California Psychiatrist

The Newsletter of the California Psychiatric Association

Volume 30, Number 2 Summer 2015

The President's Message

Integrated Care: Will Its Promise Disintegrate?

Timothy Murphy, M.D.

By Timothy Murphy, M.D.
CPA President

At the APA Annual Meeting in Toronto, "Integrated Care" was abuzz, promoted as the solution for extending access to mental health care in response to growing demand and expanded insurance coverage. But along with the exuberant descriptions of the clinical and practical attractions of integrating mental health care and physical health care, there is a growing current of concern that psychiatrists could be largely carved out.

Most of the early models of Integrated Care were developed and implemented in university settings where physicians worked on salaries partly covered by grants for pilot projects. These programs placed psychiatrists in key roles, working collaboratively with primary care physicians and their behavioral specialists. Patients requiring direct care by psychiatrists got it promptly. But what is happening in the real world of profit-driven medicine, without grant funding and without established academic psychiatrists at the helm?

Well, it's worrisome. Reports of integration activities in the private sector suggest that money, not quality, is the driving factor. The mental health component of care, when it is offered, is provided with only infrequent involvement of psychiatrists. Rather than being contracted to provide the daily consultation, support and oversight typical of pilot projects,

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From the President-Elect

Does the *Aid-In-Dying* Bill (SB 128) in California Need Resuscitation?

William Arroyo, M.D.

By William Arroyo, M.D.
CPA President-Elect

An opportunity to improve the circumstances surrounding death for people with terminal illness or, as its detractors claim, the cloning of Dr. Kevorkian, has finally come to California in the form of a bill, **SB 128**, "End of Life Option Act". Many members of the general public say it's "way too soon", others chime "it's about time" and still others claim "it's criminal". Judging from many conversations with psychiatrists throughout California, the positions mirror that of the general public with varying levels of intensity and passion. If this bill were to become law, California would follow Oregon (its law took effect in 1997), the first State to have a law on "physician-aid-in-dying." Washington (2008), Montana (2009), Vermont (2013) and New Mexico (2014) have previously enacted such laws. **SB 128** is the twin of the law in Oregon where approximately 850 individuals have requested this intervention. Senators Monning and Wolk introduced the bill, while Assembly members Alejo and Talamantes-Eggman are principal co-authors. It was in part inspired by the harrowing demise of Brittany Maynard, a 29 year old Californian, diagnosed with grade 4 glioblastoma multiforme who ultimately moved to Oregon in order to legally end her suffering and life.

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Inside This Issue

From the Editor ...

Yvonne Ferguson, M.D.

Spring has traditionally been a time for housecleaning and wrapping up loose ends. The house of California, the APA, and the CMA are no exceptions. You will find many of the articles in this issue dealing with reviews of legislative actions that transpired this spring at the state level and organizational actions by APA's and CMA's Board of Trustees. Spring is a time of transition in other aspects as APA officers pass their batons to incoming officers. During these changes there must also be planning for summer and fall and the CPA is well entrenched in planning an exceptional annual meeting at Dana Point in September which you'll be able to preview. Congratulations to those of you who are taking the helm of the House of Psychiatry or continuing to keep us steady.

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

Volume 30, Number 2 Summer 2015

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Capitol Insight and Special Inserts

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

Physician Attitudes on Aid in Dying and the CPA Survey

Ronald Thurston, M.D.

By Ronald C. Thurston, MD,
Immediate Past President

California Senate Bill 128 would allow treating physicians to prescribe–but not administer–a lethal dose of medicine to competent California residents diagnosed with an illness expected to be fatal within six months.

The California legislation is modeled after Oregon's Death with Dignity Act. A total of four states, one county in New Mexico, all of Canada, and several European nations currently allow some version of "physician-assisted suicide."

An alternative term is "physician aid in dying." Indeed, the California bill explicitly requires that the cause of death be attributed to the underlying fatal illness, not suicide.

Physicians have traditionally opposed "aid in dying." The American Medical Association position is that it is "fundamentally incompatible with the physician's role as healer."

That said, my informal poll of physicians finds that most would like to have the option for themselves. If so, why not for others? And is "healing" really our highest calling? Perhaps compassion trumps healing. Whatever your guiding angels, the devil is surely in the details of any aid-in-dying legislation.

In April, the California Medical Association repealed its longstanding policy of opposition to aid in dying and took a "neutral" position on SB 128–pending amendments to enhance patient and physician protections. Given CMA's demonstrated ability to stifle such legislation in the past, "neutral" was seen as a blessing for the amended SB 128, which was recently approved by the Senate.

As a CMA Trustee, I voted with the majority to repeal our longstanding opposition and to establish the "neutral" policy. I argued that aid in dying is really social policy. Our role should be limited to blessing (or not) those physicians who choose to participate and to ensure that both

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Board of Trustees (BOT) Highlights

By Melinda L. Young, M.D.
Area 6 Trustee

Melinda L. Young, M.D.

There have been two BOT meetings since the last Newsletter, a regular 1½-day meeting in March and a mostly ceremonial 2-hour meeting in May. A brief summary of actions, primarily from the March meeting follows.

Five-Year Strategic Plan

The BOT adopted a five-year strategic plan for the APA that focuses on the integration of psychiatry into all care settings and support for members in this transition, as well as support for research, education and diversity. The BOT reinforced support for advocacy and communications. The Board's goal is to determine how to best meet the challenges and opportunities ahead, internally and externally, and have a consistent and focused multi-year plan. Specific initiatives in the strategic plan can be found at www.psychiatry.org/strategicplan. The APA administration is working to integrate each priority into all core areas of responsibility and functionality and to develop member-focused work products that incorporate one or more of these priorities. The BOT and Assembly will focus on these initiatives as they bring forward new action plans.

