LOUISIANA FAMILY DOCTOR

An Official Publication of the Louisiana Academy of Family Physicians

Winter 2015

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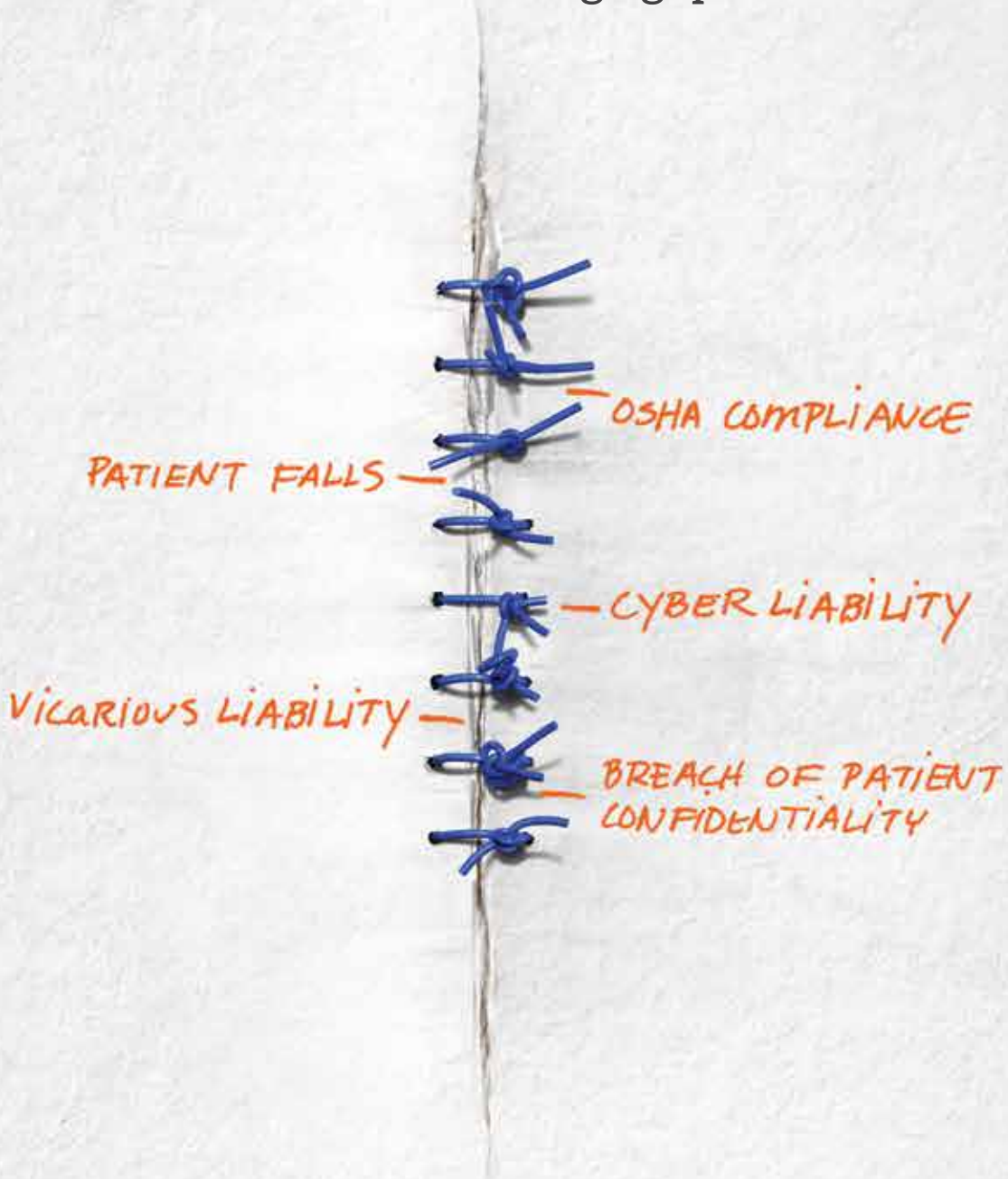

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LOUISIANA FAMILY DOCTOR
Published by Louisiana Academy of Family Physicians
Volume 28 • Issue 3
919 Tara Blvd. • Baton Rouge, LA 70806
Telephone: 225-923-3313 • Fax: 225-923-2909
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Edition 24

A Message from the President

Brian Elkins, MD, FAAFP
LAFP President

As I spend my Friday afternoon supervising in the Alexandria Family Medicine Residency procedure clinic, I am again impressed with the knowledge and skills these young physicians have at this stage of their careers, and I can't help but wonder about the shape of the medical practice landscape they will see in their practices. Their reasons for choosing a career in medicine, and in family medicine in particular, are largely similar to my own: they genuinely want to serve people and often have a role model in the medical field such as their own family doctor growing up. They are highly intelligent; they are effective in accomplishing their goals; they are sincere, kind, and enthusiastic in their desire to learn and to care for patients. They are among the nicest and most talented people I know, and they follow in the tradition of the colleagues alongside whom I practice every day.

Unfortunately, the landscape of medicine into which they are entering is in a period of upheaval. With the now widespread adoption of electronic medical records, the challenge remains to meet Meaningful Use requirements to avoid penalties (while the promised safety and efficiency gains remain elusive); the Affordable Care Act, for all it has accomplished to increase the number of insured in our country, has actually resulted in higher health care costs for many; and looming before us is the massive effort to reorganize our systems into Accountable Care Organizations designed to improve outcomes and decrease costs (a promise that also has yet to be realized in the real world). In the background of all these pressures, the migration to ICD-10 seemed almost lost in the shuffle. With such challenges today, what will the next generation of physicians have to face?

Whatever those challenges may be, I am confident they will be able to find ways to serve that are equally as satisfying as the old paradigms. When pressure reaches a certain point, some will find outlets to get relief from that pressure, with resultant innovative models that produce better results for both physicians and their patients. Direct primary care and employer-based primary care are two examples of such new models that were developed outside the halls of government. It is the creative energy behind such innovation that is needed to find genuine solutions to today's healthcare delivery challenges.

Whatever the model of care your practice embodies, your Academy advocates strongly to keep you, the physician, in the lead role of the healthcare team. Like you, your Academy firmly believes that setting non-physician practitioners free to practice medicine without physician direction would be moving healthcare in the wrong direction. For example, what would the potential harms be of allowing chiropractors to be designated as primary care physicians? For all the value of their training and experience, it would be hard to understate the potential harms of permitting them into such a role for which they are not suited.

As we think about the future of our own practices, the future of primary care within our state, and the future generations of family physicians that will follow us, in addition to being creative in the development and refinement of new models of care we will have to be vigilant in protecting our patients from forces that threaten to move us backward, not forward, in the provision of that care. The legislative and advocacy activities of the Academy are working hard with you to do just that, and to not just defend, but to lead. (We encourage you to watch for tweets from @lafp_familydocs for timely updates on developments during Louisiana's legislative session from mid-March to early June. Adding our individual voices at the right time makes our collective voice so much louder.)

I believe the future for our successors in family medicine will be bright for many reasons, but most of all because I believe that the recognition of the primacy of primary care in an effective healthcare delivery system is simply inevitable. So the LAFP will continue to support you developing creative solutions to the problems of our day, and will together with you lead the way to the future that we envision together for the good of our patients, fulfilling our mission "to promote and support Louisiana's family physicians in providing excellent health care, service and leadership."

Brian Elkins, M.D., FAAFP

A Message from the Secretary

Christopher Foret, MD
LAFP Secretary

LAFP members,

Hope all are enjoying the wonderful fall weather! The remainder of the year will pass quickly and 2016 is rapidly approaching.

As of this writing, we are in the first month of ICD-10! Like Y2K, maybe all of the fears of reimbursement delays will be unsubstantiated. However, since Louisiana is one of four states that will convert ICD 10 codes to ICD 9 codes for Medicaid charges, the concerns could be legitimate. Before October 1, ICD-10 only was a reference to an interstate. My have things changed!

October also brought another election cycle. Because of the scope of practice threats, the LAFP Legislative and Membership Issues Committee has been as active as ever. From vetting candidates to maintaining relationships with current legislators, preparation for the legislative session is a weekly function. We need your help. Ask the local candidates in ones district positions on issues important to organized medicine. With your help, we can ensure the quality of care all Louisianians deserve.

Further changes are occurring in Louisiana healthcare. The stand alone emergency room movement will increase through the Ochsner Health System next year. The number of small hospitals in financial distress is increasing weekly. Thus far Louisiana has been immune. With increasing deductibles and the demographic challenges how long will that last?

On the heels of a successful Assembly in NOLA, it is never too early to plan a beach trip to the LAFP meeting in Destin, Florida, in July at the Sandestin Golf and Beach Resort. Let the thoughts of white sand and beautiful water help with the rainy winter days!!

Sincerely,
Christopher Foret, MD
LAFP Secretary

Executive Vice President

Ragan LeBlanc
LAFP Executive Vice President

A Look Back Over the Past Year

Ragan LeBlanc is the Executive Vice President of the Louisiana Academy of Family Physicians (LAFP), LAFP Foundation and LaFamPac.

How lucky I am to work for family physicians who always make "health primary!" December 6th will mark my 10th anniversary with the LAFP. It is an honor and privilege to work for you. I am also very blessed to work alongside of some of the brightest colleagues that keep your chapter's momentum moving forward.

The past year has been another stellar year for the Louisiana Academy of Family Physicians. Your LAFP office is located in Baton Rouge and our office hours are Monday through Friday from 8:30 am – 5:00 pm. Please know that we are always on the "other side" of the phone and we hope you will utilize us as a member benefit.

Staff

There are currently four of us who work in your headquarters offices. I would like to extend my thanks to your staff who work tirelessly and cheerfully on your behalf: Lee Ann Albert - Director of Membership and Education; Clay CoCo – Manager of Communications and Marketing; and Mary DuCote – Administrative Coordinator. We also have contracted with the lobbying firm, Mapes and Mapes.

Finances

Your finances remain strong, and as we approach the mid-point in the year we are poised to have one of our strongest financial years in the last several due to performance in several key areas Our membership numbers are at an all-time high and will provide the strongest dues revenue in our history in the coming year. At a time when we know that the practice environment is challenging at best, family physicians in the state continue to look to the LAFP and AAFP as a critical resource, and more of them have voted "yes" with their dues dollars than ever before.

