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**LSU and West Jefferson to announce healthcare initiative**  
**The Times-Picayune | 07.21.08**

Representatives from LSU Health Sciences Center and West Jefferson Medical Center will unveil plans to bring new healthcare services to the New Orleans area during a press conference scheduled for later this morning.

The partnership will "leverage expertise and resources to provide a clinical medical home" for the patients of New Orleans, Leslie Capo, a spokeswoman for LSU Health Sciences Center, said last week.

More details will be announced during the press conference, beginning at 10:30 a.m. at West Jefferson Medical Center, 1101 Medical Center Blvd., Marrero.

[http://www.nola.com/news/index.ssf/2008/07/plans\\_to\\_be\\_unveiled\\_today\\_for.html](http://www.nola.com/news/index.ssf/2008/07/plans_to_be_unveiled_today_for.html)

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## **HIV cases on the rise, funding low in the South**

**The Times-Picayune | 07.20.08**

The Associated Press

BIRMINGHAM, Ala. (AP) — The Deep South's poor residents are plagued by HIV and the region isn't receiving its fair share of federal money for prevention and support, according to a report to be released Monday.

The report by the Southern AIDS Coalition says federal funding for treatment, education and support services is concentrated in wealthier parts of the country that have fewer new HIV cases and declining death rates.

"Rising infection rates, coupled with inadequate funding, resources and infrastructure have resulted in a catastrophic situation in our public health care systems in the South," the report says.

Kathy Hiers, chief executive officer of AIDS Alabama and co-author of the report, told The Birmingham News that HIV/AIDS is taking hold in isolated parts of the South.

"The ruralness of the epidemic is what's becoming painfully clear," Hiers told the paper.

The report says the number of deaths from AIDS dropped in the rest of the nation between 2001 and 2005 but continued to increase in the South.

Health authorities have known for years that the 16-state Southern region was leading the country in the number of new infections. But, Hiers said, they thought the increase was concentrated in big cities in Florida, not spread across the region.

Experts have now focused in on the Deep South — Alabama, Georgia, Louisiana, Mississippi, North Carolina and South Carolina. They have found HIV infections rising in rural areas populated by blacks with financial, health and social problems.

Gary A. Puckrein is the president and CEO of National Minority Quality Forum in Washington. He said the shift in HIV infections has to be highlighted.

"Certainly one of the big misconceptions is it is big cities on the West Coast and East Coast that are really driving the disease, and it's not so," Puckrein said. "It's moved both in terms of geography and demography. It's really important for people in Southern states to know that because they're not getting their fair share of support."

Formulas for HIV/AIDS funding have traditionally focused on the number of cases of full-blown AIDS, not HIV infections. That means more money goes to large urban areas. For example, in Alabama, 40 percent of HIV cases have matured into AIDS, while in New York, where the epidemic started earlier, 62 percent of cases have matured into AIDS, Hiers said. For that reason, New York receives more per-person funding.

The Southern AIDS Coalition last year convinced authorities to change the funding formula for the Ryan White HIV/AIDS Treatment Act, which includes much of the federal funding for the fight against the disease. That helped, but the South still leads in new HIV cases and is still last out of four regions in overall federal funding.

"We're driving the epidemic, but we're still getting the least money," Hiers said.

The South also gets less private funding to fight HIV, according to another recent report from Funders Concerned About AIDS, a New York-based organization. That report focused on Alabama, saying the state's challenges and funding problems are typical of the South.

That report said fighting HIV/AIDS in Alabama faces many challenges, including, but not limited to, high rates of other sexually transmitted diseases, a rural population, poverty, mental health problems and lack of insurance.

<http://www.nola.com/newsflash/index.ssf?/base/news-40/121658725765300.xml&storylist=louisiana>

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## **Congressional delegation struck by lingering recovery needs in metro area**

**The Times-Picayune | 07.20.08**

by Sarah Carr

For U.S. Rep. Laura Richardson, one member of a congressional delegation touring the New Orleans region, a few images from the opening two days made her wonder, "Do we live in America?"

She recalled a large family in St. Bernard Parish living in a FEMA trailer containing a single twin bed, with a bathroom that would cramp just one adult trying to bathe. The family was recently notified by FEMA that it would have to leave the trailer, according to Richardson, a Democrat from California.

Government has to "stop looking at a manual and look at the people," she said.

The message delivered at a Sunday news conference in New Orleans, called by several Democratic lawmakers, was nuanced:

Delegation members were struck by the stark human needs remaining several weeks before the third anniversary of Hurricane Katrina. But they also touted evidence of the progress that has been made -- on the ground here and in the halls of Congress -- toward helping the region move forward. Several of the speakers rattled off recent federal allocations, including billions of dollars for a home-rebuilding program and levee improvements.

As a group, they stressed that their interest in the region isn't fading.

"There is no one in this group that has grown tired of what is required here," said House Majority Whip James Clyburn, D-S.C., the top House Democrat at the event. "We're here to see what issues remain . . . and to check on some new friends."

Although some members of the delegation, which will likely include only Democrats, began touring the region Saturday, several arrived in town Sunday evening, following the news conference. By today, about 30 lawmakers -- including House Speaker Nancy Pelosi of California and Majority Leader Steny Hoyer of Maryland -- are expected in town.

Clyburn said the delegation would have preferred for the visit to coincide with Katrina's third anniversary, but that would clash with the Democratic National Convention. Whatever lessons group members learn on this visit are likely to frame their portrayal of the region's remaining needs at the convention. Based on the remarks Sunday, they seem to be preparing to attack the Bush administration's responses to natural disasters throughout the country as inadequate.

On Saturday, members of the delegation met with local criminal justice officials.

Their itinerary also has included stops in Baton Rouge and St. Bernard Parish, a visit to the 17th Street Canal, and a meeting with leaders of a hurricane victim support project in the Lower 9th Ward.

The delegation plans to visit several New Orleans sites this morning, focusing on housing, health care, infrastructure and education issues. The stops include visits to Xavier University, a Louisiana State University community health clinic in eastern New Orleans and Unity of Greater New Orleans, an alliance that serves the homeless. They then plan to continue to Mississippi for meetings related to insurance issues.

At Sunday's news conference, lawmakers emphasized the area's remaining housing and medical needs, as well as concerns about how Louisiana will pay a share of the massive cost of levee improvements.

The lawmakers stressed the need to ensure that residents retain the right to return as housing-voucher programs come to an end.

They also warned that New Orleans and St. Bernard Parish, in particular, will struggle in the long term if monies are not allocated to shore up the region's struggling hospitals.

"A city like this cannot be without a major trauma hospital," said Rep. Sheila Jackson Lee from Houston.

Rep. Charlie Melancon, D-Napoleonville, pointed out that St. Bernard Parish had a 400-bed hospital before Katrina and now has no hospital.

"If we build it, they (residents) will come," he said.

Nearly all of the lawmakers who spoke at the news conference, held at the Royal Sonesta Hotel in the French Quarter, tried to broaden the lessons of Katrina, noting that several recent disasters, including the Midwestern flooding, show the federal government needs to respond more quickly and forcefully to natural disasters.

Melancon said he hopes people affected by future disasters "don't have to spend time begging and groveling as such. Their government should be able to respond."

Clyburn urged President Bush to give Louisiana 30 years, rather than three, to pay its \$1.8 billion share of federal levee construction costs. Last week, Gov. Bobby Jindal and his recovery coordinator, Paul Rainwater, made the same appeal.

This need "can be addressed tomorrow at 9 a.m., or whatever time the president gets to his office," Clyburn said.

The House dropped a Senate-passed provision that would have given Louisiana 30 years to pay its share. Clyburn has said that and other changes were made to prevent a Bush veto.

