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JANUARY / FEBRUARY 2013

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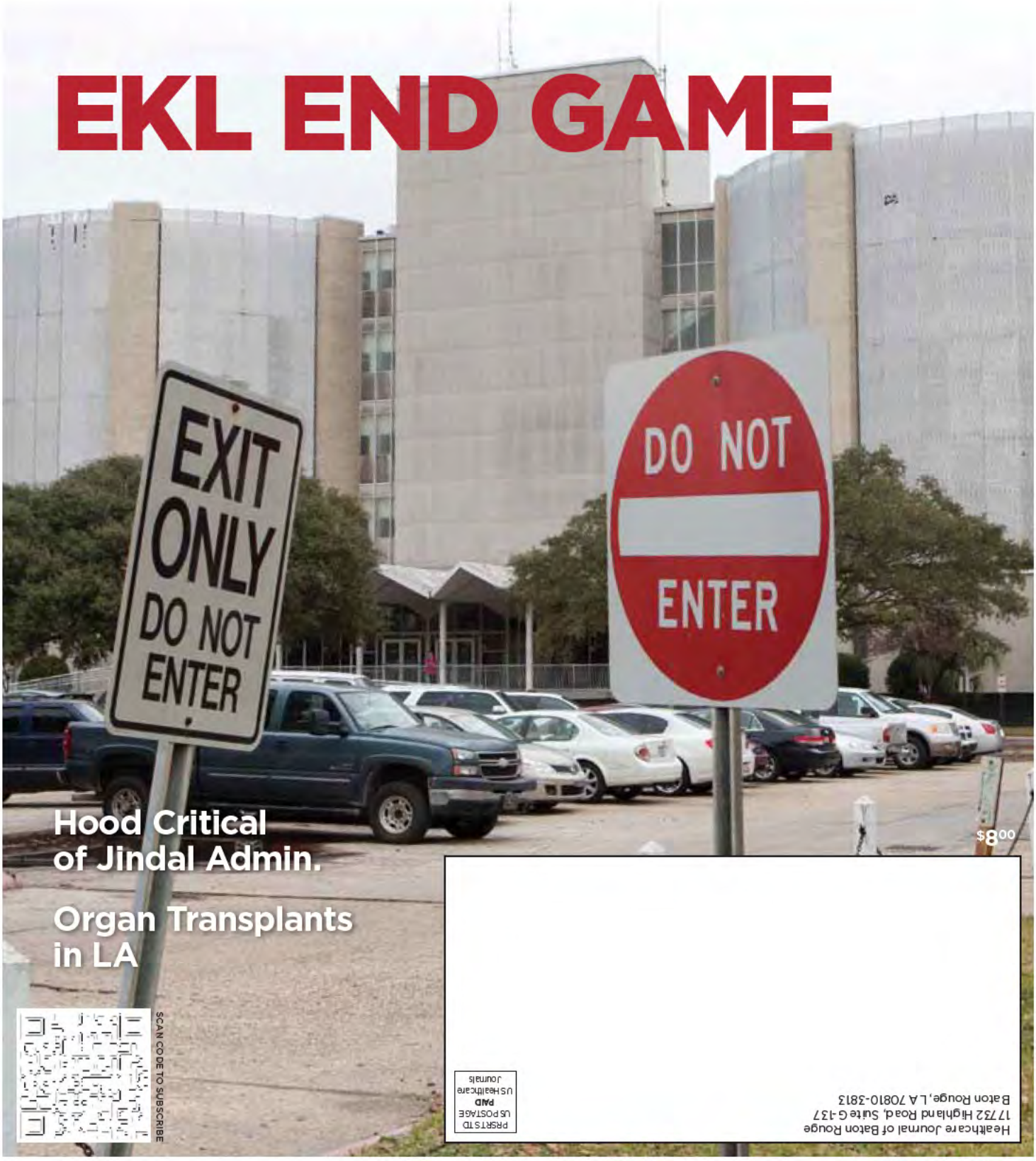

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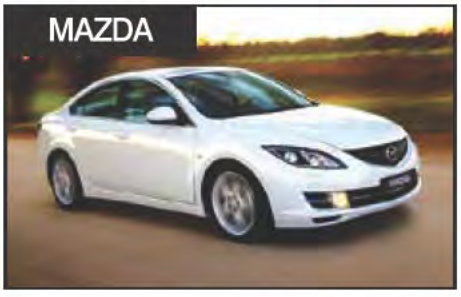

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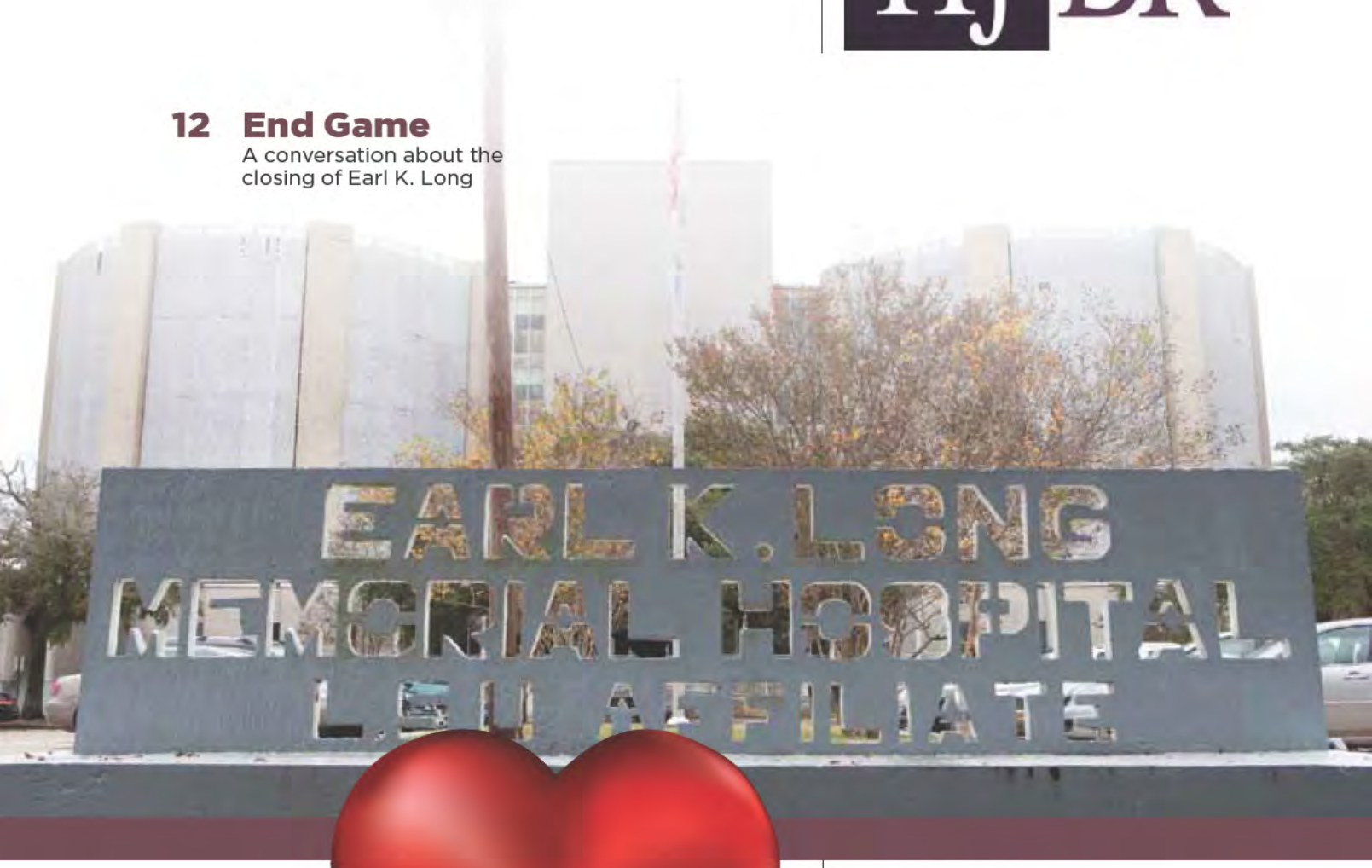
TABLE OF CONTENTS

JANUARY / FEBRUARY 2013

HJ BR



COVER & CONTENTS PHOTOS BY MELISSA CANNON

Departments

Correspondents

> It is our choices...that show what we truly are, far more than our abilities.
>
> — J.K. Rowling, Harry Potter and The Chamber of Secrets, 1999

ONE OF THE SIGNIFICANT REASONS I CHOSE HEALTHCARE AS an industry was because of the complexity of the issues. Problems and challenges don't boil down to simply selling the most widgets with the lowest possible cost, although some suggest they should. Problems and challenges in healthcare include people and lives and decisions that represent our views of humanity. I've always found this balance to be intriguing.

That being said, I would briefly like to present just another point of view, which perhaps deserves a bit more attention within this healthcare balance. I would like to consider personal decisions toward health and our environment.

Let's face it. We all make choices that impede good health. Take, for example, food. We eat chemically processed food. Have you read lately the chemicals listed as ingredients in the products we call food? I bet there are fewer than 1000 people in the world who can understand the exact nature of these chemicals. As a random example, we can consume apple flavored cereals, muffins, or chew apple gum and all the while have no real apple in the product. There is a picture of an apple on the products, but we are usually just eating some manufactured concoction, created with odd chemicals in a refinery or lab, which can somewhat replicate to our brains the sensation of an apple. We, perhaps unconsciously, approve that the apple flavor is a close enough reflection of an apple to accept it as good food. But, it may as well just taste like sulfur or plastic to better reflect its actual nutritional value.

We know exercise is good for us. We know that certain fruits, vegetables, and grains are significantly better for our bodies than deep-fried chicken products with Texas toast. We know stress is harmful. We know a clean and beautiful environment is better. We know treating each other fairly and compassionately is ideal. We know we can live differently. But, we choose not to exercise our bodies. We choose chemically produced and processed food products. We choose to be stressed. We choose a degree of unclean and unattractive environments. We choose to be mean and unfair to each other.

We may not like to read or hear these things. Or, we may pretend our excuses are adequate. But, the truth is that we, as individuals and communities, can choose at any time to live differently. Let's don't blame governments or corporations. We, as people, have choices. Either we are unaware that we have choices, or we are completely content with the decisions we have made.

As citizens of Louisiana, we can decide at any moment to complement our place in the world as a "place for fabulous food" with fields of fruit trees and farms of exquisite organic vegetables, water which is close to pure, and beauty in our design. Some say this is too expensive to do. Some say we need to boost the economy. I say these two groups should get together because it sounds like a perfect match for brainstorming. We just have to want to do it.

I met a man who said he would gladly trade 20 years of his life to eat and drink as he saw fit. I simply congratulated him on making a rational, conscious choice. I just wonder if we are all as aware of our choices and the power of our choices.

Smith W. Hartley
Chief Editor

END GAME

A CONVERSATION ABOUT THE CLOSING OF EARL K. LONG

with KEVIN REED, MD,
Associate Dean and Medical Director
of LSU Health Baton Rouge

PHOTO COURTESY OF LSUHCSD

PHOTO COURTESY OF LSUHCSD

Short on style, but never substance, **LSU's Earl K. Long Medical Center**

has been a fixture in North Baton Rouge for almost 45 years. Countless patients have come through the doors and hundreds of local doctors either first got their feet wet at EKL or put time in there training our future providers. However, an aging physical plant, budget cuts, and a cooperative endeavor agreement with Our Lady of the Lake Regional Medical Center will bring that era to an end in November. We sat down with EKL's Medical Director to discuss the path to closure, the transition of services, and what that means to both healthcare in this area and the future of graduate medical education (GME) in Baton Rouge. ➡




SMITH W. HARTLEY, CHIEF EDITOR **Dr. Reed, can we start by defining exactly what your role is?**

DR. REED My role, which was created about six years ago, is kind of a dual role between the hospital and the school. I serve as medical director for Earl K. Long, which is sort of the liaison between the hospital and our medical staff. But since the school is integrated, I also have the role of associate dean for Baton Rouge affairs. So that's the graduate medical education (GME) programs for Baton Rouge, both the programs that are based here and the programs that rotate here, because a lot of the New Orleans-based programs rotate through Earl K. Long and our clinics.

EDITOR **And you are also a practicing physician?**

DR. REED I am. I do pulmonary and critical care. I've been here 15 years in the Internal Medicine department. We have a group that does critical care for Earl K. Long and we also run the ICU for the Baton Rouge General. So our group stays busy.

EDITOR **Can you explain from your point of view why we are in this situation, why Earl K. Long is closing and moving its services?**

DR. REED From a historical perspective our path to closure and to public/private partnership has really been going on for some time. A cooperative endeavor agreement (CEA) was signed over two years ago, but really discussions began post-Katrina, when all the GME was relocated around the state. At that point in time the discussions were always about whether there should be a university hospital in Baton Rouge or whether there was some other arrangement that could be made. This predated me in my role, but there were a lot of discussions with Our Lady of the Lake (OLOL) and other parties in the city to establish the public/private partnership.

The CEA, which often gets referenced as a public/private document between LSU, the Louisiana Department of Health and Hospitals, and OLOL, really set us on the path to our public/private relationship. For the last two years, we've known Earl K. Long was going to phase out as an inpatient facility and we were going to move into OLOL as a training ground for inpatient. The predominant portion of the outpatient, which is where a lot of the training is, would stay under the LSU umbrella, because we have satellite clinics around.

I wasn't privy to a lot of the early discussions, but I think lots of people can look around and see that the public hospitals, Earl K. Long being the one that I am most closely aligned with, have not been, from a capital outlay and support stance, supported that well. So the physical plant has been less than desirable over the years. For example, we still have a ward system when most places don't. So I think there were lots of issues, lots of forces at play that said this was maybe an opportunity to, rather than build a new facility, establish the public/private relationship.

For us, over the last couple of years, it's something we've been working toward, we've been planning. Since I've been in my role we've been planning and doing a lot of legwork for that transition.

EDITOR **Can you characterize Earl K. Long's current status?**

DR. REED From a clinical perspective we've gotten smaller, partially due to programs moving out and partially due to budget constraints. For example, we did have a non-GME pediatric service that we no longer have. On the inpatient side it was the loss of a NICU that was sort of tied to our OB program, and on the

A SNAPSHOT

EKL TRANSITION

EKL is planning for the November 2013 transition of inpatient services to OLOL, at which time LSU Health Baton Rouge will continue to provide outpatient surgical and clinical care.

Renovations are underway at the LSU Surgical Facility for a transition of outpatient perioperative services to relocate from EKL in the spring of 2013; this will include four Operating Suites and two Endoscopy Suites, along with Diagnostic and Imaging Services, and selected clinic and ancillary services. Master Facility Planning for the campus is scheduled for next year, to include the further development of the Medical Office Building for General Surgery, Surgical Specialty (ENT, Ophthalmology, Orthopedics), and Oral Maxillofacial Surgery, as well as a Pain Management and Physical Therapy Center.

The North Baton Rouge Clinic is the future home of the Urgent Care Clinic, with a spring 2013 completion date.

Currently consolidated on the campus of EKL are all inpatient care operations, Emergency Room, the Mental Health Emergency Room Extension, Intensive Care Unit, all perioperative (inpatient and outpatient surgeries and special procedures), inpatient physical therapy, and the hub of pathology, diagnostic imaging, dietary services, respiratory, and pharmacy.

Clinics currently housed on the campus of EKL include Medicine, Medicine Subspecialty, Surgery, OMFS, and Surgical Subspecialty. EKL also operates outpatient services at North Baton Rouge Clinic, Mid City Clinic, South Baton Rouge Clinic, and the LSU Surgical Facility on Perkins (Ophthalmology, Dermatology, Dentistry). The LSU OB/GYN Clinic has relocated to the new Woman's Pavilion at Woman's Hospital.

Underway is the implementation of an Electronic Health Record for an outpatient health system, and two pending applications for NCQA Medical Homes. EKL currently operates two existing NCQA approved Medical Homes, and works hand-in-glove with system Health Care Effectiveness and Clinical Leadership in an extensive care management model for reducing the cost and impact of illness and injury, and to promote the management of health for the right care, in the right setting, at the right time.

outpatient side it was a clinic. So from a facility standpoint we got smaller. Another inpatient service that we no longer have here, because we transitioned to a private partner, was our OB program. Our program for obstetrics and gynecology actually transitioned out over about a year and is almost totally at Woman's Hospital now. The only portion that remains here on the campus at Earl K. Long is outpatient GYN surgery. Our clinics operate out at Woman's as LSU Health Clinics.

So over the last years we've gotten smaller and our inpatient size has gotten smaller. I think that's the trend in healthcare because lots of things are done in outpatient now, lengths of stay are shorter. But our census has gone down and we have to monitor it for a number of reasons. The number one reason is we have a hospital to run so we are always watching it, but the other is we can't get below a certain threshold because we have programs within this facility that depend on a volume of business coming through. The gateway into our facility is an emergency department, which trains our emergency medicine residents, and we need to keep the volume. We've been very innovative about doing more with less. So despite reductions in beds and other things we've kept the volume pretty constant. We see between 40,000 and 50,000 patients in the ED and continue to work towards those goals.

On the inpatient side we have Medicine, which is a home-based program and we have a lot of rotational programs with surgery and others. So despite the reductions here we've managed to get a lot of people through the hospital and take care of a lot of patients. We've just gotten smaller and the programs have remained. At the same time we have done a lot of work on our outpatient operations.

