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The Shreveport Model

The LSUHSC-S is viewed as a relatively successful operation, especially for a Louisiana state entity. During the past several months of deliberations about the conditions of Louisiana's public hospitals, the contrasts between the LSU Hospital and the hospitals of the Health Care Services Division have become more apparent and our operation has been termed "The Shreveport Model," a term coined, I believe, by Mr. Boudreaux. I have been asked to speak about the conditions which have allowed the LSU Hospital to be successful.

I want to make it clear that Shreveport is not the Garden of Eden, and there are serious economic problems there. Despite these issues, the hospital is successful and generates a funding stream that supports not only its entire budget, but also one-half the cost of the medical school.

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Specifically - the budget of the LSUHSC-S is in excess of 350 million dollars of which the state general fund supplies 34 million. That is, 10% of the Health

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Sciences Center - Shreveport is supported by appropriated tax dollars, and 90% is self-generated. Stated another way: for every tax dollar invested in Shreveport, the state gets $10 in return.

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The cost of operating the medical school exceeds 64 million. Therefore, 30

million of hospital revenues goes to operate the medical school. This is not, as some would like to suggest, profit. It is money which LSUHSC-S desperately needs to reinvest into equipment and modernization of the hospital to avoid a downward spiral and undo the progress made during the last quarter century . With those clarifying remarks, I will now address why the LSU Hospital is a success.

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1) Local and regional support:

The Health Sciences Center - Shreveport is there because the local community wanted a medical school there and that community effort was led by the practicing medical community. It took over 10 years to accomplish that, but once done, it was their medical center and their support has been unwavering for the past 37 years. Community confidence in our economic value was validated last year when the Health Sciences Center - Shreveport was named "Industry-of-the-Year" by the Chamber of Commerce.

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2) Serving as a regional resource, not a competitor:

The medical center has tried not to compete with the private practitioners of

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medicine. We have first and foremost attempted to provide state-of-the art care for the poor and we have never refused to accept patients eligible for public care from any hospital.

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We have, however, attempted to and do provide tertiary care for all citizens, a mission that we view as intrinsic to any true academic medical center. We have focused on bringing capabilities to our area that were not present or are difficult for

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private hospitals to provide. Examples include the first level I trauma center in Louisiana, a full-service academic burn center, the first PET scanner in the state, the first gamma knife in the state, complex neurosurgical care, and a regional transplant program. A number of other examples are shown. In short, we have focused on building resources for North Louisiana, all of North Louisiana.

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In more recent years a number of public-private cooperative programs have developed. Because of these mutual efforts, we enjoy a superb relationship with our community and town-gown problems are rare. This did not occur by accident.

What factors allowed this to happen?

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1) In 1976 the operation of our hospital was removed from the Department of Health and Human Resources and transferred to LSU. Its operation as a university teaching hospital for the medical school became a function of the LSU Board of Supervisors. This event, under the leadership of Chancellor Allen Copping, was a brilliant move and, I think, second only to the founding of the school in historical importance.

Thereafter, the CEO on the Shreveport campus was the CEO of both the medical school and the hospital. The academic Chief of Surgery was the Surgeon-in-Chief of the hospital. The academic Chief of Medicine was the Physician-in-Chief of the hospital, etc. The budget of the center was merged into one, duplicate support services were eliminated, and funds could be moved about for the betterment of the institution as a whole. To reflect the change in philosophy from a charity hospital to a university teaching hospital, its name was changed from the Confederate Memorial Medical Center to the LSU Hospital in Shreveport. Our full-time faculty practiced almost exclusively in our own hospital, and we did not go out into the community to practice except when invited for special purposes.

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In 1976 we also were granted the privilege of retaining self-generated funds in accounts that went across budget years. In other words, if we generated revenue above budget, those funds could be carried forward and could be reinvested into either the physical facilities or into programmatic development. Neither did we have to get legislative approval before modifying our programs. We could downsize or eliminate programs or begin new ones needed to meet patient needs based upon medical judgment. These two advantages have made all the difference.

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Still, progress has been incremental and it has not been easy. It has taken about 25 years and the commitment of our faculty to produce a true academic health sciences center. The LSU Hospital is theirs and they are committed to it. In

1977 virtually no patient came to the LSU Hospital who had any other option. In 2002, 50-70% come because they choose to be there.

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Dual initiatives to assist free-care patients in applying for third party reimbursements and an effective collections policy implemented in the hospital by LSU after the transfer continue. There is a concerted effort to make sure that LSUHSC-S captures all reimbursements possible.

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Can the Shreveport model be reproduced and even more importantly, should it be reproduced? The answer to the first question is, "I don't know." The answer to the second question is, "absolutely."

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I want to state here that in my opinion the most tragic aspect of the history of medicine in Louisiana has been the segregation of public and private care. For almost 200 years now it has been philosophically accepted in Louisiana that the poor get their care in one place and the affluent get their care in another. Further, that care has been qualitatively different, and that has been acceptable to the state's power structure. I submit that this philosophy is unacceptable. It is akin to advocating separate but equal schools. Not only is it morally wrong, it does not work. It separates the teacher from the practitioner and the student from best practice. The clinical investigator cannot supplement income. A young Mike DeBakey cannot stay in the hospital system because he has neither the resources to

expand his expertise nor an appropriate income in today's world. I do not know of a single world-class medical center that does not have some access to private patients.

If you do not believe it does not work, look around. Where are our transplant centers comparable to Pittsburgh, or cancer centers comparable to M.D. Anderson, or cardiovascular centers comparable to Baylor or University of Alabama? They do not exist in Louisiana.

This task force has the opportunity to make landmark recommendations to improve medical care in this state, and I hope it will. There are probably a number of ways to reform the medical care of the poor. I was not charged to address those issues, but I will make a couple of philosophic comments.

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1) The medically underprivileged should have some choice in where they receive their care.

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2) The health sciences centers should have the authority to modify missions of individual hospitals, to be reimbursed for the services they provide--without cap, and to carry forward any over-realized earnings for reinvestments.

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3) The historical separation of public and private care has not served the state well.