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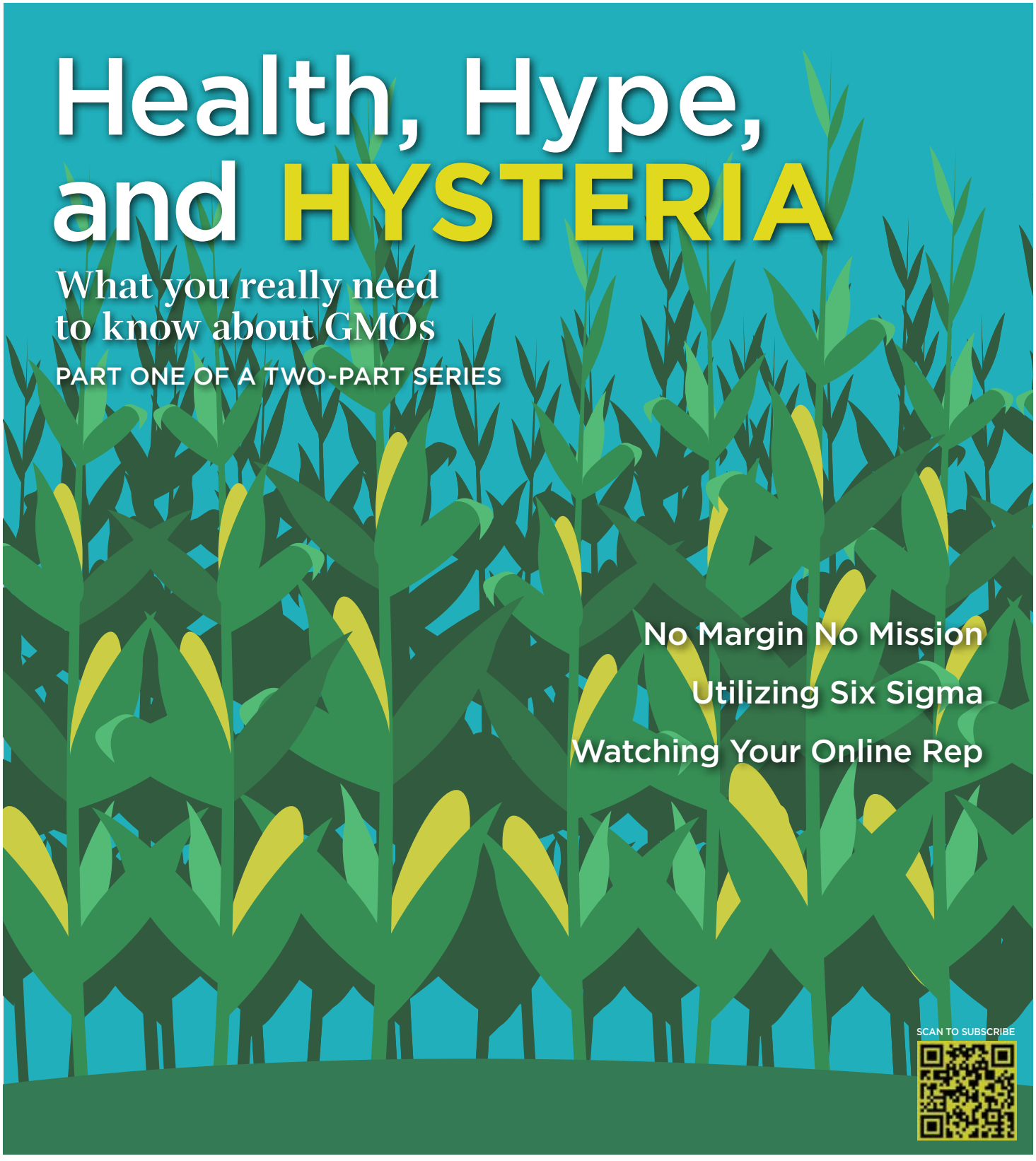

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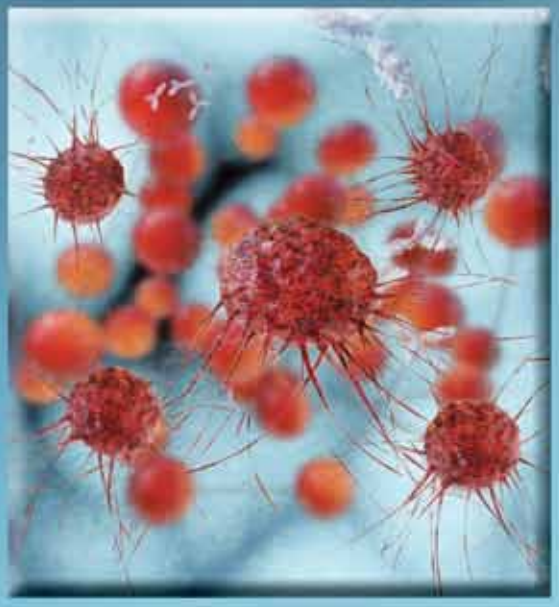

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WE ACCEPT DEATH AS PART OF LIFE. But, we perhaps haven't quite turned the corner in discussing it openly and honestly – perhaps it's still too uncomfortable.

Let's look at some data. It's estimated that 5-10% of cancer is genetic and unpreventable. That means 90-95% of cancer is to some degree preventable. But, to be preventable requires major lifestyle changes concerning tobacco use, diet, stress, environmental factors, etc. It's also estimated that this coming year about one million Americans and 10 million people worldwide will be diagnosed with cancer. In America we spend about $100 billion a year just on cancer medication.

Let's look at automobile accidents. Over recent years there have been more than five million auto accidents a year, with more than two million injuries, and over 30,000 deaths per year. That's more than 90 deaths per day for auto accidents just in the United States.

These are uncomfortable topics. My point in mentioning these two examples is the opportunity for individuals and society as a whole to be aware of our everyday choices. We sometimes pretend we do everything to prevent deaths, but we clearly don't. We make rational decisions. We accept a certain number of deaths.

In the latter example of auto accidents, we can consciously state that we can bring 2.5 million injuries and 30,000 deaths per year to zero. What would we give up? Well, off the top of my head, we would give up convenience and freedom of individualized transportation, not to mention the economy of automobile travel. I don't hear anyone recommending we give up auto travel. We accept the deaths.

With regard to the millions of cancer deaths, we choose to accept environmental and lifestyle choices. One can only imagine if the $100 billion spent annually on cancer medication was spent in one year on cancer prevention. However, there is no economic benefit to preventing cancer so it is a highly unlikely scenario. Besides, prevention isn't that expensive.

Please know I'm not making a case for or against any choices. It's just interesting to consider them. We all know people who have died of cancer and auto accidents, and it's painful. My only point is we have more control and power to do things than we give ourselves credit for. Let's just don't pretend we haven't considered an acceptable level of deaths in our equations. It's a more honest and conscious approach.

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By **Claudia S. Copeland, PhD**

HEALTH, HYPE, AND HYSTERIA

Part one in a two-part series on GMOs

Every year, an estimated 250,000 to 500,000 children go blind due to vitamin A deficiency. According to the World Health Organization, half of these children will die within 12 months of losing their sight. This is because rice is the staple food for many impoverished people without access to high-quality, varied produce, and conventional rice does not provide vitamin A. Despite decades of global public health efforts, vitamin A deficiency continues to be a public health problem in more than half of all countries, especially in Africa and South-East Asia. What if it were possible to create a new strain of rice that was rich in vitamin A? In the late 1980s, a team of molecular biologists supported by the Rockefeller Foundation set to work using the new techniques they were developing in the lab to address this global challenge. Over a decade later, in 2005, a new strain of vitamin A-rich rice, dubbed Golden Rice, was being field tested right here in Louisiana.

Golden Rice grain compared to white rice grain in screenhouse of Golden Rice plants.

IMAGE BY INTERNATIONAL RICE RESEARCH INSTITUTE (IRRI)

Using bioengineering techniques, they introduced genes from daffodil and the bacterium Pantoea ananatis into a commercial rice genome, and then spent years optimizing the rich golden-orange colored rice. One bowl now provides about half of a person's daily requirement for Vitamin A. For its work, the non-profit Golden Rice Project—in particular Drs. Ingo Potrykus, Peter Beyer, and Adrian Dubock—won a 2015 Patents for Humanity award.

According to the Golden Rice Project humanitarian board, "Once locally developed varieties containing the Golden trait have cleared the regulatory hurdles at the national level, they will be made available to subsistence farmers free of charge. The seed will become their property and they will also be able to use part of their harvest to sow their next crop, free of cost. Golden Rice is compatible with farmers using traditional farming systems, without the need for additional agronomic inputs. Therefore, no new dependencies are created."

In other words, this is a not-for-profit project that is committed to giving free nutrient–enhanced seeds to farmers in developing countries for the purpose of saving lives. A win-win project to be sure—what's not to love about this?

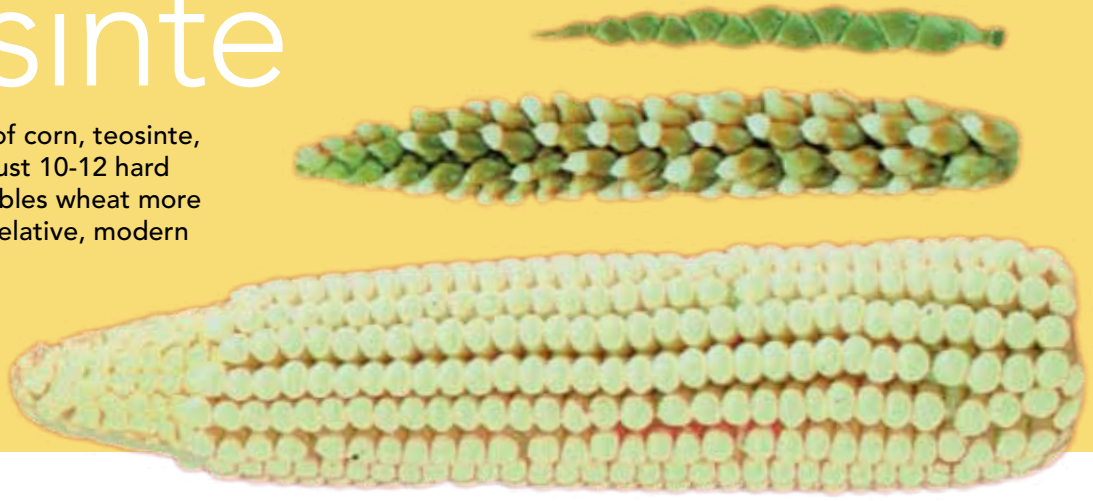
And yet, not everyone is happy, and some are downright furious. Greenpeace, opposed to all genetically modified organisms, claims that Golden Rice is an industry-sponsored ploy to introduce GMOs to the world; an agricultural trojan horse that "poses risks to human health, and could compromise food, nutrition, and financial security."

Though they present no solid evidence supporting their claims about human health risks, they have a point about Golden Rice promoting GMOs. Dr. Steve Linscombe, the LSU AgCenter's regional director and a key collaborator in the Golden Rice project through LSU's field testing, openly states, "We look at this as a good mechanism for informing the public that genetic engineering does have a lot of positive benefits. This is just one example of many things to come down the road. This is the first step of many different things that can be accomplished with genetic engineering—and not just in rice."

But is this a good thing? Peruse the internet and you'll hear plenty of voices decrying the danger of GMOs. There is unease about tinkering with nature, and this fear

teosinte

The wild ancestor of corn, teosinte, has tiny ears with just 10-12 hard kernels, and resembles wheat more than its succulent relative, modern commercial maize.



has been further increased by the lack of labeling of GMO food products. Concerned consumers feel like anything they eat could contain shadowy, unknown dangers. Dr. Shahla Wunderlich, in a recent publication in *Advances in Nutrition*, examined consumer knowledge and preference regarding GMOs. Awareness and understanding of GM foods was extremely low and subject to the way in which the investigators framed their questions. At the root of the issue is the newness of bioengineered food for humans–these products have not been around long enough for long-term epidemiological studies of humans. She believes that there "have not been enough research studies and evidence-based publications to confirm the health effects (positive or negative) of GM foods, as they have been only available commercially for purchase since the 1990s. Many consumers are, therefore, puzzled as they receive their information about GMO food products from the media, internet, and other news sources that may not be reliable. The scarcity of scientific research in this area leads to uncertainty among consumers about the direct health effects of GMO products."

Common supermarket strawberries have octaploid genomes, and are huge compared to their tiny wild ancestors.

This uncertainty has been fanned into public fear by anti-GMO activist groups and propagated in popular media outlets by non-scientist writers. It has also been compounded by serious social missteps and media naiveté by scientists. A study on the bioavailability of beta-carotene in Golden Rice fed to Chinese children was retracted for ethical reasons this September–the parents had been informed that the children in the study would receive beta-carotene, but not that the rice was genetically engineered. Quite understandably, they are worried and angry, even though there were no adverse health effects, believing that the rice must be dangerous if its nature was omitted in the consent forms. "If it's safe, why did they need to deceive us into this?" asked one angry father. It was not a simple oversight; according to *Nature* news, a Chinese Centers for Disease Control and Prevention official had changed the wording from the original consent forms to avoid mentioning Golden Rice because it was "too sensitive".

In this roiling social cauldron, getting a clear, objective picture of GM food is a formidable challenge, even for educated consumers. Are GMOs a better way to feed the world, or a threat to human health? And, what exactly are GMOs, anyway?

The term "GMO" is not a well-defined one. Virtually all food crops are genetically modified; organisms that have not been changed from their wild ancestors are few and far between, and in general not to be found in supermarkets. Unless you foraged your food from a forest, or hunted or fished it, you have been eating genetically modified organisms. Most crop plants, in fact, barely resemble their unmodified relatives. The wild ancestor of corn, teosinte, has tiny ears with just 10-12 hard kernels, and resembles wheat more than its succulent relative, modern commercial maize. Common supermarket strawberries have octaploid genomes, and are huge compared to their tiny wild ancestors. Wild almonds are bitter and filled with cyanide–a dozen could kill you. Genetic modification over thousands of years has given us food crops that are leaps and bounds above the natural fruits and vegetables our hunter-gatherer ancestors ate, in terms of size and nutrition.

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Fundamentally, GMOs are defined by legal bodies, not scientists, and are designated according to the processes used to create them, rather than the products that they are.

But wait, that is natural genetic modification; GMO refers to artificial genetic modification, right? Well, not really. Scratching the surface to try to discern what is and is not a GMO, it quickly becomes clear that there is no solid biological dividing line between legally natural and legally modified. (For example, many would be surprised to know that a crop plant produced through mutagenesis by nuclear radiation is not only considered natural, but can also be farmed organically and labeled as organic.) Organisms have traditionally been genetically modified through a number of means, from selective breeding of organisms with favorable traits to application of radiation or chemicals to produce mutations. According to European Union law, which is quite restrictive regarding GMOs, organisms produced through in vitro fertilization, conjugation, transduction, transformation, polyploidy induction, mutagenesis, and cell fusion (including protoplast fusion) of plant cells of organisms which can exchange genetic material through traditional breeding methods are all considered natural and not genetically modified. The GMO label is limited to organisms produced through recombinant DNA technology.

Since the products of these different methods are not substantially different, this has caused problems for bodies like the European Union, which has had working groups bogged down for years in the task of trying to define which organisms are GMOs. Fundamentally, GMOs are defined by legal bodies, not scientists, and are designated according to the processes used to create them, rather than the products that they are. Since the same product can be created using different means, this has led to a frustratingly irrational framework for biologists. Giovanni Tagliabue of the National Research Council in Rome, puts it this way: "The basic concept boils down to the following: there is no such thing as 'GMOs' (it's not a significant category), and therefore any question regarding 'them' as a supposed whole is nonsensical." He has a point, but at the same time, world governing bodies have made GMOs into a legal category, and therefore GMOs do exist in human society, biologically nonsensical or not.

Two plants with the same genetic change being labeled and regulated differently because of how that change was induced may seem absurd. However, there are clear examples of crop plants produced through recombinant DNA technology that could not have been produced by conventional techniques, such as strawberries made cold-resistant through the insertion of a gene from arctic flounder. The idea of inserting a gene from one organism into a very different organism is unsettling to many, especially those who are either religious ("the world should be as God created it") or uncomfortable with the idea of the artificial ("food products should be natural"). Certainly, we all should live according to our own values, but, objectively, is there reason to believe that engineered foods are more dangerous or less healthy than "non-GMO" foods?

Ironically, genetically modified foods may in fact be safer than non-GM foods, for two reasons. First, all foods produced through recombinant DNA technology require extensive testing for toxicity, allergenicity, and nutritional content prior to allowing them to be introduced as food or animal feed. Non-GMOs do not require such testing, even if they are produced by high-tech modern breeding techniques. Second, genetic engineering is a more targeted approach than traditional methods, which are quite

random—either chance, or a "shotgun"-type treatment, e.g. dousing the plant with mutagens—followed by selection of plants with positive traits. Traits are the outward expression of genes via the proteins they encode. Genetic engineers know exactly what genes they introduced into the plant, and therefore what proteins are being expressed in the phenotypic trait. Traditional plant breeders do not; they see the final trait, but they do not know what mutations underlie it, nor do they know about other genes that may have changed alongside the new trait. Fundamentally, the new organisms are not well-understood, and could be dangerous, especially since many plants produce toxic substances in order to defend themselves.

This has happened in the past on a number of occasions. For example, solanine is a natural toxin present in all potatoes in small amounts. The conventionally bred Lenape potato, however, had almost four times as much solanine as normal potatoes, resulting in severe gastrointestinal sickness in people who ate these potatoes before they were withdrawn from the market. The Solanaceae family includes potatoes, tomatoes, peppers, and eggplant, but also tobacco and the hallucinogenic and highly toxic mandrake, deadly nightshade, and Datura. With a little spontaneous mutation from nature or chemical mutagenesis, mild domesticated potatoes can regain traits more characteristic of their toxic cousins. Such mutations arise spontaneously, and can be selected by natural selection, since they protect plants from herbivores. Not only the Lenape, but other varieties of potatoes have spontaneously mutated to become toxic, such as a 1986 harvest of Magnum Bonum potatoes in Sweden.

Other examples of spontaneously toxic vegetables include zucchini, yellow squash, and celery. Outbreaks of celery-induced photodermatitis in grocery and farm workers were caused by psoralens, normally low-level toxins that were expressed at high levels in a strain of celery that had mutated under natural conditions. Natural toxins can even be deadly, as in the case of the cytotoxin curcurbitacin, responsible for killing an elderly man in Germany who ate zucchini grown by a neighbor. (The emergency department leader, Norbert Pfeuer, stated that the highest risk is in fact in small gardens, when gardeners use their own seeds each year to grow more zucchini. The development of a toxin is a natural evolutionary process to protect a plant.) Curcurbitacin has been found in the USA as well, arising from sources as divergent as home-gardened yellow squash from Alabama and conventionally farmed zucchini from California.

"spontaneously toxic vegetables..."

Natural toxins can even be deadly, as in the case of the cytotoxin curcurbitacin, responsible for killing an elderly man in Germany who ate zucchini grown by a neighbor. (The emergency department leader, Norbert Pfeuer, stated that the highest risk is in fact in small gardens, when gardeners use their own seeds each year to grow more zucchini. The development of a toxin is a natural evolutionary process to protect a plant.) Such poisonings have never happened with GMOs, because not only do biologists know exactly which genes are being modified, and how, but all transgenic plants must be rigorously tested before being approved for marketing.

Consistently, GM feed had fewer unintended effects than feed developed through conventional breeding techniques.

Such poisonings have never happened with GMOs, because not only do biologists know exactly which genes are being modified, and how, but all transgenic plants must be rigorously tested before being approved for marketing. In contrast, the actual genetic change in conventionally modified foods is unknown, so toxicity (including carcinogenicity) will not be detected until after consumers become sickened.

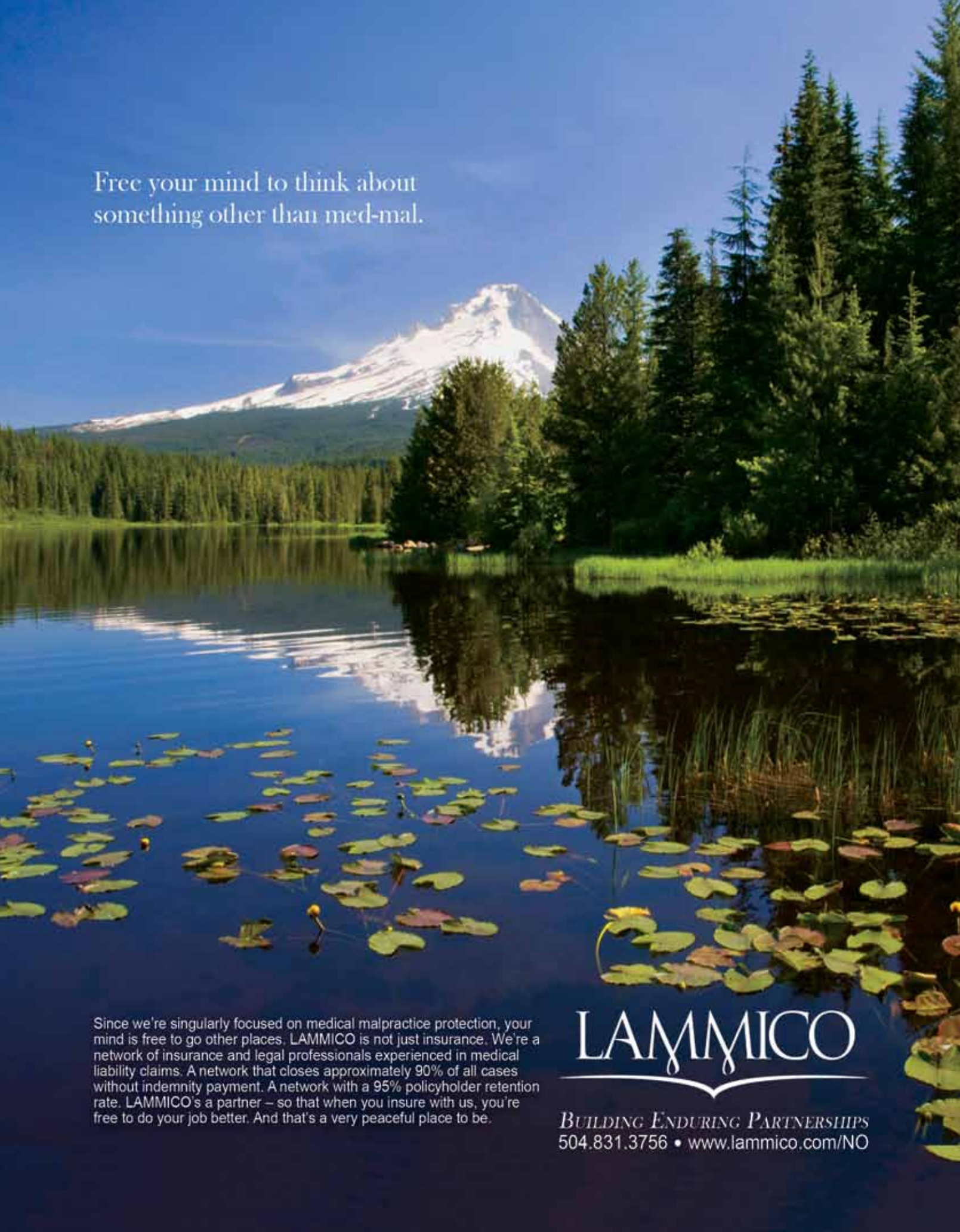
In addition to requiring testing for toxicity and allergenicity, the Food and Drug Administration requires testing for nutritional quality; newly engineered plants must provide the same nutrition as their conventional counterparts. Also, if a pest-resistance gene has been introduced, the plant requires EPA approval as well. The FDA maintains a public database of all genetically engineered plants with a summary of their testing results. The searchable database can be accessed at http://www.accessdata.fda.gov/scripts/fdcc/?set=Biocon.