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Membership

We want our members to view their membership as valuable, even critical to **THEIR SUCCESS**. We strive to provide the right programs and services and to ensure that family physicians understand the value of what is provided. The LAFP has continued to receive the 100% resident membership award and also received a second place award for the highest percentage of increased active membership.

Membership Data (as of November 1, 2015)

- The AAFP has 114,753 members
- The LAFP had 1,703 members including 886 actives, 4 inactive, 74 life, 211 resident, 525 student, and 3 supporting
- The AAFP market share is 76.4%
- The LAFP market share is 76.1%

Membership Retention (calendar year 2014)

- 93.9% LAFP active members retained their membership
- 89.7% of LAFP new physician members retained their membership
- 83.7% of LAFP resident members converted to active membership upon completion of residency

Membership Demographics

- 66.7% of LAFP members are male
- 33.2% of LAFP members are female (remainder did not identify gender)
- 21.8% of LAFP members are AAFP Fellows
- 75.8% of LAFP members attended a U.S. medical school
- 24.1% of LAFP members are international medical school graduates
- 96.4% of LAFP active members graduated from a family medicine residency program

Advocacy

This was a relatively busy year for the LAFP, and there were a number of potentially harmful bills that were addressed to help ensure that they not pass, and a few others that we supported as they became law. Your legislative team worked diligently to protect the interests of family physicians and our patients. Thanks to Mapes and Mapes for their continuing invaluable efforts this year, to our (mostly) tireless LAFP office staff, and to our Committee members who actively participated in the development of our positions. We, the LAFP, are well served by these members and staff.

Our legislative committee met before and during the session to set priorities and define specific positions on bills that we were following. We worked effectively on issues with other organizations, both healthcare and non-healthcare, and communicated with the Louisiana State Medical Society and Medicine Louisiana on several bills. The committee met on several occasions and asked for opinions and guidance by email when needed when emergent issues arose. Additionally the LAFP held a successful legislative social during the session that was well attended by legislators and LAFP members.

In the past three legislative sessions, family physicians have been threatened with scope of practice expansion by allied health professionals. A total of 4 bills attempting to expand the scope for nurse practitioners and chiropractors were presented before the legislature. All of these bills were successfully defeated, either directly or indirectly, thanks to hard work, diligence, and collaborative efforts. We were able to help organize the medical legislative teams into a force that is now relevant to the legislative process. Most of our members understand what kinds of precedents are being established by these kinds of bills, and each year this threat continues and shows no inclination of changing. They will not stop until we make them stop.

In 2015, the LAFP continued the Louisiana Legislative and Advocacy Series, designed to improve the communication and education between physicians and legislators. The advocacy series was planned with LAFP staff, the LAFP Committee on Legislation and Board of Directors to introduce members to their role in the legislative process and encourage members to participate in the Louisiana legislative session as a key contact or witness. There were some changes that were made to the schedule of the series, where the legislative and advocacy training as well as the legislative socials will be held later in the year, after the close of the 2015 session, as part of the strategic plan to address threats that the LAFP anticipates leading into and during the 2016 session. We were able to function effectively in the 2014-2015 legislative year without that expenditure, and therefore will enable the LAFP to preserve those funds to dedicate for future use.

White Coat Day at the Capitol was hosted on May 27, 2015. Five residency programs, which included Baton Rouge General, Kenner, East Jefferson, Bogalusa and Lake Charles, set up various screening booths in the State Capitol Rotunda. Here, many legislators and Capitol staff were able to see our residents and physicians and interact with them directly and informally, while hearing the concerns and feeling the presence of Family Medicine. Over 30 residents and active members participated. The day as a whole was a great success, and we greatly appreciate all of our members who took the time to participate and help strengthen the voice of Family Physicians in Louisiana.

Family Medicine Legislative Champion of the Year

The LAFP held their annual meeting last month at the Hotel Monteleone in New Orleans and recognized Senator Dale Erdey and Representative Katrina Jackson for their leadership and support of the practice of family medicine. The LAFP was honored, to express our sincere appreciation to two outstanding legislators who voted to protect family physicians and their patients on budgetary issues and attempted intrusions in the practice of organized medicine by other healthcare professionals. Senator Dale Erdey and Representative Katrina Jackson were presented with Legislator of the Year Awards during the 68th Annual Assembly & Exhibition Awards and Installation Ceremony.

Individual Involvement – Family Physician of the Day

I want to express my gratitude to the members of the legislative committee for their time, advice, and expertise. It was a very active and involved group this year. Thanks also to those LAFP members who volunteered time as Family Physician of the Day, which had the highest number of member participants in our tenure at that facility. There is no way to overstate the value this program brings to our Academy, and to the House of Medicine in general, in terms of our profile, our reputation, and our mission. The time those members give when leaving their practices, on behalf to our colleagues and our profession, is precious and is appreciated as such. Legislators and Capitol staff continue to provide feedback on how much they appreciate our presence through the Family Physician of the Day program. The following members volunteered their time during the 2015 Legislative Session:

Dr. Shavaun Cotton	Dr. Jessica Gilbert	Dr. Megan Hartman
Dr. Jovan Kakish	Dr. Lacey Knowles	Dr. Alan LeBato
Dr. Neil Nixdorff	Dr. Stephen Ogden	Dr. Bryan Picou
Dr. Smita Prasad	Dr. Zachary Pray	Dr. Maryann Sandy
Dr. Jason Schock	Dr. Ronnie Slipman	Dr. Nathan Sutton
Dr. James Taylor	Dr. Kristen Thomas	

LAFP also extends warm thanks and appreciation to our nursing staff at the Capitol, Pat Rusk, RN and Errol McCrae, RN, who are there every day whether or not a doctor comes in.

Your LAFP Legislative Affairs Committee

The following LAFP members serve on the Legislative and Membership Issues Committee:

Chris Achee, MD
Eldridge G. Burns, MD
James Campbell, MD
Lacey Cavanaugh, MD
Mark Dawson, MD
Phillip Ehlers, MD
Chris Foret, MD
Indira Gautam, MD
Wayne Gravois, MD
Alan LeBato, MD
Edward Martin, Jr., MD
Meredith Maxwell, MD
Patrick Moore, MD
Joseph Nida, MD
Bryan Picou, MD
Marguerite "Cissy" Picou, MD
M. Tahir Qayyum, MD
Nicholas Seelinger, MD
Carol Smothers, MD
Zeb Stearns, MD

The need for physicians' voices is continuing to grow. Issues concerning health care are becoming increasingly complex and the policy makers need to hear from physicians as more and more challenges are being faced at both the state and federal levels. Physicians make a big impression when they show up and talk with Senators and Representatives from their hometown. **You are the voice for your patients** and when it comes to issues your patients and your colleagues need your help.

Education

We continue to produce excellent educational programs under the leadership of our Education Committee and the direction of our education director, Lee Ann Albert. Our Education Committee is considering changes in our out of state annual assembly. We have held the out of state meeting in Destin for the past several years. Attendance has varied significantly in recent years and costs have increased. The Committee is considering options to increase attendance and reduce costs by moving the conference to another location outside of Louisiana besides Destin, Florida.

Major Initiatives

DOT Workshops

In 2013 the Federal Motor Carrier Safety Administration announced a new program called the National Registry of Certified Medical Examiners (National Registry) which dictated that all commercial drivers be examined by a certified medical professional by May 2014. This also meant that only medical examiners that had completed training and successfully passed a test on Federal Motor Carrier Safety Administration's (FMCSA) physical qualification standards by May 2014 would be listed on the National Registry.

In 2014 and early 2015, the LAFP offered multiple DOT Medical Examiner Training Courses. Sessions were held on March 17th and May 17th in 2014 and March 15th and July 18th in 2015, where more than 150 physicians and clinicians attended theses sessions. The courses, led by Dr. Esther Holloway and Dr. Magdy Eskander, offered clinical guidelines that physicians and other clinicians need to follow in order to conduct updated DOT physicals.

The training also offered practical tips on completing the required documentation needed to certify a Commercial Motor Vehicle (CMV) driver. At the end of each course, faculty work with attendees to register on the National Registry System to receive their unique identifier needed to register for the federal exam.

PBRC Partnership Opportunity:

The LAFP also formed a partnership with the Pennington Biomedical Research Center. LAFP members were provided the opportunity to inform patients about the studies currently being conducted at PBRC and the ability to participate in these studies. The membership also can make suggestions to PBRC on studies that they would like to see conducted at the center.

This partnership is a valuable benefit for residents to meet research criteria. Information was provided to the LAFP and sent to all of the Louisiana residency directors and published in the various communications tools (i.e. The Weekly Family Medicine Update and *Louisiana Family Doctor*) to make members aware of the need for research participants.

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Thanks to our Education Committee for their participation and support of the LAFP educational initiatives.

Derek Anderson, MD
Donnie Batie, MD
Gregory Bell, MD
Kenneth Brown, MD
James Campbell, MD
Brian Elkins, MD
Fred Gaupp, MD
Jody George, MD
Pamela Guoth, MD
Michael Harper, MD
Richard Hines, MD
Jan Hood, MD
Harold Ishler, MD
Daniel Jens, MD
Latonya Kelly, MD
Alan LeBato, MD
Euil Luther, MD
Michael Madden, MD
Ronald Menard, MD
Ellen Mullen, MD
Kiernan Smith, MD
Michael Williams, MD

The continued goal of the Education Committee is to make the LAFP the "Premier Provider" of CME for our members.

Communications

Our quarterly journal, ***The Louisiana Family Doctor, A Journal of the LAFP***, continues to receive very positive support from readers and advertisers. I serve as the editor of the journal, along with our editorial board comprised of Dr. Michael Williams, Dr. Derek Anderson, Dr. Alan LeBato, Dr. Brian Elkins, and Dr. Tobe Momah Education Committee Chair, who have produced consistently high quality issues featuring current articles that have been accredited for CME. The CME accreditation for articles in the journal was discontinued in the Winter 2014 journal due to the lack of members taking advantage of the free CME credits and the cost associated with having them accredited.

