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mind matters

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President's Message

Ryan Finkenbine, MD



Ryan Finkenbine, MD


The Illinois Psychiatric Society has been busy this winter. We should be proud of our recent accomplishments and efforts to continue to meet our mission of advocating for the highest quality care for patients with psychiatric disorders. IPS leadership began last summer with the development a strategic plan. After careful consideration and a great deal of meaningful dialogue, the Council members arrived at three important objectives.

The first, to increase member and nonmember engagement, highlights our intent to expand the reach of IPS through active involvement with psychiatrists throughout the state. Part of this reach will depend on our ability as an organization to remain at the forefront of change and to address shared concerns head-on. Daniel Yohanna, MD, Chair of the Recruitment and Retention Committee, has led the effort to meet this objective through the creation of an awareness campaign and through recruitment of new, active members. The results of these efforts have been promising thus far and include a drive for increased membership from new training program graduates and better engagement with the current members.

A second strategic objective is to enhance our relationship with consumer, political and professional organizations. IPS has had a major positive impact on patients, families and clinicians in communities throughout Illinois. Yet because much of the work occurs behind the scenes, our efforts sometimes go unrecognized. IPS is the largest member organization, with over 1100 individuals, representing psychiatric and patient interest in the state. We believe it is important to collaborate with other like-minded organizations that share common interests. All

parties will benefit from better communication, collective planning, and joint implementation of the many programs and initiatives sponsored by IPS. The Public Affairs Committee Chair, Lisa Rone, MD, will be assisting Council members to meet this objective as we identify partner organizations and reach out to our state legislative representatives.

The strategic plan's third objective is to improve access to quality mental health care. Limited access to care has been, in part, due to a shortage of psychiatrists. But IPS leaders recognize that improving access must not devolve to simply diluting care through lesser trained or experienced clinicians. The role of psychiatry must remain present and available to those with all forms of mental illness. The strategic plan includes identifying expertise among the membership such that patients and other providers may readily get the help they need. Likewise, we intend to generate a list of IPS members who are accepting new patients and, with member permission, make it available to the public. Efforts to meet these two goals are being led by Vinod Alluri, MD, and Dr. Yohanna, Co-chairs of the IPS Access to Care Committee. We anticipate sending a survey to members to learn more about their practices, while also asking about the challenges faced today in providing clinical care. Finally, our immediate IPS Past-President, Jeffrey Bennett, MD, has already begun to lead the effort to meet a third goal to help improve access to quality care. This goal will involve the creation of a state-wide CME program that will be offered to non-psychiatrists. By enhancing the psychiatric knowledge and skills of primary care providers, IPS will have a positive impact in increasing access while maintaining high quality.

As a final note, I extend thanks to Betsy Mitchell, our new legislative advocate who joined us in the fall, for her terrific work on behalf of IPS. Ms. Mitchell, who brings a wealth of experience with over 30 years in the field, has already been instrumental in guiding us through the morass of continuing and new legislation. 

Women's Committee Brunch Discusses Impact on Microaggressions on Mental Health

Georgina Srinivas Rao, MD

The Illinois Psychiatric Society's Women's Committee met through the past year to discuss its objectives and goals. The Committee has been hosting a yearly brunch taking on topics that impact women and is chaired by Dr. Aida Mihajlovic. This year the American Psychiatric Association's Division of Diversity and Health Equity Chair Ranna Parekh MD, MPH provided a very pertinent lecture on microaggressions on November 20, 2016 at the East Bank Club.

Dr. Parekh noted that many advances have taken place in the recognition and treatment of women's mental health, which is impacted by biology and experience. Premenstrual dysphoric disorder has been placed in the DSM V while more recognition and treatment of conditions impacted during the perinatal and postpartum periods are evident. In addition, perimenopause and postmenopausal stages of the women's lifecycle are also seen as a potentially vulnerable time for some women. The course of treatment is also heavily influenced by specific hormonal and physiological differences as well as gender specific differences in drug absorption, bioavailability, metabolism and elimination of psychotropic medications.