This testing regimen appears to be working well, with respect to food safety. Undesirable traits have certainly been found, but they have been discovered during the premarket testing. This testing process is not infallible, of course, and significant differences between GM plants and conventional plants have been noted, such as reduction in phytoestrogens in a strain of GM soy, which could have health effects in the form of reduced nutrition. The testing does, however, provide a level of protection against major health risks that is absent from conventionally bred crops.

While there is no solid evidence (accepted by the scientific community) of health dangers stemming from GMOs, several studies have been published in the past proposing GMO-associated health problems. All have failed to be replicated and some have been retracted. One of the most recent and well-known is a report in *Food and Chemical Toxicology* by Seralini et al. (2012) of cancer, liver necrosis, and increased mortality in rats fed genetically modified corn. The study was widely criticized due to small sample sizes, a lack of a dose-response effect, and other flaws, and Elsevier retracted the report in 2013. It has been republished in *Environmental Sciences Europe* without peer review.

Earlier, in 1999, Ewen and Pusztai reported abnormalities in development and immunity in rats fed transgenic potatoes. While the report was published in the *Lancet* and widely disseminated in popular media, it was only published alongside a letter from a committee of researchers from the Rowett Institute and the Royal Society questioning the study. Subsequently, several researchers tried and failed to replicate the findings. A number of other studies that were too methodologically flawed to be accepted in peer reviewed journals have nonetheless been widely circulated on the internet.

In contrast, a large body of widely respected, peer-reviewed literature documenting a lack of safety issues has failed to garner the media spotlight. Dr. Alison Van Eenennaam of the University of California at Davis recently reviewed hundreds of studies of the effects of GM feed on animals over the past 15 years. Since over 70% of GM biomass is fed to farm animals, this provides a very large population of animals in which to examine any possible health effects of GMOs. Several long-term studies, including multigenerational ones, have been conducted (the longest of which was a 10-generation study of quail fed 50% GM corn). Consistently, GM feed had fewer unintended effects than feed developed through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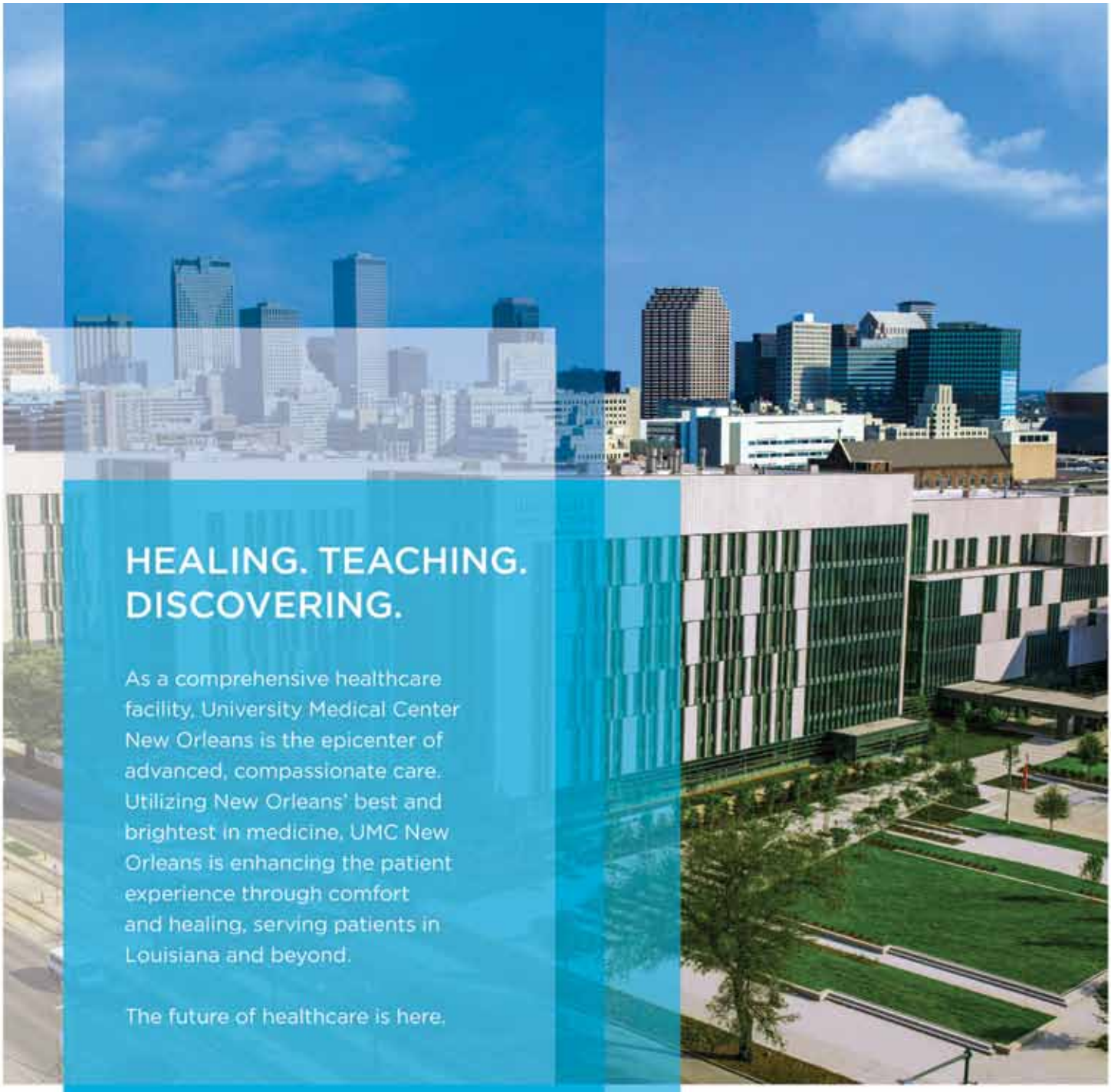
"The labeling of all GMO products would give consumers the choice to select their food as they wish. It would be like organic foods that are labeled now and consumers have freedom to choose."

conventional breeding techniques. None of the unintended effects were at the level to be considered health hazards.

This preponderance of scientific evidence, and the view of the scientific community at large, has not reached the majority of the population. Most consumers do not have a good understanding of genetics, and with strong media attention to flawed, alarmist studies alongside little coverage of solid, "boring" studies, many feel a sense of misgiving or even fear towards GMOs. One proposal to ease this fear is to allow labeling of GM foods. Dr. Wunderlich emphasizes that choice can help allay consumers' fears about engineered food. "The labeling of all GMO products would give consumers the choice to select their food as they wish. It would be like organic foods that are labeled now and consumers have freedom to choose. Organic products are by definition non-GMO and so they offer consumers at least one option if they are concerned about GMO foods."

GM growers tend to be against labeling, but it may in reality be in their best interest, since a lack of labeling feeds into a sense of GMOs as shadowy unknowns being imposed on concerned consumers. It does not facilitate understanding and rational comparison between foods developed through genetic modification vs. conventional breeding. Dr. Wunderlich understands the concerns of GM growers, but does not believe that labeling will result in the large-scale economic consequences the growers fear. "The GMO growers may have a fear that labeling their products may initially change the consumers' selections, but ultimately consumers will expand their knowledge and learn more about the differences in food production systems. Consumers with higher scientific knowledge may tend to have less negative attitudes towards GMOs. Our studies show that consumers' attitudes, however, impact purchasing behavior more than knowledge." A perhaps more palatable alternative might be an official "non-GMO" label, regulated like the USDA organic label.

Setting aside the issue of consumer attitudes, overwhelmingly, the evidence points to a lack of any significant direct negative health effects of GMOs. So, does this translate into a lack of any problems related to GMOs? Well... no. There are a host of indirect effects that could stem from GMOs, from natural pesticides killing "good" insects to increased herbicide use with engineered glyphosate-resistant crops. Such effects could stem from the way GMOs are farmed or from behavioral changes by consumers. For example, if people who have access to carrots and other orange vegetables stop eating them because they think they'll get plenty of vitamin A from Golden Rice, they will be ingesting fewer of the micronutrients and other macronutrients in those vegetables. Environmental effects could also impact human health. These indirect effects will be considered in the March/April issue of the *Healthcare Journal*, in the second part of this 2-part series on GMOs and health. ■



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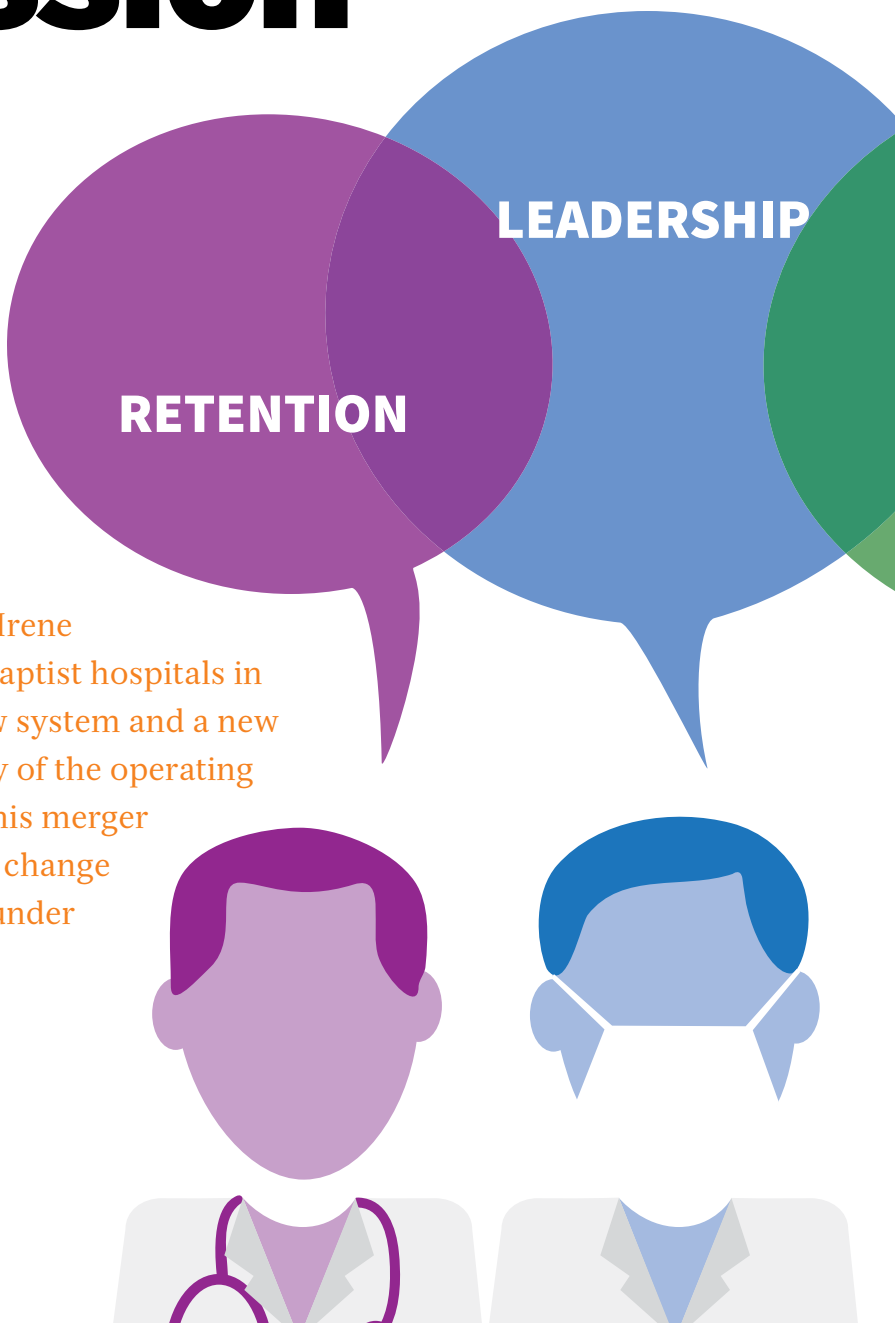
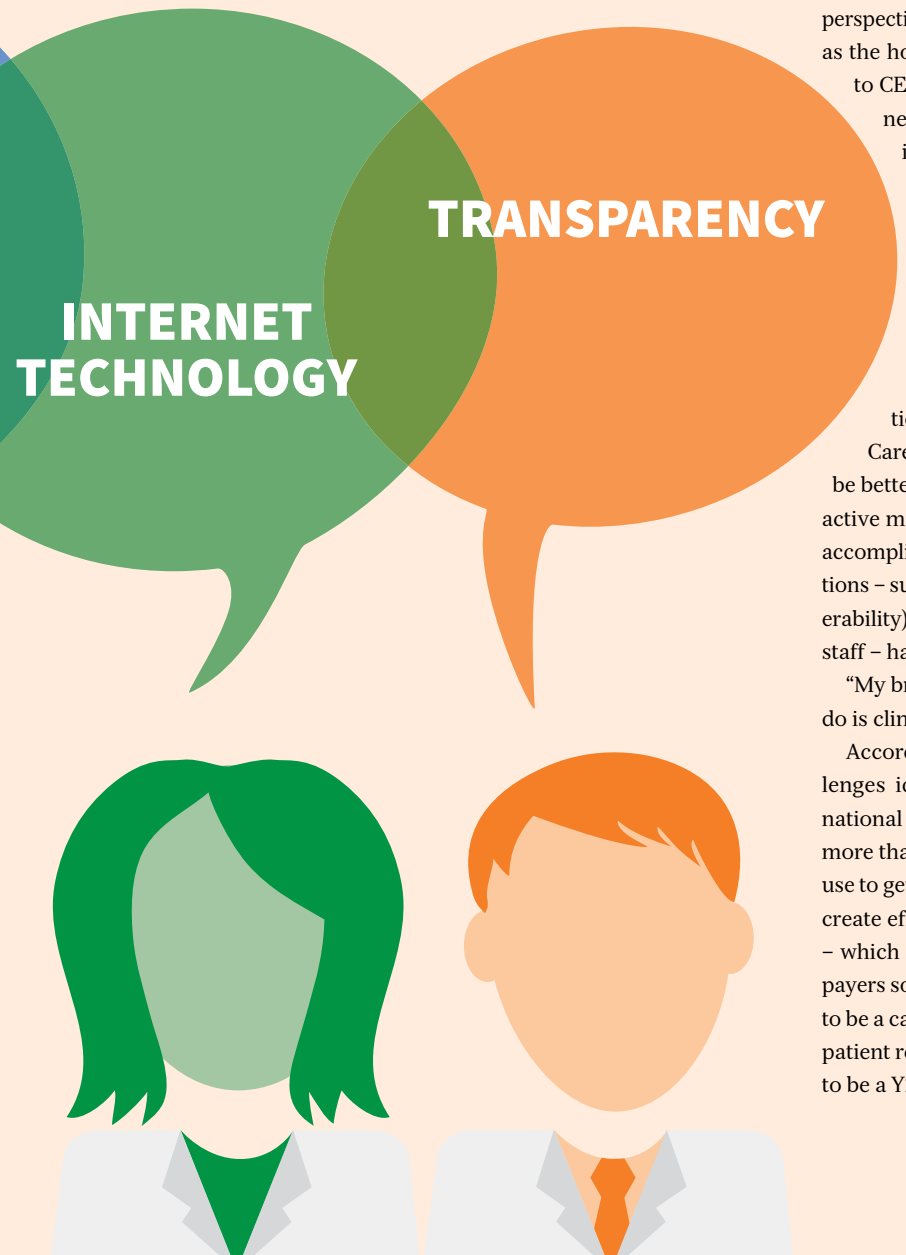
NEW URGENCY WITH SHIFT TO VALUE-BASED HOSPITAL REIMBURSEMENT

"No Margin No Mission"

By **John W. Mitchell**



Sister Irene Kraus is credited for coining the phrase "No margin, no mission." A hard charging Daughters of Charity nun and nurse by training, she went on to become a visionary hospital administrator who engineered one of the first major hospital system mergers in 1994. Sister Irene led the union of Catholic and Baptist hospitals in Jacksonville, Florida into a new system and a new model for providing care. Many of the operating efficiencies she reinvented in this merger were predecessors to the rapid change occurring today in healthcare under the Affordable Care Act.



The "no margin, no mission" mantra is in full effect in Louisiana. While area hospitals work to meet new "mission" quality and outcomes for better patient care, the nonclinical business "margin" back end of hospital operations is also undergoing rapid change. In a recent survey commissioned by *HealthLeaders* Media and Parallon[1], a company that consults on a wide range of hospital operational areas, senior hospital leaders identified several key financial/operational performance challenges. The top three were:

-System implementation and interoperability (different electronic records systems that "talk" to other electronic systems)

-Recruiting and retaining talent

-Reengineering the revenue cycle (collecting reimbursement)

Bill Davis, CEO at Slidell Memorial Hospital (SMH), has a broad perspective for managing such changes. He joined the facility in 2001 as the hospital's Chief Financial Officer (CFO) and was promoted to CEO four years ago. He said the first requirement any leader needs is to be up for the challenges of these changes and see it as an opportunity.

"It's easy to think of the changes going on in healthcare as a burden," said Davis. "But that's not taking ownership. Healthcare is local and it's better for patients and the local economy if we jump in head first into managing the population health of the community."

He said that more than three years ago, he worked with the hospital board to get agreement that a major transition was coming with the implementation of the Affordable Care Act. It was obvious that, more and more, hospitals would be better reimbursed to keep patients out of the hospital through active management of chronic disease in an outpatient setting. To accomplish this "mission" goal, many of the backend "margin" functions – such as the management of patients' health records (interoperability), collecting reimbursements (revenue cycle), and retaining staff – had to improve.

"My brain goes down the path that all process improvement we do is clinical, even the nonclinical work," Davis emphasized.

According to Sandy Badinger, Davis' CFO at SMH, the top challenges identified by Parallon mirror her priorities. The recent national conversion to ICD-10 – a new medical coding system that more than quadrupled the number of billing codes hospitals must use to get reimbursed – is one example of how the hospital works to create effective interoperability platforms. The ICD-10 conversion – which properly documents and codes patient care to submit to payers so that hospitals can be paid for services – was widely feared to be a catastrophic event that would severely disrupt hospital care, patient records, and cash flow. But, for most hospitals it turned out to be a Y2K-variety false scare.

"My brain goes down the path that all process improvement we do is clinical, even the nonclinical work."

–Bill Davis, CEO, Slidell Memorial Hospital

Any interoperability accomplishment at SMH is notable given their medical staff remains largely in private practice, as opposed to hospital employed. But she said interoperability progress between any hospital and its private practice partners takes shared commitment to create and share the electronic health records.

"Affordability for adopting an electronic health record is sometimes a challenge for physicians in private practice. I think we're seeing more physicians consider employment in the market because of this cost and as a way for some hospitals to get everyone on the electronic health record (to achieve interoperability)," said Badinger. "But we had a lot of success with our medical staff when we brought up a new physicians documentation system in June, three months before ICD-10 went live."

Bill Davis

Sandy Badinger

Davis notes that the medical staff rises to the occasion when system changes such as ICD-10 are required.

"We have some really good physician leaders. The doctors participate with us in achieving clinical system effectiveness," he said.

This can-do attitude has paid off for SMH; in the past few years, the hospital has increased its market share by at least eight percent, according to Davis. While a new ED and heart center contributed to this growth – ED visits are up 23 percent since the new facility opened with patient throughput down from 370 minutes to 210 minutes – they have also strived to be the healthcare subject matter experts in the community. To date, the hospital has offered 830 class sessions with attendance by 22,000 people as part of their population management strategy to better educate patients.

At Woman's Hospital in Baton Rouge the number one priority is employee and physician engagement.

"Research shows there that there is a direct positive correlation between an engaged team and patient experience," said Stephanie Anderson, Executive Vice President and Chief Operating Officer. She noted strategies to support staff engagement are key for employee retention.

For Woman's Hospital this includes a gain-sharing plan. If certain targets for patient satisfaction, patient safety, and financial goals are met, the employees receive a performance payment. They also conduct regular department and hospital-wide employee satisfaction surveys to identify and resolve employee concerns.