Our weekly electronic newsletter, ***LAFP Weekly Family Medicine Update***, is our principle vehicle for communicating current and breaking news. This newsletter is sent out every Tuesday to all LAFP members. Our staff has been excellent at maintaining our social media presence with regular meaningful and promotional content with both our Facebook and Twitter accounts. If you have not liked our Facebook page or do not follow us on Twitter, I encourage you to do so.

Website/Social Media

We are continuing to improve the LAFP and just completed a complete redesign in January of 2015. Last year the staff began discussions centered on enhancements to gain greater attention to the website such that it may remain up to date and prove useful for members, residents and students.

The Career Center –FP Jobs Online with Job Target has been in place for almost the last year. It provides for broader reach and more royalty income. The use of this site remains suboptimal, however. Discussions regarding the possible optimization of this site occurred but no formal process has been decided on at this time.

Our facebook page, www.facebook.com/lafamphysicians, has nearly 400 followers. Posts relevant to health care in Louisiana and nationally are made several times a week by LAFP staff. Membership welcomes comments and suggestions from members and prospective members in this forum.

We continue our **@lafp_familydocs** twitter handle, with nearly 100 followers, including key AAFP leadership as well as Family Medicine publications and organizations interested in keeping an eye on what LAFP has to say. Members are encouraged to contribute using our handle @lafp_familydocs or hash tag #lafp_familydocs.

LAFP Board

It seems rather self-serving, and perhaps even gratuitous for someone in my position to suggest that they are "thankful" for their leadership. So be it. The group of physicians, residents and students that serve on the LAFP board give of their time and energy, both of which are in short supply for almost every family physician I know, in an effort to promote the specialty and protect the patients you all care for each day. These leaders are not compensated, and in fact are rarely even acknowledged for their service, but they serve a vital purpose in the work of the LAFP, which has become a significant voice in the healthcare policy discussions in Louisiana. The partnership between these dedicated elected leaders and your professional staff is a model for a successful association, and I am thankful both for the work that we've done in the past year, and the growth we continue to achieve throughout the organization.

Leadership

We have continued to support delegates to the Southeastern Family Medicine Conference, the Annual Chapter Leader Forum (ACLF), the National Conference of Constituency Leaders (NCCL) and the National Conferences of Resident and Student Members. These important regional and national conferences are consistent sources of leadership development for Academy members.

Resident & Student Activities

We have continued to support resident and student activities within the Academy. Our primary commitment has been financial subsidies for our resident and student members to attend LAFP and AAFP meetings. We also encourage resident and student members to serve on our committees and to participate in our Assembly.

Governance

Our committee structure continues to provide an effective and efficient vehicle for member involvement in directing the affairs of the Academy. More than 70 members served on committees this past year. Our committees dealt with a broad range of issues and concerns on behalf of members and were expertly managed by our team of volunteer chairs and professional staff. I appreciate the efforts of those individuals and would like to acknowledge them here:

Committee	Chair	Staff
Nominations	James A. Taylor, Jr., MD	Ragan LeBlanc
Operations	Bryan Picou, MD	Ragan LeBlanc
Legislative and Membership Issues	James A. Taylor, Jr., MD	Lee Ann Albert
Education	Tobe Momah, MD	Lee Ann Albert
Resident and Student Leadership	Becky Batiste/ Koby Lanclos	Lee Ann Albert

I confer regularly with the president, president-elect and vice president to keep our leadership team apprised of developments that may require policy decisions. These communications also afford the opportunity for me to obtain membership perspective on issues and opportunities as they may occur.

Conclusion

Change remains a constant factor in health care and in medicine. I have observed, with increasing concern, the impact which this is having on Academy members. The dreams and aspirations which so many members had upon making the decision to become a physician and then deciding to specialize in family medicine, have been severely strained by developments in insurance, regulation and technology which have dramatically altered the practice environment and the physician-patient relationship. We have been fortunate to have leaders who have been undeterred by the stress and persistence of change. Each time we are confronted with some new policy, program or practice our leadership has marshalled the fortitude and creativity to respond. In this regard, our members are very well served by the men and women who share their commitment to Family Medicine and their concern for the patients they serve and the profession they have chosen.

We have been successful in producing quality programs with professionalism and efficiency. It is my pleasure to work with an outstanding leadership and staff and I deeply appreciate that opportunity.

So as always, I will take this annual opportunity to thank you for allowing me to serve alongside each of you over the past 10 years. It is been my pleasure to serve the Board and the membership. I remain passionate in my advocacy on your behalf, determined in my persistence to see a brighter future for family physicians in Louisiana, the LAFP and the members we serve. I am looking forward to the next 10 years.

It has been a good year, and we are poised for even better things in the coming year. As always, I am well aware that the environment could, and in fact should, be better for many of our members. Small, independent practices still find themselves in a fight for survival. The changes that are taking place within the healthcare arena throughout the state and across the country are still unproven and require vigilant attention and advocacy. Still, no other organization in the state is exclusively dedicated to those interests, nor more equipped to lead the fight. I am thankful that I will begin another year leading that charge. Happy New Year and best wishes for a safe, healthy and prosperous 2016.

Sincerely,

Ragan LeBlanc

Executive Vice President

FP ad to come

FP ad to come

Augmentative and Alternative Forms of Communication

By Pathways.org

For children with severe expressive communication disorders, augmentative and alternative communication (AAC) can improve their ability to interact with others in everyday settings. AAC promotes wider social interaction by offering different functions from supporting existing speech to providing an alternative for verbal communication. Individuals with autism, cerebral palsy, genetic syndromes, cognitive impairments, hearing impairments, and head injuries use AAC to enhance their communication abilities.[1]

Depending on a child's needs, AAC can be applied through the means of unaided and aided forms of communication. Unaided forms of ACC require children to use their bodies to communicate and include sign language, gestures and facial expressions.[2] Aided forms of ACC involve the use of equipment/devices to communicate and are categorized by low tech and high tech options.[3]

AAC was originally the last type of intervention recommended for children with communication disorders.[4] Older devices were limited in function because they exclusively helped children with their expressive communication to better convey their wants and needs. Today, there is an increased recognition that AAC devices can also be used to improve children's receptive communication abilities by helping them receive and understand messages from others.

Examples of AAC features:

- Speech output using text displays that allow two people to exchange information
- Picture board touch screens that use images and symbols
- Spelling and word detection
- Internet to access information
- Multimedia components for videos and photos
- Texting and cell phone features
- Social media to connect with others[5]

Mobile technology has made AAC more accessible to families with phones and tablets, because these devices are light and portable, less costly and are widely used in society. Although these technologies are easily accessible, it is important for children to receive a referral and formal evaluation for AAC software and devices. A speech and language pathologist will choose a program that uses the best language concepts, organization and layout, selection of target concepts and support for a child's needs.

Obtaining a referral and arranging funding and training for an aided AAC device can be complicated for any family. Primary care providers can facilitate this process by:

- Identifying communication issues early and making timely referrals – pediatric clinics often offer free developmental screenings[6]
- Coordinating the AAC assessment with other therapeutic services the child is currently receiving
- Supporting funding of AAC devices and services by providing "medical necessity" letters to funding sources[7]
- Working with a team of educational and therapy professionals to monitor the effectiveness of the chosen AAC device
- Assisting parents in conversations with school staff and child care staff to ensure that AAC devices are being used effectively in both school and home settings

Children with suspected communication issues should always be referred for an additional evaluation. Early detection and treatment can help children reach their fullest potential.

[1] Information for AAC Users. American Speech-Language-Hearing Association. ASHA Homepage. www.asha.org. Accessed 22 Apr 2015.
[2] Communication Services and Supports for Individuals with Severe Disabilities: FAQS. American Speech-Language-Hearing Association. ASHA Homepage. www.asha.org. Accessed 17 Dec 2014.
[3] Assistive Devices for People with Hearing, Voice, Speech, or Language Disorders. National Institute on Deafness and Other Communication Disorders. NIDCD Homepage. www.NIDCD.nih.gov. Accessed 17 Dec 2014.
[4] Romski, M.A, & Sevcik, R.A. Augmentatie communication and early intervention: Myths and realities. Infants & Young Children. 2005; 18: 174-185.
[5] Light J, McNaughton D. The Changing Face of Augmentative and Alternative Communication: Past, Present, and Future Challenges. Augmentative and Alternative Communication. 2012; 28(4): 197-204.
[6] Desch L, Gaebler-Spira D. Prescribing assistive-technology systems: focus on children with impaired communication. Pediatrics. 2008; 121(6): 1271-1280.
[7] Funding for Service Delivery: FAQS. American Speech-Language-Hearing Association. ASHA Homepage. www.asha.org. Accessed 21 Aug 2014.

Pathways.org is a 501(c) 3 not-for-profit organization dedicated to empowering parents and health professionals with FREE tools and resources to maximize children's motor, sensory, and communication development. All materials are created under the direction of the esteemed Pathways.org Medical Roundtable. Our video library contains 40+ free videos to encourage the early detection and intervention of developmental delays.

Acquired Hemophelia

Micah Pippin, MD and Anne Pinfold, MD-Faculty Advisor
Department of Family Medicine
Family Medicine Residency – Alexandria

Case Report

History of Present Illness:
69 year old Caucasian female presented with sudden onset of right lateral thigh pain on the morning of admission. Pain was 8-9 out of 10 in severity, non radiating, and was associated with localized swelling and tenderness to palpation. Patient denied any trauma to the area before onset of pain. She had been seen in the Emergency Department 2 weeks previously for swelling of the left forearm which was diagnosed as a traumatic ecchymosis. At the time, it was believed that patient possibly had a coagulopathy; however, the etiology was not investigated. The cause was thought to be secondary to alcoholic liver disease

Past Medical History:
Hypertension
Cholecystectomy, hysterectomy, back surgery x2,
Smokes one pack of cigarettes daily for 40 years
History of Alcoholism and reports current consumption of 3 beers daily
No family history of coagulation disorders
Allergy to Codeine

Physical Examination:
Vital signs stable, Alert and Oriented, Regular cardiac rate and rhythm, no murmurs, lungs clear to auscultation bilaterally, soft tissue swelling of the proximal, lateral, right thigh which was exquisitely tender and with no overlying erythema.