Mental health needs are impacted by medical, social and developmental history. Psychosocial life events heavily influence the course of an illness and its recovery. Negative life events such as childhood abuse and neglect, rape, domestic abuse, poverty, care giving responsibilities of multiple children or family members, divorce or widowhood and medical illness are significant risk factors. Indeed, mental disorders such as eating disorders, major depressive disorders, some anxiety disorders, seasonal affective disorder, posttraumatic stress disorder and somatoform disorders have a higher prevalence in women than men.



Special Guest Speaker, Ranna Parekh, MD with Aida Mihajlovic, MD

Dr. Parekh went on to define terms such as micro aggressions and micro insults. Dr. Chester Pierce first defined this term in 1970 through his experiences as a black man during the time of Jim Crow. They were a subtle form of racism that are "subtle, stunning, often automatic, and non-verbal

exchanges". Micro aggressions are acts that infringe on a person's time, space, energy, mobility and include verbal exchanges. They include conscious and unconscious micro-prejudices. The cumulative burden of lifetime exposure to micro-aggressions can contribute to physical illness and flatten self confidence. The term has been further broadened to minority groups and the "others".



From Left: Martha Zuehlke, MD; Margery Johnson, MD; Shannon Gritzenbach, MD; Laura Lee Anders, MD; Saba Syed, MD

Micro-aggressions have been further categorized. Micro-inequities were defined by Dr. Mary Rowe in 1974 as "apparently small events, often ephemeral and hard to prove, events that are covert, often unintentional, frequently unrecognized by the perpetrator, which occur wherever people are perceived to be different." Examples of micro-inequities include some employees being favored over others and receiving more favorable work schedules or opportunities than others.

In 2004 Dr. Derald Wing Sue expounded on terms such as micro-assaults, micro-insults and micro-invalidation. Micro-assaults are conscious, explicit derogation characterized by verbal/nonverbal attack meant to hurt the intended victim through name calling, avoidant behavior or purposeful discriminatory action. On the other hand, micro-insults are unconscious communications that convey rudeness and insensitivity and demean a person's gender. "You are beautiful and smart" may be an example of this. Micro-invalidations are unconscious communications that exclude, negate or nullify the psychological thoughts, feelings or experience of a woman. An examples of this may be a woman being told she is being too sensitive when she brings up an experience of discrimination.

The health impact of microaggressions and perceived discrimination may be based on mental and physical health outcomes that are a result of the stress response and health behaviors. Social support, active coping styles, and group identification serve as protective functions in these stress pathways. Elizabeth Pascoe et al published in Psychological bulletins in 2009 a meta-analytic review of the impact of discrimination and the protective factors.

Core Competence

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Independent Living

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The group that attended this lecture went to learn and discuss strategies for addressing micro aggressions. Recognition of micro-aggressions committed against you and by you is essential, followed by understanding the bystander recognition. A call for self-respect was also identified as needed to overcome prejudice at work. Reflection and processing of experiences helps in formulating a response and strategy to address microaggressions and to build resiliency. Reality testing the microaggression helps in providing perspective followed by addressing it appropriately. Build resiliency through support networks, education and training, mentorship, sponsorship, focus on self-care and affirming other women.

Building micro-affirming environments are those that have consistent and appropriate affirmation, modeling of healthy behaviors, morale and productivity, the new IQ (inclusion quotient) and re-message diversity and cultural competency. Dr. Parekh spoke to an enthusiastic crowd that were interested in further discussions on strategies to build micro-affirming environments. She suggested assessing potential for change, implement sustained change and that it requires patience and practice. The APA also has initiatives such as Council on Minority Mental Health and Health Disparities,



From Left: Andrea Mann, MD; Angela Shrestha, MD; Danijela Stojanac, MD; Laura Craig, MD; Jennifer Sprague, MD

Caucus for Women Psychiatrists, Best Practice Highlights, Cultural Competence webpage, mentorship and scholarship programs.

