

THE SafetyNet

THE MAGAZINE OF



National
Association
of Public
Hospitals
and Health
Systems

SPRING 2006

VOLUME 20

NUMBER 1

ISSUE 2 OF THE 25TH ANNIVERSARY TRILOGY



Of Public Trust

TWO CENTURIES OF CARE IN AMERICA'S PUBLIC HOSPITALS

NAPH

Larry S. Gage President
Christine Capito Burch Executive Director

2005–2006 NAPH EXECUTIVE COMMITTEE**Officers**

John A. Benz Chair
Memorial Healthcare System
Hollywood, FL

Sandra Hullett, MD, MPH Chair-Elect
Cooper Green Hospital
Birmingham, AL

John W. Bluford, III Secretary
Truman Medical Centers
Kansas City, MO

Gene O'Connell Treasurer
San Francisco General Hospital
San Francisco, CA

Margo Hilliard Alford, MD Past Chair
Harris County Hospital District,
Lyndon B. Johnson Hospital
Houston, TX

At Large Members

Bob Baker Ex-Officio
University HealthSystem Consortium
Oak Brook, IL

Kirk Calhoun, MD
The University of Texas Health Center at Tyler
Tyler, TX

Lynda D. Curtis
Bellevue Hospital Center
New York, NY

Lisa E. Harris, MD
Wishard Health Services
Indianapolis, IN

Dennis D. Keefe
Cambridge Health Alliance
Cambridge, MA

Stephen W. McKernan
University Hospital, The University of
New Mexico Health Sciences Center
Albuquerque, NM

Marvin O'Quinn
Jackson Health System
Miami, FL

John Sideras
The MetroHealth System
Cleveland, OH

Mikki Stier
Broadlawns Medical Center
Des Moines, IA

Thomas P. Traylor
Boston Medical Center
Boston, MA

Gary Wells
Los Angeles County Department
of Health Services
Los Angeles, CA

CONTENTS

- I From the Chair
- 2 President's Message
- 3 **For Us the Living ...**
Medical Treatment and Innovation in the American Civil War
- 6 **A History of Public Hospitals in the United States**
From City Almshouse to Medical Innovator —
Two Centuries of Triumph and Trial
- II **The Cutting Edge**
Heard of Ambulances? Blood Banks? Catheterization?
It Happened Here First.
- 14 **"As Real as it Gets"**
The Evolution of Trauma Care and Emergency Medicine
- 18 **Physician Training: Past and Present**
Public Hospitals and Medical Schools Shared Mission
of Graduate Medical Education
- 22 **Photo Essay: A Place of Care**
Historic Images of the Safety Net
- 27 **Called to Care**
CDC Director Julie Gerberding Got Her Start in Public Hospitals
- 28 **Epidemic Emerging**
How Public Hospitals Set the Bar for Early AIDS Care
- 30 A Slice of Life
- 31 Destination: Public Hospitals
- 32 The View from Here
- 34 Meet the Staff
- 35 **Special Feature** JPS Health Network Celebrates 100 Years
- 36 People & Places

John A. BenzMemorial Healthcare System
Hollywood, FL

A Long and Rich History

As NAPH celebrates its 25th anniversary, this issue of *The Safety Net* looks back at the long and rich history of public hospitals in the United States. Collectively, our institutions have been the foundation of health care, public health, research, and medical education for the better part of two centuries. In that context, NAPH may be the new kid on the block, but its influence has been profound.

My relationship with NAPH dates back about 18 years, when we at Memorial made a conscious decision that other national organizations did not place priority on some issues that were important to us, especially Medicaid and the preservation of the safety net. When we joined NAPH in 1988 it was a revelation. There were people from across the country dealing with similar issues and lots of communication – both in person and in newsletters and other forums.

Over the years, I've particularly valued the personal connections with the NAPH staff and my colleagues at other safety net organizations. NAPH represents a unique opportunity for meaningful dialogue among people who are doing what they do for the right reasons. For me, it's also been intellectually stimulating. The depth and breadth of knowledge of the NAPH staff is remarkable. They're immersed in safety net issues but also have great practical knowledge of public hospitals and are a real resource for the membership. And NAPH working with Powell Goldstein is a unique tag team. One of the greatest lessons I've learned from them is there are numerous sides to an issue, both practical and political. More than once I've gone into a meeting thinking an issue was black-and-white and come out seeing it in a far more nuanced framework.

Among NAPH's greatest accomplishments has been the progress made on Medicaid financing mechanisms over the last two decades. NAPH has been the key organization advocating for safety net hospitals in a pure sense. The staff, working with Powell Goldstein, really understands the Medicaid statutes and has written policies and procedures to maximize state and federal reimbursement. Related to that, they've helped members access congressional leaders and script consistent, compelling, and concise messages that resonated with lawmakers. NAPH also has been integral to telling the safety net story to different audiences, and for assisting members as we reach out to local leaders and media.

It's not a stretch to say NAPH has made the difference in survival for many of us.

There are several well-known examples of public hospitals literally going out of existence because they lost support and weren't able to find sustainable financing. Many of us would be at that juncture today if NAPH hadn't been our partner in advocacy.

Finally, it's impossible to reflect on the history of NAPH without mentioning Christine Capito Burch and Larry Gage. They've been our guiding light over the past quarter-century. As chair of the executive committee, I've developed an incredible appreciation for their commitment, knowledge, and determination in leading the organization and in pushing our advocacy agenda. On behalf of the entire membership, I thank them for their extraordinary contributions. Congratulations and best wishes for another 25!



It's not a stretch to say NAPH has made the difference in survival for many of us.

Larry S. Gage
President, NAPH

Celebrating 25 Years



It turned out to be a daunting task to write a meaningful message to NAPH members on the occasion of our 25th anniversary. Where to begin?

Do I look backward at our association's many achievements over the last quarter century: the billions of dollars that have flowed to NAPH members through funding mechanisms like Medicare and Medicaid DSH; the range of other legislative and regulatory victories we've gained? Do I give voice to the community of selfless, dedicated administrators, Board members, physicians, and other staff that NAPH has helped bring together over the years?

**Let me speak for our whole staff
in saying "Thank you" to all NAPH
members for a great 25 year
collaboration and friendship.**

Or should I look forward, to the opportunities and challenges of the future: the perpetual funding crisis that confronts most NAPH members; the need to fill the huge gaps that remain in health

coverage; the need for safety net hospitals to participate fully in the revolutions occurring in quality of care, patient safety, information technology, genetic engineering, and the ability to respond to natural and man-made disasters?

As I mulled over what to write, one thought kept coming back to me: 25 years after the founding of NAPH, why do we still need safety net hospitals? Certainly, Medicare and Medicaid did not eliminate the need for them, as some people predicted in the mid-1960s when those programs were enacted. This is why a visionary group of public hospital administrators decided to form a national association in 1981. But how can we tell whether that need will continue into the future?

A recent article in the *Los Angeles Times* told of the extraordinary efforts of pathologists and other clinicians in the LA County health system to head off an outbreak of a dangerous but unknown disease. People began showing up at the County hospital with alarming symptoms — bloody cough, painful, egg-sized swollen glands — and soon began dying. Working around the clock, County physicians finally determined that the disease — which was originating in a poor community of Mexican immigrants — was bubonic plague. An entire community was successfully quarantined, and the outbreak subsided. The year was 1924.

Just a couple of days after I read this article, DHHS Secretary Mike Leavitt appeared before the Senate Budget Committee. Among other things, Secretary Leavitt told the committee that the federal government was "not going to be able to help thousands of communities at once" if an avian flu pandemic broke out. He said "local communities were going to have to be prepared to handle it themselves." Given the government's recent track record in responding to disasters, this is not just news but a warning. And it provides the starker possible answer to the question: Are we going to need safety net hospitals and health systems in the future?

As I close this column, let me speak for our whole staff in saying "Thank you" to all NAPH members for a great 25 year collaboration and friendship. We hope we can continue to help in the future, because we know that you will be needed for at least another 25 years.

Editor's Note

This issue of The Safety Net is the second of three special issues marking the 25th anniversary of NAPH. The first issue, Winter 2005, focused on leadership and represented the present. This issue harks back to the history of public hospitals, and the final issue, Fall 2006, will look to the future. Join us on this remarkable journey celebrating the safety net — past, present, and future!



FOR US *the* LIVING

MEDICAL TREATMENT AND INNOVATION IN THE AMERICAN CIVIL WAR





The year was 1863, the height of the Civil War. In the field, soldiers on both sides were dying not only from battle wounds but from dysentery, pneumonia, and smallpox. Amidst the brutality and the overwhelming human suffering, however, medical science responded with creativity, innovation, and compassion.

In Richmond, the Medical College of Virginia (an antecedent of the modern-day VCU Health System) helped fuel this innovation through the training of new physicians. The college graduated a class during each year of the war, something no other Southern school still in existence can say.

These physicians were in great demand on both sides, and many brought creativity as well as commitment to their battlefield labors. In 1863, for instance, physician John J.

Terrell, stationed at Lynchburg's General Hospital No. 1, began to pack wounds with lint to exclude air, a practice that predated modern germ theory. It was one of many innovations that helped advance American medicine during this era.

As historian Peter Houck writes, "Post Civil War medicine improved because this major event . . . cloistered numerous doctors who had been working in a vacuum into a crucible where they had to communicate, share ideas, set standards."

"It is for us the living... to be dedicated here to the unfinished work which they who fought here have thus far so nobly advanced."

—ABRAHAM LINCOLN, THE GETTYSBURG ADDRESS, NOVEMBER 19, 1863

INNOVATIONS OF CIVIL WAR MEDICINE

- + Development of the "general pavilion hospital," with better ventilation and access to patients.
- + The ward system, whereby patients with similar health problems were segregated. This, in itself, stimulated more accurate assessments and treatment plans.
- + Expansion of ambulance systems, progressing from horse-drawn wagons to trains and ships.
- + Significant improvements in medical education and training.
- + Establishment of the American Red Cross.
- + Advances in nursing, spearheaded by the Ladies Relief Societies on both sides of the Mason-Dixon line.
- + Improved medical record-keeping.
- + The beginnings of specialty care, especially in orthopedics.
- + The use of prosthetic limbs, beginning when a Confederate private, James Edward Hanger, fashioned an artificial leg out of barrel staves.



