Health Care and Payment Reform 2011: Psychiatry Speaks Out!

Best wishes to you all for a happy, healthy, and active 2011! We are hitting the ground running at MPS as the new legislative session begins. This month we are featuring articles from several of our member leaders. Eugene Fierman MD begins by providing some background and introducing our MPS Position Paper on Psychiatrists in a Global Payment Environment. Gene is a past president of MPS and he is spearheading legislative efforts for the society. Despite completion of the position paper, there remains a wide array of opinions, positions and strong feelings on this issue. Our purpose is to ensure that psychiatry has a place at the negotiating table, and that our patients’ voices are heard as these decisions are being made. The position paper has been through much iteration and was circulated to the entire membership in late October. Please continue to convey your feedback to us, and to use the local press to raise awareness on these issues.

In related article, Ceil Mikalac MD has taken on the task of trying to explain what an Accountable Care Organization (ACO) might look like, and how psychiatry can approach the potential options. She discusses this issue from the perspective of someone providing general adult psychiatry in the community, but addresses concerns pertinent to many types of psychiatric practice. There exists both opportunity and risk for our field in the adoption of ACOs; it is incumbent upon us to work together to guide the development of these organizations for the benefit of our patients and our professional practices.

Though Massachusetts has not yet had a bill relating to psychologist prescribing, this type of legislation has been proposed in several states, with more legislation likely in the coming years. Kate Knutson MD, our Member in Training representative to the MPS Council does an excellent job of reviewing the current state of this legislation around the country, as well as highlighting its clinical and policy implications.

In addition to preparations for responding to payment reform legislation, we are working on testimony regarding the upcoming state budget. Once again, mental health and substance abuse services are facing potential cuts. Is there any way that service delivery and payment reform can be utilized to stem this tide so as to insure that essential, high quality services remain available for all?

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One example of how such reform could aid in insuring services is our ongoing advocacy for the use of E&M codes by psychiatrists. By affording us the opportunity to accurately account and bill for the true complexity of care we provide to a wide variety of patients and families, this reform will help ensure such services by psychiatrists in the future.

We will be presenting our position statement on Psychiatrists in a Global Payment Environment to various legislators and governmental officials. We will be sending small groups of MPS members for face-to-face meetings throughout the winter and into the spring. If you are interested in joining this effort, please contact us right away. As Dr. Fierman mentions in his article, we are particularly interested in involving early career psychiatrists. The future of your careers will be dominated by the evolution of health care reform over time; the MPS is your vehicle for influencing that reform in the best interests of our patients and our profession.

Marie H. Hobart, MD
President

MPS is Pleased to Welcome the Following New Members:

General Member:
Melvyn Louis Lurie, MD

Member-In-Training:
Irina V. Barankaya, MD
Christina Ann Brezing, MD
Jwag Du, MD
Iren C. Couteos, MD
Brian Andrew Falls, MD
SuEllen Hamkins, MD
Lauren Mercer, MD
Priyanka Mili, MD
Laura Catherine Politte, MD
Justin Joshua Schleifer, MD
Zoe Selhi, MD
Michael Huan Tang, MD
Christopher Tangren, MD

Advancement:
Gina Newsome Duncan, MD
Tristan Gorrindo, MD

Transfer In:
Steven Bonauto, MD

Managed Care Update
Gregory Harris, MD, MPH, FAPA

Upcoming MPS Member Survey on Practice Patterns:
We are at a time of momentous changes at the federal and state levels. These are daunting times for us all, but particularly for the majority of MPS members who practice in solo or small practices.

We have designed a Survey to look at outpatient practice patterns; (with data analogous to two prior surveys) and managed care impact on small practices. The Survey will ask all providers to rate managed care companies on a variety of parameters and or let MPS know what areas of health care change are most important to you. We have designed it to be as comprehensive as possible, while being easily completed in less than 15 minutes time.

The data you provide will be used nationally and statewide in support of MPS’ advocacy work with managed care organizations and governmental/regulatory agencies and to guide MPS priorities going forward. We will pass the results to APA to inform national advocacy.

Please give this Survey your attention; we value your input and will actively use the information you provide to work on your behalf.

Remember, that all are welcome at the Managed Care Committee Meetings, which occur on the third Tuesday of the month (from 7-9 PM; dinner served!) at the MPS offices in Wellesley. Check the MPS website for details or contact me at gregorygharris@sprynet.com

APA ANNUAL MEETING
Aloha! Plan to attend the 164th Annual Meeting of the American Psychiatric Association from May 14-18, 2011, in Honolulu, Hawaii.

Registration and Housing Now Open!
We are all aware that we are facing major changes in the world of health care and medical practice. Of course, the difficulty is that we are unsure exactly what form those changes will take. However, here are some of the changes that are beginning to take shape:

Electronic Health Records (EHR): As many of you know, the Commonwealth has issued a regulation that physicians must demonstrate competency with EHR as a condition of licensure beginning in 2015. On the Federal level, incentives are being offered to Medicare providers to adopt certified electronic records that meet standards for “meaningful use” of such records.

Electronic Prescribing: Medicare is offering monetary incentives in 2010 and 2011 for electronic prescribing and will begin assessing a penalty of 0.5% in payments for providers that do not demonstrate adoption of electronic prescribing in 2012.

Global Payments: On the State and Federal level, a significant change in reimbursement is under discussion. The Governor is expected to file legislation in January laying out his proposal for a change from traditional fee for service to a system of global payments. As part of this proposed change, the Centers for Medicare and Medicaid (CMS) will issue proposed regulations for Accountable Care Organizations (ACO’s) early in 2011. Primary care practices are exploring and gaining NCQA accreditation as Patient Centered Medical Homes (PCMH) that are designed to provide a coordinated system of care. Principles for the PCMH have been issued the Patient Centered Primary Care Collaborative, a broad coalition of over 700 organizations interested in promoting the PCMH, and have called for the inclusion of psychiatric services in the PCMH. To date, the role of psychiatry in such a system has not been delineated.

Evaluation and Management (E&M) Coding: E&M codes are the codes by which a physician can bill one of 5 levels for the management of illness based on comprehensiveness of the exam and the complexity of decision making. These are “general medical” that are in addition to traditional psychotherapy codes. Insurers (except Medicare) have generally not allowed psychiatrists to use E&M codes, even when the service is not traditional psychotherapy and the management is similar to acute and chronic medical conditions. These codes carry documentation requirements that all other branches of medicine must use. Recently, Blue Cross Blue Shield of Massachusetts announced that psychiatrists would be allowed to use these codes (which MPS has long advocated) and New York State announced regulations specifically allowing psychiatrist to use them.

Health Care Reform: The Commonwealth has continued to achieve a high level of insurance coverage but the strains on the budget are quite apparent. At the Federal level, the Affordable Care Act has been passed, although most provisions are to be implemented in the coming years and challenges to the law are working their way through the Court system. Changes in the political climate may produce more uncertainty.

Where does psychiatry fit in? The MPS Council has approved a draft position paper on Global Payments, which has been posted on the MPS website and was the subject of a prior e-mail to the Membership. The text of the position paper is printed in this bulletin. As we have explored the role of psychiatry in the discussions concerning global payments, ACO’s and PCMH, it is apparent that there has been only limited discussion on the State level about how psychiatry would function in a global payment environment. We believe that inclusion of psychiatry in the general medical care system with full parity is essential to the care of our patients. While we must adopt many of the above changes as physicians, we will insure that our future is in the House of Medicine.

