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[THURSDAY, MAY 07, 2009]

Letter: Cooperation spans the globe  
The Times-Picayune | 05.05.09 ..... 3

Justices mull venue for Charity Hospital case  
The Advocate | 05.07.09 ..... 4

Letter: Cheaper, faster? Doubtful  
The Times-Picayune | 05.07.09 ..... 6

Budget bill takes center stage at Capitol today while LSU hospital debate is postponed  
The Times-Picayune | 05.07.09 ..... 7

Parish protests cuts to medical centers  
The Times-Picayune | 05.07.09 ..... 10

Our Views: Cuts, choices in health care  
The Advocate | 05.07.09 ..... 12

Blakely confirms he's leaving recovery director post 'as soon as I can,' but definitely by July 1  
The Times-Picayune | 05.07.09 ..... 14

Tobacco tax would save lives, fund health care  
The Times-Picayune | 05.07.09 ..... 16

Letter: Why was cigarette tax rejected?  
The Advocate | 05.07.09 ..... 17

Doctors to buy River West  
The Advocate | 05.07.09 ..... 18

Suspected flu cases up  
The Advocate | 05.07.09 ..... 20

La. sends 7 more samples for H1N1 testing, to limit information  
The News Star | 05.07.09 ..... 21

Swine flu developments  
The Advocate | 05.07.09 ..... 22

Civil Service proposal hit  
The Advocate | 05.07.09 ..... 24

Weight Loss Wednesday: Man loses hundreds of pounds -- and keeps it off  
WWLTV | 05.06.09 ..... 26

Officials Note Youth of Serious Flu Cases  
The New York Times | 05.06.09..... 29

Government Reports Criticize Health Care System  
The New York Times | 05.06.09..... 31

Rangel Bars Any Taxes on Workers' Health Care  
The New York Times | 05.06.09..... 33

New Effort Reopens a Medical Minefield  
The New York Times | 05.06.09..... 35

Curative Powers, on the Night Shift  
The New York Times | 05.02.09..... 38

**Letter: Cooperation spans the globe**

**The Times-Picayune | 05.05.09**

Shaminder Gupta, M.D.

Re: "Ochsner gains foreign med school: Australian deal targets La. doctor shortages, " Metro, May 1. I would like to commend Ochsner medical center on their affiliation with Queensland Medical School to generate more doctors for southeast Louisiana.

Leonard J. Chabert Medical Center in Houma has been affiliated with foreign medical schools for over 10 years. At Chabert Medical Center, we have U.S.-born students, many with Louisiana roots, who attend these schools and then do their clinical rotations at our hospital. We have over 60 students rotating on pediatrics, internal medicine, surgery, ob/gyn and various medical subspecialties.

As a result, we have placed multiple students in various training programs across our state over this time period.

Now we have examples of both public and private institutions in our state using innovative techniques to remedy our physician shortage.

I think it is a wonderful example of progressive thinking and shows great leadership by our medical leaders in both the public and private arenas.

Shaminder Gupta, M.D.

Houma

[http://blog.nola.com/letterstotheeditor/2009/05/cooperation\\_spans\\_the\\_globe.html](http://blog.nola.com/letterstotheeditor/2009/05/cooperation_spans_the_globe.html)

[\[BACK TO TOP\]](#)

## **Justices mull venue for Charity Hospital case**

**The Advocate | 05.07.09**

By ALLEN M. JOHNSON JR.

Advocate New Orleans bureau

NEW ORLEANS — The Louisiana Supreme Court by noon Wednesday had not announced a decision on where to try an emotional civil suit against three state executives for the allegedly unauthorized closing of Charity Hospital after Hurricane Katrina.

After hearing oral arguments in the case Tuesday — and twice evacuating the Royal Street Courthouse in the French Quarter for false fire alarms — the justices did not indicate when they would rule.

The court had a full calendar of disciplinary hearings Wednesday, including two Baton Rouge lawyers and a state judge.

Today, the court will hear a death penalty appeal of a Baton Rouge man sentenced to die for the killing of Baton Rouge Police Lt. Vickie Wax.

However, attorneys have said they expect the justices to decide soon whether the suit should be tried in New Orleans Civil District Court or the 19th Judicial District Court at Baton Rouge.

Leonard W. Aragon, a plaintiff's attorney from Arizona, told the court the suit should be tried in New Orleans, "because that's where the operating facts are."

Aragon said Charity was preparing to resume operations after cleaning up from Katrina's floodwaters on Aug. 29, 2005.

However, Larry Hollier, chancellor of LSU Health Care Science Center-New Orleans ordered the closing of Charity, without the required approval of the Louisiana Legislature.

"The hurricane did not close Charity Hospital," Aragon said. "Larry Hollier closed the hospital."

Hollier is a defendant in the suit, along with Dwayne Thomas, the former chief executive officer of Charity, and Dr. Michael K. Butler, acting chief executive officer of the LSU Health Care Services Division, which operated the eight charity hospitals south of Shreveport in 2005. The former patients filed suit in New Orleans last year, seeking to reopen Charity for the under- and uninsured residents of Orleans, Jefferson, St. Bernard and Plaquemines parishes.

LSU attorney Preston Castille Jr., of Baton Rouge, said only the LSU Board of Supervisors had the authority to order the closing of Charity, but the 20-story facility was shuttered by the storm.

"If it was closed by anything, it was closed by the hurricane," Castille said.

Castille said it would be "inappropriate" to have a state agency travel to one of its "branches" to address an administrative decision. "We have to look to the state agency," Castille said of the Board of Supervisors. "That agency is located in East Baton Rouge Parish."

Several justices said they had difficulty understanding why three individual executives were the sole defendants named in the suit.

LSUHSC, a former defendant, was removed from the case by an appellate court, Aragon said. The plaintiff's attorney said the petition could be amended to include the board of supervisors.

LSU attorney Harry "Skip" Philips objected.

"This isn't vicarious liability," Philips said. "It's a question of who has the authority. Only the LSU Board of Supervisors could have made the decision, the plaintiffs allege."

Pressed by Justice John L. Weimer to say precisely who closed Charity, Philips said the board of supervisors made the decision to close and replace the hospital long before Katrina, and with cooperation from the Legislature.

"We've never gotten that far into the record," Philips told the court, referring the progress of the lawsuit filed in January 2008.

Philips said, "The Legislature in 2003 funded a study directed to closing and replacement of the Charity Hospital New Orleans building."

Earlier, co-counsel Castille said LSU wanted to avoid getting into the merits of the case.

<http://www.theadvocate.com/news/44510947.html#>

[\[BACK TO TOP\]](#)

**Letter: Cheaper, faster? Doubtful**  
**The Times-Picayune | 05.07.09**  
Zack Dileo

When discussing remodeling Charity into a new LSU teaching hospital, repeating the phrases "cheaper, faster and better" doesn't make it true.

I do not have the expertise to debate with two architects on which option is cheaper. But, having helped my mother rebuild her home in Lakeview post-Katrina, I do know that everything turns out to be far more expensive than the original cost estimates.

It is also disingenuous to argue that it would be better to shoehorn a state-of-the art medical facility into an existing, dilapidated structure.

While it could be made to work, it is unbelievable that anyone could argue that it would be better than designing a brand new hospital to modern standards.

"Cheaper, faster, better" is an interesting mantra, but it doesn't make it the truth.

Zack Dileo

<http://www.nola.com/news/t-p/letterstoeditor/index.ssf?/base/news-13/1241674319290440.xml&coll=1>

[\[BACK TO TOP\]](#)

## **Budget bill takes center stage at Capitol today while LSU hospital debate is postponed** **The Times-Picayune | 05.07.09**

by Jan Moller, The Times-Picayune

BATON ROUGE -- The first week of May used to be a somewhat sleepy time for observers of the state budget, a period when state agencies made their ritual visits to the House Appropriations Committee to discuss their plans for the year ahead.

Not this year. Today the budget panel is expected to finish its work on House Bill 1, the 244-page, \$26.7 billion spending proposal for 2009-10, and move it on to the full House, which will likely take it up late next week.

That's about two weeks earlier than in most years, when the bill would get shipped over to the Senate just in time for hearings to start on Memorial Day weekend.