PAGE 3: Wounded soldiers gather at the field hospital at Savage Station, Va. after the battle of June 27, 1862.

TOP: A Zouave ambulance crew demonstrates the removal of wounded soldiers from the field.

BOTTOM: Ward K of Armory Square Hospital, Washington, DC





A HISTORY *of* PUBLIC HOSPITALS IN THE UNITED STATES



FROM CITY ALMSHOUSE TO MEDICAL INNOVATOR —
TWO CENTURIES OF TRIUMPH AND TRIAL



By John Galbraith Simmons





Hospitals in the United States emerged from institutions, notably the almshouse, that provided care and custody for the ailing poor. Whether dispensed at a poorhouse, pesthouse, or “retreat” managed by a Christian charity, medical care was usually marginal, and prospective patients seeking admittance were often obliged to prove their moral worth or seek a well-off benefactor. In the early nineteenth century, and for more than a century to come, most Americans gave birth and endured illness and even surgery at home. They belonged to a largely rural society, and few among them would ever have occasion to visit a hospital. At a time when even contagion was poorly understood, it is fair to say that this was just as well.

Rooted in this tradition of charity, the public hospital traces its ancestry to the development of municipalities and requisite community efforts to shelter and care for the chronically ill, bereft, and disabled. A six-bed ward founded in 1736 in the New York City Almshouse became, over the course of a century and more, Bellevue Hospital. The

antecedent of Charity Hospital in New Orleans opened its doors the same year. Today’s Regional Medical Center in Memphis, the oldest hospital in Tennessee, was founded in 1829. Similar origins trail many other public hospitals, places where the “care of strangers” grew from most modest origins into multifaceted municipal institutions.

Emergence of Public Hospitals: 1860–1930

Although the almshouse forms its oldest root, the American hospital as we know it today emerged over the course of about 60 years, beginning around the time of the Civil War. Physician-staffed hospitals, with professional nursing and specialized departments and services, were products of urbanization and economic expansion during the Second Industrial Revolution, together with massive immigration and, above all, rapid strides in medicine itself. The early and middle decades of the nineteenth century had been a period

CONTINUED ON NEXT PAGE





of “therapeutic pessimism” when, in spite of improved and accumulating knowledge, physicians could do little to treat almost any serious illness. About 1880, however, asepsis opened broad new horizons for surgeons, and within a generation the bacteriological revolution commenced in earnest. As physicians won growing respect and looked to the future with a new sense of hope, hospitals became emblematic of their new optimism and authority.

Each of today’s public hospitals has a unique story, and many trace their origins to this historic period of growth. The Cambridge Health Alliance in Massachusetts, created in 1996, for example, brought together Somerville Hospital (founded 1891), Whidden Hospital (1897), and Cambridge Hospital (1917). The present University of Kansas Hospital owes to Kansas University School of Medicine (1880) and the Eleanor Taylor Bell Hospital (1906). Some public hospitals were established originally by the work of states and counties, others by municipalities.

Physicians “medicalized” the hospital, wrote historian Charles Rosenberg, in *The Care of Strangers*, while in turn they were themselves “hospitalized.” Once established and staffed by trained physicians and nurses, both public and not-for-profit hospitals became key components in a rapidly expanding medical culture. By the 1920s, the hospital was a place where one could hope illness might be treated and even cured. Not-for-profit hospitals at this time began reducing their traditional charitable role in favor of creating prestigious institutions attractive to an upper middle class clientele. Although the medical culture demanded in

principle a single standard of quality care, public hospitals operated with their commitment to treat the poor and a consequent fiscal challenge.

Indeed, hospitals in the second quarter of the twentieth century entered into a thoroughly new relationship with money. All hospitals before the 1920s had operated without much of it, relatively speaking. Physicians donated their time, and costs for nurses and staff tended to be low. For the first time, hospitals required significant funds, just as doctors and surgeons began getting paid and nursing and staffing were professionalized. Many urban public hospitals recast themselves appropriately as major and sometimes highly regarded institutions, often establishing affiliation with universities and medical schools. At the same time, they remained committed to the mission of treating all, and they became ever more vulnerable in the marketplace.



Challenges in a Changing Marketplace: 1930–1965

The Great Depression represented a challenge to hospitals and, decades before the term “safety net” came into currency, on a de facto basis the public hospital began to play just such a role.

Municipal hospitals were particularly busy during the 1930s. In one statistical analysis, between 1929 and 1933 public hospitals (including all government hospitals) saw an increase of 21 percent in patient load with an average 1933 occupancy rate of 90 percent. The nongovernmental hospital patient load declined by 12 percent during the same period, with a 1933 occupancy rate of just 55 percent. Increased funding for public hospitals was not





forthcoming, however. A 1936 survey found that in New York, for example, although subsidized for indigent care, the not-for-profit hospitals restricted it; the public hospitals had no such prerogative.

Demographic shifts and rapid advances in scientific medicine determined the character of the public hospital after World War II. With a mature biochemistry as its lingua franca, medicine had a growing authority buttressed by the advent of penicillin for a host of diseases,



streptomycin as a cure for tuberculosis, and the Salk vaccine for polio. At the same time, with unprecedented prosperity and unemployment rates as low as 2 percent, millions of Americans moved from city to suburb, and their health needs were met largely by private insurance.

For a time around 1950, the future of city hospitals seemed in various ways sanguine. In spite of persistent lack of funds, many were well-staffed and buttressed by affiliation with medical and nursing schools. However, although they benefited from and also helped to implement the multitude of mid-century medical advances, public hospitals were scarcely favored by the population shift from the urban center to the suburban sprawl. Within less than a generation, tax bases eroded in the large cities in which many public hospitals were located, leaving concentrations of poor and unemployed in their precincts, far outside the American dream. In addition, outpatient visits to public hospitals skyrocketed, rising some 310 percent from 1944 to 1965. "The hospital," wrote Harry F. Dowling in *City Hospital*, "was becoming the general practitioner of the masses."

In addition, the hospital system expanded rapidly, especially after the 1946 *Hill-Burton Act* launched an immense government-financed construction effort. But the public hospitals did not benefit proportionately to the populations they served, in part because legislative provisions favored funding not-for-profit hospitals in middle-class areas.

The Advent of Medicaid and Medicare: 1965–1980

By the 1960s a larger conundrum began to afflict medicine in the United States, and it hit public hospitals especially hard. The prosperous country that boomed after World War II revealed an impoverished underbelly that could not be ignored. Health care for the urban and rural poor alike was sorely lacking in a society regarded as the wealthiest on earth. In this context, many of the largest public hospitals became stages of conflict where physicians, nurses, and hospital staff struggled to provide adequate care in deteriorating physical plants that were often ill-equipped and poorly provisioned.

Health and hospital insurance represented another register in the post-war public hospital blues. It was largely a feature of business expansion, when employers in all sectors typically covered employees on every rung. However, this system, which eventually eroded for millions of Americans, left the indigent and elderly without resources at a time when medicine had grown capable of treating literally thousands of diseases in new and effective ways. Although President Truman had planned a national health system in 1949, it proved politically impossible to forge into law, especially during the Cold War. But in 1965, with President Lyndon B. Johnson's "War on Poverty" and the "Great Society," Congress enacted Medicaid and Medicare to provide some access to care for the indigent and elderly.

These government programs, which largely enabled patients to apply to hospitals of their

CONTINUED ON NEXT PAGE





own choosing, did not resolve what experts had begun to call the “plight of the public hospital.” Now chronically and in some cases critically underfunded, public hospitals required administrative and structural changes if they were to survive. A variety of proposals floated in the early 1970s involved severing, partially or wholly, the public hospital from direct control by local governments and municipalities. The New York public hospitals came under control of a public benefit corporation, while in Denver the public hospitals merged with the municipal public health system to create a successful municipal health care system. Full divestiture was another solution chosen by other local governments, which transferred the public hospital to a medical school or other organization. For these hospitals, mission generally outlasted governance; divested hospitals frequently retained the public hospital commitment to serve all in need.



Establishing the Safety Net Hospital: 1980–2005

Prognostications in the 1960s and even later forecast the demise of the public hospital, in great part due to the projected benefits the poor and elderly could receive from Medicaid and Medicare. Although the number of public beds declined and some hospitals would eventually shut their doors due to lack of funding, nothing like that came about. Medicaid from the start failed to cover at least one-quarter of the poorest patients, while Medicare never paid more than about half the costs of care for seniors; and those costs rapidly mounted in real-dollar terms. While the consumer

price index rose 300 percent between 1960 and 1980, the per diem cost of hospital beds rose by 900 percent. A clear need for “open door” hospitals with a high standard of care continued to exist and, in fact, to expand.

Creation of a Commission on Public-General Hospitals in 1976 brought a report two years later that crystallized the fact that “The future of the urban public-general hospital . . . must be uniquely treated.” The National Association of Public Hospitals (NAPH) was established just to that aim in 1980 as an umbrella advocacy group. It opened for business the day before the inauguration of Ronald Reagan, and one of its early legislative victories was recognition for the Disproportionate Share Hospital (DSH) that serves more than its share of low-income patients. DSH alone over the years has brought public hospitals billions of dollars and represents a critical source of funding.

Another aspect of the “safety net” hospitals, as they now designated themselves, was a redesigned commitment to the communities they served. Today, in addition to inpatient and outpatient services, safety net hospitals typically offer HIV/AIDS care, substance abuse counseling, prenatal care and obstetric services, and Level 1 trauma care. These services enlarge the scope and reach of public hospitals while maintaining their basic mission. “It’s a safety net for everybody,” explains Christine Capito Burch, executive director of NAPH, “the insured and uninsured.”

Twenty years ago, Harry F. Dowling concluded his history of municipal hospitals with succinct and felicitous words. With enough public support and resources, public hospitals can survive, he wrote, adding, “The vital question has always been and still remains: ‘Does anybody care?’” The answer, two decades later, is not merely affirmative. In a health care environment in which upwards of 46 million Americans are uninsured, public hospitals can point to a higher standard of care, a deeper reach into the communities they serve, and a continuing commitment to serving all in need. ■



Public hospitals have been home to illustrious physicians and Nobel laureates, the sites of historic clinical "firsts" and crucibles of world class research. Here is a brief sampling of some of the innovations and discoveries that have helped shape both scientific medicine and community health care in the United States and the world.



