diagnoses. In the absence of stated preferences or a clear plan, routine questions and second-guessing among family members sometimes balloon into personal and bitter disputes.

Those are precisely the scenarios LaPOST was designed to prevent. Family members, as well as caregivers, have peace of mind knowing that loved ones are treated according to their own wishes.

Ultimately, my sisters and I decided that above all, we didn't want our mother to suffer. In the last several months of her life, our focus turned to palliative care and ensuring she remained comfortable. Through an extraordinary bit of coincidence, luck or perhaps fate, her hospice care was overseen by Dr. Nelson, who demonstrated an inspiring level of compassion and personal concern during my mother's remaining time with us.

"We want the medical community to know that LaPOST is here and the change it represents. Most of all, we want to help prepare physicians for patients who ask about LaPOST."

— DR. SUSAN NELSON

A few years later when Dr. Nelson and I were reacquainted through the LaPOST Coalition, I knew firsthand that she was among the very best to lead this effort with a deft understanding of countless related issues. She knows, too, that the hard work is just beginning.

"Though the document is complete, we're still in the early stages of education and awareness," Dr. Nelson said. "We'll be meeting with medical professionals to fully explain LaPOST and the resources that are already available on our website, www.la-post.org."

As a private, nonprofit organization, LHCQF is committed to improving health care for all Louisiana residents through a number of initiatives. I have no doubt that LaPOST will be one of the most important moving forward. <<

Congressman Bill Cassidy, MD

The GOP Approach to Medicare

Paul Ryan's budget has ignited the debate over the future of Medicare. CMS Director Don Berwick recently opined in the *Wall Street Journal* on the superiority of Obamacare in controlling Medicare costs. Dr. Berwick and Congressional Democrats believe that increasing the role of Washington, D.C. in everyday health care decisions will lower costs. On the other side, Republicans believe that giving patients a choice and encouraging competition is the best way to preserve Medicare for those on or about to be on Medicare and also strengthen the program for future generations.

All acknowledge that Medicare is unsustainable in its current form. Medicare is projected to cost $569.3 billion this year and grow at an astonishing 5.6% annual rate through 2021 - exceeding the growth of GDP. This growth will be fueled by the more than 16.5 million baby boomers entering Medicare. Since almost half of Medicare's funding comes from general appropriations, Medicare's growth directly contributes to the deficit. If nothing is done to change our current trajectory, the entitlements of Medicaid, Medicare, Social Security, and the interest on our debt will consume every federal tax dollar by 2025 - 14 years from now.

Dr. Berwick and other apologists insist that Obamacare will save Medicare by capping expenditures by fiat. To enforce this, Obamacare created the "Independent Payment Advisory Board" (IPAB), a new government bureaucracy of un-elected officials who are supposedly empowered to address waste. However, the chief CMS actuary questions the ability of IPAB to achieve savings through decreasing Medicare payments. A report from the actuary states, "Similarly, the further reductions in Medicare growth rates mandated for 2015 through 2019 through the Independent Payment Advisory Board may be difficult to achieve in practice."

In reality, the IPAB is severely restricted in the areas where it can address waste. It specifically cannot recommend rationing of care, raising revenues, increasing Medicare beneficiary premiums, increasing cost-sharing or restricting benefits. Since hospitals and nursing homes are not subject to cost-cutting until 2020, the IPAB will most likely attempt to save money by cutting payments to physicians, Medicare Advantage plans, and prescription drug plans. The principal effect of IPAB will be to eliminate the private sector's role in Medicare and decrease payments to providers, thereby decreasing beneficiaries' access to physicians.

If nothing is done to change our current trajectory, the entitlements of Medicaid, Medicare, Social Security, and the interest on our debt will consume every federal tax dollar by 2025 - 14 years from now.

Indeed, if the current reductions in physician reimbursements and Obamacare's productivity updates are enacted, payments to Medicare physicians would be cut nearly in half by 2019. A recently released report from CMS shows these cuts are unrealistic and virtually certain to be overridden by Congress. Yet on the basis of cuts like these, Obamacare is touted to save money.

Dr. Berwick also states that the Accountable Care Organizations (ACOs) that Obamacare establishes will control Medicare costs. ACOs theoretically encourage coordination of care between doctors, hospitals, and other providers. However, demonstration models do not support these

claims. A recent article in the *New England Journal of Medicine* states that seven out of the ten demonstration projects designed and funded to prove that ACOs could work actually lost money in the time period analyzed. Of note, the locations for the pilot programs were specifically chosen because they seemed likely to succeed as ACOs.

