

HEALTHCARE JOURNAL

of Baton Rouge

July / August 2008

**Managing
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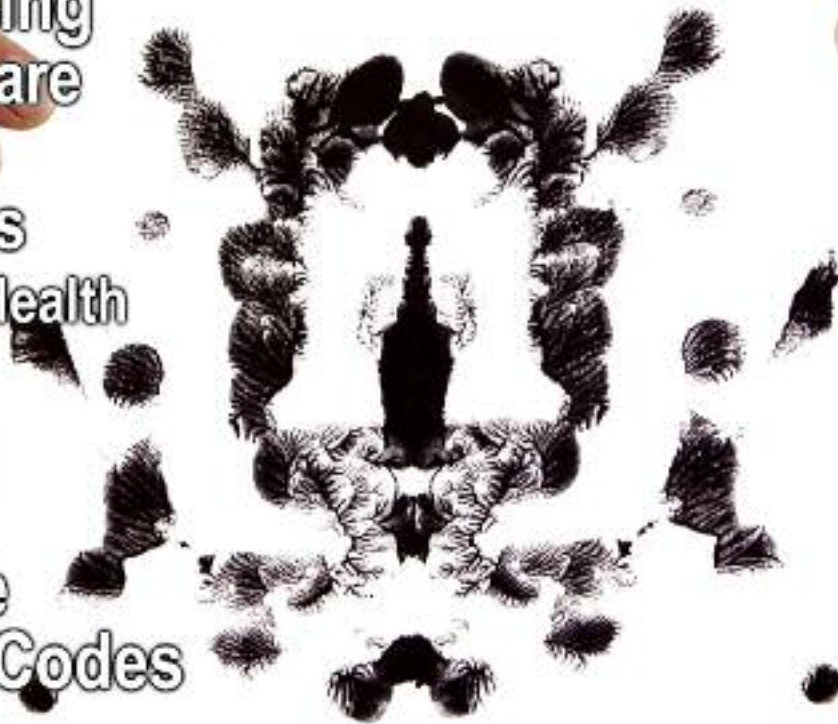
Mental Health

**Reimbursing
Psych Care**

**Louisiana's
Mental Health
Crisis**

**Rapid
Response
Teams vs. Codes**

**One on One:
Mitch Wasden, CEO
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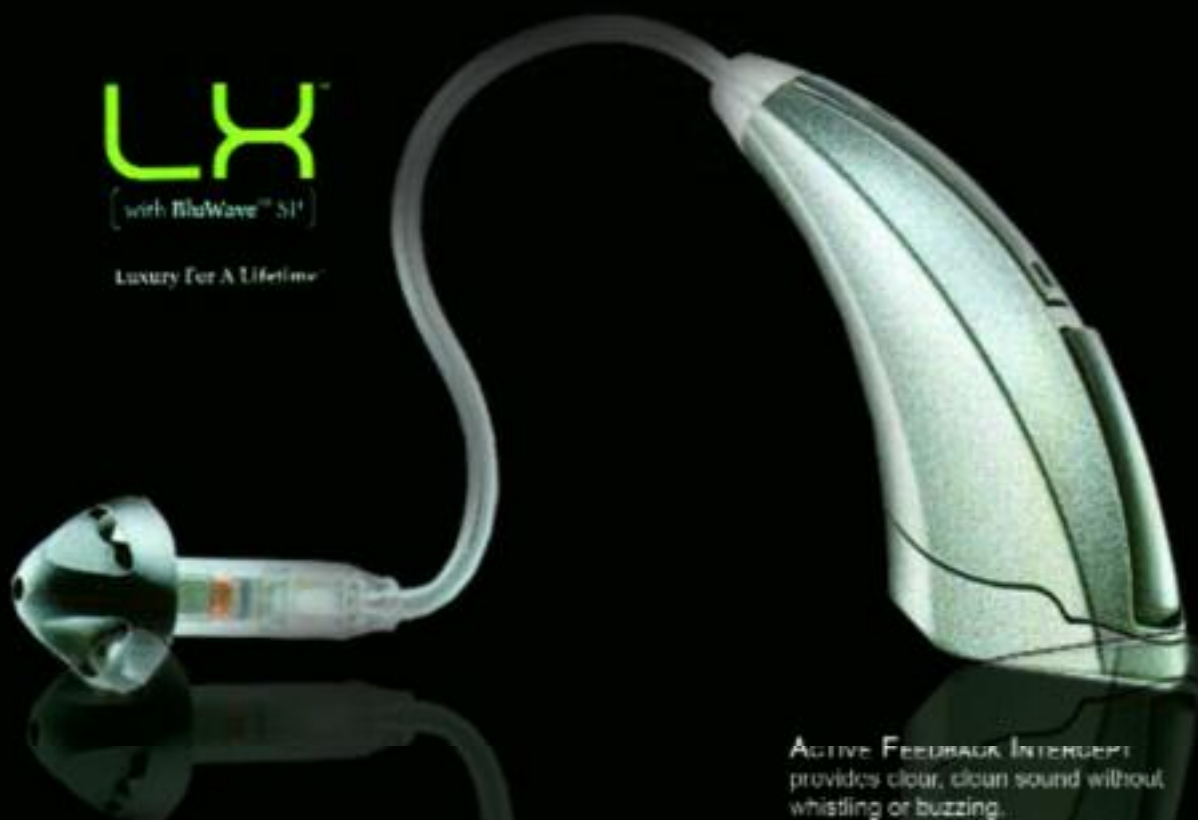
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LETTER FROM THE PUBLISHER

Vitality shows in not only the ability to persist but the ability to start over.

-F. Scott Fitzgerald

Greetings,

People around the country are interested in how Louisiana is handling our rebuilding process. Many of you attend national conferences. A few months ago I was honored to deliver the keynote speech at a healthcare conference in Las Vegas. The speech was billed as “Louisiana and a post-disaster healthcare system.” Is it just me or have you also experienced that most everyone from around the country will politely treat you like your dog just died. With lingering images of police officers looting, cries for help unanswered, and a reputation for having a less than credible good ol' boy system, it's no wonder people take some degree of pity on us. Old reputations die hard. But for me this conference was a small opportunity to present what most of the country should know about us.

Most people are not fortunate enough to begin with a clean slate. A post-hurricane environment is likely the closest we can get to such an opportunity. We did the right things. We formed redesign and collaboration teams to address this opportunity. Some great ideas emerged and our leaders are on board. But now the challenge, the implementation.

Healthcare has evolved into a labyrinth of competing factions. We are all trying to protect and enhance our own interests. While this is natural, self-preservation can be in conflict with large scale progress. We form organizations, unions, special interests, and alliances to protect ourselves. But, what do we do if the ultimate best for all is in contrast to our self-interest? If the new design on a clean slate means a diminished role for some interest group—insurance companies, hospitals, physicians, pharmaceutical companies, lawyers—will we continue to support the change?

I believe that to some degree we all act in our own self-interest. But, I believe most people working in the healthcare field choose at some point in their lives to do this work out of an innate sense of serving and caring for others.

This sense of selflessness is necessary on a larger scale to implement and effect the right change we need. We are the industry that can lead the way of selfless acts to achieve the results we desire such as high quality with lower costs, and access and coverage for all. As another Fitzgerald might say, ask not what your healthcare system can do for you, but rather what can you do for your healthcare system. Something like that.

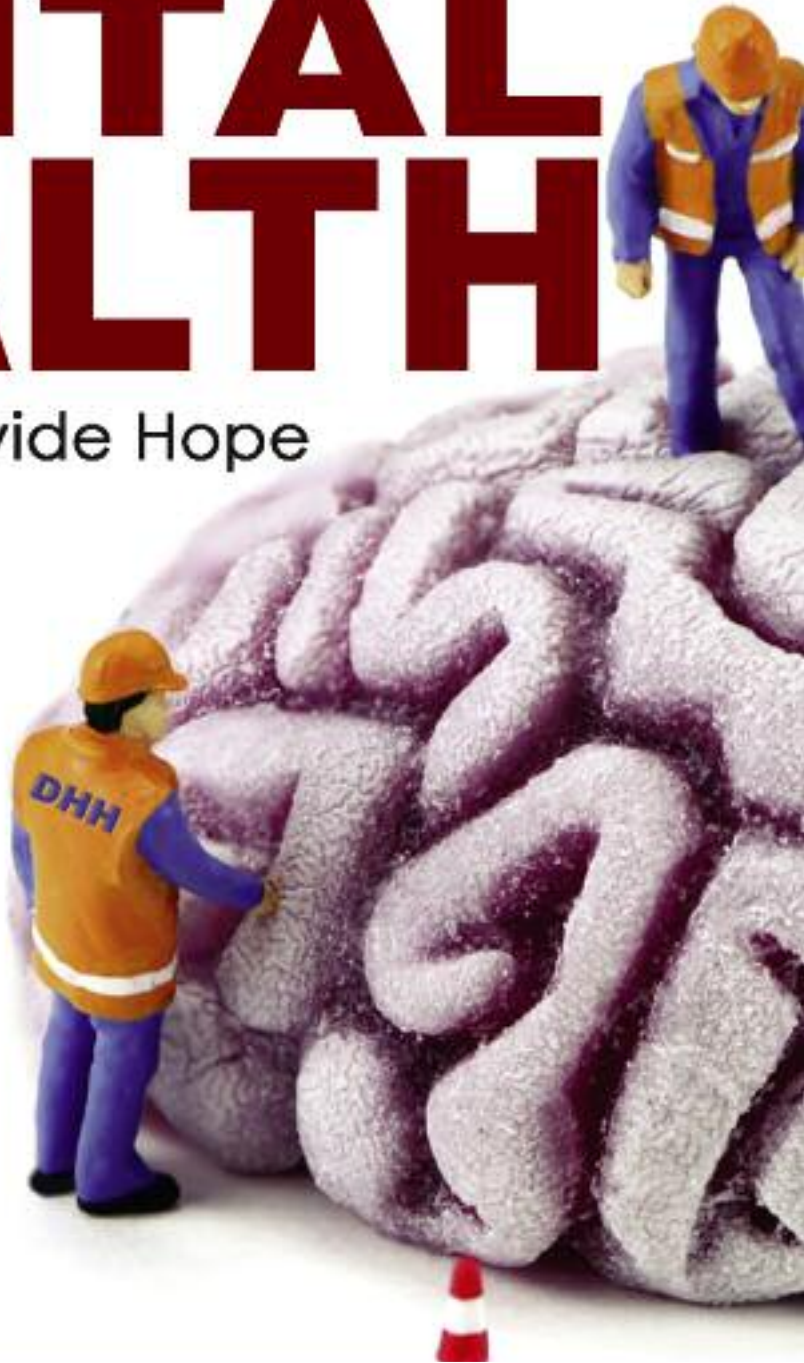
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THE STATE OF LOUISIANA'S MENTAL HEALTH

New Initiatives Provide Hope

by: Karen Stassi

Like many of the state's other woes, Louisiana's mental health crisis was not caused by Katrina and Rita, but it was exacerbated and thrust into the public eye by the storms. And that perhaps is the only silver lining to the story. The terrible devastation and its continuing aftermath have forced our city, our state, and the nation to look more closely at a situation that was easier to turn away from. It's an uneasy stare at best. Like much of the country, Louisiana is faced with a growing demand for mental health resources, while funding and qualified personnel are increasingly hard to come by. The challenges are clear for the new Assistant Secretary for the Office of Mental Health, Jennifer Kopke, appointed by Louisiana Department of Health and Hospitals (DHH) Secretary Alan Levine in March. Her arrival



A Timeline of Mental Health

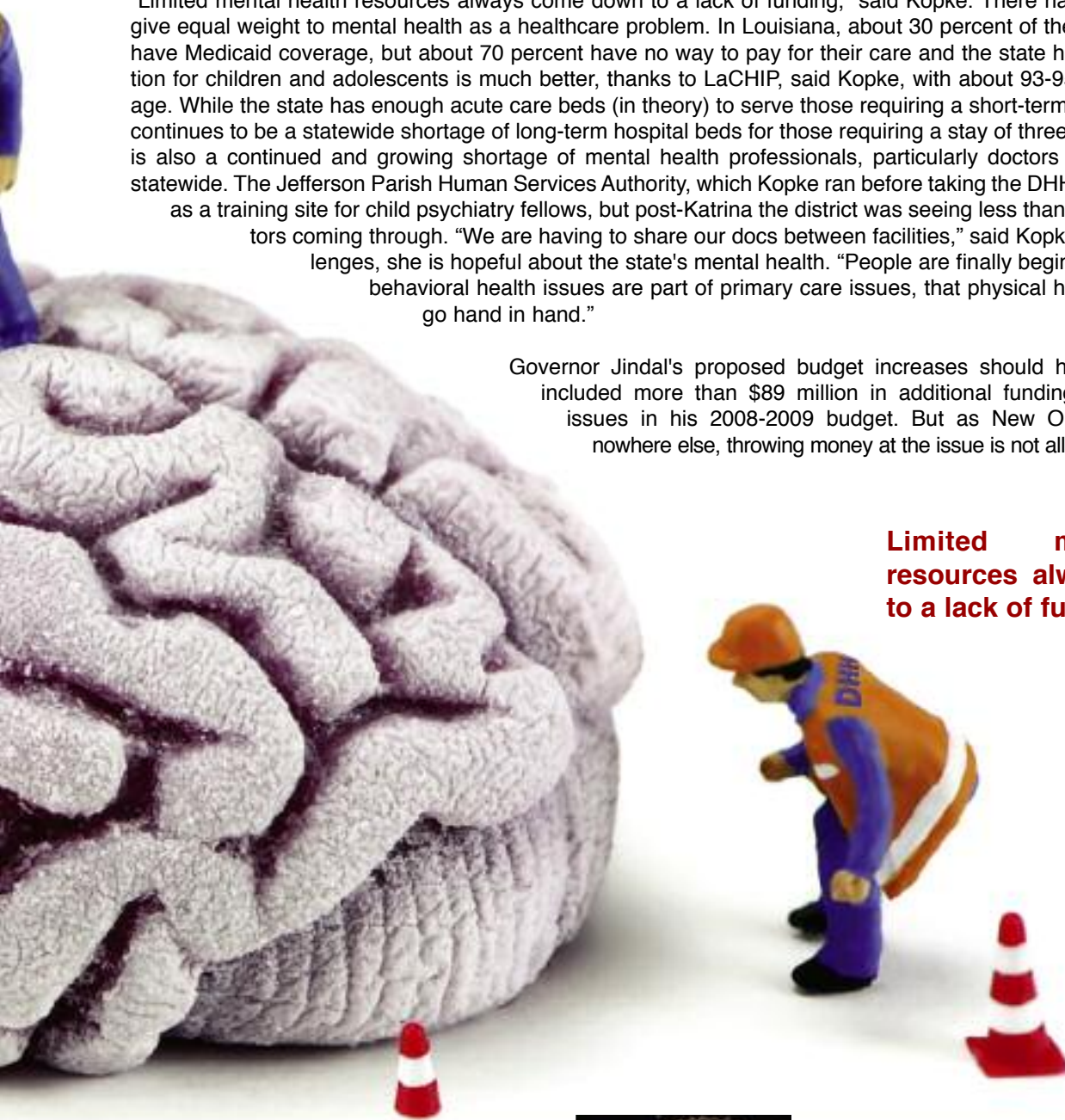
coincided with a new push by DHH and Governor Bobby Jindal to revamp and reinforce mental health services in our state, and in particular, New Orleans.

“Limited mental health resources always come down to a lack of funding,” said Kopke. There has long been a failure to give equal weight to mental health as a healthcare problem. In Louisiana, about 30 percent of the mental health patients have Medicaid coverage, but about 70 percent have no way to pay for their care and the state has to step in. The situation for children and adolescents is much better, thanks to LaCHIP, said Kopke, with about 93-95 percent having coverage. While the state has enough acute care beds (in theory) to serve those requiring a short-term stay, said Kopke, there continues to be a statewide shortage of long-term hospital beds for those requiring a stay of three months or more. There is also a continued and growing shortage of mental health professionals, particularly doctors and child psychiatrists, statewide. The Jefferson Parish Human Services Authority, which Kopke ran before taking the DHH position, used to serve as a training site for child psychiatry fellows, but post-Katrina the district was seeing less than half the number of doctors coming through. “We are having to share our docs between facilities,” said Kopke. But, despite the challenges, she is hopeful about the state’s mental health. “People are finally beginning to understand that behavioral health issues are part of primary care issues, that physical health and mental health go hand in hand.”

Governor Jindal's proposed budget increases should help. The governor has included more than \$89 million in additional funding for behavioral health issues in his 2008-2009 budget. But as New Orleans has proved like nowhere else, throwing money at the issue is not all it takes.

Limited mental health resources always come down to a lack of funding

-Jennifer Kopke, DHH



500 BC: Ancient Egyptians refer to dementia and depression as well as primitive neurosurgery.



500 BC: Mental illness regarded as punishment for offending the gods.

People are finally beginning to understand that behavioral health issues are part of primary care issues, that physical health and mental health go hand in hand.

-Jennifer Kopke, DHH

So, in addition to the budget recommendation, Jindal and DHH have proposed a package of bills which will create standards for local behavioral health agencies, allow for the use of telemedicine in assessment and treatment to compensate for a shortage of mental health professionals, create a mental health safety net for those in crisis, and provide a mechanism to ensure that those exhibiting high risk behavior receive the treatment they need. While the bills will have the most immediate impact in New Orleans, they are designed to address access issues statewide. "Right now we are responding to a crisis, but we certainly don't want to put all of our resources in New Orleans," said Kopke. "The budget increases are enough to allow us to address other parts of the state."

DHH's legislative package includes:

- SB 182 (Gray), dubbed Nicola's Law, which came in direct response to the deaths of Nicola Cotton and LaToya Johnson, two New Orleans police officers who were killed by mentally ill suspects. The Nicola's Law bill provides treatment professionals and the courts another tool to compel treatment and enforce treatment protocols, when necessary, and to ensure intensive care management is provided. The bill mirrors a similar law in New York, Kendra's Law. Officials there report that Kendra's Law significantly reduced crime, incarceration, and hospitalizations linked to mental illness in a very short period of time.

- SB 228 (Heitmeier), which establishes gateways to facilitate access to mental health care for those in crisis. The bill will allow for the establishment of crisis receiving centers not just in New Orleans, but across the state.

- HB 930 (Mills), which creates readiness criteria for human service districts across the state; establishes ongoing review and oversight of established districts, and provides for creation of additional human service districts across the state, in addition to the four currently in existence. The first of these, the Jefferson Parish Human Services Authority was established by the Louisiana Legislature in 1989 to provide local control in the management and delivery of mental health, addictive disorders, and developmental disabilities services. Prior to its formation, these services were managed by the State of Louisiana. The success of this authority resulted in the creation of other human service districts in Baton Rouge,

greater New Orleans, and in the Florida Parishes. Two other such districts are already in the planning stages.

- HB 653 (Labruzzo), which uses cutting edge telemedicine to address the ongoing shortage of mental health professionals. The bill creates a 24/7 hotline for those in crisis to receive evaluation, counseling and instructions for further care especially in areas where there are not enough doctors on the ground.

DHH has also proposed some long-term initiatives which, while focused initially on the New Orleans area, may eventually be expanded to other parts of the state. Some are already in place. DHH's long-term initiatives include:

- Enhancement of the existing 24/7 crisis phone service. The 211 system is a toll-free, live answer link to behavioral health and social services. It will have multi-line and multi-lingual capacity.

- Crisis Intervention Teams made up of law enforcement officers that have received specialized training to be first responders to mental health emergencies.

- A regional receiving and triage center providing a uniform system of entry and immediate assessment. This may be free-standing, hospital based, or may be established at an existing facility.

- Mobile Clinical Treatment Teams consisting of a psychiatrist, nurse, and four mental health practitioners to provide services at community, home, or school settings as an enhancement to existing clinical services in the greater New Orleans area.

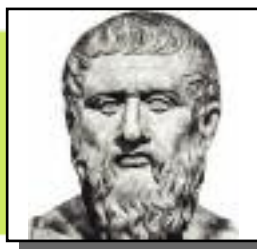
- Mental health staffing assistance to the Orleans Parish Prison. Necessary treatment and the potential for rehabilitation are hampered by minimal staffing and oversight.

Right now we are responding to a crisis, but we certainly don't want to put all of our resources in New Orleans. The budget increases are enough to allow us to address other parts of the state.

-Jennifer Kopke, DHH

In the meantime, initiatives like the Louisiana Spirit Hurricane Recovery program, which offers assistance to those impacted by the storms continues statewide. "This program has had a tremendous impact, particularly among the elderly, for those

400 BC: Hippocrates considers mental illness to be more like other ailments, a problem in the balance of the humors, than a reflection of the gods' displeasure.



387 BC: Plato posits that mental reasoning occurs in the brain. In Plato's *Republic*, Socrates recommends sending the deformed and the offspring of the inferior away to a mysterious place.

who were displaced or had their entire social structure and support system destroyed by the storm,” said Kopke.

All that said, three years post-Katrina, and billions of dollars in aid later, New Orleans remains anything but easy for the mentally ill. Long-term psychiatric care is still hard to come by, mental health professionals continue to be in short supply, and the psychological scars of a traumatized city are plain to see. Prior to Katrina, there were somewhere around 500 psychiatric beds in the greater New Orleans area with Big Charity boasting the most. While many of those beds, with the exception of the still-shuttered Charity's, have come back online, many feel the numbers are still too small, particularly for long-term stays. In New Orleans, since Charity was the best resource for those unable to pay, those beds are the most sorely missed. The New Orleans Mental Health Center, the Desire Florida Mental Health Clinic, and the St. Bernard Mental Health Clinic also remain closed. While the New Orleans Adolescent Hospital has been modified to house about 40 adult patients, resources are still inadequate. Even those hospitals with additional psych beds available are unable to open them to patients due to both reimbursement issues and a continuing shortage of professional staff.

Access, continuity of care, and housing issues mean many of the city's mentally ill are untreated or on the streets, increasingly leading to clashes with law enforcement. Even if they are lucky enough to be seen at a medical facility, they are often

back on the streets in a matter of hours. There have even been reports of desperate family members falsely reporting their mentally ill loved ones for criminal behavior so they might end up at the parish prison, which has 60 psychiatric beds. The hope is that the tradeoff for the stigma and trauma of incarceration is regular psychiatric treatment, but even that facility is grossly understaffed. There are clinics and counseling centers to offer assistance to those with depression, PTSD, etc., but if someone needs more acute care, it is hard to find a spot for them. The worsening situation was starkly illustrated when a New Orleans police officer was killed by a mentally ill suspect she was trying to subdue.

Access, continuity of care, and housing issues mean many of the city's mentally ill are untreated or on the streets, increasingly leading to clashes with law enforcement.

That's why the bulk of the DHH's new behavioral health strategy is targeted toward the Crescent City and surrounding areas. “The priorities for New Orleans are crisis response, putting intensive community services in place, and providing safe, affordable housing for the mentally ill,” said Jennifer Kopke. “Our priority is to treat them and keep them in the community.



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Hospitalization is the least ideal option.” In addition to the legislative package and the long term initiatives, the department has formed a four person transformation team to assist the Metropolitan Human Service District in New Orleans to stabilize the area. The team is led by retired U.S. Army Colonel James McDonough who helped turn around the Florida prison system. DHH has also embarked on several urgent short term initiatives in response to Executive Order No. BJ-2008-12, to improve access to mental health care in the city. The fact that DHH moved forward without the standard RFP process is a clear indicator of the urgency of the situation.

