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Local physician to chair Go Red for Women luncheon
Shreveport Times | 08.25.08
From staff reports

Dr. Mary Mancini has been named the chairwoman for the 2009 Northwest Louisiana Go Red for Women Luncheon.

Mancini is a professor of surgery at LSU Health Sciences Center in Shreveport and maintains an active open heart surgery practice.

She also is one of the chief editors for the eMedicine textbook hosted by Web-MD.

The Go Red for Women luncheon will be Feb. 26. Call Rachel Miller or Nichole Smith of the American Heart Association at (318) 677-2483 for more information.

http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=/20080825/NEWS01/80825029

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Touro Fights Healthcare 'Brain Drain'
Nurse.com | 08.25.08

New Orleans—Touro is introducing local high school students to nursing and a number of allied health professions through a five-day career camp. The hospital hopes that by introducing teens to these professions early, students will consider careers in the field and eventually practice in the city.

Twenty students will participate in a five-day intensive course from July 28 to August 1. A main focus of this year's program is nursing, although a number of allied health professions will be explored. Participants will be partnered with Touro nurses and techs and will receive "hands-on" experience performing surgery on a chicken breast, learning CPR and observing samples under the microscope in the lab, among other activities. Students will rotate between specialty areas throughout the duration of the program to ensure exposure to a wide variety of career options.

The "brain drain" of New Orleans' healthcare professionals has been making headlines nationwide since Hurricane Katrina devastated the city in 2005. Research has shown that 70 to 75% of students who complete medical training within the state generally practice health care in Louisiana upon graduation. Touro hopes that by fostering young professionals' careers, they will consider staying in the community and sustaining the depleted work force.

http://include.nurse.com/apps/pbcs.dll/article?AID=/20080825/SC02/108250004

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Employment mostly up in La.
The Advocate | 08.26.08
By CHRIS GAUTREAU

All but one of the state's eight major metropolitan areas saw July employment figures rise from one year ago.

Nonfarm employment in Louisiana gained 32,700 jobs, or 1.7 percent, to 1,937,600. New Orleans accounted for about half the gains, adding 16,300 jobs from the year-ago period, according to data released Monday by the state labor department.

The Baton Rouge market added 4,500 nonfarm jobs — an increase of about 1.2 percent — to 371,200.

The report was rather rosy for the local market, considering job growth after the 2005 hurricanes already had started slowing.

"The economy is very vibrant and adding jobs across the board," Patty Granier with the state labor department said of the Baton Rouge market.

The educational and health services sector posted some of the biggest gains, adding 1,600 jobs from a year ago.

Baton Rouge economist Loren Scott said he was not surprised to find the health-care industry growing.

"Health care has been a hot sector for quite some time, and it's going to be hot for a really long time, because the (baby) boomers are aging," he said.

The number of government jobs jumped by 1,500, most of them in local government. Scott said he didn't expect the figure to be that high. He theorized the increase could be an anomaly like the timing of summer vacation when schoolteachers officially are out of work.

Some of the big losses came in manufacturing sector, a sector that dropped 1.5 percent to 25,900 jobs. Scott said that likely reflected the closure of Tembec Inc.'s St. Francisville paper mill last year and 540 subsequent layoffs.

Statewide, goods-producing jobs increased by 3,300 over the year, largely due to the construction sector. The state added another 29,400 jobs in the service-providing sector with the big gainers coming in educational and health services, leisure and hospitality and state and local governments.

Alexandria was the only metro area to lose steam in July, dipping slightly by 400 jobs to 64,900.

Scott echoed his earlier analysis that Louisiana is doing better than the U.S. economy. The state is benefiting, he said, from high oil and gas prices and construction funded by the federal GO Zone tax-credit program. Moreover, Louisiana has not been dragged down by the housing sector as other states have.

The New Orleans metropolitan area, still trying to recover from huge job losses after Hurricane Katrina, posted a 3.1 percent increase in July.

Scott pointed out, however, that the 527,900 jobs there in July were still well below pre-Katrina figures, and the economic picture is likely to begin deteriorating.

The convention business, a crucial part of the city's tourism industry, "is about to go south," he said. Conventions are planned several years out, and bookings dropped dramatically after Katrina hit three years ago.

