

IN THE NEWS

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What You Don't Know About UMC Independent Weekly | 08.06.08

By Lisa Hanchey

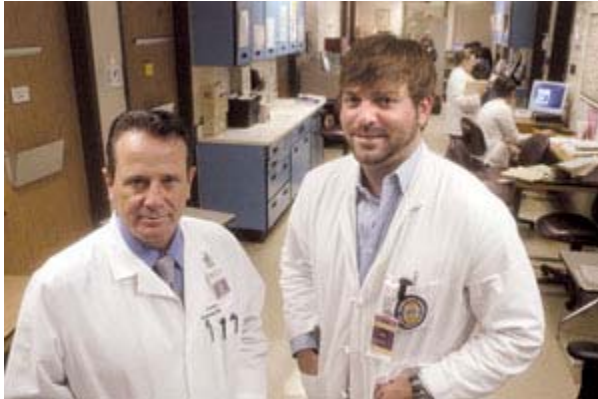


photo by Terri Fensel

UMC's Dr. Lonn Guidry, who has been training interns and residents since 1993, and Dr. Justin Ardoin, the hospital's chief resident and a regular volunteer at the Lafayette Community Health Care Clinic.

University Medical Center doesn't advertise and, unlike other hospitals in the area, doesn't have a sophisticated public relations rep or communications department. But that doesn't mean you don't hear a lot about it, most of which is negative. Over the years, University Medical Center in Lafayette has gotten a bum rap. You've all heard the complaints — long lines, hours of waiting time.

But there's a lot more going on at UMC than meets the eye.

A more accurate picture of the facility and the critical role it plays in the Acadiana community lays in the fact that it delivers quality medical care to hundreds of thousands of patients each year, most of whom are employed. The hospital also annually serves as a training center for dozens of bright, eager residents and fellows — many of whom choose to stay in the Acadiana area after completing their required rounds. Besides devoting countless hours to treating the working poor at UMC, all of the hospital's residents and many of the teaching faculty volunteer at the Lafayette Community Health Care Clinic.

UMC's patient base consists primarily of patients who are working but unable to afford insurance. Louisiana has 657,000 uninsured people. At UMC, greater than 85 percent of the patient population has no insurance, with the remainder having Medicare, Medicaid or private insurance.

The number of patients seen each year at UMC is staggering. For the fiscal year July 1, 2006, to July 1, 2007, the hospital had 237,010 visits from patients living in Acadiana, southwest Louisiana and even north Louisiana. Servicing a patient population of approximately 71,136 were 987 employees. Licensed beds number 146, with 104 staffed beds. The facility trains 182 medical residents and fellows, and 439 students in nursing and allied health, drawing trainees from as far away as Texas. UMC's estimated economic impact in overall business activity is \$228.7 million.

UMC is part of the LSU Health System, Health Care Services division, which also administers Earl K. Long Medical Center in Baton Rouge, LSU Interim Hospital in New Orleans, Bogalusa Medical Center in Bogalusa, Lallie Kemp Regional Medical Center in Independence, W. O. Moss Regional Medical Center in Lake Charles, and L. J. Chabert Medical Center in Houma. These hospitals share a total appropriated budget of \$850.5 million, including \$200 million in non-federal match funds and \$25.6 million in state appropriations. For fiscal year 2007, total collections at UMC were \$118.9 million from the state general fund, commercial/private pay, miscellaneous self-generated funds, Medicare, Medicaid, and Medicaid Uncompensated Care.

Although Louisiana ranks near the bottom of the list in health care, UMC's outcomes buck that statistic. "Taking the criteria that Medicare uses to score health care and applying it to the health care outcomes that we have in our state hospitals, we score within the top 2 or 3 percent in their criteria in the United States," explains Registered Nurse Lou Ann Gerard, director of patient relations. "And, it's because we're an integrated health care system, we are practicing disease management, and we are using a standard of care method of delivering health care to these people. And, that's how we can capture these scores and provide better health care for them."

UMC houses two residency programs — a family practice with 26 residents, and an internal medicine rotation with another 26 trainees. Walking through the residency wing is a surreal experience, almost like viewing a live set of *Grey's Anatomy*. Dozens of young doctors-in-training scurry about, following mentors like Dr. Lonn Guidry, a specialist in internal medicine and geriatrics and assistant professor of clinical medicine with the LSU Medical School in New Orleans. Guidry has been training interns and residents at UMC since 1993.

About a year ago, UMC launched a geriatric scholarship program, which hosts two spots for graduates in family practice or internal medicine in a specialized field that teaches doctors how to take care of frail, elderly patients. UMC's first geriatric fellow will complete training this fall.

In the wake of Hurricane Katrina, UMC inherited additional services from displaced doctors. One of the most valuable was a renal transplant program, which got a big boost when a New Orleans-based transplant surgeon, Dr. Daniel Frey, decided to stay in Lafayette. Since its inception, UMC has performed approximately 64 kidney transplants, which is the only type that the hospital does, and is now a Medicare-approved transplant center.

Budding physicians also assist with disaster relief. After hurricanes Katrina and Rita, many residents and faculty members took care of displaced patients at the Heymann Center and the Cajundome. Like his cohorts, chief resident Justin Ardoin volunteers at the Lafayette Community Health Care Clinic after completing his shift at UMC. On average, the internal medicine residents see 25 to 35 patients on three Thursday evenings a month. The family practice residents cover the other Thursday nights. "It's a great experience for us," Ardoin says. "It helps the community out, but we are also learning. No matter how long of a day I've had, no matter how tired I am, it still feels good to go over there."

Settling in Acadiana is a common trend for most residents and fellows at UMC. As experienced doctors retire, these younger physicians fill in the gap to provide care for the growing patient census. "The community in general benefits not only from the care, but also from the physicians who stay here, replacing retiring physicians," Guidry says. "As physicians retire and our population enlarges, we need not only the physicians to replace the retiring physicians, but we also need additional physicians to take care of the expanded population. And, many of the residents stay here."

About seven years ago, UMC launched the disease management program, an initiative focusing on five areas — heart failure, diabetes, asthma, chronic renal disease, and breast and cervical screening. The program, which is monitored by LSU's headquarters in Baton Rouge, ensures UMC follows nationally established guidelines for treatment of these conditions. "We are educating these people to take ownership of what is going on with them, with the ultimate goal of providing a great quality of life if we can," says Betty Lindberg, clinical coordinator for disease management. "We are required to provide national and regional statistics of how we are doing in our job."

Patients are sent to this program when identified by UMC, or through referrals from outside physicians. Nurse practitioners in collaboration with internal medicine physicians monitor and treat these specialized patients as needed. "The goal is to get them to a point where they are in their illness to where they are managed and they are stabilized," Lindberg explains. "I think our biggest asset is our accessibility," she says. "And mainly, it's because patients feel like they matter, and that is huge. Disease management is not an entity that stands by itself. This is a very cooperative effort that goes on through all departments in this hospital. We are kind of like a watchdog, if you will. We really try to pass on what we learn and make sure that we're all on the same page when it comes to patient care. And, it's worked beautifully for the most part."

Outcome measures show that collectively, LSU's disease management programs, including UMC, are working, with patients living beyond their expected lifespan. "This is because of education, medication, and adherence to guidelines," Lindberg says. "So, we are seeing good things happen."

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The spirit of New Orleans endures Smokey Mountain News | 08.06.08

By Michael Beadle

Mention you're going to New Orleans to most anybody these days and immediately you get the look.