The MPS position paper on global payments is not an endorsement of global payments. The strategy that we have adopted thus far is to make a strong statement with the administration, the Legislature, and other interested parties that psychiatric services are critical to the success of any new patient centered care initiative and that psychiatry must be represented. We believe that national carve-outs are inimical to the delivery of locally based care. We have maintained liaisons with Mass Medical Society (and in particular our members who are active at MMS), other specialty groups and APA in planning strategy. In essence, we are, at this point, advocating for an active place for psychiatry in the planning process.

What can you do?

Stay informed. We hope that these developments will stimulate discussion among the membership. In this issue of the Newsletter, you will see an excellent article on ACO’s by Cecilia Mikalac, MD, one of our members active in MMS and MPS and an excellent article by Kate Knutson, MD, our MIT Representative on psychologist prescribing. We have a few article on ACO’s already lined up for the next newsletter. For those of you who are familiar with these issues, let us know about your experience and submit articles to the MPS Newsletter to share your thoughts with colleagues.

If you can, participate in MPS Committees and consider running for office in MPS. The more of our membership that participates, the stronger our voice can be.

We are hoping to develop a CME program in the Spring to address issues of global payments and technology.
The Nation and the Commonwealth are moving in an incremental way to reform health care and to achieve near universal health care. The Massachusetts universal health care initiative has been a model for Federal reform legislation. On July 16, 2009 the Massachusetts Special Commission on the Health Care Payment System, consisting of Legislative and Gubernatorial appointees, issued it recommendations. The report can be found at http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf. The core of the recommendations included a proposed move away from fee for service payments and toward an organization of health care where global payments are administered by entities called Accountable Care Organizations (ACO’s). The ACO’s would be responsible for episodes of care under a global payment system, where actuarial risk is retained by the insurance companies and performance (quality) risk is carried by the ACO.

For almost two centuries, psychiatry has operated in a substantially separate system of care with state hospitals as the core loci of care. In recent decades, this has changed with the advent of medications, community based care and improvement of coverage for outpatient service. However, in functional terms, mental health treatment continues to be delivered, in many settings, as a separate, often carved out system of care. As health care reform proceeds, the Massachusetts Psychiatric Society believes that such reform will represent a vital opportunity to insure that psychiatric care is delivered as an integral part of any new structure. The wide prevalence of psychiatric disorders and their impact on employment, family and personal well-being and general health is well known. As medical specialists, psychiatrists possess unique skills to treat acute and chronic psychiatric illness and substance use disorders, to collaborate and consult with primary care physicians and other medical specialists and to assess psychiatric emergencies. Indeed, for many patients with psychiatric disorders, the psychiatrist may be the patient’s most frequent point of contact with the medical care system.

Psychiatrists function in a variety of roles in the health care system. Many, in common with other mental health professionals, perform valued psychotherapeutic service. For purposes of the world of insurance, as it exists today and as it likely will exist in any future insurance system, psychiatrists as fully trained, experienced physicians will be called upon to participate in the medical management of psychiatric illness. Medical training is more than simply prescribing medication. It provides a way of understanding biological developments within psychiatry, the management of acute and chronic psychiatric and substance use disorders (some of which, like depression and substance use disorders, have high prevalence in the general population), differential diagnosis of psychiatric and somatic illness and understanding the interplay between them, drug interactions, and the impact of psychosocial factors which are an integral part of our training. We do not believe that a medical perspective is necessary for all aspects of psychiatric care, but that it is a vital aspect of any comprehensive system of care.

We believe that integration of psychiatrists into a global payment system can offer the potential of improving outcomes for patients through improved access to psychiatric treatment and better coordination of care with primary care and specialty physicians. Additionally, we believe that by participating in a global system with other medical specialties, entities such as ACO’s can more easily address cost and utilization issues within an integrated rather than substantially separate or carved out system of care.

Psychiatrists are highly motivated to see patients and to provide high quality care. To achieve this end, we propose the following principles be considered as health care reform moves forward.

1. Any global payment system must insure that acute and chronic psychiatric and substance use disorders and psychiatric care that is necessary to preserve major areas of functioning are covered with full parity.

2. Psychiatrists are medical specialists whose proper place is integrated into the general medical system. The inclusion of psychiatrists in adequate numbers, we believe, will improve patient care for patients with psychiatric, will improve outcomes for patients with medical illnesses with psychosocial and psychiatric complications and will allow inclusion of psychiatry in the delivery of high quality, cost effective care.

3. The core tasks of psychiatrists are medical, and include the diagnosis and management of acute and chronic psychiatric illness, collaborating with primary care physicians and other medical specialists in the management of patients with co-morbid disorders and the assessment of psychiatric emergencies. For these tasks, a global payment system should treat psychiatrists as they would any other medical specialist, in terms of utilization management, quality assessment, reimbursement and cost control, that is with full parity.

4. We believe that insurers and ACO’s will be better served by direct management of mental health services, with the active participation of psychiatrists. Currently, national, for-profit behavioral health carve out organizations have been hired by insurers to manage behavioral health care. In our experience, national organizations have difficulty responding to local conditions and maintain networks that do not conform with integrated referral patterns that would be required in a global payment environment. Ultimately, we are confident that ACO’s can deliver cost effective psychiatric care in the same way that they would deliver other aspects of medical care, with a potential increase in access to medically

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What is an ACO or Accountable Care Organization?

Short answer: no one knows for sure.

Long answer: the definition of an ACO has yet to be determined and likely will evolve over time. There are many models of ACOs proposed both at the Federal level and state level. Differences include structural details as well as payment methods. Some of the proposed ACO models are reviewed below.

Why are people talking about ACOs?

ACOs have been proposed as a possible means for lowering or containing health care costs and increasing availability of data to make sure the health care paid for is effective. ACOs are being considered by the Commonwealth of Massachusetts as part of the payment reform package because the cost of providing universal access to health insurance has proved costly. In addition, there are problems with access to primary care providers, which an ACO model could conceivably address. The formation of ACOs is being considered as part of health care reform at the Federal level as well, to control costs associated with the Medicare program. If ACOs are developed in Massachusetts, it would be desirable to make state models compatible with the Federal program. It is likely that legislation will be proposed in Massachusetts about the formation of ACOs in the near future and physicians would like to shape those proposals.

How will ACOs save money?

The main goal of pursuing ACOs is to lower health care costs. If ACOs do not save money, they may not go forward. How they are predicted to save money varies with the model type. Since most of the gains are theoretical, it is desirable to have actual evidence of cost savings before money is spent changing infrastructure. Pilot studies could be conducted with the various models to see if they do in fact save money and/or improve health care outcomes.

What’s the quality piece?

That’s the ACCOUNTABILITY part of Accountable Care Organizations. The idea is that through an integrated electronic medical record and billing database, information can more easily be collected and analyzed over time and across populations, specialties, and settings. The efficacy of treatments and interventions could be measured, analyzed and used to improve medical practice. In addition, medical information about each patient would be available to every provider, facilitating communication and eliminating unnecessary procedures. Patient outcome and physician prescribing practices could be tracked over time or compared from provider to provider. It is expected that feedback to physicians would be useful and help them improve their practices. This would be hard to control within a fully integrated system over time. Finally it would allow more precise measurement of case mix, which could allow practitioners with difficult or complex cases to be treated more equitably.

What are some of the proposed models for ACOs?

