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## **Mid-City's health needs attention**

**The Times-Picayune | 08.06.08**

Lolis Elie

"Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things -- to help, or at least to do no harm."

Hippocrates, Epidemics, Bk. I, Sect. XI.

Neither the Latin phrase "primum non nocere," nor its English equivalent "first, do no harm," appears in the Hippocratic Oath. Yet it has loosely governed the actions of medical professionals for centuries.

It's a useful adage not only for doctors, but also for allied health professionals, such as the architects and city planners who will determine where the new Charity Hospital and Veterans Affairs Hospitals will be located.

Both of these institutions have stated a preference for being downtown, and current plans call for a substantial portion of Mid-City to be razed for the new facilities.

This plan raises several questions.

--- Retrofitting Charity ---

If the old Charity Hospital and Veterans Affairs sites are not part of the plan, why not demolish them and rebuild the new facilities on those sites? In that way we could avoid disrupting life in Mid-City while still allowing the plans for their new hospitals. We would also avoid adding two huge structures to the blighted and abandoned properties in our city.

I would like to see the current Charity Hospital retrofitted for use as a modern facility. Critics of that idea have argued the stigma of Charity will forever make it unattractive to the paying patients the new facility hopes to attract.

Why not spend some of the millions of dollars it will take to construct a new facility marketing the old location? Imagine if word got around that all the best doctors in the region were practicing medicine there.. How long do you think it would take for paying patients to line up.

--- Lindy Boggs site ---

Another possibility that has emerged recently holds some promise for fidelity to the "first do no harm" dictum.

Veterans Affairs officials are considering locating their new hospital in the old Lindy Boggs Medical Center at the corner of Bienville Street and Jefferson Davis Parkway. Moving the facility there should minimize or eliminate the need to destroy a neighborhood to construct a new facility.

The Department of Veterans Affairs will hold a public hearing to discuss this possible site and seek input on the location of the facility.

This is a wise approach, given that New Orleanians, not officials in Washington, D.C., will ultimately have to live with this decision.

The Veterans Affairs meeting will be Monday at Grace Episcopal Church, 3700 Canal St., from 7 p.m. to 9 p.m. For information, visit [valsumedcenters.com/index.htm](http://valsumedcenters.com/index.htm).

<http://www.nola.com/timespic/stories/index.ssf?/base/library-153/1218000140181860.xml&coll=1>

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## **Proposed clinic gets \$200,000 gift**

**The Times-Picayune | 08.05.08**

By Jennifer Evans

Staff writer

A corporate donation of \$300,000 has moved a New Orleans nonprofit closer to its goal of opening the city's first faith-based clinic for the working uninsured.

With the new donation from Kaiser Permanente, a nonprofit integrated health plan, the New Orleans Faith Health Alliance, has raised more than \$800,000 toward the \$1.3 million cost of opening the clinic, project director Guy Fournier said.

The clinic is slated to open its doors next year in Mid-City, although organizers haven't yet settled on an exact location. It would serve a population that generally can't afford rising health insurance rates.

A grant of \$250,000 in 2007 from Baptist Community Ministries covered the costs of launching the nonprofit that would develop plans and raise money for the clinic.

"We want to create a health center that provides the same quality of health care as (that provided to) those who have insurance," Fournier said.

In addition to offering medical services, the health center will offer preventative care as well as spiritual counseling.

"We look at a patient not just as a sick person but as a whole person," Fournier said. "In addition to offering continuity of care, we want to empower members to manage their own health."

With most operating costs expected to be covered by donations, the center will begin small, with a six-member staff -- including one doctor and one nurse -- taking on only 2,000 patients each year. By the second year, Fournier said, the clinic would expect to serve twice that many people.

Eligibility for treatment will be based on proof of employment and lack of private and public health insurance. Spouses and children of qualifying workers also will be eligible for care.

The health center will be modeled after the Church Health Center of Memphis, which began as a small faith-based clinic in 1987 and has since grown to serve an average of 36,000 working uninsured patients each year, according to a representative of the Memphis clinic.

<http://www.nola.com/news/t-p/metro/index.ssf?/base/news-30/1217913637203790.xml&coll=1>

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## **Hospital nearly 3 years away** **The Times-Picayune | 08.06.08**

By Mary Elise DeCoursey  
St. Bernard bureau

Residents will have to wait almost three more years for a hospital in St. Bernard Parish, officials said Tuesday.

The parish had hoped construction on the hospital would begin later this year, but a developer told the Parish Council that the project won't begin until June.

After months of meeting separately, the Parish Council and the Hospital Service District Commission held a joint meeting Tuesday morning to "get everyone on the same page."

Phillip Wendling, a developer with Hammes Co., said the hospital would be treating its first patients in May 2011. Construction is expected to begin in June and take 22 months, he said.

A site for the 40-bed hospital has not yet been determined, though the front-runner is a tract of land across from Chalmette Battlefield owned by the Meraux Foundation. Once land is secured, a six-month environmental study must be completed.

"I'm just afraid they'll find a buried British soldier on the site, and everything will be delayed again," commission member Ron Chapman said.

Lining up state and federal funding has caused the delays, commission members said. As proposed, the hospital will cost \$61 million to build. Funding stands at \$42 million, with \$17 million expected from state capital outlay funds and \$25 million earmarked in federal Community Development Block Grants.

The \$19 million shortfall could be covered by a loan from the USDA, for which the commission, not the parish, would be liable. Earlier this year, the council mandated the hospital be built debt-free.

Commission members said they have been working under the assurances that the parish would be eligible for USDA funding. But members said Tuesday the agency's lawyers informed them last month that they would not be eligible because Chalmette's population is "too large." Chapman said the USDA is using census information from 2000, which lists Chalmette's population as 35,000. The commission is working with members of Congress to convince the USDA to look at post-Katrina population figures, which are much lower, he said.

"It's not a race; it's a steeple chase," Chapman said. "People keep putting more obstacles in front of us and slowing it down."

The parish's lone hospital before Katrina -- the privately owned Chalmette Medical Center -- flooded during the hurricane and has been bulldozed.