It's not quite sadness. More like sympathy mixed with nostalgia and a hint of regret. It's like you're talking about a favorite relative — irreverent and sassy Aunt Maybelle, who's been going through chemo. There are rumors she's not fully recovered even though doctors say they got the tumor and she's in remission.

And so it is with New Orleans, a city that will forever be linked to one of the worst disasters in U.S. history — though some swear the worst of it came after the extensive flooding caused by the Category 5 hurricanes Katrina and Rita.

Three years later, the clean-up continues, and there are still plenty of groans, jokes and head shakes when you hear stories about government dysfunction, poor planning, strained budgets and that bureaucratic concoction of red tape soaked in the liquor of racism and corruption. Church groups, movie stars, famous musicians, native residents and volunteers are still picking up the pieces and restoring civic pride in the neighborhoods once condemned by floods, fires and trash.

On a recent trip to the Big Easy, I wanted to see for myself just what was going on in this city known as much for its debauchery and Mardi Gras mayhem as its landscape of live oaks and swamp marshes, savory foods and jazz clubs, and the gumbo culture of creole, cajun, Caribbean, Spanish, French and Native American.

This Delta ecosystem where the mighty Mississippi meets the Gulf of Mexico is home to more than 170 bird species and more than 100 species of fish and shellfish — about a third of the total U.S. seafood harvest. But the land and the water are always shifting, an impermanence that lends itself to the kind of spontaneity and dynamic energy found in jazz. With rising seas and climate change, some scientists predict New Orleans and much of the low-lying areas of Louisiana will be gone within the next 50 years — all the more reason to go and see it while you still can.

Certainly New Orleans won't be built back up just like it was, but many don't want the rebuilding of New Orleans to include the box stores and standard brand names that make it Anytown, America. As a city struggles to heal itself, as perhaps the very identity of American culture tries to endure, the scars are bound to show.

Like the cheap feather and sequin masks sold at souvenir shops in the French Quarter, there will always be a flash and flare to the Big Easy, but with only about 60 percent of the city's inhabitants back from its pre-Katrina population of a half million, there is still a palpable emptiness. Something is missing from behind that party mask.

Charity Hospital, Louisiana State University's Interim Hospital and one of the two teaching hospitals in New Orleans, endured extensive flooding damage during Hurricane Katrina and had to close. The lack of schools and hospitals remains one of the big reasons people can't move back.

In the meantime, the enduring tourist remains the city's biggest cash crop.

I'm happy to report — after a serious fact-finding mission fraught with barley, hops and a couple tall hurricanes at Pat O'Brien's — Bourbon Street is alive and well. As is Cafe du Monde, where you can still get your yearly dose of transfat and sugar in a couple of beignets. The blackened drum with sautéed veggies at K-Paul's on Chartres Street is still worth the airfare to get there. As for a lunch respite, I recommend a muffuletta and a fried apple pie at Johnny's Po-Boys.

July in New Orleans' French Quarter is still a steamy stroll through the touristy section of town. Knots of businessmen and vacationing families gather along the souvenir shops on Decatur Street as you head

toward the French Market, Jackson Square and the Cabildo building where the French signed away the Louisiana Purchase in 1803.

Louisiana is named after King Louis XIV. The French explorer La Salle sailed down the Mississippi River and claimed the land in honor of the king in 1682. Three of the streets in the French Quarter — Conti, Toulouse and Dumaine — are named after the Sun King's illegitimate sons. Bourbon Street gets its title from the king's family name rather than the choice drink of bead-wearing luses known to stumble through America's most famous avenue of lust and liquor.

New Orleans, meanwhile, got its name from Philippe II, the duke of Orleans, who served as a regent, or head of state, over France after Louis XIV's death. The king's heir, Louis XV, was too young to rule at the time.

After the French took the highest ground, which is today called the French Quarter, a military engineer named Adrien de Pauger designed the Vieux Carré, or "old square" to feature 100 blocks of equal size. The French Quarter sustained wind damage and lost power during the 2005 hurricanes, but it didn't get flooded because of its relative elevation as compared to the rest of the city.

Early on in its history, New Orleans served as a key port for cotton, sugar and lumber industries. After the Civil War, rock candies and chocolates made with locally grown sugar became all the rage. Then came oil and now it's tourism.

Further along the riverfront heading west, the Garden District maintains its status as the neighborhood with high-priced homes and gardens, where multi-storied residences sell for \$3 to \$5 million. Novelist Anne Rice and the parents of NFL Quarterbacks Peyton and Eli Manning live along these streets. For \$1.50, you can still ride the St. Charles Street streetcar to sightsee that part of the city.

The Garden District earned its name from the vegetable gardens grown by early residents. Wrought iron fences kept out livestock. Later, cast iron balcony and stair railings were fashioned with unique designs. The artist would destroy the mold after it was used once to preserve its individuality — thus the expression, "breaking the mold."

Oddly enough, the Spanish moss I thought I saw dangling from the live oaks was actually Mardi Gras beads. Dozens of krewe dress up floats and parade up and down the streets of New Orleans in celebrating the Bacchanalia marking Fat Tuesday and the start of Lent.

For the past few years, New Orleans' residents started a new tradition to go along with their Spanish past — the running of the bulls. But instead of a head of beef tearing through narrow streets, there are lovely ladies sporting horned helmets, roller blades and plastic bats eager to smack grinning men who don't seem to mind if they are "gored."

New Orleans still knows how to laugh at itself, to party at every chance it gets and play those soulful melodies, to strike up the band, bury the dead above ground, and share a joyful hymn of praise on the way home from the cemetery.

Katrina has given rise to a litany of artwork. Photographs show scenes of terrible beauty — a family Bible caked in mud, fishing boats stacked atop each other like toys, chewed up houses in an early morning fog. But there's a spirit of endurance that pervades the city after centuries of living precariously on drained swampland that seems to defy logic. It's the city's irrationality that gives it its charm, makes it a haunting setting for movies, TV shows and best-selling novels and plays.

And, of course, there's always some great music to be had in the Big Easy, whether it's a street corner singer crooning covers of old favorites or nightclubs blasting away brassy solos. The New Orleans Jazz and Heritage Festival — known to its fans as Jazzfest — is still a standard tradition where you skip work and then meet your boss among the throngs who come hear the masters, many of whom also happen to be native sons like the Marsalis family and Harry Connick Jr. This past year's Jazzfest in late April and early May drew some 400,000 fans — more than any year since Katrina.

A tour through New Orleans now includes — to some folks' dismay — a ride through the Upper and Lower Ninth Ward districts, where some of the city's worst flooding took place. Like a tour past Ground Zero in Manhattan, it provides a mixed brew of emotions from empathy and sadness to guilt and anger.

Imagine bending over to tie your shoe and by the time you're done, the water is up to your knees. That's how fast it came in, and health workers and stranded residents who had to wade through it later ended up with sores and infections since the water included toxic chemicals from flooded cars, sewers, businesses — you name it.

Katrina made landfall at 6:10 a.m. on Monday, Aug. 29, with 125 mile-per-hour winds. Sure, plenty of people left town, but not everybody had cars to leave. Hospital patients, the elderly, and the poor were stranded. Emergency shelters were set up at the Convention Center and the Superdome, but that was still too far for some residents to go since the water trapped them in their homes, in their attics, on their roofs. Lake Ponchartrain to the north of the city swelled from heavy rains and poured through weakened levees. By nightfall, the city had lost power. In the darkness, neighbors could hear screams of people drowning in their attics or floating on their houses that were torn off their foundations.

