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## Health care community shifts focus after storm

**New Orleans CityBusiness | 08.25.08**

by Richard A. Webster Staff Writer

"I'm a Charity patient and I will always be a Charity patient."

This was the mantra of old New Orleans, said Dr. Cathy Fontenot, medical director for the Medical Center of Louisiana at New Orleans.

Before Hurricane Katrina, the majority of low-income, uninsured patients were completely dependent on Charity Hospital for all of their medical needs. A trip to the emergency room was the solution for everything from minor pains to serious injuries. And people were resistant to change.

"When we encouraged them to go to our partner clinics like St. Thomas and Daughters of Charity or somewhere else as opposed to the emergency department, they would say, 'Oh no. I'm a Charity patient and will always be a Charity patient,'" Fontenot said. "We wanted to move the focus to primary and preventative care, but it was difficult to break these old habits."

Difficult for LSU, maybe, but not for a hurricane.

Three years ago, Katrina closed Charity, along with six other hospitals, decentralizing public health care in New Orleans. Public and private hospitals, faith-based organizations and other groups seized the opportunity to redesign how health care is delivered in the city and committed to a community-based model that focuses on primary and preventative care.

Before the storm, there were 70 clinics on the Charity campus. After the storm, LSU relocated the majority throughout New Orleans and added an additional 40.

"We want our patients to look at these clinics as their medical homes that can take care of their families from little babies to grandmas on a day-to-day basis," Fontenot said.

The Tulane Community Health Center opened Wednesday in eastern New Orleans. Since the storm Tulane University Medical Center has opened seven neighborhood clinics that serve 20,000 people per month and changed its mission statement to "We heal communities" to reflect its post-storm focus on establishing neighborhood primary care clinics.

Dr. Karen DeSalvo, Tulane vice dean of community affairs and health policy, compared New Orleans' pre-hurricane health care system to anti-crime strategies that focus on building more prisons instead of focusing on preventative measures.

"You can't just build more hospitals because all you're dealing with is the end results of an illness," DiSalvo said. "You need hospitals but you also need prevention and mitigation. As we've built back the health care system, we've been able to pay more attention to the front end."

Katrina decimated New Orleans' health care infrastructure, resulting in a loss of 1,809 beds, and laid waste to a mental health care system that lost more than 300 beds.

The storm also put a severe financial strain on the remaining facilities that have had to care for the uninsured patients who once depended on Charity. In 2007, the five major hospitals in the region — Touro Infirmary, East Jefferson General Hospital, West Jefferson Medical Center, Ochsner Health System and Tulane Medical Center — lost a combined \$135 million.

But despite the challenges that arose after the storm, hospitals have never put their bottom line above the safety of their patients, said Ochsner CEO Dr. Pat Quinlan.

"There are services where it would be easy to cut because they're expensive, but we all recognize that we're in this together," Quinlan said. "If one hospital fails, the others will have to pick up the slack and they'll probably fail as well. So there is a sense of shared possibility. And it's a testament to our dedication that we're willing to bet on our companies' survival to do the right thing for the people of this region."

<http://www.neworleanscitybusiness.com/viewFeature.cfm?recid=1153>

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**Health care system needs it all**

**The Times-Picayune | 08.24.08**

Louis Trachtman, M.D.,  
Orleans Parish Medical Society

The article by Jennifer Evans regarding the status of health care in the New Orleans area was excellent. The pessimist may see a water glass half-empty and the optimist half-full, but the reality is that it's half a glass of water. Our health-care system needs the full glass.

We have not lacked for quality health care, but we have certainly lacked quantity post-Katrina.

Measurement of the number of doctors in the area is a good indicator of the availability of health care. The programs sponsored by the state to bring physicians and other health care professional persons to the area are most praiseworthy.

The efforts by the state to build a new large teaching medical center in New Orleans are most worthy as well.

In looking to the future, we know a well-trained, full medical team is needed to provide proper health care for our entire community. For the five private hospitals mentioned, full "back pay" and continuing supplementing of the dollars being lost in this post-Katrina era are necessary.

All of these things are needed for us to attain a full and complete health care system in this area again. Thank you for presenting this matter so well and for making it a front-page article.

Louis Trachtman, M.D.,

President

Orleans Parish Medical Society

New Orleans

<http://www.nola.com/news/t-p/letterstoeditor/index.ssf?/base/news-12/1219556048176550.xml&coll=1>

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### **3 years later, Katrina is reshaping area's life**

**The Times-Picayune | 08.23.08**

by John Pope and Andrew Vanacore

Three years after Hurricane Katrina laid waste to the New Orleans area, there is indisputable evidence of recovery.

Houses are being repaired or built. New and long-established restaurants are seeing busier days. Health care institutions are reopening. Music is pouring out of crowded clubs lining Frenchmen Street. Streetcars are clattering once again along the entire St. Charles Avenue line.

And sales of cafe au lait and beignets at Cafe du Monde's legendary French Quarter stand have climbed back to about 80 percent of what they were before the storm struck on Aug. 29, 2005, said Jay Roman, vice president of the business.

But Xavier University President Norman Francis has a warning for the overly cheerful: Don't be deceived.

For Francis, whose home near the London Avenue Canal was wrecked by floodwaters, Katrina has left a lingering presence that he likens to a garish dye stain in a rug.

"The deeper you go, you see more," he said. "You keep rubbing and say, 'I think I've got it.' No, we don't have it all."

While communities that didn't flood have few visual markers from Katrina, a reshaped physical and human landscape is found in places that sustained high water. In Plaquemines Parish, for example, some riverside hamlets were virtually wiped off the map by storm surge, and residents have recongregated on higher ground around Belle Chasse.

