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**CORRESPONDENTS**

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One on One with

Rob Blair

CEO, NeuroMedical Center Surgical Hospital
Rob Blair has served as CEO of the NeuroMedical Center Surgical Hospital (NeuroMed) since 2010. NeuroMed is a for-profit facility, privately owned by 28 physicians, including Neurosurgeons, Pain Management physicians, Neurologists, NeuroRadiologists, and NeuroPsychologists.

NeuroMed's primary services include neurosurgery, pain management, and diagnostic imaging. In addition, the hospital provides non-surgery admissions, sleep studies, and electromyography, with new services on the horizon. Blair is also a healthcare consultant for two physician owned hospitals in Louisiana and serves on both hospitals' boards.

Prior to joining NeuroMed, Blair served as CEO of the Greater Baton Rouge Surgical Hospital for five years. The for-profit facility was collectively owned and operated by a local group of Baton Rouge physicians and United Surgical Partners International (USPI). GBR Surgical Hospital's primary services included a large variety of surgical services, complimented with diagnostic imaging.

Blair has also served as CEO for several hospitals and hospital management groups, including Kindred Healthcare–Hospital Division in Los Angeles, California, Healthsouth Rehabilitation Hospital of Baton Rouge, and Gulf States Health Services. He served as director of administration for the Surgery Department at Penn State Geisinger Health System and finance manager at the Milton S. Hershey Medical Center in Hershey, Pennsylvania.

Blair holds a degree in Health Care Administration from Pennsylvania State University. He is the President of the Louisiana Physicians Hospital Association and a member of the American College of Health Care Executives.
Chief Editor Smith W. Hartley: When it was passed in 2010, the Affordable Care Act included a restriction that blocks building any new physician owned hospitals and preventing existing ones from adding beds and operating rooms by blocking Medicare payments. Why is the federal government doing that and why is preventing physicians from owning hospitals a mistake?

Rob Blair: Their initial thought was that physicians would skim off the top and only take the highest paying cases. When in fact, they did the research and found out that’s not the case. But since then you have a few folks in Congress that are just adamantly opposed to the physician hospital industry. Some of those people that adamantly oppose us in Congress have family members who went to a physician owned hospital for surgery. Physician Hospitals of America (PHA) went and interviewed those folks and they went on and on about what a wonderful experience it was and how the outcomes were great. Then when PHA went back to that Congressman and asked about his daughter that had surgery and had a good experience he wouldn’t comment.

It’s a huge mistake. Who is CMS and the government to restrict the general public from getting top notch healthcare, from giving them options to go wherever they want? If a CVS opens on the corner the government can’t say Walgreens can’t open something up next door or similarly restrict any other industry. Competition is what brings out the best in people. The physician owned hospitals (POHs) have consistently provided better outcomes, lower infection rates, and better nurse to patient ratios. They provide jobs to the community, they provide taxes for the community. Of all the reasons the government tries to come up with to prevent the
physician owned hospital industry, none of those things they’ve tried to point out have come to fruition.

That’s even more so recently. Several years ago CMS came out with some initiatives that every hospital throughout the country must adhere to. Those are applicable to any size hospital that’s out there, whether it’s a small ten-bed hospital or a large acute care hospital. Everybody has to comply with the same rules, the same regs, the same quality controls. Several years later they’ve come out with a report that has all the hospitals in the country ranked. Nine of the top 10, 16 of the top 20, 23 of the top 30, 35 of the top 50, and 53 of the top 100 hospitals in the country are physician owned hospitals according to CMS regulations. So how can the government put restrictions on providing quality care? This industry has continuously proven to put up better outcomes.

Why? A perfect example is NeuroMed. All we do is neurosurgery. We know how to register the patient. All the people in the OR do is neurosurgery. It’s not that today you are doing neurosurgery, tomorrow ENT, the next day, ortho. All the scrub techs, all the nurses, all they do is neurosurgery. Even the multispecialty hospitals, all they are doing is surgery, they are not doing rheumatology, dermatology, radiology, oncology, or anything else. Their sole focus is on one thing. How is that not fair to provide that opportunity to the general public...to say this is what we do and we do it best? If I was having elective surgery I would definitely go to a physician owned hospital.

If this industry puts out the best outcomes, the best patient satisfaction...that’s what they are preaching right now—quality—and we are meeting those requirements...who is the government or CMS to not allow the public to have the full array of opportunities for their healthcare?

Editor: For years the American Hospital Association and the Federation of American Hospitals have raised some concerns with physician owned hospitals. They claim that they serve a healthier population and that’s more profitable. Is it a fair assessment for them to say POHs are cherry picking patients?

Rob Blair: The honest answer to that is yes and no. Yes we do provide services to patients who are healthier, but that’s in the patient’s best interest. We don’t have the full array of ancillary services to provide post-operative care if things go wrong, so, in the patient’s best interest, we are not going to do those types of surgeries here. When a surgeon meets with the patient in the clinic, they are going to determine where it’s most appropriate for them to have their surgery.

The flipside to that is no, we are not cherry picking by any means. It is the doctor’s...
dialogue

Editor: The data shows that physician owned hospitals usually have about a 20 to 35 percent profit margin compared to community hospitals, which are closer to 7 percent. Why is that the case? Are POHs just better run?

Rob Blair: Basically it boils down to just that...they are run more efficiently. I am going to be a lot more hands-on in the operations than say the CEO of a large, acute care hospital. I don’t want to necessarily refer to the Lake and the General, because it’s everywhere across the country. For example here, human resources and credentialing is done by one person. Whereas at a large acute care hospital you would have a whole department of HR folks and a department of credentialing folks. It’s very challenging finding individuals that can wear many hats, but we do and we roll up our sleeves, and get involved in the operations. My CFO and my Chief Nursing Officer probably do a lot more than their counterparts at a large acute care hospital. But we’re also just doing neurosurgery here. Down the street Surgical Specialty Center is doing multispecialty surgery and they are not getting involved with everything else. So it’s just run so much more efficiently.

Editor: I guess there is evidence that being a physician owned hospital does improve quality, but why is physician ownership significant in that calculation?

Rob Blair: The government had a theory that if the physicians had ownership that the referral patterns were going to change or that they might be doing surgeries that aren’t appropriate. But that also has been proven not to be the case. It’s kind of a question for all of us, why are they so opposed to it when for years the government has been focused on quality, quality, quality? Now these statistics come out and we’ve proven quality, but we are still not allowed to expand or build new hospitals.

Editor: Are there ways, if you are a physician owned hospital, to get around these rules?

Rob Blair: There are a few things that some of the places in the country are doing. One is, if you can’t expand your OR then you can expand your hours. Instead of stopping operations at 5 p.m., you can go until 8 p.m. You can do surgeries on Saturdays. You can also be strategic with the way that you do your inpatient beds. For instance, you can have extended stay recovery for those patients that will stay less than 24 hours and you can add extended stay recovery beds, but not add inpatient beds. So there are some ways around it, but it still doesn’t provide the full expansion opportunities that we should be able to have.

Editor: Is there something that society feels is intrinsically wrong with physicians referring to companies that they own?

Rob Blair: I don’t think that the general public is opposed to it at all. And that’s another issue—patient satisfaction. The patient satisfaction for physician owned hospitals is so much better than the patient satisfaction results at the big acute care hospitals. It’s pretty obvious in that if you are a smaller entity and provide more of a one on
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one relationship with your patients they are going to feel like family. It’s a different environment. It’s like going to your friend that owns a car mechanic shop and you know you are going to get really good results going to that person, versus going to a big dealership where you are just another car that comes through the line and you get that same generic care that everyone else gets.

Editor: You are president of the Louisiana Physician Hospitals of America. Do you have any lobbying efforts in the works to try to change these laws? Are you optimistic or do you think this is going to be the case for a while and you are just going to have to work around them?

Rob Blair: The industry within each one of the states has been fairly quiet...we don’t want to raise any red flags or fight more than we have to. We are pretty much more in reactive mode. We have a national organization, PHA, and they are a little more aggressive in fighting these laws. The only time in Louisiana where we collectively fought it was back when they instituted the first moratorium in 2005.

Editor: Do you feel like there might be a release on these laws in the future?

Rob Blair: I think that there will be some sort of middle road—I just don’t know what that is yet. The fact that all these statistics came out recently based on what CMS put in place, and we’ve done very well, helps. We’re getting a lot of public support for going back and saying, “You are preaching quality and these physician owned hospitals are providing quality, why won’t you allow them to grow?”

The latest regulation or compliance issue that they are trying to make sure we comply with is avoiding readmission. In other words take care of the patient’s issues in the hospital before you discharge them. Ideally you want to discharge them home rather than to another part of the healthcare continuum. So they are trying to lower readmission which is ultimately going to lower the cost of healthcare in general.

Another issue is we are not only providing better outcomes with lower infection rates, but we are also doing it for a cheaper price. We can’t get the same contracted rates as some of the big acute care hospitals. The physicians are typically going to get a lesser rate doing a procedure in a clinic. They take a little bit of a step up and get a little better reimbursement if they do it in a surgery center. Then you are going to get a little better rate if it’s done at a surgical hospital. The insurance industry knows we can provide the same service, but our overhead’s cheaper because they give us cheaper rates. So the same surgery that’s done here versus say at the Lake, is going to be significantly less. As a result of that we get a reasonable amount of attorney cases because the attorneys want to provide the surgical needs to their client at the lowest rate possible so the remainder of the funds that they may win in that case the client can pocket.

There are just so many reasons why this industry should exist, but it’s a David versus Goliath. It’s one of the main reasons we don’t fight so much—we don’t have the deep pockets to fight these battles so often.

Editor: What is the relationship between physician owned hospitals and large acute care hospitals? Is it competitive, contentious?

Rob Blair: If you take 53 out of 243 surgical hospitals that’s one fifth of our industry that is in the top 100 hospitals in the country. When these results came out the big acute care hospitals said the indicators weren’t fair, they weren’t applicable to us. You can’t please everybody all the time. It’s not going to be fair for everybody. These statistics that they were calculating over the years were a little more specific to orthopedic and general surgery and we don’t do those here, so we didn’t make the top 100, but there are enough surgical hospitals out there that do and there are certainly enough acute care hospitals that do so that there’s a fair comparison.

I think whether you are a big community hospital, small community hospital, physician owned hospital, everybody serves a purpose in the community. The general public needs all of us and I commend all of the hospitals on the service they provide the community.”
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Who Ya Gonna Call?

HAVE YOU EVER FAILED TO MAKE EYE CONTACT OR LOOKED sheepish while admitting you went to the doctor? Probably not unless the medical problem itself was a tad embarrassing.

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What is it about chiropractic care that still inspires skepticism despite the fact that chiropractors are the third largest group of healthcare providers in the country after MDs and dentists? Why is it that we have lower expectations of a practitioner with five or six years of focused study on the musculoskeletal system and who is licensed to practice in our state?
In the United States, visits to chiropractors have nearly doubled in the past couple of decades, numbering more than 280 million a year.
Some would say it’s a result of the ambulance chaser type chiropractor commercials one sees on television or the seemingly outlandish claims that some chiropractors make about curing just about anything with chiropractic care or special supplements. And there are of course, as in any profession, some bad apples. But Dr. J.C. Smith, chiropractor and author of The Medical War Against Chiropractors, thinks the reason is a bit more malicious. Smith, an outspoken advocate for chiropractic’s place in the care continuum, believes the hesitancy displayed towards chiropractors is a vestige of a longstanding and concerted campaign by the medical community to defame and discredit chiropractors and chiropractic research.

Smith said the war against chiropractors began in the 1920s when Morris Fishbein was Executive Director of the American Medical Association (AMA). Fishbein, who Smith claims was referred to by contemporaries as the Medical Mussolini, sought to eliminate any competition to the medical profession, waging war on not only chiropractors, but also homeopaths, naturopaths, osteopaths, and podiatrists, and creating a medical monopoly that Smith says still exists today.

Even after Fishbein left office, the war against chiropractors continued. In the 1950s the AMA’s code of ethics stated that physicians should not associate with practitioners of scientifically unfounded treatments, like chiropractors. At that time, said Smith, MDs who associated with or referred patients to chiropractors could lose their medical license. In 1966, AMA policy described chiropractic treatment as unscientific, irrational, and a hazard to health care. In 1976 several chiropractors filed a lawsuit, Wilk et al. v. the AMA, et al., against the AMA, the American Hospital Association, and several other medical societies alleging anti-trust activities to hinder the development of chiropractic care. The AMA, in fact, had a “Committee on Quackery” whose mission it was to “contain and eliminate chiropractic.” The chiropractic community finally won that case in 1987, although detractors still say the case should not be used to legitimize the profession, just correct the discriminatory behavior.

In 1992, the AMA softened its position and issued Opinion 3.041 – Chiropractic which states:

It is ethical for a physician to associate professionally with chiropractors provided that the physician believes that such association is in the best interests of his or her patient. A physician may refer a patient for diagnostic or therapeutic services to a chiropractor permitted by law to furnish such services whenever the physician believes that this may benefit his or her patient. Physicians may also ethically teach in recognized schools of chiropractic.

According to Dr. Smith, evidence-based chiropractic research had also lagged due to it being considered a taboo topic for many years. However, around the time of the AMA opinion, groundbreaking research by the RAND Corporation revealed some benefit to spinal manipulation in the treatment of acute low-back pain, which prompted a reevaluation of chiropractic care and a call for more studies. According to the current National Institutes of Health National Center for Complementary and Alternative Medicine website, multiple studies have shown that spinal manipulation is one of several options—including exercise, massage, and physical therapy—that
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can provide mild-to-moderate relief from low-back pain, often as effectively as conventional medical care. Research continues to be done on the effectiveness of all back pain treatments, both medical and chiropractic, with varied results. Despite the studies and the fact that chiropractors may no longer be legally marginalized, there still remains a large breach in the public’s understanding of what chiropractors do and what training is required of them, says Smith. Doctors of Chiropractic (DC) must:

- Have a minimum of 8-9 years of college, with 4-5 post-graduate years in chiropractic education and training.
- Graduate from a chiropractic school accredited by the Council on Chiropractic education, which generally entails about 2000 hours of education on the musculoskeletal system alone.
- Pass the National Chiropractic Board Exam.
- Be licensed by the state in which they practice (although scope of practice does vary from state to state).