Laboratory:
Hemoglobin and Hematocrit 12.8/37.8, WBC 11.3, Platelet count 244
Na 122, K 3.6, Cl 91, CO2 21, BUN 10, Cr 0.6
PT 13.0, PTT 66.6
Factor VIII level 1 (Range 56-191)
X-ray of right thigh negative for fractures
CT of right thigh with contrast showed 10 x 4cm fusiform hematoma within posterior vastus lateralis muscle

Assessment

Large hematoma secondary to coagulopathy. Patient was given 2 units of fresh frozen plasma and Vitamin K. Factor VIII level resulted and revealed an acquired hemophilia. Planning for transfer to hemophilia clinic at Tulane in New Orleans was initiated with the assistance of Hematology

Treatment

Patient initially received two units of fresh frozen plasma and vitamin K. She was evaluated by Surgery and Hematology. No surgical intervention was pursued. Patient was transferred to the hemophilia clinic at Tulane in New Orleans and was treated with Factor VIII replacement, cyclophosphamide, and prednisone.

Characteristic Features of Patient

Sudden onset of large hematoma or extensive ecchymosis in an elderly individual without significant trauma or known bleeding disorder or anticoagulation medication. Patient also had similar previous episodes and also reported recurring epistaxis.

Typical Physical Findings

Large hematomas or extensive ecchymosis.

Common Laboratory Abnormalities

- Prolonged activated partial thromboplastin time and normal prothrombin time
- Decreased Factor VIII

Characteristics

- Caused by Factor VIII inhibitors – the most common autoantibodies that affect clotting factor and lead to a bleeding disorder. Most patients are over the age of 50 except women who are pregnant or postpartum. The major identifiable causes are: pregnancy or the post partum period, rheumatoid arthritis, malignancy, SLE, and drug reactions. However, in almost half of cases there is no identifiable underlying disorder.

- Clinical features include bleeding, often noted after a surgical procedure. Patients often present with large hematomas, extensive ecchymosis, or severe mucosal bleeding, including epistaxis, GI bleeding, and gross hematuria. Hemarthrosis, which is common in hereditary hemophilia, is unusual in acquired hemophilia. Soft tissue bleeding is the most common form of bleeding in the disorder.

- Inhibitor screen- Patients plasma and normal plasma are mixed and aPTT measured. Correction of aPTT suggests a factor deficiency or VWD, while persistent prolongation indicates the presence of an inhibitor

•Bethesda assay – Patients plasma is mixed with serial dilutions of normal plasma and Factor VIII is measured. The stronger the inhibitor, the greater the dilution required to allow for factor VIII activity.

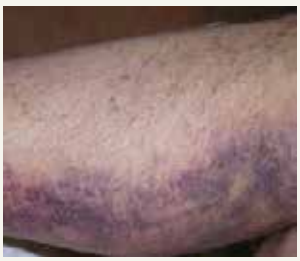

Figure 1.

Figure 2.

Figure 3.

Figure 4.

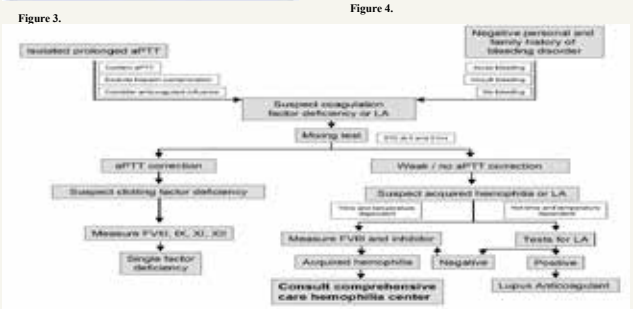

Figure 5.

Summary

Acquired Hemophilia results from the development of autoantibodies to the coagulation Factor VIII. It commonly presents as spontaneous large soft tissue hematomas or ecchymosis. Half of cases have no associated condition; however, pregnancy and post partum, rheumatoid arthritis, malignancy, and drug reactions have been associated with acquired hemophilia.

Mixing tests are performed to assess presence of inhibitors while the Bethesda Assay is performed to quantify the inhibitors. For patient with factor VIII inhibitors, initial control of active bleeding should be done using factor VIII concentrates for those with low inhibitor titers (>5 Bethesda units). If patient has higher titers, use either activated prothrombin complex or recombinant human factor VII A.

To eliminate factor VIII inhibitors, up-to-date recommends the use of prednisone at an initial oral dose of 1 mg/kg per day in all patients. It is also suggested to initiate oral cyclophosphamide at 2 mg/kg day.

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Acute Ethylene Glycol Intoxication and Treatment

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Case Report

History of Present Illness:
Patient is a 49 y/o AAF presenting to RRMC ER with abdominal pain, n/v and AMS. The patient is not answering any questions due to profound AMS, upon all questioning she only holds her abdomen and moans. EMT reports finding empty bottle of antifreeze near patient.

Past Medical History:
Hepatitis C
HIV
Heavy alcohol abuse and cocaine abuse
Schizophrenia

Physical Examination:
Vitals : Pox 100, BP 128/75, Temp 99, Pulse 115, Respiratory Rate 17
General: ams in moderate distress, lethargic
HEENT : normocephalic, dilated pupils, sweet smelling breath
Cardiovascular: RRR, no murmurs, rubs or gallops
Respiratory : clear to auscultation
Abdomen : soft, normal bs, tender in all four quadrants
Extremities : moves all, no edema, clubbing or cyanosis
Neuro: AMS, abnormal speech, uncooperative

Laboratory:
UDS: positive for cocaine
Cmp: Na 135, Anion gap 42, Glucose 129,
ABG: Ph 7.26, PCO2 15.3, PO2 116, HCO3 10.9, FIO2 21%
CBC wbc 14, h/h 13/42, plt 215
UA: +ketones, +protein

Assessment

Patient is a 49 y/o AAF with metabolic anion gap acidosis likely due to ethylene glycol ingestion.

Treatment

Patient was placed in MICU and started on aggressive rehydration with NS and bicarbonate. Had central line placed in femoral vein, and temporary dialysis catheter placed . Order was placed for folic acid, thiamine, pyridoxine and fomepizole. Initially, fomepizole was unavailable at RRMC and had to be flown in from LSUHSC Shreveport. Once the patient received the fomepizole, cofactors and dialysis she rapidly improved and was eventually d/c to an inpatient psychiatric facility.

Characteristic Features of Patient

Alcoholic, and polysubstance abuser with chronic mental illness presenting with anion gap acidosis and fruity odor to breath.

Typical Physical Findings

- Profound altered mental status
- Fruity odor to breath
- Otherwise normal physical exam unless patient has sustained trauma

Common Laboratory Abnormalities

- Anion gap metabolic acidosis
- Ketonuria
- Oxalate crystals in urine which glow blue under fluorescence light.

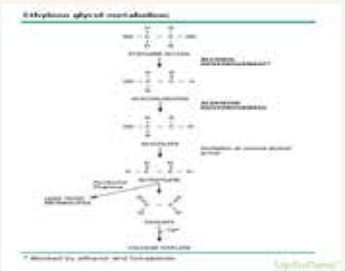

Figure 1.

Figure 2.

Figure 3.

Figure 4.

Summary

This patient had a near classic presentation of ethylene glycol intoxication/poisoning. The patient had multiple comorbid conditions that increased the risk of this intoxication (chronic mental illness, alcohol and drub abuse). The patient made a rapid recovery once the clinical picture was recognized and appropriate treatment was provided. Of note is the shortage of fomepizole at the admitting hospital, this is in part due to the rarity of cases of ethylene glycol ingestions. In the event of a situation where the appropriate antidote can not be readily provided to the patient other options for treatment include dialysis, exchange transfusion, oral ethanol (per ng tube or orally) and IV ethanol. Luckily in our case there was a supply of fomepizole that could be obtained in a very short period of time.

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Management of Newborns exposed to Maternal HIV infection

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Family Medicine Residency – Alexandria, LA

Case Report

History of Present Illness: **HIV positive baby**

Newborn female born via normal spontaneous vaginal delivery to 28 year old G2P2 mom with a history of mild intellectual disability and seizures. Mom denied knowing that she was pregnant and had no prenatal care. Her boyfriend was HIV positive and she had acquired the infection from him. She found out she was HIV positive a few weeks prior to her delivery but she did not seem to understand the significance of the infection. Baby arrived in the nursery hypothermic and in respiratory distress. Was resuscitated and placed under radiant warmer and responded well.
Birth weight: 5lb 14oz (2662 g); Ballard score: 41 weeks; No congenital anomalies
Was started on ZDV, Nevirapine, Ampicillin, Gentamicin

Physical Examination:
Normal newborn exam

Laboratory:
Na-136, K-3.6, Cl-100, CO2-20, BUN-8, Cr-0.8, Alb-3.7, Ca-9.5, T.bil-6.6, AST-50, ALT-13, ALP-257; H/H-19.7/55.1, Plt-249, WBC-12.0

Blood cultures-no growth after day 3 after which ampicillin and gentamicin were stopped

Urine drug screen and Meconium drug screen were negative

HIV 1 antibody screen by EIA and Western both were positive

Reflex HIV-1 RNA viral load arrived 3 days after admit and was indeterminate

Baby was placed in state custody (same foster parents as couple's first child)

Discharged at 6 days of age after completing 3 doses of nevirapine to complete 5 more weeks of ZDV

Weight at discharge: 6 lb 1 oz

Labs at discharge: H/H: 17.5/50.0, WBC-10.3, Plt-291, T.bil-2.1, AST-58, ALT-14, ALP-268
HIV DNA PCR at 2 days, 3 weeks and 2 months and 4 months of age were all negative

HIV Classification

HIV -1 is the commonest worldwide and the main subtype in the US; HIV-2 is mainly in W. Africa esp. Guinea Bissau

HIV -1 is grouped as M, N, O and P

M (main) is the pandemic strain; O (outlier) represent fewer strains from Cameroon, Gabon and Equatorial Guinea; N (non M, non O) and P are very rare and have only been documented from Cameroon.

Group M viruses are divided into 10 clades, A-J, with clade B being the most common subtype in the US.