The priorities for New Orleans are crisis response, putting intensive community services in place, and providing safe, affordable housing for the mentally ill.

-Jennifer Kopke, DHH

The first of DHH's short term initiatives is the creation of a Forensic Assertive Community Treatment (FACT) team to serve residents in the greater New Orleans area (Orleans, St. Bernard, Plaquemines, and Jefferson parishes) affected by mental illness and/or substance abuse who have frequent interactions with law enforcement and/or the criminal justice system. The team, which would annually serve about 100 people, would provide ongoing outreach, mental health treatment, medication management, addiction counseling, case management, and social services. Team members would include a psychiatrist, psychiatric nurses, social workers, case managers, and substance abuse counselors.

In theory there are enough beds to accommodate the city's mentally ill. What there is not enough of are the community services that provide care and keep them out of the hospital

-Jennifer Kopke, DHH

DHH also aims to create two Assertive Community Treatment (ACT) teams, one for Jefferson Parish and one for Orleans, Plaquemines, and St. Bernard parishes. The ACT teams would offer evidence-based, comprehensive, highly structured clinical and rehabilitative service 24/7 to those with severe mental and co-occurring substance abuse or developmental disabilities who have demonstrated an inability to engage in traditional community mental health services and high rates of inpatient hospitalization recidivism. The

335 BC: Aristotle argues that man “thinks” with his heart.

ACT teams, which would also each serve about 100 people annually, would address individual needs for symptom management, substance abuse treatment, interpersonal relationships, skill development, housing issues, healthcare, legal issues, financial issues, etc., so would naturally be comprised of many disciplines. Unlike traditional community services, the teams would go directly to those in need. "In theory there are enough beds to accommodate the city's mentally ill," said Kopke. "What there is not enough of are the community services that provide care and keep them out of the hospital."

It is hoped that these short term initiatives will stabilize the greater New Orleans area while also serving as pilots for some of DHH's new approaches.

In recognition of the importance of a home base for continuity of care and mental stability, DHH is also seeking those who could provide monthly housing subsidies and supports in the greater New Orleans area. This transitional service would allow those with mental disabilities to afford rental units until a traditional rental subsidy through HUD or other sources can be obtained. Those accessing the services of the FACT and ACT teams would have priority for these subsidies.

For those in crisis, DHH also wishes to create access to six crisis respite beds for temporary residence and stabilization for adults with either a psychiatric or behavioral emergency.

The beds, which would be available 24/7, would avert the need to go to an emergency room, mental health emergency room extension, or placement in an acute psychiatric hospital bed. Despite the limited number, DHH expects to serve 500 people annually with the six respite beds. Respite beds would be accessed through referral from a community service, through a triage center, or from an emergency room.

Finally, DHH wishes to create a Child Adolescent Crisis Response Team (CART) for Orleans, Plaquemines, and St. Bernard parishes. The program would provide a telephone triage system followed by a face-to-face assessment within two hours either in-home or in-community if necessary. Licensed mental professionals and para-professional staff would provide in-home stabilization for a maximum of seven days. The CART would operate out of the New Orleans Adolescent Hospital.

It is hoped that these short term initiatives will stabilize the greater New Orleans area while also serving as pilots for some of DHH's new approaches. In the meantime, the state will fine tune the human service district concept, which seems to work well in other areas, and expand that model to other regions. Of course, the collaboration of law enforcement, public and private hospitals, clinics and primary healthcare providers is essential to managing mental health in Louisiana. When asked what Louisiana's healthcare community could do to help, Kopke answered, "Keep up the good work...everything they do is critical." ❖





The Parity Debate

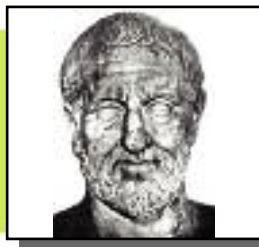
by: Philip Gatto

Parity. A simple word, a simpler concept. One that is woven into our American fabric—equal treatment for all. But for the mentally ill, and sometimes those who treat them, parity is still a wish, a dream, dare we say a delusion. Because despite years of debate and some steps in the right direction, mental illness is not given the same weight as physical illness, either in terms of insurance

coverage for patients or reimbursement to healthcare providers. If 15 percent of American adults require mental health care annually, why is there such a reluctance to pay for it?

The original disparity was understandable—the physical and medical underpinnings of mental illness were

280 BC: Theophrastus describes 28 “characters” or personality disorders.



23 AD: Pliny the Elder's natural cures include treatments for the afflictions of the mind.



unidentified or poorly understood. Mental illness was also considered by many to be untreatable, although in fact, treatment outcomes for mental illness are similar to and sometimes more successful than those for other chronic health conditions. There was also an implied reliance on the public safety net system for those with severe mental illness. If care became too burdensome or expensive, the mentally ill were placed in public, usually state-run, institutions. Several decades later, despite a better understanding of mental illness and very different ways of treating it, many insurance plans still do not offer coverage for mental illness and those that do, provide less or more expensive coverage than for general medical conditions. The disparity produces problems with access, adds to the stigma of mental illness, and creates higher out-of-pocket costs for those who require treatment. While some studies have shown that requiring parity for mental health coverage in managed care plans has not significantly increased costs, even the potential for increased premiums is worrisome during a time of ever-increasing healthcare expenses. Both employers and insurers argue that as premiums go up, fewer Americans can afford any insurance coverage. For that reason they tend to be wary of legislation that is too broad or that mandates coverage.

In an attempt to level the playing field, the Mental Health Parity Act of 1996 was passed by Congress and implemented in 1998. Although it was a first step in the right direction, it only served to

If 15 percent of American adults require mental health care annually, why is there such a reluctance to pay for it?



prevent insurers from imposing stricter caps and limits on mental health coverage than on general health coverage. It also exempted smaller companies (those with 50 employees or less) and did not cover treatment for substance abuse. Last year the Senate passed the Mental Health Parity Act of 2007 to continue those protections and add more teeth to them. That legislation sought parity not just in caps and limits, but also in co-pays, coverage, deductibles, and lengths of stay for both mental health and substance abuse treatment. The Senate bill also had broad support from both business and the insurance industry, who were invited to the table to help craft the legislation. The primary criticism of this bill by opponents is that it does not require insurers to cover all mental illness.

A few months later, the House passed a much broader bill, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. The primary difference to the Senate bill is that insurers would have to cover all mental illness as defined in the DSM-IV. In addition, if insurers provided out-of-network benefits for general health they would have to do the same for mental health coverage.

400: In Europe, for the next several hundred years, mental illness is linked with witchcraft or demonic possession.



700: Middle Eastern countries create asylums for the treatment of mental illness.

Probably most disputed are some controversial funding provisions the House bill has included. One would limit federal healthcare spending by prohibiting physicians from referring patients to hospitals where they have a financial stake. The bill would also significantly increase the manufacturer's rebate for brand-name drugs in Medicaid. In addition, the bill bans both employers and insurers from using genetic information (a key component of mental illness) in determining job placement, eligibility, or premiums. Now Congress must come to some sort of compromise between the bills. That has mental health parity advocates, who don't want to lose the ground they have gained on this issue, a little nervous.

In the meantime, individual states, including Louisiana, have implemented a wide variety of state-level parity laws over the years. In 1999 Louisiana actually enacted a state statute that was broader than the Mental Health Parity Act of 1996. Louisiana's law required mandated benefits for serious mental illness and mandated offerings for other mental illness. Current law also has a mandated option for substance abuse, meaning that health plans are obligated to offer coverage, but employers are not obligated to purchase it for their employees. It also includes coverage limits such as 45 inpatient hospital days and 52 outpatient visits annually. Like the federal law, Louisiana exempts small employers and allows an opt-out of the law if cost increases top one percent.

This year, the Louisiana Legislature considered SB 535 (Cassidy, Nevers) which required insurance coverage of certain medically necessary treatments for alcoholism, drug abuse, and mental illness, effective upon the enactment of an income tax credit equal to the cost of premiums related to providing such coverage. The law would have applied to group policies offered by companies with 50 or fewer covered employees. In response to concerns by business and insurance providers, the bill allowed for an exemption from this requirement if premium costs increased more than 1.5% over the previous year. The bill also would have created an insurance parity group of representatives from the National Alliance on Mental Illness, the Louisiana Association of Business and Industry, Blue Cross/Blue Shield of Louisiana, the Louisiana Association of Health Plans, the University of Louisiana Lafayette Center for Child Development, Picard Center, the Louisiana Chapter of the National Federation of Independent Businesses, the Louisiana State Medical Society, the Louisiana Association of Medical Psychologists, the Louisiana Association of Board Certified Social Workers, Louisiana Association of Non-Profit Organizations, the Louisiana Psychiatric Medical Association, The Extra Mile-Southeast Louisiana, and the Louisiana Department of Insurance, to track the costs of providing these benefits.

The Louisiana Association of Health Plans (LAHP) had been engaged in monthly conversations on mental health parity legislation since last October, according to CEO Gil Dupré. "As a policy, the LAHP has been opposed to mandated benefits through the years

because they raise the premiums on individuals and small companies," said Dupré. "This leads to an increased number of uninsured, and we already have too many uninsured in Louisiana." Faced with a record number of proposed mandated benefits bills this session, Dupré indicated that LAHP felt the need to educate legislators about the impact of increased premiums. "We feel strongly that employers should have the right to purchase the benefits for their employees that they can afford." Dupré also pointed out that like many other mandated benefits, the parity bill would apply to only about one-third of private insurance because of the federal ERISA law which preempts state law. So employer sponsored health plans covered by ERISA, typically the larger, self-insured ones, would be exempt. Mandated benefits therefore tend to have a greater impact on the smaller companies, which are the ones that are already struggling the most, said Dupré. SB 535's provision that it would only apply if the tax credit was approved showed an effort to relieve some of that burden.

LAHP has moved away from its policy in the past when mandated benefits stuck closely to medical guidelines, such as for mammography and colorectal screening, said Dupré. "We do acknowledge that there is a need for certain benefits to improve the quality of care, and we can work with the bills' authors to make them cost-effective." He indicated that while Senators Nevers and Cassidy had adopted all of LAHP's proposed amendments, some employers still had concerns. "It still falls under our policy to oppose mandated benefits, but it is different in its design," said Dupré. "If the business community can

"As a policy, the LAHP has been opposed to mandated benefits through the years because they raise the premiums on individuals and small companies. This leads to an increased number of uninsured, and we already have too many uninsured in Louisiana."

-Gil Dupré, LAHP

embrace it, then we will not oppose it." LAHP stood by that promise, but the bill ultimately died in the Senate. Despite that, LAHP applauded the authors for being passionate not only about providing the benefits, but also about limiting the burden on employers. Although not passed into law, the bill was at least successful in sparking the discussion and compromise that will likely be necessary for the future success of mental health parity in our state.

850: Power of suggestion and music therapy used to treat the mentally ill in Eastern culture.



1020: Avicenna or Ibn Sina asserts that the brain has three ventricles that control common sense, imagination, cogitation, estimation, and memory.

An Account of the Jackson *Insane* Asylum

by: Martha Field (*Picayune*, Oct. 7, 1888) reprinted with kind permission of Joan B. & Jake McLaughlin

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hat follows are excerpts of an account written for the *Picayune* by travel writer Martha Field (pen name Catharine Cole) in 1888. The Insane Asylum of Louisiana was founded in Jackson in 1847. When Field visited the institution in 1888 it had recently been turned over to a new administration. From 1874 until 1888 it was run by John W. Jones, an idealistic physician who was responsible for building the facility. Lacking money from the Legislature, Jones purchased a cheap brick-making machine and had the inmates produce three million bricks, which were used to construct the imposing main building. The institution is still there but is now known as

Eastern Louisiana Mental Health System and East Hospital. This account highlights how far we have come. For Field's full account and other travel writings, please go to <http://www.catharinecole.com>.

Up on the top of a hill overlooking the town stands the Insane Asylum. It looks like a courthouse, and in front there is a deep porch with huge yellow pillars as big around as redwood trees in California, or the marble columns in Canterbury Cathedral in England. On the top of this majestic building is a little wooden cupola with a double-faced clock telling the hours. On either side are big brick wings—three-story high houses—and most of the windows are protected by wooden bars.

...Upon close inspection the fine old building proved to be more nearly than anything else a fine old ruin; shaking floors, peeling walls, big holes gaping in the roof, heavy cornices about to fall, mortar and plaster gone in many places from the ceilings. Ruin is very picturesque at times, and ivy is most artistic, but it is to the eternal shame of any state that leaves its insane people huddled like rats in a prison that the teeth of time has gnawed into the merest shell.

A state that repudiates its debts is in a bad way, goodness knows, but it would be difficult to say which were the deeper disgrace, repudiation of a money debt or hard-hearted neglect of men, women and children from whom God has taken brains, homes, friends, food, clothing, feeling—all the sum of sweet life.

...There are at present, or were on the day of my visit, 456 patients in the

1100: First record of a European asylum at Metz, France.



1250: Adoption of the term *lunatic* from the Latin *lunaticus* meaning "moonstruck" an indication that temporary insanity was thought to be affected by moon phases.

asylum, the sexes being evenly divided. Of these, sixteen are pay patients, paying from ten to thirty dollars a month each. There are five or six little idiot or "foolish" children in the asylum who live, eat, sleep, and are confined in along with men and women who are raving lunatics. For better protection and comfort these little children, ranging in ages from seven to ten years, are kept housed in the hospital wards. These children are victims. They are not properly inmates of such an institution at all, and being there is a crying shame that they must be confined in the same rooms with persons who are afflicted with all the chronic and acute forms of mania.

Save in the items of sex and color there is no subdivision or classification of patients in the asylum. All-simple idiots, "silly" ones and epileptics, are dumped in together. It is not easy to see how any cure can be truly effected. The demoralizing mental influence of one lunatic over another must be disastrous and evil in an asylum where the majority of the patients sleep, not in cells or single rooms, but in long dormitories with five or ten or more beds in a room. If one girl can give hysteria to a whole seminary, why may not one howling bedlamite demoralize a whole madhouse!

...According to law of recent enactment, every inmate of the asylum has the right to select and name one person with whom he may correspond without submitting his letters to the asylum authorities. A big mail box, provided according to law, stands in the hall, and into this patients put their letters, sealed, stamped and directed. It is very generally used. But there are no mail carriers in Jackson and the law does not oblige the asylum authorities to forward these letters; so there they lie, dusty, unanswered documents, of God knows what madness and misery.

...I have in my day visited many insane asylums. Our state institution is the cleanest I have ever been in. It is also the bleakest, the barest, and offers the least possible chance of recovery to its inmates; that is, if recovery is to be assisted by comforts, delicacies and amusements. There is a hand organ, and sometimes on rainy days the women go into a huge, unfurnished amusement hall-as big almost as Grunewald Hall-and grind out a tune or two. That is all. There are no books, no pictures, no cards, no musical instruments, no games, no nothing. It is not safe to give mad folk furniture, and this is given as the reason why the dormitories are absolutely bare of even chairs. I should say for the two hundred odd women in the asylum,

1400: Mentally ill are treated by ritually "casting out the devil."



1403: St. Mary of Bethlehem, a facility near London, begins to accept psychiatric patients.



1407: A Spanish asylum created in Valencia begins a trend across Spain for treating the mentally ill.



save in the dining-room, there are not ten chairs. Those patients who might be benefited by comfortable and pretty surroundings must squat around on the floor, sit on their beds, or walk about along with the most terrible cases in the asylum. The bedding in all the wards is good and comfortable, but there are no mosquito bars, and during the winter, with the exception of one or two wood fireplaces in the immense halls, these miserable wretches live in the cold.

...There are no water closets in the building, but in the center of each wing there is a little room with a hole in the ground and a bit of sewer pipe. Into this, excreta is thrown and the stench arising therefrom is enough to soon wipe the asylum's population off the face of the earth.

Strange to say, however, with the exception of one young attendant, ill with typhoid fever, the inmates are remarkably healthy. If a fire should break out in the building, the only means of putting it out is a bucket of water. There is not even one Babcock extinguisher, nor a yard of hose on the place. Water, however, is brought into the building from a fine well. The electrical and pumping machinery, etc. are first-class, but are housed under an old, wooden shed, that is almost rotted away.

...There are no operating rooms in the asylum, no surgical instruments, no surgical chairs or tables and the lack of these things shows wanton neglect on the part of the state, for they are as necessary as good water, a perfect system of sewerage, good food and a comfortable temperature.

A futile effort has been made to render the institution self-supporting. This is, of course, out of the question. The inmates, however, do much of the work—the sewing, wood-chopping, gardening, mattress-making, etc. The care of the insane, as we

1500s: More than a hundred thousand mentally ill people were tortured and executed, many at the stake, in order to rid the devil from their souls. St. Mary of Bethlehem is re-founded in a new location and cares (term used very loosely) exclusively for the mentally ill. A slang pronunciation of the name, Bedlam, becomes synonymous with mistreatment of the mentally ill.

perform our duty, is but poorly done. It is a shame to huddle these unfortunates together the way they are; to have a common sleeping-room for a vulgar, raving maniac and a gentle, refined, soft-voiced woman suffering from melancholia. It is a shame to leave these unfortunates living in rooms almost unroofed to the storms, with the water and the winds visiting them and constantly menacing their health.

It is a shame to kennel them in this big barn, clean and sunshiny as it is, to leave them without any of the softening and soothing effects of music, books or amusement of any sort. The attendants are good and kind and capable, the superintendent and staff of officers apparently do the best they can, but nonetheless it is true that the huge yellow building on a hill in Jackson in which the law provides we must house our insane pauper population is a blot on civilization and a disgrace to our state.

Catharine Cole

Source: catharinecole.com; "Louisiana Voyages, The Travel Writings of Catharine Cole," edited by Joan B. McLaughlin and Jack McLaughlin, University Press of Mississippi, 2006

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Collaboration Key to Easing Capital Area Crisis

by: Jan M. Kasofsky, PhD, Executive Director, Capital Area Human Services District



For the past 22 months, Capital Area Human Services District (CAHSD) has taken the leadership role toward the development and implementation of functional community-based alternatives to the use of the emergency department and hospitalization for people experiencing behavioral health crisis. CAHSD is the regional quasi-governmental agency responsible for the Department of Health and Hospitals' community-based mental health, addictive disorders, and development disabilities services to Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana Parishes.

1570: Felix Platter of Switzerland notes different kinds of mental illness.



1586: First book in English on mental illness, *Treatise on Melancholy*, is published by Timothie Bright.

1600: Little distinction made between the mentally ill, the handicapped, and the homeless—equal mistreatment for all.

Working through the joint efforts of law enforcement, the medical and other clinical staff and administrators in local public and private emergency departments and hospitals, local jails, emergency transportation, emergency call centers, coroner's offices, mental health and addiction specialists, mental health lawyers and advocates, and housing specialists, the Behavioral Health Emergency Services Collaborative developed the "Community Specific Plan to Address the Needs of Increasing Numbers of People in Behavioral Health Crisis in the Greater Baton Rouge Area."

Factors such as the hurricanes of 2005 and their impact on the mental health of the pre-existing population and the relocated evacuees, the loss and disruption of the housing and healthcare infrastructure in the New Orleans area, and the loss of emergency departments and inpatient psychiatric beds in the greater New Orleans area, contributed to the 30 percent increase in the number of adults presenting in psychiatric crisis to local public and private emergency departments in the capital area. This increase was the impetus for the formation of the collaborative. The capital area community continues to struggle with a greatly increased population suffering with mental illness, substance abuse, and homelessness. The collaborative concluded early on that without a continuum of services to prevent and address the demand for ongoing

behavioral health treatment and crisis services, there would never be an appropriate, successful response to the needs of the population.

The components of the continuum developed by the collaborative are as follows:

1. Standardized screening and assessment tools & training for use in all Emergency Departments
2. Access Service: Immediate public mental health/addictive disorders clinic screen/assessment/treatment or referral. These clinics currently receive over 47,000 calls annually
3. Interagency Services Coordination: Development of an individualized plan by local providers for citizens with high levels of recidivism
4. Crisis Intervention Team: Specially trained law enforcement officers who can better engage/assess/de-escalate/refer citizens in crisis
5. Mobile & Assertive Community Treatment Team: Publicly funded mobile teams to provide preventive and treatment interventions/ongoing treatment at alternative settings

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9. Housing: Provides for housing coordination and placement for behavioral health clients who would otherwise remain homeless and unconnected to treatment
10. Community Advisory Board: An oversight council representing treatment and first responder sectors across the greater Baton Rouge, seven parish region.

The participants comprising the collaborative have shown a great ability to work together creatively, both across and within their respective specialties. Notable components such as the Crisis Intervention Unit, Crisis Intervention Team, and Medical Case Management, required problem solving by law enforcement, behavioral health/medical treatment providers, and mental health lawyers. Each of these components requires some rework of agency processes to support these new community-wide components.

The following are highlights of these newly established, or soon to be established, local services:

The Crisis Intervention Team (CIT): This team is a group of law enforcement officers trained to handle behavioral health crises within the community. These officers are carefully selected within their respective departments/agencies to undergo a forty-hour curriculum specializing on being first responders to these dispatched calls. The CIT training curriculum has nineteen modules taught by local specialists, at and through CAHSD, to help educate and teach officers about the various issues with addictive

1621: Englishman Robert Burton publishes a description of depression.

disorders, mental health, and developmental disabilities. It also has modules on effective communication skills and de-escalation tactics. Twenty-two officers had been trained as of June, with a second class underway that month. Local law enforcement agencies across the seven parishes currently receive 3,350 behavioral health crisis calls and transport 5,300 people in crisis to EDs annually.

The Crisis Intervention Unit (CIU): A specialized Emergency Department (ED), staffed by mental health professionals to manage behavioral health crises, is to be sited at Earl K. Long Hospital this fall. The CIU is designed to serve those individuals suffering from serious mental illness residing within the seven parishes of the Capital District who present either to a public Community Mental Health Clinic, Addictive Disorders Clinic or are otherwise identified (by law enforcement, coroner, etc.) as experiencing an emergency behavioral health condition or crisis situation (e.g. the individual's need may be such that they require treatment to reduce the likelihood of death, harm to self or others, serious injury or deterioration of physical condition, or a major setback in their condition or illness). Currently, approximately 8,400 individuals in this community have this need annually and are seen in all existing emergency departments. Once this unit opens, all citizens meeting this

criterion will be taken to the CIU. Services include triage, observation, assessment, and stabilization or discharge into a higher level of care, or referral and linkage to ongoing services in the community.

Medical Case Management: It was determined that many people with chronic mental illness use the emergency department to access primary care services since they have no assigned or ongoing provider, much like others without health insurance. One approach currently being utilized is a partnership with CAHSD and Our Lady of the Lake Regional Medical Center (LOL). The LOL Mobile Clinic is providing primary care at the Baton Rouge Mental Health Clinic (BRMHC) and The Center for Addictive Disorders once a month, to clients who do not have a primary care provider. The Mobile Clinic is able to provide some basic diagnostics and labs and is staffed by a licensed nurse practitioner. It can provide care to 20 patients per day. Another initiative is a serious focus on tobacco cessation for all public behavioral health clients. There are multiple other approaches currently being implemented to address the need for medical care by this vulnerable population, identified by the Centers for Disease Prevention and Control to die of common medical needs typically 25 years before their age cohort in the community. ❖



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Do Hospitals Have To Treat Psychiatric Emergencies?

