

IN THE NEWS

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Louisiana Health Sec Talks New Orleans LSU Hospital, Mental, US Congress

BayouBuzz | 08.19.08

Written by: BayouBuzz Staff

It was in poor shape prior to Katrina and Rita but worsened by the twin storms.

The Governor Bobby Jindal administration has recognized the shortcomings in health care and has tried to address it. The person at the helm is Alan Levine, the Secretary of Health and Hospitals.

In the third segment of the Bayoubuzz exclusive interview with the Secretary, Levine discusses major legislation that passed this session that created "crises receiving centers", goes into detail concerning the LSU VA hospital that the state hopes will help deal with the medical needs in that area and the explains the Administration's attempt to obtain federal funding to reimburse hospitals for hard costs it incurred after the hurricanes and which have caused a hardship on the private vendors.

The crises receiving centers are for mental health needs. While the entire plan is not fully determined, it appears that the centers will be ambulatory in nature. Six million dollars has been allocated this year. The centers will not be statewide yet and will be data driven in terms of placement based upon needs.

Levine also discussed the safety net in the health care system in New Orleans and talked about the importance of the LSU hospital that is being considered. The key is obtaining federal money for its construction and the Secretary argues that much of the old facility was destroyed by the hurricane. Looking forward, Secretary Levine is pleased that the Medical Universities are working together on the project and said that creating a structure must consider the future of medicine in the upcoming decades since health care is rapidly changing. Levine noted that it is important to train residents because many of the residents actually practice in the location where they perform their residency and the job market is very competitive so obtaining more residents is very important.

Levine also addressed his attempts to obtain federal funding for private medical institutions that suffered significant "hard costs" during Katrina and seeks reimbursement for the actual services rendered. Part of the problem is the next Medicaid index for reimbursement will not be available until 2010 which would have factored in inflation. These institutions were available in the post-Katrina period helping patients but have not been fully reimbursed. Levine had written a letter to House Speaker Pelosi asking for reimbursement and hopes that there would be federal money available during the next Congressional supplemental funding requests.

http://www.bayoubuzz.com/News/Louisiana/Government/Louisiana_Health_Sec_Talks_New_Orleans_LSU_Hospital_Mental_US_Congress_7310.asp

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LSU chemist isolates air pollutants

The Advocate | 08.18.08

By JORDAN BLUM

Newly discovered air pollutants could cause health risks similar to smoking a pack of cigarettes a day, new LSU research contends.

Environmental chemistry professor Barry Dellinger presented his findings on the pollutants Sunday at the 236th National Meeting of the American Chemical Society in Philadelphia.

The pollutants are known as “environmentally persistent free radicals,” called PFRs. They are microscopic particles released into the atmosphere from any flame-producing chemical reaction.

Dellinger, whose research focuses on the environmental effects of combustion, said the “PFRs” study results could eventually explain why so many nonsmokers get lung cancer and other pulmonary diseases.

“At the worst, it still looks like it could be equal to a pack of cigarettes a day,” Dellinger said, “if you live in a polluted area.”

Nearly 15 percent of lung cancer cases are diagnosed in nonsmokers, according to the American Cancer Society.

But Dellinger said more research is needed before such cancer cases can be definitively linked to persistent free radicals.

What is most fascinating from a science perspective, though, is that health risks in the air do not necessarily come from chemicals, Dellinger contended. Rather, the dangers come from the persistent free radicals formed during the chemical combustion processes, he said.

“It’s an amazing result to find these things,” Dellinger said. “I was shocked, but it makes perfect sense. “People study the toxicity of chemicals — that’s all anyone studies,” Dellinger said. “And I’m coming along saying it’s not really the chemicals.”

Dellinger is working with the LSU Health Sciences Center in New Orleans on acquiring a \$20 million grant from the National Institute of Environmental Health Sciences to further the research.

Dellinger said he is cautiously optimistic the funding will come through.

Persistent free radicals are formed during the combustion process anywhere from coal and fuel power plants to simply burning a tree.

“Wood smoke is the worst,” Dellinger said, discussing the large heart and lung health risks.

Scientists used to believe free radicals died quickly, he said, typically in microseconds. But new evidence shows many live for days or even indefinitely, Dellinger said, hence the term “persistent free radicals.” The particles get into the air and can be hazardous to our health, he said.

In cigarettes, the harmful particles are known as semiquinone radicals, he said.