Maintenance of Certification (MOC)

The Board addressed ongoing concerns about MOC, voting to support the elimination of Part 4 of MOC (Performance in Practice) and recommending to the American Board of Psychiatry and Neurology (ABPN) that it advocate for the elimination of Part 4 of MOC to the American Boards of Medical Specialties (ABMS). Additionally, the BOT reaffirmed the APA's commitment to lifelong learning and quality improvement as well as support for the highest scientific and ethical standards of medical practice, and voted to create a joint Board-Assembly Work Group on MOC.

Advocacy

The Board approved the amount requested by the

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2016 CPA Annual Meeting Preview

Robert McCarron, D.O.

By Robert McCarron, D.O., Chair, CPA Annual Meeting Planning Committee

On behalf of the CPA Annual Planning Committee, I am excited to provide a brief summary of our upcoming **28th Annual California Psychiatric Association Premier Conference**, which will be held at the picturesque **Laguna Cliffs Resort and Spa, Dana Point, on September 25-27, 2015**.

Please mark your calendars and lock in your room reservation today! Just call the Laguna Cliffs at 800-228-9290 and let them know you are with the CPA. Make sure to invite colleagues who have not recently come to the CPA meeting and have them email me directly at: rmmccarron@ucdavis.edu for a personal welcome and a chance to win a raffle prize for all newcomers, as well as those who have made the referral.

Some of our featured speakers include: **Renee Binder, M.D.**, APA President, (UCSF Psychiatry), who will be speaking on forensic topics in psychiatry; **Jose Maldonado, M.D., FAPM, FACFE** (Stanford University Psychiatry) who will discuss cutting edge treatments for alcohol withdrawal / dependence and chronic fatigue syndrome, and **Scott Fishman, M.D.**, (American Academy of Pain Medicine Past President; UC Davis Psychiatry and Pain Medicine) who will present an overview on diagnostic and treatment considerations in pain psychiatry and responsible opioid use.

Other topics include technology in psychiatric practice with **John Luo, M.D.**, (UC Riverside Psychiatry); a discussion on access and use of firearms and mental illness with **Amy Barnhorst, M.D.**, (UC Davis Psychiatry), psychiatric legal updates, **Dan Willick, J.D.**; and medical updates for psychiatrists with **Dave Folsom , M.D.** and **Rachel Robitz, M.D.**, (UC San Diego Family Medicine / Psychiatry).

We will host four inaugural professional caucuses at the meeting: Women in Psychiatry; California Psychiatry Residency Training Directors; Resident-Fellow Members (RFM); and Senior Psychiatrists.

Please let me know if you have an interest in forming a new caucus or joining one of these. It's a great way to network outside of the meeting!

Lastly, **David Safani, MD, M.B.A.**, (UC Irvine Psychiatry), has graciously offered to organize our first **RFM mentorship and career planning workshop**, which will be held on Sunday, September 27th AM. If you are a resident or fellow and plan to attend the CPA conference, please contact Lila Schmall, CPA Executive Director, at: lila-schmall@calpsych.org to get information on CPA travel stipends for trainees.

I would love to hear any suggestions for this and future conferences, as the Annual Planning Committee makes it a point to select topics and speakers which have been recommended by CPA members and meeting attendees. Please email me with any questions about the conference and I very much look forward to talking with you in beautiful Dana Point on **September 25-27**!

Happy Summer!

Quick-Look Conference Time Schedule

➢FRIDAY SCHEDULE

2:00	PM	Registration Open
4:00	PM	Exhibits Open
5:00-6:30	PM	**President's Reception in Exhibit Area** - Hosted beer, wine and soft drinks "Meet/Greet" your colleagues
6:30-7:30	PM	**Friday Night Buffet Dinner** (Please purchase tickets in advance)
7:30-9:30	PM	**The Exercise of Ethical Practice in Medical Research, Then and Now** *Yvonne Ferguson, MD*, Discussant

➢SATURDAY SCHEDULE

7:00	AM	"Fun Run" (Participants meet at CPA registration table)
7:00–8:00	AM	Breakfast in Exhibit Area (registrants only)
7:00-8:00	AM	Resident Fellow Member Caucus Psychiatry Residency Training Director Caucus Women in Psychiatry Caucus Senior Psychiatrists Caucus
8:00–8:15	AM	**Welcome** *Timothy Murphy, MD*, CPA President *Robert McCarron, DO*, CPA CME Chair
8:15 -9:15	AM	**Updates in the Diagnosis and Treatment of Delirium** *Jose Maldonado, MD*, Associate Professor of Psychiatry, Medicine & Surgery Stanford University
9:15-10:15	AM	**Legal and Legislative Updates in Psychiatry** *Daniel Willick, JD*, CPA Legal Counsel *Saul Levin, MD*, MPA, CEO and Medical Director American Psychiatric Association
10:15–10:45	AM	Refreshment Break in Exhibit Area Keynote Speaker: Assemblywoman Susan Talamantes Eggman of the 13th Assembly District Presentation of the Edward Rudin, MD & Warren Williams, MD Awards
10:45-12:15	noon	**Chronic Pain and Psychiatry** *Scott Fishman, MD*, Professor and Chief, Division of Pain Medicine, UC Davis
12:15-1:45	PM	**LEGISLATIVE LUNCHEON** Keynote Speaker: *Dave Jones*, Insurance Commissioner for the State of California
12:30-3:30 (Concurrent)	PM	**Early Career Mentorship and Career Planning Symposium** (pre-register) *Timothy Murphy, MD*, CPA President *Charles D. Cash, JD*, LLM, Assistant Vice President, Risk Management, Professional Risk Management Services, Inc. (PRMS) *Brian S. Hart, MD*, Staff Psychiatrist, Midtown Community Mental Health Center/Assistant Professor of Clinical Psychiatry, Indiana University School of Medicine *David Safani, MD*, MBA, Chief Child and Adolescent Psychiatry Fellow UC Irvine
1:45-3:15 (Concurrent)	PM	**Updates in Medicine and Psychiatry** *Jabe Best, MD* *Dave Folsom,MD*, Associate Professor Psychiatry and Family Medicine UC San Diego *Rachel Robitz, MD* *Jessica Thackaberry, MD*
3:15-4:00	PM	**Refreshment Break in Exhibit Area** (registrants only)
4:00-5:30	PM	**The Future of Psychiatry** *Renee Binder, MD*, President, American Psychiatric Association, Professor of Psychiatry and Associate Dean, University of California San Francisco School of Medicine
5:30-6:30	PM	**PAC Reception (any contribution level welcome)** *Larry Malak MD*, Chair CPPAC

