

The NEWSSTAND



items of interest from the media

New York Times – March 26, 2006

For Some Who Solve Puzzle, Medicare Drug Plan Pays Off

By Robert Pear

TULSA, Okla., March 21 — When Virginia G. Shores went to a pharmacy here to pick up five prescriptions, she thought she heard the pharmacist say she owed \$250, but she was wrong. The cost, with her new Medicare prescription drug card, was just \$50.

"I was flabbergasted," said Mrs. Shores, whose kitchen counter looks like a medicine chest, full of pills for high blood pressure, heart failure, arthritis, nerve pain and lung disease.

Mrs. Shores, 80, had been buying medicines from a mail-order pharmacy in Winnipeg, Manitoba, but now uses Medicare instead. "I was amazed at the amount of money it saved," Mrs. Shores said. "It was hard to believe."

She is one of Medicare's satisfied customers. They are not vocal, they are not organized, but they say it was worth wading through the hassles, confusion and complexity of the new program to enroll.

Treasury Department figures show that Medicare spent a total of \$5.1 billion on prescription drug benefits in January and February, the first months of the new program, which is expected to cost more than \$675 billion over 10 years. Medicare officials say the program is paying for more than a million prescriptions a day.

One way to assess the program is to talk to people in a place like Tulsa. People here are far removed from the raucous debate in Washington, where Republicans describe the drug benefit as a boon to older Americans and many Democrats call it a disaster.

The experience of those who have enrolled is particularly significant because millions of Medicare beneficiaries face a May 15 deadline for signing up. Current beneficiaries who decide to join after that date will generally have to wait until Nov. 15 and will then pay higher premiums as a penalty for late enrollment.

In Oklahoma, Medicare beneficiaries can choose from 43 prescription drug plans, with premiums ranging from \$10.07 to \$70.79 a month, different co-payments and very different lists of covered drugs.

Satisfied beneficiaries say they could never have analyzed the options or made a choice without the help of friends and relatives, pharmacists or counselors from groups like LIFE Senior Services, a private nonprofit group, which offers advice at seminars and enrollment clinics in the Tulsa area.

The counselors are adept at using the Medicare Web site to compare drug plans and identify the ones

with the lowest overall annual cost for a particular beneficiary. Before selecting a plan, a beneficiary typically must spend an hour with a counselor, but some spend much more time.

For example, Bobby G. Brown, a retired letter carrier, and his wife, Anna, both 71, spent four hours with a LIFE counselor. "It was well worth the time," said Mrs. Brown, who is being treated for congestive heart failure, rheumatoid arthritis, lupus, high cholesterol, depression and other ailments.

He takes 6 drugs; she takes 18. They enrolled in different plans — WellCare's Signature plan and the basic plan offered by Blue Cross and Blue Shield of Oklahoma — and their combined drug costs will plunge to \$4,900 or less a year, from more than \$25,000.

Mrs. Brown, 71, had been relying on free samples from doctors for some expensive medications, but she found it demeaning to ask for them. "You get the feeling you're a beggar," she said.

The satisfaction of some beneficiaries stands in contrast to the frustration of many others, who were overcharged or unable to get essential medicines in the first chaotic weeks of the program.

"People who are satisfied are the quieter voices," said Leslie A. Dick, executive director of the Burgundy Place retirement community in Tulsa.

Many beneficiaries say they are grateful to local insurance counselors, rather than to Medicare, the government or politicians.

"We had a whole lot better deal before the government started messing with it," said Francis A. Murphy, 79, a retired airline mechanic who is losing drug benefits from a former employer. He said he did not expect to see any savings under Medicare. Beneficiaries are anxious about their choices for good reason. Their out-of-pocket costs under different plans can vary by hundreds or thousands of dollars a year.

Jack L. Coffey, associate dean of the University of Oklahoma College of Pharmacy, owns four drugstores. "In a majority of cases, I have seen some reduction in costs to the patient," Mr. Coffey said. "But for some people, their medications will cost them more."

People may pay more if they already had good coverage, from Medicaid or private insurance, or if they select a Medicare drug plan that does not cover the drugs they need.

Even those who save money may complain because the new program is "much too complicated for a lot of people to understand," Mr. Coffey said.

Todd E. Pendergraft, owner of a Medicine Shoppe pharmacy in Broken Arrow, Okla., outside Tulsa, said the new drug coverage was "significantly beneficial" to one-third of his 750 Medicare patients, "marginally beneficial" to half the patients and "no benefit at all" to the remainder.

