THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A District Branch of the American Psychiatric Association

Summer 2010

A Message from the President

By Cheryl Jones, MD, DFAPA

Cheryl Jones, MD, DFAPA
President

Greetings to all. Summer has been moving on by and our Fall Meeting is fast approaching. Before moving forward, I would like to take time to reminisce on my experience at the 2010 APA meeting in New Orleans, May 22-26, entitled *Pride and Promise Toward a New Psychiatry*.

The July Virginia heat has been record setting, but New Orleans was sizzling in May. New Orleans is a welcoming city and did not disappoint on this trip. The food, jazz, and nightlife were all exciting. Visiting New Orleans is like being on a cruise ship on land. There is always some place open with good food and fun.

The meeting attendance was fair. A recurring theme was how the APA could stay relevant to its current membership and invite new membership. The meeting itself was shortened. The lack of pharmaceutical endorsements was evident from the sparse pharmaceutical dinners available to the membership. In addition, the program guide condensed the program book, *The New Research Program Book and Exhibits Guide* into one volume, which was a change. Still the program was quite varied and attendees certainly could find something to meet their interests.

One goal of my attendance was to invite Drs. Scully and Primm to our Fall Meeting. I met both in several settings. Both were very approachable and immediately agreed to attend and present at our Fall meeting. (I felt like a stalker but it was well worth tracking these busy people down to invite them to Virginia!) In addition, I saw several PSV colleagues including Adam Kaul, Varun Choudry, Ram Shenoy, Tony Fernandez, Ashra Mishra, Neena Singh, and Wesley Carter, to name a few. Dr. Alice Jesudian was present to receive her Distinguished Fellow appointment. Drs. Silverman and Pandurangi were there for their various committee appointments.

Besides the social networking, members of the PSV were also involved in Research. Dr. Antony Fernandez and colleagues presented a poster for the New Research Poster Symposium. I presented a poster as well, entitled *Improving Efficiency and Access to Mental Health Care: Integrating Mental Health and Primary Care Services at McGuire Veterans Affairs Medical Center*. We would love to hear from all members that attended. Email your article to Andrew at psv@societyhq.com.

A major change in the APA structure is the lack of committees. I chair the Veterans Administration Caucus and I attended the Black Caucus. This change has brought about much discussion in how various patients' issues and concerns of the various groups will be represented. In addition, Drs. Shenoy and Shemo attended the Assembly as our Area 5 Representatives and commented on discussions about ethical guidelines and the pharmaceutical industry as prompted by the Applebaum Report on ethical practices. Other areas of debate included the recertification of psychiatrists and the growing preliminary requirements in addition to testing.

Emphasis was placed on the upcoming 164th Annual Meeting of the American Psychiatric Association which will take place from May 14-18, 2011 in Honolulu, Hawaii. The APA leadership is hoping the location will improve attendance. Some members such as myself, registered onsite. Our members had mixed thoughts about the expense and distance of travel. There are many challenges and opportunities for growth facing the APA in the new decade.

Speaking of the new decade, this is an excellent segue into our Fall Meeting which will be held in scenic and historical Williamsburg. The upcoming Fall Meeting and Resident Scientific Program is entitled: *Get the Word Out: Challenges and Innovations of a New Decade in Mental Health Care*. The meeting will be held on Saturday, September 11, 2010 from 8:00 am to 3:45 pm. The focuses will be areas in which the Society has identified as key

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A Message from the Editor

Kathleen M. Stack, MD, DFAPA

The Recovery Model and the Psychiatrist

By Kathleen M. Stack, MD, DFAPA

I first began to hear and read about the Recovery Model three or four years ago. It seemed idealistic to the point of naiveté. To change one's view from psychiatric treatment's goal being "symptom management" to total "recovery" seemed unrealistic. This view fit nothing in medicine other than infections which responded to antibiotics and simple fractures. All the chronic illnesses, COPD, asthma, hepatitis, diabetes, HIV and depression, schizophrenia, bipolar disorder, addictions, PTSD are illnesses that rarely if ever go away, and have to be managed longitudinally. The person with the diagnosis has to expect to have this illness for a lifetime. They should expect exacerbations and quiescent periods and only rarely resolution.

The second part of this model is that the patient should drive the treatment goals. The patient should set the priorities. This also rankled me somewhat. When a patient has chronic mental illness, I felt that decrease in voices and improved reality testing were the goals. They should take their medication and then we would see what else needed to be done. Accomplishing this was challenging enough, without setting many other goals.

The most difficult part of the recovery model for me as a psychiatrist, is having current patients and former patients working with staff on committees, on projects and, at times, even on treatment teams. This is not something I was comfortable with at all. I was complaining about this to a vocational counselor and the response was "Why should someone not get the job they want and are qualified for because you work there?" Well, that gave me pause. I asked myself the question and the answer was clear. Having been treated by me should not limit their employment. I am still uncomfortable with it, but I needed to find a way to "get over it."

