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Ouachita Medical Society
Mission Statement

The Society commits itself to these goals:

1. To pursue and maintain access to quality medical care
2. To promote public education on health issues
3. To provide value to members by the representation and assistance of member physicians in the practice of Medicine

OMS Executive Committee 2010–2012

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Jason Read, MD

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All hospitals have medical equipment and perform procedures. So what makes one hospital different from the rest? It’s the people who operate that equipment, and the innovative efficiency of procedures. It’s the ability to provide quality hospital care with a true sense of compassion. That’s what makes our hospital stand apart from the rest to give you the confidence to choose us for quality medical care. When you want the best, choose Glenwood.
Instead of making tough but necessary decisions regarding our state’s health care future, the easy way out is to pass those decisions to physicians and other providers. If Medicare and Medicaid cut reimbursements again, then the providers will either discover new forms of “efficiency” or leave the system entirely. The hope is that providers will absorb the cuts without impacting patient access. However, the quality of the entire system will suffer if too many providers leave.

As one physician stated during a recent OMS meeting, there are three main factors that affect healthcare: quality, access, and costs. His point being that we must admit that creating a system that positively influences all three is an impossible task.

Therefore, we must decide our priorities and address it accordingly. Politicians on both sides promise all three but fail to deliver. In order to solve our current crisis, politicians need to sit down and discuss the issues in a realistic manner with our citizens’ best interest as their goal. We must avoid the status quo of attacking those who attempt to make tough decisions by those whose agenda is political gain. Whether it’s the Republican’s claims of “death panels” or the Democrat’s claims of benefit cuts, the political gamesmanship must end to accomplish true health care reform.

We can hope and pray for leaders with the courage and perseverance to make the right decisions for the future of all Louisianans.

Better solutions to the Medicaid crisis could include:

- Limit the number of enrollees by age or income
- Limit the covered services
- Limit the types of providers in the Medicaid system (Physician services and Hospitals are only 2 of the available 22 Medicaid Provider Groups)
- Limit the quantity of covered medications
- Limit the quality of covered medications (e.g., stringent formulary)
I asked if he piloted planes anymore and was told he felt he had used up all his luck in the service and had lost interest in that. Over the years I have come to learn why Clancy felt that way. Having grown up in Ohio, he enlisted in the Army Air Core in 1942. After going through flight school and despite being undersized for the job, he was assigned to pilot B-24 bombers. He was shipped to Italy as part of the 15th Air Force, where he flew 44 combat missions against the Nazi forces. Some of these missions were quite hair raising. Probably the most famous mission he was involved in was nearly his first. This mission was the second bombing of the Ploesti oil refinery in Yugoslavia, the first being renowned for its high casualty rate. At the last minute he and one half of his crew were pulled from the mission. The other half did not return. No wonder Clancy felt like he used up all of his luck!

Clancy did eventually participate in many challenging missions, including one where the crew threw parachutes out of the waist gunner’s window to help land their disabled B-24 on a short runway. (All the crew survived without injury.) After discharge Clancy returned to Ohio for college and medical school before completing his anesthesia residency in New Orleans. He came to Monroe in 1958 and practiced here through 1989. Clancy enjoyed his passion for deep sea fishing in the Gulf after his retirement. This is despite having his boat sink on him once and another time having it pass him on the highway, after the trailer he was towing came loose from his car. I’ll never forget what he told me when I asked him what he was going to do when he retired. He said he thought he would go to Europe and “see some of the places I bombed.”

Clancy is currently a resident at the Veterans Home in Monroe and his wife Helen also continues to reside here.

Reaching The Summit in patient care.
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P&S Surgical Hospital recently received the prestigious Summit Award for 2009 – one of only 22 hospitals in the U.S. to receive the award for in-patient satisfaction. The award goes to hospitals that sustain the highest level of patient satisfaction – in the 95th percentile or above – every quarter for three or more consecutive years. It’s the health care satisfaction industry’s most coveted symbol of achievement given annually.

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Small hospital. Big heart. Precisely.
Medicare, the government run health insurance program for those 65 or older and the disabled is on fire and may burn to the ground.

