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Mental Health Emergency Room Extension creates model
The Advertiser | 08.10.08
Marsha Sills

Diane Farley lowers her voice and keeps it level as she eases a blood pressure cuff around a patient returned to her unit.

The man is agitated.

"These lights are too bright. I don't see how you expect anyone to sleep in here," he tells the UMC registered nurse.

"We'll help you rest," she says, never changing her tone. He's given a lunch tray and moves to a bed. Before he begins eating, he places his elbows on his knees. His face falls into his cupped hands.

The rest of the room is void of the ambient noises found in an emergency room - crying children, incessant beeping monitors, the hustle of staff working on critical cases. And often not enough space to do what the patient asks, "Where can I pace?" or for Farley's response, "Anywhere you'd like."

This emergency room is a new model being implemented statewide in public hospitals not only to ease congestion in overcrowded emergency rooms, but to respond to the overwhelming population of behavioral health patients who end up in emergency departments with crises. The model moves patients out of the emergency room to designated stabilization units where the patient is an a more controlled and quiet environment.

"The emergency room was too much stimulation for them. With emergencies coming in, their stress level goes out the roof," said Keith Guidry, director of UMC's Mental Health Emergency Room Extension Unit. "We're taking patients into an environment more therapeutic to meet their needs. It's calm, quiet and structured."

Many of the patients are escorted into the hospitals by law enforcement after disorderly public episodes resulting from being off medication that treats their mental health disorder. But some come voluntarily.

"They start to know that they can get the help that they need here," Guidry said.

The model is one way that the public hospitals are working with the state to improve mental health care access. While patients are finding the stabilizing care they need in emergency rooms, inpatient services are also in such a demand that patients often had to wait hours in emergency rooms to be transferred to an available inpatient bed.

"For two years, maybe 2 1/2 years after the storms, the only cry that we heard at this office was, 'We need more beds. We need more beds,'" said Jo Pine, deputy assistant secretary of the Louisiana Office of Mental Health. "Having this front end has helped sort out who needs an acute bed, versus who can be served in some other method that is less restrictive and less costly. We don't have to have as many people looking for beds as before."

Often patients can be released after eight hours, Guidry said.

"Their symptoms appear to be less aggravated and less acute in the unit," Guidry said. "Still in all, because we have an environment conducive to calmness and structure that has the staff to accomodate their needs, even if they end up going to an inpatient psych facility, they're a lot calmer before they get there. Their therapy has actually started here, instead of waiting 12 hours."

Hospitals work together

The week after Katrina, LSU hospitals began collaborating extensively with the state's Office of Mental Health to devise a solution to alleviate the expected burden on the hospitals' emergency rooms. In the past, the emergency rooms had been the entrée for mental health patients in crisis and with the overwhelming disaster of Katrina and Rita, a different deluge was expected.

"We expected people in mental crisis because of what happened to them, but for a long time our state had a problem with people presenting to emergency rooms with behavioral health issues," said Jane Herwehe, project manager with LSU Health Care Services Division. "We didn't have a strong continuum of care for patients with this type of need. The emergency room was the place they ended up when they were in crisis."

One of the answers was the MHERE approach. Grant funding from the federal grants helped the program get started at interested hospitals - LSU Medical Center in New Orleans, UMC and Huey P. Long in Pineville.

Of the three, UMC was the first to begin its unit. This past March, New Orleans opened, while Huey P. Long is still in the process of finding staff.

Last year, Lake Charles Memorial partnered with Office of Mental Health to provide the service to Region V. The locally owned, not-for-profit hospital now has a medical and mental team that staffs a psychiatric triage and observation program within its emergency department. The staff works closely with local law enforcement, who are trained in crisis intervention. The unit is a four-bed triage unit with eight chairs for patients. The unit stays at capacity, said Sharon Coleman-Simien, Lake Charles Memorial's emergency room director.

In North Louisiana, public hospitals in Shreveport and Monroe both have crisis intervention units that serve a similar purpose.

Earl K. Long in Baton Rouge is in the initial stages of opening up its own MHERE unit. And more are planned at public and private hospitals through partnerships with the Office of Mental Health.

The concept has allowed hospitals to address a state and national issue of emergency room saturation, said Mary Broussard, nursing director at UMC.

"In addition to compromising our ability to deliver emergency care to the traditional patient presenting to the ED for a medical surgical emergency, the addition of psychiatric patients to the acute ED environment limited our ability to effectively care for either group in the safest, most therapeutic environment," Broussard said.

Last May, UMC began its model with newly hired staff, and last month moved into a modular building specifically designed for psychiatric emergency care. At times, the demand has exceeded the 10-bed capacity with some patients having to remain in the acute emergency department for supervision, but the length of stay there remains shorter, Broussard said.

"As an extension area of the acute ED, MHERE staff are dedicated to working with public and private psychiatric agencies around the state to refer and place these patients in the best care setting as expeditiously as possible. The time to appropriate setting has been improved with better patient outcomes the ultimate goal," she said.

From May to December 2007, 638 psychiatric patients were admitted to the emergency room through MHERE. Of those patients the majority - 56 percent - were released to an inpatient facility for further treatment, and 36 percent were able to be discharged to their home, according to hospital statistics.

Between January and June, patients admitted to the unit have exceeded the 2007 reported data with 696 patients admitted to the unit. In June, 65 percent of the patients were referred to another facility and 11 percent were referred to UMC's inpatient psych facility.

New model is working

While psychiatric emergency services isn't a new model for the state, the care delivery is evolving in a way that is providing better patient outcomes, according to Dr. Scott Griffies, director of behavioral services at LSU Medical Center in New Orleans.

Prior to Katrina, LSU Medical Center in New Orleans had a crisis intervention unit that provided emergency psychiatric services, but in March it opened its mental health emergency room extension. The 20-bed unit stays at or near capacity and this new model is working, he said.

In June, 294 behavioral health patients were treated at the unit - a 43 percent increase from March when the unit opened, according to stats from LSU Health Care Services Division.

"It has definitely decreased the amount of bottlenecking that has occurred in the emergency room," said Griffies.

Following Katrina, Griffies was displaced and returned to the facility in January 2007.

"When I got back to the emergency room with one intern and started seeing emergency psych patients, of the 23 beds in the emergency room, one particular day 18 of those were filled with behavioral health emergency patients," Griffies said. "This has markedly improved that. We don't have an overflow in the emergency room therefore, the emergency room can do their job, too."

So far, about a third of the patients who have been treated in the unit have self-reported that they've sought prior emergency care related to their behavioral health in the past two to three months, Griffies said.

What also makes the units different is the mix of medical and behavioral health staff who work with the patients. As part of the team at UMC, nurses, counselors and social workers provide comprehensive care to the patient during his or her stay in the unit. A Lafayette Parish Sheriff's deputy stationed in the middle of the unit eyeing video that flips from room to room in the unit also ensures patient safety.

The staff knows that once patients leave to either go home or to inpatient care, it's probable that they'll be back.

"We know that it's a sickness ... whether psychiatric or cardiac, patients do come back," said Leona "Penny" Belcher, a licensed practical nurse who's been with the unit since last September. "We just start from where they are and try to help them."

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Mob scene follows double shooting
The Times-Picayune | 08.09.08
By Leslie Williams
Staff writer

Violence that began about 4 p.m. Friday in the St. Roch neighborhood spilled over to the emergency entrance of the University Hospital nearly two hours later.

A security officer for the hospital at 2021 Perdido St., trying to disperse a mob, fired her handgun once in the air.

Assistant Police Superintendent Marlon Defillo linked the agitated-crowd incident to a shooting earlier in the 1300 block of St. Roch Avenue, near Urquhart Street. Two men were wounded by gunfire about 4 p.m. from an assault rifle. One was shot in the leg; the other was wounded in the abdomen.

Both men -- who were reported in stable condition -- were taken to the hospital. Soon dozens of relatives, friends and acquaintances gathered at the hospital's emergency entrance area on Gravier Street between South Johnson and South Prieur streets.

An odd set of circumstances then occurred, Defillo said.

As the security guard reported for work shortly before 6 p.m., two men arrived in a white SUV and exited the vehicle, Defillo said.

According to a preliminary investigation, some members in the crowd, apparently without provocation, charged two men who were near the security guard.

"This massive crowd was coming over the wall toward her," Defillo said.

She fired one shot in the air, he said. Other members of the hospital's security force quickly came to her aid, said Kenneth Scott, the hospital's chief of police.

Defillo said police still are trying to determine why some members of the crowd reacted this way to the two men in the white SUV.

"It happened so fast," said Gladys Graham, a relative through marriage of one of the shooting victims she described as "brothers."