I will not detail the process I went through or my ongoing struggles. However, I will share a few points which helped me "get over it." I realized that if my goal for those I treat is not full recovery, than I am not doing all I can for them. I needed to raise the bar for myself to assure I did not accept "better" as good enough.

When it comes to setting the goals of treatment, my priorities – and those of the people I treat – did not line up. (I had to ask this to figure it out.) Nearly every patient wants a better relationship with family, an income and a place of their own. Because I impact these concerns only indirectly at best, I tended not to make this a priority during treatment. I had scoffed at the "housing first" pilot data. It made no sense to me. Well, I now accept that it did not have to "make sense to be effective." It worked in statistics, in dollars and especially for the person. Maybe I was the one who needed different priorities, not my patients.

In the last 18 months, I have been on treatment teams, work groups and committees with peer counselors and others that I may have treated in the past. Initially, I assure you, I did not like it. I had the same objections that most in our profession would have. I did not, however, have a choice. I sought guidance from different sources, but there is little out there yet to address these situations. But despite my misgivings, I have come to value the skills and perspective that patients bring to the process of treatment.

I also look forward to APA guidance for these situations.

In The News

UVA Update

By Scott Beach, MD

On Tuesday, April 27, the PSV and the UVA Department of Psychiatry and Neurobehavioral Sciences co-sponsored a reception for faculty, residents and medical students at the X-Lounge in Charlottesville. In all, 36 guests, including the Chair of Psychiatry and the Program Director at UVA, enjoyed drinks and light hors d'ouerves. The medical student showing was particularly strong. Three of the fourth year medical students, who have already matched into psychiatry residency programs, had a chance to catch up with the residents and faculty who supervised them during their rotations. Peter Oliver will be staying at UVA, Steven Sust will be heading to UPenn, and Dan Murray to Washington University in St. Louis. Also in attendance were three rising fourth-year students, all of whom plan to go into psychiatry, as well as seven second year students who each have a strong interest in the specialty. This is the fourth year that the PSV has co-sponsored the event, which is intended to generate interest in the field of psychiatry among medical students and encourage them to become involved with the PSV.

In Memoriam

Merritt W. Foster, MD

Passed away October, 2009

By Joe Mason, MD, DFAPA
President, PSV Blue Ridge Chapter

Dr. Merritt Foster, of Richmond, VA, was an unforgettable character. He was a great storyteller who was always irreverent and frequently off-color, but always jovial and good-spirited. He entertained us at my fourth year residency retreat and later referred many of his patients to me when he tried to retire. He unretired before his death because he still had something to contribute. He was a true southern gentleman and lived a full life, both professionally and personally, and will be greatly missed by all who knew him.

Have You Supported Your PSYCHMD-PAC?

Below is a chart showing the 2008-09 activity of several political action committees (PACs) that are of similar size and that operate in the same political realm as PSYCHMD-PAC. As you can see, PSYCHMD-PAC lags far behind most "competitor groups" in numbers of total contributors, average donation size, and total money raised.

What does this tell us? That a very small percentage of the PSV membership is supporting PSYCHMD-PAC. Despite strong support from a small group of consistent contributors, psychiatrists are not competing with other health professions. These other professional societies also care about scope of practice, quality care, public health dollars, malpractice liability, and insurance laws. However, they have broader participation in their PACs and this helps them advance their messages.

There is a clear correlation between the strength of a PAC and the visibility and success of profession's advocacy program. Not just because of the dollars it raises to invest in candidates, but because it means the organization's members are engaged and active supporters of the goals.

Please consider an investment in your profession – Support PSYCHMD-PAC today by visiting this site:
https://secure.societyhq.com/psv/PsychMD-PAC.iphtml

PAC	Parent Organization	# of Donations 08-09	Avg Donation	08-09 total
Dentists	VA Dental Association	3275	$251	$822,025.00
Optometry	VA Optometric Association	913	$239	$218,207.00
Anesthesia	VA Society of Anesthesiologists	146	$749	$109,354.00
Radiologists	VA Chapter American College of Radiology	81	$455	$36,855.00
Physical Therapy	VA Physical Therapy Association	284	$107	$30,388.00
EYE PAC	VA Society of Eye Physicians & Surgeons	73	$348	$25,404.00
Nurses PAC	VA Nurses Association	692	$32	$22,144.00
Podiatrists	VA Podiatric Medical Association	200	$100	$20,000.00
Ortho PAC	VA Orthopaedic Society	35	$254	$8,890.00
Psych Med PAC	**Psychiatric Society of VA/NOVA Chapter WPS**	**43**	**$118**	**$5,074.00**

Data compiled from the Virginia Public Access Project (www.vpap.org)

ELECTRONIC COMMUNICATIONS AND PSYCHOTHERAPY[1]

By Jerome S. Blackman, MD, DFAPA, FACPsa
Virginia Beach, VA

At the 1964 World's Fair in New York City, the AT&T Pavilion featured a "Picturephone."[1] Now, 46 years later, Apple has put out its iphone4, which has phone-to-phone real-time videoconferencing.