➢SUNDAY SCHEDULE

7:00-8:00	AM	Breakfast in Foyer (registrants only)
8:00-9:00	AM	**Firearm Law and Mental Illness: What Every Psychiatrist Should Know** *Amy Barnhorst, MD*, Assistant Clinical Professor, University of California, Davis Department of Psychiatry and Behavioral Sciences
9:00-10:00	AM	**The App Revolution and Its Impact on Psychiatric Practice** *John Luo, MD*, Clinical Professor of Psychiatry, UC Riverside
10:00-10:15	AM	Break in Foyer (registrants only)
10:15–12:15	noon	**Updates in Treatment of Alcohol Misuse and Withdrawal** *Jose Maldonado, MD*, Associate Professor of Psychiatry, Medicine & Surgery Stanford University
12:15–12:45	PM	**Wrap Up and Closing Remarks**

Conference Registration Form CPA's 28th Annual Premier Conference at Laguna Cliffs Marriott Resort & Spa, Dana Point, CA September 25-27, 2015

Name_____

Address_____

City/State/Zip_____

Phone_____

Email_____

Circle one: **CPA/APA Members:** $355
Non-Members: $430 **ECP:** $275
Residents: $100.00 - Registration price will be refunded after completion of program.

Yes_____ **No**_____ Attending the Early Career Mentorship and Career Planning Symposium lunch will be included

Tickets for the Legislative Luncheon are included in your registration fee. However, all other tickets for yourself and family or friends must be ordered below and included with your payment.

Please include the number of tickets needed in the space provided.

_____ # of Tickets for Friday Night Buffet $45.00 each

_____ # of **Guest tickets** for Legislative Luncheon $45.00 each

_____ Late Registration Charge of $25 **after September 10, 2015**

_____ Cancellation Fee of $75 **after September 10, 2015**

_____ **PAC Donor Reception**. Any contribution level is welcome. Or contribute online at www.calpsych.org

_____ # of guest tickets for PAC reception $30

_____ Charge for Printed Syllabus $30.00, PDF is included in registration fee.

REGISTER ONLINE AT WWW.CALPSYCH.ORG
Or
Please make checks payable to California Psychiatric Association or charge your VISA or MasterCard by calling CPA at 800-772-4271 or filling in the information needed below and return this form to:
California Psychiatric Association
921 11th Street, Suite 502
Sacramento, CA 95814
(916) 442-5196 1-800-772-4271 FAX: (916) 442-6515

Check Enclosed for Total Amount of $_____

Please Charge My: (circle one) VISA / MasterCard

Credit Card # _____

Expiration Date: _____

HOTEL RESERVATIONS

Please make hotel reservations early. The hotel has reserved a number of rooms for the California Psychiatric Association's Annual Meeting, September 25-27. **After these rooms are filled, reservations are accepted only if additional space is available and may be at a higher cost.**

Laguna Cliffs Marriott Resort
25135 Park Lantern
Dana Point, CA 92629
800-228-9290 for reservations
949-661-5000 directly to the resort

$215.00 Single or Double Occupancy. Hotel room rates are subject to applicable state and local taxes in effect at time of check in. **Please note, the hotel website states a Resort Fee of $25.00- this is inaccurate. This charge will not be included in your final payment.**

The conference rate applies to 3 days prior and 3 days after the conference, based on availability. **Please specify that you are with the California Psychiatric Association to get this special rate.**

RESERVATIONS MUST BE MADE BEFORE SEPTEMBER 4, 2015

Reservation requests are subject to availability.

To book your room directly with the hotel via their website please log onto: http://www.calpsych.org/conferences/2015HotelReservations.pdf

CHECK-IN AFTER 4:00 P.M.

CHECK-OUT TIME IS 11:00 AM

Reservations must be guaranteed with one night's advance deposit by credit card or personal check. **You may cancel reservations by 4 p.m., 48 hours prior to arrival.**

Legal Update

January 1, 2016 Deadline to Apply to Acess the Cures Database. Cures Monitoring by the State is an Invasion of a Psychiatric Patient's Right to Privacy.

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

January 1, 2016 Deadline

Senate Bill 809, enacted in September, 2013, amends Health and Safety Code §11165.1 by requiring that health care practitioners, including physicians, authorized to prescribe, administer or dispense controlled substances listed under Schedules II, III or IV must, by January 1, 2016, register with the California Department of Justice to obtain online access to the CURES database. This will allow the practitioners to access their patients' prescription history for the controlled substances. This law implies that the standard of practice for psychiatrists and other physicians will soon require review of CURES records when prescribing controlled substances for a patient. As you know, the CURES database, which is operated by the State of California, routinely collects information on prescribing practices for controlled substances, with information identifying both the prescriber and the patient. There is a serious question of whether CURES violates the Constitutional rights of patients receiving psychotherapeutic treatment or treatment for substance abuse.