"It was scary because there were many children out there," Graham said. "Everyone started running."

Graham said she saw some men in the crowd "without saying a word" just start hitting on a least one man.

Defillo said no one was injured in the hospital incident. He declined to identify the two men who arrived in the white SUV and the two men shot in St. Roch.

He said the earlier shooting in St. Roch "culminated from an argument."

Police still are gathering facts about both incidents, he said. No one was booked late Friday afternoon, but police will consult with the district attorney's office, Defillo said.

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LSUHSC awards degrees in summer ceremony
Shrevepoert Times | 08.10.08
By Jane Bokun

Daytheon Sturges was all dressed up in his finest suit for a day he long hoped would come.

"It has been a long time coming," Sturges said.

The Haynesville native graduated along with about a hundred fellow students from the Louisiana State University Health Sciences Center at Shreveport in a late-summer ceremony held at the Bossier Civic Center on Saturday morning.

Sturges received his certification as a Physician Assistant along with others who got their bachelor of science and master's degrees in dardiopulmonary science, medical technology, communication disorders, occupational therapy and physical therapy. Students also received their doctorates from the School of Graduate Studies.

How did the students feel after receiving their diplomas?

"I feel relieved because I worked so hard," Sturges said. He received his bachelor's degree in biology from Louisiana Tech University. "But it was nothing compared to the two and one-half years I spent studying at LSUHSC for this degree."

The commencement program began with an introduction by Joseph McCulloch, dean of the School of Allied Health Professions at LSUHSC. The commencement address was given by Dr. John C. McDonald, chancellor and dean of the LSU Health Sciences Center at Shreveport. McDonald has served as chancellor at the college since 2000. His key interest at the school has been bringing organ transplantation to Louisiana.

The ceremonies ended with a benediction and the mood became joyous as students, family and faculty made their way to the parking lot.

Kayla Lafleur, of Ville Platte, got her master's degree in occupational therapy and was excited to get on her way for a celebratory family dinner to Macaroni Grill in Shreveport.

"We're just so proud of her," said Wanetta Fontenot, Kayla's mother.

http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=/20080810/NEWS01/808100311/1060

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Katrina recovery too slow, poll says
The Times-Picayune | 08.10.08
By Nicole Dungca
Staff writer

With the three-year anniversary of Hurricane Katrina fast approaching, most New Orleanians are dissatisfied with the pace of rebuilding and recovery efforts, even as they remain hopeful about the city's future, according to a survey by the Kaiser Family Foundation released today.

The survey of 1,294 New Orleans adults, conducted from March 5 to April 28, offers troubling signs regarding attitudes in the city, noting that reported stress levels are rising, perceived job opportunities are limited and more people, especially young adults, are considering relocating.

Among more encouraging findings, 74 percent of respondents said they are optimistic about the future of the city and 56 percent think recovery and rebuilding efforts are headed in the right direction.

The in-depth survey, using interviews conducted in person, by telephone and through the Internet, followed up the foundation's 2006 survey of post-Katrina sentiments. The polls are part of a long-term effort by the California nonprofit to track the views of those in the Katrina recovery zone and convey the findings to government officials and media outlets.

The 2006 survey focused on residents from Orleans, Jefferson, St. Bernard and Plaquemines parishes, while this year's targeted only New Orleans residents. Difficulties in obtaining an accurate representative sample from parishes with smaller populations and the storm's massive impact in New Orleans influenced the reach of this year's survey, said Mollyann Brodie, a Kaiser vice president.

Nine in 10 of the respondents lived in the city when Katrina hit. Among those individuals, 41 percent said their everyday lives are still somewhat to very disrupted by Katrina, and 53 percent said their general level of stress has worsened.

Foundation officials said Katrina survivors will likely have "high expectations" for the city, influencing their dismay with the pace of recovery.

"These residents knew the city pre-disaster, and not only have that pre-flood city as their baseline but may also have overly high expectations about the power of the rebuilding process to create a 'new' New Orleans, one in which pre-existing social problems would be lessened or even erased," a foundation report said.

New survey results are "sobering," it said.

"With the exception of one area (levee rebuilding), there wasn't a critical area where the majority saw substantial, significant progress," said Kaiser President Drew Altman.
Many of the high-priority issues for residents of the four parishes in 2006 topped the list in New Orleans again this year. Asked to note which issues should be "one of the top" rebuilding priorities, 64 percent said repairing levees, pumps and floodwalls; 63 percent said controlling crime and assuring public safety; and 53 percent said making medical facilities and services more available were most important.

Among those priorities, respondents said only levee rebuilding had seen significant progress, with 60 percent saying they saw "some" to "a lot" of progress.

Seventy-one percent saw "not too much" or no progress at all on the issue of controlling crime. In terms of the availability of medical facilities and services, 59 percent said they saw little or no progress. And 72 percent saw little or no gain in making more affordable housing available.

In response to a related health care question, the survey found a smaller percentage of citizens reported having no medical insurance, dropping to 18 percent from 26 percent in 2006. But 58 percent reported problems with their health care coverage and access, up from 55 percent in 2006.

Despite the federal government's investment of billions of dollars in the area's levee rebuilding and other recovery projects, 77 percent of the survey respondents said the federal government has provided "too

little" money and other support since Katrina. At the same time, 72 percent said they believe federal money provided to the area has been misspent.

Disappointment with city leadership came through clearly, with 86 percent saying that political corruption is a "somewhat serious" problem, at the least.

New Orleanians offered a generally positive response to one issue that is drawing nationwide attention. When asked about the recent influx of immigrant workers, 58 percent thought they were generally good for the city. Thousands of Hispanic workers new to the area have played a critical role in the rebuilding effort.

"The role (immigrants) played in recovery was seen as helpful and not as taking jobs away from others," said Diane Rowland, Kaiser's executive vice president. But she added that "it may get more and more negative as they put more pressure on the health care system."

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Frustration and Optimism in New Orleans
3 Years After Katrina, Poll Finds Anger Over Slow Recovery but Hope for Future
Washington Post | 08.10.08
By Jon Cohen

Nearly three years after Hurricane Katrina devastated their city, New Orleanians are deeply dissatisfied with the rebuilding and feel overlooked by the federal government, the national media and the American public.

Still, a new poll by the Henry J. Kaiser Family Foundation also reveals a deep-rooted optimism among residents of Orleans Parish, many of whom think that the area's revitalization efforts are headed in the right direction, even if they have yet to yield clear dividends.

Overall, nearly three-quarters of residents feel hopeful about the future of the greater New Orleans area. This comes despite broad pessimism about their economic prospects -- nearly two-thirds said good jobs are rare -- and low ratings for the multibillion-dollar recovery effort.

For Wanda Bailey, 54, a community activist from the Algiers neighborhood, the pace of the rebuilding is the most frustrating part. "It's just moving too slow," she said. "After three years, it's unbelievable that everything is taking so long to get moving."

More than half of New Orleans residents, 52 percent, are "dissatisfied" or outright "angry" about the amount of progress that has been made. Twenty-three percent say that their lives are "largely back to normal" since the storm hit in August 2005, and nearly a quarter are seriously considering leaving the area.

Few residents think there has been significant progress in dealing with key issues such as crime, access to health care and the public school system. More than seven in 10 are dissatisfied with efforts to increase the availability of affordable housing. Overall, few are very satisfied with their own lives, and nearly six in 10 said it is a bad time for children to be growing up in the city.

"I think it's bad," said Merline Kimble, 59, a music promoter from the Treme neighborhood who recently returned to New Orleans. "For people who want to come home, rent is more expensive, utilities are more expensive, everything's more expensive. Nobody's doing anything to get people home. A lot of people are in bad health because of stress."

One of the starkest changes compared with a similar Kaiser poll two years ago is a sharp rise in the percentage of residents reporting health problems. In part, the increase may stem from greater access to health care and professional diagnoses -- more people are now covered by health insurance, and fewer rely on emergency rooms for primary care -- but the numbers are dramatic.

Three in 10 residents rated their health as "fair" or "poor," more than double the percentage saying so in the fall of 2006. The share saying they have a serious mental illness has tripled to 15 percent, and 17 percent now take medication for "emotions, nerves or mental health." Nearly four in 10 said they have hypertension.

About eight in 10 of those surveyed said the federal government has not provided sufficient support; most think the rebuilding of New Orleans is simply not a priority for the president and Congress.

But Crescent City residents aim their criticism not only at elected representatives in Washington. Nearly two-thirds think that the American public has largely forgotten about their problems. Even more, eight in 10, are dissatisfied with insurance companies, and nearly half rated the national media's coverage negatively.

