MEDICINE in Oregon

A publication of the Oregon Medical Association

Policy · Community · Practice

Spring 2009

Psychiatric Care Challenges *in Oregon's Emergency Departments*

Treating Depression in Teens

Scope of Practice and Mental Health Treatments

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Chairman and CEO, The Doctors Company

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Spring 2009

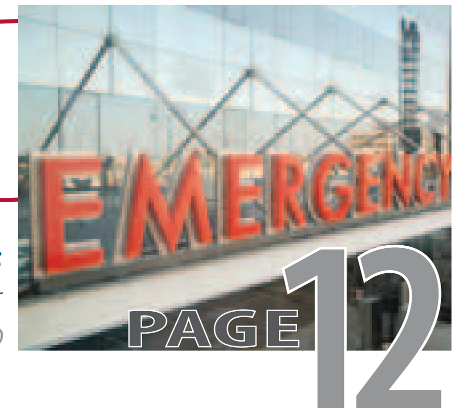
POLICY ✧ COMMUNITY ✧ PRACTICE

MEDICINE in Oregon

Psychiatric Care Challenges in Oregon's Emergency Departments

By Abby Christopher

PLUS…Science of Addiction, by Nora Volkow, MD



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Untitled (photo)
By Dr. Adam Angeles

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On the Cover

Pink cherry blossoms greet the Oregon spring. Japan gave 3,020 *sakura* (cherry blossom) trees as a gift to the United States in 1912 to celebrate the nations' then-growing friendship. *Photo by Bettina Chuck.*

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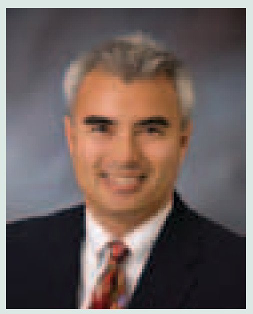


Peter A. Bernardo, MD

What Normal Means

I have watched the darkness fall across my children's faces. I have seen the storms raging behind their eyes. I have searched for them on the streets of the city, following the spoor of madness.

IN 1958 THERE WERE 3,345 INPATIENT PSYCHIATRY BEDS IN OREGON. The Oregon State Hospital in Salem was just one of many sites used for short and long term residential treatment of the mentally ill. Psychiatry and the treatment of mental illness have changed quite a bit in fifty years. Attitudes towards inpatient treatment have evolved; now more of the mentally ill are treated in the community setting. Deinstitutionalization has not always been a good thing: a third of the homeless people in America have a serious psychiatric illness.

Has the prevalence of psychiatric illness increased in our society? There is certainly an increased recognition of the problem. Any adult primary care doctor will tell you that a third of their day might be spent on counseling, evaluation, and treatment of anxiety, phobias, eating disorders, depression, PTSD, ADD, drug and alcohol dependence, sleep disorders, dementia, bipolar disease and even schizophrenia. Overall, 26 percent of Americans may suffer from some mental health problem. Five of the top 20 prescription drugs in this country are for mental or emotional problems.

The numbers are startling. Twenty percent of Americans over age 55 may have a mental illness. Over 7,500 Oregon National Guardsman have been sent overseas in the last seven years; one in five may have some degree of PTSD. In our correctional system 41 percent of inmates have an Axis I or II diagnosis. National studies suggest that 5.4 percent of Oregonians may have a serious mental illness such as Bipolar Disorder or Schizophrenia. That is almost 200,000 people. Of these, almost 16,000 have no insurance coverage.

Patients with medical insurance don't necessarily have coverage for mental health issues. Insurance companies, in the past, would cover mental illness differently from other health problems. If coverage existed at all, it was usually at a lower percentage of the billed charges, or came with higher deductibles and co-pays. Most of that changed with passage of the Federal Mental Health Parity and Addiction Equity Act of 2008. Psychiatric care has taken a back seat to general medical care in Oregon and nationwide. We have a shortage of physicians, but no one would suggest that we do not have enough hospitals or operating rooms.

We do not have enough psychiatric facilities. Oregon, in 2008, has 1,032 beds available for psychiatric care. Of those beds, only 260 are available in community hospitals for use by the general public. The majority of beds are in the state hospital system and are occupied by forensics patients (civil and criminal commitments). On any given day, state patients also occupy two thirds of the available general community hospital beds. These might be patients undergoing court ordered evaluations or emergency commitments. For Oregonians with new onset schizophrenia, mania, or depression with suicidal ideation, that means that there are 100–120 beds available for care. It is not enough. An accepted standard is 50 beds per 100,000 population. For Oregon that would be 1,800 beds. The two new Oregon State Hospital Facilities in Salem and Junction City will replace

Peter Bernardo, MD is president of the Oregon Medical Association. He is a general surgeon in private practice in Salem, and has been an OMA member since 1992.

the old state hospital (702 beds) with 980 new beds. We will still be short some 400 beds.

Acute psychiatric patients fill our emergency rooms. Often they must be boarded there awaiting the availability of a psychiatry bed. They, in turn, prevent other patients from getting medical care. Any physician involved in acute care medicine recognizes the severity of this problem. Families around Oregon face this issue every day; like most medically-related misfortune, you hope it doesn't affect you. I know I never gave it a second thought.

I have three beautiful, intelligent, talented children, each of whom has struggled with serious mental health issues. Over the last four years, my wife and I have become very familiar with the mental health system in Salem and Portland. We have met counselors and adolescent psychiatrists. We have spent time in offices, and emergency rooms, and behind the locked doors of an inpatient facility. We have left a child in the emergency room, under the care of the doctors and nurses, waiting for an inpatient bed to open up the next day. We have come to know many of the members of our local police department, never under pleasant circumstances.

It has been unexpected and confusing. As we say, every day is an adventure (and not in a good way). We are thankful for the professionals that have given us support and guidance. There is a system there, if you can access it. We have health insurance that covered those visits and stays. Somewhere in all of this we have come to see that we are not alone. Many of our friends, unbeknownst to us, have struggled with similar problems.

One day my daughter said to me that she just wanted to be normal. Strange to say, but she is, and we are.

UPCOMING events

OMA Headquarters
11740 SW 68th Pkwy, Ste 100, Portland
(503) 619-8000 • *www.theOMA.org*

OMA Executive Committee Retreat
May 16–17, Cannon Beach

OMA Board of Trustees Meeting
June 6, OMA Headquarters

AMA House of Delegates/ AMA Alliance House of Delegates
June 13–17, Chicago

OMA Executive Committee Meeting
July 9, OMA Headquarters

Important Deadlines

Red Flag Rules Compliance Deadline
For more information, visit www.theOMA.org/files/redflagrulesarticle.pdf.

May 1

OMA Roster Inquiries Due
June 15

Non-OMA events

Lane County Medical Society Monthly Dinner Meeting
May 5, Hilton Eugene & Conference Center

Oregon Academy of Family Physicians Annual Spring CME Weekend
May 7–9, Sunriver

OR/WA MGMA Annual Meeting
Visit www.omgma.com for more information.

May 17–20, Portland

Oregon Pathologists Association Dinner/ Membership Business Meeting
May 22; 5:30 pm, OMA Headquarters

Oregon Pathologists Association Scientific Seminar
May 23; 9:00 am

Risk Management Seminars
For more information, visit www.theOMA.org/lossprevention.

Risk Management for Medical Office Personnel *(noon–4pm)*
May 8, Grants Pass

May 22, Sisters

June 12, Pendleton

Advanced Training in Risk Management *(8–11am)*
May 9, Grants Pass

June 13, Pendleton

Workshops
For more information on OMA workshops, visit www.theOMA.org/workshops.

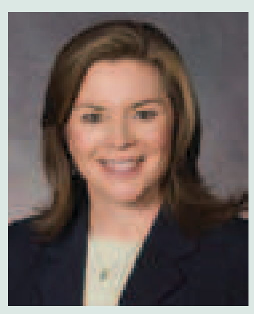
HIPAA "How-To's" Series
May 5 (8am–5pm), OMA Headquarters

Medical Collections Workshop
May 12 (1–5pm), Bend

May 28 (8:30am–12:30pm), OMA Headquarters

Practice Management Webinar Series
Appealing Unfair Payments[SM]: Recession-era claims follow-up tactics

May 7 (10–11:30am) *or*
May 27 (1:30–3pm)



Joanne K. Bryson, CAE

Things Are Better Than They Seem

As I sat down to begin writing my column for this issue of MiO*, focusing on mental health, ironically, I received a news alert: "Portland, Oregon Ranks First Among 20 Unhappiest Cities in the United States."*

The rankings were based on, among other criteria, depression, crime, suicide (12th highest in the nation) divorce (4th highest), unemployment (near 10 percent), and cloudy days (222).

OUR STATE WAS AT the center of mental health advocacy when former Senator Gordon Smith's son committed suicide in 2003. As a result of that personal tragedy, Smith worked to have the Garrett Lee Smith Memorial Act signed into law in 2004, which authorized funds to prevent youth suicide nationwide.

The OMA has also worked closely with the Oregon Psychiatric Association to ensure mental disorders are covered by group insurance plans, and covered like all other medical conditions for Medicare beneficiaries.

In 2003, the Oregon Legislature passed the mental health parity law, following a decade-long effort. Key to achieving that landmark legislation was information obtained through an actuary study funded by the OMA with assistance from OPA. The study laid the groundwork for convincing legislators that ending insurance discrimination against patients with a medical condition diagnosed as a mental disorder was cost effective.

On the Medicare front, the Medicare Improvements for Patients and Providers Act was signed into law last July and provides for Medicare coinsurance parity for Medicare beneficiaries. Currently, Medicare beneficiaries are responsible for paying 50 percent of the approved amount for outpatient mental health services, but only 20 percent for other services. This phase-in to coinsurance parity for outpatient mental health services begins in January 2010, when beneficiaries will pay 45 percent coinsurance. The figure drops to 40 percent in 2012, 35 percent in 2013 and 20 percent in 2014. The Act also mandates that Medicare will pay for benzodiazepine and barbiturate prescriptions, effective January 1, 2013. Vulnerable patients will be assured access to "all or substantially all" of the medications they require, specifically including antidepressants and antipsychotics.

Collaboration continues to improve medical treatment of psychiatric conditions today. Family practice physicians, pediatricians, psychiatrists, and child psychiatrists have undertaken important initiatives to build consultative interactions in underserved areas. While these projects are just beginning, already they have improved patient care and built important relationships that will serve Oregon citizens well.

