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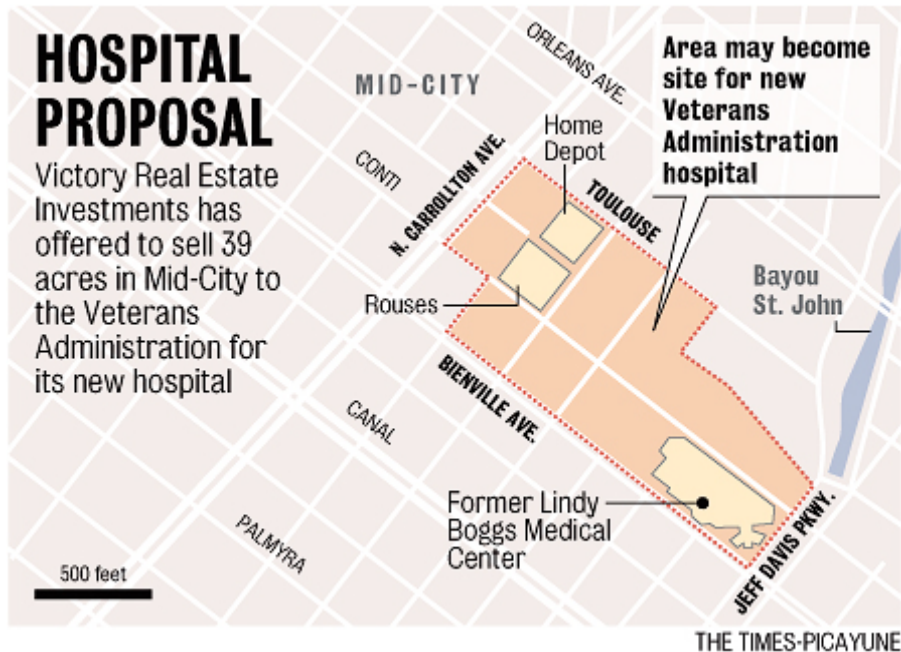
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## Future location of veterans hospital debated

The Times-Picayune | 08.13.08

By Kate Moran  
Business writer



What would serve the greater good -- building a new veterans hospital where the vacant Lindy Boggs Medical Center now stands, or tearing down a neighborhood so the hospital can be close to the downtown medical schools and the city's nascent bioscience corridor?

The hospital's future location is a study in tradeoffs, and residents, university leaders and veterans debated the relative merits of the downtown and Lindy Boggs sites at a public hearing Monday night that filled Grace Episcopal Church.

The U.S. Department of Veterans Affairs has planned for two years to erect a new hospital on the edge of downtown, where it could share services with Louisiana State University's new teaching hospital and help anchor a biosciences district that city leaders envision as a powerful economic driver for the region.

But building the hospital downtown would mean displacing a neighborhood filled with historic houses, four of which received preservation grants from the lieutenant governor after the storm. People who live there contend that moving the hospital to the Lindy Boggs site would not only spare their houses, but would also allow the VA to move forward with construction more quickly.

"I hate to see so many home and business owners who struggled to rebuild have yet another struggle to relocate," said Renee Boudreaux, whose family owns an auto repair shop that would be uprooted if the downtown site were selected. "Why tear down more homes if there is a site ready to develop?" The debate seemed to turn Monday on whether the city could succeed in fostering a vibrant medical corridor if the veterans hospital were to leave downtown. University leaders contended that proximity to the downtown medical schools and the LSU hospital is of paramount importance, while residents argued that hospitals are spread miles apart in cities like Boston considered hubs for medical research.

"Placing the hospitals within walking distance would greatly benefit medical students and residents," said Michael Kaiser, chief medical officer for LSU's health care services division. "The same opportunity simply does not present itself when clinic locations are separated by a car ride."

Ed Blakely, the city's recovery czar, said a collaborative LSU-VA medical center in the downtown area would allow the two institutions to share expensive diagnostic equipment. He said each would be able to

take advantage of specialists on the other's payroll. He also argued that downtown is the superior site because of the easy access it offers to hotels where veterans and their families who come from outside New Orleans can stay.

"That medical complex was designed so we would have the forces of the two universities and the VA doctors, along with the bioinnovation and cancer centers, positioned so this city would have one of the greatest medical complexes in the southern United States," Blakely said. ". . . The city of New Orleans is pledging its resources to purchase only one site: the site we proposed originally."

Harvey Stern, one of the citizens who attended the hearing, countered that the Lindy Boggs site was only a five-minute car ride from the downtown location.

"Many healthy downtown medical districts do not have a VA hospital," Stern said. "Let's be honest about this and get past the spin. Why choose a site which will destroy an intact neighborhood?"

Lindy Boggs is currently owned by a Georgia real estate firm, which has offered to sell both the hospital and some nearby warehouses -- a total of 39 acres. The proposed VA hospital would encompass 1.1 million square feet, roughly double the size of the existing Lindy Boggs.

Several veterans said Monday that the debate over the hospital's location seemed to have overtaken their main concern: that hospital services be restored as quickly as possible. Veteran Gayle Clark said she has to travel to VA hospitals in Alexandria and Biloxi to get treatment for depression and post-traumatic stress disorder, where she is separated from her family when she needs their support the most.

"We need health care now. I cannot go to a civilian health care facility, because they don't know how to handle veterans' health care needs," Clark said. "We are a special bunch of people, and we need special care."

Julie Catellier, director of the local VA hospital, also expressed a desire to get construction under way as quickly as possible.

"Our patients have been exceptionally tolerant because they appreciate the efforts we're making on their behalf, but it's been a long three years and they need their hospital back," Catellier said.

<http://www.nola.com/news/t-p/index.ssf?/base/news-0/1218604820272350.xml&coll=1>

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**Letter: Downtown hospital is best for veterans, city**  
**The Times-Picayune | 08.13.08**  
Kurt M. Weigle

In the interest of best serving our veterans who have served us so well, it is time to proceed immediately with construction of a new Veterans Affairs Medical Center on the proposed downtown site adjacent to the Tulane and LSU medical schools.

Experience in New Orleans and across the nation demonstrates that locating VA medical centers adjacent to medical schools and academic hospitals leads to better medical care for vets, and the reasons for this are obvious to those with first-hand knowledge of the facts.

First, VA medical centers ensconced within larger academic medical districts give vets immediate access to the excellent care of university medical faculty and medical residents.

Second, VA medical centers adjacent to academic research centers offer vets access to the leading-edge medical treatment that flows naturally from university research labs like those at Tulane, LSU and Xavier universities into adjacent academic hospitals.

In this world of integrated research, teaching and patient care, distance is measured in steps and blocks, not miles. Making stretched-to-the-limit researchers, clinicians and students drive or take public transit to the VA Medical Center will be more than just an inconvenience. It will put New Orleans at a competitive disadvantage with the world's leading medical complexes, where the commute is "up the elevator" or "across the street." This is a disadvantage we can ill afford at this early stage of developing New Orleans' new and improved bio-medical industry.

Clearly, doing what is best for vets is also best for New Orleans' economy and the health of all our citizens. The time to act is now.

Kurt M. Weigle

President and CEO

Downtown Development District

New Orleans

<http://www.nola.com/news/t-p/letterstoeditor/index.ssf?/base/news-12/1218604970272350.xml&coll=1>

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## **N.O. crowd protests VA hospital site**

**The Advocate | 08.13.08**

By ALLEN M. JOHNSON JR.

NEW ORLEANS — More than 200 people filled a Mid-City church Monday night for an emotion-charged hearing on where to rebuild a new Veteran's Affairs hospital.

"Why would the city want to displace hundreds of residents who are struggling to rebuild their community, and to destroy their homes — in a city where housing is so scarce?" Elizabeth S. Merritt told the site selection panel. "We're mystified."

Merritt, an attorney for the nonprofit National Trust for Historic Preservation at Washington, D.C., said the national organization of preservationists opposes a 34-acre hospital development offer made to the VA by Mayor Ray Nagin last year.

The new 200-bed VA facility would share a total of 71 acres with a new LSU-operated 424-bed hospital, designed to replace Charity Hospital.

However, Dr. Michael Kaiser, chief medical officer for LSU Health Care Services, argued that "co-location" of hospitals is best for operations, whether for clinic visits or emergencies.

"There can be no doubt that the benefits far outweigh the impacts," Kaiser said of the LSU/VA proposal.

Both Charity and the old VA facility, on 6.6 acres of downtown property near City Hall, were heavily damaged by Katrina's flood waters. The new VA hospital would require approximately 1 million gross square feet, 140 hospital beds, 60 nursing beds, and 410,000 outpatient visits a year — up from 220,000 annual visits, pre-Katrina, records show.

Signed on Nov. 19, Nagin's memorandum of understanding with the VA called for the city's expropriation or removal of some 200 homes in a historic district of Lower Mid-City, with the exception of the old Dixie Brewery on Tulane Avenue.

The agreement also infuriated many residents, who decried the lack of public hearings before Nagin signed the agreement. VA officials reportedly said Tuesday that they would rewrite the memorandum with the city.

At Monday's hearing, Don Orndoff, director of the VA's office of Facilities and Construction Management and Planning, got a dose of the public suspicion that typically accompanies government-backed development projects in many of the city's neighborhoods.

"I assure you, (the hearing) is not a 'sham,'" Orndoff replied to questioners of the site selection panel. Meanwhile, the National Trust announced support for a grass-roots proposal that would relocate the VA facility to a 39.8-acre campus on the vacant Lindy Boggs Medical Center in Mid-City.

Neighborhood residents say the "Lindy Boggs site" is ready for sale by Victory Real Estate Investment.

The Boggs building is not in a historical district and because the sale would not require expropriations or adversarial legal proceedings, the alternative site can proceed more quickly than the downtown site offered by the city.

Virginia Blaque, a daughter of a military veteran and a niece of seven veterans, backed the Boggs hospital plan.

"I support it in my neighborhood," Blaque said.

But William Detweiler, a past national commander of the American Legion, said the downtown site recommended by the Regional Planning Commission is the optimal location, because of its "close proximity" to both Tulane and LSU medical schools.

Detweiler also doubted the Canal Street streetcar line would provide sufficient transportation to the Boggs site.

Urban planner Robert Tannen disagreed, saying the 1-mile distance from Lindy Boggs to the LSU facility could easily be overcome.

Meanwhile, Edward Blakely, executive director of the city Office of Recovery and Development, said the city would not support the alternative site.

“The city is pledging its resources only for one site, the preferred site,” Blakely said.

“We need the mayor not to sign another agreement without our consent,” Mary Howell, a Mid-City resident and attorney, who supports the Boggs plan.

<http://www.2theadvocate.com/news/26901079.html>

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## Site for VA hospital remains up in the air

WWL-TV | 08.12.08

Meg Farris / Eyewitness News



WWL-TV

One possibility for where the new VA hospital could end up is the vacant Lindy Boggs Medical Center in Mid-City.

The decision about where the new VA medical center will be built has gotten more complicated.

Now neighborhood and historic preservation networks want to be heard on their idea to put the VA in yet another new location.

WWL-TV

One possibility for where the new VA hospital could end up is the vacant Lindy Boggs Medical Center in Mid-City.

There's a new proposal for the VA Medical Center to be built from Mercy or Lindy Boggs Hospital all the way to Carrolton Avenue.

"We think it would be fabulous it's reusing something that was there before without destroying something else," says Virginia Blanque the Vice-President of Mid-City Neighborhood Organization.

That discussion was part of a meeting Tuesday afternoon at the Marriott Hotel Downtown with FEMA, Federal VA and state officials, economic development groups and historic preservation leaders. A meeting where Eyewitness News was not allowed, and this reporter and our camera was told to leave.

This discussion is required by federal law to see how a new construction project could impact historical properties. The state is concerned if the VA moves to the closed Lindy Boggs Hospital or near Ochsner on Jefferson Highway, from the proposed shared site with its new academic hospital near downtown, it would be costly.

"There's no question there is tens of millions of dollars of savings built in to this model by having high end services shared between the new academic medical center and the VA," says Dr. Fred Cerise, LSU Vice-President of Health Affairs and Medical Education.