[http://www.nola.com/news/index.ssf/2008/07/congressional\\_delegation\\_check.html](http://www.nola.com/news/index.ssf/2008/07/congressional_delegation_check.html)

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## Nurses find that helping is best medicine

**The Times-Picayune | 07.20.08**

By Easha Anand

It had all the trappings of a road-trip buddy flick. An idle phone call and well-meant "what if" snowballed into an 18-hour drive with a generous supply of Zapp's potato chips, Hubig's pies and Abita beer.

Except in this case, the snacks were to give away, the destination was recently flooded Iowa, and the buddies were emergency room nurses from the New Orleans area. And even as they helped resuscitate their counterparts up north, driving a Ryder truck stuffed with donations to two Iowa hospitals, the nurses put the final sutures in some of their own post-flood wounds.

"It really felt like we'd come full circle, that we could think of someone else," said Cheryl Carter, East Jefferson General Hospital's emergency room director. "The trip was as therapeutic for us as it was for them."

Big Relief in the Big Easy began, Carter said, when some East Jefferson nurses touched base with hospitals in Iowa. Amid memories of working full-blast after Katrina, the nurses started to wonder: What if they mailed a package of extra scrubs to the Iowa nurses? Or, what if they solicited donations for the small things that kept them going after the storm? And then what if, after appealing to other nurses and donors, they got so many donations that they would be too expensive to mail?

So on the morning of July 11, Carter, Beverly Marino, Layne Mistretta and Bernie Cullen of East Jefferson General, along with Kerry Jeanice of West Jefferson Medical Center, Louisiana State University nursing instructor Karen Filaby and one chef-spouse, hit the road.

They had \$6,000 and a truck filled with toiletries, cleaning supplies and clothing. When they pulled up to St. Luke's Hospital in Cedar Rapids, the Iowa nurses started clapping.

The Louisiana nurses started crying.

"It was moving, almost spiritual, to see folks who had gone through a very similar set of circumstances reach out to us in our time of need," said Ted Townsend, the CEO of St. Luke's.

Big Relief from the Big Easy made vats of jambalaya -- a bit milder, Carter said, for Iowa tongues -- and threw Carnival beads from their truck. They played zydeco music, and they told hospital administrators what East Jefferson General had done to support its nurses during the storm.

Katrina comparisons were inevitable, Marino said. The standing water gave Cedar Rapids "that Katrina smell," and the site for their picnic in Iowa City, where they delivered supplies to the University of Iowa Hospital, was City Park.

Carol Rowland, vice president of the St. Luke's Health Care Foundation, related examples of small acts of heroism similar to those that were everywhere after Katrina: the housekeeping staffer who went home only to pick up uniforms from her flooded house and the bioengineer who climbed onto the hospital roof to install a new antenna.

But while St. Luke's treated twice its usual patient load because a second Cedar Rapids hospital staff evacuated, St. Luke's saw only one death suspected of being flood-related.

"What we went through was minor compared to what you went through," Rowland said. "But the nurses from Jefferson Parish understood what it means to rise to an occasion like this."

<http://www.nola.com/news/t-p/frontpage/index.ssf?/base/news-11/121653184847570.xml&coll=1>

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## **La. doctor cleared in patient deaths recalls storm**

**The Times-Picayune | 07.20.08**

Mary Foster, The Associated Press

NEW ORLEANS (AP) -- Dr. Anna Pou wasn't worried as she made her way to Memorial Medical Center that sultry August weekend in 2005.

Hurricane Katrina appeared headed to Florida. Even when warnings were issued for New Orleans, the respected cancer surgeon never thought of leaving. She stayed with her patients in what would become a personal and professional hell.

Katrina struck Monday morning, Aug. 29. Power failed, levees broke and 80 percent of New Orleans was flooded. Four days of misery, leading to 34 patient deaths, began at Memorial. In the aftermath, Pou would be accused -- and later cleared -- of giving lethal doses of drugs to four patients during the chaos.

Three years later, in her most detailed account of the scene since, Pou told The Associated Press she would stay with her patients again if called upon.

Her experience made her a champion of emergency care workers and disaster planning. She helped get landmark state legislation approved to protect the actions of doctors and nurses during disasters.

As the storm passed three years ago, it seemed the decision not to evacuate patients and staff was a good one. They didn't know levees were collapsing.

"We made it through the storm pretty good," Pou remembered. "On Monday, it was just a little hot, but we had some generators working and food and water twice a day."

By Tuesday, water was rising in the streets, eventually reaching 10 feet. The hospital basement flooded and the generators failed.

With nightfall came, Memorial and the city were in darkness. Water pressure dropped, toilets backed up and the temperature in the eight-story building, where windows could not be opened, rose to almost 110 degrees.

"The smell got to be rancid in no time," Pou said. "It burned the back of your throat."

The deteriorating situation had dire consequences for the 2,000 people at Memorial, including more than 200 patients.

"You can't really understand what it was like if you weren't there," Pou said. "Nothing can describe it."

Those trapped in the hospital could hear voices in the dark. People had broken into a credit union office across the street and holed up there.

"We started hearing stories about murders, about gangs raping women and children," Pou said. "The women that had their children there were really scared."

They had a few flashlights but no spare batteries. At night, rooms and stairways were completely dark.

"One of the nurses showed me how to bump my foot against the next step to find it," Pou said. "We counted the steps from one floor to another so we wouldn't miss one and fall."

Pou said staff struggled to climb stairwells, carry supplies, and spent two-hour shifts squeezing ventilators to keep patients alive.

"The heat was so terrible, it wore you down," Pou said. "We were trying to keep the patients comfortable. The 9-year-old daughter of one of the nurses even took shifts fanning them."

Airboats evacuated some patients and babies from the nursery, but most remained. All Pou said she could do was try to keep critically ill patients comfortable.

"Tuesday night was when we realized we were going to be there for a while," Pou said.

They gathered supplies, rationed food and water with non-patients, and prayed.

About seven medical staffers, including Pou, stayed with patients. Others went to the roof and the ground floor to coordinate the intermittent rescue efforts with the few boats and helicopters that showed up.

"When a helicopter left, we never knew if they would be back," Pou recalled. "They might be sent to another rescue. And after dark it was too dangerous for them to fly at all."

Under the military's orders, the staff did reverse triage. The healthiest patients were taken out first in an effort to save the greatest number of people.

Many had to be carried to the roof. It was slow, backbreaking work, with as many as 10 people struggling up the dark stairs with a stretcher. At least 34 people died waiting for rescuers.

Pou was one of the last to leave Memorial. She returned to New Orleans -- her house had not been flooded -- from Baton Rouge a few months later at Thanksgiving. In January 2006, she started working at a Baton Rouge hospital, trying to put Katrina behind her.

Then, in July 2007, she was greeted by four police officers on her arrival home from a 13-hour day of surgery. They handcuffed her, still in her scrubs, and drove her to jail. She was booked on four counts of second-degree murder.

Attorney General Charles Foti accused Pou and two nurses of using a "lethal cocktail" of medication to kill four elderly patients. Pou has always maintained she killed no one during those desperate days, though she acknowledges patients were sedated.

She was forced to give up private practice and started teaching at the LSU medical school in Baton Rouge.

Months of pain and frustration set in.

A year after their arrest, the New Orleans district attorney dropped charges against the nurses, and a grand jury refused to indict Pou. Two civil lawsuits in the deaths are pending.

"I felt very alone," Pou said of her year of fighting the criminal accusations. "Even if people were around me I felt an intense loneliness. It was as if no one knew what I was going through."

Pou's supporters believed she and the nurses acted heroically. A group of doctors and nurses held a rally on the anniversary of her arrest, and hundreds turned in support.

"It was that support and prayer that got me through it," said Pou, who is back in private practice.

As Katrina's third anniversary nears, Pou said the experience was life-altering.