There are several bills in play this legislative session regarding the mental health system in Oregon. Below are three bills the OMA is monitoring:

- SB 25, initiated by Senate President Courtney at the request of a Patient Care Committee at the state hospital, seeks to establish an Oregon State Hospital Advisory Board to oversee the Oregon State Hospital.
- SB 156 would require the Department of Human Services to ensure that mental health, addiction and physical health services are provided in an integrated manner.
- HB 2054 would require the Oregon Department of State Police to create a voluntary mental health database which would serve to alert law enforcement officials when they are dealing with a person who has a mental illness.

Unfortunately, we tend to only hear about the latest tragedy involving an individual with a mental illness, a confrontation with law enforcement, suicide, or, hearing that Portland has been ranked number one of the 20 unhappiest cities in the US. The reality is, though few would argue with the need for the system to improve, tens of thousands of individuals who suffer from a mental disorder are leading normal, fulfilling lives because of the quality treatment they receive from Oregon physicians.

OMA Medical Professional Resources

Confidential, peer-review services for physicians

By Jennifer Nordgaard

OMA OFFERS A VARIETY of confidential "peer-review" protected services for physicians and other medical practitioners that provide consultation and advice around issues such as accreditation requirements, credentialing, risk management assessment and others.

Since 2007, OMA has offered Office-Based Surgery Accreditation. This service enables Oregon physicians to comply with the Oregon Medical Board mandate (OAR 847-017-0005, October 2006) which requires physicians who conduct **conscious sedation** when performing in-office surgery to receive accreditation from a Board-recognized entity. The Oregon Medical Board recognizes OMA's program as such an entity.

This program includes a review by peers who are familiar with issues specific to Oregon medical practices, and offers both telephone and on-site educational consultation and assistance. In addition, the OMA program offers outpatient facilities a practical, meaningful and economical method for improving health care quality.

OMA's rates are substantially below those of other accrediting bodies, and members are eligible for a 20 percent discount. Information about the service is available online at *www.theOMA.org/page.asp?navid=468.* **The deadline to comply with this Oregon Medical Board accreditation requirement is August 1, 2009. Plan now to enroll in the program!**

The Risk Assessment and Management Program (RAMP) is designed to help physicians identify and correct practice problems that otherwise might lead to malpractice lawsuits, loss of license, or loss of insurance or hospital privileges. Participants may become involved in RAMP through referral by their insurance carriers, the Oregon Medical Board or hospital medical staffs.

RAMP candidates undergo an extensive Baseline Practice Review in order to help them recognize practice and personal behaviors that have contributed to or may in the future bring about practice difficulties. Following this assessment, a corrective action plan is developed with the help of physician consultants. Once the review has been completed and a plan is in place, RAMP will monitor physicians for up to two years or as deemed necessary.

RAMP is approved by the Oregon Medical Board as well as malpractice insurance carriers. As long as physicians remain in compliance with the plan, they will not be subject to disciplinary action.

Joining the Circle

OMA thanks those members who have paid their 2008 dues, and welcomes the following new members and those who have reinstated their membership with the OMA in January and February.

Heidi A. Allen, MD
Barry M. Austin, MD
Maureen O. Baxter, MD
Natalie E. Boodin, MD
Chad Burk
Michael Joseph Burns
Laura K. Byerly
Cody Anne Byrnes, PA-C
Ellen Cheang
Brian Burgess Chesebro, MD
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Deanna E. Cully, PA-C
Erin J. Cunningham, PA-C
Gabriel Philip Currie
Emmy Nakasu Davison
Katherine J. Fifer, PA-C
Michelle L. Fitts, PA
Travis Charles Geraci
Mark A. Gibson, MD
Lorraine W. Gohman, PA-C
Chad R. Goins, MD
Ann M. Gould, PA
William Allen Gray
Alissa Greenbaum
Christopher B. Hagen, MD
Lawrence F. Haglund, MD
Maria Lourdes Herrera
Rebecca G. Hills, MD
Robert C. Hinz
Jody E. Hooper, MD
David L. Hotchkin, MD
Ashley P. Hyder, MD
Dan M. Hyder, MD
Norah Ruth Janosy, MD
Shehzad Jinnah, MD
Stefan Jozef Jodko, MD
Donna Kang
Jade Michiko Koide
Zachariah Kramer
Rick Miller Krebs
Brian R. Kreul, MD
Edna Kung, MD
Christopher J. Lace, MD
Veronica Lagos
Terrence Chung-Hun Lee
Khilo Lim
Dennis M. Liu, MD
Ilan Igor Maizlin
Laura K. Mavity, MD
Sharon E. Meieran, MD
Robert T. Melton, MD
Jeremy P. Middleton, MD
Jessica Lynn Miller
Mary L. Moore, MD
John R. Pattee, MD
Jeffrey Peter Pavelka, DO
Fernando J. Pena, MD
Ralph G. Peterson, PA
Ragna K. Rey-Rosa, MD
Robert S. Riddick, MD
Paul S. Rostykus, MD
Antoine Sayegh, MD
Caroline Schier
Stephanie R. Scott, PA-C
Utako Sekiya, MD
Ryan William Snow
Nina Sparr
Carol A. Squyres, MD
Sandhya Venkata Srikantom
Trebor Taylor Struble, PA-C
Daniel E. Sullivan, MD
Eric B. Swetland, MD
Cynthia Tai, MD
Shandiz Tehrani, MD
Jeremy Ross Tesar
Leo Thai
Tula Top, MD
Anna Maire Urbanc, PA
Matthew J. Wood, MD

Magazine Submission Guidelines

We welcome submissions from our members, including opinion pieces, essays about your practice, or visual art. We do not offer payment for published work, but can provide additional copies of the magazine in which your work appears.

If you are interested in writing but do not have a clear idea or a specific topic in mind, you may wish to contact a member of the editorial advisory board or the staff editor. They may be able to assign you a topic or make suggestions for content we are seeking for a particular issue.

Get a sense of what is planned by viewing the editorial calendar for the year, which is kept up to date on the OMA website at *www.theOMA.org/MiO*. Submission deadlines and tentative themes for each issue are as follows:

June 5: Summer 2009 issue; Politics and Medicine

Sept. 5: Fall 2009 issue; Oregon's Research Hub/Quality & Performance in Practice

Dec. 4: Winter 2010 issue; Preparing for the Worst: Doctors and Disaster

March 5, 2010: Spring 2010 issue; topic TBA

Send your submissions electronically to *betsy@theOMA.org*.

Written submissions should be sent in rich text format or MS Word 2003. Any accompanying photos or illustrations can be sent either on CD or via e-mail. Please note these must be high-resolution files, 300 dpi or higher. We have a 6MB size limitation on e-mail we can receive. Include a brief (25 words or fewer) biographical note, including your specialty, where you practice and (optionally) how long you have been a member of OMA. Works of visual art can be submitted either via mailed CD or e-mail, or contact Betsy Boyd-Flynn to arrange an in-person meeting.

Confidential, peer-review services, cont.

OMA's Medical Review is a service for individuals and groups—ranging from member physicians to hospitals, insurance companies and IPAs—who are seeking an objective, private review conducted using the peer-review process.

Through the Medical Review service, OMA finds appropriate physicians to conduct chart reviews who are familiar with the practice type and/or specialty. The benefit to those who use this service is access to an external peer-review process that is protected under state medical law. The Medical Review service is quick, confidential and offered at a low rate to OMA members.

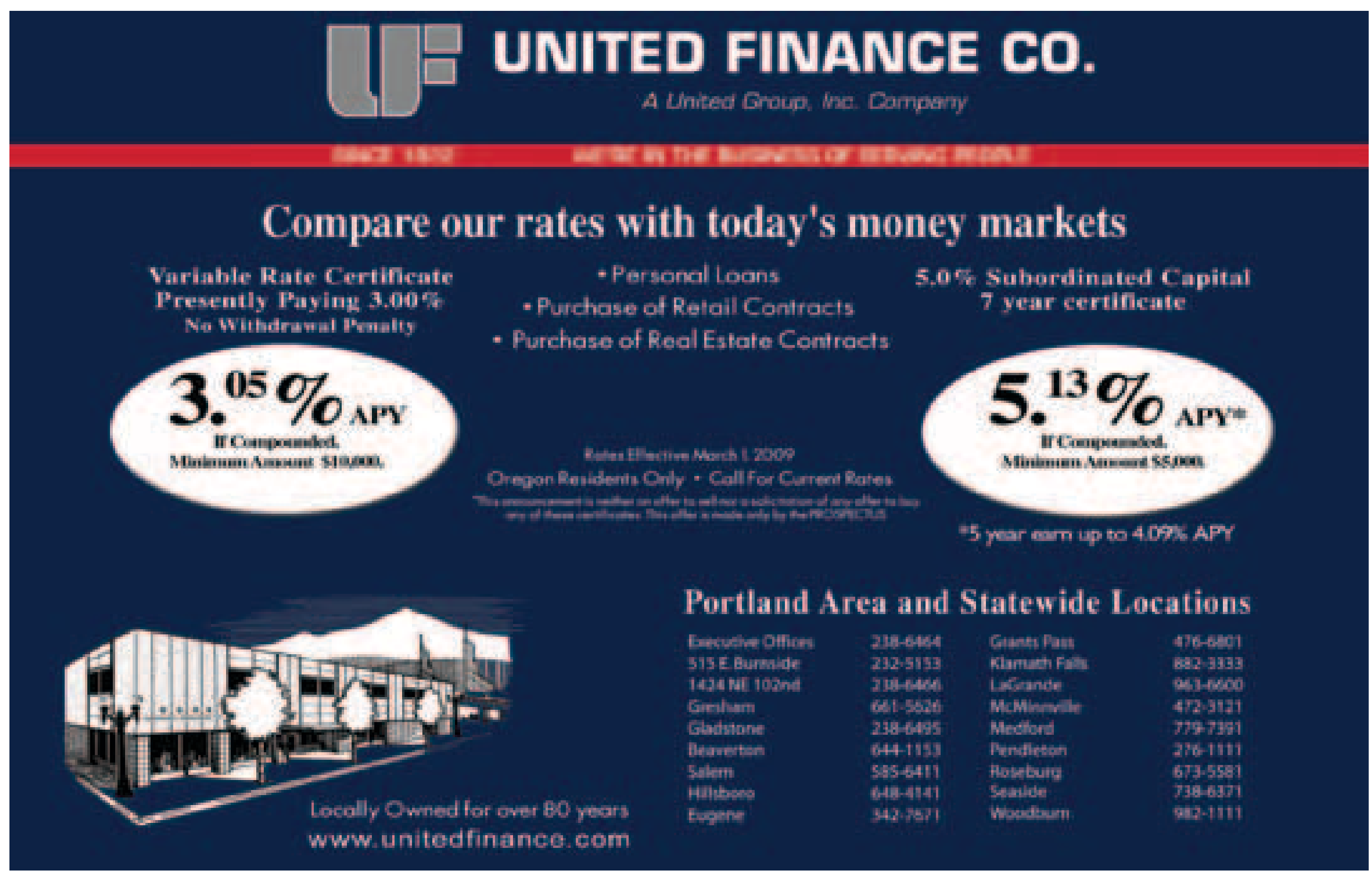
Developed through a joint effort with the Oregon Association of Hospitals and Health Systems, and supported by Oregon medical liability insurers, the **OMA Mediation Service** is a voluntary, non-binding service that gives conflicting parties a private, objective arena for resolving differences apart from a court of law. OMA members and others in the medical field may take advantage of this service to help resolve disputes. For example: if a physician and hospital are co-defendants in a malpractice case and there is a dispute between the two, rather than argue in court, the differing parties can request to use OMA's Mediation Service.