By the time it was all over, more than 1,800 people had lost their lives in seven states from Louisiana and Mississippi up to Kentucky and Ohio. Gulf coast damages were estimated at \$81 billion, by far the costliest hurricane in U.S. history. Nearly a month later, Rita struck New Orleans yet again as the worst tropical cyclone in Atlantic hurricane history, inflicting more flooding and yet another \$11.3 billion in damages on the Gulf Coast.

Katrina's legacy is apparent in paintings, sculptures and photographs that line the walls of various art galleries. A dark humor finds its way onto T-shirts and assorted souvenirs. "Hurricane Katrina Beignet Rescue Team 2005," one shirt reads at the Cafe du Monde gift shop. Other slogans aren't so kind to the Federal Emergency Management Agency, or FEMA, which was widely criticized for its bungling of rescue efforts and emergency planning after Katrina struck. One T-shirt refigures the FEMA acronym as "Federal Excuse Making Agency." Another reads, "Sorry I'm late. I work for FEMA." Still another shows a cartoon picture of George Bush sitting on the roof of a flooded home and declaring his now infamous approval of former FEMA director Michael Brown: "Brownie, you're doing a heckuva job."

Passing by homes and businesses today, you find that some still have that notorious red "X" on their fronts. The top of the "X" denotes the date when it was searched for bodies. The bottom quadrant of the "X" tells how many dead people were found inside the home. The left side of the "X" is the military designation of who searched the residence.

Some keep the "X" on their homes as a reminder of what happened.

"Do Not Demo," one home's sign reads.

"Yes, we are back," another business sign declares.

Some have returned. Others won't be back.

A marquee on a closed school in the Upper Ninth Ward still reads "Classes Begin 2005."

On one side of the Industrial Canal — the levee protecting the Lower Ninth Ward (lower because it's on lower ground in relation to the water level) has been rebuilt to withstand a Category 5 hurricane — that's a 13-foot high wall. However, on the side protecting the Upper Ninth Ward, the new levee is only 10 feet tall, able to sustain a Category 3 hurricane. Meanwhile, FEMA trailers — nicknamed "toxic tin cans" for their high levels of cancer-causing formaldehyde — are all that some residents had over the past two or three years since their homes were destroyed.

On a bus tour through the Ninth Ward districts, I saw these ubiquitous trailers as well as various construction teams hard at work building new homes. Brad Pitt's Make It Right Foundation is set up in the

Lower Ninth Ward, where the flooding was as high as 13 feet and much of the neighborhood is overgrown grassland.

One house at a time, one business at a time, one party at a time, the city of Satchmo and Saints, dirty rice and hot sauce, voodoo and gris-gris somehow finds a way to endure.

http://www.smokymountainnews.com/issues/08_08/08_06_08/art_fr_neworleans.html

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Muscular dystrophy support group is active around here

The Times-Picayune | 08.07.08

Jane Pic Adams

Muscular dystrophy (MD) is a term that refers to a group of diseases that cause degeneration of muscles that control movement. MD is characterized by progressive skeletal muscle weakness, defects in muscle proteins and the death of muscle cells and tissue.

The Muscular Dystrophy Association (MDA) is the world's largest nongovernmental sponsor of research seeking the causes of and effective treatments for neuromuscular diseases, including ALS (Lou Gehrig's disease).

According to the National Institute of Neurological Disorders and Stroke, some disorders can occur in infancy or childhood, while others may not appear until middle age or later.

Locally, the New Orleans District MDA offers comprehensive patient services and provides no-cost clinic services at Children's Hospital and through the LSU Health Sciences Center at Napoleon Plaza (the Ochsner-Baptist Hospital Alliance).

Services include initial diagnosis; follow-up medical care; physical, occupational and respiratory therapy evaluations; genetic counseling; and influenza vaccinations.

The local MDA sponsors a summer camp for children and teens, 6-17. This summer's Camp Sunshine was held in Bunkie, where campers enjoyed fishing, swimming, dancing, and arts and crafts.

About 175 campers, counselors, and staff attended the camp. Most of the volunteer counselors took part in past camps.

To help finance services and programs, MDA relies on public support.

The annual Jerry Lewis Labor Day Telethon will take place locally at The Esplanade mall in Kenner on Sept. 1 from 7 a.m. to 6 p.m. and will air on CW38 in the New Orleans area.

Another group that is supporting MDA this year is "Capricious Productions," a theater troupe at St. Paul Lutheran Church in New Orleans formed in 1972 by high school and college students performing original scripts.

It was such a success that the troupe decided to donate proceeds from each production to a local charity.

This year's production was tied to a summer camp theme, and MDA's Camp Sunshine was chosen as the recipient of monies raised.

"They Called It Camp Winnetka," a comedy with music, will be presented Aug. 30 at 7 p.m. and Aug. 31 at 3 p.m. at the St. Paul Lutheran Church Basement Theatre, 2624 Burgundy St.

Suggested donations are \$6 for adults and \$3 for children 12 and younger. Theatregoers may also bring canned goods for Second Harvesters Food Bank. For information call (504) 945-3741.

For information about MDA support and services, contact Beth Bender, MDA District director, or Diane Dobbs, health care services coordinator, at (504) 455-4460.

The MDA New Orleans district office is at 3925 I-10 Service Road, No. 211, in Metairie.

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COLLEGES

The Times-Picayune | 08.07.08

--- Loyola University ---

Lori A. Zawistowski recently was promoted to dean of Admissions at Loyola University after serving one year as interim dean of Admissions and Enrollment Management.

Zawistowski will continue to represent Loyola in national markets and will train, mentor and manage admission staff. She will collaborate with Sal Liberto, vice president of Enrollment Management, to craft unit policies and strategy and with faculty and other university stakeholders to forge partnerships designed to advance enrollment.

Zawistowski holds a bachelor's degree in international business with a minor in economics from Spring Hill College in Mobile, Ala. She also has earned a master's in business administration from the University of South Alabama in Mobile.

Zawistowski joined Loyola in 2000 as associate director of admissions. She has been a faculty member with the Admissions Middle Management Institute of the National Association of College Admission Counseling since 2003 and recently was selected as co-director of the program. She also is a member of the Spring Hill College Business Advisory Board and has read for ETS Scholarship and Recognition Programs since 2003.

--- LSU Health Sciences Center ---

Governor Bobby Jindal recently appointed Margaret Tennyson, professor of Nursing at LSU Health Sciences Center New Orleans School of Nursing, to a two-year term on the Louisiana Advisory Committee on Midwifery. She was nominated by the Louisiana State Board of Nursing.

Tennyson has been a certified nurse midwife since 1997. She joined the faculty of the LSU Health Sciences Center School of Nursing in 1981 and has served as a certified nurse midwife at Daughters of Charity Services since 1999.

The Louisiana Advisory Committee on Midwifery establishes and publishes the minimum curriculum and experience requirements for persons seeking a license to become a midwife, establishes and publishes the minimum standards of the midwifery practice, and examines, approves, denies, revokes, suspends and renews licensure of qualified applicants.

LSU Health Sciences Center New Orleans School of Medicine faculty members who recently were promoted include: Dr. Brian M. Barkemeyer, promoted to Professor of Pediatrics; Dr. Rodolfo Begue, promoted to Professor of Pediatrics; Dr. Fred A. Lopez, promoted to Professor of Medicine; Dr. Harry J. Gould, promoted to Professor of Neurology; and Dr. Anna M. Pou, promoted to Professor of Otolaryngology.

--- Orleanians Out of State ---

Carolyn Elizabeth Gibson of New Orleans was selected a member of the inaugural class of University Fellows at Samford University. Gibson, a 2008 graduate of Benjamin Franklin High School, will receive funding for undergraduate research and a two-week study trip to Rome. Less than seven percent of this year's Samford freshmen were selected to be University Fellows.