Daniel H. Willick, Esq.

Lewis v. Superior Court

Lewis v. Superior Court, which is presently pending before the California Supreme Court (Case No. S219811), raises the issue of whether CURES violates privacy. *Lewis* challenges the Medical Board's usual investigatory technique of accessing the CURES records for a physician's prescription of controlled substances when there is any complaint made against that physician, even if the complaint does not concern prescribing practices and the patients involved do not authorize access to their records. The issue before the Court is whether this investigatory technique is a violation of the Constitutional

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APA Assembly Summary • May 15-17 2015 • Toronto, Canada

By Joe Mawhinney, M.D. Area 6 Assembly Representative
Barbara Weissman, M.D. Area 6 Assembly Deputy Representative

The American Psychiatric Association Assembly met in May in Toronto, prior to the Annual Meeting. It was a very busy meeting as there were 30 action papers and 19 position statements for the group to consider as well as an internal reorganization. Our medical director reported that membership was increasing for the second year in a row, and reviewed many of the actions of the APA in the past months including a new branding image, the development of a DSM-5 guide targeted for a lay audience, the recent opposition to Part 4 of the MOC, and ongoing involvement in comprehensive mental health care reform. The APA is developing a "Find A Psychiatrist" database, on the APA website at http://apps.psychiatry.org/optinfap/Default.aspx if you are interested. Also, if you have questions related to APA issues you can contact the staff through the "Contact Us" site at the top right of every page of the APA website. We heard from our outgoing APA president as well as incoming APA President Californian Renee Binder, M.D. who stated, "There is no health care without mental health care" and outlined her goals for the year including a major initiative to address the incarceration of those with mental disorders.

Highlights among the action papers include a paper addressing the survivors of the Fort Hood shooting incident and advocating for comprehensive mental health benefits for their survivors and significant others. Dr. Mawhinney wrote a series of successful action papers furthering issues around access to care, including the development of a tool kit and compendium on access to care action papers and position statements and development of a level of intensity of services instrument. The Assembly asked advocacy for timely payments for psychiatric treatment, asked for a position paper regarding the psychiatric morbidity of sexual

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Assembly Work Group on Access to Care

By Joseph Mawhinney, M.D., Chair

While we welcome expanded access to health insurance through the Affordable Care Act and Federal and State legislation supporting parity, access to timely appropriate and effective care is still not a reality for many who suffer from mental disorders. Barriers to care are many but financial barriers are still the most daunting for many patients. Out of pocket costs in the form of deductibles, copays, share of costs, "donut hole" etc. discourage early treatment, appropriate follow-up, intensity of care and medication adherence. Centers for Disease Control (CDC) studies confirm the obvious, that out of pocket costs as barriers to care, result in adverse medical, psychiatric and social outcomes. Other barriers include unnecessary administrative complexity for patients and providers, inadequate provider panels, delay and disruption of effective treatment due to requirements for prior authorization even for previously effective medication and medications known to be effective. Other barriers include denial of clinically appropriate levels of care, intensity of care, duration of care or "chronicity" of the disorder. The implications of these delays, disruptions and denials for individual patients and their families, are immense. Effective health care impacts public health, educability, employability, productivity, physical health and quality of life.

Joseph Mawhinney, M.D.

We psychiatrists on the front lines are often frustrated by these access issues and can be further demoralized and discouraged by administrative burdens, inadequate reimbursement and lack of adequate resources. Opting out of insurance-based practice is an understandable coping strategy but this practice raises concerns for global health and the future of psychiatry in the evolution of health care. Those practicing or considering opting out might consider seeking part time integrated care or organized health care systems as part of the solution. A patient centered focus on access at the grass roots level is an essential complement to broad stroke policy development

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The Journey of an Action Paper from Idea to Action

By Melinda L. Young, M.D.
Area 6 Trustee
Past Speaker of the Assembly

An Action Paper (AP), comparable to a "Resolution" at the American Medical Association, is an instrument of change employed by members of the APA's legislative body, the Assembly. Action Papers typically initiate, change or terminate an activity or process within the APA.

An Action Paper originates with an idea and, when fully written, sets forth reasons for the intended action(s) (the "Whereas" section) as well as specific actionable items (called "Resolves"). Ideas may come from any member of the APA and are formulated and crafted into an Action Paper by the Assembly member who will serve as first author. Updated tips for writing a successful AP, an AP template, formatting instruction, cost estimates and other important information relevant to writing an Action Paper are found on the APA's website (www.psych.org) by clicking on Home>Network>Assembly>Action Paper Central.

Essential questions authors should ask themselves before writing and submitting an Action Paper include:

Melinda L. Young, M.D.

- *Is an Action Paper really necessary?* At times, changes are more effectively or efficiently accomplished by a call or an email.
- *What do I really want and/or what is my real purpose?* If the purpose of the AP isn't clear, even an AP that has been approved by the Assembly may not yield the results the author intends.
- *Does this, or something like it, already exist at the APA?* (refer to "Policy Finder" on the APA website)
- *Does the "Whereas" section match and support the "Resolves"?* Engage a reliable friend or fellow Assembly member as a proofreader.
- *What do the experts* (Council or component chairs, Assembly Reps on Councils and components, staff,

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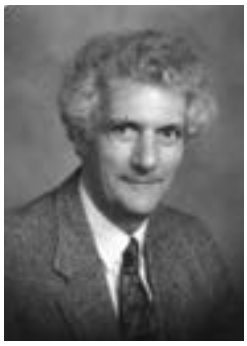
Does the Name Change the Game?

By Richard A. Shadoan, M.D.