Mediations are conducted by defense lawyers, hospital risk managers and retired judges who have expertise in the mediation process, yet offer an objective viewpoint. These experts listen to the differing opinions and provide an external assessment of the arguments. OMA's Mediation Service is peer-review protected under Oregon law.

The Teamwork in Medicine Project is a newly developed initiative that assesses medical practice situations in an effort to help identify systemic problems that may affect quality, safety and/or morale. It offers a way for practices to improve internal communications and set processes in place so that quality and safety are routine procedure. Consultations may also include external groups—for instance, multiple practice groups that may work together—in order to help them develop and promote good intra-communications and quality care.

Interested physicians, individual practices or groups may request a consultation, which is conducted at an hourly rate. The overall goal of this project is to help groups identify concerns that may result in potential malpractice or quality problems, and assist them in developing jointly agreed-upon solutions.

For information about these services, including rates for members, contact Paul Frisch, OMA General Counsel at paul@theOMA.org, *or D'arcy Renhard, Manager of Loss Prevention Education and Accreditation Services at* darcy@theOMA.org, *or by calling the OMA directly at (503) 619-8000.*



Payment Advocacy Corner

Did You Know?

By Reina O'Beck

THE OMA HAS A variety of member benefits specifically geared towards assisting physician practices and their staff. With this current economy, it is a great time to access the following ***FREE*** member benefits, to stay on top of your practice and to improve your bottom line:

Insurance Carrier Advocacy: Are you experiencing reimbursement, customer service or other issues in working with Medicare, Medicaid, TRICARE or a commercial health insurance payer? The OMA is available to interface with private and public payers to work towards resolving these matters on your behalf.

Coding Questions: Not sure if the code you are using is correct? Need a second opinion or coding advice? The OMA can work with coding experts to offer technical assistance to answer tough coding questions.

HIPAA Resources: Have HIPAA questions? The OMA has updated HIPAA policies, procedures and templates available on the HIPAA section of the OMA website. These free tools for members provide an overview of HIPAA policies as well as customizable templates and forms for your office. Developed for OMA by Chris Apgar, a nationally-respected expert on HIPAA, these tools help physicians to ensure they meet the HIPAA requirements. Visit *www.theOMA.org/hipaa* to access this exclusive member benefit. You will need a member login to access this OMA website. For login instructions, visit *www.theOMA.org* or contact Stephanie at *stephanie@theOMA.org* or (503) 619-8000 for further login information.

The OMA also offers a HIPAA online training course that provides the latest information and instruction on HIPAA Privacy, Electronic Security/Transactions, and Enforcement. If you would like to learn more about this courseware, visit *www.hccs.com/docs/brochures/hipaa_brochure.pdf* or register for this course by clicking the "Online HIPAA Training Register Today" link on the OMA HIPAA website.

Aetna Contract Review: OMA reviewed Aetna Health Management, LLC's Physician Group Agreement for OMA members. The review contained observations about several sections in the Agreement that needed further clarification, but did not make any recommendations as to whether or not physicians should participate in the agreement. As a result of the review, Aetna's Medical Director for the Northwest Region and their legal counsel met with the OMA in late November of last year to discuss these observations. Aetna has since produced several changes to the agreement because of this collaborative approach on this agreement review process. To view this contract review, visit *www.theOMA.org/contract.*

Other Tools for Your Office: The OMA is also in the process of creating resources to assist physicians in complying with other governmental regulations such as the Red Flag Rules, and will inform physicians and their staff when those tools are available.

Contact Reina O'Beck to learn more about these FREE technical resources for members at reina@theOMA.org *or (503) 619-8131.*

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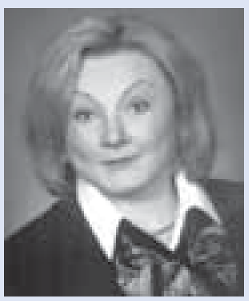

Eva Germaine-Shimotakahara

Looking Back on a Successful Year

The OMAA has been very busy and continues to be very engaged this year.

Eva Germaine-Shimotakahara, BSc.N, BA, is the immediate past president of the OMA Alliance. She was born in Nova Scotia, Canada, and completed her nursing education at St. Francis Xavier University. She has been married to Steven Shimotakahara, MD, for 25 years, and has three grown children.

OUR MAJOR FOCUS HAS been increasing awareness of the health issues facing returning war veterans. In September, at our fall meeting, we co-hosted a two-day Veterans Education and Awareness Forum with Bay Area Hospital in Coos Bay. The guest speakers were Lynn Van Male, PhD, a psychologist at the Portland VA Hospital; James Calvert, MD, Vietnam veteran and 2008 OMA Doctor-Citizen of the Year; and OHSU psychiatrist Scott Babe, MD, an Iraqi war veteran. They gave presentations for health professionals, as well as veterans and the general public, regarding Post Traumatic Stress Disorder and Traumatic Brain Injury. Another reflection of our focus on support for the military this year is that six soldiers were adopted by members and/or county alliances through the Adopt a US Soldier Program. This service provides support through cards, letters and care packages for currently deployed soldiers.

In October, we hosted the 20th Annual Teen Health Workshop in Eugene. The keynote motivational speaker was Steve Arrington who teaches young people about the perils of taking drugs; 280 students from across Oregon were bussed to this event.

The Southwestern Oregon Medical Society Alliance has been particularly active in volunteer work. Steve Arrington spoke in Coos Bay in January to nearly 2900 teenagers, teachers and parents about wise choices to make to avoid drug use. Because of a grant from SWOMS, SWOMSA was able to host this incredible speaker.

I Can Handle Bullies and *Hands are Not For Hitting* coloring books produced by the AMAA were distributed to over 1200 children in Coos County. Items were distributed to a Safe House for Valentine's Day, 30 Hero packs were dropped off at the Ronald McDonald House in Portland and numerous contributions were made to local charities.

In an attempt to increase membership, SWOMSA hosted a heartwarming party with SWOMS on April 4; similarly, Jackson County hosted a party with their medical society in December.

Eleven members attended the OMA/OMAA Day at the Capitol in Salem on February 17. This was a project first initiated by the OMAA, and then coordinated jointly with OMA. OMAA members met with their representatives and senators and expressed their opinions regarding upcoming issues that affect medicine such as HB 2009 to expand Medicaid coverage and tort reform. Prior to the Day at the Capitol, State Representative Arnie Roblan, and Courtni Dresser, Associate Director of Government Affairs for the OMA spoke on upcoming legislative issues at our OMAA winter meeting.

Pointman Ministries volunteer and Vietnam veteran, Tom Birdsong spoke about his experience as a sufferer of PTSD and ways in which we can assist veterans.

On Doctor's Day, March 30, SWOMSA sold carnations at two medical clinics and donated the proceeds to a local charitable health clinic. Special agents Micah Persons and Ben Hicks from the Oregon Dept. of Justice, Criminal Division, Internet Crimes Against Children Task Force spoke in Coos County to four middle schools on Internet safety on April 21 and 22. Our spring meeting in Eugene included speakers on the medical marriage and military family support groups.

This synopsis is only a portion of all that the OMAA does toward promoting better health. Our active members that participate in volunteer activities are small in numbers but the work that they do provides huge benefits to the communities in which we live.

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Psychiatric Care Challenges

in Oregon's Emergency Departments

By Abby Christopher

OREGON'S EMERGENCY DEPARTMENTS ARE ranked among the worst in the country according to a study published by the American College of Emergency Physicians in December 2008. Oregon received an 'F' for access to emergency care and a 'D' overall. The study also indicated that Oregon's ED physicians are struggling to care for the mentally ill. To make matters worse, Governor Ted Kulongoski has recommended cuts in mental health services of roughly 16 to 20 percent for the 09–11 budget because of the state's increasingly limited resources, and these cuts could be even steeper if the economy worsens.

According to a recent study conducted by Boston based researchers, Public Service Group for Oregon's Department of Human Services Addictions and Mental Health division, hospital EDs continue to be a default source of mental health services. In the absence of sufficient access to community based care, Oregonians with mental illnesses often receive "higher cost services including preventive and maintenance services in emergency departments, acute care hospitals and state psychiatric hospitals." The Public Service Group's November 2008 report, "Assessment and Evaluation of the Mental Health Care Delivery System in Oregon," also states that "these trends are not clinically appropriate, cost effective, nor financially sustainable."

Madeline Olson, deputy assistant director of DHS' AMH agrees with this assessment. According to Olson, "If people do not receive treatment before their mental illnesses progress too far, they will deteriorate to the point where they end in an emergency department or in jail. Without proper care, people's mental illnesses will progress and they will get too sick to manage outside a hospital setting."

Boarding and diversion

It is not uncommon for ED physicians to hold mentally ill patients in ED beds or "board" them for several days until a bed is available at a psychiatric facility. Volatile intoxicated patients are also held in EDs for observation until they are sober enough to be evaluated. Many patients under the influence are dual diagnosed with a mental illness in addition to substance abuse. The boarding of patients with severe mental illnesses in EDs can last several days because of the lack of available beds in psychiatric facilities in the state, and even in bordering states. Finding any sort of emergency psychiatric care can also be especially challenging in remote parts of the state, according to Dan Handel, MD, an ED physician at OHSU and president of the ACEP Oregon Chapter. For example, "Harney only has one hospital and the next closest one is a two hour drive."

In addition to being boarded in ED beds indefinitely, mentally ill patients can often be more time consuming and demanding to treat. According to Dr. Anthony T. Ng, president of the American Association of Emergency Psychiatry, "Patients coming to an emergency room for psychiatric reasons often report fearfulness, sadness, sudden crying and suicidal thoughts, disruptive or agitated behavior, severe anxiety and an inability to work or function in some manner." Patients requiring some form of psychiatric treatment are often dropped off by police or by an acquaintance, but they are often left on their own waiting for care in the chaotic ED.