Cigarettes also have other unhealthy elements, Dellinger said, but so does air pollution.

<http://www.2theadvocate.com/news/27081169.html>

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Letter: The other national drug problem

The Advocate | 08.19.08

Reggie Pulliam

Today, we are facing a major problem in this country: Our addiction not to oil or nonrenewable resources — though it is another travesty how we do not have the foresight to see where we are headed if we continue our cycle — but our overwhelming intake of pharmaceutical drugs.

Just recently, it was discovered that after 180 million people and \$14 BILLION later, Nexium and Prilosec have been discovered to stop the absorption of calcium and speed up osteoporosis.

This is just the latest “miracle drug” found to have adverse side effects. This whole process started in the 1990s when DTC (direct to consumer) advertising began. Just 10 years earlier, Big Pharma voted against it but soon realized that profits would skyrocket if it could just sell a lifestyle to Americans, who are material consumerists and want the quick fix.

There are currently 80,000-90,000 medical representatives in America. That is one for every five doctors! They spend between \$8,000 and \$15,000 per doctor.

In 2002, 28 percent of all hospital admissions for the elderly were due to medication problems — at a cost of \$20 billion!

We, as Americans, should understand that there is no “quick fix” for the human body. A balanced diet with moderate exercise will help the vast majority of us.

We also need to understand the millions of dollars being placed into the pockets of Washington in order to continue the barrage of “medication” for our “health.” It is truly a shame.

Reggie Pulliam
aspiring educator/waiter
Baton Rouge

<http://www.theadvocate.com/opinion/27118384.html>

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Just what the doctors ordered

Gazette.net | 08.15.08

by C. Benjamin Ford and Meghan Tierney | Staff writers

One of the side effects of Maryland's hospital construction boom is an increased need for health care workers, so some hospitals are looking at expanding teaching partnerships to help meet that demand.

By 2016, a Maryland Hospital Association study projects, the state will be short 10,000 nurses alone to meet the needs of aging baby boomers, said association spokeswoman Nancy Fiedler.

"When you calculate what is needed, more nurses and health professionals are working, but still more are needed," she said.

The association is working with Maryland legislators to come up with a way to double the number of nurses educated in the state from close to 2,800 a year to roughly 5,600 by the end of next year.

"A lot of candidates are out there, but are being turned away from nursing schools due to a lack of faculty," Fiedler said.

Part of the problem is that health care workers "are graying like the rest of us," she said.

The U.S. Census Bureau estimates that when the last of the baby boom generation hits 65 in 2030, one in five people in the United States will be 65 or older. That group will grow to 88.5 million by 2050, more than double today's population.

When Holy Cross Hospital of Silver Spring announced its plan to build a new 93-bed hospital in Germantown, it cited the location on the Montgomery College campus as an opportunity to provide new training and classes for students there, said Kevin J. Sexton, president and CEO of Holy Cross.

"We have to fill the pipeline [of new workers] way more than we are now," Sexton said.

Not only would it allow for the hospital to gain more workers, but it would help older nurses who might otherwise burn out to take a sabbatical and teach to escape the day-to-day pressures for a while, Sexton said.

"The new hospital would allow the college to expand its nursing program to Germantown," said Hercules Pinkney, vice president and provost of the Germantown campus.

Students could help with research, work there part time or participate in internships, he said. Shared laboratories and classroom space are a possibility, and doctors could be guest lecturers at the college. "We don't get involved in things unless there's a direct benefit for the students," Pinkney said, noting that the college's Board of Trustees must approve the Holy Cross plan. "... Everybody's excited, but nothing is set in stone yet."

Giving hospital staffers an opportunity to teach at the college will help Holy Cross retain them as well as help provide a source of new workers, Sexton said.

The partnership also would give students more clinical experience and hands-on work, he said.

The Washington County Health System in Hagerstown has a similar arrangement with Hagerstown Community College to provide faculty and for students to do their clinical work.

While the new \$294 million hospital is not being built on the same grounds as the community college, the properties adjoin and there has been talk of building a road to link them, said James P. Hamill, president and CEO of Washington County Health System.

Although the construction boom is estimated at \$3 billion in projects statewide, Hamill said costs are a small part of the price being paid to expand services.

"Hospitals are expensive ... about our mortgage will only be one-tenth of what we spend on wages and benefits for employees," he said.

The goal of the partnership with the college is to double the number of nurses being trained as well as the supply of other health care workers, Hamill said.

