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I just read your Journal and wanted to let you know that the article on Minorities in Clinical Trials was important but only addressed the consent process, arguably the most important part of subject protection, in a superficial way. When it comes to minorities, research is no different than standard care in that a culturally competent encounter should be the goal. Cultural competence is no more than patient centered care, with an understanding that each patient presents a unique set of circumstances that shape the way that patient lives his life. Without understanding those circumstances and accounting for them, there is always a risk that consent was not truly informed.

Ernesto Marrero, Jr.  
Director of Medical Research  
Bellevue Hospital  
NY, NY

We’re always impressed when someone outside the greater Baton Rouge area takes an interest in our publication. Thanks for your comments.

I appreciate so much ya’ll pointing out the disparities in healthcare in your last issue. The way doctors and hospitals deal with these differences, either in treatment or communication, is so important.

Lisa Heidel  
Nurse  
Baton Rouge

That was a great article on Louisiana Medicaid reform. It was almost a public service to summarize all that material. Most of us don’t have time to do that. Thank you.

René Goux  
Executive VP, COO  
CommCare Corporation

In your Jan/Feb issue The Letter From The Publisher was about the auto industry. Why did you feel the need to talk about the auto industry in the healthcare journal?

Ronald Gautreau Gonzales

That probably won’t be the last time. However, the auto industry satire was simply designed to shine some light on government taking irresponsible approaches to solving deeper and more complex issues. Healthcare systems are always in debate. The point being any system of this magnitude requires critical examination of all possible outcomes rather than knee jerk reactions and oversimplified fixes. Besides, we had another 60–something pages devoted to specific local healthcare issues. Thanks.

The Jan/Feb Issue on Minority Health is very well done, and the cover is quite eye-catching. Nice work! We passed out the journal at our leadership meeting this morning.

Scott Flowers  
Louisiana Health Care Review

Submit comments to editor@healthcarejournalbr.com
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Return to Color this Spring

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Greetings,

I’ve always been a fan of The Advocate. They do good work and have been doing so since before I could read. So I was a little disappointed when we agreed to sign up for a booth at WBRZ/The Advocate’s Life After 50 event only to have our check returned and be told we were not allowed to participate. For years I’ve known a number of people at WBRZ and have always enjoyed their company. When they asked me to get involved, I said, “Of course, whatever I can do to help.” It’s a fine event and I was glad to be associated with it.

The Advocate later decided that we were their direct competitor and therefore not allowed to participate. We thought the Life After 50 event was an important opportunity for many of Baton Rouge’s seniors to receive our Consumer Issue to help with a variety of personal health issues. Perhaps Healthcare Journal of Baton Rouge has too frequently made reference to its medical journalism awards and this is a source of frustration for The Advocate.

Memo to The Advocate: Please ease up on us. If this was college football, you would be LSU and we would be Appalachian State. Please quit considering us as such a serious threat. We are in different segments of the market. You are dominant in the newspaper market. Just as Appalachian State’s national championships are in Division II, our recognition is just in the medical/healthcare field.

Memo to everyone else: If you see someone from the The Advocate, let them know you like the newspaper and you can’t imagine a Baton Rouge without it. Let them know that variety is what makes Baton Rouge a wonderful place to live. Let them know you like Healthcare Journal of Baton Rouge, but you would never give up your subscription to The Advocate. Let them know you care.

May God bless us all and allow us all to flourish. I’m looking forward to tomorrow morning’s coffee and newspaper.
Coming to Terms With Complementary and Alternative Medicine

by: Karen Stassi

It is important to remember in any discussion of alternative health that many of the treatments and therapies we use today were met with skepticism when they were first practiced. In addition, many of the therapies we consider alternative or unconventional today have been in existence for hundreds, sometimes thousands of years before the birth of what we consider modern medicine. So why does hesitancy remain to embrace these new/old approaches? Closed mindedness? Unwillingness...
to change? Suspicion of the unknown, perhaps? While these may all play a role, scientific evidence is probably the biggest factor. Modern medicine relies heavily, as it should, on evidence-based practice. Experience, scientific study, and documented outcomes reassure us that what we are practicing or prescribing works. A failure to find that evidence or more commonly, a lack of studies to determine if that evidence exists, breeds suspicion of some of the complementary or alternative medicine (CAM) out there. And let’s face it, some of it sounds pretty “out there.” However, and it may just be me, injecting children with cow pox because milkmaids didn’t get smallpox, sounds pretty “out there” too. Are we really that arrogant to dismiss as quackery, something that thousands swear by just because we can’t empirically prove it? Or is our concern justified?
We are too quick to give them a drug or treat ‘em, and street ‘em.—Karen Dantin, MD

Obviously there are some very sound reasons for demanding scientific evidence. Not all “natural” remedies are safe, especially in the hands of the inexperienced and in combination with other substances or medications. In addition, many natural substances, effective or not, are not subjected to the same scrutiny as other medications by the FDA. Questions about dosage, contraindications, and inclusion of potentially dangerous additives make the use of supplements without a doctor’s advice a little like Russian roulette, yet spending on these types of substances continues to grow. There is also a fear that someone who could benefit from conventional medicine will eschew it for something unproven, and in a largely unlicensed field, there are a lot of practitioners taking money from patients for treatments that have no effect. The good news is that increased licensing of certain CAM practitioners such as chiropractors, massage therapists, and acupuncturists, not only weeds out the bad actors, but also provides some accountability and guidance for patients. But not all CAM is unproven. The National Institutes of Health (NIH) states that there is scientific evidence that certain therapies once considered on the fringe of western medicine do have benefits. Headlines abound about studies that have proven the benefits of certain vitamins or the efficacy of various hands-on treatments. In light of a growing trend by the public to embrace them, proven or not, NIH’s National Center for Complementary and Alternative Medicine (NCCAM) is also in the process of beefing up testing of complementary and alternative treatments.

It may be a moot point, because regardless of the lack of studies or a blessing from NIH, thousands of Americans are seeking out complementary or alternative treatments. As NIH defines it, complementary medicine is used together with conventional medicine and alternative medicine is used in place of conventional medicine. According to recently released figures, in 2007 almost 38 percent of American adults had used CAM therapy in the past 12 months, with the most commonly used therapies being nonvitamin, nonmineral, natural products (17.7%) and deep breathing exercises (12.7%). Results from the 2007 NHIS also found that approximately one in nine children (11.8%) used CAM therapy in the past 12 months, with the most commonly used therapies being nonvitamin, nonmineral, natural products (17.7%) and deep breathing exercises (12.7%). Results from the 2007 NHIS also found that approximately one in nine children (11.8%) used CAM therapy in the past 12 months, with the most commonly used therapies being nonvitamin, nonmineral, natural products (17.7%) and deep breathing exercises (12.7%).

Overall I just feel like most physicians don’t have an understanding yet for what I do, and I don’t think they realize the part biochemistry plays in my practice.

—Stephanie Cave, MD
nonmineral, natural products (3.9%) and chiropractic or osteopathic manipulation (2.8%). Between 2002 and 2007 increased use was seen among adults for acupuncture, deep breathing exercises, massage therapy, meditation, naturopathy, and yoga. NIH surmised that the increases for acupuncture, massage therapy, and naturopathy may in part be due to the greater number of states that license these practices and a corresponding increase in the number of licensed practitioners between 2002 and 2007. NIH also noted a large number of articles in the lay press extolling the benefits of these therapies, increasing awareness of them in the general population.

Even the traditional medical community may be becoming more open-minded. In 2006, at the urging of its medical student section, the American Medical Association (AMA) adopted Resolution 306 promoting awareness among medical students and physicians of the wide use of complementary and alternative medicine, including its benefits, risks, and evidence of efficacy or lack thereof. The student section had recommended stronger language incorporating CAM into medical education and continuing medical education, but AMA balked at going that far. However, many medical schools are doing just that. Locally both Tulane and LSU medical schools offer elective courses and presentations on CAM. For this they have tapped the knowledge of two Baton Rouge physicians, Karen Dantin, MD and Stephanie Cave, MD, who have transformed their traditional medical education and practices into Integrative Medicine. Integrative medicine combines treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness. So, while they may treat chronic conditions and write prescriptions, they may also recommend acupuncture or IV nutritions for their patients. According to both doctors, their practices include many traditional approaches and treatments, but they tend to look deeper for the cause of illness than traditional medicine dictates. Both Dantin and Cave are members of the American College for the Advancement of Medicine (ACAM), a not-for-profit association dedicated to educating physicians and other healthcare professionals on the latest findings and emerging procedures in complementary, alternative, and integrative medicine. ACAM’s goals
are to improve physician skills, knowledge, and diagnostic procedures as they relate to complementary and alternative medicine; to support integrative medicine research; and to develop awareness of alternative methods of medical treatment. ACAM represents more than 1,000 physicians in 30 countries.

If you’ve got the courage to look out and do something that’s basically healthy for the patient you are not going to go wrong. I’m probably a lot more conservative than many of my traditional friends. We are not taking the chances that any of them take with trying new drugs.

—Stephanie Cave, MD

Trained by the U.S. Navy, Dr. Karen Dantin’s medical background couldn’t get much more conservative. But after 25 years in family practice, Dantin said she became very frustrated with traditional western medicine in a lot of respects because it is not really supportive in helping people make lifestyle changes. “We are too quick to give them a drug or treat ‘em, and street...
‘em,” said Dantin, who went into private practice almost nine years ago in an effort to practice medicine the way she wanted. “At one place I worked I was told to keep my visits to one patient, one problem, one appointment, and I didn’t feel like I wanted to be treated that way and I didn’t feel like I wanted my patients to be treated that way. I needed to get to where I had a little more control over my life and my patients’ lives.”

Traditional western medicine consists, said Dantin, of diagnosing a problem and prescribing a medicine. Integrative medicine is taking the studies on nutritional supplements and looking at aspects of lifestyle and nutrition, and putting them into the practice. A patient may come in for a refill on blood pressure medication, which she will write, but she will also ask if they are interested in non-drug therapy for blood pressure, like adding magnesium to their diet. She is simply offering other options which can be just as effective with fewer side effects and lower cost. “I do practice traditional western medicine, but I go a little deeper looking for the cause,” said Dantin. If the patient is interested, Dr. Dantin will do some advanced nutritional testing. She explained that it makes sense that the body might react poorly if it is missing vitamins or substances it’s supposed to have due to illness, lifestyle, or side effects of other medications. Replacing those substances can make people feel better immediately. “There’s so much study going on in the area of vitamins,” said Dantin. “Everyone is looking at vitamin D and saying ‘oh we are all vitamin D deficient’ and that can lead to things like lupus, rheumatoid arthritis, 17 different cancers, and fibromyalgia—so many medical issues.” Conversely, we don’t need extensive scientific studies to indicate that more physical activity
or drinking more water might help an overweight patient with diabetes improve, said Dantin. “If people come in with those issues or have them in their family we will start digging, looking at what medications they are taking and the side effects or deficiencies that may result.” She can then work to reestablish nutritional balance. “Nutrition wasn’t taught when I was in med school. The studies haven’t been done, so for a lot of physicians much of the nutrition and vitamin stuff is like voodoo. I think it is changing, but the mindset is that we need the studies and they aren’t being done in huge numbers. There is not a lot of money to be made there.”

Dr. Stephanie Cave also places much of her focus on reestablishing the body’s balance at the cellular level. Cave is board certified in family medicine, but before med school she taught clinical chemistry at LSU. “I have a chemistry background so my thrust is to normalize cellular chemistry before we use drugs, but we do employ some medication when we need to.” Dr. Cave worked in family practice for 12 years but was doing biochemistry on the side and was taking courses in integrative medicine. When she realized that those patients were doing the best she decided in 1998 to go into integrative medicine.

Dr. Cave said many people do not realize that integrative medicine is part of Louisiana’s Medical Practice Act. Several years ago, the Louisiana Board of Medical Examiners established an advisory committee in integrative medicine to provide some oversight in our state. She has served on that committee for some time now and considers it quite a step forward for Louisiana although many remain in the dark about integrative medicine. “Overall I just feel like most physicians don’t have an understanding yet for what I do, and I don’t think they realize the part biochemistry plays in my practice. They put integrative medicine off into an alternative area, but it’s really not I think a lot of our problems stem from the fact that we don’t eat food close to the way God made it. We are stressed out, we don’t go outside and play, we don’t have recreational time, we operate at high stress with low nutrition, and we don’t get enough sleep. Our bodies respond by getting out of balance, which sets us up for things to grow that aren’t supposed to grow.”

Karen Dantin, MD
Copyright 2008 Leslie Henderson Photography
alternative, it’s doing what we learned to do and that’s getting the lifestyle and biochemistry right before we start into drug therapy.” Cave said that although that’s what she learned in school, “we’ve kind of lost that in the last ten years in medicine.” She said that medical students used to be interested in biochemistry and physiology and every part of medicine, but now all they want is the pharmacology because they feel it is a lot easier to write prescriptions. She teaches an integrative medicine elective during which she has a month to get them back into an appreciation of the chemistry involved. “Then they realize they need to know the biochemistry before they use the medicine. For some reason they don’t put it together.”

If these are going to be given as alternative medical treatments to patients we would ask that they be given the same rigor as more mainline medical treatments, that they should be scientifically valid and evidence-based, and that the people that are practicing them should have some qualifications to do so.

—Roger Smith, MD, LSMS

Part of the reason healthcare is over-priced and people are over-medicated, said Dr. Cave, is that the pharmaceutical firms pay for medical education. She said students focus on pharmacology instead of biochemistry because the board exam has a strong pharmacology emphasis. “Money runs most of what we do and drugs are a multibillion dollar industry. Physicians don’t know the side effects because the pharmaceutical reps teach them how to use them. Plus we don’t know what the drugs do when given together.” Cave said that now we can look at the human genome and see what drugs a person can tolerate, “It may eventually be malpractice to prescribe something that might not be safe for that person based on their genome.”
Both doctors feel it is the emphasis on pharmaceuticals and the tendency of insurance companies to pay for procedures and pharmaceuticals rather than time spent with the patient that has affected how medicine is taught and practiced these days. “Really most of what I do is traditional. I spend a lot of time doing lifestyle counseling, but I haven’t figured out how to get the insurance companies to pay for it,” said Dantin. “No insurance company is paying for a doctor to spend 45 minutes with patients.” Dantin described working with an overweight patient that wanted her to prescribe a diet pill. Instead Dantin recommended drinking more water, increasing physical activity, and eating breakfast in the morning. “The easiest thing for me would have been to write a prescription, but that’s not what she needed. She needed to drink water, to eat breakfast—things our mommas taught us.” Dantin asks that her patients meet her halfway and take some responsibility for their own health, but studies have proved that many patients don’t feel like it’s been a good visit if they don’t get a diagnosis and a prescription. “I only see 5 patients a day,” said Dr. Cave. “Integrative medicine takes a lot of time. We set aside an hour-and-a-half to two hours with each patient.” She said
medical students are learning they should spend 15 minutes and they get nervous when they come to her office and she spends so much time with each patient. And they are looking for one diagnosis. Cave tells them there is not one diagnosis, that the patient may have 35 problems and if they map out the biochemistry they are going to take care of all of them. “They don’t have any concept of that. They want a disease process and to treat one problem a day. I guess we’ve done that to them over time. I guess that’s the way we tend to practice medicine.”

“Insurance companies are not really health insurance companies; they are more like sick insurance,” said Dantin. “Their job for the most part is to take care of you when you are sick and for them, sick is one step up from dead. They don’t pay for the things that keep you well like massage, nutritional supplements, hyperbarics, but they’ll keep you just above death.” Dr. Cave agreed that what insurance companies consider wellness falls short. “They cover vaccinations, mammograms, pap smears, and prostate exams and that’s all part of it, but with true preventive medicine you can get down to what caused the problem and try to correct that and you can do it biochemically.” She indicated that a Blue Cross marketer once commented that she spent 40 percent less in taking care of her patients than anyone in the area. She told them, “That’s drug and hospital. If they are healthy and looking to stay healthy they don’t end up on medication and in the hospital. If you covered workups like this and nutritional therapy you would invite people who want to be healthy.” As far as reimbursement, Cave said she hasn’t had any problems with insurance companies except Blue Cross which she said has a reputation in this area for being tight with their funds. “Blue Cross does takes care of a lot of patients in Louisiana, but Humana, Aetna, United they’ve all paid the patients.” Cave provides patients the information they need to file claims, but is not contracted with any insurance companies because she has no call back-up for her unique practice. She said there is still too little coverage for the treatments she uses with her autistic patients, but that a law was recently passed that at least requires insurance companies to pay for behavioral therapy.

Despite the label of integrative medicine both doctors insist that their work is evidence-based, effective, and safe, and in some respects less risky than traditional medicine. “Most of what I do, because I have a biochemistry background, is to replace cellular biochemistry and I do quite a bit of toxicology working with heavy metal toxicity in people who are lead poisoned or mercury poisoned,” said Cave. Cave is perhaps best known for her work with special needs children. She has treated almost 9000 autistic children from ten countries. She works...
out their regimens with cellular chemistry and hyperbaric oxygen therapy. “I’ve done a lot of work with children injured by vaccines and people don’t like to hear the negative side of vaccines. We employ metabolic treatment in addition to behavioral treatment. They can all do better if you treat them metabolically, get back to the biochemistry.”

In her practice Cave also uses some laser therapy, IV vitamins and minerals, chelation, specific metal treatments with calcium EDTA, and handles a number of chronic problems such as auto-immune diseases, allergies, depression, anxiety, inattention, diabetes, and hypertension. She practices bioidentical hormone replacement and also works with cancer patients, restoring their nutritional status after chemo and radiation. Once a week a Naturopath comes from Houston to work with Dr. Cave and uses acupressure to treat allergies.

There’s very little risk. Just a risk of getting better. –Stephanie Cave, MD

“I don’t think anything we do is way out,” said Dantin, “but maybe IV nutritionals and chelation are the most non-traditional.” Dantin points out however, that she is a test site for an NIH study on high dose multivitamin IV treatments, “so it can’t be too way out. It’s not that bizarre, it’s just vitamins, minerals, etc.”