Structural Models

Model 1: separate PCP ACOs, Specialist ACOs, and hospital ACOs, which may or may not have contracts with each other. In this model, people would receive their primary care from a group of primary care specialists who are not necessarily part of a hospital. This might be the so-called medical home. It is unclear whether patients could choose their PCP ACO or if this would be dictated by their insurance plan. Certainly they could choose within an ACO. Specialists, like psychiatrists, might band together to form specialty ACOs, perhaps over a geographical region and each hospital might form its own ACO. The advantage to this model is that, except for the specialist piece, much of the infrastructure is already in place, especially in more urban areas. Another advantage is that it allows the development of different ACO models by specialty, for example a psychiatry ACO might be fee-for-service but the PCP ACO might be a combination of capitation and fee-for-service, while the hospital might receive mostly global payments for episodes of care. The disadvantage is that there may or may not be EMR compatibility between all ACOs so this model might not integrate care as well as some desire. On the other hand, this might be an easy starting place with compatibility issues to be worked out later. In psychiatry, having a separate ACO and EMR could be desirable in controlling the flow of psychiatric information outside the mental health setting.

Model 2: Multispecialty ACO outpatient + hospital ACO

In this model, hospitals would be their own ACOs but outside the hospital there would be large multispecialty group ACOs where patients would obtain their care. The advantage of this model is that it allows significant integration between specialists, like psychiatrists, and primary care physicians. One disadvantage is that it might place hospital outpatient departments, which are part of the hospital ACO, in direct competition with outpatient multispecialty ACOs. A disadvantage is that there would be an incentive for hospitals to direct inpatients to their own outpatient department rather than the local freestanding multispecialty ACOs. Of course hospitalized patients are more complex so this may not be an advantage if it worsens the case mix for the hospital ACO. Another disadvantage is that there would be an obvious split in communication between the outpatient multispecialty ACO and the hospital ACO, which might have different EMRs, at least at the outset.

Model 3: hospital medical staff organization (MSO) and/or physician-hospital organization (PHO)

In this model, only hospitals and their affiliated providers would form an ACO. Non-hospital affiliated physicians would continue to practice as they are doing now. This would direct energy and attention to the hospital setting where costs are...
most out of control. The disadvantage is that there is less accountability for outpatient providers, particularly those who do not track their patients closely or attempt to meet guidelines for good practice. Inpatient providers could argue that poor outpatient management is leading to hospitalizations for which they then become responsible. There is no built-in compatibility or EMR communication between the hospital and nonaffiliated physicians.

Model 4: organized delivery systems consisting of a hospital, all their employed physicians, and other subacute outpatient providers.

In this model, there would be no independent practices. All outpatient providers would be tied to a hospital. Outpatient physicians may or may not be allowed to contract with multiple hospital ACOs, depending on their specialty. For example, if there are few neurosurgeons, one neurosurgeon may be part of multiple ACOs. Psychiatrists in Boston, on the other hand, are myriad, and so may be allowed to attach to only one ACO. Patient care would be provided by a single ACO but some care might be delivered by other ACOs or regional referral centers like tertiary hospitals and their associated specialists. The advantage of this model is that care would be fully integrated across time and specialty, whether inpatient or outpatient. The disadvantage is that such large systems could monopolize health care in a geographic area and thus would be free to increase costs as high as the market could bear. Other disadvantages are those associated with highly complex computerized systems – difficulties with internal and external security, maintenance, training and education, and managing large system failures, especially in disaster situations. Patients may not have a choice about which ACO they use. It could be determined by geographical location or perhaps by insurance coverage.

Payment Models: Capitation, Global payment, and risk-assumption

Global payment and capitation are often mentioned in talk about payment reform and have many negative associations for physicians who lived through unsuccessful capitation programs back in the 1980s and 1990s. Both words are thrown about to indicate some form of lump payment, as opposed to fee-for-service, which eliminates the financial incentive to provide more or costlier services. At the simplest level global payment refers to any lump sum payment for services, which may include capitated payments, but often physicians think of global payment as synonymous with a global fee, or a lump sum given for an episode of illness which may include all services. For example, a lump sum for treatment of a hip fracture could include the surgical supplies, the physician services, hospital services like meals and linens, and all the post-operative rehab up to a certain point in time. It may allow extra compensation for complicating factors like diabetes but might not allow compensation for preventable complications like hospital acquired infections. The main disadvantage to global payment from a cost perspective is that it drives hospitals and physicians to avoid accepting higher risk patients, like the elderly or alcohol dependent. This may be addressed through risk or case-mix adjustment and stop-loss insurance. Another problem is that many conditions for which patient are treated are chronic and not characterized by discrete episodes, especially if they are well-controlled. This could potentially be managed by giving a lump payment per annum for each patient with a medical condition, similar to capitation, however, this in turn provides an incentive to over diagnose.

Capitation refers to global payment per capita (per head), or per patient, each year. In return, the ACO provides all the care necessary for that patient. There are two main problems with capitation. One is that it provides an incentive to under-utilize services. Since payment is fixed in advance, the fewer services provided, the unused monies are left for the organization. The other problem is that when funds are low at the end of a pay period, physicians may be asked to delay or limit services until the next payment period. Payments methodologies could also be combined with an episodic payment for an inpatient stay but a capitated payments per patient per condition for outpatient care.

Risk-assumption occurs with any health care delivery system. In our current system, health insurance companies assume and manage that risk. If an organization accepts a lump sum for care of a person or population for the year, as is done with capitated contracts, it assumes a, hopefully low, risk that the patient’s or population’s services will exceed the amount paid. If the population is relatively healthy, the risk is low. If the population is unhealthy, the risk is higher, so again there exists a tendency to avoid seriously ill or complex patients under capitated contracts. That said, risk assumption occurs even in fee-for service models like we have now. Psychiatrists who do not accept Medicaid lower that risk, as do psychiatrists who do not accept insurance at all.

The smaller the population an insurance company, employer, or ACO carries responsibility for, the higher the mathematical risk of one seriously ill patient blowing the budget. This risk is lower over large populations (which is why health insurance was developed in the first place), hence the tendency to group small businesses when purchasing health insurance. Large companies in Massachusetts that have relatively healthy young employees have found it cheaper to self-insure than to purchase health insurance from a company. Self-insured companies assume the risk and payment for their employees health care services, while the health insurance company acts only as administrator of the plan. However, self-insured companies then have an incentive to layoff older workers, who are at higher risk for serious illnesses like coronary artery disease and cancer.

The bottom line is that any system of payment has inherent financial incentives and disincentives which can only be managed by some system of checks and balances. The ACO debate and proposals will likely include formation of an oversight body as well as requirements to restrict over- and under-utilization of services.

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The Proposed Federal Model of ACO

The Federal model would require each ACO to serve at least 5000 Medicare beneficiaries. If a group or practice does not carry that many Medicare patients, it might have to join another group to achieve that number. In addition, each ACO must be primary care based (the medical home model) so in this model, so as it is now proposed, psychiatrists might not be permitted to form a single-specialty ACO.

Medicare would contract directly with ACOs, not individual physicians.

The EMR would be fully integrated across the ACO.

Payment to ACOs would be comprehensive and risk-based, perhaps a single payment per capita for each Medicare beneficiary scaled upward for increased age, complexity of problems, or seriousness of illness. Or it may mean a global payment for each medical condition per beneficiary per year – perhaps a dollar amount for every Medicare beneficiary with a certain stage of diabetes, and another one for each patient with depression and a third for each patient who suffers a hip fracture. In this payment model, patients with more difficult problems would generate more income.

The Federal model would move physicians in ACOs away from fee for service and toward salary since ACOs would pay physicians. This is an economic trend already in evidence – physicians are increasingly paid by salary.

