Person-Centered Care: For Psychiatry and All of Medicine

At first, the concepts of person-centered care, and its conceptual cousin recovery-focused treatment, seem so obvious in psychiatric practice. Didn’t many of us choose psychiatry in order to work with the whole person? I vividly remember my frustration during medical and surgical rounds in medical school because we knew so little about whom the patients were that we were treating. I was both relieved and inspired on my psychiatry rotation, where we were able to learn so much about a person’s life story. In psychiatry, we try to learn as much as possible about each individual patient; not only to more effectively diagnose and treat the patient’s disease, but also to facilitate the person’s engagement in pursuing and maintaining health. We know it is essential to include the family and to take the school, work and social setting into account. We need to consider the community in which our patient lives. True?

Over time, however, many of us have found ourselves in outpatient settings that require us to see many patients in strictly limited amounts of time, or inpatient settings that require rapid turnover and place particular emphasis on what the next medication change will be. These demands on our practice constrict our thinking about those we care for. We limit ourselves to inquiring about symptoms, side effects of medications, and any urgent or high risk issues. By doing so, we limit our ability to find out what really brings that patient into treatment, why he/she may want to get better, to do better, to be better. Moreover, we have little time to collaborate with others, much less the patient, to get the whole picture.

But we may be at a turning point as a consequence of current developments in mental health and medical care. In mental health care, the consumer movement has evolved over many years in response to the needs of patients and families to have a voice concerning the care they receive, in all types of treatment settings — emergency rooms, inpatient units, residential and school programs, and substance use treatment facilities. The delivery of services has already been meaningfully impacted by input from these patients and families, and further changes are likely. With respect to general medicine, patient-centered care is the watchword, with publications and programs abounding across the country. Donald Berwick, MD, head of the Center for Medicaid and Medicare Services, has been promoting this way of organizing and delivering medical care for many years. Now that he

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is in a position of national leadership, this focus is gaining widespread attention and acceptance. Another advocate of patient-centered care, Atul Gawande, MD, wrote in a recent article in the New Yorker entitled “The Hot Spotters” that we overlook the individual and community needs of our patients at our own peril. He described how care becomes fragmented and of limited benefit to the individual, as well as extremely costly. There is a tendency to repeatedly employ the same interventions despite poor results, without making changes based on the circumstances or wishes of the patient or the opportunities offered by alternative forms of intervention. By taking a patient-centered, outcomes-oriented approach, he illustrates how we can achieve better outcomes at lower cost.

So what does recovery-focused, person-centered practice mean for us as psychiatrists? For many, it may seem like going back to the roots of good psychiatric care; for others, it may be a new way of looking at the way we think about and provide care. Dr. Mark Ragins, Medical Director of the Mental Health Association Village Integrated Service Agency in Long Island Beach, California, has written and spoken eloquently on this topic, based on his over 20 years of experience working in community mental health. His approach comprises 10 guiding principles of care:

1) **Engagement and welcoming:** meet people where they’re at
2) **Person-centered planning and goal-driven services:** develop a shared story of the person’s life in addition to a history of their illness; identify strengths
3) **Sharing decision-making and building self responsibility:** develop a collaborative relationship, describe service choices in clear language, use peer driven services, focus the patient on identifying and learning from consequences of his/her decisions – “don’t waste suffering”
4) **Rehabilitation - building skills and supports:** assist with pursuing resources and opportunities besides individual treatment (e.g. psychiatric rehabilitation, psychosocial rehabilitation, clubhouses and peer support)
5) **Recovery-based medication services:** utilize goal-driven, rather than symptom-driven prescribing of medications so that taking medication is accepted as a means to rebuild a life, not just to improve symptoms. This enables self-help coping techniques, rather than competing with them
6) **Peer support and self help:** encourage participation in peer advocacy, peer support groups, 12-step programs, wellness plans, and other community-based resources

7) **Trauma-informed care:** focus on personal safety, boundaries, and avoiding recurrent trauma; in the institutional setting focus on reducing coercion, seclusion and restraints
8) **Spirituality and alternative approaches:** support healing in the context of the individual’s religious beliefs; collaborate in helping the patient finding meaning and his or her own place in the world
9) **Community integration and quality of life support services:** advise and advocate for access to benefits assistance; housing, education, and/or employment; and encourage finding a path toward inclusion in the life of a community
10) **Graduation and self-reliance:** build upon strengths, foster resilience, overcome fear of losing material and/or psychological benefits of the sick role, replace professional supports with personal supports, and fight stigma and discrimination.

The degree to which these principles apply to each of us clearly depends upon our type of practice and the kinds of patients we treat. But the challenge for all psychiatrists is to determine how to make our work more inclusive and collaborative, which will also make it more rewarding for us and more beneficial for our patients. This renewed emphasis on person-centered, recovery-focused treatment presents us not only with an opportunity to reinvigorate many of the foundational principles of modern psychiatric practice, but also with the possibility of playing a key role in the reorganization of health care service delivery more generally. As “carve-outs” are systematically replaced by various models of integrated health care delivery, there will be much we have to share with our medical colleagues concerning how to practice in a patient-centered, recovery-focused manner.