Tucker has said the plan is for the Senate to finish its work on the budget by early June, which would leave the last couple of weeks of the session (adjournment is June 25) to reconcile the House and Senate versions of the bill in a conference committee. The idea was for the House to get away from recent tradition, where the budget would get sent back from the Senate just a few short days before Sine Die, which left some House members feeling like the Senate had the upper hand in conference committee.

If the schedule holds, expect even more horse-trading than usual in the final days as the two chambers settle their differences.

With the budget bill having already gone through a round of amendments in committee -- and the Division of Administration having proposed \$679 million worth of changes, mainly new federal dollars - the only remaining mystery at this early stage is how much the committee will set aside for the 500-plus non-governmental organizations that asked the state for aid.

Appropriations Chairman Jim Fannin, D-Jonesboro, said earlier this week to expect some money for parish councils on aging, but that's as far as he would go.

The other big budget question: When will Democrats, to the extent that they are an organized force in the Capitol (and that's an open question), make their move? So far they've done little besides complain about the size of the cuts -- Speaker Pro Tem Karen Carter Peterson, D-New Orleans, and her ill-fated cigarette-tax being the lone exception -- but they have several tools left in their drawer, such as manipulating the state's rainy-day fund to free up money for health care and education.

Jindal, according to chief of staff Timmy Teepell, has been telling lawmakers that he's fine with their shifting money around as long as it doesn't make the state's budget problems worse in future years. Translation: The administration will fight any attempts to use more "one-time" money for recurring expenses beyond the \$1.1 billion plus that's already in the budget.

Next door in House Ways and Means Committee, meanwhile, the \$5.3 billion capital construction bill -- House Bill 2 by Rep. Hunter Greene, R-Baton Rouge - is also scheduled to be heard.

Speaking of Peterson, she has not given up on the cigarette tax. House Bill 889, submitted just before Wednesday's 6 p.m. deadline to file bills, would raise taxes by 50 cents a pack (as opposed to the \$1 per pack increase that was defeated last week). It already has 20 co-sponsors, including three Republicans.

The other big news from today's docket was supposed to involve House Speaker Jim Tucker's bill to take Louisiana State University out of the hospital business in New Orleans in favor of an independent governing board that would have no ties to any local colleges or universities.

House Bill 830, which has plenty of fans at Tulane but few at LSU, was scheduled for an afternoon floor debate, but the speaker told The Times-Picayune late Wednesday that he has decided to put things on hold while he negotiates with the interested parties, including Gov. Jindal. The governor earlier this week

said he supports an independent governing board, but that the schools should have representation -- something not currently contemplated in Tucker's bill.

Tucker declined to share the details of any amendments being drafted for his bill, but he indicated that he's not necessarily opposed to the schools retaining some presence on the board. But he won't accept any board that is controlled either by one school or that does not include at least a majority of directors without ties to any of the institutions.

The debate is very inside baseball and may never have any practical effect on patient care. But LSU, Tulane, Dillard, Southern and Xavier all want to protect their turf. The outcome even carries reverberations for the eventual name of the new hospital.

Many of the planning documents put forward by LSU and the state refer to the LSU Academic Medical Center. But Tulane and the other schools likely won't sit idly by for that name. There's also a contingent in the Legislature that will simply want to transfer the existing name of Avery C. Alexander Charity Hospital. The Legislature likely will have the final say -- and Tucker's bill is the opening round. Stay tuned.

In other action, Senate Bill 146, is slated for its first hearing in the Senate Education Committee. Sen. Ann Duplessis' proposal would make several changes to the application process and regulation of charter-school organizations, but one stands out: The bill would delete the existing prohibition on religiously affiliated charter schools. Duplessis was the Senate sponsor last year for Jindal's \$10 million scholarship program ("vouchers" if you're an opponent) that pays private school tuition for certain New Orleans children previously in public school.

From the morning papers:

Is the Shaw Group's announcement that it plans to forgo \$172.5 million in state subsidies for a Lake Charles manufacturing project and its Baton Rouge headquarters a pure business decision? Or should the explanation offered by CEO Jim Bernardt -- that the company doesn't want to take state resources that might otherwise be used for health-care and education when Louisiana is facing a budget crunch -- be seen as the opening salvo in a future run for public office, say, perhaps, the U.S. Senate in 2010?

The Baton Rouge Advocate strips the story across the top of its front page and looks at the positive public-relations aspect for Shaw a time when state support for a chicken plant is in the headlines.

"Observers saw many benefits for Shaw from its gesture, including distancing the company from the testy megafund debate and giving Bernardt an effective bully pulpit by turning down state money," the newspaper writes.

"That's a big thing to walk away from: Let me say this, he's a stronger man than me," LeAnne Weill said, with a chuckle. She's president of The Weill Agency, the state's oldest public relations and advertising firm. "I would say this is a legitimate show of the corporate conscience. Having said that, two things come to mind" -- political ambition and the megafund controversy.

Barry Erwin at CABL gives his take on the first nine days:

The Jindal administration's attempt to form a government-streamlining panel got off to a clumsy start, with the bill stalling in committee.

Booze and barber shops don't mix, according to a House committee.

Baton Rouge-based freelancer Jeremy Alford, writing in the Lafayette Independent, has taken perhaps the most in-depth look at Jindal's campaign fund-raising, and what donors get for their money.

The Associated Press looks at the Stormy Daniels "listening tour."

Lawmakers continued to debate transparency in the governor's office.

[http://www.nola.com/politics/index.ssf/2009/05/budget\\_bill\\_takes\\_center\\_stage.html](http://www.nola.com/politics/index.ssf/2009/05/budget_bill_takes_center_stage.html)

[\[BACK TO TOP\]](#)

## Parish protests cuts to medical centers

**The Times-Picayune | 05.07.09**

By Paul Rioux

West Bank bureau

Already bleeding cash from a surge in uninsured patients linked to Charity Hospital's closure, Jefferson Parish's three large hospitals stand to lose a combined \$20 million from recent emergency cuts to Medicaid reimbursement rates, a hospital administrator said Wednesday.

The state Department of Health and Hospitals issued emergency rules cutting Medicaid reimbursement rates, on Feb. 20 by 3.5 percent and again on Friday by 7.2 percent.

Nancy Cassagne, chief executive officer for West Jefferson Medical Center in Marrero, said the cuts will aggravate brutal market conditions that have left local hospitals operating in the red since Hurricane Katrina.

"We are struggling to provide services to our citizens," she told the Jefferson Parish Council. "These cuts will be detrimental. They will be drastic."

Cassagne estimated that the parish's two publicly owned hospitals, West Jefferson and East Jefferson General in Metairie, along with the private nonprofit Ochsner Medical Center, will lose a combined \$20 million because of the cuts.

That's on top of more than \$300 million the three hospitals have lost since 2005 thanks to skyrocketing labor costs, a spike in uninsured patients and lagging Medicare reimbursements, according to a report by the federal Government Accountability Office.

Cassagne said hospital administrators were aware that Gov. Bobby Jindal's administration was proposing cuts in Medicaid, the government health care program for the poor, to help balance the state budget. But Cassagne said she was blindsided by the emergency rules, which immediately implemented the proposed cuts.

Saying she didn't learn about the cuts until a hospital vendor showed her a newspaper report, Cassagne accused DHH of "circumventing the legislative process."

State health officials said they are implementing the cuts now to maximize the savings if a bill containing the lower reimbursement rates becomes law. If the Legislature doesn't pass the bill, the officials said, they will adjust reimbursement rates to offset the cuts.

After passing a resolution calling on Jefferson Parish's state lawmakers to try to undo the emergency rules, council members took turns blasting the Jindal administration.

"This is absolutely absurd that they would make these types of cuts to our medical facilities and to just assume everyone is aware that they need to amend their budgets," Councilman Chris Roberts said.

Councilman Byron Lee questioned the governor's priorities in agreeing to \$85 million in Superdome upgrades to keep the Saints in New Orleans while cutting money for hospitals.

"The Saints are going to get their money," said Lee, who professed his "absolute love" for the team. "However, it's going to be on the backs of a lot of people, and it's sad that our priorities are so screwed up that we're not funding things that are truly important."

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Noting that state and rural hospitals are exempt from the Medicaid cuts, Parish President Aaron Broussard said it's unfair to reduce money for Jefferson's hospitals while they are treating uninsured patients who previously would have gone to the state-run Charity Hospital in New Orleans, which has been shuttered since Katrina.