Local officials are not spared. More than seven in 10 respondents believe that the federal money allocated to the recovery effort has been mostly misspent. Nearly all of those polled said political corruption is a problem in New Orleans, with nearly six in 10 calling it a "very serious" concern.

"The problem is that too many people have their hand in the cookie jar," said Hanson Smith, 45, a firefighter from the Irish Channel section of the city. "A lot of people are thinking too much about themselves and not looking at the bigger picture. . . . That goes for city government all the way up to the federal government. Politicians will promise you the world, but when it comes down to it, it's politics as usual."

Most residents see New Orleans as split along racial and economic lines, and many see that as a problem. Among blacks, nearly half see the recovery effort as biased against them; few see their lives as back to normal; and they are more apt than whites to report physical health challenges, problems with health-care coverage and access, and inadequate wages. Twenty-six percent of blacks said they are "living comfortably," compared with 56 percent of whites who said so.

The survey was conducted March 5 to April 28 with a random sample of 1,294 adults living in Orleans Parish who were interviewed by telephone, over the Internet or face to face. The results from the full poll have a margin of sampling error of plus or minus three percentage points.

Special correspondent Mike Perlstein in New Orleans contributed to this report.

http://www.washingtonpost.com/wp-dyn/content/story/2008/08/10/ST2008081000120.html

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Survey: New Orleans optimistic in spite of troubles
The News Star | 08.10.08
Associated Press

NEW ORLEANS — New Orleans residents are surprisingly optimistic three years after Hurricane Katrina, considering that most see little or no progress in key areas and feel the rest of the country has forgotten their lingering troubles, says the head of the foundation that did the research.

But the percentage of residents who said they are planning to move out of the city or seriously considering such a move has nearly doubled since 2006, from 12 percent to 22 percent, according to the study released Sunday by the Kaiser Family Foundation.

The foundation, a nonprofit, private group focused health care issues, said repairing levees, pumps and floodwalls was the only key area where a solid majority — 60 percent of the 1,294 New Orleans residents interviewed — said there has been at least some progress.

Seven in 10 saw little or no progress in either availability of affordable housing or controlling crime, the report said.

In addition, 64 percent said it's hard to find good jobs, six in 10 say they don't think rebuilding the city is a priority for Congress and the president, and 65 percent said they think most Americans have forgotten about the problems facing New Orleans.

Even so, 56 percent still told researchers in March and April that the rebuilding and recovery are going in the right direction, and 74 percent said they are optimistic about the city's future.

"The fact that so many people in the city are still optimistic about the future is surprising," Drew Altman, president and chief executive officer of the foundation, said last week. "It also frames the challenge of the future — whether the recovery can maintain enough momentum to sustain that optimism."

Altman said New Orleans' optimism makes the city vary from other cities with problems and large populations of low-income residents.

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Nurses in high demand
The Town Talk | 08.10.08
By RT Morgan

Amelia Wheeler, a nurse at Rapides Regional Medical Center, starts an IV on a patient on Friday. While local businesses in the medical field are experiencing growth, the number of nurses available has not kept pace. (Tia Owens-Powers/tpowers@thetowntalk.com)

A quick scan of a newspaper's classifieds tells the tale: Nurses are needed in Central Louisiana.

And from hospitals down to home health agencies, all medical-related organizations are making their best pitches to entice and hire new and veteran nurses.

"$10,000 SIGN ON BONUS," screamed the advertisement that Byrd Regional Hospital in Leesville placed in the Aug. 3 edition of The Town Talk.

The hospital's ad called for registered nurses -- "new grads" or "experienced RNs" -- to join its staff. On the other side of the page, an advertisement placed by Rapides Regional Medical Center in Alexandria made similar offers.

"It's not a new issue," said Steve Skull, Rapides' vice president and chief staffing officer.

While the hospital does have enough nurses to make ends meet, the demand for care is typically greater than the supply of caregivers such as nurses. It's a demand that's further complicated by the aging population, Skull said.

Recruitment involves more than just base salary, Skull explained. The hospital does a number of things to add staff, which includes sign-on bonuses and other incentives.

Competition is heavy

Like its larger brethren, smaller hospitals also are offering incentives to get nurses in the door. Riverland Medical Center in Ferriday offers scholarship assistance to nurses who will join the staff, said Tammy Abernathy, director of nursing.

"That's the biggest pull we have because we can't afford big sign-on bonuses," Abernathy said.

Compared with Rapides' 314 beds and 467 registered nurses, Riverland is a rural, 25-bed critical access center with approximately 75 nurses. This lack of a competitive edge creates an environment in Riverland in which new nurses get trained and then leave, Abernathy said.

And it's more than larger facilities that are stealing away recruits, Abernathy said. Home health agencies, hospices, management opportunities and marketing companies also are luring away trained nurses from large and small hospitals alike.

"(Nurses) are pulling away from regular 24-hour hospitals," said Abernathy, a 30-year veteran of nursing. While Riverland is able to keep up with patient demand, this ample competition for nurses did force the medical center to recently close its labor-and-delivery department.

"We haven't struggled this much until the last five years or so," Abernathy said. "We have managed to keep up with demands mainly because most of our employees are long term."

Ties with universities

In addition to financial incentives, hospitals also have developed strong ties to local universities in hopes of attracting nurses.

Rapides teamed up with Northwestern State University in Natchitoches and the university located a branch of its nursing program at the medical center, said Cheryl Wilson, Rapides Regional's chief operating officer.

It handles 40 students, and the hospital helps subsidize the faculty salaries and provides classroom space.

Likewise, Christus St. Frances Cabrini Hospital in Alexandria participates with university advisers and gives input into the class curriculum of local universities and vocational schools, said Celeste Bordelon, a Cabrini nursing director.

Bordelon sees a shortage of qualified nursing instructors as the biggest challenge to the nursing population. Nursing programs always are looking for instructors, a master's-prepared individual with an aptitude for teaching.

This educational challenge is old hat for Dorothy Lary, chair of the nursing department at Louisiana State University at Alexandria.

"We see the nursing shortage, and the community and politicians are putting pressure on us to admit more students," Lary said.

She said the college is working to increase the number of students but that the number of educators is a barrier.

The department graduates 100 students per year, but in its clinical program can have only 10 students per teacher by state mandate. Lary said finding educators is hard because many graduates stay in the nursing field.

"We understand there is a shortage, but we have to have the educators to teach the clinicals," Lary said.

She said the hospitals are supportive and have helped in meeting the demands by offering employees as adjunct clinical professors.

Bordelon is one such employee who stepped up to be an adjunct professor to help increase the training potential.

Cabrini is currently working toward a step already taken by Rapides -- expansion.

And similar to Rapides, the added facilities will require additional nurses. Bordelon said Cabrini already works intensely on daily staffing needs and has begun planning for its future.

That's why a relationship with local universities is so important to meeting community health needs, Bordelon said. A hospital has to do whatever it can to supplement its nursing population.
Town Talk reporter Mandy M. Goodnight contributed to this report.

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Aging Baby Boomers Drive Hospital Growth
Washington Post | 08.10.08
By Lori Aratani
Washington Post Staff Writer

Holy Cross Hospital's announcement last week that it hopes to build a hospital in Germantown is just the latest example of a baby boomer-fueled building frenzy sweeping the health-care industry in Montgomery County and other parts of the country.

Over the past several years, all five of Montgomery's major medical centers have decided to expand, upgrade their facilities or build ones. The changes sometimes pit hospitals against each other as they vie for patients. Holy Cross's announcement has prompted Rockville-based Adventist HealthCare to urge greater regulatory scrutiny of its rival's plans.

Medical centers in some nearby counties are also growing.

Howard County General Hospital broke ground in September on a $105 million expansion that will increase the number of beds from 219 to 261. Kaiser Permanente of the Mid-Atlantic States, which has 29 medical centers in Maryland, the District and Virginia, plans to open a medical center in Fredericksburg early next year. In 2006, Potomac Hospital in Woodbridge opened a four-story, 180,000-square-foot patient care building that added 30 private rooms.

"You're seeing this all over," said Charlene Wilkins, spokeswoman for Potomac Hospital.

What's happening locally mirrors a national trend, fueled by concerns that aging baby boomers will put new demands on the health-care system and that old hospital buildings can no longer accommodate changing and complex medical technologies, said Mary E. Stefl, chairwoman of Trinity University's Department of Health Care Administration.

"It's the most significant [hospital building boom] since after World War II," said Rick Wade, senior vice president of the American Hospital Association.

According to an annual survey by Modern Healthcare magazine, 2007 was a banner year for hospital construction. Last year, 3,552 health-care construction projects were completed, compared with 3,441 the year before.

Amid the boom, however, D.C. area hospitals in less affluent areas have struggled to stay afloat. In the District, officials hope new ownership will prevent Greater Southeast Community Hospital from having to close. In Prince George's County, state and county officials are working to keep the publicly owned Prince George's Hospital Center open until a buyer can be found.

Although some say the economic downturn will slow the trend in more affluent areas, the boom continues in Montgomery. In addition to Holy Cross's plans for a new hospital and renovations at its Silver Spring campus:

· Montgomery General Hospital in Olney will break ground in a few weeks on an addition that will double the size of its emergency room.

· Washington Adventist Hospital is laying the groundwork for a move to a site in White Oak/Calverton that's almost quadruple the size of its 13-acre campus in Takoma Park. It is also in the midst of a $99 million expansion that will add about 45 beds to its Rockville campus.

· Suburban Hospital in Bethesda is in the planning stages of a renovation that will upgrade and expand its operating rooms.

"Montgomery County's health-care infrastructure clearly has not kept up with the needs of a growing and aging population," said Ronna Borenstein-Levy, spokeswoman for Suburban. "Each hospital is trying to serve the community the best way it can, which is why you see these various initiatives being proposed."

Montgomery County Council member George L. Leventhal (D-At Large) added: "We've had the same infrastructure we had 30 years ago, but we have a dramatically larger population."

In addition to changes at its Takoma Park and Rockville campuses, Adventist HealthCare opened the Shady Grove Adventist Emergency Center in Germantown in 2006 to help meet the demand for emergency room services. Holy Cross's plan for a hospital in Germantown has been greeted with enthusiasm from elected officials, who have long heard complaints from residents about access to medical facilities.

"I'm very excited," said Montgomery Council President Michael Knapp (D-Upcounty) about Holy Cross's plan. "To look at where we were 10 years ago [in terms of medical facilities] and look where we'll be in five years, it's a great turnaround."

But officials at Adventist have concerns.

"There needs to be more public and regulatory scrutiny over various aspects of [Holy Cross's plan]," said Robert Jepson, Adventist HealthCare's associate vice president of government relations and public policy. Jepson noted that several years ago, when Adventist HealthCare sought to increase the number of beds as part of a renovation at its Shady Grove Adventist campus in Rockville, Holy Cross officials were among those who argued fewer beds were needed.

"There's a very energetic rivalry going on between two hospitals, Holy Cross and Adventist," said Leventhal, who chairs the council's health and human services committee. "I don't know what to make of it. They're both nonprofits. They ought to be working together, but they're clearly very competitive."

Although it established its first hospital in Takoma Park, Adventist HealthCare has slowly carved out a presence in the western part of the county with Shady Grove Adventist in Rockville and the emergency center in Germantown.

Holy Cross is based in Silver Spring. The Germantown site would be its first major push into the western portion of the county, though it plans to open a primary care clinic in Gaithersburg this year, said Holy Cross's president and chief executive, Kevin J. Sexton. Its proposed hospital would be about a mile from Adventist HealthCare's emergency center, Jepson noted.

Holy Cross's proposal will probably face scrutiny from the state's health-care commission, the state agency that will determine whether it can move forward.

No matter the outcome, expansion advocates say Washington area patients will benefit from the construction boom. Many of the building projects are focused on making hospitals more user-friendly and less institutional with amenities such as valet parking and private rooms with pullout beds for family members to stay overnight.

Said William G. Robertson, president and chief executive of Adventist HealthCare, "Certainly there are good hospitals all over this region."

Staff researcher Meg Smith contributed to this report.

http://www.washingtonpost.com/wp-dyn/content/article/2008/08/09/AR2008080901836.html

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Gardasil's chorus of doubters
Industry Watch | 08.11.08
By Linda Marsa

Sandra Levy wants to do everything she can to safeguard the health of her 11- year-old daughter -- and that, of course, includes cancer prevention. She has had her child inoculated with one shot of Gardasil, the human papilloma virus vaccine that may prevent cervical cancer. But now, she says, she has serious reservations about going ahead with the next two injections of the course.

"It's very confusing, and we really don't know if it's 100% safe," says Levy, of Long Beach. "I'm not against vaccines, but I don't want to do anything that would harm my daughter."

Though most medical organizations strongly advocate using the HPV vaccine, some doctors and parents, like Levy, are asking whether the vaccine's benefits really outweigh its costs. They say they aren't convinced that the expensive shots offer any more protection than preventive measures already available -- principally, regular screening via the Pap smear test.

A handful worry that blanket immunizations of the nation's adolescents could backfire by lulling them into a false sense of security that leads them to neglect regular screening. If that happened, vaccination could eventually boost cervical cancer rates instead of lowering them.

In addition, because Gardasil protects only against the HPV strains linked most strongly to cervical cancer, "we don't know if it will make a difference in the ultimate rates of cancer," says Abby Lippman, an epidemiologist at McGill University in Montreal who has researched the HPV vaccine.

"The jury is still out on how much benefit we're actually going to get with this vaccine."
A report released in June stirred up more doubts. Although cause and effect were not proved, the report listed serious events -- such as seizures, spontaneous abortions and even deaths -- among teens, preteens and young women who had earlier had Gardasil shots.

As a result, the decision -- to vaccinate or not? -- has become controversial. Sorting through the pros and cons can be daunting for many parents. Promoted on TV since its approval in June 2006, Gardasil has been promoted via TV ads featuring girls jumping rope and chanting "One less, one less," a reference to the promise that they won't be another statistic. The vaccine has been hailed by physicians' groups as a breakthrough that could potentially eradicate cervical cancer in the U.S. within a generation.

The American College of Obstetricians and Gynecologists recommended that girls get the required series of three doses (given over a six-month period) at age 9 or older; the American Academy of Pediatrics and the Centers for Disease Control and Prevention recommended the same, with a starting age of 11 or later. (Because HPV is normally spread by intimate contact, the vaccine is considered most effective when given before the beginning of sexual activity.

It will not eradicate HPV if someone is already infected.) Since 2006, about 8 million females in the U.S. have received at least one shot of Gardasil, according to the vaccine's maker, Merck & Co. of Whitehouse Station, N.J., which based these estimates on data from government and private insurers.

Of the 100 known strains of HPV, about 30 cause cancer or genital warts. Two -- HPV-16 and HPV-18 -- are responsible for 70% of cervical cancers. Pre-market studies showed that the vaccine is 90% to 100% effective in thwarting the transmission of these two strains and two others, which are linked to 90% of genital warts.

The vaccine is expensive. It costs $360 for the series of three shots, andadministrative fees can add $100 or more. Though insurance companies sometimes cover costs, the overall expense for vaccinating the nations' teenagers could run into billions, a bill that will affect taxpayers as the shots are given to recipients of government health programs and health insurance premiums rise.

The price may not be worth it, says Dr. Karen Smith-McCune, an obstetrician and
gynecologist at the UC San Francisco School of Medicine. Because it takes years for cervical cancer to develop, it is easily preventable as long as HPV infection is detected early. Though the cancer is common in developing countries and kills more than 280,000 women worldwide every year, it is much less of a

health threat in the U.S., she says, where 11,000 women are diagnosed with the disease annually, and about 3,700 will die of it.

The comparatively low U.S. incidence of cervical cancer is due to one of the public health system's triumphs: widespread use of Pap smears, which detect abnormal cervical cells so they can be removed before they turn into cancers.

Adoption of the Pap test caused a reduction of cervical cancer rates by 74% between 1955 and 1992, according to the American Cancer Society. Rates continue to drop by 4% each year.

Smith-McCune and other critics of Gardasil also note that up to 90% of HPV infections in adolescents clear up on their own -- meaning that cervical cancer will not develop even in most women infected with the most aggressive type of HPV. In other words, a woman's risk of developing cervical cancer is already extremely low, and the immune system normally makes short work of HPV without outside help.

Even if women get the vaccine, they still need to continue annual Pap screenings because they could contract other cancer-causing HPV strains that the vaccine does not fight.

"The crux of it is that we know how to prevent cervical cancer," Smith-McCune says. "One of the key questions is whether this huge outlay of money for the vaccine is a better strategy than reaching out to the women who aren't getting Pap tests and follow-ups."

Studies inconclusive

It is not yet proven that Gardasil actually prevents cervical cancer, which can take a decade to develop after HPV infection, because tests of the vaccine before the FDA greenlighted it didn't run long enough to prove that conclusively. "Even though it guards against two HPV strains, the other HPV types need to be taken into account," Smith-McCune says.

"It will take a long time before we know the true efficacy of the vaccine." Even doctors who helped devise the vaccine point out that Pap screening may be more effective in cutting cervical cancer rates. "If we vaccinate every single 12- year-old, it should reduce by half the number of cervical cancers in the next 35 years," says Dr. Diane Harper, director of the Gynecologic Cancer Prevention Research Group at Dartmouth Medical School in Hanover, N.H., and a lead researcher in the development of the HPV vaccine.

"With Pap screening, we've reduced it by nearly 75%." Then there is the issue of side effects. When the vaccine was tested in more than 11,000 females age 9 to 26 before its FDA approval, no serious ones emerged, though some subjects felt soreness at the injection site and, in rare instances, fainted after the shot.

But an analysis released June 30 by the Washington, D.C.-based public interest group Judicial Watch raised some red flags. Judicial Watch obtained records from the FDA's Vaccine Adverse Event Reporting System (VAERS), a voluntary system used by doctors, patients and drug companies to report side effects with vaccines to the federal agency.

The report revealed that since the vaccine's 2006 approval, when girls began getting it, nearly 9,000 had bad health events after receiving Gardasil. The incidents included 10 miscarriages, 78 severe outbreaks of genital warts and six cases of Guillain-Barre syndrome, an autoimmune disorder that can result in paralysis.

There were also 18 reported deaths. Since the FDA's VAERS is known to catch perhaps 10% of adverse events at best, according to a 2004 report in the New England Journal of Medicine by the FDA, the actual numbers may be far higher.

It is difficult to prove whether the vaccine was the culprit behind these side effects -- just because two events happen, it does not mean that one caused the other, says Dr. Laurie E. Markowitz, an epidemiologist at the CDC who has had her own daughter vaccinated. The deaths, and all the other serious events, could have happened in the absence of the vaccine, she says.

Markowitz remains convinced the vaccine is safe. "The CDC and the FDA checked out these reports very carefully," she says. "And we've done calculations
for the number of cases reported and the number of cases that you'd find in the general population, and we have not found an increase." Given these caveats, should girls be getting the shots?

Most major medical groups still think Gardasil should be part of routine immunizations for 11- and 12-year-old girls. Shots still strongly urged There is more than the matter of cancer prevention, says Dr. Joseph A. Bocchini, chief of pediatric infectious disease at Louisiana State University Health Sciences Center in Shreveport and chairman of the American Academy of Pediatrics committee on infectious diseases.

The vaccine could spare hundreds of thousands of women from the psychological trauma and physical pain of a cycle of follow-up tests when they have an abnormal Pap test result and the treatments for pre-cancerous lesions that can cause infertility.

"You can actually prevent these infections and the cervical abnormalities that require more invasive interventions," he says. Whether the shots should be mandatory -- a step that has been considered by Texas, Michigan and Virginia -- is another issue.

"This decision should be up to parents, and mandates are silly," says Harper of Dartmouth. "While the vaccine will improve the health of American women, its real benefit is in the developing world. And no matter what, Pap screening shouldn't be neglected. That's still our best safety net."

http://www.industrywatch.com/pages/iw2/Registration.nsp?P=AdminSubscribeV2a&pr=news&story_id=120066295

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Articles explore blow to psyche of children
The Times-Picayune | 08.11.08
By John Pope
Staff writer

The broad scope of Hurricane Katrina's devastation will require consideration of a variety of factors, including separation from parents, racism and family structure, to devise successful treatments for children, according to a special section of a peer-reviewed journal that two local university psychologists edited.

The articles in the current issue of the Journal of Clinical Child & Adolescent Psychology "show that the impact of the Katrina disaster was felt at societal, community, family and individual levels," Stacy Overstreet of Tulane University and Carl Weems of the University of New Orleans wrote in the introduction. "Thus, one of the main lessons learned from the Katrina experience is that we must consider these multiple levels of impact when designing and implementing future research and prevention efforts."

The reports include studies showing:

-- People are more resilient if they feel safe and have other people around them.

-- Post-traumatic stress disorder symptoms were less likely if parents who had to work during the storm were separated from their evacuated children because the youngsters saw less of the disaster and the parents had less anxiety about caring for their children.

-- Children's mental health is strongly affected by the mental health of adults caring for them.

-- A strong, protective family can make a child better equipped to withstand disasters.

--- Landing Fulbright grants ---

Two Tulane students and one recent Tulane graduate will study abroad because they have received grants from the Fulbright Program.

-- Joseph Kanter, who is working on a medical degree and a master's degree in public health, will be in Malaysia working with an AIDS organization to conduct HIV tests, counsel patients and set up treatment programs.

-- Nilda Rivera, who is working on a doctorate in Spanish, will spend a year in Spain studying "Don Quixote."

-- Melinda Ammann, who received a master's degree in international development in December, will go to North Sulawesi in Indonesia as a teaching assistant at a Catholic high school where she hopes to launch a bilingual student newspaper.
--- Key players saluted ---
A surgeon from the University of Colorado has been named this year's recipient of a Mayo Clinic visiting professorship in vascular surgery named for LSU Health Sciences Center Chancellor Larry Hollier.

Dr. Robert Rutherford, an emeritus professor of surgery, is a trauma and vascular surgeon who received the first Lifetime Achievement Award from the Society of Vascular Surgery.

Hollier, a graduate of LSU's medical school, was on the Mayo Clinic staff from 1980 to 1987. While at the renowned Minnesota medical center, he founded what became the division of vascular surgery and set up programs for researching the subject and training surgeons in the specialty.

Rutherford was the second honoree. Hollier was the first.

http://www.nola.com/news/t-p/frontpage/index.ssf?/base/news-30/121843211441180.xml&coll=1

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Blue Cross CEO leaving
The Advocate | 08.12.08
By TED GRIGGS

Blue Cross President and Chief Executive Officer Gery J. Barry is resigning to take a job as chief strategy officer for Aetna Inc., where he will guide the company's domestic and international strategy.

"It's a big loss for Blue Cross and for the state. Big gain for Aetna," said Alan Levine, secretary of the state Department of Health and Hospitals. "Gery Barry's a forward-thinking guy. He is a visionary. The position of chief strategy officer is just perfect for him, and I can't imagine anybody better for it. It was a great get for Aetna."

Blue Cross said it plans to launch a national search for Barry's replacement, while also considering in-house candidates.

Barry said he will be helping put an interim management structure in place, and the team will probably be announced during the last week of August.

Barry's first day with Aetna, unofficially, is Aug. 29. He will continue helping with the Blue Cross transition after that as needed, Barry said.

Barry said he was "deeply personally and emotionally invested" in Blue Cross and Blue Shield of Louisiana when Aetna approached him two or three months ago.

"This was not an easy decision. It was not something at all I anticipated," Barry said. "I was by no means looking for a position. I was kind of reluctant in fact to even take the call or even consider it."

But gradually Barry realized that the Aetna job would allow him to concentrate on the things he loves and has been spending his personal time doing since Hurricane Katrina: changing health care and making fundamental improvements to the system.

Barry had been involved in a number of health-care reform efforts in Louisiana, serving on the board of the Louisiana Recovery Authority Public Health and Healthcare Task Force following Hurricane Katrina, as vice chairman of the Louisiana Health Care Redesign Collaborative and on the board of the Louisiana Health Care Quality Forum.

Levine said Barry would be missed.

"Gary was always the guy that we knew we could count on to collaborate with other organizations, even his own competitors, if it was in the best interest of state policy," Levine said.

Barry's health-care redesign efforts also required him to spend a fair amount of time in Washington, D.C., working with the Centers for Medicare & Medicaid and other government agencies on health quality and quality improvement issues.

"This is an opportunity to continue to be involved but clearly at a very national level with a very large, prominent organization that just has outstanding values," Barry said.

It's also an organization with which Barry, 55, is more than familiar. Barry began his career with the Hartford, Conn.-based insurance giant and spent 21 years there before leaving to become chief executive officer of Liberty Health, formerly Ontario Blue Cross. He left Liberty Health in 2003. Barry was doing consulting work when Blue Cross of Louisiana called, and he took over as CEO in November 2004.

At Aetna, Barry will be a member of the executive committee and report to Chairman and CEO Ronald A. Williams.

Aetna made the formal, written offer last week. Barry said he told the Blue Cross board, and told employees on Monday. "It was an emotional day," Barry said.

A Blue Cross news release said the company's board accepted Barry's resignation "with great reluctance."

"Speaking on behalf of the entire board, we're very sorry to see Gery go," Brent McCoy, board chairman, said in a prepared statement.

McCoy said Barry has done a remarkable job for the state's largest health insurer. He leaves Blue Cross, with its 1.1 million members, stronger than it has ever been on every level, McCoy said.

"He has also made a great contribution to the state of Louisiana, providing outstanding leadership in health care during and after Katrina, and working tirelessly to establish a better health-care system for all people of Louisiana," McCoy said.

John Matessino, president and chief executive officer of the Louisiana Hospital Association, said Barry's and Blue Cross's decision to continue paying hospitals after Katrina, even though the storm-affected facilities could not turn in insurance claims, kept those hospitals from going under financially.

"That was a big thing for them to do," Matessino said.

As the head of Blue Cross, Barry was always fair to the hospitals, Matessino said, even though providers and payers don't always agree.

Matessino said he got to know Barry after Katrina and by working together on the state's health-care redesign efforts.

"I think he really cared about the people in this state and tried to make the situation better for the uninsured," Matessino said. "I think he has a real spot for those folks and trying to get those people health coverage."

Others, including Insurance Commissioner Jim Donelon, wondered, after talking to Barry, whether the lack of progress in redesigning health-care played some part in Barry's decision.

"But I'm sure he is disappointed that the work of the task force has not produced the results that they would have liked so far at least," Donelon said.

However, Matessino said he doesn't think the state's health redesign efforts had anything to do with Barry's decision.

"Some of those things are slo-o-o-owly but surely beginning to move," Matessino said.

While the movement may not exactly follow the path recommended by the Health Care Collaborative or the Coalition of Leaders in Louisiana HealthCare, some of the principles are very much the same, Matessino said.

http://www.2theadvocate.com/news/business/26855439.html

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Health care costs seen rising 10 percent in 2009
Yahoo News | 08.11.08
By TOM MURPHY, AP Business Writer

Health care costs are expected to rise more than 10 percent into next year, according to a survey of insurers by Aon Consulting Worldwide.

But that increase is the smallest Aon has seen in six years. Experts say it shows that efforts to tame costs, such as employee wellness or disease management programs, may be paying off.

"There's a variety of tactics that employers have been employing over the last 3 to 6 years that has had an impact on the market," said study director Bill Sharon, an Aon Consulting senior vice president.

Aon Consulting surveyed about 70 health insurers around the country, including companies such as Aetna Inc. and Cigna Corp. It found that actuaries expect costs to rise an average of 10.6 percent during 12-month rating periods starting this year between April and September.

That represents a slight drop from last year's forecast of 10.9 percent and a bigger fall from 2002, when health care costs were expected to rise by more than 16 percent.

But the percentage likely won't be what the average employee faces for a premium hike next year. It doesn't reflect insurance plan designs or changes an employer might make to benefits plans.

"Pretty much every employer has to do something or is doing something in an effort to bring that number down," Sharon said.

He said actual cost increases have wound up being three to four percentage points lower than preliminary estimates in the past couple of years. Still, he said Aon Consulting's survey gives employers a benchmark to use as they consider premium renewals.

Many employers have started researching their benefit options for 2009. Consultants say it's too early for predictions on next year's health care plan costs.

But Ken Ambos of Equity Risk Partners Inc. said midsize employers could see a cost increase of roughly 9 to 12 percent that they pare down to 6 to 9 percent. Equity Risk Partners is a risk management and employee benefits consulting firm

Costs are still rising to keep up with growing patient demand for services, the needs of an aging population and prescription drug and technology costs, according to Aon Consulting, a subsidiary of Aon Corp.

Overuse and misuse of services and an "out-of-control medical liability system" also contribute to increases, said Robert Zirkelbach of America's Health Insurance Plans, a trade association representing nearly 1,300 insurers.

"It is encouraging that the growth in health care costs is going down, but there is still more work to be done," he said.

Zirkelbach said health insurers have offered disease management programs and encouraged the use of cheaper generic drugs to help contain costs.

Employer wellness programs also have played a role, Sharon said. He noted that doctors, hospitals and employers all have worked to curb costs.

"When costs go up as great as this, there's a lot of market pressure brought to bear on all of the parts of the market to bring those costs down, and I think that's what's been happening over the last six years or so," he said.

Aon Consulting has forecast a steady decline in cost increases since 2002. But Sharon said this decline has grown smaller the past few years, a sign the reductions may be bottoming out.

http://news.yahoo.com/s/ap/20080811/ap_on_bi_ge/health_care_costs_forecast_2

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Prescriptions for Health, the Environmental Kind
The New York Times | 08.12.08
By AMANDA SCHAFFER

Ruby Washington/The New York Times

Dr. Natalie Jeremijenko.

In a bright studio at New York University, Natalie Jeremijenko welcomes visitors to her environmental health clinic. She wears a white lab coat with a rotated red cross on the pocket. A clipboard with intake forms hangs by the door.

Inside, circuit boards, respirators, light bulbs, bike helmets and books on green design clutter the high shelves. In front of a bamboo consultation desk sits a mock medicine cabinet, which turns out to be filled with power tools.

Dr. Jeremijenko, an Australian artist, designer and engineer, invites members of the public to the clinic to discuss personal environmental concerns like air and water quality. Sitting at the consultation desk, she also offers them concrete remedies or “prescriptions” for change, much as a medical clinic might offer prescriptions for drugs.

“It’s a widely familiar script,” said Dr. Jeremijenko, 41, who has a doctorate in engineering and is an assistant professor of visual art at N.Y.U. “People know how to ring up and make an appointment at their health clinic. But they don’t really know what to do about toxins in the air and global warming, right?

“So the whole thing is how do we translate the tremendous amount of anxiety and interest in addressing major environmental issues into something concrete that people can do whose effect is measurable and significant?”

Visitors to the clinic talk about an array of concerns, including contaminated land, polluted indoor air and dirty storm-water runoff. Dr. Jeremijenko typically gives them a primer on local environmental issues, especially the top polluters in their neighborhoods. Then she offers prescriptions that include an eclectic

mix of green design, engineering and art — window treatments, maybe, or sunflowers, tadpoles or succulents.

“People are frustrated by their inability to cope with environmental problems in their apartments and their neighborhoods,” said George Thurston, a professor of environmental medicine at New York University School of Medicine. Dr. Jeremijenko, he continued, “provides a service that’s needed, educating people about what they’re up against and showing them that they can do something themselves while waiting for larger societal solutions.”

Dr. Jeremijenko has worked with scores of individuals and community groups since starting the clinic last fall. “I call them impatients,” she said — meaning that they don’t want to wait for legislative action.

She holds daily office hours at N.Y.U., but also runs periodic off-site clinics at sites around the city — “like the M*A*S*H field offices,” she said.

For instance, she met with “impatients” on the edge of the East River and took some of them out on a float made of two-liter soda bottles connected to a flexible polycarbonate sheet. Micah Roufa, who recently graduated from architectural school, was one of those present, though he said he chose to remain on solid ground.

Mr. Roufa owns a vacant lot in St. Louis that is contaminated with low levels of lead. He said he wanted to remedy that problem while using the space in a creative way and raising awareness about lead poisoning in the neighborhood.

Dr. Jeremijenko suggested planting a grid of sunflowers, along with a chemical agent called EDTA, to draw lead out of the soil. (EDTA is used to bind metals, making it easier for them to be taken up by plants; scientists caution that the approach requires technical care, because if too much of the chemical is added, a contaminant could migrate to neighboring property.)

Mr. Roufa planted the sunflowers this summer within an artistic grid of steel bars and glass orbs. “She has been a great guide and an inspiration,” he said.

Of all the concerns Dr. Jeremijenko hears about at the clinic, she said indoor air quality tops the list. For common pollutants like formaldehyde, benzene and toluene she typically prescribes the copious use of houseplants, which have been shown to absorb some chemicals.
With the designers Will Kavesh and Amelia Amon, she has also developed a system that uses solar energy to power customized L.E.D. lights, which promote plant growth while providing a light intended for human use. The sun’s energy is captured by a “solar awning,” which is a stretch of glass, fabric or stainless steel that can be fitted to an apartment or office window.

And Dr. Jeremijenko has a prescription for storm-water runoff, which can cause sewers to flood and can increase pollution in rivers: putting small plots of greenery, including mosses and grasses, in no-parking zones around the city. One such temporary plot, on Stuyvesant Street in the East Village, was called a “butterfly truck stop,” with plant life specifically designed to attract butterflies.

In past projects, Dr. Jeremijenko has coupled art and environmental activism. During the Republican National Convention in 2004, she organized a group of bicyclists to ride around New York wearing air-filtering masks, as an ironic comment on the government’s Clear Skies Initiative.

In 2006, as part of the Whitney Biennial, she installed a series of bird perches in the museum’s sculpture court. When birds landed on the perches, they set off computer sound files with comments on the interdependency of birds, other animals and people.
Dr. Jeremijenko’s work occupies a niche “between popular culture and high art, between art, science and engineering,” said Amanda McDonald Crowley, executive director of Eyebeam, an art and technology center in Chelsea. “In a sense it’s performance, in a sense it’s awareness raising, and in a sense it empowers an audience to take action.”