Economic development leaders and doctors say medical students and their physician teachers need the hospital close to the two downtown medical schools, LSU and Tulane.

"The researcher who can go upstairs to treat patients after doing his research on the ground floor or across the street is going to make that decision to be in that kind of environment as opposed to something where they have to travel across town," says Kurt Weigle, President and CEO of the Downtown Development District.

Those for the Lindy Boggs Hospital site say the land would be easier to acquire from one owner. Those for the medical corridor near downtown say while there are historic buildings such as the Deutsches Haus in the area, the city has made a commitment to the VA to deliver that parcel of land ready for development within 18 months.

VA Washington officials say they are still committed to metropolitan New Orleans and not another state such as Florida.

"The downtown area has been designated as the preferred site and so that's the status that it has at this point although we are looking continuing to look at and assess all of the alternatives including Lindy Boggs," says Donald Orndoff, the director of Construction and Facility Management for the Department of Veterans Affairs in Washington, D.C.

But in another twist, a statewide historic preservation group is about to release a new study about whether or not big Charity can be refurbished.

"If Charity is reusable then we don't need to have a discussion about destroying an entire neighborhood. We can just go back into Charity -- if that is a possibility and the Lindy Boggs site is an absolute wonderful alternative to taking down a neighborhood," says Sandra Stokes, the Vice-Chairwoman of the Foundation for Historical Louisiana.

A final decision on the VA Medical Center could be made by October.

<http://www.wwtv.com/topstories/stories/wwl081208mlva.3e9d62b2.html#>

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**The new guy**  
**Baton Rouge Business Report | 08.11.08**  
By Steve Clark



**RIGHT SAID FRED:** As vice president for health affairs and medical education, Fred Cerise answers directly to LSU System President John Lombardi.

Fred Cerise gets around.

From his job as head of Earl K.

Long Medical Center, the city's charity hospital, Cerise was promoted to secretary of the Department of Health and Hospitals by then-Gov. Kathleen Blanco. Last summer, Cerise was made health care czar for the LSU System, where his official title is vice president for health affairs and medical education and he answers directly to LSU System President John Lombardi.

Cerise is the first person to hold the job, which LSU created 10 years after taking over the state's troubled public hospital system in 1997. Until last year, the job of managing LSU's sprawling health care and medical education enterprise belonged to board members, system presidents and system staff.

It's thought that Merv Trail, former chancellor of the LSU Health Sciences Center in New Orleans and the architect of LSU's takeover of the charity system, was planning to take on a similar role. But he died before that could happen.

Dr. John George, a Shreveport physician and LSU board member, says health care expertise was scarce in the system office before Cerise and his team showed up. George was a vocal proponent of getting the executive position created.

“It can’t be anything but good,” he says. “You might not like his style, but in my opinion Fred brings a lot to the table in the fact that he’s an honest broker. LSU has needed an honest broker because of our lack of understanding at the system office about what’s going on in our hospitals and in [board members’] respective congressional districts. Each one had their own fiefdom. There wasn’t a lot of coordination between hospitals.”

Cerise says he’s determined to change that, by helping the fragmented LSU health system act like a system—a major task any way you look at it. Cerise ticks off the individual components: a health sciences center in Shreveport with three hospitals and three medical professional schools; a health sciences center in New Orleans with six professional schools [but, since Katrina, no hospitals]; and a Health Care Services Division that runs seven charity hospitals in the southern part of the state. “We’ve got all these pieces of a health system,” he says. “I work with the president and the board to coordinate the various pieces of the health care system.”

Cerise says his experience as administrator of EKL is handy because it gives him an understanding of how things work—or at least how things worked five years ago. It’s taken some reorientation and getting up to speed on progress since he was at EKL.

“It certainly is helpful if you’ve worked in that health system before,” Cerise says. “You understand the challenges that they’re facing. It helps to have an understanding of the implications of certain decisions. And what you’re asking people to do. Where you can push for more, and where it’s not reasonable to push.”

His time heading DHH gives him a totally different perspective—a more broad view of the state’s health care landscape and its competing priorities among public and private providers. Though LSU is responsible for the lion’s share of uninsured “business” in the state, community and private hospitals deal with it too, he says.

“Being at DHH, you get a better perspective of some of those other entities and the pressures that they’re facing,” Cerise says. “It probably helps to be a bit more collaborative in understanding how we can use our strengths to be part of a bigger overall solution.”

A solution to the state’s deeply imperfect health care delivery system for the uninsured and underinsured is what Cerise is referring to. He sees plenty of opportunities for the LSU system to do “good stuff,” such as furthering medical training and research by coordinating and taking advantage of all the pieces of the enterprise.

One very big project right now is the conversion to electronic medical records in LSU’s clinics and hospitals throughout the state—not an easy transition but necessary considering it’s the wave of the future. Going electronic is more efficient, saves money, reduces medical errors and improves access to medical records among physicians.

“There’s big advantages from a clinical health care delivery perspective on that,” Cerise says. “It’s one of the key features of how the Veterans Administration transformed themselves as a system, was through electronic medical records.”

LSU is involved in a major initiative in Shreveport to implement common electronic records with rural health care providers, he says.

“We share a lot in common issues with the rural providers in terms of caring for the uninsured, where you’ve got access challenges,” Cerise says.

Asked whether the structure of LSU’s statewide health care system will look different if the state manages to follow through on a major health care delivery revamp, Cerise says it’s hard to tell. Over the years, there have been many voices calling for blowing up the charity hospital system and using the money to treat indigent patients at non-LSU affiliated community hospitals, which wind up getting high numbers of indigent patients in their emergency rooms anyway.

“The strength of our system is not necessarily in individual hospitals, and bricks and mortar and things like that,” Cerise says. “The strength is in having a health care delivery system. If you’ve got a coordinated system, you’re going to be able to manage a population, to stretch your dollars for outcomes. It’s not so

much about whether you have to have a hospital in every part of the state. People can get a hospital bed when they need it, but just as important is that they're able to get into a clinic to take care of their diabetes."

He says the current state of the state's health care system is a microcosm of the fragmentation and inefficiency that exists nationwide. Whatever LSU's role looks like post-revamp, if it happens, Cerise as LSU health care czar likely will play a major part in crafting it.

LSU System counsel Ray Lamonica says Cerise has done a great job coordinating the disparate components of an unwieldy sector. Having him around has made establishing "clear policy" for the health system much easier, Lamonica says.

"Fred is truly dedicated to providing services to the uninsured and also to medical education," he says. "He is not simply a professional administrator. He really believes in this stuff. He's a genuine public servant. It's a hard job and he spends lots of hours working at it."

<http://www.businessreport.com/news/2008/aug/11/new-guy-hlcr1/>

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**LSU, West Jeff Medical Center partner for epilepsy care  
New Orleans CityBusiness | 07.22.08**

NEW ORLEANS - LSU Health Sciences Center New Orleans and West Jefferson Medical Center have teamed up to provide comprehensive epilepsy care for patients in the metropolitan New Orleans area.

An Epilepsy Monitoring Unit is at WJMC, 1101 Medical Center Blvd., in Marrero.

“With the addition of a 'clinical home' for epilepsy monitoring, surgery and outpatient care for LSUHSC physicians and their adult patients at West Jefferson Medical Center, LSU Health Sciences Center is now able to fully re-establish its Epilepsy Center of Excellence and Level 4 Epilepsy Center,” said Peter Olejniczak, LSUHSC Epilepsy Center of Excellence director.

“Partnering with LSU Health Sciences Center affords patients in our region the full service benefit of LSU and the community care available at WJMC,” said Nancy R. Cassagne, CEO of WJMC.

New equipment will complete the unit to provide the full range of diagnostic, monitoring and treatment services.

<http://www.neworleanscitybusiness.com/uptotheminute.cfm?recid=18701>

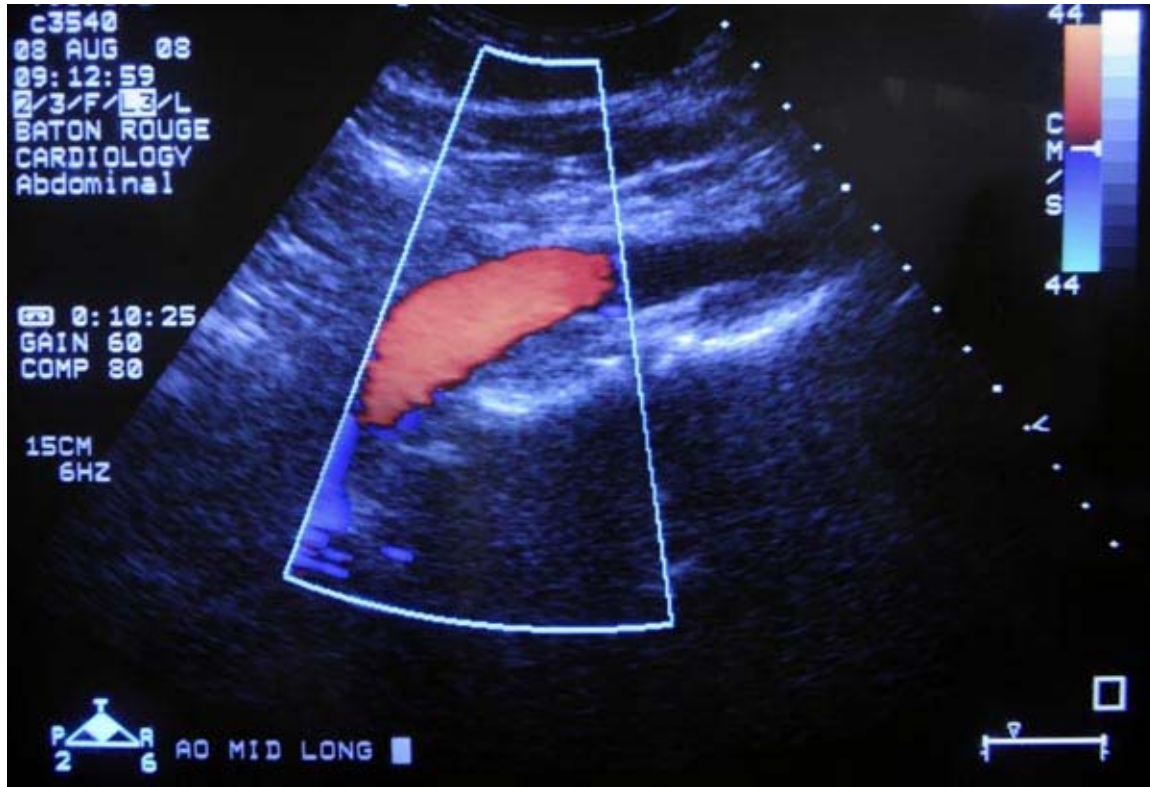
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## Group targets aortic aneurysms

The Advocate | 08.13.08

By JOHN BOYD

Advocate staff writer



ICHARD ALAN HANNON/Advocate

An ultrasound image of patient Wayne Fuselier's aortic artery shows his blood flowing normally during a routine test at the Baton Rouge Cardiology Center.

Aortic aneurysms are a sneaky killer, lying in wait inside a victim's body for as long as 25 years waiting to pop.

"Lazy" might be another word for it.

With a lag time of one to two decades between development and rupture, aortic aneurysms are an easily treated condition once detected.

Aneurysm Outreach, a Prairieville nonprofit, is trying to ensure more at-risk individuals receive the available life-saving ultrasound screening.

On Aug. 22 Aneurysm Outreach hosts Louisiana Friday Night, a benefit at The Varsity Theatre to raise money for its free screening program.

The benefit will feature music by the Michael Foster Project and Something Blue, dancing and a silent auction.

Next month, Aneurysm Outreach and a team of sponsors will offer free aortic aneurysm screenings at Baton Rouge Cardiology Center to at-risk patients.

Dr. Larry Hollier, dean of the LSU School of Medicine and Louisiana Friday Night guest speaker, said screenings are crucial because the condition generally cannot be detected any other way.