John Hopper sees reminders if he deviates only slightly in his daily commute from his Uptown home to City Park, where he is chief development officer.

"Either direction you go, left or right, there's still a whole lot of empty houses and vacant lots," he said. "The biggest optimist in the world would go there and acknowledge that there's still a whole lot of work to be done."

For Tulane University President Scott Cowen, that's an unwelcome fact of life -- and a source of frustration.

"I wouldn't have expected that, at this point, we'd still be talking about the issues of funds recovery, whether they're from FEMA or the Road Home," he said. "Those issues are still outstanding, and I would have expected at this moment that the great policy issues would have been settled."

"After three years, you can't use the excuse of this being the biggest disaster ever," he said. "This was appropriate for a year or two, but not three years out. Even though there are no benchmarks to compare this with, certain things should have been improved."

#### Sparse neighborhoods

The signs of Katrina's legacy are both visible and subtle. Although a smattering of homes are rising in the Lower 9th Ward, much of that working-class neighborhood -- and swaths of Gentilly, eastern New Orleans and St. Bernard Parish -- remain virtually untouched.

Thousands of people who fled Katrina's wrath are still struggling to come back home from what they had envisioned as temporary havens across the country. And the storm left its psychological impact on just about everyone, even if it amounts to little more than tensing up when storm clouds form.

**"I think that, since Katrina, everyone reacts in a much more hypervigilant way than we did before," said Joy Osofsky, head of the pediatric mental-health division at LSU Health Sciences Center.**

Although she said tests have shown that the number of people suffering from post-traumatic stress disorder and depression has dropped by about 30 percent since the storm, Osofsky, a professor of pediatrics and psychiatry, said the symptoms are more acute among some people with those conditions.

"The recovery has been slow," she said. "There are neighborhoods still with just a couple of houses on the street. Families are still separated."

Even in neighborhoods that have bounced back, stubborn reminders of the hurricane linger in the form of blighted properties. A report released last week showed the percentage of vacant homes in New Orleans outranks any other American city by a huge margin, with New Orleans' rate, 34 percent, nearly doubling that of Detroit.

And despite stiff new blight regulations passed this spring, code-enforcement hearings that have hauled homeowners before judges to explain tall weeds and rotting homes and a new brand of activism in many neighborhoods, the signs of frustration are unmistakable.

### Highs and lows

Connie Uddo heads the blight committee in Lakeview, one of several neighborhoods that, like Broadmoor and Mid-City, have attacked the problem aggressively, contacting homeowners who haven't addressed their storm-damaged houses and even threatening them with lawsuits.

She sees huge progress in cutting down the number of unkempt properties in the area, but she laments the pace of the city's code enforcement. "They're working hard, bless their hearts, but they're just not as together as they need to be," she said. "At this rate, we'll be doing this for the next 20 years."

The sharp contrast between restored neighborhoods and communities that look almost as if they haven't been touched since the floodwaters receded is a visual metaphor for New Orleanians' conflicted emotional state three years out, said Richard McCarthy, a founder of the Crescent City Farmers Market.

"The highs are higher, and the lows are even lower," he said. "The challenge is how to hitch yourself to the highs because you're going to need it to get through the lows."

But even with the stresses that residents of New Orleans face every day, resilience and strength are easy to find.

### 'Slight blip' of progress

In the past year, Francis, the former chairman of the Louisiana Recovery Authority board, said he has noticed "a slight blip" of progress in housing, schools, employment and nearly every other aspect of life that Katrina savaged.

"Is that enough? No," he said. "But the process has started. There are those of us who say you just can't come back to where you were. You've got to come back to where you should have been."

Doris Voitier sees that happening. She's the superintendent of the public school system in St. Bernard Parish, where everything was flooded by Katrina.

"In the first few months after the storm, we thought: 'My God, nobody's going to help us. We've got to get together and make this happen,'" Voitier said. "We dug in our heels. . . . We know it's going to be a long road, but we're going to achieve that success."

Three years out, "we do have a lot of people (who are) frustrated," Voitier said, "but I think we're also beginning to see what the important things in life are. Our kids are being educated. We have a much closer community feeling. The civic organizations and groups are pulling together."

If Katrina had any positive impact, Voitier and Cowen said, it is this: By forcing some educators to build school systems from scratch, the storm has given them a once-in-a-lifetime opportunity to reshape public education.

In St. Bernard, Voitier said, two brand-new schools have been built, and six others were renovated, all with state-of-the-art technology.

"We feel we are coming back strong," she said.

In New Orleans, Cowen, working through the Tulane public education think tank bearing his name, is helping to bring about what he calls the largest transformation of an urban school system in America. Dozens of charter schools have turned New Orleans into a potent laboratory for testing new ideas.

"It's always been my belief that after the levees, the single most important thing for New Orleans is public education," Cowen said. "If we don't get that right we'll have a population of poor people, and that will be a reflection of the poor educational system."

#### Scarce housing options

But in this case, solving one problem only forces policymakers to struggle with another: If schools and businesses are going to lure people to New Orleans, they will have to have affordable homes.

With a large slice of the area's rental stock destroyed, meeting the need for affordable housing will pose a challenge for years, experts say.

"At Tulane, we have a lot of open positions," Cowen said, "and we'd like to hire them, but there's a lack of affordable housing, particularly in midlevel management and below. The cost of housing is so much more than it was before the storm."

And some New Orleanians who have returned from their storm-imposed exile have found that getting back home to New Orleans didn't bring the sense of relief they had longed for, Joy Osofsky said.

"They thought their problems would be solved," she said, "but people weren't happy. Even though they were back in a house, there are all the reminders."