"We also understand the importance of transparency (to employee satisfaction) and have a variety of ways to accomplish that," Anderson said. For example, the leadership team maintains constant communication through a variety of channels. These include an intranet site called "Ask Anything" that provides a forum for employees to ask questions or express concerns and get a response from a member of the senior management team. She said the leadership team also often goes to the employees to get feedback to give them a voice in decisions that affect them. The hospital relies on

"Champions for Change" – highly regarded leaders in the organization – to help get buy-in for operating benchmarks.

This focus on staff retention has paid off. According to Anderson, Woman's is the "preferred employer" in the market and they have the accolades to prove it. Among numerous recognitions, Woman's Hospital has been: named "Top 100 Places to Work" eight consecutive years by *Modern Healthcare* magazine; a "150 Best Places to Work" by *Becker's Hospital Review*; and attained a four-star rating in the HCAHP (Hospital Consumer Assessment of Healthcare Providers) patient satisfaction survey.

Anderson also pointed out that Woman's Hospital has other "margin" success stories. It works closely with its medical staff (who are mostly in private practice) through several initiatives. This includes co-management agreements in their surgical service lines for outcomes improvement. They also work to improve their revenue cycle, including a "V2V" (Volume to Value) program to involve staff to identify process improvements, many of which have been hardwired into operations. The hospital is working to adopt a new cost accounting system to determine costs of episodes of care. Anderson said this will help position the hospital for risk-based reimbursement models, such as bundled payments (for episode of care under the Affordable Care Act). And like the other hospitals interviewed, one of its top priorities for capital spending is on the information technology (IT) platform (interoperability), which Anderson said "is in some ways related to clinical operations."

Stephanie Anderson

"Research shows there that there is a direct positive correlation between an engaged team and patient experience."

–Stephanie Anderson, Executive Vice President, COO, Woman's Hospital

At LCMC Health in New Orleans, a different kind of transition is under way. The hospital system has grown rapidly, from a two-hospital system in 2013 to a five-hospital system today. This includes the new University Medical Center, which was built partly as a replacement hospital for the old Charity Hospital damaged during Hurricane Katrina ten years ago. For CFO Suzanne Haggard, who after nine years in her own consulting practice came out of retirement and was appointed to her current position in 2014, the chance to rise to this unique challenge was too interesting to pass up.

"One of our key initiatives is information technology," Haggard said. "When you bring five hospitals together at such as exponential pace you're dealing with five platforms for everything."

To achieve interoperability, they are working with a new Chief Information Officer to create common IT governance – and are close to announcing a common electronic health record system across the LCMC system.

"When I started looking at this, I interviewed CFOs at large systems outside of our market – from systems that were new, to systems that were 20 years old. I was surprised by the variability I found. One longtime system had not even started working on their interoperability; the attitude

Suzanne Haggard

seemed to be if it's not broke, don't fix it," explained Haggard.

But with the Affordable Care Act, which requires that hospitals reinvent themselves from fee-for-service to fee-for-value, the switch to a common electronic health record platform is a must. This is why Haggard feels LCMC is in the right place at the right time.

"Every system we are putting in place now – from the electronic health record, to the revenue cycle, to the supply chain – is going to be connected from the front to the back," she said. "We're doing this to make the patient experience better – for us, the patient is the tail that wags the dog."

"...the LCMC leadership is also re-emphasizing old school rounding, where hospital administrators get out of their office to visit and talk with staff on all shifts about what they need."

To address employee retention, LCMC is working on its infant culture. This includes developing a new employee forum to help improve care, be more patient friendly, and get input from caregivers.

"I'm not on the frontline taking care of patients, the employees are," said Haggard. She said the LCMC leadership is also re-emphasizing old school rounding, where hospital administrators get out of their office to visit and talk with staff on all shifts about what they need. She said the LCMC senior Human Resources leader is also working closely with the teaching programs at Tulane and LSU to recruit specialties such as laboratory techs and physical therapists.

"We want all our employees to feel engaged, and not just be the system that throws dollars at staffing," Haggard stressed.

LCMC is also turning to benchmarks, which is generally a proprietary database that compares like hospitals to each other. Such performance improvement benchmarks can include labor productivity (staffing), supply chain costs, and quality measures.

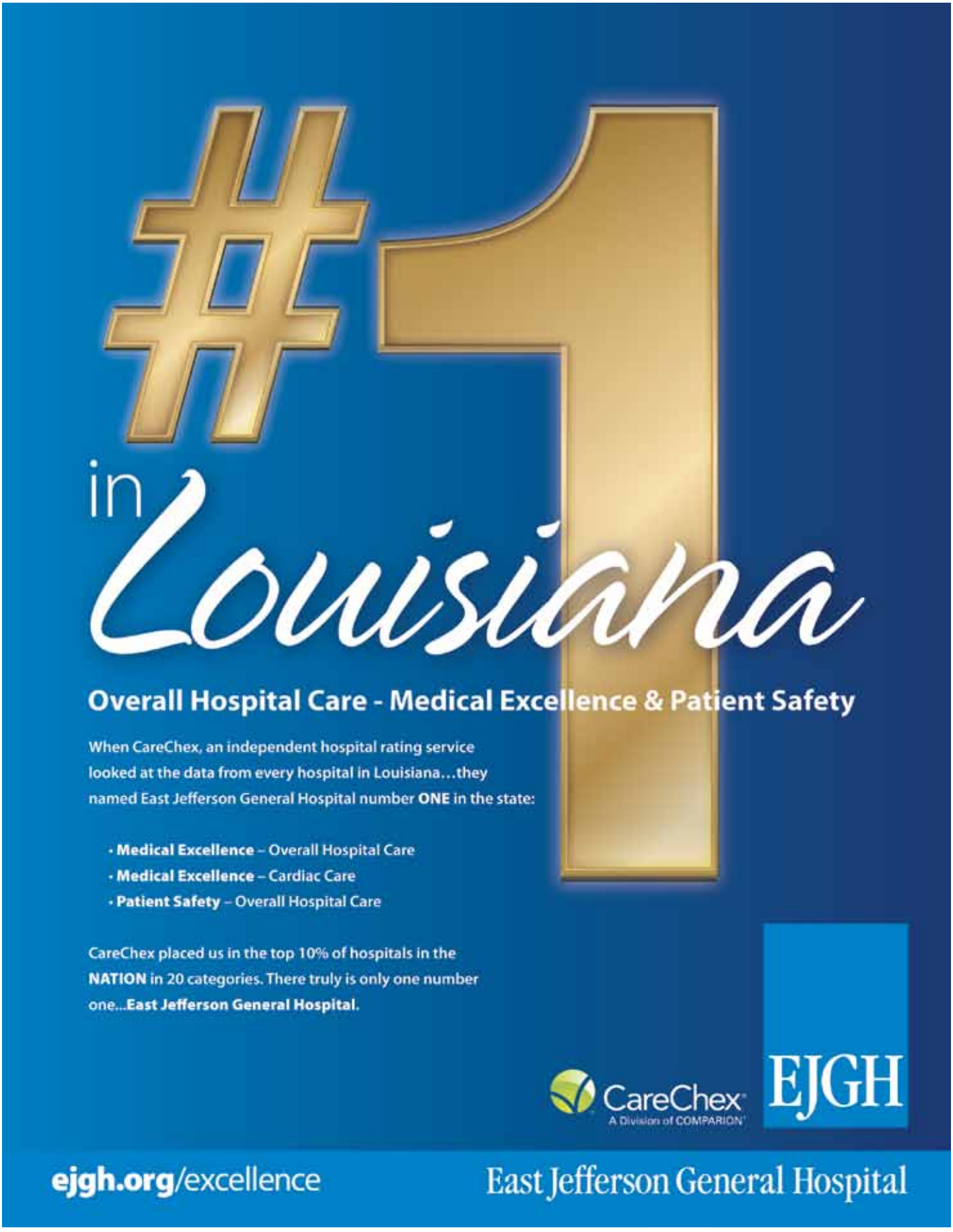
"We've just completed over a year-long review of benchmarks with a consulting group. To be effective, we have to solve the IT platform first, but definitely have our eye on using a benchmark service," Haggard said.

Despite the challenges that come from the birth of a new system, Haggard said she's proud of their progress.

"We brought together five hospitals in 30 months and we're still standing," she said. "That's a success story and says something about our vision. This included rebuilding a destroyed and antiquated facility, which was a good federal, state, and city effort." ■

(Endnotes)

[1] http://images.parallonassets.com/Web/ParallonBusinessSolutions/%7b71c998a5-8f3a-4fe3-8f5b-126db7b6b6f7%7d_Parallon_HealthLeaders_Intelligence_Report.pdf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Overall Hospital Care - Medical Excellence & Patient Safety
When CareChex, an independent hospital rating service looked at the data from every hospital in Louisiana…they named East Jefferson General Hospital number ONE in the state:
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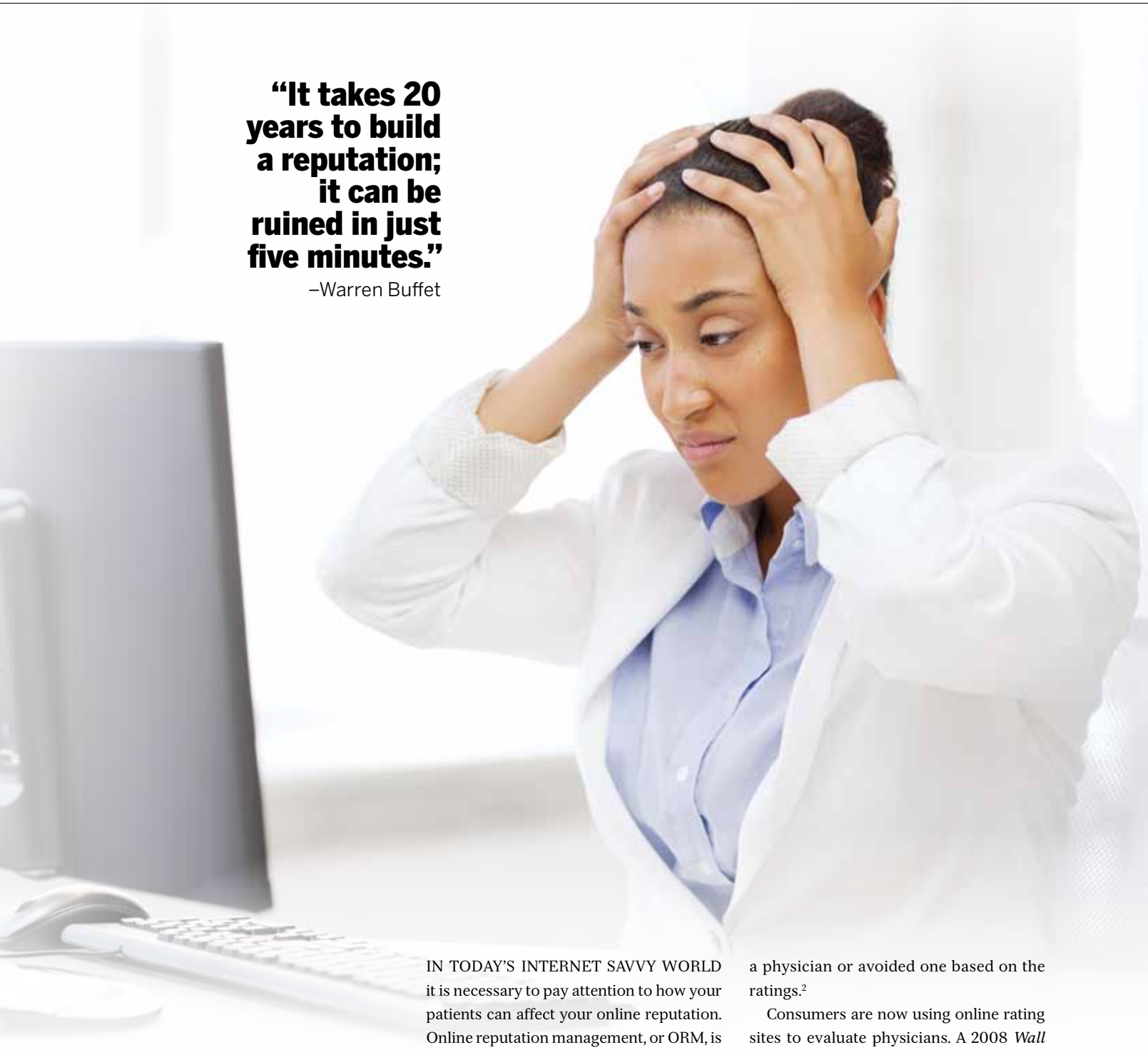
It is possible for a physician to have his/her reputation tarnished by just one patient who has had a negative experience with the practice. The Internet has replaced the Yellow Pages for patients to obtain information about our practice and our services. Research has emphasized that 61% of American adults look online for health information.[1] Every doctor has, at one time or another, had to deal with a disgruntled patient, and some of these unhappy patients may choose to share their displeasure through an online review. You don't want to take your reputation for granted and you want to be proactive in protecting your most valuable asset, your reputation.

Online Reputation Management for Physicians

By **Neil Baum, MD**

Neil Baum, MD is a Professor of Clinical Urology at Tulane Medical School and is in private practice in New Orleans.

"It takes 20 years to build a reputation; it can be ruined in just five minutes."
–Warren Buffet



IN TODAY'S INTERNET SAVVY WORLD it is necessary to pay attention to how your patients can affect your online reputation. Online reputation management, or ORM, is the art of making your name and your practice look their best on the Internet.

The Journal of the American Medical Association reported that 25% of U.S. adults consulted online physician rating sites, and more than 33% of online viewers went to a physician or avoided one based on the ratings.[2]

Consumers are now using online rating sites to evaluate physicians. A 2008 *Wall Street Journal* Harris Interactive poll found that 91 percent of those surveyed would refer to online information about doctors provided by their health plan(s) and 87 percent expressed interest in providing feedback to health plan sites for physician rating. [3]

Risks of ignoring your online reputation

What this means to the practicing physician is that the Internet provides patients opportunities to read what others are saying about you. A few decades ago your reputation was primarily known to your peers and to your patients through word of mouth. In this Internet era your exposure is much greater and negative comments can go viral and be viewed by thousands of potential patients. What is posted on the Internet, including comments from a dissatisfied patient or even another physician, will remain on the Internet forever. The reality is that just a few negative reviews can ruin your reputation, which has taken years to build.

There are risks of ignoring your online reputation. The Internet makes it possible that your good name can end up in the hands of people you can't identify—and who are in places you may not be able to point to on a map. If someone has had a negative experience or is unhappy with their treatment, they may find multiple online review sites and tell the Internet world about their negative experience. Unfortunately, patients who are pleased with their experience rarely bother to place a positive review. Malicious comments are often anonymous or the writer may use a false name, thus making it impossible for the physician to even attempt to reach out in a personal and conciliatory manner. Additionally, in such cases, there is often no way to verify if the review originates from an actual patient or is the handiwork of a competing physician or angry employee.[4]

The Internet has given existing patients an open forum to the whole world to say whatever they want about their experiences with you and your practice. Unfortunately, the favorable experiences do not find their way on-line nearly as often as the negative ones.

In today's Internet savvy world you must recognize that your patients can easily affect your ORM. There are many review websites where your patients can express their experience with you and your practice. These include: www.RateMDs.com; www.vitals.com; www.ZocDoc.com; www.HealthGrades.com; www.ucomparehealth.com; CitySearch.com; Google Plus; and www.Yelp.com.

These review sites allow patients to rate a physician on:

- how your staff has treated a patient
- patient wait time
- the doctor's diagnosis
- his\her attitude
- the level of trust in the doctor's decisions
- their treatment and their results

There are unscrupulous doctors who may post negative comments about their fellow doctors to put their competition in an unfavorable light. Fortunately, this doesn't happen very often.

Most physicians have a very favorable rating score of 9.3 out of 10 with their patients and 70% of physicians have perfect scores.[5]

How you can control your online reputation

So what can you do? First, it is incumbent on you to monitor your online reputation. If someone has posted a negative review, respond to those comments directly in the review site. This does not violate privacy laws if you do not mention the patient's name or details that identify the patient. You can explain aspects of your practice without confirming or denying that the dissatisfied reviewer was or is a patient. It is imperative that you do not talk about the specifics of any patient's condition online.

Don't wait for a bad review to show up before starting to solicit positive reviews

Dr. Robert Wachter, Chairman of the Department of Medicine at University of California, San Francisco said it so poignantly in the forward to the book, Establishing, Managing, and Protecting Your Online Reputation: "Whether we like it or not, our online reputation is becoming the main prism through which we will be known – to colleagues, to friends, to patients, to prospective employers ... With this realization comes the recognition that we can no longer afford to be passive observers of our online persona."[6]

As large and unwieldy as the Internet is, you do have a lot of control with respect to monitoring and controlling feedback from your patients and what you can do with the feedback you receive. This does require you and/or your staff to set up a system to

"...it is incumbent on you to monitor your online reputation.

33%

The *Journal of the American Medical Association* reported that 25% of U.S. adults consulted online physician rating sites, and more than 33% of online viewers went to a physician or avoided one based on the ratings.

continually request feedback/testimonials from your patients. This is where most practices fail. There is no system in place to solicit positive reviews. It can be as simple as having a quick meeting with the doctor and his/her staff mentioning that the practice will now obtain testimonials from patients. There are two places you want to have patient reviews posted. The first is on your website and the second, of course, is on the review sites.

Put patient feedback surveys on your website

Another way to get your patients to give you their feedback/testimonial is to have a "patient feedback survey" on your website. This is a convenient way for the physician to ask for feedback. The doctor or the staff asks the patient if they would go to your website and complete the survey. Many patients will agree to this suggestion, but very few will leave the office and actually follow up and complete the survey.

A far more effective way is to request that they complete the survey while they are still in your office. Have your receptionist hand the patient an iPad after their appointment and ask them if they would take a couple of minutes to complete your feedback form on your website.

Ask patients to post their testimonials on review websites

This is more difficult to accomplish, as most patients will not take the time or effort to follow through on it. So you have to make it as easy and as fast as possible. This means you have to provide your patient with very clear instructions of what to do and how to do it.

The first step is to provide your patient a feedback form that has 4 or 5 questions that they answer. Giving your patients the questions will elicit an emotional response that helps the patient describe their experience with you and your practice. If you let the patient create a testimonial on their own without specific questions to answer, you merely receive a bland or neutral comment such as: "I'm very happy with my results", or "He/She is a nice doctor".

Next, you will have to provide your patient with a step-by-step process and direct them to rating websites and provide instructions to navigate the website in order to enter their feedback. This is often a daunting task for your patient so your instructions should be clear and simple.

A well-respected physician, who is one of the best in his field, was complaining that the number of new patients had decreased drastically and he didn't know why. The first thing that was suggested was that the doctor Google and enter in the search box "Reviews for Dr. <his name>." Upon examination of his online reputation with the review sites he found that his reputation had plummeted because there were four negative reviews and no positive reviews.

The good news is that it can be fixed. Don't get caught with one or two unhappy patients ruining your well-deserved reputation. We highly recommend that you don't wait for a negative review to appear on the review sites, but that you start collecting positive reviews so that any negative reviews can be diluted by the many positive reviews that you so rightfully deserve.