The proposed rule for ACOs defies description. Patients will not know what ACOs they belong to, and doctors and hospitals will not know if patients belong to the particular ACO for which they work. Making matters worse, doctors and hospitals will be penalized if the patients, whom they do not know for sure are in their ACO, do not follow their advice. If this seems convoluted, good luck with the rest of the rule. To imagine that this will yield savings places too much faith in the power of supercomputers to track individual doctor-patient interactions.

Dr. Berwick and others have contrasted health care with other areas of the economy where competition has led to higher quality and lower consumer costs. When consumers spend money they control and are equipped with information about quality and price to make the best decisions for their pocket books, quality increases and cost decreases. Strangely enough, Dr. Berwick does not acknowledge that there is evidence of this working in Medicare.

When Republicans enacted Medicare Part D drug coverage, the program was constructed to encourage competition and cost consciousness. Because of this, the program is 40% under initial cost estimates. In addition, direct medical costs are lower because, thanks to the prescription drug benefit, patients are able to manage their diseases at home instead of being admitted to a hospital. In order to avoid the "doughnut hole," patients, undirected by a central planner, choose to purchase generic drugs. In response to market forces, Wal-Mart and others began to supply generic drugs at $4/prescription, generating savings for patients and Medicare.

The irony is Dr. Berwick is right: competition increases quality and lowers cost. But this is the foundation of the GOP approach to Medicare, not that of the legislation he defends. **<<**

Bruce D. Greenstein
Secretary, Louisiana Department of Health and Hospitals

Planning for Better Health

There is no doubt that a well-performing government, at any level, is an important part of a successful society. Where failure has occurred is when public institutions begin counting success as simply continuing to exist. The world is changing, particularly around health care. We may continue to merely exist and churn out the same processes of each previous year, perhaps with fewer dollars and people, but then we should not be surprised when our children remain among the most obese, our babies continue to be born premature, and our adults die earlier with unmanaged chronic disease.

Governor Jindal took office in 2008 with a vision to transform government to deliver better services at lower costs. While DHH is an organization filled with dedicated individuals, we have lacked the structure to plan executable goals and effectively manage and measure our progress. In early September, the Department of Health of Hospitals publishes its business plan for fiscal year 2012 (the second of its kind). I do not pretend this plan will solve our state's health challenges. What it does say—and I think this is incredibly important—is that the government agency charged with the mission of protecting and promoting the health of the people of this state is, in many areas, challenging the notion of "business as usual."

I invite you to visit dhh.louisiana.gov and explore the plan thoroughly. Within, you will find thoughtful analysis of our state's current health status, including both challenges and opportunities we have before us. We'll explore DHH's impact as the state's health care agency, including a business review of critical functions and an honest look at performance. The heart of this plan is a detailed description of our top policy and programmatic priorities for health care that put the Governor's vision into action. It also includes internal development initiatives designed to help us work smarter and deliver higher value to taxpayers and the people who receive our services.

These priorities are expressed through transformative initiatives that, while not inclusive of the department's entire book of business, fit within a business platform we have identified as the basis for our objectives: using technology to transform health care, innovating delivery of care, improving our health outcomes, and building a smarter and more efficient agency. They include things like the successful transformation of Medicaid through implementation of Coordinated Care Networks, continued execution of the state's health information technology agenda, and our commitment to expand access to community-based care for the elderly and people with developmental disabilities.

While this business plan is focused on objectives for fiscal year 2011-2012, we have an eye on the long-term horizon as we begin to think carefully about how our state is preparing and responding to an evolving world. That's why you will also find passages aimed at sparking a thoughtful dialogue about the future of public health, rural health, our health care workforce and long-term care in our state. Following the release of this plan, DHH will publish a series of white papers around these issues and host summits where stakeholders and consumers can participate in a discussion about their future. Hopefully, together, we can create an executable plan that will place Louisiana at the forefront of innovative and effective health care delivery in the twenty-first century.

Another overarching theme of this plan, and of our entire philosophy, is ownership. Through the priorities and commitments made within, DHH is accepting ownership and accountability for the successful execution of the responsibilities bestowed upon us by people of this state. We pledge to seek every opportunity to ensure that we are spending the dollars that you, the taxpayer, have entrusted to us with the highest levels of integrity, efficiency, and effectiveness. But, in this case, ownership is a two-way street. It is no secret that our state lags in countless health rankings and indicators, but we should not accept 49th in perpetuity. Our potential is much greater and we will only succeed by working together and taking personal responsibility, so I encourage you to take ownership of you and your family's health. Better well-being can be achieved one thoughtful decision at a time: soda or water; fried or baked; an hour of television or a walk around the neighborhood. These are the challenges we are faced with. They are not easy and, like you, I face my own each day. Nevertheless, I aim to choose better health: for me, my family, and my state, and I hope you will too.