“It’s really something people don’t generally notice,” Hollier said. “It doesn’t generally cause any pain until it starts to get into trouble.”

An aortic aneurysm is characterized by the ballooning of the central artery that delivers blood from the heart to the lower half of the body. The aneurysm puts increased pressure against the artery wall which, over time, can lead to a rupture.

The result is often lethal.

White men, age 60 or older, with a family history of the condition are the most at-risk group, but Hollier recommends the screening for anyone 60 or older.

A January 2007 Aneurysm Outreach screening might have saved William Avery’s life.

Avery was battling cancer in 1996 when doctors noticed a small aortic aneurysm during a body scan.

“It was kind of like driving across the Mojave Desert, and you’re not sure if you’re going to make it anyway — a low tire is the last thing on your mind because it may be a moot point,” Avery, 65, said.

He ignored the condition to continue — and eventually win — his fight with cancer.

Last year, his wife heard about an Aneurysm Outreach free screening, bringing to mind her husband’s condition that had been forgotten for more than 10 years.

The screening found a 4 centimeter bulge that has since grown to 5.5 centimeters.

Next week he undergoes surgery to repair the aneurysm which otherwise might have been fatal.

His doctors say that after an initial few months of caution, Avery will be able to return to the lifestyle he now enjoys.

Success stories like Avery’s are both a professional and personal success for Sheila Arrington, president of Aneurysm Outreach.

Arrington founded the organization, the only one of its kind in the United States, in response to her father’s death from an aneurysm burst.

Removing the cost barrier from a person’s decision to be screened is an important reason her organization arranges the free screenings, she said.

According to Baton Rouge Cardiology Center, Medicare normally reimburses the screenings at a cost of \$217. However, Medicare doesn’t pick up the cost of the screening in all circumstances, leaving the patient to pay.

For those patients in whom an aortic aneurysm is detected, careful monitoring is usually the recommended treatment.

“There is no medicine that makes this go away,” Hollier said.

Once the bulge reaches 5 centimeters or more, surgery to repair or replace the aorta is required.

However, Hollier said, “the long-term prognosis is excellent.”

<http://www.2theadvocate.com/features/26890824.html>

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## **La. hopes for quick approval or health-care plan for poor**

**The Advocate | 08.13.08**

By MARSHA SHULER

The Jindal administration is on a fast-track to get federal approval of a plan to test a new health-care delivery system that serves Louisiana's poor, state Department of Health and Hospitals Secretary Alan Levine said Tuesday.

The Baton Rouge region is one of four areas being eyed for a managed-care plan that Levine said would put physicians, hospitals and other providers in control of health-care decisions.

Other areas are New Orleans, Shreveport and Lake Charles, he said.

Between 50 and 60 percent of about 1 million residents enrolled in Medicaid live in the four areas. Medicaid is the government's insurance program for the poor.

Levine told a newly formed technical advisory group that the Jindal administration wants federal Centers for Medicare and Medicaid Services, called CMS, approval by January.

When a new U.S. president takes office, "there is a huge transition period and pretty much everything gets puts on hold and it could delay anything we want to do for another year," Levine said.

"I don't think we can wait," he said.

The state largely relies on its charity hospital system to care for the poor and uninsured. Exactly what role the hospitals — now run by LSU — would play is an unknown.

U.S. Health and Human Services Secretary Michael Leavitt — who oversees CMS — wants to end the charity system of care.

With federal and legislative approval, Levine said, the first of what are termed "provider service networks" could be on-line by mid-2010 under the plan.

At the heart of the plan is establishment of medical networks of care. The state would oversee managed-care networks that public and private health-care providers would put together. Primary-care physicians and clinics would provide "medical homes" and act as gatekeepers, referring patients to specialists and hospitals as needed.

Under the DHH proposal, providers would have to have at least a 25 percent ownership in the organization put together to deliver care, DHH Deputy Secretary Sybil Richard said.

Richard wants two to three provider service networks in each area in which the program is implemented, to provide patient choice. The program will mostly cover children and adults who qualify for Medicaid because their income is less than \$600 a month, she said.

Levine said DHH officials have been negotiating with CMS and has been in discussions on various issues related to the filing of what would be a Medicaid pilot program.

Those talks should be complete in the next couple of weeks, Levine said, and he will be able "to roll out the proposal" to both the advisory committee and legislative panels that must sign off on it around mid-September.

The advisory team was holding its first meeting Tuesday.

Levine said there would be lots for the advisers to help with in the coming weeks and months as provider service networks are developed.

"Don't think for a minute this is for show. It is not," he said.

<http://www.theadvocate.com/news/26895674.html>

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**Louisiana Health: Interview With Bobby Jindal's Secretary of DHH, Alan Levine, Part I**  
**BayouBuzz | 08.13.08**  
BayouBuzz Staff

The Health of Louisiana appears to be in good hands but the challenges are substantial.

On Monday, Bayoubuzz interviewed Alan Levine, Governor Bobby Jindal's choice to lead the mammoth Department of Health and Hospitals. The purpose of the interview .is to obtain a "State of the Health" report of Louisiana. It is part of a multi-part series.

Levine hails from Florida, praises Jeb Bush, the former Governor of Florida, and also has high marks for Bobby Jindal, (his now-boss). He had previously told Bayoubuzz that he took a major pay cut from his former employment to become the Secretary of Health and Hospitals for the Jindal administration. Levine manages the largest department in Louisiana state government. Today's three-part-video interview segments starts with some biographical information, the range of the Department of Health and Hospitals services and the "biggest challenges" the state faces in health care.

Without doubt, Levine is supporting a private-based program to deal with the burgeoning Medicaid costs. Medicaid covers individuals who are disabled and poor and the recipients make up approximately one-fifth of the state's population. He said the poor "are not stupid" and they should be given choices in plans which they can opt-in as consumers.

Levine discussed his Florida roots, the reasons he chose health care as a profession, his initial meeting with then Governor-elect Jindal. He also explained how his department interfaces with so many agencies and every day and important issues ranging from licensing, hurricanes and even tattoo parlors. A quick review of the department's web site clearly demonstrates the panoply of topics the Secretary and his agency becomes involved with on any given day.

Levine Interview segments available at:

[http://www.bayoubuzz.com/News/Louisiana/Medical\\_and\\_Healthcare/Louisiana\\_Health\\_Interview\\_With\\_Bobby\\_Jindals\\_Secretary\\_of\\_DHH\\_Alan\\_Levine\\_Part\\_I\\_7272.asp](http://www.bayoubuzz.com/News/Louisiana/Medical_and_Healthcare/Louisiana_Health_Interview_With_Bobby_Jindals_Secretary_of_DHH_Alan_Levine_Part_I_7272.asp)

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## **Mission of Mercy**

**Bogalusa News | 08.12.08**

By Bob Ann Breland



**Dr. Dennis LaRavia motions as he describes the living conditions in the areas of Mexico where a team of doctors, pharmacists, medical students, interpreters and others recently went, meeting both medical and spiritual needs of the mostly poor citizens. LaRavia, who is a past president of the Bogalusa club, was also presented with the prestigious Paul Harris Award for his work as a Rotarian by the local club. Paul Harris was the founder of Rotary and this is the highest award presented within the organization.**

**Health concerns close to home were brought to the forefront when a recent mission trip to Acuna, Mexico was described by Dr. Dennis LaRavia for a recent Bogalusa Rotary Club meeting.**

LaRavia was assisted by Dr. Eros Sanchez in the slide presentation.

LaRavia explained that the team included 70 college students, 18 translators, three doctors, including himself, Dr. Sanchez and Dr. Brian Galafaro; one medical student, two pharmacists and nine support staff. They were also greatly assisted by three churches in Mexico.

“The logistics are huge getting materials there and setting up. There’s a great amount of work that has to be done before we can actually start,” LaRavia said.

The mission entourage included one bus, five vans, one truck and trailer and one Expedition, carrying personnel and all medical and pharmacy supplies. These were furnished by First Baptist Church and local pharmacist Kevin Nielsen.

LaRavia said a mission trip to another country is very stressful, not just with cultural shock, but also being out of a regular routine.

“Getting a good night’s rest is important,” he commented, adding that they had the best accommodations this year that he had ever experienced.

Each day the team started out with leadership meetings for all teams and getting ready for clinic and a worship service. At different churches, they had different set-ups for seeing patients.

One of the churches was in a very poor area and they saw people with very bizarre beliefs, including demon possession. The team was able not only to minister to patients physically, but also spiritually.

“We found a lot of abusive relationships. The medical things were simple, but the chronic social problems were harder. Abuse starts at a young age and young boys in particular have no respect for older people,” LaRavia said.

Dr. Sanchez, who speaks Spanish, could understand many of the situations the people faced.

Sanchez told about some of the people who were changed spiritually, including one entire family, adding, "Only God could change them".

Both said the people really need a dentist and the dental student was a big help. The people eat a lot of the wrong things, with no fruit and vegetables in their diets. They have no vitamins and vitamins can make a big difference in their health.

"Ministry was going on at all times and many people accepted Christ," LaRavia said.

After clinic every day, the teams spent time talking. They had a very busy triage, seeing some 700 patients as well as others who just walked in. They saw everybody who came, most of whom lived in great poverty.

"The set-up for clinic was tough," LaRavia said. "We ran an inspection station for allergies and infections, which were high. We gave a lot of injections."

He added that in the clinic rooms they had to cover the bottom of the windows because the kids would come up and peek in the windows. In many areas they had never seen a doctor.

"Parents are scared for their children, but we welcomed them and offered them three months of medications for their problems. Since this is our third year in the same place, we saw some of the same patients with different problems.

"The kids are adorable. They need attention and they don't get it. They get pushed out in the streets much too soon. They loved the attention we gave them," LaRavia said.

"Once we cross the barrier with the kids, we can see in their eyes that what they say is wrong isn't really what is wrong. The problem is starvation and abuse. We see a lot of earaches and partial hearing loss from lack of medical care. We always check both ears, even though only one is hurting." LaRavia said they had a great pharmacy team with Bill Nielsen and a wonderful evangelism team praying for the people.

"Our medical team gets students involved as much as possible and we teach them along the way. They see problems they will never see in medical school or in regular medical practice in the U.S."

Sanchez said the trip last year changed his life as when he came home, he accepted the Lord as Savior.

"We go to minister and treat and we tell them about Jesus," he said.

Both said they have no problem getting students to go, their big problem is getting supplies and translators.

"The pastors tell the people we are coming," LaRavia said. "They have already handed out numbers, mostly to church members, but when we come we hand out new numbers to both the church and the unchurched. We need regimentation and we have to have control of the triage and treatment. We also go into the homes of people who can't come."

He told about one woman, a double amputee who was in the care of her 12 year-old grandson. She was very malnourished.

"We also have to have continuing support, such as from these three churches. The impact we make continues to roll. The government there does not care about the people. The poor are considered vermin in all of South America. It is hard work but we try to make an impact that will last. It is a privilege to go."

The mission trip is sponsored by the LSU Chapel on Campus, churches and other donations. Everyone who goes along pays their own way.

<http://www.gobogalusa.com/articles/2008/08/11/lifestyle/doc48a0a59284c45317408209.txt>

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## **Editorial: Three Years After Katrina The New York Times | 08.12.08**

The pace of recovery is slowing in New Orleans as the city approaches the third anniversary of Hurricane Katrina late this month. The next president and Congress will need to expedite assistance before the city's mood turns from guarded optimism back to despair.

With a mélange of federal, state, city and private recovery efforts under way, it is difficult to grasp what is really happening in the stricken city. Fortunately, two reports on New Orleans's condition have just been issued by authoritative outside organizations.

The Henry J. Kaiser Family Foundation released its second survey of the attitudes and experiences of the city's residents. The good news is that 6 in 10 Katrina survivors say that their lives are almost or largely back to normal, and most see recovery moving in the right direction. The bad news is that 4 in 10 respondents say their lives are still disrupted, and more than 7 in 10 see little or no progress in making housing affordable or in controlling crime, which they view as the city's top problem. Smaller majorities see little or no progress in making medical services available, strengthening public schools, attracting jobs or rebuilding neighborhoods.