FIRST HOSPITAL AMBULANCE SERVICE

When a sleek horse-drawn ambulance made its debut at Bellevue Hospital in New York City in 1869, tucked beneath the driver's seat was a quart of brandy. There were tourniquets, sponges, bandages, splints, blankets and, if you envisioned difficult customers, a straitjacket. The driver cleared traffic ahead with an imperious gong, and a doctor bounced along in back. Removable floor slats served as a stretcher. The first such service in the world was so innovative, it was soon imitated in major cities across the country and throughout Europe.

These vehicles laid a clear milestone in hospital history, but their equipage also testifies to the strict limitations of medicine in the 1870s, an era in which tobacco was used to stave off infection and asepsis was tomorrow's invention.

Bellevue's ambulance was the brainchild of Edward B. Dalton, a staff surgeon whose

administrative skills won him an appointment as Inspector of the Army of the Potomac during the Civil War. Placed in charge of transport and care of the wounded, he created an efficient service for bringing casualties to field hospitals. Returning to Bellevue after the war, he recognized how a relatively lightweight vehicle — the first carriages weighed just 600–800 pounds — could be adapted to the streets of burgeoning New York City.

The first year they operated, Bellevue ambulances answered some 1,401 calls. Two decades later the service brought in nearly 4,400 patients. Equus caballus at Bellevue turned out to be a durable affair. Not until 1924, a generation after the arrival of the automobile, did the last horses retire, turned out to pasture at an upstate farm. John O'Neill, the last driver, watched them go with head bowed.

ABOVE: Typical supplies in the 1869 Bellevue ambulance: tourniquets, sponges, splints, blankets, a quart of brandy, and a straightjacket.

THE CUTTING EDGE

By John Galbraith Simmons

*Heard of Ambulances?
Blood Banks?
Catheterization?
It Happened Here First.*



FIRST HOSPITAL BLOOD BANK

Serving the industrial hub of the nation, Cook County Hospital in Chicago (now The John H. Stroger, Jr. Hospital of Cook County) opened a huge new facility in 1916 and by 1925 was treating some 42,000 patients annually. It was an institution, wrote a contemporary, “where the turn over is rapid and emergencies constantly at hand.” The hospital’s director of therapeutics, Bernard Fantus, a highly respected figure in American medicine, in 1937 created what is generally conceded to be the first hospital-based blood exchange facility in the

United States. The concept was soon copied the world over; and the brutalities of the Second World War would only underscore its vital significance.

Knowledge and technology made the blood bank a much-desired innovation after the key discovery of the ABO blood groups by chemist and physician Karl Landsteiner in 1900. The value of extra blood for surgery was obvious, but collection and especially storage were problems. Discovery of anticoagulants and ways to store blood, at least briefly, enabled

Bernard Fantus (left) created the first hospital-based blood exchange facility in the U.S.

Britain to use “blood depots” in World War I; and by the early 1930s the Soviet Union had developed a system of blood exchange. Although not widely publicized, the Mayo Clinic effectively employed a blood bank in 1935.

But the facility that opened at Cook County Hospital on March 15, 1937, became widely understood as the first hospital blood bank, and Fantus’ article in the *Journal of the American Medical Association* that same year, entitled “The Therapy of the Cook County Hospital,” was highly influential. “No one acquainted with the situation constantly arising in large general hospitals,” wrote LeRoy Sloan MD, in his obituary of Fantus in 1940, “doubts its value.” The model was adopted around the country and throughout the world.

MODERN SURGICAL TREATMENT OF ANEURYSM

To surgeon Rudolph Matas, a creative genius at Charity Hospital in New Orleans, are owed any number of “firsts.” He inaugurated spinal anesthesia, developed the saline drip, and invented a catgut ring for suturing intestines, among many other innovations. But his most famous operation, which became the model for surgical treatment of aneurysm, was a successful and heroic effort to save the life and arm of a plantation worker suffering from a shotgun wound.

When an aneurysm — a localized dilation in a blood vessel — occurs in a peripheral artery, it can be extremely painful and carries the danger of a life-threatening blood clot. In 1888 Manuel Harris, a young black man, presented

at Charity with just such a pulsating, swollen arm. The usual ligation procedure, employed for two hundred years and more, would in his case have led to amputation at best. Determined to avoid that outcome — “He needs two good arms,” Matas is supposed to have declared — the surgeon decided to tie off, open, and reduce the aneurysm while cutting out the offending blood clot. The result was to preserve the artery intact and save the arm and life of the patient. An admiring William Osler called Matas the “Modern Antyllus,” after the ancient Greek surgeon who had treated aneurysms in wounded soldiers with a similar operation.

HEART CATHETERIZATION

As twentieth-century medicine advanced, despite the electrocardiogram and improved understanding of basic cardiovascular physiology, quantifiable chemical details about the way the heart works, in both health and disease, were long in coming. An extraordinary series of experiments by Dickinson Richards and André Cournand in the 1940s, just as heart disease began to spike in industrialized countries, brought unprecedented precision to the diagnosis of heart and circulatory disease.

With a research program that adapted an old tool, the catheter, and a hypermodern instrument, the fluoroscope, Richards and Cournand were able to make unprecedented measurements of blood flow from within the heart itself. Viewing the heart, lungs, and pulmonary circulation as an integrated system, they developed descriptions of hemodynamics that led to a new taxonomy of heart disease.

Work at the pulmonary-coronary laboratory at Bellevue, the first of its kind in the world, overcame shibboleths about invasive procedures and the human heart and opened the way to a wide variety of diagnostic and therapeutic uses for catheterization, including angiography, angioplasty, and stent implantation.

With Werner Forssmann, Cournand and Richards were awarded the Nobel Prize in 1956. In her history of Bellevue Hospital, *No One Was Turned Away*, Sandra Opdycke recounts that, on the morning after returning from Stockholm, Richards led an admiring staff on rounds. At the first bed he approached, the elderly female patient whispered to him for all to hear, "Doctor, darling, could you bring me a bedpan?" The anecdote, emblematic of the head, heart, and heels of the hospital, became part of its lore.



André Cournand (left) and Dickinson Richards won the 1956 Nobel Prize for their pioneering work in heart catheterization.

CHROMOSOMAL TRANSLOCATION IN LEUKEMIA



Cancer is understood today as arising from mishaps on the level of the genome. This focal grasp represents hard-won knowledge, acquired over the course of a half century and more.

A key observation, made about 1960 by Peter C. Nowell and colleague David Hungerford, concerned a genetic anomaly discovered while working with cancer cells in culture. The cells, from patients suffering from chronic myelogenous leukemia (CML), possessed what came to be known as the "Philadelphia chromosome" — a small, misshapen chromosome 22 that soon won recognition as a marker for the disease. Its role in CML, however, remained unknown until Janet Rowley of the University of Chicago Hospitals began researching it in 1970.

Using a just-developed technique known as quinacrine chromosomal banding, a staining technology, Rowley could visualize the unique conformation of each chromosome. This improved level of discrimination enabled her to discover that the "Philadelphia

chromosome" was a recurring abnormality in CML and involved a translocation. In patients with CML, a crucial segment of chromosome 22 broke off and moved to chromosome 9. At the same time, a tiny piece of chromosome 9, which included an important cancer-causing gene, had moved to the breakpoint on chromosome 22. Because of this transfer, important genes that regulated cell growth and division were no longer located in their normal position.

This work turned out to be key both for the larger picture of cancer causation and the biochemical events that result in leukemia. Indeed, one result was a promising and uniquely rational addition to chemotherapy for CML. Gleevec (Imatinib Mesylate) was developed directly from investigation into the expressed product of the fused genes arising from the chromosomal translocation that Rowley discovered in 1971. Since its introduction in 1998, some 90 percent of patients using Gleevec have seen their cancer enter remission.

Janet Rowley's identification of a chromosomal translocation in one type of leukemia has led to new, more effective cancer treatments.



AS REAL THE EVOLUTION OF TRAUMA CARE AND EMERGENCY MEDICINE AS IT GETS

By Barbara Ravage

Born on the battlefield, trauma care came of age during the turbulent 1960s, when the lessons learned in the Korean and Vietnam conflicts were brought back to the United States to treat trauma on the home front. To be sure, there were hospital emergency rooms long before that time, but they would hardly be recognizable compared to today's high-tech emergency departments and Level I trauma centers.

Specialty emergency medicine and trauma care developed in response to the unique dangers and needs of the urban environment, driven by the demand for better care on the part of both providers and patients, and by technological advances ranging from CT scans to remote field telemedicine. Three public hospitals—Los Angeles County+USC, San Francisco General, and Cook County—were on the front lines of developing trauma care.

The Birth of Emergency Medicine

In the late sixties, the emergency room at LAC+USC Medical Center was no different from that in most municipal hospitals in the country, except it was bigger and busier. Patients by the hundreds walked or were carried through its portals every day. From bullet wounds to heart attacks, spinal cord injuries to severe burns, drug overdoses to miscarriages, patients in need of immediate care were tended to by a handful of residents on rotation, with the support of nurses and orderlies. According to Gail V. Anderson, MD, under whose stewardship the LAC+USC Medical Center ER became a world-class emergency department, “Before the advent of emergency medicine as a specialty, emergency rooms were staffed by part-time, itinerant physicians who were essentially moonlighting. Physician groups formed and were practicing emergency medicine on a full-time basis, but no one had been

specifically trained in emergency medicine.”

In 1910, the Flexner report, *Medical Education in the United States and Canada*, spurred the evolution of medicine into a specialty-driven field. But it took the National Research Council’s 1966 report, *Accidental Death and Disability: The Neglected Disease of Modern Society*, to provide the impetus for specialty training of physicians in emergency medicine.

At the time, Anderson was professor of obstetrics and gynecology at the University of Southern California School of Medicine and

CONTINUED ON NEXT PAGE

OPPOSITE: Rancho Los Amigos National Rehabilitation Center.

BETWEEN: Doctors work on injured at General Hospital, Los Angeles, after the series of earthquakes that rocked Southern California, 1933.



Inner-city public hospitals remain the last, best training grounds for trauma surgery.

chief of the obstetrics and gynecology service at LAC+USC Medical Center, its main teaching hospital. In 1971, he was asked to chair a new department of emergency medicine at USC, the first in the nation. In 1976, Anderson helped found the American Board of Emergency Medicine. Emergency medicine was accepted as the twenty-third board-certified medical specialty in 1979 and administered its first certification exams in 1980.