EMTALA and Mental Health

by: Emily Black Grey, Breazeale, Sachse & Wilson, LLP



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busy emergency room handles many different cases: car accident injuries, gun-shot wounds, children with soaring fevers or broken bones. And perhaps a patient with a mental disturbance. Most people know that the ER must handle the emergency medical conditions, and maybe they have even heard of the federal anti-dumping statute. But does a hospital also have to handle emergency mental conditions? Does it have the same types of obligations to someone who's suicidal as it does to someone suffering a heart attack?

EMTALA Basics

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that requires hospitals with emergency departments (ED) to provide a medical screening examination to anyone who comes to the ED and requests examination or treatment for a medical condition. If it's determined that the person has an emergency medical condition, the hospital can't refuse treatment. Even if the hospital doesn't have the capacity or capability to treat the patient, it has to stabilize him or her before making a transfer to a facility that does have the ability to care for the patient.

1700s: Some reforms are seen in care of the mentally ill, with shackles and dungeons regarded as improper.



1703: John Broughton coins the term psychology in *Psychologia: the nature of the rational soul*.

1752: Pennsylvania Hospital devotes area in the basement to treating the mentally ill.

Hospitals have to treat “emergency medical conditions,” but does that include mental problems?

Yes, if an individual comes to the emergency department and a medical screening exam indicates a psychiatric emergency, appropriate treatment is required. The Centers for Medicaid and Medicare Services (CMS) issued guidance which explains that an emergency medical condition exists if the person expresses homicidal thoughts or gestures, or if the person is determined to be dangerous to himself or herself or to others. Under EMTALA, the hospital must screen, treat, and stabilize these patients.

Can an individual ED doctor decide to only handle physical emergencies, not mental ones?

The refusal of an ED doctor to screen or treat a patient because (s)he is “mentally” unstable rather than “medically” unstable can be an EMTALA violation. If an on-call physician refuses to respond to such a call, (s)he can face EMTALA exposure including a \$50,000 fine and potential exclusion from participation in federal and state healthcare programs. Further, a refusal to treat a psychiatric emergency can arguably result in the loss of the protections of the Louisiana Medical Malpractice Act, including the damages cap, because that physician debatably did not provide healthcare services to the patient in order to qualify for the protection.

If the hospital doesn't have a psychiatric department, can they just call 911?

The Medicare Conditions of Participation do not allow a hospital which provides emergency services to use 911 services as a substitute for its own responsibility to provide emergency services. All hospitals are required to assess medical emergencies, provide initial treatment, and make a referral when appropriate, regardless of whether psychiatric facilities are available at that particular hospital.

Patients must be stable before being transferred, but when is a psychiatric patient stable?

Generally, a patient with an emergency medical condition is considered stable if, within a reasonable medical probability, no material deterioration will result from the transfer of the individual. Certainly, it can be difficult to determine when a patient with a psychiatric emergency is stable and this should be carefully charted prior to transfer. CMS guidance explains that psychiatric patients may be considered stable when they are protected and prevented from injuring or

harming themselves or others. Administering chemical or physical restraints to enable a transfer may be sufficient to stabilize a psychiatric patient for a period of time and can remove the immediate emergency medical condition. However, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints, particularly since the underlying medical condition may persist, and if not treated for longevity, the patient may experience exacerbation of the condition.

When Does the Hospital's Obligation End?

The hospital's EMTALA obligation ends when a physician or qualified medical person has made one of the following determinations:

- No emergency medical condition exists (even though the underlying medical condition may persist), and specifically that the patient is no longer a danger to himself/herself or others.
- An emergency medical condition exists, and the patient is appropriately transferred to another facility.
- An emergency medical condition exists, and the patient is admitted to the hospital for further stabilizing treatment.

In light of the limited mental health services available in our state, particularly after Katrina, it is crucial to understand a hospital's obligations to treat emergency psychiatric conditions. As our state's healthcare providers develop innovative ways to address mental health issues, it is important to keep in mind the established requirements of EMTALA which apply whenever a person with a psychiatric disturbance presents in an emergency department requesting care. ❖



1769: First use of the term neurosis.



1770: Bedlam begins to restrict public access to its wards which had served as one of the city's attractions.

Involuntary Civil Commitment: Protecting the Public Right To Safety or Violating An Individual's Right To Liberty?

by: Robert Berding, LMHC, Executive Director for the Bureau of Regulatory Compliance and Outcomes Management, NYC DOHMH Correctional Health Services



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hether or not you have ever been exposed to the process, chances are you have some opinion on involuntary civil commitment. Moreover, that opinion is probably aligned with your position on whose rights have been

infringed as a result. If the news reports that a recently released psychiatric patient harmed some innocent person, you might think public safety was unduly compromised by allowing the release. On the other hand, if you learn that someone was forcibly locked away despite showing the mental and emotional capacity to return to their own home, you might think that person was wrongly deprived of liberty.

Sadly, while the former example is rare in comparison to the latter, such instances are typically sensationalized and become indelibly stamped in the public conscious-

ness. This in turn, serves to stigmatize those who suffer from a mental disability. Conversely, few of us ever hear about the multitude of individuals who are denied in their requests for freedom. Thus, a person seeking release from involuntary civil commitment must not only prove the merit of his or her own case, but sometimes overcome reluctance on the part of a clinician who is wary of potential public backlash from a perceived premature release.

The general standard for involuntary civil commitment is whether or not the person poses a danger to self or others. An individual's "dangerousness" is clinically evaluated by one or more psychiatrists, but accurately predicting future harmful acts is far from an exact science. This can lead to a conflict between doctor and patient when they are not in agreement about the clinical evaluation. As a consequence, the ultimate decision to continue the involuntary commitment or not falls under the purview of the courts.

An individual's "dangerousness" is clinically evaluated by one or more psychiatrists, but accurately predicting future harmful acts is far from an exact science.

1773: First American insane asylum opens in Williamsburg, Va. and remains there today.



1774: Franz Mesmer lays foundation for hypnosis.

How has it come to be that our legal system plays such an integral role in mental health issues? One simple answer is by means of evolution. Long gone are the days when families assumed caretaking obligations for relations who suffered from a mental disability. This was followed by the predominantly clinician-centered approach of the past century which

allowing sterilization of the mentally ill in *Buck v Bell*. As the great Justice Oliver Wendell Holmes said, “three generations of imbeciles are enough.” However, the issues are very complex, and the stakes exceedingly high, when attempting to balance the potential dangerousness of an individual to self or others with the Constitutional right to liberty.

Among the more technologically innovative approaches is a trend toward on-line education in Mental Disability Law.

proved to be overly inclusive and all too often produced an unconscionable human warehousing of persons who did not comport with society's behavioral expectations. Thus, courts now often decide whether a person will remain confined or be allowed to live in a less restrictive environment.

Since such unenviable tasks have been passed to legal minds, it must be asked if the profession is prepared for this responsibility. History would suggest not. Granted, the United States Supreme Court has moved well beyond its low-water mark of

A growing number of legal educators are focusing their efforts on addressing these types of issues. Among the more technologically innovative approaches is a trend toward on-line education in Mental Disability Law. This allows lawyers, clinicians, and students from around the world to share ideas and experiences. Michael L. Perlin, JD, a New York Law School Professor, created the first Internet-based Mental Disability Law courses to be offered by an American law school. Many legal educators have responded enthusiastically to both the importance of the legal issues and the unique opportunity to



1793: Philippe Pinel starts a movement in France for better treatment of the mentally ill. Although mistreatment remains widespread, a similar movement is pursued by Eli Todd in America.



1808: The idea of phrenology suggests that personality traits are determined by skull shape and bumps on the head.



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actively participate in shaping the future of this process.

In Baton Rouge, Southern University Law Center (SULC) has established its presence in this global endeavor by offering courses in Mental Disability Law and the Americans with Disabilities Act. Of course, trailblazing is nothing new to this local law school that was founded in 1947 in response to civil rights violations. Since that time, it has forged a proud tradition of developing many civil rights leaders in a diverse learning environment.

SULC Chancellor Freddie Pitcher (Retired Judge) is always seeking to enhance the curriculum of the law school and did not hesitate to respond when he noticed the recent course offerings from New York Law School on a Dean's Inter-Law School List Serve. After downloading the relevant material and discussing its potential with staff and faculty, it was decided that the content would be well matched with the vision and mission of SULC. In particular, it is consistent with the foundational knowledge needed for a law school that sees a high percentage of its graduates go onto public service as legislators, prosecutors, defenders, and advocates.

For the most part, our world is unresponsive to the needs of the mentally disabled.

These courses have been well received by the student body. Beyond finding the material to be thought-provoking and essential to their overall legal education, they appreciate the flexibility of being able to view lectures at times that are convenient to their other studies and obligations. In addition, there are unique opportunities to co-learn with students from other law schools through teleconferences designed to collectively problem-solve multilayered legal dilemmas. It has not been surprising to find that students separated by large geographic distances still find great similarities in the Mental Disability Law issues in their local communities.



1812: First American book on psychiatry, *Medical Inquiries and Observations upon the Diseases of the Mind*, by Benjamin Rush, remains only such text for most of the century.

It is encouraging that Mental Disability Law is receiving this level of attention, especially among those who will become future leaders. But the accompanying realities still present substantial barriers to those who seek their release. For the most part, our world is unresponsive to the needs of the mentally disabled. This apathy may be rooted in a variety of attitudes that range from misguided prejudice to sympathetic fatalism. However, no matter what underlying reasons exist, many people who suffer from a mental disability find themselves without adequate financial resources, living arrangements, social support, political voice, or meaningful future hopes.

will trigger public outcry for retribution against a guilty party and the media will self-servingly concoct imagery of a deranged and dangerous psychopath. Once again, the exception will become the rule in the minds of the public. Never mind that many innocent people must then endure undue stigma for the acts of an infinitesimal few.

The legal profession appears to be taking its responsibility to the mentally disabled seriously by providing access to the courts and improved legal education. It is even promoting partnership with clinical

In Baton Rouge, Southern University Law Center (SULC) has established its presence in this global endeavor by offering courses in Mental Disability Law and the Americans with Disabilities Act.

Given these circumstances, the odds appear stacked against a person who challenges an involuntary civil commitment order. It is inevitable that some future tragic fatality will occur through the actions of a mentally disabled person. That event

providers through innovative online discourse. It can only be hoped that such efforts produce a fair process to protect both public and private rights in a reasonable, compassionate and dignified manner. ❖

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Dr. Boedefeld joins us from Charlottesville, Virginia where he has completed his Fellowship in Cardiovascular and Thoracic Surgery at the University of Virginia. He is a graduate of Washington University in St. Louis, Missouri and Creighton University School of Medicine in Omaha, Nebraska. Dr. Boedefeld completed his surgical training at the University of Alabama at Birmingham.

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Physical and Mental Health Treatment for Women Survivors of Violence



by: Laura Hensley Choate, EdD, LPC, NCC
Associate Professor of Counselor Education, Department of Educational Theory, Policy, and Practice, LSU

1843: Hypnosis, from the Greek, *to sleep*, is introduced by Scotsman James Braid as a form of anesthesia for surgery.



1844: Printing shop created for occupational therapy at the New York State Lunatic Asylum publishes first journal devoted to mental illness, *American Journal of Insanity*.

Violence against women is a significant social problem, as there is a high probability that any woman will experience some type of violence in her lifetime. According to the most recent National Violence Against Women survey, over half of all women report an experience of attempted or completed rape and/or physical assault sometime in their lifetime. Further, around 30% of women say they have been abused by a current or former intimate partner.

Even though they generally do not seek out counseling, women with an abuse history do utilize the healthcare system, and do so at much higher rates than non-abused women. Compared with women who have no abuse history, they use a disproportionate amount of healthcare services (including visits to EDs and to primary care providers), use more prescription drugs, are hospitalized more frequently, and undergo more surgical procedures. These data are important

According to the most recent National Violence Against Women survey, over half of all women report an experience of attempted or completed rape and/or physical assault sometime in their lifetime.

These numbers are staggering when considering the significant physiological and psychological consequences of sexual assault or intimate partner violence. The numbers are also alarming considering that many women do not report or disclose the violence in their lives due to their fears about negative, skeptical reactions from legal and law enforcement professionals. They also fear negative reactions from family and friends, particularly when the violence was perpetrated by an acquaintance, family member, or intimate partner. In addition, they blame themselves, questioning their role in the event. Often women delay disclosures for years, never telling anyone about their experiences. Sadly, because of their fears and self-blame, many women conceal their pain and do not seek out the support services and mental health counseling they need.

because they indicate that healthcare providers may be among the first professionals to work with women survivors of sexual assault or intimate partner violence. Therefore, it is important for them to remain mindful of potential signs/symptoms and to be as prepared as possible to make adequate referrals.

Providing information about appropriate resources in the Baton Rouge community can be an important first step.

1847: The governor of Louisiana approves legislation establishing the state's first state mental hospital at Jackson.



1848: New Jersey builds humane facility for the mentally ill largely due to efforts of American Dorothea Dix. Entire mentally ill population (approx. 85 patients) of Charity Hospital in New Orleans transported by steamboat up the Mississippi River to Bayou Sara and then by oxcart to the Insane Asylum of Louisiana at Jackson.

Physical Symptoms Related to Sexual Assault and Abuse

Women who have experienced previous violence may frequent the healthcare system, but they rarely present with obvious trauma. Instead, they may present with unexplained medical complaints, including the following:

Functional health problems found more frequently in women with a history of victimization:

- Chronic fatigue
- Chronic musculoskeletal pain
- Chronic pelvic pain
- Chronic headaches
- Irritable Bowel Syndrome
- Premenstrual Dysphoric Disorder.

Women who have experienced violence are also more likely to be at risk for serious long-term health problems such as arthritis, asthma, chronic lung disease, diabetes, heart disease, liver disease, stroke, and skeletal fractures.

Psychological Symptoms Related to Sexual Assault and Abuse

While women may seek treatment for the physiological problems listed above, they are generally reluctant to seek assistance for their psychological symptoms. The best explanation of the constellation of symptoms experienced by women who are survivors of violence is Post Traumatic Stress Disorder. The vast majority of women who are raped experience PTSD in the immediate aftermath of the trauma, and PTSD continues to persist at lifetime rates between 30-50%. In addition, over half of women abused by an intimate partner also experience PTSD. Commonly experienced symptoms include intrusion (re-experiencing of the trauma, including nightmares, flashbacks, recurrent thoughts); avoidance (avoiding trauma-related stimuli, social withdrawal, emotional numbing); and hyperarousal (increased emotional arousal, exaggerated startle response, irritability). Many women also experience comorbid mental health problems such as depression, anxiety, and substance abuse disorders.

Referrals, Resources, and Treatment

Women who are survivors of sexual assault or intimate partner violence can clearly benefit from support and counseling to assist them in their recovery from PTSD and associated mental health concerns. So what can a healthcare provider do to encourage women to seek counseling? Providing information about appropriate resources in the Baton Rouge community can be an important first step. For example, displaying

brochures from the Rape Crisis Center and the Battered Women's Program in waiting rooms or patient lounges can be an unobtrusive method for disseminating information. When speaking with patients, healthcare professionals can ask sensitive questions, listen carefully to women's responses, and refrain from skepticism or victim-blame. Some local resources are highlighted below:

Rape Crisis Center—Provides an advocate to assist the victim during the forensic exam, crisis hotline support, legal advocacy, and individual and group counseling for survivors. (225) 383-7273

Battered Women's Program—Provides crisis hotline, safety planning, safe housing, and/or protective order assistance for women in abusive relationships. (225) 389-3001 or 1-800-541-9706 (state-wide hotline)

The Phone—Provides confidential counseling assistance by phone. (225) 924-5781

Women who do choose to seek mental health counseling for rape-related trauma or for intimate partner violence should be aware that there are empirically-supported counseling approaches for treating these concerns and that recovery is possible. During treatment, effective counselors will use the following recommended techniques: (a) provide education about commonly experienced PTSD symptoms through psychoeducation, (b) facilitate the client's retelling of the event through exposure-based techniques, (c) challenge the client's maladaptive beliefs about her role in the event through cognitive restructuring, and (d) enhance her coping skills through anxiety management techniques. Group counseling is also beneficial because women can receive support from other women who have survived similar experiences.

Through counseling, women can eventually learn to view the assault or violent relationship as a traumatic but growth-enhancing experience that can ultimately provide them with a more flexible world view, an increased sense of empathy and empowerment, and enhanced coping skills for managing future life demands. Healthcare professionals can play an important role in opening doors so that this type of recovery and resilience becomes possible. ❖

Reference: Dallam, S. J. (2005). Health issues associated with violence against women. In K. A. Kendall-Tackett, Ed., Handbook of Women, Stress, and Trauma, pp. 159-180. New York: Brunner-Routledge.

1849: Electrical stimulation introduced as method to treat depression.



1854: In her continuing campaign against the mistreatment of the mentally ill, Dorothea Dix asks Pope Pius IX to address the issue.



1861: 8,500 Americans are institutionalized for mental illness.

Top 5 Mental Health Myths

1. Myth: There's no hope for people with mental illnesses.

Fact: There are more treatments, strategies, and community supports than ever before, many of which are more effective than treatments for medical disorders. Studies show that most people with mental illnesses get better, and many recover completely. People with mental illnesses lead active, productive lives as evidenced by scores of famous people throughout history that have lived with mental illness. Abandoning labels, stigma, and discrimination can go a long way.



2. Myth: People with mental illnesses are violent and unpredictable.

Fact: In reality, the vast majority of people who have mental health needs are no more violent than anyone else and are far more likely to be victims of violence.



3. Myth: Mental illnesses cannot affect me. They are brought on by a weakness of character.

Fact: Mental illnesses are surprisingly common, affecting approximately 57 million Americans annually. Mental illnesses are a product of the interaction of biological, psychological, and social factors. Research has shown genetic and biological factors are associated with schizophrenia, depression, and alcoholism. Social influences, such as loss of a loved one or a job, can also contribute to the development of various disorders.



4. Myth: People with mental health needs tend to be second-rate workers on the job or cannot hold down a job.

Fact: Employers who have hired people with mental illnesses report good attendance and punctuality, as well as motivation, quality of work, and job tenure on par with or greater than other employees.

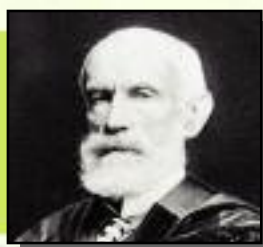
5. Myth: Children do not experience mental illnesses. Their actions are just products of bad parenting.

Fact: A report from the President's New Freedom Commission on Mental Health showed that in any given year 5-9 percent of children experience serious emotional disturbances. Just like adult mental illnesses, these are clinically diagnosable health conditions that are a product of the interaction of biological, psychological, social, and sometimes even genetic factors. ❖



Sources: Substance Abuse and Mental Health Services Administration, www.allmentalhealth.samhsa.gov/myths_facts.html; "Mental Health Overview," Jennifer Hoehn, Graduate Student, MPH Program, Ohio State University College of Public Health, www.netwellness.org/healthtopics/mentalhealth/overview.cfm

1878: G. Stanley Hall, who later founds the American Psychological Association, is first American to earn PhD in Psychology.



1880: U.S. Census lists seven types of mental illness: mania, melancholia, monomania, paresis, dementia, dipsomania, epilepsy.



One On One

with Mitch Wasden, CEO, Baton Rouge Region-Ochsner

Smith W. Hartley: Since Ardent was completely bought out by Ochsner what are some of the specific changes that the Baton Rouge hospital has experienced as a result?

Mitch Wasden: Probably the biggest one is, like with any joint venture, you've got two separate companies that have two separate boards, which means they are going to have two separate opinions about what programs to invest in, what IT systems to use. With the buyout of the hospital, what's been nice is the clin-

1883: Psychiatrist Emil Kraepelin makes a distinction between depressive psychosis and schizophrenia. Johns Hopkins creates first American laboratory of psychology.



1886: Sigmund Freud begins treating patients with "personality disorder" in Vienna.

ic and the hospital have gotten on the same page—which is the entire Ochsner page—because during the joint venture, the clinic here was wholly owned by Ochsner and only the hospital was the 50/50 joint venture. So we were sometimes a little bit out of step. Now our big push has been that for this region, we now have one vision, one team; it feels more like one company—a little bit better integrated.

SWH: Where do the majority of your patients come from? Is it the Livingston area?

Mitch Wasden: Because we have satellites pretty much everywhere, we kind of see ourselves as a two main campus entity where we've got our west patient population, which the Bluebonnet campus services; we've got a Prairieville primary care campus; we've got a mid-city primary care satellite; and Denham Springs. Then at O'Neal, on our hospital campus, we've got a multi-specialty clinic there. So we see us drawing really from areas around our satellites, but our two big ones are the O'Neal and the Bluebonnet sites. That's where people are coming from mostly. We want to grow everywhere, but we are focusing most of our growth for the future around the O'Neal site for the outlying communities, like Walker, Denham Springs, or the Sherwood Forest area and immediately around the hospital.

SWH: What are some of the reimbursement challenges you guys are dealing with now? With the Medicare cuts being proposed...are you bracing for that at all?

Mitch Wasden: Every year Medicare will talk about, "Is there going to be a cut?" "How big is it going to be?" And a lot of years it gets reversed at the last minute. So a lot of times you hear it, but you don't really know if it's going to occur until the final hour. Probably from the Medicare standpoint, the biggest difficulty has been that the wage index has been tied to old figures on what you should pay people and how much we should get reimbursed based on what we've historically paid. And with Katrina I think everybody around this region has really felt that the wages have escalated faster than Medicare's wage index. So, when you typically could have covered your costs with Medicare, now it's getting to where it's a lot of pressure to try to cover your costs.

You know with commercial insurers, I think it's worth saying what everybody's saying and that is premiums are going up so fast because the cost of care is going up so quickly. That the responsibility is being pushed more to employees, where the companies are having trouble affording what they could afford in the past. So we are seeing more patients that have high deductible plans which really are

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kind of a throwback to the old insurance days, where you had 80/20 plans. Where an insurer would say, "you cover the first 20 percent and we'll cover everything after that." It's basically what a lot of high deductible plans are.

So I think like most health providers, we're really looking to the presidential election, saying, "What's going to happen in two years?" Because there's clearly going to be a debate about how the system should be changed, how do we get more people insured? You know Louisiana as a state has a pretty high uninsured rate. The challenge is, and what a lot of people don't realize—because they kind of assume that people without insurance can get on Medicaid—the uninsured are actually the people who make too much to be on Medicaid, but they don't make enough to have insurance. That's really the difficult situation—that population is growing as healthcare insurance becomes less affordable. So everyone, I think, is looking to Washington to see how we can fix that. How can we make it so that everybody in the country can get health coverage if they need it? Because today the providers are really just having to absorb that, so it becomes tougher and tougher to be able to cover your costs.

And then I think in general nursing is a profession we see as a challenge, in that we need more than we can train. And that's going to be interesting to see where that goes, because it doesn't seem like anybody has really cracked the code on how do you train more nurses? How do we expand the nursing programs to get more people in them? In 2011 the first baby boomers hit sixty-five, and everyone sees this wave of demand coming and we just don't have the supply of healthcare workers. So how do we get people interested in healthcare careers? How do we get them seeing that as a good career opportunity?

SWH: How has the board treated their new CEO?

Mitch Wasden: Our board is a Board of Trustees that reports to the New Orleans Ochsner Board, so we have a very good board relationship. A very committed mix of community representation and physician representation. We have a good group; they get involved in philanthropic and money-raising issues. They kind of just give us a pulse of what's going on in the community.

1890: Every state has at least one mental hospital. New York State creates first American institution for psychiatric research. First frontal lobotomy performed in Switzerland, but met with disapproval.

What could we do better? So I think it's been good. They've been nice to me.

SWH: What is your take on Louisiana's healthcare system now? What direction do you think the state needs to go?

Mitch Wasden: The burning issue, after Katrina, has been what's the future of charity based systems? Is this really a model that's going to work going forward? Like most hospitals we tend to advocate a system where the dollar follows the patient. So if we're going to have charity care, it's almost ironic that the people that can't afford the care have to travel to one particular hospital when transportation is usually the problem as to why they can't get good care. So in a system where the dollar follows the patient, we are basically saying you can go to any hospital. We'll take care of it and we'll make sure there is some remuneration for the providers of it.

So to me, if we are really interested in providing care for people that can't afford it or that can be served by the charity

system, it would be, let them go wherever they can get care and have those providers file with the state. That doesn't mean you don't have charity hospitals, it just means that they don't have to take the entire load. I think you could look at charity hospitals in other states and they actually see a mix of non-charity patients as well, as teaching facilities. So we've kind of evolved into a system that's predominantly charity in the public hospitals and then very little in the private. And I think the ratio is probably better for the patient and the facilities if they get a mix of both.

That's the big stuff. ❖



An advertisement for Flybtr.com. The top part shows a woman smiling at a laptop. Below her is a large globe. To the right, there are flight search results for Baton Rouge Metropolitan Airport. The text "FLY" is at the top, and "btr.com" is written vertically on the right. At the bottom, there is a dark banner with the text "One Click Puts The World At Your Command The New www.flybtr.com" and a paragraph of text: "Travel has never been easier. Book flights, hotels, and car rentals in one place at your convenience, and get a real time comparison of your travel costs at www.flybtr.com. Make your travel plans wherever you have internet access and whenever you want. See your local travel agent, or travel at your command, the all new flybtr.com." At the very bottom, there are logos for American Eagle, Continental Airlines, Delta Air Lines, and Northwest Airlines.



1892: American Psychological Association founded.



1896: University of Pennsylvania launches the field of clinical psychology.

Crack Teams Reduce Codes at Area Hospitals

BR Ahead of the Curve for RRTs

by: Karen Stassi

Did you ever look at a patient, and feel instinctively that something was not right? You reassess the vitals, but nothing jumps out at you. You recheck the chart, double check all the orders, make sure the meds were given...but there's still something you can't quite put your finger on. At one time, the next move would be to summon a charge nurse or call the ICU and ask for advice or a second opinion. In the worst cases, the patient would continue to subtly deteriorate until he or she coded. In audits of codes, researchers have found that more often than not, there were signs that a patient was decompensating hours before the code, but in the hectic, busy world of the hospital they were missed. The literature calls this "failure to rescue" and the thought is that codes can be prevented if a more concerted effort is made to recognize, assess, and treat these patients at the earliest stages of decompensation. "Gut instinct is one of our most valuable assets," said Kathy Peairs, Performance Improvement Officer at Lane Regional Medical Center (RMC).

1900: Sigmund Freud publishes "Interpretation of Dreams." Psychoanalysis is the latest craze (pun intended).



1900s: Psychoanalysis and institutionalization are primary modes of treatment for the mentally ill.

The Australians were the first to formalize the concept of a Medical Emergency Team or MET back in the 1980s. The idea was to create a team of specific individuals that could be called to any bedside by a page or overhead announcement. The team would include a critical care or ICU nurse, a respiratory therapist, and a charge nurse. Unlike a code team, the MET could be summoned on the basis of a single criterion such as increased respiration, seizure activity, or simply a gut feeling. Instead of rushing in and taking over, the team would work with the floor nurse to assess, identify, and intervene. Early studies indicated significant drops in the number of codes and the number of transfers from the floor to ICU when MET teams were activated. The studies started to make the rounds in medical literature and the concept made so much sense that METs and Rapid Response Teams (RRTs) started to pop up in isolated hospitals around the United States.

In 2000, the Institute of Medicine (IOM) issued a statement concerning the 50,000 to 100,000 lives lost annually to adverse events in hospitals. The IOM stated that “the decentralized and fragmented nature of the HC delivery system...contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety.” Dr. Stephen Briere, Assistant Professor of Clinical Medicine and Critical Care Coordinator at Earl K. Long (EKL) pointed out that, “When the IOM issues a statement like that, regulation is quick to follow.” And he was right. In 2004 the Institute for Healthcare Improvement (IHI) incorporated rapid response teams as a performance indicator, first in its 100,000 Lives Campaign, and then later in its Five Million Lives Campaign.

The trend took off, but the final impetus to put RRTs in place came when the Joint Commission added rapid response teams as one of its patient safety goals with an implementation target of 2009. According to the Joint Commission, “the goal is to improve recognition and response to changes in a patient's condition by selecting a suitable method that enables healthcare staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.” Exactly who serves on the team and how they are summoned is left to the discretion of the hospital, depending on levels of experience, staffing, and patient loads. The idea is to have people on the team that can drop what they are doing and respond immediately. For the most part, teams are comprised of an ICU or critical care nurse and a respiratory therapist. Others may include the charge nurse, a house manager, or in the case of teaching hospitals, a resident. “The old adage, 'an ounce of prevention is worth a pound of cure' describes rapid response teams per-

fectly,” said Ochsner Critical Care Charge Nurse, Prentice Massey, Jr.

Here in Baton Rouge we are well ahead of the curve. Our Lady of the Lake Regional Medical Center (LOL), Baton Rouge General, and Ochsner, have each had rapid response teams in place for more than three years. Cathy Guay, Assistant Vice President of Patient Care Services at LOL said that when she first heard about rapid response teams, it was through an article about the Australian study brought to her attention by one of the hospital's intensivists. “I read the article, but couldn't find anything else about METs in the literature. So when we created our team, we called it a MET. It wasn't until much later that we realized the rest of the country was calling them RRTs, but the name had already stuck,” she laughed. The Baton Rouge General refers to its rapid response team as a Medical Response Team or MRT. The team was the brainchild of Julie Whitaker, Nurse Manager, Critical Care, and Pharmacist Louis Blair, who had worked with similar teams at hospitals in Tennessee. At Ochsner, Prentice Massey, Jr. was delighted to find the MET in place when he started there. “It mirrored what we were doing when I was on active duty...I was really excited,” said Massey. At Woman's Hospital, three distinct teams were created in 2006 to serve the hospital's unique population, according to Staci Sullivan, Vice President of Infant and Pediatric Services. There is a Pregnant Adult Team, a Neonatal Team, and an Adult Post-partal or Post-surgical team. At Earl K. Long the Medical Response Team went into action in March, 2008, under the guidance of Dr. Stephen Briere, who worked with the MRT at Baton Rouge General and had witnessed positive results firsthand. Lane Regional Medical Center got final approval to implement its team in April, 2008 and planned to train team members immediately.

It's a win-win always. The ICU nurses can help reduce codes and reduce or avoid inappropriate admits to ICU, the floor nurses get an added level of support, and most importantly it's a win for the patients—we are picking up on things a lot quicker.

-Julie Whitaker, Baton Rouge General

1905: Publication of Alfred Binet's Intelligence Test in Europe. Carl Jung introduces word association. Group therapy gets its start.



Courtesy Woman's Hospital

Hospital	Team Name	Date Implemented	Team Members	Alert System
IHI	MET	2008	Nurse Manager (or critical care nurse) Respiratory Therapist	Pager plus Overhead Activated by calling 1776
Dennison Island	MRT	2005	ICU Nurse Respiratory Therapist	Pager
Ochsner	MET	2005	ICU Nurse Respiratory Therapist ER Physician or Nurse	Pager
Lafayette Clinic	MRT	2008	ICU Nurse Respiratory Therapist Admission or On-Call Physician	Pager
Lane RMC	RRT	2008	ICU Nurse Manager Nurse Supervisor Charge Nurse (from Booth) Respiratory Therapist Lab/Delivery Charge Nurse NICU Charge Nurse Respiratory Therapist	"Red Phone" and Charge Nurse Sports-Link Phones
Woman's Hospital	Intensivist Adult RRT	2006	NICU Charge Nurse Respiratory Therapist ICU Charge Nurse Respiratory Therapist	"Red Phone" and Charge Nurse Sports-Link Phones
	Neonatal RRT	2006	NICU Charge Nurse Respiratory Therapist	" "
	Adult Post-Pneumonia RRT	2006	ICU Charge Nurse Respiratory Therapist	" "

of directives or mandates. For example, at many hospitals the stated goal of the RRT is to reduce codes, but it is far from the only reason. "Obviously our code numbers at Woman's Hospital annually are very low," said Sullivan, "but it's a wonderful idea, to have that consultation ability, to assess the situation before getting to a code." Sullivan said it is also an excellent mentoring and teaching tool for new staff. EKL's John Germany agreed, pointing out that the system has existed informally—you could always call an ICU nurse for advice—but that the formal team takes some of the pressure off the floor nurse. Woman's Hospital NICU Nurse Manager Glyn David added that, "The RRT adds a whole new dimension to that call to the ICU for advice, because they actually come to the patient." It is also invaluable to have an immediate response and assessment while waiting for a test or lab to come back, a doctor to come out of surgery, or any of the many other factors that can delay tackling a change in a patient. At Lane RMC, the rapid response team plan follows the Five Million Lives Initiative terminology and IHI criteria pretty closely. "That way if we have new staff come on board, it will be familiar to them," explained Kathy Peairs.

While staff at each of the hospitals mentioned the IHI and Joint Commission goals as background information, across the board the feeling was that rapid response teams made so much sense, they would have been implemented regardless

1906: Ivan Pavlov's studies of conditioning are published.



1907: Indiana enacts law allowing sterilization of the mentally disabled. Other states follow suit.

Regardless of its name or origin, at each area hospital, the rapid response team's job is to assist the nurse or other clinician in critically assessing what is happening with a patient. While specific triggers vary from facility to facility, common criteria include:

- unexpected changes in heart-rate, blood pressure, and/or respiration
- difficulty breathing
- poor oxygen saturation
- seizure activity
- bleeding
- altered mental status
- unresponsive pain
- the ever-popular and instinctual, "the patient just doesn't look right."

With one call, the floor nurse can summon a team of the hospital's most experienced personnel to help evaluate what is happening. While they may often be required to do little more

Gut instinct is one of our most valuable assets.

-Kathy Peairs, Lane RMC

When the IOM issues a statement like that, regulation is quick to follow.

-Dr. Stephen Brierre, EKL

than offer reassurance, the team can also suggest and implement treatment to turn the patient around. The rapid response team is also very useful when a nurse is having trouble contacting a physician in the middle of the night, pointed out Whitaker. Not only can they advise, but the team can also help the nurse convey to the doctor all the information he/she needs to make a decision or adjust treatment. Physicians are reassured if they know the RRT has been called and is weighing in on a situation. "Our physicians like the MET so much, if the nurse is unsure, they'll say, 'Well, call the MET team and call me back,'" said Corey Summers, House Manager at OLOL. In more extreme cases, they can also intervene in the physician's absence. At OLOL for example, after ten minutes without the primary physician's feedback, the MET can summon the intensivist to take over the patient's care if necessary. "I think the nurse on the floor is happy to have someone to call for reassurance," added Tammy Dickerson, Critical Care, Clinical Coordinator at Ochsner. "It's team nursing."

At each hospital however, team members stressed that the

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LOLO MET Members
 Donna Smith, RN, House Manager
 Corey Summers, RN, House Manager

job of the rapid response team is not to take over for the floor nurse. "ICU nurses tend to be a Type-A bunch and want to take charge," said Julie Whitaker, "that's not what the MRT is about. It's about providing support for the floor nurse and growing our younger floor nurses in their critical thinking." Prior to and even after implementation of the rapid response team, each of the hospitals provided extensive education to its staff about not hesitating to activate the team and to remind them that it was an option. "We would send them thank you notes and Spirit Grams (LOLO's internal recognition program) to encourage them to use us," said Summers. "We had to emphasize that we would rather be called for nothing, than not be called for something." Whitaker said there have been times when the team has been paged for seemingly minor or obvious issues, but she urges team members not to complain as she never wants a floor nurse to hesitate to call. And, while the

symptoms may seem obvious to someone fresh to a situation, she acknowledges that floor nurses have several patients and work long shifts...sometimes they just need an extra set of eyes and ears to assess what's going on. "There is no problem too small," emphasized Whitaker. EKL Nurse Manager John Germany acknowledged there is a little learning curve, but "we are confident the system will improve, the more people know about it."

The old adage, "an ounce of prevention is worth a pound of cure" describes rapid response teams perfectly.

-Prentice Massey, Jr., Ochsner

1909: National Committee for Mental Hygiene is founded. Later becomes National Mental Health Association.



1910: Ward for mentally ill criminals added to asylum in Jackson, La. The American Association for the Study of the Feeble-Minded coins terms moron, imbecile, and idiot for categories of impairment.

While some hospitals assign staff members to the team based on their experience, others also require additional training and/or certification. For example, ICU nurses that wish to serve on the General's MRT must pass a special certification. The certification requires them to apply critical thinking skills to a variety of patient scenarios. When a page goes out for the MRT, any MRT certified ICU nurse can respond, depending on what else is going on in the ICU. At Ochsner, team members are drawn from the ER and ICU staff because they are there 24/7, but members must also have basic and advanced life support certification. "It's like the medical special forces," said Massey, "an elite team gathered for a collaborative intervention." At OLOL, it was decided not to pull nurses from the critical care team, said Cathy Guay, but instead tap into the house managers, because they are there 24/7, they are very clinically oriented, and do not have a specific patient load. "They really have their fingers on the pulse of the hospital," said Guay.

The RRT adds a whole new dimension to that call to the ICU for advice, because they actually come to the patient.

-Glyn David, Woman's Hospital

earlier," he said. The General has found that the number of codes has decreased noticeably, which is one of the driving factors in instituting a rapid response team. "It's a win-win always," stated Julie Whitaker. "The ICU nurses can help reduce codes and reduce or avoid inappropriate admits to ICU, the floor nurses get an added level of support, and most importantly it's a win for the patients—we are picking up on things a lot quicker and codes are decreasing." Woman's Hospital also uses its tracking data to determine if there are any areas on the floors that require additional education, said Staci Sullivan. OLOL reports that it has seen an increase in MET calls and a decrease in codes. "It saves lives and saves money," said Guay, "but it is also such a huge nurse satisfier." Guay said the hospital also looks at MET failures, i.e. when the MET team responded, but the patient coded later. "We are going to do an audit and go back to see if we missed something."

What's the next step? Well, the Joint Commission has also included a goal of having patients and their families more involved in their care. Some of these measures came about through the efforts of the Josie King Foundation. Josie King was a little girl who died at a prominent U.S. hospital because a parent's concerns were not adequately addressed. The Foundation created Condition H (for Help) which encourages more interaction between staff and the patient's family members and allows the family member to get a response team to the room on their own. Most area hospitals plan to implement some system by which the patient or his/her family can activate the RRT. At others, the standard system of the patient telling the nurse and having the nurse make that call will remain in place. "Sometimes the family member is the first to notice something's not right," acknowledged Anne Steib, a team member from Ochsner's Emergency Department. "They

We had to emphasize that we would rather be called for nothing, than not be called for something.

-Corey Summers, OLOL



Ochsner MET Members
 Anne Steib, RN – Emergency Department
 Prentice Massey, Jr., BSN, RN, Charge Nurse, Critical Care Department
 Tammy Dickerson, BSN, RN, Clinical Coordinator, Critical Care Department

At every hospital with a rapid response team in place, numbers of calls, responses, and outcomes are recorded and tracked. For those that have had teams in operation for a while, the results have been dramatic. Codes have dropped and transfers to the ICU have decreased. Some also go back and audit their codes, to see if the RRT could have been called. "All of our data since implementation have shown that it is working," said Ochsner's Prentice Massey. "In 2007, we went five months without a code outside of ICU." But he is also impressed with the less easy to track results. "It is really opening up dialogue and encouraging everyone to communicate

1911: The term schizophrenia, meaning *split mind*, is coined.



1913: Carl Jung starts field of analytical psychology.

can let the nurse know and then she can activate the RRT as necessary.” OLOL recently implemented what they call a Five Star program where patients can get an immediate response to anything they need within 30 minutes, although this so far does not include the MET. OLOL also provides a whiteboard in each room with the treatment goals for the day and the attending staff listed. Patients and family members are encouraged to call the House Manager if they have a problem. A patient initiated RRT is the next step, said Cathy Guay.

Also on the books for some area hospitals is tying the RRT in with the electronic health record, so that information about a patient entered into the electronic system could alert the nurse that there is something amiss, or in some cases even automatically trigger the RRT. “There’s a good possibility we will eventually tie this in somehow

It's like the medical special forces—an elite team gathered for a collaborative intervention.

-Prentice Massey, Ochsner

with the electronic health record,” said John Germany at EKL. “It would certainly be beneficial and we need to get away from paper.” Some are further along than others, primarily due to how far along the hospital is with implementing both EHRs and RRTs. However at OLOL, they have also come up with a medical emergency team alert. The system, specially written for them by Cerner, works when certain vital signs are entered into the computer record by the nurse (now that they have hand-held devices, this can be real time). If certain changes are detected, such as a sudden drop in respirations, then an immediate alert goes out to the MET. “We are still working out the bugs on this system,” said Guay, “but I think we are one of the first in the country to take it this far.” ❖

Sources: Institute for Healthcare Improvement, www.IHI.org; The Joint Commission, www.jointcommission.org; ‘Failure to Rescue’ Phenomenon Rouses Rapid Response Teams to Action, *NTI News Online*, American Association of Critical Care Nurses; Kremsdorf, Richard, MD, “Failure to Rescue and Errors of Omission,” Lionheart Publishing, Inc. 2005; Institute of Medicine, Committee on Quality of Health Care in America, “To err is human: Building a safer health system,” L. T. Kohn, J. M. Corrigan, & M. S. Donaldson, (Eds). Washington, DC: National Academy Press, (2000); JCR Book Excerpt: Good Practices for Medical Emergency Teams, Joint Commission International Center for Patient Safety, www.jcipatientsafety.org/15439; The Josie King Foundation, www.josieking.org



1917: World War I recruits screened for psychiatric disorders.

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WHO Praises Noguchi Awards For Service To Public Health

The World Health Organization recently announced that the Government of Japan awarded the first Hideyo Noguchi Africa Prize for service to global public health. The two recipients of the prize were **Brian Greenwood**, Professor of Clinical Tropical Medicine at the London School of Hygiene and Tropical Medicine, and distinguished innovator in malaria research; and **Miriam K. Were**, an AIDS specialist performing ground-breaking community-based work in East Africa.

Dr Were has been recognized for working all her life to deliver basic health services to the people of Africa at the local level, including her contribution to the AIDS fight. As chairperson of Kenya's **National AIDS Control Council**, Dr Were has provided critical leadership which has contributed to both a reduction in HIV prevalence and AIDS-related mortality. Dr Greenwood has worked for 30 years in Africa on one of the continent's deadliest diseases—malaria. Malaria is a tragedy in Africa, killing one child under five every 30 seconds. The Government of Japan noted in its award that Dr Greenwood has done pioneering research on the immunology, pathogenesis and epidemiology of the disease. His work has provided the foundation for much of the national and international public health policies established to confront the disease.

Poor Sanitation Threatens Public Health

Sixty-two percent of Africans do not have access to an improved sanitation facility that separates human waste from human contact, according to the **WHO/UNICEF Joint Monitoring Program for Water Supply and Sanitation**. A global report will be published later this year, however, preliminary data on the situation in Africa was released as part of World Water Day 2008. The Day, built around the theme that "Sanitation matters," seeks to draw attention to the plight of some 2.6 billion people around the world who live without access to a toilet at home and thus are vulnerable to a range of health risks. Although WHO and UNICEF estimate that 1.2 billion people worldwide gained access to improved sanitation between 1990 and 2004, an estimated 2.6 billion people—including 980 million children—had no toilets at home. If current trends continue, there will still be 2.4 billion people without basic sanitation in 2015, and the children among them will continue to pay the price in lost lives, missed schooling, in dis-

ease, malnutrition and poverty.

Somalia is Again Polio-Free

Somalia is again polio-free, the **Global Polio Eradication Initiative (GPEI)** announced, calling it a 'historic achievement' in public health. Somalia has not reported a case since March 25, 2007, a major landmark in the intensified eradication effort launched last year to wipe out the disease in the remaining few strongholds. This landmark victory is a result of the efforts of more than 10,000 Somali volunteers and health workers who repeatedly vaccinated more than 1.8 million children under the age of five by visiting every household in every settlement multiple times, across a country ranked one of the most dangerous places on earth. The use of innovative approaches tailored to conflict areas was pivotal in stopping polio in



the country. These included increased community involvement and the effective use of monovalent vaccines to immunize children in insecure areas with several doses within a short period of time.

Polio, which can cause lifelong paralysis, has been stopped nearly everywhere in the world following a 20-year concerted international effort. Only four polio-endemic countries remain—Afghanistan, India, Nigeria, and Pakistan—and the eradication of polio globally now depends primarily on stopping the disease in these countries. Somalia had eradicated polio once before, but the disease regained entry through Nigeria.

ART Could Reduce Deaths in South Africa

More than 1.2 million deaths could be prevented in South Africa over the next five years by accelerating efforts to provide access to antiretroviral therapy (ART), according to a study released online by the *Journal of Infectious Diseases*. Using a sophisticated mathematical model of HIV disease and treatment, a team of researchers led by **Rochelle Walensky, MD,**

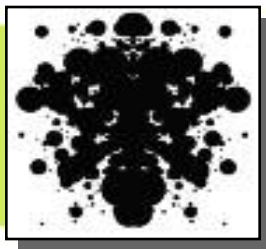
MPH of Massachusetts General Hospital (MGH) estimated the number of AIDS-related deaths in South Africa through 2012 under alternative ART scale-up assumptions. The study results underscore the urgent need for Congress to reauthorize the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which has supported the South African government's effort to increase access to antiretroviral therapy, the researchers note. South Africa has one of the largest burdens of HIV infection in the world, with 5 to 6 million individuals and 19 percent of adults aged 15 to 49 infected. While government programs supported by PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria have steadily increased access to antiretrovirals, at the end of 2006 only a third of individuals eligible for the therapy were receiving it.

HHS Secretary Leavitt Visits Southeast Asia

HHS Secretary Mike Leavitt recently visited Indonesia, Singapore, and Vietnam to advance the administration's efforts to improve the safety of imports, and to review cooperative efforts to reduce the spread of disease, including HIV/AIDS and highly pathogenic avian influenza. Secretary Leavitt met with senior government officials and business leaders, and visited sites related to product safety, and the research, care, and treatment of infectious diseases. In November, 2007, as chair of the **President's Interagency Working Group on Import Safety**, Secretary Leavitt presented the President with the group's Import Safety Action Plan. The plan contains short- and long-term recommendations for continuing to improve the safety of imports entering the United States. The group's plan works in harmony with the **U.S. Food and Drug Administration's** Food Protection Plan. Among the recommendations of the Import Safety Action Plan:

- Developing arrangements with counterparts in other governments to facilitate the exchange of

1920: Beginnings of behavior therapy. State hospitals for the treatment of the mentally ill mercifully begin to drop the word lunatic from their names.



1921: Rorschach creates his diagnostic inkblots although they do not catch on for a few years.

information, such as import and recall data;

- Increasing training for foreign inspection agencies to help other governments ensure the safety of products;
- Increasing the U.S. presence abroad in these activities; and
- Working with other governments and manufacturers to help to ensure compliance with U.S. safety standards.

The Secretary is also interested in learning about steps taken in the three countries to help reduce the spread of avian influenza and other infectious diseases. The United States has identified Indonesia and Vietnam as priority countries for pandemic influenza preparedness and response, and has provided funding and expertise for these efforts. The United States also assists in combating HIV/AIDS through such programs as the President's Emergency Plan for AIDS Relief (PEPFAR). Vietnam is one of the 15 focus countries of the Emergency Plan.

Global Forum Calls For Urgent Action To Resolve Health Worker Crisis

The first **Global Forum on Human Resources for Health** called for immediate and sustained action to resolve the critical shortage of health workers around the world, setting out the essential steps that need to be taken over the next decade to turn the crisis around. Nearly 1500 participants, including donors, experts,

and more than 30 ministers of health, education and finance, endorsed the Kampala Declaration and Agenda for Global Action. The Forum, held in Kampala, Uganda, and organized by the **Global Health Workforce Alliance (GHWA)**, mandated the Alliance to monitor progress made on the Agenda and report its findings in 2010. The Agenda calls on all countries to give top priority to training and recruiting sufficient health personnel from within their own country and to provide adequate incentives and better working conditions to ensure the retention of health workers. It calls on international and regional financial institutions to relax constraints such as public health recruitment ceilings, and calls on **WHO** to accelerate negotiations for a code of practice on the international recruitment of health workers. WHO estimates that the world needs over 4 million additional health workers, and 57 countries are suffering from an acute shortage. Sub-Saharan Africa is particularly affected by this crisis, with one million health workers needed for this region alone.

Climate Change Will Erode Foundations of Health

According to **WHO**, scientists tell us that the evidence the Earth is warming is "unequivocal." Increases in global average air and sea temperature, ice melting and rising global sea levels all help us understand and prepare for the coming challenges. In addition to these observed changes, climate-sensitive impacts on human

health are occurring today. They are attacking the pillars of public health. And they are providing a glimpse of the challenges public health will have to confront on a large scale, WHO Director-General **Dr Margaret Chan** warned on the occasion of World Health Day.

Human beings are already exposed to the effects of climate-sensitive diseases and these diseases today kill millions. They include malnutrition, which causes over 3.5 million deaths per year, diarrhoeal diseases, which kill over 1.8 million, and malaria, which kills almost 1 million. Examples already provide us with images of the future:

- European heat wave, 2003: Estimates suggest that approximately 70,000 more people died in that summer than would have been expected.
- Rift Valley fever in Africa: Major outbreaks are usually associated with rains, which are expected to become more frequent as the climate changes.
- Hurricane Katrina, 2005: More than 1,800 people died and thousands more were displaced. Additionally, health facilities throughout the region were destroyed, critically affecting health infrastructure.
- Malaria in the East African highlands: In the last 30 years, warmer temperatures have also created more favorable conditions for mosquito populations in the region and therefore for transmission of malaria.
- Epidemics of cholera in Bangladesh: They are



closely linked to flooding and unsafe water.

These trends and events cannot be attributed solely to climate change but they are the types of challenges expected to become more frequent and intense with climate changes. They will further strain health resources that, in many regions, are already under severe stress. To address the health effects of climate change, WHO is coordinating and supporting research and assessment on the most effective measures to protect health from climate change, particularly for vulnerable populations such as women and children in developing countries, and is advising Member States on the necessary adaptive changes to their health systems to protect their populations.

Monitoring AIDS Treatment by Physical Symptoms is Effective

When millions of HIV-infected people in poor countries began receiving advanced drug therapies, critics worried that patient care would suffer because few high-tech laboratories were available to guide treatments. But according to a study published in *The Lancet*, these concerns are as yet unfounded. In fact, the study indicates that when clinicians use simple physical signs of deteriorating health, such as weight loss or fever, these doctors can provide therapies almost as effective as those relying on the most advanced laboratory analysis.

The aim of the study was to look at the medium and long-term consequences of different approaches to monitoring antiretroviral therapy in a resource-limited setting: using clinical signs and symptoms alone as recommended in WHO guidelines; or more sophisticated and costly but far less accessible immunological and virological load tests. The scientists used a model that had been tried and tested in London, and shown accurately to predict the course of the epidemic in the UK over 20 years, but with various changes to reflect realities on the ground.

According to the study authors, survival rates for individuals assessed for clinical symptoms alone were almost identical to survival rates for those who underwent laboratory monitoring. The 5-year survival rate was 83% for individuals monitored for viral load, 82% for CD4 (a critical immune component) monitoring, and 82% for clinical monitoring alone. Corresponding values over a 24-year period were 67%, 64%, and 64% respectively. Although the survival rate was slightly higher with viral load monitoring, study authors pointed out it was not the most cost-effective strategy in the poorest countries. The study also examined whether clinical observation alone was effective in determining when to switch

patients from WHO-recommended first-line treatments to more costly second-line medicines. Again, diagnosis based on an assessment of clinical symptoms was almost as effective as those relying on expensive laboratory tests. Study authors concluded that for patients on the WHO first-line regimen of stavudine, lamivudine, and nevirapine, the benefits of CD4 count or viral load monitoring were only modest at best.

NATIONAL

Real Men Wear Gowns

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) joined with The Advertising Council to launch a national public service campaign designed to raise awareness among middle-aged men about the importance of preventive medical testing. Men are 25 percent less likely than women to have visited the doctor within the past year and are 38 percent more likely than women to have neglected their cholesterol tests (Source:



AHRQ Medical Expenditure Panel Survey, 2005). Furthermore, men are 1.5 times more likely than women to die from heart disease, cancer and chronic lower respiratory diseases (Source: Centers for Disease Control and Prevention, 2005). The new campaign encourages men over 40 to learn which preventive screening tests they need to get and when they need to get them. This campaign complements AHRQ's existing efforts toward improving the safety and quality of healthcare and promoting patient involvement in their own healthcare, including the "Questions are the Answer" campaign launched with the Ad Council in March

2007 and the "Superheroes" Spanish-language campaign launched in March 2008.

Public Worried About Medicare Cuts Impact on Seniors, Boomers

Eight out of 10 Americans are concerned about access to care for seniors and baby boomers because of government cuts to physicians caring for Medicare patients, according to a new public poll released by the American Medical Association (AMA). On July 1, Medicare payments to physicians will be cut 10.6 percent, and over the next decade the cuts will grow to about 40 percent while medical practice costs increase 20 percent. Seniors who rely on Medicare will be hurt by the Medicare cuts, as 60 percent of physicians say this year's cut alone will force them to limit the number of new Medicare patients they can treat. Already 30 percent of Medicare patients looking for a new primary care physician are having trouble finding one, and the cuts will make access woes much worse.

Action by the U.S. Congress is the only cure to the cuts, and nearly three-quarters of Americans polled believe Congress should stop the cuts so that physicians can continue to care for Medicare patients. The Save Medicare Act of 2008 (S. 2785), which would replace 18 months of cuts that began in July with payment increases that better reflect medical practice costs, was recently introduced in the U.S. Senate.

New Study Shows Colorectal Cancer Screening Rates Increasing

The percentage of U.S. adults aged 50 years and older getting screened for colorectal cancer is increasing according to a study released by the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report*. The study uses state-level Behavioral Risk Factor Surveillance Survey (BRFSS) data that have been combined to estimate that 60.8 percent of adults were current with colorectal cancer screening recommendations in 2006, compared with 53.9 percent in 2002. Screening prevalence was lower among all racial and ethnic minorities studied compared to whites. The study also reports that screening rates continue to be lower among those without health insurance, with low income, and with less than a high school education.

Colorectal cancer is the nation's second leading cause of cancer deaths. In 2004, almost 145,000 people in the United States were diagnosed with colon cancer and more than 53,000 died from the disease. Regular screening is recommended for men and women beginning at age 50, using one or a combination of these

1930: Lobotomies and electroconvulsive therapy become the norm among other dramatic approaches.



1932: Piaget's ideas on cognitive development take root.

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- Double contrast barium enema - a series of x-rays of the entire colon and rectum.

Screening tests for colorectal cancer can find precancerous polyps (abnormal growths) in the colon and rectum before they turn into cancer. Screening also helps find this cancer at an early stage when treatment can be most effective.

Past Child Abuse Plus Variations in Gene Ups PTSD Risk

A traumatic event is much more likely to result in post-traumatic stress disorder (PTSD) in adults who experienced trauma in childhood—but certain gene variations raise the risk considerably if the childhood trauma involved physical or sexual abuse, scientists have found. The research was conducted with funding from the **National Institute of Mental Health**, which is part of the **National Institutes of Health**, and others.

Results of the study were reported on March 19 in a special issue of the *Journal of the American Medical Association* devoted to the influence of genes on health and disease, by **Elisabeth Binder, MD, PhD, Kerry J. Ressler, MD, PhD**, and colleagues from **Emory University** and other facilities. The gene in question is active in the biochemical make-up of the body's stress-response system. Results of the study suggest that early-life abuse can result in particularly potent changes to this system as it develops, depending partly on whether or not the variations are present in the gene. Inherited variations in multiple genes, which have yet to be identified, are estimated to account for 30 to 40 percent of the risk of developing PTSD. The gene identified in this study is one likely candidate, although others are almost certain to emerge.

New Web Site Helps Patients Shop for Hospital Care

The Centers for Medicare & Medicaid Services (CMS), part of the **U.S. Department of Health and Human Services (HHS)**, has posted new survey information at the Hospital Compare consumer web site offering consumers more insight about the hospitals in their communities. In addition to adding the new information from **Medicare** patients about their hospital stays, CMS is adding information about the number of certain elective hospital procedures provided to those patients and what Medicare pays for those services. For the first time, consumers have the three critical elements—quality information, patient satisfaction survey information, and pricing information for specific procedures—they need to make effective decisions about the

1935: Frontal lobotomies on chimpanzees observed to reduce agitation. First leukotomy (destroying connecting fibers from frontal lobe to rest of the brain) performed on female patient. The idea was embraced even though patients were apathetic post-surgery.

quality and value of the healthcare available to them through local hospitals. The Hospital Compare web site currently provides information on 26 quality measures, which include process of care and outcome measures. Process of care measures report how well a hospital provides care and outcome measures reflect the results of the care that beneficiaries received while in the hospital. With the addition of the 10 new patient experience of care topics, consumers will now be able to get a better picture of the quality of care delivered at their local hospitals. To access the Hospital Compare web site, please visit: www.hospitalcompare.hhs.gov.

Medical Organizations Issue New Guideline on Drugs to Treat Dementia

The American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) have issued a new guideline on current pharmacologic treatment of dementia. The guideline appears in the March 4, 2008, issue of *Annals of Internal Medicine*, ACP's flagship journal, and is available online at www.annals.org. A committee representing ACP and AAFP reviewed dementia literature for outcomes such as cognition, global function, behavior/mood, and quality of life/activities of daily living—areas of importance to physicians treating patients. The committee found that high-quality scientific evidence was limited and so developed cautious recommendations:

1. Clinicians should base the decision to try therapy with the FDA approved drugs for dementia on an individualized assessment of the patient.
2. Clinicians should base the choice of drugs on tolerability, adverse effect profile, ease of use, and cost of medication.
3. Further research is urgently needed to address gaps in knowledge about the clinical effectiveness of pharmacologic management of dementia.

Currently five drugs are approved by the FDA for dementia: four acetylcholinesterase inhibitors [donepezil (Aricept®), galantamine (Razadyne™, Reminyl™, Nivalin), rivastigmine (Exelon), and tacrine], and one neuropeptide-modifying agent [memantine (Mamenda®)]. These drugs do not cure dementia (there is no cure at this time) or repair brain damage. They may improve symptoms or slow down the disease. The guideline also outlines research that needs to be done:

- Evaluate the appropriate duration of therapy.
- Test drugs head-to-head.
- Test drugs in combination therapy.

One reason for the urgent call for research is the deficiencies found in the existing medical literature. The ACP-AAFP committee found that most of the existing studies focused on statistical significance of changes, but patients with dementia, caregivers, and physicians are more interested in clinically important improvement. In summary, no convincing evidence demonstrated that one therapeutic treatment is more effective than another, the committee concluded.

Medicare Acts to Reduce the Number of Yearly Drug Plan Reassignments

The Centers for Medicare & Medicaid Services (CMS) has issued a final regulation that could allow nearly one million Medicare beneficiaries with limited income and resources to remain in the Medicare prescription drug plan in which they are enrolled without having to pay a premium. The new rules apply to people with Medicare who are eligible for Medicare's extra help program, the low-income subsidy (LIS) provided under the Part D prescription drug program. Currently, LIS beneficiaries who are enrolled in prescription drug plans that no longer offer a zero-premium plan, and who have not made an affirmative choice to change plans, are reassigned by Medicare to a different prescription drug plan in their region that offers coverage with no premium.

The final rule changes the way that Medicare will calculate the regional low-income subsidy benchmarks, based on comments received on the proposed rule issued in January. The LIS benchmarks reflect the amount of a plan's premium that will be paid by the Federal government through the low-income subsidy. For example, the Federal government pays up to 100 percent of the Part D premium for LIS beneficiaries who are in plans with premiums below the regional LIS benchmark. Lower low-

income subsidy benchmarks mean that there are fewer plans that offer low or zero-premiums for low-income subsidy beneficiaries. That results in more beneficiaries being reassigned to other plans.

Under the final rule, these benchmarks will be weighted based on each plan's share of enrollees receiving the low-income subsidy, rather than their share of total Part D enrollment. This means plans with a greater number of low-income subsidy enrollees will be a larger factor when CMS calculates the benchmark. This will help to ensure that the premium subsidy amount better reflects the plans that low-income subsidy beneficiaries are enrolled in. This will result in fewer LIS beneficiaries seeing their drug coverage disrupted by having to change prescription drug plans in order to avoid paying a premium. For example, if this regulation had been in place for 2008, the number of reassignments would have been reduced by 850,000. The final rule went into effect May 31, 2008. The rule can be read online and will be available at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/CMS4133F.pdf>.

Diverse Populations Pose Special Health Needs

As the face of America continues to change, a research report released by The Joint Commission, entitled "One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations," urges healthcare organizations to assess their capacity to meet patients' unique cultural and language needs. In its 2001 report "Crossing the Quality Chasm," the Institute of Medicine identified patient-centered and equitable care as important elements of quality. The new report is based on successful practices now being used in hospitals, and underscores the need to move away from a "one size fits all" approach that negatively affects the quality and safety of care for diverse



1938: Electroshock therapy is introduced based on observations at a slaughterhouse. Heredity is thought to be a factor in schizophrenia.

1939: The mentally ill are among those considered biologically unfit by Hitler. Approximately 270,000 mentally ill patients are murdered by medical personnel in accordance with racial purity doctrine.

patients. The report includes a self-assessment tool that can help healthcare organizations tailor their initiatives to meet the needs of diverse populations. The tool addresses the main issues found in the report, and provides a framework for discussing needs, resources, and goals for providing the highest quality care to every patient served.

The report urges hospitals to systemically engage in a range of practices across four areas:

- Build a foundation. Leadership must drive efforts to establish specific policies and procedures for better meeting the diverse needs of patients. For example, cultural and language considerations should be included in the organization's mission, vision, and value statements. The foundation should also include devoting resources for organizational planning and organization-wide policies that integrate cultural competence and support improved patient care for diverse populations.

- Collect and use data to improve services. Before determining which cultural and language services are most appropriate to implement, it is important to collect and review demographic data to assess both community and patient needs. To better evaluate an organization's current cultural and language services, it is critical to track how often these services are used. Some of the services that may be monitored include language services, religious and spiritual care services, and special dietary requests

that are cultural in nature.

- Accommodate the needs of specific populations. A continuous process is necessary to target culturally competent initiatives to specific populations. This includes staff training and education, as well as patient education and other strategies that help patients better manage their care.

- Establish internal and external collaborations. Organizations must work together with the community in order to share information and resources that meet the needs of diverse patients. Involving the community and making use of available external resources can help keep costs down, while taking steps to develop a more diverse workforce, bridge cultural barriers and become a more active part of the community.

To access the complete text of "One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations," visit The Joint Commission website at www.jointcommission.org.

Thousands More Medicaid Enrollees Could Get Home And Community-Based Care

Thousands of Medicaid beneficiaries who were previously limited to receiving care in an institutional setting may now be given the option to receive that care in their homes and communities, under a proposed rule published by the Centers for Medicare & Medicaid Services (CMS). The Deficit Reduction Act of 2005

(DRA) gave states a new option to provide home- and community-based services (HCBS) to Medicaid beneficiaries without applying for a demonstration waiver. The proposed rule provides guidance to states on how to implement this provision of the DRA. Under this option, states will now be able to set their own eligibility or needs-based criteria for providing HCBS. Previously, to qualify for assistance with personal care, home health care or other services in the home or community setting, beneficiaries were required to be at imminent risk of institutionalization. The DRA provision eliminates this requirement and allows states to cover Medicaid recipients who have incomes no greater than 150 percent of the federal poverty level, or \$15,600 per individual in 2008, and who satisfy the needs-based criteria.

The proposed rule emphasizes "person centered" care, giving individuals an active role in developing their care plans, and the "self-direction" option in which states can allow individuals to take charge of their own services. The services states may make available under this benefit include case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care. The DRA also allows states to provide special services to individuals with chronic mental illness, including day treatment or other partial hospitalization, psychosocial rehabilitation, and clinic services. Under the proposed rule, states would no longer have to apply for a waiver to provide



The advertisement features a collage of images: a plate of oysters with a lemon wedge, hands playing a piano, a piece of salmon with asparagus, and a chocolate dessert topped with an orange slice. A gift card for Mansurs On the Boulevard is shown in the bottom left corner. The text reads: "Celebrating 20 Years of Entertaining The Senses", "Lunch, Dinner & Sunday Brunch", and "5720-A Corporate Blvd. (225) 923-3366 Reservations Recommended".

HCBS to Medicaid beneficiaries. Under the DRA, states only need an approved state plan amendment (SPA) satisfying the DRA criteria. Once approved by CMS, the SPA does not need to be renewed nor is it subject to some of the same requirements of waivers such as budget neutrality. Since the DRA made the HCBS option available beginning in January 2007, CMS has provided technical assistance to states wishing to move forward prior to publication of the proposed rule.

Major Collaboration Uncovers Surprising New Genetic Clues to Diabetes

An international team that included scientists from the **National Human Genome Research Institute (NHGRI)**, part of the **National Institutes of Health (NIH)**, reported it has identified six more genetic variants involved in type 2 diabetes, boosting to 16 the total number of genetic risk factors associated with increased risk of the disease. None of the genetic variants uncovered by the new study had previously been suspected of playing a role in type 2 diabetes. Intriguingly, the new variant most strongly associated with type 2 diabetes also was recently implicated in a very different condition: prostate cancer.

The unprecedented analysis, published in the advance online edition of *Nature Genetics*, combined genetic data from more than 70,000 people. The work was carried out through the collaborative efforts of more than 90 researchers at more than 40 centers in Europe and North America.

Joint Commission's Quality Check® Now Features Disease-Specific Care, Health Care Staffing Services

Joint Commission organizations certified in specialty areas of care will now be featured on The Joint Commission's Quality Check® website (www.qualitycheck.org). The inclusion of certified organizations adds to the existing resources for patients seeking information on Joint Commission accredited organizations. Health care organization-specific reports are now available for organizations with certified programs such as primary stroke, heart disease, kidney disease, and heart failure as well as organizations earning health care staffing services certification.

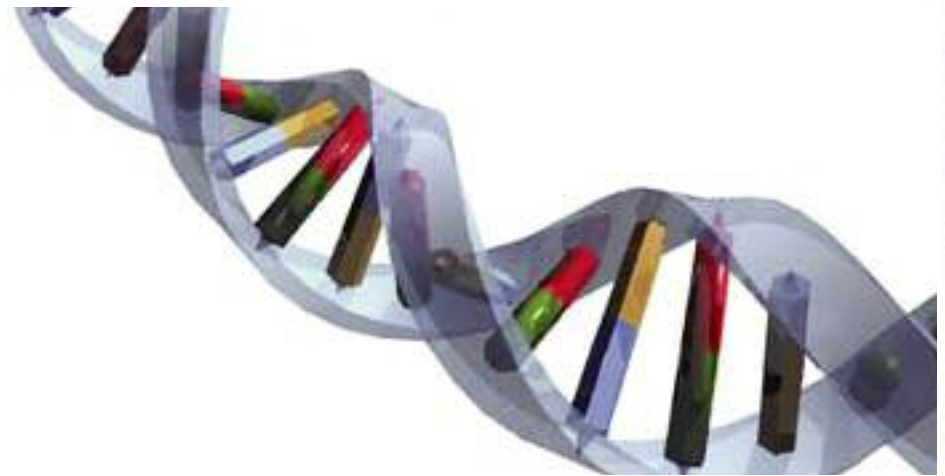
The addition of certification programs gives patients and families access to finding quality care close to home. Certification Quality Reports include:

- Certification decision and effective date;
- National Patient Safety Goal compliance (as applicable);
- Last full review and last on-site review dates;
- Demographic information; and

•Certified locations of care.

Economic Burden of Health Insurance Increasing for Small Employers Providing Health Insurance

The economic burden of providing health insurance for workers increased more for small businesses than for large ones from 2000 to 2005, but the spike did not cause a significant number of small employers to abandon the benefit, according to a study issued by the **RAND Corporation**. Small businesses (those with 25 or fewer employees) saw the expense of providing health insurance rise by nearly 30 percent during the study period—significantly more than the hikes experienced by medium and large businesses examined by the study. Researchers found no evidence that small businesses were more likely than large employers to quit providing health insurance for their workers, although small employers did remain less likely to provide health benefits to workers.



Christine Eibner, author of the study and an associate economist at RAND, a nonprofit research organization, found that typical businesses offering health insurance spent between 7 percent and 10 percent of their payroll on health insurance. But small companies saw their share grow from an average of 8.4 percent in 2000 to 10.8 percent of payroll by 2005, an increase of nearly 30 percent. In contrast, companies with 25 to 49 workers saw health insurance costs grow by 16 percent, and businesses with 50 to 99 workers saw costs grow by 25 percent. Overall, more than half of the small companies spent more than 10 percent of payroll on health insurance costs during 2005, according to the study. One unexpected finding was that both small businesses and large businesses (those with more than 100 employees) have higher health insurance burdens than medium-sized businesses (companies with 25 to 99 employees). The study, "The Economic Burden

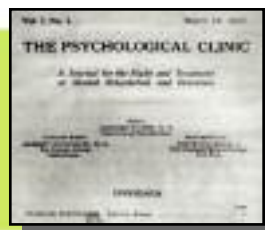
of Providing Health Insurance: How Much Worse Off Are Small Firms," can be found at www.rand.org.

New Guidelines for Colorectal Screening
The American Cancer Society, the **American College of Radiology**, and the **U.S. Multi-Society Task Force on Colorectal Cancer** (a group that comprises representatives from the **American College of Gastroenterology**, **American Gastroenterological Association**, and **American Society for Gastrointestinal Endoscopy**) have released the first-ever joint consensus guidelines for colorectal cancer screening. The guidelines add two new tests to the list of recommended options: stool DNA (sDNA) and CT colonography (CTC), also known as virtual colonoscopy, and for the first time include a preference for screening tests that can not only detect cancer early, but also detect precancerous polyps, as those tests provide a greater potential for cancer prevention

through polyp removal. The guidelines, which represent the most current scientific evidence and expert opinion available, also outline quality elements essential to each of the recommended testing methods. They appear in the May/June issue of *CA: A Cancer Journal for Clinicians*, and are published early online on *CA First Look* and will also be published in upcoming issues of the journals *Gastroenterology* and *Radiology*.

In addition to the new tests, the focus on quality and the new delineation of tests into two major types, the expert panel also concluded that any proposed colorectal screening test that has not been shown in the medical literature to detect the majority of cancers present at the time of testing should not be offered to patients for colorectal cancer screening. That includes some types of previously endorsed guaiac-based stool tests. Based on a review of the his-

1942: Introduction of the Minnesota Multiphasic Personality Inventory for psychological Assessment.



1945: *Journal of Clinical Psychology* founded.

toric and recent evidence, the following tests were deemed acceptable options for the early detection of colorectal cancer and adenomatous polyps for asymptomatic adults aged 50 years and older:

Tests That Detect Adenomatous Polyps and Cancer

- Flexible sigmoidoscopy every 5 years, or
- Colonoscopy every 10 years, or
- Double contrast barium enema (DCBE) every 5 years, or
- CT colonography (CTC) every 5 years

Tests That Primarily Detect Cancer

- Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer, or
- Annual fecal immunochemical test (FIT) with high test sensitivity for cancer, or
- Stool DNA test (sDNA), with high sensitivity for cancer, interval uncertain.

The full guideline can be viewed at <http://caonline.amcancersoc.org/>.

HHS Awards \$1.1 Billion for HIV/AIDS Care, Medications

HHS Secretary Mike Leavitt has announced grants of more than \$1.1 billion to provide primary care, medications, and services for low-income and underinsured people living with HIV/AIDS. Funded under Part B of the **Ryan White HIV/AIDS Program**, the grants are awarded to all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S.

Virgin Islands. Also receiving grants are the U.S. Pacific Territories of American Samoa and Commonwealth of the Northern Mariana Islands; and the Associated Jurisdictions of the Republic of the Marshall Islands, Federated States of Micronesia, and Republic of Palau. HHS' **Health Resources and Services Administration (HRSA)** manages the Ryan White program. The majority of the funding, \$774 million, supports state AIDS Drug Assistance Programs (ADAPs) that provide prescription medications for HIV/AIDS patients. In 2006, close to 158,000 ADAP clients were served through state ADAPs. Part B awards also include formula base grants that can be used for home and community-based services, insurance continuation, ADAP assistance, and other direct services. Fourteen states will also receive Emerging Community (EC) grants based on the number of AIDS cases over the most recent 5-year period.

Health Professionals and the Public Unprepared to Make Use of Genomic Medicine for Adults

Although advances in genomic medicine for common adult chronic diseases such as heart disease, diabetes, and cancer hold promise for improved prevention, diagnosis, and treatment, health professionals and the public are not prepared to effectively integrate these new tools into practice, according to a study released by researchers from the **Department of Veterans**

Affairs and the **RAND Corporation**. Physicians and patients are optimistic about the health benefits that genetic testing might provide, but neither group is well informed about genetics and there are likely too few experts available to meet growing demands for genetic testing, according to the study in the March 19 edition of the *Journal of the American Medical Association*. Researchers say the findings demonstrate a need for a large-scale effort to educate both health professionals and the public about genomic medicine, and to develop and evaluate new ways to deliver genetic services.

Researchers from RAND Health and the Department of Veterans Affairs reviewed all studies published from January 2000 to February 2008 about the delivery of genomic medicine for common chronic diseases. The authors synthesized the findings from 68 relevant studies to develop a picture of the status of the delivery of genomic medicine in developed countries to diagnose, prevent, and treat common chronic adult illnesses. The studies consistently found that primary care physicians feel "woefully underprepared" to integrate genetics into their practice. This includes having neither the time nor the skill necessary to obtain and interpret family histories that might detect disease patterns that merit a referral for genetic testing or specialty consultation. Consumers, while interested in the possibilities genetic testing offers, are worried about the prospect of

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adverse consequences to genetic testing—particularly loss of privacy and discrimination by health insurers or employers among those found to be predisposed to disease, according to the study. Despite this concern, researchers found there have been no well-documented cases of health insurers asking for or using presymptomatic genetic test results to define eligibility for coverage.

STATE

DHH Conducts Review of Emergency Disaster Plan

As part of its ongoing effort to ensure optimal preparedness for a natural or man-made disaster, the **Department of Health and Hospitals** held a symposium and plan review with employees and partners from throughout the state. Included in the review were federal partners from the **United States Department of Health and Human Services**. Two experts in emergency management participated in the review. **Dr. John Agwunobi**, immediate past assistant secretary of the U.S. Department of Health and Human Services, and **Craig Fugate**, director of emergency management for the State of Florida, worked as a team to review Louisiana's plan and provide feedback to the state. While with the federal government, Agwunobi was responsible for the nation's pandemic flu response plan and he supervised the **U.S. Surgeon General** and the public health service corps. Currently, he is the president of the Health Services Division for **Wal-Mart USA**. As head of Florida's emergency management, Fugate is responsible for preparing and implementing a statewide Comprehensive Emergency Management Plan, and his division routinely conducts extensive exercises to test state and county emergency response capabilities. Fugate led Florida's response through eight major hurricanes.

DHH Secretary Alan Levine said that even though hurricane planning and emergency response is an ongoing effort at DHH, the meeting served as a kick-off to the agency's preparations for the 2008 hurricane season. Agwunobi also noted that Louisiana could use the lessons learned during Katrina and Rita to help the rest of the country prepare for disasters. He said Louisiana is in a unique position to be able to share its knowledge, expertise, and experience to help other states with their planning. Levine reiterated the importance of each Louisiana family having a disaster plan, including a plan for pandemic flu.

Health Care Leaders Meet to Advance Quality in Delivery and Measurement

1946: National Mental Health Act signed by Harry Truman.



Louisiana Health Care Review hosted 300 people at its 1st Louisiana Health Care Quality Summit at the Hilton Baton Rouge Capital Center Hotel. The event brought together providers from nursing homes, hospitals, home health agencies, physicians' practices, and policy makers to discuss quality initiatives now underway and how to improve the current state of healthcare delivery. **Gary Curtis**, CEO of LHCR, told attendees that despite recent national reports placing Louisiana near the bottom of rankings, Louisiana providers are actually making great strides in many specific areas. In fact, Louisiana ranked number one in the nation for percent of seniors 65 and older receiving pneumonia vaccinations, according to the 2007 State Snapshots report from the **Agency for Health Care Research and Quality**.

Attendees also heard from **Louisiana Department of Health and Hospitals Secretary Alan Levine**, whose department is working in the legislature to increase transparency in the health care system to improve overall quality. Secretary Levine highlighted the \$18 million expenditure in **Governor Bobby Jindal's** budget to enable rural hospitals and physicians to adopt electronic medical records. The forum included four breakout sessions covering physician offices, home health agencies, nursing homes, and hospitals, as well as a panel discussion with candid discussions about their healthcare quality agendas over the next several years. Panelists included **Jerry Phillips**, Louisiana director of Medicaid; **Senator William Cassidy, MD**; **Dr. Jolene Johnson**, a diabetes expert with the **LSU Health Sciences Center**; **Gery Barry**, president and CEO of **Blue Cross and Blue Shield of Louisiana**; **John Matessino**, president and CEO of the **Louisiana Hospital Association**; and LHCR's **Scott Flowers**.

Ochsner Receives National Medical Education, Innovation Award

Ochsner has been named a 2008 Alliance Innovation Award winner for exemplifying creative and innovative approaches to medical education and research which, in turn, have resulted in better patient outcomes. Ochsner was recognized for its Alliance of Independent Academic Medical Centers (AIAMC) National Initiative: Improving Patient Care through GME. Ochsner was selected to participate because it demonstrated leadership in utilizing graduate medical education to improve quality, patient safety, and the cost-effectiveness of care. The Alliance Innovation Award is presented annually by AIAMC. Winners must demonstrate a change in development of innovative medical

education programs for residents, physicians and other staff, or the development and/or application of scientific discoveries.

Ochsner Medical Center-Kenner Recognized for Excellence in Surgical Services

Ochsner Medical Center-Kenner is one of 13 hospitals in Louisiana to receive the 2007 **Louisiana Health Care Review Hospital Quality Bronze Level Award** for improvements in patient care. Specifically, Ochsner Medical Center-Kenner is recognized for achieving quality improvement in its Surgical Care Services. The Louisiana Health Care Review Board focused on Ochsner-Kenner's ability to provide immediate assessment for new patients, proper patient care techniques, and appropriate discharge counseling. Ochsner-Kenner received the Bronze Level award for its success in maintaining a greater than 90 percent level of performance in surgical services.

LHCQ Forum Adopts National Standards for Patient-Centered Medical Homes

The **Louisiana Health Care Quality Forum (Quality Forum)** recently adopted a definition and standards set forth by the major professional medical societies and the **National Committee for Quality Assurance (NCQA)** on the Patient-Centered Medical Home, becoming the first statewide, multi-stakeholder group in the nation to do so. The Patient-Centered Medical Home is a model of primary care where a team led by a primary care physician partners with the patient and the community to deliver high quality, cost effective care. The concept of the medical home puts the patient at the "center" of healthcare. This model is also known to improve patient satisfaction and reduce health disparities.

The adopted NCQA standards include expectations for access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. The NCQA guidelines will serve as a voluntary framework for patients, payers, providers and purchasers to develop and certify the medical home. Several payers across the country and in Louisiana are considering using them as the foundation for enhanced payments to practices that meet these standards. The Quality Forum will work with primary care groups to evolve into a Patient-Centered Medical Home and will publish a web-based tool kit.

1948: Returning to the earliest primitive methods (ice pick and hammer), actress Frances Farmer is lobotomized in an attempt to cure her Communist leanings and her aggressive behavior. The World Federation for Mental Health is formed to promote world peace by reducing aggression in individuals (it hasn't worked yet).

DHH-LSU Issue Joint Statement on Future of Academic Teaching Hospital in New Orleans

As debate continues over the future of Louisiana's healthcare, **Alan Levine**, secretary of the **Louisiana Department of Health and Hospitals**, and **Dr. Fred Cerise**, Vice President for Health Affairs and Medical Education with **Louisiana State University**, released the following joint statement:

The Louisiana Department of Health and Hospitals is conducting a review of the proposed business plan for the building of a new academic hospital in New Orleans. Louisiana State University and its medical training partners, including **Tulane University** and others, are participating in the review process, with the goal of concluding a thorough review within the next two months. The review is focused on ensuring the proper size, scope, and cost of the new hospital with the purposes of providing world class academic training and needed tertiary services such as trauma and other highly specialized services appropriately provided in an academic setting, while assuring the providing of care for the uninsured.

All efforts to acquire the property—already designated through the consensus of the **Veterans Administration** and local officials—are continuing, including seeking the proper approvals from federal historical preservation and environmental agencies. Subject to successful comple-

tion of the environmental and historical preservation review process, there will be a new hospital in downtown New Orleans. The process continues, with the goal of ensuring maximum success in both financing and the ongoing operations of the new hospital. The taxpayers should expect no less.

LSU Programs Are Models of Patient Centered Care for Underserved Populations

Alan Levine, secretary, **Louisiana Department of Health and Hospitals**, presented "Looking Forward with the New Administration: Heading Toward Patient-Centered Care" as the keynote address for the **LSU Health Care Services Division** Spring 2008 Health Care Effectiveness Meeting. **Dr. Fred Cerise**, LSU System vice president for health affairs and medical education, presented "Charting Our Future: A Vision for the LSU Health System. The meeting, entitled "Lessons Learned in Patient Centered Innovations," also presented three LSU programs as models of patient-centered care for underserved populations. **Dr. Jule Assercq** discussed the **Earl K. Long Medical Center Asthma Program**, **Dr. Charles Patout** the **LSU Diabetic Foot Program**, and **Dr. Kathleen Willis** the **Lallie Kemp Regional Medical Center Hypertension Clinic**.

The LSU Diabetic Foot Program has created a statewide program with 100 percent access and

has provided 133 telemedicine clinics since 2001. Each LSU HCSD hospital has specialists at Earl K. Long Medical Center, where the program is based, on whom they can rely. The program is instrumental in reducing the number of diabetes-related amputations in Louisiana. In addition, the Earl K. Long Medical Center Asthma Program has shown measurable results in the improvement in the overall quality of life for patients with asthma including a reduction in emergency department visits. Even the smaller LSU HCSD hospitals reflect this posture of continual improvement. The innovative Lallie Kemp Regional Medical Center Hypertension Clinic in Independence has shown significantly lower blood pressure results for its patients with elevated blood pressure participating in the program.

Ochsner CEO Named #7 Most Powerful Physician Executive in U.S.

Patrick Quinlan, MD, Chief Executive Officer of **Ochsner Health System**, has been named the #7 most powerful physician executive in the nation by *Modern Physician Magazine*. This honor is part of the magazine's fourth annual ranking of the "50 Most Powerful Physician Executives in Healthcare." After Quinlan ranked No. 1 in last year's poll and No. 10 in 2006, readers of *Modern Physician* and *Modern Healthcare* in 2008 voted him to the No. 7 spot on the magazine's fourth annual ranking of the 50 most powerful physician executives. Other



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honorees include executives from the health-care industry, including hospital systems, the U.S. Senate, federal health agencies, patient advocacy groups, health insurance companies, unions, prestigious journals, and academic programs. The list is compiled from reader nominations and rankings can be seen in the April 2008 issue of *Modern Physician Magazine* or at www.ModernPhysician.com.

Blue Cross and Blue Shield of Louisiana Wins Brand Excellence Award

Blue Cross and Blue Shield of Louisiana has received a 2007 Brand Excellence Award for Member Retention from the **Blue Cross and Blue Shield Association**. The award is given to Blue Cross and Blue Shield plans that retain a high percentage of their members from the previous year. The annual award honors Blue Cross companies that excel in developing and enhancing the overall image of the Blue Cross and Blue Shield brands, some of the most recognized and trusted in the world. The Brand Excellence Award program began in 1995. The Blue Cross and Blue Shield Association is a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for more than 100 million individuals—one in three Americans.

Ochsner Home Health Partners with Enterprise

Ochsner Home Health has announced an innovative recruiting and retention strategy in a partnership with **Enterprise Fleet Management**. This new employment initiative includes giving nurses and therapists who perform extensive driving in the New Orleans region a new 2008 Ford Focus automobile. This option will allow Ochsner to eliminate mileage reimbursement for these employees and reduce the maintenance on and diminished value of their personal vehicles. Additionally, Ochsner is providing all home healthcare workers with state-of-the-art hand held PDA devices by **Homecare Homebase**. Increasing the staff's access to technology will allow them to document patient information faster and communicate more easily with physicians and pharmacists; via email, text or phone.

DHH Medicare Crisis Looms, \$180 Million Cut for Care of Elderly and Disabled

On July 1, 2008, **Medicare** payments to physicians will be cut by more than 10 percent, leaving Medicare patients in Louisiana with fewer options and less funding for health care. With an additional 5 percent cut scheduled for January 2009, a total of \$180 million will be

cut for Louisiana senior citizens and people with disabilities who rely on the Medicare program for their health care needs, unless Congress acts in time to prevent a crisis. In Louisiana alone, 40,414 employees, 597,653 Medicare patients, and 122,355 TRICARE patients will be affected, according to data released by the **American Medical Association (AMA)**. Medicare pay cuts will exacerbate patient access problems already plaguing Louisiana. With 18 practicing physicians per 1,000 beneficiaries, Louisiana's ratio of physicians to Medicare beneficiaries is below the national average, even before the cuts take effect. In addition, 42 percent of Louisiana's practicing physicians are over 50, an age at which surveys have shown many physicians are now considering reducing their patient care activities.

In a survey of **Louisiana State Medical Society** members in March 2007, Medicare reimbursement and future funding of this program was identified as one of the top three concerns to respondents. The survey reflected:

- Medicare reimbursement and future funding concerns have increased drastically over the last 10 years, from 13% in 1998 to 36% in 2007
- 81% reported providing care to Medicare patients in 2007; this is down from 85% in the 2003 Member Survey results.
- 59% of respondents reported they would begin restricting the number of Medicare patients they treated if payment cuts are imposed in the future.

The LSMS scheduled meetings with members of the **Louisiana Congressional Delegation** to discuss the impending Medicare physician reimbursement crisis. The LSMS will urge lawmakers to enact legislation that will stop the pay cuts over the next 18 months and provide payment relief for rising practice costs, and begin paving the way for permanent replacement of the physician payment update formula. Without replacing the flawed formula, the extensions and continued payment reductions will only prolong and compound the Medicare coverage problem, just as millions of baby boomers are becoming eligible for Medicare.

Ochsner Welcomes Chief Medical Officer

As **Ochsner** continues to expand medical care and services throughout Southeast Louisiana, the health system is proud to welcome **Joseph E. Bisordi, MD**, who has been named Chief Medical Officer for Ochsner Health System. As a Board Certified Nephrologist, Dr. Bisordi brings to Ochsner over 30 years experience in medicine and

academia. At Ochsner, he will be responsible for overseeing clinical quality and performance improvement initiatives within Ochsner's seven hospitals and 33 health centers and will play an integral role in furthering the development of medical informatics and clinical data management.

Throughout his career, and his many roles and accomplishments, Dr. Bisordi has held key leadership roles in recruitment for senior clinical and administrative leadership and developed enterprise-wide electronic medical records systems. Most recently, Dr. Bisordi served as Associate Chief Medical Officer for **Geisinger Health System** in Danville, Pennsylvania, and Chief Medical Officer for **Geisinger Medical Center**, a 437-bed tertiary care, academic referral hospital with 332 physicians. He also served as Vice President for Clinical Research for nine years and was a professor of clinical medicine at **Pennsylvania State University** and **Thomas Jefferson Medical College**. Dr. Bisordi received his medical degree from **Georgetown University Medical School** and attended **Manhattan College** for his undergraduate studies.

Medicaid Prescriptions Go High-Tech

A new electronic system for the prescribing of medications launched in April will provide **Medicaid** physicians in Louisiana access to cutting-edge technology to provide safe and efficient prescribing services as well as help drive down medication costs. Perhaps most importantly, this new program will increase the quality of the Medicaid prescription drug program. Approximately 65 percent of Louisiana's Medicaid patients (737,380 people) received a pharmacy service last year. This resulted in Medicaid paying for more than 9.4 million prescriptions. This year, the **Department of Health and Hospitals** expects to spend about \$537 million on pharmacy expenditures. Being introduced by **DHH**, this hand-held electronic system will allow physicians to prescribe medications via wireless devices. The devices, similar to a state-of-the-art cell phone, can access Medicaid's Preferred Drug List, patient-specific prescription histories, Clinical Pharmacology® drug information, and drug interaction screening tools. The system provides a 100-day history of all Medicaid drugs dispensed to a specific patient, allowing physicians to better monitor and consider all patient medications.

By having the Preferred Drug List accessible on the handheld device, the doctor has immediate access to a list of the most safe, effective and cost-efficient medications available to

1949: National Institute of Mental Health established. Lithium introduced for treatment of psychosis. It later becomes treatment of choice for manic depression (bi-polar disorder).



1950: First identification of psychosomatic symptoms, i.e. physical symptoms brought on by psychological problems.

Medicaid patients. Because the program also stores the last 100 days of a patient's medication history, it can help prescribers prevent the writing of drugs with harmful interactions or duplicate prescriptions. Point-of-care technology initiatives such as this are already established in other states including Florida and Mississippi where they have been shown to prevent errors, help physicians make more informed decisions, and save the states millions of dollars. DHH Secretary **Alan Levine** said DHH will spend \$1.2 million (or about \$2,350 per device) to put this technology into the offices of about 500 Medicaid providers. The expected savings from this investment is estimated at roughly \$4.8 million annually. The savings come from reducing the number of prescriptions per patient, reducing the cost of each prescription by using generic instead of brand-name drugs and by using drugs from the Medicaid Preferred Drug List. This method actually makes prescribing safer because the program checks for harmful interactions between other drugs prescribed to a patient.

To make this technology a reality, DHH has partnered with **Gold Standard, Inc.** of Tampa, Fla. Gold Standard, a qualified contractor with Medicaid experience, will provide the devices and necessary computer applications under the brand name **eMPOWERx®**.

Gold Standard will also prepare physician offices with the hardware and software to be able to update the devices daily with patient information and train participating doctors to effectively use the database.

Expanding Screening for Genetic Diseases in Newborns

The **Department of Health and Hospitals** is finalizing new regulations for the screening of an additional 18 genetic diseases in newborn babies. Previously, only 10 genetic disorders were screened for at birth. About 65,000 babies are born in Louisiana each year and receive screenings for genetic diseases before they leave the hospital. The tests identify disorders from sickle cell anemia to cystic fibrosis to metabolic disorders that can cause mental retardation. The new regulations are welcome news to hospitals as they streamline the requirements for routine repeat testing. The regulations include requirements for follow-up action which is taken to ensure the infant with a positive screening result is immediately referred to specialized care. This effort is a result of legislation passed during the 2006 Legislative Session. Since that time, a pilot program has been in place to ease the new testing measures into hospitals throughout the state. The regulations went into effect on March 20, 2008.

For more information on the Louisiana Newborn Heel Stick Screen Program, check the Genetic Diseases Program Web site at <http://www.genetics.dhh.louisiana.gov/>

LOCAL

Dr. Michael Butler of LSU Selected as One of the Top 25 Minority Executives in Healthcare

Modern Healthcare has selected **Dr. Michael Butler**, acting CEO of **LSU Health Care Services Division (HCSD)**, as one of its top 25 minority executives in healthcare. The April 7, 2008, issue of the healthcare business news weekly features Dr. Butler on the cover and examines minority leadership and inclusion in healthcare executive management in its cover story "Sustainable Diversity." Dr. Butler, 52, still works emergency department shifts "to keep abreast of front-line issues and maintain contact with patients," according to the *Modern Healthcare* profile. Trained in general and gastrointestinal surgery, he also continues to practice surgery.

As acting CEO, Dr. Butler oversees seven public hospitals, nearly 300 clinics, more than 9,000 employees, and a budget of more than \$800 million. He designs and directs the

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patient care delivery system, clinical information systems, and the continuous improvement of care management programs. He is also responsible for the disease management programs and medical staff training, all directed towards the improvement and measurement of the quality of care of the LSU HCSD. Dr. Butler has served as chief of surgery and medical director of **Leonard J. Chabert Medical Center**, where he developed its disease management program. He also served as chief operating officer and medical director for the **Medical Center of Louisiana** at New Orleans and as chief executive officer at **South Louisiana Medical Associates**, where he initiated a successful economic restructuring of the **Ocshner** education affiliate. Dr. Butler received his undergraduate degree at **Amherst College**, his medical degree at **Tulane University School of Medicine**, and his management degree at **Tulane University School of Public Health and Tropical Medicine**. He completed his postgraduate training in general and gastrointestinal surgery and trauma in New York. Dr. Butler is a certified physician executive and his board certifications are in surgery, quality assurance, and medical management.