Councilmen Ray Lauga and Mike Ginart urged the commission to consider building a stand-alone emergency room until the rest of the hospital could be completed.

"I think it grows more and more important that we have an emergency room in St. Bernard Parish," Ginart said. "I don't see us going to May 2011 without that."

Commission member Bryan Bertucci said that having an ER isn't as simple as constructing a building.

"You have to get doctors before you open up a hospital," he said. "You really can't provide all the services without specialist (doctor) backup."

<http://www.nola.com/news/t-p/metro/index.ssf?/base/news-30/1218000696221820.xml&coll=1>

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## Feature

### Gambit Weekly | 08.05.08

by Shantrell Cook and David Winkler-Schmit

#### Feeding Baby

It's World Breastfeeding Week through Thursday, and for expecting parents, there's no better time to learn the benefits of breastfeeding.

— Breast milk contains antibodies, which protect infants from bacteria and viruses.

— Breastfed children are less prone to infectious disease.

— Infants who do not breastfeed have a 21 percent post-neonatal infant mortality rate in the United States.

— Infants who are not breastfed have higher rates of lymphoma, leukemia, overweight, obesity, high cholesterol and asthma.

There are benefits for mom as well: nursing burns up calories, lowers the risk of certain cancers and helps establish a close bond between mother and child.

Unfortunately, Louisiana ranks low on the 2007 Centers for Disease Control's breastfeeding report card. Only 50 percent of Louisiana babies are ever breastfed, and only 2.8 percent of infants exclusively breastfeed through the first six months of life, which is recommended by the American Academy of Pediatrics. — Winkler-Schmit

#### Life After Death

Researchers at LSU Health Sciences Center (LSUHSC) in New Orleans may have discovered a way to revive heart-attack victims long past the traditional threshold for survival. By using high-dose hyperbaric oxygen, researchers were able to resuscitate laboratory swine that had been dead for 25 minutes after suffering sudden cardiac arrest. Dr. Keith Van Meter, who led the study and is a clinical professor of medicine at LSUHSC, says the research is groundbreaking.

"To resuscitate any living organism after 25 minutes of heart stoppage at room temperature has never been reported and suggests that the time to successful resuscitation in humans may be extended beyond the stubborn figure of 16 minutes that has stood for 50 years," Van Meter says.

Heart disease is the No. 1 cause of death in the United States.

The researchers used three groups of laboratory swine for the study. All of the groups suffered cardiac arrest, and after 25 minutes, one group received advanced cardiac life support (ACLS). The second group was given ACLS but also received standard-dose hyperbaric oxygen. The third group was provided ACLS and a high-dose of hyperbaric oxygen, which was nearly 33 percent more than the highest dose currently given to humans. Four of the six animals in the high-dose hyperbaric oxygen group were resuscitated. Researchers could not revive any of the subjects in the other groups.

The results of the study will be published in the August 2008 issue of the journal *Resuscitation*. — Winkler-Schmit

#### Just For Women

St. Charles Surgical Hospital, scheduled to open early next year, advertises that it will be the first and only hospital in the world dedicated to breast reconstruction surgery. The 60,000-square-foot, 17-bed facility will be equipped to address numerous stages before, during and after breast restoration.

"It is our mission to restore the lives of our patients, both physically and emotionally, as quickly and gently as we can," says Dr. Scott K. Sullivan, a co-founder of the Center for Restorative Breast Surgery.

"Immediate reconstruction after mastectomy helps a woman regain a semblance of her body and uplift her psychological peace of mind."

Aside from a wide spectrum of reconstructive procedures, patients also will have options like support groups and a center for spalike treatments. For more information, call (888) 899-2288. — Cook

#### Learn More

LSU Health Sciences Center's (LSUHSC) Epilepsy Center of Excellence is partnering with two national foundations to present Epilepsy Awareness Day Thursday, Aug. 7, from 5:30 p.m. to 8:30 p.m. in the Armstrong Ballroom of the Sheraton Hotel (500 Canal St.). Experts from LSUHSC, the Epilepsy Foundation and the American Society of Electroneurodiagnostics will answer questions about diagnosis, treatment, symptoms, safety precautions and other topics relating to adult and underage epilepsy patients.

Epilepsy affects approximately 3 million Americans and is a disorder marked by recurring and unprovoked seizures. Without diagnosis and treatment, the risk rises for additional seizures, brain injury, disability, decreased quality of life, and death.

The awareness day outreach effort is part of the public education component of the LSUHSC Epilepsy Center of Excellence. The center, which had been closed since Hurricane Katrina, recently reopened in the West Jefferson Medical Center. It houses two epilepsy-monitoring beds, provides a full range of services and is staffed with LSUHSC personnel.

Epilepsy Awareness Day activities are free and open to the public. For more information, call (800) 960-0587. — Cook

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## A Promising Breakthrough

**Gambit Weekly | 08.05.08**

By Cyd Casados

Atrial fibrillation is an abnormal heart rhythm that currently affects over 2 million people in the United States. During atrial fibrillation, the heart's two upper chambers (the atria) beat erratically. The irregular and usually rapid heart rate causes poor blood flow, resulting in heart palpitations, shortness of breath and fatigue. Individuals who have this condition also are at greater risk of developing blood clots that lead to stroke, which occur in about 15 percent of people with atrial fibrillation.

Cynthia Crain, a registered nurse at East Jefferson General Hospital (EJGH), had experienced occasional, or paroxysmal, atrial fibrillation for about 15 years when something suddenly changed. Normally, the episodes would last a few days and happen only a couple of times a year. But about two years ago, the fibrillation started and didn't let up. Under the care of her cardiologist at EJGH, Dr. Fortune A. Dugan, Crain started taking medication to control her condition.

"It's exhausting," Crain says. "Your oxygen levels are just so low that you're tired and short of breath all the time. It's no fun."

After a year of trying to manage her heart rate with medication, Dugan suggested Crain talk to Dr. David W. Snyder, an electrophysiologist, a physician that specializes in dealing with abnormal heart rhythms. After running a number of tests, Snyder thought Crain might be a good candidate for a minimally invasive procedure being performed by Dr. Michael N. Brothers, a cardio-thoracic surgeon with the Heart, Lung and Vascular Institute at EJGH.