Psychiatric patients can compromise physicians outside the ED

ED physicians' colleagues in other specialties nominally outside the ED generally believe that the challenges of providing emergency psychiatric care on this last resort basis are, while unfortunate, not their problem, according to Chip Sanchez, MD, an ED doctor at Providence Hospital in Portland.

Sanchez, points out that the burdens of the ED affect the whole of the health care system. When "ambulances are on total diversion [from an ED] when you have 5–10 mental health patients boarding, you are operating at limited capacity. Diverted ambulances drive around to find an ED that can take them. This results in delays in treatment of heart attacks, strokes and other medical emergencies. There is a cost of recovery to the patient and in the case of an MI, the patient's cardiologist will have less muscle to work with, because time is muscle. The earlier the treatment, the more heart muscle you can save. Diversion—often caused by boarding mentally ill patients—is a serious issue." Adds Handel, "many [colleagues] don't appreciate the challenges we face. They're not directly involved [in the care and treatment of mentally ill patients]."

As a result, while many other specialists may believe that they are far removed from access bottlenecks caused by the mentally ill, many whose patients may land in the ED will experience longer waiting times. This directly affects how an ED patient presents to consulting physicians who are called in and/or to a specialist who is already treating a patient with any number of serious chronic conditions. In short, mentally ill patients whose treatment needs escalate can have a ripple effect on the whole of the health care system and physicians in all areas of specialization, not just ED physicians.

Legislation and health reform offer alternative solutions

In an effort to improve ED conditions and quality of care and to tamp down the "us vs. them" mentality between ED physicians and other specialty physicians, the ACEP has helped reintroduce "Access to Emergency Medical Services Act"

Science of Addiction

By Nora Volkow, MD

Drug addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite devastating consequences. Breakthroughs in drug abuse research have led to a better understanding of how drug addiction develops and illuminated the challenges to sustained recovery. Research estimates that genetics accounts for 40 to 60 percent of an individual's vulnerability to addiction, with environmental and developmental variables influencing whether and how particular genes are expressed. Further, brain imaging studies have revealed that repeated drug use can cause changes in the brain resulting in diminished decision-making ability and behavior control, thereby hindering quit attempts as well as prolonged abstinence. However, addiction is a treatable disease—advances in drug abuse treatment have enabled people to counteract addiction's powerful effects on the brain and behavior and regain control of their lives.

Drug abuse trends

It is estimated that 22.6 million persons in the US, aged 12 or older were dependent on or abused substances—including alcohol, illicit drugs, and prescription medications—in 2006 (The National Survey on Drug Use and Health, 2007). Although these numbers indicate the enormity of the US drug abuse problem, there have been advances in prevention. NIDA's Monitoring the Future Survey (2007) reported substantial declines in past-year illicit drug use for 8th, 10th, and 12th graders since a decade ago, and use of nicotine is lower than at any time since the survey began in 1975. However, challenges remain, with nearly 1 in 10 high school seniors reporting non-medical use of Vicodin in the past year.

Pending mental health and related bills

Oregon Bills	Description	Sponsors
HB 2052	Requires governmental entity establishing specified facilities for mentally ill to obtain advice from local community's public safety council.	House Committee on Human Services and Women's Wellness
HB 2054	Requires Department of State Police to create mental health database to aid law enforcement agencies in assisting persons with mental illness in obtaining services.	House Committee on Human Services and Women's Wellness
HB 2144	Requires specified state agencies and commissions to participate in wraparound initiative for provision of youth services, including mental health services.	Governor Kulongoski and DHS
HB 2461	Beer tax: Imposes prevention, treatment and recovery tax on malt beverages. Establishes Alcohol Impact Remediation Fund.	Reps. Canon, Dembrow; Sens. Dingefelder, Morrisette, Rosenbaum
HB 2702	Authorizes State Board of Psychologist Examiners to grant certain licensed psychologists the authority to prescribe from a limited formulary of medications to treat mental illnesses.	Reps. Greenlick, Kotek, Maurer Sens. Bates, Nelson
HB 3243	Allows Oregon Medical Board to refuse to grant license to practice, or to suspend or revoke license to practice, if person terminates relationship with patient solely because of patient's eligibility for Medicare.	Rep. Barton
SB 368	Establishes Office of Consumer Affairs in DHS to promote consumer-directed mental health services.	Sen. Morrisette
SB 575	Allows physician assistants to authorize commitment of person who is mentally ill.	Sen. Morrisette
Federal bills		
HR 1188 **SB 468**	Access to Emergency Medical Services Act 2009. Increases reimbursements to all clinicians who treat patients under EMTALA.	American College of Emergency Physicians, lead sponsor: Rep. Barton Gordon (D-TN), also 50+ additional sponsors including Rep. David Wu (D-OR)

Note: This is not an all inclusive list but provides examples of relevant legislation that affects Oregon physicians and Oregonians with mental illnesses. Updates on legislation of interest to members will be posted on theoma.org web site periodically throughout Oregon's 2009 legislative session. Visit *www.theOMA.org/News_from_Salem* for updates.

legislation, which would lower liability for physicians who provide consults to EDs, and increase reimbursement. The bill, originally introduced in 2007, provides for a 10 percent increase in reimbursement and caps on malpractice awards in an effort to attract more on call specialists to EDs. Currently, many specialists are concerned about their liability in EDs when they provide consults, making it difficult for EDs to treat patients, particularly outside of normal business hours.

The focus of the legislation "is not just to help ED physicians but all physicians that provide EMTALA (Emergency Medical Treatment and Active Labor Act) care," said John Moorhead, MD, a former president of OMA, an ED physician at OHSU, and a national consultant on ED and healthcare workforce issues.

The legislation would also help assess the state of EDs throughout the country, provide some solid data on the sorts of challenges ED physicians face day to day and propose standards for boarding and diversion of patients in EDs.

Scope of practice debate

In Oregon as elsewhere, scope of practice legislation is being hotly debated as lawmakers seek cost effective strategies for improving access to mental health care, and taking some of the pressure off ED physicians and psychiatrists. For example, one bill introduced in Oregon earlier this year would allow physician assistants to hold mentally ill patients for observation and evaluation. Another bill also introduced during this legislative session proposes that licensed psychologists become authorized to prescribe certain classes of medications for treating mental illnesses.

"Expanding scope of practice is a relatively inexpensive way to broaden access to mental health services," says Robin Henderson, MD, a licensed psychiatrist, and one of 13 members of the American Hospital Association's Governing Council on Psychiatry and Substance Abuse. "Patients are ending up in the ED when they can't get their

meds because of the long delays in getting appointments with psychiatrists," adds Henderson, who is also Director of Behavioral Services, Cascade Healthcare Community in Bend.

However, expansion of scope of practice makes some physicians uneasy. "There is a big tension between psychiatrists and psychologists around prescribing," says OHSU's Handel. "Training is needed to prescribe, and psychologists have no medical training. They need to know about the potential interactions with the other medications their patients may be taking. Our job is first, do no harm. To be honest, there are no cheap solutions."

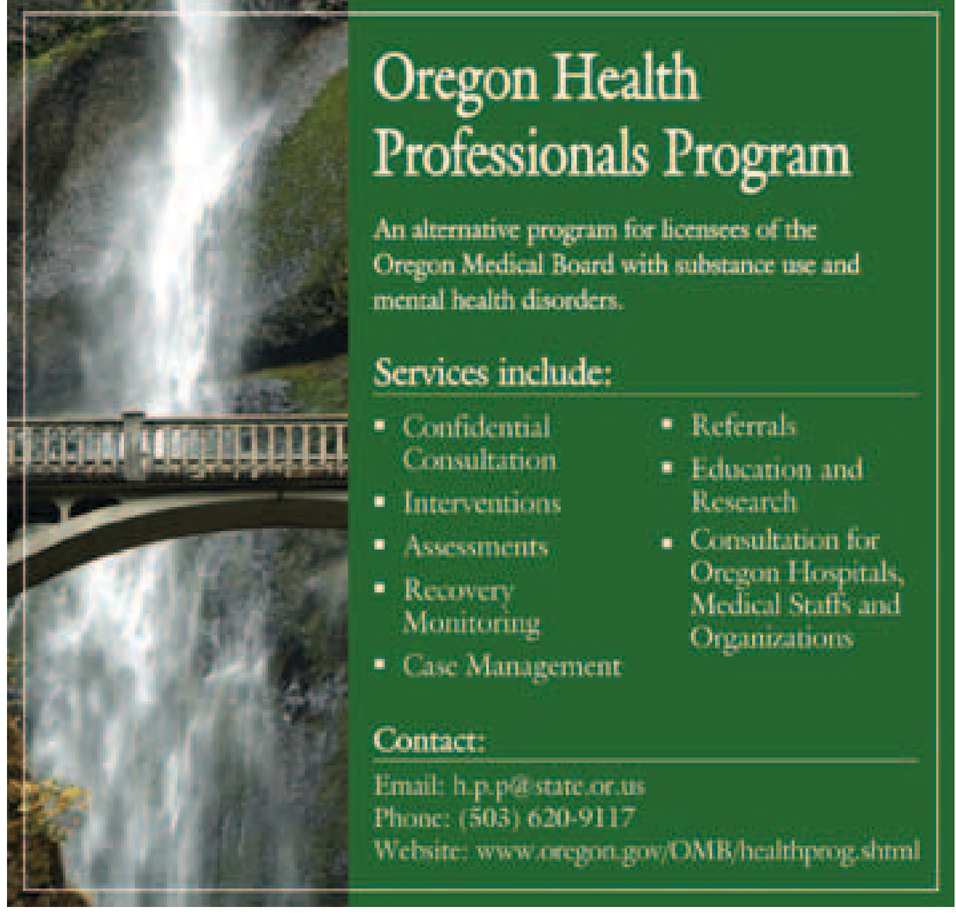
So, then, without sufficient support for proposed and relatively affordable remedies, what can be done to improve conditions and access to care in Oregon's EDs?

From crisis management to reform

In Oregon, according to the Public Consulting Group study, "the focus of mental health care delivery in recent years has shifted from prevention to crisis management." According to Moorhead, Oregon can learn about the whole healthcare system from its EDs and the demand for emergency psychiatric treatment.

"We need to keep an eye on the long term," says Moorhead. "We need to agree on where we're going [with health reform strategies]. You jump too soon into what the 'solution' is and then you find you are not offering the whole solution," adds Moorhead. "I'm encouraged by the work of the Archimedes Movement as well as the Oregon Health Fund Board. We need to keep working at it. The challenges we face providing emergency psychiatric services in the ED is illustrative of the crisis in delivering all services in the health care system."