Of course, "texting" is with us. Teenagers have, no doubt predictably, turned this into "sexting:" sending ribald messages (and sometimes nude photos) over phone and internet conduits.

Sexting and scandalous Facebook pages are hidden from parents – the curious marriage of autonomy and sexuality that has characterized American adolescent individuation since...18-year-old Josie Marcus ran away from her middle-class parents in San Francisco, wound up living with a crooked sheriff in Tombstone, and eventually left him to "marry" the gambler-turned-gunman-turned-lawman-turned-entrepreneur, Wyatt Earp[2].

Practically speaking, people now "need" cell phones for reasons from safety to convenience to business decorum. Video conferencing helps "secure"[3] warm, close relationships in families where one spouse must be out of town. In addition, e-matching can replace blind dates, and Skype allows parents to contact children who live far away or are attending college.

Internet use, however, can go awry. Lori Drew and her daughter created a fictitious teenage boy named Josh Evans who, through MySpace, first flirted with and then rejected Megan Meier. Megan then killed herself, and the case wound up in criminal court. (Hufstutter, 2007).

For the past several years, video conferencing has been used by psychoanalysts for teaching and even treating people in Shanghai, Beijing, and Wuhan.[4]

A recent case report of Skype analysis (Philadelphia analyst, Chinese analysand)[5] indicated that the analyst was able to establish trust, interpret transference and defense, and thereby relieve difficulties in a female patient who had experienced unresolved object loss.

An interesting case presented to me, in a Skype CAPA class from China, involved a married man who, after admitting to his wife that he had had a one-night stand with another woman, insisted on getting a divorce. His wife, the patient, was willing to forgive him. But he felt he had brought such shame on the family (loss of face), that he did not deserve his wife's forgiveness. Divorce, then, acted as his defense against shame.[6]

Dr. R. Fishkin (2010 in press) reported on his Skype psychotherapy of a Chinese man with borderline personality. Although the patient was open during Skype sessions, in a "live" meeting in China with Dr. Fishkin sometime later, the patient avoided eye contact and became guarded. Apparently, the 7,000 miles represented what Akhtar (1992) has called "optimal distance" – relieving identity diffusion anxiety.

The April 2010 Margaret Mahler Symposium in Philadelphia was replete with examples of children and adolescents using the internet as an autistic defense: losing themselves in chat rooms, experiencing self-disintegration and psychotic episodes.

The internet may encourage autistic withdrawal, but there is real money to be made! At *Second Life,* you choose your avatar and then involve yourself in art imitating life, where retailers are selling virtual trinkets for *real* dollars.

In my practice, teenagers who got in trouble (with some authority) for making violent threats on the internet became ashamed and contrite in my office. It seemed the internet had caused a temporary dilution of – or regression in – superego functioning and impulse control.

Aside from violence, sex is on the internet: internet pornography. See the *Wall Street Journal* (Orol, April 23, 2010) regarding porn and the SEC; also the daunting statistics on internet porn usage (Brigham Young University, 2010; Family Safe Media, 2006).

Finally, the prerequisites for dynamic psychotherapy, whether in person or over the internet, seem the same. The patient must possess a quantum of abstraction, integrative functioning, and reality testing; reasonable affect tolerance; a modicum of trust; and a reasonably active superego – especially honesty and reliability (Blackman, 2010) for interpretive treatment to be successful.

References:

1. [Excerpts from Blackman, J. (2010). Separation, Sex, Superego, and Skype. In: *The Electrified Mind* (tentative title). Ed: S. Akhtar, MD Northvale, NJ: Aronson. In press for October 2010.]
2. Through the wonders of the internet, I was able to find confirmation of my memory with more specifics. (*Hand*, Accessed 2010).
3. *Josephine Earp* (2010). In 1879, Josie had initially run away with her friend, Dora Hirsh, to be an actress and singer. Josie wound up in Tombstone, AZ, where she lived with Johnny Behan, eventually became close to his son from his prior marriage, and apparently stayed close to the son throughout her life. She left Behan for Earp around 1881, and appears to have been the "common-law" wife of Earp until his death 46 years later. See also Tefertiller (1997), Wyatt Earp (2010).
4. *In Ainsworth's Sense* (Bretherton, 1992)
5. Especially through the China American Psychoanalytic Alliance, www.capachina.org
6. Fishkin, L. and Fishkin, R. (2010 in press).
7. Blackman, 2003.