Marie H. Hobart, MD
President

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**Save the Dates!!**

**April 2, 2011**

**MPS Risk Management Update**

Massachusetts Medical Society, Waltham MA

**May 9, 2011**

**MPS Annual Meeting**

Doubletree Guest Suites, Waltham MA

Representative Ed Markey will be keynote speaker
Member-in-Training Corner
Kate Hobbs Knutson, MD

In the current setting of financial constraints and limited access to mental health care, an interesting system of integrating specialty psychiatric treatment and primary care has been developed. In the stepped care model, the appropriate amount and level of resources are provided to meet the clinical needs of patients. Within an integrated healthcare system, stepped care allows the patient’s clinical complexity to determine the level of specialization of clinicians assigned to care for the patient.

For example, in the stepped care model a patient with uncomplicated psychotropic medication needs would be managed by a Primary Care Clinician (PCC) alone. Mental health care for patients with more severe illness, psychiatric comorbidity and/or complicated medication regimens is “stepped up” for more specialized treatment by a psychiatrist. Similarly, complex cases that are stabilized by a psychiatrist would be “stepped down” to a PCC for long term management. Thus through stepped care, gone are the days of psychiatrists treating “simple” cases requiring only the q3 month Prozac prescription. Specialized psychiatric care would be reserved for more complex patients whose cases psychiatrists are specifically trained to manage.

In the stepped care model, decisions about clinical complexity of the patient, and therefore the level of medical resources the patient receives, are based on clinical rating scales for psychiatric disease, functional ability and social support. Therefore, patients with relatively uncomplicated mental illness who have poor functional capacity and limited social support may be treated medically by a PCC but receive additional therapy and case management services to address psychosocial needs. Furthermore, patients with moderately complex mental health problems may be managed by a PCC with direct guidance by a psychiatrist.

Understanding that the supply of psychiatrists is limited, reserving specialty psychiatric care for the most complex patients (i.e. those that cannot be managed by a generalist) is appropriate. Furthermore, allocating the most expensive specialty care to the most complex patients makes good economic sense in our current climate of financial limitations. The stepped care model requires the clinical infrastructure to support meaningful communication among providers and may be readily incorporated into proposed changes to the healthcare system including Accountable Care Organizations (ACOs). Core components of ACOs are a system of physicians working together to treat a population of patients and an electronic medical record supporting communication and coordinated medical care. The stepped care model may be a method of organizing and formalizing the process of providing psychiatric care within an integrated system such as an ACO.

The Intermountain Healthcare group in Salt Lake City, Utah has developed a Mental Health Integration (MHI) project incorporating depression treatment into primary care. When patients present to their PCC, the patient and his/her family complete a comprehensive mental health evaluation including clinical rating scales for mental disorders, functional ability and social support. Based on the initial evaluation patients are assigned to “routine care,” “collaborative care” or referral to a mental health specialist (Psychiatrist or psychiatric Nurse Practitioner). Routine care involves treatment by a PCC alone and is reserved for patients with uncomplicated depression and good social support and functional ability. Collaborative care includes medical treatment by a PCC, therapy and/or case management and possible consultation by a mental health specialist. Collaborative care is for patients with moderately complex depression or uncomplicated depression combined with poor functional ability and limited social support. Finally, patients with complicated depression and psychosocial stressors are referred to a mental health specialist who determines if the patient can be managed effectively within the primary care setting or should be referred to a community psychiatrist for ongoing mental health care. In this stepped care model, the patient’s clinical presentation determines the level of specialization of clinicians assigned to care for the patient with greater resources devoted to patients with more complex mental health needs.

The Intermountain Healthcare group collects data on quality and cost associated with the MHI project. An initial study compared patients treated in the MHI program versus usual care during a 12 month period following the diagnosis of depression. While the cost of mental health care for the MHI group was higher due to increased cost of therapy and filled psychotropic medication prescriptions, the overall psychiatric and general healthcare costs for the MHI group were reduced. The overall decrease in healthcare costs for the MHI group was thought due to decreased Emergency Department visits, lower general medical healthcare costs and to a lesser extent decreased use of inpatient psychiatric care. These are promising results for the MHI project and lend support to the stepped care model as an effective method of integrating psychiatric specialty treatment and primary care.

As the state and nation move forward on radical changes to the healthcare system, it will be important to develop methods of coordinating psychiatric care with the medical system in an efficient and cost-effective manner. If psychiatrists are to be responsible for caring for a greater number of patients with complex mental disorders, we need to ensure appropriate levels of clinical support. Within a model such as

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stepped care, psychiatrists also may have to relinquish responsibility for treatment that can be addressed as effectively by clinicians with less specialized training. Psychiatrists may have difficulty limiting their scope of practice in this way, but on the other hand we would be fulfilling a desperate need for treating complex psychiatric patients who are going without care or who are receiving substandard care in the current system. We are specifically trained to meet the needs of patients with complicated psychiatric disease and serve as a leader to other clinicians with less formal training. Developing meaningful ways of incorporating ourselves into the changing healthcare system is important for the survival of our field and the wellbeing of the patients we serve.