There seems to be more stigma against mental illnesses than against heart illnesses, liver illnesses, and kidney illnesses. I would like to suggest a hypothesis that we clinicians are partly to blame. I think when we say that "Depression", "Manic-Depression" "Schizophrenia" are mental disorders, we are using a euphemism "disorder", which we thought would be less frightening to the public. Instead, it gives the impression that it is only a "disorder", and therefore can be changed with effort. We all have disorders: stomach disorders, back disorders, but the implication is that by just trying harder we get over them. We change diet, lose weight, exercise more. So does the public think that people who have mental disorders and do not get over them because of lack of effort or willpower? Could part of the stigma against mental disorders be because the public feels our patients are partly at fault for not trying harder to get over their illnesses?

We all know, there is stigma for those unemployed, those on welfare, and even the homeless. Many think their situation is partly their own fault for not applying themselves or trying hard enough.



Richard A. Shadoan, M.D.

Stigma does not seem to apply to one of our diagnoses and that is Alzheimer's disease. Patients who suffer with it are not blamed for their disorder or not being able to hold down a job. There is no blame when they are on welfare or homeless. No one is against forcing treatment on those with Alzheimer's. So why do many people not support Laura's Law that forces treatment on those with mental illness? The general public knows that over 20% of our jail and prison population are people with mental illnesses, and they are not outraged. Is it because it is "only" a mental illness? If the

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Essentials of Primary Care Psychiatry CME Conference

Organized by the CPA Integrated Care Committee,
Co-Chairs Robert McCarron, DO and Shannon Suo, MD

Friday, January 15 to Saturday, January 16, 2016
Hilton Sacramento Arden West in Sacramento, CA
Jointly Sponsored by the California Psychiatric Association and the University of California, Davis, Department of Psychiatry and Behavioral Sciences

- Registrants receive Lippincott's Primary Care Psychiatry Textbook included with registration!
- Practical "primary care psychiatry" clinical pointers for primary care providers and mental health providers
- Important DSM-5 diagnostic updates
- Topics include: Mood/anxiety disorders, substance misuse, personality disorders, collaborative care, pain psychiatric management and how to do a primary care psychiatric interview
- Hear from speakers who are national experts in the practice of psychiatry in the non-psychiatric setting
- Small group discussion and personalized learning with faculty who practice in both primary care and psychiatric settings
- CPA / UC Davis Certificate of Completion for each attendee

For more information please contact Lila Schmall at Lila-schmall@calpsych.org or call 800-772-4271. Website info will be available mid August (www.calpsych.org) for program and registration info.

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

the psychiatrist's role is kept to a minimum. Psychiatrists are not being given contracts to cover telephone and online consultation to the primary care team. Instead, when they are used at all, they are paid only for actual time spent in the direct care of (typically) very ill patients.

Large organizations, such as Kaiser and the VA, that could be offering care in integrated models with full use of psychiatrists' expertise, have yet to do so.

What is being done to steer the integrated care movement back on course?

1. The APA is working with public and commercial payors to assure a strong psychiatric presence in integrated care systems. It can be a hard sell without more outcomes data proving the value of psychiatrists in the consultative role.
2. CPA is monitoring for parity violations in which Californian's are denied proper access to a psychiatrist when one is required.
3. APA is advocating for CPT codes, and CMS polices that allow their use, for specialty consultations not involving face-to-face encounters. Progress so far has been limited.
4. Better quality measures are being developed, essential so that we can demonstrate that care systems using psychiatrists to their fullest extent produce better outcomes.

Psychiatrists also need to reach out to their fellow physicians in primary care, conveying enthusiasm, and reminding them of what we have to offer in an integrated care model. If primary care physicians demand regular collaborative access to psychiatrists, their organizations may accommodate them. Their patients will be the winners. Psychiatrists also need to embrace new quality measures despite the inconvenience, because those measures will produce the data needed to prove their value.

Integrated Care, as envisioned by those who have developed and championed it, has great potential to improve the quality of health care provided to our patients. This will not be the case if psychiatrists are marginalized to a minimal role. CPA and APA are working hard to make sure a great opportunity is not lost.

Aid-in-Dying Bill *(Continued from page 1)*

As a member of the California Medical Association's (CMA) Council on Ethics Affairs (CEA), I participated in the deliberations related to informing the CMA Board of Trustees (BOT) on the ethical issues of the bill. Preparations included a review of documents including recent and historical AMA and CMA policy documents of opposition, and peer reviewed research among others. The President of the Oregon Medical Association (OMA) at the time of the enactment of the law in Oregon joined our deliberations. (Apparently the OMA did not systematically examine the ethical issues.) Palliative care in Oregon has been widely expanded since the law was passed. We engaged in discussions of the fundamental ethics principle of *do no harm*; the physician's duty to preserve life; patient autonomy (self-determination vs. patients' choice restricted to treatments offered); legal competence (**SB 128** language) vs. mental capacity (not in bill); the recent California law which mandates that all physicians must inform terminally ill patients about treatment options and palliative care, including terminal sedation; the determination of the terminal illness as cause of death on the death certificate (**SB 128** language) when a medication was specifically requested to end one's death (in the case of a death due to an overdose, the drug would be listed as the cause of death); the recent support of the intervention by the younger members of CMA's House of Delegates; and the Hippocratic oath.

The primary task of the CEA was to answer the following three questions: (1) do terminally ill patients with capacity to make medical decisions have the prerogative to decide to intentionally end their own lives? (2) Is it ethical for a physician to determine and document a terminally ill patient's diagnosis, prognosis and capacity to make medical decisions where that information will be used by others to determine the patient's eligibility or qualification to receive medication to intentionally end the patient's life? (3) Is it ethical for a physician to prescribe or provide medication to intentionally end the life of a terminally ill patient with capacity to make medical decisions? There was a consensus in the affirmative about the first two questions but not the third one. In a historic move by organized medicine on May 20th, the CMA BOT, after the new amendments were added rescinded its opposition. Prior to the CMA's BOT vote, the CPA Council had voted to be "neutral" on this bill.