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DATE: Saturday, October 9, 2010
LOCATION: Innsbrook in Glen Allen, VA
DISTANCE: 5 Kilometers

To register please visit:
www.nami.org/namiwalks/VA

For more information on NAMIWalks Virginia, please contact: Farleigh Fitzgerald (804) 285-8264 ext. 202 or ffitzgerald@namivirginia.org

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PSYCHIATRIC SOCIETY OF VIRGINIA

DEADLINE – SEPTEMBER 1, 2010

APA ASSEMBLY MEETING AND PRACTICE GUIDELINES STEERING COMMITTEE MEETING

NEW ORLEANS • MAY 21 - 24, 2010

By John P. D. Shemo, MD, DFAPA
Ram Shenoy, MD, DLFAPA
Assembly Representatives

The American Psychiatric Association Assembly Meeting in New Orleans was fast moving and intense. A number of issues were presented which have serious implications for our members.

One of the most significant of these relates to proposed and considerably expanded provisions related to the maintenance of (Board) certification (MOC). This issue has a lot of complexity, but I will try to provide a synopsis.

First, it must be recalled that the American Board of Psychiatry and Neurology is a private/for profit corporation totally distinct from the APA. They have for many years held the "franchise" to run the board certification process for physicians who complete approved residency training programs in psychiatry or neurology. A number of years ago the process moved from being a one time testing experience to one requiring retesting every ten years, both for general and subspecialty certifications. As we are aware, this is a time consuming and expensive process, especially for those of us with multiple board certifications. Now, they are proposing a considerable expansion of this process with various ongoing steps that must be taken (and apparently paid for by the applicant) over each ten-year period. These requirements are being pushed by the Federation of State Medical Boards (whose fees have also increased considerably in recent years). These requirements will extend even to those physicians who are currently grandfathered into life-long specialty board certification.

Briefly, the requirements will break down into four parts:

Part I – Unrestricted license to practice in the Untied States or Canada.

Part 2 – A self-assessment (SA) process with two SA activities required every ten years, the first in years one to three of the cycle (beginning in 2011), and the second in years six to eight. These tests will cover "new knowledge and best practices." There will additionally remain the current requirement of 30 CME credits being earned each year.

Part 3 – Cognitive expertise – A test will be administered to each diplomat every ten years at the Pearson Professional Centers. A passing score will allow extension of certification for ten years, but the applicant must complete all other MOC requirements to be eligible to take the test and there will be random audits of the documents supporting the diplomats' applications.

Part 4 – Performance in practice (PIP) – three PIP "events" are required over the ten years MOC cycle.

- Collect data on five patients in a similar category.
- Compare data to practice guidelines.
- Identify opportunities for improvement.
- Implement improvements.
- Recollect data within two years to demonstrate improvement.

As part of this process, the candidate must obtain "reviews" from "peers" and patients.

There are three aspects of this process that I think the APA must aggressively address.

1. The ABPN, to "accommodate" psychiatrists who practice in areas where there are not a lot of psychiatrists, plans to designate other practitioners as "peers." This could include psychologists and social workers. The "Pandora's box" this could open in terms of these groups seeking expanded scope of practice is obvious.

2. Especially in our field, soliciting patient evaluations represents what seems to me a rather clear boundary violation.

3. Will these self-assessments be legally "discoverable?" With this process, we are being expected to document our own "weaknesses." Again, the potential legal consequences if this material is discoverable seems obvious.

The above outline and the ABPN's perspective are taken directly from the notes I took during a presentation to the Assembly by Larry Faulkner, MD, President and CEO of the ABPN. You can learn more about their perspective on this issue at www.abpn.com.

Ardis Dee Hoven, MD, Chair-Elect of the Board of Trustees of the AMA, also addressed the Assembly.

She reviewed recent successes in the parity bill and some positive provisions in the health reform bill, but also discussed the AMA's ongoing goals of working towards a permanent SGR fix – which evidently Congress will again avoid this year – again merely delaying the currently slated 22 percent reimbursement cut that will just grow each time they delay a true "fix" until the price tag will be so large that it will be the final excuse to not repair the system.

The AMA wishes also to get rid of a newly enacted fee that will be required for a physician to be "allowed" to see Medicare/Medicaid patients. This fee will start at $350 a year.

Finally, the AMA wants to try to limit the scope/power of the I-PAB's (Independent Physician Assessment Board) that are created by the health reform bill. These will be politically appointed boards empowered to set physician pay rates.

The APA has taken the recent position of endorsing a new APA sponsored medical liability option. The APA formerly administered an insurance option as an APA member benefit until that plan was sold to Legion Insurance in 1999. Legion then failed and the option was taken over by Professional Risk Management Services (PRMS). PRMS has recently decided that they would not continue an exclusive relationship with the APA for their coverage. This is apparently disadvantageous for APA members in that APA members have a better risk history than do non-APA member psychiatrists. An APA appointed work group selected American Professional Insurance (API) to

issue this new APA sponsored option. This group already provides insurance for child psychiatrists through the American Academy of Child and Adolescent Psychiatry, who have been pleased with them. API is in the process of getting licenses to issue insurance in all 50 states. Members can elect to stay with PRMS or switch to API. It was clear from the presentation that the APA needs to avoid contract provisions that restrict/eliminate transparency as they have had with PRMS.