Management

HIV exposed infants should receive all the recommended childhood immunizations until a definitive diagnosis is made.

Use inactivated vaccines as much as possible eg. Yearly Trivalent Inactivated Flu Vaccine.

Live virus vaccines (MMR and varicella) should not be given to HIV infected infants because of lack of safety date in this population.

Rotavirus vaccine (LAV) may be given to HIV exposed and HIV infected infants irrespective of CD4+ T lymphocyte count.

HIV infected children should all receive a dose of the 23 valent polysaccharide pneumococcal vaccine after 24 months of age, with a minimal interval of 8 weeks since the last conjugate pneumococcal vaccine.

Diagnostic and treatment details discussed in tables 1, 2 and 3.

Trimethoprim sulfamethoxazole is given starting at 4 to 6 weeks of age for PCP prophylaxis until HIV infection is definitively ruled out.

Screening for Tuberculosis

Infants should be kept away from any person with active pulmonary disease until that person is no longer considered to be contagious.

Such infants should also receive a PPD and CXR.

Even if the PPD test is negative, infants who have been exposed to tuberculosis should be given INH for 3 months.

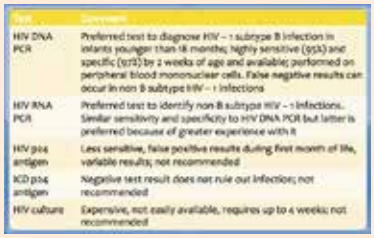
Can stop INH if repeat testing is negative at 3 months; otherwise, continue INH prophylaxis for 6-9 months

Follow up

Consider passive immunoprophylaxis or chemoprophylaxis regardless of immunization status with exposure to any vaccine preventable disease unless recent serologies are available showing adequate antibody concentrations.

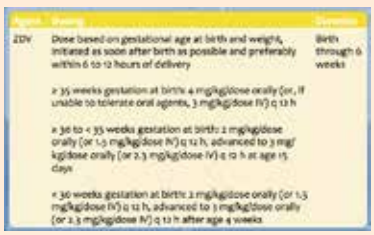
Parental/Caregiver education at every follow up visit is critical.

Remember the multiple physical, emotional and social concerns of HIV infected mothers and provide appropriate support.



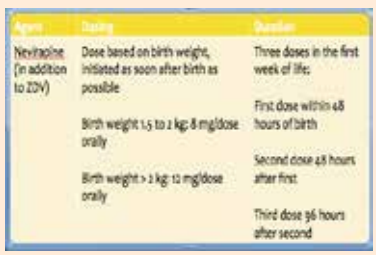
Test	Comment
HIV DNA PCR	Preferred test to diagnose HIV – 1 subtype B infection in infants younger than 18 months; highly sensitive (95%) and specific (97%) by 2 weeks of age and available; performed on peripheral blood mononuclear cells. False negative results can occur in non B subtype HIV – 1 infections
HIV RNA PCR	Preferred test to identify non B subtype HIV – 1 infections. Similar sensitivity and specificity to HIV DNA PCR but latter is preferred because of greater experience with it
HIV p24 antigen	Less sensitive, false positive results during first month of life, variable results; not recommended
ICD p24 antigen	Negative test result does not rule out infection; not recommended
HIV culture	Expensive, not easily available, requires up to 4 weeks; not recommended

Figure 1 Diagnostic tests



Agent	Dosing	Duration
ZDV	Dose based on gestational age at birth and weight, initiated as soon after birth as possible and preferably within 6 to 12 hours of delivery ≥ 35 weeks gestation at birth: 4 mg/kg/dose orally (or, if unable to tolerate oral agents, 3 mg/kg/dose IV) q 12 h ≥ 30 to < 35 weeks gestation at birth: 2 mg/kg/dose orally (or 1.5 mg/kg/dose IV) q 12 h, advanced to 3 mg/kg/dose orally (or 2.3 mg/kg/dose IV) q 12 h at age 15 days < 30 weeks gestation at birth: 2 mg/kg/dose orally (or 1.5 mg/kg/dose IV) q 12 h, advanced to 3 mg/kg/dose orally (or 2.3 mg/kg/dose IV) q 12 h after age 4 weeks	Birth through 6 weeks

Figure 2 Reduction of perinatal transmission



Agent	Dosing	Duration
Nevirapine (in addition to ZDV)	Dose based on birth weight, initiated as soon after birth as possible Birth weight 1.5 to 2 kg: 8 mg/dose orally Birth weight > 2 kg: 12 mg/dose orally	Three doses in the first week of life: First dose within 48 hours of birth Second dose 48 hours after first Third dose 96 hours after second

Figure 3 Additional prophylaxis for infants of women who received no antepartum antiretroviral prophylaxis

Summary

The risk of infection for an infant born to an HIV seropositive mother who did not receive any PMTCT intervention is about 21-25%. 2 forms; first is like in adults i.e. has a prolonged course with progression to AIDS over 8 to 10 years. The 2nd and more aggressive form is characterized by early conversion to AIDS and increased risk of opportunistic infections and mortality. Without treatment the most common age at presentation will be 12 to 18 months. Passive maternal antibody transfer means that HIV antibody assays can only be used after 18 months of age. HIV DNA PCR is used prior to this age and approx. 30-40% of infants tested within 48 hours will be positive. Approx. 93% of infected infants will be positive by 2 weeks of age. Testing is recommended at 14 to 21 days of age, and if negative, repeated at 1 to 2 months and again at 4 to 6 months of age. An infant is only labeled as HIV positive with 2 positive DNA/RNA PCR assays. Routine immunization as indicated, PCP prophylaxis, screening for TB and close follow up remain essential. Importance of HIV screening in all pregnant women is also highlighted.

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Erythema Multiforme: A case presentation and a brief review for primary care providers.

Sudeep Singh, MD
LSU Family Medicine

Abstract

A 62 year old male presented to clinic with a maculopapular rash that emerged over his chest wall then rapidly spread to his arms and face over 48 hours. Punch biopsy confirmed Erythema multiforme which was likely secondary to an undiagnosed herpes simplex infection versus concomitant use of narcotics and carisoprodol. He was treated with high-potency topical steroids and acyclovir with gradual resolution of the rash over 4 weeks. Erythema multiforme is a self-limiting illness that is primarily a clinical diagnosis. The majority of cases are associated with infection, however numerous medications can be linked to this condition as well.

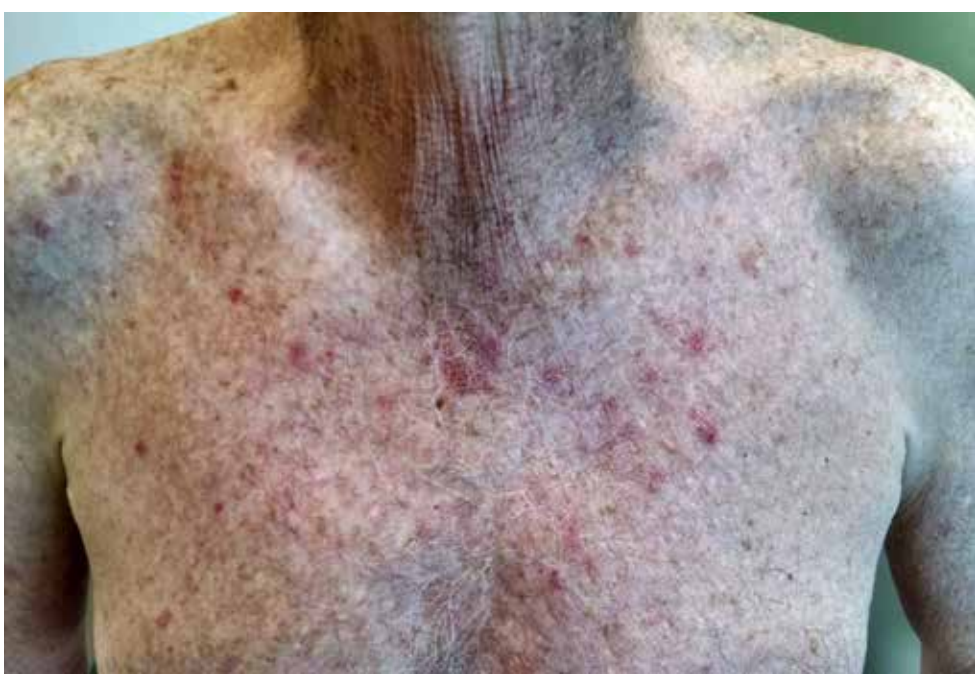
Case Presentation

62 male with a past medical history of ischemic stroke in 2009 with no residual neurologic deficits, medically controlled hypertension, and chronic back pain secondary to multiple motor vehicle accidents presented to the clinic with multiple 0.2- to 0.5 cm pruritic rashes that started over his chest wall then rapidly spread to his arms and face over 48 hours. His medication regimen at the time included aspirin, lisinopril, atorvastatin, carisoprodol, and oxycodone/acetaminophen daily. He had no known drug allergies. He was a current 1 pack per day smoker for the past 40 years and denied any alcohol or illicit drug use. He denied any recent travel, new foods, soaps, lotions, over the counter supplements, or insect bites. On initial exam, he was afebrile and vital signs were stable. Physical exam revealed multiple 0.2- to 0.5 cm scattered macular lesions on his chest wall with similar lesions affecting the dorsal aspect of his arms and hands, diffusely over the back, and his forehead (Figure 1, 2). No lesions were noted in the oropharynx or over the genitalia. Mild non-tender submental and axillary adenopathy were noted. He was initially prescribed clobetasol 0.05% cream for allergic and possible atopic dermatitis as well as acyclovir 400 mg three times a day for 10 days. Marginal improvement at 1 week follow up led to a punch biopsy which revealed "subepidermal vesiculation with near total epidermal necrosis. Residual viable epidermis shows interface alteration. Dermal inflammation is minimal. No definitive evidence of malignancy is identified." The official impression was Erythema multiforme. He also tested IgG+ for both HSV1 and HSV2 antibodies however he denied ever having any oral or genital flairs in the past.