Meanwhile, the phase-out of NASA's space shuttle program will mean layoffs for New Orleans' Michoud Assembly Facility, which makes the shuttle's external fuel tanks.

Though NASA hasn't said exactly how many jobs the Michoud plant could lose, the agency said the number could be as high as 1,300.

"There's not a whole lot that's very encouraging about the New Orleans area," Scott said.

Statewide, seasonally adjusted data showed a civilian labor force of 1,959,785. With 90,674 unemployed, the July unemployment rate was 4.4 percent.

That compared with a civilian labor force of 1,940,943 in July 2007, with 85,767, or 4.2 percent, unemployed.

http://www.2theadvocate.com/news/business/27417734.html

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Cancer Test for Women Raises Hope, and Concern
The New York Times | 08.26.08
By ANDREW POLLACK

Dung Hoang

A new blood test aimed at detecting ovarian cancer at an early, still treatable stage is stirring hopes among women and their physicians. But the Food and Drug Administration and some experts say the test has not been proved to work.

The test, called OvaSure, was developed at Yale and has been offered since late June by LabCorp, one of the nation's largest clinical laboratory companies.

The need for such a test is immense. When ovarian cancer is detected at its earliest stage, when it is still confined to the ovaries, more than 90 percent of women will live at least five years, according to the American Cancer Society. But only about 20 percent of cases are detected that early. If the cancer is detected in its latest stages, after it has spread, only about 30 percent of women survive five years.

But far from greeting the new test with elation, many experts are saying it might do more harm than good, leading women to unnecessary surgeries. The Society of Gynecologic Oncologists almost immediately issued a statement saying it did not believe the test had been validated enough for routine use.

"You've got industry trying to capitalize on fear," said Dr. Andrew Berchuck, director of gynecologic oncology at Duke University and the immediate past president of the society. "We'd all love to see a screening test for ovarian cancer," he added, "but OvaSure is very premature."

OvaSure's debut also raises questions about whether greater regulation is needed to assure the validity of a trove of sophisticated new diagnostic tests that are entering the market and are being used as the

basis for important treatment decisions. OvaSure did not go through review by the Food and Drug Administration because the agency generally has not regulated tests developed and performed by a single laboratory, as opposed to test kits that are sold to laboratories, hospitals and doctors. (All OvaSure blood samples are sent to LabCorp for analysis.)

But the F.D.A. has now summoned LabCorp to discuss OvaSure, saying the data appear insufficient to back the company's claims about the test. “We believe you are offering a high-risk test that has not received adequate clinical validation and may harm the public health,” the agency said in an Aug. 7 letter sent to LabCorp that was posted on the F.D.A. Web site. A spokesman for LabCorp, which is short for Laboratory Corporation of America Holdings, said the company looked forward to reviewing the data with the agency but would continue offering the test in the meantime.

Dr. Myla Lai-Goldman, chief medical officer of LabCorp, said that OvaSure had been validated in several studies and that additional data were expected by the end of this year. Diagnostic tests typically are studied further after they have reached the market, she said. Dr. Goldman said there was “tremendous interest” from physicians in learning more about OvaSure.

Patients and advocacy groups seem divided on OvaSure, which costs about $220 to $240.

“We are hearing from people that they are very excited about it,” said Cara Tenenbaum, policy director for the Ovarian Cancer National Alliance. But the alliance urges women to wait for more data before relying on the test.

More than 21,000 new cases of ovarian cancer will be diagnosed in the United States this year and more than 15,000 people are expected to die from the disease, according to the American Cancer Society.

OvaSure measures the level of six proteins in a sample of blood, some produced by a tumor and some produced by the body in reaction to a tumor. It then calculates a probability that the woman has ovarian cancer. One of the six proteins is CA-125, which is used by itself as a test to monitor disease progression in women who already have ovarian cancer but is not good at picking up early disease.

In a study published in the journal Clinical Cancer Research in February, the test correctly classified 221 of 224 blood samples taken from women with ovarian cancer or from controls. It identified 95 percent of the cancers, and its false positive rate — detecting a cancer that was not there — was 0.6 percent.

But Dr. Beth Y. Karlan, director of the Women's Cancer Research Institute at Cedars-Sinai Medical Center in Los Angeles, said the samples tested were not representative of what might be encountered in routine screening. There were very few blood samples from women with early stages of the most deadly type of ovarian cancer. “That's really what we want to find,” she said.