The APA is holding reasonable financial stability despite a $7.5 million decrease in revenues. There was a projected deficit for this year of $1.5 million. Instead, it is now projected that there will actually be about a half million dollar surplus. This has been due entirely to budget cuts.

The DSM-V program continues. The APA has spent $10.7 million on this so far. It is expected that they will spend $25 million by the projected publication date in 2013. The DSM-V comment website had 40 million hits. Most of these comments are reported to have been very thoughtful. There was a recent article in JAMA addressing why all physicians should be concerned with DSM-V.

The Assembly was updated on the actions of the "Coalition for Parity," a "double-speak" named group of insurance companies opposed to parity who are trying to block implementation of the 2008 mental health parity bill.

The American Psychiatric Foundation presented a report on their success with the *Healthy Minds* television program which is now available to 60 percent of U. S. households and was nominated for an Emmy.

Finally, there were a lot of action papers debated on the floor of the Assembly. One such paper, which was passed, asked the APA to support adequate regulation of direct-to-consumer medication advertising. Another addressed the problem of mail order pharmacies requiring physicians to write only for 90 days of medication, even when the physician does not think that this is in the patient's best interest. This becomes especially relevant for those MCO's that require patients to use their own profit-centered mail-order pharmacies.

The most hotly debated issue in the Assembly related to several papers addressing the relationship of psychiatrists and pharmaceutical and device manufacturers. The Assembly passed a broad statement of principle, but by a large majority, defeated several papers aimed at setting complicated and micromanaging guidelines.

A broad position statement on psychiatry and primary care integration was passed. In this action paper, the Assembly supported my amendment to this position statement to remove the term "evidence-based" from the paper. While I am certainly a proponent of legitimate evidence-based practice, I oppose the use of that phrase because of the usurpation and distortion of the concept by managed care.

Another paper passed supported the ability of psychiatrists, both in inpatient and outpatient care, to use E&M (evaluation and management) codes and receive reimbursement for such services in parity with all other physicians. It is noted that a law establishing this right of any physician to use any applicable code was passed in New York State and the insurance companies in New York State have further been instructed to compensation physicians for their past blockage of their ability to do so.

Finally, the Practice Guidelines Steering Committee is developing a broadly based network of psychiatrists with expertise in various areas of practice/research to address the development of consensus guidelines in those areas where the "evidence" is as yet inadequate to provide a Category I evidence-based recommendation.

As always, Ram and I remain open to the concerns and suggestions of the PSV membership in our commitment to our representative roles, especially at a time when budget cutbacks raise concerns about a shrinking representative presence with more decisions in the APA being made by the Executive Committee.

REPORT FROM THE MANAGED CARE LIAISON COMMITTEE

By John P. D. Shemo, MD, DLFAPA

As a function of the PSV Managed Care Liaison Committee, I had a long discussion on Saturday, June 5, with Kurt Elward, MD, Interim Medical Director of Southern Health Services. As you may be aware, Coventry, the parent organization of Southern Health, had been ranked among the worst three insurance companies for physicians to try to work with in 2006 and 2007, and in 2008, they were ranked as the worst in the country. The rankings for 2009 will come out some time in June.

Dr. Elward, as noted, is currently their Interim Medical Director, since their former medical director just resigned. Dr. Elward is a family physician in Charlottesville and I have known him for years. He is a good physician and has always struck me as a good person, so I thought this would be an opportune time to initiate a dialog about Mental Health Net, to whom Coventry has outsourced mental health management.

As noted, we had a long and comprehensive discussion. Issues addressed included the micromanaging style used by MH Net, providing coverage for only a few sessions at a time, thereby requiring the submission of repetitious treatment plans, as well as their very inhospitable telephone etiquette. We discussed a number of operational issues related to delays in responding to treatment plans when they are submitted in the context of a short time frame for charge submission. Finally, we discussed their poor reimbursement in general, and especially for CPT Code 90807, which discourages psychiatrists from doing psychotherapy despite the evidence that combined treatment is associated with better patient outcomes than split treatment. I did discuss with Dr. Elward the possible option of allowing psychiatrists to use the E&M CPT codes like all other physicians providing cognitive services rather than being limited to use of "mental health codes."

Dr. Elward is aware that many psychiatrists are not accepting, or limiting, the number of Southern Health patients they see because of these combined problems of administrative hassle and poor reimbursement. He says he will address these concerns with the Southern Health corporate executives. We shall see what comes of his efforts.

Psychiatry in Hospice and Palliative Care

By Jorge A. Cortina, MD, DFAPA

Palliative care generally brings to mind images of pain and physical suffering and, not surprisingly, investigators have described that physical symptoms receive greater attention than psychosocial symptoms in the dying. However, loneliness and anxiety often complicate suffering at the end of life.[1] The need to better assess and treat psychiatric symptoms at the end of life highlights a need for greater involvement by mental health professionals in the care of the terminally ill.