Bottom Line: The most precious asset a doctor has is his\her reputation. We spend our entire medical lives protecting that asset. A patient using the Internet and their First Amendment right of free speech can ruin our reputation with a click of the mouse. We can protect our reputation by practicing good medicine and taking good care of our patients. We can protect our online reputation by using the techniques that are described in this article. ■

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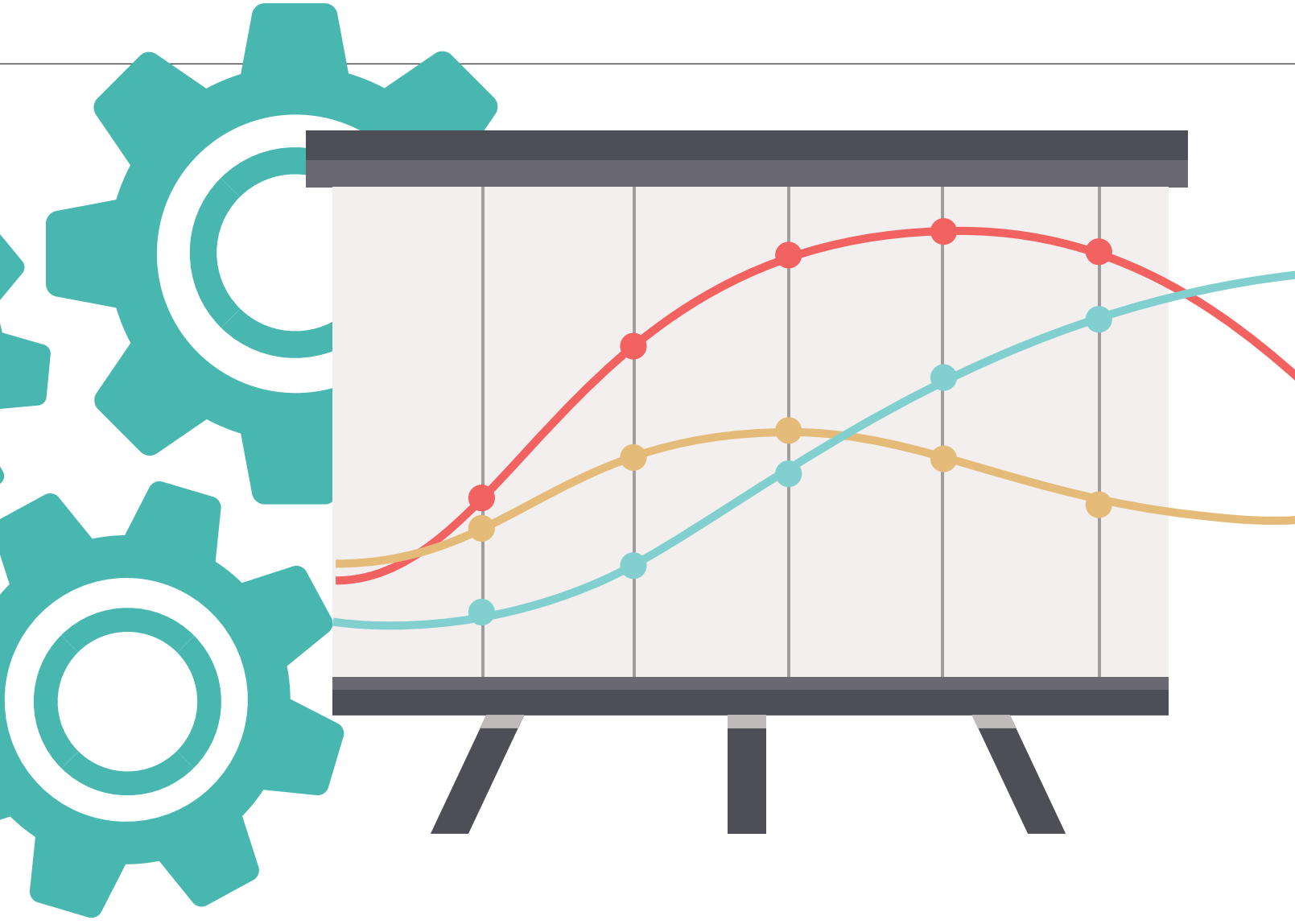
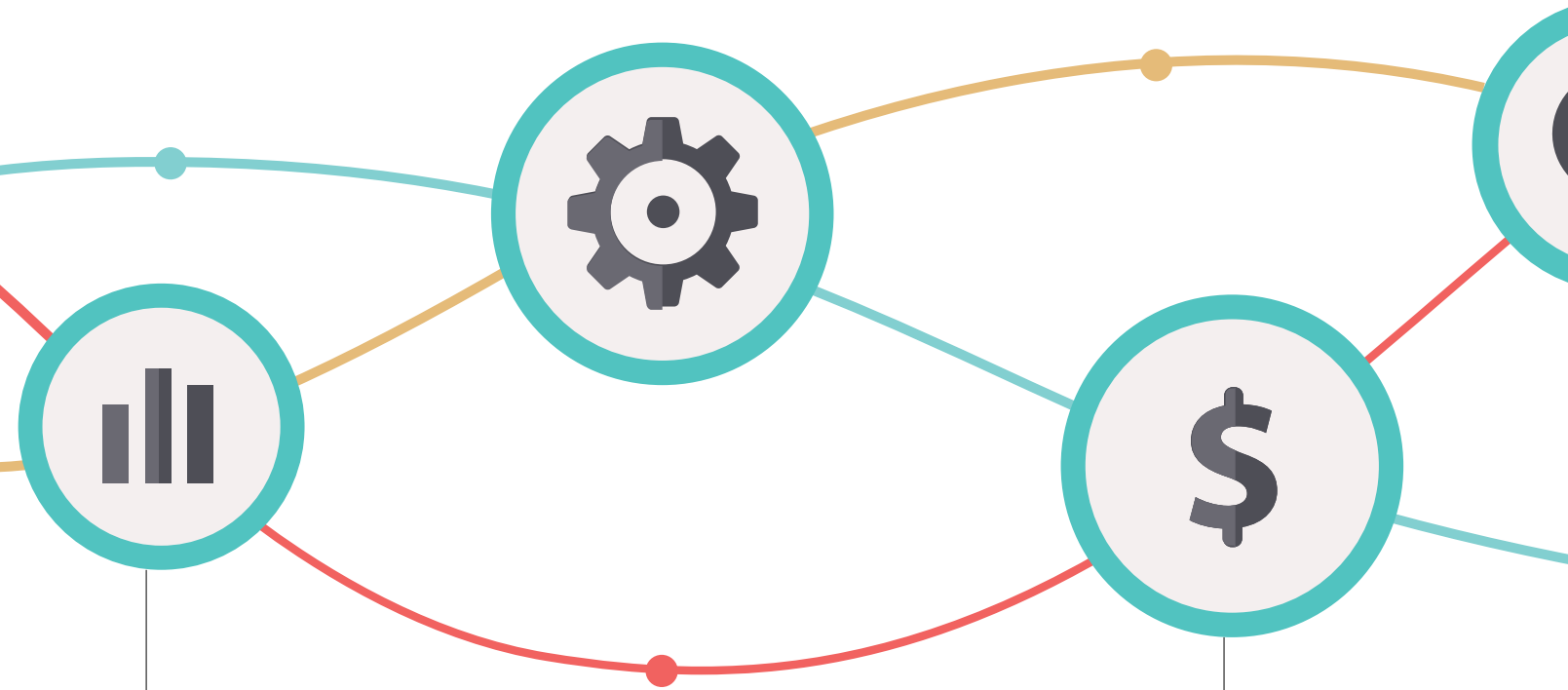


CREATING AN INFRASTRUCTURE TO THRIVE

Utilizing Six Sigma Lean Processes and Define, Measure, Analyze, Improve, Control (DMAIC) to Create an Infrastructure to Thrive Under Value Based Quality Agreements Undertaken by Tulane University Medical Group (TUMG)

Nicholas Bernard MS, Ahmed Mohuiddin MD, Timothy S. Harlan MD, Zachary Stauber, MPH, and Albert D. Sam II, MD, MMM, Tulane University School of Medicine



INTRODUCTION

In order to realize and maintain success in a rapidly evolving healthcare environment, it is imperative to develop an infrastructure for population health and chronic disease management. Third party payors (e.g., Medicare, Blue Cross) are implementing agreements that reward or penalize physicians based on patient outcomes, experiences, and costs. Value based agreements will incentivize physicians for providing preventative care, controlling certain chronic conditions (e.g., diabetes), and lowering the total cost of care. These new agreements are not surprising; in 2010 86% of U.S. healthcare dollars were spent on patients with one or more chronic conditions[1]. Healthcare providers will need to focus on all points of patient care in order to thrive under these agreements. Utilizing the methodology of "Define, Measure, Analyze, Improve, Control" (DMAIC), we describe the impact that analytics improvements have had on both outpatient quality and population health management at the Tulane University School of Medicine and the faculty practice, Tulane University Medical Group (TUMG).

OUTPATIENT QUALITY

Define

A focus of programs implemented by payors is the management of specific chronic conditions (CC) as well as multiple chronic conditions (MCC). Chronic conditions are disease processes that last a year or more and require ongoing medical attention and/or limit activities of daily living, whereas MCC are two or more chronic conditions that affect a person at the same time[2]. CC contributes to the majority of the cost of healthcare in the United States, and it is imperative for physician groups to tightly control these conditions[1]. Controlling these disease states will help providers in preventing unnecessary readmissions, admissions, and emergency room visits, in turn spurring success under the new healthcare model focused on value-based care.

Our approach is to apply resources and process mechanisms to ensure that patients receive all necessary care for the betterment of their health and to leverage that success in improved payor contract negotiations. TUMG is focusing on all patients; however, this report describes our initial work with a specific private payor population. By concentrating on a smaller population we had better control of processes before applying them to our other populations. In addition, two main value based agreements undertaken by TUMG are with this private payor.

The aforementioned program places physicians into one of three performance tiers. Each tier represents an incentive range, and payments are in addition to current fee for service agreements. Appendix A.1 and A.2 demonstrate the structure of the tiers and the specific quality measures against which physicians are evaluated. Our physician-led Board of Managers dictated that the main deliverable was to be in the highest tier by the end of the second year, resulting in higher incentives for physicians. Team members include internal medicine and family practice physicians, nurse practitioners, a quality analyst, a patient care coordinator, and quality extenders (physician scribes). The team helped to design and implement an analytics platform to monitor quality measures and ensure success. We designed customizations within this system that provide higher-level analytics for the quality team as well as at the point of care for providers. The team scheduled the project for a two year time period.

There are five clinical suites addressed under the value based program (Appendix A.2). A patient qualifies for points when they satisfy all measures within the suite. Each of the suites is weighted, and total points across the five suites are calculated for the TUMG physicians. For example, assume that a patient carries a diagnosis of both diabetes and hypertension. The program will place this patient into both the diabetic and hypertension suites. In order for the patient to be considered "controlled" in the hypertension suite, the patient must have a blood pressure <140/90. In order for the patient to be considered "controlled" in the diabetic suite, the patient must have a blood pressure <140/90, HbA1c<8.0, LDL <100, and tobacco-free. If TUMG's diabetic population has 23% of patients controlled, the payor dictates that TUMG receives 2 earned points for this suite. Multiply this point total by the weight (1.0); this results in TUMG earning a score of 2.0 for the diabetic suite.

To allow physicians to monitor each patient, it was clear that we needed not only the analytic infrastructure, but also the resources to reach the highest tier status by the end of year two.

Measure

At the beginning of this project we lacked the ability to monitor specific chronic disease states, as the only mechanism was for our physicians to review notes within our electronic medical record during a patient visit. Therefore, the process was reactive and added a layer to their already busy schedules. For the payor program, TUMG fell in the middle tier; and we identified key opportunities in the hypertension and pharmacy sectors. Recognizing the need to improve these scores – as payors will likely determine reimbursement based on similar outcomes – the first step was to adopt technology to streamline information for the physicians and have a reliable means of measuring performance. We selected an analytics tool that has both dashboards integrated within our EMR and high-level reporting that the quality team can utilize to improve patient outcomes on specific measures pertinent to the program. The platform has clinical quality measures that display provider outcomes on the payor's defined quality measures (Appendix A.3). In addition, the tool has population health

Appendix A.1

# of Targeted Chronic Conditions	BASE CMF Year 1 Annual Rate Per Member	Year 2 and 3 Annual Rate Per Member
1	$100	$120
2+	$100	$180

Adjustments Based on Clinical and Efficiency Outcomes

	Year 1	Year 2	Year 3
Lowest Tier	x1.0	x0.75	x0.5
Middle Tier	x1.0	x1.0	x1.0
Highest Tier	x1.0	x1.25	x1.5

•For this example, look to the highlighted red items above.
•In year 2 of the program, a patient has 1 chronic condition; his base CMF will be $120. The physician produced optimal care which placed him in the Highest Tier with an adjustment of x1.25. Therefore, his monthly CMF for this patient is **$150**.

Appendix A.2

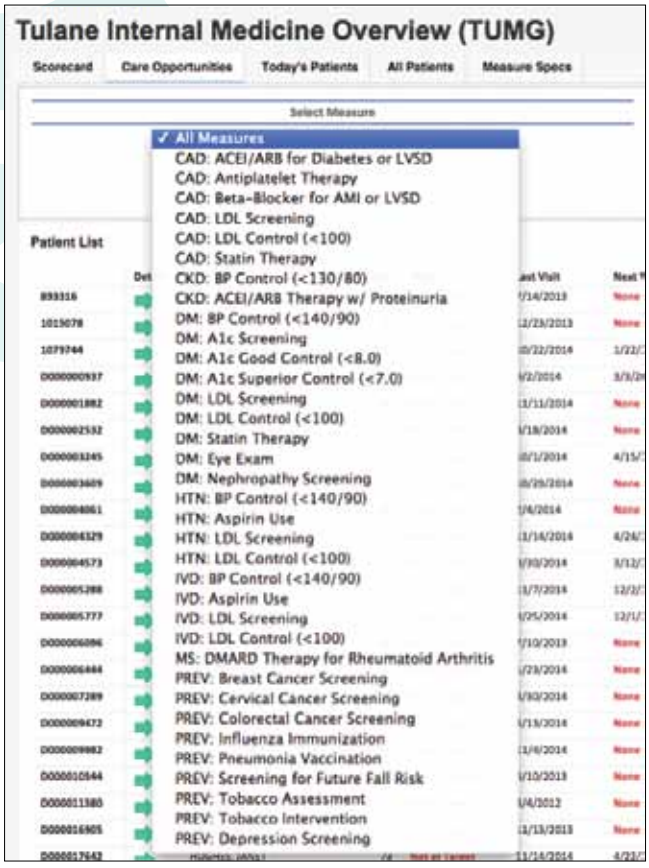
CLINICAL QUALITY AND EFFICIENCY MEASURES	Weight	Earned Points	Weighted Score	Max Score
Optimal Diabetes Care A1c <8.0 + BP <140/90 + LDL <100 + Non-smoker	1.0	0-3		**3.0**
Optimal Vascular Care LDL <100 + BP <140/90 + Non-smoker + Anti-platelet Rx	0.80	0-3		2.4
Vascular Pharmacy Measure On Statin + Proportion of Days Covered >0.8[1]	0.20	0-3		0.6
Optimal CKD Care BP <140/90 + ACEI/ARB Therapy if diagnosis of proteinuria* present[2]	0.80	0-3		2.4
CKD Pharmacy Measure ACE/ARB + Proportion of Days Covered >0.8[1]	0.20	0-3		0.6
Hypertension Control BP <140/90	1.0	0-3		3.0
Composite Efficiency Measure[3] Advanced Imaging for Low Back Pain[4] Potentially Preventable Emergency Room Visits[5] Risk-adjusted Generic Fill Rate[6]	1.0	0-3		3.0
TOTAL SCORE				**15.0**

Appendix A.3

INTERNAL MEDICINE GROUP SCORECARD

	Current/Past Performances	Current	Past	Total	At Target
CAD					
CAD: LDL Control{<100}		62.3%	55.9%	329	205
CAD: LDL Screening		69.9%	62.5%	329	230
CAD: ACEI/ARB for Diabetes or LVSD		84.1%	88.5%	164	138
CAD: Statin Therapy		84.2%	84.3%	329	277
CAD: Antiplatelet Therapy		86.9%	84.3%	329	286
CKD					
CKD: BP Control {<130/80}		49.3%	47.9%	73	36
CKD: ACEI/ARB for Proteinuria		72.7%	63.6%	11	8
DM					
DM: A1c Superior Control {<7.0}		40.9%	41.0%	994	407
DM: LDL Control {<100}		42.9%	40.6%	994	426
DM: A1c Good Control {<8.0}		59.7%	57.3%	994	593
DM: BP Control {<140/90}		62.3%	61.4%	994	619
DM: Eye Exam		67.2%	56.0%	984	661
DM: LDL Screening		71.3%	66.6%	994	709
DM: Statin Therapy		78.3%	72.0%	994	778
DM: A1c Screening		80.8%	73.2%	994	803

Appendix A.4



dashboards, which allow for analysts and providers to identify specific care gaps for our patients in real time (Appendix A.4).

While the payor program has specific measures, our physicians felt that it was imperative to track additional, meaningful measures. In Appendix A.3, we identify current performance (today's performance on the past rolling 365 days) and past performance (the performance for the past rolling 365 before the current performance). It also provides the number of patients that fall into the measure denominator and numerator for each measure. We are able to evaluate grouped physician performance for these measures as well as drill down into individual physician performance.

As Appendix A.3 is helpful, Appendix A.4 shows a screenshot of a dropdown menu listing all specific measures that we are currently tracking for our physicians. After selecting each measure, we are able to identify specific patients who are "compliant" or "non-compliant" for each measure. Appendix A.3 is advantageous for physicians to view their performance, while our analysts utilize the care opportunities tab to identify specific areas for improvement.

For example, as shown in Appendix A.5, an analyst selects a measure such as "DM: A1c Good Control (<8)." Then, the analyst uses a filter to identify patients who are not at target for this measure and when the patient is next due for a visit. This process allows for targeted outreach through email, patient portal integrated into our EMR, and telephonic outreach.

The analytics platform has the ability to measure all of the outcomes from Appendix A.5 by pulling the data directly from the EMR as well as from other sources, such as a billing and claims data. It was critical that we capture external data for a complete evaluation of the patient's care profile.For example, if a patient has filled a prescription for a drug at another site, we would have no way of identifying that this prescription has been filled without engaging with the payor to provide those data via claims made. This prescription example is directly related to the measure mentioned in Appendix A.2 noted as Proportion of Days Covered >.8 as well as Generic Fill Rate. The proportion of Days Covered >.8 refers to patients having necessary medication to manage his/her condition greater than 80% of the required time. By incorporating the claims feed into our analytics platform, it will allow us to have a full picture of the care patients receive outside of Tulane.

A key efficiency measure is prescribing generic drugs when an alternative to named brand drug exists. A claims feed helps to capture this information that is less readily available via clinical data from the EMR. We began with baseline data from the payor and created reports to share with physicians. This created not only an opportunity for improvement but allowed for significant feedback. For example, many brand named drugs do not have a generic alternative. A gastroenterologist received a report of a 22% generic dispensing rate; however, this percentage failed to take into account that the majority of the medications prescribed have no generic alternative.

"Physicians now have the ability to look at all patient care opportunities within the program in near-real time and address them proactively."

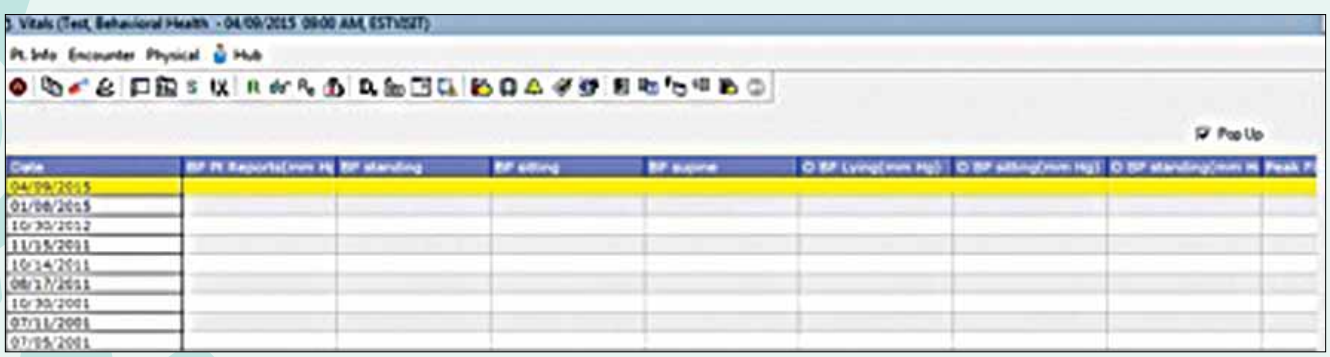
Appendix A.5

Status	Last Visit	Next Visit
Not at Target	7/14/2013	None
Not at Target	12/23/2013	None
Not at Target	10/22/2014	1/22/2015
Not at Target	9/2/2014	3/3/2015
Not at Target	11/11/2014	None
Not at Target	8/18/2014	None
Not at Target	10/1/2014	4/15/2015
Not at Target	10/29/2014	None
Not at Target	2/4/2014	None
Not at Target	11/14/2014	4/24/2015
Not at Target	9/30/2014	3/12/2015
Not at Target	11/7/2014	12/2/2014
Not at Target	8/25/2014	12/1/2014
Not at Target	7/10/2013	None
Not at Target	1/23/2014	None
Not at Target	4/30/2014	None
Not at Target	3/13/2014	None
Not at Target	11/4/2014	None
Not at Target	6/10/2013	None
Not at Target	4/4/2012	None
Not at Target	11/13/2013	None
Not at Target	11/14/2014	4/22/2015
Not at Target	12/27/2012	None
Not at Target	10/29/2014	3/10/2015
Not at Target	7/16/2014	None
Not at Target	11/17/2014	3/17/2015
Not at Target	3/12/2013	None

Appendix A.7

	Status	Reference Date
DM		
DM: BP Control {<140/90}	✚	9/22/2014
DM: A1c Screening	✚	9/22/2014
DM: A1c Good Control {<8.0}	✚	9/22/2014
DM: LDL Screening	✚	5/20/2014
DM: LDL Control {<100}	✚	5/20/2014
DM: Statin Therapy	✚	9/22/2014
DM: Eye Exam	✚	7/22/2014
DM: A1c Superior Control {<7.0}	✘	N/A
HTN		
HTN: BP Control {<140/90}	✚	9/22/2014
HTN: Aspirin Use	✚	9/22/2014
HTN: LDL Screening	✚	5/20/2014
HTN: LDL Control {<100}	✚	5/20/2014
PREV		
PREV Breast Cancer Screening	✚	12/16/2013
PREV Colorectal Cancer Screening	✚	1/28/2007
PREV Influenza Immunization	✚	9/22/2014
PREV Pneumonia Vaccination	✚	7/22/2011
PREV Screening for Future Fall Risk	✚	5/20/2014
PREV Tobacco Assessment	✚	4/30/2013
PREV Depression Screening	✘	N/A

Appendix A.6



Analyze

While the analytics platform was in place, it was also imperative to put a process in place to ensure that those data were reliable. In order to ensure that we were able to draw meaningful conclusions from the data, our analysts performed audits on each measure checking specific outcomes within the analytics platform and ensuring that the data matched our EMR.

One example of how auditing drives improvement grew out of hypertension measures. Accurate blood pressure is a key driver of documenting hypertension control, one of the main measures of the program. When the analytics platform pulled information from our EMR for blood pressure, the tool only pulled the blood pressure recorded at the first reading. Typically, two or three blood pressures are taken at a visit by medical assistants and physicians. The measure for the program states that we should demonstrate the lowest systolic and the lowest diastolic blood pressure. We dramatically improved performance by having code rewritten to pull the lowest systolic and diastolic reading. Appendix A.6 shows the different fields where physicians or staff can populate blood pressure in the EMR.

Appendix A.7 is an example of a patient's care opportunities that physicians can utilize at the point of care. The reference date refers to the specific time that the measure took place. For instance, the patient had an LDL screening taken on 5/20/2014, yet the patient did not have a depression screening. One will notice that the measures encompass more than the program measures. We believed that it was important to track all care opportunities for patients, regardless of the program, to provide comprehensive and quality care. In addition, we anticipated that other payors would include these measures in the future and believed that it would be necessary to track them.

Improve

The initial rollout of the product required the user to access the analytics dashboards through a web browser. The lack of integration with the EMR decreased usability and physician adoption. Therefore, we developed and deployed an "integrated hub" within the EMR. Currently, when physicians have a patient's medical record up on the screen in the EMR, they can click on the integrated hub (Appendix A.8) and view the patients' care opportunities immediately without opening a separate browser.