The "gold standard" for atrial fibrillation surgery is known as the Cox-Maze. "In this procedure, a series of incisions arranged in a maze-like pattern are made in the atria on the heart-lung machine," Brothers says. "The scars from these incisions block the abnormal electrical circuits that cause atrial fibrillation, returning the patient to what is referred to as a normal sinus rhythm, or a regular heartbeat."

The Cox-Maze requires the chest and heart to be opened, which affects recovery time and raises the risks associated with the surgery.

But for patients like Crain, who don't have other heart problems, open-heart surgery is no longer necessary. Instead, Brothers suggested she undergo a relatively new procedure, a bipolar radiofrequency ablation Mini-Maze, which requires only three small incisions on each side of the chest. Through these incisions, Brothers uses a camera to view inside the chest and special instruments to repair the problem.

"Instead of a scalpel, this procedure uses radiofrequency energy, delivered through a clamp, to scar the atrial tissue, stopping the irregular electrical signals that cause atrial fibrillation," Brothers says. "A special linear probe and pen are also used to connect both sides of the heart."

Crain was relieved to hear she wouldn't have to have open-heart surgery. "Nobody wants to have their chest opened up from here to here (she indicates a footlong length on her chest) if they can help it," Crain says. "The fact that the surgery was minimally invasive was wonderful."

Using his previous experience in video-assisted thoracic surgery (VATS) for lung cancer, Brothers found the transition to the Mini-Maze a natural fit. "I had done hundreds of VATS lobectomies (the removal of cancerous tissue), so I was already very comfortable doing this type of minimally invasive cardiac surgery, using only small ports on the sides of the chest."

Crain was back at work only two-and-a-half weeks after the surgery. She feels healthy again and is ready to start working out. "It's a wonderful thing," she says. "It's not widely known about and there are lots of people living with afib [atrial fibrillation] who could benefit from this. They should all have an opportunity to know about it."

Success rates for this type of surgery have been very promising. One study, completed by the University of Cincinnati, showed 91.3 percent of patients who had a radiofrequency ablation Mini-Maze and removal of the left atrial appendage were atrial fibrillation-free after six months.

"We hope this procedure will be equally effective to the classic Cox-Maze — which has an almost 95 percent rate of effectiveness — but will be much less invasive," Brothers says. "We are already looking at rates of 75 to 85 percent, but the technology must continue to evolve, and we must be selective in choosing our patients."

<http://bestofneworleans.com/dispatch/current/feat2.php>

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## Veterans of the Health-Care War

Gambit Weekly | 08.05.08

By David Winkler-Schmit



Photo by Cheryl Gerber

**Lilliman shows off a tattoo that boasts of her ties with her fellow Louisiana soldiers. Tiffany Lilliman remembers the explosion. It was the last thing she heard.**

It was a near-freezing morning, made even colder by the surrounding desert-like isolation of Khost, a base camp in a mountainous region of Afghanistan near the Pakistan border. Lilliman, a sergeant in the U.S. Army, decided to leave her warm room to go outside.

She was smoking a cigarette and drinking coffee when she felt the ground shake.

Lilliman wasn't alarmed. She had been in the camp for 11 months, and the Taliban frequently attacked it with rocket fire. She didn't hear the whistle of an incoming rocket, leaving her with a false sense of security that the base was firing on outside targets. Seconds later, she looked up just in time to see a rocket coming right toward her.

The blast slammed Lilliman into a wall.

"It was like somebody hit 'Pause'," Lilliman recalls. "Everything stopped. Everything was humming. I kept trying to lift my head up and I couldn't. The sergeant ran over, picked me up and brought me in the bunker, and I still didn't have any control. I didn't feel pain or anything. I was just numb. Then it was like somebody hit 'Fast-forward' and everything just hurt and I was bleeding."

In the bunker, Lilliman's staff sergeant held her, and she could see the veins in his neck sticking out. He was yelling at her, but Lilliman could no longer hear. For the next hour until the attack ended, she sat with her sergeant in the bunker, bleeding from her ears, mouth and hands — in her new silent world.

Now, back home in Marrero, honorably discharged from the Army and with a chest full of medals for her bravery, Lilliman still lives in a mostly silent world — and she continues to fight. But this time, she is fighting government bureaucracy and the battle is over health care.

For injured and disabled veterans returning to the New Orleans area, getting adequate health care is a challenge. There is no central hospital for inpatient treatment, there are far fewer doctors than before the storm, specialty services are scattered and sometimes unavailable in the region, and many veterans travel outside the state for care. Disabled veterans don't have private health insurance, but are part of the Veterans Administration (VA) system, so they have few choices. Without insurance, they can't switch hospitals, and, if they're unhappy with a doctor, they often have a hard time finding another. Local hospitals treat these veterans, but it is with the understanding that the VA is slow to pay the bills and won't pay for inpatient care.

With more and more disabled veterans returning to New Orleans and no end in sight to the Iraq War, is this the best we can do for all of these people who put their lives on the line in defense of our country?

Lilliman, a petite 34-year-old with short ash-blond hair and a sun-kissed face, looks like the girl next door, someone's younger sister or someone's daughter. She is all of those things, but she also is a soldier. Her shy smile and healthy appearance belie the physical and mental injuries she will carry with her the rest of her life.

Due to her extensive injuries, she was honorably discharged from the Army and is now living on disability checks she receives from the VA. After four surgeries on her ears, she is 90 percent deaf. She's undergone four additional surgeries on her right leg, which was fractured and torn at the hip from the rocket blast. Despite all of this, Lilliman struggled just to get into the VA system.

When she left the Army in December 2006, Lilliman already had undergone three surgeries on her ears, so the Army was aware of her hearing loss (somehow, the medical staff had missed the fractures in her right leg and her torn hip). Prior to her discharge, she went before an Army medical board that decided the Marrero sergeant was only 10 percent disabled and ineligible for benefits. Lilliman returned home thinking she would only receive a standard six months of full medical coverage for returning veterans.