The following students from New Orleans made the dean's list for the spring semester at the University of Cincinnati: Bernard Landry, Casey Schneider and Julius Feltus IV.

Aswin Sairam of New Orleans recently graduated from the University of Cincinnati with a master of science degree in Engineering.

Robin A. Azeez, who attended John McDonogh Senior High School, has been named to the dean's list at Waynesburg University for the spring term of 2008. She is pursuing a bachelor of arts degree in Criminal Justice Administration.

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Rate of return to N.O. is slowing dramatically

WWLTV | 08.06.08

Paul Murphy / Eyewitness News

The city's population stands at about 70 percent of what it was prior to Katrina but the rate of people returning has slowed dramatically, signaling that New Orleans may be at the size it's going to be for a while.

A survey by the Brookings Institute showed that fewer than 3,000 people relocated to the city in the second quarter of 2008. That's a dramatic drop from the total of 6,000 that returned in the first quarter of 2008 and it pales in comparison to the numbers of people that returned in 2006 and 2007.

"When we look at the city's population, at about 325,000, there were many of us early on who thought the city would probably reach about 350,000 before we really saw a true leveling out," said Eyewitness News analyst Greg Rigamer. "I think that's the process we're seeing right now."

The survey also showed that the population in the metro area is about 90 percent of what it was prior to the storm, indicating that the rebound has been stronger outside of New Orleans.

The lagging recovery of New Orleans' population probably owes a lot to a lack of affordable housing, according to Allison Plyer of the Greater New Orleans Data Center.

"Rents have increased 46 percent and we're seeing all of our businesses are reporting they have vacancies, particularly among low wage workers," she said. "We could have more population returning or new people coming if we had more affordable housing."

Rigamer says new jobs in the proposed medical corridor could also prime the recovery pump.

"The LSU Health Sciences Center/VA Complex is the type of project that we're speaking of," he said. "That goes beyond what we have now, to attract people, to provide an incentive for people to come back."

The population shift could have a devastating effect in the 2010 census. Louisiana is expected to lose a seat in the U.S. Congress. The city of New Orleans could lose several seats in the state legislature in Baton Rouge.

<http://www.wwltv.com/local/stories/wwl080608tppop.1f6edf2e.html#>

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LSUHSC's Lazartigues awarded \$1.2 million grant EurekAlert | 08.06.08

New Orleans, LA – Dr. Eric Lazartigues, Assistant Professor of Pharmacology at LSU Health Sciences Center New Orleans School of Medicine, has been awarded a \$1.2 million Research Project (RO1) grant by the National Heart, Lung, and Blood Institute of the National Institutes of Health. The 5-year grant will support his research to advance our understanding of the role of the brain in regulating blood pressure and the development of hypertension. Dr. Lazartigues' research could pave the way for the development of new treatments for cardiovascular disease – America's #1 killer.

Dr. Lazartigues' research group was the first to identify the presence of a new protein (ACE2) in the mouse brain. ACE2 can degrade the hormone, Angiotensin-II, in the brain. Angiotensin-II can increase blood pressure by acting in the brain and on blood vessels.

Hypertension and other cardiovascular diseases are currently treated with drugs designed to block the production and action of Angiotensin-II. Dr. Lazartigues' grant will help determine the importance of ACE2 in the brain and how it alters the angiotensin system during the development of hypertension and other cardiovascular diseases.

"This grant represents national confidence in the quality of research being conducted at the LSU School of Medicine as we continue to rebuild our research infrastructure after the devastation following Katrina ," notes Dr. Larry Hollier, Chancellor of LSU Health Sciences Center New Orleans. According to the Centers for Disease Control's National Center for Health Statistics, an estimated 79.4 million American adults, or one in three, have one or more types of cardiovascular disease.

These include high blood pressure, coronary heart disease, heart failure, stroke, and congenital cardiovascular defects. Cardiovascular disease is the #1 killer in America, with an average death of one death every 36 seconds. Cardiovascular disease claims more lives each year than cancer, chronic lower respiratory diseases, accidents and diabetes mellitus combined.

According to the Louisiana Department of Health and Hospital's and the American Heart Association's 2005 Louisiana State of the Heart and Stroke Report, cardiovascular disease, including heart disease and stroke, was the number one killer of Louisianians in 2002, accounting for 35% of all deaths. In 2002, Louisiana had the ninth highest mortality rate due to cardiovascular disease and twelfth highest mortality rate for stroke when compared to all states and D.C.

"ACE2, is a natural regulator of cardiovascular function, transforming a bad guy into a good guy," says Dr. Lazartigues. "It is very likely that a few years from now, new therapies will target this enzyme to improve the treatment of cardiovascular diseases. This new grant provides us with the opportunity to figure out how it works."

According to the NIH, the Research Project (R01) grant is an award made to support a discrete, specified, circumscribed project to be performed by the named investigator(s) in an area representing the investigator's specific interest and competencies, based on the mission of the NIH. The Research Project Grant (R01) is the original and historically oldest grant mechanism used by NIH. The R01 provides support for health-related research and development based on the mission of the NIH.

"Dr. Lazartigues joined our faculty in August 2005," said Dr. Steve Nelson, Dean of the School of Medicine at LSU Health Sciences Center New Orleans. "Despite the challenges of the unprecedented disaster that struck as he was settling in, Dr. Lazartigues refused to abandon his school or his new home, continuing this promising line of research here at LSU. This is his first RO1 grant, awarded on its first submission when it's not unusual for investigators to submit grant proposals multiple times before they're funded."

LSU Health Sciences Center New Orleans educates Louisiana's health care professionals. The state's academic health leader, LSUHSC comprises a School of Medicine, the state's only School of Dentistry, Louisiana's only public School of Public Health, and Schools of Allied Health Professions, Nursing, and

Graduate Studies. LSUHSC faculty take care of patients in public and private hospitals and clinics throughout Louisiana. In the vanguard of biosciences research in a number of areas worldwide, LSUHSC faculty have made lifesaving discoveries and continue to work to prevent, better treat, or cure disease.

http://www.eurekalert.org/pub_releases/2008-08/lsh-lla080608.php#

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Meningitis case's cause unknown; risk small

The Advocate | 08.06.08

By JORDAN BLUM

The cause of the meningitis that killed an LSU student a week ago may never be known, but that does not mean there is a threat of an outbreak, the state's top infectious disease expert said Tuesday.

Louisiana has only had one major meningitis outbreak in the past 50 years, so "it would be unusual" to have another one now, said Dr. Raoult Ratard, the state epidemiologist.

At least 100,000 people in the state are carriers of bacterial meningitis, or meningococcal disease, but carriers are safe from the disease, Ratard said.

Only about 1 percent of the 100,000 will ever contract the disease from a carrier when a new meningitis strain develops, Ratard said. Exactly why is the great unknown, he said.

"So it's really a rare disease," Ratard said. "Hopefully, nothing else will happen."

LSU student Kaleigh Lynn Guy of Greensburg died from bacterial meningitis July 30. Guy, 22, first showed severe symptoms two nights earlier and was hospitalized the following day at Our Lady of the Lake Regional Medical Center before succumbing.

Meningitis is the inflammation of the lining around the brain and spinal cord, according to meningitis.org. The disease starts out with flu-like symptoms and often stiffness of the neck but can lead to death in just 24 hours.

Bacterial meningitis is spread through intimate contact such as kissing or sharing food or drinks. Viral meningitis is spread more easily but is much more benign, Ratard said.