EDITOR That was my next question. What is the outpatient equivalent healthcare or replacement for the services that were or are being provided here?

DR. REED We still have our same outpatient service. It is smaller, partly from funding, partly through staff attrition. It's difficult to recruit staff into a place that is perceived to be, and in some cases is, unstable. There's a lot of uncertainty. But through all this transition and all the things that have happened we've done a very good job in our disease management programs, in our outpatient clinics. The one thing that LSU and our staff has gotten very, very good at in all the years I have been here, is we have always faced cuts, perhaps not this big, but we are very adept at doing more with less. So despite all those things we have great outcomes in a lot of our disease management programs. We look at common diseases that we see in our patient population and we try to case manage them and population manage them so that we get good

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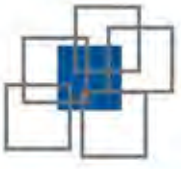

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> The gateway into our facility is an emergency department, which trains our emergency medicine residents, and we need to keep the volume. We've been very innovative about **doing more with less.**

results with those patients and they live healthier, they're in the ED less, and it costs less. With things like heart failure, diabetes, asthma, and HIV care our numbers are outstanding.

EDITOR **What's the status of the outpatient clinics now?**

DR. REED We're still operating under LSU and we still have our primary care clinics. We have multiple satellites around the city. We still have some specialty care clinics in Medicine that are operational. And we have Surgery and some surgical subspecialty clinics that are still operational and attached to GME. One of the concerns with the current cuts is that some of those services are phased to go away. Things like oral maxillofacial surgery, which serves a big population. ENT and Urology will no longer be here. And some of the others have been reduced because of staffing, and we are fighting to try and keep those intact.

EDITOR **In terms of staffing, has much of it moved over, are they going to be relocated somewhere else, or are there going to be people that are losing jobs?**

DR. REED Obviously there is staff that will be part of the layoffs–people that are not going to have jobs. I don't have that number yet. We tried to focus most of our reductions on the inpatient side because that's where we were going away. And we tried to limit what we were cutting on the outpatient side because that was our future. With the cuts there has been some spillover into the outpatient side. There's a layoff that's looming and people know that so there's a percentage of people that will not work. A lot of thought in that two year planning was that we knew the inpatient side was closing and we were looking for opportunities elsewhere. Part of the overall plan is that some will move into outpatient and we've been working with the Lake about maybe increased jobs on that end.

EDITOR **What about the building itself and the equipment? Is it being sold off, moved?**

DR. REED The building is a state building, so I guess there's a process as to what happens physically with the building. We haven't heard. The equipment that is needed for outpatient operations can be moved, so the surgical equipment that's in the OR here could be moved to the surgical facility out on Perkins Road and be utilized. We've done that through the years that I've been here; we've moved things back and forth as we needed to. Some of the equipment is at its end of life so we are assessing all that to see whether that moves or not. The stuff that is feasible to move we'll look to see whether we have the opportunity to move it to one of our outpatient clinics or the outpatient surgical facility.

EDITOR **As far as services to this area, the outpatient is probably now enhanced, but what is the understanding as far as the emergency care now that this emergency department will be closing?**

DR. REED I can tell you what the plan is. A large percentage of our emergency room visits are levels that could be handled in an urgent care clinic. So as part of the cooperative endeavor agreement we had always planned that LSU and the state would build an urgent care clinic and that would take that large part of the volume. Those cases could still be seen here, less than a mile up Airline Highway next to the North Baton Rouge Clinic. They've already started to work on the urgent care clinic. The more

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ABOVE A rendering of the LSU medical education building on the OLOL campus.

RIGHT A look at OLOL's ED expansion.

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emergent needs obviously won't be taken care of in the urgent care clinic and they are going to be handled in the EDs elsewhere. The Lake is expanding its ED to meet that need and we're transitioning our ED program over there.

EDITOR What about the prison services? Has that been fleshed out?

DR. REED As it stands now we handle them the way we've been handling them; nothing's really changed. We have made some fundamental changes to try to be more efficient. We do a lot of telemedicine, which has really helped us with our clinic wait times and helped the prison because of transport issues. And the prisoners get their care where the services are available in our LSU system. A lot of it is in New Orleans, but we still get a fair amount of it because of proximity; we're the closest. We still have some inpatient. The long term part of it has not been answered yet.

EDITOR What's the future of graduate medical education here with all that's going on?

DR. REED Everyone is waiting to see where everything goes because we're linked all over. We have four programs that are based in Baton Rouge. Three are sponsored by Earl K. Long—the Internal Medicine program, the Emergency Medicine program, and the OB program. Then we started a new Psychiatry program as part of the cooperative endeavor with the Lake. That is an LSU-sponsored program that is based at Our Lady of the Lake. So we are obviously looking out for those. Then we have a lot of programs that rotate up here—General Surgery, Orthopedics, ENT, OMFS, Dermatology, Ophthalmology, etc., and for a lot of those programs a significant volume of their training is done in Baton Rouge. So we are planning very carefully for the future for all of those.

OB is the simpler one to discuss because that's the one that's furthest along. We knew that OB was not going to move over to the Lake because they don't provide those services. So we had discussions with and transitioned the program into Woman's Hospital and have been successful with it. There were a lot of reasons for the transition besides the impending closure. We had to look at a partner because the number of deliveries at EKL had gone down so low they had fallen below the threshold of patient encounters that we needed for the residents. That transition has really helped the program. From that standpoint their numbers are up and they're doing well.

With the other programs, Internal Medicine and Emergency Medicine that are based here, we've got some long-standing discussions with the Lake and have really been working on our transition plan. It is always better for us if we move our programs almost totally at one time because there's a near learning phenomenon. If you separate the residents too much and they don't see each other that much they miss the opportunity to learn from each other. They are more likely to ask questions of someone a year ahead of them than someone like me that's 15 or 20 years ahead of them. So we've planned

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LSU GME

With an approved expenditure authority of $121M (down from FY 2012 of $154M), and filled FTEs of 832 (down from 1,054 in January), EKL is the Baton Rouge home base for LSU Graduate Medical Education serving our community. LSU Graduate Medical Education of 192 residents training in Baton Rouge includes both Baton Rouge based programs and New Orleans GME rotations.

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- Internal Medicine.....40 MDs + Faculty
- OB/GYN.....16 MDs + Faculty

NEW ORLEANS GME ROTATIONS.....91 MDs + Faculty

- General Surgery, ENT, Ophthalmology, Orthopedics, OMFS, Dermatology

purposefully over the past two years about taking our Internal Medicine and Emergency Medicine programs over there. The leaderships of both programs have had discussions with the Lake and we're working on those.

We realized early on in this process that even under the best of circumstances, with that November 2013 timeline that was set for us, as you got closer and closer to the closure of this facility there may be attrition, there may be issues that come up. So we always have contingency plans in case we have to transition things earlier. We've established rotations for the Internal Medicine and Emergency Medicine programs at the Lake and have been successful. We will continue to do so to see if we need to try to grow those in transition.

The concern is the pace because now it has really picked up. There's a challenge to make sure all the infrastructure there is ready and to make sure the residents don't lose their experience in that transition. They have a 36-month training period for the programs we have, EM and IM. When you start having months that are not as good it's a portion of their training that we have to be careful about. The lucky part for me is we have great program leadership that watches and monitors and makes sure the residents are getting their experience. That's our job.

We're doing the same thing for all the other rotational programs, too. The ones that have big presences in Baton Rouge and some of the ones that have smaller presences. We realize that now there's lots of movement around the whole system and we're working with the Lake and others to make sure that those programs like General Surgery and ENT and Ortho still get the experience they need in Baton Rouge. The OLOL leadership and medical staff have been very helpful in this process.

Our programs in Baton Rouge also do a large part of the medical student training for the Health Sciences Center in New Orleans. We see a lot of the third year students and a large portion of the fourth year students. Third year students have a curriculum that rotates them through here and fourth year students usually do electives or some other required things up here. A large part of the medical education program is done by the faculty at EKL so as we make all our decisions about GME we also take into account the medical students. We've got to take care of the students because they are our future. A lot of our programs recruit from the School of Medicine.

EDITOR What will that integration at the Lake be like in terms of medical records, administration, etc.?

DR. REED I think there is still a lot of fluidity about how it looks overall. What the plan has always been is that this is not a hospital within a hospital. We are moving our inpatient into the Lake, into the Lake's beds. The analogy is we have LSU patients that we've cared for through our clinics just like the Baton Rouge Clinic and other groups have them. So when they come into the ED they will be identified as an LSU patient and be admitted to the appropriate LSU service. The CEA was crafted not based on uninsured or insured, but assigned and unassigned. So our patients will be assigned, not unlike any other group's patients. There are a large number of unassigned patients, and in that unassigned group there are insured and uninsured. So those unassigned will be handled just like they would be today at the Lake.

EDITOR So it won't affect bed placement or anything? It's all integrated?

DR. REED Yes. In fact the Lake often admits by service so there may be a Cardiology area, a Neurology area, and LSU admits to a General Medicine service. We've worked with the Lake to sort of craft that. If a patient comes in that's got a cardiology program they can still be admitted to our General Medicine service and we can

EKL By The Numbers

ANNUAL VOLUMES

(reflecting compression from March 2012 reductions)

Admissions	3,457
CMI Weighted Adjusted Daily Census *(equivalent daily occupancy of inpatient and outpatient, weighted for severity)*	232
Surgeries *(of which 2,322 were outpatient)*	3,769
Endoscopy Procedures	2,903
Emergency Encounters *(post mid-year bed reductions, we are seeing 1,000 less patients per month in the ED; demand for 33 beds, operating 17)*	45,907
Clinic Encounters	156,000
Pharmacy Prescriptions *(eliminated outpatient Medicaid service; does not reflect inpatient pharmacy)*	126,000
Imaging Procedures	90,000
Pathology Tests	700,000
EIC Clinic Care Management	1,400 patients

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consult cardiology when needed, because that's part of the experience that the residents need–to take care of the patient and be the decision-maker and decide where the patient gets admitted, who to consult. That's part of the training we want to preserve.

EDITOR **So are we on track?**

DR. REED We are. Once again I think the pace is what's the most concerning, I think for us and for the Lake, because of capacity. So those are the things we are trying to work out.

EDITOR **What are some of the benefits or positives of this transition?**

DR. REED At EKL, we've always had some limitations in services and specialties and certainly physical plant, not only on the inpatient side, but for our faculty. Medical education is changing both for the student and the resident. Because of duty restrictions there's less patient contact time. They are looking at new ways of educating residents and students. You have to have simulation that takes place outside the hospital setting. So the CEA was crafted in such a way that there are a lot of benefits that we get from the expansion of the Lake. In old areas they have actually retrofitted GME space, created areas to round and conference. Then in the new construction of the East Tower there are more GME spaces. Some of us have had experience having a public service at a private hospital and we realize there are things that need to be done differently. For instance, the residents and the students who tend to be slower than the private faculty need to have their space. So the new East Tower has new rounding space.

Another positive is that the ED is going to be a Level I trauma center. Level I is a designation that is determined by research. I think the collaboration will bring everyone together to foster research to be a Level I trauma center, which is certainly needed in Baton Rouge with the intersection of two interstates.

The medical education building is a block off campus. It's a four-story 45,000 square foot building. Over the years we have been marginalized by geography, and nobody really knows a lot about what happens with the education programs. We've actually done a good job with the educational programs so that first floor is going to be a meeting space that ties in our programs with the community docs, many of whom trained here or trained with LSU. There's going to be a conference room that we can use and share, a library, a common area where we can meet.

The second floor is dedicated to Simulation and Innovation. You have to realize what your strengths are and out here we have never been able to do a lot of research, although we've done some, but what we've done really well is education. So on that second floor, in addition to having simulation, where we can model cardiac arrest or shock, we are actually tying that simulation into the OR so that students can be remote, seeing a case, talking to the faculty; they don't have to be in the room. That serves a lot of purpose because infection control dictates how many people can be in the OR, and there are time constraints for the residents and students.

With the innovation we are looking at educational based research. We have a few faculty members for whom that's their career path–exploring how to train residents and students side by side, how do you train in a multidisciplinary approach? So we are going to be on the Lake's campus with the Lake's college, the nursing school, all those others, and we can bring them all together so we have multidisciplinary education.

You know Pennington is also right there. We've all existed in the same community, but never really worked together. This gives us an opportunity to be in the same geographic region. So the research and the translational research is one of the big things–being able to take the research from bench to bedside. I think the building and that second floor offers facilities for a lot of that.

The third and fourth floor will be traditional offices. We've recruited kids to come and train with us with offices that are probably seven by eight feet in a temporary 40-year-old building so I think that will be nice. It will give us the opportunity to continue to recruit our students from LSU, but maybe even expand our borders a little bit.

As part of the CEA, we are also going to have a clinic next door to the Lake that's going to house our Medicine clinics and our Medicine subspecialty clinics. And as part of this and the growth with the urgent care, the surgical facility is going to be the hub for our surgical services. So there are a lot of good things happening in the midst of all this stuff. We've got to keep pushing those positives.

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ORGAN DONATION AND TRANSPLANTATION IN LOUISIANA

BY KAREN STASSI

On a trip to renew my Louisiana driver's license a few years ago, the lady behind the counter asked me if I would like to be an organ donor. Thinking myself relatively savvy on the subject (I have since learned otherwise), I answered, "Yes" without hesitation. She looked up from the paperwork surprised. "You are my first in a long time," she said. "Not only do most people not understand the question, but when I explain it, they usually still say, 'No'." ➡

After my initial disappointment in my fellow man, I remember thinking that perhaps the Department of Motor Vehicles, known for long lines, lackluster service, and impatient customers, was not the best place to approach people about such an important issue. However, since a driver's license is the only identification most of us carry and the DMV database is so extensive, I understand why it makes sense as a tool for registering and tracking donors.

There has, in fact, been a concerted effort in our state to increase awareness about organ donation so those conversations and decisions can properly occur before a trip to the DMV or, worse, the hospital. And it is working. With apologies to my fellow Louisianans for doubting them in the DMV, I am happy to report that the percentage of Louisiana adults that are registered as organ donors, as well as the per capita number of actual donors, far outstrips rates in most of the country and indeed the world. Louisiana's rate of approximately 35 deceased donors per million population is similar to Spain, which boasts the highest rate of any country in the world.

Credit is largely due to the collaborative efforts of the Donate Life Louisiana partners. In 2006, the Louisiana Organ Procurement Agency (LOPA) and Legacy Donor Foundation partnered with the Department of Motor Vehicles, the Louisiana Hospital Association (LHA), the National Kidney Foundation, and several eye banks and transplant hospitals to increase the donor registry. The Donate Life Louisiana (DLL) state team recently received a silver medal from Donate Life America in recognition of its achievements in increasing the number of registered organ, eye, and tissue donors who save and heal lives. The team was recognized for having 58 percent of all state residents age 18 and older registered as donors; 52 percent of organ and tissue donors registered at their time of death; and a 56 percent Donor Designation rate.

"We are blessed with a population that wants to give, wants to make sure their organs are donated."

In 2008, LHA and hospitals throughout the state launched the Donate Life Louisiana Hospital Campaign to help educate and register hospital employees and people in the community. The campaign was so successful that it is now the national model for hospital donor registry drives. Since 2006, Donate Life Louisiana has added more than 650,000 new individuals to the registry. Their goal is to have 2.2 million registered donors by 2014 and they have already passed the two million mark. Last year, by November, 2012, 153 Louisiana donors had provided 515 organs for transplant.

"We are blessed with a population that wants to give, wants to make sure their organs are donated," said George Loss, Jr., MD, PhD, FACS, Chair of Surgery and former head of Ochsner's Multi-Organ Transplant Institute. "I think a lot of that is because there is such a need here. We are at the center of the U.S. in terms of the need for kidney transplantation. Our incidence of end stage kidney disease is probably as high as anywhere in the Mississippi Delta region, which is the area with the highest incidence of renal failure in the country. So we need organs and because we have that need it touches a lot of people's lives, I guess. But they certainly are more willing to give and that's a great thing."

Transplantation Facts TOC

The Challenge

Before you feel too warm and fuzzy or think that we have the issue under control, however, there are more sobering statistics to consider. While organ donation has increased considerably in recent years, the demand still far exceeds the supply. According to the United Network for Organ Sharing (UNOS), on December 10, 2012, 116,658 men, women, and children were on the national transplant waiting list and every 10-12 minutes another person is added. In Louisiana about 1700 people are waiting for organ transplants, 90% of whom are waiting for kidneys. Across the country, nearly 20 people a day die unnecessarily because there are too few organ donors.

One of the problems, despite the growing number of registered donors, is few



FROM LEFT George Loss, Jr., MD, PhD, FACS, Chair of Surgery and former head of Ochsner's Multi-Organ Transplant Institute; Barry Marshall, MBA, FACHE, Director of Tulane's Abdominal Transplant Institute; and Joey Boudreaux, RN, BSN, CPTC, Clinical Director for LOPA.

people die in such a manner that allows their organs to be donated, pointed out Kirsten Heintz of LOPA. Other potential donors might never have registered or might have been willing to donate their organs, but never let their families know. That places families in the very difficult position of trying to decide what the patients' or their own wishes might be in the midst of the grieving process and frequently within a very limited time frame. Those decisions are often made more difficult by lingering myths or misunderstandings about organ donation, some of which we will try to clear up here. "The biggest thing we can do to improve transplantation in our state is for people to tell their loved ones what their wishes are," said Loss. "And to make sure you become a donor." It is also important to recognize that while both eye and tissue donations are an important part of the transplant world and occur regularly across our state, this article will focus primarily on major organ transplants such as heart, lung, liver, kidney, and pancreas.