And among the people who come back, there are nagging questions about the wisdom of that decision, said her husband, Dr. Howard Osofsky, chairman of the psychiatry department at LSU Health Sciences Center. "There are people who are wearing down," he said. "It's still a hard town, even though things are improving."

Everyone agrees that the rebuilding of New Orleans will take a long time.

"There is no silver bullet," said Melissa Flournoy, director of the RAND Gulf States Policy Institute. "It's going to take 20 to 25 years to build the city of New Orleans in a way that we can be fully proud of."

Has population leveled off?

Population estimates increased in parishes across the metropolitan area in the past year, in nearly every case by small margins.

While estimates for Orleans Parish rose sharply, by 21 percent in the view of one national research firm, several experts think New Orleans' population has reached a plateau of about 320,000 as the third anniversary of Katrina's onslaught approaches. That assessment is based on such factors as school enrollment and the number of building and demolition permits.

"We're starting to get a glimpse of the post-Katrina city that we all wondered about back in the days of the uncharted future of the autumn of 2005 and early 2006," said Richard Campanella, a Tulane University geographer who wrote "Geographies of New Orleans: Urban Fabrics Before the Storm."

In assessing current conditions in the city, "I would put the characterization of good and bad to the side," he said. "This is the reality we have to deal with. I don't think anyone could look at the potential loss of about 100,000 people, the people who make up the culture of New Orleans, as a good thing, but this is the reality now."

[http://www.nola.com/news/index.ssf/2008/08/3\\_years\\_later\\_katrina\\_is\\_resha.html](http://www.nola.com/news/index.ssf/2008/08/3_years_later_katrina_is_resha.html)

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## **Program aims to aid families of mentally ill**

**The Times-Picayune | 08.22.08**

By Karl Kell

Contributing writer

The St. Tammany affiliate of the National Alliance for the Mentally Ill will sponsor a Family to Family education program for loved ones of individuals diagnosed with a mental health-related illness. The sessions will begin on Sept. 2 and run from 6:30 to 9 p.m. in the administration building at Southeastern Louisiana Hospital in Mandeville.

The 12-week course is designed for parents, siblings, spouses, teenage or adult children and significant others of a person with a severe and persistent mental illness.

It is not appropriate for individuals who suffer from one of the major mental illnesses, said Dave Mancina, board treasurer.

"Most people are unprepared and know nothing about dealing with a family member in a crisis. It is often good for them to know that they are not alone in dealing with such a life-changing event."

The course will cover information relating to schizophrenia, mood disorders, bipolar disorders, major depression, panic disorders and obsessive compulsive disorder.

Other areas to be covered will relate to coping skills, such as handling a crisis or relapse; information about medications; listening and communication techniques; problem-solving skills; recovery and rehabilitation; and self-care around worry and stress.

The curriculum has been written by experienced family members and mental health professionals and will be taught by NAMI St. Tammany family member volunteers who have had extensive training as instructors.

Board member Yvonne Venable said the course "balances basic psycho-education and skill training with emotional support, self-care and empowerment. We hope families with relatives who have a serious mental illness will take advantage of this unique opportunity."

The Family to Family course is interactive and will allow time for participants to ask questions or share information with others.

The NAMI St. Tammany group remains a strong advocate for the mentally ill in proposing new legislation on the state and federal level as well as offering monthly support groups throughout the parish.

For more information or to register for the upcoming course, contact Executive Director Kera Moseley at 985.626.6538.

<http://www.nola.com/picayunes/t-p/covingtonpicayune/index.ssf?/base//news-3/121943462437650.xml&coll=1>

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## Change In Tone In New Phase Of Katrina Recovery

WGNO | 08.22.08

The Associated Press

Personality matters.

How much? Ask the people in charge of helping rebuild the region after Hurricane Katrina.

On Thursday, the day before the storm's third anniversary, federal, state and local officials plan a bus tour to highlight the progress made and work that remains in the New Orleans area. A year ago, such a trip would have seemed unlikely - or at least uncomfortable - since officials often had to work hard to conceal their animosity toward one another and fingerpointing was down to a science.

More recently there's been a notably different tone among the chief players. They chock it up to changes in leadership and redefining their relationships.

The leadership changes have taken place at the local, state and federal levels.

Gil Jamieson's gone from the Federal Emergency Management Agency. Kathleen Blanco is no longer governor. And Henry "Junior" Rodriguez, a leading critic of FEMA, lost a bid for re-election as president of St. Bernard Parish. That's just a few.

Jim Stark, who assumed Jamieson's Gulf Coast administrative duties, said Blanco's administration, "reacting and reeling from the initial response to the storm," sometimes used the press as a pulpit to drive a push for maximum federal recovery funding.

"But that was a different time," he said.

It was. The first years after Katrina were marked by contentious, fight-for-what-you-can-get funding battles. Officials carried the baggage of the storm and the burden of trying to help frustrated residents reclaim a sense of normalcy in their devastated communities. And there were struggles navigating the bureaucracy and at-times onerous rules governing disaster recovery that almost everyone agreed were not designed for a Katrina-size event.

Rodriguez said the bureaucracy was his biggest frustration though he believes he was successful in laying a recovery groundwork for his successor. But he also thinks personality conflicts played a role.

"We had personality problems and we got frustrated and one thing leads to another and everybody thinks they're right," said Rodriguez, whose cell phone message prompt is a verse of Johnny Paycheck's anthem "Take This Job and Shove It."

"But everything resolves itself and gets better," he said.

Now, officials are finding different ways to better work through the system, and there's money to work with. It's just a matter of, in many cases, sitting down, agreeing on what needs to be done and doing it.