The integrated hub has also created additional opportunities to enhance the program. For instance, in the future we will build in risk scores for patients so that the provider within the practice is aware of illness severity. In addition, we have engaged in other value based agreements (focused on sharing incentives for coming underneath a budget for a population established by a payor), and this hub will allow us to view the total cost of care for the patient within a specified time period. This hub will also allow us to flag patients that fall into different programs as our enterprise expands. Another recently implemented initiative involves the adoption of a patient care coordinator utilizing the non-compliant list (as noted in the measure section) to conduct outreach to patients and set up office and lab visits. When she completes outreach to a given patient, she notes the visit as a "TUMG Quality Visit" in the EMR. The providers are then made aware that the patient is related to the quality initiative and is alerted to patient care opportunities. Bringing these patients in for visits allows for improved patient care, increased patient satisfaction and rapid success under the program.

Acquiring claims data is another vital aspect of tracking patient care and providing a comprehensive image of a patient's health profile. Appendix A.10 shows a count of patients receiving care at all facilities (including Tulane). If a patient is seen at another facility, we can evaluate the specifics of that encounter.

One challenge is that the claims feed is not provided in real time. We receive data from the payor monthly and thus are only able to offer predictive analytics to physicians. However, this feed allows for physician-to-physician communication on patient specifics as well as the ability to identify duplicative services (e.g., multiple tests) that patients receive at different sites. The claims feed does have many gaps in it (e.g., missing diagnoses, procedures, physicians, places of service) and we believe that this is a function of newer programs not familiar to payors and highlights the need for close collaboration.

Appendix A.9 demonstrates the generic dispensing rate based on claims data. At a high level, physicians and analysts will be able to access this dashboard and see all brand named drugs prescribed to a patient and generic substitutes. One opportunity addressed is adding an "adjusted" GDR column that gives a hard percentage engendering more physician engagement.

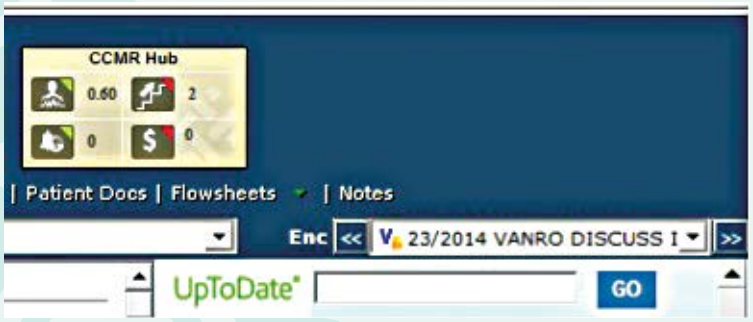
Physicians now have the ability to look at all patient care opportunities within the program in near-real time and address them proactively. Our future plans include improving timeliness of claims data from and building out a more robust pharmacy dashboard for greater usability.

"We believe that engaging our entire medical group is necessary in order be successful in value-based care."

Control

In January of 2015 our quality score improved to 11.33 and we were able to accomplish our two-year goal within four months, moving us to the highest tier. (Note that the payor moved target scores higher during this period). Appendix A.11 shows our performance in August of 2014. Appendix A.12 shows our

Appendix A.8



Appendix A.9

Adjusted GDR	Cost/Script
87.76%	$53
88.10%	$41
85.55%	$29
91.08%	$29
93.04%	$15
90.75%	$44
90.54	$31
93.93	$39
87.55%	$36
44.87%	$119
66.39%	$98
93.08%	$46

Appendix A.10

CLAIMS KPI ANALYSIS: DRILL DOWN FROM "CLAIM COUNT BY CLASSIFICATION"

Provider Name	Inpatient Pt.	Patient Count	Claim Count
Tulane University Hospital & Clinic	0	832	10734
GSQN - Tulane University Medical Group	0	453	6100
Quest Diagnostics Clinical Labs, Inc.	0	266	1803
Ochsner Medical Center - Westbank	0	132	1710
Rade Pejic	0	313	1254
Terry Cummings	0	303	1132
East Jefferson General Hospital	0	30	993
Lab Corp of America Holdings	0	103	672
University of Texas MD Anderson	0	5	647
Touro Infirmary	0	65	645
Ronald Helwig	0	15	607
Carepoint Partners	0	14	596
Kiernan Smith	0	136	498
Magellan Behavioral Health Inc.	0	59	471

Editor's Note:
Charts in Appendices have been recreated for legibility.

performance in January of 2015.

The team continues to monitor and improve processes on a daily basis by tracking physician performance and designing intuitive, novel ways to monitor quality.

We have adopted a "payor agnostic" mentality, suggesting that we have implemented these processes for all patients, not just those falling under this specific program. Therefore, when other payors implement similar programs, we will have all analytics and an infrastructure in place to be successful.

TUMG is also building out a provider scorecard that exhibits how all of our physicians are performing regardless of specialty. TUMG's emphasis on quality care is focused not only in the realm of primary care, but within all specialties responsible for controlling specific disease states and complying with preventative measures. We believe that engaging our entire medical group is necessary in order be successful in value-based care. ■

(Endnotes)

[1] http://www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

[2] http://www.hhs.gov/ash/initiatives/mcc/

Appendix A.11

Points							
Highest Tier 10.50-15.00							
Middle Tier 3.00-10.49							
Lowest Tier 0.00-2.99							
Suite	**Total Patients**	**Patients at Target**	**Patients Not at Target**	**% of Patients at Target**	**Goal**	**Points**	**Points if Goal Met**
Optimal Diabetes Care	231	44	187	19%	≥20%	2	3
Optimal Vascular Care	71	22	49	31%	≥22%	2.4	2.4
Vascular Pharmacy Care	70	37	33	53%	≥42%	0.6	0.6
Optimal Hypertension	562	300	261	53%	≥64%	0	3
Optimal CKD Care	33	22	11	67%	≥52%	2.4	2.4
CKD Pharmacy Care	0	0	0	N/A	≥47%	0.6	0.6
Efficiency Measures	**Total Patients**	**Patients at Target**	**Patients Not at Target**	**Overall Score**	**Goal**	**Points**	**Points if Goal Met**
Low Back Pain Index (Observed/Expected)	Not Available	Not Available	Not Available	1.779	≤0.6	0	1
Potentially Preventative Visits	Not Available	Not Available	Not Available	1,0701	≤0.85	0	1
Generic Fill Rate	Not Available	Not Available	Not Available	0.9987	≥1.02	0.33	1
					Total Points	**8.33**	
						Middle Tier	

Appendix A.12

Points							
Highest Tier 10.50-15.00							
Middle Tier 3.00-10.49							
Lowest Tier 0.00-2.99							
Suite	**Total Patients**	**Patients at Target**	**Patients Not at Target**	**% of Patients at Target**	**Goal**	**Points**	**Points if Goal Met**
Optimal Diabetes Care	210	45	165	21%	≥20%	3	3
Optimal Vascular Care	67	35	32	37%	≥22%	2.4	2.4
Vascular Pharmacy Care	67	41	26	61%	≥42%	0.6	0.6
Optimal Hypertension	505	313	192	62%	≥64%	2	3
Optimal CKD Care	31	20	11	65%	≥52%	2.4	2.4
CKD Pharmacy Care	0	N/A	N/A	N/A	≥47%	0.6	0.6
Efficiency Measures	**Total Patients**	**Patients at Target**	**Patients Not at Target**	**Overall Score**	**Goal**	**Points**	**Points if Goal Met**
Low Back Pain Index (Observed/Expected)	Not Available	Not Available	Not Available	1.5256	≤0.6	0	1
Potentially Preventative Visits	Not Available	Not Available	Not Available	1.0084	≤0.85	0	1
Generic Fill Rate	Not Available	Not Available	Not Available	0.9894	≥1.02	0.33	1
					Total Points	**11.33**	

LSU MED STUDENTS BRIGHTEN HOLIDAYS FOR FAMILIES

The third-year class of medical students at LSU Health New Orleans School of Medicine made the holidays a little merrier for eight metropolitan New Orleans families. The students "adopted" the families in need through Catholic Charities' 2015 Christmas Family Adoption Program.

The students filled the wish lists of the 23 individuals in their "adopted" families, all single-parent families with children ranging in age from newborn to 11 years old. The items requested included clothing, coats, household items, small appliances, educational toys, books, race cars, and grocery gift cards. Most of the medical students purchased the items. Some donated money that was pooled to purchase some gifts, and LSU Health New Orleans faculty donated funds that were used to buy the gift cards.

The class of 2017 wanted to give back to the community during the holiday season. A small group of students delivered nearly 100 gifts to Catholic Charities. The families received the presents in time for Christmas Day.

"Next year, we are planning to expand the program to include the entire medical school student body and hopefully, adopt about 20 families," says Christine Settoon, L3 Vice President of Community Service, who led the effort.

HealthcareBriefs

STATE

DuFour Appointed Chairman of Telehealth Task Force

Lonnie DuFour, Director of Client Services for the Louisiana Health Care Quality Forum, has been appointed Chairman of Louisiana's Telehealth Access Task Force, effective Jan. 1, 2016.

DuFour is a recognized champion of telehealth in Louisiana and has spoken at numerous state and regional conferences about the value of telehealth in advancing access to quality, connected healthcare for patients. He has been a member of the task force for several years and serves as the Louisiana Project Coordinator for the Texas/Louisiana Telehealth Resource Center, based at Texas Tech University in Lubbock, Tex.

The Telehealth Access Task Force was created through Louisiana House Concurrent Resolution No. 88 (HCR 88) as an advisory body to the legislature and the Louisiana Department of Health and Hospitals (DHH) on policies and practices that expand access to telehealth services. The task force is required to report to the governor and the legislature on the status of telehealth access in Louisiana.

20 Charities Given Blue Cross Foundation Grants

The Blue Cross and Blue Shield of Louisiana Foundation wrapped its special 2015 Angels of Change grant program in December, commemorating the 20th anniversary of the Angel Award® program. During the course of the year, the Foundation demonstrated its ongoing commitment to the health and safety of Louisiana's children by awarding 20 grants of $50,000 to Angel Award recipients' charities that need continued assistance.

Eligibility for the 20th anniversary grants program was open only to Louisiana-based 501(c)(3) nonprofit organizations that are affiliated with one of the 160-plus Angel Award honorees. The Foundation elected to fund innovative projects that improve children's well-being by changing community policies, social norms, and the physical environment. The Foundation evaluated each grant application based on community need, the impact on children, the initiation of new or innovative programs, and each project's success in overcoming challenges and achieving goals. Grant applications were submitted by Feb. 28, 2015. After a careful selection process, the Foundation presented grants to organizations across the state with the last one presented in December, 2015.

Lonnie DuFour

James Campbell, MD

The Angels of Change Grantees are (listed by area):

Baton Rouge Children's Advocacy Center (Baton Rouge). Supporting Angel: Sue Bernie, 2004

Big Buddy Program (Baton Rouge). Supporting Angels: Nancy Zito, 2014; Gaylynne Mack, 2012

Heritage Ranch (Baton Rouge). Supporting Angel: Vicki Ellis, 2009

Louisiana Resource Center for Educators (Baton Rouge). Supporting Angel: Nancy Roberts, 1995

McMains Child Development Center (Baton Rouge). Supporting Angel: Albert Hindrichs, 2004

Volunteers of America (Baton Rouge). Supporting Angel: Virginia Pearson, 2002

Volunteers in Public Schools (Baton Rouge). Supporting Angels: Carolyn Carnahan, 2008

St. Nicholas Center for Children (Lake Charles). Supporting Angel: Christy Papania-Jones, 2010

Healing House (Lafayette). Supporting Angel: Sarah Callaway Brabant, 2001

Hearts of Hope (Lafayette). Supporting Angels: Cory Hebert, 2007; Mary Moss, 2000

Cultural Crossroads of Minden (Minden). Supporting Angels: Dee Scallan, 2010; Chris Broussard, 2008

Christopher Youth Center, formerly Our House (Monroe). Supporting Angel: Carol Christopher, 2000

Pilots for Patients (Monroe). Supporting Angel: Phillip Thomas, 2009

A's & Aces (New Orleans). Supporting Angel: Anna Monhartova, 2010

Catholic Charities, Archdiocese of New Orleans (New Orleans). Supporting Angel: Cory Howat, 2006

Children's Health Fund (New Orleans). Supporting Angels: Carlos Naranjo, 2013

New Orleans Women's and Children's Shelter (New Orleans). Supporting Angel: Jackie Silverman, 2014

Vietnamese American Young Leaders Association of New Orleans (New Orleans). Supporting Angels: KG Marshall, 2010; Minh Nguyen 2009

Food Bank of Northwest Louisiana (Shreveport). Supporting Angels: Dr. Phillip Rozeman, 2002; Isaac McFarland 2014

Louisiana Partnership for Children and Families (Statewide). Supporting Angel: Stewart Gordon, 1997.

Campbell named to AAFP Commission of Education

The American Academy of Family Physicians (AAFP) Board of Directors recently announced that James Campbell, MD has been appointed to the AAFP Commission of Education for a four-year term. His term of service began on December 15, 2015 and ends December 14, 2019.

In his role on the Commission for Education, Dr. Campbell will work with the other commission members on priority areas of workforce, curriculum development, and student interest as it relates to family medicine.

Dr. Campbell is the program director at the Family Medicine Residency Program, Ochsner Medical Center-Kenner. He is an active member of the Louisiana Academy of Family Physicians and currently serves as LAFP's alternate delegate to AAFP Congress of Delegates.

LaPOST Offers End-of-Life Care Planning Resources

Medicare recently finalized a rule that will reimburse doctors who discuss advance care planning options with their patients. The policy change took effect on Jan. 1, 2016. The Louisiana Physician Orders for Scope of Treatment (LaPOST) Coalition encourages healthcare professionals across the state to consider the LaPOST website as a valuable source for advance care planning information.

The program is centered around LaPOST, a specialized advance care planning document designed for those facing serious, advanced

illnesses. The LaPOST website consists of instructional resources for physicians, patients, and caregivers that include the Conversations Change Lives guidebook, a web-based video learning series, a religious and cultural resource library, a guide to medical treatments and the official LaPOST document.

The LaPOST Coalition also offers webinars for professionals and has launched a statewide educational program that will assist long-term care facilities in implementing advance care planning and LaPOST into their existing operations. For patients and caregivers, there are community forums to discuss issues related to end-of-life care.

For more information about advance care planning and LaPOST, see page 48.

BCBSLA Names New President and CEO

The Board of Directors of Blue Cross and Blue Shield of Louisiana has named Dr. I. Steven Udvarhelyi as the company's new president and CEO. Udvarhelyi, who is currently executive vice president, health services, and chief strategy officer at Independence Blue Cross in Philadelphia, will assume his new responsibilities in the first quarter of 2016.

Udvarhelyi spent almost 20 years at Independence Blue Cross. His current role, held since 2012, is executive vice president of health services and chief strategy officer, which includes responsibility for the health services division, comprising medical management, pharmacy management, provider contracting and provider relations, and enterprise-wide informatics; and for strategy and planning, corporate development, and innovation, including the Independence Blue Cross Center for Health Care Innovation. As Chief Strategy Officer, Udvarhelyi is responsible for working with the CEO and senior leadership team to help Independence achieve its vision and mission.

Udvarhelyi joined Independence in 1996 and in his time there served as senior vice president and chief medical officer before moving into his current position.

A board-certified internist, Udvarhelyi has almost 25 years of experience in the managed care industry, including roles with the Prudential Insurance Company of America in its corporate offices in New Jersey, and in its southeast regional office, running the Prudential health plans in Florida. Before his career in the health insurance industry, he was a faculty member at Harvard Medical School, and he has published numerous articles on quality in healthcare.

Udvarhelyi serves as chair of the board of directors of NaviNet, is on the national board of trustees for the Devereux Foundation and is on the board of directors of the Franklin Institute. He holds a Bachelor of Arts degree from Harvard College, an MD degree from the Johns Hopkins University School of Medicine, and a Master of Science degree in health services administration from Harvard School of Public Health.

Well-Ahead Louisiana Designates More than 1,000 WellSpots

The Louisiana Department of Health and Hospitals' (DHH) Well-Ahead Louisiana initiative has designated 1,166 WellSpots across Louisiana in only a little more than a year of implementation. Well-Ahead supports healthier communities across Louisiana by promoting and making smart changes in the spaces and places we live and work in every day that make it easier for us all to live healthier lives. Organizations that meet certain voluntary health and wellness criteria are as designated as various tiers of WellSpots based on the level of wellness they achieve.

Since April 2014, DHH's Health Promotion team has provided technical assistance on the design and implementation of health policy or programs to 586 organizations in 169 cities in all 64 parishes across the state.

Well-Ahead has proven unique and incredibly successful by providing technical assistance to 586 organizations, designating 1,166 WellSpots that impact residents across Louisiana. A few of the most recently designated WellSpots include, Lake Charles Memorial, the City of Slidell, Christus Health, Lafayette Parish School District, Bossier Parish School District, and all of the LSU AgCenters. For a full list of WellSpots, visit www.wellaheadla.com/wellspots.

Small choices towards wellness, enabled by the environments we're in every day, allow us the opportunity for balance. For more information on Well-Ahead Louisiana or to become a WellSpot visit the web site at www.wellaheadla.com or call (225) 342-9307.

Nursing Workforce Study Reveals Demand for Nurses

The questions continue to be: Is there a nursing shortage? If there is an actual or impending nursing shortage, what is being done at the national, state, and regional levels? The responses to these questions will vary depending on who is asked, the geographical location under consideration, and the data sources brought to bear

In 2014, the Louisiana Center for Nursing launched the state's second Nurse Employer Survey to determine the demand for registered nurses (RNs), advanced practice registered nurses (APRNs), licensed practical nurses (LPNs), and nursing assistants (NAs) in Louisiana based on data obtained from employers. Major healthcare industries employing the vast majority of nurses such as hospitals, long term care (LTC) facilities, home health agencies, hospices, and public health facilities were surveyed to gather information about vacancy rates, turnover rates, and growth rates for the various types of nursing personnel.

I. Steven Udvarhelyi, MD

Highlights from the Survey include:

There was a significant increase in unmet demand for RNs between 2010 and 2014, driven largely by an increase in the number of direct care RN vacancies in hospitals. When the current unmet demand for personnel (vacancies) is combined with anticipated growth, the additional 2015 demand for all types of nursing personnel in Louisiana is estimated at 8,983.

Of all healthcare industries surveyed, psychiatric hospitals, long term care (LTC), public health, and hospice had the highest vacancy rates for direct care RNs, 13.8 percent, 11.9 percent, 11.7 percent, and 10.9 percent, respectively. High vacancy rates are generally associated with a nursing shortage. These industries are struggling to attract qualified nurses, and though it may not indicate a statewide shortage, it certainly indicates a shortage of personnel qualified and willing to work in these industries.

Between July 1, 2013 and June 30, 2014 (or the most current report year), there were an estimated 6,602 RN separations, 3,509 LPN separations, and 9,817 NA separations. The majority of the separations for RNs were within hospitals, whereas the majority of the separations for LPNs and NAs were in LTC/SNF and hospitals.

The median turnover rate for direct care RNs in hospitals, the largest personnel category identified in the employer survey in terms of budgeted positions, was 13.8 percent over the course of one

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Walker First to Use New Technology
Dr. Craig Walker is pictured with Brandon Hendrick, Project Leader at Spectranetics (left) and Claude Lafont, Account Manager at Spectranetics (right).

BioAesthetics Wins BioInnovation Center Pitch Contest
BioAesthetics founder Nicholas Pashos (left) and the Center's Director of Technology Commercialization Shafin Khan.

year. Psychiatric hospitals had the highest median turnover rate for direct care RNs (56.6%) and NAs (45.8%). The largest median turnover rate for LPNs occurred in LTC/SNF (33.3%).

The utilization of temporary nursing staff was up in several industries, which is also consistent with an improving economy and increased difficulty in hiring permanent staff. In 2014, there was a substantial increase in the percentage of temporary staff utilized by the public health system when compared to 2010. Approximately 43% of the public health system nursing personnel were temporary employees in 2014.

The healthcare industries included in the current study reported that they expected a substantial increase in new direct care RN positions over the next year. In particular, elder care settings such as hospice and home health expect their direct care RN positions to grow at a faster rate than acute care hospitals over the next year – a sign that the aging population is anticipated to increase demand in settings offering specialized aging care. Recommendations: Continue to support Louisianas nursing programs through federal, state, and private funding to ensure that there will be a continuous pipeline of new RNs available to meet the ongoing demand for nurses in Louisiana.

The report in its entirety can be accessed at: http://lcn.lsbn.state.la.us/Portals/0/Documents/NursingWorkforceDemandReport2014.pdf.

LOCAL

Voters Still Approve of Smoke-Free Ordinance

A recent poll found that New Orleans voters overwhelmingly approve of the law prohibiting smoking inside all workplaces, including bars and casinos, after six months in effect. The poll indicates that support for the law has increased as NOLA residents have experienced the benefits of a smoke-free environment.

Nearly 8 out of 10 New Orleans voters support the new law, including 64 percent who strongly favor it. Support for the law has increased from 66 percent in December 2014 to 78 percent a year later.

NOLA residents recognize the benefits of a smoke-free environment, saying that smoke-free bars and casinos are healthier and more enjoyable. Nearly nine out of ten voters (89 percent) agree that smoke-free bars and casinos "are healthier for customers and employees," and 85 percent agree that "it has been really nice to go out and enjoy bars and casinos without breathing cigarette smoke or smelling like cigarette smoke" when they get home.

These poll results come on the heels of a recent study finding indoor air pollution levels having fallen dramatically in bars and the city's casino since the smoke-free law took effect. The level of fine particle air pollution fell by 96 percent in venues that had previously allowed smoking, and it was virtually eliminated in the casino, where there was a 99 percent reduction.

The New Orleans City Council unanimously (7-0) passed the ordinance sponsored by Councilmembers LaToya Cantrell and Susan Guidry on January 22. Mayor Mitch Landrieu signed the measure into law a week later with the law going into effect on April 22, 2015.

Among the other poll findings:

•89 percent of NOLA voters say it is important that they have a smoke-free environment inside all workplaces – including restaurants, bars and casinos – while just 11 percent find it is not important.

•88 percent of voters feel that secondhand smoke exposure is a health hazard – and 70 percent label it a serious hazard – with just 11 percent calling it either a minor or no health hazard.

