Blue Cross, FMOL Struggle With Split

The Dish on DSH Funds

AIDS in Africa
A Baton Rouge Angle

Unlocking Potential at McMains

One on One with Dionne Viator
Baton Rouge General Health System
The Louisiana State Medical Society Awards

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Greetings,

We recently moved up to 47th in a national health ranking. This is great, I guess. I don’t want to minimize this accomplishment, but I’ll save the champagne for when we get to 37th. While there are many positives to be proud of, I have no doubt there are many in town who would not be so thrilled with a 47 in BCS rankings. Even as the Editor of the Healthcare Journal, I would not be so bold as to suggest our priorities are somewhat misplaced as they relate to being a fan of LSU athletics vis-a-vis our aggregate health rankings. It’s just not as exciting to jump up and down over lower smoking prevalence as it is a nice Brandon Lafell grab.

However, as the nation’s elected officials continue to wrangle over who will pay for our current system of healthcare coverage, I would like to take a moment to focus on one of the greatest issues affecting our healthcare. This issue is our health. More specifically, I would like to discuss our ideas of risk as it relates to health and children.

One of our more severe health risks in modern times is childhood obesity. Yet more and more you hear parents rationalize why their children should not go outside and play. For sure there are risks. The national 24-hour media never lets us forget all the dangers associated with being alive. Parents, excuse my critique, but I would rather expose my child to the risk of a sprained ankle, ant bite, scraped knee, and bee sting over more damaging health risks such as diabetes, cancer, heart disease, emotional fear, etc., etc. Children should not wheeze from their out-of-shape bodies for their parents to change out a video game for them in the parents’ hopes this isolated, television-based, controlled environment will spare them the harm associated with riding their bicycles or running outdoors. I don’t question the parents’ motives, but I do question their statistical understanding as it relates health and the risks associated with simply living a full life.

I’ll avoid any walking to school five miles in the snow stories. But if you are like me, growing up as a kid in the 70s and 80s in average areas like Sherwood Forest and Broadmoor, you likely don’t recall many obese children in the neighborhood. The statistics say there was significantly less obesity. Our memories tell us there was much less obesity. Kids didn’t have to rely on all their sports/activities to be parentally organized. They just played.

Let the kids throw rocks, let them ride their bikes, let them swim, run, and take chances. They will get hurt sometimes. But it is much better than the alternative.

Hope you had a fun and safe holiday.

Smith W. Hartley
Louisiana

Overall Rank: 47
Change: ▲2
Determinants Rank: 44
Outcomes Rank: 46

Ranking: Louisiana is 47th this year; it was 49th in 2008.

Strengths:
- Low prevalence of binge drinking
- High immunization coverage
- Few poor mental health days per month

Challenges:
- Low high school graduation rate
- High rate of uninsured population
- High premature death rate

Significant Changes:
- In the past year, the rate of preventable hospitalizations decreased by 11%.
- In the past five years, the prevalence of smoking decreased by 23%.
- In the past ten years, immunization coverage increased by 34%.
- Since 1990, the prevalence of obesity increased by 135%.

State Health Department Web Site: www.dph.hhs.state.la.us
U.S. Sen. Mary Landrieu has been under enormous pressure from supporters and critics of healthcare reform, state officials, and healthcare providers facing shortfalls in Medicaid, and her own political party. One thing is certain—she is working diligently to ensure the best outcome for Louisiana. The state is rapidly approaching a major healthcare funding crisis, which will have a negative impact on the approximately one million children, mothers, elderly, disabled and others who benefit from the Louisiana Medicaid Program. Because of this, Sen. Landrieu negotiated with Senate leadership to include a provision in the Senate healthcare bill that would adjust the calculation that determines the amount of federal money Louisiana receives for the Medicaid program. With that provision, Louisiana stands to receive around $300 million in additional funding to help care for our state’s most vulnerable patients.

We appreciate the work Sen. Landrieu has done and urge her and our Congressional Delegation to focus on two other critical health reform issues being considered. Hospitals statewide are facing cuts of approximately $2 billion over the next ten years due to cuts in Medicare payments to fund expanded healthcare coverage for the uninsured. Hospitals are also potentially facing up to $770 million in additional reductions annually resulting from cuts that may accompany a public insurance option. This could lead to a loss of approximately 16,200 jobs statewide.

There is still much work to be done locally and nationally, and healthcare providers will continue to work with Sen. Landrieu and the rest of Louisiana’s Congressional Delegation to protect patients throughout Louisiana.

John Matessino
President and CEO
Louisiana Hospital Association

When news broke that Senator Mary Landrieu would vote to allow the Senate to begin debate on the health care bill with the insertion of $300 million in Medicaid money for Louisiana, I knew she would be criticized. I also anticipated that the next round of criticism would surely be aimed at Governor Bobby Jindal, our fiscally conservative Governor, because he asked the Senator and all members of Louisiana’s delegation for their assistance with this particular issue.

One can imagine my disbelief then, at the outrage expressed nationally towards Senator Landrieu over the following weekend and the form it has taken. These comments have become extremely sexist and inappropriate. These vicious attacks are indicative of our loss of respect for politicians and the political process. I also fear the implication is that we have lost respect for each other. In this situation, I cannot watch this mockery without voicing my opinion. One thing which seems to be driving the extremes in language is the continual desire for attention and ratings.

This situation should prompt our elected officials and community leaders to say enough is enough. We are adults and must find a way to respectfully disagree with candor and without humiliation and bias. As parents, we must start holding elected officials and the media accountable. I hear adults often express concern about the next generation and their lack of respect for elders, authority and their community. What are we teaching young people if we allow this sort of dialogue to continue? Furthermore, how can we expect the rest of the country to respect Louisiana if we cannot show that respect for one another. It is simply unacceptable. I applaud Congressmen Scalise and Cao for issuing written statements expressing disdain for Rush Limbaugh and Glenn Beck’s comments. I am hoping our Governor will also set an example by publicly denouncing the degrading and insulting comments directed at one of Louisiana’s senators.

(cont.)
I do not agree with Senator Landrieu on several issues, however, in this situation she is responding and acting on behalf of Louisiana at the personal request of Governor Jindal and his administration. So, what name shall we call him?

Laurinda Calongne
President, Robert Rose Consulting

I have read several of your articles and although you are a registered independent, I'll bet you side with the GOP 99.99% of the times. It would be interesting to know the political affiliation of your editorial advisory board, let me guess all GOPers. Please advise me who isn't. If they all belong to the GOP how can you present an unbiased and fair roundtable discussion on healthcare reform. Where is the diversity or does it matter. After reading each of their responses one can very easily understand that they like all of the LA congressional representatives are not for their constituents but for the failure of healthcare for all Americans, never mind it includes Louisiana. It's no wonder LA is at the bottom and will continue to be there, especially when our reps are constantly biting the hands that feed us. At all levels we are looking and begging for Federal help while we are constantly degrading it. This is true when it comes to the recovery as well. All of you know so well what will work, but none of you are young so explain why over the years you have not been able to fix LA and lift it up from last place. I like Levine's comment also, however, it should read Louisiana are poor but not stupid. Next month trying writing your point of view while holding the Democratic flag and getting comments from that side of the aisle, would make for some very interesting reading. And oh! what is the market share of health insurance providers in LA and please don't quote their point of view, especially when it is strictly profit driven. Remember some of our past insurance commissioners are behind bars.

Jules Ambrose, Sr.

Nobody is fooled when you say you are an independent. It's clear from your writing you are a liberal.

Christopher Cokinos
Houston, TX

In an unprecedented show of support and compassion for our state's elderly by a First Lady of Louisiana, Supriya Jindal embarked on a three-week tour visiting nursing facilities and distributing Christmas ornaments to its residents.

Mrs. Jindal arrived at the idea herself to give the ornaments to the nursing homes and to let the residents hang them on the facility's Christmas tree. The ornaments, which once donned the Governor's Mansion tree, were handmade by Louisiana schoolchildren. During her visits, Mrs. Jindal was gracious and sincere, visiting and shaking hands with each resident and staff member.

On behalf of the nursing facilities of Louisiana, I thank Mrs. Jindal for her act of kindness towards our state's seniors. It is well beyond the mandates of her position, and she is to be commended for her generosity and forward-thinking.

Joseph A. Donchess
Executive Director
Louisiana Nursing Home Association
With all of the talk about healthcare reform nationally and ongoing worries about Medicaid cuts locally, one of the things consistently discussed as being in danger is our DSH or Disproportionate Share Hospital funding. A loss of DSH funds spells bad news both for our public hospitals and for the private hospitals treating the uninsured and under-insured. But what exactly are DSH funds, why are they so important, and why are we in danger of losing them?
Disproportionate Share Hospital (DSH) funds were the brainchild of the U.S. Legislature in the 1980s—a way to help out so-called safety net hospitals, i.e. the ones providing more than their share of uncompensated care or unreimbursed care for Medicaid and Medicare patients. The idea was to make up for the reduced or complete lack of compensation to keep those hospitals in business and to provide continued access for that portion of the population. DSH payments are made in addition to the money hospitals already receive for treating Medicaid and Medicare patients and are designed to take up the slack between actual cost and CMS reimbursement and to cover the costs of treating those without insurance. Nationally DSH accounted for about $11 billion of the approximately $216 billion in projected Medicaid spending for 2009, but the distribution of those funds between states varies drastically. Despite its size, for example, Louisiana has the fourth largest DSH allotment behind New York, California, and Texas. In FY 2009 Louisiana’s DSH allotment would have been $731,960,000, but it was temporarily bumped up to $750,259,000 thanks to stimulus provisions as part of the American Recovery and Reinvestment Act (ARRA).

We probably have one of the most strict and most tight DSH programs you can find in the country now.

-Dr. Fred Cerise

While DSH funds are federally mandated and matched, states have historically been given a lot of discretion as to how they are distributed. States are required to pay DSH dollars to hospitals with a Medicaid inpatient use rate of at least one standard deviation above the mean for all the hospitals in the state, or to those that can demonstrate a low-income utilization rate exceeding 25%. However, at its discretion, the state can pay DSH funds to any hospital with at least a 1% Medicaid use rate. Here in Louisiana, the bulk of our DSH funds go to the LSU public hospital system, with the remainder distributed between private and local hospitals with significant Medicaid and uninsured populations. According to LSU Vice President of Health Care and Medical Education, Dr. Fred Cerise, the combined federal and state DSH funds amount to a little over $1 billion in our state. Of that, $100 million goes to the state psychiatric hospitals; roughly another $200 million goes to the private, community, and rural hospitals; and another $650 million or so goes to the LSU system. “Over half of the DSH funds go to LSU and it makes up a significant part of our overall budget,” said Cerise. “It’s what allows us to get reimbursed for the care of the uninsured.”

Ultimately the dispersion of DSH dollars is up to the legislature, explained Department of Health and Hospitals Undersecretary Charles Castille, who runs the Office of Management and Finance, the arm responsible for Medicaid funding. For example, DHH is bound by law to maximize the amount of DSH funding rural hospitals receive, paying close to 100 percent of their uncompensated costs. The amount each hospital receives is based on a formula that is set out in the appropriations bill and generally not all of the hospitals’ uncompensated care costs are paid off; only a portion. “Over the last several years, particularly after Katrina when ‘Big Charity’ closed down and University hospital closed for a while, there was a significant shift in the cost of the uninsured to the hospitals that remained open,” said Castille. “There was also a corresponding shift of DSH. We created a community DSH pool using the DSH dollars that Charity and University could not earn.”

So how does a hospital qualify to receive DSH dollars? The process is not automatic and places the burden of proof on the hospitals. Basically, a hospital must demonstrate that its disproportionate patient percentage (DPP) or its unreimbursed costs are at or over a certain threshold. The DPP is the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) and the percentage of total patient days attributable to patients eligible for Medicaid, but not eligible for Medicare Part A. Hospitals may also qualify if they are located in an urban area, and have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from state and local government sources for indigent care (other than Medicare or Medicaid). While states are not required to use a Medicare payment methodology to determine DSH payment rates, those payments should increase proportionally with a hospital’s low-income utilization rate. In Louisiana a hospital does not qualify for DSH payments if unreimbursed cost/total hospital cost is less than 3.5% and the hospital is not located in one of these parishes: Orleans, Jefferson, Calcasieu, and Cameron. In addition, hospitals of a similar type must be treated equally. Finally, payments to hospitals cannot exceed their actual costs of providing care to Medicaid patients and the uninsured.