Many were enlightened and inspired by Dr. Parekh's timely and relevant talk which concluded with this: "You must be the change you wish to see in the world." -Mahatma Gandhi

Legislative Update

Betsy D. Mitchell, IPS Legislative Consultant

Waiting on IDFPF Response

A response from the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation is anticipated any day regarding a joint letter from ISMS and IPS commenting on our concerns to their proposed clinical psychologist prescribing proposed rules. As outlined in our previous IPS newsletter, our concerns primarily addressed some of the proposed rules extend past the legislative intent. We remain hopeful that IDFPF will respond favorably to our concerns. Please stay tuned for more information on this vital issue.

IPS on 1115 Waiver Working Group

Last fall when IPS leadership met with HFS Director Felicia Norwood, she invited IPS to participate in the recently created 1115 Waiver Working Group on behavioral health. This working group functions to outline the behavioral health system in Illinois. The waiver is the result of 12 state agencies working together to create an advanced planning document for mental health policy in Illinois. IPS Co-Chair of the Access to Care Committee and Past President, Dr. Dan Yohanna and IPS Executive Director Meryl Sosa are representing IPS on this important committee. Watch for their updates.

Newly Introduced Legislation

On Wednesday, January 11, the 100th General Assembly was sworn into office which signaled the beginning of new legislation to be introduced. Hundreds of bills (that will turn into thousands of bills) have already been introduced. The IPS Governmental Affairs Committee is busy reviewing all bills that could impact psychiatrists and/or mental health patients in Illinois. Some of the expected legislative

issues to be considered during this year include:

- Comprehensive behavioral health legislation
- Changes to Telehealth
- Possible changes to Workers' Compensation as it relates to physicians
- Scope of Practice Issues
- Medicaid Reimbursements and Possible Rate Increase
- Parental Cyber-bullying
- Sobriety and Drug Monitoring Program
- Creation of Network Adequacy and Transparency
- Budgetary issues

Advocacy is Essential

Effective advocacy is key to the success of any organization. For an organization to be effective, it depends upon each member to have an effective working relationship with their legislator. Do you know who your legislator is? Do you have a good relationship with your legislator? If not, contact me and we can discuss how you can become an effective advocate for your profession. I am always eager to help you get to know your legislator, and more importantly, how you can help your legislator learn more about what it takes to be a psychiatrist, what you do for patients in need of mental health, and what this state would look like without you in it.

One quick way to meet your legislator is to come to Springfield, IL and join other IPS members for the 2017 IPS Advocacy Day on Wednesday, April 5, 2017. The day will begin with a Legislative Briefing before heading to the Capitol to meet with legislators, staff and other public officials.

For more information on any legislative matter, never hesitate to contact me: Betsy@cook-witter.com

IPS CALL FOR EXPERTISE

IPS is interested in learning about its members' experience and expertise. One of our strategic goals this year is to enhance our relationships with consumer, political and professional organizations. IPS shares common interests with many state organizations, some of whom have reached out to us for assistance, education, or referrals. We hope to identify IPS members with specific expertise who are willing to be connected with outside organizations to act as a liaison. So, if you have experience or expertise in a clinical, administrative, political, community, fundraising, outreach, spiritual, social, or subspecialty and are interested in helping IPS reach out to our community partners, please email Kristen Malloy at kmalloy@ilpsych.org. (Of course, approval will be obtained from IPS members before we make the connection).

Guns, Rights, Safety & Stigma: Where Should We Stand?

Firas A. Nakshabandi, MD

CEO & Founder of Empathic Resonance, LLC

Under federal law, anyone with a history of involuntarily hospitalization for psychiatric reasons is permanently barred from possessing a gun. However, in September of 2016, the U.S. Circuit Court of Appeals for the Sixth Circuit ruled that the law in question was unconstitutional.