According to Joey Boudreaux, RN, BSN, CPTC, Clinical Director for LOPA, in order for a donor's organs to be viable for transplant, the donor must die in a very specific way, i.e. through brain death (usually due to head trauma or hemorrhagic stroke), in a hospital, on a ventilator. Ideally they should be fairly healthy at the time. As you can imagine, the vast majority of registered organ donors do not die in this manner and their organs cannot be "recovered"–a more sensitive term that is now used in the transplant community instead of "harvested." Another challenge is that the population in Louisiana has a higher incidence of comorbidities such as high blood pressure, obesity, kidney disease, etc., than the rest of the country, which can affect the viability of their organs. "When we evaluate a patient for donation there's usually some chronic issues that are involved," said Boudreaux. The presence of certain diseases or infections may also make organ donation impossible.

The Process

In the cases where a patient might indeed be a viable donor, the process begins with the realization by the medical staff that brain death has occurred or is imminent. The hospital notifies LOPA that there is the potential that the patient is a candidate for organ donation. Often, says Boudreaux, that's the last they hear, either because the patient is saved or is not a good candidate for donation, but it gives him an opportunity to make sure he has staff on hand to talk to the patient's family should the patient die. If brain death does indeed occur, after the family has had some time to assimilate the news, a LOPA staff member will be assigned to not only talk with them about organ donation, but to also assist them with anything they might need in that difficult time, such as answering questions, helping to contact family members, etc. If consent is received, the process of maintaining and optimizing the patient's organs and trying to find matches for those organs begins in earnest.

The United Network for Organ Sharing administers the national Organ Procurement and Transplantation Network (OPTN) which links the 58 organ procurement organizations across the country. When a potential donor is identified, their data is entered into the UNOS electronic system, which identifies potential matches based on a multitude of factors including blood type, tissue type, organ size, medical urgency, time on the waiting list, etc. One of the key factors is proximity. Because major organs only remain viable for a limited period of time, UNOS tries to match recipients that are in the same immediate area, but the search can also be extended to the surrounding UNOS Region 3, which

Louisiana TRANSPLANT CENTERS

Ochsner Multi-Organ Transplant Institute at Ochsner Medical Center - New Orleans ADULT AND PEDIATRIC HEART, LUNG, KIDNEY, LIVER, PANCREAS

Tulane Transplant Institute at Tulane Medical Center - New Orleans ADULT AND PEDIATRIC LIVER, KIDNEY, PANCREAS

Children's Hospital New Orleans - New Orleans PEDIATRIC KIDNEY

Willis-Knighton/ LSUHSC Regional Transplant Center - Shreveport KIDNEY, LIVER, PANCREAS

NOTE: None of the Louisiana transplant centers currently perform intestine transplants.

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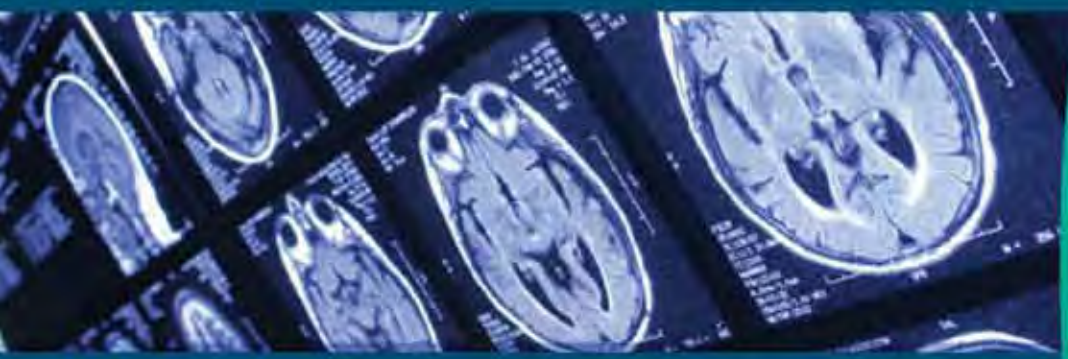

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"So by the time we are getting involved we often have kidneys that are injured and lungs that are oxygenating very poorly. That's where we get really aggressive on our treatment protocols."

is roughly the SEC plus Puerto Rico, and in very rare cases to points beyond. In 2010 about 75% of organs donated in Louisiana stayed in the state.

There are also different eligibility factors and scoring depending on the required organ. For example, for the liver it's a MELD (model for end-stage liver disease) score. The sicker the patient is, the higher they move on the list. For kidneys, selection depends more heavily on how long the recipient has been waiting. Size of the organ is also a consideration, especially if the donor or recipient is a child. Blood type matching and further testing at the antigen level are done to see what the likelihood of that person's body accepting the organ is going to be. Sometimes if a patient's death is imminent (48-72 hours) without a transplant, that will override some of the other considerations and jump them higher on the list. However, contrary to popular opinion, gender, ethnicity, religion, wealth and/or celebrity status are not considered by the computer matching system.

When a potential match is found an offer is made, usually with a backup candidate in hand. Even then the organ may not be accepted. The transplant surgeon may not like the history of the donor and have concerns about the viability of the organ. Or, explained Barry Marshall, MBA, FACHE, Director of Tulane's Abdominal Transplant Institute, the recipient patient may not be strong enough for the surgery at that given time or may not be able to get to the transplant center in time. "Even if your patient is first on the list, how are they healthwise at that particular moment in time? Are they well enough to accept an organ and have a good outcome? Or does that offer need to go to the next highest person on the list or another center?" If an organ is refused it is offered to the next person on the UNOS list and so on. As you can imagine, it is a complex, time-consuming process. "As these decisions are being made, the ischemic time increases and as that happens the more likely it is to have a less than perfect outcome. It's a continual game of beat the clock," added Marshall.

While all this is occurring, the donor is kept on the ventilator and tests are run to make sure they don't have any communicable diseases. This is especially important because organ recipients are going to be immunosuppressed, often for the rest of their lives. Interestingly, the presence of certain conditions, such as Hepatitis B or C, does not rule out a potential donor, but that information must be known so that the recipient and his/her doctor can make an informed decision about whether they want to accept it or not.

There are also steps that can be taken to optimize the organs while waiting for the transplantation, said Boudreaux, who credits some of these new practices for greatly enhancing the success and longevity of the transplanted organ. "With a brain injury oftentimes there is a cascading of events that cause some organ damage," said Boudreaux, "particularly to the lungs and kidneys." Diabetes insipidus is one of the body's automatic responses to severe brain injury. An enormous amount of urine is released in a short period of time, which can completely dehydrate the patient and cause acute renal failure and damage to the kidneys. Another problem actually stems from the tests conducted for brain death. In addition to attempting to stimulate each of 12 cranial nerves, physicians will conduct an apnea challenge, where they take a patient off the ventilator for ten minutes to see if they breathe spontaneously. Unfortunately, acute lung damage can occur during this test which can affect future lung function.

"So by the time we are getting involved

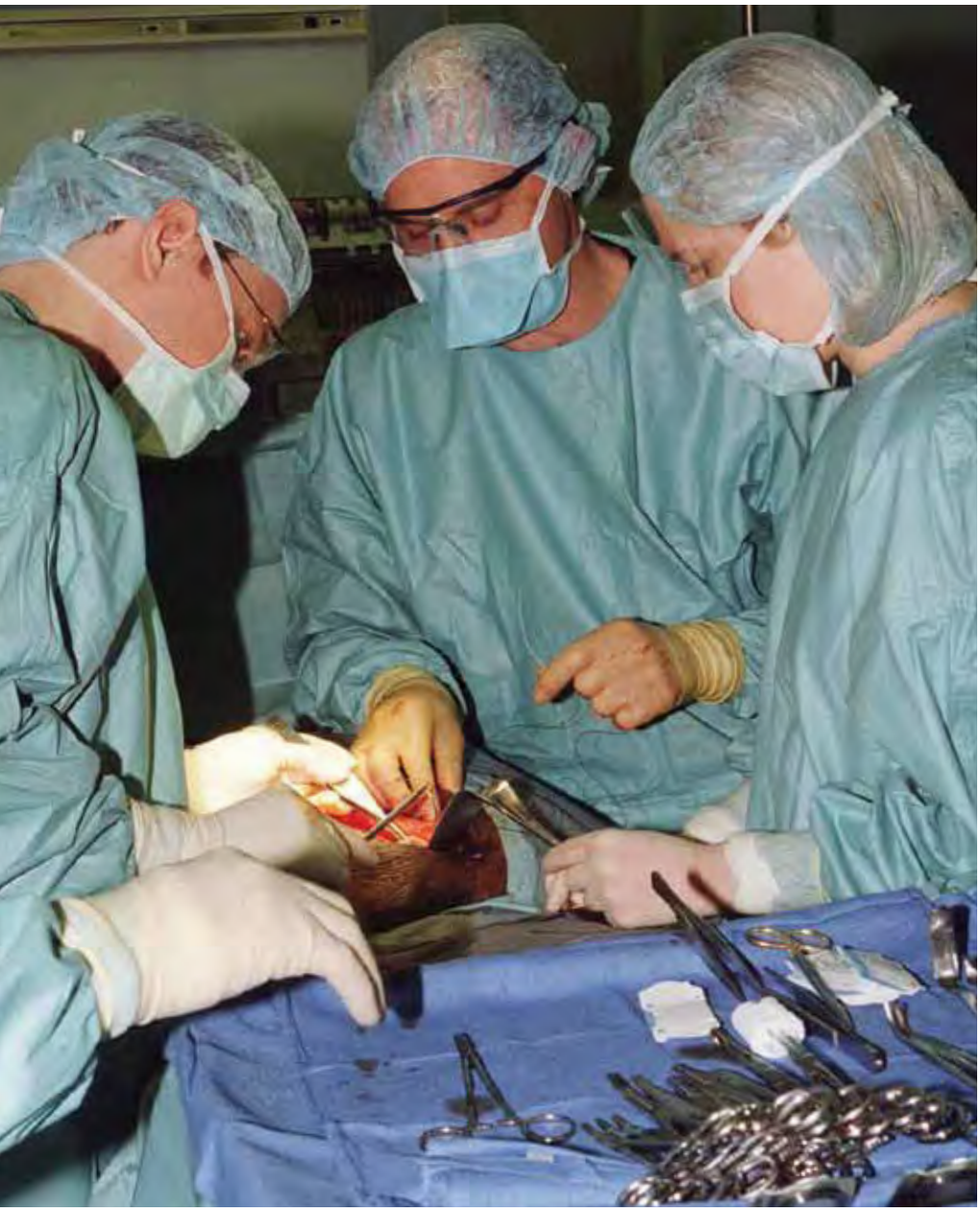
Transplant Milestones

1954 First successful **kidney** transplant

1967 First successful **liver** transplant

1968 First isolated **pancreas** transplant in U.S.

SOURCE: OPTN



we often have kidneys that are injured and lungs that are oxygenating very poorly," said Boudreaux. "That's where we get really aggressive on our treatment protocols." In the past, prior to 2009, the driving concept was to hurry up and get the patient to the operating room because the further they were removed from the time of death, the more the organs were injured. In 2009, LOPA shifted to a new strategy of reprofusing the organs (kidneys and lungs) and improving their function before going to the OR. In 2010, based on collaborative discussions with Ochsner's transplant team, the OPO switched to the San Antonio Lung Transplant (SALT) protocol. Basically it is a way to increase airway pressure without increasing the chance of acute lung injury from the ventilator. The patient is switched from volume control to pressure control. Higher pressure is applied for a couple of hours at a time then backed off for a couple of hours. Since switching to this protocol, Louisiana moved from the bottom 10 in the nation for the number of lungs they were able to transplant to second in the nation in 2011. "We realized they didn't have to get worse during the time after brain death–that we could actually improve the function," said Boudreaux. Now, the time of consent to time of OR is somewhere around 24 hours. "The first 8-10 is when we are aggressive on recruitment and maximizing organ function. Then from 10-18 hours we're

Tulane transplant surgeon Doug Slakey in the OR.

1968
First successful **heart** transplant in U.S.

1986
First successful **double lung** transplant

1987
First successful **intestine** transplant

2001
First time the no. of **living donors** (6528) **exceeded deceased donors** (6081)

focused on trying to find a good home for those organs."

The Transplant Team

Once an organ is accepted, a surgeon from the transplant center caring for the organ recipient will fly to the hospital where the donor was treated to recover the organ. It is a little known fact that transplants don't usually occur in the hospital where the donor patient was treated, unless that hospital happens to be a transplant center. This particular fact should dispel a lingering and misguided concern of hesitant donors that known donor status will prevent doctors from doing all they can to save one's life. There are, in fact, two distinct medical teams that do not even communicate until after death occurs. Besides, pointed out Boudreaux, the more that is done to save the patient's life, the better shape the organs will be in if that patient ultimately is declared brain dead. An informed medical team can make a huge difference if they remain vigilant about the health of organs even in a patient with a poor prognosis he explained.

In Louisiana there are just four transplant centers: Tulane Transplant Institute at Tulane Medical Center, the Ochsner Multi-Organ Transplant Institute at Ochsner Medical Center, and Children's Hospital New Orleans, all in New Orleans, and Willis-Knighton/LSU Health Sciences Center Regional Transplant Center in Shreveport. Doctors from those transplant centers and from others across the country, depending on where the donated organs will go, travel to the donor patient hospital to recover the organs and bring them back to the transplant patient. In the case of a multi-organ donor, there could be three to five different transplant surgeons in the OR. Because timeframes are important, most of the transportation of organs, and often surgeons, occurs via aircraft.

Building on Success

Success rates for organ transplantation have improved over the years. Obviously efforts to maintain and enhance organ function prior to transplantation have made a difference, but there has also been improvement in the development of anti-rejection medications required by organ recipients to maintain those organs. Jean Borel's discovery of an immunosuppressant called Cyclosporine in the mid-1970s revolutionized the field of transplantation, radically increasing survival rates and boosting the number of transplants being performed, but the field continues to develop. "The technology is ever evolving. Immunosuppressant protocols are ever evolving. The need for steroids, depending on the protocol, is dramatically decreased," said Marshall. "That is why the list continues to grow–because we have the technology and the capability to do really great things for these patients with very high quality outcomes."

LOPA's Heintz agreed. "It used to be that someone might have lived five more years," said Heintz. "Now you meet people all the time that got their transplant 20 or 25 years ago and they are still doing great. Transplantation has really come a long way and it really is a viable option for a lot more patients."

Marshall first began working in the transplant field 13 years ago and emphasized that organ transplants are a far more common and successful modality now. "The overall longevity of the organs and the quality outcomes for the patients are such that they can essentially, for all intents and purposes, get back to a complete and total quality of life, however they measure their quality of life. Depending on the organ type and patients' ability to tolerate the immunosuppression these organs can last 20-30 years."

It also comes down to better education and increased collaboration, said Boudreaux. "Everybody is getting more educated, not only from the community about being organ donors, but from the hospital standpoint, and of course the collaboration that occurs between us and the hospital staff and between us and the transplant physicians. It's just been on a much higher level and we are seeing increased success rates because of it."

Loss also attributes some of Ochsner's success to the dedication of LOPA and the willingness of the transplant team to consider organs that come from less than perfect scenarios. "Nationwide, if you have a 60-year-old donor who is hypertensive there's a six out of ten chance you'll get a

WAIT TIMES

ORGAN	MEDIAN NATIONAL WAIT TIME
Heart	113 Days
Lung	141 Days
Liver	361 Days
Kidney	1,219 Days
Pancreas	260 Days
Intestine	159 Days

NOTE: Factors such as numbers of registered donors and disease incidence in the region can affect wait times dramatically from state to state.

SOURCE: OPTN ANNUAL REPORT 2008

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LOPA'S SUCCESS

There are 58 organ procurement organizations (OPOs) including LOPA, across the 50 states, but there is no nationwide standard as to the protocols used to maintain organs prior to transplant. There is an effort to compare best practices and eliminate disparities, said Boudreaux, but LOPA's seem to be working. In 2011 the state organization was 6th out of 58 for the number of organs transplanted per donor.

YEAR	2008	2009	2010	2011
LOPA	2.9	3.21	3.25	3.57
U.S. Avg.	2.99	3.02	3.08	3.08

The number most often used by LOPA is the conversion rate, which is the number of actual donors divided by the number of eligible donors. From 2008 to 2011, LOPA has increased its conversion rate significantly.

YEAR	2008	2009	2010	2011
LOPA	55.7%	65.8%	82.6%	83.7%
U.S. Avg.	71%	73.7%	75.6%	76.7%

NOTE: OPTN defines an eligible death in their website's glossary at **http://optn.transplant.hrsa.gov/resources/glossary.asp#E**

liver out of that donor. For us it's eight out of ten. Our OPO is very good about looking at every single donor as a potential lifesaving event for somebody else and we at the transplant center are looking at every single donor despite the story that goes with that donor." Says Loss, just because a person died while driving drunk or was obese doesn't mean they have a bad liver. "I don't use bad livers, I just use good livers from donors with bad stories."