LSU’s charity hospital system has historically been the largest recipient of DSH based on the populations they are committed to treat. The state’s early and extensive
use of DSH is in fact what allowed it to create the public hospital system run by LSU. "Other states have other mechanisms they use to pay for their uninsured and take advantage of different pieces of the program," said Cerise. "But DSH is the mechanism we have used over the years to fund the large share of uninsured care in the state." However, Cerise says the funds go beyond the old charity hospital concept. "People think of DSH as an archaic, hospital-based program and therefore not addressing what needs to be addressed in healthcare such as prevention and primary care, but in a health system like LSU we have a large number of clinics associated with our hospital and some of that clinic activity is reimbursable through DSH as well," he said. "There's not a great understanding of this program. It's not just ER or hospital care. Instead, roughly half of the DSH that we use is in our outpatient settings. All of our primary care clinics and specialty clinics, as well as our outpatient services rely heavily on DSH." Cerise explained that DSH pays for a portion of electronic records, disease management programs, preventive services, nurse educators, etc. In fact, said Cerise, it pays for many of the things standard insurance, Medicaid, or Medicare won't. "It gives great flexibility to craft programs that address the health of an entire population as opposed to having to rely on individual patient encounters to generate a bill for each service," said Cerise. "It's actually a very flexible funding stream for states if used properly."

Failure to use the program properly is one of the reasons DSH funds are now diminishing. As we mentioned before, DSH funding comes from both federal and state funds. The higher the federal match, the less the states had to contribute. Usually the state portion of DSH comes from general funds, intergovernmental transfers, and certified public expenditures. Initially states had a lot of freedom as to how the state portion of DSH was acquired, including some very creative taxing and donation schemes. The problem was that in the early days of DSH, states were encouraging these funding mechanisms to raise the amount they could claim from the federal government, then making an artificially high DSH payment to the providers (in effect repaying the tax or donation plus a bonus) and keeping the surplus for other uses. The practice led to large DSH programs and a skyrocketing Medicaid budget. Castille said that at one time, Louisiana had an approved state plan that allowed the state to pay up to 300 percent of the costs of the charity hospitals that were providing the care. Over the years, several rule changes have attempted to reign in this practice through capping growth in federal DSH payments to states and limiting the amount any given hospital could receive.

Over half of the DSH funds go to LSU and it makes up a significant part of our overall budget. It’s what allows us to get reimbursed for the care of the uninsured.

- Dr. Fred Cerise
The most significant of the rule changes was the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 which limited the use of donated funds and provider taxes for leveraging federal DSH dollars, placed an upper cap on hospital payments, and placed a national limit on federal funds used for DSH. As a result of these rules, any given hospital may no longer receive DSH payments in an amount higher than 100 percent of their uncompensated care costs. In addition, states’ DSH programs may not make up more than 12 percent of their total Medicaid expenditures. Finally, states may not receive federal matches for DSH expenditures above their published allotment for that year. “Initially in Louisiana the DSH program was not very large,” said Castille. “But over the years the state kind of married the opportunity of DSH funding with our charity hospital system. We found out that we were in a rather unique position to be able to leverage a lot of the disproportionate share funds.” Because of Louisiana’s early involvement and significant DSH program in the early days, when the allotments were grandfathered in, Louisiana maintained a high allotment. Once the feds cracked down on states’ abuses of the program, Louisiana had to wean itself off the high payouts. In an effort to ease that pain, during the Foster administration Senator John Breaux was able to get an amendment from the department of Medicaid to allow the state to get an enhanced match rate for a couple of years. Dr. Cerise also acknowledged that the DSH program got a bad reputation because of the early days when states were abusing it. However now, despite the fact that Louisiana still receives a large share, the state has an approved plan with CMS and all of its activities are legitimate, said Cerise. “We probably have one of the most strict and most tight DSH programs you can find in the country now,” he said.

And it’s getting tighter. According to Castille, the state’s total allotment, combining state and federal funds, was recently as high as $1.1 billion and for a few years hospitals were paid very close to that allocation. “Under the state plan amendment, when we paid DSH to a hospital, we would take their uncompensated care costs, back out the revenue they made from Medicaid, back out the revenue they made from treating Medicare patients, back out the revenue they made from private pay or insurers, and whatever was left over, was uncompensated cost,” said Castille. “I called it kind of a ‘back out rule’—basically back out other sources of revenue and whatever’s left over would be paid through DSH funding.” Those freewheeling

I think the impact of that will be that there may very well be some hospitals that do not survive. I’m not saying the entire system will go under, but there may need to be some potential realignment. -Charles Castille
days came to an end when in December 2008, CMS made final the disproportionate share hospital (DSH) audit rule that implements Section 1001 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The DSH audit rule will substantially reduce the amount of federal match available for DSH payments to state and rural hospitals. The rule requires states to do audits of the actual costs for hospitals to provide uncompensated care. The state has been required to do audits since 2008, but with no negative impact. However, starting next fiscal year, on July 1, 2010, the audit rule will require the state to tie a DSH payment to a patient-specific uncompensated cost. “As a result of the audits that we have been doing during this transition period, we know there will be a significant impact on the charity hospitals and rural hospitals, as well as some of our own mental health hospitals that get DSH,” said Castille. “We estimated that the total reduction in state and federal dollars will be between $190 and $250 million. If you take only the federal portion of that (around 67%) we figure the loss of federal funding will be between $120 and $160 million. Since the majority of the DSH payments we make are to the charity hospitals, they will be very significantly impacted.” Castille said the charity hospitals and rural hospitals feel the rule goes further than the legislation required and have asked the Louisiana delegation to request that CMS pull back on the DSH audit. However, in the meantime, the state has to budget based on what it thinks will be available through federal funding. “As of now, our estimate is that there will be at least $120 million less than there was this year,” said Castille. “I think the impact of that will be that there may very well be some hospitals that do not survive. I’m not saying the entire system will go under, but there may need to be some potential realignment.”

As part of the audit rule there’s some difference of opinion as to what constitutes uninsured costs eligible for DSH, said Charles Castille. Where previously costs associated with patients who were underinsured, whose insurance did not cover the whole treatment, could be submitted, CMS is now discounting them. “Recent guidance from CMS seems to take a much more stringent view of what was eligible,” said Castille. The combination of this revised definition of uninsured and the requirement to have payments tied to specific patients will have a significant impact on the amount of DSH paid to hospitals, said Castille. Cerise agrees that the program is limited by costs that are not allowable, but that it was a problem even before the rule changes. For example, said Cerise, DSH will pay for the hospital-based clinics, but it won’t pay for the physician costs. “This is something the state has disputed for a long time as it seems like it should be allowable,” said Cerise. “Other states can include those costs in their DSH cal-
Recent guidance from CMS seems to take a much more stringent view of what was eligible. -Charles Castille

culation, but we’ve been told by CMS that it’s not allowable, so that’s a big hole for us. We have to pay for those physician services through state funds only and we don’t get federal share for that.” However, if the patient care is happening in the context of training then that is an allowable cost. “That’s one of the reasons, though not the only reason, there’s a trend to do training in the public hospitals and clinics,” said Cerise. “Because there’s a federal source of reimbursement you wouldn’t have if you were just hiring docs who weren’t teaching and seeing patients in those clinics.” Cerise said when people talk about moving the training out of the public hospitals they don’t generally talk about the offset; that you would have to pick up the cost for those physician services. Another big cost that the federal part of the DSH program does not cover is outpatient medicines for public hospital system patients. Those costs have traditionally been covered by state funds and by dealing directly with pharmaceutical companies who provide free or deeply discounted drugs for the uninsured.

While the state contemplates future costs that won’t be covered, it is also in an ongoing dispute with CMS over past disallowances. In recent months CMS issued a formal disallowance requesting the return of the federal share of disproportionate share hospital overpayments of $362 million made to LSU-HCSD between 1996 and 2007. Based on a legislative auditor’s report it was determined that beginning in 1996 there had been federal payments for which LSU had not incurred the costs. “In those days we paid to LSU what the amount of their appropriation was and we assumed that there were costs to back that up,” said Castille. According to the auditor’s report and a difference in accounting systems, it was difficult to determine that the payments were justified. LSU’s
Cerise said the hospitals were never overpaid. They had to do the services, generate the costs, to get paid. Part of the dispute was over physician services. “Other states do include those costs and get reimbursed so there is a certain amount of frustration with the inconsistencies there,” said Cerise. “The assertion is that the state paid with federal funds when they should have used state funds that were not eligible for federal match.” DHH and CMS had gone around and around on this topic for several years until CMS finally issued a formal disallowance in 2009. DHH continues to appeal the matter, because the burden of both proof and repayment falls on the Medicaid agency, not the hospitals themselves. “Obviously this does not help our situation,” said Castille. “We had asked that they hold off because of the waiver that we had submitted and part of the waiver was trying to find a way to resolve these disallowances. But ultimately CMS decided they couldn’t wait any longer.” Luckily the state did not take full advantage of the Breaux amendment back in 1997 and still can. “We have determined, and I think they have agreed, that we can take advantage of that and get a state plan amendment to reduce our disallowance by about $76 million,” said Castille. “In addition, since we were made aware of these overpayments, the department has withheld Medicaid cost report payments that we could have made to LSU, to perhaps offset the disallowance if and when it occurred. We’ve submitted our appeal and we are trying to negotiate a settlement with CMS on what we owe and how long it will take us to pay it off.”

Another potentially significant blow to DSH funds in Louisiana is a significantly reduced FMAP that went into effect in 2009. FMAP stands for Federal Medical Assistance Percentage and is the formula used to determine the federal funding match for state Medicaid expenditures. It is calculated by comparing the average per capita income of each state to the national per capita income average for the three most recent calendar years. Therefore, states with a lower per capita income relative to the national average receive a higher amount of federal match funds (FMAP) for their Medicaid program. In the past this calculation has benefitted Louisiana, helping justify one of the highest FMAPs in the country. However, due to huge amounts of recovery money that came into the state post Hurricane Katrina, the state’s per capita income was artificially elevated. The resulting calculation reduced the FMAP from 72% to 67.6% in October, 2009 and again to 63.2% in October, 2010. DHH has appealed the new FMAP, arguing that the state should not be penalized for income rates generated during a recovery period. The initial pain of this change has been alleviated since the federal government suspended scheduled decreases in
FMAP and temporarily increased every state’s allotment as part of the federal stimulus package. However the stimulus funding will not last. In 2011 the artificially increased FMAP will plummet from 80% to just over 63%, the largest percentage decrease in the nation. The reduction of Louisiana’s FMAP rate is estimated to result in a devastating $1.2 billion decrease in funding for the state’s $6.3 billion Medicaid program and a 20 percent cut to the program’s total budget.

The most recent and least defined threat to the DSH program is healthcare reform. Though nobody can claim to know what shape reform will take, there have been many discussions of rerouting DSH dollars to fund reform. Castille said he is concerned about the fate of DSH in the reform atmosphere. “DSH was meant to pay for the cost of folks that are uninsured. Under healthcare reform more folks are going to be insured and Medicaid eligibility will be expanded. The logic is that if there are less uninsured there should not be as many DSH payments to hospitals,” said Castille. “If there are less uninsured, there’s less of a need for DSH, and there will be a shift of funding from DSH to cover the increase in Medicaid membership. It is likely some of the charity hospitals will have a tough time surviving unless they can compete for those Medicaid and newly insured patients.” Dr. Cerise agrees reform will probably mean a loss of DSH, but he is the first to acknowledge that at the point that everybody has insurance that pays the cost of the care then we won’t have a need for the DSH funds. However his major concern is that if people are not adequately insured somebody is still going to be expected to provide care and services. “What people in my business are afraid of is that some of the people get insured, but there are still a lot that are uninsured, and the insurance that people get may not cover the full cost of their care. You’ve got the DSH funds to fund reform, but you really haven’t fixed the problem.”

He cited as an example the situation in Massachusetts where they used a significant portion of DSH funds to fund their insurance expansion. He said the state is now being sued by the safety net hospitals because they are still seeing uninsured patients and their Medicaid reimbursement is not covering their costs. There was an expectation that those costs would be covered through the Medicaid program, but the Medicaid rates never went up while their DSH funds went away. “They’ve been kept afloat this past year with federal stimulus dollars, but when that runs out they are going to be in a heap of trouble,” said Cerise. “That’s the fear nationally. Every region with safety net hospitals is nervous.”

What people in my business are afraid of is that some of the people get insured, but there are still a lot that are uninsured, and the insurance that people get may not cover the full cost of their care. You’ve got the DSH funds to fund reform, but you really haven’t fixed the problem.