•80 percent believe the rights of employees and customers to breathe clean air in casinos, restaurants and bars is more important than the right of smokers to smoke and owners to allow smoking inside their establishments (16 percent).

The citywide survey of 500 registered voters was conducted by Public Opinion Strategies and released by the SmokeFree NOLA coalition. The poll was funded by the Robert Wood Johnson Foundation.

The air quality study was conducted by nationally recognized indoor air quality researchers at the Roswell Park Cancer Institute in Buffalo, New York, using state-of-the-art air pollution monitors to measure the levels of fine particle air pollution in 13 bars and one casino both before and after the smoke-free law took effect.

That study concluded that New Orleans' smoke-free ordinance is protecting the health of New Orleans workers, entertainers, residents, and visitors.

Walker First to Use New Technology

Cardiovascular Institute of the South announced that founder, president, and medical director Dr. Craig Walker, was the first in the world to use the Turbo-Power laser atherectomy catheter by Spectranetics for in-stent restenosis in peripheral arteries.

The Turbo-Power laser atherectomy catheter is the latest technology in treatment for in-stent restenosis, which refers to the narrowing of a previously-stented vessel with restricted blood flow.

The catheter allows for better directional control and a larger opening in the blood vessel. The tip rotates by the use of an external remote and uses radiofrequency ablation to open the vessel. The procedure took place in the cath lab at Terrebonne General Medical Center.

BioAesthetics Wins BioInnovation Center Pitch Contest

Emerging biomedical startup BioAesthetics won the 2015 BioChallenge, an annual pitch competition held by the New Orleans BioInnovation Center for Louisiana-based life sciences startups. BioAesthetics won $25,000 after pitching the startup's regenerative graft that offers an improved reconstruction option for breast cancer patients who have undergone a mastectomy.

As an alternative to current permanent and temporary reconstruction options, BioAesthetics has developed a novel graft that would allow the patient's body to regenerate a permanent nipple-areolar complex. Founder Nicholas Pashos, a PhD candidate at Tulane University and a National Science Foundation fellow, delivered the company's winning pitch.

The other three finalist startups competing were:

Flux Diagnostics aims to revolutionize rapid, low-cost diagnostics for various diseases like dengue fever without the need for extensive training or complex equipment.

InnoGenomics is developing genetic testing solutions that solve crimes and save lives, including a minimally invasive blood test to detect and monitor cancer.

Zenopharm, a Xavier University of Louisiana spinout, is developing a drug to treat and prevent the recurrence of breast cancer more effectively than current treatments.

The judges who selected the overall winner were industry experts and investors from Johnson & Johnson Innovation, Becton Dickinson, Louisiana Funds, Ben Franklin Technology Partners of Southeastern Pennsylvania, Houston Angel Network, and Mercury Fund. InnoGenomics was awarded the $2,500 Audience Favorite award, based on the winner of text votes submitted by event attendees.

UQ Ochsner Clinical School Honors Largest Class

Like all medical students, Joshua Mauro can look back on his schooling and recall many late nights of studying and long hours of hard work in clinical settings. But unlike other medical students, Mauro's clinical experience included a remote Australian mining village with flights into neighboring aboriginal villages to provide much-needed healthcare services.

In November, Mauro and his classmates from the University of Queensland (UQ) Ochsner Clinical School gathered for another memorable experience — a Culmination Ceremony marking the completion of their medical school training. The class of 63 aspiring physicians was the 4th in this unique program's brief, but successful, history.

Since 2009, UQ Ochsner Clinical School has been on a steady growth track — expanding from 9 to an estimated 100 graduates in 2016, a targeted increase of 725%. Class sizes still remain small with an average of 120 students per year in the current program, allowing for more one-on-one instruction opportunities than larger programs. Students come from reputable undergraduate schools from all over the country, including Johns Hopkins University, Dartmouth College, Brown University, Cornell University, and University of California – Berkeley.

Students at the UQ Ochsner Clinical School have not only shown a desire for meaningful experiences, they have also exhibited a strong community connection. Nearly 70% of students find times in their very busy study schedule to volunteer for community service.

As an indication of its success, the program currently boasts a 90% Match rate in the National Resident Matching program — with the majority of students securing a place at their first or second choices for residency. Also of note, 48% of the students choose Primary Care fields, an area of great need in today's healthcare system.

Avanti Senior Living to Expand

Lori Juneau-Alford, COO for Avanti Senior Living, has announced plans to expand into Covington. Avanti Senior Living at Covington will have spacious suites, luxurious amenities and innovative technology within a boutique-style senior living community. The 77,000-square-foot, $15 million community will provide 60 assisted living suites and 50 memory care suites.

Avanti Senior Living at Covington will be located off Ochsner Blvd. in the Water Cross at Nor du Lac. Avanti plans to break ground on the new community in the first quarter of this year. Last year the company also announced plans to build communities in Baton Rouge and Lafayette.

Avanti Senior Living at Covington will include a state-of-the-art wellness center with ballet barre and fitness programs, a theater area, a full-service salon and spa offering relaxation therapy, aromatherapy, therapeutic massages, hair styling and manicures/pedicures. In addition, the community will have a fully functional art studio with an abundance of natural light and a stone wall for displaying the residents' artwork. ■

UQ Ochsner Clinical School Honors Largest Class

In Louisiana, quality of care is a primary focus in statewide efforts to improve health and health care, and for the Quality Forum, it is more than a focus – it's a mission.

LaPost 101

ADVANCE CARE EDUCATION FOR LONG-TERM CARE SETTINGS

IMPROVING QUALITY across the spectrum of care, from the earliest point in life to the last, is critical, but it is often the latter that gets overlooked, if for no other reason than the difficulty of broaching the subjects of death and dying with patients who have life-limiting illnesses.

This is why advance care planning education and training is a key objective for our organization.

Louisiana's patients and families are fortunate to have a number of ways to document their advance care planning preferences and wishes, including a health care power of attorney and an advance directive or 'living will.' But since 2010, patients in Louisiana with serious, advanced illnesses have had another way to record their end-of-life treatment wishes and goals of care: the Louisiana Physician Orders for Scope of Treatment (LaPOST) document.

A quality initiative of the Quality Forum, this voluntary, non-biased document places control into patients' hands. It serves the dual purpose of allowing them to determine what kinds of medical treatment they do and do not want to receive at the end of life and preventing their loved ones from having to make difficult decisions about their care.

Susan Nelson, MD, LaPOST Coalition Chair, explained, "Many years ago, patients had limited options when it came to the selection of treatments at the end of life. Today, in some cases, medical advancements have made it possible for doctors to significantly extend patients' lives, but while some patients could benefit from those advancements, they may not be ideal for everyone. LaPOST gives patients more control in deciding the point at which curative treatment is no longer attempted, and focus then shifts to comfort and symptom management."

LaPOST serves as a physician's order, traveling with patients across health care settings to serve as a point of reference for all members of the patients' care team. Because the LaPOST document is so critical to ensuring that patients' end-of-life care wishes are met, the Quality Forum, in coordination with the LaPOST Coalition, is committed to providing advance care planning-focused education to Louisiana's health care professionals. These efforts have included the development of instructional materials and resources; local, regional and national speaking engagements; community outreach; and educational workshops and webinars.

Now these efforts include a specific focus on educating long-term care staff and residents about the value of communicating and documenting end-of-life care wishes, and for long-term care professionals, this

Cindy Munn
Chief Executive Officer
Louisiana Health Care Quality Forum

training program could not have come at a better time.

In late 2014, the Louisiana Department of Health and Hospitals (DHH) began requiring all nursing homes across the state to record the completion of a LaPOST document as part of their Minimum Data Set assessments. The adoption of this measure reflects the importance of tracking such information to better monitor LaPOST residents and to ensure their treatment needs are met.

In addition, Medicare has finalized a policy change that, beginning Jan. 1, 2016, will reimburse physicians who discuss end-of-life care planning options with their patients.

In response to this increased state and federal focus on quality of care at the end-of-life, the Quality Forum has launched a 12-month, grant-funded project designed to educate and train long-term care staff in advance care planning processes and options, including LaPOST.

Nelson said, "By preparing long-term care staffs to discuss end-of-life care planning options such as LaPOST with their patients, we are helping to ensure that those patients receive the kinds of care and quality of care that they want."

She added, "It is so important for health care professionals to educate and talk with their patients and their families about the types of care available, who provides it, who pays for it, and other related issues. Having these conversations is difficult for families, but they can also be difficult for health care professionals. Our nursing home-focused educational efforts will better prepare them for those conversations by arming them with the information and training necessary to ask and answer questions and document treatment wishes and goals of care."

AFTER SEEING THE VIDEO AND READING THROUGH THE MATERIALS ALONG WITH LaPOST, IT BECOMES PERSONAL...

As part of this project, the Quality Forum and the LaPOST Coalition have developed a toolkit of training videos, downloadable materials, and other resources to facilitate LaPOST implementation at each nursing facility. Regional symposiums, in which trained health coaches guided participants in how to appropriately initiate discussions with residents about advance care planning and the LaPOST document, have been held. As of December 2015, more than 90 nursing facilities in Louisiana have participated in the training program.

Kim Byers, a Baton Rouge long-term care facility administrator, recently completed the training. Having this targeted education is critical because while many long-term care professionals are aware of LaPOST and other advance care planning documents, they may not fully understand how those documents are applied, she said.

For example, noted Byers, part of the training is focused on how to include LaPOST as part of the admission process. She said long-term care facilities can include a review during admission to determine whether a patient has a LaPOST or other advance care planning documents in place. If not, she said, the facility can "use that as an opportunity to start that discussion."

Byers added that the training assists long-term care professionals in initiating those conversations about end-of-life goals of care. "After seeing the video and reading through the materials along with LaPOST, it becomes personal... They begin to understand the importance of the patient and the patient's family having comfort in knowing their end-of-life care wishes will be carried out."

Nelson agreed, "This program is equipping nursing care administrators and staff with the necessary knowledge and training to guide residents through the advance care planning process and to best support their treatment wishes."

"Most importantly, it requires health care professionals, patients, and caregivers to have real conversations about treatment options for end-of-life care," Nelson said. "These can be difficult conversations to have, but by discussing treatment options and personal goals, values and beliefs, we can help make patients' final days easier, for themselves as well as for their loved ones."

To learn more about LaPOST, participate in online advance care planning education training, download educational materials or find out about upcoming webinars and events, visit www.la-post.org. ■

Soon a new legislature will assemble in Baton Rouge with a new governor. The legislature convenes on March 14, 2016, and the public eye will be fixed on the 90-day session with the hope that state leaders will correct many of the problems the last administration left our state. Here are several long-time trouble spots that can be resolved only by the governor and the legislature working together.

THE TO-DO LIST GETS LONGER FOR Governor-elect John Bel Edwards

Medicaid Expansion

Louisiana, and other states, have wasted time and money by refusing to participate in the Medicaid expansion, a part of the Affordable Care Act that allows states to enroll persons with incomes below 138% of poverty. For the first three years, states do not have to provide matching funds and only small amounts thereafter.

Louisiana, for example, could have provided no matching funds until 2016 and then small amounts until the tenth year, paying only 10% state match in the tenth year and thereafter. That is quite a bargain compared to the regular state Medicaid match for our state, which is 35% for almost all Medicaid services.

So Louisiana will pay approximately $1.2 billion over the 10-year period ending 2022. The federal government will pay $15.8 billion over the same period. Without the very favorable match rate (7% rather than 35%) Louisiana would have to pay about $6 billion instead of $1.2 billion over the 10-year period. And the reward for this will be coverage for 289,000 low-income persons who will now have healthcare coverage.

The gubernatorial election in November 2015 changed the outlook for Louisiana. Governor-elect John Bel Edwards had Medicaid Expansion as part of his platform and now it appears to be a certainty.

As of November 2015 the state count for and against Medicaid Expansion is as follows:

- 31 states (including D.C.) have joined the Medicaid Expansion
- 19 states have refused the Medicaid Expansion
- 1 state (Louisiana) is now a certainty to join the Medicaid Expansion

For those readers who remain skeptical, I remind you that our capability to operate a Medicaid Expansion program has already been tested–20 years ago on LaCHIP (Louisiana's Children's Health Insurance Program). While we did not have the incentives I describe above (billions of federal dollars, etc.), we were certainly ready to "make things happen." Our Medicaid staff got to work and within two years we were being heralded as one of the top five states in the nation. By the end of Governor Foster's term, more than 320,000 children were enrolled–a testimony to our fine staff. It was an honor to work with them.

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

Control Private Health Insurance Costs

The Louisiana Department of Insurance (LDI) website states that "LDI does not have approval authority over health insurance rates." Louisiana is one of only seven states that lack the ability to stop health insurance companies from hiking rates. Just a few examples from the LDI website of high health insurance rate increases during 2015 are noted in Fig. 1. These are well above national averages for health insurance premium increases. Although LDI does analyze in detail each proposed rate change, it cannot stop a company from proceeding with a planned change.

The Louisiana legislature can help solve this problem by changing the statutes which prevent LDI from ensuring fair pricing of health insurance for families and individuals in Louisiana. Additionally, high deductibles have become a problem for many consumers who may pay relatively low premiums but must also pay huge sums out-of-pocket in accordance with the policy they have chosen. For many families and individuals who don't have thousands of dollars on hand, they may have health insurance, but it is worthless if they can't pay the deductible. Health insurance without the ability to access health care—that's another problem LDI and the legislature should minimize.

Reinvest in Higher Education

Governor-elect Edwards has made it clear that Louisiana's higher education facilities have suffered significantly during the past administration and recovery is needed fast.

This represents a major about-face in higher education financing compared to the deep cuts almost every year during the Jindal administration.

The budget for the current fiscal year is $769 million for Louisiana's four public university systems. The Louisiana Board of Regents has requested $1.7 billion for next year's higher education budget. According to Dr. Joseph Rallo, Commissioner of Higher Education, the budget that was appropriated to higher education five or six years ago was approximately $1.5 billion but it was significantly cut each year down to about half of that amount ($769 million) in the current fiscal year (WRKF, Nov. 4, 2015).

"All these jobs that are coming to Louisiana require a skilled, educated workforce. And if we are not even right now graduating enough people to fill the current jobs, how are we going to be able to fill the jobs that are coming?" Ralla asks (WRKF, Nov. 4, 2015).

It seems inevitable that a tax increase would be needed to properly fund state colleges and universities, as well as numerous areas of the state budget that have suffered deep reductions over the past eight years. Taxes are typically unpopular among many legislators and their constituents, yet many taxes are clearly indispensable in areas like education, road construction, coastal restoration, healthcare, and hurricane recovery.

Yet, even though a tax may provide needed aid in many areas, the opposition may be overwhelming and the tax is doomed. Here is a recent example:

In 2002, Rep. Vic Stelly (Republican from Lake Charles) authored a constitutional amendment that would impose a sales tax. In the general election in 2002, Louisiana voters approved the Stelly Plan, listed as a constitutional amendment, 51 percent to 49 percent.

Under the Stelly Plan, the state sales tax on food for home consumption and the sales tax on natural gas, electricity, and water for residential use was lowered on January 1, 2003, from 3.9 cents to 2 cents per dollar. To replace revenue lost through Stelly, individual income tax returns were not filed until after January 1, 2004, the withholding tax tales were revised, and the new rates went into effect on January 1, 2003.

Governor Mike Foster (1996-2003) (Republican) wasted no time in taking advantage of the new dollars coming in, and some $800 million was dedicated to Higher Education. Governor Kathleen Blanco (2004-2007) (Democrat) added $700 million to education, $600 million for road construction, $200 million for coastal restoration, and $1 billion to the Road Home program for hurricane recovery. With large amounts in several areas, this is definitely progress. Or...should be.

Foster and Blanco are no longer in the top position to maintain course with Higher Education. The Stelly Plan was dismantled in 2011. ■

FIG. 1

DATE FILED	COMPANY	PROPOSED RATE CHANGE	IMPLEMENTED RATE
05/14/2015	United Healthcare Life Insurance Co.	24.00%	29.50%
08/24/2015	Aetna Health Inc. (Coventry Healthcare of LA, Inc.}	22.85%	22.85%
05/14/2015	Louisiana Health Service & Indemnity Co. (BCBSLA)	19.68%	19.68%

BECOMING AN INFLUENCER: Leading Change in the Volatile Healthcare Environment

I recently read a book by Patterson, Grenny, Maxfield, McMillan, and Switzler called "Influencer. The Power to Change Anything."[1] The book was a *New York Times* bestseller by the authors of "Crucial Conversations" and, while not directed at healthcare workers specifically, contains lessons for all of us, from CEOs to the lowest level of the organizational ladder. It promotes ideas that allow for anyone to lead change by empowering us to influence human behavior. Since patient care is a uniquely positioned industry that relies on humans to care for other humans, I thought that the lessons of the book could inform the everyday actions that nurses take on behalf of their patients.

WHEN YOU ASK MOST NURSES WHY THEY chose the profession in the first place, the answer most often provided is "to make a difference." But when faced with overtime, lack of sufficient staff, non-compliant patients, unhappy family members, unreasonable administrators, inter-departmental competition for scarce resources, and the myriad other challenges of everyday patient care, we don't often feel very successful at making a difference. These authors point out that the reason for this is because the tool we most often attempt to use to change others' behaviors is verbal persuasion. When that doesn't work, we fall back on that time tested acceptance of "que sera sera" (what will be, will be) and we ask God to grant us the strength to change what we can, the serenity to accept the things we cannot change, and the wisdom to know the difference. But what if we didn't have to be serene; what if we could use our wisdom not to *know* the difference, but to *make* a difference? I am not Steve Jobs and I will never build the next Apple computer, but I can influence people by identifying vital behaviors and then developing strategies to influence others to action.

What are the other strategies that have been identified as powerful influencers? One of the first is to create personal experiences. While you may not be able to take your entire nursing staff on a field trip to a Magnet® institution, you can share the successes of these institutions through virtual or vicarious experiences.[2] Magnet recognizes hospitals that promote nursing excellence by promoting quality in a setting that supports professional practice, identifies excellence in the delivery of nursing services to patients, and disseminates best practices in nursing services. There are numerous articles in the literature that define what it means to be a Magnet® institution, but to have your staff experience this virtually, follow the experiences of the nurses at Lowell General Hospital in Lowell, Mass. at http://www.lowellgeneral.org/about-lgh/a-magnet-hospital/what-it-means-to-be-a-magnet-hospital including two videos on supporting nursing excellence and Magnet® redesignation.[3]

Another strategy used to change minds is to tell stories. One doesn't have to be a published author or Hollywood producer to use stories to change minds. I have over 40 years of nursing stories to tell and I use them on a regular basis to try to get nurses and nursing students to change their behavior. One of the most influential stories I tell nursing students is about an experience in which one of my students went to Facebook to rant about a nursing manager who had verbally reprimanded her loudly and in public for some minor infraction of hospital policy. This occurred in the hospital hallway in the presence of other nurses, physicians, and members of the public. The nurse manager was wrong in her behavior, but posting the

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

name of the nurse and, more importantly, the hospital was also wrong and a significant violation of professional boundaries. The hospital had sophisticated security systems that alerted them whenever their name was mentioned in any publication, written or on the web. As a result, they were aware of the post and prohibited the student from returning to do any clinical work, not only in their facility, but in their entire national system. Additionally, the student was banned from ever being employed in any institution in the system. It is a powerful story and, I believe, has influenced more students than any lecture on privacy rights.

The authors end by describing a model of six sources of influence as depicted in Fig. 1.

So, to give an example of how this model might work, suppose a nurse was faced with a physician who constantly went from patient to patient without washing his hands, but was afraid to confront him on this behavior. We would assess that he finds washing his hands before and after each patient encounter undesirable. How do we use personal motivation to change this behavior? Try confronting the physician with one of his own patients who developed a hospital-acquired infection (HAI). Ask him to investigate the case himself, not to delegate it to others, including complications the patient had developed, increased length of stay with associated costs, etc. Make the population statistics of HAIs real and personal for him. Assuming he has a positive and personal relationship with his patients and wouldn't want harm to come to them as a result of physician-initiated bacterial infection, we can make the undesirable washing of hands desirable for him in order to avoid causing harm to his patients. Structural ability has also been used to address this infection control problem by placing hand antiseptic dispensers throughout hospital public access throughways to remind nurses, physicians, allied health workers, patients, family members, and the public to sanitize their hands often.

Nurses do not work alone and neither do *INFLUENCERS*. In the complex system of healthcare, it takes a village to effect change. We must all work together using the principles of behavior change to solve institutional challenges. Fostering innovative work environments that use the principles of influence will help us work smarter, faster, and more efficiently. Open networks of communication and support of the risk takers who challenge group think and model creativity will go a long way in producing the innovation that we all seek. ■

FIG. 1

	Motivation	Ability
PERSONAL	Make the undesirable desirable	Surpass your limits
SOCIAL	Harness peer pressure	Find strength in numbers
STRUCTURAL	Design rewards and demand accountability	Change the environment

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In this age of social media, 24-hour news, and viral videos, it's easier than ever to fall prey to fad diets or the newest exercise crazes before medical science has had the chance to truly evaluate their benefits. The overabundance of information available to the public can be intimidating, contradictory, and difficult for individuals to evaluate critically. Louisiana residents need to know what works best for maintaining health, improving life expectancy, and losing weight. Eating a healthy, balanced diet and exercising for at least 150 minutes a week is the best recommendation for most of them.

Making Health A HABIT

LOUISIANA RANKS AMONG THE WORST states in the nation in obesity. Many of the leading causes of death in our state, including heart disease, cancer, stroke, diabetes, and kidney disease, can be prevented by keeping a healthy diet and routinely exercising. In fact, the Milken Institute has predicted that we could avoid 612,000 cases of chronic conditions in 10 years if we made healthier choices in our lives. Each year millions of Americans, including those right here in Louisiana, make New Year's resolutions to get in shape and stay healthy. I myself recently changed my regular workplace snack from chips to carrots. This year will surely be no different, and it is as important as ever for Louisiana's residents and their care providers to know how to best accomplish these goals. According to the best research available, the answer for most individuals looking to start healthy habits in 2016 is really quite simple: participate in at least 150 minutes of moderate-intensity exercise a week and eat a healthy, balanced diet. Every medical provider should know these basic recommendations and that they are suitable for most adults.