The Recipients

Transplant centers also help ensure successful transplants through an extensive screening or evaluation of potential recipients, who must be approved to be on a transplant center list. This evaluation is not just about their physical need for a new heart, kidney, lung, pancreas or liver. It also covers whether the patient is psychologically ready, if they have family or community support to maintain a healthy lifestyle, if they can afford the multiple medications they will likely require for the long term, etc. Both the evaluation and the management of that patient after the transplant therefore requires an entire team of experts, not just a transplant surgeon. For example, explained Marshall, some patients struggle with the guilt factor that someone else gave the gift of life to them so Tulane has a very strong psychosocial program to work with them. "They also end up on a lot of medications for a long period of time, which can be financially draining without education on what to expect," so a strong financial program is also necessary. "The viability of the organ is paramount," said Marshall, "We don't ever want a patient to be in the position of having to decide between paying rent or taking their medication." Loss also emphasized the importance of the team approach to not just achieve a good initial result, but long-term survival. "In the old days, you had a surgeon who was sort of a cowboy and worked alone. That's just not how healthcare works anymore. We work as groups of physicians, medical providers, nurses, pharmacists, nutritionists, social workers, financial counselors, all together as a patient-centered team providing care to help keep that patient going."

More and more transplant centers are looking at their patients as partners, too. "If you are going to use that organ you have to be very responsible with it," said Loss. "You have to make sure your results are good, and that the people you put them in are accountable and responsible." Although transplantation is becoming a

"We don't ever want a patient to be in the position of having to decide between paying rent or taking their medication."

Top **Ten Myths** About Organ Donation

Myth #10
Wealthy people and celebrities are moved to the top of the list faster than "regular" people.
Fact
The organ allocation and distribution system is blind to wealth or social status. The length of time it takes to receive a transplant is governed by many factors, including blood type, length of time on the waiting list, severity of illness, and other medical criteria. Factors such as race, gender, age, income or celebrity status are never considered when determining who receives an organ.

Myth #9
Donation will mutilate my body.
Fact
Donated organs are removed surgically, in a routine operation similar to gallbladder or appendix removal. Donation doesn't disfigure the body or change the way it looks in a casket.

Myth #8
My family will be charged for donating my organs.
Fact
Donation costs nothing to the donor's family or estate.

Myth #7
If I am in an accident and the hospital knows that I want to be a donor, the doctors will not try to save my life.
Fact
Organ and tissue recovery takes place only after all efforts to save your life have been exhausted and death has been legally declared. The medical team treating you is completely separate from the transplant team. The organ procurement organization (OPO) is not notified until all lifesaving efforts have failed and death has been determined. The OPO does not notify the transplant team until your family has consented to donation.

Myth #6
I am not the right age for donation.
Fact
Organs may be donated from newborns on up. The general age limit for tissue donation is 70. At the time of your death, the appropriate medical professionals will determine whether your organs are usable.

Myth #5
My religion does not support donation.
Fact
All mainstream organized religions approve of organ and tissue donation and consider it an act of charity.

Myth #4
Only heart, liver, and kidneys can be transplanted.
Fact
Needed organs include the heart, kidneys, pancreas, lungs, liver, and intestines. Tissue that can be donated include the eyes, skin, bone, heart valves, and tendons.

Myth #3
I have a history of medical illness. You would not want my organs or tissues.
Fact
At the time of death, the appropriate medical professionals will review your medical and social histories to determine whether or not you can be a donor. With recent advances in transplantation, many more people than ever before can be donors. It's best to sign a donor card and tell your family your wishes.

Myth #2
I don't need to tell my family that I want to be a donor because I have it written in my will.
Fact
By the time your will is read, it will be too late to recover your organs. Telling your family now that you want to be an organ and tissue donor is the best way to ensure that your wishes are carried out.

Myth #1
I've heard about a business traveler who is heavily drugged, then awakens to find he or she has had one kidney (or sometimes both) removed for a black market transplant.
Fact
This tale has been widely circulated over the Internet. There is absolutely no evidence of such activity ever occurring in the US or any other industrialized country. While the tale may sound credible, it has no basis in the reality of organ transplantation. Many people who hear the myth probably dismiss it, but it is possible that some believe it and decide against organ donation out of needless fear.

SOURCE: NATIONAL KIDNEY FOUNDATION OF LOUISIANA

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more and more viable option to end organ disease, the demand continues to grow. The waiting list for organs was about 70,000 a few years ago and now surpasses 115,000. Part of this is because we are not as healthy as we used to be, said Loss. "Renal failure, hypertension, diabetes, obesity–this is an epidemic in our country so the need for kidney transplantation is probably higher than it ever has been because the factors that determine end stage renal disease have increased." Marshall pointed out that there are far more kidney patients than liver patients so organ availability is an even bigger issue for them. "Here in Louisiana the wait time is longer for a kidney because of that fact," he added.

Obesity may be the single largest factor that will drive the need for organ transplants for the next fifteen years speculated Loss. For example, the most common reason for needing a liver transplant currently is a distant (sometimes 10-20 years old) and unknown viral infection of Hepatitis C, said Loss. "The new cases of Hepatitis C have gone way down because people are more educated. In the future the need for liver transplantation due to Hepatitis C is going to go decrease dramatically, but we're seeing that replaced by liver disease caused by obesity."

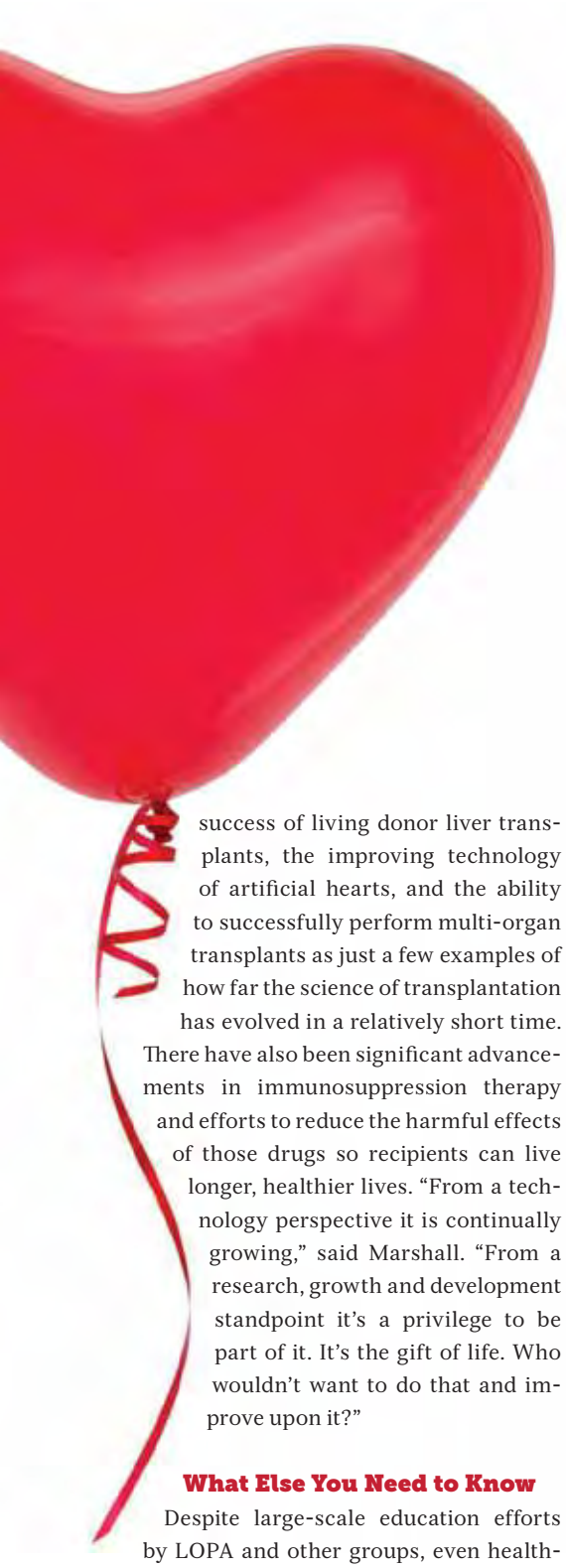
Innovation

Innovations in organ transplantation border on the realm of science fiction. At Ochsner's living donor kidney program, for example, the Da Vinci robot is being used for the nephrectomies. The surgeon works at a console and the robot arms use the implements to both remove and sew in kidneys. "You can magnify up to 30 times, there's no tremor, it's precise, you can literally split hairs," said Loss. Smaller incisions allow for less collateral damage, less pain after surgery, quicker recovery and fewer wound issues after transplant.

Researchers and transplant teams also continue to seek ways to improve the viability of, or somehow heal, organs that aren't currently usable so more donor organs can be utilized. The success and frequency of living donor transplants has increased substantially, but the real dream is to not need donated organs at all. While living donor liver and kidney programs have been successful, that's obviously not an option for heart patients. There have already been pioneering steps made towards cloning or growing new or replacement organs from cells or repopulating the matrix of an old organ with new cells that grow to create a functioning organ, said Loss. "This is not as science fiction as it sounds initially, but I think the future is going to be in regenerative medicine and trying to regenerate organs to either avoiding transplant altogether or creating new organs in the laboratory. That is really the neat stuff. It may not be in my lifetime, but long term that's the future." Marshall also pointed to the growing

DID YOU KNOW?

One organ donor can save up to nine lives and enhance the lives of 50 more through tissue donation.



success of living donor liver transplants, the improving technology of artificial hearts, and the ability to successfully perform multi-organ transplants as just a few examples of how far the science of transplantation has evolved in a relatively short time. There have also been significant advancements in immunosuppression therapy and efforts to reduce the harmful effects of those drugs so recipients can live longer, healthier lives. "From a technology perspective it is continually growing," said Marshall. "From a research, growth and development standpoint it's a privilege to be part of it. It's the gift of life. Who wouldn't want to do that and improve upon it?"

What Else You Need to Know

Despite large-scale education efforts by LOPA and other groups, even healthcare workers still share some of the same misconceptions about organ transplants said Heintz. This is unfortunate because healthcare providers, from emergency medical technicians to nurses, to primary care doctors, to surgeons, can all take steps to promote and ensure the success of organ donation. "We have accountability in the transplant world to ensure that when someone gives the gift of life that organ gets placed in a patient that has the best possible predicted outcome," said Marshall. He believes one of the key factors to success is to get patients evaluated as early as possible. He urges physicians to have their patients evaluated for a transplant even if it is only a remote possibility they might need one. In the case of kidney patients, being evaluated prior to starting dialysis can make an even bigger difference should they need a transplant down the road, he added.

Also vital is the need to understand and communicate to the family of a potential donor what donation means for the donor and recipient. "I wish people understood how important it is to the families," said Loss. "I think we understand when there's a loss, especially if a parent loses a child, how important it is to that parent that something good came out of that tragedy. That closure is so important for that family and as healthcare workers we often are so focused on saving the lives of our own patients that we don't think of families who are losing a loved one and what good can come of it." Usually donors and recipients are not in the same hospital and healthcare workers must take time away from their patients who are alive to help keep this patient who is brain dead, optimized. "A well treated donor is like a well treated patient. They take just as much effort," said Loss. "If they would know how important what they are doing is and how many lives they are changing, not just the lives of the recipients across the country who will get those organs, but also the lives of the family members who want some closure, for something good to come out of it."

For more about organ donation, please visit OPTN at optn.transplant.hrsa.org. If you are not already a donor, visit www.donatelifela.org and sign up today.

Approximate Ischemic Times

BLOOD FLOW TO BLOOD FLOW—MAJOR ORGANS

- Heart and Lung **4-6 hours**
- Liver - **8-12 hours**
- Kidney - **24 hours**
- Pancreas - **24 hours**
- Intestines - **24 hours**

SOURCES: Children's Hospital New Orleans, www.chnola.org/PageDisplay.asp?p1=4335; Donate Life America, donatelife.net; Louisiana Organ Procurement Agency (LOPA), www.lopa.org; Ochsner Multi-Organ Transplant Institute, http://www.ochsner.org/services/multi_organ_transplant/; Organ Procurement and Transplantation Network (OPTN) http://optn.transplant.hrsa.gov; Scientific Registry of Transplant Recipients, www.srtr.org; Tulane Transplant Institute, tulanehealthcare.com/our-services/transplant-institute/; Willis-Knighton/LSUHSC Regional Transplant Center, www.wkhs.com/Transplant/Home.aspx.

A NEW ERA for Safety-Net Care and Graduate Medical Education in Louisiana

December 10, 2012. This date will be remembered as a watershed moment for Louisiana's healthcare system. I wrote about this opportunity a few months ago as we grappled with the sudden loss of hundreds of millions of dollars in federal Medicaid financing.

We've known for years that the LSU Health System at it exists today is unsustainable. Louisiana is one of the last states with a large, publically owned and run charity hospital infrastructure. In fact, a 2005 report published by a leading private healthcare system in our state included an urgent call to action to address concerns the system was failing to keep pace with national trends in public healthcare and medical training. Specifically, it noted declining utilization, high uncompensated-care costs, high Medicaid reliance, and insignificant investment from local communities as worrisome variances from other successful models. Shortly after its publication, Hurricanes Katrina and Rita devastated our state, putting any plans for significant reform on hold as the state struggled with a monumental recovery effort.

Fast forward to this summer: faced with a new normal in terms of funding and under the visionary leadership of System President William Jenkins and Executive Vice President for Health Care and Medical Education Redesign Dr. Frank Opelka, LSU Health Care Services Division began aggressively pursuing new models to stave off a loss of critical services. Those efforts resulted in three historic events in three regions of the state in December to announce that agreements have been reached to form public-private partnerships involving three LSU hospitals. Interim LSU Hospital and its successor University Medical Center in New Orleans will partner with Louisiana Children's Medical Center; Leonard J. Chabert Hospital in Houma has reached agreements with Ochsner Health System and Terrebonne General Medical Center; and University Medical Center in Lafayette has formed a partnership with its neighbor,

Lafayette General Medical Center.

These agreements are tailored to the dynamics and needs of the individual community, and put local leaders at the helm of charting the course for their own healthcare markets. Most significantly, the private hospitals that are part of these emerging partnerships around the state are together making lease payments totaling $12.1 million to the LSU hospital system, allowing them to avoid immediate staff layoffs at the public hospitals, and maintain current services as these partnerships progress toward completion. As part of this agreement, the partner hospitals will lease the public hospitals' property, which has been operated by LSU, including both the hospitals themselves and their affiliated networks of outpatient clinics. This maintains the LSU hospitals as safety net providers in their regions, and allows patients to keep accessing care at the same location. Each of the partners will expand their roles in the clinical care, medical research, and education programs provided through the LSU hospitals. Over time, LSU employees will transition to employment by the partner hospital, which will use its expertise and management infrastructure to run the enterprise more efficiently and effectively.

What does this mean? It means that we are finally getting our state out of the business of running hospitals. Instead, we see our role as a purchaser of quality care, driven by our responsibility to be a good steward of public resources. These partnerships give us the opportunity to deliver high quality care to people who need it at a better value for taxpayers. It also means that those who have sought care from the LSU system in the past will become more integrated into the health system, with opportunities for improved access to specialty care and other services in the community. It also means that our medical residents will begin training in more modern settings with higher volume and more diverse patient case loads–enriching the educational experience. As Dr. Opelka has repeatedly said, we cannot keep training tomorrow's healthcare professionals in yesterday's system.

"...we are finally getting our state out of the business of running hospitals. Instead, we see our role as a purchaser of quality care, driven by our responsibility to be a good steward of public resources."

I also commend and thank the local healthcare leaders and members of each region's legislative delegation. Without their willingness to roll up their sleeves and broker these historic agreements, our recent announcements would not have been possible. To be sure, there is much work to be done yet. We continue to work in other communities to forge similar partnerships. And as LSU solidifies these agreements and makes decisions in the different communities, we'll work with them to finalize the terms of the financing arrangements, to create the best value for our taxpayers and ensure we are optimizing our use of federal Medicaid matching dollars. We'll work carefully to make this as seamless a transition for patients and employees as possible. But in the long run, this is the right move for LSU: their patients, their doctors, their students, and their future.

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

Briefs

STATE

OPH to Enhance Retail Food Inspections

In late December, Department of Health and Hospitals Office of Public Health Assistant Secretary J.T. Lane outlined the office's plan, in development since February 2012, to enact more robust, consistent health inspections of retail food establishments statewide.

Lane detailed the department's four-point improvement plan, which focuses on implementing new management tools statewide; centralizing and standardizing the inspection process; adding performance metrics to health inspectors' annual performance evaluations; and streamlining the process of issuing compliance orders. OPH will roll this plan out in stages over the next year.

For more information on the health inspection process, visit www.eatsafe.la.gov.

March of Dimes and Partners Urge Expectant Mothers to Wait

The March of Dimes is urging expectant mothers to do all they can to promote a full-term pregnancy – more than 39 weeks. The agency has kicked off a campaign in partnership with LaCare, a Medicaid health plan in Louisiana.

To get the word out, LaCare, a participant in Louisiana's Bayou Health program, presented March of Dimes with a $20,000 gift. The central message is "Healthy Babies are Worth the Wait," meaning a wait of the full term of 39 to 41 weeks. Television viewers in New Orleans and Baton Rouge, as well as radio listeners across the state, started seeing and hearing commercials in December.

Data from the National Center for Health Statistics (NCHS) shows Louisiana's premature birth rate is 15.6 percent. The March of Dimes goal is to reduce premature birth by at least eight percent between 2009 and 2014. In the report, the agency named three things that contribute to premature births: smoking among women of child-bearing age, lack of prenatal health care, and late preterm births (those between 34 and 36 weeks due to induced labor or C-section). Women can reduce the risk of premature birth if they quit smoking and get early and regular prenatal care throughout their pregnancies.