-Dr. Fred Cerise
something no longer needed,” he said. “But, in addition to our healthcare service mission we also have a medical education mission. So in some areas, particularly where we have very active programs, we expect that we would continue to have hospitals and a widespread clinic operation, and we would compete because demand and utilization will go up.” Cerise pointed out that statistics show the uninsured utilize services at a much lower rate than the insured so there will be greater demand for medical care if everyone has insurance. “In places where you have a bad facility in an area that has capacity, people are not going to go into your hospital, but people will still need doctors, will still need outpatient services,” said Cerise. “Without the hospital somebody may be able to absorb the admissions, but they would have a hard time absorbing all of the outpatient care.” That said, Cerise has no doubt that the LSU system would be impacted by a loss of DSH dollars and would have to redefine its role and discover new funding sources. However, they would certainly expect to continue to operate their major academic centers. “I think for the foreseeable future there are going to continue to be uninsured and underinsured people and a need for the work that we do,” said Cerise. “We are not making any plans to stop anything.”

It’s a known fact that family relationships can be strained during the stress of the holiday season and apparently major hospitals and insurers are no exception. In mid-December the Franciscan Missionaries of Our Lady Health System (FMOL) and Blue Cross and Blue Shield of Louisiana (BCBSLA) announced their intent not to renew their current two-year contract. The cause of the rift? The all too familiar breakdown of communications over money. Having reached an impasse, Blue Cross was first to the punch, at least publicly, announcing that Franciscan Missionaries was pulling out of the contract. FMOL negotiators issued their own statement saying the Blue Cross release came as a surprise as they were merely waiting on a response to a request for mediation.

Despite the initial “he said” “she said” both parties indicated they were willing to reenter negotiations, but neither seemed to want the blame for pulling out of the contract.
first because of the serious ramifications it could have on thousands of patients and policy holders. OLOL CEO Scott Wester was critical of Blue Cross for bringing the dispute to a public forum. “This public display that Blue Cross continues to foster in the community is extremely unhealthy—with the anxiety it’s creating for our patients, the employers. No one wins in these situations.” However BCBSLA President, CEO Mike Reitz said the company had no other option. “We have contractual obligations to our customers to notify them in advance of significant network disruption. Ten days before my meeting with Mr. Finan (FMOL’s President and CEO) the system sent out letters to some of our accounts, brokers, and consultants letting them know that there were concerns about reaching an agreement with Blue Cross. We had to go out with clarification for our members.” Wester said who jumped first, and when, is no longer important. “It’s not about what happened three or four weeks ago, it’s how do we get this resolved between our two organizations?”

This year’s events mirror a similar dispute two years ago when both parties announced a failure to reach an agreement but then hammered one out in the final days. Gil Dupré, president of the Louisiana Association of Health Plans indicated that, “When you are dealing with two organizations of this size, who are so important to the community, they put forth a lot of effort to try to make things work. We saw the result two years ago and everybody hopes the final result will be the same—that they’ll find a way to work together.” Many join Dupré in suspecting this break will also end in an 11th hour reconciliation, but sources close to these discussions say the differences appear to be a little more serious this time around and mediation may indeed be necessary. “It is different,” said Reitz. “I think the economy has worsened. I know our customers are extremely sensitive to the cost of the product and have sent us a very clear
Healthcare providers like FMOL are typically underpaid by government programs and are always trying to find a way to make that up in their contracts with the private sector. Meanwhile, the health plans that represent employers and individual consumers have an obligation to try to keep premiums down as low as possible. So there’s just this natural tendency to get into this kind of situation when contracts come up for renewal.

Gil Dupré, LAHP

Signal to address high cost healthcare by doing everything we can to impact high costs. The second thing that has changed is we now have access to data which we use as the basis for contracting and negotiating with our providers. As we understand more today than we did two years ago about the cost of providing care to our members at these facilities, we can negotiate from a better perspective.

At the heart of the matter is FMOL’s request for a single-digit increase in reimbursement and BCBSLA’s refusal to grant it. Reitz said the insurer denied the request because there was insufficient justification to increase rates when FMOL was already the highest paid system with whom they negotiate.

“We are a mutual company which means we are owned by our policyholders and our policyholders have asked for us to please look for ways to provide services and provide coverage to the market on a more affordable basis without necessarily sacrificing quality,” said Reitz. “In this latest round of negotiations with the FMOL system—and these negotiations have been going on for months—we have been trying to understand the cost basis of the FMOL system.” Wester defended the FMOL request as a response to the normal increases of doing business at its facilities. “Like most other businesses these facilities continue to have increases in their supply costs, salary costs, operating expenses, those things that drive up the cost of doing business.”

Included in their mission piece are things like running nursing homes, providing free clinics, operating a school of nursing. The question is how much of this should be paid for through the premium dollar that our customers are paying?” Mike Reitz, BCBSLA

Reitz also indicated that government reimbursement that is consistently below the facilities’ costs is another issue, one that Dupré believes is at the heart of the matter. “I think that the fact that this kind of situation occurs is a sign of the stress that’s in the healthcare system today that usually is about money,” he said. “Healthcare providers like FMOL are typically underpaid by government programs and are always trying to find a way to make that up in their contracts with the private sector. Meanwhile, the health plans that represent employers and individual consumers have an obligation to try to keep premiums down as low as possible. So there’s just this natural tendency to get into this kind of situation when contracts come up for renewal.”

BCBSLA’s Reitz agreed government reimbursement is a problem and acknowledges that facilities have to do a little cost-shifting to make things work, but he asserted that the FMOL system does more cost-shifting than other facilities with whom Blue Cross contracts. “Our customers are getting to the point where they are getting tired of paying taxes for Medicare and Medicaid, then to turn around and have a silent tax on all the cost-shifting that’s being borne and being billed to us through the FMOL system,” asserted Reitz. “Included in their mission piece are things like running nursing homes, providing free clinics, operating a school of nursing. The question is how much of this should be paid for through the premium dollar that our customers are paying?”

Wester said that he does not have access to Blue Cross data that indicate FMOL’s cost-shifting is higher, but he strenuously defended the health system’s mission as providing necessary services to the community, not “a luxury” as characterized by Blue Cross. “Our mission of healing often means we provide profitless services that our customers are paying,” said Reitz. “Knowing that there are some things in their mission that we should be paying for. Our question comes when we put the FMOL system against other peer group type systems and their cost is significantly higher,” said Reitz.

Mike Reitz, BCBSLA
that we have to supplement some of our costs on some of those services, call it cost-shifting, call it whatever Blue Cross wants to call it, we believe it’s a community obligation for us to deliver that. The question is do we start rationing or deciding to eliminate some of these products and services or do we feel we have an obligation to maintain or improve those levels of service?"

Wester also objected to implications by Blue Cross that some of FMOL’s cost issues were a result of inefficiencies. “If they are communicating that we are inefficient providers of services that is definitely not a true statement. We work on cost control, we do everything we can to preserve the resources and I think we do it very well,” he said. “If you look at national data we’re in the top 25% of cost per discharge. We think we do a very good job of controlling our internal expenses. I think we’ve had some very good demonstrations of that and we’ve shared that with Blue Cross.” Reitz made it clear that Blue Cross has no issue with the quality of care FMOL provides to its members and to the communities they serve. “But there’s a point in time where you have to justify the cost in order for us to continue to pay the amounts they are asking for,” said Reitz. In order to do that, Reitz indicated that FMOL was given two options. One was a 12-month extension of the current contract which would continue to pay FMOL the highest rate in the state. The other was a 3 percent increase, but with that 3 percent increase would come some additional member liability, said Reitz. In fact, said Wester, that minimal increase included an additional $4000 surcharge per member for a visit to any FMOL hospital. “We thought that was pretty outrageous for a patient to bear in addition to the premium increase they already paid, especially knowing that most of the premiums have gone up higher than the increase we were asking from Blue Cross this year,” said Wester. Separately both parties have indicated that a zero or minimal increase would be acceptable if the savings could be passed on to the customer. However a meeting to discuss that possibility did not produce any feasible plans, said Wester.

The current contract between the two healthcare giants is not actually up until January 31st. In the meantime, tens of thousands of consumers are on hold as to whether they will need to shop for a new provider or a new insurer. The potential impact is huge. Our Lady of the Lake is one of the largest hospitals in Louisiana. Five affiliated facilities under the Franciscan Missionaries of Our Lady umbrella would also be affected, including the Tau Center in Baton Rouge and St. Elizabeth Hospital in Gonzales. Also affected would be Our Lady of Lourdes Regional Medical Center, Lafayette; Heart Hospital of Lafayette, Lafayette; St. Francis, Monroe (both campuses); and Assumption Community Hospital, Napoleonville. Blue Cross, for its part, is the largest insurer in the region and has contracts with several competing facilities. In addition, those covered by Blue Cross may be hesitant to go policy shopping in a time of economic downturn and uncertainty about insurance options and requirements under healthcare reform. Reitz indicated that so far Blue Cross has been encouraged by the support they’re getting from their membership for standing up and attempting to address the cost of health insurance, but acknowledges that failure to come to an agreement may cause some members to shop for new insurance. “It’s a very price sensitive marketplace and people shop every year regardless of whether they are in the network or not. If we are able to reflect in our rates to the marketplace a more efficient provider network then I think people will have an opportunity to choose price over provider network.” Wester was less concerned about whether FMOL will lose patients than about presenting the patients with that dilemma in the first place. “If no agreement is reached thousands will be affected, but I can’t guess which way consumers will jump. The tragedy about all this is it puts the patient in a very difficult position as well as the physicians that are serving our organizations,” said Wester. “We are just asking for fair payment for the services we provide which is no different than the increases that Blue Cross has told employers and subscribers will be reflected in their renewal rates.”

Our mission of healing often means we provide unprofitable services that other hospitals or doctors choose not to or can’t, such as pediatrics, mental health, addiction help, trauma services, which are not priorities for Blue Cross. Our mission to provide compassionate care to anyone who walks through the door of our facilities and to those most in need is not a luxury. Scott Wester, OLOL

While each company indicated a willingness to continue negotiations, neither seemed ready to jump first. Wester indicated that FMOL continued to await a response to their request for mediation. “We have done everything we can to try and reengage Blue Cross in negotiations. We are waiting for them to reengage with us and move the ball forward. At this point they have showed zero indication that they are ready to do that.” However according to Reitz, the Blue Cross offers were still on the table for FMOL to consider. “The ball is definitely in their court,” he said. Since we’re mixing sports analogies—it looks like we might be headed into overtime, but we’ll keep you posted.
We have all seen the stories about the high rates of HIV/AIDS in sub-Saharan African countries. The parentless children. The infected babies. It is heartbreaking indeed, yet, faced with the chronically ill patient sitting in your exam room in distress, the crippling obesity epidemic in the U.S., and the threat of the latest round of reimbursement cuts, it is sometimes easier to tune out the troubles on the other side of the world. For one local gastroenterologist, however, it is not so simple. For while he gives his patients in Baton Rouge and Gonzales the best of care, his heart, his mission, his vision remains in Uganda where he was born. Dr. Robert Muhumuza works at Our Lady of the Lake, teaches at LSU and is part of a private practice in Gonzales, but he is also a founder and board member of Savannah Sunrises (SAS), a foundation dedicated to providing affordable healthcare to the people of Uganda and to the eradication of HIV/AIDS in that country. Muhumuza and his foundation are not alone in that
Our parents are our mentors and we learn most of what we need to know in life, that which sticks, from our parents.
goal, but their approach is a little different, and it seems to be working.

Traditionally, the approach to AIDS eradication has been the ABC approach, urging Abstinence, Being faithful, and Condom use. The educational program has targeted adults and has been quite successful in reducing HIV/AIDS rates from 25% to about 7% in Uganda, but it has not eliminated the disease, and in certain population clusters occurrence remains high. In contrast, Muhumuza’s approach is called Immunization By Education Strategy (IBES) and targets children under the age of 15. The idea is to create a behavior change in young children that will carry on to adulthood and to the next generation. The goal is to save an entire generation of Ugandans by educating and mentoring them long before they become sexually active.

“Savannah Sunrise means hope for the savannas, for sub-Saharan Africa,” says Muhumuza. The idea dates back to 1986 when Uganda was in the midst of an HIV epidemic. At that time, the founders of the organization, Dr. Robert Muhumuza, Dr. Grace Kaisa, his sister, and Dr. Moses Balabyeki were still in medical school, but agreed that this was something they wanted to fix. Their goals were to provide accessible and affordable quality healthcare, HIV eradication, and education and research in their native country. They decided they would form clinics, build hospitals, and create a foundation that would provide a link with the public and private enterprises to assist in achieving their goals. The foundation was actually formed here in the United States in 1998 and achieved 501c3 non-profit designation. A sister organization was formed in Uganda in 2005. That’s when the organization launched the IBES program.