Notably, Louisiana was the last state to agree to licensing of chiropractors, earning the title, “bastion of medical conservatism” from Smith. When asked if there was an ongoing feud between the medical and chiropractic communities in our state, both the Louisiana State Medical Society and the Capital Area Medical Society declined to state a position, indicating it wasn’t really on their radar.

So are Smith's concerns justified? As noted before, the chiropractic profession seems to be thriving, coming in third in number of practitioners behind physicians and dentists. In the United States, visits to chiropractors have nearly doubled in the past couple of decades, numbering more than 280 million a year. Insurance companies now cover chiropractic treatments, although generally cap the number of visits per year. Even Smith admits that the situation has improved, saying a recent study indicated one third of MDs surveyed said they referred patients to chiropractors, and another third would consider doing so. It's that last third, the doctors that would not refer, that gets Smith's goat. He says there is an apparent continuing media bias against conservative chiropractic manipulation as a viable alternative to drugs and surgery that he suspects is fueled by Big Pharma. "Even though there is this more egalitarian attitude by some MDs, the flowers in the desert, it really hasn't changed that much," said Smith.

The treatment of back pain is also big business. It is the number one disabling condition worldwide and a nearly $300 billion industry in the U.S. alone. Smith believes the continuing bias against chiropractors is driven by simple greed—an unwillingness to give up a major portion of business that he believes can be better handled by chiropractors. He wants chiropractors to be the first choice for back pain, while conceding that about 15% of cases are due to medical causes like cancer, fractures, and infections and should be handled by MDs. Smith says the primary justification for most medical back treatments is “bad discs” but he argues the true problem is mechanical, in joint misalignments, which affect the nervous system. "I think we need to start addressing the intellect of Americans and help them make an informed choice," said Smith. "I want them to come here because they understand what's going on. I am trying to crack this nut of this medical and media boycott of chiropractors."

Smith is hoping that provisions in the Affordable Care Act will increase coverage for chiropractic care and make it a more viable option for more Americans. "We're on the brink of being saviors in the back pain epidemic once we get this medical bigotry and this stigma off our backs," said Smith. "Chiropractors should be known as America's primary spine care providers, just like a dentist is the primary dental care provider."

Sources:
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STAGE 2
of the electronic health record incentive programs: Building from Stage 1

The Centers for Medicare & Medicaid Services recently published the final rule for Stage 2 of the Medicare and Medicaid electronic health record incentive programs. The rule provides new criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet to participate successfully in the incentive programs.

Stage 2 core and menu objectives
Stage 1 established a core and menu structure for objectives that providers had to achieve in order to demonstrate meaningful use. Stage 2 retains that core and menu structure for meaningful use objectives.

In Stage 2:
Eligible professionals will be required to meet 17 core objectives, as well as three menu objectives (which they select from a list of six), for a total of 20 objectives.

Eligible hospitals and critical access hospitals must meet 16 core objectives, as well as three menu objectives (which they select from a list of six), for a total of 19 objectives.

Changes to Stage 2 meaningful use objectives
Most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of those Stage 2 objectives, the threshold that providers must meet to achieve them has been raised. CMS expects that providers who reach Stage 2 in the incentive programs will be able to demonstrate meaningful use of their certified electronic health record technology for an even larger portion of their patient populations.

Some new objectives were also introduced for Stage 2, and most of those were introduced as menu objectives. As with Stage 1, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside their normal scope of clinical practice.

Providers can visit the CMS website and download comparison tables for the Stage 1 and Stage 2 core and menu objectives and measures: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

FOR MORE INFORMATION ON THE CMS EHR INCENTIVE PROGRAMS, PLEASE VISIT HTTP://WWW.CMS.GOV/EHRINCENTIVEPROGRAMS/
What is the mission of the Capital Area Medical Society?

A. The mission of the Capital Area Medical Society (CapitalAMS) is to unite, serve, and represent physicians as advocates for the well-being of patients, for the health of our community, and for the profession of medicine.

The Society holds membership meetings twice each year, during which we conduct society business, hold elections, and discuss important healthcare related topics.

Recent speakers have discussed the future of medical education in Baton Rouge and how Healthcare Reform is going to affect physicians and their patients.

How many members are in the Capital Area Medical Society?

A. The CapitalAMS is comprised of 675 total members, including medical students, residents, active members, and retired physicians.

Are all specialties equally represented?

A. Formerly known as the East Baton Rouge Parish Medical Society, the CapitalAMS was founded in 1878 and is the only medical organization in the region that represents physicians from all specialties.

Our Board of Directors exemplifies the diversity of our membership and includes practitioners in emergency medicine, internal medicine, pediatrics, OB/GYN, urology, ENT, ophthalmology, general surgery, trauma surgery, and plastic surgery.

The Society advocates for its members of all specialties, uniting them around common values and principles shared by all physicians.

How do you attract membership?

A. We try to educate local physicians about the benefits of membership and the importance of being a part of the voice of organized medicine in the community.

Last September, we threw a membership recruitment party at the home of President-Elect, Dr Beau Clark, during the Auburn/LSU football game.

What are some benefits to being a member of the Capital Area Medical Society? Why should a physician join?

A. There are several reasons why Baton Rouge area physicians should join the CapitalAMS. The following are some benefits our members enjoy:

Grassroots Advocacy

The Society functions as a grassroots organization to support or oppose legislative initiatives that impact the practice of medicine.

We are the regional component society of the Louisiana State Medical Society, which is the largest physician organization in the state, with more than 6,500 physician members. The LSMS is the only physician organization with the size and experience to consistently influence policy makers.
Conflict Resolution
With the goal of preserving the doctor patient relationship, the Society helps members and patients resolve misunderstandings and problems with communication. This valuable service assists physicians and their patients in settling conflicts as an alternative to the patient seeking resolution within the legal system.

Networking
General membership meetings and social functions offer a forum for physicians to network and cultivate relationships. Members have access to the Capital Area Medical Society online physician directory on our Website, www.capitalams.org.

Opportunity for Service
As a member, a physician is eligible to serve on the Capital Area Medical Society Board of Directors, committees, and task forces. In addition, a member may serve as a Delegate or Alternate Delegate to the annual LSMS House of Delegates meeting, at which LSMS members meet each January to debate the relevant issues impacting physicians and to set policy for the upcoming legislative session and calendar year.

Visibility to Patients
The “Physician Locator” Section of our Website is a free, online service for the community that helps doctors, too. We provide names of member physicians and information to assist patients in locating a physician. In addition, the Society receives hundreds of calls each year from potential patients seeking physicians. Callers are referred to the CapitalAMS Website Physician Locator Section, where they can search through the names of our member physicians.

Staying Informed
Our informative quarterly newsletter, The Stethoscope, features articles on healthcare legislation, healthcare reform, and hot topics which impact the practice of medicine. MemberFAX & MemberEMAIL networks keep physicians informed about pending legislation, breaking news, and upcoming events and activities.

What are some changes going on with healthcare in Baton Rouge and Louisiana?

A. The Society board of governors is concerned about the speed with which the state government has dismantled the charity hospital system, which served for generations as the safety net for the healthcare of Louisiana’s poor and uninsured, as well as the training ground for our medical students and residents. Reform of this antiquated system was no doubt inevitable and necessary, but the rapidity of the transition, with no well-defined contingency plan, raises valid concerns. The state’s current solution, as we have gleaned from attendees at closed door meetings and the surprisingly rare media clip, is that the private sector will assume responsibility for taking care of the poor and uninsured and for training Louisiana’s future doctors.

Baton Rouge physicians are currently...
feeling the effects of this past April’s closure of Earl K. Long Hospital. The closure has left patients, medical students, residents, nurses, and ancillary healthcare personnel clamoring for a location to seek treatment, education, or employment. Our Lady of the Lake Regional Medical Center has contracted with the state to provide care for indigent patients in exchange for subsidies, but it remains to be seen whether the money promised will be there over time, considering the state’s precarious financial situation.

A significant portion of the residency programs at Earl K. Long have also transitioned to OLOL, but the American Council for Graduate Medical Education (ACGME) and several Residency Review Committees (RRCs) have already voiced serious concerns with the impending overhaul of LSU’s residency programs.

Last October, then president of the Louisiana State Medical Society, Dr. Andy Blalock, sent an open letter to LSMS members, which emphasized the society’s support of preserving quality graduate medical education in Louisiana. He concluded, “We will not cut our way to successful and prosperous healthcare outcomes. Balancing the cost of budget reductions on the backs of current and future physicians training in Louisiana is going to take its toll. In fact, damage is already manifesting itself in medical students’ and residents’ hesitancy and avoidance of training programs in Louisiana.”

The majority of physicians practicing in Louisiana either attended an LSU medical school or were trained by in-state residency programs. It is generally observed that most physicians practice near the geographic location of their residency programs. If the state is unable to retain the “best and brightest” medical students to complete their residencies here, the logical conclusion is that our finest physicians will not return here to practice.

### What are some complaints you have heard about the direction healthcare is going?

**A.** I think physicians are rightfully concerned about the overhaul of the Louisiana charity hospital system and how it will affect their practices as well as graduate medical education.

Doctors are increasingly aware that the practice of medicine is besieged on all fronts—by insurance companies, pharmaceutical companies, the federal government, state legislators, state executives, plaintiff’s attorneys, lobbyists of ancillary healthcare providers, and special interest groups. Each year, the CapitalAMS and LSMS fight to stop legislation that will adversely affect the practice of medicine and to pass legislation that will strengthen it.

There is no small amount of uncertainty regarding the future of the medical profession in terms of the implementation of national healthcare reform, the possible expansion of Medicaid, the advent of ICD-10, the establishment of Affordable Care Organizations, and the potential dissolution of the fee for service physician payment model.

Physicians are concerned about the dubious efficacy and onerous reporting requirements of performance-based outcome measures, which are now mandated by national healthcare reform. Physicians have seen reimbursement decrease year after year, while premiums for our own healthcare insurance have climbed precipitously since the 2010 passage of the Patient Protection and Affordable Care Act.

### Does the Capital Area Medical Society have anything important on its agenda such as future plans or directions?

**A.** While the 2013 Louisiana state legislative session was in full swing, the CapitalAMS and LSMS were hard at work at the capitol, advocating for Louisiana physicians and their patients. Perhaps the most contentious healthcare bill of this session was HB 527, introduced by Representative Frank Hoffman (R – West Monroe).

HB 527 would have given optometrists license to perform conventional and laser surgery of the eye and eyelids. It would have allowed optometrists to call themselves “optometric physicians.” The bill would also have authorized optometrists to prescribe potentially addictive schedule 2 narcotics (e.g. oxycodone, hydrocodone), among other medications.

In addition, the regulation and discipline of these newly legislated “surgeons” would be governed by the Louisiana Board of Optometry. Physicians voiced serious concerns that a board comprised of non medical doctors would be able to effectively regulate the practice of surgery, in which the board members have no expertise.

The response of organized medicine toward this vast expansion of the scope of practice of optometrists was swift and effective. The message was simple. Educate the public about the differences between ophthalmologists and optometrists. So fierce was the opposition and so compelling were the arguments against HB 527 that ultimately, Representative Hoffman withdrew the bill on May 2nd.

Sometimes it takes something like this bill to unite physicians over shared convictions of promoting patient safety, preserving the doctor patient relationship, and upholding the ethical practice of medicine. This bill is but an example of the challenges physicians (and indirectly our patients) face each year in the state legislature.

Another area of focus for the CapitalAMS and LSMS is to enact meaningful tort reform to limit the frequency of frivolous medical malpractice claims. I urge all physicians in the Baton Rouge region to join the Capital Area Medical Society so that medical doctors will have a stronger voice in shaping the future of health care in Louisiana.
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“Our affiliation with Our Lady of the Lake Regional Medical Center, Woman’s Hospital, OLOL Livingston and Lake Imaging Center has provided us with state of the art neuroimaging for our patients including access to a new 3T MRI. We are a comprehensive neuroradiology practice, offering a full range of neurointerventional procedures and high quality interpretations in the neuroradiology subspecialties of brain, head and neck, spine, and pediatrics,” says Dr. Christian Morel.

Radiology Associates welcomes our third neuroradiologist, Dr. Laura Miller. She is a board certified, fellowship trained neuroradiologist from Vanderbilt University. Dr. Miller will be a valuable asset to our neuroradiology team of Dr. Dwayne Anderson and Dr. Christian Morel.

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However, what many did not know was the growing use of these injections had already drawn considerable scrutiny as to their appropriateness, effectiveness, and even as to who was administering them and how. Although several professional pain organizations had already begun to question the utility of some interventional tests and treatments for back pain, in our instant gratification society, patients expect and sometimes demand a quick fix for what ails them. According to the American Pain Society, low-back pain is the fifth most common reason for doctor’s visits and in 2009 accounted for $26 billion in healthcare costs.

As growing abuse of prescription painkillers gave some unscrupulous pain management clinics a black eye and forced providers to exercise caution about the medications they prescribed for the nation’s seemingly ubiquitous back pain, the use of ESIs blossomed—by some reports, increasing over 600% in a four year span. Like the imaging boom of a few years ago, it seemed everyone wanted a piece of the action. Soon physicians in non-pain management specialties were acquiring the training (sometimes completed over the course of one weekend) to add the shots to their repertoire. While it can be argued that they were simply expanding the services they offer to their patients to address their pain, others attribute financial motives to these physicians as the shots are quite expensive and generally well reimbursed.