"I've learned a lot from this," she said. "I thought I had suffered at times in my life, but I had no idea the depths of pain one person could feel. I think that has made me a better person and certainly a more compassionate doctor."

[http://blog.nola.com/updates/2008/07/la\\_doctor\\_cleared\\_in\\_patient\\_d.html](http://blog.nola.com/updates/2008/07/la_doctor_cleared_in_patient_d.html)

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## **GAO releases audit of 5 N.O.-area hospitals**

**New OrleansCity Business | 07.18.08**

by The Associated Press

Posted:

NEW ORLEANS - The General Accountability Office says five major New Orleans-area hospitals and hospital systems hit hard by Hurricane Katrina had operating losses of nearly \$387 million in 2005 through 2007. It says they are expected to lose another \$103 million this year.

Congress asked for the audit last year, after executives from Touro Infirmary, Tulane University Hospital and Clinic, East Jefferson General Hospital, West Jefferson Medical and Ochsner Medical Center asked for help.

The GAO says Ochsner and East and West Jefferson are back in the range of pre-Katrina figures. But it also notes that the Jefferson Parish hospitals, Touro and Tulane all have lower assets than before the hurricane. It says that indicates they have been using assets, borrowing or both to cover operating expenses.

<http://www.neworleanscitybusiness.com/print.cfm?recid=18669>

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## **New test finds risks for breast cancer before lump appears**

**WWLTV.com | 07.16.08**

Meg Farris / Eyewitness News Medical Reporter

Imagine knowing your risk for getting breast cancer long before there is a lump, just when there are some abnormal microscopic cells. Well now there is an easy test that few patients and even doctors know about.

Erin Pesquie decided to try a medical test that few people know about. It's a 5-minute non-invasive procedure that will let her know if she is at high risk for getting breast cancer one day.

"It's pretty innovative to be able to test something like that so far in advance that it makes sense to me. Why not? And it wasn't a bad test at all," says Erin.

The test is called the breast pap test and it's done by a HALO machine that works and feels like a breast pump used by breast feeding mothers to extract milk. It's the only one of its kind in the state.

"This test can pick up detect abnormalities up to 7 years before you might see something on mammography so you can see potential changes in the ductile cells before you may actually see a mass. And that's what we are looking for is those changes because 95 percent of breast cancers start in the duct," says Dr. Leslie Rodrigue Internal Medicine specialist at the Center for Longevity and Wellness in Metairie.

Through a warm massaging and suction motion the machine works to pull any fluid out of the breast. Only half of the women will produce fluid. For those who have none, they are at average-risk for breast cancer. Those who produce fluid with normal cells are also at average risk but those who have fluid with atypical cells are flagged as being at a higher risk for one day developing breast cancer.

"The goal of this test is to try to help discover the cancers at an early stage where we can cure and treat them," says Dr. Rodrigue.

While this does not take the place of a regular mammogram, those who discover that they are at higher risk could change their lifestyles, such as losing weight, quitting smoking and drinking alcohol -- all known to decrease risk. They could also be more diligent in checking for lumps through self exams and mammograms.

Erin was glad to learn that she is not at higher risk and hopes women she knows will find out if they are.

"There's quite a few ladies at my office who told that I was going to get the test," she says. "And then I told them about it after, but I don't see anybody beating down the door to come get it done so. But I encourage people to come get it."

The test costs \$95 and even though it was FDA approved nearly 3 years ago, insurance will not pay for the test but may pay for the lab results.

Doctors at the Center for Longevity and Wellness in Metairie will send your lab results to your personal doctor. Call (504) 885-7360 for more information.

<http://www.wwltv.com/topstories/stories/wwl071608mlbreast.60693158.html#>

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## **Prevention, Management and Treatment Strategies for the Treatment of Obesity Informa Healthcare | 07.21.08**

Maria Pacheco

Handbook of Obesity: Clinical Applications Informa Healthcare, one of the world's premier medical scientific publishers, is introducing Handbook of Obesity: Clinical Applications, Third Edition, an in-depth examination of all the clinical aspects relating to obesity.

Society's view of obesity has changed throughout history. In the past, obesity was perceived as a symbol indicative of strength and wealth; nowadays, it is identified as a rising threat to our collective well-being.

In the past, weight gain was traditionally associated with the normal aging process. Nowadays; however - thanks in part to our increasingly sedentary lifestyles - weight gain has become a growing trend among children. Obesity is an issue of particular interest in developed nations where its proliferation has reached almost epidemic proportions.

Handbook of Obesity: Clinical Applications delves into all the critical aspects of evaluation, prevention, medical management and treatment alternatives - delivering a comprehensive resource that aims to answer all clinical questions related to adult and pediatric obesity.

Edited by Drs. George Bray and Claude Bouchard - leading a team of world-recognized experts - Handbook of Obesity: Clinical Applications is an academic tour-de-force which features all the latest information in the field.

Pharmacological alternatives are thoroughly explored with individual chapters on sibutramine and orlistat (both FDA approved) and pramlintide (currently approved in Europe). The roles of culture and economic factors, as well as the evolving role of governments, are also amply discussed. With seventeen chapters - out of a total of forty - exclusively focused on the medical management of obesity including, among others, behavioral approaches, diets, exercise, neurohormonal issues, and gene therapy Handbook of Obesity: Clinical Applications is a must-have resource for endocrinologists, cardiologists, internal medicine clinicians, and other professionals working in the field.

This book is available from wholesalers, online retailers, book stores, as well as directly from Informa Healthcare through [www.informahealthcare.com](http://www.informahealthcare.com).

### About the Editors

George A. Bray is the current Boyd Professor at the Pennington Biomedical Research Center in Baton Rouge, Louisiana. **He is also Professor of Medicine at the LSU Health Sciences Center in New Orleans, Louisiana.** Dr. Bray has served with NIH, the Department of Health, Education and Welfare, and WHO. He received his A.B. in Chemistry from Brown University in Providence, Rhode Island, and his M.D. from Harvard Medical School in Boston, Massachusetts.

Claude Bouchard is the Executive Director of the Pennington Biomedical Research Center in Baton Rouge, Louisiana and holder of the George A. Bray Chair in Nutrition. Prior to joining Pennington, Dr. Bouchard held the Donald B. Brown Research Chair on Obesity at Laval University where he was the Director of the Physical Activity Sciences Laboratory for almost 20 years. He holds a B.Ped. from Laval University in Quebec Canada; a M.Sc. in exercise physiology from the University of Oregon, in Eugene, Oregon; and a Ph.D. in population genetics from the University of Texas in Austin, Texas.

[http://www.informahealthcare.com/Press\\_Releases/2008/Prevention\\_Management\\_and\\_Treatment\\_Strategies\\_for\\_the\\_Treatment\\_of\\_Obesity\\_230608](http://www.informahealthcare.com/Press_Releases/2008/Prevention_Management_and_Treatment_Strategies_for_the_Treatment_of_Obesity_230608)

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## Drug company still seeking trial participants

Shreveport Times | 07.21.08

By Melody Brumble

A local company testing a drug to help curb cocaine addicts' cravings hopes to wrap up the trial by the end of the year.

The company, Embera NeuroTherapeutics, still needs 19 cocaine addicts to undergo the six-week trial. Twenty-six are in the trial or have finished it. Participants get a placebo or a combination drug consisting of a tranquilizer and a stress hormone blocker. **The drug, named EMB-001 by developer Dr. Nick Goeders, is based on his 25 years of research into addiction at LSU Health Sciences Center in Shreveport.** Goeders founded Embera to try to bring EMB-001 to market.

A 2006 national drug use survey estimated that 1.7 million Americans could be classified as dependent on cocaine or abusers of the drug. Experts say there's an 80 percent relapse rate following 12-step programs.