Individuals who maintain these habits have lower rates of all-cause mortality, coronary heart disease, high blood pressure, stroke, type 2 diabetes, metabolic syndrome, colon cancer, breast cancer, and depression. They have a lower risk of a hip or vertebral fracture and exhibit higher levels of cardiorespiratory and muscular fitness. Such individuals are also more likely to both achieve weight maintenance and have a healthier body mass indices.

The 150 minutes is just two and a half hours of total time each week, and exercise sessions can be broken up into increments as small as 10 minutes. By exercising five days of the week, individuals can focus on getting just half an hour a day, making goals achievable within almost anyone's schedule. The 10- to 30-minute exercises can be just about anything, including climbing stairs or playing sports. Aerobic exercises benefit the heart and should take up the bulk of the 150 minutes. Aerobic exercises are those that elevate the heart rate and use the major muscle groups, like the arms and legs. Examples include walking, jogging, swimming or biking. Two sessions of strength or resistance

Kathy Kliebert
Secretary, Louisiana DHH

By exercising five days of the week, individuals can focus on getting just half an hour a day, making goals achievable within almost anyone's schedule.

exercise should also be included. Strength exercises don't have to be complicated or use weight machines. Simple activities like moderate yard work can fulfill the need.

While the 150 minutes is a minimum, it's also important for Louisiana's residents to understand that the benefits of this level of exercise are tremendous and that they do not have to be athletes to be healthy. In fact, the health benefits from performing minimal weekly exercise compared to no exercise at all are far greater than the benefits of exercising beyond the 150 minute minimum.

As for diet, we Louisianans sure do love our food. It's one of the things that makes our state special, but a healthy diet is part of the foundation of staying healthy. After all, what you put in your body becomes your body. Eating healthily means focusing on plenty of fruits, vegetables, and whole grains. Fat-free or low-fat dairy products are also important, and everyone should include healthy, protein-rich items like poultry, fish, beans, eggs, nuts, and lean meats in their diet. We should also try to avoid foods that are high in saturated fats, sodium, and added sugars. More thorough diet recommendations and tools to help Louisianans of any age keep a healthy diet can be found at choosemyplate.gov.

Finally, those looking to lose weight as part of their commitment to a healthier life should know that the best way to lose weight is to keep a healthy diet and spend more energy than you eat through exercise. How much you adjust your diet and how much you must exercise to lose weight is different for every person, as we all have different metabolisms. If an individual is interested in going beyond the recommended 150 minutes of exercise, the World Health Organization recommends that adults either double their moderate-intensity aerobic physical activity to 300 minutes per week or engage in 150 minutes of vigorous-intensity aerobic physical activity per week (or an equivalent combination of the two). However, the best way to find out the healthiest way for anyone to lose weight is to speak to a medical provider about what balance of diet and exercise might work best.

As medical providers, I urge each of you to make these recommendations to your patients at every opportunity. The health benefits of a healthy diet and regular exercise are undisputed, and they are also the best and most affordable way we can combat many of the leading causes of death in Louisiana. As employers and employees, I also call on you to participate in worksite wellness. Creating healthy workspaces that encourage regular exercise and healthy eating are crucial to this fight. To find out more about the Department of Health and Hospitals' program for worksite wellness, visit wellaheadela.com. ■

We enjoy receiving awards and recognition from our peers, but the joy we get from seeing positive outcomes for patients is our true reward. We achieve those positive results thanks to the dedication of our nurses. On their behalf, we're proud to announce that STPH is one of only three hospitals in the state to achieve the Pathway to Excellence® from the American Nurses Credentialing Center. We're also excited to have received our second consecutive Women's Choice Award for Heart Care & Obstetrics.

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OUR NURSES ARE TRUE CHAMPIONS.

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TGMC RECEIVES STROKE GOLD

Terrebonne General Medical Center (TGMC) has been honored with the American Heart Association/American Stroke Association's Get With The Guidelines®-Stroke Gold Quality Achievement Award.

TGMC received the Gold Quality Achievement Award by achieving 85 percent or higher adherence to all Get With The Guidelines-Stroke achievement indicators for two or more consecutive 12-month periods. These quality measures are designed to help hospital teams provide the most up-to-date, evidence-based guidelines with the goal of speeding recovery and reducing death and disability for stroke patients.

TGMC focused on appropriate use of guideline-based care for stroke patients, including aggressive use of medications such as clot-busting and anti-clotting drugs, blood thinners, and cholesterol-reducing drugs, preventive action for deep vein thrombosis and smoking cessation counseling. Before receiving the Gold designation, TGMC was also awarded the Bronze and Silver Stroke Quality Achievement Awards.

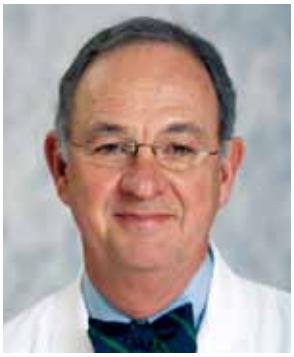
ABOVE Sid Hutchinson, Vice President of Ancillary Services, Catherine Straatmann Robichaux, American Heart Association representative, Lisa Mimnagh, RN, Emergency Department, Nancy Yzaguirre, RN, Emergency Department Director, Donna Ward, RN, Critical Care Unit, Kellie Gros, RN, Quality and Business Development, Phyllis Peoples, President and CEO of TGMC.

HospitalRounds

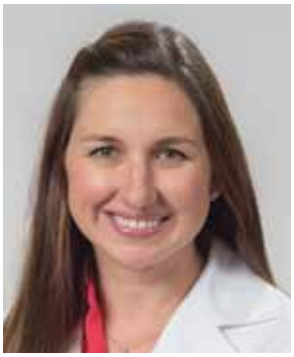
Roberts Joins LHA as VP of Clinical Affairs

Dr. Floyd J. "Flip" Roberts, Jr., FACP, FCCP, has joined the Louisiana Hospital Association as the vice president of clinical affairs. In this position, Dr. Roberts will provide strategic leadership on clinical and professional matters impacting the Association and its member hospitals in all areas pertaining to physician/hospital integration, clinical affairs, quality improvement, and patient safety.

Dr. Roberts previously served as the chief medical officer of Baton Rouge General Medical Center. He was responsible for developing the Tulane University School of Medicine satellite campus in Baton Rouge and served as the first regional dean. Dr. Roberts also served as medical director of graduate medical education at BRGMC, as well as the initial program director of the Baton Rouge General/Tulane Internal Medicine Residency Program.



Floyd J. "Flip" Roberts, Jr, MD, FACP, FCCP



Aimee Mackey, MD

Mackey Joins Ochsner

Dr. Aimee Mackey has joined Ochsner as the hospital's only female breast surgeon. Her specialty is breast surgical oncology and the diagnosis and treatment of breast cancer. Clinical interests include the surgical treatment of breast disease, nipple-sparing mastectomies, sentinel lymph node biopsies, young women with breast cancer, and quality of life after breast cancer treatment. She also treats and manages benign breast disease.

A native of Baton Rouge, Mackey is one of the only board certified, and fellowship trained female breast surgeons in New Orleans and the GNO area. Dr. Mackey's office and clinic are located at the Lieselotte Tansey Breast Center across from the Main Campus Hospital on Jefferson Hwy. She hopes to expand her clinic to include the Ochsner Baptist facility by the end of the year.

Family Medical Clinic Opens in Folsom

Medical Clinic at St. Tammany Parish Hospital has relocated to Folsom in an all-new medical office. The new Family Medical Clinic, which includes Dr. Libeau Berthelot, Dr. Christopher Foret, and Dr. Mark James, is the only primary care provider in Folsom.

The clinic's board-certified physicians have more than 30 years of experience in caring for patients, newborn to geriatric, for comprehensive primary care needs. Its affiliation with St. Tammany Parish Hospital gives patients of Family Medical Clinic seamless access to all STPH resources, including the new electronic health record, MyChart.

LHH Announces New Physician Alliances

The Louisiana Heart Hospital (LHH) recently completed agreements for clinical integration with electrophysiologist Bassam Georges Wanna, MD, general surgeon Darren Michael Rowan, MD, FACS, and Doctor of Podiatric Medicine, Daniel H. Hake, DPM, FACFAS.

Dr. Wanna is Board Certified in Internal Medicine, Cardiovascular Disease, and Echocardiography. Dr. Rowan is Board Certified in General Surgery by the American Board of Surgery. Rowan is also a Fellow of the American College of Surgeons and the Southeastern Surgical Conference. Dr. Hake has practiced on the Northshore since 1999 and is Board Certified in Foot and Ankle Surgery by the American Board of Foot and Ankle Surgery.

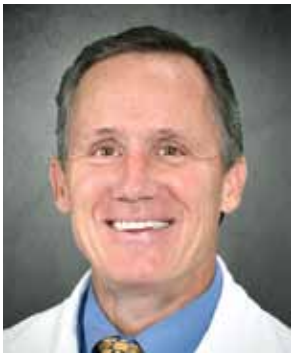
MBPCC at TGMC Named Great Oncology Program

Mary Bird Perkins Cancer Center at TGMC has been named one of *Becker Hospital Review's* "100 Hospitals and Health Systems with Great Oncology Programs" for 2015. The list features organizations dedicated to treating cancer patients as well as researching the deadly disease. Mary Bird Perkins Cancer Center at TGMC stands out in terms of quality patient care, clinical outcomes, and research achievements.

Mary Bird Perkins Cancer Center at TGMC was selected by the *Becker's Hospital Review* editorial team based on recognition received, accreditations earned, and memberships held in cancer care-oriented groups. Specifically, the *Becker's* team examined *U.S. News & World Report's* hospital rankings for treating cancer, CareChex

Family Medical Clinic Opens in Folsom


Bassam Georges Wanna, MD


Darren Michael Rowan, MC, FACS


Daniel H. Hake, DPM, FACFAS

cancer care rankings, BlueCross BlueShield Association Blue Distinction Center designation, National Cancer Institute designations, and Commission on Cancer accreditations and awards received, as well as membership in the National Comprehensive Cancer Network.

STPH Welcomes New Physician Associations

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

- Christopher Beck MD, Radiology
- Michael Feldman MD, Orthopedic Surgery
- Jeremy W. Henderson MD, Pathology
- Melissa A. Inman MD, Nephrology
- Clayton J. Overton, III MD, Emergency Medicine
- Jamie A. Hymel MD, OB/GYN
- Pamela M. Bartholomew MD, Pathology
- Parrish T. Eilers MD, Emergency Medicine
- Stacy L. Fernandez-Rodrigue MD, Emergency Medicine
- Lesley A. Meng, MD, Hematology/Oncology
- Andrew M. Stone, MD, Radiology
- Misty Wetzel, MD, Emergency Medicine

Slidell Memorial Earns "A" for Hospital Safety

Slidell Memorial Hospital was honored with an "A" grade in the Fall 2015 update to the Hospital Safety Score, which rates how well hospitals protect patients from accidents, errors, injuries, and infections. The Hospital Safety Score is compiled under the guidance of the nation's leading experts on patient safety and is administered by The Leapfrog Group (Leapfrog), an independent industry watchdog. SMH Chief Executive Office Bill Davis noted that SMH was the only hospital in metropolitan New Orleans to achieve the "A" rating.

To see SMH's scores as they compare nationally and locally, and to find safety tips for patients and their loved ones, visit the Hospital Safety Score website at www.hospitalsafetyscore.org.

Ochsner Installs Low Dose CT Technology

Ochsner Health System is one of the first and largest health systems in the nation and the first in the Southeast to partner with GE Healthcare to provide patients with higher quality images with lower, safer doses of radiation. Ochsner now offers low dose radiation computed tomography (CT) technology across most sites and will be all low-dose across its entire system by March 2016.

The American College of Radiology and The Joint Commission have increased awareness to the cumulative doses of radiation a patient receives. They also call on healthcare providers to better monitor radiation levels and to avoid radiation unless medically appropriate.

Cancer Center Receives Outstanding Achievement Award

Mary Bird Perkins Cancer Center at TGMC was recently presented with the 2015 Outstanding Achievement Award by the Commission on Cancer (CoC) of the American College of Surgeons (ACoS). The Cancer Center is one of a select group of only 23 U.S. healthcare facilities with accredited cancer programs to receive this national honor for surveys performed January 1 through June 30, 2015. The award acknowledges cancer programs that achieve excellence in providing quality care to cancer patients. In addition, the Cancer Center also received Three-Year Accreditation with Gold State Commendation, the highest level of reaccreditation.

The Cancer Center was evaluated on 34 program standards categorized within one of the four cancer program activity areas: cancer committee leadership, cancer data management, clinical services and quality improvement. The Cancer Center was further evaluated on seven commendation standards.

St. Tammany Diabetes Education Merits ADA Recognition

The prestigious American Diabetes Association Education Recognition Certificate for a quality diabetes self-management education program was recently awarded to the Diabetes Self-Management Education Program at St. Tammany Parish Hospital.

The Association's Education Recognition Certificate assures that educational programs meet the National Standards for Diabetes Self-Management Education Programs. These Standards were developed and tested under the auspices of the National Diabetes Advisory Board in 1983 and were revised by the diabetes community in 1994, 2000, 2007 and 2012.

Benson Gift to Advance Clinical Cancer Research and Care

Ochsner Health System recently announced a $20 million gift – the largest gift in the history of the organization – from New Orleans Saints and Pelicans Owners, Gayle and Tom Benson to expand cancer care services and advance clinical research within the Gulf South region. This is part of a major expansion of the Gayle and Tom Benson Cancer Center, making it one of the leading comprehensive destinations for cancer care across a multi-state region.

The Cancer Center expansion will include:

- 100,000 square feet of expanded oncology clinics across five floors with the addition of over 50 personalized and semi-private patient chemo infusion stations; more than doubling the patient space in a relaxing and compassionate atmosphere.
- A full spectrum of specialty-trained physicians who employ a team approach to treating cancer

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Benson Gift to Advance Clinical Cancer Research and Care

patients through weekly conferences and open and integrated communication.

•Comprehensive approach to urologic, gynecologic and surgical oncology for all cancer types.

•A clinical cancer research program with a large range of clinical trials for all cancer types; including cutting edge drugs, new agents and anti-cancer agents for treating cancer.

EJGH Ranked Tops for Overall Hospital Care

East Jefferson General Hospital has been rated No. 1 in medical excellence and patient safety for overall hospital care in the state of Louisiana, garnering "check-plus plus" status by the CareChex quality rating system.

CareChex provides a composite evaluation of all components of medical quality including process of care, outcomes of care, and patient experiences.

STPH Honors Long-term Employees

St. Tammany Parish Hospital hosted its 43rd annual Service Award Banquet to honor this year's employees who reached special service milestones.

Two employees were recognized for 40 years of service: Floretta H. Abrams, Food Services, and Larry C. Lamarca, Laboratory.

Five employees were honored for celebrating 35 years of service: Freda M. Darby, Food Services; Lyndia C. Morris, Cardiology; Joseph G. Pechon, Surgery; Marylyn S. Skinner, Home Health Care Services; and Sharon C. Stiles, Rehab Unit.

Marking 30 years of service were Louise Dill, Rehab Unit; Marilyn K. Fourcade, Surgery; and Byron E. Frazier, Information Systems.

Honored for 25 years of service were Susan C. Bond, Finance; Belinda A. Fitzsimons, Imaging Services Admin; Debora H. Howie, Patient Financial Service; Royce Keaton, Intensive Care; Cynthia A. Keen, Pharmacy; Mary B. Mauthe, RCIA; Bobbie R. Tosso, Endoscopy; and Jacqueline N. Townsend, Access.

Celebrating 20 years of service were Lori N. Chatelain, Information Systems; Edwin H. Jordan, Pharmacy; Glen J. Kesler MD, STPN-Covington; Geralyn F. Klebba, Home Health Care Services; Marilyn L. Moore, STPN-Covington; Donald D. Perkins, Physical Therapy – OP; Esther C. Stuard, Environmental Services; and Cindy L. Turner, Women's Pavilion.

More than 30 employees celebrated 15 years of service, including Jessica H. Barbara, 3 East; Chandra S. Barre, 2 North; Larry C. Bates, Anesthesiology/Prof; Susan M. Bessent, STPN-Covington; Erin W. Blessing, Covington Surgery Center; Erwin G. Boehm, Information Systems; David M. Breland, Pharmacy; Cheryl A. Delagrange, Surgery; Patricia T. Doell, Occupational Therapy – OP; Mary K. Duet, Endoscopy; Patti M. Ellish, Administration; Patricia D. Falgout, Finance; Debra B. Fascio, Radiology/Mammography OPP; Patricia A. Harris, Human Resources; Tiffany L. Huffman, STPN-Covington; Shirley J. Lewis, Laboratory; Alicia L. Llovet, Covington Surgery Center; Keli S. Lumpkin, Family Medical Clinic; Donna C. Mayeux, 3 East; Annie J. Moses, Food Services; Sandra L. Nelson, Materials Management; Tanesha R. Nixon, Food Services; Elizabeth D. O'Daniell, Finance; Annette L. Pittman, Clinical Doc Improvement; Christina E. Raquet, Intensive Care; Robert L. Schellhaas, Jr. Food Services; Juliette B. Simms, Tele-Communications; Mary M. Smith, 2 South; Debbie S. Soileau, Radiology/Diag/OPP; Darla W. Steadman, Pulmonary Rehab; Anna M. Thomas, Family Medical Clinic; Toby W. Tournillon, Intensive Care; Kim Walters, Communication; and Angela C. Wilkie, Physical Therapy – OP.

Honorees for 10 years of service are: Stefanie A. Alford, Family Medical Clinic; Rebekka L. Amick, 3 North; Jason E. Bernard, Anesthesiology/Prof; Alicia R. Bernard, Intensive Care; Debora M. Bertucci, Case Management; Sarah E. Blenet, 2 North; Joseph R. Bobrowski MD, STPN-Covington; Sandra S. Bono, Health Information Management; Gretchen S. Bourque, Case Management; Kenny P. Brewer, Respiratory Services; Meghann C. Brown, Pediatric Unit; Bryan E. Burleson, Imaging Services Admin; Dominick G. Calderone, Pharmacy; Kerry A. Chanson, 2 West; Cary C. Clary, Respiratory Services; Lauren D. Corcoran, Cath Lab; Geneva Daniels, Pediatric Unit; Amy W. Deane, Information Systems; Glenn L. Debarbieris, Pharmacy; Deborah D. Deweese, Physical Therapy – OP; Jennifer G. Dupont, Human Resources; Jaime B. Dupre, Labor and Delivery; Catherine S. Dwight, Intensive Care; Darlene S. Faciane, 2 North; Geoffrey S. Fendley, Anesthesiology/Prof; Heather B. Flynn, NICU; Tonya C. Fowler, NICU; Dea M. Frederick, Speech Therapy – OP; Paula R. Fryou, Labor and Delivery; Lorella L. Grinnell, 3 East; Michelle L. Hackman, Emergency Care Services; Adrienne C. Hilliard, Intensive Care; Melissa Hodgson, Communication; Lauren M. Horridge, Covington Surgery Center; Courtney C. Jee, Cardiac Rehabilitation; Melonie W. Lagalante, OP Pavilion Administratio; Alicia S. Larriviere, Administration; Lenny P. Ledet, Radiology/CT Scan Mandeville; Kim S. Lofaso, Pediatric Unit; Cynthia A. Marange, Family Medical Clinic; Luis A. Marquez, Cardiology; Randy S. Martinez, Physical Therapy – IP; Jonathan L. Mayeux, Respiratory Services; Tara L. Miller, Community

Wellness; Gail P. Mizell, Post Anesthesia Care Unit; Sandy W. Morgan, Cath Lab; Diane L. Navoy, Food Services; James L. O'Connor, Respiratory Services; Sue B. Osbon Ph. D, Administration; Erin G. Owens, Pharmacy; Dale E. Peschlow, 2 North; Marcy L. Plaisance, Radiology Diagnostic; Emily F. Price, Labor and Delivery; Sherri A. Rorie, Utilization Management; Bryan J. Roser, Construction; Danielle M. Salles, Cardiac Rehabilitation; Michael R. Sanchez, Cardiac Rehabilitation; Richard F. Satter, Sr. CCU; Paula D. Schindler, Inpatient Wound Care/ PIC; Edward T. Schiro, Rehab Unit; Craig A. Seicshnaydre MD, Hospital Medicine; Pamela S. Sharp, 2 South; Raye A. Story, Corporate Compliance; Teresa S. Thibodeaux, Infusion Services; Brian W. Thiel, Access; Patrick J. Torcson MD, Administration; Janice R. Tridico; Specialty Out Patient Clinic; Karen A. Tucker, Family Medical Clinic; Mary F. Vegas, Respiratory Services; Gina R. Ward, CVO; and Dionne M. Williams, STPN-Administration.

Louisiana Heart Hospital Signs Integration Agreements

Louisiana Heart Hospital recently signed integration agreements with family practitioner Christina M. Leal McKinley, MD, and cardiologist Jay R. Silverstein, MD, FACC, FASNC.

Dr. Leal McKinley has practiced medicine on the Northshore since 2011, and is Board Certified in Family Medicine. Dr. Silverstein has practiced medicine since 2008, and is Board Certified in Internal Medicine, Cardiovascular Disease, Echocardiography, and Nuclear Cardiology.

Christina M. Leal McKinley, MD

Jay R. Silverstein, MD, FACC, FASNC

TGMC Receives Pathway to Excellence® Re-designation

Terrebonne General Medical Center (TGMC) has once again achieved the Pathway to Excellence® designation by the American Nurses Credentialing Center (ANCC). This is the second time TGMC has been honored with the Pathway to Excellence and is one of only three facilities in Louisiana, and the only one in its region, to receive this prestigious nursing designation.

The Pathway to Excellence designation identifies that TGMC has provided the elements of a work environment where nurses can flourish and be proud of their work. The re-designation substantiates the professional satisfaction of nurses at TGMC and identifies it as one of the best hospitals to practice nursing.