The biggest concern is not that the test will miss cancers but that it will say a cancer is there when it is not. That would then subject women to needless surgery to have their ovaries removed.

Dr. Berchuck of Duke said only 1 of 3,000 women has ovarian cancer. So even if a screening test had a 1 percent rate of false positives, it would mean that 30 out of 3,000 women tested might be subject to unnecessary surgery for every one real case of cancer.

Teresa Hills, who had a visible mass on her left ovary, got a positive result from OvaSure. But when the ovary was removed, the mass turned out to be benign.

The false positive did not prompt unnecessary surgery because Ms. Hills was going to have the mass removed in any case. But it did cause needless anxiety.
“You can't sleep, you can't eat, you're paralyzed with fear,” said Ms. Hills, a 44-year-old mother of three from Rockford, Ill. She said she lost 10 pounds in two weeks after the false diagnosis.

Dr. Lai-Goldman at LabCorp said that OvaSure should be restricted to women at high risk of ovarian cancer and that the test should be repeated if the result is positive. Those measures would limit the number of false positives.

LabCorp estimates that there are 10 million women at high risk. These include carriers of mutations in genes called BRCA1 or BRCA2, as well as women with histories of ovarian or breast cancer.

Dr. Gil Mor, the lead developer of the test at Yale, said the use of OvaSure might reduce ovarian surgeries, not increase them. That is because women with BRCA mutations often have their ovaries removed to prevent cancer. A negative result on the OvaSure test might allow such women to put off the surgery.

“They are removing the ovaries without the test,” said Dr. Mor, an associate professor of obstetrics and gynecology. “So what are we talking about here? We are trying to do the opposite and say don’t remove the ovaries.”

That logic appeals to some. Dr. Elizabeth Poyner, a gynecologic oncologist in Manhattan with a lot of high-risk patients, said she was thinking about how to incorporate OvaSure into her practice. One of her patients, a Manhattan woman with a BRCA2 mutation, said she was planning to take the test in hopes of postponing ovary removal.

“I’d really like a couple of more years to have the heart health and the bone health and all the benefits that come from having estrogen naturally,” said the woman, who is in her early 40s and spoke on the condition she not be identified because she had not told some relatives that she has the mutation.

But Dr. Julian C. Schink, director of gynecologic oncology at Northwestern University, said it would be “playing Russian roulette” to put off ovary surgery unless OvaSure detected cancer. “We just don’t have any data to show this test will turn positive before the disease turns metastatic,” he said.

The test is also not intended to detect the recurrence of cancer. Jean McKibben, a retired schoolteacher from Centennial, Colo., said her test result suggested zero probability that her cancer had returned. But scans then found a tumor. Only later did Ms. McKibben learn that the test does not work for women whose ovaries have been removed.

The ovarian cancer detection field has had disappointments before. Four years ago, the F.D.A. intervened to effectively stop the marketing of another complex ovarian cancer screening test developed by a company called Correlogic Systems. The test, called OvaCheck, had also spurred great hope, but never made it to market as experts questioned its validity.

With the number of genetic and other tests proliferating, the agency has been under pressure to assure that the tests are accurate. Two years ago, the agency said it intended to regulate complex tests, like OvaSure, that measure multiple proteins or genes and use a mathematical formula to compute a result. But it has not finalized the policy.

Peter J. Levine, president of Correlogic, said the company was developing a new ovarian screening test and would apply by the end of the year for F.D.A. approval. He said it would be unfair if LabCorp did not need approval.

Another company, Vermillion, applied to the F.D.A. in June for approval of a test, called OVA1, aimed at determining whether ovarian masses are cancerous.

Dr. Daniel Schultz, who oversees diagnostic tests for the F.D.A., said the agency was trying to balance demands for greater oversight of tests against concerns that regulation could impede development of needed diagnostics.

“We understand that concerns have been raised regarding the impact that F.D.A. regulation would have on this whole field,” he said.

Even if OvaSure is validated, or a better test is developed, questions will remain on whether screening is useful, similar to controversies that have arisen about prostate cancer screening.

Dr. Berchuck of Duke said it had not been proved that a test that detects cancer early would cut deaths from the disease. It could be that cancers detected early were the less aggressive ones that would not have killed the woman anyway.