Americas 46 million elderly and disabled patients are at the center of this “firestorm” as the deficit burdened federal government grapples with payment cuts to Medicare. By law the Sustainable Growth rate formula is used to calculate what Medicare pays for care of these patients. Each year the law has calculated a substantial cut to physician payments and each year Congress has passed a “Medicare patch” to delay the cuts, knowing that such cuts would devastate elderly and disabled patients’ access to health care. And since Tricare, the health insurance program for military members uses Medicare rates for payment to physicians, and many private insurance companies payments are indexed to a Medicare fee schedule every patient who walks into a doctor’s office with some type of insurance coverage is a stakeholder in this debate.

This year the Congress has instituted a nearly month-to-month “Medicare patch” to avoid dealing with the $210 billion price tag, the amount of dollars estimated to solve the problem. The latest patch ends November 30th. If Congress does not act a combined pay-cut of nearly 30% will go into effect for Medicare beginning January 1, 2011. If this goes into effect, an AMA survey of practicing physicians predicts that 54% of the doctors surveyed would restrict the number of Medicare patients that they treat, 50% would stop taking new Medicare patients, and 31% would stop taking any Medicare patients. This would have a seismic effect throughout the health care system since many private insurance companies could use this new Medicare fee schedule to lower their payment rates to physicians also.

Louisiana has a significant stake in this debate because we are below the national average in practicing physicians per 1000 Medicare beneficiaries. Another problem is that 44% of our practicing physicians are over age 50, an age at which surveys have shown many consider reducing their patient load. Louisiana seniors would face a significant challenge in obtaining access to physicians if this across-the-board pay cut is enacted.

This year the Congress has instituted a nearly month-to-month “Medicare patch” to avoid dealing with the $210 billion price tag . . .
the new health care law will change the Medicaid eligibility level from 26% of the federal poverty level to 133%

Medicaid

Medicaid is the health program for eligible low income individuals that is jointly funded by the states and the federal government.

The federal government guarantees matching funds to states, officially known as the Federal Medical Assistance Percentage (FMAP). This program provides health coverage and long-term care services, including nursing home care, for 60 million low-income Americans including nearly 30 million low-income children. The elderly and people with disabilities account for 70% of the program spending.

In bad economic times unemployment rises and state revenues decline. At the same time Medicaid enrollment increases requiring states to increase their funding for Medicaid. Add to this the fact that the new health care law will change the Medicaid eligibility level from 26% of the federal poverty level to 133% and you have a real mess. This is where Louisiana finds itself in 2010.

Louisiana Medicaid is now a fee-for-service model. Critics say the current system does little to prevent patients’ health problems and result in more visits to the emergency rooms, more hospitalizations, and higher costs. Dr. Alan Levine, secretary of the state Department of Health and Hospitals believes shifting Louisiana’s Medicaid system to managed care coordinated care networks (CCN’s) will save the state money and improve patient outcomes.

Louisiana Medicaid now covers around 1.2 million emergency medical providers have absorbed Medicaid cuts exceeding 250 million dollars over the past 2 years. Physicians, community hospitals, and emergency medical providers have absorbed Medicaid cuts exceeding 250 million dollars over the past 2 years.

"More than 40 states already use managed care in their Medicaid programs," Levine said. When asked about her thoughts on how Coordinated Care Networks would impact health care in Northeast Louisiana Linda Holyfield said, “Coordinated Care Networks, if managed properly, can be a great advantage for the people of Northeast Louisiana. Conceptually, CCN’s can provide a medical home for patients. In a medical home, if done well, physicians can assist patients in managing their health and help ensure that they receive the most effective health services in the most appropriate settings. However, if the system is not managed well, and is simply used to cut cost at the expense of patient choice and quality, it may prove to make it harder for the people of Northeast Louisiana to receive the care they desperately need.” The states that do not are moving to managed care.” This decision has met resistance from many medical providers and organizations including the Louisiana State Medical Society. The LSMS says that implementation of CCN’s, as currently structured, will reduce provider participation in Medicaid, reduce the

Legislative Update:

130th Annual Meeting of the House of Delegates

Feb 4-5 Hilton Capital Center, Baton Rouge, Louisiana

Ouachita Medical Society is allowed to be represented by 11 Delegates.

Medical Malpractice Surcharge Reduction

According to the Louisiana Hospital Association, physicians will see their medical malpractice rates drop, on average by 35.8 percent in January 2011. The rate cuts will translate to annual savings of around $500 a year for primary care physicians and even more for higher risk practices.

