California Psychiatrist

The Newsletter of the California Psychiatric Association

Volume 29, Number 1 Spring 2014

The President's Message

Great Ride and Some Lessons Learned

Ronald Thurston, M.D.

By Ronald C. Thurston, M.D.
CPA President

This is my last column as CPA president. On the final day of the APA Annual Meeting in May, our very capable President-elect Tim Murphy takes the helm.

My life in the California Psychiatric Association began as SCPS representative to the Government Affairs Committee almost 30 years ago. I continued that role—eventually as Chair–through my 4 years as CPA Treasurer, 2 years as President-elect and now 2 years as President. I'm not going away, but I thought it might be a good time to sum up a few lessons:

You've got to sell what you believe in. No idea, no truth, and no scientific evidence is so compelling that it sells itself. Coming out of residency, I was comfortable in the delusion that my diligent study, my license and my board certification conferred upon me a private, durable–and unassailable–shelter for doing my good work.

But it's the State of California that has its name on my license, not my medical school. It's the Legislature that determines the requirements for–and what is and what is not–medical practice. The laws governing the circumstances of our lives, including the practice of medicine, are created in legislatures, where competing interests and opinions—and very little science—get reduced down to acceptable compromises.

(Continued on page 8)

From the President-Elect

$398

Tim Murphy, M.D.

By Tim Murphy, M.D.
CPA President Elect

As most members know, the APA requires membership in three linked organizations: the APA itself, focusing on national affairs; the California Psychiatric Association – APA's "Area 6", focusing on state affairs; and the five district branches, focusing on local concerns. Yearly dues statements separate the dues required by each. Full dues paying members pay $398 a year to support the CPA. What do they get for their money?

Members join for different reasons, and what I value may differ from what others value. But for what it's worth, here's what I get for $398:

- I get a full-time lobbyist in Sacramento.
- I get an aggressive attorney, eager to take our battles to court if necessary.
- I get an executive director who has spent her career in politics, who knows our organization inside and out, and who has built the reputation of CPA as the "go-to mental health organization" in the Capitol.
- I gain an amplified voice through the California Medical Association and its lobbyists.
- I get a sustained and reliable presence in key allied organizations.
- I get a responsive team of dedicated staff that understands what California psychiatrists can accomplish if they remain unified.

(Continued on page 8)

IMPORTANT
CPA change of address

Everything stays the same except for the Suite number

California Psychiatric Association
1029 K Street, Suite 23
Sacramento, CA 95814

From the Editor ...

Yvonne B. Ferguson, M.D., MPH

This is a changing of the guard edition. Your dedicated officers will be stepping down after an arduous tour of duty and passing the batons to the newly elected. We applaud the outgoing officers for their years of service and congratulate the incoming. Standing ready to assist in this transition are CPA's staff whose qualifications and duties are summarized in President-elect Murphy's article. This issue also has a couple of new features, a book review and a tutorial that will be featured in installments. These are examples of your editorial committee's responsiveness to submissions by our readers. That's a hint. Enjoy your read.

--Yvonne B. Ferguson, M.D., MPH, Editor

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Table of Contents

Spring 2014

Capitol Insight and Special Inserts

CPA Email Troubles

The CPA emails were down or not going during several weeks in March. The emails would appear to go out but actually did not. If you contacted the CPA office by email anytime in the last month and did not receive a reply please email the office again or call 800-772-4271 or 916-442-5196. Our sincere apologies if this happened to you since our goal is to always answer promptly. This has been a bit of a burden to all of us but hopefully it is now resolved.

Check our WebSite at www.calpsych.org
APA WebSite: www.psych.org

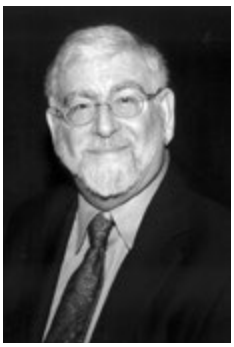
Board of Trustees

By Marc D. Graff, M.D.
Area 6 Trustee

The newly elected BOT members—Renee Binder, MD, (from our own Area 6) President-elect-elect, Ravi Shah, MD, Resident-Fellow Deputy Representative (PGY-2, from Columbia University), Scott Benson, new Area 5 Trustee and Vivian Pender, MD, new Area 2 Trustee were invited March 8-9, 2014.