Learn more at dhh.louisiana.gov. <<

HOSPITAL ROUNDS

Ochsner Offers eICU

Ochsner Health System has signed an agreement with Philips VISICU to implement its state-of-the-art eICU Program to enhance critical care. Ochsner states it is the only provider in Louisiana to offer the program, which has been proven to reduce complications, shorten hospital length of stay and save lives. Ochsner will serve as a statewide resource to community and rural hospitals which can benefit from expanded critical care staffing and technology.

Studies have shown improved outcomes and decreased lengths of stay for patients in ICUs managed by intensivists (physicians trained as specialists in critical care). However, as there is a severe shortage of these specialized doctors in the U.S., many hospitals are unable to have critical care physicians on-site 24 hours a day. The eICU Program solves this problem.

The eICU Program will connect Ochsner's bedside care teams with off-site critical care physicians and nurses using advanced software and continuous remote monitoring technology from Philips VISICU. The software detects and advises clinicians of important trends and changes in a patient's condition, enabling more proactive care with fewer complications. Use of the 2-way audio-video capability also allows the off-site intensivist to interact and collaborate with the bedside medical team and the patient's family to make important, time-sensitive patient care decisions.

The installations began in July at Ochsner Baptist Medical Center, Ochsner Medical Center-Kenner and Ochsner Medical Center-Baton Rouge with plans to go live in the first quarter of 2012. The rollout to remaining Ochsner hospitals will continue through 2012.

Volunteers Help NICU Infants Heal

For the past decade, babies in Woman's Hospital's NICU and Special Care nursery have enjoyed the warmth, tenderness, and TLC of volunteer "Cuddlers." While these volunteers are strangers to the infants, they are well known and valued by the Woman's staff. Celebrating its 10th year of service, the Cuddler Program currently has 29 active volunteers from around the region.

Celebrating its 10th year of service, the Cuddler Program at Woman's Hospital in Baton Rouge, currently has 29 active volunteers from around the region.

The role of the Cuddler is three-fold: to calm and interact with premature babies, offer support to families of NICU infants who can't be at the hospital with the babies, and to offer assistance to the nursing staff in providing additional human touch. Studies show that tactile stimulation such as massage, human touch, and cuddling can help improve weight gain in newborns, especially premature babies. The calming effects allow the infant to relax and focus its energies on growing and hopefully go home sooner.

The Woman's Cuddlers don't give medications, feed babies or walk around with them. They just hold them, rock them, read, or sing songs to them, providing whatever stimulation the baby responds to best. Sometimes, when all the babies are at rest, Cuddlers help replenish supplies in the unit and run errands around the hospital to support the staff. Each volunteer chosen to participate in the program must complete a detailed screening and training process to learn special techniques required to handle the babies. Over the last ten years, there has almost always been a waiting list of volunteers.

Rideau and Ragsdale Appointed to Lane Board of Commissioners

Mayor Harold Rideau and Frank Ragsdale were both recently appointed by the Metropolitan Council of East Baton Rouge Parish to a four-year term on the Board of Commissioners at Lane Regional Medical Center. Rideau is replacing James "Goose" Carroll who left the board after 8 years of service. Ragsdale replaces Robert Williams who served on the board for 22 years.

Rideau has served as Mayor of Baker since July 1, 2004. He retired from Exxon Chemical in 2004 after more than 36 years of service. Rideau also served as an Assistant Professor at Southern University College of Engineering.

Ragsdale, a Certified Registered Nurse Anesthetist, retired from Lane in 2009 after 17 years of service, where he served as director of Anesthesia.

Lane Regional Medical Center is governed by a nine member board of commissioners who are appointed by the Metropolitan Council. Current members are Dell Guerra (Board Chair), Dr. Keith Elbourne, Pat Gauthier, Jimmy Johnson, Joan Lansing, Judy Myles, Frank Ragsdale, Mayor Harold Rideau and Mark Thompson.