Sources:

Managed Care Update
Gregory Harris, MD, MPH, FAPA

E&M Codes
MPS and APA have been advocating non-discrimination for Psychiatrists who wish to use Outpatient E&M codes to better reflect medical-psychiatric work with sick patients. As previously reported, in September 2010, BCBSMA began to reimburse Psychiatrists for a range of E&M codes. MPS is strongly advocating with other providers, including UBH/HPHC, Tufts and MBHP/Medicaid. Medicare allows use of E&M codes by Psychiatrists; documentation requirements are available on the CMS web site.


In addition, the New York State Division of Insurance has ruled that restricting E&M codes violates state insurance and parity rules. MPS is advocating this position in Massachusetts and recently the APA submitted a letter of advocacy to the Divisions of Insurance of all 50 states.

For MPS members unfamiliar with outpatient E&M codes, the Managed Care Committee is planning to sponsor a CME course specifically about E&M codes specifically and more broadly about practicing under insurance.

BCBSMA:

BCBSMA recently changed their reimbursement policy for out

of network, as announced in a recent “FYI”. For MPS members who are in-network, this new policy changes nothing. The aims of this new policy are cost containment (they will pay the same for participating and non-participating providers) and to encourage providers to join the BCBSMA network. BCBSMA will be paying for services using their “usual and customary” formulation, with is constant across all products (with exceptions, such as Medicare, Medicare, VI, delineated in the recent FYI). In addition, they will now paying patients (NOT providers) for covered services.

We have advocated against this policy to no avail. We have received complaints from members about the implementation of this policy. If you are encountering difficulties, please contact us as we track the problem. In addition, we recommend that patients be directed to raise their concerns about this policy with both BCBSMA and with Massachusetts Office of Patient Protection (Mass OPP) at 1-800-436-7757 or opp.opp@dph.state.ma.us or http://www.mass.gov/dph/opp

UBH/HPHC:

UBH/HPHC will soon be making an announcement regarding alterations in authorization and reauthorization processes for this year. No authorization will be required for initiation of services (this was previously true for Psychiatrists, but not for other providers) and UBH will track “outliers” for reauthorization over time. Details are uncertain at the time of this writing, but UBH/HPHC will be making an announcement in the near future. We will be closely tracking these processes as they are announced implemented.

We continue to track complaints from members about UBH processes for continued approval of long-term psychotherapy services. If you are encountering difficulties, please contact us as we track the problem.

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

MPS is Pleased to Welcome the Following
New Members:

General Member:
Antonio E. Bullon, MD
Lucy Czarnota-Dolliver, MD
Chandlee Dickey, MD
Alison Fife, MD

Member-In-Training:
Nabil Ali, MD
Joan Albert Campodon, MD
Madhusmita Dhakal, MD

Juan Galvez-Buccolini, MD
Madhavi Kamireddi, MD
Lucy Tsirulnik-Barts, MD
Brown E. Hannah, MD
Joshua Haugh, MD
Brian J. Schulman, MD
Below is the slate of officers for the 2011/12 Election. I want to thank all of the MPS members who nominated candidates, and to all the candidates who have agreed to run for office. I would also like to thank the Nominating Committee (Chair Person: Theo Manschreck, Committee members: Jonathan Alpert, Brent Forester, Joe Jankowski, Paul Plasky, and Rohn Friedman) for their work on the Committee.

According to the Massachusetts Psychiatric Society Bylaws, additional nominations to those listed below may be made by a petition signed by twenty-five (25) or more members eligible to vote. The nominating petitions must be filed with the Secretary before a designated date, not earlier than twenty-one (21) days after the mailing of the newsletter or special membership mailing announcing the nominations of the Nominating Committee. This year, the petitions must be filed no later than March 15, 2011.

Members will be voting online beginning April 5, 2011 and will have 4 weeks to vote until May 3rd. The candidate information will be available online with the ballot. Members will be able to log onto the MPS Member’s Only page and select the link for the 2011 Ballot. If you do not have access to a computer, please contact the MPS office and we will make arrangements for you to cast your vote by paper ballot. By doing the online voting, we are able to save more than $5,000 in printing, mailing and tabulating cost.

**President:**
- Dr. Amy Lisser
- Dr. Alex Sabo

**Treasurer:**
- Dr. Phil Burke
- Dr. Sarah Langenfeld
- Dr. Nancy Reed

**Council:**
- Dr. Joe D’Afflitti
- Dr. Sheldon Benjamin
- Dr. Mark J. Hauser
- Dr. Ceil Mikalac

**APA Rep**
- Dr. Brian Palmer
- Dr. John Palmieri
- Dr. David Henderson
- Dr. Tony Rothschild

**Nominating Committee:**
- Dr. Stuart Anfang
- Dr. Rebecca Brendel
- Dr. Alan Brown
- Dr. David Harnett
- Dr. Gordon Harper
- Dr. Peggy Johnson
- Dr. Dost Ongur
- Dr. Paul Plasky

**MT Rep**
- Dr. Isis Burgos Chapman (BU)
- Dr. Daniel Karlin (Tufts)
- Dr. Jimena Tuis Elizalde (Baystate)
February 15, 2011

Re: Greater Boston Broadcast with Michelle McPhee

Dear Sir/Madam,

We are writing to express our strongest possible outrage and objection to the manner in which the serious issues surrounding the tragic killings of two human service workers were “allegedly” examined and discussed by Michelle McPhee on the Greater Boston Show, which was broadcast on February 1, 2011.