The premise behind Muhumuza’s approach is that HIV is a behavioral disease and we learn behavior in childhood. As a result, Muhumuza believes one should be able to target children so as to help establish a permanent imprint of protective behavior from which they will not depart when they come of age. The program targets children in kindergarten through middle school, trying to make a permanent imprint through the vehicle of mentorship. Muhumuza says mentoring is the most intense form of education. “Our parents are our mentors and we learn most of what we need to know in life, that which sticks, from our parents.” In the IBES program, the mentors are, whenever possible, HIV-positive individuals. The mentors go through a selection and training process, and as time goes on, refresher training. The mentors are provided background on HIV/AIDS as a disease, sociological skills, and educational skills on how to handle classes, then are deployed to kindergartens and primary schools. They interact with children through lessons on a weekly basis and help establish Winner’s Societies in the schools. The Winner’s Societies are child-based societies that meet weekly to help reinforce what they study in class and to come up with child-centered solutions to
the epidemic. In Kampala IBES is currently in place at 87 schools. Each school has a Winner’s Society and each society has a president. Every two years the foundation chooses an overall president for the entire 87 schools. As the program grows and more schools are involved, the overall president will be selected through an election process.

When we talk about impact however, there is a chain reaction; these children interact with community children. So you need to multiply that number by 5-10 to get the true impact.

Dr. Muhumuza believes that currently in Kampala, where the program was launched, 50,000 children are being exposed directly to the IBES program and in Hoima maybe 30,000 plus. “When we talk about impact however, there is a chain reaction; these children interact with community children,” said Muhumuza. “So you need to multiply that number by 5-10 to get the true impact.” His immediate goal is to directly reach a critical mass of 300,000 children, because of the multiplicative effect of these children on both other children and adults. “If you have 300,000 children well indoctrinated in the ways and means of not getting HIV, you can picture each child comes from a family, each one talks to the parents, to the siblings, goes to church, plays in the community. The message takes on a viral nature.”

IBES does not just focus on HIV/AIDS itself, but shares a whole host of life skills such as decision-making processes, building self esteem, avoiding dependency syndromes, overcoming peer pressure, avoiding situations that put one in danger. Muhumuza said that there is a real problem in Uganda of adults taking sexual advantage of young children. The program gives these children the tools to avoid those situations, the confidence to say they will tell an adult, the ability to see through false promises and flattery, he said. “The previous strategy for HIV/AIDS eradication was ABC, Abstinence, Be faithful, use Condoms, and was quite successful with some adults, but that means nothing to a six-year-old child.”

The previous strategy for HIV/AIDS eradication was ABC, Abstinence, Be faithful, use Condoms, and was quite successful with some adults, but that means nothing to a six-year-old child.

Instead the IBES approach is building decision-making processes that are a part of these children and formalizing these skills in a curriculum offered in local schools. “We evaluate whether the teachers are teaching that curricula,” said Muhumuza. “In the next year we plan to evaluate how well the information is sticking; forming child focus groups to see what they have learned.” He explained that qualitative and quantitative factors have been built into the Institution Review Board (IRB), and that formal studies will be coming out next year. Further down the road, Muhumuza plans to look at quantitative studies on things such as school absenteeism, teen pregnancy, etc. He believes that if children have the proper life skills, it follows that they will not only avoid HIV/AIDS, but they will also not miss school, drop out, become pregnant. “All those things are going to go down and we need to monitor them,” he said.

Once the IBES program reaches critical mass and there are data to show it is working, Muhumuza hopes they will be able to spread this program throughout Africa and beyond that to the world. “There has to be a paradigm shift
in the way things are done. I really look down the road and see HIV prevention as being a class that has to really be taught and taught by people who are willing to mentor children through the whole process, from pre-K to 18, getting the behavior mechanisms taught from the outset.”

Because of our high HIV/AIDS rates here, Muhumuza’s foundation tried to start the IBES program at Oasis Church in Baton Rouge. They went so far as to find and train mentors, but had trouble deploying them into the educational system. He recognized that the stigma of HIV/AIDS alone would be enough to create resistance to having seropositive mentors in the schools and that they might never get past the bureaucracy without hard facts to show the program works. “I know people here who have lost their jobs because they are HIV positive,” said Muhumuza. “Even if that had been their status for years, once it was discovered, they were immediately terminated because of their potential contact with children. That’s how bad it is.” He also acknowledged that stigma is still present in Uganda and that some of the work his foundation does in the community through the clinics helps with acceptance of the program. The other reason they have focused in Uganda first is that they get more bang for their buck there. “In Uganda the current cost of the mentorship is $1 per child per year. Here it would be $5-$10 per child,” said Muhumuza. “We need to first have a program that really shows that it works and use it as a platform to go to other areas.”

He supports efforts to find a vaccine for HIV/AIDS, but believes that there will be something else that takes its place, like Hepatitis C, Ebola, or similar, because the dangerous behavior has not been changed. “Just a single needle prick or just one minute of stupidity can cost you your whole life.”

Dr. Muhumuza has been in the United States since 1990. He completed his residency at Baylor and finished his fellowship and an MBA in the late 1990s. He said that although the foundation was not started until 1998, his group has been making preparations for almost 20 years. Their first achievement was to get funding to start clinics in Uganda. Setting the foundation up here gave them access to equipment, monies, tax-deductions, etc. Now they have two clinics, one for-profit and one non-profit, and recently acquired a site for a new hospital. The foundation and the non-profit clinic provide affordable access to healthcare and help buy the
foundation goodwill in the community, which uses the for-profit clinic. Funds from that clinic can be used to support the non-profit clinic. Muhumuza’s group also engages in aggressive advocacy, building awareness, hosting charity walks, etc. trying to get the local business community and local people to feel the need to pitch in. “That’s where the critical mass is so important,” said Muhumuza. “You have to get the society to own the problem.”

His sister, Dr. Grace Kaisa, is a graduate of the University of Rochester in Family Practice. She went back to Uganda to serve as Director of Medical Services for the SAS clinic and he works here to support her efforts. He currently visits two or three times a year, but plans to eventually return home. “I want to go back to Uganda in about two year’s time. I want to get funds for the hospital and the like. The program is now at a critical stage. I will have to be there to really push it.”

At this point Muhumuza says it’s all about sowing a seed, convincing people to make a monetary contribution. “Because I know that at this point in time, if I raise $1 million, that’s it. With $1 million I will be able to meet my critical mass of 300,000 and that’s the vision for the whole country, the whole of Africa, the whole world.” He feels the seed has already been planted and that once these children go through school and become the future leaders they are going to turn around and keep the program going. “You are planting the seed in Uganda but you are laying the foundation for Baton Rouge. This is a principle you can apply in life.” Muhumuza said if he can raise $1 million he knows he can reach the critical mass required, but even if he doesn’t get that, he will keep marching forward, confident that he will reach that goal. He also needs funds to keep the program going in Hoima. However, even if people cannot donate to this mission, he seeks those who will advocate for the program and grant him an audience.

Dr. Muhumuza believes that each person has their own vision that involves doing well, raising a family, etc., but that they also have a vision that emanates from them to their environment, to their surrounding society. SAS is his life vision and is part and parcel of who he is. “Yes I run a clinic, I work in the emergency room, I teach at Earl K. Long, but this whole vision is part of me, and as a result my wife is involved, my children are involved; they all understand and they are all on board,” said Muhumuza. “Each day that I spend doing what I do I am pushing the entire vision forward.” Muhumuza said it takes twenty years to achieve a vision, to provide it with the life to carry on without its creators. “We are coming to the 20th year of our vision and it is well-placed. There is all the evidence that this is happening, we just need that little boost and this is going to have an impact on how HIV is looked at world over. This disease is going to be put in check.”
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ONE ON ONE

WITH DIONNE VIATOR

EXECUTIVE VICE PRESIDENT OF BUSINESS DEVELOPMENT & CFO, BATON ROUGE GENERAL HEALTH SYSTEM
Dionne Viator, CPA, FACHE, has held the title of Executive VP of Business Development and CFO of the General Health System since February, 2009, but has served as the system chief financial officer since 2001. In fact, she has been serving as a financial officer with Baton Rouge General since 1993. She started her financial career in New Orleans at Ernst and Young in 1987, where she quickly developed a passion for healthcare. Proud to admit she is Louisiana born and raised, Viator attended the University of Southwestern Louisiana, earning a BS in Accounting in 1987. She serves on the Ethics and Strategic Planning Committees of the Louisiana Society of CPAs (LCPA). She also sits on the boards of Louisiana Health Care Alliance, Louisiana Business Group on Health, Mid City Redevelopment, and many others. Recognized in numerous venues as a leader in the healthcare industry, most recently Viator was the 2009 Recipient of the Outstanding CPA in Business & Industry Award presented by LCPA.

Smith W. Hartley: In today’s capital markets, could you discuss with us some of your capital strategies?

Dionne Viator: Our capital strategies are really twofold here in the organization. Part of my role as chief financial officer is that I am also the executive vice president of business development. A key piece to that is the development of the rest of the property here at Bluebonnet. We have a little over 150 acres with only about 75 of that developed. So clearly we do have plans to move forward with new construction, new buildings, healthcare related support and enhance the hospital and its growth into the future. However, with healthcare entities and the bond market we’re no different than a lot of others and have plans that we are looking at again, at how to time them a little differently and also at the size and scale. So our long-term vision for the overall development of a lot of our strategy has been delayed. We’ll start smaller scale and move forward.

We also look at capital on an ongoing basis with the operations of the hospital. We have made some significant investments with our information technology, radiology, and Pennington Cancer Center with our cutting edge Artiste technology. However, for last fiscal year and this fiscal year we are looking very seriously at reducing the overall level of capital we are spending. We’re still leaving some for strategic initiatives capital, especially in the area of surgery and other things, but more than I’d like is going to be spent just making sure break/fix and the basics are covered as we continue to try to make sure our footing is solid with all the changes in healthcare.

SWH: Medicare and Medicaid reimbursement often does not completely cover the costs incurred by hospitals for those patients. Is that the case here?

Dionne Viator: That is the case. I think that’s a mixed bag and a global statement. With Medicaid and Medicare, especially all the outpatient services that are provided, there are a few services on the inpatient side where we are covering our cost, but globally we are in an upside-down position. The future of both of those funding sources for hospitals is uncertain at this point. Medicare, Medicaid, and indigent care combined for our two hospitals is about 60 percent of what we do. So clearly a big issue for us.

SWH: There’s national talk about how there is not enough competition in the insurance industry. Can you tell us how many insurers Baton Rouge General is contracted with? Do you feel like there is enough competition out there?

Dionne Viator: I believe there is. Clearly we have a market with Cigna and Aetna and a lot of other insurance companies that do provide for a competitive base in this community. Blue Cross is the giant though. So far, in my working relationship with Blue Cross they have handled that position fairly responsibly and I believe deal with us fairly. So although I would always like a continued increase in competition in that area, I think the platform here in Baton Rouge right now does not put the community at a disadvantage.

SWH: Do you think with the proposed Medicare and Medicaid cuts that some of your services may have to suffer, perhaps affecting the quality of care?

Dionne Viator: Well, that’s a difficult question. I think that as we look forward we know change will happen. And directionally we know it’s probably going to be in reduced payments from both Medicare and Medicaid. We have begun looking at a lot of our programs and services that we offer, but have not reached any conclusions at this point. The approach that we’ve taken is that we have begun holding leadership seminars and daily retreats to try to generate ideas of where we can remove waste from our system. That’s our first approach. What just doesn’t make sense? How can we
If you are a practitioner doing innovative work here in Baton Rouge, then tell us about it at editor@healthcarejournalalbr.com
get rid of rework? How can we streamline things? We've held different groups recently and we've got hundreds of ideas. Our COO Edgardo Tenreiro and I will get together to go through those again and see what we can do.

So to me it's a continual journey of removing waste, removing inefficiency and any rework, so that programs and services can be maintained for this community. We've also started an overall training for our employees that is just change management. Because I think with a lot of what we're going to do, we may end up consolidating services, we may end up consolidating departments, we may end up reducing hours on different shifts, but our goal would be to try to protect what we can provide to this community.

**SWH:** One of the challenges for hospitals is their supply chain management. Could you share some of the things that you've found have worked for you?

**Dionne Viator:** As far as our supply chain goes, we have been evolutionary. We've implemented, as a part of our technology change over the past few years, a new information technology system for our distribution and purchasing. To try to make sure we know what we have and where it is in our pipeline at all times helps us reduce the overall inventories. We have done a good job of reducing our overall inventory by almost $1 million over the course of the last year. We are looking more at a just-in-time type of inventory management. We are also looking at our highest cost items as an organization–our surgical equipment, surgical stents and implants, and things like that. The most important thing we'll be doing over the course of the next year is working with our physicians to see where we can consolidate to as few vendors as possible. If we are doing the same surgery with five different implant vendors we're not getting the best price from any of them. If we can get the physicians to agree to two vendors or come to some agreement, that will help from an overall purchasing standpoint and with how much you have to keep in inventory. There's still a lot of work to do, but we have made some great strides, primarily through technology, in the past year.