During the CPA Advocacy Day, prior to the CMA BOT

initial vote, about the bill; Dr. Captane Thomson and Dr. Brenda Jensen and I met with Senator Wolk and her key staff. Concerns about the technical aspects of the bill and ethical issues were shared with the Senator and her staff. Some of the problems remain in the subsequently amended revision, namely, (1) the conflation of competence and capacity. Legal "competence" refers to a patient's legal state of mental soundness to make decisions about a specific issue or to carry out a specific act often weighed in light of potential consequences and is a judicial decision. while "Capacity" relates to being able to provide informed consent for treatment is often determined by a physician. Also, problematic are: (2) the request for such medication to be witnessed by two individuals who have a responsibility to determine that the patient is "competent" when there is no provision to train witnesses about the concept of competence; (3) one of the two witnesses to the written request may be a domestic partner; (4) the terminal illness to be listed as cause of death on death certificate; (5) the omission of the option for those individuals who cannot swallow oral medication; and (6) omission of a provision for disposing of unused medication should patients change their decision after receiving medication remains problematic.

Should this bill be a matter of concern to psychiatrists? I would say yes given the fact that there is a provision to involve psychiatrists to whom an individual seeking aid-in-dying is referred for (1) "counseling" and (2) the determination of "competency. The bill allows for the referral to a psychiatrist "if appropriate" by the primary attending exclusively and does not extend this option to the "consulting physician" who provides the second opinion. A brand new amendment requires that the psychiatrist (or psychologist) determine whether or not a mental disorder is causing "impaired judgment".

My opinion is that every individual should be entitled to death in as dignified and humane a manner as possible. This intervention should be an option for an individual with a terminal illness who is judged to have six months or less to live and who continues to suffer severely from his/her illness after an array of supportive measures such as palliative care, including terminal sedation, have been exhausted. There should also be sufficient legal protections for both the terminally ill individual and the physician in whom the individual's care has been entrusted.

(For an additional point of view, please see Dr. Ronald Thurston's article in this issue.)

Thurston *(Continued from page 3)*

patients and physicians are protected in the details of the law.

SB 128 generated considerable passion within CPA leadership, something I personally witnessed at CPA and SCPS Councils. Thus the Survey.

Available technology, in the form of Survey Monkey, allowed us to send an email survey of current opinion to members–at least all members with an email on file. We asked how members felt personally and what stance–if any–they felt our organization ought to take. Personal opinions are free, but committing the organization's credibility and limited resources to a divisive issue not central to our mission would be costly.

The survey also asked members what sort of protections ought to be included.

Ten percent of members responded. Two-thirds personally supported aid-in-dying and most of them (54% of total respondents) wanted CPA/APA to take this position. On the other side, 25% of respondents were personally opposed and most of them (20% of total respondents) wanted CPA/APA to take an oppose position. Twenty-six percent of total respondents did not want CPA/APA to take a position.

As a measure of passion on both sides: On a personal level, 44% of respondents "strongly" supported and 13% "strongly" opposed physician aid in dying; 29% felt "strongly" that CPA/APA should take a support position and 12% felt "strongly" that CPA/APA to take an oppose position.

Currently, CPA/APA has no policy on the issue and is therefore, without saying so, "neutral."

You may peruse the survey at http://bit.ly/1RZDjpP.

Imperfections and hazards aside, surveys are a good thing. The available and not-too-expensive technology will encourage CPA to query membership more often. Keep an eye on your mailbox. thurstonrc@gmail.com

(For additional point of view, please see Dr. William Arroyo's article)

Board of Trustees (Continued from page 3)

Department of Government Relations to enhance state advocacy and state advocacy staffing to address bills being proposed in various states around the country and to increase support for District Branch advocacy efforts.

Elections and Bylaws Changes

The Board approved several significant changes to the Bylaws: It approved an electronic signature submissions process replacing the cumbersome paper signature submissions for petitions. It voted to limit senior leaders from the Board of Trustees, Assembly and members of the Nominating, Elections and Tellers Committees from supporting or endorsing APA candidates during their own terms of office. And, as a result of experiences in Area 6, the Committee on Bylaws recommended, and the Board approved, new language concerning the replacement of Area Trustees should unforeseen in-term vacancies occur.

APA Branding

The Board approved the recommendation of administration and brand consultant Porter Novelli and, with further minor edits of its own, voted to adopt a new brand for the APA to address the multiplicity of competing marks, fonts and colors evident in APA's prior branding and to more firmly establish the APA as the association representing "medical leadership for mind, brain and body". The Benjamin Rush mark will continue to serve as the Seal of the APA for certain formal documents and events.

Conflicts of Interest

The Board approved revisions to the APA disclosure policy, lowering the financial threshold from $10,000 to $5,000 for individuals within the most stringent tier of disclosure. The language within the policy was rewritten for clarity and consistency based on the evolution of disclosure standards (e.g., Institute of Medicine (IOM) and Centers for Medicare & Medicaid Services (CMS), Principles for the Development of Specialty Society Clinical Guidelines 2012).

APA Headquarters

The BOT voted to pursue purchasing a property in Washington D.C. and directed the APA Administration to enter into negotiations and perform a due diligence review with the developer. The American Psychiatric Foundation Board and APA's BOT have decided to proceed as co-purchasers. Attorneys for the APA are continuing to work with the developer's representatives on details of a purchase.

The next Board of Trustees meeting will be held in mid-July.