There are up to 60 cases of bacterial meningitis in Louisiana a year, Ratard said, but most of the victims are infants or the elderly.

Few people pay attention when those deaths occur, Ratard said. But everyone notices when it happens to a college student, he said.

The only recent outbreak in many years was in 2006 when six people linked to the University of Lafayette-Louisiana contracted meningitis. Three of them died. There were other isolated cases that year at Loyola University in New Orleans and at Broadmoor Middle School in Baton Rouge.

College dormitories can be prone to meningitis outbreaks because of the close living quarters.

LSU officials said they acted fast to ensure there would be no new outbreak in Baton Rouge. Guy lived off campus and was not enrolled in summer classes, so there were fewer chances for spreading the disease. However, she did have an on-campus job.

About 25 of Guy's co-workers at LSU Tiger Talk and those she was recently in contact with were treated and showed no symptoms, said Tim Honigman, LSU Student Health Center medical director.

Honigman said the health center was able to get the necessary information about Guy's case from Our Lady of the Lake in order to treat her co-workers and others in close contact with her.

State law was approved in 2006 requiring incoming college students to show proof of meningitis vaccination.

But the vaccines, which include four meningitis strains, are still only 90 percent effective.

<http://www.2theadvocate.com/news/26323554.html>

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Average ER waiting time nears 1 hour, CDC says

Washington Post | 08.06.08

By MIKE STOBBE

The Associated Press

ATLANTA -- The average time that hospital emergency rooms patients wait to see a doctor has grown from about 38 minutes to almost an hour over the past decade, according to new federal statistics released Wednesday.

The increase is due to supply and demand, said Dr. Stephen Pitts, the lead author of the report by the Centers for Disease Control and Prevention.

"There are more people arriving at the ERs. And there are fewer ERs," said Pitts, an associate professor of emergency medicine at Atlanta's Emory University.

Overall, about 119 million visits were made to U.S. emergency rooms in 2006, up from 90 million in 1996 _ a 32 percent increase.

Meanwhile, the number of hospital emergency departments dropped to fewer than 4,600, from nearly 4,900, according to American Hospital Association statistics.

Another reason for crowding is patients who are admitted to the hospital end up waiting in the ER because of the limited number of hospital beds, Pitts added.

A shortage of surgical specialists also contributes. So, too, does the difficulty many patients have in getting appointment to doctor's offices _ which causes some to turn to emergency departments, experts said.

"It takes me a month to get an appointment for my own doctor, and I'm a physician, for God's sake," said Dr. Ricardo Martinez, an Atlanta emergency physician. He is executive vice president of Schumacher Group, an organization that manages about 140 hospital emergency departments.

The amount of time a patient waited before seeing a physician in an ER has been rising steadily, from 38 minutes in 1997, to 47 minutes in 2004, to 56 minutes in 2006.

Pitts added that 56 minutes may be the average, but it's not typical: The average was skewed to nearly an hour because of some very long waits.

"Half of people had waiting times of 31 minutes or less," Pitts noted.

Researchers also found that there has not been any recent increases in the number of patients arriving by ambulance, or in the number of cases considered to be true emergencies.

Black patients visited emergency departments at twice the rate as whites in 2006. Among age groups, the highest visitation rates were for infants and elderly people aged 75 and older.

About 40 percent of ER patients had private insurance, about 25 percent were covered by state programs for children and about 17 percent were covered by Medicare, the report found. About 17 percent were uninsured.

Some more findings: Summer and winter were the busiest season in ERs, and the early evening _ around 7 p.m. _ tended to be the busiest time of day. There were geographic differences as well, with hospitals in the South having the highest ER visitation rates.

Also, half of hospital admissions in 2006 came through emergency departments, up from 36 percent in 1996.

"The ER has become the front door to the hospital," said Pitts, a fellow at the CDC's National Center for Health Statistics.

Some doctors said the report supports a call for increased governmental funding for hospital emergency services.

"Millions more people each year are seeking emergency care, but emergency departments are continuing to close, often because so much care goes uncompensated," Dr. Linda Lawrence, president of the American College of Emergency Physicians, said in a statement.

"This report is very troubling, because it shows that care is being delayed for everyone, including people in pain and with heart attacks," her statement added.

The results are based on a national survey of 362 hospital emergency departments.

<http://www.washingtonpost.com/wp-dyn/content/article/2008/08/06/AR2008080601223.html>

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Tulane med school welcomes largest incoming class

WWLTV | 08.06.08

By Meg Farris Eyewitness News Medical Reporter

A new study finds that in the next few years there will be a shortage of doctors in the U.S. and that's especially a concern in New Orleans with the post-Katrina doctor shortage.

But now, doctors are seeing a surge in medical students who want to come to New Orleans for an education.

With hundreds of proud family members and friends looking on, 178 young men and women entering their first year of medical school at Tulane got the first symbol of their future.

But this white coat ceremony will go down in history. It's the largest medical school class since Tulane opened its doors in 1834.

"What we really hope is to get is to get a lot of these young people to come down and then want to stay in New Orleans and practice medicine here," says Dr. Marc Kahn, Tulane Senior Associate Dean of Admissions and Student Affairs.

The class is nearly half men, half women, from 36 states, 91 universities, and a few foreign countries. And while some were warned in their home towns not to come to a city in recovery, they say that is exactly why they came.

"One of my close family friends is a fire chief back in Chicago, so he was here helping out during Katrina and he sort of couldn't understand (why I want to come here) and with the heat and humidity it's a lot different here than Chicago. But I said for a great education it's worth it!" says first year medical student Carrie McIlwain of Chicago.

Incoming first-year medical student Sean Kim of Baltimore added, "Why be a part of something that's established when you can be part of a great story here." "Every year we see an increasing need for more and more physicians and it's great to see so many people from out of state want to come and rebuild the city," says Samita Das, first year Tulane medical student from Metairie.

"Just to help out, they saw the city coming back and they just want to be a part of it," adds Samy Abdelghani of New Orleans, also a first year Tulane medical student.

After the four years of medical school, Tulane usually has a third of its students stay in the state to do their residency training.

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Hospitals still feeling Katrina sting
New Orleans CityBusiness | 08.07.08
By Deon Roberts, Online Editor

The third anniversary of Hurricane Katrina is this month, and, to hear the interim CEO of Touro Infirmary explain it, hospitals are still reeling.

In a CityBusiness story this week, Michael Sniffen, who was brought on at Touro on April 28 after Les Hirsch's departure, said, "Organizations like Touro and the other hospitals all are challenged financially. Everyone is losing money this year."

Charity Hospital has been shuttered since the storm, forcing patients to seek out other hospitals. Hospitals, including Touro, have been hurt financially because of uncompensated care and rising labor costs coupled with inadequate reimbursement from the feds and state for Medicare and Medicaid, he said.

"Touro was the first hospital back after the storm," he said. "It did all the right things, but now it's struggling because the people who said 'Don't worry, we'll take care of it' are still telling us that the check is in the mail.

"Not getting money from the state for Medicaid was very disappointing, especially when the state has a huge surplus. It makes no sense. As a result we've been forced to go into our reserves, and we'd rather invest our reserves than use it to cover payroll."

<http://neworleanscitybusiness.wordpress.com/2008/08/06/hospitals-still-feeling-katrina-sting/>

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Touro CEO shapes post-K strategy
New Orleans CityBusiness | 08.07.08
By Richard A. Webster Staff Writer

Touro Infirmary interim CEO Michael Sniffen handed out business cards at a recent meeting that noticeably did not include the word "interim."