All physicians would be integrated into some form of ACO, but ACOs could be independent outpatient groups or hospital groups. Psychiatrists, for example, might be free to join any ACO. Each ACO would have the legal ability to receive and disburse payments to member physicians and would have overarching practice management and governance structures.

The theoretical advantages to the Federal model are that transitioning physicians to salary from fee-for-service would result in significant cost containment because there would be no incentive to provide extra services. The requirement for full integration would allow measurement of outcome and productivity data in a comprehensive way. It may also allow detailed case-mix assessment so compensation could be improved for complex patients.

The disadvantage of this model (and perhaps some of the other models) is that it requires revision of current fraud and abuse laws particularly around kickbacks, and anti-trust because there would be considerable “self-referral” within the ACO and collective bargaining among physicians who may or may not be in legally integrated units. (ACOs may or may not be legal business entities.) In addition, there are serious technical issues for massively integrated EMRs. For example, a single system failure or security breach could result in devastating data loss or inaccessibility of records. With the need for large numbers of employees for data management, system maintenance, billing, and coordination of care, limiting access to the record also presents considerable challenges since many health data security breaches occur internally or as a result of employee behavior. Finally, current law prohibits the free exchange of certain kinds of health care information, such as substance abuse and psychotherapy notes without specific permission of the patient. This has special implications for psychotherapists who need some level of detailed documentation to maintain the flow of therapy and to protect themselves medicolegally.

Current State Models

We are fortunate that the current secretary of health and human resources, Judy Ann Bigby, MD, is a physician who understands the complexities of the health care system from a practitioner’s point of view. Thus far, the thinking at the state level seems to lean toward a model where ACOs could be composed of hospitals, physicians and other clinical and nonclinical health care providers who may or may not form networks or incorporated organizations. Each ACO would have to include primary care and must have at least one physician on the governing board.

ACOs would perform all the population management functions and financial management, including contracting with insurance companies, Medicare and Medicaid and any outside-the-ACO providers. The ACO would also provide quality assessment and communicate that with patients, physicians and payers in the ACO. Based on this data, the ACO would adjust policies, payments, and procedures to improve performance and efficacy.

In the state model, ACOs would accept global payment for most care but there are likely to be some services for which fee-for-service will continue. Mental health is a potential target for continued fee-for-service because of privacy and under-utilization issues (see below.)

There would be an Oversight Board for ACOs which, in addition to other functions, would establish guards against under-utilization of certain services, for example mental health treatment, and inappropriate selection of low cost patients, for example driving away addicted patients through poor provision of services.

The Big Questions

There are several big questions about ACOs and the biggest one of all is Will any model of ACO save money? The Massachusetts Medical Society is strongly advocating for pilot studies of the models to help answer this question before conversion to such a system. This is evidence-based medicine at the macro-level.

Will there be political support for the necessary regulatory and legal changes needed for wide spread establishment of ACOs? This is likely IF legislators come to believe ACOs will save money and that financial exploitation by physicians or ACOs will be minimal. Again, this might require evidence from pilot studies.

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If ACOs assume risk like self-insured companies, will health insurance still be necessary? Health insurers are understandably concerned about this development and are cautious about supporting ACO models which assume risk for a given population.

What will be the relationship between ACOs and health insurance? Will all ACOs accept all insurances? Will ACOs be required to accept Medicare and Medicaid? This is completely unresolved and depends heavily on the type of model chosen.

Will the public accept full integration of their health record, including psychiatric and substance abuse records? It seems as if most of the public is in favor of medical record integration, but only a minority of patients have any psychiatric record. It may end up being the responsibility of psychiatrists and patient advocacy organizations like NAMI to take the lead in this regard, one way or the other, and advocate for the privacy needs of all people who use psychiatric services.

Will people be locked into an ACO because of geographical or insurance constraints? Are consumers ready to accept limitations in who they can see? This seems unlikely given that HMOs fell out of favor for precisely this reason. This hurdle could be overcome by including virtually all providers in the ACO, as has happened with some HMOs but then there are monopoly concerns.

Will a large ACO be able to exert monopolistic control over the delivery of health care in a region? Again, this depends on the level of oversight and the constraints placed on such a system.

Will ACOs be for-profit or not-for-profit? Should there be limitations on administrative costs or executive compensation? What should happen with cost savings or profits? The influence of money will exist no matter what model system emerges. It is important for any model to have checks on these potential sequelae.

Why might outpatient mental health remain fee-for-service?

1. Patient choice
2. Underutilization by patients
3. Underfunding by organizations and insurance companies
4. Shortage of child psychiatrists
5. Problems associated with privacy of records

Should I be for or against ACOs?

That depends on how you are practicing now, where you envision yourself in the future, and how the picture evolves. Many psychiatrists are currently practicing in systems not so different from some of the proposed ACO models. Independent practitioners who do a lot of psychotherapy may find some of the models infringe on their independence and the privacy their patients are used to having. There may also be considerable financial costs in terms of IT requirements and servicing.

What is happening now?

At the state level, the Payment Reform Legislative Committee is finishing up its discussions with the Health Care Quality and Cost Council and other stakeholders and will likely file legislation in January or February of 2011. Although no knows for sure, this legislation is likely to include global payment models with some flexibility for fee-for-service. It will probably lean toward the development of ACOs and a “medical home model” for primary care. Interoperability of EMRs will be important. And it most certainly will suggest formation of an oversight body, hopefully composed of governmental, nongovernmental, and physician members, which would work out the details of how the program should be implemented. Once legislation is filed, it will have to go through the normal legislative cycle, including review by multiple committees, amendment, and several votes. This provides many opportunities for changes and debate.

At the Federal level, Health and Human Services, CMS, and the Institute of Medicine are working together to explore and implement new payment models and the vehicles to make that possible. As happened with the Health Care Reform Act, if and when Massachusetts makes a move toward payment reform, the Feds and other states will be watching closely. Conversely, as the Federal program evolves, state reforms may have to change to follow suit.

Professional organizations need to be involved in the process. The Massachusetts Medical Society has been gathering information on proposed payment reform from physician focus groups, on-site outreach, representation on a Task Force on Health Reform, member surveys and educational symposiums. This informed the MMS testimony to the Payment Reform Committee, which is available on the MMS website, along with other resources about payment reform and ACOs.

[See www.massmed.org, click on MMS Advocacy tab, then click on Healthcare Reform or Payment Reform] The Massachusetts Psychiatric Society has formulated a position paper on ACOs, which is presented in this issue. Other professional organizations will also provide input.

The future of ACOs and payment reform is evolving and uncertain. Education, communication, and informed debate will be necessary for physicians to adapt to whatever changes are ahead.

* The National Comorbidity Replication Survey done in 2001-2003 showed that only 33% of people with a psychiatric disorder were receiving treatment for it. This represents an improvement from 1992 when only 20% of patients with a psychiatric disorder received treatment. Kessler et al (2005) Prevalence and Treatment of Mental Disorders, 2001-2003, NEJM, 352(24):2515-2523
The issue of psychologists being allowed to prescribe psychotropic medications is a significant topic of debate, and bills to grant psychologists prescribing privileges have been proposed in Massachusetts for several recent legislative cycles. Most of us have a clear “gut reaction” to the prospect of psychologists prescribing medications, but maybe it would be helpful to take a closer look at both sides of the debate.