Dantin also offers infrared sauna, hyperbaric treatment, is a reike practitioner, and works with an acupuncturist who shares the office and treats some of her patients. Both practices involve intensive testing to find areas they can help with. “I don’t make it up,” said Dantin. “Some of it is a return to what our grandparents did. I think a lot of our problems stem from the fact that we don’t eat food close to the way God made it. We are stressed out, we don’t go outside and play, we don’t have recreational time, we operate at high stress with low nutrition, and we don’t get enough sleep. Our bodies respond by getting out of balance, which sets us up for things to grow that aren’t supposed to grow. We may have family predispositions to certain things but our lifestyle determines when and how bad we may get it.” Dr. Cave agreed, saying that unfortunately doctors learn to treat the disease instead of the person and even talk about people by their disease name, saying, ‘I have a diabetic in my office’ instead of ‘a patient with diabetes’. “With integrated medicine you get back to the cause. And if you go back to cellular biochemistry you are going to find the cause. That’s where illness begins and that’s where it’s going to end.”

So why the controversy? Cave thinks it is just misunderstanding, because it is the most evidence-based medicine she has ever practiced. “It’s in the literature. It’s just that doctors learn what they learn in medical school and they don’t look out of that. They don’t want to see an alternative so they just keep doing what they are doing for a lifetime. Everything we do in integrative medicine is in very strong peer reviewed journals. The easiest thing for a traditional physician that doesn’t know anything about integrative medicine is to say it’s not evidence-based, but it is very much evidence-based. I don’t think I’ve ever had such bibliographies in my life as I have right now.”

Despite the controversy, Cave said physicians come to her to treat their children and Dantin regularly gets referrals from other doctors. Dantin said for the most part her reception in the Baton Rouge medical community has been positive. “Apparently I had a good reputation as a family practitioner,
so they know I am not doing this because I don’t know how to be a ‘real doctor’. I think they just don’t know about the nutritional side of it and are not interested in pursuing that route.” Both doctors have also received some negative feedback from other physicians, but are confident they are doing what’s best for their patients, so they are not concerned. “Other people’s opinions of me are none of my business,” quipped Dr. Dantin. “I don’t discard what I have learned and what I continue to learn,” said Dantin. “I still have to take boards and maintain CME credits and modules. I have been a doctor for over 25 years, but my second 25 years are going to be a little bit different. It’s not a profitable thing to do, but it’s the right thing to do.” Cave said physicians have to stop being afraid of being different. “If you’ve got the courage to look out and do something that’s basically healthy for the patient you are not going to go wrong. I’m probably a lot more conservative than many of my traditional friends. We are not taking the chances that any of them take with trying new drugs.”

Dr. Roger Smith, President of the Louisiana State Medical Society (LSMS) sees the acceptance of CAM growing. “There has been recognition at high medical levels, NIH and Washington, that the public is very much involved in their own healthcare, particularly with vitamins and health stores, and the different treatments outside standard medical care. Because that’s so commonly used by the public, physicians are thinking is this someway beneficial or interfering, should it be better monitored and better regulated?” The federal government has responded by giving grants to mainline medical schools to pursue these alternative medicine principles and try to see which ones might work, which ones don’t, and work a little to bring the ones that work into the mainstream, said Smith. “The LSMS point of view, and I think
Natural Supplements Not What They Seem

One of the oft-repeated warnings about health supplements used in CAM is that they are not always what they seem and could cause adverse reactions when taken at the wrong dosage or in combination with other supplements or medications. In the most extreme cases they may contain harmful substances. A case in point, the U.S. Food and Drug Administration recently sent out a nationwide alert to consumers warning them about 25 different products marketed for weight loss that contain undeclared, active pharmaceutical ingredients that may put consumers’ health at risk.

The tainted weight loss products include:

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These weight loss products, some of which are marketed as “dietary supplements,” are promoted and sold on various Web sites and in some retail stores. Some of the products claim to be “natural” or to contain only “herbal” ingredients, but actually contain potentially harmful ingredients not listed on the product labels or in promotional advertisements. An FDA analysis found that the undeclared active pharmaceutical ingredients in some of these products include sibutramine (a controlled substance), rimonabant (a drug not approved for marketing in the United States), phenytoin (an anti-seizure medication), and phenolphthalein (a solution used in chemical experiments and a suspected cancer causing agent). Some of the amounts of active pharmaceutical ingredients far exceeded the FDA-recommended levels. These products have not been approved by the FDA, are illegal, and may be potentially harmful to unsuspecting consumers.

Dr. Smith thinks that CAM treatments that are found to be valid in a scientific, evidence-based manner and to help patients need to be included in the medical curriculum and he sees a trend toward that. “Medicine has made incredible advances over many years. People live longer, they live better, but there are still a lot of situations where patients still suffer and are not benefitted

most physicians’ point of view, is if these are going to be given as alternative medical treatments to patients we would ask that they be given the same rigor as more mainline medical treatments, that they should be scientifically valid and evidence-based, and that the people that are practicing them should have some qualifications to do so.” Dr. Smith said this view goes back to the 19th century when there was a free-for-all for people “practicing medicine.” Healthcare practitioners, traditional or alternative, should also be responsible for and capable of handling the consequences or outcomes of their medical decisions, said Smith.
or cured by what we have available and they seek other treatments,” said Smith. He also acknowledged that some people don’t completely trust that mainline medicine provides the care they are looking for and hope that more hands-on, less invasive techniques might help. “Are we too regimented, too scientific? I hope that really isn’t the situation, but some patients perceive it that way,” said Smith. However, because people who are ill or are in pain may not be in the best frame of mind to make an informed decision, “These treatments need to go through an evaluation that is scientific, that uses the principles we have learned over the last hundred years to look for what’s true and valid and not just based on speculation, hope, or wishing.” Smith concedes that many things that are routinely done now would probably have been considered unusual in a different era.

Unusual or not, it’s a very satisfying practice for both patient and doctor said Dr. Cave. “There’s very little risk. Just a risk of getting better.” She believes that the future of medicine will eventually revolve around the person instead of the disease. Dr. Dantin agreed, saying there is a growing recognition of the value of nutrition to health. “It is going back to the root of medicine. Over the years we moved from using plants as medicine to making synthetic versions of plant extracts, but now we are returning to what is natural. We also need to look at lifestyle choices, supplements, nutrition, and personal responsibility. It’s psychic income when you can make that change in someone’s life.” Dr. Cave said the move toward integrative medicine was necessary. “How could we be complacent and stay with what we were doing? It’s frustrating giving these medicines and watching people go through side effects. We have some wonderful outcomes sometimes, but if we combined it all, the pharmacology with the biochemistry, we would have better outcomes.”

She believes that integrative medicine will eventually be mainline medicine. “It’s got to be. We are going to implode if we keep going the way we’re going with the expense that we have.”

Perhaps one of the most common practices in the complementary and alternative medicine realm is chiropractic care. It is so common in fact, that few realize it falls under the National Institutes of Health definition of CAM, and some, like the Chiropractic Association of Louisiana, would argue it doesn’t. “We do not consider chiropractic as CAM,” said Executive Director, Kathy Chittom, “Chiropractors are primary care physicians.” Despite its prevalence and its clear place in society as a method of healthcare, it remains one of the most controversial. This perhaps has more to do with the line in the sand that has remained between medical doctors and chiropractic doctors for decades over the title “doctor” and the battle for patients than it does with the methods being practiced, but have no doubt it’s a touchy subject. As recently as last June the American Chiropractic Association cried foul when American Medical Association (AMA) Resolution 232 was introduced seeking to legally restrict the term “physician” to MDs and DOs. The ACA said that “under federal statute, all doctors of chiropractic are considered physicians in Medicare and doctors of chiropractic are legally deemed chiropractic physicians in an overwhelming majority of states.” And the controversy doesn’t end there. Chiropractors themselves disagree on the scope and methods of chiropractic care—a feud between “straight” and “mixer” practitioners that has existed from its earliest days. And if that wasn’t enough, the common dismissal of chiropractors as “glorified physical therapists” causes rancor on both sides of the comparison. So what exactly is chiropractic and why do people get so bent out of shape about it?

The term chiropractic comes from the Greek cheir (hand) and praxis (action) to describe treatment “done by hand.” One of its central methods,
manipulation of the spine, has been practiced for thousands of years. However, in the United States, chiropractic as we know it is generally traced back to 1895 and the theories of Daniel David Palmer, a self-proclaimed magnetic healer from Davenport, Iowa. Palmer believed that the body has a natural ability to heal itself and that misalignments or “subluxations” of the joints or spine could affect the flow of energy necessary to promote health. Since the spine is the center of the nervous system, misalignments there could potentially impact all areas of health. D.D. Palmer and his son B.J. who later took over the Palmer school considered chiropractic distinct from the realm of allopathic medicine. However another school of thought soon emerged in which spinal manipulation was combined with other adjustments and techniques to relieve pain and cure illness. These “mixers” believed that improving that flow of energy through manipulation, nutritional therapy, and physiotherapy could be used to treat all manner of ailments from back pain to allergies to gastrointestinal problems. Depending on who you speak to, the rift between these two factions is either non-existent or remains almost as heated as the one between MDs and DCs. “The only thing holding our profession back is the separation between straight chiropractors and mixers,” said Gerald Bell, DC, a self-proclaimed “mixer” practicing in the Baton Rouge area. “I am a very dynamic chiropractor. I like to send my patients out for labs, diagnostic tests, and imaging, just like a medical doctor. Straight chiropractors don’t believe in all that and practice in a more narrow scope.” In fact the scope of B.J. Palmer’s definition of chiropractic ultimately became limited to a small section of the cervical spine only. However, Kathy Chittom insisted that sort of divisiveness only exists in certain pockets of the country and has never been an issue in Louisiana.

The American Chiropractic Association defines chiropractic as “a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, pain in the joints of the arms or legs, and headaches. Doctors of Chiropractic—often referred to as chiropractors or chiropractic physicians—practice a drug-free, hands-on approach to healthcare that includes

We do not consider chiropractic as CAM. Chiropractors are primary care physicians.

— Kathy Chittom, Chiropractic Association of Louisiana
patient examination, diagnosis, and treatment. Chiropractors have broad diagnostic skills and are also trained to recommend therapeutic and rehabilitative exercises, as well as to provide nutritional, dietary, and lifestyle counseling.” The ACA follows the core chiropractic principle, “which holds that the relationship between structure and function in the human body is a significant health factor and that such relationships between the spinal column and the nervous system are highly significant because the normal transmission and expression of nerve energy are essential to the restoration and maintenance of health.”

I am a very dynamic chiropractor. I like to send my patients out for labs, diagnostic tests, and imaging, just like a medical doctor. Straight chiropractors don’t believe in all that and practice in a more narrow scope.

—Gerald Bell, DC

Members of the National Association of Chiropractic Medicine (NACM) take a much narrower view and renounce the chiropractic hypothesis as a basis for their scope of practice. NACM members accept the scientific fact that "manipulative procedures" have validity simply for affecting joint dysfunctional disorders. NACM members confine their scope of practice to “the treatment of joint dysfunctional disorders, which include the biomechanics
of the human frame, posture, weight bearing and gait, and the pain or discomfort concomitant with this dysfunction which may result in excessive ‘wear’ of these joint structures.” NACM members do not consider themselves to be an “alternative” to scientific medical care and attempt to work closely with medical/osteopathic professionals. Nor do NACM members consider themselves to be “primary care” practitioners, but are “portal of entry” doctors, in that the consumer does not need referral from any other type of healthcare professional.

According to Bell, chiropractic medicine as he practices it, is inclusive of three aspects of medicine. The first is the psychological influence, positive motivation, and coaching. “If we do not encourage our patients to get better they are going to stay ill.” The second aspect is nutrition. “As chiropractors we do nutritional counseling and speak to the patient about their diet and prevention of disease. We order, prescribe, or administer nutraceuticals, which are herbal supplements, vitamins, and minerals, as well as chelating agents to remove toxic elements from their bodies.” The third aspect is the biochemical aspect concerning the nerves, muscles, and joints. “Basically chiropractic medicine is a neurological assessment of the body and treatment of the body by hand, with particular emphasis on treating the spine to increase neurocommunication from the brain, down the spinal cord and out the nerve roots to the soft tissue that is injured or in a diseased state,” said Bell. “Also of course it is the rehabilitation of the muscles by hand and tak-

If patients were being injured by chiropractors our insurance would be very high.

—Gerald Bell, DC

ing the patient through stretches and active exercises, and it is the mechanical manipulation of a joint to place it into normal position and correct aberrant motion. The joint manipulations that relieve the pain, the adjustment to the spine that allows optimal communication from the brain to the injured tissue, and the rehabilitation of the muscle is the therapy side of chiropractic care.” Chiropractic medicine is practiced by hand, by instrumental adjusting, and by light therapy (cold laser) said Bell.

As part of his practice, Dr. Bell and his wife, who is also a chiropractor, treat for headaches (tension, migraine), TMJ, Bell’s Palsy, neck pain, upper back pain, disc lesions, herniated disk, numbness and tingling in the arms, weakness, cervical reticulopathy, midback pain, intercostal neuralgia, lower back pain, joint dysfunction, sciatic pain, lumbar sacral reticulopathy, shoulder pain, rotator cuff syndrome, elbow, wrist sprain, carpal tunnel, knee pain, foot and ankle problems, sprains and strains. In addition, because the nervous system controls everything, in theory if it is functioning at its highest capability then the body will respond and problems such as allergies and gastrointestinal problems can also be relieved, said Bell.

Although he believes his training is compatible to a medical doctor’s, Bell does not, like some chiropractors, eschew traditional medicine for chiropractic care. He accepts referrals from primary care doctors and specialists and will refer patients back to them when he feels it is in the best interest of the patient. He likes the team treatment approach not only because it is better for the patient, but it reduces liability. He admits that even those doctors who refer to him are sometimes concerned about possible injury to the patients particularly during manipulations of the cervical spine, but that is due to a misunder-
standing of what he does. He also cited a recent study in the journal, *Spine*, that indicated there was no greater risk of a patient suffering a stroke after a chiropractic adjustment than after a visit to the family doctor. According to the ACA, a research paper published by the same researchers in 2001 in the *Canadian Medical Association Journal* found there is only one a-in-5.85-million risk that a chiropractic neck adjustment will be associated with a subsequent artery dissection (CAD) and stroke. Bell also points out that he knows what he is doing. Not only does he have a four-year degree from Parker College of Chiropractic in Dallas, but he also holds a bachelor’s degree in anatomy from Parker and a bachelor’s degree in biology and pre-med from the University of Louisiana-Lafayette. In addition he argued that he had to pass both a national and state board exam and is required to complete continuing education hours to maintain his license. “Our malpractice insurance is also very low,” said Bell. “If patients were being injured by chiropractors our insurance would be very

**I am a neurosurgeon, and not speaking for LSMS, but I find many of my colleagues do work with chiropractors as far as patients with spinal pain. They have also had patients referred to orthopedists or neurosurgeons from chiropractors so I think the cooperation and civility has improved.**

—Roger Smith, MD, LSMS

Dr. Bell said the medical community is still very uneducated about chiropractic medicine because medical students are not taught about what they do. Dr. Bell said the medical community is still very uneducated about chiropractic medicine because medical students are not taught about what they do. Friends in orthopedics have suggested he speak to groups of doctors about how to utilize chiropractors in their patients’ treatments to help educate the medical community. There are also federal programs that are funding chiropractors to go to medical schools to talk to students. Dr. Bell thinks patients are also asking their primary care physicians about chiropractic treatment because they have not had success and have questioned doctors about alternatives. We have helped them when others have failed. That’s how we have built a name for ourselves."

Despite improvements in the acceptance of chiropractic care, Dr. Bell said the medical community is still very uneducated about chiropractic medicine because medical students are not taught about what they do. Friends in orthopedics have suggested he speak to groups of doctors about how to utilize chiropractors in their patients’ treatments to help educate the medical community. There are also federal programs that are funding chiropractors to go to medical schools to talk to students. Dr. Bell thinks patients are also asking their primary care physicians about chiropractic treatment because they have heard it works. "The bread and butter of most chiropractors are the patients that have been to regular doctors and have not had success and have questioned doctors about alternatives. We have helped them when others have failed. That’s how we have built a name for ourselves."

Dr. Bell sometimes sees a more confrontational relationship with physical therapists than MDs. "Physical therapists want to do what we do, spinal manipulation, and are lobbying hard to do it. It’s kind of controversial because they say bad things about chiropractors, but then lobby to do what we do," Karl Kleinpeter, PT, a physical therapist practicing in Zachary said it is true there is tension between physical therapists and chiropractors, but he believes it is more due to the overlap in their practices and ultimately the competition for patients. Physical therapists are at a disadvantage because for the most part their patients have to come from referrals, said Kleinpeter. That means that a patient that wakes up with back pain can’t come straight to him, but must first see his primary care physician, who may want to see x-rays before he refers the patient for physical therapy, all of which might take a few days. Conversely that same patient could decide to bypass the process and go straight to the chiropractor. Kleinpeter said the positive side of the referral process is that when he receives a patient for physical therapy he can be fairly confident that the
patient's pain is a result of something musculoskeletal, and can refer him back to the doctor if something doesn't seem right. He also feels that because physical therapists are trained in the traditional western medicine approach there is a comfort level between MDs and PTs that they are on the same page. Dr.Bell said it is illegal for physical therapists to manipulate the spine and that even though his practice includes some of the same treatment methods as physical therapists, he can’t say he practices physical therapy, but has to call it physical rehabilitation. That works both ways said Kleinpeter, and ultimately comes down to semantics. He may work on spinal problems but can’t call it manipulation because that is a chiropractic term. “Some of our techniques are similar and we may come to the same conclusions about a patient, but we have different philosophies and different thought processes to reach those conclusions,” said Kleinpeter. “I am not saying one’s better or worse.” Kleinpeter doesn’t think the relationship needs to be adversarial and does see improvement, but admits that competition makes it difficult. “We just need to put the facts out there about what we each do and let the public decide what works for them.”

It is obvious that confusion over what each profession does can sting. “People call us glorified PTs,” said Bell, “but we are doctors—the only thing we can’t do is prescribe medication, but we’re moving that way.” He said New Mexico will probably be the first state to allow chiropractors to prescribe medicine and it will likely be a limited formulary of natural drugs. “I am not against it because I am very allopathic minded,” said Bell. “I like to be part of the medical team. Not all chiropractors do. Some feel we are overmedicated and want to hold strong to non-drug treatment. I think I can preach less medication and the need to try other alternatives first, but still advise my patients to take them when medically necessary.”