People satisfied with the new drug benefit appear to share these characteristics:

They did not sign up for one plan and then switch to another.

They did not rely on advertising or their own instincts, but got help from Medicare experts, insurance counselors or computer-savvy friends and relatives, who used the automated "plan finder" at the medicare.gov Web site.

They are not on Medicaid, the federal-state program for the poor. People eligible for both Medicaid and Medicare had comprehensive drug coverage under Medicaid, but lost it on Jan. 1 and were assigned at random to private Medicare drug plans. The Medicare plans may charge slightly higher co-payments and often cover fewer drugs.

Also, Medicare beneficiaries are more likely to appreciate the new benefit if they live in places like Oklahoma that did not have generous state-financed programs to help them with their drug costs. Drug benefits have been available for years to low-income people through state programs in Maine, New Jersey, New York and Pennsylvania, among other states.

Dr. M. Jean Root, a geriatrician in Tulsa with several hundred Medicare patients, said: "About half of my patients say they like the new benefit and are saving money. The people most likely to benefit have enough education and perseverance to navigate the system, which is extremely convoluted and complex. Or they have friends and relatives to help them."

But Dr. Root said, "The other half of my patients, including those with dementia and terminal illnesses, don't have the energy, the interest or the mental capacity to work through the system."

Counselors are reaching a small fraction of all beneficiaries. Carol H. Carter, a spokeswoman for LIFE Senior Services, said: "Many beneficiaries are terrified of making the wrong decision and overwhelmed by having so many choices. The only reliable way to compare plans is on the Medicare Web site, and that in itself is scary to some seniors."

Beneficiaries could face new problems in coming months. Insurers can impose stricter limits on access to certain drugs after March 31, when a 90-day transition period ends. In addition, some beneficiaries will have to pay more at the pharmacy counter, because most drug plans have a gap in coverage after a person's total drug costs reach \$2,250. The gap lasts until the beneficiary incurs total drug costs of \$5,100. Beyond that point, Medicare pays about 95 percent of the cost of each prescription.

Still, counselors say, many beneficiaries will come out ahead if they enroll.

Those who have signed up say the total cost of all their drugs under Medicare is often less than the amount they were paying for just one prescription in the past.

Mary N. Hooser, 89, of Sapulpa, Okla., takes eight medications for heart disease, ulcers, depression and early signs of Alzheimer's disease. Her children had been chipping in to cover the cost, \$476 a month, including \$155 for the Alzheimer's drug. Under Medicare, the cost for all her drugs is less than \$100 a month.

"This is a tremendous help to my mother and me," said Mrs. Hooser's 73-year-old daughter, Mary L. Ward.

Charlene G. Bandurski, who had polio as a young child, was not

enthusiastic about the prospect of signing up for the Medicare drug benefit. Indeed, she said: "I looked forward to it with dread. We had

heard that it was a mess, and so confusing."

But since signing up in December, Ms. Bandurski said, she has been

pleasantly surprised. "For a medicine that cost \$120, we now pay \$20," she said. "At first, you don't believe it. It's almost like it's too good to be true."

Sioux City Journal – March 27, 2006

St. Luke's provides millions in community benefits

St. Luke's Health System provided \$21.4 million in community benefits to the Sioux City area, according to an assessment of those programs and services completed late last year.

That amount, based on 2004 figures, includes \$3.1 million in uncompensated care and \$2.9 million in free or discounted community benefits that St. Luke's specifically implemented to help Siouxland area residents.

Community benefits are activities designed to improve health status and increase access to health care. Along with uncompensated care, which includes both charity care and bad debt, community benefits include such services and programs as health screenings, support groups, counseling, immunizations, nutritional services and transportation programs.

The results for St. Luke's are included in a statewide report by the Iowa Hospital Association that shows Iowa hospitals provided more than \$393 million in community benefits during 2004. That figure includes more than \$217 million in uncompensated care and \$59 million in free or discounted programs and services that hospitals

offered to help the communities they serve.

As a full-service community hospital, St. Luke's not only provides medical care but also provides key community benefits such as outreach programs, health screenings and health education classes.

"As a community hospital, St. Luke's is privileged to have the opportunity to enrich the community through quality medical services and health programs, both of which impact the quality of life in Siouxland," said Peter Thoreen, president and CEO of St. Luke's Health System. "All proceeds St. Luke's receives from services are invested back into the purchase of new equipment, advanced technologies and upgrading our facilities, helping further our mission to improve the health of the people of Siouxland."