The inaccuracies reported by Michele McPhee were an embarrassment to WGBH and painful to watch. We cannot and do not expect every discussion or segment on Greater Boston to be “balanced” or even presented by “experts” on the topic. However, when the issues are as serious as the treatment of people with mental illnesses and the circumstances surrounding the separate incidents of the deaths of a young woman and a young man killed, allegedly by the very people they were caring for, knowledge of the facts is imperative.

In the approximately 12 minute segment Ms. McPhee repeatedly alluded to a young women being left alone with 27 men with violent backgrounds. Very dramatic – factually wrong. The group home, where the young woman worked, did not have 27 men; that was the transitional shelter where the young man worked and was killed. To be sure, both incidents were tragic and deserved discussion, but was it too much to expect that the person you select to “report” on these incidents at least know the locations of each and the gender of the victim? In addition, Ms. McPhee’s conflation of unrelated issues and the utter failure of the interviewer to correct her misstatements or to question any of her odd assertions further garbled this shameful piece.

Since she got it wrong on at least five occasions, we cannot help but suspect that Ms. McPhee either (1) had no interest in learning something about the incidents on which she was “reporting”; or (2) didn’t care since it was clearly more inflammatory to depict the tragic killing of this young woman as the consequence of being left alone with 27 violent men. We suspect it was number (2), but either way, she and that segment were an embarrassment to WGBH and, more importantly, a great disservice to the families of the victims as well as to serious issues that deserved examination and discussion.

Let’s be clear, we don’t care if Michelle McPhee is conservative or progressive, democrat, independent or unenrolled. We believe WGBH has every right – indeed an obligation – to provide broadcast time to people of all political beliefs. But we
expect discussions that are presented and introduced as “reports” to be factually accurate. This was not even close. As a result, viewers were presented with inflammatory inaccurate and an opportunity to rationally discuss two tragic deaths giving rise to serious issues was lost.

We know change is needed. We also know that efforts at reform which are spurred by the desire to prevent further deaths of this kind have great potential to improve safety and well-being of human services and our system of care, provided the reforms are based upon thoughtful and productive analysis and discussion of the facts. That did not occur on Greater Boston. Instead, inflammatory and wholly inaccurate misstatements were offered up as reporting.

We have always viewed WGBH as an oasis in a desert of noise and mediocrity. Perhaps that is why this segment was such a disappointment. You have enjoyed a well-deserved reputation for intelligent commentary and journalistic professionalism. The February 1st Greater Boston Show fell far short of that standard and your reputation, and it left us angry, disappointed, and, at least for the time being, former viewers.

Sincerely,
Bernard J. Carey, Jr., Executive Director
MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH, INC.

Cliff Cohn, Director of Operations
SERVICE EMPLOYEES INTERNATIONAL UNION – LOCAL 509

Vicker DiGravio, President & CEO
ASSOCIATION FOR BEHAVIORAL HEALTHCARE

Elena Eisman, Ed.D., ABPP Executive Director/Director of Professional Affairs
MASSACHUSETTS PSYCHOLOGICAL ASSOCIATION

Marie Hobart, MD, President
MASSACHUSETTS PSYCHIATRIC SOCIETY

Lisa Lambert, Executive Director
PARENT/PROFESSIONAL ADVOCACY LEAGUE

Laurie Martinelli, Executive Director
NATIONAL ALLIANCE ON MENTAL ILLNESS OF MASSACHUSETTS

David Matteodo, Executive Director
MASSACHUSETTS ASSOCIATION OF BEHAVIORAL HEALTH SYSTEMS

Reva Stein, Executive Director
MASSACHUSETTS CLUBHOUSE COALITION

Marylou Sudders, President & CEO
MASSACHUSETTS SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN, INC.

Barbara Talkov, Executive Director
CHILDREN’S LEAGUE OF MASSACHUSETTS

Cc: Emily Rooney
Last month, our mental health community was shaken by the death of Stephanie Moulton, a mental health worker with our partner provider North Suffolk Mental Health Association. We all grieve her loss and are deeply saddened for her family, friends, co-workers and clients who knew and worked with her.

Because we need to understand the factors in this very tragic death, I convened the Department of Mental Health (DMH) Task Force on Staff and Client Safety. Over the next three months, the Task Force will assess current policies and practices around safety and training for those who provide and receive Department of Mental Health services in the community.

The Department is committed to the safety of the dedicated workers who provide services and supports to DMH consumers in the community and in our hospitals and facilities. In light of recent events, I want to strengthen this ongoing commitment and be mindful of the importance of ongoing review and continual improvement of how we do our work and meet our challenges in our efforts to provide every opportunity for recovery for the individuals we serve.

I also remain committed to the vision of Community First and promoting the dignity and rights of people with mental illness to live in communities of their choice. The vast majority of individuals served by DMH live in the community. The Community First vision acknowledges that symptoms of mental illness rise and fall and our mental health system must be responsive to the changing levels of need that some individuals can experience. But ultimately, it is a home, a job, an education, relationships, social connections that people with mental illnesses want – it’s what we all want – and that is what Community First is all about.