Sounds easy enough. **But there are plenty of thorny issues sure to put the new relationship to the test, from pushing the city of New Orleans to finish demolishing could-fall-at-any-time, storm-damaged properties to deciding what to do about the old Charity hospital.**

What happens there could have a domino effect. City and business leaders are counting on a medical corridor that includes new teaching and Veterans Affairs hospitals to spark an economic revival.

The state, in a letter to Stark in July, said FEMA valued project worksheets for Charity at \$23 million, funding meant to repair the site. The state, citing different damages assessments and cost analyses, asked FEMA to create a worksheet reflecting nearly \$492 million in replacement costs.

Lots of room for compromise. However, at least publicly, neither side has indicated a willingness to move much, if at all, from its staked-out positions.

"We have an opinion about what the numbers are, and we're going to hold strong on those, let me make this clear," said Paul Rainwater, tapped by Gov. Bobby Jindal this year to take over as head of the Louisiana Recovery Authority and a newly restructured, state-level recovery bureaucracy.

A few months ago, President Bush's hurricane recovery chief began holding sit-downs with federal, state and local officials, hoping to find out what might be holding up rebuilding projects.

A key element: agreeing not to point fingers or talk specifics with reporters, an apparent effort to avoid a new round of hard feelings.

"This has never been about resources; they're there," said retired Maj. Gen. Doug O'Dell, who took over as federal Gulf Coast rebuilding coordinator earlier this year.

It's not that everybody's best buddies now. Officials stress there are points on which they still disagree.

But Stark said not "raising the flag" with every unpopular decision has gone far toward improving personal and professional relationships with the state.

As the recovery from Katrina moves into its fourth year, the new detente may be one of the keys to getting on track what has been a difficult recovery.

[http://abc26.trb.com/news/wgno-katrinarecovery082208\\_0,1342853.story](http://abc26.trb.com/news/wgno-katrinarecovery082208_0,1342853.story)

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Doctors urge men to change habits  
The Advocate | 08.24.08  
By JARED JANES

A point all the doctors at the Louisiana Men's Health Conference continually stressed Saturday was that it doesn't take much to live longer.

Whether they were advocating exercise, better sleep or a healthy heart, the doctors emphasized the basics in preventing, identifying and treating all types of typical men's medical maladies.

Many leading causes of death for men such as cardiovascular disease, diabetes and certain types of cancer are treatable or preventable, said Dr. Curtis Chastain, the president of the Louisiana Men's Health Organization. But the diseases have to be prevented through healthy behavior or detected early through routine visits to the doctor.

"It's a learned behavior that causes us problems," Chastain said Saturday during the seventh annual conference on men's health at the Pennington Biomedical Research Center. "Women learn to go to the doctor and make healthy decisions — we don't."

That's why the Louisiana Men's Health Organization hosts the conference to give men access to health advice and routine screenings, Chastain said. For many of the nearly 1,000 men in attendance Saturday, the conference has become, in effect, their primary care physician.

Former LSU men's basketball coach Dale Brown, who survived a stroke in 2003, was the keynote speaker, encouraging the audience to be proactive in seeking health care and maintenance.

Then what Chastain called a "superstar lineup of doctors" followed up Brown's advice by encouraging men to watch for problems with their prostate, heart, sleep, weight and more.

Men, who are 25 percent less likely to see their doctor than women, usually ignore their health until they notice a problem with it, said Dr. Tim Church, a Pennington researcher who lectured on the importance of exercise. But regular maintenance — such as care tune-ups — is a cheaper and safer bet.

He said preventative approaches — including annual doctor visits, regular exercise and weight control — lead to a dramatic reduction in the risk of having health problems and open the way to a higher quality of life.

Once men "get off the couch and get moving," Church said, the action would motivate them to improve other aspects of their health.

"Even small changes in your lifestyle lead to big changes in health," Church said. "But you've got to take that first step forward."

<http://www.2theadvocate.com/news/27327099.html>

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## Medicare gap leads to elderly skipping drugs

MSNBC.com | 08.21.08

The Associated Press

WASHINGTON - Many people in Medicare with diabetes, high blood pressure and other chronic conditions stop taking their medicine when faced with picking up the entire cost of their prescriptions, researchers say.

About 3.4 million older and disabled people hit a gap, known as the doughnut hole, in their Medicare drug coverage in 2007. When that happened, they had to pay the entire costs of their medicine until they spent \$3,850 out of pocket. Then, insurance coverage would kick in again.

About 15 percent of those hitting the coverage gap stopped their treatment regimen. That rate varied depending upon illness. For example, about 10 percent of diabetes patients stopped buying the medicine, as did 16 percent of patients with high blood pressure and 18 percent of patients with osteoporosis.

The drug benefit, which began in 2006, has come in under budget. Most participants report they are satisfied with the program. But many lawmakers and health analysts say improvements could be made.

"If a new president and Congress consider changes to the drug benefit, it will be important to keep in mind that the coverage gap has consequences for some patients with serious health conditions," said Drew Altman, the chief executive officer and president of the Kaiser Family Foundation. The foundation conducted the study with researchers at Georgetown University and the University of Chicago.

### 2003 Congress crafted the hole

The Republican-led Congress in 2003 crafted the doughnut hole as a way to make the drug benefit more affordable for the federal government.

The researchers based their findings on pharmacy claims data provided by IMS Health, a company specializing in collecting health care data. They excluded people who get extra help in paying for their drug coverage because of their income; they do not pay the full cost of medicine even when in the doughnut hole.

When looking at spending by people who did not receive the extra help, researchers could determine when they hit the coverage gap, which began at \$2,400 in total drug spending. They also could determine when they passed through the gap and catastrophic coverage kicked in.