Abby Christopher is a Portland, Oregon-based writer and editor. She can be reached at achristopher@achristopher.com



Medical Consequences of Addiction

Every year, abuse of illicit drugs and alcohol contributes to the deaths of more than 100,000 Americans. Additionally, drug abuse causes a broad array of medical consequences (*www.nida.nih.gov/consequences/*) including cardiovascular problems and neurological effects. Drug abuse also continues to play a major role in the spread of HIV, hepatitis C, and other infectious diseases, not only through injection drug use but also by altering judgment that leads to risky behaviors.

Treatment and Recovery

For most individuals, combining medications where available with behavioral therapy is the most successful treatment approach. Different types of treatments may be beneficial at different stages of recovery (e.g., medications to ease withdrawal symptoms; medications and behavioral therapies to help people stay in treatment and to prevent relapse). The process of recovery from drug addiction, however, is generally long and complex, requiring people to rebuild their lives and regain the trust of family, friends, and employers. Therefore, the most effective programs incorporate a variety of services to address a person's medical, psychological, social, vocational, and legal needs.

We at NIDA believe that better understanding of the science of addiction will reduce the stigma associated with addiction, increase the early diagnosis and treatment of addiction, encourage the adoption of research-based policies and programs for drug abuse prevention, and increase support of groundbreaking research. Visit the NIDA website to access a wealth of resources: *www.nida.nih.gov/medstaff.html.*

Nora Volkow is Director of the National Institute on Drug Abuse (NIDA), National Institutes of Health.

TREATING

Let's Deal with Depression in Teens!

By Kirk Wolfe, MD

THIS LETTER PROVIDES AN UPDATE on the controversy of the black-box warning on suicidality with antidepressants in teens, and makes general recommendations for you to consider in your assessment and treatment of youth who are struggling with depression.

The 2003 death by suicide of Garrett Lee Smith, son of then-US Senator and Mrs. Gordon Smith, serves to highlight the need to identify and fully treat depression in youth. Suicide is the number two cause of death in Oregon youth age 10–24.

There was a 28 percent improvement in the U.S. youth suicide rate from 1990–2003, following several decades of dramatic worsening of the rate. Youth suicide prevention experts speculated the improvement was due to the extraordinary increase in antidepressants prescribed for adolescents during the period of improvement.

In 2003, the FDA issued a public health advisory suggesting an association between antidepressants and suicidality in teens. The formal black-box warning (see *www.fda.gov*) was initiated in October, 2004, as compiled studies in teens showed 4 percent developing suicidal thinking/behavior on antidepressants compared to 2 percent on placebo (there were no deaths by suicide).

Since the black-box warning, one study showed: (1) a 30 percent reduction in new diagnoses of teen depression by primary care physicians; (2) an increased proportion of teens receiving no antidepressant; and (3) a 58 percent lower SSRI prescription fill rate. Given the media attention of events leading to the black-box warning, these changes may be important contributing factors to an 18 percent increase in the suicide rate in U.S. teens age 10–19 in 2004 (vs. 2003). The 2005 rate was also significantly greater than expected, given the previous improvement, the most recent year national data is available. Oregon's youth suicide rate increased 24 percent from 2005 to 2006. These deaths can be prevented. It is clear the risk in not identifying and treating depression in youth far outweighs the risk in treating their depression.

The November, 2007 issue of *Pediatrics* provides a framework for guidelines for the treatment of adolescent depression in primary care (GLAD-PC). The following recommendations should prove helpful with the treatment of depressed youth:

1) All youth in your practice should be evaluated for depression, suicidal thinking/actions and substance use. As the GLAD-PC guidelines note, major depressive disorder in youth is under identified and under-treated in primary care settings.

2) Families need to know more about the depression their youth is struggling with. The Oregon Council of Child and Adolescent Psychiatry produced brochures for parents to help in supporting your discussion. These brochures are available through Donna Noonan of the Department of Human Services at (971) 673-1023.

3) Evaluation or consultation with a child and adolescent psychiatrist is recommended for youth with moderate to severe depression, psychosis, coexisting conditions or with safety issues. Please recommend that families of depressed youth take steps to remove lethal means with youth, including firearms, medications and potential hanging materials.

4) The best outcomes with the Treatment of Adolescents With Depression Study after three months of treatment for moderate to severe depression was with a combination of Prozac (fluoxetine) and cognitive behavioral therapy. Depressed youth should also be referred for counseling, with regular communication between providers. Good support and

TEENS 2 Views from OMA Members

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A Brief Review

Before and After the Warning

By Bob McKelvey, MD

THE FDA'S BLACK BOX WARNING on antidepressants had a chilling effect on their prescription for young people. The warning stated that antidepressants increase the risk of suicidal ideation and behavior (suicidality) in children and adolescents. Because of this, the FDA recommended that physicians prescribing antidepressants to children and adolescents should evaluate them every week for the first four weeks of treatment, every two weeks during the second month, and at the end of the 12th week of treatment.

The Black Box Warning was based on the FDA's review of all published and unpublished studies of double-blind, placebo controlled trials of antidepressants in children and adolescents. It included studies not only for the treatment of major depressive disorder, but also for other disorders including ADHD, Generalized and Social Anxiety Disorders, and OCD. There were 24 studies in total with a combined number of subjects of 4,582. The review evaluated each drug's efficacy and its risk for suicidality. For major depressive disorder, fluoxetine was found to be most effective, followed by citalopram and Sertraline. Regarding suicidality, citalopram was found to be least likely to increase the risk of suicidal ideation and behavior, followed by fluoxetine and mirtazapine. It is important to emphasize that the term "suicidality" includes only suicidal ideation and suicidal behavior, ***not*** completed suicide.

Of the 4,582 subjects, none completed suicide. This may appear reassuring, but since the suicide rate is so low (~3–15/100,000 adolescents) and the rates of suicidal ideation (12/100 adolescents) and attempted suicide (5–8/100,000 adolescents) are so high, it would require an enormous number of subjects to turn up a suicide.

The warnings from the FDA came in two phases. In the first phase, beginning in June 2003, a warning was issued about an increase in suicidality among children and adolescents prescribed paroxetine. Over the next 16 months, prescription rates dropped dramatically for paroxetine, but also to some degree for other antidepressants. Then in October 2004, with a black box warning for ***all*** antidepressants there was a further decline in prescribing rates for both paroxetine and other antidepressants. In addition, there was a shift away from primary care providers prescribing the majority of antidepressants for those under 18 to psychiatrists becoming the primary prescribers. One salutary effect of the warnings was that it led to a dramatic increase in physician monitoring of children and adolescents receiving antidepressants to conform with the FDA's monitoring schedule.

Alarms about the dangers of not prescribing antidepressants to children and adolescents with major depressive disorder began to appear after the FDA warning took effect. It was noted that the suicide rate in adolescent males, which had risen dramatically from the 1960s, began to decline around the time that SSRIs started to be widely prescribed. In addition, Hamilton et al. (2007) in an article in *Pediatrics* reported that the suicide rate among young people in the US had ***increased*** between 2003 and 2004, the years before and after the first FDA warning, from 2.2/100,000 to 2.6/100,000. While such "ecological" evidence did not prove an inverse cause and effect relationship between SSRI prescribing and completed suicides, it did suggest that such a relationship might exist and that SSRI's might be "protective" against suicide.

Additional evidence about the protective effects of SSRI's was provided by Gibbons et al. (2006) in the *American Journal of Psychiatry.* Utilizing national county-level data on suicide rates and antidepressant prescription rates in children ages 5 to 14, they demonstrated that higher prescription rates of SSRIs were correlated with lower rates of suicide. The authors estimated that if SSRIs had not been prescribed, there would have been an additional 253 child and adolescent suicides nationally.

Let's Deal with Depression in Teens!, cont.

supervision of the depressed teen will also be an important recommendation.

5) Families should be made aware that fluoxetine, an SSRI antidepressant, is the only one approved by the FDA for treating teen depression. Other SSRIs can be considered based on family response and preference. Tricyclic antidepressants (e.g. imipramine, desipramine and amitriptyline) should generally not be prescribed for depressed/suicidal youth, given the increased potential for death by overdose compared to SSRIs as well as the lack of efficacy compared to placebo with depressed teens.

6) Families should be made aware of potential adverse effects with antidepressant medication in teens, including possible increased suicidal thinking/behavior, behavioral activation and development of mania. Families should be encouraged to call you with adverse effects; regular appointments are recommended, including timely visits by the youth and family until the youth's depression fully resolves.

7) It is important to make sure the youth's depression is fully treated, with resolution of any safety issues and improved functioning. An adequate trial of antidepressant medication to a maximum dose and duration is recommended, as tolerated, if the depression has not resolved. Diagnosis and treatment should be reassessed if no improvement is noted after six to eight weeks of treatment (or sooner with any safety issues), with consultation by a child psychiatrist given serious consideration as well.

8) Medication should be maintained for six to 12 months after the full resolution of depressive symptoms. If the depressive episode is a recurrence, clinicians are encouraged to monitor patients for up to two years given the high rates of recurrence.

9) After the depressive episode has been resolved and monitored for the respective time period noted above, medication discontinuation should be done gradually with close follow up for recurrence for at least two to three months. Warning signs of recurring depression should be reviewed with the youth and family. The need for timely communication with you, should symptoms return, cannot be overemphasized.

10) You can download the GLAD-PC "Toolkit" on teen depression in primary care online: *www.glad-pc.org*

Thank you for attending to this critical area of health in teens.

Sincerely,
Kirk D. Wolfe, MD

Kirk Wolfe, MD, was president of OCCAP in 2001–2002, is an Oregon Delegate to the American Academy of Child and Adolescent Psychiatry, and received the 2001 Oregon Mental Health Award For Excellence for youth suicide prevention.

Resources

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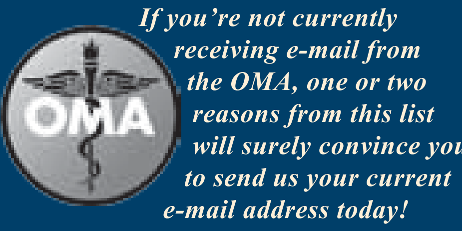

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Before and After the Warning, cont.

Finally, Bridges et al. (2007) in *JAMA* conducted a meta-analysis of data from 27 randomized, placebo controlled trials of antidepressants to calculate the Number Needed to Treat (NNT) and the Number Needed to Harm (NNH) in the treatment of pediatric major depressive disorder. The NNT was 10 and the NNH was 112, numbers that should reassure physicians and parents concerned about the efficacy and safety of these medications in young people. In addition, they also determined the percentage of new suicidal ideation and attempts in the antidepressant group (3 percent) vs. the placebo group (2 percent). These figures are actually lower than those determined by the FDA in its initial analysis of the then available data.