The most commonly cited reason in favor of allowing psychologists to prescribe medications is access to mental health care. Particularly in rural areas, psychiatrically ill patients are unable to access care, and increasing the workforce may alleviate the shortage of mental health providers. A major rebuttal to this argument is that psychologists are no more likely to relocate to rural areas than psychiatrists, and workforce shortages in underserved areas are unlikely to be alleviated by prescribing psychologists.

Patient safety is a common concern for those who oppose psychologists being allowed to prescribe medications. Psychotropic medications affect systems outside the central nervous system (CNS), and it is unclear that psychologists could be adequately trained to identify adverse effects of medications on other organ systems. Furthermore, would psychologists recognize medical comorbidities that present with psychiatric symptoms and understand which psychotropic medications are contraindicated for patients with underlying medical conditions? There is evidence in fields such as optometry and anesthesia that non-physician prescribers practicing alone have worse outcomes than those who practice with supervision. However, bills in many states include proposals for psychologists to prescribe medications without physician supervision.

The US Department of Defense (DOD) developed a program training psychologists to prescribe psychotropic medications from 1991-1997. The program evolved to include one year of didactic medical training in biochemistry, physiology and pharmacology followed by one year of practical clinical training involving a 6 month inpatient unit rotation under supervision by a psychiatrist. Following graduation, each of the ten psychologists who completed the program practiced for at least one year under guidance by a psychiatrist. Psychologists were not allowed to treat medically complicated patients or patients outside the age range 18-65 years. Psychologists were allowed to prescribe most psychotropic and adjunctive medications, but carbamazepine and MAOIs were not on the psychologists’ prescribing formulary. Ultimately the DOD program was discontinued due to financial issues and because it was felt that workforce of military psychiatrists was adequate. The American College of Neuropsychopharmacology (ACNP) made several visits to the DOD training facility to evaluate and report on program implementation and effectiveness, and the ACNP 1998 report was overwhelmingly in support of the DOD’s program. Many people who oppose to psychologists prescribing feel the DOD demonstration is not representative of the experience of civilian psychologists. Specifically, most civilian training programs require 450 hours of didactic training rather than the 660 hours required in the DOD project. Furthermore, psychologists prescribing in civilian communities may be exposed to more severe psychopathology and medical comorbidities, and supervision may not be as robust.

In 2002 New Mexico passed a law allowing psychologists to prescribe medications and in 2004 Louisiana followed by passing a similar law. In New Mexico, psychologists complete 450 hours of didactic training and 400 hours of clinical supervision by a psychiatrist. The psychologist then practices for two years under supervision by a psychiatrist before being able to practice independently. In Louisiana psychologists are allowed to prescribe upon graduation from the two year didactic and clinical training program, but may never prescribe medications without supervision by the patient’s primary care physician.

The APA is against psychologists prescribing based on patient safety concerns. NAMI is specifically concerned for severely ill patients in the public sector being treated by psychologists and recommends further research into New Mexico’s experience with particular attention to safety and patient outcomes. Supporters of the legislation point out that no negative consequences on patient safety have occurred as a result of psychologists prescribing psychotropic medications through the DOD project or in New Mexico and Louisiana.

Psychiatrists have voiced concerned that psychologists prescribing medications may deteriorate our field, putting it more in the realm of psychosocial treatments than medicine. Many areas of medicine are at risk for this effect given the increase in non-physician prescribers such as nurse practitioners and physician assistants. Insurance companies would likely favor psychologists prescribing due to the savings in reimbursement by combining visits for medications and therapy with one non-MD provider. Physicians have completed rigorous medical training, and to maintain our identity, it is important to define what this training offers beyond the non-physicians who seek prescribing privileges. Engaging in the debate is important for our field as well as for the safety and security of people with mental illness.

(On November 22, 2010, Dr. Jim Ellison testified at a legisla-
tive hearing on Cognitive Impairment on behalf of the MPS. 
His testimony is below)

My name is James Ellison. I am representing the Massachu-
setts Psychiatric Society, which is the largest professional
association of psychiatrists in Massachusetts, comprising
1700 members. The MPS is our district chapter of the Ameri-
can Psychiatric Association, the largest national association
of psychiatrists. The Geriatric Interest Group of the Massa-
chusetts Psychiatric Society has long been interested in the
individual and public health implications of Cognitive Impair-
ments that may affect operation of a motor vehicle.

The MPS applauds the legislature’s progress in improving
individual and public safety through implementation of in-
person license renewal beginning at age 75 and through defi-
nition of a process for involving the Registry of Motor Vehicles
when a Severe Cognitive Impairment relevant to safe opera-
tion of a motor vehicle is determined by a health care pro-
vider. The MPS supports the involvement of health care pro-
viders, in collaboration with the Registry of Motor Vehicles, in
determination of such impairments and implementation of
appropriate restrictions on application for a learner’s permit
or new license or on renewal of an existing license.

The MPS asks that the following additional considerations be
noted in order to improve the efficacy of the process through
which health care providers will interact with the Registry of
Motor Vehicles to assess the presence of Severe Driving
impairment in motor vehicle operators of any age. The MPS
wishes to emphasize that medical conditions such as intoxica-
tion or adverse medication effects, sleep deprivation, sensory impairment, and neurological
or musculoskeletal problems each or in combination can
impair driving and that health care providers should re-
main alert to the potential for these conditions to affect
driving.

2. The MPS asks that provisions be made so that health care
providers can receive appropriate training about driving
impairments from various causes so that they can fulfill the responsibilities imposed by current
and proposed legislation.

3. Finally, the MPS recognizes that driving is an important
aspect of autonomy for older individuals and that health care
providers should exercise caution, judgment, and
knowledge when asking that an individual’s license to
operate a motor vehicle be restricted or assessed on the
road. Furthermore, restriction of driving for impaired indi-
viduals must be coupled with health care provider and
public education on the relevant issues, increased avail-
ability of affordable driving assessment, and increased
availability of viable transportation alternatives.

Sexual Disorders Workshop
January 10, 2011 at MPS Office

5:00 to 5:15 pm - Welcome
5:15 to 6:30 pm - Phenomenology of sexual disorders:
                  Michael Schwartz, MD
6:30 to 7:45 pm - Treatment and Risk Management of
                  Paraphilic disorder:                     Fabian Saleh, MD
7:45 pm to 8 pm: Break
8:00 to 9:00 pm - Legal Issues: Albert Grudzinskas, JD

Please plan to join us for what promising to be a very informa-
tive program. Seating is limited to the first 25 so please make
your registration early. A light dinner will be available.

The Massachusetts Psychiatric Society designates this live
activity for a maximum of

3.5 AMA PRA Category 1 Credit(s)™

Physicians should claim only the credit commensurate with
the extent of their participation in the activity.

The Massachusetts Psychiatric Society is accredited by the
Massachusetts Medical Society to provide continuing
medical education for physicians.

Wishing a Happy
and Healthy New
Year to you all!!

THE DEADLINE FOR THE FEBRUARY 2011 MPS NEWSLETTER IS
JANUARY 14, 2011. FOR ADDITIONAL ADVERTISING INFORMATION,
PLEASE CONTACT THE MPS OFFICE AT (781) 237-8100
OR MPS@PSYCHIATRY-MPS.ORG.
APA Resource: “Tips to Protect your Practice While You Are Away”

Taking some time off to attend the American Psychiatric Association’s annual meeting? How about scheduling that much needed vacation? Or could a personal emergency draw you away from your practice for a while? The APA has created a resource guide with tips to help psychiatrists protect their practices while they are away.