The researchers focused their analysis on eight categories of drugs. Those least likely to stop taking their medicine were Alzheimer's patients, at 8 percent. Those most likely, at 20 percent, were patients taking medicine for heartburn, ulcers and acid reflux disease, 20 percent.

Jeff Nelligan, a spokesman for the Centers for Medicare and Medicaid Services, said the coverage gap kicks in after participants have saved about \$1,600 on their drug costs, on average. He also noted that many plans offer some coverage when beneficiaries hit the doughnut hole. Those plans cost at little as \$28.70 a month, and are available in every state for less than \$50 a month.

"We urge beneficiaries to choose wisely when selecting their drug coverage," Nelligan said. "Again, we emphasize that any changes to the coverage gap would need to come from Congress."

### Impact varies widely across nation

The share of Medicare recipients who reached the doughnut hole varied widely by region. About one-third in Arkansas and seven states in the Northern Plains hit the coverage gap in 2007, but only 12 percent in Nevada did.

Researchers said such regional differences may occur because of physicians' prescribing patterns as well as overall health of the population. A separate factor may be enrollment in Medicare Advantage plans. Such plans offer comprehensive health coverage on top of the drug benefit. Regions where Medicare Advantage plans were most prevalent had fewer enrollees hit the coverage gap, which could reflect stronger management of drug use.

Democratic lawmakers have led efforts to let the government use its purchasing power to negotiate cheaper drug prices. They say the savings could be used to reduce the coverage gap, though the Congressional Budget Office projected that the legislation would not lead to any significant savings.

About 5 percent of the people who hit the Medicare coverage gap switched to another medication, most often a generic drug, while 1 percent reduced the number of medications they were taking in a particular class of drugs, the report said.

<http://www.msnbc.msn.com/id/26329915/>

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## **Our view: Hospital data will help all improve care** **The Town Talk | 08.22.08**

Good hospital care is essential in Louisiana, where heart disease and diabetes take a disproportionate toll on the population.

Now there's help to evaluate that care.

The U.S. Centers for Medicare and Medicaid Services has published a comparison of hospital death rates.

The report shows mortality rates by U.S. hospital for deaths caused by heart attack, heart failure and pneumonia; and compares each to a national average.

The information, which had been kept from the consumer, gives hospitals ways to assess their quality of care and, if they choose, make improvements.

Now, for good reasons, the information is available to consumers.

Such information gives consumers more power to influence decisions regarding their medical care, said Lisa Iezzoni, associate director of the Institute for Health Policy at Massachusetts General Hospital. She was interviewed by USA Today.

The report includes more than two dozen other measures of how well hospitals meet patients' needs. These include the percentage of patients who get appropriate care for a variety of ailments, including childhood asthma, and 10 measures of patient satisfaction with the hospital experience.

The statistics do not reflect a hospital's overall mortality rate; they compare mortality rates for common life-threatening conditions.

For example: Christus St. Frances Cabrini Hospital and Rapides Regional Medical Center, both in Alexandria, had a 30-day mortality rate for heart attack at 16.8 percent and 16 percent, respectively. The national average of 16.1 percent.

Huey P. Long Hospital in Pineville did not submit information for the analysis.

In comparison, Willis Knighton Medical Center in Shreveport had a 6.7 percent heart attack death rate. Danville (Va.) Regional Medical Center, was among the worst, with a mortality rate of 24 percent.

The report does not reflect the experiences of the general population. It is based on the outcomes of 35 million Medicare beneficiaries nationwide.

The information is essential to hospital administrators who put patient care first. It points to smart practices as well as areas for improvement.

Likewise, it gives consumers, their families and their doctors information that, in a word, is vital.

<http://www.thetowntalk.com/apps/pbcs.dll/article?AID=/20080822/OPINION/80822031>

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## **The system needs mending** **The News Star | 08.24.08**

The system needs a doctor.

That might be tough, and the long-term prognosis is grim.

Northeastern Louisiana's dwindling number of private primary care physicians — those practicing general family medicine, pediatrics, obstetrics and internal medicine — threatens to stretch an already strained medical community.

In the past four years, more than 12 primary care physicians have left their private practices. Some have taken positions at hospitals, some have left the area. Many of those who remain in private practice are staring at retirement.

That leaves families, and the remaining doctors, in a precarious position.

With the loss of the Guide plant and State Farm's regional office, many patients who once had employer-sponsored insurance have turned to Medicaid rather than pay for private insurance. The growing elderly population has increased the number of patients on Medicare. Those federal programs are not keeping up with costs.

"You have overhead costs for private practices increasing. You have inflation. But reimbursements from Medicare and Medicaid aren't keeping pace. Oftentimes, they're paying less and less," said Bubba Rhymes, director of physician practice management at St. Francis.

Add to that soaring liability costs and increasing red tape by insurance plans that often require a patient to start with a general practice physician, and it becomes obvious the area's system is in trouble.

As the number of private physicians shrinks, patients face a growing frustration unable to get in to see a doctor. Those still practicing see a growing patient load, working longer days. That means less time with patients and a growing possibility of error.

Many patients, told their doctor's calendar is full, visit hospital emergency rooms, where sick people face long lines and a doctor they've never met. That increases costs to insurance companies, which in turn increase premium costs.

As more baby-boomer physicians approach retirement, the ability to replenish them becomes urgent.

The region has come to rely on the physicians themselves to recruit others to practice in the area.

"It's really the medical staff that recruits. The physicians need to be comfortable with the abilities of the staff," says Aimee Kane, director of corporate communications and physician relations at St. Francis.

Those efforts must continue.

The state might consider methods to encourage placements here in terms of reduced tuition to the state's medical schools in return for an agreement to practice for a period of time in rural northeastern Louisiana. It can be modeled after the federal government's National Health Service Corps, a \$126 million federal program under which newly minted doctors agree to work for a few years in underserved areas in exchange for partial repayment of their medical school loans.

That program, however, had to turn away about half of the 1,800 doctors who applied last year, having exhausted its budget. Congress should steer more money into that program as well.

Poverty and poor health go hand in hand. The unavailability of physicians aggravates the problem.

A prescription of heightened recruitment and added incentives could stem the pleading.

<http://www.thenewsstar.com/apps/pbcs.dll/article?AID=/20080824/OPINION01/808240310>

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## **Uninsured to Spend \$30 Billion, Study Says**

**The Wall Street Journal | 08.25.08**

By JANE ZHANG

Americans who lack health insurance will spend about \$30 billion out of pocket on medical care this year, but others -- mainly the government -- will end up covering another \$56 billion in costs, according to a new study.

The tab to cover all the uninsured would be \$208.6 billion -- \$122.6 billion more than this year's projected total -- mainly because people with insurance tend to use more health-care services, the study found.

The report from researchers at George Mason University in Fairfax, Va., and the Urban Institute think tank in Washington, D.C., is to be published Monday in the journal Health Affairs online.

With the Census Bureau set on Tuesday to release two major reports on income, poverty and the uninsured, the study is likely to spark debate on health-care reform and rising health costs.

Health-care spending accounted for 16.3% of gross domestic product in 2007, or about \$2.2 trillion, and that amount could nearly double in 10 years, according to federal figures. More of the cost is expected to shift to the government, even as it seeks to shrink large deficits.

Democratic presidential candidate Barack Obama says he would seek to give coverage to nearly all Americans by requiring parents to insure their children and large employers to offer a plan or pay into a fund. His plan relies on government subsidies, including for low-income families, and would cost an estimated \$110 billion a year.

Republican presidential candidate John McCain has promised to offer more choices, but also would offer subsidies to help lower-income patients with pre-existing illnesses. His plan would provide tax credits to individuals who buy private health insurance. His campaign has offered a preliminary estimate of \$7 billion to \$10 billion a year for the cost.

The new study estimates the government pays 75%, or \$42.9 billion, of the amount uninsured patients can't pay -- through Medicaid, the federal-state health-insurance for the poor and Medicare, the federal program for the elderly and disabled, as well as state and local taxes.

Complicating the measure: Some doctors and hospitals donate time and forgo profit to cover poor people, and in some cases private donations cover the costs. Just how much money doctors and hospitals lose in caring for the uninsured is difficult to pin down, partly because group plans often negotiate lower payment rates than other consumers are billed. For this study, Mr. Hadley of George Mason University defined uncompensated care as the difference between how much the uninsured paid and what the providers would have received had those patients been privately insured.

While many have argued that uncompensated care will translate into higher premiums to patients with private insurance, Mr. Hadley said the impact is "very small," noting that despite an increase in the number of uninsured, hospital spending on uncompensated care has been relatively stable. That is partly because the public hospitals and clinics that most often care for the uninsured often don't have many privately insured patients to absorb the costs.

"It's more through taxes than private insurance bills," Mr. Hadley said.

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## **New Insurance, Poverty Data to Play in Races**

**The Wall Street Journal | 08.25.08**

By CONOR DOUGHERTY

On Tuesday, with the Democratic National Convention in its second day, the Census Bureau will release two reports detailing the poverty rate, income and the number of Americans without health insurance. They are sure to find traction in the presidential race, where health care remains a large issue.

Predicting numbers is a dangerous business, but the reports will almost certainly show that there are more uninsured Americans than there were a year ago, as the rising cost of health care prompts more employers to cut back on benefits. This fact will give both candidates a springboard to tout their very different health-care plans. Among other things, Sen. John McCain would change the tax treatment of health insurance to help people even if they don't get insurance from their employer.

One of Sen. Barack Obama's solutions would be to set up a government-organized insurance marketplace in which private companies would compete with a medicare-like plan. Given a shaky economy and rising prices, the rest of the report would seem to benefit Sen. Obama over Sen. McCain. It is expected to show that the poverty rate stayed essentially flat from a year ago, and inflation-adjusted median earnings increased slightly. That would mean that despite six years of economic expansion, the poverty rate remains higher than it was in 2000, and middle- and low-income earners are worse off than they were at the end of the last expansion. Given the state of the economy today, that's as good as it's going to get for middle-income families.

"For Democrats this is Exhibit A in the failure of Bushonomics," says Jared Bernstein, an economist at the Economic Policy Institute, a liberal think tank in Washington, and an informal adviser to Sen. Obama. "The economy expanded but it did a total end-run around middle- and low-income families."

The economic picture is likely gloomier even than the Census report, which covers only 2007, when the economy grew and unemployment averaged a low 4.6%. Things have worsened since then. The first half of 2008 showed weak growth and today the unemployment rate stands at 5.7%. The American Enterprise Institute, a conservative think tank in Washington, predicts that the poverty rate will increase slightly, but that today's poverty rate is about half a percentage point higher than in June of 2007. That means that roughly 1.2 million additional people are living in poverty now than a year ago.

"There is no doubt that if you are measuring poverty from August 2007 to June 2008, you'd be talking about a very different story than what's going to come out on Tuesday," says Douglas J. Besharov, a resident scholar at the American Enterprise Institute.