CAM Coverage Increasing

Insurance companies more open to complementary and alternative treatments

by: Philip Gatto
Along with the growing trend of Americans seeking out complementary and alternative medicine, is a mirrored increase in the number of health insurance companies offering some kind of CAM coverage. Although many limit their coverage to treatments conducted by licensed practitioners such as chiropractors, acupuncturists or massage therapists, such coverage is on the rise. Some attribute the move to cover CAM to customer requests, increased licensing, increased studies on the efficacy of some of these treatments, and legal requirements. Still, coverage is often offered with caveats such as out-of-network fees, mandatory referrals, or treatment plan approvals.

If an employer offers CAM coverage, it usually has one or more of the following features:
- Deductibles that may be higher than those for conventional care
- Policy riders
- A contracted network of providers who agree to offer their services at a lower rate to members than to nonmembers

So far there is not much evidence of the trend in our state. In Louisiana, chiropractic care is a covered item as required by law, but other CAM treatment coverage may vary from company to company. None of the companies we spoke with indicated much CAM coverage outside of chiropractic and wellness programs. Dr. Laura Trunk, Humana’s Louisiana market medical officer, indicated that Humana does not typically cover alternative or complementary medicine for its members because it is a health benefits company focused on preventive care, disease management, and wellness, but it does provide its members in many cases with discounts to these providers for acupuncture, massage, and other alternative health care services. Also, if a member’s primary care physician does prescribe physical therapy as a course of treatment for a back,
neck or other medical condition, that physical therapy is covered and often includes massage as part of the therapy. Coventry’s Belinda Lazaro noted that the company does contract with a high number of chiropractors and is very committed to its wellness program, but had few details on coverage of other alternative treatments. Blue Cross and Blue Shield of Louisiana declined to comment on their CAM coverage.

The Federal Government helps with at least some of the health expenses of people who are eligible for Federal health benefit programs. Examples of programs that may provide some CAM coverage under certain circumstances are:

- The Department of Veterans Affairs (for chiropractic care and acupuncture).
- Medicare, which covers chiropractic but does not cover what it calls "alternative therapies," giving as examples acupuncture, chelation therapy, biofeedback, and holistic medicine.

It was Medicare’s coverage of chiropractic that eventually led to chiropractic care being licensed and covered across the country, so government driven initiatives may increase other CAM coverage in the future. According to the White House Commission on CAM Policy Final Report, an annual survey of employer-sponsored health plans in recent years has included questions regarding specific CAM services offered in benefit packages. In 1998, 49 percent of survey respondents indicated that chiropractic was covered; by 2000, the number had risen to 70 percent. Over the same time period, coverage of acupuncture rose from 12 percent to 17 percent, and coverage of massage therapy increased from 10 percent to 12 percent. The survey also found that large employers (those with more than 20,000 employees) were more likely to offer CAM benefits than medium and smaller employers. PPOs and indemnity insurers were more likely than HMOs to offer health plans that include CAM benefits. Although most respondents anticipated increasing their coverage of CAM programs in the future, they cited a number of obstacles to such increases, including inadequate research, regulatory concerns, lack of understanding and knowledge about CAM, and lack of data on utilization and costs. As part of its report the WHCCAM recommended that insurers and managed care organizations offer purchasers the option of health benefit plans that incorporate coverage of safe and effective CAM interventions provided by qualified practitioners, and that purchasers, including Federal agencies and employers, should evaluate the possibility of covering benefits or adding health benefit plans that incorporate safe and effective CAM interventions.

Among the most commonly covered CAM treatments are chiropractic, massage therapy, acupuncture, naturopathic medicine, herbal remedies, homeopathy, mind-body stress management, and meditation. They are all on the fairly conventional side of CAM, and most are offered with significant restrictions.

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From Pennington’s Files

Ginkgo Biloba

- For over 5,000 years, the fruits and seeds of the Ginkgo biloba tree have been used in traditional Chinese medicine for the treatment of various conditions such as asthma and cough.
- The first publication of the internal use of G. biloba leaves for medicinal purposes dates back to 1505 A.D.
- Since the early 1990s, the standardized extract of G. biloba leaves, EGb 761, has become one of the most popular supplements for memory enhancement in the U.S.
- G. biloba is one of the top selling herbs in the U.S. and is usually consumed as tablets, capsules, or teas.

G. biloba Extract (GBE)

Depending on country of origin, time of harvest, and other factors, the amount of individual constituents found in G. biloba can vary considerably. Therefore, it is important to have a standardized preparation with known composition for the purposes of drug regulation, clinical trials, human consumption, and for reproducibility.

A standardized form of G. biloba leaf extract (EGb 761) has been approved by French and German companies, which contains 24% flavonoid glycosides, 6% terpene lactones, and less than 5 ppm ginkgolic acid (a component with possible allergic properties).

Health Effects

The current evidence suggests that G. biloba may have benefits in the following conditions:

- **Cardiovascular disease**: a heart and blood vessel disease with plaque formation and hardening of the arteries, high blood lipid levels, and possible hypertension.
- **Ischemic Stroke**: a stroke which occurs when a blood vessel that feeds the brain gets blocked from a blood clot, causing injury to that part of the brain. The injury can be mild or severe.
- **Dementia**: a condition in which memory and behavior are altered and a person has difficulty coping and interacting with others.
- **Claudication**: a circulatory problem that causes lower leg pain during exercise and is usually associated with peripheral artery disease.
Acute Ischemic Stroke

- Ginkgo biloba extract has been widely used in the treatment of acute ischemic stroke in China and has been used occasionally in Europe.
- A survey of treatments used in routine practice in China showed that 75% of doctors surveyed believed that Chinese herbal products were effective treatments for acute stroke, and 66% of doctors used them routinely for most patients.
- Despite the routine use in Chinese medicine, the medicinal effectiveness of herbs remains uncertain.

A recent publication (2006) reviewed all current randomized trials of G. biloba extract in patients with acute ischaemic stroke. The final review looked at 10 trials (N=732 patients). In nine of the trials, assessed to be of inferior quality, significant improvement in neurological deficit was used as the outcome measure.

When the trials were analyzed together, G. biloba extract was shown to be associated with a significant increase in the number of improved patients; however, the evidence was not convincing.

In addition, in one placebo-controlled trial assessed to be of good quality, no improvement in neurological deficit was noted at the end of the treatment.

Chronic Diseases and G. Biloba

- There is increasing evidence of the potential role of G. biloba extract (GBE) in treating and delaying the development of cardiovascular disease (CVD) and other chronic diseases. The underlying mechanism of action is not fully understood.
- GBE is believed to exert its effects in several ways:
  - as an antioxidant
  - in improving vasomotor function
  - in reducing cell adhesion
  - in reducing platelet activation
  - in inhibiting smooth muscle cell activation
  - in improving cell signal pathways

High quality, large-scale, randomized clinical trials, including a control group, are needed to examine the potential relationship between G. biloba and stroke recovery.

Clinical Use in Peripheral Artery Disease

Clinical trials have demonstrated certain therapeutic benefits of GBE in the treatment of peripheral vascular diseases, especially of intermittent claudication—pain in the legs caused by peripheral artery disease (PAD).

- One of the largest randomized double-blind clinical trials on claudication and G. biloba was conducted in Germany. The trial, involving 111 patients with symptoms of intermittent claudication, showed that although Doppler indices (which examine blood flow in the legs) remained nearly unchanged during the therapy, walking distance improved substantially in patients treated with GBE.

Several other studies have also reported significant improvements in GBE treated subjects when compared with placebo.
**Clinical Use in Small Vessel Disease**
Ischemic vasculopathy involving small vessels may affect multiple organs and systems. Clinical trials have demonstrated the clinical efficacy of G. biloba in Raynaud's syndrome, retinopathy, and nephropathy associated with the insufficiency of various vascular beds.

**Clinical Use in Venous Insufficiency**
GBE has also been reported to have a beneficial effect in patients with chronic venous insufficiency. G. biloba is effective by preventing the first step of the endothelium activation cascade leading to epithelial growth and vessel narrowing.

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**Alzheimer's Disease**
- In Europe, GBE is registered for the treatment of memory impairment, dementia, tinnitus (ringing in the ears), and intermittent claudication.
- Alzheimer's disease (AD) is the most common cause of dementia in the elderly, affecting 4% of those over 65, and 20% of those over 80 years of age. AD is a chronic, slowly progressive neurodegenerative disease with deterioration of memory and intellectual capacity.
- Several nutrients and chemicals have been shown to slow down the progression of the cognitive decline related to AD. These include antioxidants such as vitamin E, monoamine oxidase inhibitors (MAOIs), anti-inflammatory drugs, cholinergic agents, estrogens or neurotrophic factors.
- Many of these chemotherapeutic drugs have side effects, some of which are severe. And, up to now, none are fully effective in the prevention or treatment of neurodegenerative disorders.

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**Clinical Use in the Prevention of Thrombosis**
Thrombosis is the formation of a clot or thrombus inside a blood vessel, which in turn obstructs the flow of blood through the circulatory system. Enhanced platelet function, particularly in response to collagen, is a known risk factor for cardiovascular disease and thrombotic complications. Studies have shown that decreasing blood viscosity and preventing platelet aggregation, GBE can be useful in the prevention of thrombosis.

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**Findings on the G. biloba extract, EGB 761**
- Many studies have used G. biloba extract EGB 761.
- Animal studies revealed that EGB 761 is able to facilitate acquisition and retention of memory, with one of the major protective actions taking place in the hippocampus (which is related to the acquisition of new memories).
- In 2000, several mechanisms were proposed in explaining how EGB 761 may be useful in AD and other age-related, neuro-degenerative disorders.
- In animals, EGB 761:
  - Possesses antioxidant and free radical scavenging activities
  - Reverses age-related loss in brain receptors
  - Protects against ischemic neuronal death
  - Preserves the function of the part of the brain that is involved in memory
  - Increases activity of cells for chemical synthesis of compounds needed for memory
  - Preserves chemical receptors that may decay due to aging
  - Enhances neuronal plasticity
  - Counteracts the cognitive deficits that follow stress or traumatic brain injury

*Mechanisms by which G. biloba extract has been shown to improve the effects of AD*

G. biloba extract can prevent the formation of an amylase protein precursor, a key event in the progression of AD.
Side Effects and Cautions

- Side effects of Ginkgo biloba may include the following: gastrointestinal distress, such as diarrhea and nausea; dizziness; headaches; or allergic skin reactions.

- G. biloba may increase the risk for excess bleeding. This is particularly important for individuals on anticoagulant drugs, with bleeding disorders, or those planning to schedule a surgery or a dental procedure.

- It is important to always inform your health care provider on the intake of any herbal or dietary supplements.

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6. Nutrition and the Brain

The research fostered by these divisions can have a profound impact on healthy living and on the prevention of common chronic diseases, such as heart disease, cancer, diabetes, hypertension and osteoporosis.

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We invite people of all ages and backgrounds to participate in the exciting research studies being conducted at the Pennington Center in Baton Rouge, Louisiana. If you would like to take part, visit the clinical trials web page at www.pbrc.edu or call (225) 763-2597.

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We often hear how rising healthcare costs affect our economy, but how is the economic downturn affecting healthcare? Is it really recession proof as once believed? Of course, people still get hurt or sick and need doctors, clinics, and hospitals during a recession, but does that mean healthcare emerges unscathed? Not according to recent reports out of Moody’s Investors Service that question the old “recession proof” moniker. Instead, like everybody else, hospitals, clinics and providers have to tighten their belts as a result of people watching their money and choosing not to pursue preventive treatments, elective surgeries, visits to specialists, or brand name prescriptions. Some are even feeling enough of a pinch to opt out of their health insurance, while others are losing coverage along with their jobs. Those that do show up at clinics and hospitals are less and less able to pay and health plans have fewer members to share the cost. The trend may not only have long term effects on the people’s health, but may also dig the hole deeper for the economy. But has the recession reached healthcare in Baton Rouge? We asked a variety of local professionals to see what changes they have felt, if any, and what they are doing to adjust.

Is healthcare recession proof?

I think to say that healthcare is recession proof is really not an accurate statement. The healthcare industry is no different than any other industry. What may be a more accurate statement is illness is recession proof. Illness is going to take place no matter what happens with the economy so the demand for services continues. Ed Silvey, CEO, Baton Rouge Clinic

I think healthcare is recession resilient, but it’s not recession proof. I think we’ve seen in this latest downturn that we are, like it or not, very linked to the economy. For a long time, because governmental payers were such a large part of healthcare, there was this feeling that some of your business was insulated from national price pressures. But nowadays we are very linked. Mitch Wasden, CEO Ochsner Medical Center-Baton Rouge

To call healthcare recession proof I think is an overstatement. It may be somewhat recession resistant, but what we have found personally as an organization is that our marketplace is being challenged to be able to meet the cost of providing healthcare as an employee benefit. More and more employers and individuals are beginning to buy down coverage in order to reduce their premiums. Mike Reitz, interim President, CEO, Blue Cross and Blue Shield of Louisiana

I really think that’s a big misnomer. We are certainly impacted by the national economy as well as the local economy, particularly in our specialty of cardiovascular medicine. About 55 percent of our patients are insured by the federal government, so what’s happening with the national economy means we always worry about what that means for reimbursement for the large piece of business that is healthcare. Unlike other parts of the economy we deal with this enormous uncertainty every single year. So the national economy just adds, in my opinion, even more stress on an already stressed industry. David Konur, CEO, Cardiovascular Institute of the South

I would say that a lot of hospitals are planning for what we consider the economic storm. It’s a lot like planning for a hurricane. You go through the best through worst case scenario. We are talking about this economic downturn when the need for healthcare services is on the increase. Sean Prados, Executive VP, Louisiana Hospital Association

Well I think basically it is not, but it depends on what you are planning to do during the time of the recession. So far we are not looking for an immediate impact on our practice because we are not building anything or developing anything at this
point. What we have to watch are our patient numbers and that sort of thing. This is a time when all businesses, not just healthcare, really need to watch their Ps and Qs and control costs, overhead, and make sure they don't get behind the 8-ball. Thomas Flynn, MD, FACS, President, The Neuromedical Center

I've always felt that if you take that mentality you are lining yourself up for a dangerous situation later down the road because you are not paying as close attention to the outside factors that could drastically affect your business as you should be. Healthcare is not recession proof by any stretch of the imagination. What has been the case is that healthcare has been affected by economic downturn and every single time that's been for different reasons. Brian Barbeito, CEO, Radiology Associates

Medicine does not experience the booms, but we don't experience the busts that the rest of the economy experiences. J. Michael Burdine, MD, Spine Diagnostic and Pain Treatment Center

We as a hospital system will feel the pinch of the recession in that if the state's revenue is down, our budgets are reflective of what the state has available to allocate to healthcare. If the state's budget, with all of its various concerns, doesn't have a full share of expected money, well we will feel it. There's no question of that. Michael K. Butler, MD, CEO, LSU Health Care Services Division

I think nationally you've seen, with facilities closing across the country and locally in light of some of the recent events in our market, that the current restraints of access to capital and those things will have an impact in healthcare. There is a cycle of going from a person who may lose their job, then they lose their health insurance, then they're uninsured, and that increases the number of uninsured individuals accessing healthcare. We are not on the sharp end of the recession curve, but in markets where there are deep layoffs certainly hospitals are affected. We are not experiencing that in our market today, but we are being conservative and understanding how that cycle occurs and trying to ensure that we are managing well. We don't know what the next event might be in our market or nationally that might trickle down to us. Terrie Sterling, COO, Our Lady of the Lake Regional Medical Center

Are patient numbers dwindling?

Some of our volumes in the hospital have been kind of off what we normally see in the winter months, but that may be partially weather-related because it hasn't been too cold a winter. We are wondering if some people are postponing elective surgeries because they are unemployed or underemployed or don't have health insurance. That usually will backfire because maybe later on they'll be even sicker, so we kind of hate to see things like that. I don't know how much a part the economy is playing in these off volumes, but it is certainly part of it. Randy Olson, CEO, Lane Regional Medical Center

We are seeing groups begin to shrink a little bit, but for the most part what we've noticed here is that our sales, our premium income as a result of new people coming to Blue Cross looking for health insurance coverage, is at the same level as it was in 2007. The existing block of business that we have, those employers that are currently with us, we're finding the average group size beginning to reduce somewhat. I think this may be a result of companies downsizing or beginning to reduce their contribution on behalf of their employees. Mike Reitz

We're still very, very busy at the clinic. We're among those fortunate situations with such a huge patient base that we might not feel dips as much. But there is definitely apprehension and anxiety even in this community. Ed Silvey

Now with the recession we're seeing in our practice a few less patients making the decision to come in, but some of that is affected by deductibles. A lot of their initial expenses are going to be directly out-of-pocket. For specialists or for people who are not emergency care or pediatricians, or not an absolute necessity, we tend to be slower in the first quarter of the year. And I think that's being a little bit compounded by the perception of the national depression that's affecting us. We still see as many patients on a weekly basis in the office, but we don't have as long of a wait to get an appointment. J. Michael Burdine, MD
We are seeing a decrease in elective surgeries and in outpatient services. Very similar to what they are seeing nationally. Jodi Conachen, Public Relations Manager, Woman’s Hospital

We haven’t seen a dip in admissions or scheduled surgeries. We’ve heard around the country people are putting off elective surgeries, but we haven’t seen that yet. Mitch Wasden

We haven’t seen a drop off yet, but our staff are hearing more talk from patients about problems at home, layoffs, retirement plans evaporating. The population we treat tends to be elderly or nearing retirement. David Konur

We have not seen our volumes really decrease. Brian Barbeito

No dips yet, it might be too early, but I think we are going to see them. The last two or three months have been very busy, but I have to say the type of medicine we practice at the Neuromedical Center is a little different. The percentage of patients that are purely elective is relatively low compared to some other medical specialties and that may have something to do with it. Thomas Flynn

Not to date. We certainly understand that as a national trend, particularly individuals who may delay elective cases, but we have not seen that in our volumes to date. Terrie Sterling

Are you hiring or firing?
Cutting back on hours?