Most terminally ill patients will develop delirium. Many others suffer from significant anxiety, depression or anticipatory grief. Additionally, the stress of facing terminal conditions often exacerbates other, often pre-existing, conditions such as personality disorders, mood disorders, and psychotic illnesses. The complexity and severity varies greatly and so psychiatric practice in these settings requires flexibility and often urgency to effectively relieve psychological suffering.

Nearly all patients benefit from supportive therapy facilitating life review promoting a sense of integrity. Others need careful assessment to differentiate sadness and grief from major depression. Psychiatrists in these settings can prove to be invaluable in preparing families for the death of their loved ones and in offering bereavement services. While relatively few of the dying experience a wish for death or suicidal ideation, when present, these symptoms are usually indicative of depression and help differentiate clinical depression from sadness and anxiety associated with anticipatory grief.[2] Due to the high prevalence of insomnia, fatigue, and loss of appetite among the terminally ill, presence of these symptoms is not helpful in the diagnosis of clinically significant depression. Effective intervention can relieve depression and resolve this wish for hastened death, but alternatives modalities need to be considered. For example, limited life expectancy may not allow for the several weeks required to achieve an adequate response to traditional antidepressants. Clinicians in these settings need to be comfortable working at the bedside and comfortable addressing somatic symptoms as well. For example, interventions for pain and dyspnea may be the most effective intervention to address anxiety.

Traditionally, psychiatrists have been able to work with patients near the end of life as consultants, or members of the interdisciplinary team, but since 1996, psychiatrists have been able to seek subspecialty certification by the American Board of Hospice and Palliative Medicine, allowing them to serve as the primary physician providing care for those with life-limiting illnesses. In 2008, this path to certification was replaced, when the American Board of Medical Specialties began to offer subspecialty certification in Hospice and Palliative Medicine. Evidence of completion of fellowship training will be required after 2012 in order to sit for the certification exam.

Psychiatry consults are typically only requested in the most severe cases and may only allow for follow-up on an "as needed basis," so this role results in limited access and lower likelihood of continuous care. Having psychiatrists participate as part of an interdisciplinary term is a relative luxury that is not easily supported by current reimbursement systems, but offers much greater likelihood of early identification and treatment of psychological suffering or mild delirium. Developing hospice and palliative care clinical skills and achieving subspecialty certification in hospice and palliative medicine may well be the most efficient pathway for a psychiatrist to best address physical and psychological suffering at the end of life.

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PECOS and Coping with Change

By Helen Montague Foster, MD, DFAPA

You know how time seems to speed up as we age? One day you're fresh out of school, blink and you get the senior discount. Over the past month time has been zipping by as I've stewed over PECOS, Medicare's Internet-based Provider Enrollment, Chain and Ownership System. PECOS is a relatively recent database of Medicare providers and potential Medicare providers. By recent, I mean that it has been in use since 2003, and now it's required. I would have thought that Medicare would transfer provider information from their current database into PECOS. But no such luck. Even if you are a Medicare provider and Medicare has your National Practitioner ID number (NPI), Provider Transaction Access Number (PTAN), Tax Identification Number (TIN), and Universal Provider ID Numbers (UPIN), you may not be in the PECOS database. I know the UPIN is obsolete, but golly, just a blink ago, it was a big deal and then the NPI replaced it.

So what's the big deal? Fill out a form, enroll in PECOS or don't. But you'll have to authorize CMS to pay you by electronic fund transfer and, even if you are enrolled, you or someone in your office should be aware of the PECOS associated changes.

Even if you don't bill Medicare for your services, you and your patients may be affected by the Medicare requirement for enrollment in PECOS. By the way, the original deadline for enrollment was January 2010, but it got moved up to July 2010, blindsiding many providers, who didn't know about the requirement, were confused about the contradictory messages from their Medicare contractors, or thought PECOS didn't apply to them. And what is this? You figure you have plenty of time, and they make the deadline sooner? Fortunately, over thirty provider organizations have requested a delay in implementation of PECOS, and as of July 1, it looks as if some steps will be taken to prevent PECOS from interfering

with clinical services.

Please, do not stop reading. You may not be off the hook.

Do you order lab tests or home health services for your patients? Do you see retired patients or patients on disability? Do you ever refer for ancillary services or to other doctors? Do you accept referrals from other providers? If so, for the sake of your patients and colleagues, please call and find out if you are enrolled in PECOS. In Virginia, the number is (866) 502-9049. If you aren't enrolled, please do so as soon as possible, because if you don't, your patients and other providers may take an indirect hit.

According to CMS, if labwork is ordered by a provider who isn't in PECOS, Medicare won't pay the lab. The same goes for radiology services, home health services, durable medical equipment and Part B prescriptions.