"The surpluses for our hospitals have dwindled as they took the load of caring for the indigent off of the state," he said. "Now they're getting punched in the mouth for good measure."

Cassagne estimated that the three Jefferson Parish hospitals have lost a combined \$30 million to \$40 million caring for uninsured patients since Katrina.

To help deal with the growing crisis, the Parish Council has formed a committee to study ways the two publicly owned hospitals can work together to cut costs.

The committee is scheduled to issue a recommendation by May 20 on the feasibility of forming a parishwide hospital service district to oversee cost-saving agreements between East Jefferson and West Jefferson.

<http://www.nola.com/news/t-p/frontpage/index.ssf?/base/news-12/1241674427290440.xml&coll=1>

[\[BACK TO TOP\]](#)

## **Our Views: Cuts, choices in health care**

### **The Advocate | 05.07.09**

Advocate Opinion page staff

While studded with statistics and acronyms, Gov. Bobby Jindal's story of how the state's Medicaid program is going into a financial tailspin is worth following. What we don't know yet is the ending.

But the story tells a lot about state expenditures and what, if anything, is going to be done to correct overspending.

Jindal laid out the data before the Press Club of Baton Rouge. Medicaid costs are expected to be more than 20 percent of the state's general fund in the coming year.

As Jindal noted, one of the reasons for that increase — doubling as a percentage of the general fund in five years — is that rate increases were provided for doctors and nurses, hospitals and nursing homes. Even with sharp budget cuts proposed by Jindal's administration, he noted that the state still will be spending more on health care for the poor than in 2007. Lobbyists for the health-care providers were very active, and the state was relatively well-off because of hurricane-related revenue and high oil and gas prices.

This year is a problem for Jindal and the Legislature. But the real cliff for Medicaid comes when the U.S. government — which typically pays 70 percent of Medicaid's costs in Louisiana — changes its reimbursement rate. An obscure formula will change twice over the next two fiscal years, reducing reimbursement to about 63 percent. A small change in percentage but a huge difference, about \$700 million a year in state funds.

There are other rules changes and quirks in the program that also will cost the state, but that's a big one. Why is it occurring? The Medicaid formula considers Louisianians as being a lot better off — 42 percent better off, in fact, in personal income.

Jindal wryly notes that most of us don't feel richer even if we got checks to repair homes damaged by the visits of Katrina, Rita, Gustav and Ike. He ascribed Louisiana's shift in the formula as unreasonable considering the formula improvements for other states. Including hurricane aid to families and insurance reimbursements in the state's "income" caused the changes, Jindal said.

Needless to say, Jindal has met with the state's delegation in Congress to see if they can change what he called an egregious miscalculation.

Can this realistically be fixed? The U.S. government generally has been willing to make allowances for hurricane problems in Louisiana and other Gulf states. However, "Katrina fatigue" is now a well-advanced syndrome, and it's not clear whether this \$700 million adjustment can be made, even with strong efforts by the congressional delegation.

If it isn't, Jindal warned, the Medicaid program would face a total shortfall of about \$1.2 billion in the fiscal year 2012, when federal stimulus dollars run out after propping up the budget in fiscal 2010 and 2011.

Big numbers, but Jindal's speech glided over a key point: The reimbursements.

Part of the problem of Medicaid is that payments to health-care providers are considered too low; people who need to see a doctor or dentist can't find one accepting Medicaid, and they end up in emergency rooms for expensive care that might have been avoided with earlier treatment. The reimbursements are intended to pay for better access to health care for poor families.

So the reimbursement increases Jindal blames for the deficit are, like many things in government, a mix of good and bad. To some extent, it stigmatizes Medicaid providers to blame them for the deficit, but nevertheless Jindal is quite right to identify the deficit as a problem; the state has to balance its budget.

Louisiana, though hurt by the formula as Jindal said, is far from alone in wrestling with the tough choices in Medicaid. Budget deficits in the tens of billions of dollars have been problems in states from California to Florida during the recession, and many of those deficits involved Medicaid cutbacks.

Realistically, a national and comprehensive solution for health-care reform is necessary to address the Medicaid monster. Even changing the state's formula result, to reflect the aberration of the hurricane years, is only a start.

<http://www.2theadvocate.com/opinion/44509527.html>

[\[BACK TO TOP\]](#)

## **Blakely confirms he's leaving recovery director post 'as soon as I can,' but definitely by July 1**

**The Times-Picayune | 05.07.09**

by Michelle Krupa

More than two years after he strode into flood-ravaged New Orleans and predicted a building boom with "cranes on the skyline" by fall 2007, Recovery Director Ed Blakely said Wednesday that he plans to leave his post in Mayor Ray Nagin's administration "as soon as I can." He said he will be back home in Sydney, Australia, no later than July 1.

On that schedule, Blakely's departure will dovetail with the dissolution of the Office of Recovery and Development Administration, which under his direction has overseen nearly half of all City Hall departments, including economic development, housing and code enforcement.

In line with budget blueprints laid out last fall by Nagin, Blakely said July 1 will see his agency renamed the Community Development Department, with his deputy director, Austin Penny, sliding into the oversight role. Otherwise, Blakely said, department directors and their job descriptions will remain essentially the same.

In an impromptu interview in City Hall Wednesday, Blakely said he had been discussing his departure with Nagin for weeks, trying to nail down the best moment to shove off. As of Wednesday morning, however, Nagin spokeswoman Ceeon Quiett said Blakely had not told the mayor of any plan to resign.

In ticking off his agenda for his final weeks, Blakely said that by the time he departs every penny of \$411 million in federal block grants earmarked for New Orleans by the Louisiana Recovery Authority will be "pledged," adding that the task already is about 99 percent complete. The money will be spent on projects as varied as landscaping along commercial corridors, attracting grocers to poor neighborhoods and improving police stations.

An LRA spokeswoman, however, said that while city leaders may have the whole pot of money allotted on internal projections, the state agency has gotten requests for only about 73 percent of it.

### **Hospital purchase**

**Blakely also boasted that the city is close to inking a \$40 million deal to purchase the former Methodist Hospital in eastern New Orleans and securing \$100 million from lenders, including Fannie Mae, to restore it as a public hospital akin to Jefferson Parish's two public medical centers.**

**Nagin made a similar prediction in March. Blakely could not say how soon an agreement might be reached.**

Shortly after arriving in New Orleans, Blakely rhapsodized about his vision of a world-class metropolis recast as the nation's gateway to Latin America and sub-Saharan Africa. Restoring railroads, airports and seaports would generate tens of thousands of high-quality jobs and persuade developers to restore abandoned real estate, he said.

Reflecting briefly Wednesday on his 31 months on the job, Blakely said he does not measure his tenure against a list of projects he had hoped to complete but instead by the way he reorganized City Hall.

"My expectation was to make plans," he said. "You have to have an organizational structure to put it in place. And we got there."

Proudest achievement

Asked to name his proudest achievement, Blakely cited the ongoing effort to create a citizen-driven master land-use plan and to revise the comprehensive zoning ordinance. Under a change to the City Charter approved by voters last year, the plan will have the force of law.

"If we have a master plan, we have a destiny, " Blakely said.

Blakely authorized \$2 million from the LRA grant pool to pay a planning and architectural firm to guide the process. But his arrival in New Orleans came several years after preservationists and others started pushing for a master plan, and Blakely largely has been absent from community planning meetings.

Ahead of the curve

The target of frequent criticism, Blakely has acknowledged that trying to shepherd a clumsy and sometimes-inept City Hall bureaucracy through the maze of federal rebuilding rules has been a challenge. He admits perhaps some of his early promises about a speedy recovery were overblown.

But he insisted Wednesday that New Orleans is far ahead of the curve.

"We are, in fact, the fastest recovery that anyone has ever seen. Look at our neighbors to the north -- 2001 -- see, " Blakely said, referring to slow progress in rebuilding the World Trade Center site after the terrorist assault of Sept. 11, 2001.

Blakely also said that nearly four years after a massive earthquake mostly leveled Kobe, Japan, in 1995, officials there hadn't yet begun to stitch together a recovery plan. By that standard, New Orleans' planning progress has been "pretty remarkable, " he said.