As a pioneer of emergency medical education, Anderson asserts that the training programs in public hospitals offer "the best way of assuring quality emergency care for this large mass of people."

From M.A.S.H. to the Home Front

Every trauma is an emergency, but not every emergency involves trauma. Indeed, trauma is a complex event requiring a team of physicians, nurses, and technicians specially trained to do the right thing at top speed. Much is made of the "golden hour," the window of opportunity for saving the life of a severely injured patient, but in the most severe cases, the trauma team measures its opportunities in minutes.

Modeled after the mobile army surgical hospital (M.A.S.H.) units, the nation's first hospital-based civilian trauma units were established in 1966 at San Francisco General Hospital and Chicago's Cook County hospitals. Both had long served the poorest residents of their cities and had reputations for providing a broad range of quality emergency care. The modern facility at San Francisco General stands on the site of the old Mission Emergency Hospital, built in 1909. In 2002, the sprawling, nearly century-old Cook County Hospital was replaced by The John H. Stroger, Jr. Hospital of Cook County, with a high-tech, self-contained trauma center.

Although these two trauma units served as models in the sixties, it was a decade later that formal guidelines were established for the systematic delivery of trauma care. The 1976 report from the American College of Surgeons Committee on Trauma (ACSCOT), *Optimal Hospital Resources for Care of the Seriously Injured*, specified the requirements for effective trauma systems. Out of that report came the now-familiar trauma center levels, as well as the organization of multidisciplinary trauma teams and the trauma center verification process.

San Francisco General, LA County+USC, and Stroger hospitals are sites of Level I trauma centers. As anchors for large inner-city populations, they see more than their share of trauma cases, and as public hospitals, they are committed to offering the best possible care to all patients, regardless of ability to pay. That commitment is well expressed by Stroger's chief of trauma, Roxanne Roberts, MD, who says, "We're all here because we fell in love with the patients that we take care of and we believe in the mission of the hospital. We're certainly not here for the salaries or the glory." Or as William Schecter, MD, chief of surgery at San Francisco General, put it: "The thing about working in a place like this is that when you go home at the end of the day you at least know that you tried to do the right thing."

EARLY CIVILIAN TRAUMA CARE



The nation's first specialized civilian trauma units were established just four decades ago at San Francisco General and Chicago's Cook County hospitals. But urgent care has been an aspect of hospital services throughout their history. Here, doctors at Central Emergency Hospital in San Francisco provide emergency care in 1935.

The Training Challenge

"Trauma care is undergoing a sea change," says Schecter. Thanks to huge advances in the field, innumerable lives have been saved. Today, the

odds are that a trauma patient who reaches the hospital alive will live to be discharged. Diagnostic technologies such as CT scanners have dramatically reduced the need for exploratory surgery that was previously standard in cases of blunt trauma. Non-invasive techniques to stop bleeding also mean “the number of injured patients that actually need surgery is much lower than it used to be,” Schechter maintains.

But those advances have had unintended consequences in the training of surgeons and other trauma team members. In most hospitals, blunt trauma resulting from car accidents, for example, makes up the majority of cases. It is in the area of blunt trauma that non-surgical techniques have had the greatest utility.

“It’s becoming increasingly difficult to maintain the interest of young surgeons because the number of operations they do is much lower than before,” Schechter observes. Inner-city public hospitals like San Francisco General, however, continue to see a disproportionate number of penetrating traumas, for which surgery is a life-saving necessity. “I happen to work in a hospital where, unfortunately, we still treat numerous shootings and stabbings, so from a surgical point of view, it’s still quite interesting.” Thus, inner-city public hospitals remain the last, best training grounds for trauma surgery. “We have a saying here at San Francisco General Hospital: ‘This is as real as it gets,’” says Schechter.

If military medicine was the driving force behind the development of trauma care, LAC+USC Hospital is among a select group that is returning the favor. Taking advantage of the expertise at this public hospital, the Department of Defense initiated a cooperative program to train medical corps personnel for conditions no one in the military had seen since Vietnam. In a partnership between LAC+USC and the San Diego-based Navy Trauma Training Center, Navy fleet and forward resuscitative surgical teams gain hands-on experience in the LAC+USC Level I trauma center. Jackson Memorial Hospital in Miami, another NAPH member, provides a similar service to the Army at its Ryder Trauma Center, while the Air Force trains at the R. Adams Cowley Shock Trauma Center in Baltimore.

Trauma Care Evolves

The classic picture of the trauma team in a life-and-death race against time is only part of a larger view. Today, trauma care encompasses what happens to patients before they even get to the hospital and long after they leave. Resuscitation often begins in ambulances fitted out with advanced life-saving equipment and highly trained EMTs in constant telecommunication with the hospital-based trauma team. Rehabilitation for disabled trauma patients is also part of the mission.

End-of-life care and support for families are often neglected in a place where sudden and unexpected death is a daily reality, but not at Stroger Hospital in Chicago. In what is a new model for the hospice concept, Stroger was awarded a grant by the Aetna Foundation in 2005 to develop a hospice program for its trauma unit. “As surgeons we’re trained not to give up,” says Kimberly Joseph, MD, director of the Trauma ICU at Stroger. “Perhaps we wait too long before talking about death and asking the patient and their family what they would like.” The Aetna grant, she believes, “will help us identify specific needs of patients and their families during this time and how we can make the dying process easier.”

Increasingly, trauma centers are including prevention in their mandate. Injury and violence prevention programs at LAC+USC, Stroger, and San Francisco General employ public education, community outreach, and counseling in this effort. As Schechter puts it, “What we would ideally like to do is put ourselves out of business.” ■



PHOTOS Page 14: Submitted; Page 15: Corbis; Page 16: San Francisco History Center, San Francisco Public Library; Page 17: Pennsylvania Hospital Historic Collections, Philadelphia



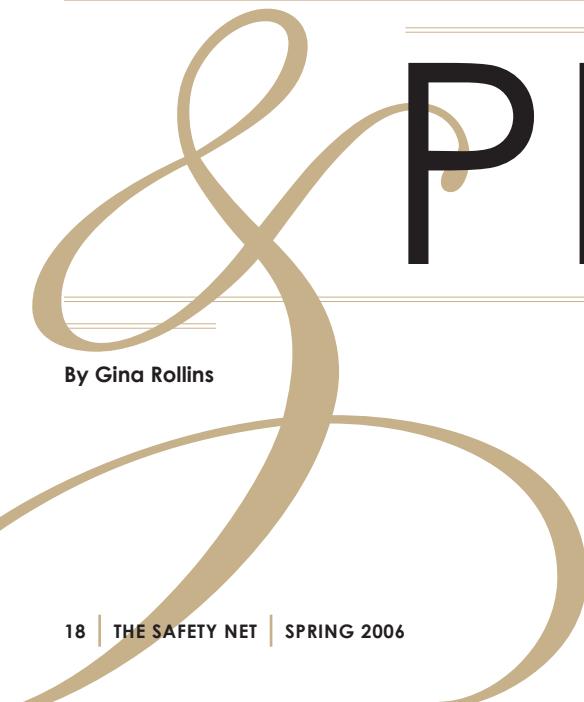
PHYSICIAN TRAINING:

PAST

*Public Hospitals and Medical
Schools Shared Mission of
Graduate Medical Education*

& PRESENT

By Gina Rollins





Public hospitals have been closely linked to the training of new physicians since graduate medical education (GME) formally came into existence in the early twentieth century. In a 1910 report, *Medical Education in the United States and Canada*, Abraham Flexner offered a scathing indictment of the state of medical education. Since then, the medical sciences have marched steadily towards more rigorous, structured GME programs and specialized training. As academic medical centers, public hospitals have led the charge.

During the first 75 years of the twentieth century, GME went from a patchwork of one-year internships — undertaken by perhaps no more than half of medical school graduates — to a formal system of training essential to the practice of medicine. The Council on Medical Education published its first guidelines on approved internships in 1919. By World War II, as hospital demand for interns peaked, there were more positions available than interns to fill them.

As GME moved away from catch-as-catch-can internships, residencies in the wards of public and private hospitals became prized training positions despite the meager com-

pensation. Residents often lived in hospitals and were paid only for room and board. Modest salaries, introduced in the 1950s, were raised in the 1960s after enactment of Medicare and Medicaid, which recognized the cost of indirect medical education.

As medical knowledge rapidly expanded from the 1940s on, specialized training and certification became more and more the norm. Before World War II, more than 84 percent of physicians reported being general practitioners, but by 1965, only 37 percent did.

Over the last 30 years, the pace of change

CONTINUED ON NEXT PAGE

accelerated even more rapidly and touched most every aspect of GME at public hospitals — from the sites and methods of providing care and the structure of the GME experience to the acuity of patients and the financing of GME. Amidst the hurly burly, however, has been one constant: the steadfast commitment of both medical schools and public hospitals to collaborate in providing excellent medical education and patient care. “Public hospitals and medical education have a broad social mission and are philosophically and inherently natural partners. They’re interlinked,” says Bob Dickler, senior vice president for health care affairs at the Association of American Medical Colleges in Washington, DC.

One important trend has been the expansion in accredited programs, specialties, and subspecialties, Dickler notes. “There are many more accredited programs and many more specialties which are accredited than there were 20 or 30 years ago. The expanded magnitude of GME is remarkable.” In the academic year 2004–2005, there were 8,037 accredited programs with 101,810 residents, up from 6,570 programs and 89,000 residents in 1989, according to data from the Accreditation Council

for Graduate Medical Education (ACGME) in Chicago. The ACGME now recognizes 26 specialties and 84 subspecialties, many of which didn’t exist in 1981, including sleep medicine, sports medicine, endovascular surgical neuro-radiology, and neuromuscular medicine.

The creation of ACGME itself in 1981 was another milestone in medical education, according to Dickler. “The rigor of GME changed substantially when the ACGME was established. When it began refining program requirements and collecting outcomes, GME matured,” he explains.

A New Care Environment

Over the past three decades, technological advances and new payment methodologies have fueled an emphasis on ambulatory care, on high-tech, less invasive interventions, and on shorter hospital stays with sicker patients, all of which impacted both GME and public hospitals.