The case centered around Clifford Tyler, who, in 2011, was prevented from purchasing a gun after a background check revealed he had been committed to a psychiatric hospital twenty-five years earlier. How might this ruling potentially affect mental health professionals, and what role do we have to play in the latest gun law debates?

The subjects of gun control and gun violence remain some of the most contentious topics in the United States. Trying to balance the Second Amendment right to bear arms with the need for increased security in light of the ever-increasing incidents of gun violence can seem like an impossible task, especially with people so passionately aligned on one side of the argument or the other. Those in favor of tighter gun restrictions will point toward statistics and studies linking higher incidents of violence and harm to self or others with easier access to guns, while those opposed argue that besides a Second Amendment right to bear arms, easier access to guns would act as a deterrent to mass shootings and other gun related violence. As a mental health professional, it is interesting to note that complicating this argument (as is the case for most divisive issues) is the pre-existing human tendency for confirmation bias: the tendency to interpret new evidence as confirmation of one's preexisting beliefs or theories. In other words, no matter how many studies or evidence one might provide for an opinion, the mind will selectively choose data that is already in line with what one holds to be true, and filter out any "noise" in the form of data that is contrary to the already held belief.

That being said, a major requirement for any mental health professional to be effective is the capacity to collaboratively tackle an issue by considering an argument both for and against it through empathy, respect, and a genuine consideration of the opposing points of view. And perhaps with this in mind this latest ruling is likely to cause ambivalence in the psychiatric community, as discussed in an excellent article by Dr. Paul Appelbaum, a former President of the APA and the Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law at Columbia University.

As he points out in the article, on the one hand mental health professionals and organizations predominantly favor tighter gun restrictions, but on the other hand they also actively favor combating stigmatization of mental health

patients. These two goals may seem at odds with each other when considering restoring gun rights to patients with a history of mental health issues.

Another likely cause for ambivalence, according to Dr. Applebaum, is that any demand for psychiatrists and psychologists to become involved in determining when it is safe to restore access to firearms has implications for liability, adverse publicity and even sanctions should an incorrect determination be made.

So how involved should we be? Dr. Maria Oquendo, current President of the APA, argues psychiatrists should take action. As she points out, even though guns kill people in mass shootings and homicide, the majority of people killed by guns are in fact killed by suicide. She argues a key step in advocating for gun safety is making sure firearms are kept safe and secure, and that the laws so far have been lacking in efficacy. She also brings attention to the fact that Florida currently forbids physicians from having general conversations counselling patients about gun ownership, and 10 other states are introducing legislation to restrict a doctor's ability to counsel a patient about gun safety, although she does point out there is no law preventing a doctor from asking about gun ownership if it is relevant to the safety of the patient or others.

Which brings us back to the case at hand. Briefly, part of the argument in favor of restoring gun rights in this case was trying to establish risk for someone who had a single psychiatric admission twenty-five years ago. Mental health professionals base risk assessments on specific risk factors, which, in the case of suicide, include things such as previous attempts, recent loss, family history and easy access to lethal means. Whereas limiting access to firearms would limit a specific risk factor (i.e. lethal means), the risk assessment is done on a case by case basis, takes diagnosis and multiple other factors into account, and is also time limited (as it is impossible to definitively predict another person's behavior). This is in contrast to laws on access to firearms that tend to lump people into much larger groups (legally termed "classes") who might be at a higher risk to use guns illegally. These include convicted felons, fugitives from justice, and most relevant to this case: people who are "adjudicated as a mental defective or committed to a mental institution." And while it is true there may be an increased risk of using a gun to harm oneself or others based on our previously discussed risk factors, the risk is by no means universal, and it decreases with time.

With that in mind, one could argue placing a lifetime ban on someone who had been admitted involuntarily to a psychiatric facility regardless of why or how long ago seems excessive, especially as the thresholds for admission have become increasingly lower.