In fact, leaders in Kobe set to work on recovery planning within hours of the quake and a put a rebuilding plan on paper within two months. Though a backlash from citizens prompted major revisions, the cornerstone principles never changed.

Blakely's taxpayer-financed salary was \$150,718 in 2007 and \$154,510 last year. But a recent review of city e-mails by The Times-Picayune revealed that Nagin arranged in 2007 to have a city-controlled off-budget fund pay the University of Sydney \$100,000 to "borrow" Blakely, who remained chairman of Urban and Regional Planning at the university's architecture school in 2007 and 2008.

The same arrangement was considered for 2008 until Blakely found a private source to repay the university.

[http://www.nola.com/news/index.ssf/2009/05/blakely\\_confirms\\_hes\\_leaving\\_r.html](http://www.nola.com/news/index.ssf/2009/05/blakely_confirms_hes_leaving_r.html)

[\[BACK TO TOP\]](#)

**Tobacco tax would save lives, fund health care**

**The Times-Picayune | 05.07.09**

Sally Shushan

Re: "Cigarette tax increase rejected: Committee members vote 11-7 against it," Page A2, April 29.

I applaud Reps. Girod H. Jackson III and Cedric Richmond for siding with the 75 percent of Louisianans who support an increase in the cost of cigarettes and voting "yes" on House Bill 75, the Louisiana Healthier Families Act.

Our state's budget and health-care system are in crisis, and Rep. Karen Carter Peterson introduced House Bill 75 as a responsible way to address these critical issues. Unfortunately, it was defeated in the House Ways and Means Committee.

Worse yet, no alternative solutions were presented by opponents. It's clear that Reps. Jackson and Richmond see the bigger picture that our governor and other committee members are missing.

This measure would have saved lives, reduced health-care costs and created a significant source of revenue for our state. Tobacco usage is the top preventable cause of death in Louisiana and is responsible for \$1.5 billion in health care costs and \$663 million in Medicaid costs annually.

In the end, this isn't a debate about a new tax. This is about saving lives and saving Louisiana taxpayers money for generations to come. It's about lifting the tremendous burden of unnecessary spending, while finding a new way to fund our state's critical health-care programs and institutions.

Reps. Jackson and Richmond clearly understand this. I ask for those lawmakers who did not support the bill to reconsider this important, life-saving legislation.

Sally Shushan

New Orleans

<http://www.nola.com/news/t-p/letterstoeditor/index.ssf?/base/news-13/1241674247290440.xml&coll=1>

[\[BACK TO TOP\]](#)

## **Letter: Why was cigarette tax rejected?**

**The Advocate | 05.07.09**

Chris Odinet

Why?

That's the question I would like to ask of the Louisiana Legislature's House Ways and Means Committee for its rejection of the proposed \$1 cigarette tax that came up for debate recently.

The committee listened to six hours of testimony from numerous individuals, including public health officials, physicians, the American Cancer Society, medical groups and professionals, economists and cancer survivors (to name a few).

The statements from experts in the fields of public health and public finance overwhelmingly testified that this measure would have done much to offset the growing health problems surrounding smoking as well as the rising cost (and decreasing revenue) to the state related to cigarette-related health issues.

Approximately 6,500 Louisianians die each year from tobacco-related causes, with an additional 1,000 deaths related to secondhand smoke. Is this not a serious public-health issue worth deterring? Additionally, smoking alone costs Louisiana \$663 million each year in the Medicaid program.

With a serious shortfall in dollars for healthcare-related costs, the \$1 tax would have helped decrease that cost and would have yielded roughly \$200 million in additional state revenue at a time when we are facing multiple years of a budget shortfall.

Louisiana is in serious financial trouble, so why would we not place a very minimal tax (Louisiana already has one of the lowest state taxes on cigarettes in the country) on a practice which is not only harmful to the public health but also a major source of state expenditures?

Even state health Secretary Alan Levine testified on April 15 in a budget committee hearing that increasing the state cigarette tax would result in fewer people smoking and would reduce the state's health-care costs overall.

What I found particularly disappointing was that, despite the hours of testimony from experts and everyday citizens alike, the committee members barely asked any questions and made no comments. It was almost as if their minds had been made up before they even entered the room, and there was nothing that could be said — however valid or correct — that would change their vote.

Was this driven by differences in public policy views or merely baseless politics? I think the people of Louisiana deserve an answer.

Chris Odinet  
LSU law student  
Baton Rouge

<http://www.theadvocate.com/opinion/44509512.html#>

[\[BACK TO TOP\]](#)

## Doctors to buy River West

The Advocate | 05.07.09

By GREG GARLAND

Advocate Westside bureau



Liz Condo/The Advocate

**Six physicians formed Iberville Health Services Inc. in order to buy financially distressed River West Medical Center in Plaquemine and convert it into a locally owned, nonprofit hospital, a group spokesman said Wednesday.**

PLAQUEMINE — A group of doctors plans to sign a deal today to acquire River West Medical Center's physical facility, a key step in transforming it into a locally owned, nonprofit hospital, a spokesman said.

Craig Ortego, speaking for the group, said purchase of the building is to be followed later this month with acquisition of equipment and other hospital assets.

"Obviously, the hospital is in major transition right now," he said.

The hospital had been operated by River West LP, whose out-of-state owner, Shiloh Health Services, was renting the building and land it sits on from a California real estate investment trust.

River West LP filed for protection from creditors earlier this year under Chapter 11 of the U.S. Bankruptcy Code.

A group of six physicians has spearheaded efforts to keep River West Medical Center open. The physicians recently formed a not-for-profit company, Iberville Health Services Inc., to buy and operate the hospital.

The doctors accelerated efforts to take over River West on Friday, Ortego said, after Shiloh Health Services, a for-profit corporation, found itself unable for the second time this year to meet the hospital's payroll.

The doctors put up \$118,000 so the staff could be paid, he said.

At the same time, the group brought Bryan Bogle back as River West's chief executive officer, Ortego said. Bogle had been fired by Shiloh Health Services owner Jim Cheeks earlier this year.

"The staff is turning cartwheels they are so happy," Ortego said of Bogle's return.

Bogle said Wednesday that local control of River West, and operating it as a not-for-profit company, is providing it with a new lease on life.

He praised the doctors for their willingness to assume a financial risk in taking over the hospital.

"This facility has a ton of potential, and with proper governance and management and community support, it will realize that potential," Bogle said.

Ortego said he is assisting in managing River West as a consultant. He is co-owner of a Lafayette-based company, Quality Health Solutions Inc., that specializes in rural hospital turnarounds.

Ortego said state and local officials have been supportive of the doctors' efforts to assume control of the hospital. He said parties involved in the bankruptcy proceedings also have cooperated.

"The community has not really had a say in their hospital for a very long time," Ortego said. "It's been owned and operated by for-profit companies that do not have a stake in the community."

He said the hospital is a vital part of Iberville Parish because of the difficulty in getting patients in need of urgent care to larger hospitals across the Mississippi River in Baton Rouge.

"They have all the ingredients for success here," Ortego said. "It's to everyone's advantage to make this thing work."

<http://www.2theadvocate.com/news/44511267.html>

[\[BACK TO TOP\]](#)

**Suspected flu cases up**  
**The Advocate | 05.07.09**  
By SANDY DAVIS  
Advocate staff writer

Louisiana had no new confirmed cases of swine flu on Wednesday but the number of suspected cases continued to increase, state officials said.

Seven new samples were sent to the U.S. Centers for Disease Control and Prevention in Atlanta for confirmation of the H1N1 virus on Wednesday, according to a news release from the state Department of Health and Hospitals.

That brings the total number of suspected cases in Louisiana to 34 in nine parishes.

The parishes and the number of suspected cases are: Lafayette, 22; Lafourche, 3; Iberia, 2; St. Landry, 2; Ascension, 1; Beauregard, 1; Livingston, 1; Orleans, 1 and St. Martin, 1.

The CDC has said it takes two to four days for its lab to complete testing on a sample because of the large volume of samples it is receiving from all over the United States.

There are seven confirmed cases of swine flu in Louisiana: five in Lafayette Parish, and one each in Ascension and Orleans parishes.

All of those with the flu are being treated at home with anti-viral medications, DHH said in the news release.