Saul Levin, MD, MPA, the CEO and Medical Director; discussed his plans for changes in the APA central office organization. Current staff openings include Chief of Government Affairs (formerly Gene Cassell, JD) and Chief of Communications (a new position). This was followed by a summary of APA's communications needs and strategies presented by Cathy Copley, from Porter Novelli, a well-respected PR firm.

An extremely powerful video of Rep. Tim Murphy (R-PA), a clinical psychologist, speaking to CMS administrator, Mr. Jonathan Blum, Principal Deputy Administrator of CMS, about the attempts of CMS to restrict Medicare Part D drug choices for antidepressants and antipsychotics (as classes of drugs) was shown. Part of Representative Murphy's comments were based on a letter provided him by APA citing and objecting to CMS's selective and misleading citations from APA Practice Guidelines to justify their proposal. That video has been posted on the APA website. I am happy to report that on March 10, 2014 CMS reversed its proposal, clearly under pressure, and clearly with pressure from the APA.


Marc Graff, M.D.

Under the heading of minority/underrepresented members, a suite of 21 proposals was advanced and ultimately referred to the Assembly for further debate and shaping. One of the major discussion points was the issue of being underrepresented—which is NOT the same as being a minority. One of the most underrepresented groups is the international medical graduates—which represent a large number of US psychiatrists.

(Continued on page 9)

Legal Update

Several Brief Legal Matters

By Dan Willick, J.D., Ph.D.
CPA Legal Counsel

Unfortunately my schedule precludes me from writing a full article this month. However, I present several tidbits of legal information.

1. The U.S. Department of Health and Human Services has released a new guidance explaining the HIPAA Privacy Rule. This is worth your review and may be found online at http://www.hhs.gov/ocr/privacy/hipaa/faq/index.html

2. A physician who wishes to opt out of Medicare MUST renew her/his opt out every two years for that choice to remain in effect (42 C.F.R. sections 405.410 -405.435). **Failure to do so may create severe legal difficulties**, including CMS contending the physician who has not renewed his/her opt out is only being permitted to charge Medicare eligible patients the Medicare allowed rates for covered services and is violating the law by charging or collecting more.


Daniel H. Willick, Esq.

3. The appellate argument in Rea v. Blue Shield will have occurred on March 18, 2014 in an important court test of the scope of AB 88 (Health & Safety Code Section 1374.72 and Insurance Code Section 10144), California's law to provide coverage for diagnosis and medically necessary treatment of severe mental illnesses under the same terms and conditions applied by health plans and health insurers for other medical conditions. I will participate on behalf of the author of the legislation, Mrs. Helen Thomson, and the CPA.

Denial is Great, but Our Patients, Families and Colleagues Need Our Attention - First in a series of articles on "professional wills, wonts and won'ts."

By Steven Frankel, Ph.D., J.D.

I'm writing to you two months after turning 71 years of age. I've been a licensed, practicing psychologist in California since 1970, I am an attorney at law in legal practice since 1997, and am a member of both the California and D.C. Bars.

This is the first in a series of articles I've been welcomed to write for your *Newsletter* on the topic of planning for and/or coping with an unanticipated terminations of practice, due to death or disability. You might not be surprised by the tendency to turn the page in this *Newsletter*, to see what else might be fun to read, but try to hang in there for at least a few more sentences so I can tell you how I got to be the person who's raising this issue with and for you.

I began my psychology career as an academic – in the Department of Psychology at USC. After12 years of full time university service, I realized that teaching was fun, but I needed to make a living. I went into clinical practice, which I still enjoy, but which I now practice only on Wednesdays. The rest of the week, I'm in the practice of forensic psychology or health care law (where my primary area of legal practice involves defending health care professionals facing licensing board actions).