So what’s the problem? Aren’t we talking about trained physicians providing a relatively routine treatment? The problem, say those who are certified in pain management, is there’s more to the management of pain than a quick shot. They are concerned about the proliferation of
doctors who might not explore other interventions such as over-the-counter pain medication, physical therapy, etc. before administering the ESI. They also stress that the shots, while routinely given, should be administered in a sterile operating room, preferably with fluoroscopic guidance, and always with patient monitoring equipment and staff trained in resuscitation should a patient have a severe reaction. Whether or not that is happening, there are also obviously considerable differences in the training received during a year-long pain management fellowship and a weekend course.

J. Michael Burdine, MD, a board certified pain management specialist with the Spine Diagnostic and Pain Treatment Center, and a member of the Louisiana State Board of Medical Examiners, says the board is seeing more and more instances of physicians being disciplined for practicing outside their specialty, not just in pain management. “The Board has a position that you should only practice within your area of expertise. What we are seeing is a lot of physicians are starting to drift outside of the area in which they are specifically trained. This is becoming clearly much more problematic. Not only is it problematic in pain management, but also in dermatology and plastic surgery.”

The problem is twofold, says Burdine. The first is that some physicians are misleading patients by claiming to be board certified. In Louisiana in order to claim that you are board certified, you must be certified by the American Boards of Medical Specialties (ABMS). “There are four or five boards that claim you can be board-certified,” says Burdine. “But not all of them have challenging exams and for some of them you just pay money. It’s really misleading to the public.”

The second problem is if these physicians are not certified by ABMS they may lack adequate training to determine when interventional methods like ESIs are indicated and also may not provide the injections in the appropriate manner or setting. Then it becomes a potential patient safety issue. “What you are not seeing is the comprehensive evaluation of the patient before you have that injection. Are they getting physical therapy, is it the right type of physical therapy, is it an exercise-based core stabilization, postural education, or are they just sending them for massage and heat and ultrasound?”

Burdine agreed that some physicians are simply taking a weekend course on injections or pain management and then claiming to practice pain management. “Not only are they not getting the evaluation of a double-board certified
“I would agree there are cases where there is not very good evidence for doing these. And then there are cases where there is good evidence for doing exactly this procedure. But again, it’s going to take someone who has the knowledge and the expertise to make that decision. We work to make sure we are not just doing shots, but that we are doing everything that’s appropriate and giving patients every opportunity to get better without having surgery. **Once you have surgery, surgery is done as an option. You’ve crossed that bridge...you can’t unoperate.**”

pain specialist, but they are really looking at it as an avenue of revenue enhancement as opposed to really quality patient care,” he said.

It also seems, based on a study conducted by the University of Colorado School of Medicine, that a small percentage of doctors may be performing a disproportionately high percentage of interventional spine procedures, including epidural steroid injections, which always raises a red flag as to the possibility of overuse, even among those who specialize in pain management.

All of these factors are troubling particularly as there are also questions as to the efficacy of ESI as a treatment. Several studies indicate that most patients with back pain and/or sciatica gain no long-term relief from ESIs and only a few experience significant short-term relief. A systematic review and meta-analysis of epidural corticosteroid injections in the management of sciatica recently published in the *Annals of Internal Medicine* suggested, “that epidural corticosteroid injections offer only short-term relief of leg pain and disability for patients with sciatica. The small size of the treatment effects, however, raises questions about the clinical utility of this procedure in the target population.”

Burdine indicated that the evidence issue is a “very gray subject” due to the difficulties of conducting controlled trials. “I would agree there are cases where there is not very good evidence for doing these. And then there are cases where there is good evidence for doing exactly this procedure. But again, it’s going to take someone who has the knowledge and the expertise to make that decision. We work to make sure we are not just doing shots, but that we are doing everything that’s appropriate and giving patients every opportunity to get better without having surgery. Once you have surgery, surgery is done as an option. You’ve crossed that bridge...you can’t unoperate.”

The concept behind the shots certainly makes sense. Steroids injected into the epidural space can temporarily calm the inflammation of nerves caused by herniated disks, arthritis, etc. However, according to a report by *Consumer Reports* and the American Society of Health-System Pharmacists, three professional organizations in the business of pain management, the American Pain Society, the American Society of Interventional Pain Physicians, and the American Academy of Neurology, each concluded that ESIs offered no long-term benefit to those with lower back pain caused by nerve inflammation. In 2009 the American Pain Society issued a new clinical practice guideline for low back pain that emphasized the use of non-invasive treatments over interventional procedures, as well as shared decision-making between provider and patient. It recommends a discussion of the risks and benefits of epidural steroid injections including a specific review of evidence of the lack of long-term benefit for patients with persistent radiculopathy due to herniated lumbar disc. Roger Chou, MD, lead author of the new guideline, said, “In general, non-invasive therapies supported by evidence showing benefits should be tried before considering interventional therapies or surgery.”

Burdine agrees with the intent of that guidance, but expressed frustration that many of the studies questioning the effectiveness of various treatments fail to offer other solutions. “You can quote all the studies you want, but when the patient is in here crying saying, ‘I have to have something done, and I want surgery as my last option’, what can you do? Then you can offer them some options and you can quote them the statistics on how effective each of them may or may not be. But it comes down to the patient wants to be treated.”

And for anyone that has ever experienced back pain, you know that short term relief may just be enough at that moment in time. Similarly, for a healthcare provider wanting to relieve his/her patient’s pain, that may seem adequate justification. Burdine acknowledges that patients may be looking for a more immediate solution to their pain than physical therapy or pain
The Louisiana Health Care Quality Forum is the state-designated entity charged with developing and managing the health information super highway for our state. To date, more than 130 hospitals, clinics, physician practices, school-based health centers and health care companies are participating in the Louisiana Health Information Exchange, or LaHIE.

For more information, contact us at (225) 334-9299 or email info@lhcqf.org.
Dr. Burdine demonstrates the proper setting and technique for an ESI procedure.

medication because they can’t miss work. So the injections can be helpful, even if it’s just to relieve the pain enough to pursue other treatment. “But injections are never the only answer for these types of problems. There are anti-inflammatory medicines, quiet nerve pain, physical therapy, workspace enhancement, correct stretching, and exercises. This is a lifestyle change.”

With the meningitis outbreak as an extreme example, the shots themselves are not without potential adverse effects such as infection, damage to nerves or the spinal cord itself, or even paralysis. That seems a lot of risk for something that may not help that much, which is another reason that some pain management specialists are concerned about who is performing the shots and where. “This is not something that a lot of pain specialists do in their office. The majority are doing them at an ambulatory surgery center or in the hospital,” said Burdine. “At that point you have state regulation, federal regulation, and you are assured a safe, clean, appropriate environment for having these done. You are really going to significantly reduce your incidence of infection and complications.”

Performing procedures at these types of facilities also adds a level of control. “When you give an attorney license to practice law, they can practice tax law, divorce law, maritime law. With physicians it’s currently the same way. You get a license to practice medicine and after one year of internship you can practice whatever you want, assuming you can get insurance and have a place to do it,” said Burdine. “There’s a certain degree of control that’s mandated through hospital boards and surgery center boards, because, for example, nobody is going to let you practice neurosurgery with one year of surgery.” It is much harder to oversee and regulate who’s performing procedures at their own clinics or facilities.

The only way to address that, said Burdine, is at the board level based on standards of care and patient safety issues, but there are some real gray areas. “That’s why the board took the position that physicians should only practice in their areas of expertise,” said Burdine, giving the example of primary care doctors and dentists now offering botox treatments or a general surgeon offering liposuction and perhaps deciding to add breast enhancement because ‘it’s not that different’. “You end up on this slippery slope,” said Burdine. “We tend to see it with these weekend courses. You go on a cruise and they will teach in office ortho, in office plastic surgery, dermatology, pain management. It’s a four day course and the first two days are on billing and marketing. We are seeing more and more of this. In the doctor’s mind he did a course and it doesn’t really look that hard.” In those physicians’ minds they are not thinking they are not qualified, they are thinking, ‘This isn’t that hard’ and that it’s something good they can offer their patients, explained Burdine.

“To do the procedure itself—anyone can be trained to do this. It’s knowing who is the appropriate person for the procedure, is the procedure appropriate for the person, have all the other options been addressed, and after the procedure how are you going to combine that with other modalities that will get this patient better?”

At this time there are no plans to crack down on the expanding use of ESIs. However the Board of Medical Examiners is almost certainly looking more closely at where those shots are being administered and by whom, as well as at misleading board certification claims. There is also no real consensus on the efficacy of ESIs and whether they will remain a routine treatment for lower back pain and sciatica, but the increased scrutiny as to their safety may well be welcome.

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**Be Heard**

**QUESTION** | Is Medicaid expansion right for Louisiana? Why or why not?

**ANSWER** | I am somewhat conflicted. On one hand I am the father of a disabled adult who receives Medicaid. On the other, I am someone who feels passionately that people, and by extension, states, have the right to choose what is best for themselves and for their families. I am also concerned about claims that accepting Medicaid expansion will be in the state’s long-term best interests. We must first reform and fix Medicaid before we seek to make it the vehicle for expanded healthcare coverage.

Roy Delaney, Sr.
LtCol USMC (Ret.)

**ANSWER** | Yes, because it will help provide some level of healthcare insurance to many people who currently have no insurance. It will help improve the primary care available to those who have very limited access due to no insurance. Also, as Louisiana continues to privatize the charity system and uncompensated payments to rural hospitals are eliminated, it is important to provide a more stable form of payment to providers for the future.

Federico Martinez, Jr.
Chief Executive Officer
St. Charles Parish Hospital

**ANSWER** | While it is important for Louisiana to take advantage of federal resources available to expand healthcare coverage, such an expansion must be done in a thoughtful manner. Currently, hospitals receive approximately 60% of what it actually costs to care for Medicaid patients. Although the LHA supports coverage for the uninsured, reimbursement to healthcare providers must cover the cost of providing care. Medicaid expansion without payment reform is unsustainable for Louisiana’s healthcare delivery system.

John A. Matessino
President & CEO
Louisiana Hospital Association

**QUESTION** | Should chiropractors be the primary providers of spinal care?

To respond, email to: editor@ushealthcarejournals.com and put “Be Heard B.R.” in your subject line. To be published, include your name and job title. Please keep your responses to no more than 75 words. We will publish up to 3 responses per issue.
First Practices Join New BCBS Program

Three primary care practices—West Monroe Family Clinic, West Calcasieu Virtual Medical Home, and Baton Rouge General Physicians—have signed up for Quality Blue Primary Care (QBPC), Blue Cross and Blue Shield of Louisiana’s innovative population health and quality improvement program. QBPC is designed to get better outcomes for patients with chronic diseases, support doctors, and transform healthcare delivery.

Blue Cross is implementing QBPC in primary care physicians’ offices and clinics, and will roll it out statewide over two to three years. In the early months of QBPC, Blue Cross is signing up network primary care practices that treat the highest number of members with chronic diseases such as diabetes.

David Carmouche, MD, chief medical officer for Blue Cross and Blue Shield of Louisiana, said that Quality Blue Primary Care is the next generation of population health management. “This model will significantly improve patient outcomes and support providers. We are making a substantial investment by paying for software and helping the participating practices through the transformation,” Carmouche said. “This will give our providers the data and support they need to improve both overall healthcare quality and the lives of their individual patients with chronic diseases.”

Two years ago, Blue Cross began using a model for primary care called the patient-centered medical home, or PCMH. It focused on improving patients’ health and lowering costs. Both QBPC and PCMH offer organized, team-based, proactive care that works to prevent disease and protect or restore health.

QBPC builds on the basic features of PCMH to offer an enhanced model for population health, in which providers can focus on improving care quality for their total patient population, not just those who are actively seeking treatment. Blue Cross will offer QBPC practices the technical and clinical support and guidance they need to manage their patients’ care in the least disruptive way. The QBPC payment structure rewards providers for better patient outcomes, with a care management fee paid on top of their usual fee-for-service setup.

Blue Cross contracted with two strategic collaborators, MDdatacor and Integrated Medical Practices, to support QBPC. MDdatacor supplies healthcare IT solutions that empower payers and providers to deliver the highest quality healthcare possible. Blue Cross will use the company’s proprietary MDInsight® technology to help practices identify, manage and improve the quality of care for their patients. MDdatacor currently supports 10 Blue Cross and Blue Shield plans throughout the country with its MDInsight software solution.

Integrated Medical Processes, LLC (IMP), a clinical integration consultancy focused on population management and value-based care models, is establishing the framework and implementation strategy that will allow this group of healthcare quality leaders to begin the process of truly transforming our healthcare system.

For more on Quality Blue Primary Care, visit www.bcbsla.com/qbpc. Carmouche is on Twitter at @DrCarmouche and hosts a LinkedIn group called the Louisiana Quality Care Network where healthcare professionals share information and best practices.

Medicare Fraud Strike Force Nabs Eleven

Attorney General Eric Holder and Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced that a nationwide take-down by Medicare Fraud Strike Force operations in eight cities has resulted in charges against 89 individuals, including doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $223 million in false billings. Among these were eleven individuals targeted by the Baton Rouge Strike Force.

The coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history. In total, almost 600 individuals have been charged in connection with schemes involving almost $2 billion in fraudulent billings in these national take-down operations alone. The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country.

The defendants charged are accused of various healthcare fraud-related crimes, including conspiracy to commit healthcare fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME), and ambulance services.