Losses to Medicare and Medicaid also figure into the community benefits equation. Both of those government insurance programs fail to fully cover the cost of care provided by St. Luke's, which in 2004 lost \$11.5 million to Medicare and \$3.9 million to Medicaid. The ability of St. Luke's to continue

financing programs such as childbirth and diabetes education, youth health classes and community health screenings is threatened by these losses.

"St. Luke's ability to serve the tri-state region 24 hours a day, 365 days a year is due to the tremendous support we receive from the community. As a full-service hospital, we depend on the community's support to allow us to continue offering state-of-the-art services and quality care," Thoreen added.

"When community benefit programs are threatened, then so is access to health care for thousands of Iowans," said Kirk Norris, IHA president and CEO. "These kinds of programs are not likely to be offered by any entity other than a community hospital. Without Iowa's 117 community hospitals offering this type of service, demand for tax-support programs to provide the same services would be greater."

The IHA hospital community benefits report, "Opening Doors: How Hospital Community Benefits Count in Iowa," is available on-line at www.ihonline.org or by calling (515) 288-1955.

Oskaloosa Herald – March 7, 2006

Study Shows hospitals have great economic impact

A recent study by the Iowa Hospital Association (IHA) shows Iowa's community hospitals generate nearly 149,000 jobs that add more than \$5 billion to the state's economy. In addition, Iowa

hospital employees alone spend \$1.8 billion on retail sales and contribute more than \$88 million in state sales tax revenue. "Iowa hospitals not only tend to be the largest employers in their

communities, but they are also a major source of job creation," said Kirk Norris, IHA President.

"Hospitals are essential partners for existing businesses and an

important component to bringing more industry to Iowa and improving the state's economic future."

Locally, Mahaska Health Partnership (MHP) directly employs 315 individuals, and creates another 580 jobs outside the health care sector. MHP provides \$13.5 million in salaries annually and \$5.3 million in taxable retail sales. According to the IHA study, MHP provides a total economic impact of \$19.8 million.

"MHP is an important part of the Mahaska community and its economy," said Scott Feldt, Executive Director of the Mahaska Community Development Group. "MHP provides good paying jobs to its employees, excellent medical services to its patients and an exceptional quality of life for Mahaska residents. MHP is an

essential part of the overall economic and physical health of Mahaska County. Our region is fortunate to have such a supportive organization."

The IHA study examined the jobs, income, retail sales, and sales tax produced by hospitals and the rest of the state's health care sector. The study was compiled with software that other industries have used to determine their economic impact. The new study found that Iowa hospitals directly employ 69,416 people and create another 79,316 jobs outside the health care sector. As an income source, hospitals provide \$2.9 billion in salaries and benefits and generate nearly another \$2.2 billion through other jobs that depend on hospitals.

Gary Kahn, President of First Newton National Bank and Chair of the IHA Board, said the study

underscores the business case for strengthening hospitals and supporting Iowa's health care infrastructure.

"Communities move forward economically when they have access to quality health care," Kahn said. "People think of hospitals as places to improve their personal quality of life. But the reality is, a well-supported system of community hospitals secures a better quality of life for everyone."

In all, Iowa's health care sector, which includes employed clinicians, long-term care services and assisted living centers, pharmacies, and other medical and health services, directly and indirectly provides 355,374 Iowa jobs, equal to one-fifth of the state's total employment.

Los Angeles Times – March 27, 2006

Tenet Wooing Disaffected Doctors

By Lisa Girion

Tenet Healthcare Corp. is trying to figure out what to do about doctors like Glen Justice.

The Orange County oncologist heads a practice that admitted more than 1,000 patients last year — most of them to Tenet's 400-bed Fountain Valley Regional Medical Center.

This year, Justice and his four colleagues will admit most of their patients needing chemotherapy, radiation therapy and other hospital care to Orange Coast Memorial, a 224-bed nonprofit hospital about two miles away.

Justice said Tenet, which is struggling to restore profitability amid many legal problems, failed to live up to promises it made at Fountain Valley — and that took a psychological toll on doctors.

"It directly impacted the morale and the care," said Justice, who began practicing at Fountain Valley in 1979 and served as chairman of the hospital's board and as a member of a Tenet physician advisory committee.