The Task Force will be co-chaired by the Honorable Paul F. Healy, Jr., retired district court judge; and Kenneth L. Appelbaum, M.D., Professor of Clinical Psychiatry and the Director of Mental Health Policy and Research for the University of Massachusetts Center for Health Policy and Research. Task Force members are representative of all areas of the mental health community that have influenced the DMH community service system. This group is charged with evaluating specific aspects of the Department’s community system, including risk management practices, appropriate access to and utilization of criminal history information (CORI) and safety training and safety provision for provider staff. The Task Force will complete its review within three months and make recommendations for consideration.

I am pleased to have the following individuals participate on the DMH Task Force on Staff and Client Safety:

- Ira Packer, Ph.D., ABPP (Forensic), Clinical Professor of Psychiatry at University of Massachusetts Medical School and Director, Mobile Forensic Evaluation Service, DMH Central-West Area, central region
- Derri Shtasel, M.D., M.P.H., Director, Adult Ambulatory Psychiatry, Massachusetts General Hospital (Massachusetts Psychiatric Society)
- Eva Skolnik-Acker, LICSW, National Association of Social Workers, Massachusetts Chapter
- Jessel Paul Smith, Consumer Youth Advocate for M-POWER
- Tina Adams, Ph.D., DMH Central Office, Manager of Juvenile Forensic Services
- Matthew Broderick, DMH North County Site Director
- Jonathan Delman, J.D., M.P.H., Executive Director, Consumer Quality Initiatives
- Vicker V. DiGravio III, President/CEO, Association for Behavioral Healthcare
- Barbara (Babs) Fenby, Ph.D., DMH Northeast-Suburban Area, Director of Community Services
- Ellen Flowers, Tewksbury Hospital, DMH Hathorne Units, Director of Nursing
- Phil Hadley, Representative of the National Alliance on Mental Illness of Massachusetts
- John Labaki, SEIU 509 Chapter President representing the Department of Mental Health
- Nancy Mahan, Director of Mental Health Services, Bay Cove Human Services Inc
- Regina Marshall, J.D., DMH Chief of Staff
- Marilyn Wellington, Esq., Executive Director, Board of Bar Examiners
- Michael Weekes, President/CEO, The Massachusetts Council of Human Service Providers, Inc.
- Anne Whitman, Ph.D., President, Jonathan O. Cole Mental Health Consumer Resource Center Board of Directors
The Task Force will also have legislative representation. Senate President Therese Murray and House Speaker Robert A. DeLeo will each recommend a member of the Senate and the House of Representatives to serve on this group.

As the Task Force co-chairs begin the task of organizing the group and scheduling meetings, DMH staff will support the work of the group. We are very fortunate to have this group of expert and experienced individuals commit their time and energy in service to improving our system and ensuring that individuals with mental illness and the dedicated workers who provide care and services are of our highest priority. I will keep you apprised as this important effort moves forward.

Thank you.
Commissioner Leadholm

News from the Executive Director

The MPS continues to be a very active organization. In February we held our Chairs and Council meeting. There are so many new and interesting committees that are working hard for the Society.

- The Alcoholism and the Addictions group is meeting on March 9th and the topic will be “Alcohol Use Disorders after Bariatric Surgery”.
- On March 9th the MPS Awards Committee will be meeting to determine this year’s awardees. The Awardees will be announced in April.
- The Distinguished Fellowship Committee will be meeting to review potential candidates for this distinction on March 16th.
- The Public Sector Committee will be pulling together a group who want to work on the issue of Outpatient Commitment. If you are interested, please let me know. The Public Sector Committee meets every third Thursday of the month (3/17) at 25 Queen Street, Worcester on the 5th floor. If you are interested in attending the meeting, just let us know.
- The Women’s Committee is meeting on March 25th and the topic will be “Sleep and Psychiatry: An update on Insomnia Management.”
- The Geriatric Committee is having a program on March 30th entitled “Sleuthing the Triggers of Troublesome Behaviors in Patients with Dementia.”
- On April 2nd we will be having our Annual Risk Management Program at the Mass Medical Society. You may register online or by calling the office.

- The Consultation Liaison Committee is sponsoring a program on April 28th presented by Dr. Ron Pies who will discuss “Psychopharmacologic Treatment of Complex Medical Patients”. The Committee will start to offer programs on a quarterly basis starting in September.
- On May 9th the MPS will have its Annual Meeting at the Doubletree Guest Suites in Waltham. Representative Ed Markey will be our keynote speaker. Please plan to join us.
- The By-law committee presented a couple of changes that the MPS Council will consider at the March meeting and if needed they will be included in the Election materials.

The MPS election will begin on April 5th and run through May 2nd. We will be doing the elections online again this year. Elsewhere in this newsletter we have printed our slate of candidates. The Nominating Committee did an excellent job in soliciting candidates for this year’s election. It is wonderful to see so many Early Career Psychiatrists willing to run for office.

We would also like to congratulate Dr. Ben Liptzin who is the 2011 Jack Weinberg Award recipient for Geriatric Psychiatry from the APA.

As you already know the Governor has filed his Payment Reform legislation. On the MPS website legislative page you will find the goals of the legislation, a section by section analysis and a copy of the legislation itself.