Woman's Receives Accreditation with Commendation

The Woman's Hospital Cancer Program has been awarded a full Three-Year Accreditation with Commendation from the Commission on Cancer (CoC). Accreditation is given to those facilities that voluntarily commit to providing the highest level of quality cancer care and undergo a rigorous on-site evaluation. Accreditation reinforces that Woman's cancer patients have access to a quality, comprehensive program with a multidisciplinary approach to treatment; from prevention and early diagnosis, through treatment, rehabilitation, surveillance for recurrent disease, and end-of-life care, including a breast health navigator, who guides breast cancer patients along their journey.

Across the United States, approximately 80 percent of all newly diagnosed cancer patients are treated in CoC-accredited cancer programs. The American College of Surgeons Commission on Cancer is a consortium of professional organizations dedicated to improving survival rates and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive, quality care.

Manson Selected for CHA Tomorrow's Leaders Program

Stephanie Manson, MSHA, MBA, Vice President of Operations for Our Lady of the Lake was honored by the Catholic Health Association (CHA) at the 2011 Catholic Health Assembly, where she was named a participant in the Tomorrow's Leaders Program. The program recognizes those young leaders who have already demonstrated commitment to advancing the mission of Catholic healthcare. Manson was selected because of her strong leadership and passionate commitment to the healing mission of the Franciscan Missionaries of Our Lady.

LEFT: Stephanie Manson, MSHA, MBA, Vice President of Operations for Our Lady of the Lake, was honored by the Catholic Health Association. **RIGHT:** Sidney Ross, Jr., MD, FACS, has joined Baton Rouge General Surgical Associates, part of Baton Rouge General Physicians.

Ross Joins Baton Rouge General Surgical Associates

Sidney Ross, Jr., MD, FACS, has joined Baton Rouge General Surgical Associates, part of Baton Rouge General Physicians. Dr. Ross is Board Certified in general surgery. He is a member of several professional organizations including the Louisiana State Medical Association, American Medical Association, and the American College of Surgeons. Dr. Ross is a graduate of Louisiana State University School of Medicine in New Orleans. He completed his internship at University of Mississippi in Jackson, Miss., and his residency in general surgery at Charity Hospital of Louisiana in New Orleans.

EKL Closes Labor and Delivery Services

Earl K. Long Medical Center (EKLMC) began closure of its inpatient labor and delivery services in July. This closure includes the Well Newborn Nursery, Intermediate Care Nursery, and Neonatal Intensive Care Nursery. EKLMC will move its labor and delivery services to Woman's Hospital. "Our plan is to ensure the best services possible for our patients while allowing the LSU Obstetrics and Gynecology (OB/GYN) residency program to maintain its high level of training," said Dr. Kathy Viator, CEO of EKLMC.

ABOVE: Laci Theunissen, MD, a dermatologist, has joined Our Lady of the Lake Physician Group.

LEFT: Team members Rachelle Noland, Dana Bellefontaine, Kasey Cooke, and Kathy Peairs accepted the Louisiana Hospital Quality Award on behalf of the Lane RMC Quality Resources Department.

The LSU OB/GYN program will continue its prenatal and woman's services and fetal stress testing at the outpatient clinic at the LSU North Baton Rouge Clinic on Airline Highway. Staff members currently assigned to labor and delivery and supporting care areas will be provided positions within EKLMC and LSU clinics in Baton Rouge. A reduction in employees is not anticipated.

All FMOLHS Hospitals Recognized for Quality

All four Franciscan Missionaries of Our Lady Health System (FMOLHS) hospitals were recently recognized for quality by the Louisiana Quality Foundation. The Louisiana Quality Foundation gives Performance Excellence Awards based on the National Malcolm Baldrige criteria. "The Louisiana Performance Excellence Award recognition for all four of our hospitals is a first for any Louisiana Health System," said John Finan, CEO, FMOLHS.

- Our Lady of the Lake Regional Medical Center in Baton Rouge received the Level III Performance Excellence Award
- St. Elizabeth Hospital in Gonzales received the Level III Performance Excellence Award
- Our Lady of Lourdes in Lafayette received the Level II Performance Excellence Award
- St. Francis in Monroe received the Level II Performance Excellence Award

The Louisiana Performance Excellence Award is a statewide award recognizing quality leadership in education, government, manufacturing, service industries, healthcare, and non-profit organizations. The purpose of the award is to promote quality and performance excellence awareness and practices in Louisiana and recognize the quality achievements of Louisiana organizations. Organizations that are recognized are evaluated based on their proven effectiveness, sustainability, innovation, integrated processes and tracked results.