Patients and office staff need to know that there will be a plan in place in your absence, and you need to feel secure knowing that all the bases are covered. The tip sheet offers a check-off sheet with reminders as simple as locking up your prescription pads and anticipating medication refills to specific instructions on how patients can get services in your absence. The guide also gives important questions to ask when you are covering a colleague’s practice.

The resource document was created by the APA Office of Healthcare Systems and Financing. It’s available on the American Psychiatric Association website under the Quick Practice Info section, which includes a variety of other resources for managing your practice.

Links:
Protecting Your Practice While you Are Away:
http://www.psych.org/MainMenu/PsychiatricPractice/ManagingYourPractice/QuickPracticeInfo/ProtectYourPracticeWhileYouAreAway.aspx?FT=.pdf

Quick Practice Info:
http://www.psych.org/MainMenu/PsychiatricPractice/ManagingYourPractice/QuickPracticeInfo.aspx

Psychiatrists Needed for DSM-5 Field Trials

Psychiatrists are needed for field trials for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). DSM-5 Field Trials in Routine Clinical Practice Settings are designed to test the feasibility and clinical usefulness of the proposed diagnostic criteria and diagnostic-specific measures in real-world clinical settings; to examine whether the measures adequately capture changes in patients’ or clients’ symptom levels over time; and to examine whether criteria are informative for treatment planning.

The American Psychiatric Association wants to include psychiatrists and other clinicians from multiple disciplines in this important phase of the DSM-5 development process. Participating clinicians will be recognized as contributors in DSM-5 and receive continuing education credits for completion of the required online DSM-5 training session and participation in the field trials.

For more information about field trials and about volunteering, visit www.psych.org/dsm5-rcp-fieldtrials.

Bradshaw ‘Conversations’ DVD Available

NFL superstar Terry Bradshaw was the special guest at the American Psychiatric Foundation’s ninth annual Conversations event at the 2010 APA Annual Meeting in New Orleans. Bradshaw shared his personal stories of mental illness, ranging from how ADD influenced his childhood and schooling, to how depression compounded difficulties with ADD in adulthood. Bradshaw also discussed the issue of stigma related to mental illness within the sports industry and the ridicule he received from his teammates on the Pittsburgh Steelers. The event lasted an hour, was recorded, and is now available as a free DVD from the foundation. To request your free copy, please send an email to apf@psych.org.

Healthy Minds. Healthy Lives. Website, Blog Offer Patient Information

The American Psychiatric Association has a consumer-oriented blog and website that may be useful to your patients. The blog is a joint effort by members of the Council on Communications and other APA members, and includes timely and consumer-friendly information about mental health issues.

Consider adding links to the website, www.healthyminds.org, and the blog, www.apahealthyminds.blogspot.com, to your website, email signature or business card.

Mental Health Works Informs Employers

The Partnership for Workplace Mental Health, part of the American Psychiatric Foundation, publishes Mental Health Works, a free quarterly publication focused on mental health in the workplace. The publication is available online and is primarily designed to help employers understand that it makes good business sense to address the mental health needs of employees. It features articles about effective employer-sponsored mental health programs. Topics covered in the current issue include a feature article on equipment manufacturer Caterpillar Inc.’s health programs, a white paper on employer use of behavioral risk management and more. It also covers the employer-led Initiative for Depression Screening and Treatment in Primary Care in New York. To subscribe to Mental Health Works, write mhw@psych.org. Please include your mailing address and phone number.

(Continued on page 12)
NEWS FROM THE APA (Cont.)

(Continued from page 11)

Links:

Call for Nominations for the American Psychiatric Leadership Fellowship

Psychiatric residency training programs are invited to nominate one resident per program for the American Psychiatric Leadership Fellowship. The two-year program is designed to develop future leaders in psychiatry. During this time fellows will participate in a component of the APA governance structure, attend APA Annual Meetings, and receive leadership training.

Psychiatric residents are eligible if they are in their PGY 2 year of psychiatric residency at the time of nomination (or PGY 3 of a five-year program), are APA members, or have applied for membership, and have passed all national or state board exams needed for full state licensure. The deadline for nominations is January 15.

Links:
http://www.psych.org/share/OMNA/psychiatric-leadership-fellowship.aspx

Legal Information and Consultation Plan Available to APA Members

The American Psychiatric Association Legal Information and Consultation Plan is available exclusively to psychiatrists who are APA members. For a separate fee, members can obtain practice related legal consultation on managed care contracts, subpoenas, HITECH amendments to HIPAA, malpractice, risk management, and third-party reimbursement. (This service is not available to residents of North Carolina.) Members who enroll by January 1, 2011 may deduct $25 from the Plan fee.

Links:

Consultation and Liaison Interest Group to Meet

The Consultation/Liaison Interest Group of the MPS is resuming regular meetings. Drs. Manny Pacheco and Patrick Aquinno have agreed to co-chair the interest group.

Our next scheduled meeting is Thursday January 13th at 6:30PM at the MPS office at 40 Washington St., Suite 201, Wellesley.

Join us in discussing the future and focus of the group. Trainees are encouraged to attend.

A Light dinner will be provided. Please contact the MPS office if you plan to attend. You may either call 781-237-8100 Ext. 210 or email mpatel@psychiatry-mps.org.

We have had a number of members request that we reinstitute this group and the MPS is very pleased that Drs. Pacheco and Aquinno have agreed to do this.

We look forward to seeing you!

Don’t forget to Vote in the APA Election

December 22, 2010 to February 7, 2011
The MPS Awards Committee will meet in February 2011 to consider the nominations from MPS Members for the following categories of MPS Awards: Psychiatric Education; Advancement of the Profession; Public Sector Service; Research; Clinical Psychiatry; and Lifetime Achievement.

The Awards will be presented at the MPS 2011 Annual Meeting in May 2011. If you have a nomination, please submit the name of the MPS member, with details of their achievements, and your reasons for nominating them. It is also helpful to include a one page bio or short CV summarizing their work.

Send your nomination to the attention of the MPS Awards Committee by January 31, 2011. You can submit this either by email to mpatel@psychiatry-mps.org, or you can mail to MPS, 40 Washington Street, Suite 201, Wellesley, MA 02481. Thank you! ~

MPS Awards Committee

Congratulations to New APA Distinguished Fellows and Fellows

The following members were approved for Fellow and Distinguished Fellow Status:

**Distinguished Fellow:**
- Fe Erlita Diolazo Festin, MD
- Marlene Picus Freeman, MD
- Mark Joseph Goldblatt, MD
- Mark Jeffrey Hauser, MD
- Helen Hisae Kyomen, MD
- Donna M. Moores, MD
- Richard S. Schwartz, MD
- Marc Alan Whaley, MD

**Fellow:**
- James Steven Harburger, MD
- Linda Carol Shafer, MD
- Lawrence Watson Raymond, MD
- Susan Rovaine Brown, MD
- Scott L. Rauch, MD
- Bruce M. Dow, MD
- Laura T. Safar, MD
- Mark N. Rudolph, MD

(MPS Position Paper—Global payments -Continued from page 4)

necessary psychiatric care, in better coordination of care and with the greater local accountability for quality and cost.

In recent years, market forces have, in our view, created existing conditions that would be a challenge for the integration of psychiatric care into a global payment structure. Low reimbursements have exacerbated difficulties access to psychiatric care under insurance in a similar way that access to primary care has been strained. Inadequate reimbursement has caused particularly severe problems of access to child psychiatrists under insurance. Income generated by psychiatry often cannot support location of services in high overhead space close to other medical services, making coordination of care more difficult. Additionally, expense for office staff and improvements in technology can be prohibitive for small practices. Privacy of psychiatric records is a particularly important issue for psychiatric patients. We believe that the advantages of integrating psychiatric care into a global payment structure has the potential to provide greater access to high quality, integrated, cost-effective medical and psychiatric care will be well worth the effort in overcoming these barriers.