You can enroll online at the Trailblazer website (www.trailblazerhealth.com) or you can go directly to https://pecos.hhs.gov, or you can request a paper form. I did the later, because my computer and yours truly, its aging operator, have some problems with the Trailblazer website. If you enroll online, you will have to print, sign and mail a form, and if you have a loan from the bank where you want your Medicare checks deposited, you may need to send a letter from your bank. Otherwise a voided check is sufficient to validate your bank account information.

Good news: if you enrolled in Medicare after 2003 and billed Medicare for at least one session a year, you are probably in the PECOS database. That's great, but if a non-PECOS-enrolled provider refers to you and you do as you should and document the referral, you may not get paid for the service you render. If you opted out of Medicare – which requires updated registration every two years – you are probably in the PECOS database. Probably. But maybe not, if you didn't update your status. PECOS may treat enrollment the way some banks treat inactive bank accounts: make them go away.

Maybe you're a child psychiatrist and didn't find it necessary to enroll in Medicare because so few of your patients were disabled and had Medicare as their primary insurance. Maybe you think you won't see any Medicare patients. Maybe you started to enroll in PECOS and realized that part of enrollment was giving Medicare the right to deposit and withdraw funds from your account and that stopped you in your tracks. Maybe you're like me and prefer old-fashioned paper check, and you don't want Medicare to be able to withdraw payments they decide weren't due to you. (Too bad. These days, retirees on Social Security get their checks by electronic fund transfer. We ought to be able to handle it.) Maybe you sent for the paper form and read the part that said "Do not submit a revalidation application until you have been contacted by the fee-for-service contractor." My diligent colleague, Dr. Mary Olinger called Trailblazer and was told that provider had to enroll whether or not they had received such a letter.

I have no employees, which gives me the pleasure and burden of running my psychiatric practice. Usually the pleasure outweighs the burden, but I don't like change all that much. I do paper billing, plug along seeing my psychotherapy patients, and subscribe to the paper version of the Trailblazer Bulletin that gives me a heads up on Medicare issues. I do my bookkeeping on the version of QuickBooks that I bought in 1997. It's really easy and makes me feel I have a handle on the business aspects of my practice.

No surprise, I enrolled as a Medicare provider before 2003 and until now I haven't had to re-enroll, because re-enrollment was automatic. I was tempted not to read the PECOS information that appeared in the paper *Trailblazer Bulletin* that I pay to receive the old-fashioned way, by mail.

Most of you probably hire people to handle issues like PECOS. Or you work for people who are supposed to handle it for you. The hassle belongs to them, and you don't worry. You're probably safe. They probably know more than I do about PECOS. But maybe not.

The rules aren't all that clear. When my diligent friend called Trailblazer to find out about PECOS requirements, she was led to believe that Medicare would not pay for prescriptions written by providers not enrolled in PECOS. I called APA to verify that information, and the very helpful Medicare expert, Ellen Jaffee, researched the question and found out that part D prescriptions will be covered even if the prescribing physician is not enrolled in PECOS. Part B drugs ordered by non-PECOS providers will not be covered.

PECOS implementation is a stepwise process. We're supposed to be enrolled before July 6, 2010, but providers are encountering many glitches along the way. Some Medicare companies posted notices warning that the PECOS system would be down from June 30 to July 5. Some people were unable to print the two-page forms that must be signed and mailed. One provider posted a message on a medical site saying he'd been trying to enroll for sixty days, but couldn't because he didn't know "what the hell a PTAN [was]?" (PTAN is the pre-NPI Medicare provider number.) During Phase 1, which was supposed to start on October 5, 2009, the Medicare contractor was supposed to verify if a provider was enrolled in PECOS, and thus eligible to order Medicare services. If the provider was not enrolled, the claim was to be processed, but the ordering or referring provider was to receive a warning message on the remittance advice. I didn't notice any such warnings, but the *Trailblazer Bulletin* advised providers to verify that they were enrolled in PECOS.

In Phase II (originally to be implemented January 3, 2011 but advanced to July 1, 2011), claims are not to be paid for services requiring an ordering or referring PECOS-enrolled provider unless the ordering or referring provider is enrolled.

Now, thanks to our professional organizations including APA and AMA, claims will still be paid for a while as CMS and providers catch up. Some PECOS-associated issues are yet to be solved.