“Technology is essential to providing an adequate teaching experience and fulfilling our public mission,” says Paul Roth, MD, executive vice president of health sciences at the University of New Mexico and Dean of the University’s School of Medicine. “In recent years we’ve seen a rise in uncompensated care brought about by cutbacks in federal programs and limited state ability to make up the difference, but UNM has done its best to acquire state of the art equipment even while federal and state resources are declining.”

In step with the movement toward ambulatory care, through the 1990s and early 2000s in particular, public hospitals established vast networks of ambulatory care centers and outpatient services, which provided residents and fellows ample learning experiences in those settings. However, the winds of change were even stronger in the inpatient environment, where patient acuity rose and treatment grew ever more complicated. “Twenty-five years ago the house staff worked many longer hours but the intensity of work was less and the complexity of the care environment was a lot less,” explains Scott Barnhart, MD, medical director of Harborview Medical Center in Seattle and associate dean for clinical affairs at the Uni-

BELLOW: Bellevue Hospital interns, 1877.

OPPOSITE: Student nurses at the University of Rochester School of Nursing attend to a “patient” in the practice room of their dormitory, 1928.



versity of Washington School of Medicine. "Now the trainees often coordinate care with multiple services; they have to integrate information from more diagnostic tests, and the range of therapeutic options is much broader."

Financial Challenges

In 2003, in response to overall heavier work loads, the ACGME issued new resident duty hour standards. These requirements, which affected all ACGME-accredited specialties and subspecialties, established an 80-hour weekly work limit (averaged over four weeks); set a 24-hour limit on continuous duty; and required one day in seven free from all educational and patient care obligations (also averaged over four weeks).

This adjustment emphasized the educational experience of house staff over their role as care managers, but it exacerbated the already strained financial circumstances of many public hospitals. The *Balanced Budget Act* of 1997, which capped the Medicare reimbursement formula for indirect medical education payments at 1996 levels, "made it very difficult for hospitals like Harborview that needed to increase the number of residents [in response to the new duty hour standards]. It put a lot of pressure on the hospital, and we had to finance that growth directly out of operations," says Barnhart. "There's no teaching hospital in the country that hasn't undergone stress around the 80-hour work week."

Financial pressures and the need to operate more efficiently led many public hospitals to change governance structures in the 1980s and 1990s. By 2003, 60 percent of NAPH members were organized either as separate public entities or non-profit corporations. Only 40 percent were operated directly by state or local governments. The new governance "permitted those institutions to run in more business-like ways, to be more responsive to their customer base and in many cases more dependent on private patients. This led to the belief by traditional public hospital funders that they could decrease support [for the public hospital]," says Dickler. "As a result, a number of public hospitals evolved into very different institutions, and how they approach



medical education changed. That's neither good nor bad; just reality."

The changed governance and financial circumstances accelerated efforts begun with the advent of diagnostic related groups (DRGs) in 1983 to hasten patient throughput and boost the quality of care while streamlining the use of resources. This led to greater use of evidence-based medicine in GME, in guiding patient care, and in making investments in technology, according to Barnhart.

As medical schools and public hospitals contemplate the next quarter century, both face numerous challenges but remain united by a shared mission to educate succeeding generations of physicians. "When I came here 25 years ago, we loved Harborview, and people working and training here today love it," observes Barnhart. "Our goal is to make the best training and care environment possible." ■

CONTACTS FOR THIS ARTICLE

Scott Barnhart, MD

Medical Director
Harborview Medical Center
Associate Dean for Clinical Affairs
University of Washington School of Medicine
206-731-3134
sbht@u.washington.edu

Bob Dickler

Senior Vice President for Health Care Affairs
Association of American Medical Colleges
Washington, DC
202-828-0490
rdickler@aamc.org

Paul Roth, MD

Executive Vice President of Health Sciences
UNM Health Sciences Center
Dean
University of New Mexico
School of Medicine in Albuquerque
505-272-2321
proth@salud.unm.edu

PHOTOS Page 18: Rush University Medical Center Archives; Page 19: Stockbyte; Page 20: The Alan Mason Chesney Medical Archives of The Johns Hopkins Medical Institutions; Page 21: Edward G. Miner Library, University of Rochester

Cleveland General Hospital
Ohio, 1884



A • PLACE OF • CARE

HISTORIC IMAGES OF THE SAFETY NET

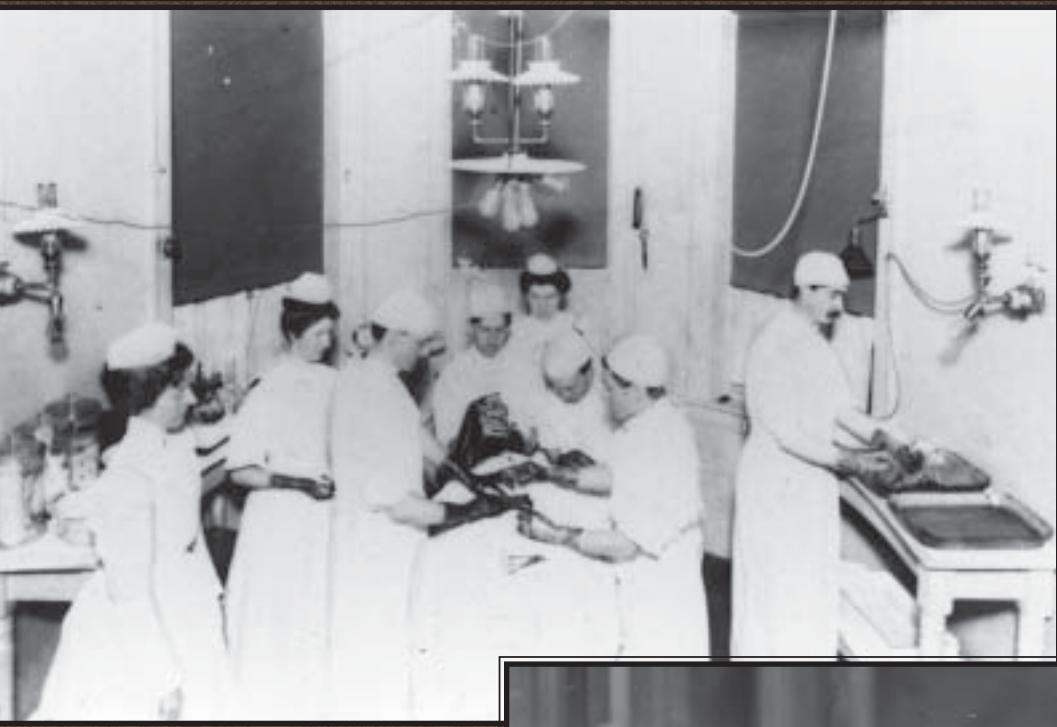
Any search for historic images of public hospitals will produce a parade of brick and mortar shots: buildings framed in the long-ago photographer's lens, their staid, faded facades staring out sepia-toned or black and white. The sheer number of these shots belies a fascination with space, with structure. Elevating edifice to a symbol of the acts and events that took place inside, these images declare, "This is where care takes place."

When TSN set out to illustrate the history of public hospitals, we chose a different tack. Among the many

building shots, we found some rare photos of the people who, throughout time, have come to public hospitals seeking care and rarer still, images of those who provided it. Peeking into the lives of these individuals, we see, for good and for bad, the conditions of health care in their time. TSN presents their images as a means of celebrating the individuals who have supported and served public hospitals for two centuries and more. Looking into the faces of these patients and providers, we declare, "This is where care takes place."



Parkland Hospital, Dallas, 1900. Hospital staff with the city's first ambulance and driver. The horse was purchased two years after the ambulance.



ABOVE
Surgical team
Grady Hospital, Atlanta
ca. late 19th century

RIGHT
Santa Claus visits
Cook County Hospital
Chicago, 1909





TOP
Negro Men's Ward
Charity Hospital, New Orleans, 1911
Patients lie two to a bed; the seated men
are not visitors but additional patients,
waiting for their turn to lie down.



BOTTOM
Nurse and patient
Middlesex Hospital, Connecticut, 1936

Children's therapy at City Hospital
Indianapolis, early 1940s





TOP

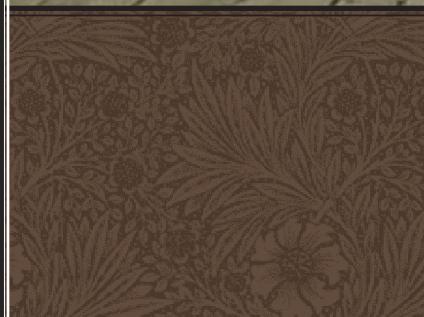
Student nurses take a break from their work to relax on the deck of the City Hospital Training School Welfare Island, New York, ca. 1910

RIGHT

Helen E. Nash, MD, (left) and members of house staff Homer G. Phillips Hospital, St. Louis, 1943

BETWEEN

Student nurses of the Pennsylvania Hospital School of Nursing enjoy "Hospital Day" festivities Philadelphia, 1970



PHOTOS Page 22: Cleveland Public Library Photographic Collection; Page 23: Parkland Hospital Archives; Page 24: (top) Submitted; (bottom) Chicago Historical Society; Page 25: (top) Submitted; (middle) Thomas J. Dodd Collection; (bottom) IUPUI Special Collections and Archives; Page 26: (top) NYC Municipal Archives; (middle) Library of Congress, Prints & Photographs Division; (bottom) Pennsylvania Hospital Historic Collections, Philadelphia

Called to Care

CDC DIRECTOR JULIE GERBERDING GOT HER START IN PUBLIC HOSPITALS

By Brian Vastag

In January 1985, a young Julie Gerberding, now the director of the Centers for Disease Control and Prevention and then a resident at San Francisco General Hospital, co-authored a first-of-its-kind case report in the *New England Journal of Medicine*. The brief publication, her first, detailed a needlestick that had caused a furor at the hospital. A physician had been poked with a needle from a patient who had hepatitis B and HIV.

"In the beginning, we didn't know it was an infectious disease and we weren't very careful. We were cavalier about our own exposure and risk," says Gerberding. But after learning HIV was a bloodborne virus, health care workers "suddenly had a lot of personal fear and anxiety." That anxiety ran high until the physician tested negative for HIV — but positive for hepatitis.