"I'm a very loyal guy — kind of like a golden retriever of the medical world," Justice said. But "we had to do what we did for our cancer program."

Over the last three years, as Tenet was rocked by one scandal after another, physicians shifted patients away from many facilities owned by the nation's second-largest hospital operator.

Because admissions drive revenue, the decline in physician loyalty is contributing to a three-year string of losses, the company says. In the most

recent quarter, ended Dec. 31, Tenet lost \$286 million.

Of the 15,000 physicians with privileges at Tenet hospitals, about 9,000 split their admissions between one of the company's facilities and one or more competitors. These "splitters" each sent, on average, fewer than a dozen patients to Tenet hospitals last year, down from about 17 per doctor three years earlier.

"It doesn't sound like a lot individually, but when you spread it across 9,000 physicians, it's significant," Tenet spokesman Steve Campanini said.

Tenet, a Dallas-based company that operates 69 hospitals across the country, says patient loads declined 2.5% from the year before in the fourth quarter alone. And among patients with private insurance,

admissions dropped by almost twice as much.

What that means, Chief Executive Trevor Fetter told Wall Street analysts recently, is that the splitters are shifting to other hospitals those patients who are less sick, more mobile and whose care is reimbursed at higher rates.

Fetter described the slide in admissions as the company's "most immediate challenge" and told analysts that winning back the allegiance of physicians was key to turning the trend around. To do that, Tenet has mounted what it calls the Physician Sales Call initiative.

The campaign sends teams of local hospital administrators to meet with physicians to learn their complaints and concerns. The company said it was addressing many of them, from the prosaic, such as lack of convenient parking, to the more challenging, such as doubts that Tenet has a future.

"We are ... taking action as a result of the feedback," said Dr. Stephen Newman, who oversees Tenet's 18 California hospitals.

The conversations have prompted a number of changes, Newman said. Some hospitals, for instance, have improved operating-room efficiency by starting cases earlier in the morning and on time.

Other complaints are easy to address by taking steps such as speeding delivery of diagnostic reports to physicians' offices, Tenet Chief Operating Officer Reynold J. Jennings told analysts recently.

In some cases, what the physicians want is more challenging, he said, such as recruitment of hospital-based doctors to support specialists.

And other issues, Jennings said, are "barriers with no immediate solution." These include the growing

number of physicians who have invested in hospitals of their own that compete with Tenet.

But the campaign is beginning to show results — at least in California, where Tenet hospitals started the effort months before it was rolled out across the rest of the country. Admissions in the state improved 1.4% last year, recouping some of the earlier losses, the company said.

Los Alamitos Medical Center, for example, has seen admissions rise for the last few years. But Los Alamitos Chief Executive Michele Finney said she used the physician sales calls anyway to make improvements. She believes that helped win new admissions.

"We were pretty successful," Finney said. "Any decline we may have seen was more than offset with growth."

Although some hospitals have seen admissions improve, Tenet executives say they expect the success of the effort to be limited until the company is able to resolve its legal problems.

Those troubles include a criminal trial in San Diego, where administrators of a Tenet hospital are accused of paying kickbacks to recruit doctors. The company also faces an investigation into deaths at one of its New Orleans hospitals during Hurricane Katrina and a long-running government probe of a billing practice the company has since abandoned.

Some physicians, analysts and other experts said the physician outreach effort might be too little, too late. In many areas, competitors have done a better job of figuring out what physicians need — and giving it to them, said Stanley Otake, a hospital consultant and former administrator.

"Now Tenet is going to do what its competitors have been doing for years," Otake said. "That's like Ford

Associated Press — March 29, 2006 saying, 'We're going to do what Toyota is doing now.' "

CRT Capital analyst Sheryl Skolnick said figuring out what physicians needed was crucial to the company's survival.

"In order to get heads in the beds, you can't ignore those doctors," she said. "You have to figure out what's going to be the catalyst to get them back in."

Even if the company resolves its legal issues this year, she said, physicians won't quickly change admitting habits that have taken root.

One of those who may be gone for good is Dr. Justice. He said Fountain Valley made overtures, but he felt that Tenet's corporate problems put too much stress on the hospital and hampered its ability to make needed capital improvements, such as a new roof.

Justice said he was attracted by the modern cancer treatment equipment at Orange Coast, its philosophy on pain management and spirituality, and the overall esprit de corps.

He said he viewed the hospital's digital imaging system as an absolute necessity for the close monitoring of cancer patients. The system digitizes radiological images, allowing physicians to easily look up patients' latest scans.