These perceptions are largely consistent with an index of progress compiled by the Brookings Institution and the Greater New Orleans Community Data Center. Their third-year report finds that the greater New Orleans area has recovered the vast majority of its pre-Katrina population and jobs but that recovery trends have slowed in the past year. Tens of thousands of blighted properties, a lack of affordable housing and thin public services continue to plague the city. Rents are 46 percent higher than before the storm.

New Orleans residents expressed mixed attitudes about their prospects. Three-fourths told Kaiser that they remained optimistic about the future even though most felt that both Washington and the American public have largely forgotten them. What is worrisome is that half of the residents are dissatisfied with or angry about the lack of progress, most think it is a bad time for children to grow up in New Orleans and 22 percent (predominantly young) are seriously considering moving away.

Unless government agencies and private organizations pick up the pace of recovery efforts, New Orleans may see its future pack up and go with them.

<http://www.nytimes.com/2008/08/12/opinion/12tue2.html?partner=rssnyt&emc=rss>

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**EDITORIAL: A golden opportunity**  
**The Times-Picayune | 08.12.08**

New Orleanians' love for this city is legendary. Entire extended families live here, often in the same neighborhood, and before Katrina many city residents had never lived outside the area -- and didn't want to.

That attachment is one of the best things our city has going for its recovery, as evidenced by a survey conducted by the California-based Kaiser Family Foundation.

The survey, completed in the spring and released this week, found that nine out of every 10 current city residents lived here before the storm. Most respondents said they are dissatisfied with the pace of rebuilding and recovery, yet the vast majority remain optimistic and hopeful about the city's future. That's a sentiment officials should capitalize on by doing everything they can to speed up the recovery.

Almost three years after Hurricane Katrina, the toll of the long recovery is evident. In the survey, New Orleanians reported rising levels of stress and a perception that job opportunities are limited. Perhaps more worrisome, 22 percent of respondents said they are planning to move or considering a move.

Still, 76 percent of respondents said they remain optimistic about New Orleans' future, and 56 percent said the recovery is moving in the right direction. Foundation officials also said city residents may have high expectations about the rebuilding process being able to correct deep-seated problems in our area.

That has been evident in civic activism post-Katrina, as residents pushed consolidation of levee boards and New Orleans assessor offices.

Such an engaged, hopeful constituency that is eager to correct long-standing problems is a gift that elected officials and community leaders ought not to waste.

It's hard to imagine residents of a more transient region being this optimistic after the suffering of the past three years. But hope and love for the city will not sustain residents forever.

Officials need to make sure the recovery shows substantial progress soon, and they need to push decisively for further reforms to make government more efficient and improve the city's quality of life.

<http://www.nola.com/news/t-p/editorials/index.ssf?/base//news-5/1218518585318090.xml&coll=1>

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## **Survey: Health problems continue to rise in New Orleans** **AHA News | 08.12.08**

The proportion of New Orleans residents reporting mental or physical health problems has continued to climb since Hurricane Katrina devastated the city in 2005, according to the latest Kaiser Family Foundation survey.

The share of residents reporting a mental illness climbed from 5% in 2006 to 15% in 2008, while the share reporting a chronic condition/disability or “fair” or “poor” health grew from 45% to 65%. One in four residents reported problems paying medical bills, up from 9% in 2006, while 18% reported skipping or postponing needed care, up from 9%.

Louisiana Hospital Association President and CEO John Matessino said, “Access to affordable health care still remains an issue in the New Orleans area. But many groups, like the Coalition of Leaders for Louisiana Healthcare and Blueprint Louisiana, and the Department of Health and Hospitals, under the leadership of Secretary Alan Levine, are dedicated to redesigning the health care delivery system within the state, as well as addressing ongoing workforce and mental health issues.”

[http://www.ahanews.com/ahanews\\_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann\\_080812\\_KFF&domain=AHANEWS](http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080812_KFF&domain=AHANEWS)

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## States fail to report health provider sanctions

Washington Post | 08.12.08

By KEVIN FREKING  
The Associated Press

WASHINGTON -- In violation of federal law, states routinely fail to notify federal authorities when they've kicked health care providers out of their Medicaid programs for incompetence, fraud and other reasons, government investigators have found.

The lack of notice makes it easier for barred providers to set up shop in other states and to continue getting payments from federal health programs.

The inspector general for the Health and Human Services Department maintains the list of health care providers prohibited from getting any federal health reimbursements. Last year, the IG's office added 3,308 people and organizations to that database, but probably could have added many more, according to a survey that investigators conducted recently.

Investigators surveyed the states to find out how often their Medicaid programs sanction a provider in a way that would in the vast majority of cases merit a spot in the IG's exclusion database. An astounding 61 percent of the 4,319 sanctions imposed by state Medicaid agencies in 2004 and 2005 could not be found in the federal database.

States with high match rates tended to be states that took action against more than 100 health care providers, though that wasn't always the case. Alabama, Louisiana and Texas had the highest match rates. More than 80 percent of the providers suspended from their state Medicaid programs could be found on the national list.

However, the two states that suspended the largest number of providers, New York and Florida, had the lowest matching rates, 21 percent and 9 percent respectively.

About a dozen states submitted incomplete data or reported not taking any action against health care providers in 2004 and 2005. Among them were California and Michigan, two states with large Medicaid populations.

Jeff Nelligan, a spokesman for the Centers for Medicare and Medicaid Services, said the agency agrees there's room to increase the number of referrals from the states. It will "strive to reduce the barriers that may currently exist," he added.

In all, 47 states responded to the survey. State officials frequently said they were unclear about what kind of information was supposed to be forwarded to the HHS inspector general.

"It would be handy to have a little cheat sheet that clearly stated refer these cases with this info," an unidentified state official wrote.

Another state official wrote that until they had responded to the inspector general's survey, "no coordinated effort existed ... to make referrals."

Reasons for exclusion from federal health programs include convictions for fraud and patient abuse, licensing board sanctions and default on federal health education loans. Under law, no federal payment can be made for anything that an excluded person furnishes, orders or prescribes.

<http://www.washingtonpost.com/wp-dyn/content/article/2008/08/12/AR2008081200036.html>

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## **Been there, done that Baton Rouge Business Report | 08.11.08**

By Steve Clark

As Louisiana gears up for a major revamp of its Medicaid system, which delivers health care for low-income and disabled people, North Carolina could offer some inspiration insofar as proving such a revamp is doable while improving the quality of care and saving big bucks.

The revamp—theirs and the one Louisiana hopes to accomplish—is based on a “medical home” primary care model: giving Medicaid patients good access to a doctor and establishing a pattern of routine preventive maintenance rather than waiting for health problems to become acute and expensive.

Dr. Allen Dobson, architect of Community Care North Carolina, says his state’s Medicaid redesign began as an experiment but turned into a serious mandate when North Carolina’s budget hit the wall in 2001. The crisis was an opportune time to make things happen; Medicaid was too expensive and somebody had to fix it quickly. Doing so required new state spending, however—counterintuitive to legislators during fiscal crisis, Dobson says.

“If you’re in a budget crisis, why would you spend any more? But for every dollar you spend developing it, you’ll save \$10,” he says. “It’ll just be next year. In reality that’s really not that long. The thing legislatures need to understand is the need to invest if you’re going to gain the savings. It multiplies as you roll out.”

What North Carolina did, and what Louisiana aims to do, is to set up a doctor-patient relationship for all Medicaid recipients. To accomplish that, the state had to get physicians in communities across the state on board. That meant making it worth their while to participate in the form of adequate reimbursements and other resources, which is where the extra state investment comes in.

It was all about taking the fragmented pieces of the state’s “system” of doctors, hospitals and other providers, and orchestrating it to a common purpose: efficient and quality care for the Medicaid population.

“We found if we enter into a collaborative agreement with the state, if we change that dynamic versus just writing regulations and paying bills, if we become more of a health manager and work with all parties and invest in infrastructure, the improvement in quality will just plummet costs,” Dobson says.

Given the right resources, doctors fell in love with Community Care because it gave them the opportunity to help effect change in improving the delivery of health care. It put doctors, hospitals, health departments, social service and community agencies all in the same room when it came to addressing health care problems—pretty much the opposite of Louisiana’s fragmented system. “It’s been a huge success,” Dobson says. “The natural evolution is what can we do for Medicare, and what can we do for other health care issues? Can we use it as a platform for doing quality for all payers?”

Medicare, not to be confused with Medicaid, is the federal health care program for senior citizens. Will a North Carolina-style makeover go over in Louisiana? Dobson says the principals are the same, though the specifics will be different. While North Carolina shared much with Louisiana’s situation—a large uninsured rural population with poor access to health care, for instance—there are differences. Louisiana’s statewide public health care system, operated by LSU, is one difference.

The North Carolina approach means not just spending money, but directing it to areas around the state where access to primary care is lacking, he says. You start in an area of the state where there’s a problem, set up a network and see if it saves money and increases quality.

“Let the community save money for you,” Dobson says.

If it does, expand it to the rest of the state. That’s what happened in North Carolina. Louisiana is just starting down that road with the Louisiana Health First demo project of physician networks to provide preventive care and chronic disease management.

“Small increments applied across a large population will yield large results,” Dobson says. “We tend to do in-depth projects on a very limited scale. Although they may be successful, they have no lasting impact because they haven’t changed the landscape. Doing something small across the entire state will yield you larger, more lasting results than getting five practitioners in Louisiana to give the best care in the world.”

North Carolina saves hundreds of millions of dollars a year on Medicaid while improving the quality of care and health of its poorer residents. With pilot projects involving 30,000 disabled Medicaid patients, the program saved \$53 million in one year, Dobson says.

“It’s spending less next year than you would have to if you didn’t do this,” he says. “Think of it as your taxes don’t go up.”

State government has to take a director’s role in galvanizing disparate health care providers and entities, he says. Louisiana Department of Health and Hospitals Secretary Alan Levine has appointed a committee to get the Medicaid reform ball rolling here in accordance with the state’s Health Care Reform Act of 2007.

Butch Passman, CEO of the Louisiana Business Group on Health, says that while Louisiana and North Carolina have much in common in terms of underserved populations, Louisiana’s physicians will have to get better Medicaid reimbursements for Tar Heel State-style Medicaid reform to work here.

“We’re going to have to get Medicaid reimbursement up in order to get people to come into the network and stay there and put in the kind of time in they need to,” he says.

Passman agrees with the medical home concept’s focus on treating chronic illnesses, which are a major driver of growing health care costs. Louisiana’s health care system, meanwhile, wasn’t designed to deal with chronic care.

Managed care, like HMOs when they were new, was supposed to get a handle on treatments and cost, though it hasn’t been coordinated as with the medical home concept, he says, plus the public turned against managed care as it devolved into an adversarial relationship.

Passman says public and private forays into the medical home idea are already happening around the state but have yet to be connected. He thinks it’ll be tough establishing medical home statewide, though he believes that it’s “probably the answer to quality health care.” Low Medicaid reimbursements and other issues will have to be resolved first.

“It’s a simple problem: how to do a better job with the money we spend,” Dobson says. “This is really a clinical model. It is really not very sophisticated IT. It’s not sophisticated financing. We’ve got a bunch of patients that cost a lot of money. How do we give them what they need?”

<http://www.businessreport.com/news/2008/aug/11/been-there-done-hlcr1/?health-care>

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## Sore sports

### Baton Rouge Business Report | 08.11.08

By Stephanie Riegel

Sports medicine isn't new, but in recent years it has become one of the fastest-growing areas in the medical field—not because college and professional athletes are injuring themselves with greater frequency but because the fitness-obsessed baby boomer generation is aging and refusing to slow down.

Thanks to the increasing popularity of activities like triathlons, master's team sports and adventure races with recreational athletes in their 40s, 50s and 60s, physicians and surgeons who specialize in sports medicine are finding they're busier than ever.

"The real business part of sports medicine is dealing with the recreational athletes," says Dr. Brent Bankston, a sports medicine specialist at the Baton Rouge Orthopaedic Clinic who also is an LSU football team physician. "We see the high-profile athletes, but that's not what brings in business for us."