It wasn't by choice, he said.

"The board chairman came into my office one day, looked at my card with the interim title and told me to get rid of those and get new cards. I think they're trying to seduce me into staying," Sniffen joked.

Sniffen's job title has not changed. Touro brought him on April 28 on an interim basis after the departure of CEO Les Hirsch, and he expects to head back to his home in New Jersey shortly after the start of the year.

But Sniffen's role is more than acting as a place keeper until a new CEO is chosen. Sniffen's job is to get the Touro house in order — put it on more stable financial footing and help develop a strategy to ensure its survival in the difficult post-Katrina environment.

When the administration feels confident these goals have been accomplished, then it will be time for a new CEO to step in. But until then, Sniffen will not be referred to as the interim CEO because, as he put it, no one really takes interims seriously.

"When they first offered me the job they wanted me here for four months, but I told them I didn't want to be a caretaker," Sniffen said. "There are major problems to address and I wanted the responsibility to help solve them and you can't do that in the rush of four months."

Sniffen runs the Manchester Group, a health care consultant and interim management company in Murray Hill, N.J. His job is to step in on a temporary basis and help turn around troubled medical facilities. But he had never experienced anything like what he faces in New Orleans.

"I was told that it was an atypical situation, but personally I tend to be drawn to atypical situations," Sniffen said. "Maybe it's my Jesuit background. They tend to impress it upon you that you should do something atypical in your life to give back to the community."

Upon first surveying the New Orleans health care system, Sniffen didn't hold any punches.

"Health care in New Orleans is in a state of crisis. Mental health is paramount and then you have the whole Charity hospital situation. It's sad because the people in these communities are not being properly served and organizations like Touro and the other hospitals all are challenged financially. Everyone is losing money this year."

With the absence of Charity Hospital after Katrina, the remaining hospitals were forced to be all things to all people, Sniffen said. But three years after the storm, to survive financially, that is no longer possible.

"Touro was the first hospital back after the storm. It did all the right things, but now it's struggling because the people who said 'Don't worry, we'll take care of it' are still telling us that the check is in the mail."

Uncompensated care and rising labor costs continue to plague Touro, but the failure of the federal and state governments to adequately reimburse hospitals for Medicare and Medicaid are the real backbreakers, Sniffen said.

This year New Orleans hospitals failed to secure \$157 million in federal funding to help offset storm-related financial losses, and the state did not allocate additional money to help with Medicaid payments.

“Not getting money from the state for Medicaid was very disappointing, especially when the state has a huge surplus,” Sniffen said. “It makes no sense. As a result we’ve been forced to go into our reserves and we’d rather invest our reserves than use it to cover payroll.”

But the news is not all bad, Sniffen said.

Touro will open a \$4.2 million imaging center at the intersection of Napoleon and Claiborne avenues in November and is in the process of expanding its cardiovascular department by way of new private practice doctors.

As of now Touro has suspended its search for a new CEO until it has figured out how best to position itself.

“I’m trying to really focus Touro on its core strengths and the community its serving and go from there,” Sniffen said. “We need to figure out the path we’re going on, get ourselves on that path, and once we feel comfortable with our finances, we can decide if we want to partner with academic institutions for educational purposes.

“The only thing we know about health care in New Orleans right now is that the market is still unsettled.”•

<http://www.neworleanscitybusiness.com/viewFeature.cfm?recid=1138>

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Care offered to BR elderly

The Advocate | 08.07.08

By MARSHA SHULER

A new community program is offering adult day care and full health-care coverage for some of the Baton Rouge area's elderly.

The Program of All-inclusive Care for the Elderly is the second of its kind in the state.

It is a collaboration of the Franciscan Missionaries of Our Lady Health System and state and federal health agencies.

The idea is to provide the necessary services to keep people over age 55 who are nursing home eligible in their homes as long as possible, said Hugh Eley, assistant secretary of the state Office of Aging and Adult Services.

The program provides coordinated preventive, primary, acute and long-term care services for those eligible for Medicaid and Medicare.

The current base of operations is the St. Francis House Adult Day Care Center at 2041 Silverside Drive. Seniors will be able to go to the center during the day for medical care, occupational therapy and companionship.

Transportation is provided to and from the center so participants can get services.

A new facility is under construction on Bishop Ott Drive and is scheduled to open in November.

Up to 180 people can enroll in the program, said Karen Allen, executive director of PACE Baton Rouge.

Allen said those applying for enrollment must go through an extensive evaluation process to determine "an appropriate care plan so people will know what they are going to get."

Participants would then decide whether to enroll in the program which essentially becomes their health insurance plan, she said.

The Franciscan Missionaries of Our Lady Health System is responsible for delivering the care for a set monthly rate per individual. The rate is based on Medicaid and Medicare reimbursement rates.

"It's total responsibility for all their health care," Eley said.

With a capped reimbursement rate, "it's really in their best interest to keep the people well" and head off medical problems that could increase costs of care, said Allison Buljoin, PACE program manager for the state Department of Health and Hospitals.

Buljoin said participants must agree to see the physicians, therapists and others in the Franciscan's network of health-care providers.

For Medicaid eligibility, a person's income cannot be more than \$1,911 per month and total resources must be below \$2,000.

However, state health officials said there are many variables when determining financial eligibility and income limits are different when an individual is married.

Information about PACE may be obtained by calling (225) 765-6497 or by visiting <http://www.ololrhc.com/body.cfm?id=384>.

PACE programs — such as the one in Baton Rouge — were approved as a Medicaid service by a federal law passed in 1997. Providers are not-for-profit organizations who submit applications to the Centers for Medicare and Medicaid Services for approval.

The Baton Rouge program operated by the Franciscan Missionaries system is the second operating in Louisiana today. The system owns Our Lady of the Lake Regional Medical Center in Baton Rouge.

The first PACE program opened in New Orleans in September 2007 and is sponsored by Catholic Charities.

Eley said his agency is working with the Franciscan Missionaries to open another PACE center in Monroe early next year. “There’s no timetable but ideally we would like one in each region of the state,” Eley said.

<http://www.theadvocate.com/news/26367724.html>

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New Focus on Children at AIDS Seminar

The New York Times | 08.06.08

By LAWRENCE K. ALTMAN

MEXICO CITY — The global response to the AIDS epidemic has short-changed children, health workers at the International AIDS Conference said here on Wednesday.

Although governments and donors provide large amounts of money for H.I.V. treatment in the developing world, too little of that money reaches children, said Linda Richter, a psychologist in South Africa who delivered the first plenary lecture on children in the history of the conference.

She also said that despite increased efforts to reach pregnant women, too few of them were receiving the antiretroviral drugs that could prevent infection in their infants.

And while the news media have often highlighted the plight of children who have lost parents to AIDS, Dr. Richter said, “children orphaned by AIDS are, sadly, only the tip of the iceberg of H.I.V.-affected children.”

All children in communities severely affected by H.I.V. require psychological, nutritional and other support, she said.

The conference, which ends Friday, is held every other year; this year there are more than 22,000 participants.

A report released at the conference by the Joint Learning Initiative on Children and H.I.V./AIDS, an independent, international study group, urged governments and donors to develop new approaches to alleviate the plight of children in areas hard hit by the epidemic.

Dr. Jim Yong Kim of Harvard University said that about 6 percent to 10 percent of children needing therapy were receiving it, compared with 30 percent of adults. An important factor, Dr. Richter said, is that too few infants are being tested for the infection.