When Deborah Keel took over as Fountain Valley's chief executive in late September, she heard a chorus of physicians making the same complaints — and she got busy. The hospital's new, \$1-million roof is nearly complete and new information technology systems, including a digital imaging system, should be in place this year, she said.

"Physicians vote with their feet," Keel said. "You have to re-earn that reputation every day."

New Orleans Health Care Still in Shambles

By Kevin Freking

WASHINGTON — The city of New Orleans has only 456 staffed hospital beds, compared with 2,269 before the city was struck by Hurricane Katrina, according to government auditors who say rebuilding the health care system will be vital for bringing people back.

While emergency care is available, auditors noted that patients at two hospitals waited up to two hours to be unloaded from ambulances. They also found patients being kept and treated in the emergency room because beds weren't available elsewhere.

The Government Accountability Office said several planning efforts are under way about how to rebuild that system, but no clear consensus has emerged.

The lack of clarity stems in part from the uncertain estimates of how many people plan to return. The latest estimates put the city's population at about one-third of the

485,000 people who lived there before Katrina hit.

Democrats who requested the study said the findings show the Bush administration must be more aggressive in leading the rebuilding efforts.

"It is unacceptable that six months after Hurricane Katrina, people are still receiving health care services in mobile tents and old department stores," said Rep. John Dingell, D-Mich., taking aim at Health and Human Services Secretary Mike Leavitt. "Exactly how does the secretary expect the Gulf Coast region to prepare for a potential flu pandemic or the next hurricane season given the current state of their health care system?"

Leavitt spokeswoman Christina Pearson said the secretary has met regularly with state officials to hear how they would like to see the health care system improved, and he sees opportunities to make the system better than it was before the hurricane struck, particularly

through the use of health information technology. She did not have a timetable for when those improvements would be proposed.

The GAO report said that when auditors visited New Orleans, they found primary and emergency health care was available, but access to specialty care was quite limited.

The report also noted that the federal government's estimate of repair costs for two major hospitals run by Louisiana State University _ Charity Hospital and University Hospital _ amounts to about \$36 million. But a private consultant estimated it would cost more than \$360 million to repair both hospitals _ aging facilities LSU had wanted to replace before the storm.

The city also relied on a network of clinics to treat poor patients before the hurricane, but more than three quarters of those clinics are closed. About 19 clinics are open now, but they generally operate at less than half of capacity.

Boston Globe – March 24, 2006

Hospitals expect hardball push to unionize

By Christopher Rowland

Executives preparing to fight a powerful union that wants to organize workers at Boston teaching hospitals are studying how the union used an aggressive public relations campaign against Yale-New Haven Hospital in Connecticut.

In recent years, Local 1199 of the Service Employees International Union has drawn media and government attention to what critics called Yale-New Haven's heavy-handed debt collection practices. It bought space on billboards to

excortiate hospital management, and recently used its influence with New Haven politicians to delay for months construction of a \$430 million cancer center.

Local 1199 and hospital officials outlined a deal Wednesday that will allow the cancer center to move forward and the union to hold an organization vote by secret ballot for about 1,800 hospital workers. But the drawn-out dispute had a paralyzing effect on Yale-New Haven Hospital.

Before this week's agreement, Dr. Peter N. Herbert, chief of staff and vice president for medical affairs at Yale-New Haven, sounded frustrated by the impasse.

"We couldn't build an outhouse at Yale-New Haven Hospital now and get it through the city planning process," he said.

Herbert cautioned Boston's medical establishment against underestimating the aggressive "corporate campaign" tactics employed by 1199 SEIU, which six

months ago set its sights on Massachusetts.

"They're smart. They're extraordinarily well funded. You have to admire the political agility of your opponent," he said.

The union sees Boston as ripe for organizing because there are few union workers at major teaching hospitals, particularly at Massachusetts General Hospital and Beth Israel Deaconess Medical Center, which have none.

While a full-blown organizing fight has yet to materialize between a Boston hospital and 1199 SEIU, that has not stopped some hospital executives from fretting about the possibility. And they are using the New Haven experience as Exhibit A.

Beth Israel Deaconess chief executive Paul Levy, whose hospital is affiliated with Harvard Medical School, is the only Boston hospital executive who has publicly criticized 1199 SEIU. Levy this week rebuffed a written request by 1199 SEIU president Dennis Rivera to meet to discuss a partnership between the union and Beth Israel.