Finally, there is the issue of stigma. A huge stigma is already associated with mental illness and people are loath

(continued on page 14)

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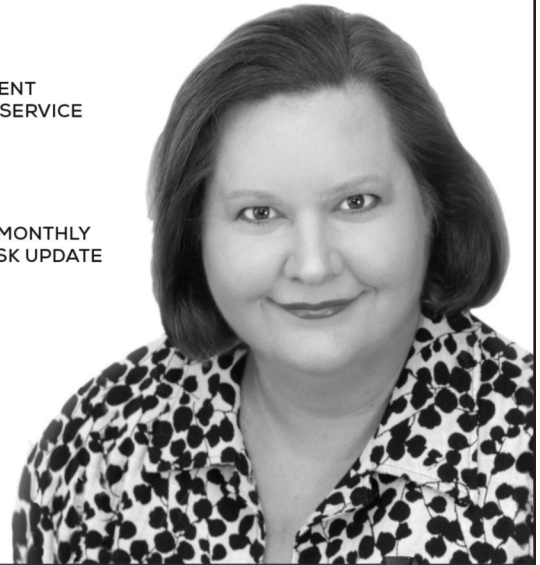
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IPS Resident's Career Fair

Bianca Pullen, MD, University of Chicago

On a mild evening in October, psychiatry residents gathered at Rock Bottom Brewery to explore post graduate career opportunities in Illinois and beyond. Residents, greeted by IPS staff members, walked through a space that was just right for the event. Dinner and drinks were provided, making it easy for residents to stop by after work. There was a diversity of representation with residents coming from University of Illinois, Northwestern University, Loyola University, University of Chicago, and Rush.



Career Fair Sponsor, Cindy Tunney from American Professional Agency, Inc. (APA, Inc.)

Residents were exposed to a wide variety of career and post-graduate training opportunities. The employer tables were full and offered information about telepsychiatry, care for incarcerated patients in the state of Illinois and other states, employment prospects in both public and private sectors, outpatient and inpatient settings, and community and academic settings. Several academic institutions offered information about their fellowships. There was indeed something for everyone. Many of the employers offered to make site visits if residency programs are interested.

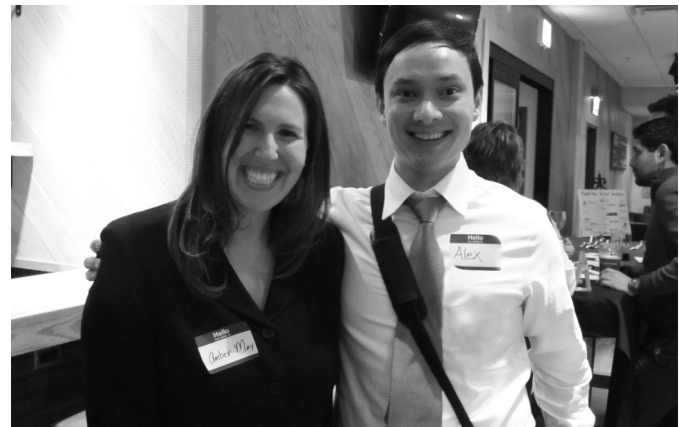
This career fair fulfilled multiple purposes. Dr. Carolyn Shima, one of the Chief Residents from the University of Chicago, found it “helpful to interface with potential employers.” Residents in attendance met members of IPS and learned more about the organization. Additionally, a fair number of first-year



IPS Members mingling and visiting booths.

psychiatric residents attended the job fair, who were not yet looking for employment. However, they were able to compare their early experiences and share their delight in choosing psychiatry.

We would like to thank the participating employers (alphabetical order): Amita Health Behavioral Medicine, Carle Physician Group, Cathedral Counseling Center, Chicago Psychiatry Associates, Cook County Health and Hospital System, Franciscan Health, Genoa Telepsychiatry, Lake County Health Department, MDLIVE, NorthShore University Health System, Northwestern Medicine, Presence Medical Group, ReGroup Therapy Inc., Rogers Memorial Hospital, Rush University Medical Center, Sinai Medical Group, Streamwood Behavioral Healthcare System, Summit Clinical Services, Thresholds, and Wexford Health Sources, Inc. We would also like to thank our sponsor, American Professional Agency Inc. and additional advertiser, Professional Risk Management Services.