After the 10 percent disability determination from the Army, Lilliman didn't think she would receive much better from the VA. The Army told her not to approach the VA for assistance until she had finished the remaining six months of her Army insurance.

Neither turned out to be true.

Through the military insurance, Transitional Assistance Management Program (TAMP), which the Army provides for six months after a soldier is discharged, she received another round of surgery for her right ear at West Jefferson Medical Center. A month later an orthopedic surgeon repaired her right hip, leaving her unable to walk for six months. The ear surgery wasn't successful and left her "completely deaf" for four months. When TAMP refused to pay for post-operative physical therapy for her leg, Lilliman had had enough.

'So I was deaf and I couldn't walk," Lilliman recalls.

She went to a VA benefits office in June 2007 and found out she'd been given the wrong information: she had been eligible for VA assistance since her discharge. It was incumbent upon Lilliman to know how the system worked. A VA nurse took charge of Lilliman's care, and she began seeing a neurologist; a physical therapist; an ear, nose and throat doctor; a brain-injury specialist and a counselor.

'Finally, I had this big weight lifted off my shoulders," Lilliman says. "Because I didn't know what the hell I was doing."

Doctors at the VA clinic soon realized that her wounds from the attack were much more severe than the medical board had surmised. They diagnosed her with Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), which helped explain Lilliman's ongoing insomnia, severe migraines and vertigo.

She now spends many of her days receiving care at the downtown VA outpatient clinic in what remains of the pre-Katrina VA hospital facility. If the clinic can't offer her the services needed, she is sent elsewhere.

Lilliman isn't alone. Last year, the Southeast Louisiana Veterans Health Care System (SLVHSC), which covers 23 parishes, provided services for more than 33,000 veterans. Like Lilliman, the system suffered a catastrophic attack in 2005 — Hurricane Katrina — and it is far from recovered.

Before the storm, the VA hospital in New Orleans housed 206 beds including 20 psychiatric beds. A staff of 1,720 — doctors, nurses and support personnel — worked for the hospital and the three outpatient clinics in New Orleans, Baton Rouge and Houma. In fiscal year 2005, the hospital treated 4,135 inpatients with a total of 40,212 veterans receiving services. That all changed when the levees broke, flooding the hospital and leaving SLVHSC with no hospital to provide inpatient care for the estimated 170,000 veterans living in the 23-parish system.

The system was decimated. The central hub of activities was lost, and like many other local facilities, VA services were set up in parking lots or housed in VFW posts. By December 2005, SLVHSC managed to open an outpatient clinic on the hospital's campus located on the ninth and tenth floors of the former VA nursing home. Since then, SLVHSC has opened another three outpatient clinics — Hammond, St. John and Slidell — doubling the number of outpatient clinics the system had pre-Katrina.



Photo by Cheryl Gerber

**Vietnam veteran Jim Stokes, at home with his wife, Liz, has suffered two heart attacks, then his neck was broken in a traffic accident and he has developed a blood clot on his spinal column. The Stokes have thousands of dollars in medical bills to pay, and Jim must travel to a VA hospital in Houston for follow-up treatments for his broken neck. That's the irony of the SLVHSC: in some ways, it's better than it was prior to the federal flood. Dr. Richard Wallace, chief of ambulatory and primary care for SLVHSC, says that finding enough space for health care operations in the area and restoring full services likely won't take place until a new central hospital is open, but there have been improvements.**

"The tragedy of the storm allowed us to create a system that now provides more access points for veterans remote from New Orleans than they ever had before," Wallace says.

The six outpatient clinics mean that 80 percent of all veterans in the system are within 30 minutes travel time of a clinic, with virtually all veterans receiving an appointment within 30 days of their request, Wallace says. He adds that SLVHSC still offers many specialty services like chemotherapy, cardiology, neurology and others. If it can't provide a service at its clinics, or is unable to do it within 30 days, SLVHSC contracts with local specialists and other facilities. For disabled veterans, this can translate into bouncing from one clinic to another.

Jay Walsh, a deputy service officer for the American Legion, reports the regular travel plight of one of the veterans he assists. "Instead of being in one building, you're going all over the place," Walsh says. "One vet I know goes to the New Orleans clinic for one thing (due to confidentiality, Walsh can't reveal which services), to the clinic in Reserve, La., for another and to Baton Rouge for another."

Veteran Archie Boyette isn't a fan of the current system of outpatient clinics. Boyette, commander of the American Legion Department of Louisiana, considers the clinics to be "like a production line: get them in

and get them out." He advocates for in-house care like that of a large hospital. That way, Boyette says, if a veteran requires a specialist, he or she can be referred to a specialist in the same facility, which means better continuity of care.

Lilliman says that even though much of her care now takes place under one roof, her doctors change frequently. She hardly ever sees her neurologist; instead she is seen by a slew of neurology residents. That can be problematic when it comes to the prescription medications that Lilliman relies on for her migraines and vertigo.

"Every time I'd go in, I'd see a different resident and they would give me a different medication," Lilliman explains. "This went on for about six months."

Currently, SLVHSC cares for 80 percent of the total number of veterans it served before Hurricane Katrina, but it is doing so with only 1,000 employees, or only 58 percent of the pre-Katrina staff. (Gambit Weekly made repeated requests to SLVHSC for a breakdown of the number of doctors it currently employs, their specialties and the number of doctors employed before the storm, but SLVHSC did not provide the information.) Still, Lilliman, Walsh and most of the veteran advocates contacted for this story, believe the local VA is doing the best it can for local veterans; it's just doing it with less. The real problems occur when the veteran is forced to go outside of the system without private health insurance.

As Rhonda George, a public affairs specialist for the Veterans Benefits Administration New Orleans Regional Offices, puts it, "VA doesn't offer insurance to veterans because we have a hospital."

So what happens when there is no hospital?

In medical emergencies, a veteran can go directly to any local hospital for care, and the VA is expected to pay for those services. But as Bruce Naremore, chief financial officer at East Jefferson General Hospital, explains, there's a difference between how the system should work and reality.

"Any veteran who shows up at the ER (emergency room), we should get paid for Naremore says. "But it is difficult and the VA is a huge governmental bureaucracy. So it's hit or miss for us being reimbursed."