"What kind of healthcare service union would stand in the way of a cancer center in New England? That strikes me as the kind of union we don't want," Levy said.

He accused the union of attempting to organize "undemocratic" union elections that stifle internal debate and intimidate prospective members.

The union's chief organizer in Massachusetts, Mary Grillo, said the union has not made organizing attempts at Beth Israel or any other Boston hospital, and that it is still in the early stages of a three-year effort.

She said it is committed to fair union elections with secret ballots. She also defended the union's tactics at Yale-New Haven, which she said have been orchestrated by a "sister union" of the 1199 SEIU unit that covers New York and Boston.

Grillo said the 1199 SEIU union in New Haven tried unsuccessfully for years to negotiate a "neutrality agreement" at the hospital that would allow the union to mount its election campaign without interference from management.

"Why would we want an employer that does not provide livable jobs? The union hasn't had an election there, and Yale has the entire community against them," she said.

"We're concerned that a hostile environment where management engages in intimidation tactics does not provide a fair election, and workers do not have a right to make fair decisions," Grillo said.

New Haven Mayor John DeStefano, who helped broker the agreement between the hospital and union and is running for governor, acknowledged that a resolution did not come swiftly -- the dispute began about seven years ago.

"Some may think this process has taken too long," he said. "We aspired to develop an agreement that would add value to the families of New Haven, and indeed, the state of Connecticut."

Hospitals in Boston are taking 1199 SEIU seriously because of its significant financial resources and successful track record. The local, based in New York and formally known as 1199 SEIU United Health Care Workers East, is part of the national SEIU, which broke with the AFL-CIO last year.

The New York unit represents 250,000 workers in 76 hospitals in that state. It has a \$20 million

annual organizing budget, and wields influence in Albany, the state capital.

It also has members in Washington, D.C., and Maryland.

An SEIU local in Massachusetts with about 12,000 members voted to merge with the New York organization last year, setting the stage for a major drive in Boston, where the healthcare industry is the biggest employer.

A Boston law firm, Mintz Levin Cohen Ferris Glovsky and Popeo, recently hosted a closed-door meeting to warn several dozen hospital officials about the union's tactics.

"This is not the traditional labor-management battle. It is a totally different landscape," said Donald W. Schroeder, a member of the labor and benefits group at Mintz Levin's Boston office.

Next month, the Massachusetts Hospital Association is planning to discuss ways to counter the union's efforts. And an April 4 conference in Cambridge planned by Dietz Associates, a Kennebunk, Maine, human resources firm specializing in employee communications, is expected to attract about 40 officials from New England hospitals.

Levy said other hospital executives in Boston have been reluctant to speak out because they don't want to become targets. "My view is you're a target anyway," he said.

Grillo said Levy sent an e-mail to the hospital last year "expressing his opposition to unionization."

A copy of the e-mail provided by Levy said he opposes the union effort, but that he would abide by workers' wishes through a "fair and free vote."

Partners HealthCare, which operates the two largest Harvard teaching hospitals, Mass. General and Brigham and Women's Hospital, declined to discuss its approach to the 1199 SEIU organizing drive.

"Within the Partners system, we have some hospitals with unions and some hospitals without unions.

This is not a new issue for us, said Thomas P. Glynn III, chief operating officer for Partners. "However, based on our experience, we prefer to handle labor-relations issues privately."

Executives at Caritas Christi Health Care System, a network of six Massachusetts hospitals operated by

the Catholic Archdiocese of Boston, said they had not seen evidence of 1199 SEIU organizing in its institutions. It already has a large 1199 SEIU presence at one of its hospitals, Good Samaritan in Brockton.

Washington Post – March 28, 2006

VA Health-Care System Is 'A Model,' Secretary Says

By Christopher Lee

When Hurricane Katrina forced the relocation from New Orleans to Houston of hundreds of Veterans Affairs hospital patients, electronic medical records enabled doctors and nurses to treat the sick and injured without skipping a beat.

"We were able in every case, after we got them resettled into another hospital, to dial up their medical record," Jim Nicholson, the secretary of Veterans Affairs, said yesterday.

In a "state of the VA" speech at the National Press Club, Nicholson cited electronic health records as one reason the VA health-care system is "a model for our nation" and said his department, with 234,000 employees, is "truly one of America's good-news stories."