AHA Seeks Fit-Friendly Workplaces

The American Heart Association is seeking nominations from forward thinking companies leading the way to provide employees with a culture of physical activity and health for the Fit-Friendly Workplace Award. There are Platinum, Gold, and Community Fitness Innovation award levels. Companies will be judged on three criteria: physical activities that are encouraged on site; nutritional education and healthy food options that are available; and the general culture of health promoted at the work place. Companies that do not yet meet the criteria can use the Association's Walking Program to be considered "Fit Friendly."

Employers who adopt the Fit-Friendly Workplace Program will also be recognized by the American Heart Association on the program's national website. In addition, eligible companies will be granted the right to use the program's annual recognition seal for internal communications to employees and external, recruitment-related communications.

Applications are due by January 31 and can be found at ffc.heart.org.

DHH Announces Mid-Year Reductions

In December, Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein announced mid-year reductions at the agency that will save $51.8 million in State General Fund for Fiscal Year 2012-2013. According to DHH, these reductions have a total impact of $82.6 million for this Fiscal Year, when federal funds that would be used to match affected programs and services are considered. DHH's reductions are part of the State's overall mid-year reduction plan that addresses the budget shortfall in the current fiscal year.

DHH indicated that it is trying to make reductions to programs in ways that optimize newly implemented coordinated care programs for Medicaid and behavioral health services to eliminate duplicative efforts. Many of the mid-year reductions also make more efficient use of contracts, rates, and staffing availability within the department. To curb operational costs, DHH is restricting employees' travel to only critical needs and enacting more effective resource sharing and supply management.

Reductions from each of DHH's program

offices are listed below, with State General Fund (SGF) savings highlighted, along with the number of positions affected within the department.

Office of Aging and Adult Services ($616,650 SGF; 0 TO, 3 NON-TO). This program office will realize savings by implementing a work-at-home program for staff in regional offices, which will reduce rental and building operations costs. Other savings in OAAS will occur through rebasing reimbursement rates for the Program of All-Inclusive Care for the Elderly (PACE) to better align them with current program costs.

Office of Behavioral Health ($860,151 SGF; $3,304,445 IAT; 1 TO, 91 NON-TO). OBH will realize savings through elimination of the Early Childhood Supports and Services (ECSS) program, which provides community-based specialized behavioral health services to children at risk for mental health conditions. This elimination will result in one TO and 76 non-TO position reductions. The recipients currently served who have more intensive needs will be able to seek access and referral of services through the Louisiana Behavioral Health Partnership (LBHP). The State implemented the LBHP in March to coordinate behavioral healthcare services across the state. OBH will also eliminate 15 non-TO positions, which provide specialty outpatient screening, assessment, and treatment services to TANF eligible low-income women and women with dependent children. OBH will also reduce bed capacity for addiction residential services for this population by 12 beds. OBH will make an overall 10 percent contract reduction for healthcare providers who deliver community-based services to indigent mentally ill and addictive disorders clients.

Office for Citizens with Developmental Disabilities ($170,280 SGF; 0 TO). OCDD will realign the Flexible Family Fund to better match resources with need. This program assists families with children who have disabilities by providing a monthly stipend. Currently, the funds are distributed on a first-come, first-served basis. OCDD is implementing financial eligibility criteria for this program to distribute stipends in a more targeted way. Under the new criteria, children whose family income exceeds 650 percent of the Federal Poverty Level (which is an annual income of almost $150,000 for a family of four) and who also receive home and community-based Medicaid waiver services will no longer be eligible for the program.

Office of Public Health ($2.1 million SGF; 21 TO). Fifteen of the TO positions OPH is eliminating are vacant direct-care service positions in parish health units. Funding for one engineering staff position will be reallocated from State General Fund to federal funds in the Drinking Water Revolving Loan Program. Vital Records will eliminate two vacant positions, seven temporary positions, and two additional positions upon employees' retirement. One position in the Bureau of Primary Care and Rural Health will also be eliminated. OPH will also achieve savings through foregoing establishment of any new School-Based Health Centers as planned (this does not affect any patient care or services currently provided through School-Based Health Centers already in place); reducing contracts for wraparound services in the Genetics program; and not conducting four Bureau of Primary Care and Rural Health workshops for medical professionals' training that had been planned for SFY13. The Bureau will hold similar workshops in spring and fall 2013 using federal funding.

Bureau of Health Services Financing/Medical Vendor Administration (Medicaid) ($1.2 million SGF; 0 TO) The bulk of savings in the Medicaid Medical Vendor Administration program will be achieved through reducing contracts. These contracts include the Enrollment Broker (MAXIMUS) and contracts for administration of Low Income Needy Care Collaboration and Physician Upper Payment Limit. Medicaid will also eliminate its Radiation Utilization Management services and KidMed payments processing through Molina, as the full implementation of Bayou Health makes these services unnecessary. The health plans are now responsible for performing these functions.

Bureau of Health Services Financing/Medical Vendor Program (Medicaid) ($45.8 million SGF; 0 TO) Medicaid will reduce Disproportionate Share Hospital (DSH) funding paid to LSU Health - Shreveport by $10 million. LSU hospitals will continue receiving DSH payments, but will do so at a reduced level. This reduction is in addition to previous DSH reductions to the LSU system for FY 2013. Even after this reduction, LSU hospital rates are still higher than the DSH rates paid to private hospitals. In addition, there will be a $2.3 million reduction in High Medicaid DSH Pool funding, which provides enhanced DSH rate payments to non-LSU hospitals that provide a higher portion of care to uninsured residents. Medicaid will also enact a 1 percent provider rate reduction to hospitals and physicians. This reduction of DSH and Medicaid payments will not affect Medicaid recipients' access to hospital care, as most recipients are now enrolled in Bayou Health plans that have private and community hospitals in their networks.

The Medicaid MVP program will eliminate the Community Hospital Psychiatric Services funding pool (recipients may access behavioral health services through the Louisiana Behavioral Health Partnership) and will eliminate dental benefits for pregnant women and hospice care provided outside of nursing homes, which are both optional services for Medicaid recipients. The hospice reduction becomes effective Feb. 1, 2013, and does not impact anyone currently receiving these services in Medicaid. They will continue receiving hospice services. Medicaid will also eliminate rehabilitation center services for adults — occupational, physical, speech or other therapies administered outside a nursing home setting — for recipients older than 21.

Medicaid is eliminating targeted case management for the First-Time Mothers Home Visit Program, in which medical professionals make home visits to encourage healthy parenting for first-time mothers who met Medicaid eligibility guidelines. Women in this program

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RACs may review the last three years of provider claims for the following types of services: hospital in-patient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. The RACs use proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding. RACs also conduct medical record reviews.

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who are enrolled in Medicaid and are in a Bayou Health plan (which includes nearly all pregnant women in Medicaid) will be eligible for case management services through their health plans. Medicaid will also eliminate case management services for recipients who have HIV/AIDS, as Medicaid recipients in the Bayou Health program can receive comparable case management services from their health plan's network. Medicaid will use pharmaceutical settlement funds recovered by the Louisiana Attorney General to replace $30.5 million in State General Fund.

Human Services Districts ($785,941 SGF, 0 TO, 26 Non TO). There are five locally governed Human Services Districts affiliated with DHH that provide outpatient mental health and addictive disorder services, along with services to people who have developmental disabilities, in their parish or region. Human Services Districts operate as independent local governing entities (LGEs). Each will achieve savings through various techniques, including restructuring services to optimize available resources, eliminating vacant positions or downsizing programs to negate the need to hire more staff, supply and travel reductions and better use of Patient Assistant Programs to save on pharmacy costs. Each will incur different levels of savings, including $141,461 for the Florida Parish Human Services District; $119,266 for the Capital Area Human Services District; $206,799 at the Jefferson Parish Human Services Authority; $18,446 at the South Central Louisiana Human Services Authority; and $299,969 at the Metropolitan Human Services District (New Orleans metro area).

In all program offices, DHH is working through the department's Human Resources section and the Louisiana Department of State Civil Service to ensure affected employees are provided, whenever possible, opportunities to fill needed vacancies in other State offices or departments.

LSMS, Others Respond to DHH Announcement

Close on the heels of DHH's budget announcement came this joint statement from Louisiana State Medical Society Executive Vice President & CEO Jeff Williams, Louisiana Hospital Association President & CEO John Matessino, and Metropolitan Hospital Council of New Orleans CEO Paul Salles

"With the Jindal Administration's announcement today of a $165.5 million shortfall for Fiscal Year 2012-13, the healthcare industry is deeply disappointed and extremely concerned that patients and their healthcare providers are once again the target of significant cuts.

"Louisiana cannot continue to balance the budget on the back of our most vulnerable patients. With the lack of stability and predictability in the Medicaid program caused by multiple cuts to physicians and community hospitals over the last five years, state officials and the public should be concerned about the Medicaid program's viability.

"Hospitals and physicians continue to be cut over and over again, and the trend does not seem to be abating. When physicians and hospitals absorb cuts, they are faced with only a few options. They may be forced to charge other patients more to offset the cost of cuts, which means a rise in health insurance costs. They may have to reduce or eliminate services, which reduces access to care for all patients. They may have to lay off employees, which causes the local economy to suffer, and if all else fails, hospitals or physician practices may be forced to close their doors.

"With so much uncertainty with national healthcare reform, federally-run healthcare exchanges, the fiscal cliff, public/private hospital partnerships, and federal cuts to Medicare and Medicaid, the Administration should be working to strengthen our healthcare system in Louisiana.

"As always, we will continue to work with Gov. Jindal, the Department of Health and Hospitals and the Louisiana Legislature to deal with this critical issue."

Nursing Board Proposes Scope of Practice Change

The Louisiana State Board of Nursing has published a Notice of Intent for a proposed amendment to one of its rules, LAC 46:XLVII.3707.B.5. The purpose of the amendment is to acknowledge the authority of an advanced practice registered nurse to determine catheter tip placement prior to the initiation of therapy where the procedure for verifying catheter tip placement has been set forth in a written policy that has been established by the institution or facility and under certain requirements. The current version of Section 3707.B.5 states that catheter tip placement must be determined by a physician.

The first step in the rulemaking process is the publication of the Board's Notice of Intent in the December 20, 2012 edition of the *Louisiana Register*. You can access the publication free of charge at the state register's website at www.doa.louisiana.gov/osr. The Board's notice can be found beginning on page 3285 of this month's edition.

The Board will conduct a public hearing on Friday, January 25, 2013.

Richmond Named LHCQF Chief Technology Officer

Brian Richmond has been named Chief Technology Officer for the Louisiana Health Care Quality Forum. Richmond has 20 years of experience in information technology (IT), including 18 in the healthcare field, and has served as manager of Business Operations and Technology Services for the Quality Forum since 2011. In his new role, Richmond will integrate the Quality Forum's processes and business strategies with its health information technology vision. He will develop and implement technology initiatives within the organization by maintaining existing enterprise systems while providing direction in technology-related issues related to the support of information operations and core company values.

Owner of LA-Based DME Company Convicted

In December, the owner and operator of a Louisiana-based durable medical equipment (DME) company was convicted by a federal jury in Houston for his role in a $6.7 million Medicare fraud scheme.

Kenny Msiakii, 44, of Houston, was convicted of eight counts of health care fraud. According to court documents, Msiakii was the owner and operator of Joy Supply and General Services, a company based in Shreveport, that purported to provide orthotics and other DME, including power wheelchairs, to Medicare beneficiaries.

Msiakii used Joy Supply's Medicare provider number to submit claims to Medicare for DME, including orthotic devices, that was medically

unnecessary and, in some cases, never provided. Many of the orthotic devices were components of "arthritis kits" and purported to be for the treatment of arthritis-related conditions; however, the devices were neither medically necessary nor appropriate for such conditions.

According to court documents, from November 2007 through September 2009, Msiakii submitted claims of approximately $6.7 million to Medicare and was paid approximately $3.6 million.

At sentencing, scheduled for Feb. 28, 2013, Msiakii faces a maximum sentence of 80 years in prison.

Louisiana Formally Opts Out of Exchanges

In November the State of Louisiana sent a letter to the federal Department of Health and Human Services declaring that the state declines to assume the risk of building a health insurance exchange as outlined by the Patient Protection and Affordable Care Act (PPACA). State Department of Health and Hospitals Secretary Bruce Greenstein confirmed the decision originally announced back in March, 2011, saying Louisiana has not changed its position that the law creating the exchanges has severe legal problems, is bad policy and does not allow the state enough flexibility.

LAHIE Turns One

The Louisiana Health Information Exchange (LaHIE) celebrated its one year anniversary on Nov. 4, 2012. LaHIE was officially launched on Nov. 4, 2011, at the Louisiana Health Information and Management Systems Society Conference with Lafayette General Medical Center and Opelousas General Health System as pilot sites in the Acadiana region. The two pilot sites went live with LaHIE in December 2011. Also now live with LaHIE are Lafayette General Surgical Center in Lafayette and St. Martin Hospital in Breaux Bridge.

In its first year, many hospitals and affiliated clinics – including the CHRISTUS network of hospitals and Baton Rouge General Medical Center – along with ambulance companies, care clinics, home health providers, and school-based health centers have signed participation agreements with LaHIE. In addition, the exchange achieved the ability in July 2012 to facilitate public health reporting in Louisiana by connecting providers with organizations such as the Louisiana Office of Public Health and the Louisiana Immunization Network for Kids Statewide (LINKS) through its web portal.

For more information about LaHIE, contact lahie@lhcqf.org.

BCBSLA Announces New Leadership

Blue Cross and Blue Shield of Louisiana recently appointed a new medical director and a new senior VP of Business Development.

Dr. Rodney Wise, former medical director at Louisiana Medicaid, has been named medical director and Tej P. Shah will serve as Senior Vice President of Business Development.

LaPOST Webinar Scheduled For January

The Louisiana Health Care Quality Forum announced that Louisiana Physician Orders for Scope of Treatment (LaPOST) will be the focus of a webinar, "LaPOST Ready," scheduled for noon on January 29, 2012. The webinar will feature Susan Nelson, MD, chair of the LaPOST Coalition, a network of Louisiana healthcare professionals dedicated to raising awareness of the LaPOST document.

The LaPOST document is designed to improve end-of-life care in Louisiana by honoring the healthcare wishes and goals of those with life-limiting illnesses. The webinar, which is certified for one hour of CEU credit for social workers, will serve to empower consumers and healthcare professionals with easy-to-access, simple-to-understand information and resources to make educated decisions about end-of-life care.

Space is limited for the complimentary webinar. Visit lhcqf.org to register.

Nurse Notification System to Launch

The Louisiana State Board of Nursing (LSBN) launched a new system, e-Notify, in December. The system is an innovative nurse licensure notification program that delivers real-time notifications to employers about nurses in their employ. The system provides licensure and publicly available discipline data directly as the information is entered into the Nursys database by boards of nursing. The e-Notify service is operated by the National Council State Boards of Nursing.

LHCQF Recognized as HIT Leader

The Louisiana Health Care Quality Forum and the Louisiana Health Information Exchange (LaHIE) have been recognized by the federal government as national leaders for their efforts to enhance the safety and quality of healthcare by embracing the use of health information technology.

The Quality Forum and LaHIE are working to help Louisiana's healthcare providers, hospitals, and pharmacies adopt and implement technologies that allow them to communicate securely and electronically, in real time. The Office of the National Coordinator for Health Information Technology is specifically recognizing Louisiana's efforts because of the increasing number of pharmacies utilizing e-prescribing capabilities as well as the growing number of healthcare providers who are actively and electronically sharing patient care summaries.

LSU Doctoral Nurse Anesthesia Program Approved

The BSN to DNP Entry Level Nurse Anesthesia Program at the LSUHSC School of Nursing has been approved by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA). The Nurse Anesthesia program at LSUHSC's nursing school will now transition from a master's degree program to a doctoral degree program, although the prerequisite degree to apply will remain a Bachelor of Science in Nursing. The American Association of Nurse Anesthetists (AANA) and the Council on Accreditation of Nurse Anesthesia Programs have adopted the position that the Doctor of Nursing Practice degree will be the entry level into practice for nurse anesthetists by 2025.

LSU Tobacco Control Initiative Staff Certified

Eight staff members of the LSU Health Tobacco Control Initiative (TCI) have completed tobacco treatment training and have earned certification as tobacco treatment specialists (TTS) through the Florida Certification Board, a nationally recognized, nonprofit, professional credentialing organization. Certification allows specialists

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A Health Care Quality Forum Initiative

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State Health Information Exchange Program

Awardee of The Office of the National Coordinator for Health Information Technology

In partnership with the Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services, Grant #90HT0050/01

Rep. Bill Cassidy, MD attends a ribbon cutting ceremony at Westdale Middle School.

to provide treatment and to educate healthcare professionals and administrators about tobacco dependence treatments.

The following have earned TTS certification:

- Nakesha Auguster, BA
- JoAnn Brooks, MA
- Michael Celestin, MA
- Deborah Durapau, MS
- Betty Henry-McFarland, MA
- Krysten Jones, MPH, CHES
- Wendy Theriot, BA
- Lucretia Young, MA

Visit www.attud.org/tts.php for more information on TTS training.

LOCAL

Cancer Center Launches Lung Screening Clinic

Mary Bird Perkins – Our Lady of the Lake Cancer Center has announced the launch of a specialized Lung Cancer Screening Clinic dedicated to the early diagnosis of lung cancer. The Cancer Center is the first site in the Baton Rouge region to offer lung cancer screenings. The Cancer Center's Lung Cancer Multidisciplinary Care Team (Lung MDC) is recommending the screening for high risk individuals who are 50 and older and are longtime smokers, exposed to occupational hazards, or have a family history.