"Clearly, the facilities are necessary, but the real essence is the people, and to make sure you got enough people," he said.

http://gazette.net/stories/08152008/polinew201050_32459.shtml

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Number of primary care physicians dwindles in NE La.

Shreveport Times | 08.18.08

By Matthew Hamilton

MONROE — Dr. Kerry Anders had expected some free time Friday.

Anders, both a chief of staff at a hospital and a private physician, instead took on the patients of two colleagues who became unavailable that day. The work added to an already crowded schedule, his typical day of at least 12 hours beginning with hospital rounds in the morning and at times ending with an evening on call.

The heavy workload did not bother Anders, whose 20 years of experience have prepared him for such days. But the prospects of the area's private practices did give him pause.

"I'm concerned about the next generation," Anders said. "The community will need replacements, and that concerns me."

The area's dwindling number of private primary care physicians — doctors in the first line of defense, including general family practice, pediatrics, obstetrics and internal medicine — has left patients with fewer choices for health care and threatens to stretch an already strained medical community.

In the past four years, more than a dozen primary care physicians have left their private practices, some taking work in hospitals, some leaving the area.

Dr. Nashat Khanfar calls the slow exodus a crisis in the making.

"The emergency room has now become a place for primary care," said Khanfar, a pediatrician who has practiced in Monroe for nine years. "The result is limited access to health care."

The U.S. Department of Health and Human Services has designated Ouachita Parish a health professional shortage area. Among other criteria, the designation takes into account birth rate, poverty and number of qualified physicians.

Aimee Kane, director of corporate communications and physician relations at St. Francis Medical Center, called Monroe's medical community competitive with cities of similar and even larger sizes. The difficulty, Kane said, comes with servicing the surrounding area.

"We serve a large rural area," Kane said. "Our region is over 570,000 in population." Kane said outlying rural clinics and hospitals are limited in resources, technology and specialty services.

According to Bubba Rhymes, director of physician practice management at St. Francis, the local economic contraction — like the departures of State Farm and GM — has forced many patients to opt out of paid insurance coverage and join Medicaid. The aging of the population also has contributed to the rise in patients on Medicare. The result, according to Rhymes, is diminishing returns for private physicians.

"You have overhead costs for private practices increasing," Rhymes said. "You have inflation. But reimbursements from Medicare and Medicaid aren't keeping pace. Oftentimes, they're paying less and less."

With more patients on public health programs, doctors have had to increase their volume, put a cap on how many Medicaid or Medicare patients they will see or stop seeing Medicaid patients altogether.

As local economic contraction has made practicing medicine more difficult, it also complicates the recruitment of future doctors.

Sabrina Ramsey, St. Francis' vice president of business development for St. Francis, said doctors take into consideration schools, local economy and a city's overall quality. Doctors' spouses often have a specific career that can influence where they settle, and cities like Dallas and Jackson provide more options.

Despite the challenges facing local doctors, Ramsey characterized the overall retention of area physicians as steady. He stressed, however, the need to replace doctors nearing retirement.

"We look at several assessments to determine our physician needs," Ramsey said, listing assessments from the American Medical Association, the Medical Group Management Association and others. "But we take a careful look at secession — the possibility that some of our physicians will retire in 10 to 15 years."

As more baby-boomer physicians approach retirement from their practices, the ability to replenish them becomes more pressing. Kane sees hope in families and the support of the medical community.

"We're finding more and more that family ties to the region help attract physicians," Kane said. "We have a strong and supportive medical community who have chosen to continue to practice in this region."

Kane said physicians often play the most crucial role in attracting other physicians to an area.

"It's really the medical staff that recruits," Kane said. "The physicians need to be comfortable with the abilities of the staff."

<http://www.shreveporttimes.com/apps/pbcs.dll/article?AID=2008808180316>

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BioInnovation project poised to rise in New Orleans

The Times-Picayune | 08.18.08

By Kate Moran



Construction should begin in the coming weeks on the New Orleans BioInnovation Center, a business incubator on Canal Street that will help researchers at the city's major universities take their findings from the laboratory to the marketplace.

The project's launch comes after years of deferments and delays, and as city and university leaders are pushing the development of two new downtown hospitals to anchor a nascent biosciences corridor. The bioinnovation center is considered another critical component of that research hub.

Aaron Miscenich, the center's executive director, said scientists will be able to use the space to adapt discoveries they make in the academy into salable technology. Without such a resource, they often have to seek patents through their university and then sell their idea to a pharmaceutical or biotech company for development, after which they lose control of its fate.