Goeders also notes most substance abuse treatments mimic the effect of the substance — like methadone for heroin addicts — or make using the substance unpleasant, like antabuse prescribed for alcoholics.

He said EMB-001 aims to break the addiction cycle by allowing an addict to control the mechanism underlying relapses.

Ads and fliers about the drug trial yielded about 100 phone calls from people interested in participating.

**Administrators conducting the study at LSU Health Sciences Center screened more than 40 people.**

Some had multiple addictions and were ruled out. People already in a treatment program weren't eligible to participate, so researchers couldn't recruit from rehabilitation centers. Some addicts started participating but dropped out, said Stephanie Casso, an Embera spokesman.

"This is something new for this area. People know about clinical trials for cancer treatments, but I'm not sure they understand what this is about," Casso said.

Lab results from addicts already in the trial sit in a locked filing cabinet in Casso's office. The information goes to a statistician in Chicago, who will compile results once 45 people complete the trial.

"This has really been hard for me. I'm used to looking at lab results every day," Goeders said.

The trial is an exploratory study. If the results show that EMB-001 helps cocaine addicts control their cravings and avoid relapse, Embera is in a better position to seek money for other trials, Casso said.

Goeders wants to test the drug's effectiveness on cravings related to other forms of addiction. Although addictive substances and stress triggers vary, he said the body's response to stress-induced cravings is the same in any situation.

If the results don't support Goeder's theory, the company may change the proportion of drugs or other variables and conduct another trial, Casso said.

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=/20080721/NEWS01/807210334>

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## **La. first to use telepsychology for involuntary commitments**

**Shreveport Times | 07.19.08**

By Melody Brumble

Parish officials who handle involuntary mental health commitments say a new state law won't change how they issue emergency commitment certificates.

The law, part of Gov. Bobby Jindal's health care legislation package, allows mental health exams for an involuntary commitment via interactive television.

People who are judged a danger to themselves or others can be committed to a mental health center against their will. People who have committed violent acts while showing signs of mental illness and those who have threatened or attempted suicide are included in those categories.

Louisiana will be the first state in the nation to use the method dubbed telepsychology for such exams, said state Rep. John LaBruzzo, who sponsored the bill. The law previously required an in-person exam.

The new law allows a mental health professional like a psychologist or psychiatrist to conduct the exam via interactive television. A health professional, like a doctor or a nurse, must be with the person undergoing the exam at all times.

The health professionals also are supposed to rule out physical problems that could cause symptoms imitating mental illness.

Existing state laws give parish coroners the authority to commit such people to a public mental health center like LSU Health Sciences Center in Shreveport for up to 72 hours.

LaBruzzo said the new law isn't a move to change that system.

"I think this bill is designed more for an area that may or may not have a psychiatrist or an area where the coroner may not be an MD," said Dr. Todd Thoma, Caddo coroner. The parish has a network of mental health professionals to handle commitment exams, he said.

In Bienville Parish, which doesn't have a medical or psychiatric clinic, Coroner Don Smith said he'll continue to handle commitment exams as people request them despite the new state law.

Smith, the parish's 911 administrator by day, examines people suspected of being a danger to themselves or others. "Usually, I talk to the family members who want something done and talk to the individual myself."

Once he makes a decision, Smith fills out commitment paperwork and sends it to the Bienville sheriff's office, which is responsible for picking up someone and taking them to a mental health facility. Smith said he can send people only to state-run centers like LSUHSC.

Telepsychology is a relatively new field, said Jon Linkous, executive director of the American Telemedicine Association.

The organization is working with national mental health professional associations to create standards for telepsychology.

Linkous said Illinois is testing telepsychology, and California is exploring it for similar purposes.

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=2008807190328>

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## **Dr. Boustany on Dr. DeBakey**

**The Advocate | 07.20.08**

By GERARD SHIELDS

As much as anybody, U.S. Rep. Charles Boustany understood the life and times of Dr. Michael DeBakey.

The Lafayette Republican's life has an uncanny parallel to the legendary heart surgeon. Debakey, who died on July 11, was a native of Lake Charles, a city near Boustany's roots in Lafayette.

Like DeBakey, Boustany is a retired cardiovascular surgeon. And the two shared another commonality in being descendants of Lebanese immigrants.

"He and my grandfather knew each other growing up and became good friends," Boustany said.

Over his 70 years in medicine, DeBakey is credited with changing the face of cardiac surgery in the world, saving thousands of patients.

He performed the first successful heart bypass operation and, as a Tulane University medical student in 1932, created the "roller pump," a heart-lung machine that made the delicate procedure more common.

Debakey, who died at 99, performed an estimated 60,000 operations, and was called to aid everyone from the Duke of Windsor to Russian President Boris Yeltsin.

In April, President Bush awarded DeBakey the Congressional Gold Medal, the nation's highest civilian honor.

Bush recounted DeBakey's years of growing up in Lake Charles, where his parents would load up the family car with clothes and food every Sunday to take to the orphanage on the outskirts of town.

"He learned the power of compassion at an early age," Bush said. "And Michael DeBakey has been giving to the world ever since."

Those attending the event laughed when Bush told the story of how a young DeBakey became angry when librarians would not let him check out the great new book he discovered — the Encyclopedia Britannica. His father eventually bought him a set.

"Michael read every word of every article in every volume," Bush said.

When studying medicine at LSU, Boustany remembers learning about DeBakey, who became the Tiger Woods of the surgical world.

"He was a giant in 20th century medicine," Boustany said. "He had impact not only on cardiovascular surgery but surgery in general."

The roller pump became one of the most critical medical devices in the history of medicine, Boustany said.

"We couldn't do open heart surgery without that," Boustany said. "He was truly a genius and I admired him greatly as a medical student and surgeon."

Boustany recalled how DeBakey cut his surgical teeth at Charity Hospital in New Orleans, where he served for two years in residency training. A World War II volunteer, DeBakey helped develop the Mobile Army Surgical Hospital units.

DeBakey is also credited with helping create the Veterans Affairs hospital research system. DeBakey was later named the chairman of the department of surgery at Baylor University College of Medicine in Houston. He remained at Baylor, eventually becoming president then chancellor of the medical school.

He became the director of the Methodist DeBakey Heart Center in Houston before retiring in 1999.

"Talk about work ethic," Boustany said. "This guy worked long hours until the day he died."

DeBakey remembered his Lebanese ancestry, Boustany said, by taking his skill and knowledge to the Middle East at one time.

"He never forgot his roots in the Lebanese community and tried to give back to a region that was terribly underserved," Boustany said

In the medical ceremony, Bush hailed DeBakey's impact on changing the history of cardiac surgery.

"His legacy is holding the fragile and sacred gift of human life in his hands and returning it unbroken," Bush said.

That DeBakey received the medal before he died was fitting, Boustany said.

"It was long overdue," Boustany said. "Louisianians need to know that they can be proud that a fellow Louisianian did all this."

<http://www.2theadvocate.com/opinion/25651964.html>

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**Miss. hospital delays cut-off of patients**  
**The Advocate | 07.21.08**

River Region Medical Center in Vicksburg, Miss., will continue providing non-emergency care for Louisiana Medicaid patients. The hospital intended to discontinue seeing these patients July 1, citing in a June 30 press release "unfair reimbursement practices from the Louisiana Medicaid Program" which caused the hospital to receive "significantly less (reimbursement) than other hospitals providing the same care."

The issue is being investigated by the Louisiana Department of Health & Hospitals. If a satisfactory restructuring is not made, the River Region Medical Center will discontinue non-emergency care to Louisiana Medicaid patients. The hospital will continue to provide emergency care.

<http://www.theadvocate.com/features/25668839.html?showAll=y&c=y>

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## Grants to help cancer patients

**The Advocate | 07.15.08**

By TED GRIGGS

Our Lady of the Lake Regional Medical Center and Mary Bird Perkins Cancer Center are among five grant recipients chosen nationwide for a pilot program designed to help patients untangle the treatment process.