OLOL Physician Group Welcomes New Dermatologist

Our Lady of the Lake Physician Group has welcomed Laci Theunissen, MD to Dermatology at Bocage. Theunissen earned her degree in medicine from the Louisiana State University School of Medicine and completed her internship at the Louisiana State University Health Sciences Center, both in New Orleans. She performed her residency in dermatology at the University of Oklahoma Health Science Center in Oklahoma City. Theunissen is a Board Certified dermatologist.

Lane RMC Receives Quality Award

Lane Regional Medical Center has received the 2010 Louisiana Hospital Quality Award, presented by eQHealth Solutions, the Medicare Quality Improvement Organization for Louisiana. With this award, Lane Regional is recognized as one of only 38 hospitals in the state for achieving continued improvement of care in the areas of Acute Myocardial Infarction (Heart Attack), Heart Failure, Pneumonia, and Surgical Care.

The clinical areas measured for the award have been designated as national health care priorities by the Centers for Medicare & Medicaid Services. Staff members from Lane Regional's Quality Resources Department have been working with quality improvement specialists from eQHealth Solutions to use proven, evidence-based practices to improve care for patients.

Team members Rachelle Noland, Dana Bellefontaine, Kasey Cooke, and Kathy Peairs accepted the Louisiana Hospital Quality Award on behalf of the Quality Resources Department.

Woman's Study Tackles Diabetes

Woman's Hospital announced a new study focused on preventing the onset of diabetes in

overweight women with a history of gestational diabetes who delivered less than a year ago. In a double-blind placebo trial, for the next two years, Woman's will monitor 150 women in order to determine the effectiveness of two drug combinations in stabilizing sugar and insulin levels and promoting weight loss.

Combined Liraglutide and Metformin Therapy in Women with Previous Gestational Diabetes Mellitus will study overweight women who were diagnosed with GDM in their last pregnancy, have not returned to normal metabolic function, and remain overweight with diagnosed insulin problems. Metformin decreases the amount of glucose (sugar) absorbed from food and the amount of glucose made by the liver. Metformin also increases the body's response to insulin. Liraglutide is a synthetic replica of a naturally occurring, long-acting glucagon-like peptide 1 (GLP-1) that stimulates insulin production only when glucose is ingested orally. It also stimulates satiety, thereby decreasing appetite. In its natural form, this peptide is short lived; however, through a daily injection, the synthetic Liraglutide works all day to stabilize blood sugar levels.

In the double-blind study, neither the participants nor Woman's researchers will know which medications are distributed. While all patients will receive Metformin, only half of the patients will receive Liraglutide and the others a second placebo medication. Participants must have delivered infants at Woman's Hospital and had GDM within the past year, be 18-45 years old, and meet all additional study requirements. Participants will be compensated for their time in addition to receiving free medication, clinic visits with the physician, and testing.

For more information, contact Woman's Health Resources at 225-231-5275.

Cancer Program Accredited with Commendation

The Commission on Cancer (CoC) has granted Three-Year Accreditation with Commendation to The Cancer Program of Our Lady of the Lake and Mary Bird Perkins, marking the 19th year of the program's consecutive Accreditation by CoC. Additionally, the Cancer Program received commendations in all eight major categories surveyed.

The eight major categories surveyed include:

- Institutional and Programmatic Resources
- Cancer Committee Leadership
- Cancer Data Management and Cancer Registry Operations
- Clinical Management
- Research
- Community Outreach
- Professional Education and Staff Support
- Quality Improvement

The Commission on Cancer, a multidisciplinary program of the American College of Surgeons, conducts regular accreditation surveys to ensure that cancer facilities offer a wide-range of medical services and a multidisciplinary approach to patient care. A facility receives a Three-Year Accreditation with Commendation following the onsite evaluation by a physician surveyor during which the facility demonstrates its ability to provide quality care close to home, clinical trials and new treatment options, a cancer registry, ongoing monitoring and enhancement of care and comprehensive care with a multispecialty, team approach.

Woman's Pathology Lab Receives Re-Accreditation

Woman's Hospital Pathology Lab has been awarded a full two-year re-accreditation by the College of American Pathologists (CAP), marking the lab's 30+ years of continuous recognition by CAP. The CAP Laboratory Accreditation Program is designed to help laboratories achieve the highest standards of excellence to positively impact patient care. The CAP Laboratory Accreditation Program, begun in the early 1960s, is recognized by the federal government as being equal to or more stringent than the government's own inspection program.