Also on Wednesday, St. Jude the Apostle Elementary School reopened, said Bill Michelet, a spokesman for the Catholic Diocese of Baton Rouge.

“The CDC changed their stance on closing schools because of swine flu,” Michelet said.

“They told us, ‘If you closed based on what we said, open back up.’ So that’s what we did.”

St. Jude closed when a child tested positive for type A influenza. Swine flu is a subtype of type A influenza.

The sample was sent to the state. If the state cannot determine what viral strain of flu the child had, the sample will be sent to the CDC for confirmation of swine flu.

The state lab has received 1,507 samples for testing since the first presence of swine flu was known last week. That lab has tested 638 of the samples, DHH said Wednesday.

<http://www.2theadvocate.com/news/44511067.html>

[\[BACK TO TOP\]](#)

## **La. sends 7 more samples for H1N1 testing, to limit information**

**The News Star | 05.07.09**

By Mike Hasten

BATON ROUGE — State health officials have sent seven more suspected cases of the H1N1 (swine flu) virus to the Centers for Disease Control and Prevention for testing.

Advertisement

Included in the list are five more cases from Lafayette Parish, one from St. Landry and one from Ascension.

Rene Milligan, spokesman for Louisiana Department of Health and Hospitals, said the agency will no longer release information that could lead to the flu victims being identified, including whether they are students or adults.

"We're trying to step back from releasing that information because of privacy concerns," he said. "We would prefer to leave it to the parish" if such information would be made public.

Milligan said DHH's attorney was consulted about concerns of violating the federal Health Protection and Promotion Act, which protects patient privacy. He said the agency now will stick with numbers, except in some cases.

"If it becomes an issue of a public health threat that would call for the closure of a school, we would release that information," Milligan said.

He explained the reason DHH changed its policy. "We were hearing cases of families getting negative feedback from the public" because a child was ill. "We certainly didn't want to foster that kind of spirit." Milligan said he expects news soon from CDC confirming that more of the

samples sent for testing contain the H1N1 virus. The labs in Atlanta say that 99 percent of the samples they test prove to be positive.

With the seven new cases, Louisiana now has sent 34 to the CDC. So far, only seven have come back positive and two negative for the virus.

Of the 34 samples, 22 are from Lafayette Parish, two from Iberia, two from St. Landry, three from Lafourche and one each from Ascension, Beauregard, Orleans and St. Martin parishes.

The state lab, which determines whether a case should be sent to CDC, has received 1,507 specimens since the first appearance of the H1N1. Of those, 638 specimens have been tested.

Five of the seven confirmed Louisiana cases are Lafayette Parish students. The others are from New Orleans and Gonzales.

Michael Brame, Region 8 hospitals and emergency preparedness administrator, said northeastern Louisiana continues to have enough antiviral drugs in preparation for any cases of swine flu.

"They are in place at every hospital in case of an emergency, but at this point the commercial market is able to support any demand," Brame said.

<http://www.thenewsstar.com/apps/pbcs.dll/article?AID=2009905060365>

[\[BACK TO TOP\]](#)

## **Swine flu developments**

### **The Advocate | 05.07.09**

Key developments on swine flu outbreaks on Wednesday, according to the U.S. Centers for Disease Control and Prevention, the World Health Organization and government officials:

**DEATHS:** 42 in Mexico and two in the U.S., both in Texas. One of those who died in the United States was a toddler from Mexico.

**CONFIRMED CASES:** Nearly 1,900 worldwide in 24 countries, more than 1,000 in Mexico, more than 600 in the United States. Sweden and Poland reported their first cases Wednesday.

**VACCINE UPDATE:** U.S. health officials say it took only two weeks to identify the genetic characteristics of the strain, and they are in good position to quickly produce a vaccine.

**VIRUS SEQUENCED:** Canadian scientists have genetically sequenced the virus, a breakthrough they hope will help identify the origins of the virus and reveal how it spreads and mutates.

**WHO CALLS MEETING:** World Health Organization calls a meeting of flu experts next week to discuss whether drug companies should switch their production from regular flu vaccine to pandemic vaccine.

**MEDIAN AGE 15:** U.S. health officials say the median age for confirmed hospital cases in the United States is 15. And in Mexico, new figures show almost half the confirmed swine flu deaths were of people 29 and younger.

**SCHOOLS REOPEN:** More than 140 schools totaling more than 100,000 students reopened Wednesday after closures stemming from swine flu, according to the U.S. Department of Education. About 590 schools totaling about 370,000 students remained closed, but many were set to reopen today or Friday. U.S. health officials on Tuesday withdrew recommendations that schools with suspected swine flu cases close.

**MEXICO ALLOWS BUSINESS TO REOPEN:** Mexico allows most businesses to reopen Wednesday, with high schools and universities to reopen today and primary schools to reopen next week. Mexico City indefinitely extends its closures of bars, discos, gymnasiums, movie theaters and dance halls. Sports arenas in the capital can reopen, but only at half their spectator capacity.

**HAITI REJECTS MEXICAN AID:** Haiti turns away a Mexican ship carrying food aid because of swine flu fears.

**QUARANTINED MEXICANS BACK HOME:** Dozens of Mexican nationals quarantined in China despite having no swine flu symptoms arrive in Mexico City on a government-chartered jet. Some complain the Chinese humiliated them and discriminated against them. China's foreign ministry denies singling out Mexicans.

**CHINA RELEASES QUARANTINED AMERICANS:** U.S. Embassy in Beijing says two Americans quarantined in China have been allowed to leave, while two others are still being kept in isolation.

China also lifts its quarantine early for a group of Canadian students.

**NAVY CANCELS DEPLOYMENT:** U.S. Navy cancels the deployment of the amphibious transport USS Dubuque (LPD-8) from its home port in San Diego, and orders crew of about 370 to be treated with antiviral drugs after a crew member's illness is confirmed as swine flu.

<http://www.2theadvocate.com/news/44511032.html?showAll=y&c=y>

[\[BACK TO TOP\]](#)



## **Civil Service proposal hit**

**The Advocate | 05.07.09**

By MARSHA SHULER

Advocate Capitol News Bureau

Proposed changes in state Civil Service would end state employee job protections and return Louisiana to a spoils system where people are politically hired and fired, state employees and their representatives complained Wednesday.

A parade of people appeared before the State Civil Service Commission — the body constitutionally charged with approving rules governing state employment practices — to protest changes to employee layoff procedures.

At the heart of the opposition is a proposed end to “bumping rights,” which generally protect senior employees from layoffs. The proposed rules would use job performance ratings in determining who goes and who stays — a move that could inject politics into decision-making, employees said.

The commission heard testimony for more than an hour at the beginning of its regularly scheduled meeting.

The commission is scheduled to vote on the proposed changes at a June 3 public hearing. The rules affect layoff procedures for some 60,000 state employees.

The Civil Service agency staff is recommending the changes in preparation for potential job layoffs and state government reorganization that may be required because of a state revenue decline and the loss of federal stimulus dollars down the road, Civil Service director Anne Soileau said. The idea is to make it easier for agencies to adjust and keep the employees needed to do required jobs regardless of their state service time, she said.

But opponents said the agency was abandoning state employees and acquiescing to the wishes of politicians who want to make state employees the fall guys for the economic ills of the state.

Louisiana State Penitentiary Warden Burl Cain — the state employee representative on the commission — advised state employees to become “proactive” in the wake of the assault on their jobs.

“You better come out from under the house yourselves and you better go to calling your legislators and you better not just let this happen to you,” Cain said.

Today, rank-and-file state employees are “insulated from political favoritism and arbitrary treatment in hiring, firing and discipline. Anything less is a politically based spoils system abandoned decades ago,” said Leonal Hardman, president of the Louisiana Public Employee Council 17.

The system being proposed would allow an individual to be laid off based on “whether or not an individual is liked or not liked,” Hardman testified.

Clyde Martin retired from the state Department of Transportation and Development, then was rehired after the hurricanes.

Martin told the commissioners he could remember when the Civil Service system was adopted to provide job protections no matter who was in office.

“At that time, the deduct system was in effect. Politicians were collecting money for jobs,” Martin said. “Now all of a sudden there’s an emergency here and we’re ... changing the rules to fit what the politicians want.”

The Jindal administration and several lawmakers are pushing for similar changes either administratively or through legislation introduced in the current session, part of “government streamlining.”