Fortunately, for patients and practitioners alike, it's an exciting time to be involved in sports medicine. New technologies and medical advances are making procedures possible that would have been unimaginable just a few years ago. And treatments that were once reserved for high-performance athletes are now available to the weekend warrior who overdoes it on the soccer field or at a 10-kilometer race.

"We're treating regular folks the exact same way we're treating the real athletes," Bankston says.

While sports medicine might sound like a new subspecialty of orthopedics, it's actually been around since 1928. That's when the First International Congress of Sports Medicine came together at the Olympics in St. Moritz, Switzerland. Back then, sports medicine was reserved for real athletes. But as the physical fitness craze took off in the 1970s and 1980s, recreational athletes began to take their erstwhile athletic pursuits more seriously.

As they have aged, their need for sports medicine has increased. Today, the business of sports medicine is growing, and fueling that growth are the soccer mom or the attorney who decides to ring in his 40th birthday by running his first marathon.

"Most of what I see are the weekend warriors," says Dr. Alan Schroeder, a sports medicine specialist at the Bone and Joint Clinic. "They aren't in the same shape they were in their 20s, and they go out and overdo it."

Among such avid amateur athletes, the most common injuries are those resulting from overuse. Stress fractures are big. So are shoulder injuries, which are frequent among those who spend lots of time on the softball field or tennis court. ACL tears are also very common, both among recreational and real athletes.

"Probably a dozen kids on the LSU football team have torn their ACLs," Bankston says. "We got them back and playing again."

The ACL is the anterior cruciate ligament, one of the four main ligaments of the knee, and the one that's most easily damaged. It can happen if you land wrong from a jump or lunge, or change directions with a sudden swift movement.

In the past few years, however, sports medicine specialists have made tremendous advances in ACL reconstruction. At Baton Rouge Orthopaedic Clinic, Bankston uses a procedure that is somewhat unique; he takes tendons from the hamstring and grafts them onto the ACL ligaments. Traditionally, tendons from other parts of the leg have been used, but Bankston prefers hamstring tendons because they grow back quickly so are well-suited to ACL reconstruction.

So far, the results are impressive. Several LSU running backs had the procedure and were playing again the following season. That would not have been possible as recently as the 1990s.

"Years ago, if you tore your ACL your career was over," Bankston says. "Now, not only can you continue to play but you can continue to play well."

Recreational athletes are getting the same kind of treatment because they're demanding it. Schroeder recently repaired the ACLs of two 40something women. One was a snow skier, the other an avid tennis player. When they came to him, they told him that giving up their favorite sports wasn't even a consideration.

"In the past, a doctor might have told an older patient not to bother repairing an ACL," Schroeder says. "To tell that to someone now simply wouldn't hold up."

Another relatively new and increasingly popular treatment to repair damage to the knees is a cartilage transplant. Essentially, surgeons take healthy, donated knee cartilage—known as meniscus—and transplant it onto the injured knee through a small incision. The technique provides long-lasting relief from knee pain; more important, it allows athletes to resume their play after just a few months of recuperation.

Many overuse injuries don't require surgery, however, and a big part of sports medicine today involves therapy or rehab. One of the more popular treatments among physical therapists involves the use of a cold laser or infrared light that is applied to an injury to speed the healing process.

It can be used for injuries to bones, muscles or joints, though physical therapist Gloria Wall, who owns GO Physical Therapy, finds it most effective in treating acute, rather than chronic, injuries.

Another popular treatment is Active Release Therapy, or ART, which is where pressure is applied to an injured area of soft tissue to help break it up and release it. Essentially, it's like a very concentrated, painful, deep-tissue massage.

"It's not really new, but it has a new name and is real big right now in sports medicine," Wall says.

While there are plenty of treatment options, experts say the best medicine is to avoid injury altogether. For the occasional or recreational athlete, Bankston stresses the importance of cross-training.

"Don't just run, but run, bike and swim," he says. "Try to mix things up so you can give the different muscle groups time to heal."

Equally important is to make sure you have the proper equipment if you're starting a new sport. Don't assume an old tennis racket or well-worn pair of running shoes will be sufficient. Finally, make sure you have some physical conditioning before you return to high level sports.

"It's important to be in shape before you jump right in," Bankston says. "Many of our patients haven't played sports in 10 years and all of a sudden they go back. That's how you get hurt."

## ACHES AND PAINS

Here are the most likely sports injuries you'll suffer:

1. Muscle pull How it occurs: A sudden, severe force is applied to the muscle, and the fibers are stretched beyond capacity
2. Neck pain/strain How it occurs: A pulled muscle or muscle spasm caused when the neck is pulled slightly to one side
3. Frozen shoulder How it occurs: Because of the shoulder's shallow socket and lack of ligament strength, any weakness of the small, rotator cuff muscles makes it easy for the head of the shoulder to slide around in the joint; tendons become inflamed
4. Strained lower back How it occurs: Twisting awkwardly to the left or right, lifting heavy excessive weight or doing some unpracticed sports activity
5. Tennis elbow How it occurs: Bad technique among tennis players who don't move their feet to put the body in the proper position to hit with full body weight and among golfers who have swing problems

6. Runner's knee How it occurs: Misalignment of the kneecap in its groove; also, fluid buildup caused by cartilage on the back of the kneecap wearing out
7. Shin splints How it occurs: Running and jumping on hard surfaces or from overuse; usually caused by people unaccustomed to exercise and training
8. Twisted/sprained ankle How it occurs: Foot twists, rolls to the outside and sprains the support ligaments on the outside of the ankle
9. Achilles heel How it occurs: Inflammation of the Achilles heel tendon, usually from overuse
10. Plantar fasciitis How it occurs: Also known as a foot strain; caused by overstretching or partially tearing the shock-absorbing arch pad.

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## Coming to a pharmacy near you Baton Rouge Business Report | 08.11.08

By Olivia Watkins

A child's cry can be heard from the gray, plastic armchair in the patient waiting room. But it's not from a nearby seat that the child is struggling for her mother's attention. It's across the building, in the cosmetics aisle. The bustle of afternoon shoppers is constant but seems not to disturb the rapid patient check-in process. That's because this is a retail health care clinic—also called a convenience clinic—located in a neighborhood pharmacy chain store.

Retail clinics are the commercial sector's solution to the health care crisis. Staffed with nurse practitioners and housed in a pharmacy like CVS or Walgreens or large retail chain store like Target or Wal-Mart, the clinics offer basic health care services for common illnesses at reduced costs.

Each service is clearly listed on the service menu, carefully hung to the side of the check-in window. Nurse practitioners follow a meticulous checklist as they treat or advise patients on preventative health care. Their practice, reviewed by physicians, makes affordable health care possible for numerous groups left aside from the mainstream system—particularly those without health insurance but ineligible for federal assistance programs.

The clinics' extended days and hours of operation also make them accessible to patients who would normally have to take off work to visit a doctor, or to busy parents. Brandi Doyle, a representative of Target Clinics, says their clinics fill a critical need. "We are focused on providing convenience to our guests and benefiting their increasingly busy lifestyles."

While retail clinics have had incredible success and growth throughout the U.S., they have not yet been able to open and maintain service successfully in Louisiana. For a brief period in time, Wal-Mart stores in the New Orleans area leased space near their eye care clinics and customer service counters to CheckUp, a retail health care chain that operated throughout Alabama, Florida and Mississippi. But on Jan. 19, the clinics unexpectedly closed after being unable to pay their medical staffing firm, MedTracker.

MedTracker president, Nikki Leimer, said that the clinics failed because "Wal-Mart seemed to have forgotten the basics of marketing. They forgot to tell people that the clinic was even there." Wal-Mart declined to comment on the closing of the clinics or on their plans to reopen clinics in Louisiana through the RediClinic model.

It might be quite a while before the Capital Region sees its first successful retail health care clinic. Of all of the existing convenience care chains—including MinuteClinic in CVS Pharmacy stores, TakeCare clinics in Walgreens stores and Target Clinics—only TakeCare clinics even hinted at the opening of a location in Louisiana in 2009. TakeCare representative Lauren Cassidy was unable to confirm a set date for expansion. However, she did confirm that there are "expansion plans within the next year."

It does seem that Louisiana would be a logical state for expansion of the retail clinics. According to the Louisiana Department of Health and Hospitals, there were 64,355 uninsured children and 546,348 [21% of the total] uninsured adults in Louisiana in 2007. A large portion of that group could be greatly served by an affordably priced health care alternative.

David Ingram, a pre-med LSU student, is an example of a potential patient for a convenience care clinic. Despite being employed while attending school, Ingram is uninsured. Over the past year, there have been several occasions on which he says he would've visited a retail clinic rather than sought treatment through traditional services.

"I broke my finger a few months back playing football," he says. "I actually went to Walgreens, bought a little splint and put it on myself. I still went to a doctor about a week later to have it checked out. All he did was look at what I'd done, tell me he'd have done the same thing and it cost me \$150 for the visit." A low-cost visit to a retail clinic would have been faster—and potentially cheaper—than the primary care physician's office visit that merely confirmed his course of self-treatment.

Ingram has been through all of the traditional available channels of health care over the past year. A recent trip to one of the Lake After Hours clinics for an ear infection resulted in an additional trip to the emergency room at Earl K. Long Medical Center a few days later.

“When I went in to the after-hours clinic, I told the physician what I usually take for an ear infection. He gave me something else, which my body rejected and I ended up having to go to the emergency room a few days later. And after it was all over with, I had to go back to the same doctor for a follow-up visit.” All of which Ingram paid for out of pocket. A retail health care clinic would have offered him the same services without the roughly \$300 in expenses.

While Ingram would still have paid for his visit to a convenience clinic, patients with health insurance would likely be able to use their coverage at most of the retail clinics if they were to open in Louisiana. Not only are health insurance companies covering the clinic costs, they often provide incentives for clinic use such as waiving co-pay fees altogether.

The immediate cost reduction is an incentive for health insurance companies, as well as the long-term cost reduction that may come as patients are given affordable access to preventative care at their local pharmacy or retail store.

Growth of the retail health care industry into Louisiana could mean the opportunity for both uninsured patients, like Ingram, and those stressed for time to access simple, affordable health care. “It would mean I could be in class or at work instead of in the waiting room,” Ingram says. “That, and quality of care, are all that really matter.”

<http://www.businessreport.com/news/2008/aug/11/coming-pharmacy-near-you-hlcr1/?health-care>

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**In summer, obesity rules**  
**The Boston Globe | 08.12.08**  
By Stephen Smith, Globe Staff



**Taina Pena, 9, of the South End worked out on an exercise machine at Body by Brandy fitness studio in Boston. (Erik Jacobs for The Boston Globe)**

Ayanna Martinez, lean and lanky and savvy beyond her 13 years, knows the recipe for children gaining weight: summer vacation.

"Now they feel that school is over, all they want to do is watch TV or just lay back on the computer and eat," Ayanna said one recent afternoon while picking up nutrition pointers at a Dorchester tennis club. "It's like, 'No school! Video game city!' It's really very sad."

It is the paradox of summertime: The very months blessed with the greatest opportunity for running and jumping and playing have instead become prime time for packing on pounds. Once the plight of adults, obesity has become alarmingly common among the young, with children under 10 even being prescribed cholesterol-lowering pills. And specialists who treat overweight children say that the summer months are emerging as a leading suspect in the epidemic of childhood obesity.

Blame it on too much time in front of screens - computers, TV, and handheld-devices - and too little routine. Without the constancy of school and, even, the bland predictability of school lunches, summer looms as three months of unending temptation, fueled by advertising promoting sugar-laden snacks.

"You would think the summer would be a time when kids are really active and running around," said Julie Vanier, coordinator of Boston Medical Center's FANTastic Kids, the fitness and nutrition program that taught Ayanna about the importance of a good diet and exercise. "For many kids, it's the opposite. They have a lot of down time in the summer that they're trying to fill."

And there is reason to believe that this summer may be worse than most.