For those interested in the relative efficacy of SSRIs, Wagner's 2008 presentation at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry showed that fluoxetine has the most studies demonstrating its efficacy, (three versus one for each of the other SSRIs with positive trials) (citalopram, escitalopram, and sertraline). In addition, fluoxetine's response rates relative to placebo are also greater than its competitors. For this reason, I utilize fluoxetine preferentially as the first agent I employ in the treatment of pediatric major depressive disorder.

I hope that his brief review will help to encourage primary care providers to utilize antidepressants in the treatment of pediatric major depressive disorder. While careful monitoring of their effects is necessary, these medications can be potentially life-saving when properly utilized to treat this common and frequently under-recognized disorder. ●

Bob McKelvey is Director of the Division of Child and Adolescent Psychiatry at Oregon Health Sciences University. He has been in practice for 30 years and specializes in complex diagnostic evaluations, psychotherapy, and psychopharmacology. He can be reached at mckelver@ohsu.edu

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Vitamin D, the Sunshine Hormone

It's Important to Bones, Brain, and More

By Mary McCarthy, MD

OVER THE LAST 10–20 YEARS, research shows that vitamin D is related to more than just bone health. It is important to health across the life cycle. There are at least 1,000 different genes believed to be regulated by the active form of vitamin D, and vitamin D receptors are on the cells of many tissues in the body, even the brain. The incidence of vitamin D deficiency is on the rise in the United States and other countries because of our indoor lifestyle.

Drs. Carol Wagner, Sarah Taylor, and Bruce Hollis of the Medical University of South Carolina summarized its importance in their article "Does Vitamin D Make the World Go 'Round".

> *Vitamin D has emerged from obscurity and its effects on various organ systems throughout the body down to the cellular level are being discovered. What was once thought to be a simple hormone affecting only bone and calcium metabolism has shifted. We no longer see vitamin D as a "vitamin" important only in childhood, but as a complex hormone that is involved not only in calcium homeostasis but also in the integrity of the innate immune system. Vitamin D deficiency is linked to inflammatory and long-latency diseases such as multiple sclerosis, rheumatoid arthritis, tuberculosis, diabetes, and various cancers, to name a few.*

Vitamin D is important in pregnancy to prevent rickets and possibly other chronic disease over a person's lifetime. "Intrauterine programming" is an area of research concerned with long term effects of nutrition or hormones (including vitamin D) during fetal development that may influence the "programming" for diseases later in life. There is evidence that vitamin D is important to brain development and function, although more research is needed in this area.

Experts say we need more prospective interventional studies to verify vitamin D's importance in health and disease prevention, and for the Adequate Intake values to be reviewed. In the meantime, Wagner says, we can test every pregnant woman for adequate levels, and it is safe to supplement up to 2000 IU's per day based on upper limits of safety set by the Food & Nutrition Board in 1997.

An expanded version of this article is available online at www.theOMA.org/MiO

Factors Influencing Your Vitamin D Status

- Degree of skin pigmentation
- Sunlight exposure
- Dietary contribution (<10 percent total)
- Latitude
- Season/time of year and angle of sun's rays
- Use of sunscreen or protective clothing (block UVB rays)
- Outdoor exposure
- Body mass/fat mass (lower blood levels with higher body mass)

Multiple factors complicate recommendations

Part of the problem with establishing adequate intake levels is that many factors influence your vitamin D status (see table, above). For this reason, persons with multiple risk factors for deficiency are probably better followed by checking their 25 hydroxy-vitamin D level. The American Academy of Pediatrics recommended in 2008 that exclusively or partially breast fed babies be supplemented with 400 IU per day based on more recent clinical trials and history of safe use.

In January 2009 The Institute of Medicine (IOM)'s Food and Nutrition Board (FNB) announced a committee that will be reviewing the Dietary Reference Intakes for Vitamin D; including adequate intake (AI) and upper limits of safety. Michael Holick, MD, suggests in his 2007 *NEJM Review* article that recommended Adequate Intakes are actually inadequate and need to be increased to at least 800 IU of vitamin D3 per day. Reinhold Vieth, MD, of the University of Toronto, gave doses of 10,000 IU of vitamin D3 per day for up to five months without causing toxicity. Because of his research, some advocate for the upper limit of safety to be changed to 10,000 IU per day.

Sources of vitamin D

Historically humans received 90 percent of their vitamin D from sunlight and only 10 percent from food. Migration away from the equator, increase in indoor lifestyle, and less sun exposure has resulted in humans being more dependent on oral vitamin D supplementation than in our distant past. By the mid 1600s, rickets began to be identified in children

Contributions from

Oregonians

One Oregonian's Contribution

Several Oregonians have contributed to the evolving vitamin D research. Michael McClung, MD, endocrinologist and founding director of the Oregon Osteoporosis Center, contributed by studying vitamin D, bone density and osteoporosis. In the 1980s "I invented an assay (for vitamin D) at Oregon Health & Sciences University medical school." He ran a laboratory there for 12 years, studying women and osteoporosis. "We didn't know what normal ranges were or how to interpret the results."

A big breakthrough came when researchers looked at blood levels in different populations, and the correlation between 25 hydroxy-vitamin D levels and parathyroid hormone. "We appreciated that vitamin D levels less than 30 (ng/ml) were too low." Levels above 30 resulted in higher bone density. When testing and following blood levels, Dr. McClung recommended you stay with the same lab as there may be variation between laboratory testing methods. Of patients tested at the Oregon Osteoporosis Center "60 percent of 60 year olds and 80 percent of the 80 year olds are vitamin D deficient." Vitamin D deficiency is a major cause of bone loss and fracture risk for older adults, but McClung emphasized how physical activity is also important in the maintenance of skeletal health in the elderly.

It wasn't until the 1990s to the 2000s that studies using higher dose of vitamin D (800 IU per day) resulted in reduction of fracture and fall risk in the elderly.

McClung went on to say that for years no one challenged the long held belief that 400 IU vitamin D per day was sufficient. Because one teaspoon of cod liver oil per day prevented rickets, the University of Wisconsin measured the amount of vitamin D in this quantity and it equaled 400 IU. "There was a myth that more vitamin D above 400 IU (per day) was toxic." Other studies have challenged this belief.

Other Oregonians Doing Vitamin D Research

Adrian Gombart, PhD, of the Linus Pauling Institute at OSU, studies vitamin D and its importance in the immune system. He will be presenting his research at the Portland "Diet & Optimum Health Conference" on May 14 (details to the right). OHSU medical student, Melissa Wei, formerly of Harvard School of Public Health published "Vitamin D and Prevention of Colorectal Ademomas: A Meta-analysis." For more information, visit *www.theOMA.org/MiO.*

as people migrated away from rural areas and farms into urban settings thus limiting sunlight exposure. Rickets was associated with skeletal deformities, but also muscle weakness. By the 19th century it was epidemic in the industrialized northern United States and it was realized that sun exposure or taking fish liver oil were effective treatments. It wasn't until the 20th century that the metabolism of the hormone was discovered in addition to its relationship to the health and disease in organ systems other than the skeleton.

Vitamin D in pregnancy and lactation

Carol Wagner MD, neonatologist from Medical University of South Carolina, collaborated with Bruce Hollis PhD, in 2001 to study vitamin D in human breast milk. Their latest preliminary data determined that mothers need 6,400 IU/day of vitamin D in order for their milk to contain 500–800 IU/liter (enough to prevent rickets in the infants). They have a larger ongoing study hoping to confirm these preliminary findings. Current prenatal vitamins and most multivitamins contain 400 IU of vitamin D, only enough to make mother's milk contain 33–68 IU/liter. This is why exclusively or partially breastfed babies should receive the AAP recommended supplementation of vitamin D.

Wagner and Hollis are also involved in a long term study of vitamin D in over 500 pregnant women in South Carolina, including follow-up of the infants until age one. The study, which completes in the summer of 2009, will evaluate medical/dental health, and bone density in the pregnant mothers as well as health and development in the offspring. Dr. Wagner is especially concerned about African American women as "95 percent are deficient (in vitamin D) in sunny South Carolina." She recommends that all pregnant women have their 25 hydroxy-vitamin D levels checked and that they receive at least 2000 IU per day, based on the current Food & Nutrition Board upper limit of safety standards. "400 IU is woefully ineffective in increasing a pregnant woman's level. We'd like to see it above 32 ng/ml."

Coming Up

Diet and Optimum Health Conference

presented by the Linus Pauling Institute at Oregon State University

May 13–16, Hilton Portland & Executive Tower

http://lpi.oregonstate.edu/conf2009/index.html

Current Adequate Intake
as set by the Food & Nutrition Board (in 1997)

Birth to 50 years	200 IU per day
51-70 years	400 IU per day
71 + years	600 IU per day
Current upper limit of safety	2000 IU per day

Can mental illnesses result from low vitamin D?

John McGrath MD, Australian psychiatrist, has hypothesized that prenatal exposure to vitamin D deficiency is a risk factor for schizophrenia, although other nutritional deficiencies may also play a role. More patients with schizophrenia are born in March, a time of year when vitamin D levels are low. A number of small studies suggest that elevated mood and well being may be related to higher amounts of vitamin D.

Gene Stubbs MD, researcher and professor emeritus in Child & Adolescent Psychiatry from OHSU, has embarked on a study on vitamin D and autism, supplementing pregnant women who have had a previous child with autism. Psychiatrist John Cannell MD, wrote a theoretical paper on vitamin D deficiency as a possible cause of autism. Stubbs, intrigued by Cannell's theory, believes that low vitamin D in the pregnant mother might predispose the fetus to brain damage, among other impairments. Dr. Stubbs is "recruiting 40 mother/infant pairs with the goal to reduce the recurrence rate of autism from seven to 10 percent to less than three percent or none out of 40." If they are successful, they would move on to a larger study. *For further information on the Autism & Pregnancy study, see the expanded version of this article online at* www.theOMA.org/MiO *or contact Dr. Eugene Stubbs at (503) 245-2719.*

What do the experts recommend for future research on vitamin D?

Dr. McClung says we need "better studies nailing down the causation to a whole list of disorders" that may be related to vitamin D deficiency. Most of the research has been correlation studies so far. "We need to do an intervention study that is prospective" with large numbers of subjects followed for years. This would be costly and require the backing of the government. McClung suggests that we "lobby senators and have dinner with Obama" to advocate for funding for such a study. Dr. Wagner believes there has to be collaboration between research centers, similar to what was done in the 1980–1990s when pediatric cancer centers collaborated and "people put their egos down for the kids." ●

Mary K. McCarthy MD, OMA member for over 20 years, is a psychiatrist in private practice in Portland OR, an Associate Clinical Professor of Psychiatry at OHSU, and a consultant to the Oregon State Hospital and Department of Corrections. She also works part-time for Tillamook Family Counseling Center in Tillamook, OR. [Written in memory of the author's brother, Ed Callicrate.]