(MPS Bulletin—January 2011)

I believe that it is particularly important for our younger members to become active. You are more informed about issues in technology and you will be most affected by any change. Don’t let those of use who have Medicare cards (I’m eligible this March!) determine your future!

We have a wonderful profession and members with intelligence and energy. Let us take the initiative to help shape the future of care for our patients and for the future of our profession.

(MPS Position Paper—Global payments -Continued from page 4)

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The New APA-Endorsed Medical Malpractice Program

The American Psychiatric Association has changed malpractice insurance carriers. If you are not already insured with the American Professional Agency, Inc., don’t get left behind! Join your fellow members who have found their protection with the APA-endorsed insurance product that best serves their needs.

**Program Enhancements**

- Years in APA’s prior program count towards tail coverage
- Fire Damage Legal Liability included
- Occurrence and Claims-Made forms available
- Information Privacy Coverage (HIPAA) included
- Internet/Telemedicine included
- Licensing Board Coverage with no aggregate
- Interest Free Quarterly Payments/Credit Card payment is available
- 10% Discount for New Insureds who are claims-free for the last six months
- No Surcharge for Claims

*Please contact our office at (877) 740-1777 to obtain rates, forms, and complete program enhancements or visit our website*

[www.americanprofessional.com](http://www.americanprofessional.com)

and select the link for the American Psychiatric Association members.
LEGAL ADVICE FOR PSYCHIATRISTS
Milton L. Kerstein, Esq.
Andrew L. Hyams, Esq.
Mr. Hyams, former General Counsel to the Bd. of Reg. in Medicine, and Mr. Kerstein provide legal services to psychiatrists and other health professionals in the following areas:
- Licensing Board Complaints and Applications
- Medicare/Medicaid Audits
- Patient Confidentiality
- Provider and Employer Contracts
- Civil/Criminal Litigation

As a service to Bulletin readers, we offer one free 15-minute consultation to discuss any general legal concerns.

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Belmont: Full-time and/or Part-time psychotherapy office rental in attractive Colonial home converted for mental health professionals. On bus line with convenient parking. Call: (617) 484-8378.

PSYCHIATRISTS

PSYCHOPHARMACOLOGIST
Southeastern Psychiatric Associates, a respected, thriving South Shore outpatient practice of psychiatrists and therapists is looking for a part time physician to help with the excess of referrals we currently have to turn away! Hours are flexible. We maintain the highest standards but also try to keep a pleasant and relaxed atmosphere. Our excellent support staff works hard to ensure that providers can spend maximum time with their patients. Offices are located in Randolph, at Carney Hospital and in Central Square, Cambridge. Cambridge hours are limited. Compensation is highly competitive.

Contact Leonard Marcus, MD.
617-696-7727 phone, 617-696-8387 fax or leonardmarcus@comcast.net.

ADVOCATES, INC. CHILD AND CORRECTIONS PSYCHIATRIST POSITIONS.
Full and part-time positions are available for PSYCHIATRISTS at our sites throughout the Metro West area. Advocates Inc is a full-service, non-profit system serving individuals with psychiatric and developmental disabilities and other challenges in a strength-based, person-centered and multi-disciplinary setting. Excellent physicians are honored, and we offer a warm, friendly practice environment. Compensation is highly competitive and benefits are available for 20 hours +.

Contact in confidence Chris Gordon, MD, Medical Director at 508.628.6652 or at cgardon@advocatesinc.org.

Exceptional Professional Opportunity for psychiatrist to provide high quality care as part of a well respected multidisciplinary private group practice located in beautiful Berkshire County and neighboring Columbia County/Hudson Valley, NY. Inpt/Outpt PT/FT. Flexible position can be tailored to physician’s needs and interests. This is your dream job in a bucolic country setting.

Excellent salary and benefits package $200,000 + (with opportunity for additional income). Call Dennis Marcus, M.D. at (413) 528-1845, fax CV to (413) 528-3667 or email to scppcmd@yahoo.com.

The Department of Psychiatry at Mount Auburn Hospital, affiliated with Harvard Medical School, is recruiting for a full-time position and a half-time position in our Outpatient Psychiatry Service. Responsibilities include evaluation and treatment of adult patients with a variety of psychiatric disorders, including dual diagnosis patients, and coordination of care with other psychiatric clinicians and with primary care and specialty physicians. Position includes participating in the teaching activities of the Department. Academic appointment to the clinical faculty at Harvard Medical School is anticipated.

Please send letter of interest and cv to:
Joseph D’Afflitti, M.D.
Chair, Department of Psychiatry
Mount Auburn Hospital
330 Mount Auburn Street, Cambridge, MA 02138
tel: 617 499-5008
email: jdaflitti@mah.harvard.edu

CLASSIFIED LISTINGS—JANUARY 2011

Massachusetts Psychiatric Society • 40 Washington Street, Suite 201 • Wellesley, MA 02481-1802
Phone: (781) 237-8100 • Fax: (781) 237-7625 • Email: mps@psychiatry-mps.org
Psychiatrist-Fitchburg, MA

The Psychiatrist is responsible for clinical psychiatric services provided to patients at Community Health Connections. The Psychiatrist will consult with primary care providers and behavioral health providers regarding individual cases, medication management, and care modalities.

**Major responsibilities:**
- Provide direct psychiatric patient care to a panel of CHC patients
- Provide medication management consultation to primary care providers at the Health Center
- Participate in the collaborative, integrated health care model of CHC
- Participate in the educational activities of the Behavioral Health Department in collaboration with the family medicine residency faculty.
- Participate in Multidisciplinary Reviews, including group meetings and reviewing documentation.
- Diagnoses, manages, and appropriately refers patients with acute, episodic, or chronic illness according to department protocols
- Orders appropriate laboratory and diagnostic tests according to established guidelines.
- Facilitates and coordinates patient care referrals to specialists and outside agencies
- Develops and provides educational materials and/or programs to patients, families, and other health care professionals.
- Actively participates in the departmental quality assurance program.
- Serves on appropriate department and/or hospital committees.
- Performs other related duties as required and as assigned.

**Minimum Qualifications:**
- Graduate of USGME Qualified Adult Psychiatry Residency Program
- Valid License for the practice of Medicine in Massachusetts
- Valid Massachusetts DEA Certificate
- Valid Federal DEA Certificate
- Board Certified or eligible by ABPN in general psychiatry

Job Listing: #78
Compensation: TBD
Qualified applicants please submit your resume and cover letter to hr@chcfhc.org or mail to Community Health Connections, Attn: HR Dept., 275 Nichols Road, Fitchburg, MA 01420 or fax to 978-665-5959 EOE
CLASSIFIED LISTINGS—JANUARY 2011

A D U L T  P S Y C H I A T R Y

About the position
Baystate Health is seeking a BC/BE Psychiatrist primarily to provide inpatient care within a 22-bed unit at Baystate Franklin Medical Center, our 100-bed community hospital located in beautiful Greenfield, Massachusetts. This is a chance to work in a superb community hospital along with the highest quality mental health team. We are small enough to get to know our patients and each other personally and create a community based upon respect, integrity, and the highest standards for clinical care.