The Lung Cancer Screening Clinic will follow National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines for Lung Cancer Screening. NCCN classifies high risk individuals as smokers and former smokers 55-74 years old with a smoking history of 30 or more pack years (number of packs smoked per day multiplied by the number of years smoked) and directs these patients to lung cancer screening. Additionally, people who are age 50 or older with a smoking history of 20 or more pack years and one additional risk factor (not including secondhand smoke), radon exposure, occupational exposure (carcinogens, asbestos), cancer history, family history of lung cancer or disease history (COPD or Pulmonary Fibrosis) – should also be screened for lung cancer.

The cost of the lung cancer screening is offered at a discounted rate of $200 for those at high risk. A physician referral is not required, but patients should speak with their primary care physician. Most insurance does not cover this cost, so the patient will be fully responsible for the fee. For more information please call (225) 215-1515.

Grant Assists School Health Centers

Westdale Middle School was the site of a Ribbon Cutting Ceremony recently to celebrate completion of renovations of three school-based health centers in East Baton Rouge Parish through a $500,000 grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The grant funded construction renovations for health centers at Westdale Middle, Istrouma High, and Glen Oaks High schools. Congressman Bill Cassidy, MD, representative from Louisiana's 6th US Congressional District, and also a Baton Rouge physician, celebrated with non-profit Health Centers in Schools (HCS) and the East Baton Rouge (EBR) Parish School System on the re-opening of the health centers.

SurviveDAT Launched for Young Breast Cancer Survivors

Young breast cancer survivors between the ages of 18 and 44 and their caregivers now have a new online resource focused on their unique needs. Mary Bird Perkins Cancer Center and LSU Health Sciences Center School of Public Health recently launched a new website, SurviveDAT (www.survivedat.org), which provides access to local and national support groups, health information, and more. SurviveDAT is the result of a Young Breast Cancer Survivorship Grant awarded to Mary Bird Perkins Cancer Center and LSU Health Sciences Center School of Public Health last year by the Centers for Disease Control.

For additional information visit www.survivedat.org.

LSU Mid City Clinic Marks World AIDS Day

The LSU Mid City Clinic recently dedicated a live oak in recognition of World AIDS Day. Large, sturdy, and mature, the tree symbolizes the enduring dedication of LSU Health in the fight against AIDS. Its location, beside a bus stop and at the busy intersection of N. Foster Drive and Gus Young Avenue, will be a constant reminder of this fight and of the need for HIV testing as a critical part of the fight.

CIS Nuclear Labs Reaccredited By IAC

Cardiovascular Institute of the South (CIS) nuclear laboratories have been granted reaccreditation for three years by the Intersocietal Accreditation Commission (IAC) which acknowledges the facility's commitment to high-quality patient care and quality diagnostic testing.

To earn this accreditation, CIS's 10 nuclear laboratories in Houma, Raceland, Thibodaux, Morgan City, New Iberia, Lafayette, Opelousas, Zachary, and Baton Rouge underwent rigorous examinations of operational and technical components by a panel of experts.

PHS

PROVIDING A PERSONAL TOUCH SINCE 1998

FERRIDAY OFFICE - Natalie Quimby, RN; Leslie Jackson, Case Manager; Glenda Lewis, Co-Owner/President; Paula Dobson, Account Manager; Sandy Maroon, Office Administrator. BELOW: Al Clifton, Founder and Chairman of the Board.

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PHS WAS AL'S IDEA

Back in 1999, my mother's nephew, Al Clifton, came to me with an unusual idea for providing a service to the elderly and disabled. He had recently lost his mother, as had I, so the understanding of his proposal hit quite close to home. This service was to be non-medical, was not a home health agency subsidized by government programs, and was not a sitter service providing hourly care or a cleaning/maid service for the client. Instead it would benefit those who needed the care that lay somewhere in between all of these other programs — a 24/7, live-in care giving service for those who wanted to remain at home during their twilight years.

At first I was skeptical. However, after seeing Al's dedication and the time he spent on the road visiting social services at hospitals and hospices, I saw the beginning of a business that could have infinite possibilities. So in 2000, I became a partner in the corporation. I have been blessed ever since with not only a sincere satisfaction from the hundreds of jobs our company has created throughout this area and the State of Louisiana, but also the joy of being able to give back what we have been blessed with — the simple caring of another person. –GLENDA LEWIS

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TEXAS OFFICE - from left, Chrystal Tabor, Manager of Business Operations; Kelly Mobley, PT, CEO of Texas and Louisiana; Susan Roberts, Director of Texas Sales and Marketing.

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The Louisiana Health Care Quality Forum: A Retrospective

Eight years ago, Hurricanes Katrina and Rita decimated the health care system in Louisiana's coastal regions, but left behind an unparalleled opportunity for fundamental change in health care for the state's residents. The daunting task of accomplishing that change was given to the Louisiana Health Care Quality Forum, which, through the efforts of more than 40 health care and consumer groups, was formally recognized by the State Legislature in 2007.

As a private, not-for-profit organization, the Quality Forum recognized the emerging crisis of rising health care costs, the growing number of uninsured and the need for greater quality in health care delivery as well as Louisiana's consistent ranking among the highest in per capita costs and the lowest in clinical quality.

Over the past six years, the organization has dedicated itself to combatting those issues by reshaping health care in Louisiana. Led by a volunteer Board of Directors, the Quality Forum serves as a neutral convener, bringing together providers, purchasers, payers, and consumers to drive improvements in health care quality, safety, and value for Louisiana residents. Its accomplishments in those endeavors have benefitted, and will continue to benefit, the state as a whole.

One of the Quality Forum's greatest successes has been its work in transitioning the state's health care providers and facilities from paper-based medical records to electronic health records (EHRs). The organization was tapped in 2010 to establish Louisiana's Regional Extension Center (REC), and with $7.8 million in federal grant funds through the American Recovery and Reinvestment Act (ARRA) of 2009, created the Louisiana Health Information Technology (LHIT) Resource Center. The LHIT Resource Center provides assistance for the state's primary care providers and hospitals in the adoption and implementation of EHRs. Today, 1,600 of the state's health care providers, along with 29 critical access hospitals and rural health facilities, are working with the Resource Center to transition to EHRs.

Louisiana's health information technology (IT) journey continues with the establishment of the Louisiana Health Information Exchange (LaHIE), which allows authorized providers and organizations to electronically access and share health-related information through a secure and confidential network – the result of a $10.6 million grant awarded in 2010 from the Office of the National Coordinator for Health Information Technology (ONC) as part of ARRA.

With the Quality Forum serving as the state-designated, neutral entity for its development and support, LaHIE officially launched in November 2011. By July 2012, LaHIE had achieved the ability to facilitate public health reporting in Louisiana by connecting providers with departments such as the Louisiana Office of Public Health and the Louisiana Immunization Network for Kids Statewide (LINKS).

As the state's health information "super highway," LaHIE's benefits include improved patient safety, timely access to patient records, increased security of records, reduced health care costs, enhanced patient/physician communication, and better coordination of care and patient management. The Quality Forum and LaHIE were officially recognized in October 2012 by ONC as national leaders in health IT advancement.

One month later, in November 2012, the statewide exchange celebrated its one year anniversary. In its first year, LaHIE has grown to include providers in 49 of the state's 64 parishes and now has pledges of support from more than 50 percent of Louisiana's acute care hospitals, along with many community clinics, private practices,

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ambulance companies, school-based health centers and home health providers. In time, the exchange will provide access to patients' EHRs to providers and health care facilities across the state, and eventually, the nation.

"Providing our physicians, on both ends of the spectrum, access to patient diagnostic information at their fingertips has improved access to information and will ultimately improve the health care that we give," says Jared Lormand, vice president of information technology and chief information officer at Opelousas General Health System. "We are looking forward to having a richer exchange by including more hospitals and care providers."

Another Quality Forum initiative – this one endorsed in 2008 – is the redesign of health care delivery systems to support patient-centered, coordinated care for the improvement of quality and health outcomes. The Patient-Centered Medical Home (PCMH) model is a team-based approach that makes the patient the most important person in the health care system by providing him/her with the education and support needed to make informed health care decisions.

Over the past five years, the Quality Forum has strived to educate health care providers across the state about PCMH and is working to help physicians and practices achieve recognition as PCMH providers. Because the Quality Forum administers the state's REC, LHIT Resource Center clients who are also primary care providers will be well-positioned to move forward with PCMH transformation. Similarly, integration with LaHIE will offer those providers access to the state's "information superhighway."

In addition, as part of the Quality Forum's focus on creating a quality-driven health care system for the state, the organization has worked since it was established to produce and promote reliable, useful, and user-friendly data and information to guide providers, payers, purchasers, and consumers in making informed health care decisions.

Through clinical quality improvement, the Quality Forum engages and assists providers in the pursuit of meaningful, specific, and quantifiable health care enhancements. In 2011, the Quality Forum moved forward with plans to develop a Quality Improvement and Measurement initiative. To further this mission, the organization met regularly with key health care groups to develop a plan that will integrate with LaHIE and focus on clinical quality improvement-related initiatives for cardiovascular disease and diabetes. The anticipated roll-out of this plan is scheduled for the first quarter of 2013.

"Through its initiatives, outreach programs and educational efforts, the Quality Forum, with its unique neutral convener status, serves to promote meaningful improvements in health care for Louisiana's residents."

As the Quality Forum continues to move Louisiana's health care system forward through these initiatives, it has also recognized the need for consumers to have information that not only improves their decision-making at the point of care, but also at the point of choosing a provider or health plan, when engaging in self-care, and with lifestyle choices that may affect their health.

The Quality Forum has utilized tools such as informational summits, multiple media outlets, and partnerships with health care, medical, and consumer organizations. The Quality Forum has also established target community outreach programs; collaborated with professional and advocacy organizations to increase public awareness regarding consumer involvement in health care; and conducted environmental surveys to gather information to support improved consumerism and health care literacy.

"Through its initiatives, outreach programs and educational efforts, the Quality Forum, with its unique neutral convener status, serves to promote meaningful improvements in health care for Louisiana's residents," says Ray Peters, president of the Quality Forum's Board of Directors and vice president of human resources and marketing for RoyOMartin in Alexandria. As the trusted, neutral convener, the Quality Forum has, since its beginning, crossed boundaries to bring people and organizations together for the purpose of planning, implementing, and advancing changes in health care for the state of Louisiana. The organization's accomplishments in those endeavors are attributed largely to the efforts of the many stakeholders who have shared its vision of providing and delivering exceptional health care to Louisiana residents. As health care remains one of the most important challenges facing the state and the nation, the Quality Forum remains committed to that vision and dedicated to its leadership role in shaping the future of health care in Louisiana.

Cindy Munn is Executive Director, Louisiana Health Care Quality Forum

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WCA WOUND CARE ASSOCIATES

Dr. Shaun Carpenter, President and CEO of WCA, is a board-certified emergency physician and Fellow of the American Professional Wound Care Association. He is a graduate of Tulane University Medical School and completed his emergency medicine residency at Charity Hospital's trauma center in New Orleans.

Plus ça change, plus c'est la même chose

The year 2012 is history. Good riddance! It's been a year fraught with bad news and uncertainty for the future of healthcare in Louisiana. As we begin a new year we should take steps to ensure that our first priority will be to better serve the healthcare needs of ***all*** Louisiana citizens. Political ambitions should take a back seat while we focus on improving our delivery system.

Trust in government–both state and federal–to solve our problems has been diminished. Will we regain the trust in our leaders, both executive and legislative, in Baton Rouge and Washington? At this point in time, there is little evidence that they can reach agreement on how to meet any of the challenges currently facing us. At the national level, the presidential election did little to break the impasse between the President and Congress on a host of issues related to the economy and, specifically, to healthcare reform. No agreement, therefore no action.

Focusing on Louisiana, we see a different situation. There is widespread disagreement on many issues between the Jindal administration, the legislature and large segments of the general public. Yet gubernatorial action is taken without a consensus on many important issues. In some cases, significant decisions are made without consulting the legislature. While some would applaud the administration's willingness to aggressively take action on critical matters, an open and transparent process is an indispensable element of democratic government.

While there is a myriad of problems to solve, here are the ones that seem most important.

HEALTH EXCHANGES. The concept of health exchanges was promoted by the highly regarded Heritage Foundation, a conservative think tank. The first application of the concept occurred as part of the Massachusetts health reform plan led by Governor Mitt Romney (2003-2007). The Massachusetts exchanges (known there as "connectors") were designed in part to strengthen competition between health plans by providing detailed and standardized information for consumers to improve decision-making.

Consumers could access the "connector" through the internet, by telephone or at certain physical locations where advisors would be available. According to a study by Kaiser Family Foundation, "The reforms adopted in Massachusetts became the model for comprehensive federal health reform enacted in March 2010." Those reforms included the "connector" which became the model for the ACA health exchange.

Considering that the exchange concept is a full-blooded offspring of conservative thinkers, it is somewhat baffling that most conservative governors have decided to oppose it. However, some Republican states, including Mississippi, have embraced the idea and most expect to have state-operated exchanges on schedule. Louisiana, on the other hand, was an early rejecter of exchanges. The Jindal administration has instead opted for the federal government to establish and run the exchange.

In the final analysis, opposition to exchanges is politically motivated. Some observers see it as an act of rebellion: "As one Republican governor after another has refused to set up a state health insurance exchange–telling the feds to do it for

them–they're hoping the rebellion can do enough damage to the law to force the Obama administration back to the negotiating table." (*POLITICO*, "GOP govs could gum up Obamacare," December 16, 2012)

Nevertheless, it seems an odd selection to make. Having an undying loathing for "the feds" (as many conservatives seem to have), it could be unwise to invite them in to help run what will be an essential part of our healthcare system. It might be the equivalent of asking the Russians to run the Department of Defense.

So, here is a "middle of the road" solution, one that six states have chosen: select the option for a state-federal partnership to establish and operate the exchange. That means the state will have a direct say in how the exchange is structured and operated. And the feds could provide technical assistance in designing the system. What's not to like?

Louisiana would have to submit its application for a partnership by mid-February. Once the exchange has been established and in operation, the state could apply to dissolve the partnership and become a state-based exchange.

MEDICAID EXPANSION. Expansion of Medicaid for persons with incomes below 133% of the federal poverty level has been discussed in prior issues in this column, but new reasons why Louisiana needs to quit opposing this important component of ACA need to be discussed.

The administration has steadfastly maintained that Louisiana should not participate in expanding Medicaid coverage for low-income persons on the grounds that the expense would be intolerable for the state. There are by some estimates 600,000 or more persons uninsured in Louisiana. They are mostly adults because about 96% of children are already covered, thanks to our Medicaid/LaCHIP program which covers children in families at or below 250% of the federal poverty level. But for many adults the eligibility level is about 11% of the poverty level (or $1,229 annual income for a single adult). Making more than that small amount would render many persons in Louisiana ineligible.

According to Kaiser Family Foundation, about 400,000 low-income persons would qualify for Medicaid under ACA provisions starting in 2014. There would be no cost to the state for the first 3 years of implementation. After that the state match would gradually rise to 10%, still much lower than the current regular state match rate of around 35%. Savings to the state for coverage of 400,000 Medicaid eligibles under ACA provisions would exceed $5 billion over a 10-year period from 2014 to 2023.

Savings of that magnitude would be worthwhile under any circumstances. However, recent developments have lent an urgency to an already enticing ACA provision. An unfavorable change in the federal match rate for Louisiana was enacted by Congress in July 2012, leaving the state with a budget problem of $860 million. The administration has decided to deal with this substantial problem with a hurried plan hatched behind closed doors without legislative involvement.

The budget shortfall is being addressed by major service reductions and large-scale layoffs at LSU hospitals. This will be followed by the leasing of three LSU hospitals to a private hospital operating in the same community. Substantial lease payments will be made by the private entity and used to match federal dollars to help address the budget shortfall. It is not yet clear if the process as described by the administration meets all legal and procedural requirements and if the Centers for Medicare and Medicaid (CMS) will condone the use of lease payments as matching funds.

And yet the administration continues to refuse to take advantage of the ACA Medicaid expansion provision, which will provide a substitute for the now broken safety net for the uninsured. A Medicaid expansion would also free up a considerable amount of funds which could then be put to good use with the budget shortfall. And most important, 400,000 lives would be covered,

In the last few months, there has been a dizzying amount of activity with healthcare budgets, prompting major changes in how services are delivered. In many cases, transparency and an open process to plan these changes has been lacking. So, is Louisiana making progress with all this activity? When the dust settles will we have a better system of care for the uninsured? The French have a term for it. *Plus ça change, plus c'est la même chose.* The more things change, the more they stay the same.

While some would applaud the administration's willingness to aggressively take action on critical matters, an open and transparent process is an indispensable element of democratic government.

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

Fiscal Cliff Threatens Medicare

By now, most Americans have heard of the "fiscal cliff." If Congress does not act, a number of major laws will expire at the end of the year causing nearly $600 billion in tax hikes and spending cuts. The Congressional Budget Office estimates that this would be devastating to the economy, causing a .5% reduction in the national gross domestic product (GDP) and increasing the unemployment rate to 9.1%. This "fiscal cliff" would produce irrational cuts to Medicare that would be devastating to beneficiaries and providers.