Weight specialists at Children's Hospital of Philadelphia, one of the nation's top pediatric medical centers, said they are seeing evidence that skyrocketing food prices and concerns about the safety of fruits and vegetables have made it harder to serve children healthy meals.

That is especially true, they said, for poorer families, who often disproportionately bear the burden of weight problems.

"Summer can be a very difficult time financially for families," said Lara Khouri, program director for the Healthy Weight Program at the Philadelphia hospital, which forged a partnership with a charity called Philabundance to collect healthy food staples for summertime dinner tables. "So this is a particularly interesting time to be thinking about the influences of this summer on obesity and kids."

Since the 1970s, the percentage of children overweight has tripled, according to the US Centers for Disease Control and Prevention. For instance, among youngsters ages 6 through 11, the rate climbed from 6.5 percent to 18.8 percent.

Schools - and the carbohydrate-rich breakfasts and lunches they often thrust in front of students - have frequently been implicated. "Schools," said Douglas B. Downey, an Ohio State University sociologist, "have been called obesity zones by some."

But Downey and colleagues at Indiana University weren't so sure. "We asked the question: When it comes to childhood obesity, are schools more part of the solution or more part of the problem?" Downey said.

The researchers calculated the body mass index - a standard measurement of size - for nearly 5,400 children, using data from a national survey. They found that during the summer between kindergarten and first grade, the youngsters' body mass index increased twice as fast as during the school year.

The rise, reported last year in the American Journal of Public Health, was especially steep for African-American and Hispanic children, as well as those already overweight at the start of kindergarten.

The lazy months of summer can also reverse progress achieved during the school year, according to a study from the University of Wisconsin. Their report in the Archives of Pediatrics & Adolescent Medicine last year found that when overweight middle-schoolers went on summer vacation, advances made during the school year in cardiovascular fitness, insulin levels, and body composition were negated, stolen apparently by summer's lack of discipline, specialists said.

"Families have agendas that are related to vacation and traveling, so it's very difficult for the child to adhere to" fitness programs, said Louisiana State University professor Melinda Sothorn, a weight and nutrition specialist who pioneered a campaign called Trim Kids. "And then they're not on a good schedule at home because there are times when they are bored, and they have more access to the refrigerator because the parent is at work."

It wasn't always this way, of course. Dr. David Ludwig, director of the Optimal Weight for Life program at Children's Hospital Boston, said that in earlier generations, summertime heralded a period of increased activity for youngsters.

But hours consumed by instant messaging, video games, and TV - coupled with parents' fears about letting their children play outdoors - now keep kids sequestered inside even when the sun is shining. And among all forms of what's known as "screen time," Ludwig said, TV may be most insidious of all "because it affects both ends of the energy-balance equation.

"Clearly," he said, "when children are watching television, they're not at the beach or playing basketball in the back yard burning off calories. But also they're receiving an unending series of messages by way of commercials to eat the highest-calorie, lowest-quality food imaginable."

There was a starkly different message one recent evening as twilight fell on Dudley Square. Brandy K. Cruthird was putting children through their paces in her Brandy 4 Kidz gym. For summertime, she emphasizes fun and games: basketball, softball, hopscotch, jump rope, Hula Hoop.

"A lot of the kids today don't have the basic, fundamental games that we did," said Cruthird, a former college basketball player who trumpets the importance of fitness with the zeal of an evangelist. "We are really going to feel the effects that technology is having on our children in 10 years, and we're all going to pay a steep cost."

On this day, 9-year-old Taina Pena of the South End was there, her cherubic face twisting with determination as she pushed an exercise machine. Her mother and a healthcare worker recommended she join the gym, Taina said plainly, "because I weigh too much for my age."

Pam Seemore enrolled her two sons. One needs to shed some weight, the other doesn't.

"When they're in school, they have their breakfast, their lunch," said Seemore, who lives in Dorchester. "Summertime brings the ice cream, the smoothies, all the tempting stuff. This will help them resist that when they're adults."

[http://www.boston.com/lifestyle/articles/2008/08/12/in\\_summer\\_obesity\\_rules/](http://www.boston.com/lifestyle/articles/2008/08/12/in_summer_obesity_rules/)

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## **New Orleans Hospital "driving" Mobile P.E. class to schools PR Newswire | 08.12.08**

Ochsner Medical Center in New Orleans is taking P.E. to schools with its Mobile Fitness Unit called On the Move. Ochsner's Elmwood Fitness Center developed a community outreach program to help fight a growing global epidemic: 32 percent, or nine million American children, are now overweight. On the Move is equipped with child-sized workout equipment, staffed by trainers, a nutritionist, and an Executive Chef, and is provided at no cost to New Orleans-area schools.

On the Move will be launched at Orleans and Jefferson Parish public schools in lower income neighborhoods. "We chose these schools for their diversity and location. Children of lower income families tend to suffer from weight problems more often," explains Michael Heim, On the Move and Youth Fitness Manager at Elmwood Fitness Center. "Our goal is to expose elementary students to activities early on that promote healthier behaviors."

Dr. Douglas Moodie, MD, Chairman of Pediatrics at Ochsner, explains that the driving force in developing On the Move was, "the growing childhood obesity epidemic and continual reduction of P.E. classes in schools. We're headed in the wrong direction in our fight against pediatric obesity, particularly in Louisiana, where we have some of the highest adult and pediatric obesity rates and we're one of the least healthy states in the country." Moodie adds that "many schools have just 15 minutes two days a week for P.E. class, and a lot of schools don't have recess so children are sitting in classrooms for several hours without moving."

Physical education programs vary from school to school and "On the Move offers supervised physical activities much like what kids would do in a school gymnasium, and in other cases, the program serves as a supplement to P.E. classes and extracurricular activities," says Heim. "Currently, we have 10 strength training machines and hope to add child-sized spinning bikes," says Heim. The bus also includes two flat-screen televisions and air conditioning.

On the Move includes strength and cardiovascular "circuit" workouts, nutrition lectures, and heart-healthy cooking classes and demonstrations by Elmwood's Executive Chef, and is designed to teach parents and kids how to incorporate healthier foods and behaviors into their lifestyle. On the Move's pilot program was launched in Spring 2008 with 4th and 5th graders at S.J. Green Charter School in Uptown New Orleans.

With parental permission, On the Move staff will collect data this Fall on the children's blood pressure readings, resting heart rate, body fat percentages, strength, flexibility and muscle mass, both before and after going through the program. Funding for On the Move is provided in part by the Frost Foundation, Coca-Cola and the New Orleans Saints.

Visit <http://www.ochsner.org> and <http://www.elmwoodfitness.com> for more information.

<http://biz.yahoo.com/prnews/080812/nyfnsb01.html?v=1>

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## **Abortion Does Not Cause Mental Illness, Panel Says**

**The New York Times | 08.12.08**

By BENEDICT CAREY

Women who choose to abort an unwanted pregnancy may experience feelings of grief and loss, but there is no evidence that a single abortion causes significant mental health problems, a panel of the American Psychological Association reported after two years of study. The findings are almost identical to a similar review by the association in 1990.

“The best scientific evidence published indicates that among adult women who have an unplanned pregnancy, the relative risk of mental health problems is no greater if they have a single elective, first-trimester abortion or deliver that pregnancy,” Brenda Major, chairwoman of the panel, said in a statement. But the report also found that many of the more than 150 studies it reviewed had major flaws, and it called for better-designed studies “to help disentangle confounding factors” like income and medical history.

[http://www.nytimes.com/2008/08/13/health/research/13brfs-ABORTIONDOES\\_BRF.html](http://www.nytimes.com/2008/08/13/health/research/13brfs-ABORTIONDOES_BRF.html)

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## Six Ways to Be a Better Patient

The New York Times | 08.12.08

Tara Parker-Pope

Last week, the Well blog featured “Six Rules Doctors Need to Know.” So what about patients?

Dr. Robert Lamberts, the August, Ga., physician who wrote the original rules in his blog, *Musings of a Distractible Mind*, says it was easy to criticize his own profession, but it's tough to turn the spotlight on patients. That said, patients are half of the doctor-patient relationship, and they need a few rules of their own. Here are his six rules for patients.

Rule 1: Your doctor can't do it alone.

The best doctor can do very little with patients who ignore instructions. Sometimes noncompliance is partly due to physicians not explaining things well, but medical compliance is ultimately in the hands of the patient. I am mystified as to why some patients will ignore nearly everything I say and yet continue coming in for regular appointments.

Rule 2: Be honest.

I think the main reason most people are untruthful is that they are embarrassed about the truth. While I can sympathize with this feeling, I don't see any good reason to be anything but truthful with your doctor. Yes, your symptom might sound strange. Yes, you may have flubbed up and not followed instructions properly. Yes, you may be afraid of what some of your symptoms may mean. But the goal is to fix (or prevent) problems, and trying to do that with bad information is an exercise in futility.

Rule 3: I don't play favorites.

I have over 3,000 patients. I try to do right by all of them. I build relationships over years and even develop quasi-friendships with some patients. But I am professionally obligated to keep emotional distance. Overly liking or disliking a patient will cloud my judgment, and so I try to treat everyone the same. It drives me (and my staff) crazy when patients come in and demand “special treatment” because “Dr. Rob knows who I am.”

Doctors I take care of can be the biggest offenders. I try to make it clear from the outset that I will treat them like any other patient and not necessarily give them better access because they are doctors.

Rule 4: Don't mess with the staff.

My staff takes an incredible amount of abuse at the hands of some of my patients. It surprises me what they are willing to say to my nurses and clerical staff but not to me. In general, people see them as an obstruction to being able to see their doctor, and so have little patience for any delay. There are certainly times that my staff is worthy of criticism, and I expect to hear some complaints. But in general, it is not the individual staff's fault for things not running well. If they don't meet your expectations, yelling at them won't fix the problem. Talk to me or my office manager. Better yet, put it in writing so that I have ammunition to change things, because chances are really good that your frustration correlates to a frustration I have.

Rule 5: If you don't trust, leave.

People go to the doctor because doctors have unique knowledge and experience. The stakes are as high as they can get, so why would you go to someone you don't trust? I have seen many patients stick with doctors in whom they have lost faith “because I don't want to hurt his feelings.” That is ridiculous. It does not matter if everyone else says this is a good doctor; if you don't trust him, find another doctor.

Please note that trusting a doctor does not mean you should not ask questions. In fact, I think a physician who does not want to be questioned is one you should not trust. Questioning is often the only way to build trust.

Rule 6: No news might be bad news.

Never assume that your doctor will call you if there is a problem. A doctor's office is always on the brink of chaos — with an incredible amount of information coming in and going out, a large number of phone calls, insurance company headaches, and personnel situations that can throw the best system flat on its face. People forget that there are hundreds of other patients with thousands of test results the office is dealing with. We do what we can to tell patients test results (and with our computerized records, we do a better job than most), and I see that as our responsibility. If you don't get your test results, call.

To read the full post by Dr. Lamberts click [here](#).

What do you think? As a patient, do you follow these rules?

<http://well.blogs.nytimes.com/2008/08/12/six-ways-to-be-a-better-patient/>

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## **U.S. Faces Serious Shortage of Primary Care Physicians, Especially in Low-Income, Rural Communities, According to National Association of Community Health Centers Kaiser Network | 08.12.08**

Community health centers have a shortage of more than 3,200 primary care providers and nurses, with larger shortages in rural and low-income areas, according to a report released Monday by the National Association of Community Health Centers, CQ HealthBeat reports. For the report, NACHC, George Washington University and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care analyzed 2006 data from the Health Resources and Services Administration.

The report found that rural states -- such as Nevada, Alabama and Oklahoma -- have the largest shortages (Nylon, CQ HealthBeat, 8/11). In addition, the report found that 56 million U.S. residents do not have a regular source of health care because of shortages of physicians in their areas. Community health centers will require an additional 60,000 primary care professionals and 44,500 nurses to provide health care for those residents and current patients by 2015, according to the report. One 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, the Sun reports (Lhee, Baltimore Sun, 8/12).

In response to the shortages, the report recommends increased funds for federal programs that place health professionals in medically underserved areas. The report also encourages medical schools to invest in programs that target minority and rural students, who studies have found are more likely to practice in medically underserved or rural areas after graduation (CQ HealthBeat, 8/11).