Shortly after finishing my legal education, I began to receive calls from the spouses and partners of mental health professionals in California – very disturbing calls – centered around the tragic losses of a spouse or partner due to unanticipated death or disability. In the midst of their grief, they also faced enormous additional distress over how to handle calls from patients, insurance companies, landlords, debt collectors, and a host of others. They were also concerned about demands for records. Were they permitted to see the records, or to be in contact with patients who were demanding records and who were suffering their own grief over the loss of their treating professional? How were they to navigate all of these issues while grieving? It might not surprise you to know that I didn't know what to tell them or how to advise them, nor did anyone else I contacted whom I thought might know.

Another post-law school development was that I was invited to develop and teach post-licensure programs for mental health professionals in laws and ethics, programs which many colleagues must take for license renewal. That meant, of course, that I had to learn the *minutiae* of legal and ethical principles that guide our practices so I could assist colleagues with that knowledge, in the service of safe and ethical practice. As I began these studies, I discovered that all of the professional societies' ethics codes for non-physicians require licentiates to prepare for unanticipated terminations of practice due to death or disability, and I also learned that an increasing number of states have enacted laws that impose the same requirements, also including physicians. Finally, I became aware that there is a group within organized psychiatry that is creating a new ethics code with the goal of having it adopted as the ethics code for psychiatrists, as a replacement for the "Annotations to the AMA Ethical Code, as Applied to Psychiatry." The proposed code will include this same ethical obligation.

As I taught this material in my law and ethics courses, I began to see eyes glaze over at the mention of the topic. When I began to ask how many colleagues had taken steps to address the issues, fewer than one out of every hundred attendees raised their hands.

I tried everything I could think of to raise the consciousness of colleagues and to explore ways that the issues could be addressed – how to break through the denial. I read (and taught about) "professional wills" – documents that professionals would create that articulated their wishes for what could most benefit their patients, families and colleagues, in the event of an "event." I read (and taught) about how to work with a single colleague or groups or "teams" of colleagues, about what to do and how to plan for "events." Over the past decade, I have been (somewhat) gratified to see an increase from less than one per hundred course attendees who had addressed these issues in their practices, to the present time, when there are approximately three out of every hundred attendees who had developed plans.

My phone continued (and continues) to ring. Significant others of colleagues continue to call, frantic, grieving,

angry, frightened and lost as to how to cope with the issues that arise as a result of an event. Surviving colleagues call when they wish to intervene at the time a colleague of theirs has an event, wanting to know how to help and shuddering at the nature of the tasks involved. To whom should patients be referred, can they actually talk to patients with no releases, what about current records, what about the old records, what about furniture, furnishings, bank accounts, art on the walls, office leases, telephone numbers, accounts receivable/payable, and on and on….

I finally "got" that the majority of our colleagues, particularly our senior colleagues, were not able or willing to come to these issues and tasks without assistance, and that there appears to be a distribution of willingness and ability to embrace the tasks and develop and implement a plan. Some of us respond to good old-fashioned shame (e.g. "How could you subject me – your partner/spouse/colleague/patient – to coping with both your loss and the desperate practical needs I have to deal with, now that you cannot help?")

Others respond to contacts from colleagues, such as "Let's work together on this – I'll do it for you if you do it for me." Of course, they soon realize that one of them will be doing it for someone else, in the future, since one will invariably pre-decease the other.

Still others respond to something like "Let's form a team of colleagues who take on the task of anticipating and coping with such events. With a team, the loads for each of us to carry are significantly less than if we do this as pairs, and, similarly, the pain is more broadly shared."

Finally, there is the emergence of a company that is creating a national network of experienced senior (in the sense of having been in practice for at least 20 years) colleagues who work, in coordination with an administrator and an office staff member, to manage the transition of a professional practice when an event has taken place. Some may find this the most efficient way of handling the issues and worth the financial cost.

In future articles, I'll address each of these coping strategies and attempt to make the approaches I've outlined above more real and clear. I'll point out the up-sides and the down-sides of each approach and will try to be as concrete as I can, regarding supportive elements available through colleagues, through the internet and beyond.

If you are interested in a closer look at the issues and support systems, you're welcome to contact me via www.practice-legacy.com

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"Hurry up—it's time"

Barton J. Blinder, M.D.

By Barton J. Blinder, M.D.
Area 6 APA Assembly Representative

A line from T.S. Eliot—applicable to our specialty as we face the challenges of an evolving health care system, innovations in health information technology, translation of basic science advances to the clinic and eventual transition of our categorical, descriptive diagnostic framework to an epigenetic neurobehavioral nomenclature.