Discussion

Erythema multiforme is a delayed-type hypersensitivity reaction that involves CD4+ Th1 activation to a stimulus. Inflammatory responses in the skin lead to keratinocyte lysis. Interferon gamma has been proposed as a primary mediator in response to a viral reaction and tumor necrosis factor has been found to be more prevalent in drug-induced forms. [1]

Typically, these lesions appear over the course of 3-5 days and resolve over the course of 2 weeks. The condition usually presents with a "target" lesion which has a regular round shape and three concentric zones: a central dusky area, a paler pink or edematous zone, and peripheral red ring is present. In contrast, atypical lesions present with raised and palpable lesions with only two zones of color



change and poorly defined borders may occur as well. [2]

Infections account for ~90% of symptoms most prevalently Herpes simplex virus (HSV) and Mycoplasma pneumoniae; 10% are attributable to medications including, but not limited to the following: barbiturates, hydantoins, penicillins, NSAIDs, phenothiazines, and sulfonamides. There have also been recent reports of associations with radiation, sarcoidosis, and vaccinations. Laboratory testing is typically not very helpful, as this is primarily a clinical diagnosis, but may be used to rule out more serious conditions such as Stevens-Johnson syndrome. Biopsy findings depend on the integrity of the samples, however early stages may demonstrate a perivascular mononuclear cell infiltrate. If HSV is suspected to be the primary cause, a direct fluorescent antibody test should be conducted as well as a viral culture, Tzanck smear, or PCR. Therapy should be initiated to alleviate symptoms. This is typically a self-limiting process and usually resolves in 2 weeks. Topical antihistamines and steroids may be used to control the pruritus. If symptoms recur, acyclovir can be used to prevent recurrences. It is important to keep Stevens-Johnson syndrome in the differential diagnosis, as both present with mucosal erosions with atypical target lesions of the skin. The lesions of Stevens-John syndrome tend to be more macular whereas the lesions of erythema multiforme are more papular. [3]

Conclusion

Erythema multiforme is a common clinical scenario that primary care providers should be prepared to see in their office. A careful history with particular attention to any recent illness and change to medication is essential. Labs and biopsy are typically not required to make the diagnosis. It is important to remember that this is a self-resolving illness and therapy should be initiated to alleviate bothersome symptoms which is primarily pruritus.

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Sternal Osteomyelitis : A Case Discussion about a rare diagnosis presenting with a nonspecific chest mass.

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Abstract:

A 53 year old Caucasian male presented with a nontender nonerythematous midsternal chest lump; which was later diagnosed by MRI and an elevated ESR and CRP as osteomyelitis of the sternum. He was subsequently placed on IV antibiotics with complete resolution of symptoms at the completion of his six week course. Sternal osteomyelitis is a rare condition diagnosed with the help of labs and imaging. It most often occurs following chest trauma or thoracic surgery. This case is unique in the fact neither one of those risk factors were present and the presenting complaint was simply a nonspecific chest mass. A review of the diagnosis and management of osteomyelitis is also discussed.

Case Presentation:

A 53 year old Caucasian male with past medical history of hypertension, type 2 diabetes mellitus, gastritis, mitral valve prolapse, peripheral artery disease, previous episode of osteomyelitis, and gastroesophageal reflux disease presented to the emergency department complaining of sternal chest mass for one day. He was previously seen in the emergency department three days prior, with a diagnosis of costochondritis secondary to recent bronchitis which had been treated as an outpatient with antibiotics. He reported no pain to touch in the area of mid sternum at the location of the mass and no associated redness. He denied fever or chills at presentation. Patient denied pertinent family history and denied smoking, alcohol use, or illicit drug use. He also denied history of chest surgery or trauma to the area.

On exam, vitals were as followed: temperature 98.2F, pulse 107, respiratory rate of 18, blood pressure of 173/88, oxygen saturation 98% on room air. Chest exam revealed an elevated area on the right upper chest and mid sternum about three inches by two inches, circular and without discrete borders. The mass was mildly tender on deep palpation, but there was no erythema or rash overlying the mass. Exam was otherwise within normal limits, except for chronic ulcerations on bilateral feet which were being followed as an outpatient by wound care. These were stable and did not appear to be acutely infected.

Initial laboratory data included a normal white blood cell count. Inflammatory markers from the previous emergency department visit three days prior were noted to be elevated. His ESR was 70 and CRP was 120. In the emergency department, Chest CT scan revealed nonspecific midline subcutaneous stranding superficial to the manubrium and sternum along with a small volume of abnormal retrosternal fluid. No osseous abnormalities were demonstrated. MRI

Continued on page 18

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was obtained and again noted soft tissue edema in the same area concerning for acute inflammation or infection; however, it was also noted there was mild edema signal within the sternum itself which represented early osteomyelitis.

The patient was admitted to the floor where he was started on broad spectrum antibiotics of vancomycin, piperacillin-tazobactam, and ciprofloxacin to cover for osteomyelitis of the sternum. Patient developed intermittent fevers up to 103F in the first few days after hospitalization. In addition, blood cultures were found to have gram positive cocci in clusters later identified as methicillin resistant *Staphylococcus auerus*. Infectious disease was consulted and believed the source of osteomyelitis and blood infection was ultimately unknown but likely secondary to foot ulceration given history of osteomyelitis in feet bilaterally approximately a year prior. Transesphogeal echo revealed no evidence of endocarditis or vegetations.

Repeat MRI showed continued localized fluid collection in the upper retrosternal region unable to exclude abscess in addition to osteomyelitis. Cardiothoracic surgery was consulted and felt that no surgical drainage or debridement was necessary. Antibiotics were de-escalated to only Vancomycin for a total outpatient treatment course of six weeks. Repeat blood cultures remained negative. Patient's initial symptoms of painless mass on his chest resolved.

Discussion:

Although there are limited numbers of case presentations discussing sternal osteomyelitis as its own entity, the majority of these are following cardiothoracic surgery or trauma. Osteomyelitis presenting solely as a mass is a much more unique presentation and one that should broaden our differential diagnosis when a patient presents with nonspecific lump or swelling for which no obvious cause is determined.

Osteomyelitis typically occurs as a result of hematogenous or contiguous spread of infection. Hematogenous osteomyelitis is most often seen in children and affects the long bones; in adults, vertebral osteomyelitis is seen. Contiguous osteomyelitis is the result of trauma or surgery in younger patients and in older patients, as a result of decubitus ulcers or infected joint prostheses. Hematogenous osteomyelitis is usually monomicrobial, while contiguous osteomyelitis can be polymicrobial or monomicrobial. Infections can be bacterial and or fungal in origin. [2, 3, 4]

Patients with osteomyelitis present differently depending on location, duration of infection and severity. In acute osteomyelitis, the affected area may show signs of erythema, warmth, swelling or ache with movement. Some patients may have fever too. Osteomyelitis of the vertebrae, hip, or pelvis usually present only with pain in the area of infection. In subacute osteomyelitis, patients typically report mild pain for many weeks with few, if any, systemic symptoms. [2] Diabetic patients can present with very few symptoms especially if they also have neuropathy.

Sternal osteomyelitis can be primary or secondary. Primary osteomyelitis is usually due to trauma, intravenous drug abuse or subclavian central lines. Secondary sternal osteomyelitis is a complication of sternotomy. Most patients present with local tissue changes and sternal chest pain which typically radiates to the shoulder. [1]

Workup of osteomyelitis is the same for most types. Imaging is the diagnostic tool of choice. Plain radiographs are always the initial imaging choice in any skeletal complaint. This does not always reflect an underlying osteomyelitis. Ultrasound is useful for assessing fluid collections and soft tissue changes. It also can help with therapeutic techniques. CT scan can help identify other infection characteristics (gas formation or foreign body) but is much less sensitive than other imaging. It can also help with therapeutic techniques. MRI is the most sensitive and specific imaging choice for diagnosing and assessing extent of infection. Nuclear medicine imaging is helpful in determining multifocal sites of infection. [5] In addition to imaging, blood work and cultures are needed. For most patients this would include a complete blood count (CBC), sedimentation rate (ESR), c-reactive protein (CRP) and blood cultures. A wound culture with or without a bone biopsy is also useful in many cases. [2]

Treatment of osteomyelitis depends on location and severity of infection as well. All patients receive appropriate intravenous antibiotic therapy for at least six weeks. Some patients require surgical debridement and at times, amputation (typically distal portions of extremities.) Hyperbaric oxygen therapy has also been used, especially for chronic osteomyelitis. It has also been used in subacute sternal osteomyelitis resulting in shorter healing time. [5]

Conclusions:

As noted above, this is quite rare diagnosis of sternal osteomyelitis with a unique presentation of. This particular patient had increased risk factors given his history of osteomyelitis in the lower extremities and poorly controlled diabetes, but no history of typical risk factors such as chest trauma or previous surgery of the chest. It is important to keep this diagnosis on the differential as primary care providers given the implications for extended intravenous antibiotic therapy. Laboratory and imaging modalities can play an important role in the decision pathway and help to guide our management.

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Importance of Play in Children's Development

By Pathways.org

Play is critical for children's development because it provides time and space for children to explore and gain skills needed for adult life. Children's playtime has steadily decreased due to limited access to play spaces, changes in the way children are expected to spend their time, parent concerns for safety, and digital media use. Between 1981 and 1997, the amount of time children spent playing dropped by 25 percent.[1] During this same time period, children ages 3-11 lost 12 hours a week of free time and spent more time at school, completing homework, and shopping with parents.[2]

Play can be defined as "any spontaneous or organized activity that provides enjoyment, entertainment, amusement or diversion."[3] When children play, they engage with their environment in a safe context in which ideas and behaviors can be combined and practiced. Children enhance their problem solving and flexible thinking, learn how to process and display emotions, manage fears and interact with others.[4] Free, unstructured play allows children to practice making decisions without prompted instructions or the aim of achieving an end goal. They can initiate their own freely chosen activities and experiment with open-ended rules.