The VA's 154 hospitals and more than 900 clinics will treat more than

5.3 million veterans this year, he said. Its health-care budget has risen 69 percent in the past five years. Under President Bush's proposed 2007 budget, the department would get one of the biggest increases in discretionary spending for any federal agency: a boost of \$2.6 billion, to \$35.7 billion.

Not all the news is good.

One of the department's missions is to help ease veterans' transition to civilian life. Yet the unemployment rate of veterans ages 20 to 24 is 16 percent, more than three times the national rate.

"To me, they're perfect for prospective employers," Nicholson said. "They made a commitment. . . . They've been honorably discharged and they deserve a job."

About 1 in 5 veterans has diabetes, compared with about 1 in 14 Americans in general. Nicholson said the VA now talks to patients about their diet and the disease even if they come in for other ailments.

More veterans, especially those returning from Iraq and Afghanistan, are having post-traumatic stress disorder diagnosed, prompting the department to ensure that all its 154 major medical centers have an expert in treating PTSD.

Then there are the old complaints that the VA is too slow to process benefits claims. "We're trying to compress the time it takes to get a decision so a veteran doesn't have to wait so long," the secretary said. "There are things that we can and we need to do better."

Waterloo-Cedar Falls Courier – March 4, 2006

Intense fighting kept Waterloo doctor busy in Iraq

By Jens Manuel Krogstad

WATERLOO --- If Dr. Steven Olsen had been drawing straws, he'd have picked the shortest one.

Olsen, an Allen Hospital physician currently serving as an Army field surgeon in Iraq, survived three months in the so-called "Triangle of

Death," an area about 25 miles south of Baghdad.

If all goes well, Olsen will return to the U.S. sometime this month. Back in Waterloo, Olsen will spend most of his time as a physician at the John Deere factories, though he also

sees patients at Allen Occupational Health Clinic.

Just as Olsen touched down in Iraq in September, a physician assigned to travel between various sites suffered several broken ribs after a roadside bomb hit the tank he was riding in. Olsen replaced him at the

base in Mahmudiyah, a city about 16 miles south of Baghdad, and resumed the previous physician's task as a traveling doctor.

During this time, Olsen lived in a small tent hidden between sandbags and concrete barriers. Gun fire sounded day and night, and he slept during the day because mortars fired all night. He showered every third day in 125-degree heat because of water rations.

"It was pretty Spartan living," he said.

The intense fighting in the region kept Olsen busy. He treated combat injuries nearly every day and administered physicals to detainees as they arrived.

"The most common condition we encountered (in detainees) was diabetes, and we made sure (they) received the proper amount of insulin and appropriate monitoring," he said.

His unit suffered 22 combat deaths and seven non-combat deaths in the six months they patrolled the Sunni-controlled area. The unit that replaced them in November, the 101st Airborne Division's 2nd

Brigade Combat Team, has lost 31 soldiers so far.

Olsen is an Army and Army National Guard veteran on his second tour in Iraq. His first trip, which lasted a year, was in January 2003 as part of the 109th Medical Battalion in Iowa City.

Today, he travels with a unit stationed about 40 miles north of the Kuwait border that provides security to truck convoys, a mission he said is safer, though just as demanding.

He works with a Combat Surgical Unit, formerly known as M.A.S.H. units, where physicians and surgeons perform emergency medical care.

"All we do is save life, limb and eyesight --- just enough to get the wounded to Germany or to the U.S. It's certainly not the Mayo clinic," he said.

In theory, Army physicians are supposed to treat only Americans and the Iraqis they shoot. But doctors will treat injured Iraqis, often children who burn themselves keeping the fire burning in their homes --- a job that is assigned to

children. He said any burn to over 20 percent of the body is fatal there because of malnutrition and poor hygiene.

"Sometimes they splash the kerosene, sometimes they mistake the benzene can for the kerosene can, sometimes the vapors ignite," he said.

In January, he went on a humanitarian mission --- something he does whenever fighting dies down --- to a village on the Tigris River in southeast Iraq. The doctors set up a makeshift hospital in an elementary school, though it could have been mistaken for a military stronghold.

"We strung barbed wire up around it, put guards on the roof," he said.

The majority of the people treated were children who waited in line in a sandstorm so strong that "sometimes we couldn't even see the vehicle 50 feet in front of us," he said. Many of the kids suffered from severe genetic birth defects because the preferred method of marriage there is between first cousins. The reasoning, he said, is that it keeps the bride's assets and dowry within a single tribe.