"That paper was very important," said Richard Chaisson, director of the Center for Tuberculosis Research at Johns Hopkins School of Public Health, who was an intern under resident Gerberding at San Francisco General. "It showed that HIV was less infectious than hepatitis B, and it kind of calmed down a lot of the anxiety among health care workers."

The article also launched Gerberding's public health career, which she says was "very clearly" forged from her experiences at a large public hospital — particularly San Francisco General which, in the early 1980s, sat at the epicenter of an emerging and deadly infectious disease. Gerberding arrived there fresh from medical school in 1981, just as the first AIDS patients appeared. Unable to provide treatment, physicians spent much of their time comforting patients as they succumbed to the disease. "We coped with the tremendous sadness that AIDS brought to the hospital by... finding new ways of diagnosing and describing and treating the problem," says Gerberding. "Everyone

really pitched in, and we did everything we could ... at a time when there weren't drugs" for HIV/AIDS.

Gerberding had finished medical school at Case Western Reserve University with a vague notion of specializing in endocrinology or nephrology. But "those sad days of seeing patient after patient with a preventable fatal disease come into our hospital really created the strong commitment I have to preventive medicine."

That commitment led Gerberding to study occupational exposure to HIV and other infectious diseases. "She selected that as a niche early on," said Chaisson. "She did a lot of the first work in health care worker exposure to HIV."

While earning an MPH at the University of California-Berkeley in the late 1980s, Gerberding expanded her purview to include all of hospital epidemiology, which brought her to the CDC in 1998 as director of the division of health care quality promotion. She was named acting deputy director of the National Center for Infectious Diseases in 2001, where she helped lead the agency's response to the anthrax letter attacks. Suitably impressed, then-director of Health and Human Services Tommy Thompson promptly appointed her CDC director.

Throughout it all, Gerberding has tried to keep a physician's perspective — patients come



first. In 2004, she returned to San Francisco General and spent two weeks as an attending physician, something she would like to do more frequently than her CDC duties allow. "I go back because [patient care] is my first love — I really miss the bedside. And it really invigorates me and motivates me to do even more at CDC. It reminds me that patients are not just statistics. They are individuals who, for whatever reason, are experiencing the complications of things that could be prevented if we had a better system."

That idea was reinforced when Gerberding tabulated the diagnoses of every patient she saw during those two weeks. "About 80 percent of them had problems that we have programs to prevent at CDC," she says. "I don't experience it as a failure of the CDC in any way, but it is a reminder of the continuum between population health and the diseases we see at the public hospitals. It's easy for me to go between the two worlds because the problems are the same."

As for the future of public hospitals, Gerberding is forthright. "I'm worried about our public hospital system. They are such a critical component of our overall system. Our public hospitals have always had open doors and will welcome any patient, anytime, regardless of their ability to pay or their life circumstances. That's a national treasure." □

How Public Hospitals Set the Bar for Early AIDS Care

By Alexandra Greeley

When the devastating illness known as Acquired Immune Deficiency Syndrome (AIDS) became generally recognized in the United States in the early 1980s, scientists and health care professionals had no idea what caused the disease nor how to treat it. But it quickly became evident that they were seeing the onset of an overwhelming epidemic that would require a dramatic shift in traditional patient care.

Many public hospitals nationwide were in the forefront of responding to the epidemic, says Mervyn Silverman, MD, former public health director of San Francisco and former President of the American Foundation for AIDS Research (AmFAR). Among the first of these was San Francisco General Hospital, reacting to a health crisis that left the city and its gay community reeling: 99 percent of the infected were gay, middle-class men.

San Francisco General's model of compassionate care became extensively followed worldwide. "We took the time to work with the community; our work was academically

based, and we provided a comprehensive program for patients," explains Paul Volberding, MD, professor and vice-chairman of the department of medicine, UCSF, co-director of UCSF-GIVI Center for AIDS Research, and formerly director of the AIDS clinic at San Francisco General.

In addition, San Francisco General Hospital was among the earliest places that used experimental treatments to improve patient outcomes, says Volberding: "This was also the first hospital in the world that had a dedicated

AIDS clinic, which opened in 1983, and the first to have a dedicated inpatient unit." Because of its outstanding levels of care, people who could have gone to private hospitals chose San Francisco General instead, according to Silverman.

AIDS was a different epidemic in different parts of the country, and in New York City, it became a mosaic of affected populations, reports Gerald Friedland, MD, director of the AIDS program at Yale School of Medicine, Yale-New Haven Hospital in Connecticut. At the onset of the epidemic, Friedland worked at North Central Bronx Hospital in New York City. Because of its different geographic neighborhoods, New York represented a complex cross-section of people, from the middle-class gay white men who lived in Greenwich Village to the mainly working-class and poor population in the Bronx and Brooklyn where the majority of AIDS patients were injection drug users and their heterosexual partners, he says.

Like his colleagues in San Francisco, Friedland and associates drew up plans for an HIV program based on the principles of comprehensive care, continuity of care, compassion, competence, and cost effectiveness but with elements necessary to address the challenging needs of this marginalized population. That meant not only developing outpatient clinics, support groups, and provisions for death and dying, but also accessing and providing mental health and substance abuse services and finding ways to involve family members, who often included spouses, parents, and children.

In Miami, public hospitals were faced

"Our hospital contributed to HIV care . . . and the people who took on the care took it on as a mission, a passion."

DEMIC RAGING

with a different challenge, says Arthur Fournier, MD, associate dean for community health, University of Miami Miller School of Medicine. "The first HIV patient with what we now call AIDS walked into my life in 1979," he says. By 1980, it was clear that AIDS was having a major impact in Miami, particularly among the poor in the Haitian community. "Because the epidemic in Miami singled out the poor, they came to our public hospital for care," he says. "Ironically, if they had gone into a community hospital, there would not have been enough academic and research resources to provide compassionate, comprehensive care to the earliest victims, to figure out the various opportunistic infections and learn about the epidemic."

Because Miami's Jackson Memorial Hospital is a teaching hospital, the house staff is on call around the clock, providing the comprehensive care needed. When a patient succumbed to AIDS, they could request an immediate autopsy. "It was only when the pathologists started doing autopsies that they realized patients had overwhelming pneumocystis pneumonia and toxoplasmosis," he says. "The pathologists played a major role in understanding the disease."

"Now, thanks to the Comprehensive AIDS Program, some of the major research is done here," says Fournier. "We had the first clinical trials of AZT. The first women with HIV were identified here. The first children with HIV were diagnosed here."

When the HIV/AIDS epidemic first began, patients in Chicago were treated at Cook County hospital, and AIDS patients were representative of the hospital's overall patient population — namely minorities and the working poor, explains Mardge Cohen, MD, director of HIV research at the Ruth M. Rothstein CORE Center, an affiliate of the Cook County Bureau of Health Services. "The county was providing an enormous amount of care for people with no health insurance, and for people who might have had the insurance but who were undesirable at the very few private settings where HIV was being addressed," she says. "Our hospital contributed to HIV care in Chicago, and the people who took on the care took it on as a mission, a passion."

Because the numbers of infected seeking care continually increased, by 1983 Cook County expanded its HIV program, and opened its own AIDS clinic, the Sable-Sheer

clinic. At that time few women were diagnosed with HIV, but the women — who may have been intravenous drug users or partners of users — were vocal in asking for care; they had nowhere else to go.

Consequently, the hospital initiated a successful program for women and children. "Our program was unique," says Cohen. "It was a family-centered comprehensive model; we thought of women and children as a unit.... We were able to get funding to provide a specialized setting for women and children, and that helped to keep money coming in for other programs. So we got many ancillary services, too, including mental health providers, pastoral care, case managers, and volunteers. We became a model for other hospitals in the city and nationwide."

And like the AIDS care programs at other public hospitals, the Cook County effort continues to make an impact today. Since 2000, there have been no mother-to-child transmissions of HIV for women in care at the CORE Center. ♦



By Gina Rollins



CAREER HIGHLIGHTS

- 2004–Present NAPH Executive Committee Member**
- 2002–Present President, University of Texas Health Center at Tyler**
- 2000–2002 Senior VP and Medical Director, Parkland Memorial Hospital**
- 1997–2000 Corporate Medical Director, UTMB HealthCare Systems**
- 1996–1997 Chief Medical Officer and Senior Medical Director for UT-MED, University of Texas Medical Branch, Galveston**
- 1993–1996 Director, Internal Medicine Clinics, Vice Chair for Outpatient Affairs, Associate Professor of Medicine, UT Medical Branch, Galveston**
- 1988–1993 Chief, Division of Nephrology, Truman Medical Centers**
- 1987–1992 Director of Nephrology and Dialysis, Menorah Medical Center**

Kirk Calhoun, MD

Kirk Calhoun, MD, president of the University of Texas Health Center at Tyler, has had a storied career as a nephrologist and as an administrator of safety net institutions, from Truman Medical Centers in Kansas City, to the University of Texas Medical Branch in Galveston and Parkland Hospital in Dallas. But Calhoun's life in medicine might never have happened had he not been desperately ill himself. Growing up on Chicago's South Side, Calhoun's life closed around him at age 13. What started as a cough and some wheezing progressed to a mysterious respiratory ailment that confined him to bed for four months. His parents, Aquilla and Charlotte Calhoun, were frightened and frustrated. The neighborhood general practitioner didn't seem to understand the illness.

Fortunately, residents of the South Side's close-knit African American community told Mrs. Calhoun about a doctor who helped children with breathing problems. She made a beeline for the office of Charles Jenkins, MD, where Calhoun's health would be restored and the great possibilities of life introduced to him. "Dr. Jenkins was the first African American doctor I ever saw," recalls Calhoun. "He ran his office like the captain of a ship, and I later realized he was a brilliant allergist." Within a few minutes of examining Calhoun, Jenkins knew the diagnosis: asthma. Jenkins looked over at Mrs. Calhoun and said, "We can fix this." That first visit cost \$7—Calhoun vividly remembers his mother taking the bills from her purse and handing them to Dr. Jenkins—an investment repaid many times over.

"Out of that experience I decided I wanted to be like Dr. Jenkins. My whole life was directed toward that goal," says Calhoun. He was a patient of Dr. Jenkins until he graduated from

high school. By then, the asthma had lost its grip and freed Calhoun to realize his dreams. Calhoun periodically talked with Dr. Jenkins as he progressed through college and medical school, but inspiration came less from the doctor's words than from his existence. "I just admired the man. That's why mentors are so important, especially for minorities. Sometimes it's just enough to know that if someone achieved something, you can do it too," explains Calhoun.