Because researchers do not always have experience attracting big-dollar investment to carry their ideas forward, Miscenich said the center will host speakers and seminars to help them learn about entrepreneurship. It also will serve as a gathering place for scientists who want to swap ideas for business development among themselves.

"The true value is in the programming and the introductions we can provide to intellectual property professionals and venture capitalists," Miscenich said.

Modern thrust, N.O. twist

The Legislature approved financing in 2002 for the construction of three bioinnovation centers, one each in New Orleans, Baton Rouge and Shreveport. The latter two are up and running, but the local facility hit its first round of delays when staff identified structural problems in the building at 1441 Canal St. where it was supposed to locate.

That building was demolished just days before Hurricane Katrina, and the center hired two architects after the storm to design a new building to modern research standards. The drawings they produced look sleek and contemporary, but they also incorporate elements from traditional New Orleans architecture, including an interior courtyard and window screens that help block sunlight and keep the building cool.

The center will rise four stories above Canal Street and encompass 65,000 square feet of meeting rooms, wet labs and offices that can house 40 to 50 startup companies. Mark Ripple, the lead New Orleans architect, said the building will have a three-story atrium that will serve as a break room for the researchers.

"Sometimes that casual interaction between scientists and lab technicians in the break room is as powerful as what goes on inside the lab, " Ripple said. "There was a desire early on to provide opportunity for socialization among the tenants."

Miscenich said the state will spend \$60 million to build the bioinnovation center. None of the office and lab space on the second and third floors has been leased yet, but the top floor will be occupied by the Louisiana Gene Therapy Research Consortium, a partnership between LSU's health sciences center in New Orleans, LSU-Shreveport and Tulane.

The consortium will, among other projects, take cell therapies produced by those three institutions and try to move them to the clinical trial stage. Such a facility requires a supreme level of cleanliness, and the air in some parts of the fourth floor will turn over once a minute to purge viruses and bacteria.

Bridging the gap

Alan Miller, associate senior vice president for health sciences at Tulane, said the university is "very excited" for construction to start in the coming weeks. He said researchers in New Orleans often sell their findings to biotech companies that sometimes end up neglecting them. With the launch of the bioinnovation center, researchers can take steps to ensure their findings become commercially viable.

"You may be a scientist who has invested a great deal of your heart and soul into an investigation, and then the company decides something else is more worth pursuing, and your idea will stay on the shelf for years, or perhaps forever, " Miller said. "If we can do little startup companies and take it through the next levels of development, including going through preliminary trials, all of a sudden you're demonstrating that this idea a winner."

Joe Moerschbaecher, vice chancellor for academic affairs at LSU's health sciences center, said the center is also a vital recruitment tool for the universities.

"When you're trying to recruit a large research group that may be involved in translational research, the availability of this type of facility is critical, " he said, noting that it also would provide high-paying jobs to technicians and others who help with research.

The bioinnovation center will host a groundbreaking Wednesday evening, where university leaders and Mayor Ray Nagin are scheduled to speak. Miscenich said contractors already have driven test pilings, and construction should begin in earnest in a few weeks. The target opening date is December 2009.

http://www.nola.com/news/index.ssf/2008/08/bioinnovation_project_poised_t.html

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New study backs angioplasty through the wrist

The Times-Picayune | 08.19.08

By LAURAN NEERGAARD

The Associated Press

WASHINGTON (AP) — The best path to a clogged heart may be through the wrist. About a million artery-clearing angioplasties are performed in the United States each year, and the usual route is to thread a tube to the heart through an artery in the groin.

Now a major study shows going through the wrist instead can significantly lower the risk of bleeding — without the discomfort of lying flat for hours while the incision site seals up.

Just one in 100 angioplasties is done via the wrist, and the approach isn't for everyone. But Monday's study promises to spur more specialists to use the method.

"In experienced hands, it can be done more," said Dr. Sidney Smith, heart disease chief at the University of North Carolina at Chapel Hill and a past president of the American Heart Association, who wasn't part of the study. "This approach, when done by experienced operators, has advantages."

Angioplasty is prized as a quick, minimally invasive way to restore blood flow in a clogged artery. A tiny balloon is inflated at the site of the blockage, pushing back the clog. Doctors often also insert a mesh tube called a stent to keep the artery propped open. It can be done during a heart attack, to alleviate worsening symptoms that signal a heart attack is imminent, or for nonemergency relief of recurring chest pain.