The \$105,000 grant from Ralph Lauren Center for Cancer Care and Prevention will allow the facilities' cancer program to develop a Patient Navigation Program. The program will help patients whose free screenings from the Lake and Mary Bird Cancer Program reveal an abnormality, such as a breast lump.

A number of studies have shown there are disparities in health care and in particular cancer care for minorities and the uninsured or underinsured, said Renea A. Duffin, executive director, Mary Bird Perkins CARE (Cancer support services, Awareness and education, Research and Early detection) Network.

Cancer incidence and mortality rates in African-American men are significantly higher than in white men, Duffin said. Among African-American women, the incidence rates for breast cancer are about the same in Louisiana, but the mortality rates are about 19 percent higher.

"That's primarily due to late-stage diagnosis," Duffin said. "You know, putting off preventive screening and having cancers diagnosed at a point where it's too late for care."

The idea behind the Patient Navigation Program is to reduce the time between when a screening reveals an abnormality and when that abnormality is resolved, Duffin said. A breast lump doesn't always mean a person has cancer; further testing is needed to resolve the question.

"Patient navigators can make the difference between someone from an underserved population becoming a cancer survivor or a cancer death," according to the National Cancer Institute.

The program will assign the Lake-Mary Bird Cancer Program patients a "patient navigator," who will help explain what an abnormality means, make sure the patient receives a timely follow-up care, even helping with transportation if the patient needs assistance getting to an appointment.

The pilot program for breast cancer screening patients at the LSU Mid-City clinic and Leo Butler Community Center is under way and ends Aug. 31. The Lake and Mary Bird Perkins will evaluate the pilot program in September, and the formal program for all breast cancer screening patients will begin in October.

Programs for prostate, skin and colorectal screening participants will be in place by June 2009. Breast screenings are available to the underserved through a partnership with Woman's Hospital.

Duffin said the \$105,000 grant is renewable every year for three years. The Ralph Lauren Center for Cancer Care and Prevention is providing the funding through the Pfizer Foundation.

The money will be used to:

- \* Hire a full-time patient navigator.
- \* Develop a tracking system that will help measure the time between detection and resolution, the barriers patients face in following up an abnormal finding and how those obstacles were overcome.
- \* The program may provide patients with a bus pass, cab fare or even a gas card to help them make their follow-up appointment or appointments.

<http://www.theadvocate.com/news/business/25453994.html>

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## **Trends in the Operating Results of Five Hospitals in New Orleans Before and After Hurricane Katrina**

### **All American Patriots | 07.21.08**

July 17, 2008 -- New Orleans faces many challenges in the aftermath of Hurricane Katrina including the challenge of reestablishing the health care system and hospitals within the system. Hurricane Katrina, which made landfall on August 29, 2005, and the subsequent flooding caused by the failure of the New Orleans levee systems, resulted in the sudden closure, damage, or disruption in services at many of the New Orleans hospitals.

On August 1, 2007, officials representing five New Orleans hospitals that have been the main health care providers in the region since the hurricane, testified before the House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations.

The officials stated that since the hurricane they have experienced significant operating losses and that they expect the losses to continue.

The official from one of the hospitals that was designated to present an overview of the specific problems facing the five hospitals stated in his testimony that the hospitals expected to experience a combined operating loss of \$135 million in calendar year 2007.

This operating loss estimate was calculated using operating revenue and expense amounts for all five hospitals for January through May 2007 and then annualized for the year.

The official also testified that the combined operating loss for the five hospitals would equal \$405 million by 2009.

The hospital official cited several reasons for operating losses, including increased labor costs and Medicare reimbursements that do not take into account the increased labor costs since the hurricane.

The hospital official appealed to Congress for additional federal financial assistance.

The subcommittee asked us to review the extent to which Hurricane Katrina adversely affected the hospitals' operating results.

To that end, Congress asked us to analyze 1) the operating results of the five hospitals before and after Hurricane Katrina and 2) the factors contributing to changes in hospital operating results and whether those factors would have a continuing impact.

Operating results of all five hospitals significantly declined in 2005, the year of Hurricane Katrina, based on the three measures of profitability we used to illustrate differences in the hospitals' operating results before and after the hurricane--operating income or loss, net income or loss, and earnings before interest, depreciation and amortization.

However, four out of the five hospitals showed some improvement in their operating results for 2006, 2007, and projected for 2008. For the fifth hospital, the amounts for the three profitability measures for 2007 and projected for 2008 declined from 2005 amounts.

In viewing these trends, it is important to consider the amount and timing of special payments that the hospitals received to cover Hurricane Katrina-related losses for 2005 through 2008.

These special payments included insurance payments from private insurers for business interruption and property and casualty claims, wage index grants from the Department of Health and Human Services (HHS) to cover some of the increases in labor costs experienced by the hospitals and funds from the state of Louisiana for uncompensated care to cover the increased costs for providing health care to the uninsured.

They also included Federal Emergency Management Agency (FEMA) and National Flood Insurance Program (NFIP) reimbursements to cover losses due to flooding and federally declared disasters.

Despite the improvements in operating results for four of the five hospitals we examined, the financial position for these four hospitals has weakened, as evidenced by declines in net asset balances since 2004.

Such declines indicate that the hospitals have been either using their assets, incurring additional debt to support operations or both.

Increased expenses have contributed to changes in hospital operating results since Hurricane Katrina.

Increases in operating expenses have generally been greater than increases in operating revenues, thereby negatively affecting operating results.

Hospitals have experienced higher labor costs since the hurricane. A nursing shortage and reduction in the physician base and workforce, exacerbated by the hurricane, forced hospitals to hire staff at salaries and wages that were higher than before the hurricane.

Generally, revenue from patient services has not kept pace with increased expenses.

Hospital officials believe that revenues will continue to lag behind expenses until some of the increased labor costs are covered in Medicare reimbursement rates through changes to the wage index.

However, this relief is not fully expected until 2010. Like hospital officials, officials in LDHH believe that increased operating expenses contributed to the decline in hospital operating results and that labor costs were a major driver of decreased operating results.

The state health officials developed an estimate and requested \$50 million in funding that the five hospitals need to cover operating losses in 2007.

Credit analysts with whom we spoke also cited the increase in labor costs as a factor.

The analysts said that the decline in hospital operating results since Hurricane Katrina could be a factor in increasing the hospitals' costs of raising funds in the bond market.

[http://www.allamericanpatriots.com/48748929\\_trends-operating-results-five-hospitals-new-orlean](http://www.allamericanpatriots.com/48748929_trends-operating-results-five-hospitals-new-orlean)

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## **American Parkinson Disease Association Awards More Than \$3.7 Million to Research Drug Week | 07.07.08**

The American Parkinson Disease Association (APDA) has announced its 2008 research awards, which include a Dr. George C. Cotzias Memorial Fellowship, a Dr. Roger Duvoisin, MD Grant, 31 research grants, 13 post-graduate grants, and six summer medical student fellowships (see also Parkinson Disease).

David Hinkle, MD, PhD at the University of Pittsburgh was awarded the Cotzias fellowship that carries an \$80,000 award for each of three years, based upon progress review by the Scientific Advisory Board, which recommends all research funding. The fellowship is named after George C. Cotzias, a pathfinder in pharmacological exploration of brain functions and in the treatment of Parkinson's disease with levodopa, which more than 40 years later is still the primary PD medication therapy.

Brown University PhD, Marc Tatar, received the awarded named for Roger C. Duvoisin, MD, an award of \$80,000 for two consecutive years.

The progress of two active Cotzias fellowships and Duvoisin grants were also reviewed and accepted.