Some experts say women should pay more attention to symptoms, like pain and bloating. But these symptoms can also be caused by other conditions.

The Canary Foundation, which finances research on early cancer detection, is focusing on developing better imaging techniques. Transvaginal ultrasound, which is sometimes used now, is not that good at detecting early disease.

“Too much of the dialogue has been on how good is the blood test,” said Don Listwin, a Silicon Valley executive who started the foundation after his mother died from ovarian cancer that was diagnosed late. “They thought it was a bladder infection.”

Mr. Listwin said mammograms and the P.S.A. test were fairly unreliable in detecting breast and prostate cancer, respectively. Yet they can be used for screening because a positive test result can be followed by a needle biopsy to confirm whether cancer is present.

But it is difficult to do a biopsy of the ovary because of its location, so a positive blood test result might lead directly to surgery. If imaging could be used for confirmation, he said, then even a somewhat inaccurate blood test might suffice for screening.

http://www.nytimes.com/2008/08/26/health/26ovar.html?_r=1&ref=health&oref=slogin

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In Prostate Cancer, Pick a Number, Any Number
The New York Times | 08.26.08
By BURT SOLOMON

My internist warned me that nobody understands enough about prostate cancer to make easy decisions about how to treat it, but he didn't prepare me for the barrage of numbers that kept pretending that all is known.

The P.S.A. result was just the beginning. I was grateful, of course, for a simple blood test as an early warning. When mine registered 4.6, crossing the threshold of evil at 4, my internist suggested that I see a urologist, largely because my father's nonfatal prostate cancer increased my risk by 30 percent. (Later I learned that my neighbor's prostate had turned cancerous when his P.S.A., a measure of prostate-specific antigen, doubled from 1 to 2.)

A follow-up test at the internist's, measuring the proportion of antigens clinging to a protein, prophesied a 17 percent chance that I had cancer.

"That sounds high," I said.

"I thought it sounded low," my internist replied. It wasn't his prostate.

After I saw the urologist, the biopsy showed that I was right.

"It's positive," the urologist told me over the phone, with a forced bonhomie. When it comes to cancer, "positive" means negative — bad news. I'd entered a looking-glass world; everything was the opposite of what it seemed.

Yet the unceasing flow of numbers kept promising precision. These were numbers, for God's sake. Of the 12 snippets of my prostate sampled in the biopsy, only 2 pieces showed any cancer, and then just a dusting, of 10 to 12 percent. And the cancer was judged to be only moderately aggressive, a 3 on a scale of 5. I was counseled to pooh-pooh the higher-than-desirable Gleason score of 6, derived by adding the aggressiveness in every spot of cancer, because there was so little cancer in each.

Eager to be convinced, I took heart. My wife accuses me — accurately — of being a glass-half-empty guy, but the flow of happy numbers (plus perhaps a touch of maturity at last, at age 58) left me uncustomarily serene.

I was only dimly aware of the evidence that most prostate cancers never become dangerous, even if left alone. But because nobody can tell which ones will and which ones won't, the information was useless to me.
I quickly decided to have surgery to remove the prostate, but I had to choose between the two types. I cared most about my plumbing returning to normal. But this was when the numbers really began to confuse things.

One option was to go to Johns Hopkins in Baltimore, my hometown, where the older-style, slash-and-scoop surgery was devised. But the doctors there, my urologist said, cherry-picked their patients — no fatties need apply — to minimize the complications in getting the plumbing up and running again.

The other choice, called robotics, was newer and cooler. The surgeon sits at a console across the operating room and essentially plays a three-dimensional video game inside the patient, controlling two thin robotic arms slipped through inch-long incisions. The computer's 15x magnification improves the subtlety of movement, and the less invasive surgery means faster recovery.

But the procedure has statistical distortions of its own. Some robotics surgeons have been known to exaggerate the speed of recovery by removing the catheter too early.

So both sides were skewing the numbers to market themselves.

A college classmate, a physician with a low opinion of his profession, advised me to forget the numbers, to visit both surgeons, look them in the eye and decide which one I liked.

Huh? Why should I care? I wasn't drinking a beer with the guy. Partly, my friend said, a likable surgeon would respond if something went wrong; an arrogant one might not admit a mistake. And partly, well, my friend really couldn't articulate it, but he felt certain.