Calhoun entertained the notion of following in Jenkins' footsteps to the extent of taking over his practice, but he discovered nephrology and ultimately took another path. Still, Jenkins wasn't far from Calhoun's thoughts. "He was a remarkable man, a good old country doctor with advanced training," Calhoun recalls. "He ran his practice the way he wanted and provided good care to his patients, who all loved him."

To be sure, Calhoun had plenty of other support in his life. His father worked two jobs for 23 years to put two sons through parochial school and college. An army veteran and Bronze Star recipient during World War II, he'd had doors of opportunity in civilian life slammed in his face due to racism, so he encouraged his sons to achieve all they could. Mrs. Calhoun was a Democratic Party organizer and eventually a supervisor in Chicago Traffic Court. Their work ethic, love, and guidance gave Calhoun and his brother the courage to pursue their aspirations. But it was Dr. Jenkins who gave Calhoun the first glimpse of his future. ♦



Bellevue Hospital Center

By Gina Rollins

One of the oldest public hospitals in the United States, Bellevue Hospital Center holds a storied place in the annals of American medical history. It was established in 1736 as an almshouse infirmary with six beds on the site of New York City's present-day City Hall. Bellevue later took its name from Belle Vue farm, an estate north of the city where it was moved in 1794. Over the succeeding two centuries it established a niche caring for the physical and mental health needs of New Yorkers through a sophisticated network of inpatient, outpatient, and emergency facilities. It also expanded tremendously: the modern Bellevue is a sprawling complex of buildings its founders could never have imagined.

Bellevue became part of the New York City Health and Hospitals Corporation (HHC) when the corporation was created in 1970, and is a member of the South Manhattan Healthcare Network, which includes two other HHC facilities, Gouverneur Healthcare Services and Coler-Goldwater Specialty Hospital and Nursing Facility, as well as other community-based health clinics. Bellevue is the primary teaching hospital for the New York University School of Medicine, a relationship that dates to 1847. It is the only hospital in New York City with concurrent designations as a Level 1 Trauma Center, Heart Station, Microsurgical and Replantation Center, and Regional Center for Head and Spinal Cord Injury. Since 1964 Bellevue has been the designated hospital for visiting U.S. presidents, diplomats, dignitaries, and injured police and firefighters.

Bellevue's comprehensive mental and behavioral health services also have a distinguished reputation. Nearly 50 percent of its beds are

devoted to psychiatric care, including an adolescent day hospital that provides services to teenagers with problems too severe to be treated in community programs. Among many innovative mental health programs, one of the oldest is a school for emotionally disturbed youth which Bellevue opened in 1935 in cooperation with the New York City Board of Education.

In February 2005, Bellevue stepped boldly into the twenty-first century with the opening of its new Ambulatory Care Pavilion, the first new building on campus since construction of a hospital tower in 1973. The \$115 million building, designed by renowned architecture firm Pei Cobb Freed and Partners, symbolically links Bellevue's past and future through a 90-foot-high glass atrium connecting to Bellevue's historic Administration Building. The 210,000 square foot facility serves as the main entrance for the hospital complex and contains more than 400 exam rooms, wired with state-of-the-art medical information systems. The hospital's modernization project also included renovation and consolidation of most of Bellevue's intensive care units to one 1.5-acre floor in the main hospital tower. The Ambulatory Care Pavilion is also home to the new Bellevue Hospital Cancer Center.

In concert with the new construction, Bellevue is piloting several HHC patient-centered redesign initiatives to improve service and better manage chronic disease populations in New York City. Through these efforts Bellevue is embracing the future, celebrating its own rich traditions, and remaining true to the HHC mission: providing highest quality care to all New Yorkers, regardless of ability to pay, in an atmosphere of humane care, dignity, and respect. ■



FACTS AT A GLANCE

| | |
|---|---------------|
| Location | New York City |
| Founded | 1736 |
| Employees | 4,400 |
| Licensed Beds | 912 |
| Average Daily Census | 705 |
| Discharges | 27,762 |
| Outpatient Visits, Non-Emergency | 487,253 |
| Emergency Visits | 89,794 |
| Births | 2,024 |
| Gross Revenue | \$799,437,659 |
| Net Revenue | \$453,865,270 |



By David Tilley, Kate Leeson,
Charles Luband

A Brief History of Medicaid DSH

The hospital reimbursement system in America is sustained by Medicare, Medicaid, private health insurance coverage for those who can afford it, and subsidies — including Medicaid supplemental payments — to hospitals that care for those who cannot. A major source of such subsidies is the Medicaid Disproportionate Share Hospital (DSH) program, which in 2003, financed 23 percent of unreimbursed care. Today, as policymakers look to curb supplemental payments, it is worthwhile to revisit the history of this program and how efforts by advocacy organizations such as NAPH have helped sustain DSH payments over the past quarter century.

Prior to 1981, Medicaid paid hospitals based on “reasonable costs.” However, the *Omnibus Budget Reconciliation Act* (OBRA) of 1981 severed the link between Medicaid rates and reasonable costs. Congress worried that moving away from cost-based reimbursement could harm hospitals that serve Medicaid patients and patients without insurance, so OBRA required states to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs....” These provisions became known as DSH provisions.

Initially, the Reagan Administration refused to provide guidance to states on how to implement Medicaid DSH. In 1983, NAPH (together with AHA and other national organizations) joined forces with a small California public hospital, the Redbud Community Hospital District, which had sued the U.S. Department of Health and Human Services (DHHS) over this refusal. A federal district court ordered DHHS to provide DSH payments to Redbud and also ordered the Secretary to issue nation-

wide DSH regulations. The case made its way to the Supreme Court, where Justice William Rehnquist overturned the nationwide directive but upheld the order to provide payments to Redbud.

While NAPH and other hospital groups pursued judicial resolution, Congressman Pete Stark, then chair of the House Ways and Means health subcommittee, promised to pursue a legislative solution — essentially proposing a race to the finish line.

Legislation required the Health Care Financing Administration (HCFA — now the Centers for Medicare and Medicaid Services) to produce a study on state DSH programs, which was released in January 1987. Also during this time, HCFA granted states the flexibility to use taxes and donations from hospitals as the non-federal share of DSH payments.

In 1987, in reaction to the HCFA study and urging by NAPH, Congress established a federal minimum definition of DSH hospitals and required states to make payments to these hospitals. It also permitted states to designate additional DSH hospitals.

A third payment option was established in 1990 when Congress enhanced state flexibility with regard to DSH program design. This flexibility allowed states to pay different categories of hospitals different amounts but, fueled by some admitted abuse by states, it dramatically increased DSH spending. In 1989, total DSH expenditures were \$569 million. By 1992, spending increased to \$17.4 billion.

Reacting to this increase in expenditures, Congress passed the *Medicaid Voluntary*

Contribution and Provider-Specific Tax Amendments Act in 1991, which limited financing for the non-federal share (while protecting inter-governmental transfers and certifications of public expenditures) and imposed a national aggregate limit on DSH spending of 12 percent of total Medicaid spending. Each state DSH program was also limited to no more than 12 percent of its total Medicaid spending.

By 1993, Congress took further steps to rein in DSH spending and imposed hospital-specific DSH caps to prevent excessive DSH payments. This legislation also specified that states could designate hospitals as DSH hospitals only if they had a Medicaid utilization rate of at least 1 percent.

The *Balanced Budget Act of 1997* (BBA) took further steps to curb state DSH spending, specifying new and declining state DSH allotments for fiscal years 1998–2002. These allotments reduced Medicaid DSH payments by 8.6 percent and cut 37.7 percent from Congressional Budget Office projections for 2002 spending.

Thanks to congressional champions who foresaw the impact of these cuts on state health care infrastructures, and to advocacy by NAPH and other national hospital groups, Congress passed the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA). This legislation eliminated DSH cuts imposed by the BBA for 2001 and 2002 and instead allowed an increase based on the consumer price index.

However, BIPA did not prevent the full BBA cuts from being implemented in 2003, causing what was commonly referred to as the “DSH

cliff.” When the full BBA cuts were imposed in FY 2003, they represented a reduction in state DSH allotments of 11.6 percent. In addition, BIPA created a new allotment floor of 1 percent of total Medicaid expenditures for extremely low DSH states (those with DSH expenditures less than 1 percent of total Medicaid expenditures).

Advocacy organizations like NAPH once again worked with congressional champions to include substantial relief in the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). The MMA provided a 16 percent bump in DSH allotments to prevent states from experiencing the “DSH cliff.” With the exception of low DSH states (defined as states with DSH expenditures less than 3 percent of total Medicaid expenditures), DSH allotments remain fixed at the new level until allotments under prior law exceed the new fixed level, at which point allotments will increase by the consumer price index. For low DSH states, allotments increase annually by 16 percent for five years.

The legislative history of the Medicaid DSH program is one of tremendous state discretion, abuse of that discretion as some states used the program in ways Congress never intended, and federal efforts to curb state abuses. Today, the Medicaid DSH program continues to play a critical role in financing care to low-income populations—particularly care to the uninsured and underinsured. ■

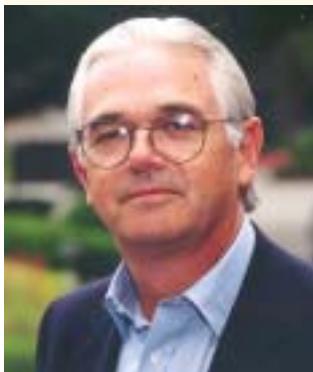
Today, as policymakers look to curb supplemental payments, it is worthwhile to revisit the history of DSH.



Larry S. Gage

President, NAPH

By Gina Rollins



Ask Larry Gage about his involvement in the formation of NAPH, and he will flippantly say it was due to “the prospect of unemployment.” But there is much more to it than that. The roots of NAPH go back to the creation of Medicare and Medicaid in the mid-1960s. “The thought was those programs would make it unnecessary for cities and counties to operate public hospitals. The idea persisted in the hospital industry and on Capitol Hill,” he recalls. Certain public hospital leaders started talking about setting up an association at that time.