**SWH:** The Baton Rouge General recently put a new IT system in place. Have you found that you've been able to define some efficiencies through that?

**Dionne Viator:** We have. I think that truly the driving factor with our information technology is that we've focused on the clinical areas first and the business areas second, so we are just now installing many of our business functions. But we installed a radiology system in 2003–2004, where we have imaging that physicians can see in their offices or anywhere else. In 2005 we went live with our electronic medical record. Since then we've gone live with automation in our lab, a robot and automation in our pharmacy, and we recently have implemented a closed loop
pharmacy system where we have bar-coding by the nurses. All nursing documentation is done in the computer system now. As I mentioned earlier, we went live with an inventory management health system, but we have also gone live now with a payroll system and a general ledger system to complement those clinical systems on the back end. We’ve installed all of those efficiencies within about three years. When we go through and try to quantify what that return on investment has been over the last few years, it looks like we are saving and removing waste from the system by about $2.5 million a year at this point. Our goal is to get to $4 or $5 million so we are still along that journey, but seeing significant strides.

SWH: Could you describe to us your physician alignment strategy?

Dionne Viator: There is a move in healthcare globally for more of an employment strategy. It’s not necessarily just driven by hospitals. With a lot of the cuts in reimbursements, changing regulations, physician ownership of hospitals, things like that, physicians are more receptive than ever in many areas to employment by hospitals. So our strategy moving forward is from a specialist standpoint—only taking those opportunities that present themselves where it’s a need for the system, as well as being approached by the specialist and it being a win-win. Our primary focus with physician employment is in the area of primary care. We have been involved for many years with a family medicine residency program, training family practice physicians for the future. So hiring from that program is an opportunity, but also growing our base of primary care is important to the continued adequacy of physicians in this community. We believe that if we have a strong base in primary care it will create a good business opportunity for the specialists and they will be here also.

SWH: With all the reform talk are you doing anything differently, anticipating anything, or are you just waiting to see what’s going to happen here?

Dionne Viator: Well, the reform talk, if you follow it day to day, can drive you crazy. But directionally it is all about being more efficient. It is about doing more with less, an overhaul of the system, and aligning incentives. I’m in support personally and organizationally of reform, but how that’s done is very critical so we don’t collapse a system.
that’s already very regulated in nature. So what we’re doing is preparing for change by giving our employees and our leadership team the tools to manage that change, keeping a continued focus on removing waste, and aligning with physicians and other organizations that have that same philosophy.

**SWH:** Baton Rouge General just purchased some land along Bluebonnet. Can you tell us what the plans are for that property?

**Dionne Viator:** Before that purchase we had about 147 acres here at Bluebonnet that were part of the initial purchase when this building was built and put into action in 1993. At that time The Advocate owned the front parcel of property. They have now relocated their facility and that piece of land was up for sale. We have acquired that piece of property, not because there are immediate needs for it, but it is the front access to this campus and we do have designs for the overall development of this campus over a multi-year time period. That includes both some good visibility for the organization up front as well as different access points into the campus. An example would be with the new I-10 interchange that goes behind the mall. It would be very nice to have that come straight across into our campus and allow something more than this streamlined Summa/Picardy entrance that creates some congestion. So more access and a part of a multi-year development plan, but nothing that you’ll see immediately.

**SWH:** What’s next for you, personally?

**Dionne Viator:** I thoroughly enjoy being here at the General. I've been here since 1993. What’s next for me? The General has provided me the opportunity to have many different roles and to focus on many different initiatives all within the same organization. So I see myself here at the General. I see my role evolving more and more from a financial focus. We have some strength we’ve built in our financial focus with the vice president of finance and the finance team. With my focus more on development, on expanding our revenue abilities within healthcare beyond just the traditional patient care, we’ll see if we can strengthen the overall system, given reform and everything else, with less dependency on one revenue source. So the development side is very much an interest for me moving forward within this organization. I am a Louisiana girl and plan on staying right here.
Unlocking Potential at McMains Children’s Developmental Center

by: Philip Gatto

For more than half a century there has been a haven in Baton Rouge for children with cerebral palsy and other disorders affecting their development. While it is located in the center of town on College Drive you might never have noticed it, but for the children and families served by McMains Children’s Development Center it is truly the heart of the city. The center, founded in 1954 by a group of parents as the Cerebral Palsy Association of Baton Rouge, has offered thousands of children with special needs therapy, counseling, socialization, and a host of other services designed to help them develop their fullest potential and quality of life. Like many centers of its type, McMains has now expanded its services and opened its doors to children with a wide variety of conditions, some extremely rare. “We take them as they are and we see where we can take them,” said Development Director Eunice McCarney. Walk in on any given day and there is an atmosphere of hope and new expectations, a sense of “What will we achieve today?” rather than “What aren’t we capable of?” Those achievements are fostered through four main types of therapy offered at the center: Physical Therapy, Occupational Therapy, Speech and Language Therapy, and Educational therapy.

All of the different areas and types of therapy at McMains work together. A child may not be able to speak until the physical therapist helps him to hold his head upright. The exercises used to develop language and speech may also help with feeding. Learning how to write in occupational therapy may encourage a child to be more communicative in speech therapy. Each therapist, though entirely committed to their own work, acknowledges that all the therapies must work together and are dependent on each other.

The physical therapy offered at McMains helps children with gross motor delays and facilitates independent movement. While all types of physical therapy are provided to improve gross and fine motor skills, one of the most unique treatments offered by the center is the Therasuit Intensive Therapy Program or suit therapy, for short. Designed by Polish physical therapists for their daughter with cerebral palsy, therasuit therapy is based on suits used by the Russian space program to help Cosmonauts adjust to the loss of bone and muscle density during space travel. The suit is comprised of a cap, vest, shorts, kneepads, and special shoes that are all interconnected by a system of adjustable straps and elastic bands. It is designed to provide support and guide and hold the body in proper alignment. When children
perform physical therapy and exercises in the suit it helps educate the brain as to the proper signals for muscle control and movement. The therapy helps with balance, coordination, and development of both fine and gross motor skills. It can even help with speech, providing proper head and trunk support. Designed for children with cerebral palsy, the suit, in combination with the Universal Exercise Unit, a system of pulleys, straps, weights and splints also known as “the cage,” is also used for those with developmental delays, traumatic brain injury, ataxia, hypotonia, and more. Suit therapy is provided in three week increments, five half-days a week and can significantly accelerate motor skill improvement. Because of the intense time frames, therasuit therapy is typically offered in the summer, when it won't interfere with school. The suits are prohibitively expensive, but the center was able to
purchase two and provide training for their therapists thanks to a grant. McMains is the only center in Louisiana offering therasuit therapy and it has paid off. With the therasuit and other forms of physical therapy, the staff here tells stories of children who arrived in a fetal position and eventually graduated from the center walking on their own.

Occupational therapy is used at McMains to address sensory and fine motor problems and to help develop basic daily living skills such as eating, writing, etc. This therapy also targets sensory problems which can lead to attention deficits, hyperactivity or social skill delays. The occupational therapy room is at once appealing and overwhelming. One half of the cavernous room is occupied by a springy gymnastics floor donated by the LSU Gymnastics program. The floor protects the children when exercising or climbing the specially designed rock wall at the back of the room. It also helps children develop balance and core strength. Giant balls and suspended equipment allow for “play with a purpose.” Occupational therapist Debbie Gauthreaux explained that, “A child’s occupation is to play, so occupational therapy here means teaching them how to play.” The rest of the room is split into areas focusing on other occupational skills such as handwashing and teeth brushing, writing and drawing, and other school-based skills.

Many of the center’s clients have issues with writing, some purely because they cannot hold a pencil, others because they can’t make their brains send the right message to their hands. The therapists derive ways to help the children express themselves so they too can “write” about what’s inside. Sometimes special assistive technology or MacGyver like gadgets are designed by therapists to help this process. “If we wait for the writing to come on its own, we may lose the writer,” said Gauthreaux. “We need to find out how they can express themselves.”

On one side of the occupational therapy room are parked the adaptive bikes that are a special part of the McMains program. They offer children with disabilities the opportuni-
ty to ride a bike like any other kid, leading to a sense of accomplishment and a way to “fit in” with family and friends. The center’s Wheels to Succeed program, which is conducted in partnership with Tiger Cycling, provides special adaptive, three-wheeled bikes that can be ridden by children at the center and can be loaned out to families. Not only does riding the bikes allow the children to participate in an activity enjoyed by all children, but it has health and social benefits that contribute to their overall development. An annual fundraiser is held each January to help raise the money to purchase bikes for children with disabilities. The center also holds demonstration days where kids and family members can try out the bikes. Bikes placed with families are returned to the center once the children outgrow them.

The speech and language therapy program is designed to develop and improve communication skills both in oral articulation and information processing. Many of the center’s clients have problems understanding and/or expressing themselves, but that doesn’t mean they don’t have plenty to say. The trick is working out how to get the words out. Some have physical conditions such as posture, support, or oral control issues that make it difficult, to make the desired sounds. Others can’t quite make their brain send the right message or process the information correctly. The therapists work with them to help them to process information and to express themselves verbally and/or through an assistive communications system. The most common problem, according to Ellen Thomas, the center’s speech/language pathologist, is the children’s inability to attend, to learn the proper motions and sounds required for speech by observing and interacting. Half the battle in speech therapy is first teaching the children to attend to the therapist, she said. Technology has also allowed children who cannot verbalize on their own to make their voices heard through devices that can speak for them when they select words, phrases or pictures. The devices can also help build vocabulary and the ability to compose proper responses.

Educational therapy targets learning disabilities and develops reading skills. It is offered in conjunction with the other therapies at the center, but also as a before and after school program for children who are struggling in school due to learning disabilities. Taking this service a step further, the center also offers a preschool called Wee Can Do. Set up like any other preschool focusing on shapes, colors, numbers, etc., the preschool also helps students overcome physical, mental, or social limitations to playing, interacting, and learning. Older children can also adapt to the routine and activities they might face in a mainstream school such as socialization, sharing, adaptation, following directions, and much more, to make for a smooth transition and educational success.

One of the most impressive features of the McMains center is the outdoor area. A playground and beautiful landscaped pathways and seating areas are adapted for children with disabilities. The outdoor area is funded by donations and maintained by volunteers so all of the United Way funding the center receives can be used for the therapy programs. That doesn’t mean that therapy isn’t happening out here, though. A garden of specially raised planters built by Al Hindrichs, husband of one of the center’s social workers, allows the children to participate in gardening. The activities allow them to be outside, to witness the miracle of growth, to work on motor skills, overcome sensory aversions, and so much more. The landscaping and gardens are maintained by Master Gardeners Nancy and Allen Broyles as well as volunteers from local industry. Nancy is also a social worker at the center.

Some of the center’s clients need all areas of therapy; others may come for just speech or just physical therapy. In addition, the McMains center provides physical, neurological, and psychological evaluations and treatments. Children may be tested for a variety of conditions that may cause developmental delays and their progress through treatment and therapy is monitored. The center also assists with evaluating the need for and procuring special adaptive equipment that can assist children’s independent functioning. Social workers on staff evaluate family circumstances, help the families carry out treatments, and assist them with exploring community resources. Orthopedists and pediatricians volunteer their time to help evaluate the children and their progress in therapy.

GOT BIKES?
Be sure to sign up for the Wheels to Succeed “No Such Thing as Impossible” Bike Ride in St. Francisville on January 16. The fundraiser helps raise money to purchase the adaptive three-wheeled bikes for children with cerebral palsy and other disorders.
Although a referral or prescription is required to seek treatment at McMains, the center is accessible to all. About 60 percent of the patients are on Medicaid, others have private insurance, and some are uninsured and pay on a sliding scale based on what they can afford. The sliding scale is also offered for those treatments not covered by insurance or that exceed an insurance cap. That’s why the center is so dependent on United Way funding and volunteer help. The center also receives funding through donations, grants, and fundraising events such as Red Nose Day and the Developing Dreams Breakfast. Despite all that they do, you can sense frustration there; that they wish they could do more. The center sees about 170 children a month, but has an extensive waiting list, especially for speech and occupational therapy. “We would love to be able to expand,” said Executive Director Janet Ketcham, “because it is clear that the needs in this community are not being met.” The staff at McMains is delighted when they can graduate a child, chalk up another success story, and make room for another, but many of their clients remain with them for ten years.

About a third of the children that come to McMains have cerebral palsy, another third have Down’s syndrome, and the remainder have autism or other developmental disorders. The center prides itself on offering the most cutting edge therapy available and sends its therapists for continuing education to learn the latest and the greatest in treating children with disabilities. They are always on the lookout for ways to improve the health and quality of life of the children they serve and their families, said Ketcham. The center was renamed for Dr. Frank McMains, an orthopedist who volunteered his services there for over thirty years. Currently filling those shoes are Dr. Barry Rills and Dr. Kyle Girod from the Baton Rouge Orthopedic Clinic and Dr. Michael Frierson from the Bone and Joint Clinic. The orthopedists prescribe therapy, track progress of the center’s clients, and provide other services, all free of charge. Also volunteering their services are pediatricians Ronaldo Funes, MD and Martha Pope, MD, and family practitioner Christine Smith, MD who help with the health and developmental assessments. Children are given a multidisciplinary evaluation including one or more of these physicians, a psychologist, and a social worker. Any health or behavioral issues, underlying illness, learning disabilities, or other factors can be explored. “By the time we are done, we are pretty confident we have a good idea of what is going on and how we can help,” said Ketcham, “But we would love to be able to offer the services of a child psychiatrist and a pediatric neurologist on our evaluation team.” Any volunteers?
HEALTHCARE BRIEFS:
State & Local
The U.S. Centers for Medicare and Medicaid Services (CMS) has recognized Louisiana’s Medicaid program as a national best practice for its efforts to simplify and streamline the state’s Medicaid eligibility processes. Louisiana’s Medicaid program, which includes the Louisiana Children’s Health Insurance Program (LaCHIP), also shows significantly lower error rates overall than the national average, according to reports released by CMS. According to CMS, the national overall Medicaid estimated error rate is 8.71 percent, while Louisiana’s estimated overall error rate is 3.96 percent due to the state’s efforts to modernize and streamline the program. Louisiana Medicaid was cited as a national best practice for eligibility procedures due to a Medicaid estimated eligibility error rate of 1.54 percent, compared with the national estimated eligibility error rate of 6.74 percent. Medicaid estimated error rates are determined by CMS’ Payment Error Rate Measurement (PERM), which measures unintentional billing errors by providers and administrative errors by state agencies in the Medicaid and Children’s Health Insurance programs.

The Louisiana Department of Health and Hospitals’ Medicaid Eligibility Division attributes the low error rate to their efforts to modernize and simplify the eligibility determination and renewal processes without sacrificing the integrity of the program. This allows the state to keep nearly 100 percent of all qualified kids enrolled at renewal, while other states lose up to 50 percent of children at renewal. This has been accomplished in spite of a 15 percent reduction in eligibility staff over the past year due to budget reductions.

Joan Alker, Co-Executive Director of the Center for Children and Families at Georgetown’s Health Policy Institute said, “The fact that Louisiana has achieved such a high rate of accuracy in its Medicaid program is validation that its innovative approach works well. LaCHIP leads the nation in removing red-tape from the Medicaid eligibility and renewal process and now it leads the nation in the accuracy of its eligibility determinations. The secret of their success is putting commonsense to work by reducing paperwork and bureaucratic hurdles from the renewal and eligibility process and empowering frontline managers to make decisions.”

In recent years, Medicaid has all but eliminated paperwork-related reasons from keeping children off renewal rolls. Because of these efforts, in October, Louisiana kept nearly 100 percent of children up for renewal, at more than 99.5 percent. As a comparison, other states around the country lose between 25 and 50 percent of children at renewal for failure to return paperwork. This has been made possible by a variety of factors, including maximizing the use of technology and reducing the documents families must produce. For example, applicants used to have to provide copies of their birth certificate, which Medicaid now accesses directly in conjunction with the Center for Records and Statistics. Also, instead of requiring eight consecutive paycheck stubs to verify employment, Medicaid now requires two, working with state databases and telephoning employers to verify additional information. Medicaid works hand-in-hand with the Department of Social Services’ Office of Family Services, which runs the state’s SNAP (formerly Food Stamp) program, as well as the Louisiana Workforce Commission, to verify income through their databases without placing additional burdens on the applicant. An added benefit to paperless processes and simplification is administrative savings and “green government.”

LAHP Says Reform Proposals Would Make Health Care More Expensive

The Louisiana Association of Health Plans (LAHP) has warned that Louisianans could experience higher health care premiums and reduced benefits if proposals being considered by Congress should become law. According to Gil Dupré, chief executive officer for LAHP, the problem with the current proposals in Congress is that they don’t address the most significant problem in health care — cost. LAHP indicated that if the reforms proposed by U.S. Senate leadership in November should be enacted, premiums in Louisiana could increase 49 percent in the individual market and 28 percent in the small group market (over ten years), according to data from the Kaiser Family Foundation, Pricewaterhouse Coopers, Oliver Wyman, and America’s Health Insurance Plans. According to Dupré, the reason for these projected increases is that “current legislation relies on tax increases and benefits cuts rather than ways to reduce health care costs.”

LAHP also expressed concerns that billions of dollars in cuts to the Medicare Advantage program are being considered by Congress. If approved, beneficiaries could see their health coverage change dramatically in the form of fewer benefits, higher premiums, and more out-of-pocket costs. In some instances, such plan options could be eliminated altogether, said Dupré. More than 150,000 Louisiana seniors choose to get their benefits from the Medicare Advantage program.

North Oaks Medical Center Expansion Plans Reinstated

The North Oaks Board of Commissioners and Administration announced that the first phase of expansion plans for North Oaks Medical Center has been reinstated and funded through a $99 million bond issuance. Major components of the 200,000-square-foot, five-story hospital addition include 14 new operating room suites, an additional 12 outpatient Same Day Surgery beds and 67 new private inpatient rooms. Sixteen of the new rooms have been designated for critical care patients, and 51 will be used as medical/surgical and telemetry beds. With the addition of the new rooms, the hospital’s inpatient bed count will increase to 326 and the private room ratio from 51% to 60%.

According to Executive Vice President/Chief Operating Officer Michele Sutton, expansion phasing has been prioritized to maintain a financially responsible course of action. With extremely high average occupancy rates, this first phase will alleviate their immediate need for additional inpatient beds to take care of their patients. The new OR Suites and the additional 12 Same Day Surgery beds will address
growing schedule demands for both emergent and elective surgical procedures. Infrastructure enhancements, such as a new central mechanical plant, medical gas farm, generator enclosure and helipad, along with site work and an entry tie-in to North Oaks Office Plaza also are components of the project. In addition, nearly 30,000 square feet of space adjoining the Emergency Department, along with 20,000 square feet of space adjoining the new operating room suites, will be shelled in for future expansion needs in phase two.

The expansion project represents $79 million in design and construction costs and $20 million in equipment, furniture and fixture costs for a total community investment of $99 million. It has been designed by Washer Hill Lipscomb Cabaniss Architecture, LLC of Baton Rouge. The North Oaks Board of Commissioners and Administration planned to break ground in November. It is anticipated that the project will take 24 months to complete and that patient care could begin in the new hospital addition as early as February 2012.

**LSU Level 1 Trauma Center Named “Spirit of Charity”**

In honor of the highly skilled and dedicated staff of the Level 1 Trauma Center in New Orleans, the LSU Board of Supervisors passed a resolution designating the Center the “Spirit of Charity Level 1 Trauma Center.” A ceremony recognizing the new designation was held in October and a new logo for the Center was unveiled. Level 1 trauma care is the highest level attainable. LSU has the only two Level 1 trauma centers in Louisiana. The other is at the LSU Health Sciences Center – Shreveport. The Trauma Center provides care to all major trauma victims not only in New Orleans but in the 10-parish area surrounding New Orleans. All patients with severe injuries are brought to the Trauma Center directly from the site of injury by EMS.

Prior to Hurricane Katrina, the LSU Level 1 Trauma Center was in Charity Hospital, part of the multi-building Medical Center of Louisiana at New Orleans. Post-Katrina renovations to the Interim LSU Public Hospital (ILH) provided the Center with a new home in a state-of-the-art area that provides immediate accessibility of physicians, nurses, technicians, and services under the same roof. The Center regained Level 1 verification in December 2008.

**DHH Announces New Effort to Combat Medicaid Fraud**

The Department of Health and Hospitals (DHH) has implemented a first-ever, aggressive fraud initiative designed to identify fraudulent providers of in-home services for people in Medicaid. This effort is part of a partnership with Louisiana Attorney General Buddy Caldwell. DHH will also work with the appropriate federal authorities.

A sample audit of in-home direct care

The new hospital tower will adjoin the Signature Building and Office Plaza on the North Oaks Medical Center campus in Hammond.
providers last spring revealed a nearly 23-percent potential overpayment rate for services from 2007 to 2008. Medicaid pays for all services billed on a fee-for-service basis. As bills are received from providers, a payment is processed, usually within a week. In state fiscal year 2009, the total claims paid for in-home direct care services amounted to $673.5 million, spanning more than 700 agencies. As a response to these initial findings, thirteen providers were referred to the Attorney General’s office for review, and those potential cases remain under review.

Now DHH is launching a full audit of all Medicaid In-Home Direct Care providers. Up to six audit firms are being engaged to do a several-month sweep throughout the state in order to review billings and report their findings. Any findings of fraud or abuse will be swiftly handed over to the offices of the Attorney General and the appropriate federal authorities.

DHH Secretary Alan Levine also criticized the system that enables this fraud to thrive, saying the fee-for-service system not only enables fraud, but encourages it, incentivizing more volume and over-utilization. DHH has proposed a transformation of Medicaid that would end the current fee-for-service system and replace it with a model that more resembles insurance, where taxpayers would not be directly at risk for fraud. Plans are under way to move forward with that initiative, which contains strict provisions for fraud mitigation, detection and reporting, thereby expanding the surveillance in the Medicaid marketplace.

DHH is contracting with up to six audit firms that will place teams of auditors and financial experts on the ground in Louisiana beginning at the discretion of the Secretary in consultation with the Attorney General's office. Over several months, the audit teams will review provider records and take other steps to conduct fraud surveillance. The initiative is funded by using some of the $3 million fund created with dollars recovered from fraudulent providers. This marks the first time DHH has initiated and led such an audit.

Watkins Promoted to Revenue Management Director of North Oaks Health System

Michelle Watkins of Ponchatoula has been promoted to Revenue Management Director of North Oaks Health System. Watkins will be responsible for the planning, organization, implementation, and direction of the day-to-day operations of Medicare and Medicaid reimbursement and cost reporting, managed care contracting, licensing and credentialing, third party payors, regulatory updates and payment audits.

Watkins earned a bachelor’s degree in accounting from Southeastern Louisiana University in Hammond. Professionally, she belongs to the Healthcare Financial Management Association. The! former Revenue Management Coordinator began her North Oaks career in 1993 and has served in several managerial and supervisory positions, including Medical Office Supervisor, Budget Accountant, Accounting Program Manager, and Reimbursement Coordinator.

Children’s Hospital Opens New CICU

Children’s Hospital New Orleans recently dedicated its new Cardiac Intensive Care Unit. The state-of-the-art 8,193-square-foot CICU features 20 beds (10 in private rooms) for children – some just days old – who are recovering from heart surgery. The Heart Center at Children’s Hospital, a collaboration with LSU Health Sciences Center, is nationally recognized for the care of patients with congenital cardiovascular disorders. The Heart Center’s team includes eight pediatric cardiologists and three cardiothoracic surgeons who service cardiologists, pediatricians, perinatal services, and neonatologists in Louisiana and Mississippi and annually treat more than 2,000 children and
adults from throughout the world. The Center also serves the very fast-growing population of adults with congenital heart disease who have survived previous surgeries and need further follow-up and/or surgeries to help them throughout their lives.

Last year, the Cardiology Department performed almost 10,000 procedures, including interventional cardiac catheterization treatments for congenital heart disease and fetal echocardiograms to help diagnose heart conditions before babies are born. The Cardiothoracic Surgery team performed 417 heart surgeries, sometimes operating on as many as three children a day. More than half of the Center’s surgeries involved children under age 1, and 30 percent were performed on newborns.

Shuman Joins Magnolia Obstetrics & Gynecology Clinic
Deborah L. Shuman, MD, has joined the practice of Magnolia Obstetrics & Gynecology, a clinic of North Oaks Health System. Along with Drs. W. Jeremy Erwin, Marya J. Porter and Thuc B. Tran, as well as Women’s Health Nurse Practitioner Keri G. Burkes and the Clinic staff, Dr. Shuman specializes in personalized health care for women from adolescence to menopause, including:
- routine gynecologic care
- pregnancy and postpartum care
- contraceptive counseling
- treatment of abnormal Pap smears and
- management of menopause and osteoporosis.

Since 2007, Dr. Shuman has practiced medicine locally and belonged to the North Oaks Medical Staff. She earned her medical degree from Louisiana State University School of Medicine in New Orleans and completed her residency and internship at Baylor University Medical Center in Dallas.

EPA Announces DEQ Meets Air Quality Standards For PM 2.5
The Department of Environmental Quality recently received a letter from the U.S. Environmental Protection Agency stating that the state meets “the National Ambient Air Quality Standards for fine particles (PM 2.5), measured over a 24-hour period.” The PM 2.5 particles pose a greater health risk than larger particles because they can lodge deep inside the lungs. Studies have shown that exposure to PM 2.5, which are generally one-40th the width of the average human hair, can cause cardiovascular disease, lung disease and asthma attacks.

The fine particles that make up PM2.5 are from solid and liquid particles suspended in the air. The particles can be directly emitted from a source or formed in the atmosphere as part of a chemical reaction. PM 2.5 is mainly caused by pollutants emitted when fuel is combusted. Power plants that use fossil fuel and automobiles are examples of PM 2.5 sources.

Julia Lively Named CFO of Health Centers in Schools Health Centers in Schools, a local non-profit, has hired Julia Lively as Chief Financial Officer. Lively comes to the organization with many years of hospital financial experience. Most recently, she was the vice president of finance at Woman’s Hospital. Prior to joining Woman’s Hospital in 1994, Lively served in various financial management positions at Our Lady of the Lake Regional Medical Center in Baton Rouge from 1981 to 1994. Before working in the hospital industry, she worked as a senior auditor for the Medicare/Medicaid intermediary, Blue Cross of Louisiana.
Having graduated cum laude from Louisiana State University with a bachelor of science in accounting, Lively is a Certified Healthcare Financial Professional, with a specialty in accounting and finance, and is a fellow in the Healthcare Financial Management Association (HFMA). She is also an alumnus of Leadership-Greater Baton Rouge, Inc. and Leadership of Louisiana. Ms. Lively serves on the Finance Committee and the Expert CFO Committee for the Louisiana Hospital Association and is also on the board of Teens as Leaders.

Updated Name Reflects Expanded Role

Louisiana Health Care Review (LHCR) has changed its name to eQHealth Solutions. The new name supports the Louisiana-based company's growth into other markets, as well as underscores its key strength of providing effective and high quality health care solutions. Gary Curtis, chief executive officer of eQHealth Solutions said the group sought a name that was not tied to a specific state or region, and that better reflected its products, services, and multi-state presence.

In addition to Louisiana Health Care Review, the company is known as HealthSystems of Mississippi and HealthSystems of Illinois in those respective states. But, because so many clients and business associates are familiar with these companies, eQHealth Solutions will continue to do business under these names in their respective markets.

OMC-WB Receives American Heart Association Silver Performance Award

Ochsner Medical Center-West Bank Campus has been recognized as one of only six hospitals in the state for its exceptional care in treating heart failure patients with the American Heart Association’s (AHA) Get With The Guidelines SM Silver Performance Achievement Award. This award recognizes commitment, success, and higher standard of patient care. The Silver Award also indicates hospitals that provide patients with 85% or higher compliance to core standard levels of care for 12 consecutive months.

Get With The Guidelines® (GWTG) is the premier hospital-based quality improvement program for the American Heart Association and the American Stroke Association. It empowers healthcare provider teams to consistently treat heart and stroke patients according to the most up-to-date guidelines.

DHH Initiative Addresses Birth Outcomes in Louisiana

Following on its success in boosting childhood immunizations, the Louisiana Department of Health and Hospitals will embark on a statewide effort to improve Louisiana's birth outcomes, one of the most important indicators of a healthy society. DHH Secretary Alan Levine has asked assistant secretary of the Office of Public Health, M. Rony Francois, M.D., Ph.D., MPH, to lead the effort full time.

Despite its high rankings for the percentage of women receiving prenatal care, Louisiana continues to rank poorly for its various birth-outcome measures. According to the 2009 America’s Health Rankings by the United Health Foundation, Louisiana ranked 49th in infant mortality at 10 deaths per 1,000 live births. And, according to the KIDS COUNT 2009 data book by the Annie E. Casey Foundation, Louisiana ranked 49th in percent of low-birth-weight babies and infant mortality rate. These poor out-
comes relative to the rest of the United States have changed little over time, despite increasing access to prenatal care for Louisiana's mothers and a child health insurance rate among the highest in the nation.

The initial focus will be to assemble department resources to support the effort, work with DHH partners (including providers, health plans, and community-based organizations) to conduct a statewide inventory of services and programs along with quality and outcomes metrics, and draft and implement a multi-year statewide plan for improving our outcomes. Key to this success will be the establishment of meaningful goals and benchmarks for the state, the Legislature and providers to monitor.

Clayton Williams Appointed DHH Assistant Secretary of Public Health

Louisiana Department of Health and Hospitals Secretary Alan Levine announced today the appointment of Clayton Williams to succeed Dr. Rony Francois as assistant secretary for the DHH Office of Public Health. Williams will assume his responsibilities January 18, 2010, when Francois begins a comprehensive, statewide effort to improve Louisiana's birth outcomes.

As director of the Health Systems Division at the Louisiana Public Health Institute, Williams has had responsibility for leading a wide variety of local and state public health programs over the past eight years. Williams has practiced as an emergency medical technician, and holds a bachelors degree from Northwestern University in Evanston, Illinois and a master of public health from Tulane University's School of Public Health and Tropical Medicine in New Orleans. He is currently working towards his doctorate in health systems management at Tulane.
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REFORM SHOULD BE DRIVEN BY FOCUS ON QUALITY, NOT COST

by: Michael Fleming, MD, FAAFP, President, Louisiana Health Care Quality Forum

Probably the most frustrating thing about the current healthcare reform rhetoric is that everyone is focusing on only one thing – in my opinion, the wrong thing – cost. Shouldn’t we instead focus on quality? There is a large body of literature that confirms that when we improve quality outcomes for patients, costs go down. Researchers at Johns Hopkins showed that this is true not only in this country, but around the world. The Dartmouth Institute has looked at extreme variations in costs and quality outcomes across this nation, and found the same paradox – better outcomes actually cost less. Then why are healthcare costs going up and up, but quality outcomes staying pretty much the same? It seems that we’re not getting the quality care we deserve. Another group of researchers at RAND Health found that when adults encounter the healthcare system, the “right” thing happens only about 55% of the
time. So what is quality?

The venerable Institute of Medicine (IOM) says that quality healthcare has six characteristics: safety; timeliness; effectiveness; efficiency; equality; and patient centeredness.

Safety. Every single one of us should have an expectation of safety when we encounter our healthcare system. Do we have this? According to the IOM in 2001, there are over 98,000 deaths each year in hospitals that occur because of preventable errors. Before the members of the plaintiffs’ bar stand and cheer, allow me to again quote from the Institute’s report: “The problem is not bad people in health care – it is that good people are working in bad systems (italics mine) that need to be made safer.” Our systems have been dysfunctional for years, but we apparently all suffer from a peculiar form of institutional insanity – at least according to Albert Einstein who said, “Insanity is doing the same thing over and over again and expecting different results.” Safety will result when we align our systems with patient needs.

Timeliness. This means that when anyone needs something to be done, it should be done. In many health systems around the world this is a major problem, and many patients wait inordinate amounts of time for needed care. Allow me to quote from the British National Health Service (NHS) website:

“The NHS has achieved the shortest waiting times since its records began, the Department of Health said today.

“It also said it had met its ‘18 weeks’ waiting time target, whereby patients referred from a GP for further treatment start that treatment within 18 weeks. The target became the operational standard for the NHS from January 1, 2009. Today’s announcement confirms that the deadline was met.

“The average waiting time for patients admitted to hospital is now just 8.6 weeks. Outpatients waited an average of 4.6 weeks at January 2009, compared to 7.4 weeks at August 2007.”¹
According to the website of the government of Ontario, Canada’s most populous province, the target waiting time for general surgery is 182 days, and their actual current wait time is 99 days.²

**Effectiveness.** Whenever any of us encounter our healthcare system, we expect the “right” thing to be done. That’s what effectiveness means, that the “right” thing gets done. But according to a study by RAND Health in 2003 the right thing happens only about 55% of the time. That means that when any of us visit our healthcare system the “right” thing is NOT done for us 45% of the time.

**Efficiency.** We should expect the right thing to be done, but only the right thing. Duplication of tests and procedures are major cost drivers in our system, and too many times, more is not best. There are many reasons for our relative lack of efficiency – defensive medicine, misaligned incentives – but all are symptoms of a broken system.

**Equitability.** There can be no excuse for any disparities in healthcare.

**Patient-centeredness.** Of all, this may be the most important. Our current system is “provider-centered,” meaning that most care takes place when providers demand and where providers demand. Patient-centered care is care that happens when and where is best for the patient. In fact, quality healthcare can be simply defined as doing the right thing, but only the right thing, at the right time for every patient.

The next step in the process is to figure out who in each community provides this quality care. The answer to this will be transparency. Hospitals are now required to report certain quality metrics to Medicare, and these are available to anyone on the CMS (Centers for Medicare and Medicaid Services) website. In some parts of the country, most notably Minnesota, the Pacific Northwest, parts of Pennsylvania, and others, physician groups are reporting their quality scores based on evidence-based guidelines, particularly for management of chronic diseases like diabetes, hypertension, heart failure, etc.

When patients demand quality – the right thing, but only the right thing, at the right time – then healthcare providers will be much more likely to offer the same transparency.

But quality has to be a team sport. Too often patients force physicians to do “more” than the right thing, such as to prescribe antibiotics when clinically unnecessary, or to demand unnecessary procedures. Every one of us must become an intelligent healthcare consumer. ✤

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Local Hospitals Respond
to USPSTF Mammogram Recommendations

Shortly after the controversial United States Preventative Services Task Force (USPSTF) recommendations to eliminate screening mammograms for women between the ages of 40 and 49, both Woman’s Hospital and the Pennington Cancer Center at Baton Rouge General released responses contradicting that guidance.

According to Woman’s Hospital, more than one-third of the breast cancers diagnosed at that facility occur in women under the age of 50, so radiologists were both “surprised and concerned” about the suggestion that screening mammograms for that age group were unnecessary. Woman’s Hospital stated that the proposed recommendations could hinder and/or discourage women from getting the screening mammograms they need and could undo years of work to boost breast screening.

Physicians at the Comprehensive Breast Program at Baton Rouge General’s Pennington Cancer Center also expressed concern over the recommendations, stating that if adopted as policy, two decades of decline in breast cancer mortality could be reversed. The center stated that ongoing early detection efforts and improved treatment have led breast cancer mortality rates to decline at two percent annually. Woman’s Hospital agreed, stating that the USPSTF ignores data demonstrating that screening mammography has decreased breast cancer deaths among women in their 40s by over 40%. In fact, the task force acknowledged that screening women in their 40s would reduce their risk of death from breast cancer by 15%, just as it does for women in their 50s. So, according to Woman’s Hospital, “the task force is essentially telling women that mammography at age 40–49 saves lives, just not enough of them.”

Physicians at both hospitals urged women to continue to follow the National Comprehensive Cancer Center Network (NCCN) guidelines. "Women in the 40 to 74 age group should continue annual mammography screening, physician breast exams and self breast exams because early detection of breast cancer affords better outcomes and more treatment choices," said Dr. Richard Burroughs, medical director of Baton Rouge General’s Pennington Cancer Center.

Dr. Surek Joins Baton Rouge General ENT

Dr. Christopher Lee Surek, F.O.C.O.O. (Fellow of the Osteopathic College of Ophthalmology and in Otorhinolaryngology) has joined Baton Rouge General ENT, a clinic affiliated with Baton Rouge General’s Community of Caring. Dr. Surek is a Summa cum Laude graduate of Chicago College of Osteopathic Medicine. He completed residencies in General Surgery at St. Joseph Hospital in Otorhinolaryngology, Head and Neck, Facial, and Plastic Reconstructive Surgery at Northwestern University Medical Center, both in Chicago. Dr. Surek is certified in Otorhinolaryngology, Head and Neck, Facial, and Plastic Reconstructive Surgery by the American Osteopathic Board of Ophthalmology/ Otorhinolaryngology and by the National Osteopathic Board of Examiners. In addition to Baton Rouge General ENT, Dr. Surek also retains a practice in Zachary.
Woman’s Annual Volunteer Luncheon Honors Secret Ingredient

More than 90 volunteers of Woman’s Hospital attended the hospital’s Annual Volunteer Luncheon in November. Volunteers were honored as “the secret ingredient in Woman’s recipe for success” and were recognized for their hours and years of service to the organization. The men of Woman’s volunteer corps presented a check to Teri Fontenot, President/CEO of Woman’s, in the amount of potential man- or woman-hours the volunteers donate to the women and infants Woman’s Hospital serves.