"Likable" and "surgeon" don't ordinarily cohabit a sentence, but when my wife and I met with the robotics surgeon, we loved him. Patient, personable and the furthest thing from arrogant, he told us how his technique had improved from his first 200 operations to his second 200. (I was No. 431.) Only twice, he said, in Nos. 4 and 17, had the robotics failed and he had proceeded to the more intrusive surgery. His percentage of complications, he added, was as low as at Hopkins. I canceled my appointment in Baltimore.

The surgery wasn't bad at all, and my recovery was startlingly swift. Eight days afterward, I returned to have the catheter removed — none too early — and to learn if the cancer had spread. When I asked the surgeon if the pathology report was "positive" — meaning good news — he winced.

The news was good: The cancer had not spread beyond the prostate. But 35 percent of my prostate had turned out to be cancerous, considerably more than a dusting. I had dodged a bullet; the numbers had lied again.

Burt Solomon is a contributing editor to National Journal.

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Medicare Ignored Its Claims Policy, Audit Says
The Wall Street Journal | 08.26.08
By JANE ZHANG

WASHINGTON -- Medicare officials underestimated the amount of incorrect payments in 2006 for medical equipment, including wheelchairs and home hospital beds, because Medicare failed to follow its own policy of making sure the purchases matched orders from doctors, a new federal audit shows.

The report by the Health and Human Services inspector general's office, based on a sampling of claims for durable medical equipment, showed that some 29% of claims were made improperly but were paid by Medicare.

Medicare officials had estimated that improper payments cost the government health-care program for the elderly and disabled about $700 million in 2006, based on its estimate that 7.5% of claims were incorrect. But that number "likely would have been significantly higher" had Medicare told its outside auditor to follow the department's written policy, according to the report.

Medicare said it spends about $9 billion a year for wheelchairs, oxygen and other types of durable medical equipment, compared with total Medicare spending of $429.7 billion.

In double-checking Medicare's 2006 audit, the inspector general's office studied only a small slice of the total claims from 112,000 medical-equipment suppliers. Because those samples weren't entirely random, the report cautioned about applying the number to the entire Medicare equipment program.

Other Medicare data indicate that the loss to the federal government may be in the billions. In 2007, Medicare ordered physicians to keep records of their prescriptions for durable medical equipment and began denying claims if suppliers didn't provide copies of those medical records. The error rate for medical-equipment claims rose to 10%. That number, too, could be low because suppliers in Miami and Los Angeles didn't comply with the directive. The 2008 error rate is scheduled to be released in November.

The inspector general's report faults Medicare officials for allowing the auditor contracted to study the error rate for medical-equipment claims in 2006 to conduct its review without fully documenting the claims from suppliers, including obtaining records from physicians.

Chuck Taylor, a spokesman for Medicare auditing contractor AdvanceMed, declined to comment, saying its contract bars it from discussing the matter without Medicare approval. AdvanceMed is a subsidiary of Computer Sciences Corp., based in Falls Church, Va.

A top Medicare official disputed the inspector general's report, saying Medicare didn't have a written policy that required its auditor to use medical records to count error rates in 2006. Instead, AdvanceMed had "discretion" not to do so, said Timothy Hill, chief financial officer and director of the Office of Financial Management at the Centers for Medicare and Medicaid Services, the federal agency that manages Medicare.

A November 2006 report on the error rate appeared to contradict Mr. Hill's statement. It said any claim not backed up by medical records should be counted as an error.

For Medicare, the problem of paying improper claims isn't new. Recent congressional reports found that Medicare paid nearly $100 million in recent years for claims submitted under the names of dead doctors for wheelchairs, canes, prescription drugs and other items. A 2001 report by the Health and Human Services inspector general found that Medicare paid $91 million in 1999 for medical-equipment and supply claims filed under providers no longer enrolled in Medicare.

http://online.wsj.com/article/SB121971017492971293.html?mod=2_1566_topbox

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A Doctor Transformed, Into a Patient
The New York Times | 08.26.08
By ABIGAIL ZUGER, M.D.

Rick Friedman for The New York Times

HARD FALL Dr. Thomas Graboys had to retire as Parkinson's progressed.

Doctors get seriously ill just like ordinary people, and some of them never recover from the shock. If of a literary bent, they are often moved to reflect for posterity on this disruption of the natural order, detailing their former hubris and the enlightening misery of health care experienced from the other side of the bed.