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## **8 States Cut From System That Tracks Rate of H.I.V.**

**The New York Times | 08.22.08**

By SHAILA DEWAN

ATLANTA — Eight states and Puerto Rico will no longer receive federal money for an advanced H.I.V. monitoring system that showed that the annual infection rate in the nation was 40 percent higher than previously estimated, officials at the Centers for Disease Control and Prevention said Friday.

The change will lower the number of jurisdictions using the system to 25, from 34, just as health departments are struggling to react to the news, released earlier this month, that the spread of AIDS is far worse than they had thought.

The jurisdictions that lost financing were Georgia, Illinois, Maryland, Missouri, Ohio, Oklahoma, Pennsylvania, Tennessee and Puerto Rico.

Terry Butler, a spokeswoman for the National Center for H.I.V., S.T.D. and TB Prevention at the centers, said that the total money for the system — which is awarded to applicants on a competitive basis — would remain the same, but that the remaining 25 participating states and cities would receive more. Ms. Butler said those participants had the most reliable systems and could help the centers produce the best estimates.

The system uses a new test that distinguishes recent infections from old ones, helping epidemiologists track them in something much closer to real time than was previously possible.

Julie Scofield, the executive director of the National Alliance of State and Territorial AIDS Directors, said that over all, money for tracking H.I.V. infections and trends had decreased and that states were struggling to keep up. Ms. Scofield estimated that the money lost by the nine jurisdictions was about \$3 million.

“Surveillance funding is starving at the C.D.C.,” Ms. Scofield said. “Their ability to say that they’re going to have ongoing reliable reports of incidence is somewhat questionable unless you have funding for that.”

The alliance has called for a \$35 million increase in surveillance financing.

The new H.I.V. report did not use data from all 34 jurisdictions, only the 22 with data that met scientists’ standards, Ms. Butler said. Future monitoring will use data from all 25 jurisdictions.

But Ms. Scofield said that using fewer jurisdictions would make more extrapolations necessary to get national estimates for infection rates.

Dr. Carlos del Rio, the co-director of the Emory Center for AIDS Research in Atlanta, said Georgia’s loss of money was unfortunate.

“If you’re trying to find an enemy like H.I.V.,” Dr. del Rio said, “you want to have as much information as you possibly can.”

[http://www.nytimes.com/2008/08/23/health/policy/23aids.html?\\_r=1&ref=health&oref=slogin](http://www.nytimes.com/2008/08/23/health/policy/23aids.html?_r=1&ref=health&oref=slogin)

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## **AHA recommends changes to proposed rural health clinic rule** **AHA News | 08.22.08**

The AHA today recommended several revisions to the Centers for Medicare & Medicaid Services' proposed rule for rural health clinics.

In a letter to the agency, the AHA said it was concerned that some clinics would lose their RHC status as a result of CMS' proposal to require new and existing RHCs to be located in non-urban areas recently designated as shortage areas, or to meet certain exceptions if the clinic does not meet one location criterion.

The AHA also urged CMS not to revise its payment methodology setting RHC Medicare payments at no more than 80% of reasonable costs after application of beneficiary co-payments and deductibles, as this would threaten the financial viability of many RHCs.

[http://www.ahanews.com/ahanews\\_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann\\_080822\\_RHC&domain=AHANEWS](http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080822_RHC&domain=AHANEWS)

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## **Editorial: LaCHIP creating healthy children Shreveport Times | 08.23.08**

While political candidates argue about health insurance for adults, the state program for children is making some progress.

According to a recent report, LaCHIP, the Louisiana Children's Health Insurance Program, has reduced the percentage of children without health insurance to less than half the national average of 9.3 percent.

Multiple studies have shown health care as one of those issues holding Louisiana back. Infant mortality is at 10.1 per 1,000 births. Only 76 percent of 2-year-olds are immunized. More than 12 percent of babies in Caddo and Bossier parishes are born with low birth weights.

LaCHIP is one step toward solving those problems.

As of Jan. 3, more than 115,000 Louisiana children receive the free coverage with LaCHIP, which is funded by federal Medicaid funds.

Thousands more became eligible in June with the new LaCHIP Affordable program, which allows families making between 200 percent and 250 percent of the poverty level (up to \$4,417 for a family of four) to have health care for a small fee.

The program's total budget is \$208 million, \$40 million of which comes from the state.

Clients include families where parents have lost jobs, those working families whose insurance premiums are too high or grandparents who now care for children.

For the remaining 3.9 percent of children without insurance, education is key. LaCHIP has taken its show on the road to tell as many people as possible about the benefits available.

Through the month of August, LaCHIP is holding a back-to-school campaign to get even more families registered. Representatives will be posted at events throughout the state. And LaCHIP has increased hours for its toll-free hot line, (877) 252-2447. Operators will be available from 7 a.m. to 7 p.m. Monday through Friday and 10 a.m. to 2 p.m. Saturdays.

Applying requires a fairly simple application with income verification. From that point, there are no enrollment fees, no premiums, no co-payments and no deductibles for everything from preventative care to hospitalization.

LaCHIP 's aggressive enrollment strategy has tried to at least eliminate cost as a reason children do not receive preventative care.

That might be the easy problem. As we look at over-all health care for our children, transportation and access are other issues that should be next as we try to raise a generation of healthy children.

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=2008808220350>

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## **Administration Won't Enforce New SCHIP Rules**

**Youth Today | 08.22.08**

by John Kelly

The Bush Administration will not crack down on states that are out of compliance with its controversial rules on state children's health insurance programs (SCHIP).

At least, not for now.

The Centers for Medicare and Medicaid Services (CMS) says it will not sanction states who expanded SCHIP coverage without meeting criteria set out in an August letter from CMS to state Medicaid directors.