Who's the best candidate for an angioplasty versus other treatments is hugely controversial. But once that decision has been made, the new study addressed whether the through-the-wrist route works as well.

Cardiologists have preferred working through the femoral artery in the groin because it is a larger blood vessel than the wrist's radial artery, easier to tug catheters through. When the procedure's over, heavy pressure — often a sandbag — is applied for several hours until the puncture site quits bleeding and essentially seals itself. But heavy bleeding and related complications are a risk, happening in anywhere from 2 percent to sometimes as many as 10 percent of patients.

Catheters have gradually gotten smaller and more flexible, and previous small studies had suggested the wrist approach could be safer because that puncture site can be bandaged. In one earlier study, the wrist method even trimmed hospital costs because patients were discharged sooner.

So Duke University researchers turned to a national registry — analyzing more than half a million angioplasties performed at 600 U.S. hospitals between 2004 and 2007 — to see how often wrist angioplasties are done, and the results.

One key caveat: These were first-time, non-emergency cases.

But just 1.3 percent of the angioplasties were done through the wrist. Both methods were equally effective at clearing heart arteries, lead researcher Dr. Sunil Rao reported in the *Journal of the American College of Cardiology: Cardiovascular Interventions*.

The wrist method cut the bleeding risk by nearly 60 percent: Nearly 2 percent of patients treated the usual way bled, compared with slightly fewer than 1 percent of those treated via the wrist.

The method may be gaining steam: In early 2007, the researchers measured a sudden jump, as the wrist method accounted for about 3.5 percent of angioplasties performed then.

Rao himself uses wrist angioplasty almost exclusively, but it takes extra training that many cardiologists haven't received.

Still, the heart association's Smith said training isn't difficult, and the need may be growing: Obesity can limit traditional access, plus more patients today have disease-damaged leg arteries.

"The procedure is not one that would be recommended for everybody," Smith cautioned. But, "there are definitely groups of patients where this can be done with the same results and fewer complications."

<http://www.nola.com/newsflash/index.ssf?/base/national-9/1219146257285020.xml&storylist=health>

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For the Overweight, a New Definition of Health

The New York Times | 08.18.08

Tara Parker-Pope

Obesity is widely viewed as the nation's biggest health problem. But research last week showing that one-third of obese people are "metabolically" healthy suggests that health can't be judged by fat alone.

Indeed, there's a growing body of evidence suggesting that many of our attitudes about health and weight are misguided. While excess weight clearly is a risk factor for poor health, it doesn't appear to be the most important issue. About half of overweight people and one-third of obese people have normal "good" cholesterol, blood pressure and other cardiovascular risk factors. And several studies show physical activity is a far more important predictor of health than body size is.

"We know that obesity by itself is a major coronary risk factor," said Dr. Kenneth Cooper, the fitness expert who launched the aerobics movement. "But you can't just rely on weight. You're better off being fat and fit than skinny and unfit."