The Sustainable Growth Rate (SGR) payment formula for Medicare physician services is, once again, scheduled to expire as part of this fiscal vortex. The SGR was enacted in 1997 to ensure that the increases in expenses per Medicare beneficiary did not exceed growth in the GDP. If Medicare spending in one year was below projected costs, physicians would receive a payment increase for the following year. If Medicare costs were above the projected costs, payments would be reduced the following year.

This scheme worked well for a few years. Medicare spending stayed within the projected targets and physicians actually received an increase in payments. However, in 2002, Medicare spending exceeded the projected target and doctors' payment rates were reduced. The following year, Congress overrode the payment cut and has done so ever since.

Were Congress to allow the SGR to take effect in 2013, physicians who provide care to seniors would have a 27% reduction in payments they receive for Medicare services. This would be below a doctor's fixed cost of seeing a patient. Surveys suggest many fewer doctors would see Medicare patients. According to *Health Affairs*, 28% of primary care physicians do not see new Medicare patients. Many cite the uncertainty of future payments as a reason. Further reducing rates to providers would lead to an access of care crisis for the most vulnerable Americans.

The longer Congress provides short-term solutions on the SGR, the more expensive it becomes. The current CBO projection is that overriding the automatic cut and freezing doctors' payments for one year would cost $25 billion. Freezing the payments for ten years would cost $244 billion.

In addition to the SGR cuts, the budget deal worked out in the 2011 budget negotiations mandates an indiscriminate across-the-board cut of 2% in Medicare. This means that all federal Medicare payments to hospitals, doctors, and health plans would be cut, regardless of quality of service. The CBO projects that the cuts would total $99.3 billion over ten years. These cuts would have the same effect as the SGR cuts in reducing patient access to healthcare services.

There are sound solutions. Medicare financing can incentivize innovative healthcare delivery models that drive lower cost and higher quality healthcare. These models should focus on physicians coordinating in a team-based model with a primary care foundation that uses evidence-based practices to better coordinate care. I introduced the Direct MD Act, which would create a demonstration project to test this type of healthcare delivery model for low-income Medicare beneficiaries. Moreover, provider networks are already moving in this direction. For example, the Wellmed Medical Group in Texas and Florida has achieved significant savings and quality improvement in the Medicare population with this basic model. Such models should be encouraged and incentivized.

We have a responsibility to current and future generations of Americans to get our fiscal house back in order and reduce our $16 trillion federal debt. The good news is we can solve these problems in a way that improves the quality of Medicare and our healthcare system. I have and will continue to fight for this approach in Congress.

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OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER

Rounds

RIGHT Ochsner-Baton Rouge nurse participants at Ochsner's Research Poster Day.

Ochsner Nurses Showcase Research

Ochsner Medical Center – Baton Rouge nurses recently showcased ten evidence-based practice research projects during the hospital's first-ever Research Poster Day. Participants previously presented their findings at the 4th Annual Evidence-Based Practice Conference in New Orleans in October.

Members of the LSU Health Science Center School of Nursing judged the projects and announced the following winners during Poster Day:

• ***First place:*** Breastfeeding Initiation and Exclusivity of Breastfeeding in a Healthy Term Newborn presented by Kaitlyn Melancon, BSN, RN, Leigh Dunaway, BSN, RN, and Stacey Lovette, RN from Ochsner Medical Center – Baton Rouge's Family Birthing Center. In addition to receiving first place locally, this presentation received third place among the presenters at the regional conference in New Orleans.

• ***Second place:*** Decreasing the Rate of Falls on Telemetry through Education of the Patient and Family with a Fall Brochure presented by Christa Wilborn, BSN, RN, Sarah Oivanki, RN, Rita Wheat, RN, and Ginger McCray, LPN.

• ***Third place:*** Increasing Breastfeeding Rates in the NICU presented by Janene Ducote, RNC, NIC, Interior Holmes, MSN, RN, Katherine Skrintney, BSN, RN, and Sarah Watts, RNC, NIC.

Honorable mention:

• Nursing Compliance with Bedside Report presented by Nicole Coco-Marcus, BSN, RN, and Jessica Craig, BSN, RN.

• Nursing Attendance and Overtime presented by Catherine Brouillette, BSN, RN, Bobby Dopson, AND, BSN, MBA/HCM, RN, Renee Erwin, Ruthie Harris, Justin Norwood, RN, Dawn Pevey-Mauk, BSN, MBA, RN, Reagan Soudelier, BSN, CEN, RN, Denys Townley, AND, RN, and Michele Willey, RN.

Additional projects included:

• Assessment of Foley Securement Devices in Critical Care presented by Necole George, BSN, RN, Christa Purpera, BSN, RN, and Lauren Simpson, RN.

• Distraction and Patient Reports of Pain During Peripheral Vascular Access Insertion presented by Denise Aymond, RN, Stephanie DeBarbieris, MSN, RN, CEN, and Lisa Ward, BSN, RN.

• Capnography Utilization presented by Belinda Mounce, RN, Robin Shoun, RN, Pam Damrill, RN, Fran Johnson, RN, Tracy Carlton, RN, Diane Gascon, RN, Carol Dupuy, RN, Theresa Chauncy, RN, and Ashley Oliver, RN.

• Maintaining Zero Infections in Implanted Ports in the Outpatient Infusion Setting while Lowering the Cost of Supplies presented by Shelley Graphia, RN, OCN and Susan Box, RN, OCN.

• Core Temp in Mastectomy Patients Using a Thermo-Cap presented by Tammie Moore, RN, Kelly Bates, RN, Angie Baldridge, RN, and Beth McElveen.

The goal of the Ochsner Medical Center

REGIONAL **HOSPITAL NEWS**

– Baton Rouge poster event was to facilitate the sharing of best practices among nurses in an effort to improve patient care and safety.

Baton Rouge General Breaks Ground

Baton Rouge General Medical Center has broken ground on its new, state-of-the-art medical office building to be located on the Bluebonnet campus. This event is part of a larger hospital expansion project on the Bluebonnet campus, and follows the recent addition of a new four room operating suite equipped with innovative hybrid heart surgery technology and minimally invasive robotics. With the completion of this surgical services expansion and the medical office building groundbreaking, Baton Rouge General moves one step closer to becoming a fully integrated medical community.

OLOL Physician Group Livingston Clinic Opens

OLOL Physician Group Livingston Clinic has opened at Our Lady of the Lake Livingston. The clinic will be staffed full-time with family medicine and internal medicine physicians Dr. DeSha Folgar, Dr. Phillip Ehlers, and Dr. Maria Maggio.

• DeSha Folgar, MD is a graduate of LSU School of Medicine in Shreveport. She completed her residency at Lake Charles Memorial Hospital Family Medicine Residency Program in Lake Charles, where she served as chief resident from 2006 – 2007. She is Board Certified in family medicine and is a member of the American Academy of Family Physicians.

• Phillip Ehlers, MD received his medical degree from St. George's University in Grenada. He completed his residency at Lake Charles Memorial Hospital Family Medicine Residency Program in Lake Charles. Dr. Ehlers is a member of the American Academy of Family Physicians and serves as a board member for the Louisiana Academy of Family Physicians.

• Maria Maggio, MD received her medical degree from American University of the Caribbean. She completed her residency at Earl K. Long Regional Medical Center in Baton Rouge. Dr. Maggio specializes in internal medicine.

Primary Care of Live Oak located on La Hwy 16, and Primary Care of Denham Springs located on Veterans Blvd. will remain open. In addition, the community pharmacy at Our Lady of the Lake Livingston is now open.

Public-Private Partnerships Announced for LSU Hospitals

In December, Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein and LSU System Executive Vice President for Health Care and Medical Education Redesign Dr. Frank Opelka held events in three regions of the state to announce that agreements have been reached to form public-private partnerships involving three LSU hospitals:

• Interim LSU Hospital and its successor University Medical Center in New Orleans will partner with Louisiana Children's Medical Center

• Leonard J. Chabert Hospital in Houma has reached agreements with Ochsner Health System and Terrebonne General Medical Center

• University Medical Center in Lafayette has formed a partnership with its neighbor, Lafayette General Medical Center.

LSU has been working to accelerate a system redesign through public-private partnerships over the past several months due to

BR GENERAL BREAKS GROUND Pictured from left to right are: Dr. Andrew Olinde, Kendall Johnson, Representative Stephen Carter, Dionne Viator, Bill Holman, Dr. Evelyn Hayes, Micah Morgan, Anna Cazes, Peyton Grant, and Edgardo Tenreiro.

WOMAN'S HOSPITAL VOLUNTERS RECOGNIZED
Far left, Mary Duhé, left, receives her 1,500 hour service pin from Jamie Haeuser, Woman's Senior Vice President of Operations. Left, Volunteer Tammie Jackson adds an ornament to decorate the Volunteer Services tree. Along with donated gifts, these ornaments were donated to Volunteer Services' "adopted" family.

Congress's sudden action in July that reduced Louisiana's Federal Medical Assistance Percentage (FMAP) rate to the lowest it has been in more than 25 years. The FMAP reduction eliminated $126.9 million in State General Funds from the LSU Health System's budget, which amounts to a total reduction of $329.2 million when federal funds that would have been used for match are considered.

LSU officials in October announced a plan for bringing their budget to balance with these unexpected FMAP reductions that keeps all hospitals operational and maintains critical services, including the medical home-model clinics that provide much of the care to recipients in the public hospital system today. The final, and most instrumental, part of this plan involved establishing public-private partnerships.

In the first stage of these partnerships, the partner hospitals will collectively make payments totaling $12.1 million in the LSU system, allowing them to avoid previously planned staff layoffs at the public hospitals and maintain patient services at existing locations as the partners involved progress toward final agreements.

Each of the partners will expand their roles in the clinical care, medical research, and education programs provided through the LSU hospitals. The public hospitals will continue serving as the safety-net hospital in their regions for people who are uninsured and high-risk Medicaid recipients, who will continue to have access at the existing LSU hospital locations.

Hospital leaders have each signed a memorandum of understanding to formally enter into a partnership.

Nearly 300 Attend North Oaks NICU Reunion

Nearly 100 children and 200 of their guests recently attended the annual Neonatal Intensive Care Unit (NICU) Reunion held on the North Oaks Medical Center campus in Hammond. The free event was held for former NICU patients and their family members. It featured holiday storytelling, face painting, crafts, and refreshments. Each graduate also received a keepsake photo with Santa Claus and a storybook through a partnership with the Hammond Kiwanis Club. Nearly 30 North Oaks Health System staff members volunteered their personal time to host the event. Neonatologist Ivan Villalta, MD, and North Oaks Medical Center NICU staff members were among those greeting guests as they arrived.

North Oaks Medical Center opened its NICU in 1991. The unit is ranked in the top 25 percent in the U.S., by the Vermont Oxford Study.

Woman's Hospital Volunteers Recognized

Woman's Hospital's volunteers were recently honored for annual hours and years of service at a holiday brunch and awards ceremony.

In 2012, Woman's volunteers donated more than 20,561 hours of volunteer service to the hospital, which is equivalent to $448,024 of volunteer time, based on the Points of Light Foundation. Woman's volunteers that received awards this year include the following:

Milestone Awards - Years of Service

5 Years: Mary Bordelon, Susan Bordelon, Alene Bourgeois, Nita Gildon, Sandra Landry, Jan LeBleu, Patti Sanders, Gail St. Amant

10 Years: Chris Browning, Pat Daniel, Cecilia Debetaz, Jeri Harper, Connie LaCour, Jerri LeBlanc, Rebecca Melancon, Rosemary Pillow, Kathy Schamber, Ruth Sessions

25 Years: Janice Carpenter

Annual Awards - Hours of service in 2012

100 Hrs: Charlene Davis, Susie Heroman, Joyce McGowan, Charlotte Roger, Lucille Roy, Cheryl Salter,

300 Hrs: Bob Carr, Helen Crouse, Frankie Edwards, Mary Ann Gorsich, Francine Groves, Marla Hoppenstedt, Tammie Jackson, Connie LaCour, Jan LeBleu, Fran Pietri, Carol Smith, L. A. Stanga, Nettie Williams

500 Hrs: Rose Marie Fife, Dee Heuvel

1,000 Hrs: Gwen Babineaux

1,500 Hrs: Mary Duhé, Peggy Rester, Ruth Sessions, Joann Walsh

2,000 Hrs: Cecilia Debetaz, Nita Gildon, Alice Pate, Gail Ryan, Bobby Walker,Helen York

2,500 Hrs: Betty Calcagno, Sandi Cox

3,000 Hrs: Nancy Hillmann, Nancy Paschal

4,000 Hrs: Betty Crawford, Mary Ann Hebert

4,500 Hrs: Ann Haile

5,000 Hrs: Pat Moreau

8,500 Hrs: Valerie Freeman

Ochsner Test Pinpoints Heartburn Cause

Heartburn is widespread among today's adult population, impacting millions of Americans, but some fail to get relief from the standard treatments and prescribed diet changes. "When we see patients who have not gained relief from symptoms despite having tried everything from antacids to avoiding food triggers, we have to delve into their problem more closely," says Ochsner Medical Center – Baton Rouge Gastroenterologist Gregory Gaspar, MD. Dr. Gaspar and other Ochsner Medical Center – Baton Rouge physicians

OCHSNER HEALTH CENTER - HARDING BLVD OPENING: Ochsner Health Center – Harding Boulevard opened with a ribbon cutting ceremony on December 12th. Celebrating the seventh Ochsner health center location in the Baton Rouge area left to right are: Eric McMillen, Dr. Andriette Martin Fitch, Dawn Pevey Mauk, Kristie Genzer, and Dr. Robert Hart.

now have a new diagnostic tool available to do just that.

PH-impedance testing is used to determine whether the patient is experiencing acid reflux or non-acid reflux. The test results can lead to a new treatment plan or an adjustment in the current plan. The test has proven effective in determining a cause in patients with frequent, unresponsive heartburn and those with chronic coughing or epigastria pain.

The impedance test is conducted over a 24 hour period. During that time the patient wears a thin catheter which is passed through the nose and into the esophagus. The monitor records and charts all reflux episodes which are then analyzed by the physician along with input from the patient as to when they experienced symptoms. Together this information alerts the physician as to which type of reflux is present and how often it occurs.

Gaspar says that Ochsner Medical Center – Baton Rouge is currently one of a few in the southeast region of the country to offer this level of precise testing, with patients coming from New Orleans, Mississippi, and Florida to have the test performed.

Wellness Can Be "A Piece of Cake"

Baton Rouge General has launched a new electronic health tool called "It's a Piece of Cake" – an innovative tool that encourages users to celebrate their health by building a relationship with their primary care physician and having regular physical exams and screenings.

Baton Rouge General's "It's a Piece of Cake" tool makes it easy for individuals to take care of their health with an annual birthday reminder that provides customized health questions and topics (based on age and gender) to discuss with their primary care physician, which could help reduce many health risks and improve long term health and wellness.

With the help of some familiar Baton Rouge faces, including former Baton Rouge Police Chief Jeff LeDuff, Bite and Booze's Jay Ducote, and up and coming singer/songwriter Justin Garner, Baton Rouge General's "It's a Piece of Cake" initiative is encouraging the community to share the tool and this important health message with family and friends: See your physician. Know your family history. The initiative is being announced in conjunction with the hospital's cancer awareness campaign.

Individuals can sign up to receive the email reminder every year on their birthday two ways: "LIKE" Baton Rouge General on Facebook at Facebook/BatonRougeGeneral or visit www.BRGeneral.org.

Ochsner Opens Health Center in North Baton Rouge

In December Ochsner Health System celebrated the opening of its newest Baton Rouge area location, Ochsner Health Center – Harding Boulevard. The 2,000-square-foot clinic is located near the interstate at 7855 Howell Place Boulevard. The building formerly housed the Greater Baton Rouge Surgical Hospital.

Dr. Andriette Martin Fitch, Internist/Pediatrician, will serve as Ochsner Health Center – Harding Boulevard Lead Physician.

Woman's Hospital Joins Live Surgery Broadcast

Dr. Drake Bellanger, Medical Director of Woman's Hospital's Bariatric Program recently performed a Laparoscopic Vertical Sleeve Gastrectomy surgery live for medical colleagues at the 4th Annual International Consensus Summit for Sleeve Gastrectomy. Held December 6-8 in New York City, this international summit focuses solely on the Laparoscopic Sleeve Gastrectomy weight loss technique by bringing together the world's best known bariatric surgeons.

Dr. Bellanger was the only U.S. physician selected to broadcast the classic laparoscopic sleeve. The Baton Rouge procedure was broadcast live alongside similar procedures from France and Spain, highlighting unique techniques and various clinical scenarios. Audience members were invited to interact with Dr. Bellanger during the procedure through the advanced video equipment located in Woman's operating rooms.

Future Doctors/Nurses Visit Ochsner

Students from Dutchtown High School's Allied Health Program recently spent the day at Ochsner Medical Center – Baton Rouge to learn more about careers in the medical field and the working environment of a hospital. Many of the high school juniors plan to one day become a nurse or doctor – occupations that continue to be in high demand across the country.

Ochsner's medical staff educated students about a typical day in the life of a medical professional, discussed education requirements, and provided tours of the hospital's ER, ICU, cardiopulmonary, radiology, and women's services departments. This is the seventh year that Dutchtown and Ochsner Medical Center – Baton Rouge have worked together to educate students on careers in medicine. This year's group of 76 students was the largest to date.

Lallie Kemp Reaches Out to Sandy Hook

Lallie Kemp Regional Medical Center in Independence is collecting monetary donations from its staff to assist families who lost loved ones in the mass shooting at the Sandy Hook Elementary School in Newtown, Connecticut, on December 14. As part of its "Box of Hearts" project, employees are also writing special messages on gold paper hearts and placing them in a beautiful box the hospital will send to the school, symbolic of their hearts going out to the Newtown community facing this tragedy.