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Scope of Practice *and* Mental Health Treatments

By John McCulley

IT SEEMS LIKE EVERY legislative session produces a host of bills where a group of non-medical professionals wants to bypass rigorous medical training in order to practice medicine. The 2009 session is certainly holding true to form.

One of the major issues this session is the continuing effort of psychologists to prescribe medications. House Bill 2702 establishes a loose framework that would permit psychologists, after limited training, to become independent prescribers. Last session OMA and a broad coalition of the medical community, consumers and pharmacists organized to defeat a similar bill. And they will need to join forces again to protect Oregon citizens from this ill-advised and dangerous legislation.

After more than a decade of intense and expensive lobbying by psychologists, only two states (New Mexico and Louisiana) currently allow psychologists to prescribe and there is little outcome data available from these prescribing experiments.

Psychologists argue that it takes too long for a patient to get a doctor appointment, noting how difficult access is in less populated area. We know most psychiatric medications are prescribed by primary care physicians. And clearly we face challenges, especially in rural areas, serving all the patients who need treatment for both psychiatric and other medical conditions. But under HB 2702 access to treatment in rural areas will not change. In New Mexico and Louisiana where psychologists can prescribe, most psychologists are located in the urban areas of the state. Oregon would be no different.

It is common knowledge that psychiatric medicines are powerful and affect all parts of the body, not just the brain. As with any medication, they can interact with a host of other prescription drugs and over the counter supplements. These medications also can have significant side effects all of which require appropriate medical training to evaluate and treat. Appropriate treatment depends on ordering and interpreting a host of medical tests.

But the training proposed in the bill is woefully inadequate. One current provider of such training in Oregon (California School of Professional Psychology) offers a 450 contact hour, distance-learning program. Psychologists go to a site in the Portland area one weekend a month where they receive instruction remotely. Preparation to prescribe these powerful medications to children and elderly citizens is minimal at best (12 total hours for each). The same holds true for treating people with chronic medical conditions and those who need special consideration, such as pregnant women.

If the psychologist lives more than 100 miles from Portland, the CSPP training program allows the person to complete their training via telephone, without having to even go to the televised program.

Clinical training beyond the didactic portion is set at 250 hours in the bill which can be completed over a two year period or conceivably about 10 hours per month. As troubling as the training, is the oversight needed for this new category of medical provider. That oversight, investigation and discipline comes from a regulatory board with zero physicians, the Oregon Board of Psychologist Examiners.

There are psychologists who already prescribe in Oregon. Those professionals have attained this privilege by going to medical school or by being trained as a psychiatric mental health nurse practitioner.

Solutions in play

In order to find a way to address the issue of appropriate preparation to prescribe, amendments are being proposed to the bill that would establish a special physician assistant training track for psychologists. Such an approach would assure appropriate medical training and supervision, with oversight from the Oregon Medical Board.

In addition, formal collaboration efforts between primary care physicians and psychiatrists are expanding. The Oregon Pediatric Society is well underway on a project with the Oregon Council of Child and Adolescent Psychiatrists. And members of the Oregon Academy of Family Physicians has just started a special consultation effort with members of the Oregon Psychiatric Association.

Time to Switch to an EHR?

Eight Tips for Successful EHR Adoption

FOR YEARS, EXPERTS HAVE praised Electronic Health Records for their potential to improve patient care, reduce medical errors, and contain costs in the American health care system.[1] Now, the Obama administration has made EHR adoption a major health care policy objective. Its goal is for all physicians to begin using EHRs over the next decade. The HITECH Act, part of the president's new stimulus package (included in the American Recovery and Reinvestment Act), commits $19.2 billion to make this a reality.[2]

The HITECH Act is a response to the reality that only a small number of physician practices have successfully adopted EHRs. In fact, only 17 percent of the nation's 800,000 physicians are currently using EHRs.[3] And a recent study in the *New England Journal of Medicine* (*NEJM*) reports that a mere four percent of physicians are using a full EHR.[4]

More than just making a practice eligible for HITECH Act reimbursement, the right EHR— successfully implemented and optimized for your practice—can have major advantages for patient care, profitability, and practice personnel. An overwhelming majority of the physicians who participated in the *NEJM* study said that using electronic records improved the quality of clinical decisions, helped to avoid medication errors, and improved the delivery of preventative care.[4]

Ultimately, the right EHR can help your practice operate seamlessly among all of your affiliated hospitals, clinics, labs, and pharmacies. It helps your providers have a current, accurate, and complete clinical picture of each patient, so that they can make the most appropriate clinical decisions. And the right EHR helps the practice manage the business side of things, enabling it to run more effectively and profitably.[5]

Specifically, the right EHR can support stronger practice profitability, better patient care and improved process integrity. To find the right EHR for you, break down your efforts to planning versus actual vendor selection. Here are eight tips for successful EHR adoption.

You know you have to prepare for an EHR, but what exactly do you have to plan for?

The right planning includes:

1. **Assessing your practice's readiness.** Before you jump into EHR implementation, do an assessment of your practice's EHR readiness.
2. **Establish your budget and project team.** When you've determined that you're ready and have a written plan, assign appropriate resources.
3. **Managing change.** Successfully implementing an EHR is not about the software—it's about embracing change by encouraging participation and communication with everyone from the start.
4. **Redesigning workflow.** There are fundamental differences in the way information is communicated and tasks are completed in an office powered by an EHR. You'll need to redesign your practice's workflow to incorporate the use of this new technology.

No matter what kind of planning you do, you need a vendor with a proven implementation methodology and excellent ongoing service and support. If you are reimbursed for Medicare or Medicaid patients, you will also want to find a vendor who is well-positioned to qualify you for federal EHR reimbursements provided under the HITECH Act.

How to succeed with your choice of vendor:

5. **Select a partner, not a product.** You are about to enter a long-term partnership with a vendor. Product versions will change over time, but once the product is implemented, and especially after paper charts are no longer available, you must rely on your vendor to provide service and support. You want a partner with a culture and long-term vision that are aligned with yours.
6. **Consider a network-based system, rather than a software-based EHR.** Some practices assume that getting an EHR means buying and installing a software package. However, an alternative to this approach is a network-based EHR system, which is accessed through

These efforts, the new medical school in Benton County, expansion of tele-medicine capabilities and a special physician assistant program for psychologists who want to prescribe, clearly protect Oregonians and help address the issues of access.

The biennial march to Salem seeking a legislative substitute for medical training likely will continue on many fronts. But there is hope this session that legislators might be able to address psychologist prescribing in a way that is productive and meaningful.

John McCulley is the Executive Director of the Oregon Psychiatric Association. He can be reached at john@profadminserv.com.

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the Internet. This approach offers remarkable benefits to the physician practice, including lower up-front costs and greater efficiency. Network-based systems are also well-positioned to integrate the evolving US Department of Health and Human Services requirements for "meaningful use" of an EHR as mandated by the HITECH Act.

7. **Ensure that your vendor has long-term readiness to adapt** to the changing reimbursement and regulatory environment. Software is static and needs to be upgraded to take advantage of new functionality. A network-based model allows your practice to maintain profitability without technical disruptions.
8. **Choose a vendor with a strong practice management system.** Maintaining financial stability during the implementation should be paramount. The right integrated EMR/PMS solution can even improve your practice's financial performance by handling claims submission and billing alongside clinical tasks. This helps ensure a smooth flow—from identifying, scheduling, and checking in each patient, to billing for the visit.

EHR implementation does require hard work and careful planning. But with the insights here, your practice is well-equipped to find and implement the right EHR for stronger revenue, better patient care, and minimal disruption. In the long term, if you've done the right planning and selected the right vendor, your practice will enjoy substantial cost efficiencies so that you can focus on what matters most—patient care.

For additional information about how to select an EHR, visit www.athenahealth.com/OMA *and look for athenahealth's whitepaper: Be Prepared for the HITECH Act: Eight Tips for Successful EHR Adoption. athenahealth is a leading provider of Internet-based business services for physician practices. The Company's service offerings are based on proprietary web-native practice management and electronic health record software, a continuously updated payer knowledge-base, patient communication technologies, and integrated back-office service operations. OMA members are eligible to receive a six percent discount on athenaCollector through OMA's participation in the athenahealth PartnerWise Affinity Program. To learn more, call (888) 402-6942 and mention that you're an OMA member.*

Endnotes

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The Engagement Model

Empowering the Treated and Engaging the Provider

By Tim Murphy, MS

TEN YEARS AGO, SALEM HOSPITAL'S acute inpatient psychiatric services operated like most inpatient programs do, serving a disproportionate number of involuntary patients and relying on power and control interventions to get through the day. More than 360 times a year, a patient was placed in seclusion and one third of the time he or she "required" restraints, as well. The process led to injuries on both sides and resulted in expensive workers' comp claims. Vacant nursing positions and physician recruiting problems stemmed, in part, from safety concerns. Further, program costs far outpaced reimbursements due primarily to mandatory overtime and the extra expense of nurse travelers.

Under the leadership of Maggie Bennington-Davis, MD, who became Medical Director of the program in 2001, the staff began to envision a new type of treatment center with decreased coercion and increased patient involvement.

Interviews of staff and patients revealed that they shared similar concerns about the existing program. Both feared for their safety and both had difficulty identifying what was "treatment." Modeled on the work of Sandy Bloom, MD, a psychiatrist from Philadelphia, they developed a theory of treatment that later became the Engagement Model. Patients (consumers) would have an increased voice in the day-to-day treatment milieu and department staff (physicians, nurses, therapists and floor aides) would spend more time building relationships to engender trust and confidence.

Intake interviews stressing safety and comfort replaced mandatory strip searches. Staff reviewed patients' belongings with them and encouraged them to send home anything that they did not need. They initiated comfort offerings when folks first arrived, postponing the necessary intake process until they'd had a chance to build positive supportive relationships with safety as the primary initial goal.

They encouraged staff to spend meal times with the patients sharing food and more "normal" conversations. "If you have a sandwich with someone in the afternoon, they are less likely to throw a chair at you in the evening."

Housekeeping and kitchen staff received invitations to attend Community Meetings so that everyone would be seen as part of the "Healing Community." At the request of those they served, they suspended traditional treatment groups and instead built "classes" where consumers and their family members could attend together to learn about mental illness and ways to manage symptoms. They replaced the signs on the unit from those that told what patients could not do with signs that welcomed them and reinforced the commitment to safety and treatment.

The unit invested in training and brought experts from around the country to help develop a curriculum and a milieu that became part of the treatment model. Despite the inevitable difficulties changing an entrenched culture, they began to see results within a year of embarking on the ambitious mission.