During this critical time the Assembly is responding with initiatives to vigorously improve communications with membership, encouraging critical and constructive feedback especially in the form of actions that can be considered and implemented by APA. There are ongoing initiatives to strengthen DB's with APA support and consultation; enhance and create a personal user-friendly internet connection to the APA and DB for members study, actions directed to Access to Care, maintaining certification, mentor Resident and Fellow Associates and developments in Public Psychiatry. CPA members have been very involved in APA and Assembly leadership:

-Dilip Jeste, M.D. – APA Past President 2012-2013
-Renee Binder, M.D. – newly elected APA President Elect
-Melinda Young, M.D. – Assembly Speaker 2013-2014
-Joseph Mawhinney, M.D. – Chair, Assembly Executive Committee (AEC) Access to Care Work Group
-Bart Blinder, M.D. – Chair, AEC, APA/DB Site Visit Work Group, Editor Access to Care Newsletter
-Barbara Yates, M.D. – Chair, Assembly Reference Committee
-Adam Nelson, M.D. – Editor, Assembly Newsletter (Succeeding Peter Forster, M.D.)

(Continued on page 9)

Book Review

By Adam Nelson, M.D.
Private Practice
Mill Valley, California

The book, *Comprehensive Care for Complex Patients, The Medical-Psychiatric Coordinating Physician Model*, by Steven Frankel, James, Bourgeois, et al presents a compact, but highly informative introduction to the concept of the Medical-Psychiatric Coordinating Physician, which throughout the text is referred to as the MPCP. By the end of the book, the reader becomes intimately familiar with all of the duties and responsibilities of the MPCP who could take charge of the care of the most complex of medical and psychiatric cases. The authors make a strong case for the interface between psychiatry and the rest of the house of medicine. Much as different communities with different cultures must be able to cooperate for the sake of their mutual health, so must the cultures of physical and mental health care find a means of communicating and cooperating essential for the highest quality of care for patients with complex needs.

The authors present a series of richly descriptive clinical vignettes, to which the reader is repeatedly referred. Details of the complexities of the most challenging of cases are presented to support the theoretical and practical bases for deriving the notion of the MPCP and the model of care that the authors ultimately present. Through a series of vignettes, Dr. Frankel describes not only his empirically derived successes, but also his failures to illustrate the value of the MPCP model of care. In the book, the authors introduce a new vocabulary, including the notion of "truing devices", such as "self-other analyses", and other techniques to break down the interface between the empirical science of data-driven decision making and the art of clinical judgment. They then show how both are critically essential to the proper and best practice of medical and psychiatric care of complex patients.

The last chapter is devoted to a brief presentation of outcome data of 52 "pilot" cases, including some of those presented in the vignettes in the text. These data show not only the improvement in care and clinical outcomes, but also the cost-effectiveness of using the MPCP model for these cases in an outpatient setting. The institutional analogue would be psychosomatic medicine, or what previously had been referred to as consultation-liaison psychiatry. Of course, the authors note, that such a model already exists in outpatient and community settings. Typically, however, it involved non-medical clinicians, such as social workers or case managers, vainly attempting to serve in this capacity. The obvious shortcomings of this current approach are easily appreciated from the text and case examples presented. Finally, the authors present a proposal for a training and certification program for MPCP clinicians, as well as ongoing research efforts based on the pilot data presented.

I highly recommend this book to any physician who has ever found himself or herself sitting across from a diagnostically or clinically challenging patient in the office with a feeling of being overwhelmed. That is to say, I recommend this book to any physician in an office or clinic practice. And to those clinicians, perhaps still in training, who have not yet encountered such a challenging patient in the outpatient setting, consider this book an essential part of your preparation for what will become a likely eventuality. For the record, I began incorporating into my office practice some of the principles discussed in the book within days of reading just the first few chapters. If imitation is the highest form of praise, then, add my voice to those who have already sung the praises for this book.