We are mindful of our volume dropping off so we try to be as efficient as we can be, making sure that we are not overstaffed. I think to some degree with our volumes off we don’t bring in additional staff or bring in people in our float pools, so there are some hours that are being cut. Lane usually has more turn-over among lower paying jobs and we’re not seeing it as much. Maybe because of a lack of other jobs out there. Randy Olson

What we as an organization are doing is being very diligent and attempting to manage this through attrition. While there are no reductions, we certainly have attempted to maintain our current fulltime employee headcount. Mike Reitz

We’ve got new physicians coming this summer and we are hiring people to come on board and get trained for those doctors. So we haven’t changed our behavior that much, but I think to say we weren’t paying attention to the economy and worried about its impact would not be an accurate statement. We just don’t know how to predict it in this community. One of the things we’ve found in the last couple of months—kind of a good news, bad news thing—whereas six or nine months ago we had trouble finding certain kinds of staff people, we have not experienced that lately. I think that people that may not have been working in the past are now seeking employment. The pool may be larger due to people being fearful of the economy or a spouse having their hours cut. Our ability to hire has been better in the last three months than it was in the first nine months of 2008. Ed Silvey

I don’t think you are seeing people in the healthcare business locally being laid off. What we are probably doing is as we have people leave jobs, we are not hiring as quickly, we’re being a little more discriminating. In our office when we hire we are looking at people who are fit to do multiple jobs so we can do more with less people. J. Michael Burdine, MD

We have a hiring freeze except for critical positions and direct patient care. We review any non clinical, non-critical hires to keep the costs down. We have done all of the usual things, trying to make sure that travel is necessary, looking at things that can be delayed or diverted, overtime is minimum. We make sure as much as we can that contract labor is kept to a minimum or cut back. Michael K. Butler, MD

We are reviewing the need to replace positions as people move on or retire, and we are looking very hard at those positions to see if we really need to replace them or can do it another way, like cross train or absorb that position to keep us as lean as we can be. One of the things most organizations do anyway is reevaluate and see if technology can come into play so we may not need the same kind of employee to do that job. The economy just makes it more necessary. We’re
maintaining, but all responsible entities look at overtime costs and try to be as appropriate as possible. **Jodi Conachen**

We’re hiring. We haven’t had any issues where we have had to freeze or cut back. It hasn’t hit us that way. We’ve always run fairly efficiently when it comes to overtime. **Mitch Wasden**

We’re not freezing hiring—our plans are to continue to grow our existing workforce. It’s been hard to recruit physicians to South Louisiana post Katrina and much more difficult in the bayou region which was hit so hard with Gustav and Ike. **David Konur**

No we have not adjusted staffing. At this point we’re actually hiring and running ads to fill both vacated positions and a couple of positions that are open. One of the problems with healthcare is you’ve got to keep the doors open and keep seeing patients—you can’t just lay people off. In our business we control overtime and that sort of thing very carefully, so it’s not an issue with us certainly at this point. **Thomas Flynn, MD**

**We are actually hiring. We’re looking at nursing positions, PA positions, even looking at adding doctors, to keep in line with the dynamics of our practice and group as well as where we think the future of healthcare is going to be. Brian Barbeito**

We are asking our managers to manage well, but we have not eliminated any programs or personnel. **Terrie Sterling**

**Are you cutting back on marketing?**

I don’t anticipate us sacrificing any of our marketing efforts at this time because so much of that effort is to go out and work with our existing 14,000 employers and roughly 175,000 individuals that purchase their insurance directly from Blue Cross. Our objective is to work with those individuals to find plans that are most appropriate for them. **Mike Reitz**

Maybe unlike other businesses we are so prudent with our marketing dollars that I don’t think we’ve changed anything. We have not cut back nor have we made a decision to do more as a result of the economy. What we have tried to do over the years is to be prudent stewards not just of our marketing dollars but of all of our expenses, so when something like this happens we don’t overreact, we don’t have a knee-jerk reaction to sudden changes in the economy. **Ed Silvey**

I think if you look at the newspaper or places where marketing is typically flowing I don’t think you are seeing as much marketing being done right now. There does seem to be a retrenchment. **J. Michael Burdine, MD**

As far as marketing goes we may, about six months ago,
have cut back a little bit, but not very much. Some of these moves can be shortsighted if you are not careful and you can lose momentum. You can make a case that this may be the time to increase marketing if you think it increases business; to do more of it when your competitors are doing less of it.

Mitch Wasden

Marketing seems to always be the first area people want to cut. I like to think that we are trying to get the best value for the dollars. We may place some more attention on prevention and screening programs to enhance getting our name out there, but we’re about the same as in previous years.

David Konur

It’s an incredibly competitive business and market share is extremely important especially in times like this. I’m sure all hospitals are looking at every aspect of cost containment, but it will depend on the facility and its location whether or not they make those decisions.

Sean Prados

One of the Neuromedical Center’s strategies is to regionalize our practice and we have not cut back on any of those promotion programs that we have instituted such as billboard ads in Hammond and that sort of thing. It’s necessary—we want to maintain and grow our patient base in these times.

Thomas Flynn

We’re still where we were on advertising, but businesses have been looking for ways to cut back and the economy is making them take a look closer at what they are doing.

Marlon Moore, CEO, Red Stick Orthopedics & Prosthetics

We have not made any changes. We certainly try to keep a very reactive process to what’s going on in the market. We are more driven by our service line and communicating those services we believe the community needs to know we provide. Our process is a very living process and very reactive, so there have been no major deviations in our marketing plans.

Terrie Sterling

Are you putting any expansion plans or capital expenditures on hold?

Right now we are seeing things I had never seen in my lifetime as a hospital administrator. The way the market is up one day and down the next is kind of disconcerting to people. Lane is in a growth mode, trying to bring new services to this region, but we kind of have to back up a little bit and see what the market rates are for potential bonds and those types of things.

Randy Olson

We’re looking at a bunch of capital expenditures and we haven’t planned to stop doing any, but we do think, “Is now the time to do it, should we delay it for six months?” We are looking at capital expenditures and trying to determine if something can wait that doesn’t impact patient care. Not so much that we are feeling the economy, but more from the standpoint of where it is, the uncertainty. You get conflicting reports.

Ed Silvey

In my own practice, having a new president come in that’s threatening to raise taxes on individuals and corporations has basically put a hold on any expansion plans that we had. We were bidding out for projects to build three new offices last fall.

J. Michael Burdine, MD
We’ve had to make changes because overall the way our budgets run, our revenues are behind what we expected to collect as far as UCC payments. We are going to have to do whatever we can to come in at budget. We’re delaying acquisitions and purchases. We’re doing all those things to make sure our revenues are consummate with our expenses. One of the things we are looking at is whether or not we should roll out the North Baton Rouge Clinic as scheduled. We might have to delay that for a month or so. Michael K. Butler, MD

This refers back to the new campus and tightening of the bond market. Investors are less willing to invest, it’s more difficult to sell bonds, and it caused us to suspend our construction project. We are also reducing operating expenses, looking at the budget to look at what we can do. We are delaying purchases on equipment that’s not critical to patient care, anything that we can defer or delay until another time. Jodi Conachen

When you have major projects you can’t really fund them out of routine operating revenue, you’ve got to go get bonds issued, and when the bond rates are unfavorable it puts those projects on hold until the rates come back. In Ochsner’s situation, we didn’t really have a lot of things we were getting bonds for. So we didn’t have a lot of things put on hold from that standpoint. But as far as routine capital for replacement equipment, new equipment, the downturn in the economy has definitely been an issue. We decided to dial back on some routine capital spending. Mitch Wasden

We had adopted in 2008 a plan to take CIS out of state, diversify. Then as the economy really started to slow down, we said maybe we need to take our foot off the pedal and make sure our existing practices are well prepared for 2010. Let some of the economic woes work themselves out. It’s just good business. David Konur

Our strategic planning is for two or three years out so as long as we can pay our consultants we are moving right ahead. We don’t really need to alter the things we have underway. I do believe we are going to have a fairly lengthy recession and we have to watch carefully. Thomas Flynn, MD

From our standpoint, the answer is yes and no. We have basically taken our key objectives in the future and taken a much closer look at them to make sure our ducks are really in a row. We’re still in a good place, not seeing the effects, but we’re making sure we don’t go down that same path without doing due diligence. I think whereas before we might have been more comfortable entering into more risky
situations, I think everyone is kind of evaluating those future endeavors with a higher level of risk awareness. That has not stopped us taking on any new project, expanding our group, taking on new employees. We’ve done that in the past year, just cautiously. Brian Barbeito

We are going forward with everything we have plans for right now and picking up new contracts. Marlon Moore

Part of our three year strategic plan was that we would be expanding a satellite clinic in Prairieville. We’re still on track and still making an investment in some of our women’s services this year. Mitch Wasden

We are in the midst of our master facility planning, so we are factoring in as we work to conclude that sequencing. We have not concluded as yet that any of our project timelines will be adversely affected, but that’s only because we are in the midst of determining the timing and financing of those things. Our current projects that are underway are continuing uninterrupted. Terrie Sterling

Have you seen an increase in patients who can’t pay?

We’re not seeing more patients that can’t pay. We won’t see that yet because of the insurance claim process time. J. Michael Burdine, MD

We can’t tell at this point, but I suspect we are going to have some of those. We’re not able to quantify at this time, but it is concerning us looking forward. Michael K. Butler, MD

We have seen slower pay, but I’m not sure if it’s the economy or higher deductibles. Ed Silvey

We have not seen an increase we would call a trend yet, but what we have seen over the last couple of years is a rise of these high deductible plans, where in essence although the patients have insurance, they’re really uninsured for the first few thousand dollars. I’m assuming we’ll continue to see an increase in that as employers have trouble during a downturn continuing their healthcare benefits. Mitch Wasden

We’re seeing an increase in the uninsured as people are laying off or increasing deductibles, so employees are faced with a greater burden. We’ve seen that trend increase over the last several years. Sean Prados

Our receivables are very sturdy, but then again as long as patients are employed, their out-of-pocket portion is relatively small. It’s when unemployment and layoffs hit that we would see a significant problem. It just hasn’t happened yet. Thomas Flynn, MD

Not yet and I think that’s because we haven’t seen tremendous layoffs in the Baton Rouge community and we haven’t seen the long term effects of layoffs in the community or downturn in the economy just yet. Brian Barbeito
If people start to lose jobs, the payer mix starts to change, but we are not seeing that yet. **Jodi Conachen**

That seems to be remaining static for now. **Randy Olson**

We will monitor that trend, but in our 4th quarter numbers for the calendar year we did not see any statistical increase that we believe was related to the economy. **Terrie Sterling**

**How else are you being affected?**

All kinds of internal things. Some projects are going to be delayed at the departmental level--maybe hiring a person or extending hours. We are just trying to make plans for next year. Hopefully the cuts in general funds will not be as high as predicted and maybe there’ll be some national relief on these issues, but we have to prepare as if those cuts are coming. **Michael K. Butler, MD**

*The word we are using is being “vigilant.” Not only do we have the economy to deal with, but nobody knows what’s going to happen with healthcare from a national perspective. I hear in the community anticipation of a shoe to drop.* **Ed Silvey**

I think the big question a lot of people are having is what will this do long-term to some of our medical staff shortages? We’re curious if a downturn will drive more people into healthcare professions and help some of the shortages. Will it keep people in the profession longer who may have planned on retiring in the next five or ten years? Not that there’s a lot of silver lining in an economic downturn, but from a human resource standpoint, we’re curious to see how this plays out for health professionals. **Mitch Wasden**

When we get into economic hard times, we stop taking vacations, we’re staying at home, eating dinner with the family, and focusing on what’s really important in life. The same thing applies as a company. We’re saying let’s make sure things at home are 100 percent before we move forward with expanding. You get energized and see opportunities you might have missed. **David Konur**

The hospitals in Louisiana are facing the same dilemmas as the hospitals across the nation—the effects of the financial market crisis, the rise in unemployment. The rise in unemployment and loss of job-paid healthcare coverage has always negatively impacted hospitals and it looks like it’s going to continue that way for a while. I think if you couple that with other payment pressures that hospitals face such as underpayment from Medicaid, Medicare, other government forces, it just compounds the problem that much more. And it’s not just the hospitals that it’s going to hurt economically, it’s also going to hurt the communities where those hospitals are located as well as the overall state’s economy. **Sean Prados**
Nationally, the American Hospital Association reports that hospitals are hurting. In a November 2008 report, the AHA said that 31 percent of hospitals surveyed reported a moderate to significant decline in admissions and elective procedures. Thirty-eight percent reported a decline in admissions. In addition a significant number were reconsidering or postponing investments in facilities and equipment due to the increased costs of borrowing and decreased access to financing. Fifty-six percent were reconsidering or postponing capital expenditures related to new capacity or renovations, 45 percent on clinical technology and equipment, and 39 percent for information technology. The hospitals also reported an increase in physicians seeking financial support from hospitals, suggesting that individual practices were also hurting. More than 50 percent of the hospitals surveyed indicated they were cutting administrative costs and reducing staff in reaction to the economic pinch.

We so far have not been affected too much in the recent economy. I tell people I never thought I’d hear the day when on Bloomberg Radio the analysts are recommending investors buy quality healthcare system bonds. I think the economic community is looking at healthcare as being a safe place in a lot of respects. I think that this, in combination with healthcare seeing ever-increasing utilization, will allow healthcare to surpass this particular downturn. Those with high debt or looking to take on debt, that’s another matter. We may see a tremendous hold off on advancement of medical facilities in this community and investment in new equipment and technology.

Brian Barbeito

It’s affecting healthcare in that people who need routine healthcare are electing not do it right now, especially on elective things. People who normally come to buy diabetic shoes are not coming in. No one knows what tomorrow’s going to bring right now.

Marlon Moore

One of the things we heard of happening in earlier periods of economic downturn is that individuals may be less likely to check on a mole that may look funny, a pain that is ongoing, that they may put off accessing their primary care. We would want to stress the importance of seeing your primary care doctor, checking on those early warning signs, not forgoing preventive screenings if at all possible. If you can’t get those things through primary care, seek out those screenings when they are offered in the community so you can maintain your health.

Terrie Sterling

How is Baton Rouge faring compared to the rest of the country?

I think there are parts of the country that are better off than we are, but I know there are parts that are much worse off than we are.

Randy Olson

I think what we’re seeing here, when I talk to other plan presidents throughout the country, are pretty similar trends.

Mike Reitz

I do think healthcare in Baton Rouge is faring better maybe than in other communities, but I don’t think it has to do with healthcare, it has to do with the fact that Baton Rouge at the moment is faring better than many other places in the country. We are reading a lot of stuff in the paper that says Baton Rouge may be fine, but I think we are intellectualizing that. I think our gut as employers, whether you are in healthcare or anything else, is not responding that way. I think everybody is trying to be vigilant and keep an eye on where things are going. Some of this may be caused by the 24-hour news that we have now. You can’t go to any station and not hear what’s happening in the stock market, how many layoffs there are in the country. I think the raised awareness of the economy, whether you are a consumer or an employer, adds to the fear level.

Ed Silvey

I think in Louisiana, at least currently, we’re faring better, but if the price of oil stays down we will begin to see the impact in Louisiana. We hear from our patients that a few of the companies have begun laying off. A few patients are coming in now because they still have a job and insurance. I have had some tell me, “I need to get everything I can done right now, because the company is going to have another round of layoffs.”

J. Michael Burdine, MD

We are going to have the same pressures as providers are having nationally, but Baton Rouge seems to be doing a little bit better, because the economy here at the moment seems to be doing a little bit better. But that could change at any moment.

Michael K. Butler, MD

It appeared that for a time we seemed to be insulated, but that’s starting to change. I think we are starting to see some of that shift locally.

Jodi Conachen
We’re probably faring about the same as the rest of the country. **Mitch Wasden**

We’ve dealt with significant challenges related to the economy for a very long time. When gas prices were $4 a gallon, gas prices were a big problem. Now that the gas prices are $2, gas prices seem to be a problem—the state’s losing money and the Medicaid program is considered a discretionary expenditure by the state, so I think in healthcare we are always dealing with pretty significant issues and are affected by the climate around us. We started taking a hard look at all of our programs in 2007, worrying about what would happen in 2010. Our industry has dealt with that uncertainty for years, relying on Medicare as the major payer. When you layer on the economy, you just wonder when is our time coming? South Louisiana had a little buffer, but it’s certainly affected. **David Konur**

Typically Louisiana is a little behind. It’s somewhat of a reverse economy due in large part to oil and gas. We consider it the last caboose on a roller coaster. **Sean Prados**

I think there’s an old saw that Baton Rouge is recession proof but I think that is very shortsighted. Up to this point we’ve been very fortunate but it will not be very long before we do feel the impact of the deteriorating economy. Healthcare providers have significant involvement in seeing patients whose families are employed by industry so we are going to see an impact. I think for many reasons, some of them unfortunate such as the impact of the hurricanes, we are doing much better than other areas of the country dependent on heavy industry or manufacturing. The downside is Louisiana should have more of that. I have a very jaundiced view of the publicity that goes on with big business during times like these because they are going to use the aura or fact of recession to make a lot of business corrections they didn’t have the courage to do otherwise. I think there are people who are going to be laid of that probably wouldn’t under ordinary circumstances, with the recession as a basis. **Thomas Flynn, MD**

Healthcare in Baton Rouge is faring better than the rest of the country. I think we’re all faring fairly well in Baton Rouge. I think we all have some concerns. We’re all kind of looking at those factors and saying how could these affect us? I call it analyzing the way of scenarios and I think we’re all asking ourselves those questions. I think this time last year healthcare organizations may have been making decent profits; now they are just hitting budget. **Brian Barbeito**

I don’t think Baton Rouge has really felt the recession like the rest of the country. We might feel it when the rest of the country pulls out, we might catch the tail end. I think everyone is just being very mindful with their spending and how they do business. **Marlon Moore**

I think it’s fair to say that we are faring better. Certainly in areas of the Ohio valley and Michigan those areas that have had particularly dramatic cuts, certainly those hospitals are facing greater challenges than we are. I do believe the hospital industry is impacted based on what is happening locally and regionally. **Terrie Sterling**
It Pays to E-Prescribe

by: Karen Stassi

As of January 1st, 2009, Medicare providers who utilize electronic prescribing are eligible for incentive payments from the Centers for Medicare and Medicaid (CMS). The agency is hoping to promote the use of e-prescribing to further patient safety and quality of care. According to CMS, widespread adoption of electronic prescribing can eliminate medication errors that result from the misreading of handwritten prescriptions. It can also lower patients’ out-of-pocket costs as it facilitates communication between providers and pharmacies on the availability of lower cost generic alternatives. It also eliminates the possibility of theft or misuse of regular prescription pads, said Trey Williamson of Baton Rouge Orthopaedic Clinic, whose electronic medical record system includes an e-prescribing feature.

Under the CMS program, physicians who successfully implement and use e-prescribing in 2009 are eligible for incentive payments of 2.0 percent of their Medicare allowed charges. An additional 2.0 percent may be earned by reporting other quality measures under the Physician Quality Reporting Initiative. E-prescribing was formerly part of those quality measures but now rates its own incentive. Because Medicare hopes that all physicians will eventually implement e-prescribing, the incentive amounts will decrease over the next couple of years. The incentive payment will be 2.0 percent for 2009 and 2010, 1.0 percent for 2011 and 2012, and .5 percent for 2013. True to government form, the incentive will turn into a mandate...
in 2012, and provider payments will be reduced for failure to implement e-prescribing. Reductions are 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 and in subsequent years.

And not just any e-prescribing method will do. In order to receive the incentive payments, providers must use a qualified system. That means it must be able to:
- Communicate with the patient’s pharmacy
- Help the physician identify appropriate drugs and provide information on lower cost alternatives for the patients
- Provide information on formulary and tiered formulary medications
- Generate alerts about possible adverse events, such as improper dosing, drug-to-drug interactions, or allergy concerns.

If you have already switched to electronic health records, chances are e-prescribing is an included feature or an available module for that system. However, you don’t have to have EHR to e-prescribe. There are stand-alone systems. The key factor is that the prescription is generated and sent electronically and not just scanned in and faxed to the pharmacy. However, not all pharmacies have the capability to receive e-prescriptions and CMS recognizes this. If the system or network converts the electronic prescription into a fax because the pharmacy can’t receive electronic faxes, this counts as e-prescribing. If the e-prescribing system is only capable of sending a fax and not encrypted electronic data then the system isn’t a qualified e-prescribing system for the purposes of the CMS incentive and may require upgrading. It is unclear whether CMS will provide incentives to pharmacies to update their electronic capabilities, but according to the eHealth Initiative, almost all chain pharmacies have the ability to receive prescriptions electronically. Unfortunately about 77 percent of independent pharmacies have yet to upgrade or activate their e-prescribing capabilities.

Other potential benefits of the entire process going electronic are fewer call-backs and prescription checks between pharmacies and providers, which can be a huge time saver for all involved. Scott Flowers, Project Director for Louisiana Health Care Review (LHCR), said that when he worked for the Veteran’s Administration in Texas, they estimated that their staff spent 30 percent of their time fielding calls and questions from pharmacies. When e-prescribing was first introduced there, there was initial resistance. Once they became accustomed to the system everyone loved it. They also saw reductions in drug interactions and allergies. E-prescribing also offers a way for doctors to know if and when prescriptions are picked up or refilled by the patient, a boost for medication compliance tracking. Statistics show that almost 20 percent of prescriptions go unfilled. “Medication management is one of the biggest challenges for doctors,” said Flowers, “and e-pre-
E-Prescribing Can Boost Drug Cost Savings

In addition to incentives for doctors who use electronic prescribing, systems that offer drug formulary information may also produce prescription drug savings. According to a recent study funded by the Department of Health and Human Services' Agency for Healthcare Research and Quality, e-prescribing systems that allow doctors to select lower cost or generic medications can save $845,000 per 100,000 patients per year and possibly more system-wide. If all doctors used e-prescribing systems with formulary decision support prescription drug spending could be reduced by up to $3.9 million per 100,000 patients per year, according to the study's authors.

To encourage the use of lower cost or generic drugs, many insurers are now using lists of approved prescription drugs known as formularies. Under these arrangements, patients are often charged the lowest co-payment for generic medications (tier 1), a higher sum for preferred brand-name drugs (tier 2), and the highest amount for non preferred brand-name drugs (tier 3). However, a major challenge to doctors' widespread use of tiered systems is the lack of current data on insurers' prescription drug formularies at the time of prescribing. Providing doctors with current lists of approved medications is challenging because the information changes frequently.

To test the cost-savings potential of an e-prescribing system that includes data on insurers' formularies, researchers at Brigham and Women's Hospital and Massachusetts General Hospital in Boston compared the change in prescriptions written in three formulary tiers before and after an e-prescribing system was launched. The study examined data collected over 18 months from two major Massachusetts health insurers covering 1.5 million patients. Doctors using e-prescribing with formulary decision support, which accounted for more than 200,000 filled prescriptions in the study, increased their use of generic prescriptions by 3.3 percent, study authors found. These changes were above and beyond the increasing use of generics that was occurring among all doctors and the already high rate of generic drug use in Massachusetts.

Like everything with CMS, receipt of the incentive payment is dependent on proper coding. When submitting claims, the physician must select one of three codes:

- No medications were prescribed during the visit
- E-prescribing was used for any medications prescribed during the visit
- A medication was prescribed but e-prescribing was not used because it is currently not allowed by law for a controlled substance. (In 2008, the Drug Enforcement Agency proposed a rule allowing for electronic transmission of controlled substance scripts.)

To be eligible for the incentive in 2009, you must be an eligible professional whose estimated allowed Medicare Part B charges for the e-prescribing measure codes are at least 10% of your total Medicare Part B allowed charges. Also, in order to be a “successful e-prescriber”

Dr. Jay Brooks accesses Ochsner's EMR system.
the e-prescribing measure must be reported on at least 50 percent of the applicable cases.

While stand-alone e-prescribing systems are cheaper than implementing an electronic health record system, in most cases both are an added expense. According to the eHealth Initiative, stand-alone systems can cost anywhere from nothing to $2500 dollars. To ensure access for all, one of the largest initiatives for e-prescribing, the National ePrescribing Patient Safety Network (NEPSI), offers a free, online e-prescribing program to any physician wanting to test the waters before investing in an expensive EMR. Backed by several major sponsors and linked to thousands of pharmacies, the site offers a very secure, user-friendly system that requires no software downloads or IT expertise. You can watch a free tutorial at www.nationalerx.com/events.htm. “This can be a way to ease into exchanging information electronically,” said LHCR Director of Communications, Lisa Stansbury. “It can take time to fully convert to EMR, but online e-prescribing is a way to test the waters.” Full EMR systems run from about $5000 to $45,000 depending on the bells and whistles you choose, but usually have e-prescribing capabilities. Medicare hopes that the incentive will encourage implementation and perhaps offset some initial setup and operating costs, but you should be aware of any ongoing maintenance, hosting, or transaction costs associated with the system you choose. According to CMS, Federal, state, and private sources are also offering financial aid for physicians to implement electronic healthcare. CMS also indicated that in certain circumstances, providers may be able to accept donations toward e-initiatives without violating the Stark Law or the Anti-Kickback Statute.

SureScripts is the operator of the Pharmacy Health Information Exchange and is a good source of information on the capabilities of any e-prescribing system you are considering. E-prescribing systems link physicians, pharmacies, and health plans via the SureScripts-RxHub network, allowing for fast, secure access to patient information, formulary and benefit information, and dispatch to pharmacies. You can visit the SureScripts-RxHub site at www.surescripts.com/Certified to see what features your choice offers and whether it has been certified according to the NCPDP Script Standard. SureScripts is also a good source for information on national and state initiatives and the progress of e-prescribing. Because many providers have concerns about the security of electronic medical records and e-prescribing, particularly as they relate to HIPPA, the Certification Commission for Health Information Technology (CCHIT) has also certified many EMR programs and is in the process of certifying e-prescribing programs so you can choose with confidence.

Dr. Jay Brooks, Chairman of Oncology/Hematology at Ochsner-Baton Rouge said that e-prescribing is a natural progression from Ochsner’s long-time use of electronic medical records. Currently Ochsner creates prescriptions electronically then prints them for the patient or faxes them to the pharmacy, but Brooks said Ochsner should have true e-prescribing implemented within the next six months. Not only does Dr. Brooks think the system will be time-saving, but it will also guarantee that every prescription written becomes part of the medical record. “The EMR is only as good as the people using it—you have to record what you are doing,” said Brooks, pointing out that using EMRs, but writing prescriptions on pads means that sometimes the prescription isn’t recorded. A fully electronic system will eliminate that problem and will also save doctors time. Brooks also likes the fact that the health insurance formulary and preferred drugs are more easily available, making the choice of lower cost prescriptions simple. “This will be a big deal for those patients on Medicare with the donut hole in their prescription plan,” said Brooks.

Incentives or not, the e-prescribing trend is catching on. Here in Louisiana, the statewide numbers of e-prescribers was 32 in 2005 and increased to 458 in 2007.

As the CIO for Medicare in Louisiana, the Louisiana Health Care Review is helping to promote e-prescribing. “As we are doing the other pieces of our work in the state, with a focus on core prevention and disparities, we are working with primary care doctors that have implemented EMR,” said Scott Flowers. “We are seeing that many don’t use all of the modules, so we are encouraging them to use the full functionality of their systems, like e-prescribing.” Flowers said that once providers start using it and realizing the benefits to the patients and the practice, it is an easy sell. Plus there are a lot of great resources out there to help providers, pointed out Lisa Stansbury. In addition to “Medicare’s Practical Guide to the e-Prescribing Initiative,” which LHCR offers on its website, Stansbury indicated that the “Clinicians Guide to Electronic Prescribing” offered by the eHealth Initiative provides all the “down and dirty” details providers need to know to get started. Both downloads are free.

Incentives or not, the e-prescribing trend is catching on. Here in Louisiana, the statewide numbers of e-prescribers was 32 in 2005 and increased to 458 in 2007. E-prescribers as a percent of total prescribers in the state was N/A in 2005, 3% in 2006, and 6% in 2007, about the same as the national average. (Data source: SureScripts) Still, it is estimated that nationwide in 2007, of the 1.47 billion prescriptions and refills eligible for e-prescribing only 2 percent were prescribed electronically. “Paying providers to e-prescribe will get some on board,” said Dr. Brooks, “but patients are going to start demanding this, so much so that it becomes the standard. Practices that don’t go electronic will start to lose business.”

Test Your Knowledge

The State Department of Environmental Quality recently announced that for the first time all of Louisiana meets federal ozone standards for both the original one-hour and the 1997 eight-hour standards. In the 1970s, the U.S. Environmental Protection Agency set a one-hour ozone standard at 120 parts per billion. This was replaced in 1997 with a rolling eight-hour average of 85 parts per billion. In 2008, that rolling eight-hour average was lowered to 75 parts per billion. Attainment designations for the new standard are scheduled for March 2010, but may be delayed pending several lawsuits. Historically, the only area in Louisiana area that has remained out of attainment for the ozone standard was the five-parish Baton Rouge area of Iberville, West Baton Rouge, Ascension, Livingston and East Baton Rouge parishes.

Ozone can be harmful to the health of Louisiana’s citizens, especially the elderly, children, those who have asthma, and those who work outdoors. DEQ credits the attainment of these standards to implementation of rules and regulations, improvement in industry practices, and greater public awareness. So how much do you know about ozone and what you can do to prevent it? Take the Louisiana Department of Environmental Quality Ozone Quiz.

1) Stratospheric ozone, the ozone layer in the upper atmosphere,
   a. needs to be reduced
   b. protects us from the harmful rays of sunlight
   c. causes skin cancer

2) Ground-level ozone pollution is
   a. also called tropospheric ozone
   b. harmful to people with asthma
   c. harmful to athletes
   d. harmful to animals and plants
   e. all of the above

3) High ozone pollution levels are most likely to occur during
   a. cold, rainy days
   b. cool, windy nights
   c. hot, sunny days

4) Tropospheric ozone is
   a. a gaseous emission from industry smokestacks and vehicle tailpipes
   b. one of the main constituents of smog
   c. formed on hot, sunny days when nitrogen oxides (NOx) and volatile organic compounds (VOCs) undergo a photochemical reaction
   d. b. and c.
   e. all of the above
Ozone IQ

5) Which of the following would reduce ozone pollution?
a. Carpool or use public transportation
b. Limit your speed to 55 m.p.h. on highways
c. Have your car tuned and inspected regularly
d. Use water-based paints and solvents, instead of volatile paints and solvents
e. All of the above

6) Cars
a. emit H2O which causes ozone depletion
b. emit CO2 which reacts with chlorofluorocarbons in the presence of sunlight to produce ozone
c. emit NOx and VOCs, which react in the presence of sunlight to produce ozone pollution

7) Which of the following is true?
a. Cars are solely responsible for ozone pollution
b. Only chemical industries are responsible for smog
c. Emissions from cars and industries contribute to ozone pollution

8) In order to protect yourself when ozone pollution levels are high, you should
a. minimize your outdoor activities
b. stay indoors if you have respiratory problems
c. jog in the afternoons
da. a. and b.

e. All of the above

9) Louisiana
a. exceeds the Environmental Protection Agency's clean air standards for ozone and lead
b. exceeds EPA's clean air standards for ozone only
c. is in attainment for all of EPA's clean air standards

10) We are concerned that ozone levels
a. are too high at ground level
b. are too high in the stratosphere
c. are too low in the stratosphere
d. a. and c.

11) During ozone season, people can help reduce ozone by
a. mowing the lawn after 6 p.m.
b. carpooling or by reducing use of cars/vehicles on days when high ozone levels are predicted
c. limiting the use of oil-based paints and volatile solvents
d. all of the above

12) Due to joint efforts by industrial groups, DEQ, and the public, the average number of "bad-ozone" days in the 1990's is
a. less than in the 1980's and 1990's
b. more than in the 1980's and 1990's
c. about the same as in the 1980's and 1990's

See how you did on page 78.
HEALTHCARE BRIEFS:
State & Local
National and State Health Policy Experts Laud Governor’s Proposed Healthcare Overhaul

Louisiana has been ranked by several studies as having the lowest-performing healthcare system in the nation, including having the highest number of avoidable hospitalizations, over-utilized emergency departments, and along with the highest rates of death in the nation, among the highest costs. Several Louisiana-based and national healthcare experts are supporting Louisiana Health First, a broad effort to overhaul the state’s healthcare system for the poor and uninsured.

As directed by the Louisiana Legislature, the Jindal Administration has submitted a broad waiver to address transforming the healthcare delivery system, while also attempting to confront several major financial issues unresolved by the state in past years – including $771 million in potential liabilities to the federal government and a looming cap on the state’s Disproportionate Share Hospital program. Louisiana Health First’s proposal to move toward a coordinated system of care has received the support of many organizations, including, among others: Blueprint Louisiana, the Council for a Better Louisiana, Louisiana Academy of Family Physicians, Louisiana Primary Care Association (a broad coalition of health centers for the poor), and Tulane University.

Leonard J. Chabert Medical Center Earns NCQA Medical Home Designation

Leonard J. Chabert Medical Center (LJCMC), in Houma has become the second medical center in the nation to receive recognition status as a Physician Practice Connections—Patient Centered Medical Home (PPC-PCMH) by the National Committee for Quality Assurance (NCQA), heralding a superior quality of healthcare at LJCMC. The LJCMC family practice, ambulatory care, and pediatrics outpatient clinics have met the rigorous NCQA requirements for LJCMC to receive this recognition. These points of care provide ongoing preventative and early intervention healthcare to patients and coordinate specialized care with LJCMC when patients require it.

The NCQA standards for receiving this designation are aligned with the joint principles of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), which define the key characteristics of the patient-centered medical home. NCQA worked closely with the four medical specialty organizations and other interested stakeholders to develop the PPC-PCMH, and the specialty societies have supported the standards as the tools to use to recognize practices as medical homes in demonstration projects around the country.

The medical home strengthens the patient-physician relationship by replacing episodic care with coordinated care and a long-term healing relationship. The AAFP, AAP, ACP, and AOA have defined the medical home as a model of care in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s healthcare needs and, when needed, coordinating care across the healthcare system. A medical home also emphasizes enhanced care through open scheduling, expanded hours, and communication between patients, physicians, and staff.

PPC-PCMH includes nine standards for medical practices to meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions, and performance reporting and improvement. To be recognized as a patient-centered medical home, practices need to demonstrate the ability to sufficiently meet the criteria of these standards (i.e., achieve a minimum of 25 points out of 100 to attain the first of three levels of recognition) and specifically pass at least five of the following 10 elements:

- Written standards for patient access and patient communication
- Use of data to show standards for patient access and communication are met
- Use of paper or electronic charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three chronic conditions
- Active patient self-management support
- Systematic tracking of test results and identification of abnormal results
- Referral tracking, using a paper or electronic system
- Clinical and/or service performance measurement, by physician or across the practice
- Performance reporting, by physician or across the practice

LA Gets Perfect Score in Public Health Emergency Preparedness

A national health organization says Louisiana is better prepared now more than ever for a hurricane, bioterrorism, or any other health emergency. In its sixth annual report, Trust for America’s Health gave Louisiana a perfect score of 10 out of 10 for health emergency preparedness. This is a significant improvement over the past two years: Louisiana received an eight out of 10 last year and a six out of 10 in 2006 for emergency readiness.

The 10 key preparedness indicators:

1. Mass Distribution – Strategic National Stockpile: Did the state test its...
plan to distribute emergency vaccines, antidotes, pharmaceuticals, and medical supplies from the Strategic National Stockpile, and receive a passing grade from the Centers for Disease Control and Prevention?

2. Mass Distribution—Antiviral Stockpiling: Did the state purchase 50 percent or more of its federally subsidized antiviral drugs to stockpile for use during an influenza pandemic?

3. Public Health Laboratories—Lab Pickup and Delivery: Does the state public health lab currently have an intrastate courier system (non-mail) that operates 24 hours per day for specimen pickup?

4. Public Health Laboratories—Pandemic Influenza Planning: Does the state public health laboratory meet the expectations of the state's pandemic influenza plan?

5. Biosurveillance: Does the state use a disease surveillance system that is compatible with federal Centers for Disease Control and Prevention's national system, including integrating data from multiple sources, using electronic lab results (ELR) reporting, and using an Internet Browser?

6. Health Care Volunteer Emergency Liability Protection: Does the state have laws that reduce or limit the liability for businesses and nonprofit organizations that serve in a public health emergency?

7. Entity Emergency Liability Protection: Does the state have laws that reduce or limit the liability for businesses and nonprofit organizations that serve in a public health emergency?

8. Medical Reserve Corps Readiness: Does the state have a Medical Reserve Corps (MRC) Coordinator?

9. Food Safety—Detection and Diagnosis: Did the state identify the pathogen responsible for reported food borne disease outbreaks at a rate that met or exceeded the national average of 44 percent (combined data 2004-2006)?

10. Funding Commitment: Did the state maintain or increase funding for public health programs during 2006 and 2007?

Five of the standards are new in the past year's evaluation, including: Public Health Laboratories—Lab Pickup and Delivery, Public Health Laboratories—Pandemic Influenza Planning, Entity Emergency Liability Protection, Medical Reserve Corps Readiness, and Food Safety—Detection and Diagnosis. Louisiana's health emergency efforts were recognized in 10 areas. Trust for America's Health and the Robert Wood Johnson Foundation worked together in evaluating the states and producing the report. Trust for America's Health is a government watchdog group, and the Robert Wood Johnson Foundation is devoted exclusively to improving the health and healthcare of all Americans. To view the full report, visit http://healthyamericans.org/reports/bioterror08/.

**LA Report Card Underlines Need for Healthcare Reform**

A national medical specialty organization says Louisiana's healthcare system is well prepared for disasters, but in poor shape for its public preventive health care, access to emergency care, and health quality. The American College of Emergency Physicians’ (ACEP) National Report Card on the State of Emergency Medicine confirms other recent reports that give high marks "for nearly every disaster planning, training, and communication systems indicator," but also show that Louisiana's emergency rooms are overcrowded, that quality delivered in ERs here lags that of the national average, and that performance results are poor for patients who need truly critical emergency care.

**Louisiana Department of Health and Hospitals (DHH) Secretary Alan Levine** said the report shows how far the state has come in one sense, and how far it still has to go in another. In its evaluation of Louisiana's emergency care environment, ACEP noted that “Louisiana's low grade in public health and injury prevention points to a critical need for greater investment in and application of targeted, effective strategies to address preventable health risks, injuries, and mortality. Louisiana also needs to improve access to emergency care in the state by addressing current shortages of primary care and mental health providers.” Levine said Louisiana Health First would expand access to affordable healthcare coverage statewide, provide truly integrated “medical homes” for patients eligible for Medicaid, engage consumers in healthier behaviors and medical choices, and report quality, satisfaction and efficiency data to the public.

The National Report Card on the State of Emergency Medicine was made possible in part by funding from the Emergency Medicine Foundation, part of ACEP, with the support of the Wellpoint Foundation and Robert Wood Johnson Foundation. ACEP is the oldest and largest national medical specialty organization representing physicians who practice emergency medicine. To view the full report card, visit http://www.emreportcard.org/Louisiana.aspx

**Louisiana Attains Air Quality Standards**

For the first time in Louisiana's history, the state meets all federal ozone standards for the original one-hour standard and the eight-hour ozone standard, which is in effect until 2010. To mark this occasion, the Department of Environmental Quality and others responsible for achieving this milestone held a celebration at the DEQ headquarters in Baton Rouge. The occasion marks the success of a collaborative effort that included DEQ, EPA, local industries, local governments, environmental groups, citizens, and community leaders in bringing the five-parish Baton Rouge area into attainment. This achievement is an example of how the air quality has improved in the Baton Rouge area and throughout the state since the ozone standards were put into place. Twenty parishes were out of attainment in 1978.

**Second Consecutive Dividend Declared To All Policyholders**

For the second consecutive year, the Board of Directors of the Louisiana Medical Mutual Insurance Company approved a dividend for all LAMMICO policyholders in Louisiana and Arkansas. The announcement affects close to 6,000 policyholders, who will receive a 20 percent dividend of a policyholder’s written premium as of November 21, 2008. All policyholders will receive divi-
dend checks starting the first quarter of 2009. The total dividend declared is approximately $10.3-million. In April 2008, LAMMICO declared its first ever dividend, totaling $10.3-million.

While LAMMICO has always supported initiatives to improve Louisiana’s healthcare environment, the company intensified its involvement beginning in 2003. At that time, Louisiana healthcare providers saw premiums peak following five consecutive years of no increases in rates from 1998-2002. LAMMICO began working behind the scenes to decrease the frequency rate of lawsuits against physicians and to arm its policyholders with more proactive “risk management” tools to reduce the incidence of loss. Efforts by LAMMICO’s Board of Directors in the state legislature played an important role in reducing claim frequency by a total of 11 percentage points from 2003 to 2007.

As a direct result, LAMMICO policyholders have experienced over four consecutive years of 0 percent base rate increases. Effective with January 1, 2009 renewals, all physician policyholders will be given an overall base rate decrease averaging 2.8 percent, depending upon specialty. LAMMICO has also been able to offer separate premium rate decreases in certain sections of Louisiana (parishes of East Baton Rouge, Bossier, and Caddo). In Arkansas, there has been no rate change since the company originally filed to provide professional liability coverage in the Natural State in January 2007.

Levine Outlines Healthcare Priorities for Louisiana Delegation

As Congress and President-elect Obama prepared to embark on their new terms, DHH Secretary Alan Levine wrote to Louisiana’s delegation outlining the state’s healthcare priorities for 2009 and requesting their support. Among the issues he brought to their attention were:

• FMAP—the federal formula for calculating the federal participation for Medicaid. Louisiana is slated to experience a decrease in FMAP, which will cost the state an additional $200 million in state general funds in the next fiscal year. DHH seeks continued FMAP relief.
• SCHIP renewal—DHH supports the reauthorization of SCHIP at current levels.
• Funding for Federally Qualified Health Centers—DHH requests that applicants receiving high scores, but not funded in the last round, be given priority status and that consideration be given to new access states in Louisiana and other states with high poverty and uninsurance levels.
• Health Information Technology—DHH wants to ensure that funding for HIT initiatives allows for money to be spent on technical assistance, business practice design, and to backfill revenue lost by physicians as they transfer over to EHR. DHH also wants to ensure that software and hardware for HIT be held to certain standards and the state-wide initiatives receive support.
• Louisiana Health First Waiver—DHH seeks support of its waiver request to revamp Medicaid in our state.
• Settlement of Louisiana Disallowances—DHH is asking for support in encouraging the federal government to allow Louisiana to instead reinvest these funds into healthcare reform.
• Training Primary Care Providers—DHH would like to see increased scholarships and support for residency programs for primary care physicians in underserved areas.
• Medicaid Certification of New Healthcare Facilities—DHH would like CMS to remove barriers to certifying new facilities.
• Reversal of Rule Limiting Use of DSH Funds—DHH seeks the reversal of a rule by CMS prohibiting the use of DSH funds for Rural Health Clinics and/or alternative funding sources for these much needed clinics.
• Additional Wage Relief for Hurricane Affected Hospitals—DHH supports efforts by hurricane affected hospitals to gain a Medicare Wage Index adjustment.
• Medicare Physicians Reimbursement disparities—DHH seeks to correct the disparities in Medicare reimbursement between physicians in Greater New Orleans and the North Shore area. DHH said because of the unfair reimbursements, the North Shore is facing out-migration of physicians and Medicare’s proposed budget neutral solution would require lowering state-wide Medicare reimbursement to all non-Greater New Orleans physicians.

LSU Cardiologists Join Lallie Kemp Regional Medical Center

Lallie Kemp Regional Medical Center (LKRMC) announced that three LSU cardiologists have joined the LKRMC staff. Drs. Frederick Helmcke, Neeraj Jaim, and Vijayendra Jaligam have extensive clinical, teaching, and research experience at LSU and adhere to the same disease management outcome goals as LKRMC since LKRMC is part of the LSU Health System. At LKRMC they will provide to adult patients 18 years of age and older general cardiology services, such as the management of coronary artery diseases, heart failure, and arrhythmias, and will perform echocardiograms, stress and nuclear medicine tests, holter monitors, and more. They will also evaluate patients who may need cardiac surgery, pacemakers, or electrophysiologic studies.

LKRMC patients will continue to receive high quality cardiology services. The doctors will follow the same all-day schedule of Tuesdays and Thursdays of the previous cardiologists, who are curtailing services to LKRMC because of a staffing shortage although LKRMC will continue a working relationship with them. The three doctors are on the faculty of the LSU Health Sciences Center in New Orleans Department of Medicine, Section of Cardiology. Dr. Helmcke is the director of echocardiography and an assistant professor, Dr. Jaim is director of cardiology fellowship and an assistant professor of medicine, and Dr. Jaligam is an instructor of clinical medicine.

DHH Submits Federal Waiver for Louisiana Health First

After receiving near unanimous approval from the Joint Legislative Budget Committee and the Joint Committee on Health and Welfare,
Louisiana Department of Health and Hospitals Secretary Alan Levine submitted the Louisiana Health First federal 1115 Research & Demonstration Waiver application to the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services. The federal waiver process is designed to allow individual states to implement improvements to their health-care systems that depend on federal funding, such as Medicaid. This waiver is the first step in Louisiana’s effort to transform the state’s Medicaid program into a higher quality, more efficient and more sustainable system. The waiver must be reviewed and approved by CMS and then brought for approval in its final form to the Joint Health & Welfare and Joint Legislative Committee on the Budget.

HHS officials are charged with working with any state or local government or entity that may be in violation of existing statutes and the regulation to encourage voluntary steps to bring that government or entity into compliance with the law. If, despite the Department’s efforts, compliance is not achieved, HHS officials will consider all legal options, including termination of funding and the return of funds paid out in violation of the nondiscrimination provisions.

The regulation went into effect in January, but HHS components have been given discretion to phase in the written certification requirement by October 1, 2009, the beginning of the 2010 federal fiscal year.

Lallie Kemp HIV/AIDS Doctor Named to 2008 Who’s Who in Infection Prevention Infection Control
A healthcare journal for infectious disease professionals has named Dr. Walter Campbell, Jr., to Who's Who in Infection Prevention for 2008. Dr. Campbell is one of only eighteen practitioners selected for this award from nationwide nominations submitted by their infection control peers. Dr. Campbell directs the Lallie Kemp Regional Medical Center (LKRMC) Infection Control program, where he primarily treats patients with HIV/AIDS and hepatitis C. Dr. Campbell has been instrumental in the implementation at LKRMC of the new OraQuick rapid HIV testing protocol that is now being offered to all LKRMC emergency-room patients. This test, administered by swabbing the inside of the patient’s mouth, yields results in as little as 20 to 30 minutes. Getting the results quicker means patients know their status almost immediately and can begin treatment sooner, which will help to slow the spread of this disease.

Although Dr. Campbell’s patient load averages approximately 200 HIV/AIDS patients and 80 hepatitis C patients monthly, he still manages to take time to explain to patients the diseases, the impact of the diseases on the patients, and to educate the patients on disease management. Dr. Campbell holds a Bachelor of Science degree in Biology from Florida A&M University and a Medical Doctorate degree from the University of Florida – College of Medicine. He completed both his Internal Medicine Residency and his Infectious Diseases Fellowship at Tulane University – School of Medicine in New Orleans. A member of the Southern Medical Association, he is certified by the American Board of Internal Medicine.

Blue Cross Announces Management Appointments
Blue Cross and Blue Shield of Louisiana has named Dr. Thomas Kim as medical director of medical policy in its Medical Management Department. In

Dr. Walter Campbell, Jr.

Dr. Thomas Kim
Dr. Thomas Kim previously served as vice president and chief medical officer for Family HealthCare Network in Visalia, Calif., where he provided medical leadership and oversight for five medical directors and more than 90 providers who delivered primary care and outpatient services to the underserved population. Kim received his medical degree from Drexel University’s Hahnemann Medical College in Philadelphia. In addition, he has earned a master’s degree in business administration from Northwestern University in Evanston, Ill., and a master’s degree in public health from the University of Illinois’ School of Public Health in Chicago. Kim is certified with the National Board of Medical Examiners and the American Board of Internal Medicine. Camille Guillot previously served as tax manager for Lamar Advertising Company. In her new role, Guillot will manage and direct the tax research and planning activities of finance personnel and consultants and other tax-related issues as needed. Guillot received her bachelor’s degree in accounting from Louisiana State University in 1995 and obtained her certified public accountant (CPA) license in 1997. She is a member of the Society of Louisiana Certified Public Accountants and the American Institute of Certified Public Accountants.

Jennifer Pinkins began her career with Blue Cross in 1985 and has more than 23 years of experience in the health insurance industry. She previously served as business analyst and product implementation specialist for Humana. In her new role, Pinkins will direct and coordinate operational activities to keep policies and procedures current, meet reporting needs, identify potential enhancements, and guarantee overall customer satisfaction. Pinkins is a graduate of the University of Phoenix, where she received a bachelor’s degree in business management. In addition, she has been designated a Managed Healthcare Professional by the America’s Health Insurance Plans (AHIP) professional development program.

In addition, the company appointed Camille Guillot, CPA, as tax manager in its Finance Department and Jennifer Pinkins as manager of its Group and Individual Membership Maintenance and Billing departments.

DHH Acts to Protect the Rights of Vulnerable Consumers at Public DHH Facilities

The Louisiana Department of Health and Hospitals will address what may be a systemic failure of reporting of potential abuse at the Pinecrest Supports and Services Center in Alexandria. These actions result from an investigation commenced upon the arrest of five employees of Pinecrest for alleged abuse of residents. The five employees, including two shift supervisors and one home supervisor, were arrested after an internal investigation conducted in partnership with the District Attorney. After the arrest, there were claims by employees of fear of retaliation for reporting abuse. Upon learning of these comments, Secretary Alan Levine asked the State Inspector General to conduct an independent review of the policies, procedures, and environment of care of the facility in October 2008. Immediate actions also ordered by the Secretary include:

1. All existing and new staff at the Pinecrest facility will receive new training provided by the Louisiana Attorney General, on reporting suspected abuse or unexplained patient injuries.
2. All existing and new staff will receive training annually.
3. DHH will appoint an ethics and compliance officer to establish a statewide compliance program for DHH facilities – to include the ability to provide employees a confidential avenue for reporting of alleged violations of policies or procedures that may impact the operating integrity of a facility.
4. DHH is implementing more frequent monitoring and reporting, including routine visits and observations by administrative and executive-level staff after hours and on weekends to provide additional oversight.
5. DHH will strictly enforce mandatory reporting when suspected abuse or neglect takes place. The policy will be amended to reflect that employees may be terminated immediately for failure to report suspected abuse. Any applicable state laws related to reporting of abuse will continue to be enforced.

In addition to these steps, DHH continues to aggressively investigate all allegations of abuse reported through the DHH abuse hotline. All allegations are taken seriously, and are investigated immediately upon receipt. DHH maintains a zero-tolerance policy toward abuse and has a standing policy of suspending any employee suspected of abuse while an investigation is pending. All investigations are reported to local law enforcement and the Attorney General’s office immediately upon receipt of an allegation by the Department.

LSU Trauma Center Receives Level 1 Verification

The trauma center at the Interim LSU Public Hospital has been verified as a Level 1 trauma center by the Committee on Trauma (COT) of the American College of Surgeons (ACS). This verification recognizes the trauma center’s dedication to providing optimal care for injured patients with...
full trauma-center staff, facilities, and services available twenty-four hours a day. Trauma-center staff includes physicians from LSU and Tulane University. The return to New Orleans of Level 1 trauma care, the highest level attainable, gives LSU the only two Level 1 trauma centers in Louisiana. The other is at the LSU Health Sciences Center – Shreveport.

Before Hurricane Katrina, the LSU Level 1 trauma center in New Orleans was one of the best and busiest in the nation. Shortly after the storm, the trauma center and emergency department relocated to Elmwood Medical Center until February 2007 when they resumed services in a newly renovated, state-of-the-art area on the first floor of the Interim LSU Public Hospital, bringing immediate accessibility of physicians, technicians, and services under the same roof.

The ACS COT requires an accumulation of data prior to verification, which LSU immediately began gathering after the February 2007 move to the hospital. For Level 1 verification, a trauma center must also meet numerous and rigorous criteria including an annual minimum of 1200 trauma patients and available 24 hours a day the following: a trauma surgeon in the emergency department on patient arrival; a multidisciplinary infrastructure to support trauma services with participation from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia; prompt and continuous neurotrauma care for severe and traumatic brain injury and spinal cord injury; musculoskeletal trauma care; operating rooms for emergency procedures; plastic surgery and hand surgery; anesthesiology services for emergency operations; operating room immediately available with complete operating team dedicated to it and in the hospital at all times; an adequate staff for a second operating room when the first is occupied; prompt radiology services; the availability of cardiac, thoracic, microvascular, OB/GYN, ophthalmology, ENT, and urology surgeons; blood bank, respiratory and laboratory services; continuous rotation in trauma surgery for senior surgical residents; and many more criteria.

DHH Responds Firmly to PAR Brief
Claiming the report contains significant factual errors and omissions the Department of Health and Hospitals responded firmly to the Public Affairs Research Council’s brief criticizing DHH’s Medicaid reform plan, Louisiana Health First. According to DHH, PAR incorrectly states that DHH’s proposal to expand insurance coverage to as many as 106,000 of our citizens will be paid for from one-time revenues. PAR also does not mention that in the next 18 months, Louisiana will exceed its limit on federal spending for the uninsured.

DHH also took issue with PAR's support of the current fee-for-service model of Medicaid; its failure to cite data or studies that support its conclusions about the implementation of coordinated care networks; and its support of the Medicaid Community Care Program under which Louisiana ranks at the bottom nationally in basic measures of Medicaid performance, such as the percentage of women who receive breast cancer screenings or percentage of children who receive well child screenings, continues to suffer a specialist shortage, and has the highest rate of avoidable hospitalizations in the United States.

PAR also failed to mention the widespread adoption of and satisfaction with Medicaid managed care in other states, said DHH, and pushes for adoption of the North Carolina model without adequate support. DHH insisted it does not reject the North Carolina approach, but that it is not a perfect fit for our state. By their own admission, North Carolina's approach has taken 10 years to implement, does not address specialty physicians' shortages, does not incorporate hospitalization, and has not helped to implement electronic medical records. DHH said that PAR's conclusion that Louisiana does not have the experience to implement managed care has a chilling effect on reform, calling it "a sad vision of the ability of our state to make change, and demeaning to those so tirelessly working towards it."

OMH Accepting RFPs for Electronic Behavioral Health Record Implementation
The Louisiana Office of Mental Health (OMH) is seeking to contract with an expert consultant to provide the necessary technical assistance for successful procurement and implementation of an electronic behavioral health record (EHR) system in service delivery settings statewide.

The state of Louisiana is in the process of transforming from now separate, non-integrated, centrally managed regional mental health, addictive disorders, and developmental disabilities service programs to locally-operated and integrated human service districts statewide over the next three years. Implementation of a uniform and viable EHR system to meet the needs of these local governing entities (LGEs) is critical to the success of their future operations and the states’ reporting requirements.

OMH is seeking a technical consultant to assist with identification of an integrated electronic behavioral health record (EHR) system that will serve the clinical record, information management, and performance reporting needs of the emerging LGEs and the state. The desired system would be modular and include the essential EHR components, including e-prescribing. The desired system will support contemporary behavioral health standards of care (mainly JCAHO and CARF) and provide data for state performance monitoring and federal reporting (e.g. NOMS-National Outcome Measures, federal URS-Uniform Reporting System and TEDS-Treatment Episode Data Set), as well as provide daily clinical decision support for service providers at the point-of-care. The ideal EHR system will not only address the needs for community-based behavioral health services, but also be capable of operating enterprise-wide, enabling continuity-of-care with the five state psychiatric hospitals and acute inpatient care settings, and possibly affiliated programs. The ideal system will also be upwardly scalable to later include integrated physical healthcare operations which are developing in some areas.

BCBSLA Receives 12th Consecutive “A” Rating from Standard & Poor’s National rating service Standard & Poor’s has given Blue Cross and Blue
Shield of Louisiana its 12th consecutive “A” rating for financial strength, citing the company’s strong competitive position in the state’s health insurance market, very strong capitalization, very strong liquidity supported by high-quality investments, and return on revenue that is consistent with what it expects from an “A” rated not-for-profit company. Standard & Poor’s is the world’s foremost provider of benchmarks for measuring corporate financial health. The Standard & Poor’s report noted the following highlights:

- **Strong competitive position:** “The company is the largest health insurer in Louisiana based on membership (1.14 million members), with an estimated market share of at least 50% of the privately insured market.”
- **Very strong capitalization:** “Historical surplus growth has been strong.”
- **Very strong liquidity:** “BCBSLA’s very strong liquidity is supported by the makeup of its investment portfolio and the short-tailed nature of its health insurance liabilities.”
- **Return on revenue:** “Operating performance is strong. The company generally targets lower return on revenue than its for-profit competitors.”

Ochsner Uptown New Orleans Campus Opens New ER, Expanded ICU, and All-Private Hospital Wing

DHH Secretary Alan Levine and New Orleans City Councilwoman Stacy Head recently joined Ochsner Baptist Medical Center and the community to celebrate the opening of its full-service Emergency Room and a 43 all-private room hospital wing at 2700 Napoleon Avenue in Uptown New Orleans. This additional $12 million investment includes expanding the Ochsner Baptist ICU from three to 12 beds and is in addition to the more than $20 million to re-open 22 medical/surgical beds, two endoscopy suites, and the Imaging Center in 2006 and 2007.
New Emergency Evacuation Model Available

A model to help federal, state, and local emergency planners estimate the vehicles, drivers, road capacity and other resources they will need to evacuate patients and others from healthcare facilities in disaster areas has been released by the Agency for Healthcare Research and Quality. The Web-based Mass Evacuation Transportation Planning Model is designed to be used prior to an emergency to help answer such questions as:

• How long will it take to move patients from one facility to another?
• How many transport vehicles, such as ambulances, wheelchair vans, and buses, are required to complete the evacuation within a certain time period?
• How might the location and other attributes of the evacuating and receiving facilities affect evacuation plans?

Emergency planners can enter into the model any number of evacuating and receiving facilities and specific conditions that could affect transportation plans. The model will estimate the resources and hours needed to move patients from evacuating facilities to receiving facilities, based on assumptions that the planner specifies. The model was pilot tested in New York City and Los Angeles and is available for use at http://massevacmodel.ahrq.gov/.

LOCAL

Local Healthcare Quality Improvement Effort to Begin

A community-wide movement to improve healthcare quality by reducing the number of re-hospitalizations of Medicare patients has begun. The effort, the Care Transitions Community Collaborative, is being led by Louisiana Health Care Review and includes five local hospitals and other community partners including home health agencies, who are working together to reduce the number of people who need to be re-admitted to a hospital within 30 days following their discharge. Collaborative members include:

• Baton Rouge General Medical Center
• Lane Regional Medical Center
• Ochsner Medical Center-Baton Rouge
• Our Lady of the Lake Regional Medical Center
• St. Elizabeth Hospital in Gonzales.

This effort follows the recent publication of state-by-state healthcare rankings that place Louisiana last. One critical factor in this low ranking was the rate of preventable hospitalizations per 1,000 Medicare enrollees. The annual study was conducted by United Health Foundation. Reducing the rate of preventable re-hospitalizations is also a subject of national healthcare quality concern. Within 30 days of discharge, 17.6 percent of Medicare beneficiaries nationally are re-hospitalized. The Medicare Payment Advisory Committee estimates that up to 76 percent of those readmissions may be preventable, representing a potential savings to Medicare of over $12 billion in one year. With the right incentives in place, the national Medicare program could save more than $100 billion over the next decade if the 30-day re-hospitalization rate is decreased to the national average. The Care Transitions Community Collaborative in Louisiana is a three-year effort to be conducted in partnership with major care providers and stakeholder groups.

Baton Rouge Physician Named To Board of Directors

A long-time Baton Rouge cardiologist is the newest Board member at the Louisiana Mutual Medical Insurance Company. N. Joseph Deumite, MD of Louisiana Cardiology Associates was appointed to the LAMMICO Board of Directors at the October 15th, 2008 Board of Director’s meeting. Dr. Deumite will continue to serve LAMMICO as a member of the Claims Committee.

Dr. Deumite is board certified in both Cardiology and Internal Medicine and a Fellow of the American College of Cardiology. He is a clinical instructor at the Earl K. Long Hospital and also serves as an associate professor at the same facility for the Louisiana State University (LSU) Medical School. A graduate of the LSU School of Medicine in New Orleans, Dr. Deumite has been in private practice at Louisiana Cardiology Associates in Baton Rouge for over 20 years.

Alzheimers Services Announces New 2009 Board Members and Officers

Dr. Jeffery Keller, Professor and Executive Director for Basic Research at Pennington Biomedical Research Center, is the latest member to join the Alzheimer’s Services Board. Dr. Keller recently established the Institute for Dementia Research and Prevention at Pennington, and is currently researching aging and age-related dementia. Other new 2009 Board Officers include William S. Slaughter, PhD, President; Wilfred Barry, President-Elect; Crissie Head, Treasurer; and Kelsey Funes, Secretary. William (Bill) Slaughter is the founder and president of SSA Consultants, a nationally recognized organizational development and management consulting firm. He has personal experience with Alzheimer’s disease (AD) as his mother was diagnosed with the disease.

The NeuroMedical Center Clinic Receives Accreditation for Echocardiography Laboratory

The NeuroMedical Center located in Baton Rouge was recently granted accreditation by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL). The laboratory is one of the first one thousand echocardiography laboratories in the United States, Canada, and Puerto Rico to be so recognized for its commitment to high quality patient care.

The NeuroMedical Center recently established the Alzheimer’s Services Board.

The NeuroMedical Center is the newest Board member at the Louisiana Mutual Medical Insurance Company.
and its provision of quality diagnostic testing. The ICAEL was established with the support of the American Society of Echocardiography (ASE), the American College of Cardiology (ACC) and the Society of Pediatric Echocardiography (SOPE) to provide a peer review mechanism to encourage and recognize the provision of quality echocardiographic diagnostic evaluations by a process of voluntary accreditation. A non-profit organization, the ICAEL is dedicated to ensuring high quality patient care and to promoting healthcare. Accreditation status signifies that the facility has been reviewed by an independent agency which recognizes the laboratory’s commitment to quality testing for the diagnosis of heart disease.

The NeuroMedical Center Surgical Hospital Receives Program Accreditation

The NeuroMedical Center Surgical Hospital in Baton Rouge recently received program accreditation from the American Academy of Sleep Medicine (AASM). To receive a five-year accreditation, a sleep center must meet or exceed all standards for professional healthcare as designated by the AASM. The accreditation process involves detailed inspection of a center’s facility and staff, including an evaluation of testing procedures, patient contacts, and physician training. Additionally, the facility’s goals must be clearly stated and include plans for positively affecting the quality of medical care in the community it serves. The American Academy of Sleep Medicine currently accredits more than 1,600 sleep medicine centers and laboratories across the country.

Capital Area Medical Society To Meet in March

The Capital Area Medical Society, which was until recently the East Baton Rouge Medical Society, will meet on March 25 at the City Club. The focus of this meeting will be legislative issues, medical malpractice, and more. The meeting will begin with networking at 6:00 pm followed by the meeting and dinner at 6:30 pm. The society, which was established in the late 1800’s under the name of the East Baton Rouge Medical Society, was one of the first Parish Societies to organize in Louisiana. It was first affiliated with the Louisiana State Medical Society in 1878 and become a chartered component in 1903. The society has grown over the years, encompassing not only East Baton Rouge Parish but also the parishes of West Baton Rouge and Livingston, and now stands as one of the largest component societies in the Louisiana State Medical Society. The Capital Area Medical Society, a multi-parish organization, unites over 700 allopathic and osteopathic physicians of all specialties toward the fulfillment of its mission: “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.” For more information about the meeting, call Deanna Menesses at 225-273-7904 or email Deanna at Deanna@CapitalAMS.org.
ince my election to Congress, people have told me how slow and tedious the process in Washington can be. Therefore, it came as a bit of a surprise when, during my first week, I was delivered all 283 pages of House Resolution 2, better known as the State Children's Health Insurance Program (SCHIP) Expansion Bill, along with a note from my scheduler that we would vote on final passage the next day!

This sort of “midnight drop” is designed to impede and discourage anyone from actually examining the legislation we are to vote on. I wondered why the Democrats would do so since the original legislation was passed on a bipartisan basis and two years earlier, Republicans and Democrats worked to expand the program.

As my family is staying in Baton Rouge and having nothing else to do, I stayed up late and read the 283 pages. As I read, I realized why the bill’s sponsors worked to prevent a careful and thoughtful assessment of the bill. This legislation takes a good and reasonable program and sends it down an unsustainable path of increased growth, spending, and potential for fraud and abuse.

In Louisiana, SCHIP is called LaCHIP and is a program similar to Medicaid where the Federal Government puts up approximately 80% of the money and Louisiana puts up 20%. In Louisiana, the LaCHIP program which covers all children from families earning up to 250% of the Federal Poverty Level, provides health coverage to over 640,000 children.

Even in these tough economic times, when federal, state, and local governments are all under immense pressure to “tighten their belts” and cut back on spending, I believe a well run and administered LaCHIP/SCHIP program is an important part of our country’s obligation to care and provide for children and others who can’t help themselves. Individual states are given great flexibility to adjust this eligibility level to suit their own needs and budgetary constraints. This is an important aspect that I wish we could see more of in other federal programs that are administered at the state level.
As a physician who works primarily with the under- and non-insured, I have seen the benefits of the LaCHIP/SCHIP program for working American families whose income is too high to qualify for Medicaid but too low to afford quality health insurance. I firmly believe that until we can find ways to lower costs and make private insurance affordable and available to all, the LaCHIP/SCHIP program is essential to ensure that the most vulnerable among us, our children, have access to the healthcare they need and deserve.

While H.R. 2, the LaCHIP/SCHIP Expansion Bill, has been marketed to the American people solely as a way to help more children, the actual text of the bill reveals that this is not the whole story. Buried within the text of the bill are provisions that essentially eliminate the ability of plan administrators to verify requirements for LaCHIP/SCHIP, such as proof of income and assets. It also includes in this Children's Health Insurance Program, childless adults. In some states, this program for the indigent includes families earning more than $85,000 a year.

There is nothing more discouraging and damaging to the credibility and sustainability of a program built on good will than people who inappropriately exploit that good will. The elimination of these safeguards will ensure front page stories and YouTube clips of those who cheat the system. Leaving the safeguards protects the integrity of the LaCHIP/SCHIP program and saves tax payers' hard-earned money. I know from the history of the Louisiana Medicaid System and from working in the Louisiana Charity Hospital System, that inevitably there will be cost over-runs and underfunding which will cause patient care to suffer.

I came to Washington, DC to use my background and experience in healthcare to work with Republicans and Democrats to create solutions. However, in this case, my background tells me that this solution will create problems.

President Obama says that he wants bipartisan support for his healthcare proposals. I look forward to working with his administration on these issues.
By now we all know the bad news statistics about our national health care system:

• In 2001 the Institutes of Medicine found that up to 98,000 hospital deaths annually in the U.S. are caused by preventable medical errors.

• A 2007 Commonwealth Fund report found that “the U.S. health system is the most expensive in the world, but comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance.”

• Robert Wood Johnson’s 2007 report High and Rising Costs found health insurance premiums increased 114 percent between 1999 and 2007, while workers’ earnings increased only 27 percent.

**In Louisiana, this situation is arguably worse:**

• The United Health Care Foundation ranks Louisiana 50th in its 2008 health report – a position we have held for sixteen of the last eighteen years.

• Louisiana ranks 46th overall in the Commonwealth Fund’s State Health 2007 Scorecard: 28th in equity, 33rd in access, 41st in quality, 50th in healthy lives, and 51st in avoidable hospital use and costs.

The good news is that the debate is over: we all acknowledge that our health care system is broken and requires reform, and leaders at every level are stepping up to the plate to make it happen: local patient advocates, physicians, employers, our own Governor Jindal, and President Obama.

In Louisiana, we especially have a unique opportunity for change. What began in the recovery efforts of hurricanes Katrina and Rita, continues today as a true partnership of community and government leaders committed to fundamentally restructure our health care delivery system to improve the health of all Louisiana citizens. We have seen real progress:

• The incorporation of the Louisiana Health Care Quality Forum, bringing together leaders in healthcare, business, and advocacy to advance quality improvement and system reform.

• The development of patient-centered medical homes within the Primary Care Access and Stabilization grant clinic network in the greater New Orleans area.

• The implementation of electronic health information exchange between rural hospitals through the Louisiana Rural Health Information Exchange.

• The posting of hospital performance information on the Louisiana Hospital Inform website.

• The submission of the Department of Health and Hospitals’ waiver application to reform the Medicaid program.

These developments are moving Louisiana in the right direction. They are based on nationally recognized best practices and are positioning Louisiana as a leader in health care reform. Of course much remains to be done.

We must work aggressively to improve access to primary and preventive care. Ninety-seven percent of Louisiana has been classified as a primary care health professional shortage area. Research shows that our low generalist to specialist ratio is strongly associated with our high per capita Medicare and hospital costs, and our low quality outcomes. We should act on the recommendations of the Louisiana Interagency Task Force on the Future of Family Medicine to pro-
duce, recruit, and retain more primary care physicians in our state.

We must more effectively manage chronic disease. The Department of Health and Hospitals estimates that approximately 10.2% of Louisiana residents have been diagnosed with diabetes, and that in 2006 the total cost of diabetes to Louisiana was approximately $2,431,000,000. Patient-Centered Medical Homes, as recognized by the National Committee on Quality Assurance, have an emphasis on effective chronic disease management, including the coordination of care across specialists and ancillary services. Physician practices should be supported in achieving medical home certification.

We must support providers in their efforts to adopt health information technology tools, such as e-prescribing, reminder systems, decision support tools, and electronic health records that improve quality and efficiency at the point of care. We must build the capacity for health information to be electronically exchanged in and out of state to provide for patient needs in times of crisis.

We must help patients become actively engaged in their own health and health care. Louisiana has one of the lowest rates of health literacy in the nation. Physician education on effective communication strategies with patients, provider incentives to engage more effectively with patients, as well as patient incentives to more assertively manage their own care are all necessary to achieve true patient activation.

Our current system is an uncoordinated, transaction based, volume driven production model. The more services performed, the more revenue generated. Tests are conducted unnecessarily and are often duplicated. Patients are left on their own to coordinate care across specialists and manage multiple medications and treatments. Support for patient transition between care sites is lacking. No one is accountable for the health of the patient or costs of unnecessary services.

We must intentionally design the system to achieve better quality of care, improved health outcomes, and cost efficiency. Providers must be supported and compensated to coordinate care in the primary care setting, provide preventive services, manage chronic disease, and encourage patients to become more engaged in their own care. We are all responsible for the state of our health and health care system. We must all come together to continue the redesign needed to achieve the quality of healthcare each of us deserves. ✰
PACE Baton Rouge Receives Blessing
The Franciscan Missionaries of Our Lady Health System held a blessing and dedication of the new PACE Baton
Rouge Center for the elderly in January. The building is located at the corner of Bishop Ott Drive and Lobdell
Boulevard near St. Clare Manor Nursing Home and the Elderly HUD Housing campus. The Most Reverend Robert
Muench delivered the blessing. PACE Baton Rouge is one of 60 Programs of All Inclusive Care for the Elderly
(PACE) in the United States. These are innovative programs for the elderly that are sponsored by the Centers for
Medicare and Medicaid Services (CMS) as well as the State Medicaid program. These programs allow patients that
are eligible for nursing home care the opportunity to continue to live in their community with the supports and serv-
cices available through the PACE program.

PACE services include: all medical care, adult day services, medications, rehabilitative and recreation therapy, med-
icinal equipment, respite and nursing home care (if needed), social services, transportation to and from the center,
nutritional counseling, pastoral care, as well as many services in the home. PACE Baton Rouge will provide servic-
es to residents of East Baton Rouge and West Baton Rouge parishes.