In 2007, New Orleans hospitals posted a combined operating loss of \$135 million.

After a veteran is treated for an emergency and is stabilized, Naremore says that it's unlikely the veteran will be admitted to EJGH. Instead, he or she will be transferred to a VA hospital. The closest VA hospitals for veterans under SLVHSC's care are located in Jackson, Miss., Alexandria and Shreveport, La., and Houston. Naremore adds that immediately following the storm, the VA did pre-authorize care so that veterans could stay at local hospitals, but in general that no longer happens. When contacted, Touro Infirmary confirmed Naremore's assessment: slow and confusing reimbursement with stabilized veterans sent to VA hospitals outside of the region.

SLVHSC disputes this claim. Stephanie Repasky, an assistant to SLVHSC director Julie Cavalier, says it's "not completely" true that once a veteran is stabilized, he or she is sent outside the SLVHSC service area.

"There's legal guidelines that dictate and part of that is dependent upon service connection disabilities (disabilities or injuries incurred while the veteran was in active duty)," Repasky says. "If their care is pre-authorized — for example if we're aware they are there — then we follow and monitor the care. So we know that they're there, so we work with the community facility to coordinate the discharge and transfer of services back to the VA."

Sometimes the VA isn't aware that one of its veterans is in a local hospital's emergency room. Bill Detweiler, former national commander for the American Legion, says that's because the VA's reputation for paying hospital bills slowly precedes them.

"Even when it's pre-authorized, a hospital is going to grab Medicare or private insurance," says Detweiler.

It's likely because the hospitals have learned the hard way, just as Jim Stokes, a 100 percent disabled Vietnam veteran, discovered. In late 2005, Stokes began experiencing chest pains. He had suffered a previous heart attack, so he was driven by ambulance from his Bogalusa home to a local hospital. Assured he wasn't having another cardiac episode, Stokes was given medication and sent home. Later that night, the chest pains returned and this time Stokes' wife Liz drove him to another facility, where they discovered Stokes had been administered the wrong medication. Doctors there were able to stabilize Stokes and he again returned home.

More than two years later, the VA hasn't paid any of the bills connected with these two episodes even though Stokes is entitled to 100 percent coverage. Collection agencies call their house daily, says Liz Stokes.

They aren't the only bill collectors calling. While driving his motorcycle in 2006, Stokes was hit by a car and thrown 30 feet in the air. He landed on his head, breaking his neck in seven places and severely damaging his back. Stokes was rushed to a nearby hospital, but doctors there said that his case was beyond their capabilities and he was transferred to Lakeview Regional Medical Center.

Once there, an ER doctor wanted to admit Stokes into inpatient care, but he couldn't until a neurosurgeon evaluated the patient. Hours later, the neurosurgeon still hadn't visited Stokes. Furious, Liz Stokes complained to a nurse about the doctor's reliability.

'He's been told your husband is a vet and that's how his bills would be paid,' a nurse confided to Liz.

When the neurosurgeon finally did arrive, he wasn't aware that Liz was in the room and he instructed the nurse to load Stokes into an ambulance and have him taken to the VA hospital in Jackson. Knowing the drive to Jackson could possibly kill her husband, Liz managed to find another neurosurgeon at Lakeview to care for him.



Photo by Cheryl Gerber

**Lilliman holds a piece of shrapnel that ripped into her body during the rocket blast in Afghanistan.**

**The Stokes' ordeal was far from over. Jim would spend another five weeks shuttled from one hospital to another. Eventually, Liz drove Jim in their pickup truck to the VA hospital in Houston, where he underwent 10 hours of surgery. After he was discharged, Stokes has had to travel to Houston monthly for follow-up care. For these trips, the Stokes are reimbursed \$70, which is supposed to cover their gas, two nights' stay in a hotel and meals. Liz feels the trips to Houston aren't about continuity of care — Stokes rarely sees the same doctor and the surgeon who performed the surgery is no longer with the VA — but has more to do with the VA's bureaucratic lethargy regarding outside care.**

'If a private doctor would see him with the VA card, it would make it much easier on him,' Liz Stokes says.

Since his chest pain ordeal and the motorcycle accident, the Stokes have amassed more than \$5,000 in outstanding medical bills. Most of the bills from Lakeview Regional Medical Center have been paid, but that money came from Medicare. Medicare and private insurance require that cardholders pay a deductible, so the Stokes have been saddled with that. Technically, the VA is responsible for the

remaining portion, but more than two years later, the bills continue to pile up and the bill collectors keep calling.

Because of his heart condition and the severity of his spinal injuries, Jim Stokes can't talk about his ongoing problem with medical bills. Liz simply says, "It upsets my husband." After his latest examination at the Houston VA, doctors told the couple that Jim has a blood clot on his spinal column and it is inoperable. At any time, the clot can break free, travel to his heart or brain and kill him.

'He is just waiting for the Lord to take him home,' Liz says.

Liz is adamant that her husband will receive a full military funeral when the time comes. She is bitter about the treatment Jim has received in the past three years since the local VA hospital was destroyed. With this experience, she says she empathizes with those "kids" who are returning to the states after serving overseas.

'I see who is coming back,' Liz says. "I see what's going on, and I know what's going to happen to these new Iraq and Afghanistan veterans."

The Southeast Louisiana Veterans Healthcare System is participating in a managed-care pilot program. It is administered by a subsidiary of Humana, the health insurance corporation, and sets up a network of healthcare providers, allowing veterans to get authorized (paid) care outside of the VA system. Although Humana Veterans Healthcare Services couldn't provide the total number of SLVHSC veterans who were taking part in the program, it reports that it has scheduled more than 3,500 medical appointments since its inception in October 2007.

The program is titled "Project Hero."

Tiffany Lilliman is not one of the program's participants, but she is a hero.

Within a few hours of the rocket attack, Lilliman was evacuated by helicopter to the main U.S. Army base in Bagram. Her ears popped and drained and she could hear noises. She stayed in the base hospital for two weeks and another two weeks on the base recuperating. Despite being unable to walk or discern voices, Lilliman begged her chain of command to let her return to Khost.