Dan Hawkins, senior vice president of programs and policy at NACHC and one of the authors of the report, said, "This is the unfortunate reality of our health care system. It's an example of how the market triumphs over public policy," adding, "Even if universal health care comes into play tomorrow, not everyone would have access to a health care provider" (Baltimore Sun, 8/12).

[http://www.kaisernetwork.org/daily\\_reports/rep\\_hpolicy.cfm#53907](http://www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm#53907)

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## **Do safety-net hospitals put money over mission?**

**The Seattle Times | 08.12.08**

By Carol M. Ostrom

Seattle Times health reporter

For safety-net hospitals, maintaining a balance between serving the poor and staying financially viable has always been tough, say the authors of a national study, "but it is becoming even more so in a marketplace that is becoming more competitive and profit-driven."

Some, including Seattle's Harborview Medical Center, are attempting to attract insured patients by building, renovating and advertising specialty services. But these and other steps to bolster the bottom line could threaten the hospitals' mission, the study warns.

At Harborview, new building and advertising campaigns have helped bring attention to "centers of emphasis" such as neurosciences, orthopedic reconstructive procedures and spinal surgery.

Harborview needs 40 percent of its patients to be commercially insured in order to stay financially viable, said Johnese Spisso, the hospital's interim executive director.

"Now, could we do that if we didn't have a world-class faculty and a state-of-the-art facility? No, we'd be another county hospital of last resort," Spisso said, listing failing safety-net hospitals in other areas.

"Those hospitals were ones that only took care of patients that couldn't pay," he said. "There's no system that can sustain that."

In general, safety-net hospitals aren't as financially healthy as the average hospital. About a third lost money in 2005, say authors of the study, which tracked 12 communities for more than a decade.

Conducted by the Center for Studying Health System Change, the study was published today in the online edition of the journal Health Affairs.

"Safety-net providers really are caught in the competitive crossfire of an increasingly profit-driven health-care marketplace," said Peter Cunningham, lead author of the study, which was funded by the Robert Wood Johnson Foundation.

But, he added, "some of the steps they are taking to maintain their margins can threaten their mission."

Harborview's Spisso says that would never happen there. "We embrace our mission," she said. "We have patients with charity care on every single service in this hospital."

The region's top-level trauma hospital, Harborview receives patients from other hospitals in a four-state region for care of complex trauma, burn and neurological injuries.

But Harborview, like some other safety-net hospitals, has taken steps to limit transfers of uninsured patients, the study said.

Harborview has told other hospitals to stop sending nonemergency patients who simply fail the "wallet biopsy," said study co-author Aaron Katz, senior lecturer in the University of Washington School of Public Health.

Spisso confirmed that Harborview, with help from the state hospital association, has intensified efforts to educate other hospitals. Harborview is there for the super-specialized services others can't provide, she said, "not for every single simple problem coming out of their communities."

The health-care landscape is changing fast, the study notes, with consolidations of insurers, new ventures by specialists, closures of money-losing services, and a new "medical arms race" for profitable services such as diagnostic services or cardiac catheterization labs.

[http://seattletimes.nwsources.com/html/localnews/2008106911\\_missionmargin12m.html](http://seattletimes.nwsources.com/html/localnews/2008106911_missionmargin12m.html)

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## **CEOs of the roundtable**

### **Baton Rouge Business Report | 08.11.08**

By Steve Clark

#### THE PARTICIPANTS

Teri Fontenot, CEO, Woman's Hospital

Bill Holman, CEO, Baton Rouge General

Randy Olson, CEO, Lane Regional Medical Center

Mitch Wasden, CEO, Ochsner Medical Center Baton Rouge

Scott Wester, CEO, Our Lady of the Lake Regional Medical Center

Health care is full of challenges these days—coordinating the schedules of five hospital CEOs for a roundtable discussion, for instance, was no easy task.

But Teri Fontenot of Woman's Hospital, Bill Holman of Baton Rouge General, Randy Olson of Lane Regional Medical Center, Mitch Wasden of Ochsner Medical Center Baton Rouge, and Scott Wester of Our Lady of the Lake Regional Medical Center joined Business Report to talk about what's new at their respective institutions, the difficulties of running a hospital in today's environment and reasons for optimism.

Question: Bring us up to speed on what's going on at your respective institutions.

Bill Holman: We have completed the \$87 million expansion at our Bluebonnet campus, so we have more than doubled the square footage on the campus and increased the bed capacity from 105 beds to 203 beds. We have a patient care tower that has 60 new general medical surgical beds in it, and a nine-bed neonatal intensive care unit and a 19-bed labor and post-partum unit. In the critical care tower, we have a 24-bed intensive care unit as well as a 24-bed emergency room. At our Mid City campus, we continue to look at building programs and services on that campus to meet the needs of West Baton Rouge and north Baton Rouge and downtown.

Teri Fontenot: The big story at Woman's Hospital is the relocation, the replacement facility. We broke ground in early June, and we are trying to stay under our price tag of \$299 million and so far we're having pretty good success with that. We're going to be building a \$50 million, 260-square-foot office building—actually it's twin towers—for physicians and outpatient services. The whole project right now is about \$350 million. We're on schedule, the construction's going well and we hope to open in January of 2011.

Back to present day, our [patient] volume statistics are holding up. They're doing better than projections. We're in our seasonal high. May, June and July is typically a high-volume time for us, for women's and infants' services. We've added three new programs since January. We started bariatric surgery, which has been successful, and then we bought a da Vinci robotics system, which is a big chunk to bite off, but the physicians are really liking it as they become trained to use it. We use it for gynecological procedures, though it has other applications. We just started a couple months ago providing gastroenterology procedures. We continue to try to be very efficient and productive at our current location. We're not just waiting till the new hospital opens to continue to implement and execute our strategic plan.

Scott Wester: The Lake over the last couple of years has established a new strategic vision called Vision 2020. We're about halfway done with what we call our onstage look of our hospital's beds. We've taken three rooms and made them into two rooms. We're about halfway completed with that project. Our new tower expansion, which is five additional operating rooms, just began construction about three months ago. That's going to be about a year and half worth of construction. One of the largest things we're continuing to plan is our Livingston site. We have about 200 acres of property in Livingston right on the Walker exit. We're beginning the mitigation phase of that and hopefully will begin the hard construction sometime in the summer of 2009.

A lot of things we call offstage with the Vision 2020 plan, some of the things with being a facility that's almost now 30 years old at the Lake—generators, air conditioning, elevator systems—all that's getting upgraded. So it's a very nice feel for the things we've done over the last couple of years to upgrade the whole main campus. We announced last week we'll have a strong partnership with Surgical Specialty Centre, located on Bluebonnet, and hopefully we'll get all that completed by Sept. 1.

Lane Regional Medical Center CEO Randy Olson

Randy Olson: Probably the biggest thing we're doing is a three-story medical office building. It's about 60,000 square feet, which is big for Zachary. One of the problems I ran into was trying to recruit doctors to quality office space. We didn't really have any, so we built one building that we opened almost two years ago and we already see that we need more. So what we've done is this three-story medical office building. The first floor is going to be our cardiology program primarily, and then we'll have some diagnostic capability there as well. The second floor is primarily office, ob-gyn and others. We're looking at the feasibility of moving endoscopy to the medical office building's third floor, which will free up some inpatient areas. Our medical office building should be done by about the first of September.

Then two years ago this month we signed an agreement with Cardiovascular Institute of the South for cardiology services, and today we opened our cardiovascular center. Today [Aug. 4] we started with our 64-slice CT scan, which is in one of our labs. In our other lab we have a Toshiba dual plane [X-ray system], which can do hearts as well as peripheral vascular work. All that's opening today and tomorrow [Aug. 4-5], and we'll have an open house the 25th of August. It's a beautiful suite. It's 9,200 square feet. Probably the biggest thing that we continue to work on is our quality initiatives. We need to make sure our quality indicators are as good if not better than the people in Baton Rouge. So we really watch those very carefully. Bigger to some people is always better, but we're trying to say it's not necessarily true.

Mitch Wasden: Our biggest news is that about seven months ago Ochsner finished buying the other 50% of Ochsner Medical Center Baton Rouge. Some people don't realize that actually we were in a joint venture for a couple of years with a company out of Nashville. It got to the point where it seemed like it made sense for us to buy the other 50%. We started with a large medical group, about 100 providers if you include midlevels and our specialty and primary care group. We've really been trying to grow a lot of programs at the hospital as well as grow some of our satellite clinics. This next year we'll look at rebuilding our Prairieville clinic and getting that to be a bit larger as well as continue our investment in robotics.

Right now we're fairly deep into robotics in gynecological surgery. We have one of the biggest programs in the country in terms of volumes. What we'd like to do for this next year is actually take that and do more urologic cases as well so that we get more use out of our robot. We get a lot of use out of it right now but we'd like to do some other specialties. We've been pretty focused on renovation at our O'Neal campus. We completed a \$2 million renovation of the medical office building space. This next year we'll be doing more renovations to patient rooms. The last couple of big programmatic items: Last year we started our open-heart program, and the volumes have grown there. We've just grown our cardiology group by two more physicians.

Q: What's making hospital CEOs grind their teeth these days?

Holman: Probably two that stand out are reimbursement—whether it's the federal government with Medicare or the state program with Medicaid. I refer to Teri as the Medicaid queen because she probably has the largest Medicaid population of any hospital in the state. I really do believe reimbursement is a major issue. Probably the other common thread that we all have is the charity health care system—how that care is presently delivered and how it should be delivered in the future.

Fontenot: I certainly don't disagree with what Bill said. There's so many different dynamics going on. There's a lot of moving parts. I guess I hear a lot about the challenges of physician relations in employment—some of the things that Randy talked about. And that is, particularly as there are more and more women becoming physicians, they're looking for places to practice where they don't have to run small businesses. They don't have to fool with the administrative hassle. They're in large groups where they take calls infrequently, where they simply are an employee. They get a paycheck and they go home and raise their families or work part time if they want.

Woman's Hospital CEO Teri Fontenot

We recently completed a strategic plan, and one of the key parts we really wanted to understand and analyze was the generational differences and the future long-term needs of physicians. Every one of us [hospitals] has got to have a vibrant medical staff in order to exist. That's something that you have to plan many years in advance: having a structure in place where physicians want to practice at your facility and being flexible with their needs. And then on the reimbursement piece, part of its government but also just simply the fact that costs are going up faster than general inflation. There's just so much cost-shifting to the private payers you can do. At that point employers start seeing their premiums go up, and they start dropping coverage, and then the hospitals have more uninsured patients to treat. It's a spiral that's out of control.

Q: Hospitals shift costs to private insurers to offset inadequate Medicaid reimbursements and bad debt from treating the uninsured, but you can't ramp it up forever. Has cost-shifting gone as far as it can?

Fontenot: I think so. Every year the number of uninsured goes up and you see employers raising the deductibles or co-insurance amounts, which means that becomes a bad debt to some of us if the person who's got insurance can't pay their out-of-pocket costs. It's almost the same thing as having an uninsured patient. Or the employer decided they just can't afford that benefit anymore and they don't offer it.

Wester: Bill said it, with reimbursement probably being the first major issue, and Teri, too, that salary and other outside costs are going higher than what the revenue stream is on a cost-per-unit basis. We have a continued shortage of nurses and other health care professionals, which drives up labor costs, but we're just not getting any relief on the state side, the federal side or even from the commercial payers.

Holman: We beat up each other, seriously. If Our Lady of the Lake does an across-the-board raise, let's just say with nurses, I've got to match that or I'm going to lose my nurses, and who does that get passed on to?

Fontenot: They'll switch for a dollar an hour.

Wasden: Because with \$4 gas you have to.

Olson: About 12% or 13% of our business is Medicaid. The way the Medicaid system started years ago, there were different tiers. Lane was kind of a sleepy old hospital when those tiers were established. We're not your father's Oldsmobile anymore, and we're still in the same tier of per-diem payments, and we just can't seem to get out of that.