Eleven individuals were charged by the Baton Rouge Strike Force. Five individuals were charged in New Orleans, including two doctors, by the Baton Rouge Strike Force for participating in a different $51 million home health fraud scheme. According to court documents, the defendants recruited beneficiaries, offering cash and other incentives in exchange for their Medicare information, which was used to bill medically unnecessary home health services. The Baton Rouge Strike Force also announced a superseding indictment and an information charging six individuals, including another doctor, with over $30 million in fraud in connection with a community mental health center called Shifa Texas. These charges come on top of charges brought against the owners and operators of Shifa Baton Rouge, a related community mental health center which is at the center of an alleged $225 million scheme charged in an earlier indictment.

The cases are being prosecuted and investigated by Medicare Fraud Strike Force teams comprised of attorneys from the Fraud Section of the Justice Department’s Criminal Division and from the U.S. Attorney’s Offices for the Southern District of Florida, the Eastern District of Michigan, the Eastern District of New York, the Southern District of Texas, the Central District of California, the Middle District of Louisiana; the Northern District of Illinois, and the Middle District of Florida; and agents from the FBI, HHS-OIG and state Medicaid Fraud Control Units.

An indictment is merely a charge and defendants are presumed innocent until proven guilty.

To learn more about HEAT, go to: www.stopmedicarefraud.gov.
AARP: Cuts Could Increase Poverty
A new analysis of Census data showing that more Louisianans are living in poverty shines a spotlight on cuts to Social Security and Medicare now being considered in Washington that could push even more seniors into poverty, said the AARP.

According to the Kaiser Family Foundation analysis, 19 percent of people 65 and older in Louisiana have incomes below the supplemental poverty line. This compares to 15 percent of older Louisianans living in poverty under the traditional measure.

Right now, some politicians support “chained CPI” which would cut Social Security by $127 billion over the next 10 years alone. The cut would start now and grow larger every year, hurting seniors the most when they can least afford it, said AARP. There are also Medicare proposals that would cut benefits or force patients to pay more out of their own pockets or even avoid care, while failing to contain long-term cost increases that are the real, underlying problem for healthcare and the federal budget.

The non-profit Kaiser Family Foundation report provides a state-specific breakdown of poverty rates among seniors using both the traditional measure of poverty and an alternative measure first released by the Census Bureau in 2011. The alternative, or ‘supplemental’ poverty measure, more accurately represents real world conditions by taking into account seniors’ disproportionately high healthcare costs. It finds a higher poverty rate among seniors in every state.

For more AARP Louisiana resources and information, visit www.earnedasay.org or www.aarp.org/la.

Strategies for LaHIE Expansion Emerge
With more than 130 hospitals, clinics, providers, and other health care companies now enrolled to participate in the Louisiana Health Information Exchange (LaHIE), strategic investments are being made to expand the reach and capabilities of the statewide health information exchange (HIE).

LaHIE, an initiative of the Louisiana Health Care Quality Forum, officially launched in November 2011 with Lafayette General Medical Center and Opelousas General Health System as pilot sites. Both hospitals went live with LaHIE in December

PARKINSON’S CONFERENCE SCHEDULED FOR PBRC
The Pennington Biomedical Research Center will host the 2nd annual Parkinson’s Conference on Saturday July 27th from 9:30 a.m. to 2:30 p.m. This free Community Education event is designed for Parkinson’s patients, caregivers, and providers. The agenda includes:

9:30 a.m. - 9:45 a.m.
- Introductions and Welcome - Main Auditorium
  • Donald Ingram, PhD, Professor, Pennington Biomedical Research Center
  • Phil Brantley, PhD, Associate Executive Director, Pennington Biomedical Research Center
  • Gerald Calegan, MD, The NeuroMedical Center

9:45 a.m. - 10:15 a.m.
- Exercise in Parkinson’s Patients: Is it Worth the Sweat?
  Cynthia Comella, MD, FAAN, Professor, Department of Neurological Sciences, Rush University Medical Center, Chicago

10:15 a.m. - 10:45 a.m.
- Deep Brain Stimulation as a Treatment for Parkinson’s Disease
  Gerald Calegan, MD and Paul Waguespack, MD, Neurologists, The NeuroMedical Center

10:45 a.m. - 11:15 a.m.
- Depression and Anxiety in Parkinson’s Disease
  Glenn Kidder, MD, Neurologist, The NeuroMedical Center

11:15 a.m. - 11:45 a.m.
- Q & A / Morning speakers will answer questions
  Stretch Time

11:45 a.m. - 12:30 p.m.
- Lunch and Exhibits

12:30 p.m. - 1:10 p.m.
- You are NOT Parkinson’s: Reclaiming Positive Perspective
  John Baumann, JD, Author of “DECIDE SUCCESS” and “Roadmap to Success”

1:10 p.m. - 1:40 p.m.
- “Moving it” to Improve Physical Function in Parkinson’s Disease
  Jan Honzinski, PhD, Associate Professor, School of Kinesiology, Louisiana State University

1:40 p.m. - 2:10 p.m.
- New Look at an Old Problem: Dopamine & Parkinsonism
  Michael Salvatore, PhD, Associate Professor, Department of Toxicology and Neuroscience, LSU Health Science Center, Shreveport

2:10 p.m. - 2:30 p.m.
- Q & A / Afternoon speakers will answer questions
  Stretch Time

Registration is required. Call 225-763-2946 or go to www.pbrc.edu/events/parkinsons/.
Recognizing the value of LaHIE to the state’s patients and health care providers, the Quality Forum continues to focus on expanding the exchange’s capabilities, says Brian Richmond, Chief Technology Officer.

“By facilitating clinical management through structured clinical data and combining HIE and analytics at multiple levels, the Quality Forum has constructed an integrated and sustainable care model that achieves improved health and a higher quality of care at a lower cost to key stakeholders,” Richmond explains. “The continued expansion of LaHIE’s capabilities and reach is a valuable and crucial investment in health outcomes and health care delivery in Louisiana.”

For more information about LaHIE, or to view a complete list of LaHIE participants, visit www.lhcqf.org, or email lahie@lhcqf.org.

CDC Honors Deris as Immunization Champion

The Centers for Disease Control and Prevention (CDC) and the CDC Foundation have recognized Gina Deris as one of this year’s CDC Childhood Immunization Champions. The award honors immunization advocates who have made immunization successes possible in their communities. Each year, one CDC Immunization Champion from each of the 50 states and the District of Columbia receives the prestigious award.

Deris is the former State Coordinator of the Louisiana Shots for Tots program. She was nominated and selected from a large pool of healthcare professionals, coalition members, parents, and other immunization leaders as having made a significant contribution to public health in Louisiana through her work in childhood immunization.

Deris has been instrumental in the development of the Louisiana Shots for Tots State Coalition, as well as helping to improve the immunization rate for children less than 2 years of age to over 70 percent across Louisiana. She was able to bring together representatives from various governmental agencies, healthcare workers, private providers, and parents working toward the common goal of improving immunization rates across the state.

First MDA/ALS Clinic Opens in N.O.

The Muscular Dystrophy Association recently announced the designation of the Louisiana State University Health Sciences Center New Orleans School of Medicine as an MDA/ALS clinic. The designation makes LSUHSC the first MDA/ALS clinic in Louisiana. LSUHSC is the 44th MDA/ALS clinic in the country, joining a national network of MDA/ALS clinics providing a multidisciplinary team of medical professionals skilled in the diagnosis and treatment of ALS (amyotrophic lateral sclerosis, or Lou Gehrig’s disease). LSUHSC has built a comprehensive medical team of clinicians including a board-certified neurologist, a pulmonologist, and respiratory, physical, and speech therapists.

MDA is the world leader in ALS research and services. MDA/ALS clinics are an integral part of MDA’s commitment to develop effective treatments and to find a cure, by conducting ongoing ALS clinical research trials and multi-state clinical trials. Currently MDA is funding 63 international ALS research projects at a cost of more than $20 million.

Root Named as DHH Chief Compliance Officer

William (Bill) Root has been hired by the Louisiana Department of Health and Hospitals (DHH) as its new Inspector General and Chief Compliance Officer to lead internal and external audit efforts. Root, the former Assistant Special Agent in Charge of the Office of Investigations at the U.S. Department of Health and Human Services, will conduct internal audits, implement plans to meet the requirements of the Legislative auditor, and oversee DHH’s Program Integrity Office, which assures expenditures for Medicaid services are appropriate, and identifies fraud and abuse in the system.

Root, a Baton Rouge native, began his career as an investigator for the Louisiana Medicaid Fraud Control Unit, in which he worked with DHH to investigate several fraudulent schemes. For the last 26 years, Root served as a special agent for the federal government investigating transportation companies, physicians, hospitals, and various inpatient and outpatient healthcare providers.

Root will directly oversee DHH’s Program Integrity section, which is responsible for identifying fraud in the Medicaid system. Program Integrity investigates complaints, performs forensic claims investigations, reviews provider eligibility, as well as enrollment and disenrollment of providers, measures payment error rates, reviews claims processing and medical reviews.
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In 2011, Root’s Health Care Fraud Prevention and Enforcement Action Team (HEAT) strike team was recognized for claiming 31 indictments of 29 Baton Rouge-area defendants worth more than $35 million in just a few short months. In the latter part of 2011 through June 2012, Root’s division of HEAT resulted in indictments regarding fraudulent Medicare schemes worth nearly $250 million.

Hospital Launches Infection Protection Robot
Louisiana Continuing Care Hospital says it is the first hospital in Louisiana to install a Xenex ultraviolet (UV) light room disinfection system. The hospital’s latest weapon to fight infection is a robot resembling R2D2 from Star Wars which delivers pulsed xenon to quickly deliver ultraviolet light throughout a room — destroying the DNA of deadly microorganisms and rendering them harmless.

A recent notice from the Center for Disease Control (CDC) warned hospitals to step up their measures to guard against “Nightmare Bacteria.” These germs are known as carbapenem-resistant Enterobacteriaceae or CRE. According to Dr. Thomas Friedan, director of the CDC, “they’re basically a triple threat.” They are resistant to virtually all antibiotics, including the ones doctors use as a last-ditch option. Second, these bugs can transfer their resistance to other bacteria. “The mechanism of resistance to antibiotics not only works for one bacteria, but can be spread to others,” Friedan says. Third, the bacteria can be deadly. Infection with the CREs “has a fatality rate as high as 50 percent,” warns Friedan.

Louisiana Continuing Care Hospital has been providing services to medically complex patients in greater New Orleans since 1995. It occupies the 7th floor of West Jefferson Medical Center and specializes in treating critical patients who otherwise would require care in a general hospital's intensive care unit.

Terry Joins The Physicians’ Trust
The Physicians’ Trust recently announced that Kathy Terry has joined its team and has assumed responsibility for Business Development and Physicians Services. Terry brings more than 25 years of experience in the insurance industry. She most recently served as the Senior Marketing Specialist at LAMMICO.

In her new role in Business Development and Physicians Services, Terry will be responsible for new growth opportunities, expanding market present and developing Physician services and programs. Terry’s more than 25 years of healthcare professional liability insurance experience includes five years at LAMMICO, where she was responsible for marketing and sales strategies.

Before moving to Louisiana, Terry was the Regional Market Manager for Medical Protective in Grand Rapids, Michigan, responsible for marketing, sales, and field underwriting.

**LSNA Hosts Nurse Day, Installs New Board**

The Louisiana State Nurses Association (LSNA) recently hosted its Annual Nurse Day. With over 380 Registered Nurses and nursing students from around the state in attendance, presentations focused on issues impacting nursing patient care at the national and state level.

Program speakers included Jennifer S. Mensik, PhD, RN, NEA-BC, Second Vice President of American Nurses Association (ANA). Dr. Mensik addressed changes taking place at ANA and within the State Nursing Associations to increase the responsiveness of the organizations to nursing issues. Calder Lynch, Health Policy Advisor for the Louisiana Department of Health and Hospitals, presented an overview on the impact of healthcare changes in Louisiana, and Randal Johnson, LSNA Lobbyist from Southern Strategy Group, gave a 2013 legislative update.

Additional activities included a lunchtime fundraiser and Louisiana Nurses Foundation update presented by Dr. Carol Tingle. Dr. Melissa Stewart conducted the annual meeting of the Louisiana Nurses Political Action Committee and election of officers and Dr. Jacqueline Hill and Rita J. Finn, MSN, RN discussed the Multi-State Division Pilot Project currently in development with the Arkansas and Oklahoma Nurses Associations to promote sharing of services and fiscal vitality for each of the states.

Immediately following the educational offerings and committee updates, Dr. Jacqueline Hill convened the Louisiana State Nurses Association biennial House of Delegates. The House of Delegates represents the voting voice of the nurses holding state membership and is composed of the LSNA Board of Directors and elected delegates from each district. All business before the House of Delegates was completed in two sessions, with the final session including the installation of the new LSNA Board of Directors for 2013-2015 and the House of Delegates was then adjourned on April 27, 2013.

The newly installed 2013-2015 Board of Directors includes:

- President, Dr. Carol A. Tingle, Baton Rouge District
- President-Elect, Mrs. Norlyn Hyde, Ruston District
- Vice-President, Dr. Carlene MacMillan, Lafayette District
- Secretary, Mr. Gordon Natal, New Orleans District
- Treasurer, Dr. Debra Shelton, Shreveport District
- Chair, Clinical Practice Council, Dr. Deborah Garbee, New Orleans District
- Chair, Leadership and Management Council, Ms. Rose M. Schaubhut, New Orleans District
- Chair, Education Council, Dr. Stephanie Pierce, New Orleans District
- Chair, Research and Informatics Council, Dr. Ann Carruth, Tangipahoa District
- Chair, Workplace Advocacy Council, Ms. Frances Finley, Alexandria District
- Additional Elected Positions included:
  - Chair, Nominating Committee, Dr. Judith Gentry, New Orleans District
  - Nominating Committee Member, Mrs. Shirley Payne, Ruston District
  - Chair, Auditing Committee, Ms. Deidra Dudley, New Orleans District
  - Audit Committee Member, Dr. Cheryl Myers, New Orleans District

The Louisiana State Nurses Association also acknowledged board members who are currently serving and have additional two-year term of service in office:

- Dr. Jacqueline Hill, Immediate Past President, Baton Rouge District
- Chair, Membership Committee, Ms. Victoria Johnson, New Orleans District
- Chair, Health Policy Committee, Mrs. Lisa Deaton, Baton Rouge District
- Chair, LSNA Continuing Education Committee, Mrs. Nancy Darland, Ruston District
- Student Representative, President of the Louisiana Association of Student Nurses, Ms. Kelsea Bice, Our Lady of Holy Cross College, New Orleans.
LHEC Picks Up 100th Partner

One hundred healthcare, community, business, trade, and faith-based organizations from across the state have joined the Louisiana Healthcare Education Coalition (LHEC) as official partners in a combined effort to help Louisianaans better understand healthcare reform and the health insurance marketplace. This major milestone comes only two months after LHEC officially launched with events held in New Orleans, Baton Rouge and Shreveport as part of a three-day tour.