Researchers at 27 institutions across the country received one-time \$50,000 research grants including four at the University of Alabama at Birmingham; and two at Johns Hopkins University School of Medicine, Baltimore, Case Western Reserve University, and Massachusetts General Hospital. Others were awarded to researchers at the Universities of Pittsburgh, Kentucky, Chicago, Florida, Illinois, California (Jolla), Southern California (Los Angeles), Miami and Tennessee; Case Western Reserve, Emory, Columbia, Louisiana State, Northwestern, Purdue and Louisiana State universities; Buck Institute for Age Research; the State University of New York (Buffalo), University of Texas Southwestern Medical Center; Portland VA Research Hospital; Lake Forest Hospital; Brentwood Biomedical Research Institute; and Penn State Hershey College of Medicine.

One-year, \$35,000 post-doctoral fellowships were awarded to two scientists at the University of Pittsburgh, as well as researchers at the Universities of Virginia, Washington, Alabama, Texas (Galveston), Chicago, Pennsylvania and Colorado; Whitehead Institute for Biomedical Research; and Johns Hopkins University.

Summer Medical Student Fellowships, \$4,000 one-year awards to students to perform supervised laboratory or clinical PD research, are designed to encourage their interest in future research work. Two students from the University of Pennsylvania and one each from Johns Hopkins University, the University of Massachusetts Medical School, Penn State College of Medicine and the University of Cincinnati received awards this year.

Dr. Frederick G. Wooten of the University of Virginia Medical Center is the SAB chairman and Dr. Paul Maestroni is APDA's director for scientific and medical affairs.

Keywords: Central Nervous System Disease, Drugs, Levodopa, Parkinson Disease, Pharmaceuticals, Pharmacological, Therapy, Treatment, American Parkinson Disease Association.

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**Area hospitals support creation of LSU-E Ultrasound Department  
Opelousas Daily World | 07.20.08**



Representatives of Louisiana State University in Eunice, Doctors' Hospital in Opelousas, Acadian Medical Center in Eunice and Ville Platte Medical Center in Ville Platte gathered for check presentation ceremonies held recently at the LSU E Campus. Among those presenting the check to LSU- E Chancellor William Nunez for support of a new Ultrasound Curricula at LSU-E are Brian Riddle, CEO of Ville Platte Medical Center, Phil Young, CEO of Doctors' Hospital and Butch Frazier, CEO of Acadian Medical Center. A total of \$54,000 was contributed to LSU-E for the creation of the Ultrasound Curricula.

EUNICE: The establishment of an Ultrasound Department at Louisiana State University in Eunice (LSU-E) is a major step closer to reality through the efforts of three area hospitals and the LifePoint Community Foundation headquartered in Nashville, Tennessee. Acadian Medical Center in Eunice, Doctors' Hospital in Opelousas, and Ville Platte Medical Center in Ville Platte, in association with the philanthropic arm of LifePoint Hospitals, Inc, the LifePoint Community Foundation, are donating a total of \$54,000 to help fund the planned Ultrasound Department at LSU-E.

"We are most appreciative of this wonderful expression of support for LSU-E as we move to create this vital educational department at our university," commented LSU-Eunice Chancellor William Nunez. "LSU in Eunice is widely known as a center of excellence for both our nursing and allied health curricula. The planned addition of an ultrasound department will further enhance our ability to meet the needs for a highly-skilled workforce in the growing medical field," he adds.

Spearheading the grant request to the LifePoint Foundation were Butch Frazier, CEO of Acadian Medical Center, Phil Young, CEO of Doctors' Hospital and Brian Riddle, CEO of Ville Platte Medical Center. Each hospital contributed \$13,000 that was matched by a \$15,000 donation from the LifePoint Community Foundation.

Speaking on behalf of the three hospitals, Butch Frazier, CEO of Acadian Medical Center pointed out the positive impact that an Ultrasound Department at LSU-E will have on area healthcare services. "Together, Acadian Medical Center, Doctors' Hospital, and Ville Platte Medical Center provide a broad and growing array of vital healthcare services to the many communities we serve. In offering those services, we depend on having a highly skilled workforce from which we can draw upon. As our three hospitals continue to utilize advanced medical technologies, such as the latest in Ultrasound technologies, our need for the staff to support that technology will continue to grow. Working with LSU-E in the establishment of an Ultrasound Department is an example of how great things can come out of cooperative approaches."

The creation of an Ultrasound Department at LSU in Eunice will allow students to receive training and education towards becoming medical Sonographers, a technologically intense field that is rapidly expanding along with a growing and aging population. Employment in the field is expected to grow by as

much as 19% annually through the year 2016, making it a very attractive field of study for future career opportunity.

LSU-E Chancellor Nunez expressed appreciation to the three participating hospitals and the LifePoint Community Foundation for the support and leadership in making the grant possible. Nunez commented, "We are very fortunate to have forward-looking leadership at the helm of Acadian Medical Center, Doctors' Hospital, and Ville Platte Medical Center. The beneficiary of their collective support will ultimately be the people of this part of Louisiana who turn to these Medical Centers for state-of-the-art medical care for themselves and their families at each of the outstanding rural hospitals. Their support helps our communities, our university, and creates wonderful career opportunities for our students."

Pending the finalization of curriculum details and instructors, LSU in Eunice plans to initiate instruction in the Ultrasound Department in early 2009.

<http://www.dailyworld.com/apps/pbcs.dll/article?AID=2008807200311>

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## Trying to Save by Increasing Doctors' Fees

The New York Times | 07.21.08

By MILT FREUDENHEIM



Bradley C. Brower/The New York Times

**Dr. Richard Baron, right, is paid extra to spend more time with patients like Robert Williamson.**

That is the premise of experiments under way by federal and state government agencies and many insurers around the country. The idea is that by paying family physicians, internists and pediatricians to devote more time and attention to their patients, insurers and patients can save thousands of dollars downstream on unnecessary tests, visits to expensive specialists and avoidable trips to the hospital.

Nationally, Medicare and commercial insurers pay an average of only about \$60 a visit to the office of a primary-care doctor and rarely if ever pay for telephone or e-mail consultations. Many health policy experts say the payments are not enough to let the doctors spend more than a few minutes with each patient.

Robert Williamson, a 60-year-old Philadelphia man, recalls the cursory exam he received a few years ago from a harried doctor who, Mr. Williamson says, missed the danger signals and sent him home. A short time later Mr. Williamson had a stroke.

For want of a careful examination by a primary-care doctor, Mr. Williamson became one of countless Americans each year whose unidentified or under-treated illnesses escalate into medical conditions with catastrophic personal and economic costs. Besides incurring \$30,000 in hospital bills paid by his employer's insurer, Mr. Williamson had to stop working as a customer service representative at Philadelphia Gas Works and go on Social Security disability, at a current cost to taxpayers of \$1,900 a month.

With Mr. Williamson's new doctor, such an outcome would be much less likely.

"I give him my heart and diabetes readings by e-mail and phone, without getting up out of my chair," Mr. Williamson said. "I can get better directions, at the very moment I need them. It's life-saving."

His current internist, Richard Baron, is one of more than 100 physicians in metropolitan Philadelphia taking part in the experiment, which is being conducted jointly by some of the region's largest insurers. Dr. Baron still gets a fee of only about \$64 for each office visit. But his five-doctor group will also receive \$200,000 to \$300,000 this year beyond their regular fees to keep better track of their 8,400 patients.

"We are trying to do more e-mail care and telephone care, which we haven't been paid for in the past," Dr. Baron said.

Insurers are conducting similar pilot projects in at least a half-dozen states, in experiments involving thousands of doctors and nearly 2 million patients. Many more are in the planning stages, at the urging of health policy experts and employers that provide medical benefits.