EJGH Earns Recognition from the Joint Commission

East Jefferson General Hospital announced that it has been recognized as a 2014 Top Performer on Key Quality Measures by the Joint Commission, the leading accreditor of healthcare organizations in the United States.

EJGH was recognized as part of The Joint Commission's 2015 annual report "America's Hospitals: Improving Quality and Safety," for attaining and sustaining excellence in accountability for key quality measures. EJGH is one of only 1,043

TGMC Receives Pathway to Excellence® Re-designation

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hospitals out of more than 3,300 eligible hospitals in the United States to achieve the 2014 Top Performer distinction.

To be a 2014 Top Performer, hospitals had to meet three performance criteria based on 2014 accountability measure data, including:

- Achieve cumulative performance of 95 percent or above across all reported accountability measures;
- Achieve performance of 95 percent or above on each and every reported accountability measure with at least 30 denominator cases; and
- Have at least one core measure set that had a composite rate of 95 percent or above, and within that measure set, achieve a performance rate of 95 percent or above on all applicable individual accountability measures.

Ochsner Recognized for Orthopedics

Ochsner Medical Center – Jefferson Highway has been named among the "100 Hospitals and Health Systems with Great Orthopedic Programs" by *Becker's Hospital Review*, for the second year in a row.

Ochsner Medical Center is the only orthopedics program in Louisiana and Mississippi to be ranked among the nation's top 50 by *U.S. News & World Report* for 2015-16. Offering more than 20 orthopedic surgeons, Ochsner is also a research facility conducting clinical research studies and interventional studies.

The center is part of a non-profit, academic health system and was also rated as high-performing in knee replacement surgery and *U.S. News*' common care ratings for this year. Within the center's orthopedic program, the hospital has specialty centers including the Back and Spine Center, the Sports Medicine Institute, and the Hand Center. It is a Blue Distinction Center+ for knee and hip replacement and holds magnet recognition from the American Nurses Credentialing Center.

McGaw Named Medical Director

Dr. Harry McGaw, a Board Certified Medical Oncologist, was recently appointed to the position of Medical Director at Mary Bird Perkins Cancer Center at TGMC. As Medical Director, Dr. McGaw will provide medical leadership essential to the successful operation of all interdisciplinary aspects of the Mary Bird Perkins Cancer Center at TGMC. This position seeks to optimize the continuum of care, achieve goals regarding clinical outcomes and patient and medical staff satisfaction.

Dr. McGaw will, with others on the Cancer Program Leadership Team, develop, implement, and maintain the direction and quality of the Cancer Program.

STQN Presents 4th Quarter Medical Director Awards

The St. Tammany Quality Network (STQN) presented its fourth quarter Medical Director Awards to two member physicians for implementing new technology and protocols, and providing education to continuously improve patient care.

Harry McGaw, MD

Dr. Ricardo Blanco, a critical care specialist and pulmonologist, was recognized for the implementation of Endobronchial Ultrasound (EBUS), which is primarily used for the diagnosis of lung cancer. In addition to his work with EBUS, Dr. Blanco was also instrumental in providing sepsis treatment education to the St. Tammany Parish Hospital medical and nursing staff.

Dr. Malcom Gray Napier, a hospitalist at St. Tammany Parish Hospital, was also recognized for his contribution to improving sepsis care. He was instrumental in the implementation of the Centers for Medicare and Medicaid Services (CMS) septic shock protocol. Identification and early detection of sepsis helps improve patient outcomes and increase safety.

WOMEN'S HEALTH ALLIANCE DONATES RATTLES TO SMH

Members of the Slidell Memorial Hospital Women's Health Alliance donated 1,000 stuffed toy rattles to Slidell Memorial Hospital. Each baby born at SMH is to receive one of the special rattles. Shown with a sampling of the rattles are (front, from left) JoBeth Kavanaugh, Kathy Lowrey and Terri Parks; and, (standing, from left) Barbara Gravois, Ellen Lamarque, Jackelyn Gallo, Frances Matthews, Liz Gambrell, Hannah Rucker, and Laurie Manley.

LHH Cardiac Rehabilitation Program Certified

The Louisiana Heart Hospital announced the certification of its Cardiac Rehabilitation Program by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). LHH was recognized for its commitment to improving the quality of life by enhancing standards of care.

The Louisiana Heart Hospital Cardiac Rehabilitation Program participated in an application process that requires extensive documentation of the program's practices. AACVPR Program Certification is the only peer-review accreditation process designed to review individual programs for adherence to standards and guidelines developed and published by AACVPR and other professional societies. Each program is reviewed by the AACVPR Program Certification Committee and Certification is awarded by the AACVPR Board of Directors.

Thomas Named "CEO to Know"

Ochsner Health System President and CEO, Warner Thomas, has been named as one of the 2015 "130 Nonprofit Hospital and Health System CEOs to Know," by *Becker's Hospital Review*. According to *Becker's*, "The men and women on this list lead some of the largest, most successful, and prominent non-profit healthcare organizations in the country. They have overseen financial turnarounds, shown commitment to their community through memberships and governance involvement with various organizations, and helped advance the healthcare industry as a whole through their advocacy and professional efforts."

Thomas joined Ochsner, Louisiana's largest nonprofit health system, in 1998 and served as president and COO for 14 years before being named president and CEO in 2012. In 2014, Thomas was appointed to the Medicare Payment Advisory Commission (MedPAC) to advise Congress on issues affecting Medicare. He has also served as Chairman of the American Hospital Association Section of Health Systems Governing Council and is a past member of the board of the American Medical Group Association and the Association of American Medical Colleges Advisory Panel for Health Care.

TGMC Honors Long Term Employees and Retirees

Over 150 Terrebonne General Medical Center (TGMC) employees were honored at the Annual Employee Service Awards Banquet. Sixty-Nine employees were long term employees recognized for providing over 20 years of service or more to TGMC.

ABOVE TGMC employees honored for 20 years of service.
LEFT TGMC Employees honored for 30 years of service.

Clifford Breaux, Jr. was recognized for an outstanding 50 years of service and Keith Matherne was recognized for 40 years of service at TGMC. Honored for 35 years of service were, Wilson Freeman, Cathy Kohmann, and Barbara Hogenstad. Employees recognized for 30 years of service were, Christine Cantrelle, Sandee Ellender, Teresita McNabb, Mary Miller, Dana Olivier, Elizabeth Rousseve, Linda Savoie, Lucetta Sweet, and Terry Wallace, Jr.

Twenty-one employees were honored for 25 years of service. Karen Billiot, Carol Burt, Urtz Cheramie, Lorraine Coleman, Simone Corley, Elsie Dabney, Kathleen Diggs, Patricia Domangue, Wendy Durocher, Gail Hamilton, Jeanne Hamner, Cynthia Harris, Donna Jackson, Charlene Josey, Denise Lajaunie, Leslie Levron, Deborah Marcel, Laura Melancon, Trudy Ordoyne, Nadeline Riley, and Diane Yeates.

Thirty- four employees were honored for 20 years of service. Tracie Achee, Edna Anderson, Donald Austin, Harold Benoit, D'lyn Bollinger, Sonda Brown, Philip Bueche, Pamela Bundy, Thomas Champagne, Gail Denson, Wayne Deroche, James Devillier, Carole Duplantis, Angela Fontenot, Henry Franklin, Victoria Grey, Angela Guillory, Kimberly Harrison, Nichol Ledet, Desaire Lirette, Harriet Lyons, Kathy McClendon, Veronica McEachern, Phyllis Peoples, Cherie Pierre- Miller, Rebecca Pizzo, Kerrie Redmond, Pamela Spearman, Mark Spence, Tommy Tabor, Troy Tabor, Nancy Theriot, Danyel VanMatre, Dean Verret, and Randy Williams.

Twenty-four employees were honored for 15 years of service. Terry Babin, Rebecca Blanchard, James Charpentier, Jean Dove, Jennifer Dufrene,

Ann Dupre, Teddy Dupre, Jr., Jacqueline Eberling, Dwayne Hornsby, Dana James, Lynn Ledet, Amber Luke, Theresa McGuire, Betty Nash, Kristi Robert, Constance Robinson, Latasha Robinson, Dana Rogers, Claudia Ryder, Amy Savoie, Penella Scott, Melanie Soignet, Michael Verdin, and James Whitney III.

Seventeen employees were honored for 10 years of service. Heidi Acosta, Rhonda Alfred, Justin Chaisson, Consuella Darjean, Dennis Dillard, Magen Dufrene, Billie Evans, Jenny Hawkins, Amy Naquin, Ryan Orillion, Jessica Quick, Dawn Richard, Susan Schexnaildre, Katherine Sims, Patricia Stanley, Stacie Tastet, and Abby Toups.

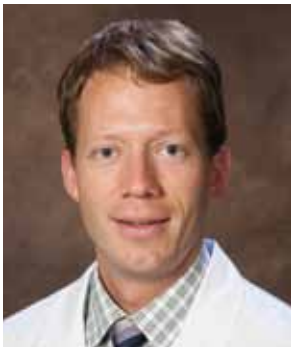
Forty-four employees were honored for 5 years of service. Ashley Adams, Angelle Bergeron, Annette Bergeron, Megan Bergeron, Richard Bergeron II, Graham Bilello, Tonya Billiot, Mandy Bordelon, Amber Cancienne, Carley Charpentier, Margaret Coleman, Gerald Crochet, Katie Danos, Crystal Dugas, Danielle Duplantis, Stephanie Evans, Jared Ferriss, Beth Fitch, Sabrina Fitch, Danielle Foret, Shalanda Frey, Sandy Griffin, Elaine Guidry, Jonathan Guillot, William Holmes, Adrienne Hymel, Amanda LaFleur, Carol Marcel, Issac Martinez, Rebecca Melancon, Geraldine Miller, Abby Moberley, Brittany Mosely, Janet Naquin, Balkissou Ningbinnin, Michelli Orodoyne, Ronald Poindexter Sr., Rae Richard, Cody Rivere, Ebony Robinson, Michelle Sandlin, Antoinette Stevenson, Jamie Walker and Kim Williams.

Eight TGMC retirees were honored for their many years of service. Gayle Bourgeois, 20 years of service, Corine Coleman, 41 years of service, Kenneth Foret, 34 years of service, Carol May, 38 years of service, Pamela Pellegrin, 34 years of service, Spicy Pryne, 29 years of service, Sheila Rhodes, 20 years of service, and Beverly Rutledge, 53 years of service.

Elson Joins Cancer Center Medical Staff

Mary Bird Perkins Cancer Center at St. Tammany Parish Hospital has announced the addition of radiation oncologist Andrew Elson, MD, to its medical staff.

Dr. Elson is a summa cum laude graduate of the University of Notre Dame in South Bend, Ind. He earned a Medical Doctorate from the University of Iowa Carver College of Medicine in Iowa City, Ia., and completed a preliminary year internal medicine residency at Tulane University Hospitals and Clinics in New Orleans, and a radiation oncology residency at the Medical College of Wisconsin in Milwaukee, Wis. Dr. Elson has also completed research fellowships at the University of Iowa Department of Radiology in Iowa City, and at the Cardiovascular Research Institute, University of South Dakota School of Medicine in Vermillion, S.D.



Andrew Elson, MD

West Jefferson Recognized as Top Performer

West Jefferson Medical Center (WJMC) announced that it has been recognized as a 2014 Top Performer on Key Quality Measures® by The Joint Commission.

West Jefferson was recognized as part of The Joint Commission's 2015 annual report "America's Hospitals: Improving Quality and Safety," for attaining and sustaining excellence in accountability measure performance for Heart Attack, Heart Failure, Pneumonia, Surgical Care, Venous thromboembolism, and Perinatal Care. West Jefferson Medical Center is one of only 1,043 hospitals out of more than 3,300 eligible hospitals in the United States to achieve the 2014 Top Performer distinction.

Ochsner Wins Innovation Award

The American Association of Integrated Healthcare Delivery Systems (AAIHDS) has announced Ochsner Health System as the winner of the 2015 Innovation Award for its Hypertension Digital Medicine (HDM) program. The second annual award sought to recognize a company or organization that is improving quality and reducing costs using an innovative method.

Using unique and collaborative methods to combine innovative technologies with treatment tools and a team of healthcare professionals, Ochsner's HDM program addresses hypertension holistically, providing patients with a convenient way to effectively manage high blood pressure while supplementing their management with in-depth education on hypertension and lifestyle changes to improve control.

Through wireless blood pressure cuffs integrated with Apple HealthKit and Epic, Ochsner's Electronic Medical Record (EMR), patients regularly measure their blood pressure and heart rate readings at home while the data is sent directly to the clinic for monitoring. Specialized pharmacists review the data in real time to make medication adjustments and lifestyle recommendations as needed to ensure blood pressure control. Results are incorporated into MyOchsner, the system's online patient portal, so that patients have access to their information and receive reports on their progress.

Healthgrades Gives EJGH 13 Five Star Ratings

With a compilation of 13 five star ratings in various categories from Healthgrades, one of the leading evaluators of healthcare institutions, East Jefferson General Hospital outpaced other New Orleans area hospitals, according to the company's most recent reports.

Healthgrades analyzes patient outcomes for virtually every hospital in the country in an effort to provide patients with an accessible and transparent rating system for healthcare providers. A five star rating in a category translates into a better than expected outcome for a patient in a given area.

EJGH received five star ratings in one category of cardiac, orthopedic, and neuroscience care, two categories of pulmonary care, and four categories of critical and gastrointestinal care.

Along with the five star accolades, EJGH also received a pair of Healthgrades Specialty Excellence Awards with the America's 100 Best Hospitals for General Surgery and the Gastrointestinal Care Excellence awards, both for the third consecutive year.

TGMC Physicians Among the Best

Eleven Terrebonne General Medical Center (TGMC) physicians have been recognized on the 2015-2016 Best Doctors in America® List. Richard P. Abben, MD, Robert M. Alexander, MD, Kimberly J. Barner, MD, Richard L. Brooke, MD, Robert Clarke Jr., MD, Mary L. Eschete, MD, Peter S. Fail, MD, Edgar L. Feinberg II, MD, Bernard F. Ferrer, MD, Ruthanne R. Gallagher, MD, and Bedford Nieves- Cruz, MD, received this prestigious recognition decided by the physicians' peers.

The Best Doctors in America® List includes the nation's most respected specialists and outstanding primary care physicians in the nation. These are the doctors that other doctors recognize as

the best in their fields. It is a list which is truly unbiased and respected by the medical profession and patients alike as the source of top quality medical information.

Cancer Centers Boost Lung Cancer Awareness

While smoking is the number one cause of lung cancer, other risk factors including age and family history of cancer, are also responsible for Louisiana's leading cause of cancer deaths. During November, recognized as National Lung Cancer Awareness Month, Mary Bird Perkins Cancer Center at TGMC and Mary Bird Perkins Cancer Center at St. Tammany Parish Hospital encouraged people to learn their risk factors by taking a free online risk assessment.

Both Cancer Centers were recognized as Screening Centers of Excellence by the Lung Cancer Alliance (LCA).

Some of the additional lung cancer resources offered include:

- Stereotactic body radiation therapy: a treatment that uses advanced imaging techniques to deliver a large, highly focused radiation dose to certain types of lung tumors
- Free tobacco cessation counseling services
- National Cancer Institute clinical trials for the treatment of lung cancer.

Ochsner Outlines Safety of Carotid Surgery

A newly released study in the *Journal of Vascular Surgery* has shown that doctors may have more treatment options at their disposal for patients who have suffered minor or moderate-sized strokes. The study, conducted by Ochsner Health System in New Orleans, could offer access to more aggressive treatment to lessen the possibility of subsequent strokes and provide better overall outcomes for patients.

The five-year study found that surgery to treat symptomatic carotid artery blockages shortly after an initial stroke is safe in patients with minor or moderate-sized strokes[1], even if they have received the clot-busting medicine — intravenous tissue plasminogen activator (tPA). The work describes the safety of carotid surgery (carotid endarterectomy, CEA) and in select patients, stent placement (carotid artery stenting, CAS). Currently, intravenous tPA is the only Food and Drug Administration medication approved for stroke treatment.

Dr. Hernan Bazan, associate professor of surgery for the Ochsner Health System, is the lead author of this work, which represents a close collaboration between the vascular specialists and stroke neurologists at Ochsner.

The study found that there were no higher complications related to performing carotid artery surgery or stent placement during the critical stroke window of two to three days after a stroke, even if patients received tPA. Dr. Bazan says that it is particularly important that in this group of patients there were also no increased risks of bleeding complications.

[1]*Stroke severity was defined using the National Institutes of Health Stroke Scale (NIHSS) scores and patients with NIHSS scores of 10 or less who did receive tPA had equivalent outcomes as those who did not undergo treatment with tPA, even if they were treated with 'urgent' carotid surgery, shortly after a stroke.* ■

LCMC PRESENTS PATIENT SAFETY & QUALITY COLLOQUIUM

In December, LCMC Health presented the system's first National Patient Safety & Quality Colloquium. During the two-day conference, held in University Medical Center New Orleans' Conference Center, over 125 senior leaders and Board members representing Children's Hospital, West Jefferson Medical Center, University Medical Center, New Orleans East Hospital, and Touro attended and gained valuable insights, practical applications, and proven methods from leaders in the healthcare industry.

Additionally, attendees heard from Sorrel King, a mother who lost her 18-month old to medical errors. Author of Josie's Story, Ms. King has become a nationally renowned patient safety advocate. She hopes that Josie's story will inspire change and create a better, safer healthcare industry for us all.

RIGHT TOP Joe Eppling, senior director of Nursing-Critical Care; Mary Kelly, senior director of Nursing-Medical/Surgical Unit; E. Roslyn Pruitt, Director, Quality Safety Risk Accreditation; Dr. Peter DeBlieux, Chief Medical Officer; Dr. Tracy Sanson, presenter, University of South Florida's Division of Global Emergency Medical Sciences and Team Health's division of Medical Leadership Education and Professional Liaison; Dr. David Beran, LSUHSC Assistant Medical Director, Emergency Medicine at LCMC Health's National Patient Safety & Quality Colloquium.
RIGHT BOTTOM Guest speaker Sorrel King shares her family's story during one of the breakout sessions at LCMC Health's first National Patient Safety & Quality Colloquium.

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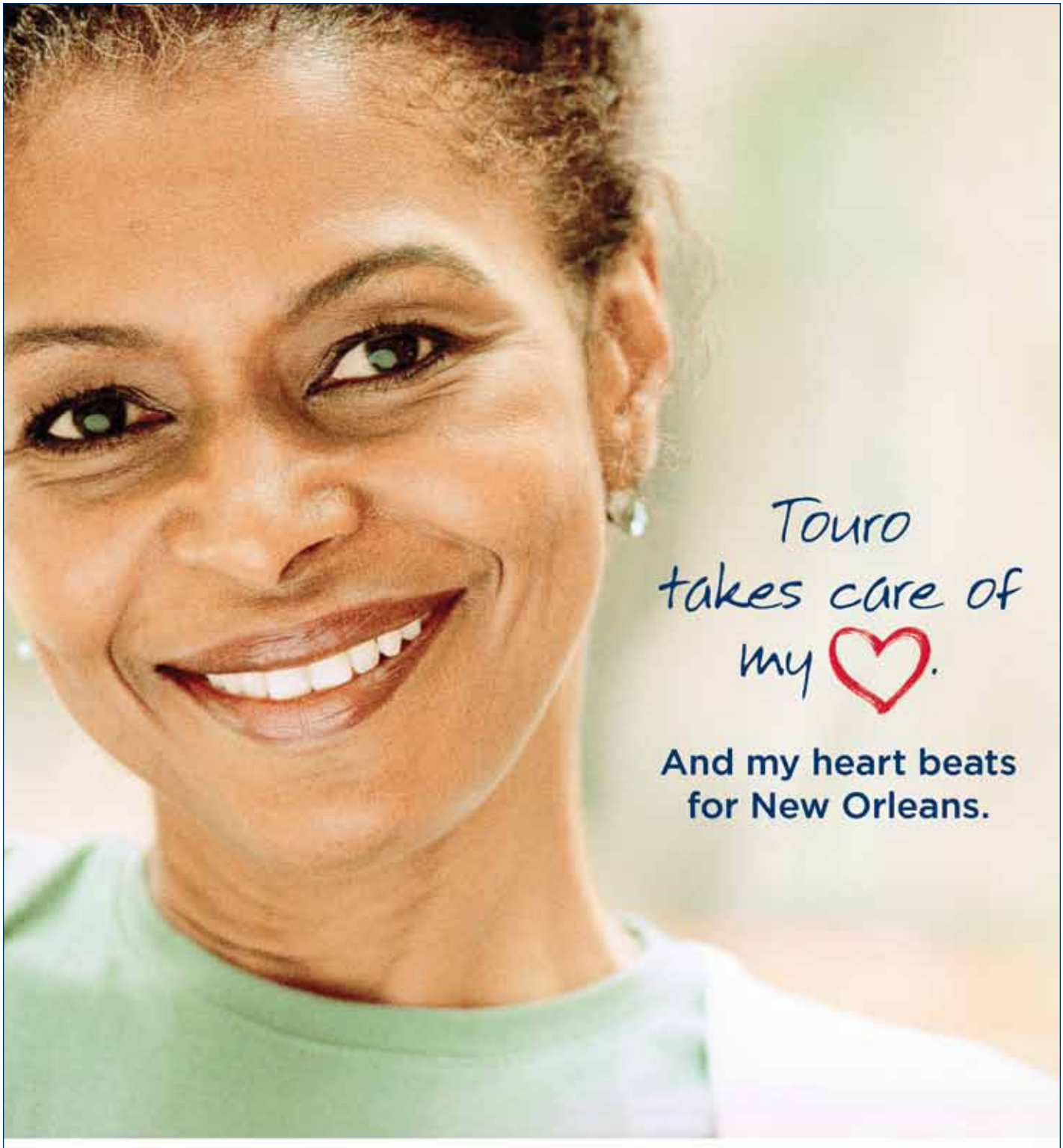

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