Baystate Franklin Medical Center is affiliated with Baystate Medical Center, a 650-bed medical center located in Springfield, Massachusetts, and a major affiliate of Tufts University School of Medicine. This creates a unique blend of the best aspects of a true community hospital with the strengths of a nationally regarded, academic department of Psychiatry.

We are located in the Pioneer Valley of western Mass., known as the “5 College” area, with a very rich cultural heritage along with some of the most breathtakingly beautiful scenery in the US.

To find your niche at Baystate, please contact:
Frank Gallagher, Senior Physician Recruiter
413.794.2623 • Frank.Gallagher@BaystateHealth.org

Baystate Health

ChooseBaystateHealth.org/Psych/MassPsych

Massachusetts Institute for Psychoanalysis (MIP)

PSYCHOANALYTIC TRAINING for the 21st CENTURY

MIP offers a full program of psychoanalytic training for licensed mental health professionals. The program includes four years of courses in psychoanalytic technique and theories, as well as supervised psychoanalytic work. Faculty members are drawn from among the outstanding psychoanalytic teachers and supervisors in the Boston area, as well as nationally.

An Advanced Candidates program is available for those clinicians (ten years or more post-licensure) who have had significant experience conducting intensive, psychoanalytically - oriented treatment, and have been engaged in self-directed psychoanalytic study and personal analysis. The application deadline is April 1.

OPEN HOUSE

Why Choose Psychoanalytic Training?

Please join candidates, faculty, and members in a lively discussion about psychoanalytic training.

Wed. Feb. 2, 2011** 7:30 to 10:00 p.m.

The Inn at Harvard ** 1201 Mass. Ave., Cambridge

For further information:
reachmip@gmail.com ** www.mipsa.org **
T: 617-232-2777

MIT is an equal opportunity/affirmative action employer. Applications from women, minorities, veterans, older workers, and individuals with disabilities are strongly encouraged.

http://medweb.mit.edu

VA Boston is an Affirmative Action/Equal Opportunity Employer with a strong institutional commitment to diversity in all areas. U.S. citizenship required.
Westwood Lodge Hospital has 2 openings for On-Call Physicians. On-Call Physicians earn substantial income which may either fully substitute for daytime income or be a major supplement to it.

ASAP: If you are interested in exploring these opportunities, or know others who may be, please email Elaine Thomson, Credentialing Coordinator at elaine.thomson@uhsinc.com or call her at 781-781-7764 x 164. We will contact you with additional information.

NEW: We are making changes in our On-Call services which will make these positions more compatible with other daytime clinical or research work. We are also adding ancillary nurse practitioner services to assist in completing some of the admission procedures.

1. In addition to our regular Full Evening/night positions, we are now offering part evening/part night positions.
   - Part Evening: On Call-Physicians arrive at the Hospital at 6 pm and leave at 10:35 pm to go home.
   - Part Night: Physicians arrive at the Hospital at 10:20 pm, stay overnight at the hospital, and leave at 7 am. This schedule provides time for a physician to be at home after daytime work for meals and rest prior to beginning On-Call duties.

2. A Senior Attending Psychiatrist and a Senior Administrator of the Hospital are on call to assist the On-Call Physician 24 hours a day.

3. A Nurse Practitioner will be available in the morning to do admission physical examinations beyond those which may be necessary in the evening.

We look forward to hearing from you.

Byron Garcia, MD Medical Director

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North Shore—Northeast Hospital Corp, a local non-profit medical and psychiatric system on Boston’s North Shore, has openings for full time and part time inpatient attending psychiatrists and night/weekend on call psychiatrists at BayRidge Hospital and Beverly Hospital. The Hospitals are teaching sites for Boston University School of Medicine, and for the inpatient psychiatrist positions, there is no required night call, a competitive salary, and a full benefit package including generous time off as well as reimbursement for malpractice insurance and CME expenses. The lucrative night/weekend on-call opportunities can be scheduled to fit your needs, and both on-site and call from home options are available.

Contact Barry Ginsberg, M.D.
Chief and Administrative Director
NHC Dept, of Psychiatry
60 Granite Street, Lynn MA 01904
Phone (781) 477-6964, Fax (781) 477-6967
email bginsber@nhs-healthlink.org
Dr. Ronald Pies is pleased to announce the release of "Becoming a Mensch", from Hamilton Books.

While primarily ethics-oriented, the book deals with many psychological issues (such as "self respect") of clinical relevance. A limited number of signed copies are available from ronpies@massmed.org.

BROCKTON, MA. 40-hr position for BC/BE* psychiatrist in Joint Commission accredit. CMHC with comprehensive outpatient, PACT, case management, CBFS, and 24-hour on-site emergency services. CMHC is part of MA DMH Southeastern Area. Active medical staff and Harvard-affiliated psychiatry residency training program. Responsibilities include outpatient psychiatric evaluations, psychopharm. mgmt., treatment planning, consultation to treatment teams. Compet. salary, benefits, daytime, flex schedule, no night-call. Available 3/10. Board certification required (*can accept BE only if plan in place for board cert exams). Transitional age youth or forensic experience, and/or Spanish speaking desirable.

Send CVs to Terri Harpold, MD, Brockton Multi-Service Center 165 Quincy St., Brockton, MA 02302 or email to theresa.harpold@state.ma.us

The Norwood area is very underserved because of too few psychiatrists. Join a congenial small group of practitioners including a psychiatrist and a Ph.D., Social Worker with great potential for a busy practice soon after arrival. Present third occupant of office is semi-retiring. Contact Alice Freeman, M.D. at 781-762-5470.

Beth Israel Deaconess Medical Center in Boston, MA, a 500+ bed tertiary care teaching hospital of Harvard Medical School, has staff openings for salaried psychiatrists. The Department of Psychiatry maintains a diverse 25 bed inpatient unit, a robust Emergency Department and Consultation-Liaison Service, as well as an active outpatient practice. Interest and experience in research is desirable. The Psychiatry Department is a major teaching site for Harvard Medical School and the Harvard Longwood Psychiatry Residency Training Program; all positions will include opportunities for teaching of medical students and residents. Underrepresented minorities, especially those who speak Spanish, are encouraged to apply. Harvard Medical School appointment at an appropriate rank is available.

Please contact:
William Greenberg, MD, Chief of Psychiatry by email: wgreenbe@bidmc.harvard.edu including a statement of interest and CV.

Psychiatrists

NLCWC is seeking two (2) BC/BE Psychiatrists to provide psychopharmacological treatment to both adults and children and to consult with families and clinical staff. Position(s) offer flexible hours & are part-time.

Contact: Dr. Duvelson, p.duvelson@newlifecounselingcenter.org or Michael Shanahan, Clinic Director, m.shanahan@newlifecounselingcenter.org, or either by phone 781-986-4800.

New Life Counseling & Wellness Center (NLCWC) is a multicultural agency dedicated to the support of children and adolescents and the empowerment of families throughout the South Shore and the Greater Boston area. Our Outpatient Clinic is conveniently located in Randolph, MA.

Because we offer a broad range of services to assist people of all ages, we engage with communities on many levels. We use a multicultural approach to offer: Outpatient Clinic Services Diagnostic evaluation; Individual, couple, and family therapy; Family Stabilization and Support Services (FSS) through DCF Family Support Services through the Parent Aide Program; faith-based counseling; support groups; community education and training; community outreach and team-building; language translation; and referral services to additional resources.

Please visit our Web site at www.newlifecounselingcenter.org for more information about the work we do.
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<th>Contact Email</th>
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<td>January 10th</td>
<td>5:00 PM - 9:00 PM</td>
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<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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<td>Mass Medical Society</td>
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