Flip forward to 1973. Fresh out of Columbia University Law School, Larry served as staff counsel to the Senate Labor and Human Resources Committee for four years. During the last two years of the Carter Administration, he was deputy assistant secretary for health legislation in the Department of Health and Human Services. Charged with leading an HHS hospital cost containment initiative, he got to know and understand the public hospital community. The initiative was aimed at curbing the hyperinflation that set in after Nixon-era price controls were lifted. “Massive lobbying forces were at play, and I was told the hospital industry was unanimously opposed to it,” he recalls. “But it occurred to me that the hospital industry couldn’t be universally opposed because cities and counties were for it, and they owned and operated hospitals.” Sent around the country to whip up support for the bill, Larry sought out public hospital executives so their voices would be heard at the sometimes raucous meetings. In the end, his efforts were for naught. The bill passed the Senate but not the House, and the hospital industry agreed to voluntary cost control initiatives. The experience left a bitter taste for public hospital leaders, who

felt existing associations were not attentive to their needs.

By this time, Larry realized he was about to be out of a job. “There was every indication that Carter would not win the election, but I had no inkling the Senate would go Republican in the Reagan landslide and there would be several hundred people on the market at the same time as I,” he says. In the waning days of the administration, Larry asked Rep. Charles Rangel (D-NY) to host a meeting of public hospital leaders to explore the formation of a separate association. After the meeting—attended by executives from six organizations—Larry began the process of establishing NAPH. Within a matter of weeks the new association had a name, articles of incorporation, five members, and a business plan written by Betsy Carrier—then a health care manager married to one of Larry’s law school classmates, now a vice president at NAPH.

For the first few years, NAPH was a shoestring operation, with just Larry and his administrative assistant. Over time, as new members came on board, the staff grew gradually. By 1990, the growing association needed more management and hired Christine Capito Burch.

Larry views Disproportionate Share Hospital legislation and other financing initiatives, which brought both operating and capital funds to public hospitals, as the greatest legacies of the past 25 years. “Almost every year of the ’80s we were able to advance our core issues through legislative victories,” he notes. “We got a critical mass of members relatively quickly, and it was clear this was an organization with staying power.” ■

EXTRaL SVTPDAn

100 Years of Caring

This year, JPS Health Network of Fort Worth, Texas, marks its centennial celebration, commemorating 100 years of caring for its community.

In 1906, a hospital affiliated with the Fort Worth Medical College was opened “free to all accident cases and any other cases which the authorities will accept,” and the foundation for JPS Health Network was laid. Seven years later, county commissioners agreed to match city funds for the operation of a “city and county hospital,” which soon opened with 25 beds.

By 1938, the downtown location could no longer meet the demands of the region, and construction of a new hospital, on land originally donated by former Fort Worth Mayor John Peter Smith in 1877, began. The 166-bed City-County Hospital served as the main trauma center for Tarrant County and tackled many community health challenges, including the polio epidemic.

In 1954, the name of the hospital was officially changed to John Peter Smith Hospital, and in 1959 the Tarrant County Hospital District was created to give the organization a sound financial footing.

The 1970s and '80s saw tremendous expansion as John Peter Smith Hospital continued to grow. By the 1990s, the need for expansion into the community was apparent, and health centers were established across the county.

Today, JPS Health Network continues to serve the needs of families in Tarrant County, working to improve health status and access to health care. The main campus facilities



The JPS Hospital in 1930 (above) and today (left). New construction at JPS Health Network honors its 100-year history while ushering it into a new era of care.

have grown to a 429-bed hospital along with a freestanding outpatient care center and a dedicated facility for psychiatric services. In addition, a new 108-bed patient tower is currently under construction across the street from John Peter Smith Hospital, and a new 30-bed hospital in Arlington, Texas, will take JPS Health Network into a new era of care. ■



Accomplishments and Accolades for NAPH Members

Five NAPH members made the *Modern Healthcare* Top 25 Minority Executives list. **Alan Aviles**, president of New York City Health and Hospitals Corporation; **John Bluford**, NAPH Executive Committee secretary, president/CEO of Truman Medical Centers in Kansas City, MO; **Vincent Lee**, Oahu Regional CEO of Hawaii Health Systems Corporation; **David Lopez**, president/CEO of Harris County Hospital District in Houston, TX; and **Rodney Miller**, CEO of Schneider Regional Medical Center in St. Thomas, Virgin Islands, were all recognized for their exceptional leadership.



Mary Holt Ashley, PhD, RN, CNA, BC, chief nurse executive of the Harris County Hospital District (HCHD), has been named 2005 Best Nurse Leader by *Advance for Nurses*

magazine. The award honors an individual who demonstrates exceptional personal and professional leadership abilities in nursing.

The **Boston Medical Center Breast Health Services** program received the 14th-annual Monroe E. Trout Premier Cares Award for helping breast cancer patients in the hospital's multicultural community access care more effectively and efficiently.

John W. Bluford, president and CEO of Truman Medical Centers, was installed as the 2006 chair of the Missouri Hospital Association Board of Trustees at the 83rd Annual MHA Convention and Trade Show, held in Osage Beach, Missouri. Bluford's one-year term as chair began January 1.



Cambridge Health Alliance announced two appointments this spring: **Randy Ellen Wertheimer, MD**, is the new chief of family medicine at the Alliance. Wertheimer is a recognized leader in the field of family medicine. She joins the Alliance from the University of Massachusetts School of Medicine and University of Massachusetts Memorial Health Care, where she was vice chair and associate professor of family medicine and community health. In addition,

Thomas Smith, RN, accepted a position as senior vice president of patient care services and chief nursing officer. Smith previously worked at Massachusetts General Hospital as chief of intensive care and pediatric nursing services and at Boston City Hospital as director of nursing and chief nurse executive.



Two NAPH members — **Denver Health** and **University of Chicago Hospitals** — were named among the 100 Top Hospitals for 2005, according to Solucient, a health care information and research company based in Evanston, Illinois. Each year, Solucient determines the nation's top 100 hospitals based on performance in four categories — quality, finances, operations, and growth.

The **Harris County Hospital District** (HCHD) was granted the 2005 Texas Healthcare Quality Improvement Award of Excellence by the TMF Health Quality Institute. HCHD is one of 25 Texas hospitals to receive the award that recognizes excellence in the quality of care provided through improved performance on national quality measures.

Melissa Stafford Jones has been named president and CEO of the California Association of Public Hospitals (CAPH). She takes the helm from Denise "Denny" Martin, who led CAPH for the past 13 years.

Lauren McDonald, MD, chair of the Parkland Health & Hospital System Board of Managers, has been named one of five recipients of the Women of Spirit Award by the American Jewish Congress. The Women of Spirit Award is presented to women who have made a positive impact on their community and whose efforts have contributed greatly to improving the quality of life for those they serve.



The MetroHealth System appointed **Barbara B. McBee** to the new position of vice president for support services, where she is responsible for the operations

in a wide variety of departments including clinical engineering, environmental services, logistics, environmental safety, facilities maintenance, food service operations, textile care, and the MetroHealth Police Department.

NAPH is pleased to announce three changes to our staff: in October 2005, **Linda Cummings, PhD**, was promoted to vice president of research and director for NPHHI. Cummings joined NAPH as director of research in December 2002. She has held a variety of positions in state government and in the private sector and has a strong background in public policy research, education, and program development. **Sari Siegel** joined NAPH in April as our new assistant vice president for research. She worked for four years at the Agency for Healthcare Research and Quality, conducting research and writing on Medicaid, health disparities, quality improvement, and minority health. **Nicola Turner** joined NAPH as a staff accountant. Turner brings more than a decade of accounting experience to her post. Previously, she worked as Accounts Payable Lead Associate at United Way of America.



Bob Sillen has accepted an opportunity to serve as a federal receiver for the state of California correctional facility health care system. He leaves his position as CEO

of Santa Clara Valley Health and Hospital System in order to take on this new assignment. Sillen's public hospital career spanned more than 25 years, making him one of NAPH's longest-serving members.

Will Trower has retired from his position as CEO of the North Broward Hospital District (NBHD). Trower began his career at NBHD in 1968 as a respiratory therapist. In 1995 he was named CEO and, under his leadership, NBHD received among the highest national scores for accredited health systems in the Joint Commission survey. Trower will continue to act as a consultant for NBHD until August 2008. In additional news, NBHD has named **Brian Rosenberg, PhD**, director of organization effectiveness and employee relations. Rosenberg will focus on strengthening workforce satisfaction and performance.

Patients and visitors to **Truman Medical Center Lakewood** will find a new three-story building, designed to provide a total healing environment. The \$38 million, 175,000 square-foot expansion includes eight outpatient/inpatient surgical suites, new emergency department, Intensive Care Unit, and 34 private inpatient rooms. The new addition also will house 28,000 square feet of medical office space. The building was designed to meet guidelines set by the Leadership in Energy and Environmental Design (LEED), using environmentally friendly building materials.

Bruce Vladeck, a former NPHHI Board member, was unanimously appointed as interim president of the University of Medicine and Dentistry of New Jersey (UMDNJ) by the university's Board of Trustees.

We are pleased to welcome two new members to the NAPH family: **University of South Alabama** joins us from Mobile, Alabama, and **Shands HealthCare** joins us from Gainesville, Florida. The University of South Alabama Medical Center traces its roots to Mobile's first hospital, established in 1830. Today, USA Medical Center is a 406-bed acute care facility that serves as the major referral center for its region, offering centers for Level I trauma, burns, cardiovascular disease, kidney transplants, stroke, and sickle cell disease. Shands HealthCare is a private, not-for-profit health care system affiliated with the University of Florida. Its mission is to provide excellent patient care; collaborate in improving community health; and support education and research in the health sciences. Areas of expertise include cancer, cardiovascular, neurological, pediatric, and transplant services. With nine hospitals and more than 80 outpatient clinical practices in north Florida, Shands is the state's leading health care referral system. ■

Share your good news! NAPH invites you to submit items for possible publication in People & Places. Email submissions to ebello@naph.org for consideration.



National
Association
of Public
Hospitals
and Health
Systems

1301 Pennsylvania Ave. NW, Suite 950
Washington, DC 20004
202 585 0100 tel / 202 585 0101 fax
www.naph.org

25th
ANNIVERSARY
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS