

## On the CUSP of culture change

Making patient safety, quality a shared priority.

By Cindy Sanders

Mistakes happen.

For many years that was the conventional wisdom in healthcare settings, but innovative programming from the Agency for Healthcare Research and Quality (AHRQ) shows mistakes don't have to happen if everyone is on board to make safety and quality a priority.

James Battles, PhD, a social science analyst with AHRQ's Center for Quality Improvement and Patient Safety, noted the Comprehensive Unit-based Safety Program (CUSP) is an example of how to change the culture to achieve dramatic results.

Battles, who has worked in the field since the mid-1990s, was focused on patient safety even before the landmark Institute of Medicine Report, "To Err is Human," was released in November 1999. The report became a catalyst for the creation of intervention strategies to avert medical errors. A year after its release, Battles became the first expert hired by AHRQ to focus strictly on patient safety initiatives.

### Roots of CUSP

By 2001, AHRQ began funding the work of Peter Pronovost, MD, PhD,



"We miraculously thought just providing the information would lead to change."

— James Battles, PhD, a social science analyst with AHRQ's Center for Quality Improvement and Patient Safety

the renowned patient safety advocate with Johns Hopkins. The roots of CUSP can be found within that early work. In 2003, a large-scale demonstration project for CUSP focused on CLABSIs (central line-associated blood stream infections) was underway.

The unique partnership between AHRQ, the Health Research & Educational Trust (HRET), Johns Hopkins University Quality and Safety Research Group, the Michigan Health & Hospital Association's Keystone Center for Patient Safety & Quality and more than 1,000 U.S. hospitals yielded dramatic outcomes. Battles said the national program has resulted in a 41 percent decrease in CLABSI

rates among participants.

"We've prevented nearly 500 deaths and averted nearly \$36 million in costs—and that's a conservative estimate," Battles noted.

### New CUSP Programs

Building on that success, other CUSP programs have been launched with similar results. The next, Battles noted, is a new national CUSP program in the area of labor and delivery. The Perinatal Safety Improvement Program is expected to roll out this fall.

CUSP is a strategic intervention that integrates communication, leadership and teamwork to create a culture of safety. The program utilizes evidence-based strategies and includes training tools, standards for consistent measurement, leadership engagement and methods to improve teamwork among physicians, nurses and others impacting the safety and well-being of patients.

"The CUSP model is designed for a unit of care, but that unit of care can be anything. CUSP itself is an intervention strategy, and then the areas where you apply it are the targets of CUSP," Battles explained. Based on the success seen in demonstration projects, he continued, "We are 'CUSP-izing' everything."

Continued on page 3

### The case for integrated care

Our healthcare delivery system has been broken for quite some time. The rising cost of healthcare has driven policy and decision makers to come up with a fix.

Read more on page 11

### Myths of mental illness

Myths and stereotypes have long fueled the fear and prejudice that keep us from truly being a compassionate and healthy society. Some will argue that recent years have witnessed a decline in prejudice against people of different races, faiths or sexual orientation, the myths concerning people with a severe mental illness have flourished.

Read more on page 14

### Autism Spectrum Disorder just as complex, varied as treatments

Autism is a brain-based developmental disorder that is part of a group of complex disorders classified as Autism Spectrum Disorders (ASD). Children with autism demonstrate restricted or repetitive patterns of behavior, interests or activities in addition to these other difficulties.

Read more on page 16

### Special Legal Series: HIPAA Final Rule What's a covered entity supposed to do?

This is part one of a four-part series of updates summarizing the HIPAA Final Rules and addressing implementation concerns that many organizations may encounter.

Read more on page 26

## ABOUT THIS ISSUE

### Behavioral Health

This month Medical News presents its Behavioral Health issue—with a twist. *Medical News'* first-ever guest editor, Anthony M. Zipple, Sc.D., president and CEO, Seven Counties Services, Inc., helped develop and manage the editorial for the issue. Our comprehensive coverage includes features about autism, mental illness myths, legislative issues, mood disorders and integration success stories. We even included a special behavioral health news section in our News in Brief department.

Articles begin on page 11



# MEDICAL NEWS

The business of healthcare

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For the first time in *Medical News*' history we turned over the reins to a guest editor, Anthony M. Zipple, Sc.D., president and CEO, Seven Counties Services, Inc. We are grateful for the expertise, guidance and time Zipple and his staff donated to make this issue a success.

## Letter from the guest editor

### The changing world of behavioral health

Historically, behavioral healthcare—the term commonly used to refer to mental health and addictions treatment and services—has been one of the more undervalued specialties in the industry. That's about to change. Emerging and compelling research, combined with practice and access changes driven by the Affordable Care Act and Medicaid expansion are likely to propel behavioral health services into the forefront of medicine. Evidence of this movement will be found in at least five trends I expect to witness in the near future.

- 1. Deeper integration of behavioral health into primary care and the establishment of health homes for high cost/high risk populations.** The Affordable Care Act and our evolving knowledge of services for people with the most severe illnesses will force primary care settings to become more skilled in behavioral health as individuals with mild to moderate behavioral health conditions look for services in generalist settings. While people with very high cost and very high-risk behavioral health conditions will do better with treatment in specialty behavioral health practices that integrate primary care into the practice. A health home model, where behavioral health and general medical care for this population is coordinated through a behavioral health home, will emerge as a best practice.
- 2. Expanded use of evidence-based practices.** The past two decades have seen a dramatic expansion in the availability of effective, well-researched, evidence-based practices for treating behavioral health conditions. These include cognitive and behavioral strategies for depression and anxiety, better medication algorithms, specialized pediatric services and supported employment, assertive community treatment, cognitive behavioral treatment for psychosis and others. Increasingly, providers will be expected by payers and patients to provide services demonstrated by the research literature to provide the best outcomes.
- 3. Increased use of behavioral health interventions to reduce medical expenditures.** Evidence suggests that a significant portion of medical expenditures is driven by undertreated or untreated behavioral health conditions, like anxiety and depression. We could avoid visits to primary care and even specialty care if the underlying behavioral health conditions were properly treated. Improved access to behavioral health treatment creates positive returns on investment in lower utilization and costs in other healthcare segments.
- 4. More attention to early mortality in behavioral health populations.** Seven years ago a nationwide study revealed that persons with severe mental illnesses typically die 25 years earlier than the general population. About two-thirds of this early mortality is the result of treatable conditions: tobacco use, obesity, hypertension, high blood pressure and high cholesterol. While we know the people with severe mental illness are at much greater risk for these conditions, we were slow to develop aggressive efforts to address these medical conditions. We can and must do better. Integrated health homes have great potential value to reverse this trend.
- 5. Diminishing institutional care.** Hospitalization, residential treatment, nursing home use for behavioral health conditions, personal care homes, and other institutional approaches to serving adults and children with behavioral health conditions are often unnecessary if we have a robust and effective network of community behavioral health services. Kentucky spends a disproportionate level of resources on institutional care. We can do better for our patients and taxpayers by aggressively expanding the use of community services and reducing high-cost institutional alternatives.

The next several years will be challenging for all branches of medicine. The period ahead also poses a tremendous opportunity to rethink and restructure services to better meet patient needs at a lower cost. Behavioral health services, particularly low cost, easily accessible, and integrated services, are important elements of this effort.



Sincerely yours,  
Anthony M. Zipple, Sc.D.  
president and CEO, Seven Counties Services, Inc.



**Anthony M. Zipple**  
president and CEO, Seven  
Counties Services, Inc.

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COVER STORY

# On the CUSP of culture change

Continued from cover

## Previous Approach to Safety

Previously, Battles said, the traditional approach to safety was to measure results—good or bad—and publish the information. “We miraculously thought just providing the information would lead to change.”

What’s different about CUSP is the level of engagement of the entire team—from housekeeping all the way up to the CEO.

“Everybody has to have a shared ownership of risk. If they don’t own that risk and don’t share in the solution, you’re not likely to change,” said Battles.

## How to CUSP-ize

To apply CUSP, the team looks at the area of concern, identifies the risks and begins to pinpoint solutions to avert or circumvent those risks. Through CUSP, the staff is educated on the science of safety and given the tools to utilize, such as checklists, to improve teamwork and processes. A senior hospital executive also partners with the unit to improve communi-

To apply CUSP, the team looks at the area of concern, identifies the risks and begins to pinpoint solutions to avert or circumvent those risks.

cations up the food chain so that the leadership is engaged in supporting the culture of safety.

Battles said the unit could range from an ICU team, a med-surg floor, an ambulatory surgery center or an entire skilled nursing facility. It could also potentially be broadened to include new methods of care delivery, such as ACOs, but might need to be tweaked a bit.

No matter the setting, using the principles of CUSP allows for a culture change and measurable improvement.

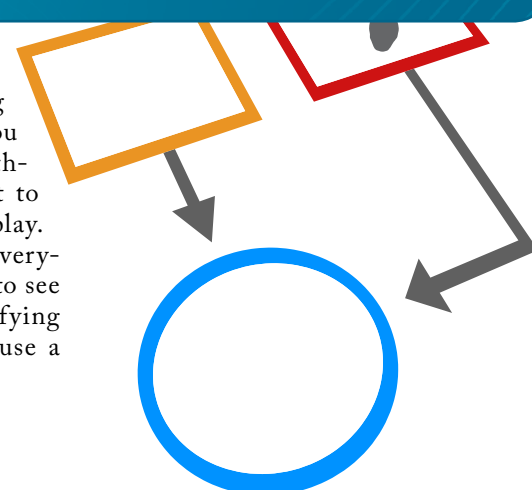
However, CUSP isn’t a magic bullet. “You’ve got to work at it, and you have to work really hard,” Battles said.

## Learning More About CUSP

A basic CUSP toolkit is offered on the Agency for Healthcare Research and Quality web site. The materials — which include videos, Word documents and Power Point displays — are available to download at no charge at [www.ahrq.gov/cusptoolkit](http://www.ahrq.gov/cusptoolkit).

“If you’re interested in improving patient care and delivering the best care to your patients, you can make improvements—and rather dramatic ones—but you’ve got to work at it, and everybody has to play.

The amazing thing is when everybody does get on board and start to see the changes; it’s immensely satisfying because no one ever wants to cause a patient harm.”



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# Pay or play?

## Employers weigh ACA coverage options, requirements.

By Cindy Sanders

*It's here.*

Somehow between years of political pontificating and awaiting court decisions, implementation of major components of the Affordable Care Act (ACA) seemed to be somewhere off in the distant future. But that distant future has drawn near—2014 is just around the corner, and ACA stands as the law of the land.

Last month, the American Health Lawyers Association hosted “Inquiring Minds Want to Know — How to Plan Now for Healthcare Reform in 2014,” a webinar focused on employers’ options and requirements for their health benefits plan.

A trio of health law experts — including Carolyn E. Smith, counsel in the Washington, D.C. office of Alston & Bird, LLP — focused on employer pay-or-play penalties, the advent of exchanges and premium subsidies and reform requirements for employer plans effective next year.

As Smith noted, “A year is not much, and the way the timeline is set up, it’s really October for the start of the exchanges and the enrollment process so it’s really less than a year.”

Of course, she continued, most employers have tried to look ahead and make plans. “It’s game-changing rules,” she said of ACA. “It definitely changes the things employers need to consider in making their decision as to the health benefits they provide employees.”

### Key Issues

Heading into 2014, Smith said the key issues facing employers are how to structure their benefit plans, who they will cover and what contribution the employer will make toward the cost of that coverage. “Those questions have always been there,” she said.

However, Smith continued, “What healthcare reform does is two main things that change the decision-making metrics for employers 1) the existence of the exchange and 2) employer pay-or-play penalties.”

Prior to ACA, the individual health market had not been very well developed so there were limited options for coverage outside of employee-sponsored benefits. Now that the option will exist for employees to be able to purchase coverage, will employers opt out?

Smith said there were originally a lot

of predictions that everyone would simply drop coverage and pay penalties. While there is clearly a financial tipping point that employers have to consider, more goes into the decision. Some companies see offering coverage as a competitive advantage to attract high-value employees, many already offer coverage that meets federal requirements and will continue with little change, some might feel an obligation to provide coverage even if it isn’t the optimal financial decision for the bottom line.

The punitive side of the equation became a little clearer when the proposed rule for employer penalties was released on Dec. 28, 2012 and published in the Federal Register on Jan. 2, 2013 ([www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf)). Additional information on the penalties is also found on the IRS’ ACA site under the heading “Employer Shared Responsibility Payment” ([www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions](http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions)).

“Not all questions are answered, but we do have far more comprehensive guidance than we had previously,” Smith said.

### Small Employers vs. Large Employers

The first consideration for any employer is whether or not they are required to provide coverage. Smith said the law exempts employers with fewer than 50 full-time equivalent employees from the penalty structure. She added the statutory definition of FTE has been set as 30 hours per week. However, Smith noted how that plays out in the real world raises a lot of questions, particularly for companies that have heavy seasonal employees.

One pleasant surprise for large employers is how the penalties will be calculated when a company has different controlled groups. In determining whether or not an employer is required to provide coverage, the company is viewed as a single entity.

However, when it comes time to calculate penalties, each controlled group is viewed separately. The benefit is that a large parent company with a number of subsidiaries would only be assessed penalties on the parts of the business that are not in compliance with ACA as opposed to paying the penalty rate times the total number of employees under the corporate umbrella, Smith explained.

Another concern for companies was

Prior to ACA, the individual health market had not been very well developed so there were limited options for coverage outside of employee-sponsored benefits. Now that the option will exist for employees to be able to purchase coverage, will employers opt out?

that penalties might be imposed across the board if a full-time employee or dependent was inadvertently missed. “The proposed rules have a five percent leeway,” said Smith. “If you offer coverage to 95 percent, then no penalty is imposed.”

### A & B Penalties

So what exactly are the penalties? Smith said there are actually two penalties, typically referred to as A & B penalties, which are based on the failure to offer adequate coverage. “These penalties are mutually exclusive. You’ll never be hit with both,” she said.

The first is the \$2,000 per full-time employee assessed to companies required to offer coverage that opt not to do so. The B penalty, which is generally lower, is calculated as \$3,000 times the number of employees who get a subsidy to purchase insurance on the exchange, and it cannot exceed what a company would have paid had they been assessed the A penalty.

“Even if you offer coverage, you can be subject to this B penalty if coverage doesn’t meet the minimum value or isn’t affordable,” said Smith. She added that at a minimum, plans must pay 60 percent of benefits.

### Corporate Strategy

One possible corporate strategy might be to offer coverage but at a higher premium to minimize penalty exposure. In this case the company would pay B penalties for those who would qualify for subsidies.

Another consideration in this strategy, of course, would be how many employees fall at or below the 400 percent of the fed-

eral poverty level threshold that qualifies for subsidies. If a company has a small percentage in this category, this strategy could be financially appealing.

Interestingly, Smith said one factor that might drive employers away from offering corporate coverage is how efficient the state and federal exchange program turns out to be. “If it works well, then over time employers may shift to exchange coverage,” she said.

### Reinsurance Contribution

While many are aware of major tenets of the 2014 reforms — no exclusions based on pre-existing conditions, guaranteed renewability, modified community ratings — one added cost has flown under the radar for many.

“One of the things we’ve found that has been a sleeper for employers, particularly those with self-funded plans, is this fee called the ‘reinsurance contribution,’” said Smith. Many employers assumed it was only tied to the exchange. In fact, it applies to almost every health plan.

For three years beginning in 2014, employers will be assessed approximately \$63 per member in the health plan. “The money is collected and paid out to insurers covering the individual market. It redistributes risk, paid for by this reinsurance contribution, to help stabilize the individual market,” Smith said.

Although employers have submitted comments to HHS opposing the fee, the expectation is that it will remain a requirement.

With the clock ticking, employers must make some quick decisions about benefit packages. Smith noted very small employers would be exempted from the task since they aren’t subject to ACA requirements, and large employers already have many consultants with whom they regularly work to help guide them through the next few months. “The middle-sized employers are going to be the ones who are going to need a little more help now making these financial decisions and running the numbers.”



Additional information on penalties can be found on the IRS’ ACA site under the heading “Employer Shared Responsibility Payment” ([www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions](http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions)).

PEOPLE *in brief*



SHAMS



YASSINE

**Baptist Medical Associates**

Mitra Shams, MD, joined Baptist Medical Associates Prospect.

Lina Yassine, MD, endocrinology, has joined Baptist Medical Associates.

**Floyd Memorial**

Dr. Juan Ortiz joined the Cardiology Center of Southern Indiana.

Ifeoma Roseline Okeke, MD, joined the Floyd Memorial Cancer Center of Indiana.



OKEKE



COUCH



JOLLY

**Georgetown Community Hospital**

Rickey Myhand, MD, formed Central Kentucky Oncology & Hematology, located at Georgetown Community Hospital.

Lon Keith, MD, joined Georgetown Community Hospital.

**Hospice of the Bluegrass**

Hospice of the Bluegrass announced that Monica Couch has been named associate vice president of Eastern Kentucky Operations.

Paul Sluss has been named site director for the Hazard office of Hospice of the Bluegrass.

**Seven Counties Services**

Kay Jolly has been elected to the Seven Counties Services, Inc.'s board of directors.

**Sullivan University**

Amber Cann, PharmD, MBA, joined the College of Health Sciences as assistant professor and director of the Drug Information Center.

**Western Kentucky University**

Leta Whited, PMHNP, joined the Western Kentucky University Health Services staff.

**To Submit to People In Brief**

Each month, *Medical News* recognizes newly hired or promoted professionals who work in the business of healthcare in Kentucky or Southern Indiana. To be considered, the employee must work in or directly support a healthcare business. Listings will be published in order of receipt as space allows and not all photos will be published.

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# Behavioral health news across Kentucky

## St. Elizabeth Healthcare expands chemical dependency program

In response to a community need to offer outpatient services that address the mental health needs of substance abuse patients in one setting simultaneously, St. Elizabeth, Edgewood, Ky., will expand its chemical dependency intensive outpatient program. Under this dual-diagnosis approach, patients will be treated by licensed independent therapists trained to address both issues on a holistic basis.

“Treating addiction successfully is very complex,” said Anthony Alvarez, MD, medical director of behavioral health at St. Elizabeth Healthcare. “I have seen many individuals struggle with these issues during my career. Approximately 50 to 70 percent of persons with dependency issues have a mental health diagnosis too. Now patients have a much-needed resource that not only treats their addiction,



but also the co-occurring diagnosis and issues beneath it.”

### Decision to Expand

Before the decision to expand the Edgewood program, focus groups were conducted with individuals, representing patients and community members which collectively stated that outpatient services addressing mental health and substance abuse simultaneously were desperately needed in the community.

No longer will only mental health issues or chemical dependency issues be treated at different locations. Each patient’s unique needs will be addressed at one location in one intensive outpatient program.

## Kentuckians’ views on integrating healthcare

New poll data indicates that the majority of Kentuckians favor healthcare providers offering physical and mental health services in the same place. Some Kentucky providers now offer their patients physical and mental or behavioral healthcare in a coordinated, convenient way, offered in the same place.

The Kentucky Health Issues Poll (KHIP) found about seven in ten Kentucky adults (69 percent) either strongly or somewhat favor such an integrated approach.

### KHIP survey highlights include:

- Thirty-five percent strongly favor offering physical and mental

health services in the same place.

- Thirty-four percent somewhat favor offering physical and mental health services in the same place.
- Kentucky adults earning less than 100 percent of the federal poverty level were more likely than those with higher incomes to strongly favor integrated care (44 percent).
- Democrats (43 percent) were more likely to strongly favor integrated care than Republicans (28 percent) or Independents (34 percent).

To download the full report visit [healthfoundation.org/kentucky-health-issues-poll](http://healthfoundation.org/kentucky-health-issues-poll).

## KY cuts child care programs

The Kentucky Department of Community Based Services recently reported that it will soon help fewer families pay for child care and dramatically cut a program that pays relatives who are caring for children

taken from their parents.

Audrey Tayse Haynes, secretary for the Cabinet for Health and Family Services, said the cuts come after years of attempts to cope with decreased federal and state funding—a projected

\$86.6 million budget shortfall—while caseloads and needs continue to grow.

### Decrease in Funds

Starting April 1, 2013 the Child Care Assistance Program, which provides financial help to low-income families who cannot afford child care while parents work, will take no new applications until at least June 30, 2014. That change is estimated to save about \$38.4 million.

Since 2009, the department has

seen a decrease of \$59.3 million from the state’s general fund. At the same time, the needs have grown with more than 11,000 children being taken care of by relatives who get \$300 monthly to help with the child’s expenses.

Despite the program cuts, there will be no staff cuts. The department will continue to fund programs for the prevention and treatment of domestic violence, rape crisis and child advocacy.

## UK researcher developing overdose treatment

Chang-Guo Zhan, professor in the University of Kentucky College of Pharmacy’s Department of Pharmaceutical Sciences, received a three-year, \$1.8 million National Institutes of Health (NIH) grant to develop a therapeutic treatment for cocaine overdose.

The development of an anti-cocaine medication for the treatment of cocaine overdose has challenged the scientific community for years. In fact, there is no current FDA-approved anti-cocaine overdose medication on the market.

“According to federal data, cocaine is the number one illicit drug responsible for drug overdose related emergency department visits,” Zhan said. “More than half a million people visit emergency rooms across the country each year due to cocaine overdose.”

### Previous Work

This new grant is the fourth in a series of investigator-initiated research project (R01) awards that Zhan has received from the NIH to continue to discover and develop a cocaine abuse therapy. In previous work, Zhan has developed unique computational design approaches to generate of high activity variants of butyrylcholinesterase (BChE), a naturally occurring human enzyme that rapidly transforms cocaine into biologically inactive metabolites.

Zhan and his collaborators have improved BChE catalytic activity specifically against cocaine by 4,000



“According to federal data, cocaine is the number one illicit drug responsible

for drug overdose related emergency department visits.”

—Chang-Guo Zhan,

professor in the University of Kentucky College of Pharmacy’s Department of Pharmaceutical Sciences

times. The focus of this new grant is to optimize and stabilize these high-activity BChE variants. The hope is that at the end of this grant, this therapy will be ready for clinical development.

Zhan has been working on cocaine abuse therapy since 2000. “When I decided upon a career in research, I wanted to conduct research that would directly benefit human health,” Zhan said. “I wanted to develop solutions to problems and to fill a void in the market. This research is doing that, and all the research projects in my lab are driven by that purpose.”

—Keith Hautala, Dave Melanson

# Behavioral health news across Kentucky

## UK Center for Drug Abuse Research Translation receives NIH grant

The University of Kentucky Center for Drug Abuse Research Translation (CDART) recently received a \$7 million grant from the National Institutes of Health (NIH), funding which will continue the center's long history of developing intervention strategies that target high-risk individuals.

CDART is connected to the Division of Epidemiology, Services and Prevention Research at the National

said. "The current grant uses both pre-clinical (laboratory animal) and clinical (human experimental research) to understand the basic relation between individual differences in impulsivity and drug use. Both behavioral and brain neuroimaging techniques will be used. The relation between impulsivity and drug use will be investigated during the transition from adolescence to young adulthood, as this represents

development of novel intervention strategies for those at highest risk," Bardo said.

### Multidisciplinary Group of Researchers

The grant will fund a multidisciplinary group of researchers, facilitating the team-oriented approach that the NIH seeks to promote. In addition to faculty, three postdoctoral scholars, eight graduate students and four undergraduate students are involved in the center.

The research team includes (from the UK College of Arts and Sciences) Ruth Baer, Department of Psychology; Michael Bardo, Department of Psychology; Richard Milich, Department of Psychology; Richard Kryscio, Department of Statistics; (from the UK College of Medicine) Thomas Kelly, Department of Behavioral Science; (from the UK College of Public Health) Richard Charnigo. Depart-



"We know that there are individual differences in impulsivity that lead to risky behaviors."

—Michael Bardo, director of CDART and professor in the UK Department of Psychology

ment of Biostatistics; and (from the UK College of Pharmacy) Linda Dwoskin. Donald Lynam from the Department of Psychology at Purdue University is also connected to CDART.

— Sarah Geegan



MEMBERS OF THE RESEARCH TEAM INCLUDE (LEFT TO RIGHT) THOMAS KELLY, RICHARD MILICH, RICHARD CARNIGO AND MICHAEL BARDO.

## UK HealthCare will operate Eastern State Hospital

UK HealthCare plans to operate and manage the newly built Eastern State Hospital under a proposed \$43 million contract with the Kentucky Cabinet for Health and Family Services.

The University of Kentucky and the state have signed a letter of intent, but details of the agreement must be worked out in the months before the new campus opens, cabinet Secretary Audrey Tayse Haynes said.

In the letter of intent, UK has agreed to meet certain performance standards that would improve the treatment of hospitalized patients and increase the number of people who return to community living after leaving the hospital.

### New Beds, Services

The new \$129 million Eastern State Hospital, scheduled to open this summer at UK's Coldstream Research Campus, will have 239 beds, a new neuro-behavioral unit for patients with acquired brain injuries, and a long-term-care unit.

The hospital provides inpatient psychiatric treatment and acute inpatient behavioral health treatment. In addition to the hospital, the new campus includes three personal-care homes, each 11,000 square feet and with the capacity to serve 16 people.

The new campus will replace the pre-Civil War-era Eastern State

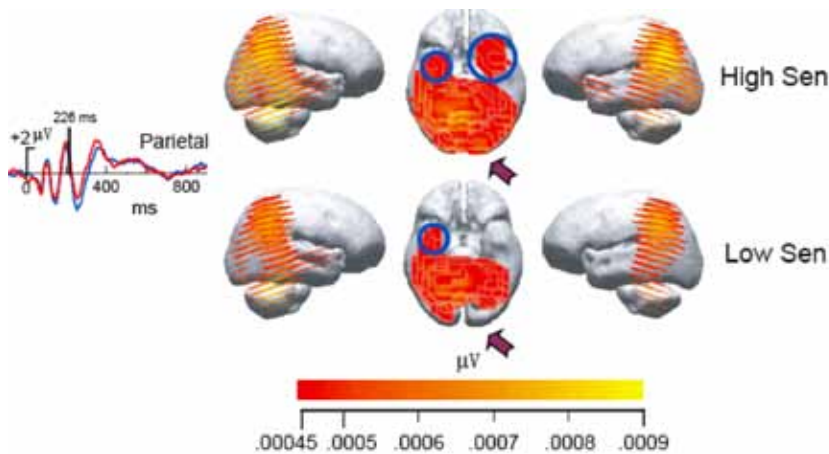
Hospital, the second-oldest psychiatric hospital in the country. That property is being reconfigured as a new campus for the Bluegrass Community and Technical College.

Haynes said the state's new contract with UK would probably be for one year, and that in the future, she plans on those contracts being paired with Kentucky's two-year budgets.

### Former Operators Audit

The Bluegrass Regional Mental Health-Mental Retardation Board has operated Eastern State Hospital since 1995. However, a state audit of Bluegrass Regional found lax board oversight and lavish spending on executives. Former Bluegrass Regional CEO Shannon Ware retired at the end of 2012 after four years at the helm. Ware's predecessor as CEO, Joseph Toy, is her husband, and remained on the Bluegrass Regional payroll through June 2012 as a paid consultant.

The state's most recent contract with Bluegrass Regional to operate Eastern State Hospital was for \$37.6 million. In 2012, the state paid Bluegrass Regional \$156 million to provide community mental healthcare, which is the bulk of the non-profit's work, and to manage Eastern State Hospital and Bluegrass Oakwood, a home in Somerset for the mentally disabled.



ERP/MRI INTEGRATION. RESEARCHERS WILL ATTEMPT TO DETERMINE IF INDIVIDUALS WHO ARE EXPERIENCING NEGATIVE EMOTIONAL STATES ARE MORE PRONE TO BECOME IMPULSIVE AND USE DRUGS.

Institute on Drug Abuse (NIDA). Though they are separate entities, CDART and NIDA have the common mission of understanding the causes and prevention of substance use disorders. The primary goal of CDART, which the grant will augment, is to move basic research findings into the application of more effective preventive intervention strategies.

"We know that there are individual differences in impulsivity that lead to risky behaviors," Michael Bardo, director of CDART and professor in the UK Department of Psychology,

a period of development of increased vulnerability to drug use and abuse."

In particular, the researchers will attempt to determine if individuals who are experiencing negative emotional states are more prone to become impulsive and use drugs. They will also test intervention strategies, based on the principles of mindfulness training, to determine if reducing such negative mood states protects against drug abuse among those at highest risk.

"The grant is going into years 22 to 26 of funding, and thus it has a long history of working toward the

## PHYSICIAN SPOTLIGHT



### Meet Rejith Paily MD; FACP Internal medicine physician

**Place of Employment:**

Internal medicine physician with Jewish Physician Group, a part of KentuckyOne Health; attending physician at Sts. Mary's & Elizabeth Hospital in Louisville.

**Why did you decide to become a doctor?**

My father is a physician, and I always wanted to be like him. I enjoy the close physician-patient relationship and the satisfaction from my ability to make a difference in someone's life. The various therapeutic options available to treat a single disease always excited me.

**Is it different than you thought?**

Yes. Healthcare has changed a lot and is changing day-by-day. A physician's ability to make the right therapeutic options for the patient is severely limited by the healthcare bureaucracy.

**What is the biggest misconception about your field?**

As an internist, I find the name "internist" itself the main misconception. The public lacks a clear understanding of what an internist is trained to do. It is the failure of the associations and societies to educate the public and patients that internists manage medical conditions of the adult population; we have the skills to manage the majority of all adult medical conditions independently.

**What is the one thing you wish patients knew and/or understood about doctors?**

Our passion to treat patients and cure illnesses has not come down even though our reimbursements have come down and work load has increased.

**What is your opinion of Managed Care and how will this affect you?**

The ideal Managed Care is a system intended to reduce unneces-

sary healthcare costs and to improve the quality of care. Who decides what is unnecessary and necessary is the debate. Managed Care significantly limits physician's ability to carry out the treatment options and ethical obligations.

**What's one thing your colleagues would be surprised to learn about you?**

Not too many surprises. I care about them more than they think.

**What's the best advice you ever received? Who gave it to you?**

From my father; "Early to bed, early to rise, make a man healthy, wealthy and wise."

**Favorite daytime beverage?**

Tazo chai tea latte from Starbucks.

**Any recent awards or accolades that you would like to mention?**

I was recently selected as the "Best Of Kentuckiana-Family Doctor" by

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## Lexington Clinic Sleep Center announces OCST accreditation

The Lexington Clinic Sleep Center has earned Out of Center Sleep Testing (OCST) accreditation from the American Academy of Sleep Medicine (AASM).

Earning OCST accreditation exhibits that sleep professionals offer "broader options to patients, while

demonstrating a commitment to quality diagnostic services," according to the AASM. Sleep facilities that earn the AASM accreditation make evident that the highest standards of quality care is provided to their patients.

## Reynolds, Borders appointed endowed chairs in rural health policy

Tyrone "Ty" Borders in the University of Kentucky College of Public Health's Department of Health Services Management, and Brady Reynolds in the UK College of Medicine's Department of Behavioral Science, have been named the Foundation for a Healthy Kentucky endowed co-chairs in rural health policy.

A \$1 million gift made by the Foundation for a Healthy Kentucky to the College of Medicine was matched through Kentucky's Re-

search Challenge Trust Fund. The endowed chair position was formed with the goal of enriching Kentucky's research capabilities in regards to rural health policy.

The College of Medicine is collaborating with the College of Public Health to share the resource, and to enhance UK's research capacity on rural health issues and rural health policy. Reynolds and Borders begin as joint co-chairs immediately.



## Hosparus named *Best Place to Work*

For the fourth consecutive year, Hosparus received the *Best Place to Work* distinction in Kentucky in the large employer category. Created in 2005, the Kentucky awards program is a project of the Kentucky Chamber of Commerce, the Kentucky Society of Human Resource Management Council and the Best Companies Group. The selection process, man-

aged by Best Companies Group, is based on assessment of company's employee policies and procedures and the results of an internal employee survey. This statewide survey and awards program identifies, recognizes and honors the best places of employment in Kentucky, benefiting the state's economy, workforce and businesses.

## St. Elizabeth offers free injury clinic

St. Elizabeth Sports Medicine, Edgewood, Ky., and Bob Roncker's Running Spot are working together to offer a free monthly runner's injury clinic. The free clinics offer assistance from St. Elizabeth Healthcare local medical providers, including

physical therapists, athletic trainers, physicians and a registered dietitian. New in 2013, the clinics will offer abbreviated one-on-one gait analysis using medical motion screens, a sports nutritionist and a licensed massage therapist.

## Saint Joseph Ambulatory Care Center receives gift

Lexington, Ky.-based Saint Joseph Hospital Foundation, part of KentuckyOne Health, received a gift from the RJ Corman Railroad Group to bring digital mammography services to Saint Joseph Jessamine. This gift was made in honor of Rick Corman's sister Sandy, and will create the

Sandra J. Adams Digital Mammography Suite at Saint Joseph Jessamine. Corman is the founder of the RJ Corman Railroad Group.

The new equipment should be in place this March and planning is currently underway for a formal ribbon cutting and grand opening in April.

## St. Elizabeth Edgewood wins excellence award

St. Elizabeth Edgewood has earned its place among an elite group of U.S. hospitals according to Healthgrades America's 50 Best Hospitals. This is St. Elizabeth Edgewood's seventh straight year to receive this award.

To be recognized with this distinction, hospitals must have had risk-adjusted mortality and complication rates that were in the best top five percent in the nation for the most consecutive years.

To determine America's 50 Best Hospitals, Healthgrades analyzed more than 150 million Medicare

hospitalization records from every non-federal hospital in the nation. Hospitals must meet minimum thresholds in terms of patient volumes, quality ratings and the range of services provided. Specifically, hospitals were evaluated based on the risk-adjusted mortality and complication rates across 26 procedures and treatments, from hip replacement to bypass surgery.

In addition, Healthgrades ranks St. Elizabeth among the top one percent of the nation for overall clinical excellence, and St. Elizabeth Edgewood is the only hospital in Kentucky to receive this distinction.

## Baptist Health marks name change



Baptist Healthcare System, which operates seven hospitals statewide, has re-branded itself and all of its hospitals to Baptist Health to unify its family of services. The new brand indicates that the system is much more than a group of hospitals, but a broad variety of healthcare services and facilities. The new brand also reflects a national shift to focus on preventive care and health improvement of the population.

Inspired by nature, the new logo conveys a Baptist Health that is growing and nurturing the vision of

a healthier Kentucky. The space between the four leaves forms a cross in recognition of the system's spiritual roots. The veins of the leaves create a star burst representing the vitality of a dynamic and innovative organization.

Baptist Health signage and other identifying features at each location will be replaced over the next few years. Eventually, every branded piece will be changed, with transitions planned in the most fiscally responsible manner possible.

Hospitals that have already unveiled new entrance signs include:

Baptist Health Lexington, formerly Central Baptist Hospital and Baptist Hospital East/Baptist Health Louisville

## Barren River Regional Cancer Center celebrates ten years

Craig Tyree, MD, and the staff at the Barren River Regional Cancer Center in Glasgow, Ky., celebrated 10 years of delivering compassionate and technically advanced radiation therapy to cancer patients in Barren

and surrounding counties.

Since opening in 2002, Barren River Regional Cancer Center has provided radiation treatment services to more 2,000 patients.

## UofL School of Medicine supports compassionate patient care

On February 14, 2013 the University of Louisville School of Medicine joined almost 60 medical schools and institutions across North America, by taking a stand for compassion in medicine by observing the third annual Gold Humanism Honor Society (GHHS) Solidarity Day for Compassionate Patient Care.

The GHHS promotes Solidarity Day by encouraging medical students to take at least five minutes during the day to show compassionate patient care – by getting to know their patients better, assisting support staff in the clinic or hospital, engaging in conversations with others or performing random acts of kindness.

GHHS Solidarity Day for Com-

passionate Patient Care was initiated after the 2011 shootings in Tucson, Ariz., to honor Randall Friese, MD, the trauma surgeon who first treated shooting victim Rep. Gabrielle Giffords. Friese said that the most important thing he did for Giffords was to take her hand in the emergency room and tell her that she would be cared for.

To honor that spirit of caring, the Gold Humanism Honor Society of the Arnold P. Gold Foundation created GHHS Solidarity Day for Compassionate Patient Care, when medical schools and healthcare institutions across North America create and undertake projects demonstrating the importance of empathy and compassion in patient care.

## KentuckyOne Health announces Louisville headquarters

After months of reviewing locations in Kentucky and Southern Indiana, including Lexington and Louisville, KentuckyOne Health officials announced that Louisville has been selected as the headquarters location. The corporate offices will be located in downtown Louisville in the Jewish Hospital Medical Plaza building.

While the corporate headquarters

will be in Louisville, KentuckyOne Health is a statewide organization. Additional corporate leadership and support offices will remain located throughout the Commonwealth, including Lexington. KentuckyOne Health's leadership team will continue to travel across the Commonwealth to interact with all constituents.

## Doctors & Lawyers for Kids marks one year anniversary

Doctors & Lawyers for Kids concluded its first full year by representing 110 low-income families in the areas of housing, utilities, income supports, education, legal status and family safety and stability.

Doctors & Lawyers for Kids is a partnership of Legal Aid Society, Louisville Bar Association and University of Louisville Department of Pediatrics. Its mission is to connect the medical and legal professions to

address legal needs that affect the health and welfare of children and their families.

The collaborative effort between the organizations works by integrating attorneys into the medical team. Doctors and social workers at University of Louisville Pediatrics and Kosair Children's Hospital learn to identify legal needs that affect patient health and refer them to the free program for patients in need.

## Highlands holds Project Lifesaver seminar

Prestonburg, Ky.-based Highlands Health System employees recently learned about Project Lifesaver, and its benefits to community members, patients and children receiving treatment at the Highlands Center for Autism.

Project Lifesaver is an organization whose primary mission is to provide timely response to save lives and reduce potential injury for adults and children who wander off due to Al-

zheimer's, autism, and other related conditions or disorders.

For those enrolled in Project Lifesaver, a small personal transmitter is securely placed around the wrist or ankle that emits an individualized tracking signal. If the person wearing the device goes missing, the caregiver is to notify their local Project Lifesaver agency, and a trained emergency team responds to the wanderer's area.

## Andover Family Medicine, PSC Joins Lexington Clinic

Lexington Clinic and Andover Family Medicine, PSC formed a strategic alliance to further enhance healthcare service delivery to patients. Andover Family Medicine, PSC, has offered personalized, comprehensive

care for the entire family, from pediatrics to geriatrics, since 2005.

On March 1, 2013, Andover Family Medicine, PSC became a member of Lexington Clinic's Associate Physician Network.

## Johnson named a top U.S. sports medicine specialist

Dr. Darren L. Johnson, professor and chair of the Department of Orthopaedic Surgery at the University of Kentucky, has been named one of the top U.S. sports medicine specialists by Orthopedics This Week. As one of the top 19 specialists — determined via recommendations given to Orthopedics This Week from

thought leaders in the field of orthopaedics — Johnson is considered a sports medicine physician who is extraordinarily equipped to meet the needs of athletes.

Johnson currently serves as director of sports medicine and head orthopedic surgeon for the Kentucky Wildcats.

## Passport Health Plan offers Text4baby program

Passport Health Plan now offers Text4baby — a free texting service to provide health information to pregnant women and new moms from pregnancy through a baby's first year.

Women who sign up for the service by texting BABY to 511411 (or BEBE for Spanish) receive three free SMS text messages each week timed to their

due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, safe sleep, and more. Text4baby messages also connect women to prenatal and infant care services and other resources.

## SCS awarded Joint Commission Accreditation

Seven Counties Services, Inc., the region's leading provider of behavioral health services, has earned The Joint Commission's Gold Seal of Approval® for accreditation by demonstrating compliance with The Joint Commission's national standards for healthcare quality and safety in behavioral healthcare. The accreditation award recognizes Seven Counties Services' dedica-

tion to continuous compliance with The Joint Commission's state-of-the-art standards.

A team of Joint Commission expert surveyors evaluated Seven Counties' locations and programs for compliance with standards of care specific to the needs of individuals served and families, including infection prevention and control, leadership and medication management.

## Warren County selected as HeartSafe community

The Cabinet for Health and Family Services and the Kentucky Department for Public Health (DPH) announced that Warren County is the next Kentucky county to earn the designation HeartSafe Community, an honor set aside for communities that have met criteria to better respond to cardiac arrests. The western Kentucky county joins Shelby and Jefferson counties on the growing list of counties working to be healthier and safer places to live.

The HeartSafe Community program was launched in summer 2011 by the Kentucky Public Health Heart Disease and Stroke Prevention Program as a way to help communities improve the chances that anyone suffering a sudden cardiac arrest will have the best possible chance for survival. Public Health is collaborating with the Kentucky Board of Emergency Medical Services (KBEMS) and the American Heart Association on the project.

# BEHAVIORAL HEALTH

Medical News

The Business of Healthcare

March 2013

## The case for integrated care

A concept whose time has come or the right thing to do and the price is right.

By Mary Helen Davis, MD



Our healthcare delivery system has been broken for quite some time. The rising cost of healthcare has driven policy and decision makers to come up with a fix. This fix has generated new buzz words: “collaborative care,” “integrated care,” “ACOs,” “medical homes,” “patient and family centered care,” “population based care,” “quality driven care,” and the list goes on. The expectations of the “fix” is to rework our healthcare system to achieve what has been referred to as the triple aim; “better care, better health and lower costs.”

It has been estimated that up to 50 percent of visits to primary care physicians involve issues related to depression, anxiety or chronic pain.

Behavioral and mental health issues have come front and center stage. Why? Cost! The United States spends more on healthcare costs than any industrialized country but scores below most in delivering quality healthcare. The increasing prevalence of chronic illness has driven healthcare spending. The top five health problems based on economic cost are drug abuse, mental illness, heart disease, alcohol use disorders and nicotine use. A case can be made that at least four of these belong in the domain of the mental health provider.

### Mental Illness Foot Soldiers

Given workforce and access to care issues we know that primary care physicians are the foot soldiers in treating

mental illness. It has been estimated that up to 50 percent of visits to primary care physicians involve issues related to depression, anxiety or chronic pain. Primary care physicians could benefit from our assistance just as our patients in psychiatry or community mental health centers could benefit from collaboration with primary care MDs.

We know that people with mental illness have significant reduction in lifespan and that their comorbid medical conditions frequently go undiagnosed and untreated. Integrated care is a concept whose time has come, forced by expectations of quality and the need for cost containment. Across the country there are multiple model programs that have ventured into integrated care with compelling data related to obtaining the triple aim.

### Goodbye, Separate Silos

A successful, integrated care program must be interdisciplinary utilizing a team approach that incorporates the use of mid-level providers including nurses, physician assistants, mental health workers, social workers and case workers. Unfortunately, physical health (PH) and behavioral health (BH) have traditionally been in separate silos. New models of care are emerging that include everything from co-located PH/BH services to fully imbedded and integrated services.

The provision of psychosocial services has found its way into standards of care in chronic medical conditions. As an example, the Commission on Cancer (COC) has incorporated the standard that programs “develop and implement a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.”

Attending to a patient’s emotional needs and distress can impact treatment adherence, quality of life and poten-

Continued on page 12



BEHAVIORAL HEALTH

# The case for integrated care

Continued from page 11

tially cost of care. All chronic disease states can benefit from integrative care that provides the range of supportive care services. Supportive care aims to optimize the comfort, functioning and social support of the patient across the illness spectrum. These supportive services should be bidirectional with mental health services coordinated in primary care clinics and primary care services integrated into mental health clinics.

**How Integrated Services Work**

The provision of integrated services in a primary care clinic would gener-

ally involve a screening process, which might include screenings for depression, anxiety or substance use and abuse. If a patient screens positive there would be a protocol for further assessment and a plan for initiating a treatment protocol when appropriate.

A psychiatrist might serve a group of busy primary care physicians a half-day a week. The psychiatrist would also provide case-based consultation to both the primary care MD and their midlevel providers on treatment and provide direct patient consultation only on patients that fail to respond to treatment.

Continued on page 13

**Models of Integrated Care**

- Center of Excellence for Integrated Care, North Carolina [www.icarenc.org](http://www.icarenc.org)
- DIAMOND, Minnesota [www.icsi.org/health\\_care\\_redesign\\_/diamond\\_35953](http://www.icsi.org/health_care_redesign_/diamond_35953)
- IMPACT Implementation Center: Jurgen Unutzer, MD [www.impact-uw.org](http://www.impact-uw.org)
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- Mental Health Integration Program, Washington State [www.integratedcare-nw.org](http://www.integratedcare-nw.org)



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# The case for integrated care

## A Successful Partnership

The waiting room for a community medical office is filled with all types of patients. Many patients have no insurance benefits. Some patients were discharged from a psychiatric facility without a follow-up appointment with a psychiatric prescriber. Other patients may suffer from mental health issues but are avoiding the mental health system because of the stigma associated with these treatments.



“Many of our patients don’t receive the medical care they need. Through integration we are able to diagnosis and treat most illnesses. It opens the door for communication between different types of providers and better continuity of care.”

— Kathy Edelen Brotzge,  
APRN

How can a primary care prescriber deal best with such patients? Just take a look at the partnership between Seven Counties Services, Inc., and Family Health Centers, which demonstrates how a collaborative care arrangement can work. Collaborators utilize the Integrated Behavioral Health in Primary Care Setting Model, which was developed by Kirk Strosahl, PhD, to integrate behavioral health and primary care in one facility.

Adult psychiatric nurse practitioner Kathy Edelen Brotzge, APRN, coordinates care between Seven Counties Services, Inc., and the Family Health Centers. She works at Seven Counties Services Inc., 3 1/2 days a week, the Family Health Center in Portland three days a week and the Family Health Center in Fairdale one day a month.

“Some of our severely ill patients refuse to seek medical care, and this connection has improved our chances of keeping our patients healthy,” she said. “In other instances I have been able to connect with a mentally ill patient and get them to agree to come to our Seven Counties Clinics for treatment. The building of trust can go a long way.”

Brotzge sat down with *Medical News* to discuss her job and the importance of integration.

### MN: Why did you decide to go into this field?

**Kathy Edelen Brotzge:** I have always enjoyed helping people. I worked in mental health a number of years prior to going to nursing school. During my undergraduate rotations, I found that I

enjoyed caring for persons with mental illness the most. It is a very rewarding profession.

### MN: What kind of patients do you see?

**KEB:** I see patients with severe mental illnesses primarily at Seven Counties. At the Family Health Center I see everything – depression, anxiety, post-traumatic stress disorder, bipolar disorder – whatever comes thru their doors.

### MN: How do you work with the primary care doctor when dealing with patients?

**KEB:** Usually the primary care prescribers (doctors and nurse practitioners) will have the patient seen by the behavioral health social worker (Licensed Clinical Social Worker - LCSW). The prescriber may have the LCSW call me regarding medications, or they will request the patient be put on my schedule. Sometimes I receive emailed questions, which I answer. There are times the prescriber will come to me while the patient is in the clinic and ask questions. The primary care prescribers also have my cell phone number so they can contact me directly.

### MN: How do patients benefit from integration?

**KEB:** They receive the treatments they need. Many would just show up for their treatment of hypertension, but omit the anxiety they have. Symptoms from a psychiatric illness may continue to keep a medical illness unstable. Psychiatric symptoms can appear but be caused from a medical illness. We work together for the best medical care a patient can receive. Being in the same clinic makes it easier for the patient.

### MN: How is your position growing?

**KEB:** I continue to have more and more requests from all of the Family Health Centers for consultation – there are six different locations. The population of uninsured continues to rise. Mental health reimbursement for the uninsured is extremely low, therefore causing a gap in care available.

### MN: Why is integration important?

**KEB:** Many of our patients don’t receive the medical care they need. Through integration we are able to diagnosis and treat most illnesses. It opens the door for communication between different types of providers and better continuity of care.

The benefits are many with this type of collaboration. I have learned a great deal from the primary care prescribers. Joining together is providing better care for the patients in our area. This relationship has built a bond between our centers. I hope this model can spread to more centers.

—Melanie Wolkoff Wachsman

Continued from page 12

Conversely, in a mental health clinic the screening might be conducted for glucose or metabolic monitoring, hypertension or other chronic disease state. Multiple models of integrated care are emerging from around the country with very promising results in terms of outcome, cost and patient satisfaction.

### Medical Schools Reflect Change

Medical school curriculums are beginning to change and place emphasis on interdisciplinary team care. These paradigm shifts represent a culture change that is vastly different from how care has been traditionally provided and will require reconsideration of reimbursement as well. Healthcare reform is likely to bring concepts of bundles payment, or reimbursement for illness episode compared to the current fee-for-service model.

Integrated care is a concept whose time has come, forced by expectations of quality and the need for cost containment.

Current practitioners interested in exploring ways to learn more about this emerging delivery system should consider one of the many courses available on integrative care models that are available at the annual meeting of the American Psychiatric Association and at other professional conferences.

*Mary Helen Davis, MD, is associate clinical professor of psychiatry at the University of Louisville, Department of Psychiatry and Behavioral Medicine, U of L School of Medicine and a psychiatrist at the Norton Cancer Institute Program Development.*

## Myths of mental illness

Throughout history, our fears and misinformation caused us to observe people with a mental illness in some rather fascinatingly harmful ways.

By Marsha Wilson



Myths and stereotypes have long fueled the fear and prejudice that keep us from truly being a compassionate and healthy society. And while some will argue that recent years have witnessed a decline in prejudice against people of different races, faiths or sexual orientation, the myths concerning people with a severe mental illness have flourished.

Instantaneous images and information about the daily violence in our country stimulates our fear and furthers our ignorance about people with a severe mental illness. In truth, an article published by the National Institute of Mental Health (NIMH) in 2011, reported that “Most people with a severe mental illness are not violent, and most violent acts are not committed by people with a severe mental illness.”

This NIMH article quoted

a 2005 study in the Archives of General Psychiatry, which studied the victimization of adults with a severe mental illness. The article stated that those with severe mental illness are “11 times more likely to be victims of violent crimes than the general population.”

### History of Misinformation

Each year in the United States there are nearly 35,000 suicides. A person with a mental illness is more likely to harm themselves than to harm someone else. How can a society that views itself as compassionate and rushes to the aid of others across the world, so stigmatize a group of its own citizens to the point that they would rather take their own life, than live with an illness?

Throughout history, our fears and misinformation caused us to observe people with a mental illness in some rather fascinatingly harmful ways. Stemming from our strong religious foundation sprang the belief that people with a mental illness were being punished by God for

A person with a mental illness is more likely to harm themselves than to harm someone else.

their sinful actions or thoughts. They needed to be kept away from our families and our neighborhoods for fear that their sins would infiltrate the thoughts and lives of our loved ones. As a result, people were ostracized, shunned, tortured and killed. And while this may seem to be an ancient belief, our country still tends to wonder what a person did wrong to deserve a mental illness.

Moving people onto large state hospitals and farms seemed to be our “compassionate” response to our fears and prejudices. And yet again, these farms and hospitals were far removed from our communities. Our actions, however benevolent in intention, further ostracized and stigmatized people

with a severe mental illness. People were forced into a dependency on the system that perpetuated the myth that persons with a mental illness were not capable of contributing to society in any meaningful way.

### Why Integration Wasn't Successful

Our judicial system finally forced the closure of these large institutions, and people were set free back into the cities. The money used to sustain the institutions did not follow people into the community, and people found themselves without the supports and treatment they needed to successfully integrate.

Millions of dollars remain in the budgets of these institutions, despite the fact that they are nearly empty. Money that could be used to educate our country about mental illness, enhance access to treatment and assist people in working and living healthy lives in the community, goes unspent.

The victimization of people with a

Continued on page 15



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# Myths of mental illness

## Often Misunderstood, a Closer Look at Schizophrenia

Schizophrenia is a term most of us have heard, but know little about. There has been more media attention to mental illness, including schizophrenia, because of the recent tragedies at Sandy Hook in Conn. and in Aurora, Colo. Unfortunately, much of what is reported lacks all the facts and some is just plain wrong. Here's some information grounded in facts and decades of clinical experience.

### Schizophrenia: Scary Word, Treatable Disease

Schizophrenia is a brain disease that interferes with the brain's normal functioning and causes affected people to exhibit odd, highly irrational or disorganized behavior. A person loses the ability to discriminate between real and "imagined" experiences, and can lose touch with reality.

Symptoms include difficulty thinking coherently, interacting with others normally, carrying out responsibilities and expressing emotions appropriately. Even simple, everyday tasks like personal hygiene can become difficult. The disease also affects family members and caretakers who can become distressed and overwhelmed by the difficulties involved in providing care.

The onset of schizophrenia is most likely to occur in early adulthood. It is relatively rare for children and older adults to develop schizophrenia, but it does happen. The incidence of new cases of schizophrenia increases in the teen years, reaching peak vulnerability between 16 and 25.

Males reach a single peak of vulnerability for developing schizophrenia between the ages of 18 and 25 years. Female vulnerability peaks twice—first between 25 and 30, and then again around 40.

Although it is not a common disease it can be a serious and chronic one. In the U.S., about 100,000 people will be diagnosed, which translates to 7.2 people per 1,000 or about 7,000 people in a city of 1,000,000 (like Louisville).

### What Schizophrenia is Not

As important as it is to know what schizophrenia is, it is equally important to understand what it is not. Rashmi Nemade, PhD, and Mark Dombeck, PhD, have written about some of the common misconceptions about the disease. All of these statements are false.

- People never recover from schizophrenia.
- Schizophrenia is contagious.
- Most people with schizophrenia need to be institutionalized.
- People with schizophrenia are not able to make decisions about their own treatment.
- People with schizophrenia are likely to be violent.
- Most people with schizophrenia can't work.
- Jail is an appropriate place for people with schizophrenia.

The two doctors say the most important thing to understand about schizophrenia is that it is not anyone's fault. It is nothing more and nothing less than a disease of the brain that some people develop. It can be effectively treated and people with schizophrenia can live productive, happy and peaceful lives in our communities.

—Dean L. Johnson, vice president of community relations at Seven Counties Services

Continued from page 14

severe mental illness is a greater public health concern than the perpetuation of violence by people with a severe mental illness. Our stereotypes and subsequent stigma legitimize the continued underfunding of mental health services, the lack of access and the reluctance of people to seek treatment.

### Mental Illness is Treatable

In the United States, six percent of adults (13.2 million people) are affected by severe mental illness. Mental illness is not retribution for our sins. Mental illness is a biochemical imbalance, a brain disorder that impacts a person's thinking, perceptions and mood. And just as epilepsy, diabetes and many other

disorders are treatable, so is mental illness.

Treatment is available for people with a severe mental illness and recovery is possible. Seven Counties Services offers education about mental illness, medication, individualized therapy, peer services and supported employment. Early identification of mental illness and improved outreach and access to treatment are crucial. If a person fears the ostracism and stigma of their family and friends, more than they dread their symptoms, then these will always be the biggest barriers to an individual's recovery.

*Marsha Wilson is vice president of adult mental health services for Seven Counties Services Inc.*

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Seven Counties Services, Inc.

# Autism Spectrum Disorder just as complex, varied as treatments

Early identification is the most important element to improve lives for individuals and families affected by autism.

By Darcie Taggart

Autism is a brain-based developmental disorder that is part of a group of complex disorders classified as Autism Spectrum Disorders (ASD). Other ASDs include Rett's Disorder, Childhood Disintegrative Disorder, Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) and Asperger's Disorder.

Each of these disorders have a specific set of criteria used to make the diagnosis but all include impairment in social interaction, communication, and behavioral functioning though the degree of these impairments can vary widely across diagnosis and from

The prevalence of autism is now estimated to be one in every 88 children, and boys are five times more likely to be diagnosed than girls.

gifted or excel in one or more academic or creative capacities. Another common misconception is that individuals with autism are incapable of forming social relationships. The variation of difficulty is wide amongst individuals with autism and while all exhibit some social

autism is on the rise. Yet the increase in diagnosis is more likely due to a widening of the spectrum and definition of autism, better screeners with which to identify autism characteristics, and an increase in the awareness of the symptoms of autism by the general public.

## Signs and Symptoms

Signs and symptoms of autism usually present before three years of age and early diagnosis and interventions are key in making strides to increase the functioning across all areas for these individuals. Screeners are administered to parents of children suspected to have autism to identify possible characteristics of ASD. If a screener indicates that a child has similar characteristics to others with ASD then a more in depth assessment and evaluation should occur to make the full diagnosis.

Some red flags associated with ASD include but are not limited to include: limited to no eye contact, not showing joint attention or shared attention on an interesting object or person (by 12 months), does not share sounds, smiles, or facial expressions back and forth with caregiver (by nine months), no babbling (by 12 months), no meaningful two-word phrases (by 24 months), stereotypic behaviors such as rocking, spinning, or hand flapping, becomes easily fixated on parts of toys rather than the toy itself, unable to make friends (either because not interested or doesn't know how).

There is no cure for autism but early and intensive treatment can make a big difference.

One of the biggest challenges to treating autism is that each program must be tailored to fit the needs of the child and of the family.

## Effective Treatments Available

While many treatments have been effective for individuals with autism, no one treatment has been found to be effective for all individuals with autism. No two individuals with autism are exactly alike and therefore no two respond to treatment in the same way.

One of the biggest challenges to treating autism is that each program must be tailored to fit the needs of the child and of the family. Individualized services including goal adjustments, strategies, and evaluations are the main elements of an effective treatment program.

Other elements of effective programs include:

- The earliest possible start to intervention
- Systematic and planned teaching
- Specialized curriculum (relating to imitation of others, use of language, appropriate play and social interactions)
- Time intensive engagement in teaching interactions and learning activities
- Developmentally appropriate practices (not just based on a child's chronological age)
- Family involvement

If possible treatment programs should also include structured, intentionally arranged environments and intervention in settings typical to the child. In addition to a tailored treatment program some individuals with autism benefit from medication or nutritional and dietary interventions.

Just as ASD is a complex group of disorders with a wide spectrum of variation among individuals, so is treatment for individuals with autism. Early identification and treatment is the most important element in improving lives for individuals and families affected by autism.

*Darcie Taggart is an early childhood mental health specialist at Seven Counties Services, Inc.*



person to person. Children with autism demonstrate restricted or repetitive patterns of behavior, interests, or activities in addition to these other difficulties.

Autism can be also be associated with intellectual disabilities, attention issues, difficulties with motor coordination, physical health problems, and sensory processing deficits. However, it would be a misconception to state that all individuals with an ASD are affected by these. Some individuals with autism are

impairments some are quite capable of forming close relationships with friends and family members.

## Autism on the Rise

The prevalence of autism is now estimated to be one in every 88 children, and boys are five times more likely to be diagnosed than girls. In the past several years the number of individuals diagnosed with autism has risen leading some to believe that the incidence of



# Get tough on Rx laws and drug abuse

## Is it better or worse for drug abuse treatment and prevention?

By Christopher Stewart, MD, and  
Diane Hague, LCSW



Laws reflect our culture and often are more reactive than thoughtful. In measuring both intended and unintended outcomes, some have been helpful. Others have not.



Prohibition laws did not stem alcohol abuse. Unintentionally, they helped create and maintain an illegal industry and dangerous black market economy during the 1920's.

Drunken driving laws grew stronger over decades of grassroots advocacy. The incidence of deaths as a result of drunk driving dropped. However, because culturally we've not fully embraced the societal consequences of any combination of drinking and driving, the full potential of such policy goes unrealized.

Cessation of smoking tobacco represents a prime example of the linking of emerging policy advocacy and laws with positive and intended behavior change. Reductions in smoking rates have been gradual, but significant, over an extended campaign that has included public education, interest group advocacy and health professionals' expertise and support.

The progress in advocacy and law making has been somewhat parallel. As advocacy grew in volume and sophistication, laws evolved from warning requirements to greater underage purchasing enforcement to local smoke-free (and not consideration of statewide smoke-free) laws. As a result, smoking became unacceptable, both culturally and, in many instances, legally.

### The Pain Problem

So what about opiates and other narcotics? The personal and public health consequences of opiate addiction are

With a "pill for every problem" mentality, it's not hard to understand that doctors and their patients who experience pain are acting out of cultural beliefs.

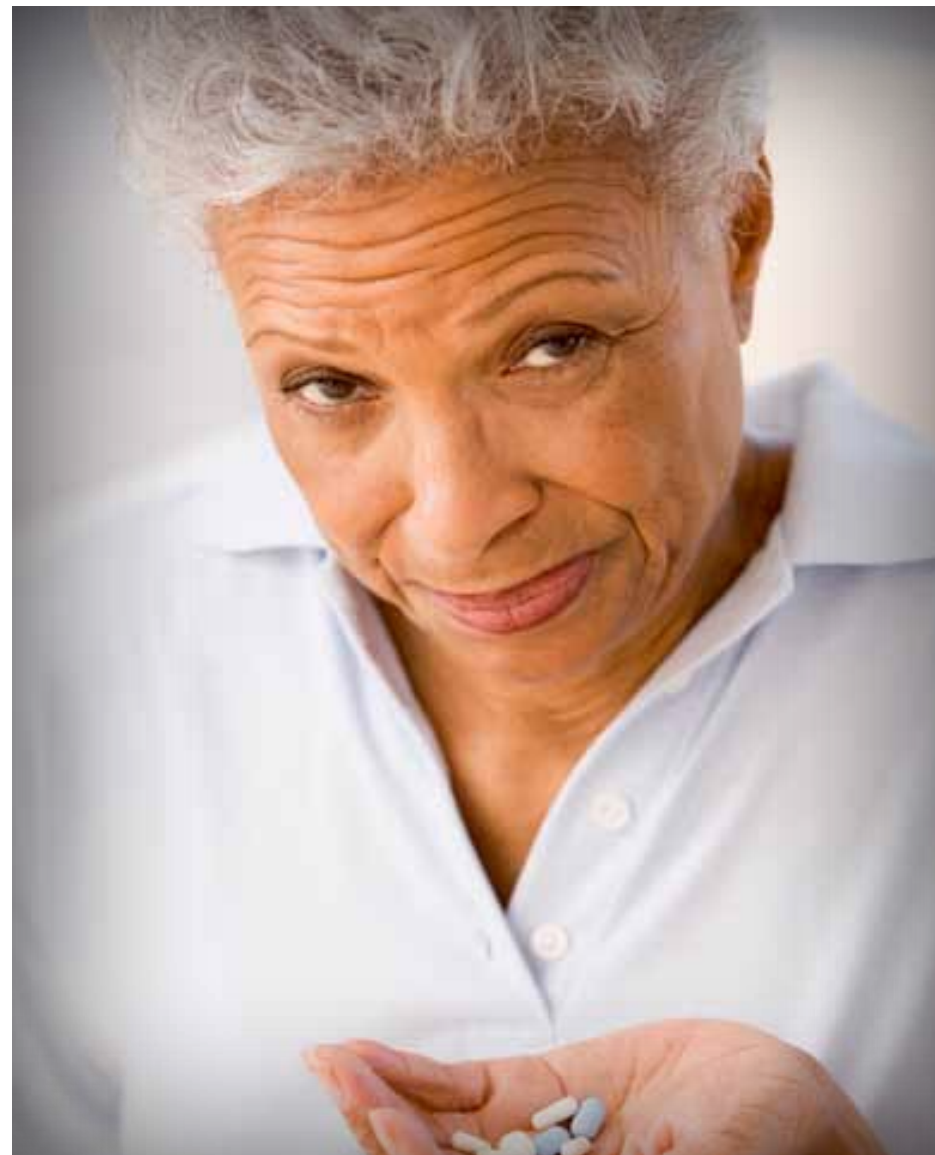
devastating. Yet, many legal medications, with legitimate medical applications, have become a plague on our state and many of its communities.

As a culture, we believe these medications are the solution to pain. As a culture, we value pain relief. With a "pill for every problem" mentality, it's not hard to understand that doctors and their patients who experience pain are acting out of cultural beliefs. An unintended consequence of prescribing and producing so many legal opiates and other narcotics is their diversion to and prevalence in the illegal drug trade.

### House Bill 1 Origins

The problem in Kentucky grew so large as to require direct legislative intervention. House Bill 1, passed in 2012, requires physicians who prescribe opiates or controlled substances to use the eKASPAR reporting system, intended to adequately record and track both prescribing and use patterns and identify practices and consumers suspected of diverting legal drugs to the illegal market. This move was long overdue in response to mounting overdose deaths and corrupt pain clinics involved in drug rings.

The opioid epidemic in Kentucky provided fuel for the engine that created House Bill 1. Pain pill addiction and the lethal overdose epidemic changed many physicians' prescribing habits. The changes in prescribing patterns for opiates started in Kentucky before House Bill 1 when



the Kentucky Board of Medical Licensure released new guidelines for physicians who were prescribing controlled substances. The attention made many physicians feel on "alert" and several doctors decided, out of frustration, to simply opt out of controlled substance prescribing altogether.

The prevalence of so-called "pill mills," practices established for the illicit purpose of supplying legal opiates to the black market, provided another significant motivation behind the passage of HB 1.

Many have closed. Several doctors have been successfully prosecuted and licenses have been revoked. The results have been mixed, with intended and unintended consequences emerging. In the Louisville treatment center where we work, we are seeing fewer admissions for prescription opiate abuse – an intended and positive result. We are also seeing significant increases in admissions for treatment of heroin addiction.

Continued on page 18

# Get tough on Rx laws and drug abuse

Continued from page 17

The heroin epidemic could be predicted as a natural trend in the opiate epidemic as persons who have survived their pill addiction are now following the laws of supply and demand economics, and switching to the more readily available and less expensive option – heroin. We are seeing more overdoses secondary to heroin abuse now, but the number of overall deaths due to narcotic or opiate addiction and abuse has declined.

## House Bill 1 Not Enough

While enforcement measures, such as House Bill 1, represent movement on an important issue, they do not substitute for the need for greater resources and greater access to treatment for those addicted. House Bill 1 does nothing to

change the inadequacy of public funding for addiction services or expand the eligible addiction services under Medicaid. Nor does it help the public understand that treatment is more than simply having fewer drugs available. It does not change our cultural value that there should be a “pill” or immediate solution for every problem and no one should have to feel pain for long.

In addiction treatment and recovery, the emphasis is on the patient managing long-term recovery from a chronic illness where there is no cure; there is no magic pill.

While the first part of treatment involves detoxification, that is really the easy part. The remainder of treatment and recovery requires much work on the part of the patient. And it is hard work.

House Bill 1 does nothing to change the inadequacy of public funding for addiction services or expand the eligible addiction services under Medicaid.

## Pain Treatment Alternatives

There is a movement to look at alternatives other than narcotics for chronic pain patients. These alternatives involve patients “working on their pain management.”

Eastern medicine practices such as acupuncture, specific physical and

mental exercises (i.e., yoga, transcendental meditation) are also becoming more prominent in American practice as solutions to non-medication remedies to pain.

Laws will prove ineffective by themselves in any drug epidemic unless we have sufficient treatment. That takes commitment on everyone’s part for the long-term solution. Laws will fall short until we become more culturally focused on long-term processes that take commitment and action from everyone.

*Christopher Stewart, MD, is the inpatient medical director at the Jefferson Alcohol and Drug Abuse Center, Seven Counties Services.*

*Diane Hague, LCSW, CADC, is vice president of addictions services, Seven Counties Services.*

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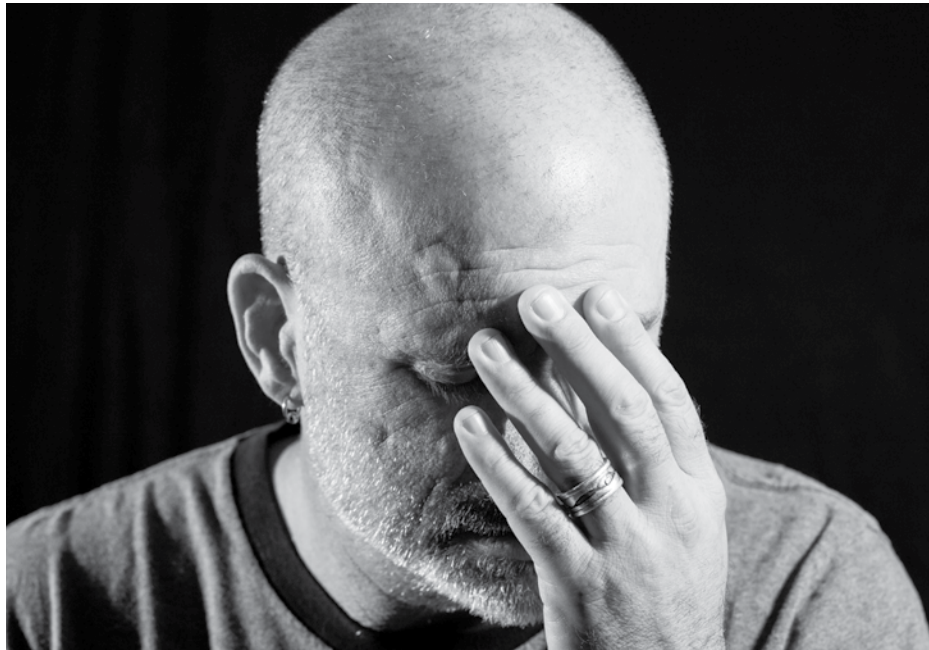
# Depression and mood disorders

Education, research on the rise as stigma remains in place.

**By Chelsea Nichols**

One in five Americans will experience some sort of mood disorder. Despite this commonality, one in four views this as a sign of personal weakness. Jesse H. Wright, MD, PhD, director, the University of Louisville Depression Center hopes to change this. He is on a quest to remove the stigma of mood disorders.

People suffering from depression, bipolar disease or other mood disorders may feel ashamed embarrassed or fear isolation. Those same people shy away from help and treatment. Wright is convincing people that there's no reason to feel ashamed. He likens the illness to cancer.



Cancer is unfortunate, but people aren't ashamed and most seek treatment. Like cancer, depression and mood disorders are illnesses and can be treated.

"There are known treatments that are evidence based that are not currently offered to people who need them," said Wright, who with his daughter, Laura McCray, MD, a family physician co-authored the book *Breaking Free from Depression: Pathways to Wellness* (The Guilford Press, 2012).

**Miseducated & Under Diagnosed**

The National Network of Depression Centers (NNDC) is a twenty-one member group dedicated to the research and

*Continued on page 20*

## Depression & Bipolar Disorder Facts

- Only 20 percent of the people in the United States who have depression are receiving adequate treatment for it.
- The most common misdiagnosis is major depression.
- About 17 percent of people in U.S. will suffer from major depression in their lifetime. In any given year seven to eight percent will have a depressive episode. The annual cost of depression in the U.S. is about \$87 billion for lost productivity and treatment.
- About four percent of people in the United States develop bipolar disorder in their lifetime.
- Studies have found that about 60 percent of people with bipolar disorder are undiagnosed, misdiagnosed or not receiving appropriate treatment for this disease.
- There is a concern with bipolar patients that treatment using antidepressants alone (without specific mood-stabilizing drug) can worsen the course of the disease in some people.

— Source "Breaking Free from Depression: Pathways to Wellness"

(The Guilford Press, 2012) By Dr. Jesse Wright with Laura W. McCray, MD.

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BEHAVIORAL HEALTH

# Depression and mood disorders

Continued from page 19

education of depression and other mood disorders. The University of Louisville Depression Center is part of this elite team. Annually, the center receives 25,000 visits, not including children and adolescents. The team of professionals at the center serves as a “resources for the treatment of depression and bipolar disorder, research and education.”

Cancer is unfortunate, but people aren't ashamed and most seek treatment. Like cancer, depression and mood disorders are illnesses and can be treated.

The NNDC reports that the public is miseducated, and professionals often under diagnose their patients. The network blames a lack of basic knowledge on both ends.

One in three Americans who seek treatment does not receive enough treatment over their life time. To make matters worse, relapsing is a common pattern seen among patients.

### Past the Stigma

As the opportunity for treatment, research and education progress, it's important to get people past the stigma. Depressive illnesses cost our economy more than \$80 billion annually in lost productivity and increasing medical costs according to the network. Mental illnesses also rob us of our livelihoods. Depression is known to weaken the body. Suicide, one of the leading causes of death, often stems from some sort of mood disorder.

It's not all bad. Eighty percent of those treated for depression show an improvement within four to six weeks, reports the NNDC.

“Researchers are now working on a lab test that can determine the types of prescriptions that would be most effective with your genetic make-up in treating your depression,” Wright said. “There are promising treatments that have been introduced recently with big success, and there will be others.”

## Is it Moodiness or a Mood Disorder?

ANXIETY DISORDERS		What it is
<b>Generalized Anxiety Disorder (GAD)</b>	<b>When Worry Gets Out of Control</b> extremely worried about things, even when there is little or no reason to worry about them. Worrying keeps people with GAD from doing everyday tasks.	
<b>Obsessive-Compulsive Disorder:</b>	<b>When Unwanted Thoughts Take Over</b> Feel the need to check things repeatedly, or have certain thoughts or perform routines and rituals over and over. The thoughts and rituals associated with OCD cause distress and get in the way of daily life.	
<b>Panic Disorder</b>	<b>When Fear Overwhelms</b> Sudden and repeated attacks of fear that last for several minutes or longer called panic attacks, which are characterized by a fear of disaster or of losing control even when there is no real danger.	
<b>Post Traumatic Stress Disorder (PTSD)</b>	An anxiety disorder that some people get after seeing or living through a dangerous event.	
<b>Social Phobia (Social Anxiety Disorder)</b>	A strong fear of being judged by others and of being embarrassed. This fear can be so strong that it gets in the way of going to work or school or doing other everyday things.	
Other DISORDERS		WHAT IT IS
<b>Bipolar Disorder (Manic Depressive Illness)</b>	A brain disorder that causes cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression).	
<b>Borderline Personality Disorder</b>	A serious mental illness marked by unstable moods, behavior, and relationships. Problems with regulating emotions and thoughts, impulsive and reckless behavior, unstable relationships with other people.	
<b>Depression</b>	<b>Major depression</b> is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. <b>Minor depression</b> is characterized by having symptoms for two weeks or longer that do not meet full criteria for major depression (includes Post Partum and SAD)	
	<b>Postpartum</b> More than the “baby blues.” When hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming.	<b>SAD</b> Characterized by the onset of depression during the winter months, when there is less natural sunlight.
<b>Schizophrenia</b>	Disabling brain disorder that cause suffers to think they may hear voices, that others are trying to harm them or that they're thoughts are being controlled. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated.	

# MEDISTAR AWARD NOMINEES

## The A.O. Sullivan Award for Excellence in Education

Dr. Alexander Digenis  
 Helen Overfield  
 John Roberts, MD  
 Kim Tharpe-Barrie  
 Louisville Water Company  
 Michael P. Muldoon  
 The Christine M. Kleinert Institute for Hand and Micro Surgery  
 ULH / UofL School of Nursing (Dedicated Education Units)

## The Consumer First Award

American Diabetes Association  
 ElderServe, Crime Victim's Services  
 InterNational Center for Advanced Pharmacy Services (INCAPS)  
 Kosair Children's Medical Center - Brownsboro  
 Patient and Family Centered Care Initiative  
 at University of Louisville Hospital  
 UK HealthCare

## The Governor's Dignity of Humanity Award

Foundation for a Healthy Kentucky  
 Hope Health Clinic  
 Hosparus, Inc.  
 JenCare Neighborhood Medical Centers  
 Jewish Hospital & St. Mary's Foundation  
 and the Center for Health Equity  
 Louisville Metro TRIAD  
 Virtual Primary Care Clinics in Powell and Wolfe Counties,  
 Saint Joseph Health System, part of KentuckyOne Health  
 Smile Kentucky  
 Supplies Over Seas  
 V. Faye Jones, MD, PhD  
 Volunteers of America KY  
 Wellspring

## The Facility Design Award

JenCare Neighborhood Medical Centers  
 Norton Hospital-Brownsboro  
 Renovation of Emergency Psychiatric Services  
 Unit at University of Louisville Hospital  
 The Cardiovascular Innovation Institute  
 University of Louisville Physicians-Geriatrics

## The Seven Counties Services Healthcare Advocacy Award

Dr. Brooke Sweeney  
 Dr. Goetz Kloecker with patient Nancy Alvey  
 Dr. Kelly McMasters  
 Dr. Tad Seifert  
 Lindy Lady

## The Crowe Horwath Healthcare Innovation Award

Asthmapolis  
 Cardiovascular Innovation Institute  
 Dr. Michael Cassaro  
 James Graham Brown Cancer Center | Louisville CyberKnife  
 John Carroll  
 John Reinhart  
 Steve Ready

## The Hall Render Leadership in Healthcare Award

Diane Hague  
 Dr. Chris Babcock  
 Dr. LaQuandra Nesbitt  
 Foundation for a Healthy Kentucky  
 Gary Marsh  
 Helen Overfield  
 InterNational Center for Advanced Pharmacy Services (INCAPS)  
 James R. Ramsey; Ruth Brinkley; David L. Dunn; James Taylor  
 Mark B. Carter  
 Mary Haynes  
 Ralph Gronefeld  
 Restorative Medical, Inc.  
 Rick Mitchum  
 Steven Hester  
 Susan Davis  
 Vickie Yates Brown

## The ARGI Financial Physician of the Year Award

Emma Birks, MD, PhD  
 Anthony Dragun, MD  
 Christian Davis Furman, MD  
 Michael Benfield, MD  
 Gina Wilkins, MD  
 Michael Marvin, MD  
 Rejith Paily, MD  
 Steven Hester, MD



# Protecting the mental health of our youth

Positive youth development, protective factors, healthy habits a start.

By **Patty Gregory**

In recent years, we've witnessed a surge of interest in addressing the physical health needs of our youth. Proper nutrition, exercise and avoidance of alcohol, tobacco and other drugs are at the forefront of many news articles and reports. The focus overshadows the neglected urgency to address the mental health needs of our children, particularly the introduction and support of preventative measures that can help youth live happier and more productive lives and make society safer.

Mental health is a youth issue. According to the World Health Organization, one-fifth of teenagers under the age of 18 suffer from developmental, emotional or behavioral problems. One in eight has a mental disorder and among disadvantaged youth, the rate increases to one in five.

What can we do to lessen the risks that our children will develop mental illness? Research shows that the pres-

The more protective factors and the fewer risk factors that a youth possesses, the greater the likelihood of being mentally healthy.

ence or absence of certain risk and protective factors can contribute to the mental health of youth. Risk and protective factors are aspects of a person's environment or personality that make it more likely (risk factors) or less likely (protective factors) that a youth will experience a given problem. Risk factors include: lack of education, unmet transportation and housing needs, access to drugs and alcohol, poverty, violence and delinquency and peer rejection. Some examples of protective factors are: social participation, em-

powerment, adaptability, feelings of security, self-esteem and literacy. The more protective factors and the fewer risk factors that a youth possesses, the greater the likelihood of being mentally healthy.

## Positive Youth Development

Positive youth development is another contributor. According to the Interagency Working Group on Youth Programs, positive youth development is an intentional, pro-social approach that:

- Engages youth within their community, school, organizations, peer groups and families, in a manner that is both productive and instructive.
- Recognizes, utilizes and enhances youth's strengths.
- Promotes positive outcomes for youth by providing opportunities, fostering positive relationships and furnishing the support needed to build leadership strengths.

Engaging youth in positive youth development strengthens the protective factors that youth need which can influence their ability to overcome adversity.

Schools can contribute to maintaining good mental health by offering programs that are researched based and are proven to reduce conduct problems and aggressive behavior. Some of these programs include: The Good Behavior Game, Bullying Prevention Program, Incredible Years and First Steps.

## Mental Health in the Womb

Promoting good mental health actually starts during pregnancy and early infancy. Good prenatal nutrition and avoidance of substances that could harm the fetus are important. Screening for postpartum depression is also vital for good health.

In early childhood, it is important to work with children to develop emotional and social communication skills along with enhancing social and self-awareness. Helping children with re-



sponsible decision making skills, having positive parenting practices and building relationship skills are also important.

In adolescences, working with children to build positive peer groups, helping them engage in pro-social activities and opening the communication lines with parents is vital to healthy mental development. Monitoring activities and setting clear and consistent boundaries are also important.

## Community Effort

Raising mentally healthy children is a community effort. Research reveals that by reducing risk factors, increasing protective factors, including evidenced-based programs and practicing good parenting techniques, we can improve the outlook for good mental

health and prevent a host of behavioral health problems. Removing or lessening toxic elements in a youth's life, such as marital conflict, poor peer relations, community violence, poverty, racism, stress and trauma are important for good mental health.

Mental health is a youth issue.

Helping children develop healthy eating and exercise habits is important. But raising the aforementioned protective factors and decreasing the risk factors in our children's lives is critical to the growth of healthy young minds.

*Patty Gregory is division director of the Regional Prevention Center of Seven Counties Services, Inc.*

# Making the case for adequacy—behavioral health

By Sheila Schuster, PhD



Kentucky was the first state in the nation to implement President John Kennedy's Community Mental Health Act. This Act put into place in the mid-1960's a statewide system of 14 Community Mental Health Centers (CMHCs), which are responsible for planning and providing the full range of behavioral health services.

These services include treatment and recovery supports for individuals and families dealing with mental illness and substance abuse/addictive disorders and those with developmental and intellectual disabilities.

Unfortunately, Kentucky has fallen from first in the nation in having that statewide behavioral health system in place to 42nd in funding for mental health and substance abuse services, and 49th in funding for mental retardation/developmental disability services.

Unfortunately, Kentucky has fallen from first in the nation in having that statewide behavioral health system in place to 42nd in funding for mental health and substance abuse services, and 49th in funding for mental retardation/developmental disability services.

### Inadequate Budget

The budget is the strongest priority-setting public policy statement that the Commonwealth can make. Over the past dozen years or more, the Commonwealth's behavioral health budget has been inadequate to meet Kentuckians' needs. **Here's How:**

- In 2001, the Statewide HB 843 Commission – made up of key legislators,

every state cabinet and department dealing with behavioral health services, consumer, family members and provider representatives – attempted to address this underfunding issue. The Commission made a recommendation that state funding for the CMHCs be increased by \$25 million/year for each of the next 10 years to move Kentucky from the bottom 10 states in funding to a national ranking of 25th in funding. Unfortunately, this recommendation was never implemented.

- While the CMHC have been largely protected from cuts, their services have been flat-funded (with no increase) for more than a dozen years, and their Medicaid rates have been frozen since 2001 at the 1999 cost-report rate.
- The number of Kentuckians served by the public-sector behavioral health system has plateaued at 179,000 over the past five years. There has been increased demand for behavioral health services, but the stagnant funding dollars simply cannot be stretched any further.
- Every aspect of the cost of doing business has increased and the demand for services continues to escalate. Everything is going up except available funding and resources.
- A Legislative Research Commission report completed in 2006 noted that "The lack of funding to meet the growing cost of doing business in providing quality behavioral healthcare challenges the sustainability of services across the Commonwealth."
- The National Alliance on Mental Illness (NAMI) has graded all of the states on the capacity and funding of its behavioral health system. In both 2006 and in 2009, Kentucky's system was given an overall grade of "F," the only state to receive a failing grade on both report cards.

### Overwhelming Crisis Looming

State-mandated employer contributions have risen dramatically over the past few years, from a rate of 5.89 percent in fiscal year 2006 to 11.61 percent in fiscal year 2010 to 26.79 percent in fiscal year

The National Alliance on Mental Illness (NAMI) has graded all of the states on the capacity and funding of its behavioral health system. In both 2006 and in 2009, Kentucky's system was given an overall grade of "F," the only state to receive a failing grade on both report cards.

2014. Now, the Pension Task Force recommendation calls for an estimated employer contribution of 42.6 percent for FY 2015 to FY2031.

### Centers Need Relief

If the Commonwealth does not give the centers some relief from this mandate or help in meeting this increase, Kentucky's behavioral health services safety net will suffer devastating damage – or will be destroyed altogether.

We will see widespread layoffs of staff, closing of service sites, particularly in rural areas, and fewer Kentuckians

Continued on page 27

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COMMENTARY

# From darkness to light

By Ramona Johnson



Life has a way of putting us in situations over, which we have little control except to choose how we will respond. Will we allow darkness to swallow us up or will we search to

turn on a light?

My mother battled severe depression and attempted suicide several times. She was engulfed in the darkness of depression and hopelessness for decades. Somehow in the turmoil of our family's life, I made a choice—to be a nurse—to help people heal and recover from illness. But three years into nursing school, it wasn't as satisfying as I expected.

Then, in 1975, the movie *One Flew Over the Cuckoo's Nest* was released. It was a fairly realistic portrayal of the state of treatment for mental illness and in that environment, as a nursing student, my light turned on. I was handed the keys to the units at Our Lady of Peace and instructed to find an acutely ill patient to work with for the semester.

My very first nursing class was about the importance of listening. So I listened. An astonishing thing happened. The longer I listened, the more sense she made.

When I met Mrs. U. she spoke in rhyming words, rocked constantly, tugged at her hair and was largely ignored by the staff because she did not cause any trouble. She took her medicine and stayed in her world. No one listened to her—her words did not make sense.

My very first nursing class was about the importance of listening. So I listened. An astonishing thing happened. The longer I listened, the more sense she made. As I listened, her eyes, which were dark pools of pain, began to shine. She was in there,

and she needed to be heard. At the end of the semester she was talking in sentences and the doctor discharged her to her home. Light had replaced her darkness.

### Path to Bridgehaven

I found my passion, and the journey led me to Bridgehaven. The agency and the people we serve (our members) have become my heart and soul. Lights are turned on every day for the 500 people with severe mental illness who pass through our doors.

They have chosen light, and they are actively involved in group therapy, in activities that develop independent living skills and in achieving their personal goals for recovery.

Our results reflect this light. Ninety-two percent of our members achieve their personal goals for recovery and that rate increases every year. They learn to be good parents. They return to college to pursue a dream that was destroyed by the onset of mental illness. They return to work in volunteer and paying jobs that allow them to be a part of the community and to give back to those that have helped them.

Many of our members were hospitalized more than once for treatment. It can be lifesaving, but it is costly and is only one aspect of treatment needed for recovery. At

## BRIDGEHAVEN MENTAL HEALTH SERVICES HOSPITAL REDUCTION RESULTS • 2001-2011

Year	Members hospitalized year prior to Bridgehaven	Members hospitalized after at least six months at Bridgehaven	% decrease in hospitalizations	Total hospital days year prior to Bridgehaven	Total hospital days after at least six months at Bridgehaven	Total days saved	Dollars saved *
2001	31	14	50%	2561	180	2381	\$ 2,023,850
2002	25	7	72%	1030	199	831	706,350
2003	35	7	80%	1725	323	1402	1,191,700
2004	74	15	78%	4979	558	4421	3,757,850
2005	57	0	100%	2302	0	2302	1,956,700
2006	22	6	73%	1101	184	917	779,450
2007	64	3	97%	3575	104	3471	2,950,350
2008	53	2	96%	2150	8	2142	1,820,700
2009	49	9	82%	1709	244	1465	1,245,250
2010	40	7	83%	573	60	513	436,050
2011	38	3	92%	700	18	682	579,700
<b>Total</b>	<b>488</b>	<b>73</b>	<b>85%</b>	<b>22,405</b>	<b>1878</b>	<b>20,527</b>	<b>\$17,447,950</b>

\*DOLLARS SAVED = NUMBER OF DAYS SAVED X \$850 PER DAY

Because CET targets parts of the brain that govern these functions it is as transformative as turning on a bright light in a dark room.

Bridgehaven, our members experience an 85 percent decrease in the frequency of psychiatric hospitalizations. Out of the institution and in our healing environment they make recovery a reality.

### Cost Savings

Equally impressive is the cost savings. Inpatient treatment costs around \$900 per day while Bridgehaven services cost \$70 per day. Our reduction in hospitalizations saves us, the taxpayers, almost \$2 million each year in hospital costs.

We are excited about serving 500 people and saving \$2 million per year, but since mental illness affects one in five people, we want to serve more. What if we could serve 1,000 people and save \$4 million a year?

### Cognitive Enhancement Therapy

Twenty members have now graduated

from our newest program, Cognitive Enhancement Therapy (CET), which we began in October 2011. Bridgehaven is the first provider in Kentucky to offer this evidence based therapy.

CET targets mental illness symptoms such as low motivation, difficulty thinking and processing information and awkwardness in social interactions that don't respond well to medication and leave people isolated and unable to function in school and work environments.

Because CET targets parts of the brain that govern these functions, it is as transformative as turning on a bright light in a dark room. Participants think more clearly, improve their relationships with others and understand how to fit in and relate. CET shines a light on the future and makes it possible for participants to realize hopes and achieve dreams that were abandoned in the despair and challenge of living with a mental illness.

### Shrinking Resources

Twenty new members have begun CET this year and will complete the one year program in 2013. Unfortunately, as the need grows, insufficient funding prevents us from providing such

Continued on page 27



# Restoring the ability to digest

Procedure helps identify patients who may benefit from permanent implantation.

By Barbara Mackovic

The first temporary endoscopic neurostimulator implantation in the region was performed this past December at Jewish Hospital, part of KentuckyOne Health. For patients with severe gastroparesis, a disorder that slows or stops the movement of food from the stomach to the small intestine, this procedure can determine if a permanent implant will restore their ability to digest.

The temporary endoscopic procedure



THE ENTERRA NEUROSTIMULATOR.

During the procedure, stimulating electrodes are fixed to the muscle of the antrum (lower stomach). The connector end of each lead is attached to the neurostimulator, which is then placed in a small pocket through an incision in the abdomen.

The stimulation triggers the muscles to move food through the stomach as it would during normal digestion, alleviating symptoms and helping patients get back to a more normal way of life.

### Procedure Benefits Patients

For patients with severe gastroparesis, this procedure can significantly improve their quality of life. Due to the condition, many patients are unable to eat full meals. In severe cases, it may have been several years since a patient's last meal.

Gastroparesis can occur in patients who have undergone a transplant, gastric bypass surgery or small bowel resection and in patients who are diabetic. Symptoms include chronic nausea and vomiting.

For patients with severe gastroparesis, this procedure can significantly improve their quality of life. Due to the condition, many patients are unable to eat full meals. In severe cases, it may have been several years since a patient's last meal.

“The addition of a clinical trial of temporary stimulation can help select patients who may benefit from an implantable (device) before they undergo a permanent surgical placement,” said Abell.

### Return Quality of Life

The patient who received the first temporary implantation was Christie Woodruff, a 54-year-old nurse practitioner from Gainesville, Ga. Woodruff has been unable to eat normally for more than six years, using an IV as her main source of nutrition. Over the course of her illness, she lost over 100 pounds.

while to fully adjust, but I look forward to getting back to normal life with my husband, enjoying life as empty nesters, working out together again and regaining the muscle I lost.”

### Pioneering Development

Abell pioneered the development of the implantable neurostimulator with medical device manufacturer Medtronic while at the University of Tennessee. His research includes conducting National Institutes of Health-sponsored clinical trials to standardize the treatment protocols for gastroparesis while at the University of



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patients who may benefit from an implantable (device) before they undergo a permanent surgical placement.”

— Thomas Abell, MD, director of the Jewish Hospital GI Motility Clinic and the Arthur M. Schoen, MD, chair in gastroenterology at the University of Louisville

was performed by Thomas Abell, MD, director of the Jewish Hospital GI Motility Clinic and the Arthur M. Schoen, MD, chair in gastroenterology at the University of Louisville. Abell specializes in gastric motility, the movements of the stomach that aid in digestion by moving food into the small intestine. The permanent device was placed by Robert Cacchione, MD, associate professor of surgery at UofL. Cacchione has extensive experience with gastric stimulation devices.

The temporary implant was followed by placement of a permanent device, which stimulates the nerves and muscles in the stomach to aid digestion in a manner similar to how a pacemaker is used to control heart rhythm.



Woodruff saw doctors at top medical facilities throughout the Midwest and Southeast, but found her options limited. When she found Abell, she said she didn't want to get her hopes up, but just days after her procedure, she was experiencing a renewed quality of life.

“I've been fortunate to already see a 60 to 70 percent improvement since the surgery,” said Woodruff. “It will take a

Mississippi. One such trial is now under way at the University of Louisville.

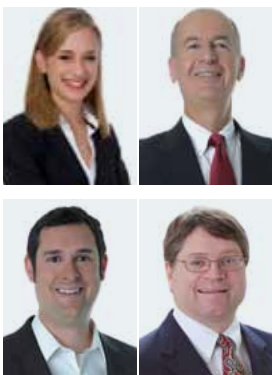
Gastric electrical stimulation was developed nearly 25 years ago for use in patients with the signs of gastroparesis, such as primarily vomiting, nausea and pain, who did not respond to other treatments. The use of gastric electrical stimulation has increased since its approval by the FDA in March 2000.

## SPECIAL LEGAL SERIES: HIPAA FINAL RULE

## What's a covered entity supposed to do?

One of the most significant revisions is the elimination of the "significant harm" threshold from the definition of breach.

By Christina Anderson, Thomas Anthony,  
Chad Eckhardt, Charles Johnson



*This is part one of a four part series of updates summarizing the HIPAA Final Rules and addressing implementation concerns that many organizations may encounter.*

The HIPAA Final Rule modifies many provisions of the HIPAA regulations. Although many of these modifications were anticipated, one has caught some by surprise.

### Breach Notification Rule Revision

One of the most significant revisions, and one that some covered entities hoped would not occur, is the elimination of the "significant harm" threshold from the definition of breach.

Under the current Breach Notification Rule, covered entities and business associates are required to notify individuals, the Department of Health and Human Services, and, at times, the media, if a breach of PHI has occurred. In determining whether a breach occurred under the current regulations, a covered entity must conduct a risk assessment to determine if the unpermitted use or disclosure creates a significant risk of financial, reputational or other harm to the individual. Under the current Breach Notification Rule, if there is no significant

Covered entities will need to review their systems and capabilities to create appropriate and reasonable safeguards to enable it to comply with restrictions requested under this expanded patient right.

risk of harm, a breach has not occurred and there are no notification requirements.

Under the Final Rule, an unpermitted use or disclosure of PHI that does not meet one of the three narrow exceptions is *presumed to be a breach* unless the covered entity's risk assessment results in a deter-

mination that a low probability exists that the PHI involved was compromised. This effectively changes the standard for breach notifications.

This revision is significant because it will result in covered entities making more notifications of breaches. This has two likely effects. First, HIPAA compliance costs will necessarily increase as more breaches are identified and handled. Second, handling the fallout from a breach upfront in business associate agreements will receive increased attention. Covered entities and business associates will need to review, and likely, revise their breach notification policies and risk assessment processes to align with the final rule's requirements.

In addition to this important revision,

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# MEDICAL NEWS

The business of healthcare

## In issues to come:

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**SPECIAL LEGAL SERIES: HIPAA FINAL RULE**

# What's a covered entity supposed to do?

Continued from page 26

the Final Rule expanded two patient rights that covered entities will want to quickly consider and address in order to be in compliance by September 23, 2013.

## Right to Request Restrictions

Currently, individuals have the right to request restrictions to the use and disclosure of their PHI. Covered entities are not currently required to agree to a restriction. The Final Rule, however, now requires covered entities to agree to restrict disclosures of an individual's PHI to a health plan with respect to any PHI pertaining to items or services for which the individual has paid for in full. This provision generated much concern in the industry when it was introduced in the July 2010 proposed rules because of its operational difficulties. The preamble to the Final Rule provides guidance with respect to these difficulties including issues regarding bundled payments and pre-certification requirements.

Covered entities will need to review their systems and capabilities to create ap-

propriate and reasonable safeguards to enable it to comply with restrictions requested under this expanded patient right.

## Right to Receive PHI in an Electronic Form

Under the Final Rule, covered entities that maintain PHI electronically are required to provide individuals with electronic access to PHI as may be requested by the individual if the PHI is readily producible in the requested form.

Covered entities maintaining electronic records will need to review their systems and develop procedures to provide PHI in an electronic form that most individuals will find acceptable.

*Christina Anderson is an associate at Frost Brown Todd LLC in Columbus, Ohio. Thomas Anthony is a member at Frost Brown Todd LLC in Cincinnati, Ohio. Chad Eckhardt is an associate at Frost Brown Todd LLC in Cincinnati, Ohio and Charles Johnson is a member at Frost Brown Todd LLC in Charleston, W.V.*

# Making the case for adequacy—behavioral health

Continued from page 23

receiving the behavioral health services and supports that they need.

What happens when individuals do not receive needed behavioral health services? They become caught in the revolving door of repeated hospitalizations, involvement with the criminal justice system, homelessness and, sadly, in some cases, suicide.

We know that treatment works. We know that recovery is possible, but only if services and supports are available. And they are available only if they are adequately funded!

*Sheila Schuster, PhD, is executive director/chair of Kentucky Voices for Health and Advocacy Action Network.*

# From darkness to light

Continued from page 24

effective services.

Because of shrinking resources throughout the community we turned away 64 people in 2012, 83 percent more than we did in 2011. We are facing the reality of reduced funding from every source: less funding from local government, a four percent decrease in our revenue from the services we bill to Medicaid and more difficulty securing grant funding. The recent recession has taken its toll on charitable giving. Without adequate funding, we will be forced to reduce services.

For most of us, all we have to do to

eradicate the dark is to turn on the light. For people with mental illness the light switch is sometimes harder to find and it takes time and patience.

As the late Albert Schweitzer, a German physician, musician and philanthropist once said: "At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us."

*Ramona Johnson is president and CEO of Bridgehaven in Louisville.*



# Better care is here.

Meet KentuckyOne Health. A new and unique partnership between two of Kentucky's leading health providers—Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System. Together we are investing \$320 million to bring the latest treatments to more people across the state. Learn more about KentuckyOne Health at [KentuckyOneHealth.org](http://KentuckyOneHealth.org).



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- Jewish Hospital Shelbyville
- Jewish Physician Group
- Our Lady of Peace
- Saint Joseph Berea

- Saint Joseph East
- Saint Joseph Hospital
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