Social changes and new technologies have greatly impacted the way children play and the amount of free time they are given. Children's playtime continues to decrease as a result of:

- Emphasis on academic preparation at an early age-30% of American kindergarteners no longer have recess.[1]
- Electronic media replacing playtime-8-10 year olds spend nearly 8 hours a day engaging with different media, and 71% of children and teenagers have a TV in their bedroom[5]
- Less time spent playing outside-a study following young children's play found that kids under 13 years old sometimes spend less than 30 minutes a week outside.
- Perceived risk of play environments-in one study, 94% of parents cited safety concerns, e.g. street traffic and stranger danger, as a factor influencing where their children's play.[1]
- Limited access to outdoor play spaces-only 20% of homes in the U.S. are located within a half-mile of a park.[1]

As a result of reduced playtime, children are spending less time being active, interacting with other children, and building essential life skills, such as executive functioning skills, that they will use as adults.[6] During well-child visits, healthcare professionals can inquire about children's playtime and media usage, and provide suggestions to promote quality playtime. The American Academy of Pediatrics recommends health professionals pick two targeted questions to ask parents at well-child visits such as:

1. The number of hours the child spends engaged in screen time
2. Whether there are digital devices in the child's bedroom.[5]

Children's play behaviors may vary based on cultural norms and family preferences. While some cultures emphasize individualism and independent play, others engage in more parent-directed play and activities. This can influence how children play with toys and interact with their peers and family members.[7] To help provide advice to families with different values, styles of play, and communication, health professionals can offer these recommendations from the American Academy of Pediatrics:

- Allow for 1 hour a day of unstructured, free play[5]
- Limit child's media time to less than 1 to 2 hours a day
- No media usage for children under 2
- Establish "Screen free zones" by keeping TVs, computers and video games out of children's bedrooms
- Limit "background media" use during playtime and family activities because it is distracting for children and adults
- Establish a plan for media use, e.g. when and where media is used and length of time child uses media

For more tips on how to encourage children's play time check out this free brochure.

About Pathways.org:

Pathways.org is a national not-for-profit dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. To help parents learn about important topics in development and milestones for their child, Pathways.org provides free supplemental materials for well child visits and parent classes. View our new play brochure here to access information created for parents on the importance of children's play.

[1] Bishop, Ronald. Go out and play, but mean it: Using frame analysis to explore recent news media coverage of the rediscovery of unstructured play. The Social Science Journal. 2013; 50(4): 510-520.
[2] S. Hofferth, J.F. Sandberg, Changes in American children's time, 1981–1997
[3] Parham, D & Fazio, S. Play in Occupational Therapy for Children: Second Edition. Mosby, inc; 2008.
[4] Ginsburg, Kenneth R. "The importance of play in promoting healthy child development and maintaining strong parent-child bonds." Pediatrics. Jan. 2007: 182. *Academic OneFile*. Web. 23 Feb. 2015.
[5] Children, Adolescents, and the Media. From the American Academy of Pediatrics: policy statement. Pediatrics. 5 Nov. 2013; 132 (5): 958-961.
[6] Lillard, A. Peterson, J. The Immediate Impact of Different Types of Television on Young Children's Executive Function. Pediatrics. 1 Oct. 2011.
[7] Farver, J.M, Y.K., & Lee, Y. Cultural Differences in Korean- and Anglo-American Preschoolers' Social Interaction and Play Behavior. JSTOR. Aug 1995: 66(4); 1088-1099.

The LAFP is Accepting Nominees for 2016-2017 LAFP Officers & Board of Directors

Do you have big ideas for the LAFP? Want to help get the momentum going?

The Louisiana Academy of Family Physicians Nominating Committee is seeking quality leaders who have the knowledge, time, and commitment to help the Academy develop policy and services that will assist the membership in dealing with the present challenges and opportunities of family practice.

Board members are expected to attend meetings and take part in the decision-making process. They are required to exercise a reasonable degree of knowledge, skill and care in bringing their best judgment to the performance of their responsibilities. The Board meets quarterly with meetings scheduled during the spring (March/April), summer (Annual Assembly), fall (September/October), and winter (January/February). It is the duty of the Board members to remain informed

of all Academy issues, to study the materials that are distributed to them and to exercise sound judgment in arriving at decisions. The Board of Directors exercises the ultimate executive responsibility and authority of the LAFP.

Each year, the General Assembly elects new officers and members to serve on the Board of Directors. In order to become a candidate for the Board, a member must be nominated. Any member may nominate themselves or a colleague. The Nominating Committee will select a slate of officers and directors for 2016-2017. If you have recommendations for consideration of the Nominating Committee, please submit them by March 1, 2016. To do so, please visit our website at www.lafp.org or contact Ragan LeBlanc at rleblanc@lafp.org.

We encourage and appreciate your input! Nominate someone **TODAY!**

Reminder: Renew Your LAFP Membership

In early October, you received your American Academy of Family Physicians and Louisiana Academy of Family Physicians 2016 dues invoice.

To continue to enjoy your AAFP and LAFP membership benefits, please visit the AAFP website to remit your payment online by Thursday, December 31, 2015, or enroll in the AAFP installment plan by calling the AAFP Contact Center at 800.274.2237.

If you have any questions about your membership or need another copy of your invoice, please contact the AAFP at (800) 274-2237 or at contactcenter@aafp.org.

We appreciate your continued LAFP membership!

2016 Annual Assembly Call for Faculty Proposals:

DEADLINE January 22, 2016

Want to show off your hard work and impress colleagues with your latest research or education discovery?

The LAFP invites you to submit a CME proposal application for our ***69th Annual Assembly and Exhibition***. We will meet July 7-10, 2016 at the Baytowne Conference Center at the San Destin Golf and Beach Resort. This year's theme is ***Focus on Family Medicine***. Annual Assembly is an interactive forum to share best practices in education, hear presentations on original research and to network with others interested in family medicine.

Download the application from our website today. Please feel free to duplicate the application for any faculty or colleague whom you think would be interested in participating. To be considered, all completed abstracts must be received by **Friday, Jan. 22, 2016.** We encourage all LAFP MEMBERS to get involved and send us your CME proposals or volunteer to moderate. As always, your support is greatly appreciated. ***See you at the beach!!!***

DEADLINE January 22, 2016

For additional information, contact Director of Membership and Education, Lee Ann Albert at 225.923.3313 or lalbert@lafp.org

Nominations Sought for LAFP 2015 Family Physician of the Year

It's that time of the year again! Do you know an LAFP member who exemplifies the finer attributes of a family medicine physician? A colleague who is engaged in his or her community as well as provides compassionate, comprehensive and caring family medicine on a continual basis? If so, it's time to submit your nomination!

The Family Physician of the Year Award is one of the LAFP's highest honors. Help us bring recognition and visibility to a deserving family physician that serves and benefits the profession, the specialty, and the community. For the award criteria and to download the nomination form, please visit the LAFP website at www.lafp.org.

Selection Criteria:

1. Be an "Active" member, in good standing, of the Louisiana Academy of Family Physicians and the American Academy of Family Physicians.
2. Provides his/her patients with compassionate, comprehensive, and caring family medicine on a continuing basis.
3. Enhances the quality of his/her community by being directly and effectively involved in community affairs and activities.
4. Acts as a credible role model professionally and personally to his/her community, to other health professionals, and residents and medical students.
5. Stands out among his/her colleagues.

Judging:

The winner is determined by the Nominations Committee consisting of the Legislative and Membership Committee Chair, who will serve as the Nominating Committee Chair, the President, President-Elect, Immediate Past President, and two other Board of Directors members selected by the President.

Nominations from:

Anyone can nominate a physician for the honor of LAFP Family Physician of the Year. Please confirm the physician's willingness to be honored and to serve.

Nomination requirements:

The nomination packet must contain the following:

1. Completed nomination form (2 page DOC).
2. Current curriculum vitae (limited to three pages).
3. Maximum of eight pages of supporting documentation. Please note the following rules:
   a. If more than eight pages are received, only the first eight pages will be used. Note: supporting documentation does not include the nomination form or curriculum vitae.
   b. No double-sided pages will be accepted.
   c. Please do not reduce more than two letters to a page. Nomination packets with more than two letters per page will not be accepted.
   d. All pages must be photocopy-ready and of reproducible quality. Newspaper articles, odd-sized pieces of paper, etc., must be copied onto an unfolded, 8 1/2 x 11 sheet of paper. Anything that is not photocopy-ready will not be used.

Electronic and hard copy nominations will be accepted. If submitting electronically, please scan the nomination form and all supporting documentation to one PDF file. Hard copy submissions also will be accepted. If mailing, please do not fold the materials. The packet should be mailed flat with no staples. No two-sided copies, please.

Nominations due:

Nominations and supporting documents are due to the Academy office no later than March 1, 2016. Nominations, along with all supporting materials and documentation, can be emailed or mailed to:

Ragan LeBlanc
rleblanc@lafp.org
Executive Vice President
Louisiana Academy of Family Physicians
919 Tara Boulevard
Baton Rouge, LA 70806

Presented At:

The LAFP Family Physician of the Year Award will be presented to the winner at the Installation & Awards Ceremony, during the LAFP Annual Assembly.

Please contact the LAFP office at 225.923.3313 or email at info@lafp.org if you have any questions.

LAFP Calendar

SAVE THESE DATES

March 14, 2016
Louisiana Legislative Session Convenes
TBD
White Coat Day at the Capitol
State Capitol Baton Rouge, LA

May 5-7, 2016
AAFP Annual Chapter Leadership Forum/ National Conference of Constituency Leaders
Sheraton Kansas City at Crowne Center
Kansas City, MO

June 6, 2016
Louisiana Legislative Session Adjourns

July 6, 2016
LAFP Board Meeting
TBD
Destin, FL

July 7th – 10th, 2016
69th Annual Assembly and Exhibition
San Destin Golf & Beach Resort
Destin, FL

July 8, 2016
General Assembly
San Destin Golf & Beach Resort
Destin, FL

July 28-30, 2016
AAFP National Conference of FM Residents & Medical Students
Kansas City Convention Center
Kansas City, MO

September 19-21, 2016
AAFP Congress of Delegates
Orlando, FL

September 20-24, 2016
AAFP Annual Scientific Assembly
Orlando, FL

Stay Connected with the LAFP

Like Us on Facebook

The LAFP is on Facebook to provide its members and others with up-to-date information about LAFP news and events and other family medicine information.