Michel Sidibe, an official of the United Nations AIDS program, said that 1.5 million children had died of AIDS in the past five years and that 15 million children had lost one or both parents to AIDS, the United Nations definition of an orphan. An estimated 2 million children under the age of 15 are living with H.I.V.

Dr. Richter said that in the developing world much of the money for children in AIDS programs went to consultants and overhead costs.

It would be more effective, and more efficient, to give money directly to families and communities, she said, adding that poor people have shown that they make good decisions about getting food and other provisions. In some cases, she said, mothers are unable to take their children for medical care because of financial barriers, including being able to pay the bus fare to treatment centers.

Other speakers said that children would also be better helped by examining the dynamics of families. Studies in Botswana and Tanzania that were cited at a news conference showed that men were often unwilling to care for the sick except when women were unavailable. Over all, the speakers said, at least two-thirds of those giving care to infected people in Africa are women and girls.

Lorraine Sherr of University College London, meanwhile, said that more needed to be done to help families cope psychologically after AIDS deaths. She said she could find only 16 published studies on bereavement in the developing world among those affected by AIDS and that in discussing fathers in affected families, researchers reported only on those who had died.

“We need to know about live fathers,” Professor Sherr said.

<http://www.nytimes.com/2008/08/07/health/07aids.html>

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CMS seeks coordination of serious adverse event payment policies
AHA News | 08.06.08

The Centers for Medicare & Medicaid Services is encouraging states to coordinate their Medicaid payment policies with Medicare's hospital-acquired condition payment policy to ensure that states do not pay for serious adverse events.

With the inclusion of two additional conditions in its fiscal year 2009 inpatient prospective payment system final rule, beginning Oct. 1, CMS will no longer pay hospitals a higher diagnosis-related group rate for 10 conditions if they were not reported as present on admission.

In a July 31 letter to state Medicaid directors, CMS pointed out that many Medicare beneficiaries are dual-eligible for Medicaid. As a result, states wishing to avoid Medicaid payment liability for the costs of serious adverse events no longer paid for by Medicare may choose to alter their Medicaid state plans to also deny payment for serious adverse events.

http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080806_cms&domain=AHANEWS

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To Be Old, Frail And Evicted:
The Wall Street Journal | 08.07.08
 By THEO FRANCIS

Since Jasmine Nguyen collapsed nine years ago, apparently from a seizure, the 32-year-old has lived in a nursing home in Lodi, Calif., dependent on a ventilator to breathe and the facility's staff for her daily needs.

But since early this year, the nursing home has been seeking to evict Ms. Nguyen and a dozen other residents in similar situations, potentially replacing them with shorter-term residents likely to bring more revenue.

Across the country, nursing homes are forcing out frail and ill residents. While federal law permits nursing-home evictions in some circumstances, state officials and patient advocates say facilities often go too far, seeking to evict those who are merely inconvenient or too costly. Residents with dementia or demanding families are among the most vulnerable, particularly if -- like Ms. Nguyen and the other Lodi residents -- they depend on Medicaid to pay their bills, the officials and advocates say.

Those on Medicaid bring facilities as little as half what they can get from residents who pay out of pocket, with private health insurance or through Medicare, the federal-state health program for the elderly.

No one counts evictions nationwide. But formal complaints about nursing-home discharge practices have doubled over a decade, to 8,500 nationally in 2006, making it the second-biggest category tracked by the federal Administration on Aging, trailing only complaints about unanswered calls for assistance.

Iowa officials say involuntary discharges have risen even as the number of nursing-home beds has declined. In the District of Columbia, officials contest roughly one in seven evictions as improper, and say still more go unchallenged. Officials in more than a dozen other states echo their stories.

"Across the board, involuntary discharge numbers have risen in recent years," says Louise Ryan, Washington state's long-term-care ombudsman, or official resident advocate. "It's a real problem."

And evictions may be even more widespread, since some eviction attempts are resolved without formal complaints. Residents may not know they can appeal or may be too ill to do so or fear retribution. "It's really hard to know how many folks were simply told, 'We think you need to find another place for your mother,'" says Robyn Grant, long-term-care policy director with United Senior Action of Indiana, an Indianapolis advocacy group.

The nursing-home industry argues that evictions are uncommon, and justified when they occur. Mark Reagan, a California attorney for nursing homes and a state trade association, says most evictions involve dangerous or hard-to-care-for residents that the facilities aren't equipped to handle, or residents who "just don't pay." The American Health Care Association, a national nursing-home trade group, says it isn't aware of broad problems with involuntary discharges, much less ones focusing on Medicaid residents.

Federal law -- enforced by the states -- says residents can be discharged involuntarily for just six reasons: if they are well enough to go home; need care only available elsewhere; endanger the health of others; endanger the safety of others; fail to pay their bills; or if a facility closes its doors. Even so, nursing homes must give residents at least 30 days' notice, explain their appeal rights, and put together a plan to make sure the move doesn't harm them.

'Objectionably Untidy'

But they don't always follow the rules. In a recent review of admission agreements at Missouri nursing homes, nearly one in five granted itself the right to evict residents without cause, the National Senior Citizens Law Center found. Almost half the agreements authorized eviction for residents who become

"uncooperative and unmanageable," "unduly noisy," "objectionably untidy" or for other reasons not permitted under federal law.

Nursing homes rarely roll evicted residents out to the curb. Instead, they transfer them to another nursing home or send them to a hospital or psychiatric facility for treatment and observation, and then refuse to take them back, a practice hospital social-workers sometimes call "nursing-home dumps."

"They basically don't want to deal with them," says Cara Pacione, social-work director for 291-bed Mount Sinai Hospital in Chicago, which sees two or three patients sent by nursing homes each month who are refused readmittance.

Even an orderly eviction can carry grave risks for the old and ill. Studies suggest "transfer trauma," or relocation-stress syndrome, can spur depression and weight loss and increase the risk of falls.

"Transfer trauma kills elderly, frail people," says Esther Houser, Oklahoma's long-term-care ombudsman for more than 25 years. After a small nursing home in her state closed suddenly last fall, 10 of the 16 relocated residents were dead by early March, she says. "People get lost, people don't know which side of the bed to get out of, or where the bathroom is."

Louis VanderLinde, a retired college professor in Frankfort, Mich., lived just six weeks after the Maples, a county-owned nursing home there, evicted him.

The facility knew he had Alzheimer's disease when it admitted him three years before, but last summer gave his wife, Nancy, 30 days to find him a new home. When she couldn't find one nearby, the Maples drove him 160 miles to a nursing home in Lincoln, Mich.

He fell within a half-hour, and soon suffered two bouts with pneumonia after inhaling food at meals; he died Oct. 12. "You could see the panicky look in his eyes -- everything was strange," Mrs. VanderLinde says. "It's a terrible thing to live through."

Marsha Latour, chairwoman of the board of the Maples, declined to comment on specifics of the VanderLindes' experience, citing patient confidentiality. She said Mr. VanderLinde's condition had reached a point that, without a dedicated Alzheimer's unit, the Maples was "not able to take care of him." The Maples ultimately released him to another facility that also lacked a dedicated Alzheimer's unit.

Like many of those served with eviction notices, Mr. VanderLinde was on Medicaid. Roughly two-thirds of those who remain in a nursing home 90 days or longer depend on Medicaid, having exhausted their own savings or other benefits. But nursing-homes are increasingly concentrating on patients coming off hospital stays and therefore eligible for Medicare benefits or private insurance, says Michael Wiederhorn, a health-care analyst for Oppenheimer & Co. "That's what they're all doing right now, is building up these recovery-rehab units."