The coalition is composed of groups and institutions interested in promoting the work of the coalition and helping Louisianaans to fully understand the Patient Protection and Affordable Care Act. Since the launch in March, efforts to educate the community have included participation in health fairs and other events, engagement in Web and social media channels, and through guest speaking opportunities, which can be requested online at the LHEC website.

Partners currently on board represent a broad spectrum of industries and avenues that play an important role in the everyday lives of Louisianaans. If your organization is interested in becoming a partner or to review the complete list of coalition partners, please visit www.lhec.net for more information.

LHA Applauds Bill Passage

LHA President & CEO John Matessino issued a statement in support of the passage of HB 532 and HB 533, two constitutional amendments that LHA says will give families, including those with private health insurance, a more stable healthcare delivery system. According to Speaker Chuck Kleckley, House Bills 532 and 533 will provide the citizens of Louisiana with a means to work together, “to create a special fund to allow Louisiana to maintain healthcare for its citizens. It provides predictability in revenues and more responsible planning for healthcare.”

HB 532 (Kleckley) provides for the legislature to establish a formula for funding hospitals by establishing reimbursement increases for hospitals; by establishing an assessment on hospitals; by creating the Hospital Stabilization Fund to deposit assessments; and using the monies in the fund for reimbursement enhancements.

HB533 (Kleckley) creates the La. Medical Assistance Trust Fund (MATF) and appropriates monies in the fund for use and expenditure under the supervision of the secretary of the Dept. of Health and Hospitals for the Medicaid program. The fees collected are from nursing facilities, intermediate care facilities for people with developmental disabilities, prescriptions, medical transportation providers, and healthcare premium assessments paid by Medicaid-enrolled managed care organizations.

Sen. Sherri Smith Buffington, R-Keithville, who sponsored the bills in the Senate, said, “This offers voters the opportunity to stabilize funding for our community hospitals and our nursing home facilities. The proposed changes in our state constitution are an effort to keep our hospitals open and to make sure vital healthcare services are available to our children and families. This is not about numbers. It is about the lives of people.”

Humana to Help Tornado Victims

Humana, one of Louisiana’s leading health benefits companies, announced that The Humana Foundation, its philanthropic arm, will make a combined contribution of up to $250,000 to the American Red Cross and the Oklahoma City Community Foundation in the wake of devastating tornadoes in that state.

The American Red Cross of Central Oklahoma will receive $100,000 to address immediate and on-going needs related to the disaster. The Foundation also will match up to $50,000 in gifts from Humana associates to the American Red Cross of Central Oklahoma. The Oklahoma City Community Foundation will receive $100,000 to support nonprofits that focus on the longer-term rebuilding efforts.

For more on the Humana Foundation, go to www.humanafoundation.org.

LOCAL

Cefalu to Replace Heymsfield at PBRC

Interim President William L. Jenkins announced that Steven Heymsfield, MD will step down as Executive Director of Pennington Biomedical Research Center to fully devote his time to his research interests after leading the Center for the past three years. Jenkins also announced that William T. Cefalu, MD will be appointed Executive Director of Pennington Biomedical.

Heymsfield, recognized as one of the world’s leading obesity researchers, will remain on the faculty of Pennington Biomedical. A prolific scientist, he has continued to be actively involved with ongoing investigations and his research publications are highly cited.

William Cefalu, who will assume the helm, is a Louisiana native who returned to Pennington Biomedical in 2003 after stints at UCLA, Wake Forest University School of Medicine, and University of Vermont College of Medicine. Cefalu has proven to be one of the most successful grant-winning researchers in the Center’s 25-year history.

Cardio Conference Features Local Docs

Drs. Craig Walker, Peter Fail, Richard Abben, Anil Chagarlamudi, Al Timothy, and Christopher Paris of Cardiovascular Institute of the South (CIS) were featured presenters at the New Cardiovascular Horizons (NCVH) conference held in June in New Orleans.

Known as the largest peripheral intervention conference in the United States, NCVH attracted interventional cardiologists, vascular physicians, surgeons, podiatrists, and other industry professionals from around the world. During NCVH, new methods and data were unveiled for the first time in the United States.

Entering its 14th year, NCVH concentrated on limb salvage and amputation prevention techniques for patients suffering from PAD and CLI. The conference drew more than 1,500 attendees and 100 exhibitors. One of the unique aspects of the conference is that it transmits more than 30 live and intricate interventional cases from eight different sites around the world. Led by a prestigious group of physicians, the live cases are a distinctive teaching method focusing on advanced techniques that will result in safe, effective, and superior outcomes for patients.

For more information, visit www.ncvh.org.

OLOL College Professor Earns Fellowship

David L. Whidden, III, PhD, Assistant Professor of Religious Studies at Our Lady of the Lake College, has been accepted for a competitive Wabash Center Summer Fellowship. The mission of the Wabash Center Summer Fellowship is to support the careers of promising young teachers and scholars in religion and theology.

Dr. Whidden, who completed his doctoral work at Southern Methodist University in 2011, is a scholar in systematic theology with a particular interest in the medieval theology of Thomas Aquinas and
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Anselm. The Fellowship will allow him to finalize work on his first book, “Christ the Light: The Theology of Light and Illumination in Thomas Aquinas,” which has been accepted for publication in 2014 by Fortress Press. The book will be a part of the Emerging Scholars Series, a selective, curated series “dedicated to highlighting innovative and creative projects from new scholars in the fields of biblical studies, theology, and Christian history,” according to the publisher.

Garner and Walker to Staff OLOL Walker Clinic

Our Lady of the Lake Physician Group Walker Clinic in the physician tower at OLOL Livingston is now open and staffed by Gregory Garner, MD and Patrick Walker, MD.

Dr. Garner received his medical degree from Indiana University School of Medicine in Indianapolis, Indiana. He completed his residency in Family Medicine at Louisiana State University Health Sciences Center in Shreveport.

Dr. Walker received his medical degree from Louisiana State University School of Medicine in Shreveport. He remained in Shreveport to complete his residency in Family Medicine at Louisiana State University Health Sciences Center.

Dr. Garner and Walker treat common disorders of the cardiovascular, respiratory, gastrointestinal, and reproductive systems including diabetes, hypertension, hyperlipidemia, asthma, chronic obstructive pulmonary disease, and chronic kidney disease. They also perform routine childhood and adolescent health exams.

McCulloh Joins Baton Rouge General Physicians

Stephen McCulloh, MD, has joined Baton Rouge General Physicians. Dr. McCulloh is a graduate of the University of Oklahoma. He earned his medical degree from American University of the Caribbean School of Medicine in St. Maarten, Netherlands Antilles, and completed his residency in family medicine at Baton Rouge General.

Dr. McCulloh is a member of the American Academy of Family Physicians and the Louisiana Academy of Family Physicians, and is board certified in family medicine. His office is located at 1286 Del Este Avenue in Denham Springs.

Shivers Named Outstanding Dietetics Educator

Vadel Shivers, clinical dietitian at Mary Bird Perkins – Our Lady of the Lake Cancer Center, received the 2013 Outstanding Dietetic Educator Award from the Louisiana Dietetic Association at the LDA Annual Meeting in Lafayette. She received this honor in recognition for her work teaching and mentoring undergraduate students pursuing careers in the dietetic field. The award criteria included demonstrated innovative teaching skills, techniques and mentoring as documented by letters from students and leadership.

Shivers is also the first registered dietitian in Louisiana to receive board certification in the specialty of oncology nutrition (CSO), and the only one in Baton Rouge with CSO certification. Her role at the Cancer Center is wide-ranging, from helping a patient deal with mouth sores or nausea to teaching nutrient-dense recipes that can be made in a blender and ingested through a feeding tube to help keep up a patient’s strength during treatment. An oncology nutritionist is a key member of the healthcare team assembled to provide integrated, comprehensive care for cancer patients.

Bolden Named Community Relations Coordinator

Sherri Bolden, RN, has been named Community Relations Coordinator at Lane Rehabilitation Center. An affiliate of Lane Regional Medical Center, Lane Rehabilitation Center, is a 30-bed in-patient acute rehabilitation center specializing in physical, occupational and speech therapy.

Bolden will be responsible for the overall marketing efforts at the center, which include communication, physician relations, and business development.

A graduate of Our Lady of the Lake College, Bolden has more than 7 years of healthcare experience including special training in strokes, spinal cord injuries, joint replacements, amputations, and infection prevention. She is a member of the Association for Professionals in Infection Control and Epidemiology (APIC).

OLOL College’s Campus Minister Recognized

Our Lady of the Lake College Campus Minister and alumna, Sister Martha Ann Abshire, F.M.O.L., ‘72, was recognized by the Baton Rouge Speech and Hearing Foundation as a 2013 Volunteer Activist.

Sister Martha Ann, who has devoted her life to serving others through healthcare, cared for the sick for six years in a clinic in Aquin, Haiti (70 miles from Port-Au-Prince) and was serving at the time of Haiti’s massive earthquake. More recently she assists with numerous worthy causes in the Baton Rouge area. Four of her many recent volunteer activities include assisting with a radiothon to benefit the children at Our Lady of the Lake Children’s Hospital, volunteering for the Friends of LPB, doing community health screening with Quota Club of Baton Rouge, and judging a chili contest, a charity event organized by the Knights of Columbus.
In June of 2010, Louisiana joined the growing number of states to adopt a Physician Orders for Life-Sustaining Treatment (POLST) program. Approved by the state legislature in May 2010, the LaPOST document took effect one year later, providing patients with serious, advanced illnesses with a mechanism to state their end-of-life care goals with a medical order that travels with them across care settings. According to LaPOST Coalition Chair Susan Nelson, MD, over the past two years, the LaPOST document has saved many families from the heartbreaking position of deciding what their loved ones would have wanted at the end of life.

Nelson says, “Without LaPOST, these families would have been forced to make those decisions for their loved ones, and unfortunately, families often are unsure what their loved ones wanted because they’ve never discussed those issues. The LaPOST document freed these families from having to make these difficult decisions at such an emotional time.”

For Marlyn Ebert, of Baton Rouge, whose mother, Mabel Moses, was diagnosed six years ago with Alzheimer’s, the LaPOST document helped bring her family together to document her mother’s end-of-life care wishes.

“Mom has always, through the years, shared with us what her wishes are,” Ebert says, adding that her mother doesn’t want extensive life-prolonging treatments. “Her faith is very strong, and she has hope of spending eternal life somewhere...she doesn’t want that delayed, and she has expressed that numerous times.”

As Moses’ physician, Nelson met with Ebert and initiated a discussion about the LaPOST document. Using layman’s terms, Nelson carefully explained each procedure referenced in the document and described how those treatments may or may not be medically effective for Ebert’s mother.

“After that meeting, she emailed me the LaPOST form and I forwarded it to our family members along with some additional reading material about end-of-life decisions,” Ebert recalls. “Most of them responded favorably...most of them wanted to honor what she wanted.”

Thanks to LaPOST, says Ebert, when her mother reaches the end of life, “I’ll be sad, but I’ll also have a sense of peace that her wishes were honored. I think I’ll also feel relieved that everything done was what we, as a family, wanted to be done.”

According to Nelson, that “sense of peace” is one of the many reasons families need to have the conversation about end-of-life wishes with their loved ones.

“It’s a conversation that can be uncomfortable, but without it, your family or caregiver may never know your wishes, and you may not receive the kind of care you want at the end of life,” she explains. “For Marlyn and her
family, it was easier to make those decisions for her mother because her mother had been very open about what she wanted at the end of life. LaPOST provided them with a voice to make those wishes heard and to make sure they were honored.

Others have not been so fortunate. Beverly Lyons, of Baton Rouge, had never discussed end-of-life issues with her mother. She and her sister, who lives in California, had to make those decisions without any guidance. After being diagnosed with dementia, receiving a pacemaker, and losing the ability to walk, her mother had to enter a long-term care facility to receive around-the-clock care. Lyons says. By then, it was too late to have that conversation with her.

“(The conversation about what to do at the end of her life) should’ve taken place long before she had dementia,” Lyons says. “It is awful to have full control of someone’s life and having to make a life and death decision for them and wanting peace in your family. It would’ve helped me a whole lot to have somebody to talk to and take me through the process.”

Mary Raven, MD, a palliative care physician with Our Lady of the Lake Physician Group in Baton Rouge, says such guidance can come from the patient’s physician. Many studies have indicated that patients want to discuss end-of-life issues with their doctor, but they want the doctor to initiate that discussion, says Raven.

“It can be hard for many physicians to discuss these issues due to time limitations, and then there’s the fact that they want to help their patients maintain hope. There’s something about talking about the end of life that makes some doctors think it reduces the patient’s hope,” Raven says. “It sometimes feels like the elephant in the room that no one wants to talk about, but it is incumbent upon us as physicians to bring it up and be willing to listen to what the patient says.”