President's Special Message Preserve MICRA

MICRA is the Medical Injury Compensation Reform Act of 1975, enacted in response to ruinous malpractice rates, driven by increasingly large awards for frivolous lawsuits. MICRA serves patients well, keeps medical costs in check and is a nationally recognized model for sensible tort reform.

California trial attorneys have written and financed a ballot measure that would change all that. It raises the MICRA cap on non-economic awards from $250,000 to $1.1M, putting a target on the back of every healthcare worker, clinic and hospital in the state, forcing higher premiums and expensive "defensive medicine."

CPA is one of the hundreds of members of Californians Allied for Patient Protection (CAPP). Here's what we are asking: write a generous check to CAPP, but send it to CPA so that we can make a list of psychiatrists who want to preserve MICRA.

More information available at micra.org

Thanks. thurstonrc@gmail

From Saul Levin, M.D., M.P.A, APA CEO/Medical Director

Handbook for Resident-Fellow Members (RFMs)

The newly created "APA Resident-Fellow Handbook," is posted at http://www.psychiatry.org/residents and attached. This handbook has detailed information regarding APA leadership positions, fellowships, awards, competitions, and the process for creating APA policy. This resource should be helpful to both new and seasoned resident and fellow members (RFMs).

Information regarding International Crises and Relief Efforts

The APA has continued to monitor the ongoing crises and corresponding relief efforts in Syria, the Central African Republic (CAR), South Sudan, and the Philippines. To help members who are interested in gaining a better understanding of these areas and want to become more involved, we have compiled resources, assessed opportunities for involvement, outlined safety considerations, and highlighted available resources for those traveling abroad.

Current Status: The United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA) is currently engaged in large-scale humanitarian efforts in multiple areas. 2014 action plans for Syria and the Central African Republic have been developed and are being implemented in cooperation with governments, UN agencies, and international non-government organizations. The United States Agency for International Development (USAID) maintains fact sheets and maps indicating current funding levels and key developments for Syria (fact, map), the CAR (fact, map), South Sudan (fact, map), and the Philippines (fact, map).

Involvement Opportunities: There are two tangible ways individuals can support efforts – through volunteerism abroad and direct organization donations.

- Doctors Without Borders, an international humanitarian organization, is recruiting licensed mental health specialists for 9-12 month field missions. The organization is currently facilitating the delivery of mental health services to refugees throughout Africa and in Syria, including providing direct medical aid in six hospitals and four health centers. Donate online.
- International Medical Corps, an international humanitarian organization, is recruiting Emergency Mental Health and Psychosocial Officers to be placed on the standby roster for 2-8 week deployments. In Syria, psychosocial services for refugees are provided at camps in Lebanon. Donate online.
- Salaam Cultural Museum, a non-governmental organization based in Seattle, WA, is coordinating week-long medical missions to assist Syrian refugees in clinics and camps in northern Jordan.
- Donation opportunities are also available through the UN Foundation, the UN High Commissioner for Refugees (Syria, CAR, S. Sudan), the UN Children's Fund (Philippines) and the Syrian American Medical Society.

More information on relief efforts and opportunities can be found through OCHA (Syria, CAR, S. Sudan, Philippines) and the International Federation of Red Cross and Red Crescent Societies (Syria, CAR, S. Sudan, Philippines).

Travel Advisories: While volunteer groups continue to work in areas of crises, the security and safety of relief workers is an ongoing concern. The US State Department has issued travel alerts and warnings for the countries being monitored by the APA as well as their surrounding areas.

Mental Health Resources for Those Traveling Abroad: Resources regarding refugee mental health are available from the UN High Commissioner for Refugees (UNHCR) and the National Child Traumatic Stress Network (NCTSN).

Colleagues with additional information are encouraged to forward it to internationaloffice@psych.org.

If you have questions, please contact Jon Fanning at jfanning@psych.org.

CPA Election Results

Congratulations to:

President-Elect,
William Arroyo, M.D.

Treasurer, Catherine Moore, M.D.

Terms begin May 8, 2014

President's Message *(Continued from page 1)*

For example, California psychologists have repeatedly tried to convince the Legislature that, if you know enough about psychology, you don't need a fundamental medical education to prescribe medications for people with mental illness and, anyway, prescribing medications is not really the same thing as assuming medical responsibility. And it's cheaper. The fallacy and hazard of this proposition is not immediately evident to the lay- legislators who determine who gets what license. CPA was at the Capitol every time, in force, to sell the counter argument—medical care, no matter what the illness, requires fundamental medical education.