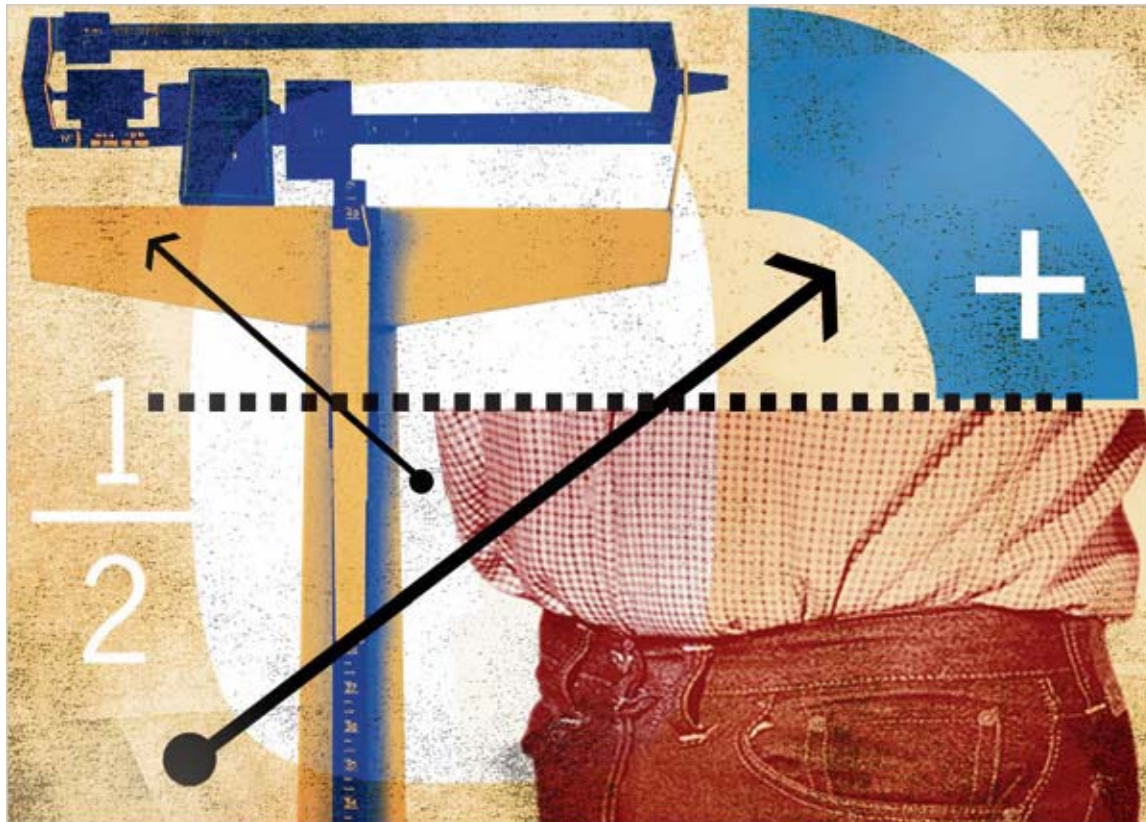
<http://well.blogs.nytimes.com/2008/08/18/for-the-overweight-a-new-definition-of-health/>

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Better to Be Fat and Fit Than Skinny and Unfit

The New York Times | 08.18.08

By TARA PARKER-POPE



Stuart Bradford

Often, a visit to the doctor’s office starts with a weigh-in. But is a person’s weight really a reliable indicator of overall health?

Increasingly, medical research is showing that it isn’t. Despite concerns about an obesity epidemic, there is growing evidence that our obsession about weight as a primary measure of health may be misguided.

Last week a report in *The Archives of Internal Medicine* compared weight and cardiovascular risk factors among a representative sample of more than 5,400 adults. The data suggest that half of overweight people and one-third of obese people are “metabolically healthy.” That means that despite their excess pounds, many overweight and obese adults have healthy levels of “good” cholesterol, blood pressure, blood glucose and other risks for heart disease.

At the same time, about one out of four slim people — those who fall into the “healthy” weight range — actually have at least two cardiovascular risk factors typically associated with obesity, the study showed.

To be sure, being overweight or obese is linked with numerous health problems, and even in the most recent research, obese people were more likely to have two or more cardiovascular risk factors than slim people. But researchers say it is the proportion of overweight and obese people who are metabolically healthy that is so surprising.

“We use ‘overweight’ almost indiscriminately sometimes,” said MaryFran Sowers, a co-author of the study and professor of epidemiology at the University of Michigan. “But there is lots of individual variation within that, and we need to be cognizant of that as we think about what our health messages should be.”

The data follow a report last fall from researchers at the Centers for Disease Control and Prevention and the National Cancer Institute showing that overweight people appear to have longer life expectancies than so-called normal weight adults.

But many people resist the notion that people who are overweight or obese can be healthy. Several prominent health researchers have criticized the findings from the C.D.C. researchers as misleading, noting that mortality statistics don't reflect the poor quality of life and suffering obesity can cause. And on the Internet, various blog posters, including readers of the Times's Well blog, have argued that the data are deceptive, masking the fact that far more overweight and obese people are at higher cardiovascular risk than thin people.

Part of the problem may be our skewed perception of what it means to be overweight. Typically, a person is judged to be of normal weight based on body mass index, or B.M.I., which measures weight relative to height. A normal B.M.I. ranges from 18.5 to 25. Once B.M.I. reaches 25, a person is viewed as overweight. Thirty or higher is considered obese.

"People get confused by the words and the mental image they get," said Katherine Flegal, senior research scientist at the C.D.C.'s National Center for Health Statistics. "People may think, 'How could it be that a person who is so huge wouldn't have health problems?' But people with B.M.I.'s of 25 are pretty unremarkable."