Results

Initial results were dramatic. In 2000, prior to implementation, the unit recorded over 1,400 hours of locked seclusion and had over 65 employee injuries. In 2001, those locked seclusion hours dropped to just over 200 and employee injuries fell by 50 percent. Both numbers continued to drop. Total time in locked seclusion decreased to 10 minutes in 2004 and fell to zero for 2005 and for the next three years.

Staff satisfaction scores at Salem Hospital, which were some of the lowest in the 1990s, became some of the highest by 2006. Mandatory overtime ceased in 2001, along with many of the old practices of doling out overtime.

Patient satisfaction increased, as well, as patients welcomed the new approach and Salem Hospital became known for their new "engaging" focus. As consumers became more engaged with treatment and less fearful, lengths of stay reduced and access improved, making the unit far more financially stable.

In 2006, Dr. Bennington-Davis and I published "Restraint and Seclusion—The Model for Eliminating their Use in Healthcare," chronicling our experience with culture change.

Both of us have moved on to other opportunities, but at a recent statewide meeting, I asked the Salem Hospital representative about the hospital's restraint rate. The rep replied, "Salem hospital has not used any leather or mechanical restraints on the psych unit for seven years."

Those words were music to my ears.

Tim Murphy was Administrative Director of Psychiatric Medicine at Salem Hospital from 1998–2005. Currently he is co-owner of Evolutions In Healthcare with Maggie Bennington-Davis MD, a consulting firm for hospitals and Healthcare Systems. Mr. Murphy can be reached at tmurphy@ashcreekwireless.com.

Creative Outlets

Creative Outlets appears in each issue of *Medicine in Oregon*. We encourage you to show us your creative side. Drawings, creative writing, paintings, poetry, etc. are all welcome.

Send your "Creative Outlets" to Betsy Boyd-Flynn at *betsy@theOMA.org*.

"Untitled" by Dr. Adam Angeles

Dr. Angeles developed his first photograph in the third grade using a pinhole camera made from a Quaker Oats cereal drum. He has finally graduated from that rudimentary camera through 35mm and 2 ¼ film and now primarily uses his digital darkroom to produce prints. His current showing is at St. Charles Medical Center in Bend entitled 'Surgical Light and Color' which encompasses what St. Charles Medical Center surgeons do in the operating room. "To many patients and families, the operating room seems like a mystery," Dr. Angeles said. "I've tried to lend a small flicker of insight to what we do as surgeons using these photographs, which have been altered and touched up," Dr. Angeles added.

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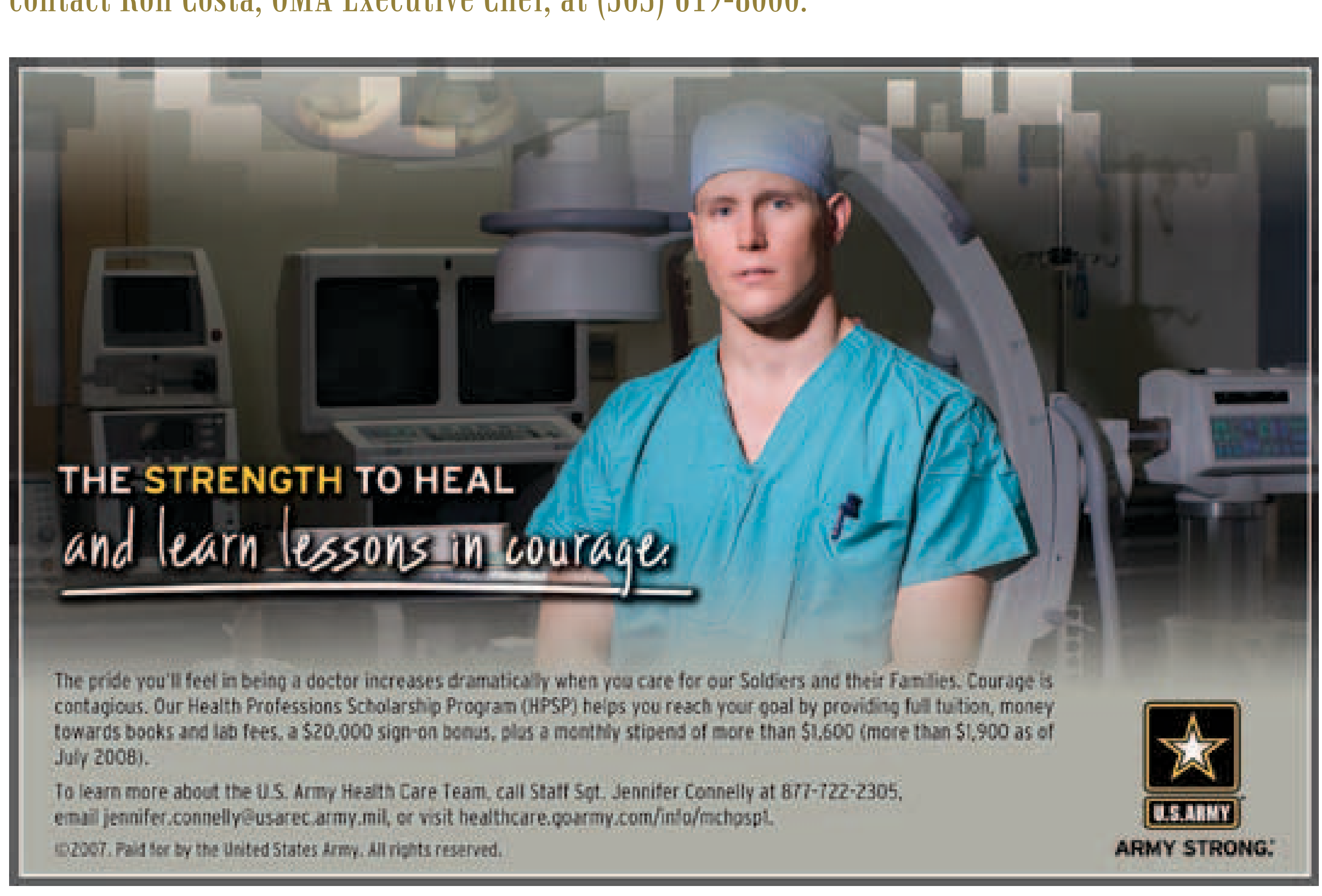

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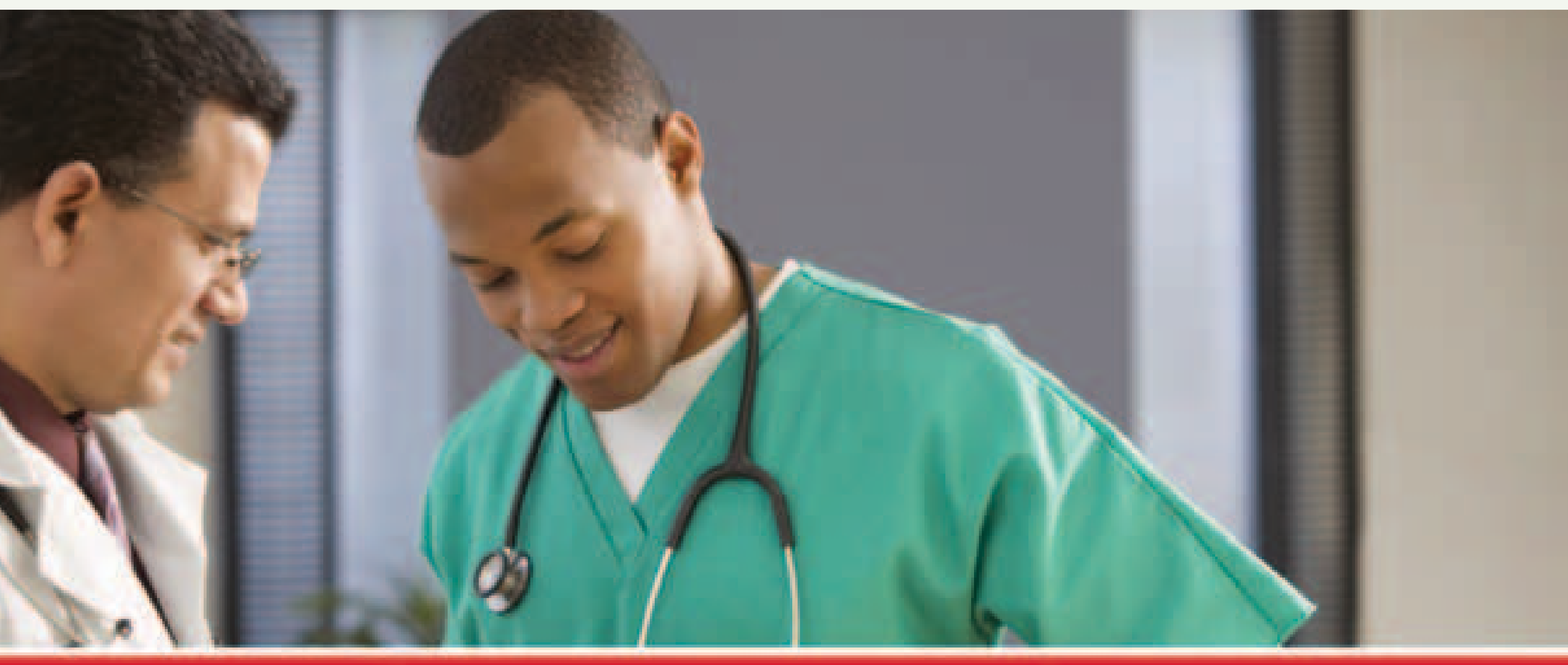

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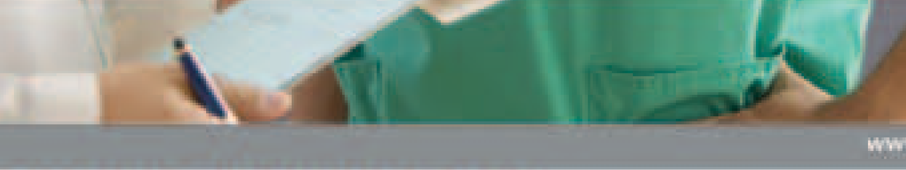

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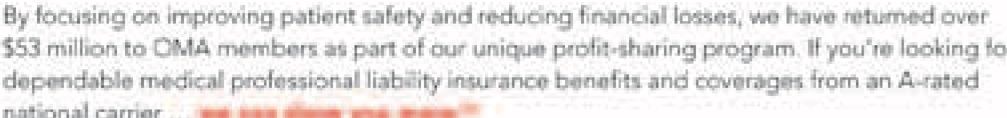
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