Doctors at the Bagram hospital couldn't determine the extent of her injuries and debated sending her to a hospital in Germany for further testing. Lilliman fought against this idea. Few in her company had her training — she had worked in the Khost camp battle room, controlling video feed from an unmanned surveillance plane that provided essential reconnaissance for the camp. She worried about her fellow soldiers. If they sent her to Germany, then the Taliban won.

Somehow, Lilliman convinced her commanders to let her return to Khost. With little hearing and on crutches, she was back in the battle room within a month of her injury.

'I didn't want to be sent back. I wanted to fulfill my duty,' Lilliman says. Sgt. Lilliman has fulfilled her duty, and it is now up to the federal government to keep its end of the bargain.

[http://www.bestofneworleans.com/dispatch/2008-08-05/cover\\_story.php](http://www.bestofneworleans.com/dispatch/2008-08-05/cover_story.php)

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## **Millions of U.S. Residents With Chronic Diseases Do Not Receive Adequate Treatment Because They Are Uninsured, Study Finds** **Kaiser Network | 08.05.08**

Millions of U.S. residents who have chronic conditions are not receiving appropriate care because they are uninsured, according to a study published on Tuesday in the journal *Annals of Internal Medicine*, the *New York Times* reports.

For the study, lead author Andrew Wilper of the University of Washington-Seattle and colleagues analyzed health surveys of adults ages 18 to 64 conducted by the federal government. The researchers found that about 11 million people out of the 36 million people who reported having no health insurance in 2004 -- the latest data examined by the study -- had been diagnosed with a chronic condition. However, researchers noted the estimate likely is low because it does not factor in uninsured U.S. residents who have a chronic condition with which they have not yet been diagnosed.

The study also found that less than 25% of the uninsured with a chronic condition reported seeing a physician within the previous year and that about 7% said they would visit the emergency department if they needed care.

The study's authors said, "For some of the 11.4 million uninsured Americans with serious chronic conditions, access to care seems to be unobtainable; many may face early disability and death as a result."

According to the *Times*, if the proportion of uninsured residents with chronic conditions has held steady over the last four years, there currently would be about 16 million uninsured U.S. residents with a chronic condition.

### Dispelling Myths

The researchers noted that the study raises doubts regarding the common assumption that many uninsured U.S. residents are young and healthy. According to Steffie Woolhandler, one of the study's authors and associate professor of medicine at Harvard Medical School, that assumption often leads to underestimating the cost of covering the uninsured. Woolhandler -- who supports a national health care system -- cited as an example Massachusetts' new health insurance law, which is costing the state more than projected and has not led to universal coverage because state lawmakers assumed more residents would be healthy (Abelson, *New York Times*, 8/5).

Online The study is available online.

[http://www.kaisernetwork.org/daily\\_reports/rep\\_hpolicy.cfm#53726](http://www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm#53726)

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## **New York Hospitals Create Outcry in Foreign Deal**

**The New York Times | 08.05.08**

By ANEMONA HARTOCOLLIS

New York City's Health and Hospitals Corporation has signed a 10-year, \$100 million contract with a profit-making medical school in the Caribbean to provide clinical training for hundreds of students at the city's 11 public hospitals.

The unusual deal, proposed by a member of the corporation's board who has long worked for the Caribbean school, has been met by an outcry from New York medical schools fearing that clerkship slots will grow scarcer and that they might have to increase tuitions to compete.

Critics worry that the hospital corporation, whose mission is to serve the city's poor, is conferring prestige on a foreign school whose curriculum, they say, is more vocational than research-based and often caters to affluent students who could not get into schools in the United States.

They say that the contract, with St. George's University School of Medicine on the island of Grenada, has turned a meritocracy into a bounty system in which struggling city hospitals collect more for every St. George's student they take, and could squeeze out local students.

"This changes the whole dynamic from an academic relationship to a dollar-based relationship," said Dr. Michael J. Reichgott, associate dean for clinical affairs and graduate medical education at Albert Einstein College of Medicine in the Bronx.

Traditionally, medical schools have sent third- and fourth-year students into city hospitals to work — and learn — alongside doctors without being charged. Health and Hospitals Corporation officials said some institutions had recently begun paying a flat fee of \$250,000 a year, which Dr. Andrew W. Brotman, a senior vice president at New York University School of Medicine, likened to a gratuity.

The clerkships, in which students assist and observe medical personnel through a rotation of individual specialties, are considered a critical component of medical education.

Over all, there are about 3,700 rotations for students at United States medical schools at the city's public hospitals.

Under the contract, which was signed last year but never publicly announced, St. George's pays the hospitals \$400 to \$425 per student per week — St. George's charges students about \$1,000 a week in tuition — on top of an annual fee of \$50,000 for hospitals that take 24 or more St. George's students.

"If that \$400 per week per student algorithm were applied to the New York schools, I think it's not affordable and it would certainly be a problem," said Dr. Brotman, estimating that it would cost N.Y.U. \$2.8 million per year. "I don't come at this from a quality point of view. I come at this from a volume and logistics point of view."

The contract also bans the hospitals from providing clerkships to other Caribbean medical schools — a critical provision to St. George's, which has faced heightened competition in recent years, particularly from Ross University on the island of Dominica, part of DeVry Inc., a publicly traded educational company, since 2003.

The board member who first proposed the exclusive contract, Dr. Daniel D. Ricciardi — a 1981 graduate of St. George's and a rheumatologist affiliated with Long Island College Hospital in Brooklyn — said he had recused himself from deliberations involving St. George's. Dr. Ricciardi, who has been on the 16-member corporation board since 2000 and on the St. George's faculty for about 15 years, said he did not benefit financially from the deal. He was promoted to St. George's dean of clinical studies and put in charge of United States clerkships shortly before the contract was signed.

"I don't have to go to confession on this one, I really don't," he said. "Everybody's saying there's a conflict here, and it comes back to me. They're disgruntled, jealous. A report was written on the school, and the judgment was made based on merit, not on political push."