Several studies from researchers at the Cooper Institute in Dallas have shown that fitness — determined by how a person performs on a treadmill — is a far better indicator of health than body mass index. In several studies, the researchers have shown that people who are fat but can still keep up on treadmill tests have much lower heart risk than people who are slim and unfit.

In December, a study in The Journal of the American Medical Association looked at death rates among 2,600 adults 60 and older over 12 years. Notably, death rates among the overweight, those with a B.M.I. of 25 to 30, were slightly lower than in normal weight adults. Death rates were highest among those with a B.M.I. of 35 or more.

But the most striking finding was that fitness level, regardless of body mass index, was the strongest predictor of mortality risk. Those with the lowest level of fitness, as measured on treadmill tests, were four times as likely to die during the 12-year study than those with the highest level of fitness. Even those who had just a minimal level of fitness had half the risk of dying compared with those who were least fit.

During the test, the treadmill moved at a brisk walking pace as the grade increased each minute. In the study, it didn't take much to qualify as fit. For men, it meant staying on the treadmill at least 8 minutes; for women, 5.5 minutes. The people who fell below those levels, whether fat or thin, were at highest risk.

The results were adjusted to control for age, smoking and underlying heart problems and still showed that fitness, not weight, was most important in predicting mortality risk.

Stephen Blair, a co-author of the study and a professor at the Arnold School of Public Health at the University of South Carolina, said the lesson he took from the study was that instead of focusing only on weight loss, doctors should be talking to all patients about the value of physical activity, regardless of body size.

"Why is it such a stretch of the imagination," he said, "to consider that someone overweight or obese might actually be healthy and fit?"

http://www.nytimes.com/2008/08/19/health/19well.html?_r=1&ref=health&oref=slogin

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Lawmakers Promote Bill To Increase Funds for Community Health Centers Kaiser Network | 08.18.08

Sen. Tom Carper (D-Del.) and Rep. Mike Castle (R-Del.) on Wednesday promoted legislation (S 901, HR 1343) that would increase federal funding for the 1,200 community health centers nationwide, the Wilmington News Journal reports.

Carper, together with Sen. Joe Biden (D-Del.), was one of 74 co-sponsors in the Senate of the Health Care Safety Net Act of 2008, which was approved in July and would authorize through 2012 about \$10.3 billion in funds for community health centers. In the House, Castle was one of 249 co-sponsors of the Health Centers Renewal Act of 2008, a companion bill that would authorize \$11.4 billion in funds over five years, the News Journal reports. A conference committee is scheduled to discuss the two bills before sending President Bush the legislation for final approval.

Castle said, "I'm a total believer, and it may be because here in Delaware these health centers work extremely well" (Haber, Wilmington News Journal, 8/14).

http://www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm#54012

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Administrative demands overburden hospitals

AHA News | 08.18.08

Administrative requirements could be streamlined or reduced to lower health care spending without sacrificing the quality of patient care, according to an AHA TrendWatch report released today.

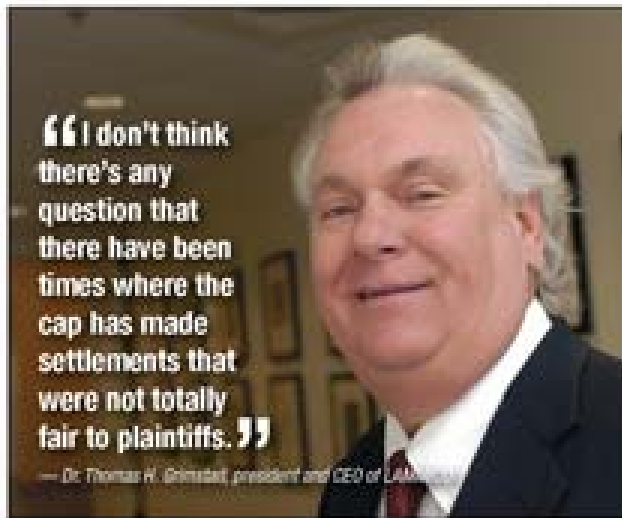
Many administrative requirements are duplicative or conflict with each other, diverting precious resources away from patient care and making health care less affordable, the report notes. Payers and regulators could streamline or align requirements and processes to reduce the administrative burden on hospitals and other health care providers, the report states.