CAP Accreditation checklists are based on rigorous accreditation standards that are used by the inspection teams as a guide to assess the overall management and operation of a laboratory. Recipients of CAP Accreditation ensure those labs incorporate the development and support of board-certified pathologists and continually evolve to reflect current technology, providing a solid foundation for ensuring excellence in patient safety and compliance. All laboratories in the United States are required to be inspected every two years.

Yorek Joins Baton Rouge Family Medical Center

Michael Yorek, MD, has joined Baton Rouge Family Medical Center, part of Baton Rouge General Physicians. He previously practiced at Oak Grove Family Practice in Prairieville, which is also a part of Baton Rouge General Physicians.

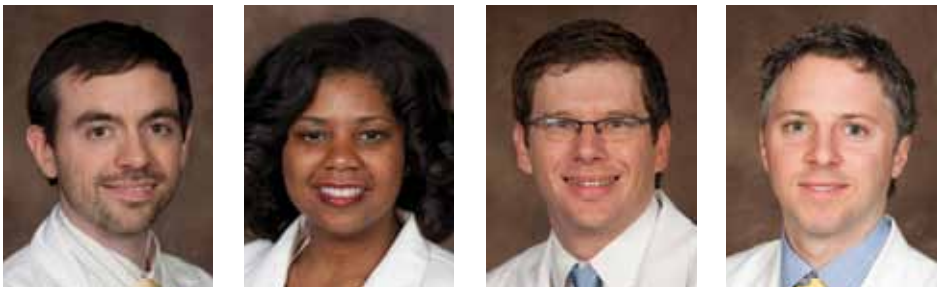
Dr. Yorek is a graduate of the University of Texas Medical Branch in Galveston, where he also completed his residency in family medicine. During his final year of residency Dr. Yorek served as Chief Resident. He also spent eight years as a staff physician in the United States Air Force. Dr. Yorek is Board Certified in family medicine and a member of several professional organizations including the American Academy of Family Physicians, Louisiana Academy of Family Physicians, and Louisiana State Medical Society.

OLOL Welcomes New Pediatric Specialists

Our Lady of the Lake Physician Group recently announced the addition of three new pediatric specialists: James Gardner, MD, Pediatric Endocrinologist; Patrice Tyson, MD, Pediatric Gastroenterology; and Michael Bolton, MD, Pediatric Infectious Disease.

Dr. Gardner earned his degree in medicine from the Louisiana State University Health Sciences Center in New Orleans, where he also completed his internship and residency in pediatrics. He completed his Fellowship training in endocrinology at the University of Alabama at Birmingham. He is Board Certified in pediatrics.

Dr. Tyson earned her degree in medicine from the University of Nebraska Medical Center in Omaha. She completed both her internship and residency in pediatrics at the Louisiana



FROM LEFT: James Gardner, MD, Pediatric Endocrinologist; Patrice Tyson, MD, Pediatric Gastroenterology; and Michael Bolton, MD, Pediatric Infectious Disease, all with Our Lady of the Lake Physican Group and Taylor Theunissen, MD with the Center for Reconstructive and Cosmetic Surgery.

State University Health Sciences Center in New Orleans, where she also trained for her Fellowship in pediatric gastroenterology and nutrition. She is Board Certified in both pediatrics and pediatric gastroenterology.

Dr. Bolton earned his degree in medicine from the Louisiana State University Health Sciences Center in Shreveport, where he also completed his internship and residency in internal medicine/pediatrics. Dr. Bolton completed his Fellowship training in pediatric infectious disease at Nationwide Children's Hospital in Columbus, Ohio. He is Board Certified in pediatrics.

OLOL Physician Group Adds Plastic Surgeon

Our Lady of the Lake Physician Group has welcomed Taylor Theunissen, MD to the Center for Reconstructive and Cosmetic Surgery. Dr. Theunissen's surgical interests are in pediatric cleft and craniofacial surgery as well as cosmetic, reconstructive, orthognathic (corrections of the jaw and face) and sleep surgery.

Dr. Theunissen earned his degree in medicine from the Louisiana State University School of Medicine in New Orleans and completed his residency in orthopaedic surgery at Louisiana State University Health Sciences Center in New Orleans. He completed his residency in plastic and reconstructive surgery at the University of Nebraska Medical Center in Omaha, Nebraska and later completed his Fellowship in craniofacial plastic surgery at Stanford University

Medical Center in Palo Alto, California. He is a member of the American Society of Craniofacial Surgery; American Society of Plastic Surgeons; and American Society of Maxillofacial Surgeons.