Baton Rouge lawyer Mark Falcon said appointed officials call the shots on agency personnel matters. Human resource officers would be afraid to step forward to complain if politics is creeping into the layoff process, he said.

The proposed rules would foster “bias, favoritism and lack of objectivity,” said Falcon, who represents employees in personnel matters.

Falcon predicted the new rules will open the door to many employee lawsuits.

Former longtime Civil Service Director Herb Sumrall said about a dozen human resource directors asked him to testify in opposition to the changes because they are “afraid of retribution.”

The scuttling of seniority amounts to “an attack on the property rights of a classified employee. That’s the only thing that gives them protection from layoff and political abuse in the guise of a layoff,” he said.

<http://www.theadvocate.com/news/44511432.html>.

[\[BACK TO TOP\]](#)

## **Weight Loss Wednesday: Man loses hundreds of pounds -- and keeps it off**

**WWLTV | 05.06.09**

Meg Farris / Eyewitness News

NEW ORLEANS – It was in a doctor's office just days before Hurricane Katrina hit when the nurse told a Belle Chasse man to step on the scale.

Video: Watch the Story

That's when he knew he had to change his life. But he could never have imagined just what was in store for him.

Roy Guillot's story of how he went from 365 pounds to 195 pounds is a very emotional one.

"I was already depressed. I just went into more depression and probably gained more weight," Guillot said. "I think I probably went to 400 at one time.

It's hard to imagine that a man who is newly in love, who regularly dances with friends, who now runs dozens of road races, who loves get-togethers with his children and grandchildren, at one time did not leave home.

"I knew I was dying, so I was like, why am I going to die like this?" Guillot said.

Roy was always athletic, running, working a very physical job for the railroad. But then, years ago, he began to ache. He stopped exercising, thinking that was the cause. Instead the pounds packed on. It turns out the years of terrible pain with hands too stiff to open, was something else.

"The R.A. was causing inflamed and amaged joints. When you're carrying extra weight on damaged joints, it's going to cause a problem. He needed the medicine," said Dr. Leonard Serebro, a Rheumatologist at Ochsner.

R.A. is rheumatoid arthritis, the kind where your own immune system begins attacking all your joints. Regular IV medication helps the symptoms but his primary doctor said his weight was killing him.

Roy said that the doctor told him he was going to be alright for about a year, but that he wouldn't bet on two years.

"That stuck with me the whole time," Guillot said.

That was major motivation.

"There are studies that have shown that a physician making that statement can have a profound effect on a person's life, and it takes a minute, but often times doctors don't take the time to say it," Serebro said.

In constant pain, obese, a recluse, unable to work, sinking into depression, not being able to enjoy his family and a doctor saying his days were numbered, caused an epiphany. He drove to a store and leaned on a shopping cart.

"So the first thing I did as far as exercise was go over to Target, get out the car, get a basket and push the basket around Target as long as I could and push the basket back to the car and get in," explains Guillot.

He called this exercise cart-cruising.

"If I dropped dead, there were people there to call people," Guillot said, laughing.

He ordered NutriSystem food, boxed in small portions. Cart-cruising graduated to bike riding, to walking, to aerobic exercise and then to weight lifting in the gym. He was out of his bodily prison. He got back into life and fell in love.

How did he feel physically when he lost the first 100 pounds?

"Like I was going down in age," Guillot said.

And how did he feel emotionally? Like a new man?

Emotionally touched, Guillot began to cry and said "yes."

195 pounds was hard to maintain with a real life. 210 was easier. But then that became hard to maintain, now with an even more active social life with Joyce. His weight crept to 225.

"That is the one thing that is associated with long term weight loss success. If you do not exercise, you will gain the weight back. Muscles that are fit burn fat, preferably over carbohydrates, and that's what we want to see people doing," says Melinda Sothern, a Weight Expert and Researcher with the LSU Health Sciences Center's School of Public Health.

"No matter whether he's losing weight or maintaining weight, the four to six meals a day concept works because it stabilizes that very powerful storage hormone insulin," said East Jefferson General Hospital Fitness Expert Mackie Shilstone.

Experts said Roy is right to do regular exercise, including weight lifting. Mackie recommends 300 minutes of exercise a week and getting tested to see how many calories Roy is actually burning daily. He also may need a regimen.

"Relapse prevention is the technique that he needs to follow. And he needs to see a professional, because he needs to have it scheduled. He needs to have scheduled time when he can be off of his meal plan and scheduled time when he goes back on his meal plan," adds Dr. Sothern.

"The best advice is planning. One of the first questions I ask patients is what are you having for dinner tonight and for the most part people can't tell me," said Tulane Internal Medicine Specialist Dr. Harlan.

"Dr. Gourmet" Timothy Harlan said boxed meals can actually be smaller than normal portions. They are good to help you learn new visual cues, but can make it hard to retrain yourself back to normal food portions.

But together Roy and Joyce are doing it.

"Lately you know what? We do. We split whenever we go to dinner. We split a meal, that's what we do," said Guillot's girlfriend, Joyce Piacun.

Joyce is down 10 pounds. Roy is determined.

"I'm just going to slack up on eating, smaller portions and quit eating. I've been eating fast food because it's easy," said Guillot.

Dr. Gourmet said food portions in the U.S. are so large, most people have no concept of what a real portion size is.

The real size of protein should be four ounces. The box meals only have two ounces, while most people eat up to a 16-ounce serving of meat.

<http://www.wwtv.com/topstories/stories/www1050609cbwlv.2809efff.html>

[\[BACK TO TOP\]](#)

## **Officials Note Youth of Serious Flu Cases**

**The New York Times | 05.06.09**

By DONALD G. McNEIL Jr.

Although very few Americans have developed serious swine flu complications, those who have are surprisingly young, United States health officials said Wednesday.

Only 35 people have been hospitalized with confirmed swine flu infections, but their median age is 15, said Dr. Richard E. Besser, the acting director of the Centers for Disease Control and Prevention.

"This is something that's raising concern," he said. "It's something we're keeping an eye on."

In Mexico, where the epidemic is believed to have started in March, hospitalizations and deaths among previously healthy young people alerted authorities that something other than seasonal flu was circulating. Although seasonal flu causes 250,000 to 500,000 deaths annually around the world, the vast majority are of the elderly, of infants and of people with other health problems.

The World Health Organization said Wednesday that there were 1,893 confirmed cases in 23 countries. The flu is blamed for the deaths of 42 people in Mexico and 2 in the United States.

Of the 35 Americans hospitalized, 7 were known to have other health problems, Dr. Besser said. He did not specify the problems, but said there was "a wide range."

He also cautioned against "overinterpretation" from such a small number of hospitalizations. The fact that many early cases were students who had spent spring break in Mexico could make the flu's spread more common in teenagers, he said. And some scientists have speculated that anyone born before 1957 has some immunity. In that year, the H2N2 "Asian flu" largely displaced the H1N1 seasonal flu that had been circulating since 1918; in 1977, the H1N1 "Russian flu" emerged and became a seasonal flu, but may not give any protection.

Across the country, the number of confirmed cases rose to 642 in 41 states, up from 408 on Tuesday. Illinois now has the most confirmed cases, with 122, surpassing New York with 97.

Dr. Besser said that might be because Illinois was testing more. He said that Mayor Michael R. Bloomberg, on a visit to the C.D.C. earlier, had been asked by a reporter why New York had been surpassed, and had answered: "You want 200 more cases? We'll test 200 more people."

In Albany, the state health commissioner, Dr. Richard F. Daines, said New York had cut back on testing and would suspend daily news briefings and treat the virus like a seasonal flu.

"We need no longer conduct surveillance to determine the existence of the virus," he said. Instead, the state will test only enough to follow overall trends in the virus.

Dr. Besser said, as he has before, that he expected the flu to spread to all 50 states and to cause more serious cases.

At a W.H.O. news conference, Marie-Paule Kieny, chief of the W.H.O.'s vaccine research initiative, estimated that the world's vaccine makers had the capacity to make a maximum of 1.2 billion doses of a new H1N1 vaccine within six months after getting a seed vaccine, which the C.D.C. is now working on.