In March, Dr. Jeremijenko had environmental clinic hours at Eyebeam, where she distributed tadpoles named after government officials whose decisions affect water quality.

“Tadpoles are exquisite sensors of water quality,” she said, adding that she had already named a tadpole after Commissioner Pete Grannis of the New York State Department of Environmental Conservation.

“I had it in a sample of water from the Bronx River and, unfortunately it died,” she said. “But we’re going to resurrect him.”

Charles M. Marcus, professor of physics and director of the Center for Nanoscale Systems at Harvard, is a longtime admirer of Dr. Jeremijenko’s work. “So much of what environmentalism involves is things you shouldn’t do, and that can be very unsatisfying,” he said. “She’s addressing that head-on.

“She seems to be saying: ‘If you’re like me and you consider action and anxiety to be poles between which we navigate, then I can help get your hands dirty and I can help get you involved in doing something that will help with your mind and will help with the world.’ ”

http://www.nytimes.com/2008/08/12/health/12clin.html

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Having Cancer, and Finding a Personality
The New York Times | 08.11.08
By RUTH PENNEBAKER

They say cancer changes you. They may be right. When I found out I had breast cancer 12 years ago, I became a comedian.

Not the kind anyone paid to see. Just the kind who lurked around hospital corridors and examination rooms offering offbeat opinions, wiseacre remarks, outrageous commentary.

To my oncologist — a short, brisk woman who informed me my tumor had been “fairly aggressive” — I complained about the title of the pamphlet she had given me, “Chemotherapy and You.” I said I’d prefer it if the title were “Chemotherapy and Somebody Else.”

I complained, too, about the little marketing-friendly write-up that listed her family and her hobbies. The family was fine. But hobbies? I didn’t want a doctor who had time for hobbies. I wanted her to spend all her waking hours focusing on curing cancer, particularly the type indicated on my own nasty little pathology report.

To everyone else, especially the people wearing white coats and carrying big needles, I announced I was writing a book about cancer. I tried to look rabidly litigious whenever I spoke.

In the midst of all this — the comebacks, the wisecracks, the flapping mouth — I had a dim idea of what I was doing. I wanted to be someone, a recognizable personality, a full-blooded, memorable human being, and not just a cancer patient. I had already lost the person I used to be, that healthy, energetic 45-year-old woman. I wasn’t capable of losing more.

Other friends had their own spins on claiming individuality in the cancer world. One, a psychiatrist, questioned every medical decision that was made. Another, never timid to begin with, terrorized the technicians. “You get one chance to stick me and find a vein,” she told them. “If you can’t do that, find me somebody who can.”

I also took comfort from Anatole Broyard’s beautifully written, intermittently hilarious account of his own cancer treatments in “Intoxicated by My Illness,” published in 1992, two years after his death from prostate cancer. Mr. Broyard, a book critic and editor at The New York Times, had fired a prominent surgeon because he hadn’t liked the way the man wore a cap in the operating room. It looked, he wrote, “like a condom stuck on his head.”

The way Mr. Broyard saw it, : “A critical illness is like a great permission, an authorization or absolving. It’s all right for a threatened man to be romantic, even crazy, if he feels like it. All your life you think you have to hold back your craziness, but when you’re sick you can let it go in all its garish colors.”
Yes! That’s what I was experiencing, too. Those garish colors, that craziness and freedom, that painfully stark clarity about what was important and what was not. It was as if, I sometimes felt, I had lived my life half asleep. But now, now, I was wide awake.

As my treatments wore on, though — the catheter in my chest, the chemotherapy, the anti-nausea drugs, the baldness, the fatigue, the radiation — my high spirits and sense of clarity began to wane. One night at a play, I noticed a woman across the room. She was attractive, middle-age, vibrant. Completely unlike me, as I had become over the past few months. I huddled in my seat, feeling spent and empty and old.

The last time I visited my oncologist after my treatments were over, I felt lost. The image that kept recurring in my mind was that someone with a gigantic pair of tweezers had picked me up, shaken me and tossed me back down. Now what?

“I feel as if I want to ask you,” I told my oncologist, “how to live.”

She told me I could live as I had before — working, taking care of kids, exercising, traveling, enjoying life. Anything, really. I could lead a normal life.

As I left her office, I realized how completely I'd lost myself over the past several months. I needed to be reminded who I was.

Can you tell me who I am now? I never asked my oncologist that question. Probably she would have thought I was joking, the way I always was.

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Early Test for Cancer Isn't Always Best Course
The New York Times | 08.11.08
By TARA PARKER-POPE

Al Francekevich/Getty Images

Sometimes what you don't know might end up being better for you.

For years patients have been told that early cancer detection saves lives. Find the cancer before the symptoms appear, the thinking goes, and you've got a better chance of beating the disease.

So it might have seemed surprising last week when a panel of leading medical experts offered exactly the opposite advice. They urged doctors to stop screening older men for prostate cancer, which will kill an estimated 28,600 men in the United States this year.

Their advice offered a look at the potential downside of cancer screening and our seemingly endless quest to detect cancer early in otherwise healthy people. In this case, for men 75 and older, the United States Preventive Services Task Force concluded that screening for prostate cancer does more harm than good.

"We've done a great job in public health convincing people that cancer screening tests work," said Peter B. Bach, a pulmonologist and epidemiologist at Memorial Sloan-Kettering Cancer Center in New York City. "We're uncomfortable with the notion that some screening tests work and others don't. That seems mystifying to people."

But the reality is that while some cancer screening tests — like the Pap smear for cervical cancer or mammography for breast cancer — clearly save lives, the benefits of other screening tests are less clear.

Studies of lung cancer screening, for instance, have failed to prove that it prolongs life. A mass screening for neuroblastoma in Japanese infants was halted after it became clear that the effort wasn't saving children and worse, led to risky treatments of tumors that weren't life threatening.

The case seemed stronger for screening for prostate cancer. By some measures, death rates from the disease in the United States have plummeted since the introduction of the screening test for prostate specific antigen, which detects levels of a protein that can signal prostate cancer.

The data, in fact, are highly misleading. The introduction of screening can trigger big statistical fluctuations that can be difficult to interpret. But if you look at prostate cancer statistics in the 1970s, long before screening was introduced, death rates have dropped only slightly since then. The small decline seems largely because of improvements in treatment, many experts say, though others point to early detection as the reason.

Whether there really is a measurable benefit from PSA screening for younger men won't be known for a few more years, after data from two major clinical trials studying the test are reported.

How can it be that finding prostate cancer early doesn't help save lives? For starters, a large percentage of prostate cancers aren't deadly. They are slow growing and unlikely to result in any symptoms before the end of a man's natural life expectancy. By some estimates, as many as 44 percent of the men who are treated for prostate cancer as a result of PSA testing didn't need to be. Had they been left alone, they would have died of something else and never known they had cancer.

"Screening tests don't only pick up life-threatening cancers, they pick up tumors that look identical to traditional tumors, but they don't have the same biologic behavior," said Dr. Barry Kramer, associate director for disease prevention at the National Institutes of Health. "Some are so slow growing they never would have caused medical problems in the person's natural life span."

In the case of PSA testing, the Preventive Services Task Force, an expert panel that makes recommendations about preventive care for healthy people, said there was not enough evidence to recommend for or against screening of younger men, although they urged doctors to advise men of all the risks and benefits of screening. But they did conclude that 75 is the age at which the risks clearly begin to outweigh the benefits, and the disease, if detected, would most likely not have a meaningful effect on life expectancy.

Another problem with determining the value of screening is that it results in "lead time bias." For instance, someone diagnosed with lung cancer at the age of 65 may die at 67 and be remembered as a two-year survivor. If the same man had been diagnosed at 57 through screening and died at the age of 67, he would be known as a 10-year survivor. That sounds a lot better, but the reality is that diagnosis and treatment didn't prolong his life. He died at 67 either way.

"Even a harmful screening test could appear on the surface as a helpful test," Dr. Kramer said. "Because you measure survival from the date of diagnosis, even if the person dies of the same cause on the same day they would have without screening, it looks like survival was longer."

Any screening test can lead to false positives, followed by invasive and risky tests. Large numbers of people often end up being poked, prodded and tested only to discover they're fine.

Biopsies to detect prostate cancer get mixed reviews. Some men find them to be a minor discomfort; others say they were left in debilitating pain. Once cancer is found, surgery, radiation or hormone therapy, or "watchful waiting," may be advised.

Treatments for prostate cancer can cause significant harm, rendering men incontinent or impotent, or with other urethral, bowel or bladder problems. Hormone treatments can cause weight gain, hot flashes, loss of muscle tone and osteoporosis.