Dr. Ricciardi, 55, who was honored by the hospital corporation last year "for his selfless dedication to furthering the mission of H.H.C.," compared the objecting American medical school officials to children crying, " 'Daddy, I can't have my free candy anymore.' "

Neither the president of the hospital corporation, Alan D. Aviles, nor its senior vice president of operations, Frank J. Cirillo, would discuss the contract. Ana Marengo, a spokeswoman for the agency, gave a primarily fiscal rationale, saying that the arrangement with New York medical schools does not cover costs, and that the hospitals operate on "razor-thin" margins and need the revenue.

Ms. Marengo said that only two Caribbean schools, St. George's and Ross, met the corporation's standards for bidding on the contract, and that St. George's made the more attractive offer, including one medical-school and one nursing-school scholarship to prospective New York City students for each hospital that provides at least 24 clerkships.

Joan Bates, director of investor relations for DeVry, Ross's parent corporation, declined to comment.

The contract, which has a five-year term automatically renewable for another five, unless either side objects, calls for up to 600 clerkships, but resistance at the city's prestigious medical schools, including New York University and Albert Einstein, has prevented the program from getting off the ground at their training hospitals, Bellevue Hospital Center on the East Side and Jacobi Medical Center in the Bronx.

According to Charles R. Modica, the chancellor of St. George's, about 200 students have been placed at six hospitals: Coney Island, Queens, Elmhurst, Lincoln, Metropolitan and Woodhull. Ms. Marengo, the corporation spokeswoman, said St. George's paid about \$2 million in the first year of the contract, adding: "We expect that to grow gradually as additional facilities prepare to take on more students."

Dr. Steven B. Abramson, vice dean of medical education at N.Y.U., said the resistance stemmed from concern about the caliber of education at St. George's, which admits about 1,000 medical students a year, compared with 160 at N.Y.U. He cited the large student body and the fact that the clerkships were divorced from the faculty and academic facilities in Grenada, noting that medical schools here integrated classroom work, research and clinical training.

"I don't begrudge the kids," Dr. Abramson said. "I just think the model takes advantage of these kids; the structure is substandard."

Jennifer Golia, who grew up in Queens and graduated from Princeton in 2003, spent two years collecting rejection letters from medical schools in the United States before enrolling at St. George's; she has done clerkships at five New York City hospitals, most recently in neurology at Brooklyn Hospital Center.

"The Albert Einstein students did the exact same thing that we did," Ms. Golia said of her stint at Flushing Hospital Medical Center last year. "We were standing next to each other on ward rounds, presenting patients together at clinic and presenting cases to each other. We had the same supervisors."

St. George's students generally attend classes in Grenada for two years, then spend the next two in clerkships in Britain or the United States, primarily at hospitals in New York, New Jersey, California and Florida.

In 1985, New York State's education commissioner barred St. George's students from New York hospitals, saying that the school's program was too fragmented and the involvement of school officials was too tenuous. After the school made some changes, that ruling was reversed, and St. George's has since routinely sent students to New York hospitals, but the new contract could quadruple the number while raising what until now had been a \$300 fee per student per week.

Jo Wiederhorn, executive director of the Associated Medical Schools of New York, argued during a presentation to a state medical licensing board in May that as American medical schools tried to increase enrollment to address a shortage of doctors, the contract could threaten access for local institutions and put pressure on them to pay the hospitals more. Noting that St. George's tuition is nearly \$50,000 a year, compared with \$40,000 at top American medical schools, Ms. Wiederhorn worried in an interview that New York schools would have to raise tuition by \$20,000 to pay for clerkships and "it would make them noncompetitive with the rest of the country."

The St. George's medical school accepted its first class in 1977, and has an admissions office on Long Island; some 70 percent of its students are United States citizens. When the United States military invaded Grenada in 1983, a principal goal was to rescue American students studying at St. George's amid the unrest.

In 2005, Senator Jeff Sessions, a Republican from Alabama, led an unsuccessful drive to cut off federal student loans to St. George's, Ross and American University of the Caribbean on St. Maarten, saying they were little more than diploma mills "created to serve American students who cannot get into American medical schools."

Mr. Modica, the chancellor, acknowledged that St. George's students generally had lower grade-point averages and lower scores on entrance exams than students at American schools, but he said the gap was narrow.

He said the school had sought an exclusive contract with the hospital corporation because "we have had problems with some of these other Caribbean schools overloading these services."

He staunchly defended the contract, saying it had drawn the ire of medical school deans only because it had threatened their monopoly. Indeed, about a third of doctors licensed in New York State went to foreign medical schools, according to the State Education Department.

"There has always been a need for foreign-trained students because these same deans like to limit the numbers arbitrarily," Mr. Modica said of school admissions policies. "They have a lot of nerve to tell us that we're taking places from them."

Dr. Eric Manheimer, medical director of Bellevue Hospital, was one of two doctors who spent a week visiting St. George's on behalf of the hospital corporation before the contract was approved and said that the Caribbean school "passed the threshold" of being a competent medical school. He said that it was hypocritical for universities with connections to pharmaceutical companies to criticize the contract.

"Some of our best doctors at N.Y.U. went to medical school in Mexico and then came in through the back door," he said.

<http://www.nytimes.com/2008/08/05/nyregion/05grenada.html?partner=rssnyt&emc=rss>

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## **Behavioral Approaches Overlooked in AIDS Fight**

**The New York Times | 08.06.08**

By LAWRENCE K. ALTMAN

MEXICO CITY — While the world awaits findings from new AIDS prevention trials, millions of people are becoming infected because governments are overlooking studies showing that behavior modification works, AIDS experts said Tuesday.

Among the behavior modifications the experts cited: promoting safer sex through delayed intercourse and the use of condoms, decreasing drug abuse, providing access to needle exchange programs and promoting male circumcision.

But none of the measures alone offer a simple solution to preventing infection with H.I.V., the virus that causes AIDS, the experts said in a number of reports and news conferences at the 17th International AIDS Conference here.

The experts said characteristics of the global epidemic varied greatly among and within countries, most of which were not focusing prevention resources where their epidemics were concentrated. Combining these measures and delivering them on a wider scale is crucial to reversing the global H.I.V. epidemic, they said.