People can do whatever they want, until somebody stops them. Even when it's illegal, but especially when there's arguable doubt, especially by the most powerful player. The recent, plainly unlawful suspension of medical staff meetings by the administrator at a state hospital went unopposed until CPA filed a formal complaint with the state licensing authority. When an insurance company refused to pay for medically necessary care because the venue for care (residential) was not specifically mentioned in the California parity law, CPA filed an amicus brief. Strong federal parity rules now govern plans subject to the Affordable Care Act but CPA must be at the Legislature and at state agencies to ensure that nuts-and-bolts implementation really happens, and that there is pro-active regulatory oversight.

A list of ideals is only a recipe for action. Consider the history of American ideals. Thomas Jefferson laid them out handsomely in the Declaration of Independence but it took a Revolution, a new Constitution, two dozen constitutional amendments, a Civil War, innumerable social movements, thousands of court battles and more than 200 tumultuous years to advance our ideals and—almost—accomplish them. America is still working on them.

If Mr. Jefferson's memo did not get the job done, why would we think that we can walk away after publishing our ideals—among which are dignity, confidentiality, parity, and quality medical care. We must keep working on them.

And success is fleeting. New technologies and new healthcare systems keep shifting the ground, destabilizing our accomplishments and creating new competitions.

We keep the roof up so that you can practice medicine. As evident by all that has preceded, the roof is not indestructable and unassailable.

Politics is not a dirty word. It's how policy gets done. You need to be at the table or, as they say, you will be on the menu.

Money is not a dirty word. Engagement costs money: No engagement, no roof, no mission, no profession, no adequate care for people with mental illness. Dues and contributions are an integral part of your professional duties. thurstonrc@gmail.com

$398 *(Continued from page 1)*

Our lobbyist: Randall Hagar is held in the highest regard by legislators and their healthcare policy aides. They trust his knowledge, his honesty, and his commitment for improving the quality of mental health care to Californians, expanding access and enforcing parity. His involvement in crafting legislation and policy is much sought after. Recently, Mr. Hagar has:

- Drafted SB 22 (Senator Jim Beall), parity enforcement and transparency legislation.
- Drafted SB 626 (Senator Leland Yee) – Laura's Law implementation, which became part of SB 585, recently signed by the Governor.
- Last year, analyzed 100 bills, some helpful, with many others hostile to our efforts to treat our patients. Persuasively communicated by Mr. Hagar, CPA's support or oppose position often helps contribute to a bill's success, or death.
- Serves as one of four hosts for the LPS Reform Task Force, which is recommending major revisions in laws relating to patients unable to consent to treatment.
- Served as President of the California Mental Health Coalition, which represents 30 organizations.
- Serves on the steering committee of the California Whole Health Coalition.
- Served as a key board member of all of the following: the Roy W. Smith Foundation, Proxy Parent Foundation, the California Chronic Care Coalition and California Public Protection and Physician Health, Inc.

Our Attorney: CPA's attorney, Dan Willick, believes in our causes, follows developments closely, and leaps into

action to protect our patients and our ability to serve them. Recent and ongoing activities include:

- He has provided written and oral argument in Rea v. Blue Shield, arguing for full enforcement of California's Mental Health Parity Act.
- Argued for the confidentiality of mental health records in the Clergy Abuse cases
- He is assisting CPA in a successful effort to protect medical staff autonomy at state and prison hospitals.
- He advises CPA on the potential efficacy and impact of proposed and enacted legislation and legal actions.
- At no charge, he writes a column on legal issues for our newsletter and presents a workshop at our annual meetings.

Our Leadership: Barbara Gard, past mayor of Redding, has been with CPA since its inception, and has trained all of its officers ever since. An expert in political strategy and tactics, she has guided CPA to successfully beat back so many attempts by psychologists to gain legal authority to practice as physicians that they appear to have given up even trying, shifting their efforts to weaker states. At the same time, her commitment to our goals of serving the mentally ill, and her capacity to develop close relationships with key policymakers, has earned CPA a stellar reputation in Sacramento. ***In February, CPA's work was recognized with a special award, presented on the floor of the Assembly***. CPA's Associate Director, Lila Schmall, coordinates the PAC, and heads the planning for our outstanding Annual Meetings and Council meetings - continually finding ways to save money while improving the quality.