Many of you may have heard the Greater Boston program recently on WGBH with Michelle McPhee and felt the same outrage as many of the members expressed to the Executive Committee and the Council. With other members of our coalition, a letter was written to express our concern. A copy of that letter is also in this newsletter.

We have printed a letter from Commissioner Leadholm who is setting up a DMH Task Force on Staff and Client Safety. Through Dr. Hobart’s intervention with the Commissioner, the MPS was successful in getting an additional Psychiatrist added to the Task Force.

On March 4th, Dr. Hobart presented testimony on the 2012 State Budget. Her testimony is included in this issue for your information.
My name is Marie Hobart, MD. I am president of the Massachusetts Psychiatric Society, which represents over 1600 psychiatrists statewide. Our Society is a district branch of the American Psychiatric Association.

Once again we come before you knowing that the Commonwealth is facing another fiscal year with severe financial constraints. The budget shortfall is exacerbated by the repeal of the sales tax on alcohol that funded many addiction programs; the absence of the American Recovery and Reinvestment Act (ARRA) funds; as well as substantial deficits in the Mass Health program. Nonetheless, the overall budget submitted by the governor is 1.7 billion dollars above last year’s budget.

We do not expect that any programs that receive state funding will be exempt from scrutiny as you search for ways to limit spending. However, we feel strongly that portions of the budget that have been held harmless these past several years be treated in the same fashion across the board as those areas that have experienced significant and repeated cuts again this fiscal year.

We make this request because we believe that EOHHS agencies as a whole, and DMH funded agencies in particular, have already been cut to the barest levels. DMH clients have lost inpatient services; yet community rehabilitation programs have also been closed. Because both inpatient and outpatient services have become so difficult to access for so many, a growing number of patients end up in emergency departments. Despite this, the Governor proposes another 21.4 million dollars of cuts, which would cause the closing of clubhouse programs and an additional 160 inpatient beds, further squeezing service provision on both the inpatient and outpatient sides. Moreover, an additional 2 million dollars in cuts for flexible services for children is also being proposed.

It is our firmly held belief, supported by decades of mental health services research, that these cuts will ultimately not save the state any money at all. When severe mental illness is not adequately treated, it does not go away, it gets worse. Our patients who drop out of treatment because of lack of service availability will end up in crisis situations necessitating emergency care, and many will end up in the criminal justice system. We are already operating with the bare minimum of services necessary to meet the needs of the mentally ill citizens of the Commonwealth; any further service reductions will inevitably result in rising long-term costs to the state and increased suffering for our patients and their families.

We know that additional beds will be closed during the course of FY12 in order to prepare for the opening of the new state psychiatric hospital in Worcester. Let me say that we are very pleased with the development of this state-of-the-art psychiatric facility, of which the Commonwealth should be quite proud. We are concerned, however, that more funding may be taken from community services in order to fund the new facility, and this we would find unacceptable. With fewer total inpatient beds available, the Commonwealth must fully fund the community system of care so as to facilitate patient adherence to treatment. Successful community-based treatment is needed to limit the number of patients who would otherwise require more costly emergency and acute inpatient care.

The Retained Revenue Accounts within several of our DMH facilities are a potential source of funds to sustain DMH services. These funds are monies that are generated by those facilities in excess of operating expenditures. We ask that you consider keeping those funds within the DMH system to mitigate some of the cuts to DMH rather than allowing them to revert to the general fund. By utilizing funds generated by these facilities for other DMH programs we will be able sustain these programs for the benefit of our patients, their families, and the Commonwealth.

These challenging fiscal times call for creative approaches. In this regard, I would point out that one of the most costly items for the state concerning the care of the seriously mentally ill are brand name antipsychotic medications, which come out of the Mass Health pharmacy budget. Given that the medical evidence for the marginal benefit of these medicines relative to generic antipsychotics is nowhere near the increase in cost, we believe that there could be some savings in this area without a major impact on treatment outcomes. We further propose that these savings be directed toward funding for clinical services. In addition, we note that despite the proposed cuts to clinical services within the DMH budget, there is actually a small increase in the administrative budget. Would it not be more reasonable to preserve funding for direct services and figure out how to manage administrative functions more efficiently?

Thank you for inviting me here today. I look forward to further dialogue with state government officials to help achieve our mutual goal of providing the best and most cost-effective public mental health services to the citizens of the Commonwealth.
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As a service to Bulletin readers, we offer one free 15-minute consultation to discuss any general legal concerns.

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.

Kerstein, Coren & Lichtenstein, LLP
60 Walnut St.
Wellesley, MA, 02481
KCL-law.com
(617) 969-7139

For Psychiatric Billing Services to the Mental Health Community

**OFFICE SPACE**

**Brookline-Weekday, Saturday & Evening**

Hours - Coolidge Corner/Beacon Street office space available for rent in 4, 8 or 12 hour slots. Saturdays also available. High speed internet/wifi and printer included. T and handicap accessible. On street parking. Call or e-mail: Gregory G. Harris, MD, MPH 617-983-0076 gregoryharris@sprynet.com

**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 full or part time physician to help with the excess of referrals we currently have to turn away! 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.

**Adult Psychiatrist**

Exceptional opportunity for Adult psychiatrist to join thriving psychiatric practice with well established referral base. Warm collegial atmosphere. Conveniently located within easy access to Rt. 128 and Mass Pike.

Contact in confidence Tanya Yanovsky, M.D. at 781-893-8762 or tyanovsky@bospysych.com

**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 chrisgordon@advocatesinc.org.

**BROCKTON, MA.** 40-hr position for BC/BE* psychiatrist in Joint Commission accredited 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 nightcall. 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.
Unique Career / Financial Opportunity
The Figman Psychiatric Group is a multidiscipline, for profit, outpatient clinic in the Raynham Woods Medical Center (near Rts 24, 95, 495) with over 2,000 active patients and, on average, fifteen to twenty new referrals each week. I seek a highly qualified, energetic psychiatrist with entrepreneurial skills and a long term vision to become a partner and within ten years, as I retire, owner of the practice. Contact Robert Figman, M.D. at nfigman@gmail.com or 617-201-8935 to learn of a very lucrative, creative financing plan resulting in ownership. This is not an offer to sell the practice.

Exceptional Professional Opportunity for psychiatrist to provide high quality care as part of a well respected multi-disciplinary 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 scppcmd@yahoo.com

CHIEF OF PSYCHIATRY - TEWKSBURY HOSPITAL
Northeast Psychiatric Group, PC seeks Chief of Psychiatry for Tewksbury Hospital, a Joint Commission certified public sector facility. The primary responsibility is leadership of a well-respected 9 person group practice providing continuing psychiatric inpatient care to DMHN eligible patients transferred from acute psychiatric units, and also to a smaller number of forensic patients. The Chief will oversee the clinical care of all psychiatric patients, and will share responsibility for risk management, quality management, utilization review, clinical improvement, and policies and protocols with the leadership of Tewksbury Hospital and the DMH Northeast Suburban Area. The Chief will also be involved with the hiring, credentialing, scheduling and supervision of staff psychiatrists and psychologists, and will also assure timely medical documentation and accurate billing records. Provision of direct care will occupy a small percentage of time. Applicants must be board-certified in psychiatry, and have both clinical and administrative experience.

Visit www.polarishealthcare.com for more info. Please email CV and letter of interest to Sheila Schwab at sheschw@attglobal.net or mail to Polaris Healthcare Services, Inc. 262 Beacon St. 5th Floor, Boston, MA 02116.

PSYCHOLOGICAL CARE ASSOCIATES, p.c.
Child/Adult Psychiatrist sought to join our group of 11 psychiatrists (3 child & 8 adult). We are a multi-specialty practice of 70 professional staff, with offices in Arlington, Woburn, Stoneham & Tewksbury. Since 1994, we have built a busy, well-managed, financially stable private practice group with great colleagues, low turnover, and close, collaborative relationships with the Primary Care Physicians whose patients we serve. We provide the administrative, marketing, billing and back-office services, as well as excellent administrative support necessary to run a successful, efficient practice, leaving our doctors free to focus on treating patients. Schedules are full, compensation is very generous; the working environment is collegial and offices are professional furnished and warmly appointed. If interested, contact:

Michael F. Jacques, Ph.D., Director Psychological Care Associates, p.c.
12 Alfred Street, Suite 200
Woburn, MA 01801-1915
mjacques@psycare.info, Tel: 781.646.0500 x 110
Fax: 781.646.7130

UMass Addiction Psychiatry Fellowship
NEW POSITION. The UMass Addiction Fellowship in collaboration with the Bedford Veterans Center for Addiction Treatment (VCAT) has expanded and has an immediate opening for one fellow to start on July 1, 2011. This fellowship program has affiliations with different private, public and federal sectors such as Adcare Hospital, Spectrum Health Systems, Community Healthlink and Bedford VA Hospital, that not only offers the fellow exposure to patients with a broad range of substance use disorders, but also prepares the fellow to be competent to succeed in highly demanding settings. Interested persons should contact: Gerardo Gonzalez, MD, Director of Addiction Psychiatry Fellowship Program Department of Psychiatry University of Massachusetts Medical School 365 Plantation Street, Worcester, MA 01605 or email gerardo.gonzalez@umassmed.edu. AA/EOE
Starting this Fall, The PINE Psychoanalytic Center is pleased to introduce our New CLINICAL FELLOWSHIP PROGRAM

A unique one-year program of training and supervision in intensive psychotherapy for adult, adolescent, and/or child clinicians

Combining a year of individual supervision with weekly seminars led by PINE faculty, this Fellowship offers clinicians a rare opportunity, within a supportive collegial community, to explore the diverse landscape of psychoanalytic ideas and techniques while at the same time deepening and enlivening their ongoing clinical work.

The Fellowship begins this fall and includes 30 weeks of evening seminars, 30 hours of individual supervision by PINE Faculty, membership in the PINE Society, participation in PINE Psychoanalytic Center activities, access to the PEP online library, and up to 60 continuing education credits.

Tuition is $2,700 (including supervision). Enrollment is limited. Financial assistance is available.

The PINE Psychoanalytic Center is pleased to announce our Spring Scientific Meeting

EXPLORATIONS OF THE ANALYST’S MIND AT WORK: THE PATIENT SAID... WHAT DID THE ANALYST HEAR?

DATE: Saturday, March 19, 2011

APPLICATIONS DUE: Friday, March 4, 2011

FEE: $50, with a $35 discount for PINE members

PINE Psychoanalytic Center’s Annual Spring Open House

Full Psychoanalytic Training and Clinical Fellowship Program

Wednesday, March 9, 2011, 8 p.m. — 9:30 p.m.

PINE Psychoanalytic Center’s Candidate Panel Presentation

Monday, March 21, 2011, 1:30 p.m. — 4:30 p.m.

At The Learning Center C & D, Cambridge Hospital

WE ARE ALSO PLEASED TO INVITE YOU TO

PINE Psychoanalytic Center’s Annual Spring Open House

Full Psychoanalytic Training and Clinical Fellowship Program

Wednesday, March 9, 2011, 8 p.m. — 9:30 p.m.

PINE Psychoanalytic Center’s Candidate Panel Presentation

Monday, March 21, 2011, 1:30 p.m. — 4:30 p.m.

At The Learning Center C & D, Cambridge Hospital

Please call Alice Rapkin at the PINE Psychoanalytic Center Office (781-449-8365) for further information.

Classified Listings—March 2011

Cambridge Health Alliance

Psychosomatic Medicine Fellowship

Cambridge Health Alliance, Cambridge, MA

Harvard Medical School

2 positions, available July 2011.

The Fellowship is a 1-year ACGME approved program for a PGY V psychiatry providing training in the delivery of psychiatric consultation in a community general hospital as well as to a culturally diverse array of patients in primary care clinics.

Specialty training in Women’s Health, Addictions and Behavioral Medicine is also available. Cambridge Health Alliance’s unique blend of community and academic resources offers exceptional opportunities for professional growth. Responsibilities: direct patient care; supervision of psychiatry and primary care residents and medical students; developing an academic project. Contact Robert Joseph, MD, Director, Consultation-Liaison Psychiatry, 617-665-1544, email Robert_joseph@hms.harvard.edu, fax 617-665-2521.

Be Mentally Well
Understanding & Treating Depression

The University of Massachusetts Medical School/UMass Memorial Healthcare Department of Psychiatry is pleased to announce its next Be Mentally Well series of educational events with “Understanding and Treating Depression” on Tuesday, March 15 from 6:30 to 8:30 p.m. in Amphitheater I at the University Campus.

Topics to be addressed include

• Recognizing the signs and symptoms of depression
• Treatments for depression
• Depression in the elderly
• Doing well and feeling better

The event is free and open to the public. To register or for more details call (508) 856-3066 or email Diana.langford@umassmemorial.org or visit http://www.umassmed.edu/Psychiatry/Depression.aspx

Community Counseling of Bristol County

Community Counseling of Bristol County is a full service mental health center serving southeastern Massachusetts. We seek the following professional:

Psychiatrist

Join our innovative team with an opportunity to provide services in our center serving the Taunton, MA area. Duties include diagnostic evaluations, medication management and consultation in our adult outpatient clinic and our emergency services program. Must have MA licensure.

Excellent reimbursement package, comprehensive benefits; flexible schedule and training opportunities.

Please send resumes to:

Andrew Dawley, LICSW
Community Counseling of Bristol County
One Washington St., Taunton, MA 02780
Email: ADawley@comcounseling.org
AAEDE

www.comcounseling.org
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

American Professional Agency, Inc.

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

www.apamalpractice.com

and select the link for the American Psychiatric Association members.
### MPS Calendar of Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>Contact Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>March 8th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Alcoholism and the Addictions Group</td>
<td>March 9th</td>
<td>6:30 PM</td>
<td>Boston Medical Center, Menino Pavilion, 2nd floor, Conference Room C</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>MPS Awards Committee</td>
<td>March 9th</td>
<td>6:45 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Managed Care Committee</td>
<td>March 15th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Fellowship Committee Meeting</td>
<td>March 16th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Public Sector Committee</td>
<td>March 17th</td>
<td>6:30 PM</td>
<td>25 Queen Street, 5th Floor, Worcester</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Women’s Committee</td>
<td>March 25th</td>
<td>12:00 Noon – 2:00 PM</td>
<td>MPS</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Executive Committee</td>
<td>March 29th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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<tr>
<td>Geriatric Committee</td>
<td>March 30th</td>
<td>8:00 PM</td>
<td>MPS</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Risk Avoidance &amp; Risk Management Update</td>
<td>April 2nd</td>
<td>8:30 AM</td>
<td>Mass Medical Society</td>
<td><a href="mailto:mpatel@psychiatry-mps.org">mpatel@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Veterans Affairs Committee</td>
<td>April 6th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
</tr>
<tr>
<td>Psychopharmacologic Treatment of Complex Medical Patients</td>
<td>April 28th</td>
<td>7:00 PM</td>
<td>MPS</td>
<td><a href="mailto:bdupuis@psychiatry-mps.org">bdupuis@psychiatry-mps.org</a></td>
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</tbody>
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**North Shore–Northeast Hospital Corp**, a local nonprofit 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.