Follow Us on Twitter

The LAFP uses twitter to provide urgent Academy news and official statements quickly and easily to members, Louisiana media, and legislative individuals. Follow us @lafp_familydocs

The "Stark" Reality about Physician Compensation Arrangements with Hospitals

A number of physicians are choosing employment with hospitals or health systems and these agreements contain a litany of terms and conditions. Some employment agreements contain pretty significant compensation packages above and beyond the base compensation, which include sign-on bonuses, education loan repayment assistance, relocation expenses, productivity bonuses and directorships. Many hospitals or health systems understand that bringing physicians "in-house" will provide their patients with better access to care, while allowing the hospitals or health systems to bill and collect for the services provided in these physician practices and/or groups.

However, compensation of physicians can easily violate the Stark Law and Anti-Kickback Statue, even when the physicians are employed by the hospitals' or health systems'. The Department of Justice (DOJ) recently announced the settlement of a *qui tam* action in the amount $69.5 million, once again placing the compensation offered to bona fide employed physicians in the spotlight. In *United States ex rel. Reilly v. North Broward Hospital District* (Hospital), *et al*., Case No. 10-60590 (S.D. Fla.), a physician on staff brought a *qui tam* action against North Broward Hospital District (Hospital), alleging that the Hospital violated the federal Stark Law, Anti-kickback Statute and/or False Claims Act in the amount of remuneration it paid to its employed physicians, specifically orthopedic surgeons, cardiologist, and the primary care, hematology/oncology, and orthopedic groups.

The compliant alleged that despite the employment of these physicians resulting in substantial losses to the Hospital, the recruitment of the physicians included offers of salaries in excess of their prior gross revenue, offers of additional compensation that were based on inflated per relative value unit rates, offers of payments for directorships, and compensation that substantially exceeded the 90th percentile for such physicians in the region and where the physicians' compensation to collections ratio was doubled that of the 90th percentile. Moreover, the complaint also alleged that the Hospital considered the volume and value of inpatient and outpatient referrals of these physicians, the impact of these anticipated referrals on the Hospital's ancillary revenue, and included these in the compensation calculation to counter the millions of dollars in losses that would be sustained by the Hospital over the term of the employment agreements, some of which were for nine years.

Hospitals are not the only parties to these arrangements that may bear some liability for improperly structured compensation arrangements. The Office of Inspector General (OIG") could not have made their position any clearer than when it issued its special Fraud Alert on June 9, 2015, advising physicians that they too are responsible for ensuring that their compensation arrangements reflect fair market value for bona fide services that are actually provided. In its *Special Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability*, the OIG expressly directs physicians to "carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them." If the OIG determines that compensation arrangements are structured with the intent of compensating physicians for past or future referrals of Federal health program business, and the physicians are "an integral part of the scheme," then they too may be subject to liability.

With the continued growth of many hospitals and health systems and the employment of various physician practices and/or groups, it is important for all parties to understand how to begin the valuation process, what information should be considered in developing proper proformas, and ensure that employment agreements are properly structured to meet the Stark Law "*Bona fide employment relationships*" exception (See, 42 C.F.R. §411.357(c)) and the Anti-kickback Statute "*employees*" safe harbor (See, 42 C.F.R.§1001.952(i)).

At the very least, hospitals, health systems and physicians should be aware that compensation must always be consistent with fair market value, must be commercially reasonable even if no referrals were made to the employer, and not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring/employed physician. Although hospitals and health systems are not prohibited under the Stark Law from paying an employed physician a productivity bonus, the bonus must also be contained in the employment agreement and structured to comply with the requirements of the Stark Law. (See, 42 C.F.R. §411.357(c)).

Berryl Thompson-Broussard, LL.M., is an attorney at Gachassin Law Firm, which is dedicated to the representation and counseling of healthcare providers. Her practice area focuses on health care regulatory compliance, administrative and judicial appeals, and health care provider transactions.

FP ad to come

Legislative Report

Joe Mapes
LAFP Lobbyist

As we approach the end of the year, much change comes our way from the current election cycle for our state legislators and the statewide elected officials. They will be seated in January of 2016, and serve for 4 years. So far, 21 Senators and 48 Representatives were unopposed and, thus, re-elected. That leaves 57 new Representatives and 18 new Senators. Some good news is that we have a good base of legislators that support family medicine still intact. More good news is that the efforts made by Ragan LeBlanc, the LAFP staff, Dr. Jim Taylor, and the LAFP legislative committee are being rewarded. Dr. Taylor has been interviewing legislative candidates for election and re-election. After assessing the interviews, the committee made decisions on which candidates to support from LAFamPac. So far, it looks like LAFP is going to be able to help some supportive legislators get in, or back into, the legislative process.

The above is just one of the important things a well-organized association can, and should, do. Dr. Taylor has called on LAFP members to hand-deliver most of the contributions. The most important thing about that is the personal contact made between a member doctor and their constituent legislator.

2016 will be a busy year at the legislature. The budget woes will loom over everything, and we need to keep family medicine clear of that issue, as we did in 2015. Naturally, the Nurse Practitioners have stated they are coming with legislation to remove the collaborative practice agreement in 2016. Three years ago, we defeated the collaborative practice agreement bill with a vote of 12 to 3 in the House Health Committee; however, that was a big lift with the current group of legislators. The new group must be educated out the gate. That will take time, and as LAFP members educate their constituent legislators, the battle will rage on with the NP's and other allied health care practitioner groups. We do have other doctor groups to assist us in defeating all comers, but we must paddle our own canoe, if it is important to us, i.e., we must take the lead like we are the only doctor group that exists in Louisiana. If we do this, in conjunction with the other doctor associations, there will be no known defense to stop the well-organized, well-oiled machine that is LAFP and organized medicine!

Have YOU Made Your 2015 PAC Donation?

Welcome to the political highway. There's a lot of traffic out there, but you can make sure we have the fuel to stay on the road.

LaFamPac has helped put family medicine on the "political" map. Contributions keep family medicine issues firmly in the driver's seat. LaFamPac is part of a deliberate strategy to drive the LAFP engine and take family medicine where it needs to go. Remember - contributions of any size can be pulled together for a much larger impact.

To make a contribution or to find out more information about LaFamPac, please visit www.lafp.org.
Thank you for your help.

Thank you to our 2015 LaFamPac Donors!

The LAFP Political Action Committee (LaFamPac) would like to thank the following individual contributors:

Derek Anderson, MD
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If you would like to contribute to LaFamPac, visit the LAFP website at www.lafp.org or contact Ragan LeBlanc at rleblanc@lafp.org or 225.923.3313.

Please Remember the LAFP Foundation in Your Charitable Giving

As 2015 draws to a close, please remember to support your LAFP Foundation in your charitable giving. Support your LAFP Foundation by making a recurring monthly or quarterly gift, or make a one-time donation by clicking here to access our online secure donation form. Contributing to the LAFP Foundation and its programs is fast, convenient and secure. If you prefer to make your gift by check, please remit to LAFP Foundation, 919 Tara Blvd., Baton Rouge, LA 70806.

Your generous support ensures the continuation of the Foundation's programs to identify and cultivate future family physicians like:

- Family Medicine Externship Program
- Michael O. Fleming, M.D. Award & Scholarship
- Resident and Student Leadership Conference
- Gerald R. Gehringer, M.D. Award & Scholarship
- Tulane Family Medicine Excellence Award & Scholarship
- F.P. Bordelon, M.D., Lectureship Fund Award
- Tar Wars Program and Poster Contest Scholarship & Award
- Smoking Cessation Health Fairs
- National Conference of Family Medicine Residents and Medical Student Scholarships and Booth Funding
- Family Medicine Congressional Conference
- Leadership Conference for Resident Representatives
- AAFP National Conference of Family Medicine Residents and Medical Students

The Foundation also endeavors to promote healthy life decisions among school-age children by assisting in implementing the American Academy of Family Physician's Tar Wars® tobacco-free education program for fourth and fifth graders.

While we apply for grants to help support costs, we still rely on donations to fund our residency programs and community outreach. Thank you for helping support us and we look forward to supporting student and resident initiatives in 2016!

The Foundation is a 501(c)(3) tax-exempt corporation and is the only charitable organization in Louisiana that exists to improve and increase access to health care by investing in the specialty of family medicine.

Thank You to our 2015 Donors

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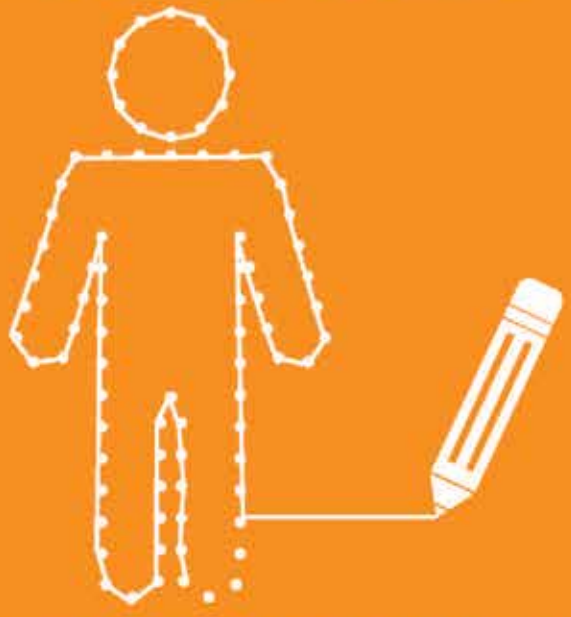

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Thank you to our 2015 Foundation Donors

The Louisiana Academy of Family Physicians (LAFP) Foundation would like to thank the following individual contributors to our 2015 fundraising efforts. The following individuals helped support Tar Wars, various awards and scholarships, and contributed to the LAFP Foundation General Fund.

Amy Abraham
AmeriHealth Caritas-Louisiana
Derek Anderson,MD
William Baron
John Bernard, MD
Ashley Berthelot
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Melvin Bourgeois, MD and Geri Bourgeois
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James Smith, MD
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Rebecca Wood

UAMS 1/3 to come

The Foundation would also like to extend a thank you to all of the LAFP membership that helped support individual fundraising activities such as the golf tournament and auction in the past. While the Foundation applies for grants to help support costs, we still rely on donations to fund our residency program and community outreaches. Thank you for helping support us and we look forward to supporting family physician initiatives in 2016!

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