Our Allies: When mental health advocacy groups are unified, we are a powerful force. Ms. Gard and Mr. Hagar have forged vital relationships with NAMI, the Coalition for Mental Health, and other mental health provider organizations. CPA staff works closely with the California Medical Association, our most important ally; psychiatry benefits enormously by having its active support and direct access to its powerful lobbyists.

Support Staff: The list of responsibilities should impress any member. Julie Morris and Vanessa Smith are busy scheduling appointments with legislators, sending letters, birthday and holiday cards to them; managing PAC membership and contributions, bookkeeping, billing, annual meeting preparation, managing databases and mailing lists, managing the key contact system, setting up committee meetings and conference calls, assisting Ms. Gard with our superb newsletter, and working on numerous special projects. CPA staff answers the phone *in person* when a legislator, a state regulator, a CMA lobbyist, or a key ally calls. Just as they answer *your* call.

That's what I get for $398. It would be a steal at three times the price.

Board of Trustees *(Continued from page 3)*

Additional reports on long-term issues were Paul Appelbaum, MD's discussion of planning for future iterations of DSM 5; Grayson Norquist, MD's report on research issues and Howard Goldman, MD's description of major health care challenges, including integrated care.

The APA continues to do well financially, with DSM 5 sales driving this. Additional DSM 5 products are in the pipeline, as well as foreign translations. Over 546,000 copies have been sold so far. The repayment for DSM 5 development is almost complete.

The Board approved the results of the election and proposed bylaws changes.

On a personal note, this will be my last Board of Trustees report, as I have resigned from the Board for personal reasons. I intend to stay active in the APA and CPA in whatever ways that I am able.

"Hurry up—it's time" *(Continued from page 5)*

-Bob Cabaj, M.D. – Chair, Council on Advocacy and Government Relations
-Larry Gross, M.D. – Member of the Assembly DSM-5 Work Group

A new APA-Assembly Commission will be appointed to address the training of residents and the preparation of ECPs to participate in and lead the movement toward integration of care in innovative medical-psychiatric models being established with the Affordable Care Act and Accountable Care Organizations. Through directed actions, the Assembly continues to address impediments to our practice at all levels and in all settings (codings, parity, formulary restrictions, and confidentiality).

Please be encouraged to contact me (bblinder@msn.com) or Joe Mawhinney (Deputy Representative) with concerns, ideas, and comments and be assured of a direct response.

CPA Medicare Carrier Advisory Committee Report

By Eleanor Lavretsky, MD, PhD

The Medicare Carrier Advisory Committee (CAC) meets quarterly: two meetings in Los Angeles and two in San Francisco. I attend CAC meetings in Los Angeles representing CPA and review minutes of San Francisco meetings.

On January 15, 2014 the first quarterly CAC meeting took place in Los Angeles. Representatives of all California Medical Societies met with the new Medicare contractor company Noridian replacing Palmetto GBA.

The following are CMS/Medicare requirements that involve and influence the practice of psychiatry. It is important to remember that all other insurance companies usually adopt and follow Medicare policies.

New Medicare/CMS Requirements and Regulations:

1. ELECTRONIC HEALTH (MEDICAL) RECORDS (EHR)
Medicare requires that all hospitals and individual doctors switch to electronic records. Medicare pays incentives for successful EHR implementation to many hospitals and doctors. APA has reported that fewer psychiatrists proportionally (7%) than other medical professionals (15-25%) have applied for and received Medicare EHR incentives. In 2015-2016 Medicare will use penalties for not implementing an EHR.

2. ELECTRONIC PRESCRIPTIONS (E-Rx)
These requirements started in 2009. In 2014-2015 physicians will get a reduction in payments by Medicare for not implementing an electronic prescription program.

3. MEANINGFUL USE OF EHR
In 2013-2014 Medicare is encouraging applications for special incentives in using EHR for communication with individual patients.