Blue Cross Executive Peggy Scott Joins LSU Hall of Distinction
Louisiana State University's E.J. Ourso College of Business has inducted **Peggy Scott**, executive vice president and chief financial officer at **Blue Cross and Blue**



Shield of Louisiana, into its 2008 Hall of Distinction. The ceremony took place April 4 at LSU's Lod Cook Conference Center in Baton Rouge. Scott joins 44 other members in the Hall of Distinction, which recognizes individuals who make significant contributions to business, academia or government as well as to their community. She was selected because of her highly successful business

career and long-term support of the college and LSU. A CPA and Certified Valuation Analyst, Scott earned a bachelor's degree in accounting from **LSU** and an MBA from **Tulane University** in New Orleans. She had a distinguished early career in public accounting and consulting with **Deloitte Haskins & Sells** and was the first woman in the firm's 100-year history to head any Deloitte office. Scott has served as the executive vice president and chief financial officer with major operational roles at several other companies, including **Pan-American Life Insurance Company**, **Novant Health, Inc.**, and **General Health System**. She received a Presidential Citation under **Ronald Reagan** for her work on Louisiana budgetary reforms.

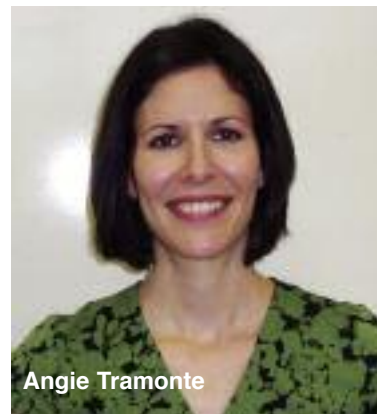
LSU Student Health Center Re-accredited
 The **LSU Student Health Center** has achieved accreditation by the **Accreditation Association for Ambulatory Health Care**, or **AAAHC**, for another three-year term, the maximum period granted, according to **Arthur A. Goulas**, assistant vice chancellor for student services and director of the Student Health Center. The organization has been accredited for 19 years, since 1989. Status as an accredited organization means the **LSU Student Health Center** has passed a series of rigorous and nationally recognized standards for the provision of quality healthcare, set by the accreditation association. More than 3,000 ambulatory healthcare organizations across the United States are accredited by **AAAHC**.

Ambulatory healthcare organizations seeking accreditation by the **AAAHC** undergo an extensive on-site, peer-based survey of facilities and services. Not all ambulatory healthcare organizations seek accreditation; not all undergoing the on-site survey are granted accreditation. Among the types of ambulatory health care organizations that can seek **AAAHC** accreditation are ambulatory and office-based surgery centers, single and multispecialty group practices, college health centers, dental group practices, community health centers, occupational health centers, and managed care organizations.

The **LSU Student Health Service** was founded in 1895 on the grounds of the current State Capitol. It moved to its present location on the corner of Chimes Street and Infirmary Road in 1905, and the existing building was erected in 1937. In 1974, it evolved from an inpatient infirmary to an outpatient clinic, the **LSU Student Health Center**. The Health Center provides integrated healthcare to students, through the **Medical Clinics**, **Mental Health**

Service and the **Wellness Education Department**.

Blue Cross Announces Management Appointments
Blue Cross and Blue Shield of Louisiana has promoted **Angie Tramonte** to Director of Actuarial Services and hired **Gina Smith** as Data Center Manager for Information



Technology. **Angie Tramonte**, ASA, MAAA, joined **Blue Cross** in 1998. She previously served as Associate Actuary over Group Actuarial, where she managed the small group block of business. In her new role, she will assume responsibility for group, individual, and valuation actuarial activities. **Tramonte** is a graduate of **Loyola University** in New Orleans and earned her Actuarial Associate designation in 2003. **Gina Smith** previously worked at **IBM Global Services** in Boulder, Colo., for more than 18 years—reaching the position of Production Support Analyst Manager. At **Blue Cross**, **Smith** will oversee the **IT Operations Center**. ❖

1952: Chlorpromazine (Thorazine) is first in a long line of anti-psychotic drugs. *Diagnostic and Statistical Manual of Mental Disorders* (DSM) first published by American Psychiatric Association.



SUBSTANCE ABUSE AND SMALL BUSINESS



by: Sen. Bill Cassidy, MD

Recently, I wrote about Mental Health and Substance Abuse issues in the *Healthcare Journal of Baton Rouge*. As this issue is devoted to mental health and the two are inextricably linked, I decided to expand my discussion to the impact of substance abuse on small businesses.

A top priority for the 2008 Regular Legislative Session is to enhance Louisiana's workforce development and training programs. Better jobs with better pay is a goal we have for all individuals and their families. Related to a better workforce is addressing substance abuse such as alcoholism or drug addiction which can impair a worker. These problems include increased accidents, errors, absenteeism, disciplinary problems, staff turnover, employee theft, and worker's compensation claims.

1953: B.F. Skinner introduces behavioral therapy. APA introduces code of ethics.



1955: 560,000 mentally ill patients are hospitalized in U.S. More than 55,000 undergo lobotomies. Behavior therapy introduced as a new form of treatment although the ancient Greeks had done it thousands of years ago. A federal commission headed by Herbert Hoover indicates that mental illness is the "greatest single" healthcare problem in the U.S.

Specific examples include these nationwide statistics. Studies show that 12.3 million adults currently use illicit drugs, and 9.4 million of them (77%) are employed.¹ According to the Substance Abuse and Mental Health Association, no occupation is protected from substance abuse. The highest rates of current illicit drug and alcohol use were reported by food workers, waiters, and bartenders (19%); construction workers (14%); and transportation and material moving workers (10%).²

Small businesses are the employer of choice for the alcoholic or addicted person seeking employment. According to the U.S. Department of Health and Human Services, among the population of full-time employed current illicit drug users: 44% work for small establishments (defined as having 1-24 employees), 43% work for medium businesses (25-499 employees), 13% work for large businesses (500 or more employees). Among the population of full-time employed heavy drinkers, 36% work for small businesses, 47% for medium size businesses, and 17% for large businesses.³ A reason that small businesses may be particularly affected is that many do not have drug-free workplace policies such as random or pre-employment drug screening.

Most small businesses do not have substance abuse coverage in their health insurance policies. I am told that this is because so few businesses have the policy, that if a small business owner requests the benefit, it is presumed that an impaired employee is a member of the group and the policy premiums are more expensive.

A solution to this is if all businesses had health insurance which provided treatment for substance abuse. The business community is concerned that this will be as expensive as it is when only one business provides the coverage. Fortunately, this is not the case. In fact, improving substance abuse treatment can actually save money.

First, providing substance abuse treatment coverage is affordable. In a study done in 2001, the privately insured on average spent less than \$6 annually, for substance abuse.⁴ It is estimated that if a \$10,000 limit on substance abuse coverage was removed and employers offered treatment for substance abuse, the estimated cost would be 6 cents/worker per year.⁵

Second, when substance abuse treatment coverage is expanded and studies are done to compare use and

expense before and after coverage, there is minimal or no increase in expense. For example, when the federal government expanded coverage of substance abuse, there was no net increase in spending for this treatment for federal employees across the United States.⁶ Similarly, another evaluation of a state parity law found a reduction in use of substance abuse services after parity.⁷

Third, effective treatment of substance abuse can decrease the amount spent on other health costs. As a physician, I see firsthand the effects of untreated substance abuse and drug addiction. For the last 20 years, I regularly dealt with patients who damaged their overall health or particular parts such as their liver or other organs as a result of alcohol and drug abuse. Less apparent, but real is the associated spousal and child abuse in the homes of a parent with a substance abuse problem. And in 2007, a total of 978 people in Louisiana were killed in traffic crashes, 49% of which were alcohol-related—far above the national average of 41%.⁸

To address these problems, Senator Ben Nevers, himself a small business owner, and I co-authored legislation that would provide coverage to treat substance abuse and mental illness in insurance policies. This legislation provided for this important coverage and included a number of measures to address the concerns of businesses and industries about the cost of such coverage. The most important is that there would be a tax credit given to offset any increased premium costs that may result. This bill balanced providing coverage for employees and not increasing costs to businesses.

It would be good for businesses, good for employees and good for Louisiana. ❖

¹ U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. (2000). 1999 National Household Survey on Drug Abuse. Rockville, MD: U.S. Department of Health and Human Services.

² U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. (1999). Worker Drug Use and Workplace Policies and Programs: Results from the 1994 and 1997 NHSDA. Rockville, MD: U.S. Department of Health and Human Services.

³ Ibid.

⁴ Mark and Coffey, "The Decline in Receipt of Substance Abuse Treatment."

⁵ R. Sturm, W. Zhang, and M. Schoenbaum, "How Expensive Are Unlimited Substance Abuse Benefits under Managed Care?" *Journal of Behavioral Health Services and Research* 26, no. 2 (1999): 203-210.

⁶ HH Goldman, RG Frank, MA Burnam, et al. Behavioral Health Insurance Parity for Federal Employees. *New England Journal of Medicine* 354: 1378-1386.

⁷ M. Rosenbach et al., "Effects of the Vermont Mental Health and Substance Abuse Parity Law," Pub. no. SMA-03-3822 (Rockville, Md.: SAMHSA, 2003).

⁸ LSU's LA Highway Safety Research Group, 2007 Traffic Crash Report.

1957: Though seldom used, 27 states (not Louisiana) still have sterilization laws on the books.



1959: Psychiatry becomes a field requiring medical training.

Electronic Health Records

Making Prevention Easier and Health Care Quality Better

By: Tony Sun, MD



Publisher's Note:

Dr. Tony Sun will be leaving the capital area for a new post in Kansas City. The Healthcare Journal of Baton Rouge wishes him the very best in his future endeavors.

Information technology gives healthcare providers the opportunity to improve the efficiency and productivity of the practice while simultaneously improving the quality of care. Research reveals that preventative care and screening for breast cancer and colon cancer, and immunization for influenza and pneumonia, can all be significantly improved by the use of disease management methods such as physician prompts and other types of reminder templates. In two meta-analyses¹, computer reminders and prompts were shown to significantly improve preventive practices in such areas as vaccinations, breast cancer screening, colorectal screening and cardiovascular risk reduction.

Colorectal cancer is the second leading cause of cancer related deaths in the United States and in Louisiana. According to the 2006 Louisiana Health Report Card, 12,487 cases of invasive colorectal cancer were reported during the most recent data years of 1999-2003. Routine screening is known to assist in early detection, treatment, and prevention of the progression of breast and colorectal cancers. But results from the 2004 Behavior Risk Factor Surveillance System show that 43 percent of the adults in Louisiana over the age of 50 have not had either a home blood stool test or a flexible sigmoidoscopy exam in accordance with the U.S. Preventive Services Task Force guidelines. The failure rate was nearly five percentage points higher among the African American population.

1962: Ken Kesey publishes *One Flew Over the Cuckoo's Nest* based on his experiences working on a VA psychiatric ward.



1963: Hoffman LaRoche creates diazepam or Valium. Move toward deinstitutionalization.

The news is better regarding breast cancer, the most frequently occurring invasive cancer among women in the United States. The 2006 Louisiana Health Report Card states that nationwide, the death rate of breast cancer has decreased steadily since the mid-1990s, and this decline is attributed to both early detection and improved treatment. According to BRFSS data, currently in Louisiana, more than 78 percent of women aged 50-plus report receiving a mammogram, which exceeds the Healthy Louisiana 2010 goal of having at least 70 percent of these women screened within the preceding two years. However, according to Medicare claims data, in the Medicare population of females 65 plus, the screening rates are much lower. Only 49.16 percent in years 2005-2006, and most of the screenings occurred in the Caucasian female population (51 percent), while only 43.2 percent of African-American females received mammograms.

Louisiana does very well immunizing its seniors with the pneumonia vaccine. We rate first in the nation for pneumonia immunizations according to the 2006 State Snapshots report from the Agency for Health Care Research and Quality released in March 2008. Yet some of our most vulnerable citizens still suffer from respiratory diseases such as flu and pneumonia. 1,750 Louisiana residents are hospitalized and 500 die because of the flu each year, according to the Louisiana Office of Public Health Infectious Disease Epidemiology Section 2006 Annual Report. Louisiana is still 13th in the nation for deaths due to influenza and pneumonia, according to the Centers for Disease Control. A physician's recommendation has the most influence on a patient's use of preventive services. EHR reminder systems can assist physicians by ensuring that their patients receive the full array of preventive, acute, and chronic healthcare services.

Louisiana Health Care Review plans to recruit 60 physician practices in the next year that are prepared to use electronic health records technology to improve the efficiency and productivity of their practice while simultaneously improving the quality of care.

- Physicians will be introduced to the DOQ-IT University and other online tools for optimizing care management processes.
- LHCR will develop presentations and educational materials on using EHR capabilities and QIO interventions to improve preventive rates.
- Mail reminders can be generated by EHRs to generate reports on preventive services and to trigger healthy screening behaviors by patients.
- LHCR QI specialists will help practices organize nurse-led group meetings for targeted patient populations to provide beneficiary

education on preventive measures and encourage the use of EHR-generated personal patient profiles (patient-specific care plans).

By helping practices design and use patient-specific care plans and EHR reminder systems for targeted populations, physicians will be able to improve the rate of health behaviors undertaken in their patient populations.


For more information about the 9th Scope of Work Prevention Activities, contact Linda Harkey or Dr. Tony Sun at Louisiana Health Care Review, 225-926-6353. ❖

*Institute of Medicine of the National Academies, Committee on Data Standards for Patient Safety, Board on Health Care Services (2003). Key Capabilities of an Electronic Health Record System (Letter Report to Agency for Healthcare Research and Quality). Washington, DC: The National Academies Press.

This material was produced by Louisiana Health Care Review, Inc. (LHCR), the Medicare Quality Improvement Organization for Louisiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. LA8SoW1D108-O1726.

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1968: First doctoral program for clinical psychology.



1973: American Psychiatric Association removes classification of homosexuality as a disease except when it is profoundly disturbing to the individual.



HOSPITAL ROUNDS

St. Elizabeth Hospital Receives Gold Level Louisiana Hospital Quality Award

St. Elizabeth Hospital has received the Gold Level Louisiana Hospital Quality Award presented by Louisiana Health Care Review, Inc. (LHCR), the Medicare Quality Improvement Organization for Louisiana. The award was announced at the first Louisiana Health Care Quality Summit hosted by LHCR in Baton Rouge in April. With this award, St. Elizabeth Hospital has been recognized for improving the quality of healthcare given to its patients. St. Elizabeth Hospital is one of only six hospitals in the capital region to receive the 2007 Hospital Quality Award.

The Hospital Quality Award honors Louisiana hospitals that successfully implement quality initiatives directed toward

improving patient care in the hospital setting. The award recognizes those facilities that are actively engaged in improving care in one or more of the following areas:

- Acute Myocardial Infarction (Heart Attack)
- Heart Failure
- Pneumonia
- Surgical Care

The clinical topics measured for the awards have been designated as national healthcare priorities by the Centers for Medicare and Medicaid Services. Team members from St. Elizabeth Hospital have been working with quality improvement specialists from LHCR to use proven, evidence-based practices to improve care for their patients. St. Elizabeth Hospital was specifically honored for the quality of care to

1977: President Jimmy Carter establishes the President's Commission on Mental Health.



1978: Italy passes a law requiring mental facilities not to admit new patients. Schizophrenia diagnoses in that country almost disappear as a result.



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patients with Acute Myocardial Infarction (Heart Attack), Congestive Heart Failure, and Pneumonia.

Our Lady of the Lake and Mary

Bird Perkins Welcomes Brad Vincent, MD

The Cancer Program of Our Lady of the Lake and Mary Bird Perkins has welcomed Brad Vincent, MD. Dr. Vincent earned his medical degree from Louisiana State Medical School in Shreveport and completed his residency in Internal Medicine at the Medical University of South Carolina in Charleston where he served as Chief Resident. Most recently, Dr. Vincent completed his fellowship training in pulmonary and critical care medicine with special focus on lung cancer. Dr. Vincent specializes in minimally invasive lung cancer diagnosis and treatment of advanced stage lung cancer. He also specializes in benign diseases which damage the trachea and airways. Dr. Vincent is now accepting new patients.



Brad Vincent, MD

Baton Rouge General Family Medicine Residency Program Receives Blue Cross Grant

The Baton Rouge General Family Medicine Residency Program recently received a \$23,050 grant from the Blue Cross Blue Shield of Louisiana Foundation to fund the Challenger Program for Residencies. Baton Rouge General's Residency Program must implement assessment protocols to measure the progress of Family Medicine residents in core academic and professional competencies to ensure it maintains accreditation as a graduate medical institution. The Challenger program will aid in these efforts by examining student performance, tracking progress, and providing instruction for Family Medicine Residents. Challenger also focuses on improving resident scores on the American Board of Family Medicine's annual In-training and final board certification examinations.

Clinical Trials Now Available For Cancer Patients

The Cancer Program of Our Lady of the Lake and Mary Bird Perkins is now accruing patients for three featured trials including:

Colorectal cancer. For previously untreated metastatic colon or rectal cancer, this trial is testing the use of two previously approved drugs (Avastin® and Erbitux®) to see if combining them with more than one type of chemotherapy will produce a more effective treatment.

Lung Cancer. This trial investigates the use of Avastin® combined with standard chemotherapy as a follow-up to surgery undergone within the past 6-12 weeks to see if the new combination will be more effective than standard chemotherapy alone.

Breast Cancer. This trial seeks to determine if using letrozole for extended adjuvant therapy will keep women disease free for longer periods. The treatment is for postmenopausal women with estrogen receptor-positive or progesterone receptor-positive breast cancer who have completed five years of specific hormonal therapies.

In June 2007, the Cancer Program of Our Lady of the Lake and Mary Bird Perkins was one of only 14 sites in the country selected to participate in the National Cancer Institute Community Cancer Centers Program (NCCCP) pilot. A major goal of the NCCCP pilot is to enroll more cancer patients in clinical trials so that patients can benefit from the most advanced treatments without having to commute elsewhere. So together, participating



1979: Advocacy and support group National Alliance for the Mentally Ill founded. The Feliciana Forensic Facility is established at Jackson as a free-standing hospital for the custody, evaluation, and treatment of the mentally disordered offender.

hospitals are joining in an intensive, coordinated effort to increase enrollment in clinical trials. For more information on these clinical trials visit www.marybird.org/clinical-trials/ or www.ololrnc.com/cancer.

LSU Health System Surgical Facility Opens

The LSU Health System Surgical Facility, 9032 Perkins Road, in Baton Rouge, has opened for the provision of ambulatory surgeries and procedures in the areas of adult and pediatric otorhinolaryngology, gynecology, orthopedics, endoscopy, diagnostic radiology, and general surgery. The 49,641 square foot facility and accompanying 7,000 square foot office building will allow LSU's Earl K. Long Medical Center to strengthen services it already offers. EKLMC will redirect less acute patients to the ambulatory surgical facility, which will increase access and reduce wait times for acute inpatients and emergency department patients at the EKLMC main campus and for less acute patients at the outpatient facility.

The ambulatory facility will have four surgical suites and two procedure rooms. It will have a full radiology department with MRI and CT, which will double current access for EKLMC outpatient populations. The facility will have a staff of 60 to 75 for full operation and is on a bus line. An outpatient facility exclusively, it does not have an emergency room. In fulfillment of its mission of medical education, EKLMC will also provide medical training at the ambulatory facility. The facility will be used for clinical education of residents, nursing, and allied health students. It will have a fully equipped endoscopic training lab with anatomic models for surgical resident training. The surgical residency chief will operate and oversee the lab.



LSU completed the purchase of the facility from Dynacq Healthcare Inc. on December 17, 2007, for \$17,600,000. The purchase included the two buildings, all furniture, beds, monitors, and ancillary equipment. LSU purchased the radiology equipment separately. Structurally sound and in good repair, the facility required little to resume service, but LSU needed to meet all Department of Health and Hospitals licensure and regulatory requirements as well as state fire marshal requirements. LSU also had to implement policy, procedure, and product standardization. The outpatient surgical facility increases in the community the healthcare access of EKLMC, which has the LSU Mid-City Clinic and primary care clinics in the Jewel Newman and Dr. Leo S. Butler community centers. The North Baton Rouge Clinic is also under construction and will offer comprehensive primary care for adults.

Workout with the Wii at OLOL

Turn on the video game, grab the controller and start your workout! That's what many Our Lady of the Lake Regional Medical Center Rehab patients are doing with the help of a Wii gaming system donated by Best Buy on Millerville Road in Baton Rouge. "We started using the Wii for physical and occupational therapy about four months ago," said Lisa Russell, Director of Rehabilitation. "Our patients are really seeing the benefits of this type of therapy. It's hard work, but a lot of fun." The Wii is a video game and it helps patients rebuild balance, coordination, endurance, and upper and lower body strength. In addition, patients can work on fine or gross motor and visuoperceptual skills.

Not all patients are able to workout with the Wii. Each patient is evaluated by a therapist and if the Wii will help that patient develop or improve a particular skill set, the therapist will incorporate

1980: Number of hospitalized people with mental illness drops to 130,000 due to medications that no longer necessitate institutionalization. One third of the homeless considered to be mentally ill. DSM-III is published.



1987: Serotonin-specific reuptake inhibitors Prozac, Zoloft, and Paxil are developed to treat depression.

the video game into individual therapy sessions. "Patients who do use the Wii for therapy get a focused treatment session and at the same time enjoy friendly, competitive games like bowling, boxing, baseball, and perhaps even tennis," said Russell. "We are able to use it individually or with groups of patients. It's a great mix of work and fun and often allows the patient to be so caught up in the moment they 'forget' about their complications."

Tenreiro Named Chief Operating Officer

Edgardo Tenreiro has joined Baton Rouge General/General Health System as Executive Vice President and Chief Operating Officer. Previously, he worked with the NCH Healthcare System in Naples, Florida serving in a variety of executive and management positions including vice president of operations and vice president of cardiology and oncology service lines. While with NCH he also gained experience in other areas of hospital management including marketing, patient satisfaction, and business services. Tenreiro attended the University of Notre Dame, earning a Bachelor's degree in Economics, as well as a Master's degree in Business Administration.



Edgardo Tenreiro

Promise Healthcare, Inc. Establishes Promise Behavioral Health Division

Promise Healthcare, Inc., a leader in the long-term acute care (LTAC) hospital industry, is enhancing its current behavioral health services and expanding availability of those services to additional markets with its establishment of the Promise Behavioral Health (PBH) Division. PBH will help to ensure the delivery of high quality, cost-effective, acute inpatient and intensive outpatient behavioral health services to adults 18 years and older. Its mission is to enhance the mental health condition status of the communities it serves by providing leadership and management with a focus on comprehensive, appropriate, and quality driven inpatient and outpatient behavioral health services. It is in recognition of and response to growing demand that Promise Healthcare, Inc. has significantly increased and expanded its commitment to this type of specialized healthcare.

PBH will be led by behavioral health industry veterans Denise Dugas, as director of behavioral health, and Salina Creswell, RHIA, as assistant director of behavioral health. Their initial focus will be to assess and analyze the services, quality and delivery of care, marketing strategies, census, revenue, reimbursement, and operating expenses of the behavioral health locations at Promise Hospitals in Shreveport and Gonzales, Louisiana, and San Diego, California. They then will seek future inpatient and intensive outpatient program (IOP) opportunities within other Promise markets. This will include a dedicated IOP section at its newest LTAC hospital under construction in Vidalia, Louisiana.