Health workers have had initial successes in providing antiretroviral drugs to treat an estimated three million people worldwide. But tens of millions more people need the drugs, and additional millions are now becoming infected.

The world cannot treat its way out of the AIDS epidemic, many experts have long said, and a scientific debate exists over the extent to which antiretroviral therapy can reduce transmission of the virus. A pressing need exists to combine H.I.V. prevention and treatment efforts, experts said Tuesday.

Researchers involved in each field “need to get married today,” said Dr. Myron S. Cohen of the University of North Carolina. “We need to be one community.”

A 50-member panel known as the Global H.I.V. Prevention Working Group, which is supported by the Bill & Melinda Gates Foundation, released a report saying that prevention efforts must address a number of perception problems.

One is misplaced pessimism about the effectiveness of H.I.V. prevention strategies. A second is confusing the difficulty in changing human behavior with an inability to do so. A third is a misperception that because it is inherently difficult to measure prevention success, those efforts have no impact, the report said.

In the wake of three scientifically controlled studies showing that circumcising adult men helps prevent H.I.V. infection, some progress has been made in offering the procedure. But no country has succeeded in fully educating its public about the benefits of circumcision, according to PSI, a nonprofit organization in Washington.

Dr. Adeeba Kamarulzaman of Malaysia said that outside Africa, about 30 percent of H.I.V. infections were among intravenous drug users. But because of stigma and a lack of resources, the world is failing to provide measures like methadone and needle sharing that can help such people.

Meanwhile, The Lancet, a medical journal published in London, released a series of papers on H.I.V. prevention to be published on Saturday.

“Behavioral strategies need to become more sophisticated,” and “that task is not easy,” Thomas J. Coates of the University of California at Los Angeles wrote in one article. In expanding prevention programs, he said, governments must be sure that they put in place “the right programs.”

Dr. Jorge Saavedra, who directs Mexico's H.I.V.-AIDS program, said that national AIDS responses needed to involve more gay and bisexual men in planning ways to reach high-risk individuals. If political leaders do not follow the epidemiological and scientific evidence and direct efforts where they are most needed, "we will lose the fight against H.I.V.," he said.

<http://www.nytimes.com/2008/08/06/health/research/06aids.html?ref=health>

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## Patient Voices: Parkinson's Disease

New York Times | 08.06.08

By KAREN BARROW



How does Parkinson's disease impact the body? What about the mind? How do families cope in the face of a progressive disease? Here, in their own words, are the stories of seven men and women living with Parkinson's disease.

[http://www.nytimes.com/interactive/2008/08/05/health/healthguide/TE\\_PARKINSONS.html?ref=health](http://www.nytimes.com/interactive/2008/08/05/health/healthguide/TE_PARKINSONS.html?ref=health)

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## **Psychiatrists offering a little less conversation, a little more medicine**

**USA TODAY | 08.06.08**

By Carla K. Johnson, Associated Press

CHICAGO — Cartoons about the psychiatrist's couch were recently the subject of a museum exhibition. Now, the couch itself may be headed for a museum.

A new study finds a significant decline in psychotherapy practiced by U.S. psychiatrists.

The expanded use of pills and insurance policies that favor short office visits are among the reasons, said lead author Dr. Ramin Mojtabai of Johns Hopkins Bloomberg School of Public Health in Baltimore.

"The 'couch,' or, more generally, long-term psychoanalytic psychotherapy, was for so long a hallmark of the practice of psychiatry. It no longer is," Mojtabai said.

HEALTH BLOG: Getting inside your head with more mental health news

Today's psychiatrists get reimbursed by insurance companies at a lower rate for a 45-minute psychotherapy visit than for three 15-minute medication visits, he explained.

His study found that the percentage of patients' visits to psychiatrists for psychotherapy, or talk therapy, fell from an average of 44% over the 1996-1997 two-year period to an average of 29% for the years 2004-2005. The percentage of psychiatrists using psychotherapy with all their patients also dropped, from about 19% to 11%.

Psychiatrists who provided talk therapy to everyone had more patients who paid out of pocket compared to those doctors who provided talk therapy less often. And they prescribed fewer pills.

As talk therapy declined, TV ads contributed to an "aura of invincibility" around drugs for depression and anxiety, said Charles Barber, a lecturer in psychiatry at Yale University and author of *Comfortably Numb: How Psychiatry is Medicating a Nation*.

"By contrast, there's almost no marketing for psychotherapy, which has comparable if not better outcomes," said Barber, who was not involved in the study.

The findings, published in Monday's *Archives of General Psychiatry*, are based on an annual survey of office visits to U.S. doctors. Of more than 246,000 visits sampled during the 10 years, more than 14,000 were to psychiatrists. The researchers analyzed those psychiatrist visits.

The study did not survey visits to psychologists or other mental health counselors who are not medical doctors, but who also practice talk therapy.

Psychotherapy uses verbal methods to get patients to explore their emotional life, thoughts or behavior. The goal is to ease symptoms, sometimes through getting the patient to change behavior or mental habits.

Its benefits can be seen in brain imaging studies, said Dr. Eric Plakun, who leads an American Psychiatric Association committee working to restore interest in psychotherapy by psychiatrists.

"The couch is far from dead," Plakun said. "The couch turns out to be an effective 21st century treatment."

Talk therapy can be done by psychiatrists less expensively than split treatment, where a patient sees a doctor for pills and a counselor for talk therapy, Plakun said, citing two prior studies.

It also works better than drugs for some patients, such as those with chronic major depression and a history of childhood trauma, he said.

Accreditation requirements for psychiatric residency programs are putting more emphasis on talk therapy, Plakun said. That may slow the decline of the couch.

The new study doesn't answer an important question: whether other professionals are picking up the slack, said psychologist David Mohr of Northwestern University's Feinberg School of Medicine. Psychologists and social workers provide counseling but most cannot prescribe drugs, so it's possible that for patients who require both talk and pills, some coordination in care may be lost, Mohr said. Copyright 2008 The Associated Press. All rights reserved. This material may not be published, broadcast, rewritten or redistributed.

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