Many wealthy countries have already made arrangements with vaccine makers to buy millions of doses, she said. The W.H.O. is meeting with vaccine companies to try to get them to reserve some doses for purchase by United Nations agencies or charities to provide them to poor countries.

In Mexico, people went back to work on Wednesday, but more than 33 million students spent another day at home. High school and university students return on Thursday, and younger students go back to school on Monday.

[http://www.nytimes.com/2009/05/07/world/americas/07flu.html?\\_r=1&ref=health](http://www.nytimes.com/2009/05/07/world/americas/07flu.html?_r=1&ref=health)

[\[BACK TO TOP\]](#)

## Government Reports Criticize Health Care System

The New York Times | 05.06.09

By KEVIN SACK

Two annual government reports released Wednesday show that progress in improving the quality of health care and narrowing health disparities among ethnic groups remains agonizingly slow, and that patient safety may actually be declining.

One of the reports, compiled by the Agency for Healthcare Research and Quality, found measurable improvement in fewer than half of the 38 patient safety measures examined, like accidental lacerations and catheter-associated infections. The agency concluded that one of every seven hospitalized adults on Medicare had experienced at least one adverse event, calling the finding "disturbing."

"Despite promising improvement in select areas, the health care system is not achieving the more substantial strides needed to close the gap or 'quality chasm' that persists," the report concluded. "Despite efforts to transform the U.S. health care system to focus on effective preventive and chronic illness care, it continues to perform better when delivering diagnostic, therapeutic, or rehabilitative care in response to acute medical problems."

A separate report on health care disparities noted some improvements in closing the gaps between ethnic groups but found little progress in addressing the most glaring differences. For instance, black Americans continue to be nearly 10 times more likely than whites to contract AIDS, little changed since 2005. They are twice as likely to have a leg amputated because of diabetes and pregnant black women are twice as likely not to receive prenatal care in the first trimester.

Dr. Carolyn M. Clancy, the agency's director, said the reports' most notable finding was "the collective lack of dramatic improvement." She noted, for instance, that only 40 percent of diabetics were receiving each of three recommended annual treatments: a hemoglobin test, an eye exam and a foot exam. That figure, for 2005, was down by 5 percentage points from 2003.

Like previous research, the studies found significant variations in quality between states and among procedures. The rate of influenza vaccinations for diabetic adults was as high as 66 percent in one state and as low as 24 percent in another. While 96 percent of hospitalized heart attack patients received recommended care, like the administration of aspirin and beta blockers, only 60 percent of colon cancer patients were properly treated through the removal of lymph nodes for biopsy.

Across 45 core measurements, the median level of receipt of needed care was only 59 percent. "We can and should do better," the report on quality said.

While progress was being made in almost all of the core measures, the median annual rate of improvement was only 1.8 percent. The rate of improvement in the treatment of acute conditions, like heart attacks, was twice that for prevention or for the management of chronic conditions, like cancer screenings. The rate of improvement was more marked in hospitals than in long-term care or ambulatory care facilities.

The agency found an average decline of nearly 1 percent in its patient safety measurements over each of the last six years. Contributing to the drop were increases in the rate of accidental punctures and lacerations during procedures and of infections and other complications stemming from the placement of central venous catheters.

The secretary of health and human services, Kathleen Sebelius, highlighted the reports on Wednesday in announcing the availability of \$50 million in federal stimulus grants to help states combat infections associated with health care. She also challenged hospitals to reduce blood stream infections from central catheters by 75 percent over the next three years.

<http://www.nytimes.com/2009/05/07/us/07care.html?ref=health>

[\[BACK TO TOP\]](#)

## **Rangel Bars Any Taxes on Workers' Health Care**

**The New York Times | 05.06.09**

By ROBERT PEAR

WASHINGTON — The top tax-writer in the House of Representatives said Wednesday that there was “no way” he would support taxing employer-provided health benefits, Americans’ leading source of coverage.

The comment came from Representative Charles B. Rangel, chairman of the House Ways and Means Committee, after a committee hearing with the new secretary of health and human services, Kathleen Sebelius.

Mr. Rangel’s remark was the clearest indication yet of the difficulties Democrats may have in raising money to fulfill President Obama’s campaign promise of offering health insurance to all Americans.

The chairman of the Senate Finance Committee, Max Baucus, Democrat of Montana, has expressed interest in the idea of limiting the tax break for employee health benefits. Some politicians of both parties, as well as many economists, say the tax break is inequitable because its benefits go disproportionately to people with higher incomes.

“It’s too regressive,” Mr. Baucus said in March. “It just skews the system.”

Mr. Rangel, a New York Democrat, did not suggest any specific way to finance coverage for more than 45 million people now uninsured. In response to a question, he said, “I would not want to get involved in cutting hospital payments.”

Hospitals are a mainstay of the economy in the New York metropolitan area, and for years Mr. Rangel has been attentive to the needs of teaching hospitals and those that care for large numbers of poor people.

Under current law, employers can take tax deductions for their contributions to the cost of employee health insurance, and the benefits are not counted as taxable income to workers.

Critics say that by subsidizing the purchase of insurance, the tax break insulates people from the cost of care, increases the demand for it and leads to more health spending.

In the presidential campaign, Barack Obama assailed the Republican nominee, Senator John McCain of Arizona, for supporting the taxation of employee health benefits. But in March, some of Mr. Obama’s economic advisers indicated that he might be open to the idea.

Since then, labor unions have stepped up their criticism of it, saying it would impose a tax increase on working families and undermine employer-sponsored health coverage. Testifying on Wednesday before Mr. Rangel’s committee, Ms. Sebelius affirmed the president’s opposition to the idea but did not completely shut the door on it.

Eliminating the tax break “has a huge potential of destabilizing the private market and leaving more Americans uninsured,” Ms. Sebelius said. Still, she said, Mr. Obama is open to “all serious discussions” of it and other ideas with members of Congress.

On another volatile issue concerning the health care overhaul, Ms. Sebelius defended Mr. Obama’s proposal to create a government-sponsored insurance program, which would compete with private insurers. Republicans and insurance companies strenuously oppose the concept.

Representative Wally Herger, Republican of California, asked if a government-run health plan would force private insurers out of business, causing people to lose coverage they already had.

Ms. Sebelius, former Kansas insurance commissioner, said it all depended on how the government program was configured. She said Mr. Obama did not support “dismantling the private market” and relying

entirely on a public program. Indeed, she said, “the president and I want to stabilize the private insurance market.”

In more than two dozen states, she said, state employees have a choice between traditional private health insurance products and a public plan. Such competition does not destroy the marketplace but simply gives people an additional choice, she said.

<http://www.nytimes.com/2009/05/07/health/policy/07health.html?ref=health>

[\[BACK TO TOP\]](#)

## **New Effort Reopens a Medical Minefield**

**The New York Times | 05.06.09**

By BARRY MEIER

A back-pain researcher, Dr. Richard Deyo recalls the uproar the last time federal officials tried to suggest how doctors should practice their profession.

It was in the mid-1990s, when Dr. Deyo helped develop federal guidelines urging surgeons not to perform spinal fusions to treat acute pain. The reason was simple: There was little evidence that the fusions worked in many patients.

Spine specialists quickly attacked the report, calling it flawed. One medical device maker, Medtronic, sued unsuccessfully to block its release. Republican lawmakers tried to kill the agency that issued the report. It survived, but its funding was drastically cut, and it decided to stop issuing guidelines.

Now, 15 years later, the Obama administration is entering this same medical minefield. And once again, opponents are gearing up for a fight.

The administration plans to spend \$1.1 billion over the next few years on studies like the one conducted by Dr. Deyo, to compare the effectiveness of competing treatments for common conditions like back pain, heart disease and prostate cancer. The studies will be publicly released, to help doctors and patients decide which treatment options they want to pursue.

Supporters include many medical researchers, consumer groups, unions and insurers. They say such studies are essential to curbing the widespread use of ineffective treatments and to helping control health care costs, which totaled \$2.2 trillion in 2007, or 16 percent of the nation's gross domestic product.

The New England Journal of Medicine published several articles Wednesday supporting the federal effort and rebutting arguments raised by critics.

But potential opponents — which include medical products companies, some doctors and their political allies — warn that the comparative effectiveness movement could lead to inadequate treatment for some patients and even the rationing of health care.