Special training in end-of-life issues can help physicians prepare to have such discussions with their patients, says Deborah Bourgeois, APRN, ACNC-BC, ACHPN, a Palliative Medicine Advanced Practice Nurse in New Orleans. “It’s not an easy topic to discuss, and many (physicians) are uncomfortable because they don’t have the skills, training or time to sit down and talk to patients and their families about it.”

“There’s a lot of medical science, data, and evidence in the specialty of palliative medicine and what we do,” she says. “There is a lot of effort being put into re-focusing physicians to take the time to learn these specialized communication techniques, and then, because they’re trained in it and exposed to it, they’re much more open to addressing it. They know how important it is. Patients and families do want to discuss these subjects with their health care providers.”

Raven recommends that physicians begin by discussing the patient’s diagnosis, prognosis, and goals of care. Once that conversation is complete, the patient and physician can then discuss and prepare a LaPOST document, she says. “I introduce the LaPOST document by saying, ‘Based on our discussion, I think it’s important for us to complete this document together. It will echo what we’ve talked about, and because it is a medical order, it will allow you to have your goals of care met, regardless of the setting.’”

The LaPOST document not only helps to reduce the emotional burden on the family, it also helps the physician by providing a roadmap of the patient’s end-of-life care goals.

“For patients who don’t have a LaPOST document, it’s problematic because their families are unprepared and don’t know what their loved ones’ wishes are. It makes the decision making difficult and leaves them with questions, concerns, and burdens,” she explains. “For the patients who do have LaPOST documents, the decision making process is made very simple. In one scenario, a patient with a LaPOST document came from out of town to a local hospice. I knew from the beginning what she wanted and didn’t want, and there was no need to burden her daughter with those issues. Her daughter needed to be grieving and caring for her mother, not having to make those decisions.”

Bourgeois notes, “If a patient does have a LaPOST document, that patient has a care plan that’s put in place so that when a medical situation arises where the patient and the family are faced with issues, those decisions are already made… That brings a lot of comfort to them to know those decisions were made by the patient. It helps with the grieving and bereavement processes because they know they’re caring for the person in the way that person wanted to be cared for.”

She adds, “It allows the patients and their families to work with their physicians to develop a care plan that follows them across the care continuum and is honored by health care institutions. That is the real benefit of LaPOST.”

As awareness continues to grow, both Bourgeois and Raven feel that it will become more common to see patients who have completed LaPOST documents. According to Raven, though the document is still “relatively new,” it remains an important tool for establishing patients’ goals of care for the end of life.

Bourgeois agrees, “As LaPOST continues to integrate into the current health care system, it will become even more vital and provide the information that families and health care providers need to meet patients’ needs… As a health care professional, I’m very grateful for what the LaPOST Coalition has done to ensure that patients, no matter where they are, have their wishes met. It’s a wonderful body of work and a well-done document.”

For more information about LaPOST, visit www.la-post.org.

Cindy Munn is Executive Director, Louisiana Health Care Quality Forum.
WELCOME TO THE “AFFORDABLE CARE ACT”
(Are we having fun yet???)

Recent Policy columns have focused on healthcare spending in the United States compared to other wealthy nations. U.S. spending on healthcare exceeds by far any other nation and is 2½ times higher than the average of the Organization for Economic Cooperation and Development (OECD), which is comprised of the 34 wealthiest nations in the world, including the U.S.

Despite its lavish splurging, the U.S. falls short in terms of system performance and health outcomes compared to many nations that spend half as much as we do. Furthermore, our partner OECD nations tend to provide healthcare coverage to 100% of their populations while the U.S. has nearly 50 million persons (about 15%) who are uninsured.

Past efforts at reform, whether to provide coverage for the uninsured, improve quality and access to care or reduce the rate of spending increases, have often failed. The most notable attempt so far has been the Patient Protection and Affordable Care Act (PPACA) of 2010. Whether it will meet the same fate as other reform efforts remains to be seen. Three years after its passage, the Affordable Care Act so far has survived the political firestorm it ignited. Its continued survival will depend on how well it fulfills a host of promises to improve our inadequate and inefficient non-system of healthcare delivery. Perhaps the most important item on the to-do list is to ensure that out-of-control spending is reined in and held in check on a permanent basis. Unfortunately, cost containment appears to be the weak spot in an otherwise strong agenda for improvement.

While healthcare costs have abated somewhat over the past few months, there is no consensus on what caused the slowdown. Most observers believe that the economy was a major factor in cutting back spending. Many predict spending will increase significantly when the Affordable Care Act enters its most important phase yet with increasing Medicaid enrollment and private plans raising premiums in response to various ACA-related mandates. Here is what top executives at Kaiser Family Foundation had to say about the “slowdown” and also about projected growth rates in health spending:
“For the past several months, analysts at the Kaiser Family Foundation and the Altarum Institute have been analyzing the recent slowdown in health spending. On average, health spending grew by 4.2 percent per year from 2008 to 2012, down from the recent peak of 8.8 percent from 2001 to 2003 and the lowest rate of growth in five decades. Our main conclusion is that most of this slowdown, 77 percent, has been due to years of a weak economy, which causes people to put off health services when they can and prompts employers and states to reduce health spending. The other 23 percent is explained by changes in the health system, including increased consumer cost-sharing, tighter managed care and modifications in payment and delivery (we can’t precisely pinpoint the separate effects of these three factors).

If the economy recovers as expected, the annual growth rate in health spending will increase by more than three percentage points over the next several years, to more than 7 percent, from the current low level of about 4 percent. This won’t happen immediately; we found that there is a lag before economic downturns and upturns affect health spending. Nor should this expected upward trend be interpreted as health costs again spiraling out of control—or, at least, no more or less so than they are now. And it won’t be because the Affordable Care Act is fueling an increase in health costs. It will simply be a byproduct of the recovering economy stimulating a return to more typical levels of health utilization and greater health spending.” (“We still have a health-care spending problem,” Drew Altman, CEO, and Larry Leavitt, Senior Vice President, Kaiser Family Foundation, Washington Post, April 21, 2013)

So, basically they describe a return to a “normal” growth rate of more than seven percent per year. That is close to the eight percent increase in health spending that we sustained year after year on average from 1960 to 2010. So does that sound like we are making progress on cost containment? Not exactly. And that seems pretty bland compared to California. That state announced a steep rate increase for at least one category of health insurance:

“Last week, California announced that the Affordable Care Act would increase non-group insurance premiums by as much as 146 percent.” (Forbes, May 30, 2013)

That sounds pretty expensive, even if it is only for a relatively small number of customers. And here’s the news from Maryland:

“In the latest preview of prices for health coverage under the Affordable Care Act, Maryland’s dominant insurer says proposed premiums for new policies for individuals will rise by 25 percent on average next year. That’s lower than what some had predicted. Just three weeks ago, the insurer, CareFirst BlueCross BlueShield, had been looking at a proposed 50 percent increase. But the company revised that initial estimate, citing worries about affordability for consumers.” (“Maryland Offers Glimpse At Obamacare Insurance Math,” Kaiser Health News, April 24, 2013)

It seems that the Affordable Care Act is moving U.S. healthcare in the right direction in many ways. Too bad that cost containment isn’t one of them. Could the Affordable Care Act have passed if there was a provision to implement very strict and effective cost saving measures? Probably not, because the health plans and other providers would have lobbied against the bill. So what can be done now?

As usual, Louisiana is a laggard state on all things healthcare. The Affordable Care Act calls for a strong review commission to oversee insurance rate increases. Louisiana had a rate review process in the past, but it was dismantled.

But if the use of a review board is just not available because private interests have lobbied it out of existence, then it will be difficult—but not impossible—to convince politicians to restore a true oversight process for rate increases. Right now Louisiana and a few other states operate on the principle of “file and use.” In other words a health plan that wants to increase rates by 10% needs only to file its intentions with the Department of Insurance so there will be a public record.

The federal Department of Health and Human Services conducts certain reviews of individual and small group rate filings in Louisiana and 12 other states. In 2011 DHHS reviewed 3 filings by plans in Louisiana with an average rate change of 12%. In all 3 cases, DHHS found the requested rate changes to be unreasonable. However, the rate changes were not withdrawn by the plans that proposed them.

Examples such as these are evidence of how difficult true cost containment will be unless there is cooperation between federal, state and private sector entities. The absence of collaboration on such issues will doom attempts to get costs under control.

David W. Hood is Former Secretary (1998-2004)
Louisiana Department of Health and Hospitals
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Three Years of Obamacare Hustling
The Price Of ‘Free’ Keeps Rising

With the passage of Obamacare’s third anniversary, I’ve been thinking about all the implications of the law and, frankly, I feel hustled. This is how every American should feel about Obamacare.

Since 1981, I have practiced medicine, treating uninsured patients in public hospitals. I have seen politicians overpromise and underfund healthcare programs while hustling taxpayers by promising “free money” and appealing to their human kindness. Too often, though, politicians don’t reveal the full cost or effects of their policies. To her credit, Nancy Pelosi was honest. She said we had to pass Obamacare to learn what was in it – and we are learning.

Obamacare will disappoint Americans who like their health insurance plan and thought they could keep it. A recent report demonstrated that premiums have increased by $3,000 since Obamacare was enacted. As Obamacare increases the price of health insurance, employers control costs by converting full-time employees to part-time workers in order to avoid the new mandate on coverage.

The primary employers in America, small businesses, will stay small in response to Obamacare. Since Obamacare regulations do not apply until a business has 50 or more employees, smaller businesses are not hiring the 50th employee or laying off to get to 49. Recently, the Department of Labor unveiled that last quarter, the United States lost 212,000 full-time jobs while adding 370,000 part-time jobs. This is not a good indicator for middle-class job growth. Once Obamacare is implemented, predictions are that 30 percent of businesses will drop insurance coverage and dump employees onto government-run insurance exchanges. According to the Kaiser Family Foundation, the typical employer plan currently covers 80 percent of costs, while the exchange plans will only cover 60 percent to 70 percent of costs. Currently, the employee who gets sick pays only an average of $2,770 before the employer’s insurance policy covers the additional costs. Under the new exchange plan, the employee would pay $6,050 and the family $12,000 before the policy pays anything. Obamacare supporters say that the rise in cost is not important because patients with chronic illness will pay less, but even this is not clear.

TPD reported that small businesses with healthier employees are now “self-insuring,” which exempts them from the Obamacare regulations. This would lower employers’ costs by 45 percent. That Obamacare forces struggling employers to self-insure means the businesses with older, sicker workers may see their premiums rise by 25 percent. This is contrary to the expectations set by advocates claiming that Obamacare will make healthcare cheaper or free.

I concede that there will be one group for...
whom healthcare may be free: individuals earning less than 138 percent of the federal poverty level, who can enroll in Medicaid and have no deductible and no co-pay. Reportedly Arkansas, Ohio, and maybe Texas are working to strike deals with the administration to give these people private insurance. Although it is tempting for states to enroll the newly eligible into private health plans rather than onto Medicaid, these governors must be mindful of the cost. Congressional Budget Office estimates suggest that private plans may cost 50 percent more than the Medicaid expansion in Obamacare.

Let’s take a single woman named Sharon who is not on Medicaid. Sharon is 30 years old and earns $22,340. Her employer drops the company insurance to save money, therefore dumping her in the exchange. Sharon now pays a premium of $1,405 per year, even with the subsidy offered on the exchange. If she has an accident, she may have to pay $6,050 out of pocket. Sharon is also paying higher state and federal taxes on a variety of goods and services so that the government can provide her neighbor at 138 percent of the federal poverty level (about $15,000 in 2012) with free private health insurance with no deductible or co-pay.

Sharon suspects that her neighbor could earn more money, but he would rather work fewer hours or work for cash, or perhaps, live out of wedlock so that he and his girlfriend both qualify for the taxpayer-provided free insurance. As Sharon pays 25 percent of her pretax income for her healthcare along with higher taxes, she is told that she lacks compassion, that she is closed-minded, that she shouldn’t mind paying higher taxes or being forced into a more expensive policy because this is for the good of her neighbor. Sharon should complain; there is a better way.

Patients should have the power, not bureaucrats. Those patients with pre-existing conditions can have access to insurance, and those working will not have to lose full-time employment. Medicaid should give the states flexibility and per-beneficiary payments to foster innovation and provide a safety net without increasing government dependency.

Sharon is right; there is a better way.

This article previously appeared in the Washington Times on March 28, 2013. It is reprinted at the request of Congressman Cassidy.
Southside Gardens Retirement and Assisted Living Center is located in the heart of South Baton Rouge, close to restaurants, hospitals, and Louisiana State University. For more than 20 years, we have been known as “the next best place to home” in our community.

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FMOL Recognized as Healthy Workplace

The Franciscan Missionaries of Our Lady Health System, including Our Lady of the Lake Regional Medical Center has earned recognition as a Best Employer for Healthy Lifestyles for the second consecutive year. This award is given annually by the National Business Group on Health, a non-profit association of large U.S. employers. Companies that demonstrate an ongoing commitment and dedication to promoting a healthy workplace and encouraging their workers and families to pursue and maintain healthy lifestyles are recognized with this award.

The Franciscan Missionaries of Our Lady Health System was among 65 U.S. employers that received the 2013 Best Employers for Healthy Lifestyles® award at the Leadership Summit sponsored by the National Business Group on Health’s Institute on Innovation in Workforce Well-being. Franciscan Missionaries of Our Lady Health System received a Gold Award for Healthy LivesTM – a comprehensive health and wellness solution that was designed for employees and their families.

In announcing the award, the National Business Group on Health said in a statement, “The Franciscan Missionaries of Our Lady Health System established a strategic imperative to serve as a leader in health care reform and created a new arm of the organization to explore innovative models of care in the area of population health management. One of its successful developments is Healthy Lives™. The program includes health risk assessments and screenings, customized wellness programming, health coaching, care management and robust analytics.”