Lane Launches Behavioral Health Services

Lane Regional Medical Center announced the opening of its newest program, Lane Behavioral Health Services, which is an intensive outpatient program designed to help individuals through times of stress, fear, depression, anxiety, and behavioral or emotional crises. It is a medically-directed, active treatment program that teaches practical ways to take charge and develop the long-term skills needed for personal success.

Anyone may contact Lane Behavioral Health Services directly, including individuals needing help, family members, friends, clergy, assisted living/group home facilities, retirement communities, physicians, and behavioral health professionals. Physician referrals are not required.

Lane Behavioral Health Services is located at 6180 Main Street, Suite A, in Zachary.

Breast Center Accredited by NAPBC

The Breast Center at Woman's Hospital has been granted three-year/full accreditation designation by the National Accreditation Program for Breast Centers (NAPBC), a program administered by the American College of Surgeons. NAPBC Accreditation is awarded to centers that provide the highest level of quality breast care and undergo a rigorous evaluation process and review of their performance. Opened in 1985, the Breast Center at Woman's is also designated a Breast Imaging Center of Excellence by the American College of Radiology (ACR). Woman's Hospital reports it is currently the only Louisiana hospital with accreditations by both the NAPBC and ACR for excellence in breast care.

To achieve NAPBC full accreditation, Woman's demonstrated full compliance of NAPBC standards for treating women who are diagnosed with the full spectrum of breast disease. These standards included proficiency in the areas of center leadership, clinical management, research, community outreach, professional education, and quality improvement. <<

AD INDEX / A RESOURCE GUIDE

AIRPORT

Baton Rouge Metropolitan Airport
9430 Jackie Cochran Dr.
Baton Rouge, LA 70807
225.778.1567
www.flybtr.com

ATTORNEYS

Breazeale Sachse & Wilson
One American Pl. # 2300
Baton Rouge, LA 70825
225.387.4000
www.bswllp.com

Jones Walker
201 St. Charles Ave.
New Orleans, LA 70170
504.582.8000
www.JonesWalker.com

Kean Miller Law Firm
400 Convention St., Ste. 700
Baton Rouge, LA 70802
225.387.0999
www.keanmiller.com

AUTOMOTIVE (DEALERS)

Brian Harris BMW
22336 Airline Hwy.
Baton Rouge, LA 70817
888.527.4269
www.brianharrisbmw.com

AUTOMOTIVE (TIRE AND CARE)

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

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

BEHAVIORAL HEALTH

LifeNet Behavioral Health
10626 Timberlake Ave.
Baton Rouge, LA 70810
225.329.2600
www.LifeNetBH.com

CARDIOVASCULAR

Cardiovascular Institute of the South
7941 Picardy Ave.
Baton Rouge, LA 70809
225.308.0247
www.cardio.com

CLEANERS

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

CONSULTING

6SigmaTek
1384 Prestbury Rd.
Concord, NC 28027
704.604.9470
www.6sigmatek.com

FINANCIAL SERVICES

Campus Federal
6230 Perkins Rd.
Baton Rouge, LA 70808
225.761.0888
www.CampusFederal.com

FLORIST

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

FOOT CARE

Foot Care and Surgery Center
Baton Rouge, Denham Springs, Gonzales, Prairieville, Zachary, Lutcher, Brusly
225.757.8808
www.FootCareAndSurgery.com

HEARING AIDS

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

HOME HEALTH

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

HOSPITALS

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

Children's Hospital
200 Henry Clay Ave.
New Orleans, LA 70115
225.383.9000
www.chnola.org

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

Ochsner Medical Center-Baton Rouge
17000 Medical Center Dr.
Baton Rouge, LA 70816
225.752.2470
www.ochsner.org

Our Lady of the Lake Regional Medical Center
5000 Hennessy Blvd.
Baton Rouge, LA 70808
225.765.6565
www.ololrmc.com

IMAGING

Radiology Associates, LLC
5000 Hennessy Blvd.
Baton Rouge, LA 70808
225.765.6470
www.lakeradiology.com

INSURANCE

Blue Cross & Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809
225.295.3307
www.bcbsla.com

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

LHA Physicians Trust
4646 Sherwood Common Blvd.
Baton Rouge, LA 70816
225.272.4480
www.hsli.com

Louisiana Health Plan
P.O. Drawer 83880
Baton Rouge, LA 70884-3880
225.926.6245
www.lahealthplan.org