I filled out my paper PECOS enrollment form and mailed it return-receipt-requested on June 25, 2010, along with the required authorization

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PRESIDENT'S MESSAGE

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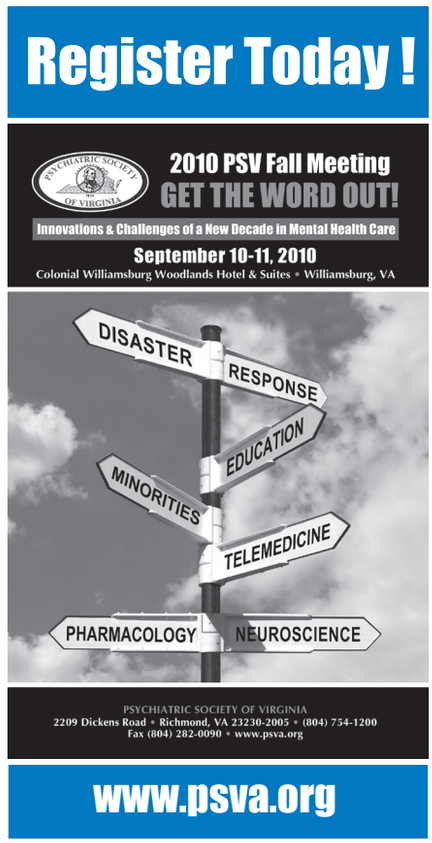
to the psychiatric community in the upcoming years. These areas include:

- Responding to global disasters that affect various cultures and ethnicities outside of the U.S., such as the earthquake in Haiti and, more recently, in Chile. Knowing that minority populations are disproportionally negatively affected, have we learned anything from Hurricane Katrina?
- Understanding our responsibility and goals for recruitment, teaching and retention of trainees and the provision of continuing education for practicing psychiatrists. This is topical for rural areas where there is a shortage of psychiatrists. Scope of practice issues are on the horizon for many states about whether other allied health professionals could better meet this need.
- Understand the Resident and early career Psychiatrist viewpoints on education. A panel will be formed to give participants an understanding of the current experience of these professionals.
- Innovations in technology, such as telemedicine are becoming more relevant across many sectors of practice. Could this technological innovation be the answer to rural communities and help with shortages of psychiatrists? Would scope of practice discussions be impacted? The Membership would like to review advances and challenges of telemedicine with a keynote speaker and a panel.
- Innovation in pharmacology and neurosciences are spawning not only new medications and medication delivery systems, but also new devices such as transcranial magnetic stimulation. The membership will receive an overview of where we might be going in the new decade.

The line-up of presenters is a "Who's Who" amongst professional circles. They include Annelle Primm, MD, MPH, Medical Director of the APA and Director of the Office of Minority Affairs of the APA and James H. Scully, Jr., MD, Executive Director of the APA. Drs. Scully and Primm will orient us to the APA's position in the world at large and in education. Both Drs. Scully and Primm are renowned psychiatrists with many accolades. They also represent the cornerstone of our professional society. It is certainly an honor to have them both for our meeting and the Planning Committee hopes that the Society's membership will make them both feel welcomed in Virginia by attending the conference.

Another exciting aspect of the conference will be a Panel consisting of an Early Career Psychiatrists and Residents in various levels of training and a Residency Training Director, who will give an experiential view of psychiatry and practice at their current level. Drs. Scully and Primm will be given the opportunity to respond to the challenges facing these individuals and accept feedback from the audience. This should make for a lively discussion. Drs. Primm and Scully will also be judging our Resident Poster session.

In terms of innovations, we are going to look at telemedicine. Drs. Tony Graham and Varun Choudry are experts in the field of telemedicine. Both utilize it in their practice. We will be treated to a historical overview and, hopefully, demonstration. The audience will be able to explore the opportunities that telemedicine offers. This may assist those in rural areas looking for ways to provide health care to rural, distant areas. Last, but certainly not least, Dr. Pandurangi will take us through a tour of neuroscience to the current age of the machine. Are medications for depression going to be a thing of the past? Come and find out from a world-renowned researcher what the future may hold.



We are encouraging all members to begin preparation for our Resident Scientific Program. This event has been a huge success. Residents have given positive feedback for the unique opportunity and learning experience in presenting a poster presentation while still in Residency. Their efforts are monetarily supported by the Psychiatric Foundation. All providers are encouraged to work with a resident in on a small Research project. We have averaged 20 entries since inception of the Program.

From the APA to the PSV, psychiatrists are fostering education and populating the advances of psychiatry. Come and join us at the Fall Meeting in Williamsburg for an academically and socially stimulating weekend.

PECOS AND COPING WITH CHANGE

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for electronic-fund-transfer. That's a relief.

If there's a lesson here, it's that we have to keep plugging along. Change is inevitable, and so is resistance to change. As you've noticed, the USA still hasn't fully adopted the metric system, and APA may be trying to slow down the process by which the American Board of Psychiatry and Neurology rescinds the grandfather clause that exempted old board certified psychiatrist from the recertification requirement. Did I say old? Oh well, congratulations to all of you who've made it into the PECOS database.

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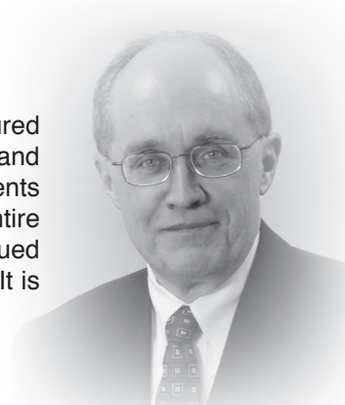

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