Baton Rouge General Launches New Internet Locator Service

Baton Rouge General recently launched Louisiana Go Local (www.medlineplus.gov/lagolocal), a new website to help Louisiana consumers locate health services. The site lists thousands of services across the state. People can find doctors, hospitals, clinics, nursing homes, support groups, diabetes care, cancer services, home health care, weight management services, and much more. Louisiana Go Local is produced by Baton Rouge General’s Health Sciences Library in collaboration with the LSU School of Library and Information Science, and the National Library of Medicine, part of the National Institutes of Health.

Lansing Appointed to Lane RMC Board

Joan Lansing was 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. Lansing replaced Andy Sessoms, who served on Lane’s board for the past seven years. A resident of Central, Lansing has been a Councilwoman for the City of Central since 2005 and is a former Administrator and Lobbyist for the Louisiana Professional Association for Child Care. She graduated from Southeastern Louisiana University with a Pre-Med degree and has dedicated her life to serving the community and area residents.

At their most recent meeting, Lane’s Board of Commissioners re-elected Dell Guerra, RN as chairperson and Robert Williams, Jr. as vice chair. In addition to Joan Lansing, Lane’s board of commissioners includes James “Goose” Carroll, Patricia Gauthier, Jeffrey Gruner, MD, Jimmy Jackson, and Mark Thompson.

LHA Thanks Governor, DHH for Medicaid Efforts

John Matessino, President & CEO, Louisiana Hospital Association, recently issued a public statement thanking both Governor Bobby Jindal and Department of Health and Hospitals Secretary Alan Levine for their efforts in the face of a $308 million budget shortfall in
the Medicaid Program. He stated that the Administration "has had to make tough, strategic decisions to ensure that core programs within Medicaid remain intact to protect critical healthcare services for those in need." LHA acknowledged the administration’s efforts during mid-year Medicaid cuts to avoid further reductions to hospitals and physicians. “Many hospitals around the state literally cannot afford another Medicaid cut without communities and patients suffering severe consequences,” said Matessino.

**Terri McNorton Joins National Healthcare Marketing Board**

Members of the national Society for Healthcare Strategy and Market Development (SHSMD) of the American Hospital Association have elected Terri McNorton to its Board of Directors for a three-year term. McNorton serves as vice president, marketing and communications, for Baton Rouge General Medical Center. She is a seven-year member of SHSMD and has served on the organization’s Member Experience and Scholarship committees, as well as on the Annual Conference Planning Committee for three years.

The SHSMD Board of Directors is comprised of 17 healthcare executives from across the United States with expertise in healthcare planning, marketing, and public relations. SHSMD is a society of the American Hospital Association, serving more than 4,500 members.

**Ochsner Nurses Named in 2009 "100 Great Nurses of Louisiana"**

Ochsner-Baton Rouge proudly announced that two nurses, Sheila N. Reynaud, MSN, RN-BC—Quality and Sydney P. Prescott, RN, MSN, NP-C—Hematology/Oncology were among 36 Ochsner Registered Nurses honored as Louisiana’s Great 100 Nurses by the Great 100 Nurses Foundation for their commitment to patient care. Ochsner nurses in the complete "Great 100 Nurses" include:

- **Ochsner Medical Center - Baton Rouge:**
  - Sheila N. Reynaud, MSN, RN-BC
  - Sydney P. Prescott, RN, MSN, NP-C

- **Ochsner Health Center, North Shore:**
  - Wendy Meibaum, RN

- **Ochsner Medical Center - Kenner:**
  - Lee Ann Dooley, RN
  - James E. House, RN
  - Lillie A. Quiett, RN
  - Pam W. Ryan, RN
  - Lorena Villalobos, RN

- **Ochsner Medical Center - West Bank campus:**
  - Thomas Butler, RN
  - Kathleen Fletcher-Carey, RN
  - Terry M. Joseph, RN

- **Ochsner Medical Center, New Orleans:**
  - Maria A. Allen, RN
  - Greta B. Bayers, RN
  - Barbie A Conley, RN
  - Perla F. Daguil, RN
  - Pleshetta Dillon, RN
  - Jamie L. Gambino RN
  - Tina Gipson, RN
  - Amanda Gregoire, RN
  - Donna K. Groteguth, RN
  - Sally Guice, RN
  - Diane Hendawi, RN
  - Jonathan M. Jenkins, RN
  - Bethany C. Jennings, RN
  - Virginia F. Resor, RN
  - Yolonda Roberson, RN
  - Colleen Sherman, RN
  - Jeanie Shiber, RN
  - Paula Simon, RN
  - Erin V. Trembley, RN
  - Claudette B. Williams, RN

**Woman’s Updates Status of New Campus**

Woman’s Hospital recently released an update on the status of construction of their new facility at the corner of Airline Highway and Pecue Lane. Construction was placed on hold last January because of a struggling economy and weak bond market. Woman’s Hospital’s financial advisors report that more favorable conditions in the financial market indicate that it may be time to move forward.
with financing the project and restarting construction. In November the hospital asked subcontractors to refresh their pricing due to improved market conditions and the modified scope of the project. Woman’s project leaders anticipated new pricing by the end of the year.

Despite the more positive outlook, Woman’s is looking to scale back on a few things on their wish list in order to allow the project to move forward. For example, surge capacity was part of the original design as Woman's served as a perinatal surge hospital in hurricanes Katrina, Rita, Ike, and Gustav. As part of its efforts to reduce the cost of the new hospital, some elements of perinatal surge capacity have been removed (most notable are proposed additional neonatal and adult bed capacity). Since emergency preparedness is a public health function, Woman’s continues to work closely with the local, state and national public health agencies to address surge capacity issues. The medical office building has also been reduced by 10,000-15,000 square feet.

Once the repricing information is received, it will be used to make a decision about the timing for issuance of permanent financing, hopefully early this year.

**Tara Allen Receives Medical Practice Executive Designation**

Tara Allen, Director of Clinic Operations for First Care Physicians, a subsidiary of General Health Systems (GHS), has earned the Certified Medical Practice Executive (CMPE) designation from the American College of Medical Practice Executives (ACMPE), the standard-setting and certification organization of the Medical Group Management Association (MGMA). The CMPE designation is a mark of distinction and demonstrates expertise in medical practice management.

Allen is an 18 year GHS employee and has held various management-level positions throughout her career with the organization. She has a Masters in Business Administration from Louisiana State University and a bachelor of science degree in Biology/Pre-Med from Tulane University.

**Recognition for Best-In-Class Quality of Care**

Our Lady of the Lake Regional Medical Center has been recognized with the 2008 Level III Louisiana Performance Excellence Award given by the Louisiana Quality Foundation. The Level III Louisiana Performance Excellence Award is the highest honor awarded by the Louisiana Quality Foundation and earned by organizations for outstanding results in key focus areas including: organizational leadership, strategic planning, customer focus, workforce focus, process management as well as measurement and analysis.

The Louisiana Performance Excellence Award is a statewide award based on the Malcolm Baldrige National Quality Award criteria recognizing quality leadership and performance excellence in education, government, manufacturing, service industries, healthcare, and non-profit organizations. Organizations that apply to be considered for this award do so under one of three levels. Level I applicants are in the early stages of performance improvement and are judged on their organizational profile. Level II applicants submit an organizational profile and information relat-
ed to their leadership, strategic planning, customer and market focus, measurement, analysis and knowledge management, human resource focus, and process management. Level III applicants submit for review of all the information listed above plus information on their business performance results and must participate in a rigorous site visit to demonstrate excellence and quality.

**Woman’s Employee Certified in Infection Control**

Angela Loving, Woman’s Hospital Infection Prevention Department, has passed her certification exam for Infection Control. The certification is awarded based on an applicant’s ability to analyze and interpret collected infection control data and her investigation and surveillance skills related to suspected outbreaks of infection. There are only 3,000 certified infection prevention practitioners in the United States.

Additional measures for certification include infection prevention knowledge related to the planning, implementation and evaluation of infection prevention and control measures, the education of individuals about infection risk, prevention and control, the development and revision of infection control policies and procedures, the management of infection prevention and control activities and the provision of consultation on infection risk assessment, prevention and control strategies.

The Certification Board of Infection Control and Epidemiology, Inc. (CBIC) is a voluntary autonomous multidisciplinary board that provides direction for and administers the certification process for professionals in infection control and applied epidemiology. CBIC is independent and separate from any other infection control-related organization or association.

**OLOL Recognized for Excellence in Cardiac Care**

Our Lady of the Lake (OLOL) Regional Medical Center was recently re-designated a Blue Distinction Center for Cardiac Care by the Blue Cross and Blue Shield Association. Blue Distinction is a nationwide program of the Blue Cross and Blue Shield Association that creates an unprecedented level of transparency for both consumers and providers of healthcare. Driven by quality, collaboration, and affordability, Blue Distinction has two goals. The program seeks to engage consumers to become more involved in making health care decisions and to collaborate with providers to improve patient outcomes through centers that meet high standards of care.

Our Lady of the Lake was selected as a Blue Distinction Center for Cardiac Care based on the ability to provide a broad spectrum of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery. To be designated as a Blue Distinction Center for Cardiac Care, Our Lady of the Lake met the selection criteria posted at www.BCBS.com, which includes:

- an established cardiac care program, performing required annual volumes for certain procedures (e.g. a minimum of 125 cardiac surgical procedures annually, including both CABG and/or valve surgery)
- appropriate experience of its cardiac team, including subspecialty board certification for interventional cardiologists and cardiac surgeons
- an established acute care inpatient facility, including intensive care, emergency and a full range of cardiac services
- full accreditation by The Joint Commission
- low overall complication and mortality rates
- a comprehensive quality management program.

**OLOL Named Consumer Choice Award Winner**

For the eleventh consecutive year, Our Lady of the Lake Regional Medical Center has been selected by the National Research Corporation (NRC) as the Consumer Choice Award Winner.
winner for the hospital with the highest overall quality and image in the Baton Rouge metropolitan area. Consumer Choice award winners are determined by consumer perceptions on multiple quality and image ratings collected in NRC Healthcare Market Guide study. The 2009-2010 NRC Healthcare Market Guide study surveyed over 200,000 households by phone representing 450,000 consumers in the contiguous 48 states and the District of Columbia.

Dr. Edward Jeffries Named Chief Medical Officer for First Care Physicians

Edward Jeffries, MD, has been named chief medical officer for First Care Physicians. In this role, Dr. Jeffries will oversee medical administration activities and provide leadership for quality assessment/quality improvement and patient safety. Dr. Jeffries is a board-certified family practice physician, previously working with Baton Rouge Family, a First Care Physician practice. He formerly served as a medical practice consultant and owned his own private practice for over 30 years.

Dr. Jeffries is a Diplomat of the American Board of Family Practice and has practiced family medicine for more than 30 years with Baton Rouge Family Medical Center, an affiliate of First Care Physicians. He is a graduate of Louisiana State University School of Medicine in New Orleans and is a member of the Louisiana Academy of Family Physicians, the American Academy of Family Physicians, the Louisiana State Medical Society, and the American Medical Association. Dr. Jeffries has previously served as President of the Louisiana Academy of Family Physicians. He has also previously served as the General's Chief of Family Medicine and as a member of the Board of Trustees for General Health System. He is a member of the American College of Physician Executives and the American Academy of Sleep Medicine. Additionally, he is a consultant in the field of medical practice management. He is currently a member of the American Academy of Family Physicians, American Medical Association, Louisiana Academy of Family Physicians, and Louisiana State Medical Society.

Woman’s and OLOL Receive 2009 Quality Respiratory Care Recognition

Both Woman’s Hospital and OLOL were recently recognized by The American Association for Respiratory Care (AARC) for providing quality respiratory care services to their patients and their community. The purpose of this program is to help consumers make choices about their healthcare by recognizing hospitals that promote patient safety by providing access to respiratory therapists to deliver their care. The AARC maintains and publishes a database of hospitals that meet their requirements. The hospitals receiving the Association’s Quality Respiratory Care Recognition (QRCR) designation meet the following requirements:

- All respiratory therapists employed by the hospital to deliver bedside respiratory care services are either legally recognized by the state as competent to provide respiratory care services or hold the CRT or RRT credential.
- Respiratory therapists are available 24 hours.
- Other personnel qualified to perform specific respiratory procedures and the amount of supervision required for personnel to carry out specific procedures is designated in writing.
- A doctor of medicine or osteopathy is designated as medical director of respiratory care services.

![Strength Faster Better!](image)

![Stronger Faster Better!](image)
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