4. NEW CLASSIFICATION OF DISEASES, DIAGNOSTIC CRITERIA, NEW CPT CODES FOR PSYCHIATRY
Psychiatry as well as other medical professions will transition from ICD-9 to ICD-10. Many psychiatrists are already using DSM-5 and new CPT billing codes for psychiatric services.

FAQs about Covered California

CMA has published an FAQ that addresses commonly asked **patient** questions about Covered California that physicians can give to their patients. The patient FAQ is publicly available on our exchange resource page (www.cmanet.org/exchange). Feel free to share with your members.

SAVE THE DATE

CALIFORNIA PSYCHIATRIC ASSOCIATION

PREMIER CONFERENCE

September 19-21, 2014

Yosemite, CA

Tenaya Lodge at Yosemite

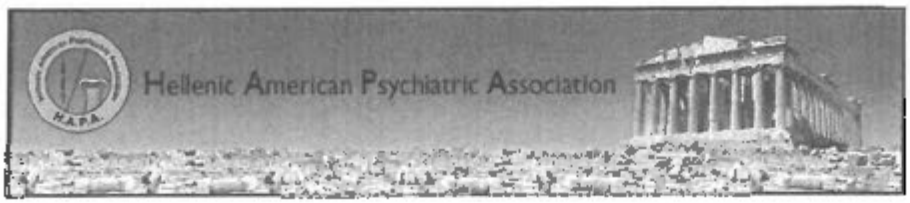
FOR MORE INFORMATION PLEASE CONTACT 800-772-4271 www.calpsych.org

Important Information about DSM-5 codes and payment

As you may know, beginning October 1, 2014, the United States will be transitioning to the ICD-10-CM system of medical codes. In anticipation of this change, DSM-5 includes both ICD-9-CM and ICD-10-CM codes. However, questions from clinicians have arisen about the nature and purpose of the codes in DSM-5 and how they should be used in light of the impending adoption of ICD-10-CM.

In order to ensure clinicians are fully aware of the issues surrounding the transition, the APA has developed a fact sheet to serve as a "quick guide for clinicians" in understanding the relationship between DSM and ICD. We are asking for your assistance in disseminating this information as widely as possible and also including this information in any trainings you conduct.

We appreciate your help in clarifying this very important matter. Please do not hesitate to contact at the APA, Jennifer Shupinka, Assistant Director, DSM Operations, at jshupinka@psych.org if you have any questions, concerns, or feedback.



JOIN US

H.A.P.A. 15th Annual Meeting in New York City

Tuesday May 6th 2014
6pm - 8pm
Marriott Marquis Hotel
New York City, NY

The Executive Committee of the Hellenic American Psychiatric Association invites you to the 15th Annual HAPA Meeting on May 6 2014 in connection with the APA's 167th Annual Meeting in New York City. Join us for the Scientific presentation, meet old and make new friends, network with colleagues and after the meeting join us for an enjoyable Dutch treat dinner with lots of Greek KEFI & good company.

Become a HAPA member or renew your membership **TODAY** and sign up for the meeting & dinner of 5/6/14.

Click here for more information and to register to attend.

Maria T. Lymberis, MD

HAPA Founder & Past President

PSYCHIATRIC MEDICAL CONSULTANTS NEEDED

Interested in moving away from direct patient contact? Prefer **not** to buy malpractice insurance, deal with overhead costs, and be on-call? Want your health benefits paid for, work flexible hours, either part or full time, and have your weekends free?

Then join our team of professionals! The California Department of Social Services is seeking a few good psychiatrists who are interested in working with outside treating sources and other State professionals that evaluate medical evidence to determine its adequacy for making disability decisions as defined by Social Security Regulations. On the job training is provided.

Interested applicants must have a current CA MD/DO License. Fulltime Salary ranges can start at $8,711 to $12,894 per month depending on experience and credentials.

Job Locations: Covina, Fresno, Los Angeles, Oakland, Roseville, Sacramento, San Diego, Stockton and Rancho Bernardo.

If you are interested, please contact Lynda Harris at (916) 285-7596 or Lynda.L.Harris@ssa.gov

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