Locally, Our Lady of the Lake has implemented low calorie Healthy Lives™ meals in the cafeteria, Holly Clegg trim&TERRIFIC®entrée, soup, and dessert selections in the hospital cafeteria, indoor and outdoor walking paths for team members and hospital guests, healthy vending machine options, and a teaching garden where team members have the opportunity to learn to grow and harvest vegetables, herbs and fruits. Other Franciscan Missionaries of Our Lady Health System hospitals have implemented similar activities to promote a culture of wellness.

Lane Expands Behavioral Health Program

Lane Regional Medical Center announced the expansion of Lane Behavioral Health outpatient services. In addition to its regular outpatient treatment program, Lane Behavioral Health Services now offers an outpatient Partial Hospitalization Program for adults experiencing acute mental health crisis, such as major depression, schizophrenia, bipolar disorder, anxiety disorder, eating disorders, and behavioral problems related to neurological-cognitive deficits and other medical conditions.

The Partial Hospitalization Program is a 5-day Intensive Outpatient Program requiring a physician referral. Depending on the physician assessment, it is often a viable alternative to inpatient hospitalization.

Symptoms may include:

- Depression: Inability to experience pleasure, pre-occupied with worthlessness, feelings of guilt, regret, helplessness, loneliness, fatigue, low self esteem
- Avoidance: Staying in bed, withdrawing from friends or normal routines, decrease in daily functioning
- Anxiety: Panic attacks, racing thoughts, apprehension, dread, restlessness, feeling trapped, excessive worry, sleep disturbance
- Eating Disorders: Anorexia nervosa, bulimia
- Schizophrenia: Hallucinations, paranoia, delusions, disorganized speech
- Other Personal Disorders: Attention-seeking, antisocial, narcissistic, avoidant, dependent, obsessive compulsive, passive aggressive, sadistic, self-defeating, bipolar disorder.

Ochsner Using TIF to Fight GERD

Ochsner Medical Center – Baton Rouge has announced new data from the Transoral Incisionless Fundoplication (TIF®) US Registry presented at the 2013 SAGES Annual Meeting. Ochsner’s Dr. Jeansonne provides the TIF procedure option to patients that suffer from gastroesophageal reflux disease (GERD). The data showed that the TIF procedure was safe and effective in eliminating or improving a range of typical and atypical GERD symptoms, including heartburn and reflux, in up to 81% of patients in the study. Also, in 81% of patients undergoing endoscopy 24-months after their TIF procedure, esophagitis was fully healed or notably improved.

The risks associated with medical management of GERD patients for years or decades are becoming more evident. Traditional surgical interventions for GERD have historically been reserved for patients with the most severe disease. However, most patients have been unwilling to accept the well documented side effects of difficulty swallowing and gas bloat associated with traditional surgery. In contrast, the TIF procedure offers an alternative option to select GERD patients because almost none of these side effects occurred in the TIF registry population.

North Oaks Dietetic Internship Graduates 20th Class

The North Oaks Health System Dietetic Internship Program recently acknowledged its 20th graduating class. The graduates are Kristin Fiorello, Mandeville; Cory Dwayne LeDoux, Eunice; Theresa
Pevey Derenbecker, Ponchatoula; Emily Loraine Thevis, Mowata; Claire Toups, Thibodaux; and Ellen Elizabeth Smith, Beaumont, Texas.

Special honors were bestowed upon three graduates, including Fiorello who received the Mary Nelson Award, given by the Dietetic Internship faculty for exceptional work, enthusiastic attitude, dedication to the dietetic profession, and academic excellence.

The Southeast District Dietetic Association chose Thevis as recipient of the Carol Bertrand Award for Excellence. The award was created in memory of the late Bertrand, who was a registered dietician and graduate of North Oaks’ second Dietetic Internship class.

Dr. Rodney Taylor presented the Dannye Young Taylor “Always Remembering Others” Award in honor of his wife to Toups in recognition of selfless assistance of others.

The North Oaks Dietetic Internship Program offers qualified individuals a unique opportunity to attain eligibility for the Registration Examination for Dietitians through one year of supervised experience.

Local Hospitals Respond to Explosion

Several local hospitals were thrust into the spotlight in mid-June when dozens of victims from the tragic explosion at the Williams Olefins plant in Geismar arrived for treatment. There was one fatality at the site of the explosion and one victim who died later, as well as several workers who sustained serious injuries. However, the majority of the more than 70 injured were treated and released.

Baton Rouge General received a total of 19 patients. Some were admitted to the hospital’s Regional Burn Center in serious condition.

St. Elizabeth Hospital in Gonzales saw a total of 45 patients from the plant. Three had burns, one was suffering with chest pain, and the rest had bruises and contusions. The majority were treated and released.

Our Lady of the Lake Regional Medical Center received 12 patients at its Trauma Center, two in critical condition. Our Lady of the Lake’s community freestanding emergency room in Livingston received one patient.

Ochsner Medical Center – Baton Rouge received 13 patients for various complaints and symptoms as a result of possible chemical exposure. All patients were treated and discharged.

BR General Recognized for Breast Imaging Excellence

Baton Rouge General has been designated a Breast Imaging Center of Excellence by the American College of Radiology (ACR). ACR awards Breast Imaging Center of Excellence designation to breast imaging centers that have earned accreditation in mammography, stereotactic breast biopsy, and breast ultrasound (including ultrasound-guided breast biopsy).

As an ACR Breast Imaging Center of Excellence, Baton Rouge General underwent rigorous peer review evaluations, conducted in each breast imaging modality by board-certified physicians and medical physicists who are experts in the field. Through these rigorous evaluations, Baton Rouge General is recognized for achieving high practice standards in image quality, personnel qualifications, facility equipment, quality control procedures, and quality assurance programs.

Escher Named Surgical Services Director

Michelle Adams Escher, RN, has been named Director of Surgical Services at Lane Regional Medical Center. A native of Zachary, she is responsible for coordinating all aspects of nursing care for the Operating Room and Recovery Room, including patient satisfaction, staffing, and physician relations.

Escher has more than 19 years of healthcare experience. Prior to this position she was a surgical staff nurse in surgery. Escher is pursing CNOR certification, a designation for perioperative nurses interested in validating their knowledge of providing the highest quality of care to patients.

She is currently a member of Lane’s OR/OB Committee and OB Task Force and is a former Lane Employee of the Month and a former Daisy Award nominee. She is also a member of AORN, the Association of periOperative Registered Nurses.

Just Say Ommmm

Woman’s Hospital realizes that sometimes, you just need to say ommmm! Working in healthcare can be stressful, and many are finding that one of the best ways to relieve stress is to strike a pose – a yoga pose, that is. As part of Employee Wellness Day, Woman’s Hospital employees channeled their inner “warrior,” “dog,” and even “tree” with beginner yoga on the helicopter landing pad.

The non-stop beeps, clicks, and buzzes heard all day in busy units and cubicles were replaced with the relaxing sounds of the fountains atop Woman’s lake. Five-minute chair massages also helped employees unwind.
Lane Breaks Ground on Radiation Oncology Center
Baton Rouge General and Lane Regional Medical Center have broken ground on a $4.5 million state-of-the-art Radiation Oncology Center located on Lane’s campus in Zachary. Baton Rouge General’s partnership with Lane to construct the new facility is part of the two organizations’ shared commitment to serving the needs of the community. Construction on the new facility is expected to be completed in January 2014.

The partnership with Lane will expand life-saving radiation oncology services and technology to benefit communities in the northern part of the parish, said William Russell, MD, Medical Director of Radiation Oncology with Baton Rouge General.

Baton Rouge General Earns “A”s for Patient Safety
For the second year in a row, Baton Rouge General earned an “A” for patient safety from the Leapfrog Group, an independent, non-profit employer-sponsored organization. Leapfrog Group’s Hospital Safety Score program reviews more than 2,600 facilities across the country and generates a report card for each, with an A, B, C, D or F letter grade. The grade indicates the hospital’s overall performance in keeping patients safe from preventable conditions, including infections, medication errors, acquired injuries such as bedsores, and other sources of harm, such as falls.

Developed by a panel of physicians and experts from Harvard, Stanford, Johns Hopkins, Vanderbilt, and the University of California, Leapfrog’s scoring methodology is comprised of twenty-six evidence-based, national performance measures to determine hospitals’ safety scores, including 15 process or structural measures and 11 outcome-based. The scores are derived from an analysis of the Leapfrog Hospital Survey data and publicly reported measures from the Centers for Medicare and Medicaid Services (CMS) as well as secondary data sources.

Learn more and see the full report at HospitalSafetyScore.org.

Ochsner Recognized for Care Continuum
Ochsner Health System has been named one of the nation’s “100 Integrated Health Systems to Know” by Becker’s Hospital Review. Scott Posecai, Executive Vice President and CFO of Ochsner Health System, was also honored as one of the “125 Hospitals and Health System CFOs to Know.” Ochsner Health System is the only health system in Louisiana and Mississippi to receive both of these awards.

Each of the health systems selected focuses on the continuum of care, from wellness and preventive services to urgent care, inpatient care, outpatient care, hospice, health plan offerings, and more. Many of these health systems have also demonstrated innovation through their participation in care and payment reform initiatives, such as accountable care organizations.

The honorees of the “125 Hospitals and Health System CFOs to Know” lead renowned tertiary centers, academic medical centers, community hospitals, and health systems in all financial matters while balancing quality patient care and innovative healthcare reform strategies.

The Becker’s Hospital Review editorial team analyzed, scored and weighted data from outside sources on factors including healthcare analytics and health systems’ financial, clinical and operational strength. After examining these national rankings, the editorial team performed additional research and sought insight from industry sources before determining final selections. Hospitals do not and cannot pay to be included on this list.

OLOL First in the State to Offer LARIAT
Our Lady of the Lake Regional Medical Center announced that it is the first hospital in the state to offer a new procedure called LARIAT which may reduce the risk of stroke in patients with atrial fibrillation (a-fib or AF). The procedure gives an option to patients who cannot take blood thinners. If a patient has an irregular heartbeat it is possible that the patient may have blood pooled in the left atrial appendage of the heart. This blood pool can form a clot which could break away and cause a stroke.

The minimally invasive procedure reduces the risk of stroke by using the LARIAT™ device to lasso and tie off the left appendage where blood can pool. An electrophysiologist threads the device up thru small incisions in the groin and mid abdomen. Previously, patients would have to undergo open heart surgery to remove this appendage to reduce the risk of stroke.

Baton Rouge General Expanding Gastroenterology
Baton Rouge General and private physicians network, Baton Rouge General Physicians, announced the expansion of its comprehensive gastroenterology (GI) and digestive health program and the
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opening of its new Gastroenterology Center. The Center is led by board certified Baton Rouge General Physicians’ gastroenterology specialists Drs. Karen Diamond, Shaban Faruqui, Paul McNeely, Alan Sonsky, and pediatric gastroenterologist Dr. Elizabeth Alonso-Rubiano, who bring seasoned GI and digestive health clinical experience to the organization. Offering patients convenient access on Perkins Road in the heart of Baton Rouge’s medical corridor, Baton Rouge General’s Gastroenterology Center brings together expert physicians, leading edge technology, and comprehensive GI services all under one roof.

Baton Rouge General’s gastroenterology program provides the full spectrum of state-of-the-art GI and digestive health services: Treatment of:
- Acid Reflux
- Celiac disease
- Crohn’s disease
- Diverticulosis and Diverticulitis
- Gallbladder disease
- Gastrointestinal bleeding
- Hemorrhoids
- Hepatitis
- Indigestion
- Irritable Bowel Syndrome
- Liver disease
- Pancreatitis
- Stomach pain/constipation
- Swallowing disorders
- Ulcers
- Services & Procedures: Colonoscopy
- Gastroscopy
- Polyp removal
- Ablation of vascular GI lesions
- Placement of gastric feeding tubes (PEG Tube Placement)
- Placement of intestinal stents

The Center is located at 6615 Perkins Road in Baton Rouge.

**Fontenot Receives Healthcare Leadership Award**

Teri Fontenot, Woman’s President and CEO, has been named to the *Becker’s Healthcare* Inaugural Healthcare Leadership Awards. Nationwide, 30 recipients have been singled out for their remarkable contributions that will leave lasting legacies to their respective health systems, hospitals, and communities. Fontenot was recognized, along with her peers, at the 4th Annual Becker’s Hospital Review Conference held in Chicago.

Awardees, which included CEOs, CFOs, CNOs, CIOs, and other executive leaders, were honored for their demonstrated valuable traits. They were acknowledged for their dedication and innovation, and for extending their leadership and vision beyond the confines of their organization to improve the well-being of their local communities. Members of the healthcare community submitted nominations. A panel of editorial team members and healthcare industry experts reviewed each nomination.

Recognition for Fontenot focused on her 17-year leadership of Woman’s Hospital, as well as her dedication and determination to consistently grow and develop the largest birthing and neonatal intensive care facility in Louisiana and the only freestanding, non-profit women’s hospital in the country. Her effort in building a new, technologically-advanced hospital allows for future expansion to meet community needs, and establishes Woman’s as a hub for healthcare throughout a woman’s lifetime.

**Erwin Joins Lane Behavioral Health Services**

Lane Regional Medical Center announced that Thomas Erwin, LCSW, has been named LCSW supervisor for Behavioral Health Services in Zachary and Baker. He is a Licensed Clinical Social Worker and will be responsible for assisting in the development of expanding behavioral health services, specifically with the opening of the Partial Hospitalization Program (PHP).

Lane Behavioral Health Services offers outpatient treatment for adults experiencing life-altering emotional crises, such as depression, anxiety, panic, stress, fear and other personal disorders. This active treatment program teaches powerful and practical ways to respond to any type of traumatic life event, behavioral difficulty or emotional distress, especially major events due to the loss of a job, health or relationship.