"At this time, we are not taking compliance action," CMS wrote in response to an inquiry from the National Association of State Medicaid Directors. "We are determining whether the relevant states are in compliance with the existing requirements."

To cover youth in families that lived more than 250 percent above the poverty line before, the new rules require a state to ensure that 95 percent of its lowest-income youth were enrolled, a test that many state agencies viewed as impossible. The rules also require states to make children go uninsured for a year before switching between private and SCHIP-funded coverage.

The news undoubtedly came as a relief to officials in California, who said last week that they would not comply with the rules imposed in August. New York and New Jersey, as well as California, filed lawsuits hoping to avoid the rules as they expanded their programs to cover more families at higher income levels.

Other states, including West Virginia and Louisiana, have backed off plans to expand SCHIP because of CMS' August letter.

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## Debate flares: Can obese patients be healthy?

Amednews.com | 09.01.08

By Victoria Stagg Elliott, AMNews staff

It's a frequent and challenging topic for exam room discussion -- do those extra pounds really undermine health and well-being? Now, a pair of studies in the Aug. 18/25 Archives of Internal Medicine has added to the discourse about whether someone can be fit and fat.

The studies upped the level of confusion and controversy by offering new evidence that some people who carry excess weight may have healthy cardiovascular and metabolic profiles while those considered at a normal weight may not have such rosy statistics. Nonetheless, experts still expressed caution about telling patients weight loss is unnecessary because it is unclear how the added bulk may affect these numbers over time. Also, the pounds often bring with them other health risks.

"Weight loss is important for all patients who are obese or overweight," said Lewis Landsberg, MD, who wrote an Archives editorial that accompanied these studies. He is director of the Northwestern University Comprehensive Center on Obesity in Chicago. "Even if one loses a small amount of weight, it definitely improves your risk factors and one's overall health, but not all obese people are at the same degree of risk."

One study, involving data from the 1999-2004 National Health and Nutrition Examination Surveys, found that almost 24% of those at a healthy weight had at least two metabolic abnormalities. These levels included low HDL cholesterol or high blood pressure, triglycerides, fasting plasma glucose or C-reactive protein. Approximately 51% of those who were overweight and 32% of those who were obese had healthy metabolic profiles.

"There's a large degree of heterogeneity in the metabolic consequences from the same amount of body fat," said Rachel P. Wildman, PhD, lead author and assistant professor of epidemiology and population health at New York's Albert Einstein College of Medicine. "And I think for a certain subset, the cardiovascular risks may not be as big as we thought."

The second study, this one by researchers at the University of Tübingen, Germany, reported the results of various tests on 314 patients. Those who were obese but insulin-sensitive had similar cardiovascular risk profiles to those who were of normal weight. Those who were obese and resistant to this hormone were at increased risk.

51% of overweight people and 32% of obese people have healthy metabolic profiles.

But experts say these studies do not exonerate excess weight as a health threat and should not change how physicians counsel patients. "From a practical standpoint, I don't think it changes our mantra at all," said Mott P. Blair IV, MD, a family physician in Wallace, N.C.

In both papers, a significant number of patients carrying excess weight still were at increased cardiovascular risk. In addition, these studies did not track outcomes. It's unknown how those with normal metabolic profiles but excess weight may fare over time. Wildman plans to investigate this issue in future projects.

"The idea that there are those who are obese and metabolically healthy appears to be true, but it's not a majority," said Dan Bessesen, MD, chief of endocrinology at Denver Health Medical Center. "And are these people really going to be healthy over the long haul? We're not sure."

These studies also did not track other health issues linked to extra weight, including an excess risk of cancer and joint problems. For example, another paper in the same issue of this journal found that being overweight increased the risk of recurrent venous thromboembolism by 27%.

"Even if there is not a cardiometabolic effect, obesity affects a person's life in so many ways," said Eric Westman, MD, associate professor of medicine at Duke University in North Carolina. He also is vice president of the American Society of Bariatric Physicians.

Watching the waist

Experts say the take-home message is that body fat is a more complicated issue than it appears, and the location of those pounds may be more important than the amount. The NHANES study found that those who were of normal weight but had a large waist circumference were more likely to have a poor metabolic profile. The German study found that those who were obese but had lower levels of fat in skeletal muscle or the liver were more likely to be heart healthy.

"It's not so much what we weigh. It's where we weigh," said Tim Church, MD, MPH, PhD, director of preventive medicine research at Pennington Biomedical Research Center in Baton Rouge, La. 24% of people at healthy weights have at least two metabolic abnormalities.

For this reason, medical societies and public health agencies are increasingly promoting the measurement of waist circumference. American Medical Association policy encourages physicians to incorporate this vital sign along with a BMI calculation into the routine adult physical. Experts say it can be particularly helpful to identify and monitor those whose total weight is normal but may not be distributed in a healthy way. But many say that although physicians generally support this practice, anecdotal evidence suggests that measuring a patient's waist has not become widespread.

"Patients feel a little funny about it," Dr. Bessesen said. "They're not used to a physician coming at them with a tape measure."

Experts said these studies highlighted the importance of healthy behaviors, such as eating well and being active, over numbers on a scale.

"There are people in my practice who have a BMI of 25 to 30 who are actually very active and very fit," said Randy Rice, MD, a family physician in Moose Lake, Minn. "They're quite healthy, and they just cannot get the weight down. It's fine to keep active and not to get to hung up on just the weight."

The NHANES study linked physical activity to greater metabolic health. Also, a study published in the Dec. 5, 2007, Journal of the American Medical Association associated physical fitness, as determined by a treadmill exercise test, with a low risk of death, regardless of body weight.

<http://www.ama-assn.org/amednews/2008/09/01/hll20901.htm>

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