Peoples Health
3838 N. Causeway Blvd., Ste. 2200
Metairie, LA 70002
800.631.8443
www.peopleshealth.com

LINEN SERVICES

Westport Linen Services
510 Kornmeyers Plaza
Baton Rouge, LA 70806
225.218.8878
www.westportlinen.com

MEDICAL EQUIPMENT & SERVICE

Majestic Medical Solutions
207 W. Eastbank St.
Gonzales, LA 70737
225.677.9867/866.580.9729
www.majesticms.com

ORTHOPEDICS

Baton Rouge Orthopaedic Clinic
8080 Bluebonnet Blvd.
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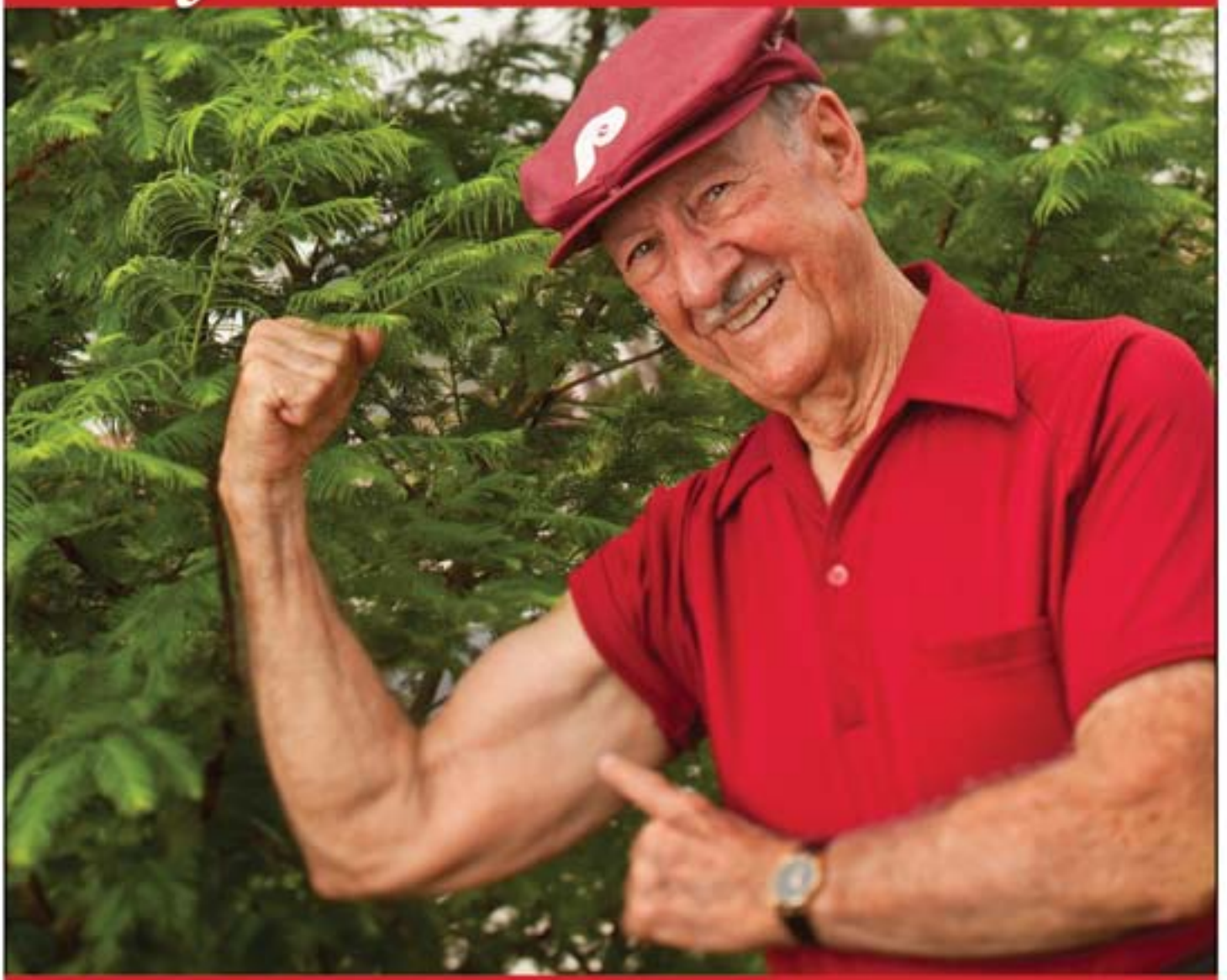

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