OLOL Recognized as Fit-Friendly Worksite

Our Lady of the Lake has been recognized as a Platinum-Level Fit-Friendly Worksite by the American Heart Association for helping employees eat better and move more. The organization offers employees physical activity options; provides access to healthy eating options; embraces a culture of wellness and has implemented at least nine criteria outlined by the American Heart Association in the areas of physical activity, nutrition, and culture.

Our Lady of the Lake has shifted to a culture of wellness by providing low calorie meals at the lowest cost in the cafeteria; implementing both indoor and outdoor walking paths for employees and guests; planting a teaching garden where employees participate in planting and harvesting a garden of fruits and vegetables; offering healthy choices in vending machines; and participating in Healthy Lives™, an innovative wellness program that gets employees and their families involved in their own healthcare management and demonstrates measurable outcomes related to workplace wellness.

The Fit-Friendly Worksites Recognition is an award given by the American Heart Association's My Heart. My Life. initiative. It is intended to be a catalyst for positive change in the workplace.

Plaza Orthopedics Joins North Oaks

Plaza Orthopedics and Drs. J. Larry Fambrough and Robert T. McAfee have joined the North Oaks Physician Group network of primary, specialty, and walk-in clinics. The clinic has moved from 15781 Professional Plaza to North Oaks Office Plaza, located at 15770 Paul Vega, MD, Drive, Suite 108 on the North Oaks Medical Center campus in Hammond.

Drs. Fambrough and McAfee are general orthopedists skilled in the medical and surgical treatment of a variety of disorders of the bones, joints, and muscles. Both are certified by the American Board of Orthopaedic Surgery and recognized on the Healthgrades® Honor Roll. Healthgrades® helps patients make informed choices about America's healthcare providers.

Baton Rouge General Expands Wound Care Services

Baton Rouge General recently announced the expansion of its wound care services to its Bluebonnet campus. Originating on the Mid City campus, the additional Bluebonnet location began services in early November.

Every year, 3 to 5 million Americans suffer from chronic wounds caused by diabetes, poor circulation or other conditions that can lead to amputation. The General's wound and hyperbaric team specializes in healing a variety of these types of wounds.

McMillen Named Ochsner CEO

Ochsner Health System has named Eric McMillen Chief Executive Officer of the system's Greater Baton Rouge locations. McMillen had been serving as Interim Chief Executive Officer and Chief Operating Officer since former CEO Mitch Wasden resigned for another position this summer.

McMillen has been with Ochsner since 2000 serving in a variety of roles including Ochsner Medical Center – Baton Rouge Chief Operating Officer, Ochsner Medical Center – Baton Rouge Assistant Administrator, and Director of Clinical Services in New Orleans. Prior to joining Ochsner he was the Assistant Administrator for Vermillion Rehabilitation Hospital in Abbeville. He earned a Bachelor of Science Degree in Rehabilitation Services from LSU Medical Center in New Orleans and an MBA from the University of Louisiana at Lafayette.

OLOL Earns Consumer's Choice Award

For the fourteenth consecutive year, Our Lady of the Lake Regional Medical Center has been selected by the National Research Corporation as the Consumer Choice Award winner for the hospital with the highest overall quality and image in the Baton Rouge metropolitan area.

Consumer Choice award winners are determined by consumer perceptions on multiple quality and image ratings collected in the National Research Corporation Market Insights/Ticker study. The 2012-2013 study surveyed more than 250,000 households representing 450,000 consumers in the contiguous 48 states and the District of Columbia.

Heintz Joins North Oaks Multispecialty Group

Urologist Jay W. Heintz, MD, joined the staff of North Oaks Multispecialty Group in Livingston in December. Dr. Heintz treats conditions of the male and female urinary tracts and male reproductive system. He also treats disorders of the kidney, bladder, and prostate.

Dr. Heintz is trained in robotic and minimally invasive surgical techniques to treat kidney and prostate cancer and Benign Prostatic Hyperplasia (BPH). He also is experienced in the treatment of low testosterone and erectile dysfunction.

New Service Allows Hospitals to Track Readmissions

ShareCor, the shared services company of the Louisiana Hospital Association (LHA) and the Metropolitan Hospital Council of New Orleans, recently launched LHIN Patient Link, a




FROM LEFT Eric McMillen; Jay W. Heintz, MD; Ericka Flood, MD; and Reynaldo dela Rosa, MD, FAAP.

new service for hospitals in Louisiana. LHIN Patient Link will assist hospital managers by providing access to reports and data that will allow them to:

- Identify patient readmissions and patient movement locally and statewide;
- Identify patients accessing both inpatient and outpatient care;
- Quantify reimbursement penalty risks; and
- Analyze data to determine gaps in quality of care and cost efficiencies.

For the first time, hospitals throughout Louisiana will have access to valuable information on inpatient and outpatient readmissions through Patient Link.

ShareCor added Patient Link to its portfolio of services to respond to CMS' new emphasis on quality and patient safety. It is now important that hospitals begin tracking patient movement and readmissions to both their own facility and to other facilities.

For more information on LHIN Patient Link, contact ShareCor staff members John Stecker at 504-837-6266 or Rebecca Bradley at 225-928-0026.

Flood Joins Baton Rouge General Physicians

Ericka Flood, MD, has joined Baton Rouge General Physicians. Dr. Flood specializes in Family Medicine.

Most recently, Dr. Flood practiced with the Metabolic Center of Louisiana in Baton Rouge where she treated patients with diabetes and weight-related disorders. As a Type One diabetic herself, Dr. Flood's empathy and sensitivity inspired her patients to learn key self-management skills that improved their diabetes control and quality of life. Dr. Flood is Board Certified in Family Medicine. She is a member of several professional organizations including the American Academy of Family Physicians and the Louisiana Academy of Family Physicians.

Dr. Flood's office is located at 17520 Old Jefferson Highway, Suite B, in Prairieville.

Pediatric Critical Care Doc Joins BR General Physicians

Reynaldo dela Rosa, MD, FAAP, has joined Baton Rouge General Physicians. Dr. dela Rosa specializes in Pediatric Intensive Care Medicine and brings more than 10 years of experience in pediatric critical care to the Baton Rouge community.

Previously, Dr. dela Rosa served as Medical Director for the Pediatric Intensive Care Unit with Lafayette General Medical Center in Lafayette, Louisiana. He also served as a Pediatric Intensivist and Assistant Professor of Pediatrics with Batson Children's Hospital at University of Mississippi Medical Center in Jackson. Dr. dela Rosa was appointed by Governor Jindal to serve as American Academy of Pediatrics representative to the Louisiana Death Review Panel for 2010-2013

Dr. dela Rosa is Board Certified in Pediatrics and Pediatric Critical Care Medicine. He is a Fellow of the American Academy of Pediatrics and a member of several other professional organizations, including the Pediatric Cardiac Intensive Care Society, Society of Critical Care Medicine, Society of Hospital Medicine, and the American College of Physician Executives.

OLOL Livingston Providing Specialty Services

Our Lady of the Lake Livingston has opened the first phase of the physician office tower and is now offering specialty services at the Our Lady of the Lake Physician Group Livingston Clinic. Several specialists will see patients at the Our Lady of the Lake Physician Group Livingston Clinic, including the following:

- Colon Rectal – Dr. Kelly Finan
- Family Practice – Dr. Phillip Ehlers and Dr. DeSha Folgar
- Internal Medicine – Dr. Maria Maggio
- Pediatric and Adult Allergy and Immunology – Dr. Sandhya Mani
- Plastic and Reconstructive Surgery – Dr. Taylor Theunissen
- General and Bariatric Surgery – Dr. Brent Allain; Dr. Mark Hausmann; Dr. Kenneth Kleinpeter; Dr. Karl LeBlanc; Dr. V. Keith Rhynes; Dr. John Whitaker
- Surgical Oncology – Dr. John Lyons, III

Additional clinics already open or set to open at Our Lady of the Lake Livingston in early 2013 include: Family Health of Louisiana, Bone and Joint Clinic, Gastroenterology Associates, Louisiana Cardiology, Baton Rouge Cardiology, Pain Management, Ear, Nose and Throat, Urology, and Eye Medical Center. Select physicians from individual practices will see patients at Our Lady of the Lake Livingston.

Urgent Care Offered at Ochsner–Prairieville

Just in time for the cold and flu season, Ochsner Baton Rouge began offering urgent care services at its Prairieville location in November. The Ochsner Health Center – Prairieville Urgent Care Clinic, located at 16220 Airline Highway, will be open from 10:00 am to 10:00 pm Monday through Friday.

The 10,200 square foot Ochsner Health Center – Prairieville opened in March 2010. Five Ochsner physicians and one physician's assistant offer internal medicine, family medicine, and pediatric services. In addition, Ochsner specialists offer cardiology and gastroenterology services throughout the month. The Ochsner Health Center – Prairieville Urgent Care Clinic is fully equipped with on-site laboratory and imaging services. In addition, patients will not need to make an appointment to see an urgent care provider.

BookCorner

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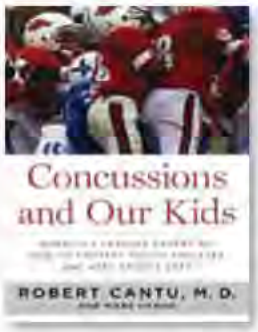


Concussions and Our Kids
by Robert Cantu, MD and Mark Hyman
c.2012. Houghton Mifflin Harcourt
$24.00 / $27.95 Canada
181 pages

The game, as they say, is the thing.

It's the thing at your house, that's for sure. Ever since your child's friends started playing sports at school, it's been the number-one topic around. He craves competition. She wants to sign up yesterday. He sees trophies and medals and honestly, you see them, too. After all, having a pro athlete in the family is a good thing, right?

For your child, it's all about the game. Still, you've got lots of reservations and, according to Robert Cantu, MD, that's great. In his new book "Concussions and Our Kids" (with Mark Hyman), you'll see how competition is important, but it's also potentially deadly.

Playing a team sport was something you enjoyed as a child and you want the same thing for your kids, too, but you worry. Even though your young athlete denies it, you've seen enough accidents on the field to know there's danger out there. Maybe you remember knocking noggins in a game yourself.

You wonder: are your kids safe enough in today's game?

Maybe not. Sports, says Cantu, are the "second leading cause of traumatic brain injury" for youth ages 15-24. Every sport, no matter how little contact there is between players, has some risk and helmets aren't always protection enough.

That's because a concussion can occur from something as minor as a hard bump or fall that snaps a player's head. Even if they're expecting it, a tackle or body check can jostle a child's brain enough to cause damage. If the player is under age 14, his muscles probably aren't mature enough to withstand a blow. And if there are multiple injuries, the danger multiplies, too.

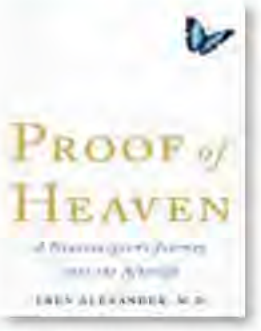
To best protect your child, know the symptoms of concussion and be sure your child's coach knows them, too. Don't rely on helmets and don't waste your money on fad fixes. Insist on a baseline brain test before the sports season begins. Lobby for less violence in children's sports. "Calm down" and remember that the players are just kids. And don't accept "it's not cool" as an excuse not to wear protective gear.

That extra-padded helmet might not be "cool," but neither is being in a coma.

You wince. You gasp. You want to cover your eyes when your child takes a hit on the field, but you should never look away from the play. Read "Concussions and Our Kids" and learn why.

Knowledge is key when it comes to head trauma, and authors Robert Cantu and Mark Hyman do a thorough job in preparing parents to be eagle-eyed on the subject. There's a lot of information packed in this book, along with myth-busters, blunt words, worksheets, cautionary tales, and one modern proverb that you can repeat to kids and coaches alike: "No head trauma is good head trauma."

There's always another ball season around the bend, but before you sign that permission slip, read this book. With "Concussions and Our Kids" and the knowledge you'll gain, you'll see that sports sometimes ain't no game.



Proof of Heaven
by Eben Alexander, MD
c.2012. Simon & Schuster
$23.99 / $27.99 Canada
208 pages

Nobody packs a suitcase like you do.

A weekend away? No problem. Cram everything you need in a tote and go.

A two-week cruise? Again, no problem. You can roll, fold, and stuff half-a-closet in a carry-on and still have room for a book.

It's a gift. You're like a squirrel when it comes to packing, but there's one trip you'll have to make someday, and you won't have to pack a thing.

Yes, you're going to die. But what happens and what awaits us on our final journey? In "Proof of Heaven" by Eben Alexander, MD, you'll read about one man's week-long experience, and the inspiring souvenirs he brought back.

It all started with a middle-of-the-night backache.

Neurosurgeon Eben Alexander awoke from the pain and headed for a warm bath, thinking it might help. It didn't, and neither did a backrub from his wife, Holley. The pain, in fact, intensified.

By mid-morning, Alexander was nearly unconscious.

Rushed to the hospital, he landed in the ICU, surrounded by baffled doctors who believed that he'd somehow acquired spontaneous E. coli meningitis. His spinal fluid and the outer portion of his brain were filled with pus. There was no brain activity, and no precedent: the affliction was a 1-in-10-million rarity.

But something amazing was happening to Eben Alexander.

Alexander says his first notion was that he was surrounded by primordial jelly, aware but not aware, and he could hear sounds. Working his way upwards and toward "dazzling darkness," he was greeted by a beautiful woman who took him on a breathtaking journey on a butterfly wing. She told him three things: he was loved, he was valued, and there was nothing he could do wrong.

One week after Alexander's coma began, doctors informed Holley that he had virtually no chance of recovery yet, literally, as they were walking to his room to stop treatment, he opened his eyes. Within months, fully recuperated, he started to cautiously talk about his journey because what he saw, he says, opened his mind and his heart.

Filled with serious science, medical information, and awe-inspiring theology, author Eben Alexander, MD gives his readers a lot to chew on.

No doubt, "Proof of Heaven" is a thinking-person's book.

Filled with serious science, medical information, and awe-inspiring theology, author Eben Alexander, MD gives his readers a lot to chew on. But this memoir isn't just that: Alexander also gives us an abundance of absorbing backstory, so we know why his spiritual journey was mind-bogglingly significant and why he believes that it unfolded as it did. What's interesting is that Alexander was a skeptic once, and now he struggles to convince the skeptics.

The only bumps in the road here are that he wrestles with descriptions of his experience. He admits that mere words don't do his visions justice, but he tries anyhow – which is magnificent at first, then just repetitious.

Even so, most of this book will stick with you for a long time after you close its back cover, making you seriously contemplate what you've read. Whether you're a believer or an undecided scoffer, in fact, I think "Proof of Heaven" will pack a wallop.

The Bookworm is Terri Schlichenmeyer.

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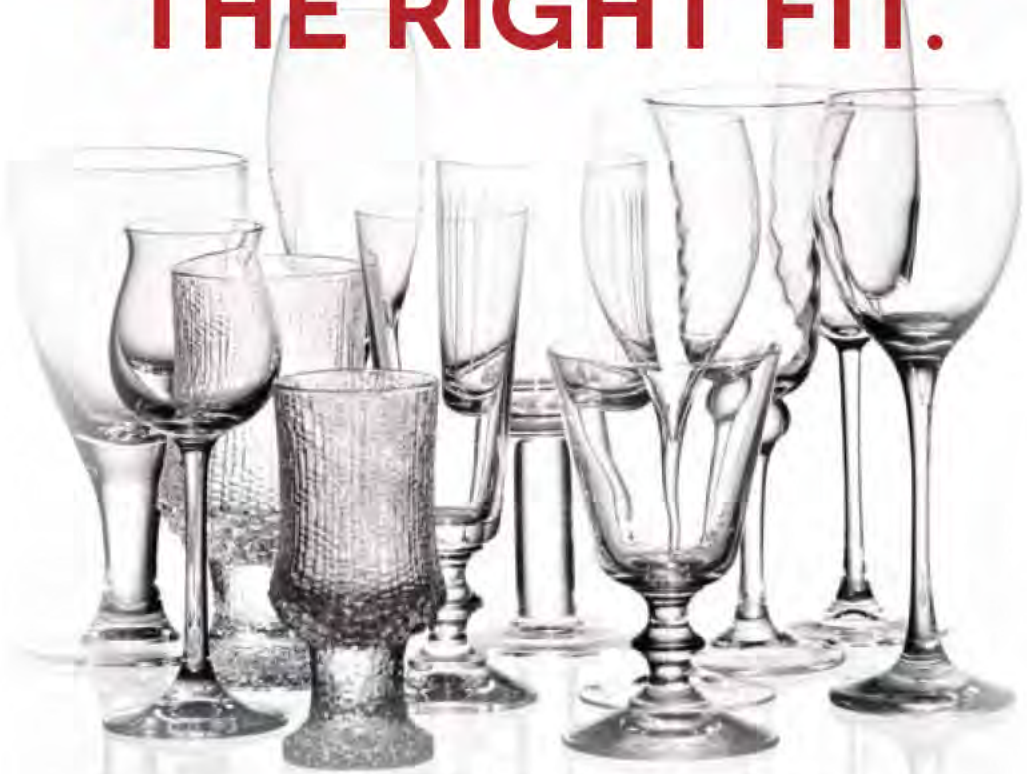

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