Amber May, MD and Alex Yuen, MD

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IPS Resident's Career Fair


(Continued from page 7)



IPS Members visiting the Wexford Health booth.



From Left: Hristos Karanikas, MD;
Tammy Tamayo, MD; Jennifer Sprague, MD;
Chandan Khandai, MD

This career fair was a success, measured by the number of attendees and employers present. Should this become an annual event? Send suggestions and comments to Kristen Malloy at kmalloy@ilpsych.org or Dr. Chandan Khandai (IPS Resident Chair) at chandan.khandai@gmail.com. 



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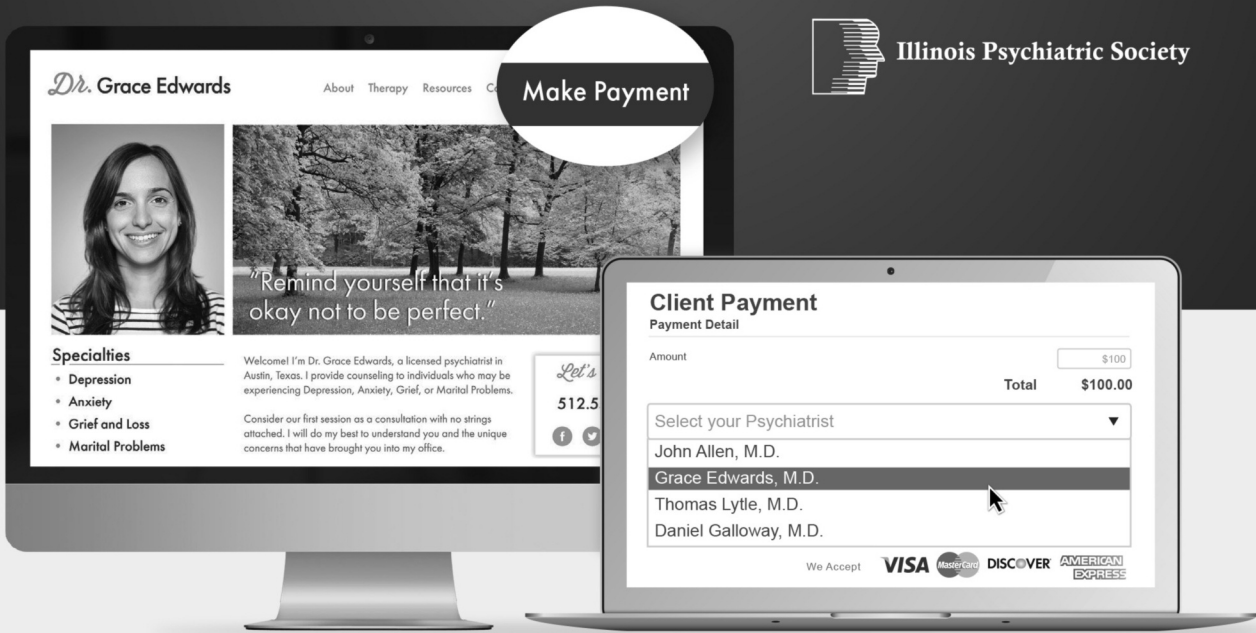
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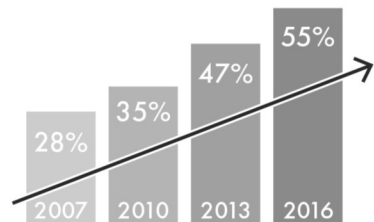
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Residents' Corner

Finding Renewed Inspiration

*Louisa Olushoga, MD, PGY-2
The University of Chicago Medical Center*

Starry-eyed. This description probably best captures my childhood perspective of becoming a physician. In fact, I spent the greater part of my youth delighting my parents and their house guests with my confident response to questions about my chosen career path. “I’m going to be a brain surgeon” I would exclaim from aunties’ laps and over the long-distance telephone calls to my grandparents in Ghana. And while I could not begin to explain why I attached myself to neurosurgery at such an early age (despite the fact that it was a true crowd pleaser), there was something very genuine in my naïve decree—I wanted to help people. It was a very simple desire folded into a lofty goal.