With a Masters of Social Work from Louisiana State University, Erwin has more than 16 years of education, medical, and psychiatric clinical social work experience with children, adolescents, adults, and families in both inpatient and outpatient settings. A life-long resident of West Feliciana Parish, Erwin is an active member of the National Association of
New Location for Lane Wound Center

Lane Regional Medical Center announced that the Lane Wound Center & Hyperbaric Oxygen Therapy has moved into its new location, 4917 West Park Drive, located directly behind the Medical Mart Pharmacy on Lane’s campus at 6300 Main Street in Zachary.

Lane’s team of nurses provides advanced therapies for most wounds, such as diabetic, non-healing surgical, traumatic and infected wounds, as well as a variety of ulcers needing wound care. Hyperbaric Oxygen Therapy is used on more serious injuries or compromised wounds, providing 100% pure oxygen in a pressurized chamber. This high pressure dose of oxygen, known as hyperbaric oxygen, greatly increases the amount of oxygen delivered to body tissues by the bloodstream.

Hyperbaric Oxygen Therapy provides:
- Advanced wound healing
- Increased oxygen delivery to injured tissue
- Improved infection control
- Greater blood vessel formation
- Preservation of damaged tissues and veins
- Elimination of toxic substances
- Reduction of gas bubble obstructions

EHR Takes Flight at Lallie Kemp

A comprehensive and instantaneous rollout of the LSU Patient Electronic Health Information and Care Network (PELICAN) has been completed throughout the Lallie Kemp Medical Center in Independence. PELICAN is active in inpatient and outpatient settings, surgery, the emergency department, and business suites, in contrast with the piecemeal implementation of such systems hospitals commonly employ.

PELICAN will make healthcare delivery at LKMC safer, more cost-effective, and more efficient. Health-care providers can use iPhones, iPads, and mobile computer stations rolled to the patient’s bedside to view medical histories, prescriptions, X-rays, MRIs, lab results, dietary needs, allergy alerts, and more.

Teens Join Junior Volunteer Program

In June North Oaks officials oriented 38 teens selected to participate in the health system’s Junior Volunteer summer program. This year’s Junior Volunteers represent 12 high schools in Livingston, Tangipahoa, Orleans, and St. Tammany parishes. Schools include Albany High School, French Settlement High School, Hammond High Magnet School, Holden High School, Jesuit High School, Loranger High School, Mandeville High School, Ponchatoula High School, St. Paul’s High School, St. Thomas Aquinas Regional Catholic High School, Springfield High School, and Walker High School.

For more information on volunteer opportunities for teens, students and adults, call North Oaks Volunteer Services at (985) 230-6811 or visit www.northoaks.org.

When Life Gives You LEMONS...

Two youngsters in the Baton Rouge community have been exercising their entrepreneurial spirit and are also apparently budding philanthropists.

As part of National Lemonade Day, Leroy Hayward III and Destiny Bernard worked hard to run their own lemonade stands and make profits – but they also made the decision to give back to the community.

Leroy Hayward III sold lemonade at Baby Grand, Woman’s biannual expo for expectant women and their families. As a former patient of Woman’s NICU, Leroy donated $100 to Woman’s NICU to help other babies who need intensive care. Leroy is pictured with his father, Leroy Hayward, Jr. and his mother, Sherilyn Hayward.

Destiny Bernard, a student at Christian Life, also donated $400 to Woman’s NICU. She raised $200 from her lemonade stand, and her mother matched her earnings.
Baton Rouge General Honors Nurses
Nurses, clinicians, and ancillary professionals were honored for excellence in nursing at Baton Rouge General’s 2013 Nurse Excellence Awards Ceremony and Banquet. The annual event recognizes nurses and individuals whose contributions support nursing in the following categories: Hall of Fame, Edith LoBue Leadership, Nurse of the Year, Non-Traditional Nurse of the Year, Nurse Rookie of the Year, Ancillary Friend of Nursing, and Physician Friend of Nursing. The ceremony opened with welcoming remarks by Anna Cazes, DNS, RN, Vice President of Patient Care Services and Chief Nursing Officer, Baton Rouge General. Evelyn Hayes, MD, Interim President and CEO, Baton Rouge General, provided remarks for the awards presentation, and Wanda Hughes, PhD, RN, Director of Quality and Patient Safety, Baton Rouge General, delivered the keynote address. Closing remarks were given by Erin Zeringue, Vice President of Quality and Performance Improvement, Baton Rouge General.

Two nursing scholarships were also presented at the ceremony to help support nurses advancing their nursing education. Andrew Olindé, MD, Chief of Medical Staff, Baton Rouge General, presented the nursing scholarship awards. Scholarships are awarded to nurses for their commitment to the highest nursing standards and providing exceptional patient care.

The 2013 Baton Rouge General Nurse Excellence Award winners included:
- Frankie King Courtney, RN, BS
- Hall of Fame
- Lou Wilda Harris
- Emergency
- Ancillary Friend of Nursing
- Neel Shah, MD
- Pediatrics Service Chief, Baton Rouge General
- Physician Friend of Nursing
- Melissa Monroe, RN, MSN, BSN
- Emergency

Edith LoBue Nursing Leadership
- Laura Davis, RN, BSN
- Same Day Surgery
- Traditional Nurse of the Year
- Elizabeth Spreen, RN, BSN, PCCN
- Burn Unit
- Non-Traditional Nurse of the Year
- Michelle Lowry, RN, BSN
- Orthopedics
- Nurse Rookie of the Year

The 2013 Nursing Scholarship Recipients were:
- Ashley Bordelon, BSN, RNC-OB
- Master of Science in Clinical Nursing Leadership, University of South Alabama,
- Kia Gordon, BSN, RN
- Master of Science in Nursing Leadership and Management, Walden University.

IN HONOR OF MOTHER’S DAY, LOCAL MOVING COMPANY TWO MEN AND A TRUCK collected essential supplies from Woman’s Hospital employees to donate to mothers living in shelters. Six donation boxes were completely filled with toiletries, pillows, blankets, basic clothing items, and more. Household goods were also collected to help women moving into their own apartments, and one employee even donated a sofa. All items will be donated to Iris Domestic Violence Center (formerly the Capital Area Family Violence Intervention Center).

Pictured are Joseph South and Candy Couhig of Two Men and a Truck moving company.
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Ruth Abdul Jamaal Chang groaned as he rolled over in bed, the gel casings long since shot within the mattress. Not because he was sick or hung-over or simply reticent in getting up. And not because of the mattress either. He groaned because he dreaded the day. His hand automatically went to the blinds beside his bed and broke them open. Just about the right shade outside; at least he wouldn’t have to rush to work. As if that was any consolation.

He pulled the SensorFeed plugs out of his nose and ears and instantly the real world came rushing back. He sighed. With plugs it was different; the smell of flowers and the gentle pulse of surf. Real nice, and not like he was used to. The beach close enough to his apartment group was a staging area for the sea fill. It was amazing sometimes to stand on the boredwalk during low tide and actually register the sheer bulk of trash that constantly rolled in. And, of course, the smell was even worse, so flowers it was when he slept.

He shuffled bare foot across the non-working ThermaFloor and squeezed into the coffin-like enclosure of the steamer. He turned the knobs thick with rust and closed his eyes and mouth against the rush of steam blowing in from all sides. He counted silently to ten and stepped out, feeling absolutely no different than when he’d stepped in, but covered head to toe with a fine sheen of water that felt and smelled a lot like sweat and something worse. He finished his toilet by peeing into the Wall Feed Recycler next to the steamer door and rubbed a finger full of Mo-Glow onto his front teeth. The ad on See News had warned against using too much since “it most rightly reached the back teeth like a dream” and assured that any pain from the molars was “expected and a sign of true Mo-Glow strength.” Well, Ruth thought, squinting into his mirror, it must be working because his hurt like hell.

He pulled on his clothes and grabbed an onion-wheat bar from the miniscule pantry. Then he left out into the darkness of the receding night. At least the street drones were working (scooting along the streets and avenues with their glaring red glow sensors), so he didn’t have to worry much about being murdered for the ration bar, unless of course there was a malfunction. Times were tight and even if it wasn’t the most tasty delicacy, it was a damn sight better than nothing.

Chewing as he kicked through the trash on the street, his mind wandered to his “new thing” which was really a stroke of genius from the Government. Unemployment was high and jobs were dangerous (hell, just going outside was dangerous), and subsequently many people didn’t want to risk their well-being or their “quality of life.” Completely understandable as far as Ruth was concerned. The government already supplied an adequate living and if you wanted more and found yourself without a skill set or paralyzed by the mayhem on See News or Celebrity Spin you could apply for Special Disability.

Disability Act 497-325c made provisions for every non-disabled citizen to achieve such disability in “a free and above all equal society.” It had been debated furiously on the Mound for months, but thank dog, Ruth reminded himself, logic and fairness had won out in the end. Now everyone was entitled to the Disability Stipend, provided they had documented evidence that they lived with their disability at least twenty out of every twenty-four hours. Be it an epoxied eyepatch, tack shoes, knee hobbler, tongue draggers or any of a number of other “disabilities,” such devices had brought about major changes in society. And most of them for the good, as the newsfeeds always reminded. Heel, he would have fashioned one for himself if his job and position weren’t so coveted and impossible to do without. Why, Mr. Twocheck had prioritized Ruth’s special fabricating lab a year ago, and whatever devices were not mandated to certain strengths and tolerances Ruth tended to come up with on his own. Just last week he’d devised a special tightening headband for an obviously motivated go-getter from the street. And a double stipend at that for such a seemingly primitive device! The studded headband caused not only excruciating headaches but also blurred vision. Even Glen Paddy Shavers had had to take a look at that one. So what if the man had had to have the Government Eye installed right in his own apartment. Everyone paid a price for progress.

After the short walk to the clinic, Ruth gently pushed back the partially-open door. Since the fluorescents were no longer blinking they had obviously been on a while already. “What the heel?” he said. But there she was, Glen Paddy Shavers, singing some little tune to herself (the new one, he recognized...
immediately, from the transgender band Wammalammas) and swaying slightly even. Dancing?
“Glen Paddy?” he said warily, wide-eyed. Then, “Morning?” as she turned full upon him. There were bags under her eyes and she looked like she hadn't slept, but she was smiling, or at least as much of a smile as Ruth had ever seen on her. He glanced around to gauge if they were under attack from some covert enemy, but Paddy's face never changed. “Are you all right?” he asked, maneuvering to the left behind a heavy stool in case she suddenly came at him
“Good Dincum yes, Ruth Chang, yes!” she answered, her eyes never leaving his and the slight, disturbed smile holding tight. “My night was sweet nothing.” Then, “Have you been to the Staring Rooms yet?”

So that was it. “Umm, no,” Ruth said, looking down. “Not yet. But I’ve been meaning to.” In fact he'd been thinking nothing of the kind. The Staring Rooms were a new fad, pushed by Celebrity Spin mostly because supposedly some Vid actors had come up with the idea. Sitting in a dimly-lit room with a handful of strangers staring at blank walls for hours on end just didn't seem to cut it. Of course, for people of a more intellectual bent, the ceilings were supposedly plastered with many-holed tiles in different patterns and colors, just in case you wanted to talk about something after the sessions. “Was it good?” he said, arching his brows.

“Very,” Glen Paddy said regally. “Was there all night, but the time just seemed to fly...” and already Ruth noticed her attention wavered. She cast a glance back toward her domain and Ruth was glad to cut her loose.

“Nice,” he replied. “I'll be sure to try it out soon,” but by this time Shavers had already turned and begun shuffling back into the deeper gloom of the back warrens. That was fine with Ruth, too; there was something about the woman that gave him the creeps. Besides, he had a lot to do. There were the mechanicals that needed finishing and there was still the problem with the medications as of late. Marilyn Twocheck had even come down from Upstairs to question him a second time and that was just skirting too close to the edge for comfort. Dammit, he had to think of something.

He rounded the corner to his desk and sat down. Rubbed his hands across his face, through his hair. Solutions, solutions, he thought. His mind rolled slowly back to his last Zoo trip, just the week before. It seemed like there was something...hah! and he had it. That old man at the Botanical Garden next door. He'd seen Ruth's official uniform and had come up to him for something. Ruth didn't remember what. Only that the guy had said something about Suicide Counseling (he had looked old enough) and having gone against the recommendation. That, really, was the only reason Ruth remembered him at all. Turning down a suicide recommendation was something he'd never heard of before, and he hadn't asked the man why then. That, surely, was none of his business. But he hadn't appeared crazy, and come to think of it, had offered Ruth some advice. Ruth didn't remember what, but seemed to recall the man writing something down and handing it to him on a scrap of paper. Yes, yes, where the hell was that thing?

Ruth began panning through the mess piled on top of his desk. Papers and wrappers and all manner of useless waste, but none the one he was looking for. He gathered another handful and pushed it to the side and right there, staring up at him like a clear yellow eye, was the piece of paper. It had two rather odd words scratched on its surface: Summa Perfectionis. “Hmm,” he said, studying the scrap. He nodded and shoved most of the junk on his desk off to the floor. He felt sudden inspiration and pulled the lapchip to him and powered up as he adjusted the screen. He typed in what the old man had written and for the next thirty minutes stared enraptured at what he had found. Never in his wildest imagination had he ever considered the past as this advanced. There were alchemical formulas and ideas here that could keep hundreds, if not thousands, of scientists busy for years to come. And here it was at his very fingertips! Suddenly his troubles seemed smaller, manageable.

He nodded again and sent up a silent note of thanks to Jesus Christmas. Then he said aloud, but quietly: “This is the Holly Rail of everything I ever dreamed of.” And again, very quietly, he began to laugh weirdly and grind his hands together.
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