Baton Rouge Physician Named to Ochsner Health System Board of Directors

Ochsner Health System has announced that Ralph Dauterive, MD, has been appointed to the system's board of directors, which oversees Ochsner's seven hospitals and 33 health centers throughout Southeast Louisiana. Dauterive, who has been with Ochsner since 1987, currently serves as the Head of the Department of Obstetrics and Gynecology at Ochsner Health Center and the Vice President of Medical Affairs for Ochsner Medical Center - Baton Rouge. Dr. Dauterive earned his medical degree from LSU in New Orleans and completed his internship and residency at Ochsner. He is board certified in obstetrics

1988: American Psychological Society created.



1989: Clozapine approved for treatment of schizophrenia.

and gynecology and is a fellow of the American College of Obstetricians and Gynecologists. Dauterive was one of the first physicians in the Baton Rouge area to perform gynecological surgeries using the da Vinci Surgical System and now trains physicians across the country on its use.

Baton Rouge General Nursing School Ranked No. 1

The Baton Rouge General School of Nursing, which has doubled in size within the last few years, was recently notified that it ranked as the top RN program in the United States. The school was ranked number one out of 818 schools nationwide for the percentage of graduates passing the National Commission of Licensing Exams (NCLEX) for Registered Nurses.

Baton Rouge Hospital Executive Receives Gold Heart Award

The American Heart Association presented its Gold Heart Award to Coletta Barrett, RN, MHA, Vice President of Mission of Our Lady of the Lake Regional Medical Center. The award is the highest honor the association gives to volunteers who have provided continued, distinguished service. The award was presented at the association's 2008 Gold Heart Banquet in Washington, D.C. Barrett was the association's chairman of the board in 2003-04 and a member of the Board of Directors from 1996 until 2006. She began volunteering for the organization in 1980 at the East Baton Rouge Division.

Barrett is a past chairperson of the association's Advocacy Coordinating Committee, Development Coordinating Committee, and the Integrated Task Force of the Strategic Planning Committee. The first registered nurse to serve as the association's chairman of the board, Barrett led the organization as it launched its groundbreaking Go Red For Women movement, which raises awareness of heart disease among women. She also co-authored the association's Answers By Heart program, a series of one-page sheets that explain cardiovascular disease topics to patients. In Louisiana, she has been a board member with the East Baton Rouge Division since 1980 and has led fund-raising events including the 2007 Baton Rouge Heart Walk and the 2001 Baton Rouge Heart Gala. She has also provided key support to association advocacy initiatives, meeting with state and federal legislators to discuss priority items including smoke-free legislation, cardiovascular research funding, and placement of automated external defibrillators in public settings.

Barrett continues to support the association as a Fellow of the Council on Cardiovascular Nursing and as a member of the Greater Southeast Affiliate Advocacy Coordinating Committee. She is a graduate of the Charity Hospital School of Nursing in New Orleans, received a bachelor's degree from Southeastern Louisiana University, and has a master's in healthcare administration from Tulane University School of Public Health and Tropical Medicine.

Local Ochsner Nurse Practitioner Named President-Elect of the American Nephrology Nurses' Association

Ochsner Health System is pleased to announce that Baton Rouge Nurse Practitioner Sue Cary, MN, APRN, NP, CNN, has been chosen as the President-Elect of the American Nephrology Nurses' Association (ANNA). Cary will serve a three year term as President-Elect, President, and Immediate Past President. During this time, Cary will assist in the overall strategic plan of ANNA, serve on the board of directors and follow national trends that may impact ANNA and its membership. Cary has been with Ochsner Health System for eight years. Since then, she has developed and implemented a chronic kidney disease program, supervised the nephrology ane-

1990: National Alliance for Research on Schizophrenia and Depression founded. Anti-psychotic drugs improve.

1991: Researchers begin identification of fragile X syndrome.



Ralph Dauterive, MD

nia clinic, preceptored nephrology nurse practitioners and students, in addition to caring for patients. Cary has been a member of the American Nephrology Nurses' Association since 1985, serving in several leadership roles and publishing articles in several national journals. She has received the Outstanding Member Award for ANNA's Fleur De Lis Chapter and was also named the Nephrology Nurse Educator of the Year. Cary was selected for and served on a task force for the Louisiana State Board of Nursing to examine the role of the Hemodialysis Nurse in Louisiana and served as committee chairman for the National Disaster Coalition. In addition, she has been recognized by the Baton Rouge Nurses' Association for nursing excellence.



J. Brannon Alberty, MD

OLOL Children's Hospital Welcomes J. Brannon Alberty, MD

OLOL Children's Hospital has announced the addition of Dr. J. Brannon Alberty, who is Board Certified in Pediatrics and Internal Medicine. He holds a bachelor's degree from Louisiana State University in Baton Rouge and earned his medical degree from Louisiana State University, Shreveport. He completed his residency in pediatrics and internal medicine at the University of Kentucky in Lexington. Dr. Alberty completed his fellowship in pediatric gastroenterology at Vanderbilt Children's Hospital in Nashville, Tenn. In addition, he earned a Masters of Science in Clinical Investigation from Vanderbilt University. Before joining OLOL, Dr. Alberty was an Assistant Professor of Pediatrics in the Division of Pediatric Gastroenterology at Kentucky Children's Hospital in Lexington. Dr. Alberty is now accepting new patients through physician referral. ❖

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Nurses of Excellence



Kristy Simmons, RN, CNOR
Woman's Hospital

“Kristy Simmons, RN, CNOR, graduated from Our Lady of the Lake College School of Nursing in 1981. She has worked as a surgical nurse for the past 27 years, with the last 23 years at Woman's Hospital. She has been certified in perioperative nursing for 17 years and has been an active member of the Association of Perioperative Nurses (AORN) for the past 20 years, serving as treasurer, board member, committee chair, and currently president elect of the Baton Rouge chapter # 1904. Kristy believes that as a professional nurse you should be actively involved in your nursing organizations in order to help make a difference for the future of nursing and for those individuals who are considering nursing as a profession.

1992: 7.2 percent of incarcerated Americans determined to be mentally ill.



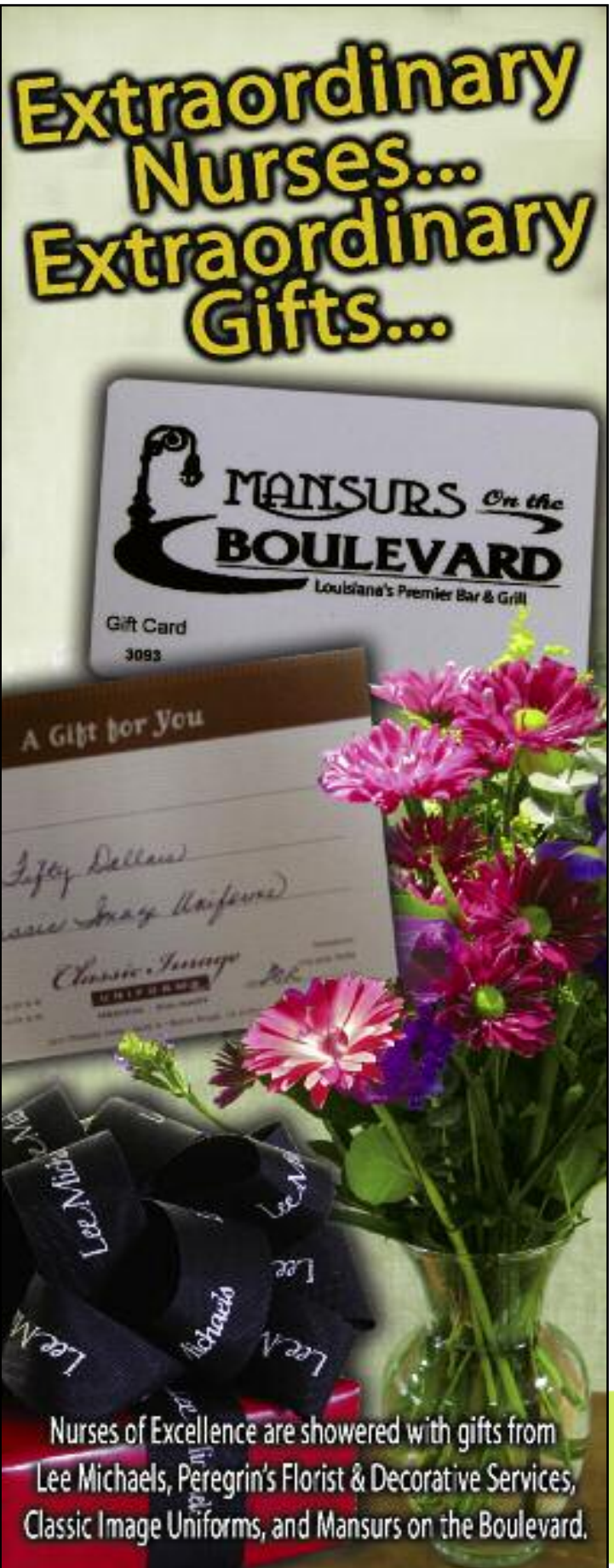
1994: DSM-IV published. Risperidone approved for schizophrenia treatment.

“Kristy serves as the Neonatal Intensive Care Unit (NICU) operating room resource nurse. She precepts other nurses who are learning to handle these types of pediatric cases. She was instrumental in the design of the current NICU operating room and is actively involved in the planning of the NICU operating room for the new hospital. She demonstrates compassion and understanding to the families who have required the services of the NICU operating room here at Woman's Hospital. She treats those infants as if they were her own and is incredibly meticulous about the preparation of the operating room. Kristy is presenting a seminar with a co-worker at the national AORN congress in Anaheim, California, this year on pediatric laparoscopy surgery. She has also submitted an article to the AORN journal for publication to help other facilities who are going in this direction with their minimally invasive pediatric surgeries.

“A recipient of the Crystal Apple award in 2005 for outstanding volunteer in the public schools and the Louisiana State Nurse's Association Nightingale award for outstanding community service in 2006, Kristy also set up the perioperative outreach program eleven years ago to introduce elementary, middle, and high schools to the nursing profession. She even manages to talk her fellow operating room nurses into spending a day in a classroom with students to unveil the mysteries surrounding surgery and to inform them of what goes on behind those closed doors. Kristy is currently working on her BSN and plans to obtain her Masters degree in nursing in order to teach nursing in the future.”

Laura Brown, RN, BSN
Deena Rabalais, RN, BSN
Our Lady of the Lake Regional Medical Center

“Some people may call them heroes, others heroines, but I prefer ‘Earth Angels.’ Laura Brown and Deena Rabalais are house managers (HMs) at OLOL. They respond to Code Blues and are members of our Medical Emergency Team, saving lives inside the hospital. But earlier this year, Laura and Deena had an opportunity to save a life outside the hospital. They were riding together following Laura's stepfather's funeral on Range Avenue in Denham Springs when they passed a very bad automobile accident. They both saw numerous people directing traffic but no one assisting the person in the small car that was broadsided. Deena told Laura, 'He does not look good.' They immediately stopped their car and ran to the injured man. When they got to him a



2002: New Mexico allows psychologists to prescribe medication.

2003: Global spending on ADHD medicine is \$2.4 million with U.S. taking the lion's share.

lady was praying very fervently for him. They asked her to continue praying, but to move out of their way so they could assess him. The man was bleeding profusely from his mouth, nose, and ears and was pinned in the car. Laura yelled for the policeman to help get him out of the car as Deena cleared his airway. They were told that EMS would arrive shortly. Meanwhile Laura was unable to find a pulse on the man. She

Soon after, we began to hear stories about the two nurses who had stopped to save a life but no one was able to identify them. On Thursday, Mark's wife, Joy, spoke with the police officer who had responded to the accident. He told her that they had already considered Mark a fatality when the two nurses arrived. He gave Laura and Deena's names to Joy who just happens to be best friends with our Divisional Nursing



started chest compressions as Deena maintained an open airway. An anonymous nursing student also stopped and assisted. When EMS arrived, Laura and Deena got out of the way and left the work to them, never sure if the man had survived or not.

“Laura went to get her hair cut later that week. The hairdresser shared with her how upset her mother was over an accident where she had prayed for the victim and still wondered if he had survived. Amazed by the coincidence, Laura explained that she was there as well.

“Mark, the man in the accident, was received by our trauma team and admitted to TNCC with very extensive injuries.

Director for Cardiology, Rachel Tidwell. Rachel called me that night to ask if I knew the nurses. I told her that they were our HMs and that they would be at work on Friday morning.

“That day, Rachel and I had the pleasure of introducing Laura and Deena to Joy. At the introduction we learned that Mark and Joy are critical care nurses. Mark is a Major in the army who survived an 18 month stint in Iraq, where he set up a critical care unit in a Baghdad hospital. He is a bronze star recipient. Laura asked if she could let the woman who was praying (her hairdresser's mother) know that he was alright. Joy said we could feel free to share their story with anyone as she now considered Deena and Laura family. We are very proud to claim them as members of our family, too.” ❖

2004: U.S. Census indicates that 57.7 million Americans suffer from a diagnosable mental disorder. That same year, 32,439 die as a result of suicide.



2005: Hurricane Katrina simultaneously incapacitates Charity Hospital's 98-bed psychiatric unit and creates untold mental stress on the city and its surroundings.

Around The Town



Baton Rouge General's Pennington Cancer Center sponsored a Minority Cancer Awareness Breakfast for the community at the hospital's Mid City campus. Left to right, Chris Gatlin, RN, OCN, MHA, Director of Pennington Cancer Center Inpatient Oncology; Baton Rouge Police Chief Jeff LeDuff; and Zack Smith, RT, MBA.

The Excalibur Club recently recognized Ochsner Medical Center-Baton Rouge volunteer Glenda Accardo with the Volunteer of the Month award. Left to right: William Snider, Excalibur Club Member; Glenda Accardo, Ochsner Medical Center-Baton Rouge Volunteer; LaMaryllis Newman, Ochsner Medical Center-Baton Rouge Volunteer Services Manager.



Mayor Kip Holden poses with staff and volunteers of the Cancer Program of Our Lady of the Lake and Mary Bird Perkins, who, with the help of Southern University, Woman's Hospital and YWCA ENCORE plus, provided screenings as part of National Minority Cancer Awareness Week.

Alzheimer's Services of the Capital Area's Memories in the Making luncheon. Left to right Beth Veazey, Executive Director; Fred and Connie Schneider; Charlie Lamar, Past Board President; Charles Valluzzo, Board Member.



2007: NIMH estimates that 9 percent of U.S. adults have a personality disorder. Rates of bipolar disorder diagnoses in adolescents increase exponentially. Male veterans demonstrate double the suicide rate of the general population.



2008: Mental Health Insurance Parity legislation seeks to give mental conditions as much weight as physical ailments in terms of coverage. Schizophrenia linked to simultaneous defects in several genes. Governor Bobby Jindal boosts budget to address N.O.'s mental health crisis.

Ochsner Medical Center-Baton Rouge recently dedicated the hospital's new Interfaith Chapel. Left to right: Jay Brooks, MD, Ochsner Medical Center-Baton Rouge Chief of Staff; Willie Talbert, Evangelist, Remnant of God C.O.G.I.C; Abbot Thich Dao Quang, Tam Bao Temple; Father Tom Ranzino, St. Jean Vianney Catholic Church; Emad Nofal, Chairman of the Board, Islamic Center; Brother Tommy Middleton, Woodlawn Baptist Church.



In recognition of National Volunteer Week, Ochsner hosted its Volunteer Appreciation Luncheon at Lake House Reception Center. From left to right are volunteers Sally Womack, Lorena Long, Georgie Durel, Brigid Durel, Ruth Newcomer, Jeanie Streat, Renee Erwin, Glenda Accardo.

Over a hundred of Dr. John R. Clifford's closest friends and colleagues recently honored him for 32 years of dedicated service as a neurosurgeon at The NeuroMedical Center. Pictured (left to right & back to front): Dr. Shawn Dunn, Dr. Joseph Acosta, Dr. Allen Joseph, Dr. Martin Langston, Dr. Allen Proctor, Dr. Kelly Scrantz, Dr. Scott Nyboer, Dr. John Nyboer, Dr. Glenn Anderson, Dr. Paul Dammers, Dr. John Clifford, Nancy Kelly (CEO), Dr. Tom Flynn, and Dr. Carolyn Baker.



Caille's Crew from The Imaging Center of LA. at the MS Walk.



Talented local artist Betsy Williamson at the Bienville Street Studio. Also shown, Christy Lee Gandy, RN; Ray Corona, MD; and Jason Hanks perform at a "Hot Art, Cool Nights" event at the studio.



Sources: National Institute of Mental Health, www.nimh.nih.gov; "Diseases of the Mind," U.S. National Library of Medicine, 09/27/2006, National Institutes of Health; "Timeline Mental Health," Aetna IntelliHealth, www.intellihealth.com/IH/intlH/EMIHC270/8271/9110/203628.html?d=dmContent; Carr, Margreta, "A Timeline in the Treatment of Madness," 2006, The Society for Laingian Studies, www.laingsociety.org/cetera/timeline.htm "Timeline: Treatments for Mental Illness," "A Brilliant Madness, PBS American Experience, www.pbs.org/wgbh/amex/nash/timeline/index.html; Roberts, Andrew, "Mental Health History Timeline," Middlesex University, www.mdx.ac.uk/WWW/STUDY/mhhtm.htm; Street, W.R., "A Chronology of Noteworthy Events in American Psychology," American Psychological Association, Addenda, 1994, Washington, D.C.



RESOURCE GUIDE

The individuals and companies listed in the **HJBR Resource Guide** are supporting the *Healthcare Journal of Baton Rouge* and are committed to supporting those in the Baton Rouge area healthcare field.

To be listed in the HJBR Resource Guide, call 225.302.7500.

Adult Day Care

Baker Wellness Adult Day Health Care 225.778.1567
2402 Main St., Baker, LA 70714
bmh@bmh.brcoxmail.com

Airport

Baton Rouge Metropolitan Airport 225.355.0333
9430 Jackie Cochran Dr.
Baton Rouge, LA 70807
www.flybr.com

Alzheimer's Services/Support

Alzheimer's Services of the Capital Area 225.334.7494
3772 North Blvd.
Baton Rouge, LA 70806
www.BRhope.com

Art Galleries

Elizabethan Gallery 225.924.6437
680 Jefferson Hwy.
Baton Rouge, LA 70806
www.elizabethangallery.com

Attorneys

McGlinchey Stafford 225.383.9000
14 One American Place
Baton Rouge, LA 70825
www.mcglinchey.com

Audio Visual

Audio Video Results 225.755.2100
11931 Industriplex Blvd.
Suite 700
Baton Rouge, LA 70809
www.avresults.com

Woofers Home Theater 225.757.6615
14241 Airline Hwy., Suite 108
Baton Rouge, LA 70817
www.woofershometheater.com

Automotive (Dealers)

Paretti Jaguar of Baton Rouge 225.756.5247
11977 Airline Hwy.
Baton Rouge, LA 70817
www.paretti.com

Automotive (Tire and Car Care)

Treads & Care 225.647.9631
1312 W. Hwy. 30, Gonzales, LA 70737

Treads & Care 225.368.1234
10711 Coursey Blvd.
Baton Rouge, LA 70716

Catering

Southern Belle Sandwich 225.927.4670
1969 N. Lobdell Ave.
Baton Rouge, LA 70806
www.southernbellesandwich.com

Cleaners

Sunshine Cleaners 225.753.4060
16645-A Highland Rd.
Baton Rouge, LA 70810
www.sunshinecleaners.net

Consulting

HealthCare + Business Consulting
Phillip H. Rees 225.767.9577
7474 Highland Rd., Baton Rouge, LA 70808
www.HCBconsulting.com

Diabetic Supplies

HealthCare 1 225.355.5880
6547 North Foster Dr.
Baton Rouge, LA 70811
sales@healthcare1la.com

Financial Services

Campus Federal 225.769.8841
6230 Perkins Rd., Baton Rouge, LA 70808
www.campusfederal.org

Capital One 225.381.2303
440 3rd St., Baton Rouge, LA 70802
www.capitalonebank.com

Florist

Peregrin's Florist & Decorative Services, Inc. 225.761.0888
8883 Highland Rd.
Baton Rouge, LA 70808
www.peregrinsflorist.com

Gastroenterology

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Baton Rouge, LA 70809
www.dhcla.com

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www.audibel.com

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Hospitals

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www.lanermc.org



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www.promisehealthcare.com

St. Elizabeth Hospital 225.647.5000
1125 West Hwy. 30, Gonzales, LA 70737
www.steh.com

Imaging

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Baton Rouge, LA 70809
www.imagingcenterofla.com

Insurance

Employees Insurance 225.273.1471
2645 O'Neal Ln., Bldg. B, Suite A
Baton Rouge, LA 70816
www.employeesinsurance.com

Louisiana Health Plan 225.926.6245
P.O. Box 83880 Baton Rouge, LA 70884
www.lahealthplan.org

Medical Uniforms

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Baton Rouge, LA 70809
www.classicimageuniforms.com

Uniforms Etc. USA 225.248.1333
7767 Tom Dr., Baton Rouge, LA 70806

Neuromedical

The NeuroMedical Center Clinic 225.769.2200
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Baton Rouge, LA 70810
www.TheNeuroMedicalCenter.com

Nursing Home

CommCare Corporation 877.277.3859
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Baton Rouge, LA 70811
www.commcare.com

Office Equipment and Supplies

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11310 Industriplex Blvd.
Baton Rouge, LA 70809
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Ophthalmology

Dr. Angela Lewis Louisiana Eye Center, A.P.M.C. 225.356.2655
7855 Howell Blvd.
Suite 130A
Baton Rouge, LA 70807

Pharmaceuticals

Gulfcoast Pharmaceutical Specialty 800.498.5220
1039 E. Hwy. 30
Gonzales, LA 70737
www.gpspharmacy.biz

Physical Therapy

Peak Performance Physical Therapy 225.295.8184
11320 Industriplex Blvd.
Baton Rouge, LA 70809
www.peakphysicaltherapy.com

Real Estate

C.J. Brown Realtors-Tom Bhramayana 225.933.8942
4314 S. Sherwood Forest Blvd.
Suite. 100
Baton Rouge, LA 70816
www.tombahama-mama.com

Restaurants

French Market Bistro 225.753.3500
6645 Highland Rd.
Baton Rouge, LA 70810
www.mansursontheboulevard.com

Mansurs on the Boulevard 225.923.3366
5720 Corporate Blvd.
Baton Rouge LA 70808
www.mansursontheboulevard.com

Skilled Nursing Facility

CommCare Corporation 877.277.3859
5550 Thomas Rd., Baton Rouge, LA 70811
www.commcare.com

Vascular Clinics

CVT Surgical Center 225.766.9212
7777 Hennessy Ave.
Suite 1008, Baton Rouge, LA 70808
www.cvtsc.com

Total Vein Care 225.761.8119
8595 Picardy Ave., Suite 320
Baton Rouge, LA 70809
www.totalveincarelouisiana.com

Vascular Clinic 225.767.5479
5425 Brittany Dr., Suite B
Baton Rouge, LA 70808
www.vasclin.com

Wines and Spirits

Calandro's Select Cellars 225.383.7815
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