The big government health care programs, Medicaid and Medicare, are also studying the concept. A Medicaid experiment already under way in North Carolina saved the government program in that state about \$162 million in 2006. That was 11 percent less than the state would have spent under the old system of reimbursement, according to an audit by Mercer, a consulting firm.

Earlier this month, as part of a bill to protect Medicare payments to doctors, the Senate overrode President Bush's veto to authorize \$100 million to finance a three-year Medicare pilot to further test the concept of spending more on primary care.

Under the various payment experiments, family doctors are encouraged to hire additional staff to help monitor patients' treatment and follow-up, and to help patients stay ahead of problems by sending reminders when they are due for preventive tests like mammograms and colon exams.

For people like Mr. Williamson with serious chronic illnesses, the doctors take personal charge, answering patients' phone or e-mail questions promptly. In emergencies, patients can show up at the office and see their doctors on short notice.

Such features add up to a model of primary care that proponents refer to as providing people with a "medical home" — a base where doctors, staff and patients pull together as one big health-care family. Or at least that is the ideal.

"It's the latest new, new thing — testing whether medical homes can be a vehicle for pulling America upwards from the grossly inefficient swamp in which our health system is currently mired," said Dr. Arnold Milstein, a senior consultant at Mercer who is also member of the Medicare Payment Advisory Commission, an independent Congressional agency.

The panel has recommended that Medicare expand its plans for a medical-home pilot project next year that is expected to pay primary-care doctors in eight states \$30 to \$40 a month extra for each person enrolled with a chronic illness.

In Michigan, the auto industry has been a major force behind one of the largest medical-home projects yet devised. Blue Cross Blue Shield of Michigan, which has 4.7 million members, plans to spend \$30 million this year to help primary-care doctors offer such services. About 4,900 primary-care doctors are participating, said Dr. Thomas Simmer, chief medical officer of Michigan Blue Cross.

Advocates of the approach hope it will attract more doctors to primary care. Last year only 7 percent of medical school graduates chose family practice, a field with a median income of \$150,000, according to the American Academy of Family Physicians. That compares with \$406,000 for gastroenterologists and \$433,00 for cardiac surgeons, as measured by the Medical Group Management Association.

The American Medical Association said that in its latest count, in 2006, there were slightly more than 251,000 practicing family physicians, general practitioners, and internists in this country, compared with nearly 472,000 specialists.

"The pipeline of primary-care doctors has been running dry for several years," said Dr. Barbara Starfield, a health policy expert at Johns Hopkins University. Many parts of the country do not meet the generally accepted standard of one primary-care doctor for every 1,000 to 2,000 people, Dr. Starfield said.

The Philadelphia pilot project is sponsored by three of the area's largest insurers — Independence Blue Cross, Aetna and Cigna — as well as some local providers of Medicaid services, which together have agreed to spend \$13 million on the program over the next three years.

Dr. Baron expects the project to add as much 15 percent to the annual revenue of his medical group. He declined to specify the practice's total gross income last year, but said that each of the five physicians earned less than the \$177,000 national median for internists.

To participate in the Philadelphia experiment, doctors must arrange for their offices to keep in close communication with their entire rosters of patients. Dr. Baron's practice, besides the physicians, a business manager and clerical assistants, has added a patient educator, whom he said would cost \$60,000 in salary plus \$60,000 more for benefits and supporting technology. The group is also spending \$25,000 for part-time services of a data analyst.

Employers predict that better early care will reduce their health costs in the long run. "We want to buy our care this way, we think it's the right thing to do," said Dr. Paul Grundy, I.B.M.'s director of health care technology and strategic initiatives.

Despite the hopes riding on the pilot projects, some experts are skeptical. "There is very little concrete rigorous evidence that the medical home will do all those wonderful things they want it to do," said Mark Pauly, a health policy economist at the Wharton School of the University of Pennsylvania.

Even executives at Aetna and Cigna are cautious about betting on a payoff from the Philadelphia project, which was orchestrated by Pennsylvania's Democratic Governor Edward G. Rendell and his office of health care reform.

It is uncertain whether there will be a direct return on the investment within a "reasonable time horizon," said Dr. Don Liss, an Aetna medical director who is an internist himself. Still, Dr. Liss added, "a reasonable body of evidence suggests that improving primary care as a foundation for health care will improve quality and access to care."

The Pennsylvania program will start expanding to other parts of the state this fall. It comes none too soon, in the view of Dr. Joseph Mambu, a family physician in Lower Gwynedd, a Philadelphia suburb. Trying to build a medical-home practice before the pilot project began, Dr. Mambu said he went into debt installing an electronic medical records system and establishing patient-friendly features like evening and Saturday office hours.

"Last year, I hit the red ink because of all the technology," he said. "Unless we get help from the insurance companies and the government, the system is going down the toilet."

But with the new medical-home money, Dr. Mambu said he expected to pay down his debts and start a patient wellness program. The insurance pilot project, he said, offers "a ray of hope."

<http://www.nytimes.com/2008/07/21/business/21medhome.html?ref=health>

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**'Tired Blood' Warning: Ignore It at Your Peril****The New York Times | 07.21.08**

By JANE E. BRODY



Jessica Kourkounis for The New York Times

Thanks to advertisements for the once-popular tonic Geritol, most people of a certain age know about "tired blood," a disorder more accurately called anemia, involving a shortage of healthy red blood cells to carry oxygen to body tissues and cleanse them of carbon dioxide.

It is not really the blood of people with anemia that is "tired." Rather, it is anemic people themselves who commonly experience chronic fatigue. Other symptoms may include weakness, shortness of breath, impaired athletic performance, rapid heartbeat, irritability, apathy, dizziness, pale skin, headache and numb or cold hands and feet. But in many people the symptoms are too mild to be recognized, and the anemia goes undetected for years.

Anemia is the most common blood disorder in the United States. Statistics indicate that 3.4 million Americans are anemic, but experts say that this is a gross underestimate and that anemia has been viewed for far too long as an "innocent bystander," considered almost normal in certain groups, like menstruating women and the elderly.

But a growing body of research indicates that anemia can seriously compromise the quality of a person's life, make sick people sicker and even speed deaths, said Dr. Allen Nissenson, a nephrologist and professor of medicine at the University of California, Los Angeles.

It is time to take anemia much more seriously, he added, making sure people have routine blood tests and are treated to restore healthy supplies of red blood cells. The testing is done either by a finger prick or by drawing blood from a vein. The finger test usually measures the hematocrit level, or percentage of red blood cells in plasma. A normal count is 36 percent to 46 percent for women and 46 percent to 56 percent for men.

A more accurate assessment measures the oxygen-carrying hemoglobin in blood, expressed as grams of hemoglobin per deciliter of blood. A normal hemoglobin for women is 12 to 13 grams, and for men, 13 to 14. Hemoglobin has traditionally been measured in blood from a vein, but a finger-prick test is now available.

Inadequate nutrition is the most common cause of anemia, Dr. Nissenson said. Production of hemoglobin, the oxygen-carrying protein on red blood cells, depends upon the mineral nutrient iron, most prominent in meat and poultry (especially organs like liver and kidneys) and egg yolks.

To a lesser degree, it is found in green leafy vegetables, dried fruits, dried beans and peas and enriched and whole grain cereals and bread. Foods rich in vitamin C help the body to absorb iron.

Also important to the production of healthy red cells are B vitamins, folic acid, B12 and B6. B12 occurs only in animal foods, especially meat, fish, eggs and milk. Dark green leafy vegetables are the best source of folic acid; whole grains are the best source of B6.

These nutrients are often in short supply among women who lose iron in menstrual blood, pregnant women, strict vegetarians, overly zealous dieters and poor people. Increasingly, the problem is found among elderly people on restricted diets.