Against this generally lackluster collection of memoirs, Dr. Thomas Graboys's stands out as a small wonder. Unsentimental and unpretentious, it manages to hit all its marks effortlessly, creating a version of the old fable as touching, educational and inspiring as if it had never been told before.

The story's success lies partly in its almost mythic dimensions: Dr. Graboys rose high, and he fell hard. Until age 50 he was a medical version of one of Tom Wolfe's masters of the universe: a noted Harvard cardiologist beloved by colleagues and patients, happily married to a tall, beautiful blonde. He was a marathon runner, a demon on the tennis courts and ski slopes, and, if he says so himself, a particularly handsome guy.

Then everything fell apart. Over a terrible two-year period Dr. Graboys's wife died a lingering death from colon cancer. In his grief he barely noticed that he was not functioning quite as well as usual. Those around him figured his fatigue and uncharacteristic fumbling were only to be expected. He pulled himself together, met another woman, and then collapsed on the wedding day — the beginning of physical problems that could no longer be ignored.

It was Parkinson's disease, the neurological condition that makes the body stiffen and shake, but it took Dr. Graboys many months to take the irrevocable step of giving his problems a name. During that time he went through every rationalization that sick people use to wish away their symptoms, then moved

smoothly from denial to deception. "I'm just tired," he snapped to concerned colleagues, even as he began taking surreptitious clinical notes on his own case.

Only when the chief of neurology at his hospital cheerfully hailed him in the parking garage — "Tom, who is taking care of your Parkinson's?" — was the terrible word said aloud. Dr. Graboys finally understood that the jig was up.
From this moment his memoir unfolds in multiple layers, some predictable, some quite unexpected.

Dr. Graboys is not the first athlete to go from tennis and skiing to cautious walking and gym work. Nor is he the first good-looking man to watch his body deteriorate, the first father to become increasingly dependent on his children or the first master of the universe to contemplate the loss of his driver's license.

His reflections as a husband are more unusual. He courted his second wife while still ostensibly healthy, although privately he knew something was wrong. He writes candidly about this duplicity, and the complicated grief and anger that infuse their relationship now as she faces a future of caretaking far different from the one she signed up for.

As a writer, Dr. Graboys is also unusual. Like many patients with Parkinson's he suffers from a slowly progressive dementia, and is losing not only his physical but also his intellectual self. The memoir is written with a co-author, an arrangement always a little uneasy-making. Yet the voice here is true, somehow almost Parkinsonian in its steady, unadorned, slightly stiff prose.

Finally, Dr. Graboys is hardly the first doctor to find that without the practice of medicine — progressive disability forced him to retire a few years after his diagnosis, at age 62 — he is barely recognizable to himself. But he does one of the best jobs on record of doggedly unpeeling the onion-skin layers of alternating ego and vulnerability that encase the doctor turned patient.

While in practice, Dr. Graboys was a master clinician who often rejected the glittery technology of his specialty for older, slower medicine. His excellence made the transition to patient more difficult than most. He knew how good a doctor he was, and surrendering control of his own case to someone possibly not quite as competent was just impossible. Every instinct told him to be his own doctor, his very own "dream team."

As he ruefully reports, he is still learning over and over that the doctor who is his own dream team has a fool for a patient. And yet, enough of the old Dr. Graboys comes through that a reader might conclude he would also be foolish to sign off his own case completely.

As he once made a point of involving patients' families in their care, he invites his own family members to talk directly to the reader. As Dr. Graboys once gave each of his patients a handwritten care plan ("I never gave the patients a photocopy"), he provides readers with Parkinson's a set of suggestions for improving their own lot.

This is the kind of book inevitably given to medical students to inculcate them in the humanistic dimensions of medicine. I wouldn't waste it on them. Save it for older doctors, still at the top of their game, gleaming and self-confident. Each of them could use this textbook of the graceful and courageous exit.

http://www.nytimes.com/2008/08/26/health/26books.html?ref=health

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Uninsured Patients Receive Unpredictable, Rationed Access to Health Care: Hospitals Do Not Adhere to Their Own Policies
Newswise | 08.25.08

Newswise — A case study of three health care institutions -- public, for-profit and not-for-profit -- within one metropolitan area found that self-pay patients must navigate a system that provides no guarantees medical centers will follow their own policies for providing uncompensated care.