The move makes good financial sense: Sun Healthcare Group Inc., a publicly traded chain with more than 200 long-term care facilities in 25 states, says it averages \$411 a day from Medicare patients -- but just \$166 from those on Medicaid. A recent industry estimate says Medicaid's rates, established separately by each state, fell \$4.4 billion short of what it cost nursing homes to care for residents on the program's rolls last year alone.

Often, nursing homes cite one of the federally permitted reasons to evict residents, but advocates for the elderly say it can be a stretch.

Closed -- For Renovations

For example, the nursing home hoping to evict Jasmine Nguyen, Lodi Memorial Hospital, told her and a dozen others in February that they would have to move by June 30 because the nonprofit organization was closing the facility -- for renovations.

All 13 residents were "sub-acute" patients, most of them dependent on ventilators or feeding tubes, or with other conditions requiring significant extra care.

Lodi Memorial told the state it planned to replace them with patients recently discharged from its hospital - who typically require shorter-term care covered at a higher daily rate by private insurance or by Medicare. (Medicare pays for up to 100 days in a nursing home following a hospital stay of at least three days.)

"They're not closing the facility," says Patricia McGinnis, executive director of California Advocates for Nursing Home Reform.

In April, after Lodi Memorial sought state approval, administrators were told that they knew when admitting the sub-acute residents that they would need extensive care, probably for many years, and it couldn't simply stop. Moreover, the state said in a letter, "your facility is not ceasing to operate as you are not surrendering your license."

Lodi Memorial has asked the state to reconsider. Spokeswoman Carol Farron says the facility described its plans as "ceasing to operate" because none of the options under federal rules quite fit, so "we had to pick the one that best met the circumstances." The move is unrelated to reimbursement, she adds. She says the hospital is now considering using the space for inpatient hospital beds, if the sub-acute residents can be moved.

The nearest nursing home certified to care for patients like Ms. Nguyen is about two hours away with traffic, says Jasmine's 23-year-old sister, Mary. Their mother, Kim Nguyen, who runs the family nail salon in nearby Stockton, visits Jasmine twice a day.

"I think it would kill her if she couldn't see my sister," Mary Nguyen says.

When residents fight an eviction, they often win, according to lawyers for both nursing homes and residents. But winning is no guarantee of staying in the nursing home. Daniel O'Connor never was able to return to the nursing home that forced him out.

A onetime first-baseman and then coach for San Francisco Bay Area minor-league baseball teams, Mr. O'Connor suffered from dementia and congestive heart failure. He had a colostomy bag, and one of his legs was amputated below the knee.

Gilroy Healthcare & Rehabilitation Center in Gilroy, Calif., sent Mr. O'Connor to the hospital in early 2006, but wouldn't take him back when doctors said he was ready to return, despite federal "bed hold" rules requiring nursing homes to give hospitalized residents first dibs on available beds.

Mr. O'Connor appealed. At a March 2006 hearing, nursing-home officials said he was argumentative, shouting and occasionally even emptying his colostomy bag on the floor in frustration. "There's probably a facility somewhere that can provide Mr. O'Connor with the treatment and the care that he needs," the nursing-home's executive director at the time told the hearing officer, according to a transcript. "It's not this one."

Hospital officials said Mr. O'Connor had arrived at the hospital with two untreated bedsores, as well as a urinary-tract infection -- conditions that "could contribute to his behavior in the facility if he was having pain," a state official testified at the hearing.

Begging to Return

Mr. O'Connor acknowledged being obstreperous at times, but begged to return, in part so he could attend Alcoholics Anonymous meetings in town. "I believe that there's some nurses there that can really help me out," he said.

In a ruling soon after, state hearing officer Kent Young told Gilroy Healthcare to readmit Mr. O'Connor, chastising it for ignoring federal and state bed-hold and eviction rules. State regulators fined Gilroy Healthcare \$1,000, plus \$50 for each day it had kept him out.

Instead of readmitting him, Gilroy Healthcare sought to overturn the decision and fines.

Dava Ashley, vice-president of California operations for Covenant Care in Aliso Viejo, Calif., which owns Gilroy Healthcare and more than 40 other nursing homes and assisted-living facilities in seven states, declined to comment on Mr. O'Connor's experience. She said company policy is to "admit patients into our facilities that we can properly take care of. We do not refuse to take them back."

Meanwhile, Mr. O'Connor remained in the hospital. His condition gradually worsened over the next 11 months. He fought off two infections and lost his other leg to amputation.

Mr. O'Connor was still in the hospital when he died in March last year. Gilroy Healthcare continues to appeal the ruling against it and can take the dispute to court if its administrative appeal fails. State officials say Gilroy Healthcare won't have to pay \$14,300 in fines levied against it until all appeals are exhausted.

http://online.wsj.com/article/SB121806702698918693.html?mod=2_1566_topbox

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HIV patients fare just as well with nurses-studies

Reuters | 08.07.08

By Tan Ee Lyn

MEXICO CITY, Aug 7 (Reuters) - HIV patients under the care and management of trained nurses fared just as well as patients treated by doctors, if not better, according to two studies that demonstrate ways to replace scarce doctors in Africa.

Areas hard hit by the AIDS virus often suffer a shortage of doctors and some of the discussion at an international AIDS conference in Mexico City this week focused on how this could be partially answered by "task-shifting," or transferring some of the responsibilities of doctors to nurses.

In both studies, nurses stepped adequately into the shoes of doctors when managing HIV patients being given drug treatment.

"It's a partial answer ... but this is a way of helping, particularly in settings where prevalence is so high," Ciaran Humphreys, a public health consultant with the Nuffield Centre for International Health and Development in Britain, said in an interview.

The AIDS virus infects 33 million people globally, according to the United Nations AIDS agency UNAIDS. Two-thirds are in Africa, in some of the poorest countries with little medical infrastructure.

But properly given, cocktails of HIV drugs can keep patients alive, healthy and working, the many are now combined into easy-to-take single pills.

"This should not be seen as a specialist condition any more. This is a condition that needs to be managed in primary care as well as in specialist centers when required," Humphreys said.

SCARCE RESOURCES

Researchers in both studies agreed that questions needed to be answered, such as whether nurses were happy with the extra workload and if they needed to pass off their own work to other hospital staff.

Many experts have been complaining for years about a shortage of trained medical experts in developing countries. Nurses are often in short supply, as are trained technicians.

In Humphrey's study in Swaziland in southern Africa, 427 patients started HIV treatment in nurse-led clinics, while 150 patients started therapy in hospitals under the care of doctors.

The nurses had all been trained to manage HIV drug treatment as well as side-effects. After a year, patients in both groups were medically stable and had the virus under the same level of control, but those who visited the clinics seemed more confident.

"They get holistic care at the local clinic level with people they know and were comfortable with," Humphreys said.

"More people at the clinics expressed their confidence in the ability to start to manage their own conditions than the people who attended the hospitals with all their doctors and facilities."

In a second, larger study in Mozambique, nurses in two public hospitals cared for 69 percent of 6,006 patients, while doctors took care of the rest.

The nurses in this study took on far more work, including reading laboratory results, identifying those who needed to start drug treatment, making prescriptions and managing treatment of patients and any side-effects.

After a year, both groups showed no difference in their state of health and viral loads.

"There was comparable level of quality of (nurses) and physicians in terms of HIV care and treatment," said Kenneth Sherr of the consultancy Health Alliance International, who conducted the study.

Patients seen by nurses took their drugs more faithfully, he added.

"Doctors are managers and see a lot of different types of patients ... nurses are more available and provide the bulk of care," Sherr said. (Editing by Maggie Fox)

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