Legal Update (Continued from page 7)

right to privacy of the patients being treated by the physician under investigation. Furthermore, there are questions of whether this investigatory technique also violates the psychotherapist-patient privilege and both federal and state requirements of confidentiality for substance abuse treatment records. (See, e.g., Health and Safety Code §11977, 42 U.S.C. §290dd-2.) The CPA will join in an amicus brief to be filed by the California Medical Association in the *Lewis v. Superior Court* case contending that the Medical Board's access to CURES prescription records without appropriate patient authorization is not permitted by law, including being prohibited by the patients' Constitutional rights to privacy.

APA Assembly Summary (Continued from page 7)

assault and evidence procurement to be developed, and adopted a position statement in support of assisted outpatient treatment. An action paper entitled "Promoting Military Cultural Knowledge among Psychiatrists" suggested that psychiatrists ask the question "Have you or someone close to you served in the military?" as part of a clinical evaluation and asked for more education in this area. We voted to support training opportunities in how to provide community-based, culturally competent therapeutic interventions for traumatized African American communities. The Early Career Psychiatrist designation will be extended to 8 years following completion of training to match the American Medical Association classifications, and a Senior Psychiatrist workgroup was established to correspond with the Life Membership category of the APA. We voted to develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders as well as one looking at mental health leaves during college and opposing forced year-long leaves. The Assembly asked that the AMA look at a process to separate actual health care costs from administrative/management costs in the Gross Domestic Product (GDP).

Position papers covered a wide range of topics from training for disorders of sexual development to consistent treatment of all applicants for state medical li-

censure and the role of electroconvulsive therapy. Dr. McCarron helped develop a successful position statement on "Reducing Physical Health Disparities in Patients with Mental Illness" which emphasized the medical training that psychiatrists have and our role in care management of patients that have difficulties accessing traditional primary care. The next meeting of the Assembly will be in Washington D.C. at the end of October. If you have ideas for action papers that would advance mental health care for our patients or improve our practices please contact Joe Mawhinney, Area 6 Representative or Barbara Weissman Area 6 Deputy Representative or one of your District Branch Representatives:

Robert McCarron, DO, CCPS Assembly Rep.
Richard Granese, MD, OCPS Assembly Rep.
John Onate, MD, CCPS Deputy Assembly Rep.
Donald Sharps, MD, OCPS Deputy Assembly Rep.
Adam Nelson, MD, NCPS Assembly Rep.
Lawrence Gross, MD, SCPS Assembly Rep.
Robert Cabaj, MD, NCPS Assembly Rep.
Mary Ann Schaepper, MD, SCPS Assembly Rep.
Peter Forster, MD, NCPS Assembly Rep.
Larry Lawrence, MD, SCPS Assembly Rep.
Raymond Reyes, MD, NCPS Assembly Rep.
Steve Soldinger, MD, SCPS Assembly Rep.
Maria Tiamson-Kassab, MD, SDPS Assembly Rep.
Steve Koh, MD, Early Career Rep.
Thomas Lian, MD, SDPS Deputy Assembly Rep.
Lawrence Malak, MD, Early Career Deputy Rep.
Alexis Seegan, MD, Resident-Fellow Rep.
Melinda Young, MD, Area 6 Federal Legislative Rep.
Jonathan Serrato, MD, Resident-Fellow Deputy Rep.

Assembly Work Group (Continued from page 8)

being carried out at the national and state levels. Barriers to care are many and they must be identified, confronted and corrected at the most appropriate levels (state, federal, legislative, regulatory, managed care organizations, public sector systems etc.) True health care reform must include improving access to timely and effective care with a commitment to health systems research, development of appropriate quality indicators and involvement of an invested appropriately reimbursed workforce of psychiatrists to provide care and thoughtful feedback.

The Assembly Workforce on Access to Care is committed to the process of integrating the grassroots experience of health care with policy development to improve access and outcomes for our patients. Health care reform is necessary, and it is a process: a marathon, not a sprint.

Action Paper (Continued from page 8)

etc.) *think about the idea?* Even if the experts don't agree with you, knowing their opinions can help with crafting your "Whereas" and "Resolve" sections.

- *Is the intended action consistent with current APA practice or policy?* If not consistent, find out why not; this doesn't mean the intended action can't happen, but knowing the circumstances and history will allow you to more effectively use the "Whereas" section to address any potential roadblocks.
- *What will the action cost in resources, staffing, time and funding, and is it a cost that the APA can or should absorb?* Council or component chairs, Assembly Reps on Councils and components, and staff can provide useful information.

It is helpful to review the mission and values of the APA, as well as the recently adopted five-year strategic plan. It's also helpful for an author to consult the author's Area Representative or Deputy Representative to the Assembly, an Assembly officer or a more experienced Assembly member for advice and assistance.

Action Papers must be submitted by the published deadline for submission, accompanied by the author's cost estimate worksheet. Once they are submitted, APs are forwarded to the Assembly's Rules Committee, which helps prepare APs for presentation and determines which reviewing body will address and evaluate the Action Paper: a Reference Committee, an Area Council, or the Assembly's committee of Resident-Fellow Members (RFMs), Early Career Psychiatrist Members (ECPs), Minority and Underrepresented Groups (MUR) or Assembly Committee of Representatives of Subspecialties and Sections (ACROSS). Reviewing groups begin to assess each AP several weeks prior to the Assembly meeting. During the Assembly meeting, each paper is "heard", discussed and debated by all interested Assembly members during meetings of the Reference Committees, Area Councils or other reviewing committees, which the author should attend to answer questions and/or defend the Action Paper. After hearing all testimony, each reviewing body then makes its recommendation to the Assembly as a whole: to support, to support with changes or amendments, or to not support. The Action Paper is discussed

(Continued on page 14)

Action Paper *(Continued from page 13)*

and debated by the Assembly as a whole and voted on. APs that have been approved move to the Assembly's Executive Committee at the conclusion of the Assembly meeting, where they are prioritized and, usually, referred for further action. Most are referred to the Joint Reference Committee (JRC), which determines whether to refer the item to an APA Council, component or other body for assignment and study. The JRC usually meets in June, October and January. If the JRC has referred the item to a Council, component, or other body, the item won't return to the JRC for further action until, at the earliest, the next JRC meeting. Rarely, the AEC or the JRC refers an AP directly to the Board of Trustees. The Board may elect to place the item on the agenda for discussion and to be voted on, or may refer the item to, or back to, the JRC or another committee for further assignment and study. The Board typically meets in July, September, December and March; items referred out by the Board will typically not be heard again at the Board until its next scheduled meeting.