The study is published in the August issue of the journal Medical Care.

"We know from previous research that the uninsured have poor outcomes on a number of measures and they are less likely to seek care when they need it," said Dr. Saul Weiner, University of Illinois at Chicago associate professor of pediatrics and internal medicine, and lead author of the study. "But we know less about what actually happens when the uninsured try to obtain health care in various settings, and more specifically, how institutions deal with these patients."

There are about 47 million Americans who do not have any health insurance and must pay for care out-of-pocket, according to Weiner.

The study analyzed how three medical centers with different ownership models rationed uncompensated care to patients without insurance. Data were obtained from hospital financial reports, a survey of 292 self-pay patients, and from the self-pay policies and practices of front-line staff.

The researchers found that all three institutions had policies for accepting self-pay patients, but that many times their practices did not match the policies. Prepayment was often left to the discretion of front line staff, who also determined whether a patient might be turned away from care.

The researchers found the differences among the three institutions were significant. The institutions and the city in which they are located were not identified.

"We found that the public institution was the most open to seeing patients in a variety of settings. By contrast, the for-profit institution would really only see patients in the emergency department," said Weiner.

Federal regulations mandate emergency care in order for a hospital to obtain Medicare and Medicaid funding.

Nearly 13 percent of patients were uninsured at the public hospital, compared to four percent and six percent at the not-for-profit and for-profit the researchers reported.

Although the public institution saw patients in a variety of diverse settings -- such as specialty clinics and surgery -- it worked really hard to obtain some payment from these patients and actually was much more successful at collecting a percentage of charges than was the for-profit, said Weiner.

The public hospital collected 67 percent of charges to self-pay patients, whereas the private hospital collected only 13 percent.

However, the public hospital actually had greater net losses in caring for the uninsured than the for-profit or the not-for-profit.

"The for-profit basically took its losses and seemed to say, 'We'll just see these folks in the emergency department, we won't work too hard to get money from them, and so be it,'" said Weiner. "And, not surprisingly, the not-for-profit fell in between."

Self-pay patients accounted for only 20 percent of bad debt at the for-profit hospital, compared with 52 percent and 76 percent of bad debt at the not-for-profit and public hospitals.

"For the uninsured, it's a pretty capricious system," said Weiner.

"As we move forward in the political process we have to recognize that this is essentially an unmanaged group -- a group of people who don't know what they're going to get. They are getting care from a set of institutions that are uncomfortable and unsure about what it is they want to provide."

The study was funded by the Robert Wood Johnson Foundation and the Veterans Administration.

UIC ranks among the nation's top 50 universities in federal research funding and is Chicago's largest university with 25,000 students, 12,000 faculty and staff, 15 colleges and the state's major public medical center. A hallmark of the campus is the Great Cities Commitment, through which UIC faculty, students and staff engage with community, corporate, foundation and government partners in hundreds of programs to improve the quality of life in metropolitan areas around the world.

http://www.newswise.com/articles/view/543768/

Joint Commission project to explore cultural competency standards
AHA News | 08.25.08

The Joint Commission seeks nominations to an expert advisory panel that will review evidence-based practices and identify principles that can provide the basis for new and revised accreditation standards for culturally competent, patient-centered care in hospitals.

The project will explore how diversity, culture, language and health literacy issues can be better incorporated into current Joint Commission standards or drafted into new requirements. Panel members will reflect a broad range of stakeholders, including consumers, researchers, purchasers, administrators, quality improvement organizations, clinicians, educators and others.

http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080825_JCo&domain=AHANEWS

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Study: Covering uninsured would increase U.S. health spending by 5%
AHA News | 08.25.08

Americans who lack health insurance for any part of 2008 will spend $30 billion out of pocket for health services and receive $56 billion in uncompensated care while uninsured, estimates a study published online today by Health Affairs.

Since government programs finance about 75% of uncompensated care, the authors estimate covering the uninsured would increase national health care spending by just 5%, or $122.6 billion.

“Failure to act in the near term will only make it more expensive to cover the uninsured in the future, while adding to the amount of lost productivity from not insuring all Americans,” said lead author Jack Hadley, who conducted the study with researchers at the Urban Institute.

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