For example, the Centers for Medicare & Medicaid Services could reduce the number and type of contractors performing Medicare and Medicaid oversight, while payers could standardize benefit packages, claims processing procedures and business practices.

http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080818_TrendWatch&domain=AHANEWS

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Malpractice Cap Work Lies Ahead Louisiana Medical News | 08.19.08 TED GRIGGS



Louisiana's medical malpractice cap emerged unchanged from the last legislative session as lawmakers, faced with a number of proposals, could not find a compromise that satisfied all parties.

One proposal with broad support sought to increase providers' responsibility to the first \$250,000 in damages and the Patient's Compensation Fund's liability to \$500,000. However, the proposal failed to gain traction in the Legislature.

Dr. Vincent Culotta, a Metairie OB/GYN who chairs the Louisiana State Medical Society's council on legislation, said the malpractice cap will have to be addressed.

"The question is 'where is the right number?'" Culotta said. "The cap has to exist."

Louisiana is very much in a health care crisis, he said. Some people, including the Louisiana Medical Mutual Insurance Co. (LAMMICO), would like to enact the Texas malpractice model, which caps non-economic damages at \$250,000.

Texas implemented the cap in 2004. The cap has reduced malpractice lawsuits and helped increase the number of physicians.

But Culotta said he doesn't believe the same thing would happen here. There are a lot of other things preventing physicians from practicing here, and those things have little to do with changing the malpractice cap, removing it or going to the Texas model, he said.

"We're still recovering from Katrina. We're basically a very poor state. We have probably the highest percentage of Medicaid (patients) of any state in the union," Culotta said. Changing the malpractice cap won't address those problems, said Culotta, who is also a member of the PCF's board of directors.

Louisiana's \$500,000 cap is 33 years old. A coalition of stakeholders, including the State Medical Society and the Louisiana Hospital Association, supported raising the cap.

Other changes suggested included eliminating the medical review panel. Instead, a victim would have to produce a certificate of merit, or letter from a practicing physician that says malpractice occurred. The medical expert would also have to swear to that in court.

Supporters said increasing the cap and the other changes could take the decision out of the courts' hands. The cap's constitutionality has been challenged, with plaintiffs attorneys arguing that the amount set in 1975 is no longer an adequate remedy.

"I think we're always afraid that the courts (will act)," Culotta said. "But the question is will the courts hear the message that the Legislature didn't want to change and leave it alone?"

Dr. Thomas H. Grimstad, president and CEO of LAMMICO, said his company could not support the coalition's proposed legislation. Among other things, Grimstad said there was no guarantee that increasing the primary layer of coverage would result in the Patient's Compensation Fund decreasing its rates.

Supporters of the legislation had said lower PCF rates would offset the increase in costs providers faced for taking on the first \$250,000 in coverage.

In addition, Grimstad said there is no way to predict how a higher cap would affect the number of lawsuits against providers.

"My guess would be, and this is just a guess, is that there would in fact be more lawsuits," Grimstad said. "If there's more money out there to be recovered, then generally speaking you probably would have at least a tendency toward more lawsuits."

However, Grimstad said the malpractice insurer remains committed to a compromise solution.

"I don't think there's any question that there have been times where the cap has made settlements that were not totally fair to plaintiffs," Grimstad said.

At the same time, one must recognize that the overall cost of medical malpractice insurance is higher in Louisiana than in many, many states where caps aren't even part of the law, Grimstad said.

One reason is frequency. Louisiana has nearly double the number of claims per 100 policyholders than Arkansas, Alabama and Texas, according to LAMMICO.

In addition, a lot of money leaves the Patient's Compensation Fund because state law sets no limit on future medical coverage expenses, Grimstad said.

The average payments for LAMMICO's policyholders are as high or even higher than the average payments in states where there are no malpractice caps, Grimstad said.

If the cap is to be changed, the legislation must address the entire system, including the PCF, he said. The system has to be modified to bring some economies into it.

"Otherwise you're just raising malpractice rates, and you're going to get to the point where physicians won't want to come to practice in Louisiana because those rates are so high," Grimstad said.

Grimstad said LAMMICO favors the certificate-of-merit approach, which requires the plaintiff to hire an expert. Under this approach, the plaintiff has to have "some skin in the game" before bringing a lawsuit, he said.

The state should also look at changing the way future medical expenses are paid, such as a system to check so that all charges are not automatically paid as billed, Grimstad said. If the plaintiff has insurance available, that insurance should be utilized.

"If we would do these things together, then I think we could raise these caps to some extent without such a burden on the physician," Grimstad said.

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