Shadoan *(Continued from page 9)*

general public knew that over 20% of our jail and prison populations are people with Alzheimer's wouldn't they be outraged?

Why the different reaction? I am suggesting that the public sees people with Alzheimer's as having a brain disease, and people with mental illness as a mental disorder. My question is that if we start emphasizing that our patients with Schizophrenia, Bipolar Illness or Depression have brain diseases, rather than mental illnesses, there would be less stigma.

As we know Dr. Tom Insel, director of NIMH, was critical of APA's recent DSM-5, because it was based on clusters of clinical symptoms. The DSM-5 did not incorporate genetics, imaging, cognitive science or any evidence of laboratory measures. Whereas definitions of heart disease, lymphoma, AIDS, or other physical illness disease do.

Even President Obama is not asking for research for mental disorders. He is asking 100 million dollars for the "Brain Initiative".

I would appreciate hearing your thoughts on changing our discussions from Mental Disease to Brain Disorder.

Judicial Action and Managed Care Committees Seek Information

California is a vast and diverse state, and staying on top of important issues can be challenging. We request your assistance in keeping CPA up to date.

The **Judicial Action Committee** invites all members to pass along information about important legal issues relating to psychiatry such as lawsuits and appellate cases. Contact the CPA office or the committee chair, Joe Simpson, MD, at jrsimpsonmd@gmail.com.

The **Managed Care Committee** invites all members to send information relating to managed care issues or problems. Contact the CPA office or the committee chair, Rob Burchuk, MD, at rburchuk@earthlink.net.

Thank you!

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

Psychiatric Computing

DSM-5 based computerized psychiatric diagnostic interview may be taken online by the patient at home or in the clinic or ER in about 10-40 minutes. Covers all diagnoses (with informant answering for child or cognitively impaired person) and provides printed differential diagnosis with all supporting symptoms. Helps focus the clinical interview and avoid missing comorbidities. Register for 10 patient free trial at www.psychdiag.com or contact us for brochure and more information at info@indigopsych.com or (714) 971-8103.

ASSISTANT MEDICAL DIRECTOR OF PSYCHIATRY- San Mateo Medical Center

San Mateo Medical Center is currently seeking an Assistant Medical Director of Psychiatry to assist in the planning, organizing, directing and administering of multiple complex components of the Health System's acute psychiatric services, including recommending, developing, implementing and evaluating goals, objectives, policies and procedures related to acute psychiatry; participating in the overall management of division and inter-division issues; coordinating services with other divisions, departments and outside agencies; providing highly complex staff assistance to higher level management; and direct and indirect supervision over all levels of medical/professional, technical and support staff.

Requires a BC/BE Medical Psychiatrist with completion of a psychiatry residency program and 1 year of supervisory experience. License to practice in the State of California must be obtained by start date. Requires knowledge of laws and regulations governing California Health Services, Lean process improvement and quality improvement, clinical advances and evidence-based practices for delivery of psychiatric and addiction medicine services, program management and health care administration.

San Mateo County is a national leader in community mental health services with a commitment to excellence in outpatient care. Our award-winning Psychiatric Residency Training Program is based at the Medical Center.

San Mateo County also has excellent benefits including retirement plans, biweekly transportation allowance, employee health & fitness programs, commute alternative program, employee assistance program, dependent care assistance plan, first time home buyer program, deferred compensation, and tuition reimbursement program.

To learn more about the position and to apply online, please visit our website at http://jobs.smcgov.org. Applications are only accepted online and a supplemental application form must be submitted with our regular employment application form. EOE

San Mateo Medical Center
A County System of Healthcare

6th Annual Conference Integrative Medicine for Mental Health

San Diego, CA | Sept. 17-20, 2015

Hyatt Regency Mission Bay Spa and Marina
1441 Quivira Rd
San Diego, CA 92109

About the Conference

Integrative Medicine for Mental Health supports a whole body approach, utilizing multiple fields of medicine and nutritional sciences to help patients obtain mental wellness. Practical applications and effective protocols will be presented that can be easily applied in a clinical setting. The concepts and guidelines offered at this conference can dramatically improve the quality of life of your patients and increase your scope of practice.

Topics for 2015 Include:

- Integrative Medicine for Mood Disorders
- Neuropsychiatric Lyme Disease and Associated Co-Infections
- Environmental Medicine: Hidden Toxins and Their Health Consequences
- No More ADHD: Treating ADHD Symptoms Without Drugs
- Healing the Brain in Eating Disorders and Substance Use Disorders
- The Effects of Hormones on Depression, Mood Disorders, Fatigue, and General Well-Being
- Autism and Integrative Medicine: A Road Map for Testing and Treatment

Conference Highlights:

- Expanded to Four Days
- CME/CEU and CE Credits Available
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- Meet and Greet Reception
- Lunches Included
- Acclaimed New Speakers including Daniel Amen M.D.

"More physicians must be exposed to this information in order to offer our patients more than writing another drug prescription."
– Eileen Marin, MD, 2014 attendee

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