Wester: And that's not just Lane. A lot of our Baton Rouge hospitals I think have different tiering than in other parts of the state. How we get paid on a medical day in Baton Rouge is different than a Medicaid patient that might be in Alexandria. They're predominantly higher outside of Baton Rouge. We've addressed it through [the Louisiana Hospital Association] and through the state. LHA's trying to get parity across the state related to Medicaid payments, but just hasn't been able to push anything through the Legislature.

Olson: Just for [Lane] alone, Medicaid's about a \$4 million shortfall from what it costs us to take care of our patients to what we get paid. You can't make that up in volume. If you're losing on one you'd lose more on hundreds. The other thing, too, is just adequate staffing. Many years ago people flocked to the health industry because it was a great profession. But nowadays there are so many other options. Plus the shifts: We're open 24/7, 366 days a year it seems like. People are looking for other places to work. There's a lot of competition out there for the same labor that we're looking for, especially some of the untrained labor.

Last but not least is the LSU issue. Because we're fairly close to Earl K. Long, we get a lot of the patients that historically had gone there who now choose not to go there because it's kind of a mess. But the money still goes to the charity system. But the patients come to us. That's just another bad debt writeoff, but I'm not sure people are hearing.

Q: Louisiana is supposedly taking its first steps toward a Medicaid overhaul. Does the administration feel your pain?

Holman: We're very fortunate that we have a new governor who is well-versed in health care. I think that he was very fortunate in recruiting an individual [Alan Levine] outside of the state to come to Louisiana to be our secretary of health and hospitals, who is a former CEO of a major health care provider in South Florida. Does that mean that it's going to be utopia? Absolutely not. He still has to work within a budget. But I think he has a better fundamental understanding of what our concerns and issues are than previous DHH secretaries.

Olson: We do have a problem with the Legislature. There are so many new faces because of term limits that it's going to take us a lot of time, each and every one of us, to educate them on what the health care issues are. They're just inundated with other stuff, and I think you saw that through the legislative session. They spent probably more time and energy on their own darn pay raise than they spent on anything else. And they expect us to do the educating I think. That's an issue.

Fontenot: One of the concerns I have is there continues to be a focus on bricks and mortar. In my opinion, until there is a collective agreement among all the stakeholders and decision-makers about what model we're going to implement, it's kind of like we're starting in the middle rather than at the beginning. There's no agreement.

Q: Anything else?

Our Lady of the Lake Regional Medical Center CEO Scott Wester

Fontenot: Since there's a real focus these days on the economy and contributors to the economy, I think that health care has long gotten short shrift. Right now in the state of Louisiana, there's over 100,000 employees in health care and the payroll is millions of dollars. Nationally, health care represents about 17% of the GDP, and it's only going to grow as the baby boomers get older. I think there needs to be a better understanding of how health care—and hospitals and physician practices in particular—contribute to the overall economy. When it's not funded adequately, not only does it affect the health of the population but it also affects the health of our economy.

Q: As for staffing challenges, Louisiana has launched a big workforce campaign. Will that help?

Holman: I believe so. Through some of the training programs that are being established, the expansion of some of the programs at the professional level and at the technical level, an increase in the volume of students that are enrolling in these programs—those will benefit health care providers.

Q: Louisiana Medicaid reform, as well as the national debate on how to fix health care, is about bringing sense to an incredibly fragmented, wildly inefficient and expensive "system" of care. What's the answer?

Fontenot: The [American Hospital Association] has been working on this for two years now to come up with some kind of consensus position so they can attack this problem of the uninsured with the intent of making it a presidential campaign issue. There are a lot of models out there, either other countries or something at the federal level that could be brought down to the state level.

Wasden: I don't know how you all would contrast how you feel today versus how you felt when health care reform was being pushed by Hillary Clinton the first time, but I've personally noticed a big difference in the attitude of hospital administrators, physicians and other people. Back then we were actually afraid of what might come out of it. Now there's almost a sense of desperation, where almost anything could be better than what we're going through now from a payer standpoint and all the rest of it. I think most industries only achieve transformation after an intense period of pain. As much as we hate \$4 gas, what's it driving? It's driving more hybrid vehicles, hydrogen vehicles. It's driving this paradigm shift.

Q: As a country, are we going to be forced into a single-payer system like Germany has?

Fontenot: And France does it, too.

Holman: I'd have to look and see what their outcomes are.

Wasden: Usually in Germany or some of these other countries, really the single-payer system is just a safety net. Most people will have a supplemental plan that you can upgrade. I don't think it completely does away with the private insurance market. If you're at a good employer, they may give you secondary insurance that covers things that the state plan doesn't. In Germany, if you're on the state plan and you need a procedure, you may be waiting three or four months, but if you have private insurance they move you in quicker. We hate that idea in America because we just think that's so wrong. But it doesn't matter what country you go to, there are always different tiers of health care depending on your ability to pay. There's no such thing as a system that's not tiered.  
Ochsner Medical Center Baton Rouge CEO Mitch Wasden

Fontenot: There's an old axiom in health care that says there's three components: quality, access and cost. Choose the two you want. You can't have all three. We're still working on all three, and that's why we're floundering a little bit.

Q: Shall we end on a positive note?

Wasden: We probably just sounded like a bunch of complainers this last hour, but this is a still a noble industry. It's a great industry to have a career, whether you're a nurse or med tech or whatever. You look at some of the scientific advances in health care and they continue to just blow you away. Health will continue to be a great industry, and we've just got to get through this snag.

Olson: Every one of our colleagues is pretty resilient. We take a punch here and a punch there and we come back. How many times have the "rules" changed in our careers?

Wester: I think the Baton Rouge region is very fortunate to have the caliber of health care it does. It's very good, if not phenomenal, compared to like-size cities. I think we do have a wonderful opportunity to help lead the charge of whatever reform road we're going to take.

<http://businessreport.com/news/2008/aug/11/ceos-roundtable-hlcr1/>

Victim of violent crime finally gets medical treatment  
WWL-TV | 08.12.08  
Dennis Woltering / Eyewitness News

Carol Raines feels dramatically better than the last time Dr. Kent saw her. In May, she was in pain, barely able to open her mouth.

"I have nightmares, some nights I wake up screaming," Carol recalled, as she faced eating through a feeding tube or starving.

Video: Watch the Story

A gunman killed her husband and shot her in the jaw 28 years ago inside their home Uptown on Cadiz Street. Over the years, the damage from that gunshot caused her jaw to lock up, led to horrible, chronic headaches.

The solution would be expensive -- total replacement of both jaw joints -- the titanium replacement joints alone cost \$14,000 thousand dollars.

"It's required. And it's the only option," said Dr. Kent

Ironically, the state would gladly pay if the gunman -- now serving life in Angola -- who killed her husband and shot her needed the same surgery.

Dr. Kent says he's done that very same surgery on inmates at taxpayer expense. But Carol's insurance and Medicare balked at paying for her surgery.

"We can operate on prisoners, we sure ought to be able to take care of these people," said Dr. Kent.

Several viewers responded to our story that aired on Eyewitness News about Carol with offers to pay for the surgery themselves.

"And I just thought that was wonderful that someone would offer that kind of money to someone they don't even know," said Carol.

Carol has coverage from Medicare and United Healthcare. She insisted they should cover her surgery.

Yet over the previous year, she said her pleas for coverage went nowhere. But when Eyewitness News questioned why inmates are entitled to better medical care than people with insurance, things changed.

"What it took was first of all was your contacting us so we could become much more involved in what was going on," Roger Rollman, a representative from United Healthcare.

United Healthcare has agreed to provide full coverage.

Rollman says United Healthcare contacted the maker of the titanium prosthesis Carol needs to assure the firm that United would pay for the device. And it gave similar assurances to University Hospital.

"The impact on the member financially is going to be minimal to nothing," Rollman said.

The surgery was a couple weeks ago and took seven hours.

Dr. Kent says he removed Carol's damaged joints, wired her teeth together to give her the best possible bite and then put in the new custom made titanium jaw joints.

"She's going to have a good opening," Dr. Kent. "And like I told her, 'You're going to be able to open like an alligator.'"

"Each day I'm feeling a little bit better," Carol said.

Her recuperation includes using a device once every hour to exercise her jaw to increase the amount she can open her mouth.

"No, this doesn't hurt," she said after demonstrating the jaw exercise. "It helps me to move my jaw. Doctor says it's like a football player."

"It's like the orthopedic surgeons when they operate on the knee and they get the knee swinging, you know, football? Same thing. It's what we call passive therapy," Dr. Kent said.

She's already able to open her mouth about twice as wide as she could before. But she has other serious needs. That gunshot wound caused her to lose most of her back teeth

"They basically just fell out like little popcorns," she said.

When she can open her mouth normally, she won't be able to chew food very well without those back teeth. Her insurance doesn't cover replacing those teeth.

But a dentist who teaches other professionals how to make natural looking ceramic crowns wants to help and has agreed to donate his services.

"What I will be doing is rehabilitating her mouth with crowns and veneers and implants," Dr. Johnny Schwartz said.

Dr. Schwartz estimates his services alone, making crowns that another doctor will implant, could run as high as \$50,000.

"And we'll be working on every tooth in her mouth to get her balance and form and function, so she can smile once again and be confident about her appearance and, at the same time, be able to eat," Dr. Schwartz said.

"I feel so lucky," Carol said. "It's a wonderful feeling. How do you thank somebody for that? I always figured that I would die with no teeth in the back and just trying to get by as best I could."

Schwartz says a big part of what motivates him is the conviction that inmates should not be entitled to better medical care than the innocent people they turn into victims of crime.

That's an issue in which Carol Raines intends to take an active role as soon as she can.

"I want to start working to try to help other victims, so they don't have to go through what I've endured," Carol said.

Months from now, when this is all over, Carol Raines will be able to eat normally.

And she'll have something else she lost when that gunman shot her 28 years ago: a beautiful smile.

<http://www.wvtv.com/topstories/stories/wwl081208mljaw.3f1de606.html>

## **Vaccination time arrives again**

**Shreveport Times | 08.13.08**

By Melody Brumble

Jaylon Cherry steeled himself for the needle but didn't get a shot after all.

Jaylon, 5, will enter kindergarten Monday. Last week, his mom, Joy Cherry, took him by a Shots for Tots van to make sure his immunizations are up to date. Children can't enter school without proof of vaccination against common contagious diseases like measles, chicken pox and whooping cough.

Shots for Tots worker Diane Job checked Jaylon's records on a laptop and pronounced the good news: "He doesn't need anything until 2013, when he's 11."

Jaylon grinned with relief and selected a sucker, while his mom got a copy of Jaylon's shot records to present when she registers him for school.

"I know he's relieved," Cherry said, laughing.

Children entering elementary school for the first time must have immunizations for diphtheria, pertussis, polio, measles, hepatitis B and chicken pox, among other contagious diseases.

Middle school students must have the same vaccines and a meningitis immunization. Students at all public community, technical and four-year colleges and universities in Louisiana also must show proof of a meningitis immunization.

Bossier Parish school nurses, for example, will check children's shot records when they return to work Thursday for the 2008-09 school year. The nurses will enter updated information in the Louisiana Immunization Network for Kids database.

The statewide computer network allows health care workers to access a child's shot records automatically. Bossier school nurses use the network to send out reminder letters when records indicate a child needs new or booster shots.

In the 2003-04 school year, the most recent period for which statistics are available, 97.3 percent of children entering Bossier public schools were up-to-date on shots. In Caddo, 98.8 percent for first-time students had all their shots.

That year, all children entering public schools in Red River, Cameron, Catahoula, Madison and West Feliciana parishes had up-to-date shots. The lowest rate was in Concordia Parish, where only 50.9 percent of children entering school had complete immunizations.

Public health units and the Shots for Tots program are putting in extra time to handle the back-to-school rush this year.

Workers at the Shots for Tots van saw a steady stream of children last week, Job said.

"They were waiting when we got here at 10 this morning," she said Friday morning. "We've had four or five families waiting at a time. We're always available in several locations the two weeks before school starts."

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=/20080813/NEWS01/808130332/1060>

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