“It is not difficult to see how you can get on a slippery slope very easily,” said Tony Coelho, a former Democratic congressman who is head of a new industry-backed Washington group called the Partnership to Improve Patient Care, formed to lobby on the comparative effectiveness effort.

The group's backers include major trade organizations that represent producers of drugs, medical devices and biological treatments.

Critics like Mr. Coelho also point to a British government agency, the National Institute for Health and Clinical Excellence, or NICE, which considers costs in judging a treatment's effectiveness. Based on NICE's findings, the British government has denied some patients access to costly drugs like those used to treat cancer.

Whether cost should be a factor in this country was a hot-button issue during the Congressional debate in February, when the comparative-effectiveness funding was approved as part of the economic stimulus package. A legislative report by Congressional lawmakers who negotiated the final version of the bill said that they did not intend the research money to be used to “mandate coverage, reimbursement or other policies for any public or private payer.”

Despite that assurance, even supporters of the effort say one goal in identifying effective medical treatments is to stop wasting money on those of little value.

For now, proponents and critics are warily circling one another, as the first administrative steps of the process unfold.

A panel of government health experts is holding a series of public hearings at which people can suggest medical conditions for comparative effectiveness reviews. Then, in late June, that federal panel and the Institute of Medicine, a part of the National Academies of Science, will issue reports recommending priorities for comparative research. Past combatants like Dr. Deyo expect the fighting to start as soon as such studies start identifying winners and losers.

“If this research is done in a rigorous way and doesn’t pull strings, then a lot of pressure will come to bear,” on the process, said Dr. Deyo, a professor at Oregon Health and Science University in Portland.

Some conservative and libertarian research groups, as well as commentators like Rush Limbaugh, have attacked the comparative effectiveness effort as a step toward socialized medicine. Some medical experts have also raised concerns that the program may slow the drive toward so-called personalized medicine — an approach in which treatments are tailored to a patient’s genetic makeup. But for now, Mr. Coelho’s opposition group and drug and device makers are using more measured rhetoric.

Mr. Coelho, a former House Democratic whip who resigned in 1989 over a controversial junk-bond investment, says his organization does not oppose the concept of comparative effectiveness. But the group is concerned, he said, that such studies could lead to a type of cookbook medicine that will ignore the needs of specific patients, including members of minority groups.

His organization includes patient advocacy groups like the National Alliance for Hispanic Health and the National Alliance on Mental Illness, which also receive financing from medical products companies. Those groups argue that their members are underrepresented in formal clinical trials of drugs and treatments, and so there is not evidence enough on which to draw conclusions on what works for them and what does not, they say.

Mr. Coelho, a driving force behind the Americans with Disabilities Act, points to his own experience with epilepsy, which he has had since he was a teenager, as an example of how patients need to be treated individually.

Under the comparative effectiveness program, the Department of Health and Human Services and two agencies under it — the National Institutes of Health and the Agency for Healthcare Research and Quality — will finance studies that will look at various treatments and will pay for the development of information-gathering tools, like databases of patients being treated for a certain condition.

Right now, “there is no place that helps you sort through a specific option and how that compares to another,” said Dr. Carolyn M. Clancy, the director of the Agency for Healthcare Research and Quality.

The agency, back when it was known as the Agency for Health Care Policy and Research, was the federal body Dr. Deyo worked with in drafting the back-pain guidelines in the mid-90s.

More recently, officials of the Oregon Evidence-Based Practice Center began producing reports a few years ago comparing the effectiveness of competing drugs, both brand-name and generic, in treating specific conditions. The work was meant to help purchasers like state Medicaid programs lower their costs, said Dr. Mark Helfand, director of the center, which is part of the Oregon Health and Science University.

Wherever they went, Dr. Helfand said, he and his colleagues met resistance from drug makers and some patient groups that had rallied to the companies’ side, who raised the same arguments that critics of comparative effectiveness are raising today. The Practice Center’s research, which is continuing, is now used by 14 states. Dr. Helfand said groups representing African-American, Hispanic or elderly patients were right to argue that they were underrepresented in clinical trials. But he added that the whole point of comparative effectiveness was to move medical practice beyond the limits of such trials, by looking at a broader range of evidence that includes the actual experience of patients undergoing treatment.

“Ironically, the motivation for comparative effectiveness is to see what works in practice,” he said, “rather than overgeneralizing from a few unrepresentative studies.”

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[\[BACK TO TOP\]](#)

## **Curative Powers, on the Night Shift**

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By MARIA CEVALLOS-MONTALVO

I'VE worked the night shift as a pharmacist at Montefiore Medical Center in the Bronx for almost four years. My hours are 10 p.m. to 8 a.m., and my schedule is seven days on, seven days off. My husband works at a bank and has a 9-to-5, Monday-to-Friday schedule. We're used to working different shifts.

I have to laugh when people say my job must be boring. They probably have this picture in their mind that nothing much happens at night and that I just stand around. If they only knew. On a slow night, there is a minimum of 200 prescriptions to fill. On a busy night, there can be 500 or 600.

I work in the main pharmacy. Other pharmacists work in satellite areas like the critical care units and on the general medical floors, but except for those in the pediatric pharmacy unit, most leave at midnight. I'm the only pharmacist for the main hospital after that.

I usually have two pharmacy technicians to help me, and, believe me, if only one is scheduled, it can get hectic. There's a saying in this field: Behind every good pharmacist, there's a great technician. If not for them, I couldn't do my job.

We receive requests for medication from several locations. People admitted from the emergency department at night may be given medication, and those who are discharged after they're seen may need some as well. If something serious happens during the night to patients already in the hospital — perhaps a stroke or a heart attack — they need medication as well.

I check the orders and pass them to the technicians to fill. If an order doesn't look right, I'll page the doctor who requested it and ask about it. When the technicians are done filling an order, they pass it to me to check their work. After I approve it, they insert the medication into our vacuum tube system for delivery to the medical floors.

An emergency gets our adrenaline going. If a patient has possibly suffered a stroke, we'll get a page to be on alert while the doctor confirms it. If it is a stroke, we'll get a second page. Then we have 10 minutes to get the necessary medication to the patient for the best outcome.

I started on one of the evening shifts at Montefiore, all of which end by 12:30 a.m., and worked in several pharmacy units. The evening-shift supervisor asked me if I would help out on the night shift occasionally because they were short-handed. I figured that they needed help, and I was awake until 2 or 3 a.m. anyway, so a few more hours wouldn't make much difference.

Six months later, I asked to be made permanent on the night shift so that I could be home during the day.

My children are 8, 14, 17 and 20. If my 8-year-old gets sick, I can take him to the doctor after my shift without having to take a day off. Or, I can attend a parent-teacher conference and not lose time from work.

It might mean that I'm up for 30 hours straight once in a while, but I can get by on very little sleep. I usually sleep five or six hours during the day, and I'll sometimes take a nap before work.

Not everyone would want to work the night shift, but I like it. I'm never bored. I play rock music, Latin songs and classical music on my iPod and attach a speaker so the technicians can hear, too.

I've developed a rapport with the nurses who call about prescriptions or with questions. They might ask about interactions between medications, or the reason for using a certain medication that may not be readily apparent. When we're done with the serious questions, we joke back and forth.

I also know the employees in the cafeteria where I order food. Our cafeteria closes at 7 p. m., so I call the cafeteria at North Central Bronx Hospital, which is connected to Montefiore and stays open. The person who answers the phone there might say, "You want soup?" Or, "Do you want the usual?"

I've been a pharmacist for more than 10 years. I got into this field because of my first job after high school, working part time in a pharmacy near my home. That pharmacist, who had watched me grow up in the neighborhood, said I had a knack for this work and motivated me to go for a pharmacy degree.

I still work part time at another retail pharmacy during the weeks I'm not at Montefiore. The owner depends on me so much that he schedules his personal appointments around my hospital work hours.

I like to feel that I'm making a difference in my work. Montefiore is a teaching hospital. Doctors in training are still learning, and pharmacists can add to their knowledge about medication. For example, we can help with what doses have been shown to work.

Each day when I leave the hospital, I'm thinking about the notes I left for the morning shift to make sure that nothing falls through the cracks. Then it's on to what I have to do — whether it's making phone calls, paying bills or picking up milk at the store.

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[\[BACK TO TOP\]](#)