LSMS to File Suit

On Wednesday, October 6, the Louisiana State Medical Society Executive Committee decided to file a lawsuit against the Louisiana Department of Health and Hospitals (DHH) challenging the validity of the recoupment process and the Medicaid cuts. The LSMS believes that this lawsuit must be filed to protect the rights of Medicaid patients to have access to quality medical care and to preserve the financial viability of the physicians who care for them. Due to the drastic cuts to the Medicaid Program in the last two years, it now costs most physicians more to treat a Medicaid patient than they are being paid. LSMS members are devoted to their patients, but at these reimbursement levels many will be forced to stop seeing Medicaid patients and some will close their practices.

LSMS President’s Update by Patrick C. Breaux, MD

1 “Providers to Seek Historic Medical Malpractice Reduction” by Ted Griggs Louisiana Medical News October 2010

2 LSMS President’s Update by Patrick C. Breaux, MD October 2, 2010

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Closing My Practice Due To Medicare & Medicaid Cuts

written by Thomas H. Fields, Jr., MD Disease of the Ear, Nose & Throat

It was with a heavy heart that I set the date for my retirement. Heavy because I am genuinely concerned about the patients that I’m leaving behind. I had planned to practice about another two years but impending Medicare fee reductions and take-backs from Medicaid of already paid fees were effectively bankrupting my practice.

Because I’ve been around for so long, a lot of my patients “grew up” with me into the Medicare years, and even though I still had a lot of private pay and private insurance patients, Medicare and Medicaid were the majority. Many have asked me to recommend another ENT doctor which is virtually impossible to do. First, because I have enjoyed a good relationship with all of them and, second, they all have thriving practices.

I am really concerned about what is going to happen to all the chronic care patients I attended. Where will my severely handicapped, stretcher patient, go for her tracheostomy change? Who will clean my elderly patient’s ears for him so he can enjoy optimum use of his hearing aids? How will the primary care doctors be able to cope with all those kids who have, or will need, tracheostomy tubes. It’s the ear tubes that bother me the most. Why? Because when I started this practice 50 years ago I was still seeing patients mastoiditis and performing mastoidectomies. This terrible disease has been virtually eradicated in this part of the world by the proper use of antibiotics and tympanostomy tubes used to provide drainage of infected matter from the middle ear. Clearing up the middle ear prevented the progression of the disease to the mastoid bone. The infection of the mastoid held the possibility of progression to meningitis and/or brain abscesses, both of which are life threatening. Of course, if the disease progressed this far, the chances of deafness were great even if the patient survived the worst.

Ear infections are extremely painful. It is heartbreaking to see a 6 month old, or an 18 month old or a 4 year old screaming and writhing in pain. It’s also difficult to see concerned young parents exhausted from taking care of these children. Over the years, I have effected cures for many of these little patients and they have later come back to me for the same procedures for their children and now grandchildren. Rewarding indeed!

But what lies ahead? With such severe cuts to physician’s fees, I predict that I am only one of many who will find that a medical practice is no longer financially sustainable. All of those children with all of those ear infections will have to rely on their primary care givers, who may very well have to close up shop for the same reasons I did.

I have been totally candid with patients about my reasons for quitting the practice of medicine.

As I have seen them in my office or out and about I have answered their questions frankly, explaining what our government is doing to all of us through Medicare and Medicaid and health care reform. I have also admonished them to think long and hard about who they vote for if they ever want to enjoy another good doctor-patient relationship again.

Along with my good wishes for good luck, I offer my prayers on behalf of us all.
A Virtual Clinic Becomes Reality in Northeast Louisiana

written by Don Givler, MD

A “virtual clinic” became “reality” in northeast Louisiana when the Northeast Louisiana Virtual Clinic (NLVC) began accepting patients in 2010. NLVC is a nonprofit organization formed with the purpose of providing comprehensive healthcare services to the low income, working uninsured population of an eight parish area in northeast Louisiana.

NLVC is a direct response to regional health needs identified by the Living Well Foundation (LWF) in its 2008 Community Health Assessment. The Community Health Assessment identified a number of areas locally which compared unfavorably to national benchmarks. The report identified barriers to accessing medical and dental care, low rates of medical and dental insurance, high utilization of emergency room services, lack of a specific source for available healthcare by those residing in the service area. The need for better access to healthcare for those with low income, ongoing medical care, and a low rating of health insurance coverage was one of three priorities outlined in the LWF 2008 Strategic Plan. Current funding for the NLVC is through a grant in the LWF 2008 Strategic Plan. Current funding for the NLVC is through a grant in the LWF 2008 Strategic Plan.

The concept of the NLVC has been modeled after the Greater Baton Rouge Community Clinic (GBRCC), which has been operational since 2000. GBRCC was one of the first virtual clinics in the country to pool regional providers together to offer free healthcare for the working uninsured. There are currently more than 400 physicians and dentists involved in the GBRCC program. GBRCC budgetary expenses are met through grants and special events.

The NLVC employees currently include an executive director and two part-time administrative staff. Community volunteers will perform many functions including screening, determination of eligibility, clerical work and data entry, grant-writing, publishing a newsletter, and marketing.

The NLVC Board of Directors is comprised of a diverse group of community leaders, including physicians, dentists, a pharmacist, a hospital administrator, an attorney, an accountant, a minister, and a newspaper editor.

The NLVC has the support of many local healthcare providers and organizations. Three members of the Ouachita Medical Society are currently serving on the Board: Tonya Sheppard MD, David Barnes MD, and Don Givler MD. The Board is well-suited for the development and implementation of the NLVC mission.

Any physicians or dentists who would like to donate their services to the NLVC can contact the NLVC office staff at 329-8490. “I’ve never regretted doing my residency at Conway,” responds Dr. Jones. “It was excellent hands-on training that prepared me well for medical practice.”

To qualify for care, an applicant must meet all of the following criteria:

- be currently employed, working a minimum of 30 hours per week
- have worked ten out of the last twelve months
- earn below 200% or below of the federal poverty guidelines
- show proof of residence in one of the eight target parishes
- not have any other form of medical or dental insurance
- not be receiving any federal or state assistance

Any physicians or dentists who would like to donate their services to the NLVC can contact the NLVC office staff at 329-8490.

“I’ve never regretted doing my residency at Conway,” responds Dr. Jones. “It was excellent hands-on training that prepared me well for medical practice.”

The NLVC is wonderful. Thank you for this service!

-NLVC patient

The NLVC is wonderful. Thank you for this service!

-NLVC patient

This service has truly been a blessing.

-NLVC patient

The NLVC is a “virtual clinic” in the sense that, although the NLVC has an administrative office, it does not have a physical clinic space. The NLVC uses the volunteer services of qualified healthcare professionals, healthcare organizations, and community members. The NLVC is a “virtual clinic” in the sense that, although the NLVC has an administrative office, it does not have a physical clinic space. The NLVC uses the volunteer services of qualified healthcare professionals, healthcare organizations, and community members. The NLVC has the support of many local healthcare providers and organizations. Three members of the Ouachita Medical Society are currently serving on the Board: Tonya Sheppard MD, David Barnes MD, and Don Givler MD. The Board is well-suited for the development and implementation of the NLVC mission.

The NLVC has the support of many local healthcare providers and organizations. Three members of the Ouachita Medical Society are currently serving on the Board: Tonya Sheppard MD, David Barnes MD, and Don Givler MD. The Board is well-suited for the development and implementation of the NLVC mission. The concept of the NLVC has been presented to the local medical and dental societies and four local hospitals, and all have expressed their support for the NLVC. To date, 18 physicians and 25 dentists have agreed to donate their services to the NLVC. In addition, two local hospitals, several medical and dental labs, and a radiology service are supporting NLVC with donated services.

Variety of Services

The NLVC offers a variety of services to its patients. Services offered will eventually be made available to those living in Caldwell, Franklin, Jackson, Lincoln, Morehouse, Richland, and Union parishes. Healthcare services are available in these parishes through private clinics and hospitals, and also through the Louisiana State health units and the LSU Health Science Center in Monroe (E. A. Conway Medical Center). However, it is apparent that the current healthcare resources are not adequately meeting the needs of low income, working uninsured persons.
OMS Membership Service / Value

Advocacy for physicians in political, regulatory and economic arenas

Legal Advice providing guidance and assistance to members on a number of Medical-Legal issues affecting physician practices and organized medicine.

Friends of the OMS program, offers discounts on products and services to all active members of the OMS and OMSA. Here are a few of our participating businesses for 2011:

Connectivity through special membership activities such as the Oyster Party, the Christmas Party, Doctors Day Dinner, Valentines Social, OMS ‘Happy Hour’, quarterly General Meetings and monthly Executive Committee Meetings.

Business – Over – Breakfast allows office managers / business managers from each member’s practice to attend a quarterly breakfast where key speakers will cover topics that address areas of concern when managing a medical practice. Everything from medical billing to personnel issues, from fiscal responsibility to safety. We’ll cover it all.

If your business is interested in applying for the “Friends of the OMS” program please contact the OMS office at: 318.512.6932 | director@ouachitams.org

Upcoming Events

December 4, 2010 | 7:00 OMS Holiday Party
at the home of Dr. and Mrs. Timothy Mickel

January 11 | 6:00pm Executive Committee Meeting

February 3rd | 8:00pm Valentine’s Party

February 4 & 5 LSMS Annual Meeting:
Hilton Capital Center, Baton Rouge

February 8 | 6:00pm Executive Committee Meeting

February 24th | 6:00pm Oyster Party

March 8 | 6:00pm Executive Committee Meeting

March 24th | 6:00pm Doctor’s Day Dinner Friday

April 12 | 6:00pm Executive Committee Meeting

May 5 OMS “Cinco de Mayo” General Meeting

For more information on these events, contact:
Krystle Medford, Director
318.512.6932 | director@ouachitams.org
The Ouachita Medical Society Alliance is off to a great start this year!

written by: Amy Taylor OMSA Vice-President

The board met several times over the summer and came up with some new and exciting ideas for the year. We are looking forward to cultivating a renewed interest in the Alliance...our goal is to have all of the Ouachita Parish physicians’ spouses become active members!

Our first meeting was held at the Biedenharn Museum and Gardens in September. We enjoyed a delicious lunch from Fiesta Nutrition as well as a tablescape demonstration by Mark Sanders. We had over 40 physician spouses in attendance! It was great to see so many familiar faces, as well as to welcome several new ones. President Kim Read presided over the meeting. Her husband Jason is the current OMS President, and we are looking forward to working closely with the OMS on community projects, social activities, and promotion of the medical community’s interests in Ouachita Parish. We were also introduced to the new Executive Director of the OMS, Kryslye Medford. She is very excited about the upcoming year and has been a great help to the OMSA board thus far.

The next Alliance meeting will be held on November 11, 2010 at 11:30am at Genusa’s Restaurant in Monroe. We will enjoy a good meal and great fellowship, and then we will enjoy a special shopping “passport” to Parterre, Material Things, Louisiana Purchases, Haven (Formally Bed Bugs) and Legacy Silver and Gifts. OMSA members in attendance will receive a special discount at these stores during this time. Look for a great door prize as well!
MEDICAID CUTS
LSMS Physician’s Share Their Perspective

Earlier this summer, the LSMS requested that you share your experience by taking the 2010 Medicare & Medicaid Participation Survey. As of August 6, 386 physicians had answered the call.

- More than half of respondents (56.6%) indicated that they have either stopped or will stop accepting new Medicaid patients; another 24.8% are considering this as an option.
- A majority (69.0%) of respondents indicated that they have either limited or will limit the number of new Medicaid patients accepted by their practice; another 16.0% are considering this option.
- 40.3% of respondents indicated that they no longer see or will no longer see Medicaid patients; another 31.4% are considering this as an option.
- When asked to indicate their experience in referring Medicaid patients for specialty care, respondents who chose “difficult to make referrals” and “almost impossible to make referrals”, the percentages are substantial: 94.9% in 2010 compared to 86.7% in 2009.

The results are telling.

OMS SEPTEMBER GENERAL MEETING

John Fleming, MD Congress
Members of the Ouachita Medical Society and their spouses were engaged by Congressman John Fleming, M.D. at the BancorpSouth sponsored, September General Meeting.

Congressman Fleming spoke on the changes that the healthcare reform law promises to put into effect. Among other OMS business, the 2010-2012 Executive Committee was voted into office at this meeting with great support.

Special Thanks to our Sponsor

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Local downtown Art Gallery Crawl artist, Andrea May had several of her pieces on display and kindly donated the painting, “She Is” as the evening’s highly valued door prize.

RACE FOR THE CURE

On September 25, 2010, members of the OMS and OMSA joined the “Team of Doctors” to walk and run with the nearly 3000 other participants in the Race for the Cure at Forsythe Park. The Ouachita Medical Society was proud to be a bronze level sponsor of the event. The OMS community outreach booth offered refreshments and a meeting place for all physicians involved in the race.

Be sure to join the “Team of Doctors” for the 2011 Race for the Cure.
Monroe family physician Gary Jones MD grew up in a medical family in the Monroe area, and it had always been his hope to return to northeast Louisiana to practice medicine. To do so, he had assumed that he’d have to complete his residency training elsewhere before returning home to practice. That is, until he met Grover Black MD while he was in medical school in 1980. Dr. Black was the program director at a new LSU-Shreveport-affiliated Family Medicine residency program based at E. A. Conway Hospital (now LSU Health Science Center-Monroe).

"Dr. Black tricked me into coming to look at the residency program," Dr. Jones recalls with a laugh. "He told me he wanted my opinion about what they were planning. But what he really wanted to do was recruit me to the residency."

As it turns out, Dr. Black was successful. Dr. Jones was one of the first residents accepted into the residency program in 1982, and he finished the three-year training program in 1985. He’s been in medical practice in Monroe ever since.

The Family Medicine residency at LSUHSC-Monroe has had a dramatic impact on medical care in northeast Louisiana. Over 140 physicians have completed the residency program over the past 26 years. Of those, approximately 50% are in practice in Louisiana, and most are practicing in the Monroe/West Monroe area or in surrounding rural communities, including Bastrop, Rayville, Mangham, Delhi, Kouton, Homer, Mer Rouge, Natchitoches, Winnboro, and Jonesboro.

LSUHSC-Monroe is a part of the LSUHSC-Shreveport hospital system. It is licensed for 199 beds, and for over 60 years it has provided patient care and medical education in northeast Louisiana.

continued on page 24

LSUHSC Residents

Rahmath Begum, MD was born in Hyderabad, India and most recently moved here from Plano, Texas with her husband, Khasim. She received her medical degree from S.V.S. Medical College, Mahboubnagar, India. Her hobbies are painting, sketching and photography.

Glen Capulong, MD was born in Manila, Philippines. Dr. Capulong graduated from Medical School University of Santo Tomas, Philippines. He comes from Califonia with his wife, Badette and their two children, Gabriel and Bernice. He enjoys spending his spare time with his family most of all and also cooking and reading.

Ruma Dahal, MD was born in Kathmandu, Nepal. Dr. Dahal graduated from the Institute of Applied Health Sciences in Bangladesh. She moved to Louisiana from Michigan with her husband, Prashanta and has a new baby girl born in June. She enjoys working out, cooking and traveling in her spare time.

Mohammed Jameel, MD was born in India and graduated from Deccan College of Medical Science. He comes to Louisiana from Chicago, Illinois with his wife, Tazeen and 3 children, Abdullah, Saad, and Mehreen. They love traveling to interesting places in the world. His hobbies are volleyball and cricket.

Christine Livek, MD Dr. Livek is originally from Missouri. She graduated from University of Health Sciences Antigua. Dr. Livek enjoys spending time with her family. Things she likes to do when she has extra time are, cooking, water sports, bowling, walking, she likes to direct school plays, playing the banjo, church activities and caring for animals.

Darshan Patel, MD was born in India and graduated from SMT N.H.L. Municipal Medical College, India. He comes to Louisiana from New Jersey, and is newly married to his wife, Kiran. His favorite things to do to relax in his spare time are swimming, cooking, playing piano, and yoga.

Nandini Sunkireddy, MD is originally from India. She graduated from Adichunchangiri Institute of Medical Sciences, India. Coming with her to Louisiana is her husband, Vijay. She enjoys teaching, cooking, painting and rafting.

Pavana Tirumanisetti, MD was born in India and recently came to Louisiana from Jamaica. He graduated from Siddhartha Medical College, India. Dr. Tirumanisetti is married to his wife, Vasundhara and they are waiting for the arrival of a new baby any day. His hobbies are cricket, tennis and table tennis.
Residents in General Surgery, OB/GYN, Ophthalmology, and Medical Oncology regularly rotate through LSUHSC-Monroe. Medical students, nursing students, pharmacy students, physicians assistant students, and nurse practitioner students also do their clinical training at LSUHSC-Monroe.

LSUHSC-Monroe has a unique combination of resources that are well-suited for residency training in Family Medicine. Perhaps most importantly, there are no other primary care residents with whom Family Practice residents must share educational opportunities. Residency training at LSUHSC-Monroe is primarily learning by doing rather than learning by observation. The family practice residents at LSUHSC-Monroe routinely care for patients that in other institutions would be cared for by specialists. Subspecialty consultation is readily available at LSUHSC-Shreveport to assist in the management of complex problems.

A second strength of the Family Medicine residency program at LSUHSC-Monroe is the faculty. The Family Medicine Department is composed of board-certified family physicians and interns. The close working relationships among the faculty and residents create an environment in which is conducive to excellent medical education and patient care. In addition, many family physicians and subspecialists in the Monroe area support the residency by allowing family practice residents to rotate through their offices as a part of their training.

A large patient population with diverse medical problems, an up-to-date medical library and electronic resources, regular conferences and teaching rounds, and modern inpatient and outpatient facilities combine to complete the resources which are essential for quality residency training in Family Medicine.

Knowing what he knows now, nearly 30 years later, would Dr. Jones still select LSU Health Science Center-Monroe for his family practice residency?

“I’ve never regretted doing my residency at Conway,” responds Dr. Jones. “It was excellent hands-on training that prepared me well for medical practice.”

The Medicare Part B premium was $3 per month. The Balanced Budget Act of 1997 brought us Medicare Part D. In January of 2006 a new Medicare Part D premium was $3 per month.

In 2008 Medicare Part A covered almost 45 million enrollees with payments of $49 billion. And Miles to Go before I sleep... And Miles To Go... Written by David Barnes, MD

The fact that it is late fall in Louisiana and soon to be winter does not bode well for snow but it does seem a good time to “stop by” and reflect on Medicare and Medicaid as we have done in this issue of the Hippocratist. It was on a warm July day in 1965 that President Lyndon Johnson signed into law the Social Security Act, authorizing Medicare and Medicaid. Medicare became the government funded and run health insurance program for those on Social Security and Medicaid the companion program began as a medical care extension program providing cash assistance to the poor, with an emphasis on dependent children, their mothers, the disabled, and the elderly. Former President Harry Truman who was present at the ceremony in Independence Missouri received the first Medicare card. The Medicare Part B premium was $3 per month.

Whose woods these are I think I know
His house is in the village, though;
But I have promises to keep
And miles to go before I sleep...

The Balanced Budget Act of 1997 brought us the State Children’s Health Insurance Program (CHIP) and at the end of 2003 President George W. Bush signed the prescription drug benefit program into law (MPPD & MI) Medicare Part D. In January of 2006 a new Medicare prescription drug benefit plan began that provided drug coverage for Medicare beneficiaries, including those who also received coverage from Medicaid. Since the new drug plan replaced a portion of State Medicaid expenditures for drugs, states began seeing reductions in Medicaid expenditures. To offset this the MMA required each state to make monthly contributions to Medicare representing a percentage of the projected reduction.

He gives his harness bells a shake
To ask if there is some mistake...

Well it was no mistake and with continued expansion of assistance more requirements were added. Now with certain Medicare beneficiaries (QMB’s, SLMB’s) can’t be eligible for other medical assistance under a state plan. So much for the simplicity of the 1965 program and the $3 per month Medicare premium.

The woods are lovely, dark, and deep
In 2008 Medicare Part A covered almost 45 million enrollees with benefit payments of $232.3 billion. Part B covered almost 42 million enrollees with payments of $380.3 billion, and Part D covered over 32 million enrollees with payments of $49 billion.

But I have promises to keep
In 2008 total expenditures for the Medicaid program (Federal and State) were $336.3 billion, including direct payment to providers of $234.5 billion, payments for various premiums (for HMOs, Medicare, etc.) of $48.4 billion, payments for disproportionate share hospitals of $15.6 billion, administrative costs of $19.4 billion, and $2.7 billion for Vaccines for Children Program.

Expenditures under the CHIP program in 2008 were $10 billion. With no changes to the program, spending under Medicaid is projected to reach $577.6 billion by 2014. In February of 2009 one of the first pieces of legislation passed by the 11th Congress and signed into law by President Obama was CHIPRA which extended and expanded CHIP.

And miles to go before I sleep
And miles to go before I sleep

Stopping by Medicare and Medicaid on a snowy evening we find two government programs with too many promises to keep and a federal government with miles to go...
Funny Bone

written by: Timothy Mickel, MD

24 hours in a row is a long time to spend in the box – a three by three foot area taped off on the floor at the check-in desk of the surgery emergency room at Parkland Hospital. As a second-year surgery resident, you had a two-month rotation of every other night duty as the doctor in charge of one of the busiest trauma ER's in the country. You were the first to examine and evaluate every patient that came through the door – from sprained ankles to acute abdomens to GI bleeds to gunshot wounds – and you learned to quickly decide if they needed urgent attention or could wait their turn. In the process, you were yelled at, spit on and puked upon by some of Dallas County’s finest.

Somewhere along the way, one of the residents created “the box”. No one but the “pit boss” – the surgery resident in charge of the ER – could be in this three by three foot square. It helped keep the riff-raff out of your personal space so you could think and write, but most importantly it gave you at least another second of reaction time to dodge mucus, blood or other bodily fluids. No one, not nurses, patients, interns or even attendants would violate the sanctity of the box.

The box developed in response to a roosting phenomenon that occurred with regularity every Saturday night between 2:00 and 4:00 a.m. in the seedy area of Harry Hines and Industrial Boulevard surrounding Parkland. Like clockwork, after the bars closed at 2:00 a.m., drunks would begin flocking into the ER. Most had been beat up, but many were just looking for a place to spend the night. They flagrantly got in your personal space if you were the pit boss, because they knew you determined how soon they got in. They slobbered and cried and hung on you, breathing their beer-fouled breath in your face, bleeding on you from scalp lacerations and generally clogging up the works. In the midst of this chaos, patients with real emergencies were still showing up, so it was a challenge to keep your cool. One industrious resident took out some duct tape, marked off a 3 X 3 foot area on the floor by the front desk, and told the drunks that any one of them that stepped in the box was going to the psych ER. It worked, and a tradition was born.

The box was situated at the entrance to the surgery ER. To the left was a long hall with six fully equipped trauma rooms. To the right was the rest of the ER. At the end of trauma hall was an emergency exit door that opened from the inside and locked when it slammed shut. It lead to the old helipad in the front of the hospital. I once made the mistake of going out this door. It slammed shut and I couldn’t get back in. It took me about twenty minutes to walk down Harry Hines and around Children’s Hospital to work my way to the ER entrance at the back of Parkland. Little did I know this information would prove useful.

A few days later I was working a Saturday shift as pit boss. At 2:00 a.m. the influx of drunks began. My shift would be over at 6:00 a.m. and it had been busy all day with no sign of letting up. I had no patience for slobbering drunks.

“When I’m goin’ be waited on, Doc?” said one.

“I need somethin’ for pain, right now!” said another.

“Gimme a drink before you sew me up”, said a third.

By now, there were eight or ten of them clamoring around, with more coming in. Then a light bulb went on in my head.

“Come here buddy”, I said to the first one. “That cut on your head doesn’t look too bad. Let’s get an X-Ray and we’ll get you out of here. Take these papers down this hall and go out that door down at the end.” Obediently, he made his way down the hall and out the door, which slammed shut behind him. One after the other, I sent the drunks staggering down trauma hall and through the exit door to “X-Ray”. Each time the door slammed shut, the ER got quieter, calmer and easier to manage. I was off in a couple of hours, and I figured if it took me twenty minutes to get back around to the ER entrance in daylight when I was sober, these drunks would never make it back around before my shift was over.

A few days later, the other resident with whom I alternated 24-hour ER shifts grabbed me as he left one morning.

“Hell, I don’t know what was up last Sunday,” he said. “About 10:00 a.m. a bunch of hung-over drunks with scalp lacerations started coming in. Must’ve been a dozen of them. You think the bars stay open all night now?”

I smiled. “I don’t know. Probably just a full moon.”
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