Baton Rouge General Foundation Names New Chair
Margaret Womack has been named chair of the Baton Rouge General Foundation’s board of directors. Womack has
been a member of the foundation board for seven years and has chaired numerous committees including the hos-
pital’s capital campaign committee, which raised over $5.5 million for the Bluebonnet campus expansion. She is also
involved in many philanthropic activities throughout the community and was the director of the Stop Rape Crisis
Center from 1983 to 1990. The Foundation board also elected three new members to three-year terms, which began
October 1, including Amy Howe, Community Volunteer; Perry Franklin, Franklin Industries; and Scott Singletary,
Bancorp South.
Edward Schwartzenburg, MD, Re-Elected Chief of Staff

Woman's Hospital has re-elected Edward Schwartzenburg, MD, as Chief of Staff for 2009. Dr. Schwartzenburg is a practicing obstetrician and gynecologist with Drs. Schwartzenburg, Lafranca and Guidry. As Chief of Staff, Dr. Schwartzenburg will also serve on the Woman's Hospital Board of Directors. Additional medical leadership for 2009 includes Jan Benanti, MD, Vice Chief of Staff; Kathy Guidry, MD, Secretary-Treasurer; Yolunda Taylor, MD, Chief of the Department of Clinical and Support Services; Timothy Maher, MD, Chief of Anesthesiology; Marshall St. Amant, MD, Chief of Maternal-Fetal Medicine/High Risk Obstetrics; Ronald Andrews, MD, Chief of Medicine; Steven Spedale, MD, Chief of Neonatology; Nicolle Hollier, MD, Chief of Obstetrics/Gynecology; Beverly Ogden, MD, Chief of Pathology; George Schwartzenburg, MD, Chief of Pediatrics; Chester Coles, MD, Chief of Radiology; Cecilia Cuntz, MD, Chief of Surgery; and Charlie Bridges, MD, Chief of Urology.

Baton Rouge General Names Randy Strother Executive Chef

Randy Strother has joined Baton Rouge General as Executive Chef over the hospital’s Nutritional Care Services. Strother will be responsible for dietary and nutritional care services, catering, Subway, and coffee shops at the General’s Mid City and Bluebonnet locations. Previously, Strother served as a chef for Hollywood Casino. He has 16 years of culinary experience and is Serve Safe certified. Strother is a graduate of The Culinary Institute of America in Hyde Park, New York and has training in international cuisines and hospitality and food service management. He completed his externship at the New Orleans Marriott.

Forum Features Medical Homes and More

The twelfth annual LSU Health Care Services Division (HCSD) Health Care Effectiveness Forum, entitled “Medical Homes and Academic Health Systems: Fostering Excellence in Health Outcomes in the LSU Health System,” was held in January. Keynote speaker Dr. Atul Grover, assistant vice president and director of governmental relations of the Association of American Medical Colleges (AAMC), gave a presentation on “Stopping Medical 'Homelessness': Academic Health Systems' Role in the Medical Home.” The presentation examined how the AAMC and academic health systems are successfully creating and implementing the medical home model and how medical home models of relationship-centered care can support the LSU pursuit of comprehensive quality care.

Dr. Grover authored the AAMC position statement on the medical-home model of care in March 2008, calling on academic health systems to lead the way in defining, implementing, and teaching the medical home and other innovative approaches to care. His session examined what teaching physicians and hospitals are doing to implement the medical home model and how their actions might be incorporated into education and training. Dr. Grover discussed how this new model might fit with what patients, purchasers, and policymakers expect from the healthcare system of the future and what role academic medicine will play.

Acting HCSD CEO Dr. Michael Butler, gave a report on the status of
and plans for LSU hospitals and also presented annual awards to HCSD staff and programs. In addition, six staff presentations reflected the six major components of quality care: effectiveness, efficiency, equity, safety, timeliness of care, and patient-centered care. Dr. Kathy Willis discussed the Lallie Kemp Regional Medical Center FAST Clinic; Dawn Hinton, RN, the Surgery Prepare Center at W.O. Moss Regional Medical Center; and Dr. Ron Horswell, Assessing Equity in Access to Healthcare and Quality of Care. Also, Dr. Wayne Wilbright presented The Expanding Role of Computerized Clinical Information Systems at HCSD; Jane Herwehe, MPH, presented HCSD, DHH/OPH and the Louisiana Public Health Information Exchange; and Dr. Brent Hemelt presented Cancer Screening at Leonard J. Chabert Medical Center.

Cindy Briody, RNC, Named as Manager of Kirk’s Kids Pediatric Center
Baton Rouge General has named Cindy Briody, RNC, manager of its Kirk’s Kids Pediatric Center, which includes the Pediatric Intensive Care Unit (PICU). The General’s Kirk’s Kids Pediatric Center is now located at the hospital’s Bluebonnet campus, 8585 Picardy Avenue. Briody was previously a clinical educator for the General’s education department and a charge nurse in the Neonatal Intensive Care Unit (NICU). Prior to Briody’s employment with Baton Rouge General, she was the Director of Nurses for Pediatric Services of America and held several leadership positions in the nursery, NICU, home health, and pediatric cardiology areas for Woman’s Hospital. Briody is certified in Neonatal Nursing and is a regional instructor for the Neonatal Resuscitation Program. She is also a member of the Academy of Neonatal Nurses and National Association of Neonatal Nurses and a graduate of Touro Infirmary School of Nursing.

Woman’s Hospital Suspends Construction at New Campus
Citing an unfavorable bond market, Woman’s Hospital has suspended construction of its new facility at the corner of Airline Highway and Pecue Lane. Woman’s plan has always been to fund the new campus by selling bonds, but recent changes in the economy have resulted in an unfavorable credit market, making it imprudent to pursue financing at this time, said hospital leadership. Stan Shelton, Senior Vice President and project manager, indicated that Woman’s will continue construction of the structural support towers already in progress. Once those are complete, the design and construction teams will focus their efforts on finishing the construction documents, refining construction plans, and finalizing construction agreements so the contractors can start work immediately once financing is secured. Hospital officials are committed to completing construction of the new facility, and will pursue obtaining the necessary financing at the appropriate time.

Helen Stepter-Collins Recognized for Longtime Service to the General
Baton Rouge General recently recognized Helen Stepter-Collins for 50 years of service to the hospital. Currently, Collins serves as a Patient Advocate, but has served in numerous management and staff positions in the hospital’s nutritional care department. In honor of Collins’ longtime dedication to the community through her work at the General, Mayor Kip Holden signed a proclamation declaring December 4, 2008 as Helen Stepter-Collins Day in Baton Rouge.
LHA Board Issues Statement on Healthcare Reform

The Louisiana Hospital Association (LHA) Board of Trustees approved a statement that the LHA is “supportive of Gov. Jindal’s efforts in healthcare reform and of the initial step of submitting the Medicaid waiver to CMS, which is a necessary first step before a more detailed plan may be developed that will reform our Medicaid system.”

John Matessino, LHA President and CEO, stated that, “The LHA supports implementing strategies to expand healthcare coverage, access and coordination; to provide adequate and sustainable funding for providers; to improve quality and outcomes; to protect and enhance graduate medical education; and to develop an academic medical center in New Orleans, all of which will be discussed and debated over the next several months.”

In 2006, the LHA approved a board position on healthcare redesign in Louisiana that parallels many of the solutions being recommended by the governor’s proposal. “Now is the time for real reform, and hospitals and physicians want to be a part of the solution. We want all patients to have access to quality healthcare and for them to have the ability to be treated close to home in the communities where they live. Putting the patient first is what healthcare is all about,” said Bill Holman, FACHE, LHA Board Chair. “After the waiver is approved, there are many important issues relating to reform that need serious consideration and input from stakeholders, including hospitals, physicians, and the legislature. Some of these issues include funding; minimum benefit plan design; new regulatory requirements; payment floors for providers; and administrative requirements, such as prompt-pay, network adequacy, and medical necessity review. These are the types of issues that will need to be debated and deliberated to create a healthcare reform system that is beneficial to the patient,” said Paul Salles, CEO of the Metropolitan Hospital Council of New Orleans.

The LHA will continue to work with Gov. Jindal’s Administration and the Louisiana Legislature on details to improve the state’s healthcare delivery system over the coming months.

Baton Rouge General School of Nursing Graduates Class of 2008

Baton Rouge General Medical Center’s School of Nursing announced the graduation of 31 nursing candidates for the Class of 2008 at ceremonies at Broadmoor United Methodist Church.

Deb Charnley, RN, MN, Baton Rouge General’s chief nursing officer, provided the welcome and Edgardo Tenreiro, Baton Rouge General’s executive vice president and chief operating officer, delivered the commencement address. Baton Rouge General’s School of Nursing operates a two-year RN program and accepts approximately 40 candidates each year.

The graduates, their hometowns, and their awards are as follows:

- Melissa Baughman, Baton Rouge
- Kate Becnel, Baton Rouge—Peggy Bradley Award and Class President
- Monique Lynn Boudreaux, Baker–Faculty Award for Excellence in Adult Health Nursing and the Special Leveraging Educational Assistance Partnership Award
Earl K. Long Medical Center Receives National Award for Outstanding Patient Satisfaction

Earl K. Long Medical Center (EKLMC) has received the 2009 Outstanding Patient Experience Award from HealthGrades, the nation’s leading independent healthcare ratings organization, for ranking in the top 15 percent nationally for exemplary service to patients. EKLMC actually exceeded the top 15 percent; its percentile ranking was 3.32, placing it among the top four percent in the nation.

The ratings are based on patient satisfaction results from...
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that hospital patients provided as part of a new federal initiative to increase public reporting of hospital performance. The survey includes 27 questions related to physician and nurse communication, responsiveness, hospital cleanliness and noise levels, medication information, and postdischarge care instructions. It is the first national, standardized, publicly reported survey of patients’ perspectives of hospital care. HCAHPS is an initiative of the Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services.

To identify the top-performing hospitals, HealthGrades analyzed survey results for the 2,592 hospitals nationwide that participated in the HCAHPS program to determine which hospitals scored highest on the surveys. Hospitals had to meet bed size, survey response size, and clinical-quality thresholds in order to be rated. HealthGrades recognized 271 hospitals within the top 15 percent. In a survey of 868 HealthGrades.com visitors, 84% said that if a hospital received a HealthGrades Outstanding Patient Experience Award it would increase their interest in choosing that hospital.

Baton Rouge General Names 2009-2010 Medical Leadership
Baton Rouge General has named physicians serving as members of the 2009–2010 Medical Executive Committee. The Medical Executive Committee serves as a liaison between physicians and the hospital to ensure continued focus on providing the highest standard of patient care and meeting the needs of physicians. Medical Executive Committee Officers include: Dr. Evens Rodney, Chief of Staff, who was elected to a second two-year term in this office; Dr. Andrew Olinde, Vice Chief of Staff; Dr. Donnie Batie, Secretary/Treasurer; Dr. Michael Castine, Chair of Medicine; Dr. and Dr. Michael Puyau, Chair of Surgery. At large members include: Dr. Kevin Reed, Dr. Jeffrey Littleton, Dr. Venkat Surakanti, Dr. William Murrill, Dr. William Anderson, and Dr. John Lopoo.

Louisiana’s Hospitals Concerned about State’s Budget
As the state discussed the next year’s budget and some necessary cuts, John Matessino, Louisiana Hospital Association President & CEO issued a statement expressing the Louisiana Hospital Association’s concern. LHA is concerned about the negative impact that budget cuts will have on our already stressed healthcare system. “Budget cuts to healthcare are bad for patients, business and our economy. Currently, hospitals are paid below cost by the state for treating Medicaid patients. By cutting an already under-funded program, Louisiana citizens may face longer Emergency Room wait times and can expect possible cuts to local healthcare services and jobs. The results of cutting Medicaid could also mean higher costs for healthcare for individuals and businesses.

“Because cutting Medicaid funding affects the amount of federal match the state receives, for every $1 million cut in state Medicaid funding for hospitals, the projected economic impact would be a $3.3 million revenue loss to hospitals; a reduction of approximately 70 jobs; a reduction of $2.8 million in personal earnings; and a loss of $7.2 million in overall business transactions.

Use of One-Time Revenues
“Statutory and constitutional provisions have required that cuts during economic downturns be targeted at healthcare and higher education. Louisiana has historically used ‘one-time revenues’ to fund ongoing, important needs in the budget, such as healthcare services for the elderly, children and those living in poverty. We recommend that Governor Jindal and the legislature use any and all available funds, including ‘one-time revenue’, to protect
services to our most vulnerable citizens. Let us not forget the economic importance of protecting payments to hospitals as ‘businesses’ in the state, which provide approximately 101,900 direct hospital jobs for our citizens with an annual payroll of $3.6 billion.

**Budget Reform Good for Louisiana**

“For too long, Louisiana has relied on cutting funding for healthcare and higher education to balance the budget during times of budget shortfalls. Gov. Jindal and the current legislature inherited a budget dilemma that began with the 1973 Constitutional Convention and has grown ever since. Constitutional Amendment No. 3 of 2002 allowed the governor and the legislature to look at other areas of the budget for reductions, but it does not go far enough to protect vital healthcare services.

“Proactive measures should be considered by the administration and the legislature to take into account all expenditures during these tough economic times to balance the state’s budget. Making smaller cuts in a number of programs rather than large cuts in one or two is not only smart, it’s fiscally prudent”

**Beth Veazey Named VP and CDO of Baton Rouge General Foundation**

Beth Veazey has been named Vice President and Chief Development Officer of the Baton Rouge General Foundation. She most recently served as Executive Director of Alzheimer’s Services of the Capital Area. Veazey is a member of the Association of Fundraising Professionals and the Louisiana chapter of the National Council of Planned Giving. She is a graduate of Louisiana State University.

**Lane Regional Medical Center Partners with CIS to Host 3rd Annual Zachary Heart Health Fair**

Cardiovascular Institute of the South (CIS) and Lane Regional Medical Center (LRMC) hosted the 3rd annual Zachary Heart Health Fair in February. The health fair featured free screenings for blood pressure, glucose, body mass index (BMI), cholesterol, and stroke assessment. Dr. Moosa, Dr. Thompson, and CIS nurse practitioner, Joey Bonin, along with

Baton Rouge General School of Nursing, Class of 2008: Top row, l-r, Monique Boudreaux, Chantelle Day, Derrick Miller, Tina McMahon, Holly Corley, Katie Lewis, Jennifer Hicks, Tessa Browning, Kate Becnel, Second Row: Casey Brown, Katie Lennie, Kim Gary, Megan Thomas, Amy Dowden, Blake Sibley, Aimee Legg, Caroline Fletcher, Adrienne Holdridge, Third row: Kaitlyn Miller, Courtland Guillot, Val Stonaker, Trish Templet, Jennifer LeBlanc, Emily Cheatham, Chad McDaniel, Fourth row: Erica Sutton, Melissa Baughman, Judy Weaver, Kay Rousseau, Misty Breaux, Lindsay Hernandez.
other medical professionals of both CIS and LRMC were available for questions. LRMC also offered tours of the new Cardiovascular Center located behind the hospital on McHugh Road. Additional patient education was available for those interested in learning more about heart health.

**BRG Partners to Increase Organ Donations**

Baton Rouge General Medical Center, along with hospitals throughout Louisiana, has committed to be a partner in the Donate Life Louisiana Hospital Campaign, which is the first-ever, statewide hospital donor registration drive initiative in the nation. The Louisiana Hospital Association and the Louisiana Organ Procurement Agency launched this initiative to help increase the number of registered organ and tissue donors in Louisiana. Hospitals have appointed Champions who will help educate their employees and communities about organ donation and encourage individuals to register as donors. By the end of 2009, the Donate Life Louisiana Hospital Campaign hopes to increase Louisiana’s donor registry by at least 10 percent or 160,676 people.

Baton Rouge General’s Champion, Laura Simon, RN, says that the number of people waiting for organs in Louisiana is very long, but the list of donors is short. More than 1,800 individuals in Louisiana are waiting for a life-saving transplant. One organ donor has the power to save up to nine lives, restore sight to two people and enhance the lives of up to 50 more through tissue donation.

To learn more about the Donate Life Louisiana Hospital Campaign, or to find more information on how to register to become an organ donor, visit www.donatelifela.org.

**Lane Regional Medical Center Medical Staff Elects Officers**

Lydia D. Lewis, MD, has been named chief of staff at Lane Regional Medical Center by the hospital's medical staff. Dr. Lewis is a graduate of the University of California-Berkeley and the University of Wisconsin-Madison Medical School. She completed an internship and residency in Obstetrics and Gynecology at Kaiser Permanente Foundation Hospital in Oakland, California. Dr. Lewis has been a member of Lane’s medical staff since 2004.

Other medical staff leadership named at Lane Regional Medical Center includes: Keith B. Elbourne, MD, vice chief of staff; Greta Monroe Wilkes, MD, secretary-treasurer; and Brian E. Kozar, MD, medical staff representative to the board.

**OLOL Children’s Hospital Photos Selected for NACHRI Photo Exhibition**

Three Our Lady of the Lake Children’s Hospital photographs by Jeannie Frey Rhodes were selected by the National Association of Children's Hospitals and Related Institutions (NACHRI) for “Champions,” its 2009 traveling exhibition of 50 photographs. One photo titled, Lots of Touch, received special recognition as a “top-ten” photo. It was chosen from nearly 250 photographs submitted to NACHRI by children's hospitals across the country.

The NACHRI traveling photo exhibition is designed to illustrate the vital role children’s hospitals play in children’s lives through compelling visual images of child patients at children’s hospitals, their family members, and the caring and compassionate staff. This year’s exhibit will travel across the country to include Capitol Hill in Washington, DC where members of Congress will be invited to experience it. The photo exhibit will debut in Nashville, Tennessee at the Renaissance Nashville and Nashville Convention Center, March 22-25, 2009.
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In a partnership with Ann Connelly Fine Art, Our Lady of the Lake Foundation and Our Lady of the Lake Children’s Hospital will present to the public 20 of Jeannie’s photos from the “Day In the Life” shoot. They will be on exhibit April 2 through April 9, 2009 with a reception on Tuesday, April 7 at 5:30.

LSU Appoints Viator Hospital Administrator for Earl K. Long Medical Center
The LSU Health Care Services Division (HCSD) has appointed Kathy Viator, DNS, RN, hospital administrator for Earl K. Long Medical Center (EKLMC) in Baton Rouge. Dr. Viator, who has served as EKLMC acting hospital administrator since March 2007, has 30 years of experience in hospital management and healthcare. As chief operating officer/associate hospital administrator from 2005 to 2007 for EKLMC, she was responsible for the management of more than 1,500 employees and three off-campus clinics. With expertise in facility management, state fire marshal requirements, and DHH licensing, she oversaw multiple new construction and renovation projects, including the start-up of the LSU Surgical Center and its on-campus clinics and the building of the North Baton Rouge Clinic, scheduled to open in the spring of 2009.

Answers to Ozone IQ Quiz on page 52.
To increase your Ozone IQ, or for more information on Louisiana’s air quality, go to DEQ’s website at www.deq.la.gov.
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