Anemia afflicts virtually everyone with kidney disease because shrinking kidneys are not able to make enough of the hormone erythropoietin, which controls the production of red blood cells in the bone marrow. In addition, many chronic diseases involving inflammation can result in anemia, including congestive heart failure, inflammatory bowel disease, rheumatoid arthritis, AIDS, liver disease and cancer.

There are also hereditary anemias like sickle cell and thalassemia, and hemolytic anemias that involve the destruction of red blood cells faster than they can be replaced. Immune disorders and medicines can also bring it on.

Anemia can also result from chronic blood loss — from an ulcer, polyp or hemorrhoid — that may not be apparent without a stool test. Occasionally, a previously undetected cancer in the digestive tract can be the cause, so if no other responsible factor is identified, a colonoscopy should be done.

Doctors have long been aware of the risk of anemia in infants and in teenage girls and women of childbearing age, but anemia is far more prevalent in people over 65, studies say. One concluded that the incidence of anemia among the elderly was four to six times as great as had been suspected, affecting as many as a quarter of those over 75.

Even among patients with nearly identical medical disorders, those who are anemic tend to die faster. In one study of Medicare patients with congestive heart failure, for example, for every 1 percent decrease in the hematocrit (or percentage of red blood cells in plasma), the mortality rate rose by 1.6 percent.

In a study of nearly 79,000 elderly patients hospitalized with heart attacks, blood transfusions greatly lowered the death rate among those with hematocrits of less than 33 percent upon admission to the hospital.

Likewise with dialysis patients. In a study of 20,000 such patients with chronic kidney failure, those who were more severely anemic had a death rate twice that of patients less anemic. But when anemia in dialysis patients was treated effectively, the death rate after one year was no different from the rate in those who were not initially anemic.

Cancer patients also seem to do better when they are not anemic. Chemotherapy and radiation often cause anemia, which is associated with a reduced ability to control the disease and a lower survival rate.

Perhaps the most common consequence of anemia is an impaired quality of life, especially among older, ostensibly healthy people. In a study published in *The American Journal of Medicine*, Dr. Brenda W. J. H. Penninx and co-authors followed a group of 1,146 men and women 71 and older for more than four years.

The participants performed three tests at the start and end of the study: standing balance, a timed eight-foot walk and rising from a chair. Those with hemoglobin levels just slightly below normal were one and a half times as likely to experience physical declines as those with normal hemoglobin. Those with greater degrees of anemia experienced greater declines.

“Although no study yet shows that treating anemia in older people reduces the incidence of physical decline, our study certainly suggests that this may be the case,” Dr. Penninx said.

Anemia treatment is mainly determined by the cause: correcting underlying disorders, changing diets, adding nutritional supplements and for many, costly genetically engineered drugs like Procrit, Epogen and Aranesp.

Updated from an article that appeared in The Times on Sept. 23, 2003.

## New Anemia Treatments Bring New Problems

By ERIC SABO

Some forms of anemia, like those from nutritional deficiencies or bleeding, can be corrected by fixing the underlying problem. But anemia from cancer and chronic ailments like kidney disease are far more complex and can require years of specific treatment. Cancer patients, for example, face severe nausea and other side effects from chemotherapy, but they rate the tiredness from anemia as the most bothersome part of living with the disease.

Studies show that fatigued patients with anemia feel more energized after receiving transfusions of donated red blood cells, a procedure that has been around since the 16th century. But the process is laborious, and transfusions carry serious risks like emerging infectious diseases, mismatched blood types or fluid buildup in the lungs.

In recent years, doctors have found that newer anemia drugs like Procrit and Aranesp could produce roughly the same effects as transfusions, but with greater ease and seemingly less risk. The medications, which are also injected but in less time, made a lasting impact on many fatigued patients, who say they regained at least some of their old vigor when little else worked. Prescriptions for the drugs soared.

Yet the top-selling medications are undergoing a serious reappraisal after being linked to higher rates of heart attacks, stroke and early death. Early in 2008, the Food and Drug Administration's scientific advisory board issued strict new warnings on the drugs, saying that higher than normal doses can lead to heart problems and also promote tumor growth in certain cancers. It was the second such warning that the F.D.A. had issued on the treatments in nearly a year.

"I think people need to be extremely cautious with the use of these drugs," said Dr. Allen Nissenson of the University of California, Los Angeles. "At a minimum, patients should be satisfied with modest improvements from low doses as a way to minimize the risks."

Dr. Douglas Rizzo, who directs the Center for International Blood and Marrow Transplant Research at the Medical College of Wisconsin, said it was still unclear whether high doses were at the root of the problem. The drugs stimulate production of erythropoietin, a hormone that helps blood cells ferry oxygen. But the natural energy booster also plays other roles in the body, including healing wounds, and making it a drug target could produce a range of unknown effects, he said.

"There's a lot of uncertainty," Dr. Rizzo said. "I think patients will have a difficult choice to make."

And it's not always a choice. A study published in The New England Journal of Medicine found that anemia drugs did not completely replace the use of transfusions in critically ill patients, so some people end up requiring both forms of treatment.

The only natural option, Dr. Nissenson said, is to move to higher ground. "It's not a joke," he said. Living at high altitude for a period of time stimulates the production of red blood cells to compensate for the lack of oxygen in mountainous areas.

"You don't need to go to Mount Everest," Dr. Nissenson said. "If you look at people in Denver, Colorado their average hemoglobin is significantly higher than people at sea level."

<http://health.nytimes.com/ref/health/healthguide/esn-anemia-ess.html?ref=health#>

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## **Senators introduce resolution to nullify 2007 SCHIP directive** **AHA News | 07.18.08**

Sens. Jay Rockefeller (D-WV) and Max Baucus (D-MT) yesterday introduced a joint resolution of disapproval (S.J.RES.44) that would nullify an August 2007 Centers for Medicare & Medicaid Services letter that placed new income limits on the State Children's Health Insurance Program.

S.J.RES.44 cites a report from the Government Accountability Office that the limits should have been subject to the rulemaking process.

"The Bush administration wasn't playing by the rules when they issued the directive," Rockefeller said.

"They issued an illegal regulation and violated the spirit of the children's health insurance program."

The CMS directive requires states to enroll 95% of children in families with incomes up to 200% of the federal poverty level before expanding coverage to children in families with incomes greater than 250% of the poverty level.

The resolution currently has 41 bipartisan cosponsors.

[http://www.ahanews.com/ahanews\\_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann\\_080718\\_schip&domain=AHANEWS](http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080718_schip&domain=AHANEWS)

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**Magic City**  
**Times-Picayune | 07.21.08**  
Terri Troncale

The early 1980s were a grim time in Alabama's largest city. With the demise of the steel industry in Birmingham, unemployment topped 15 percent. Thousands of out of work residents lined up for help retraining for a new career.

The one-time boomtown nicknamed the Magic City had lost whatever magic it had. As a newly minted college graduate working as a reporter at The Birmingham News, I felt lucky to have found a job during such bleak times. As one urban planner noted at the time, "If this is the Sunbelt, Birmingham is the shade."

But during the decade and a half that I lived there, Birmingham transformed itself from a dying industrial town into a hub for banking and medicine.

A report last year by American City Business Journals quantified the metamorphosis. Among the nation's top 100 cities, Birmingham had the best record of sustained income growth. Between 1980 and 2005, personal income there increased 292 percent.

I've been away from Birmingham for almost 12 years but was back last week for my father to meet with a University of Alabama at Birmingham specialist who is doing trials on a new treatment for lung fibrosis.

The appointment was at the Kirklin Clinic, a five-story physicians' building that anchors one side of the downtown medical district.

Through the glass front wall, you look out over the expansive medical complex. Every block or so, it seems, a new building is going up where an empty storefront had been.

It's not exactly a skyline full of cranes. But it does provide a glimpse of what a biomedical district can do for an economy.

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