"It's just a needle stick, but the cascade of events that follows are fairly serious," Dr. Bach said. "I think the burden is on medicine to try and generate some evidence that the net benefits are there before drawing that tube of blood."

The problem with prostate screening is that some men are very likely to have been saved by early detection. But how many have been hurt?

"I'm a little worried we may look back on the prostate cancer screening era, after we learn results of clinical trials, and see that we've harmed a lot of people without doing them good," said Dr. David Ransohoff, a professor of medicine and cancer screening researcher at the University of North Carolina at Chapel Hill. "By being so aggressive with so many people, did we do the right thing? I don't know that it's going to turn out that way."

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Family doctors called scarce
Baltimore Sun | 08.12.08
By Euna Lhee, Sun Reporter

When his colleague departed in December, family doctor Charles Bennett thought he would soon find a new partner for his private practice in Lusby. But he has had no luck for the past eight months.

"I'm still trying to find someone, but I don't think it will get any better in the foreseeable future," said Bennett, whose Calvert County practice employs four staff members. "The process is very time-consuming, and I am already very busy as it is."

Bennett's troubles stem from the fact that the United States faces a serious shortage of family physicians, especially in rural and poorer communities. There are too few primary care doctors and nurses to meet growing health care needs, according to a report released yesterday by the National Association of Community Health Centers. The study found availability depends on location.

More often than not, fewer clinicians practice in areas that need them most.

"This is the unfortunate reality of our health care system. It's an example of how the market triumphs over public policy," said Dan Hawkins, the association's senior vice president of programs and policy and one of the authors of the report. "Even if universal health care comes into play tomorrow, not everyone would have access to a health care provider."

Although many of these people are insured, 56 million Americans do not have a regular source of health care due to shortages of physicians in their communities, according to the online report. Hawkins said that this translates to poorer health outcomes and less coordinated care for this group.

The study estimates that, in order to provide services to these medically disenfranchised Americans as well as current patients, health centers will need up to 60,000 more primary care professionals, and up to 44,500 additional nurses.

For Maryland, this would translate into hiring an additional 133 primary care providers - including doctors, nurse practitioners, physician assistants and certified nurse-midwives - by 2015.

Another report released earlier this year, the Maryland Physician Workforce Study, emphasized that southern and western counties and the Eastern Shore are seeing "critical" physician shortages, which included not only primary care, but also in most specialties, such as dermatology and thoracic surgery.

Overall, Maryland is 16 percent below the national average for the number of physicians in clinical practice, according to the Maryland Hospital Association.
"Maryland is mirroring national trends," said Dr. Robert Barish, professor of emergency medicine at the University of Maryland and chairman of the steering committee that supervised the study. "For the future, we need to retain at least 50 percent of residents trained inside of Maryland and also make it more attractive for those who want to come from outside the state."

On of the main factors contributing to the shortage is that too few medical students choose primary care, which includes family practice and general pediatrics, internal medicine, obstetrics and gynecology.

Rich Bryson is a third-year medical student at the University of Maryland. Although he hasn't finished his clinical rotations, he is already leaning toward a specialty, not primary care. For one thing, he said, there would be lifestyle benefits.

"The hours and pay are better for specialists," said Bryson, 24, a native of Hagerstown. "And that is definitely appealing."

In addition, Bryson also worries about his student loans, which he estimates to be around $100,000. "I don't want to be strapped down with loans forever, and I know that primary care pays on the lower end of the spectrum."

Bryson alludes to another factor, which is that primary care physicians are not reimbursed to the same level as specialists by insurance companies. Since they are paid lower rates, general physicians need to work more hours to compensate for their rising expenditures, such as malpractice insurance and supplies.

"The largest insurance companies in the state ... have not raised their reimbursement rates," said Calvert County's Bennett, who now works around 50 hours a week, including some Saturdays. "Ongoing expenses, such as vaccines, cost me more than what the insurance companies pay me."

Despite these challenges, Bennett remains. "I love what I do, and I get to take care of people on an extended basis," he said. "I develop a relationship with patients, some through three, four generations."

Although Dr. Sylvia Batong enjoys practicing primary care for similar reasons, she left the private practice that she shared with Bennett for 15 years.

"It became economically unfeasible," said Batong, a family practitioner who now practices in Waldorf, in Charles County.

She entered private practice with Bennett in 1992. Starting in 1995, insurance reimbursements became unfavorable, she said. Since then, she saw her income stagnating or declining. In 2000, she took a second job at an urgent care center, which paid at an hourly rate, to support her two children as a single parent. After seven years of working 55 hours a week, she had had enough.
Currently earning an hourly salary, she has vacation time for the first time in her life and works 40 hours a week. The income is comparable to earnings from the two jobs, she said.

"I knew that Dr. Bennett was going to have trouble finding another partner," Batong said. "I know at least three, four family practices that can't find anyone, and they've been looking longer than him."

To address these problems, the association's Hawkins says that politicians need to change their policies and revise the provider payment system to attract more primary care professionals. In addition, he suggests more loan forgiveness programs and economic incentives to encourage medical students to go to underserved areas.

Hawkins said the public needs to become aware of the need for more family doctors. Otherwise, he said, "We'll all end up in duck soup, to put it politely."

http://www.baltimoresun.com/news/health/bal-md.doctors12aug12,0,2416897.story

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March of Dimes Mobile Health Centers Providing Care to Moms in Gulf Coast Areas Still Lacking Public Health Services
Hispanic Business | 08.11.08

NEW ORLEANS, Aug. 7 /PRNewswire-HISPANIC PR WIRE/ -- Three years after the hurricanes of 2005, four March of Dimes Mom & Baby Mobile Health Centers(R) are bringing much-needed maternal and infant health care to the Greater New Orleans and Gulf Coast area, especially aiding new Spanish-speaking residents who came to help rebuild the region that still is plagued by limited access to public health services.

Although almost all of the hospitals in Jefferson Parish have reopened, fewer than two-thirds are operating in Orleans Parish, and none have reopened in St. Bernard Parish.

Since their launch in 2007, the March of Dimes Mom & Baby Mobile Health Centers have provided more than 3,000 patient visits to the areas hardest hit by the hurricanes: New Orleans; its suburbs St. Bernard Parish and the Lower 9th Ward; the Lake Charles area; and Biloxi, Mississippi. The program is on target to provide more than 15,000 visits in three years.

"These four March of Dimes mobile health centers bring preconception, prenatal and well-baby medical care to pregnant women, new mothers and babies who desperately need it," said Dr. Jennifer L. Howse, president of the March of Dimes. "Because our centers are mobile, we can bring quality health care where it's needed most, like St. Bernard Parish."

The March of Dimes Mom & Baby Mobile Health Centers continue to bring doctors, nurses, medical supplies, the latest technology and information directly to mothers and their babies, an important component of rebuilding communities. Providing access to high-quality medical care is vital to improving birth outcomes in the region.

For example, in 2004, before the hurricanes, Louisiana's preterm birth rate was 15.6 percent, nearly 25 percent above the national average. In 2005, the state's preterm birth rate increased to 16.5 percent. Mississippi's preterm birth rate increased to 18.8 percent in 2005, from 17.9 percent in 2004.

As workers moved to the Gulf Coast to rebuild, the Spanish-speaking population significantly expanded, and access to health care is limited for them.

"Many of our patients are Spanish-speaking, and because we are bi-lingual we can offer these women access to quality health care," says Rosa Bustamante-Forest, RN, MPH, MN, program director for the Mom & Baby Mobile Health Center in New Orleans. "We're seeing repeat patients from last year who are pregnant again, which speaks volumes to the quality of care we offer."
The Mom & Baby Mobile Health Centers were funded through the March of Dimes Hurricane Assistance Fund that included a $3 million gift from the people of Qatar. The mobile health centers are staffed by the Daughters of Charity Services of New Orleans, Southwest Louisiana Area Health Education Center and Coastal Family Health Center.

Inside, the Mom & Baby Mobile Health Centers look like a regular healthcare provider's office, with private exam areas, waiting areas and nurses' station. They are equipped with fetal monitors, ultrasound and other equipment, and a backup generator. The handicap accessible centers have bilingual staff, including an obstetrician, nurse practitioner or midwife, a nurse, lab technician and an outreach worker. The vehicles have a fixed schedule at consistent locations each week so services will be dependable and expected.

The March of Dimes is the leading nonprofit organization for pregnancy and baby health. With chapters nationwide, the March of Dimes works to improve the health of babies by preventing birth defects, premature birth and infant mortality. For the latest resources and information, visit marchofdimes.com or nacersano.org.

http://www.hispanicbusiness.com/news/2008/8/11/march_of_dimes_mobile_health_centers.htm#

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