My experience with psychiatry began on my front porch where my adolescent neighbors and I would exchange stories about the happenings in my neighborhood—high school drop outs due to unplanned pregnancies, prominent substance use within families, or assaults while walking home from school. For some of us, those front porch conversations may have been the only ones we ever had about the issues that surrounded us. Being a black girl growing up in Jersey City, New Jersey I witnessed young lives shattered by teen pregnancy, gang violence, drugs, and physical/sexual abuse. Some of these people were my friends and many of them were my neighbors. These conversations motivated me toward a new goal of becoming a physician for underserved people—particularly high-risk youth. By the time I got to college, I had abandoned my neurosurgery plan. I spent my years in undergrad traveling and working in clinics around Africa and mentoring students from underserved backgrounds in various capacities. I was motivated, passionate, and excited about what I would achieve as a physician. I was going to change the world. After undergrad, medical school proved to be quite challenging. The basic sciences left me wondering if I had made a bad decision to “follow my dream.” By some divine grace, there was a spark that was reignited in me when I was able

to work with the young men of the Chicago juvenile detention system. It seemed by working with these adolescents, I had again found my purpose in this field of medicine.

Residency began and I remember how excited I was to receive my own pager. I had just finished taking one year off after medical school graduation to spend time at home with my second child. I was reenergized and re-focused to get back to changing my community and world. My intern excitement quickly turned into frustration. I hated getting called and paged for consults even though that was precisely my job. I did not want to argue with the emergency



room residents about laboratory tests I thought were necessary and they thought were excess. I did not feel like spending hours speaking with patients about their depression and anxiety only for us to talk in circles about my reasoning behind recommended treatment plans. But most of all, I hated being powerless which is the way I often feel operating in a resource-challenged mental health system.

Some may feel powerless is too strong of a word. I think it perfectly captures my emotion as I try to make this system work for my patients and me. Now, six months into my second year of residency, I have had far too many conversations with social workers on inpatient units about the need for more days for a very sick patient who is no longer covered by their insurance because their suicidal ideation from three days prior had “resolved.” I hate sitting with patients in the emergency room trying to locate an appropriate inpatient placement only to find that they do not have any insurance and even the state hospital is refusing to accept them. It is awful when completing disposition plans for a patient, I realize that they may not be eligible for once weekly psychotherapy—a treatment that could make the difference in preventing their re-hospitalization. It seems every week I am forced to discharge patients before they are well enough to leave because there is no money to keep them hospitalized. And it gets worse as persons with addiction are turned away at the door because the Illinois SMART Act prohibits re-hospitalization for detox within thirty days of discharge. Just this week, I had conversations with three different patients explaining that despite their determination, motivation, and desire to remain sober—if there was no room in rehab or worse yet, if insurance would not pay for treatment, I could only give them resources for community support groups. The system fails far too often and I am left feeling powerless.

I am aware that I am highlighting all that is wrong. I also realize and understand how much we are often able to help patients. But we, residents, do not become jaded and burnt out secondary to all the good we do. We do not lose sight of our motivation because of the success stories. Instead, we find ourselves in a fog of disappointment asking ourselves “what’s the point” because it all sucks anyway. Specifically today, as we train in a society that seems to be deteriorating by significant proportions daily and a system that just cannot seem to get it right, we are left trying to remember why we’re here in the first place.

The fact is, we are not powerless nor should our convictions be crippled by a failed system. Instead we should recognize that in order to advocate for our patients and ourselves we must first tend to our own personal needs—our physical and emotional health and the balance that exists between work and life. My journey to becoming a psychiatrist has involved becoming a wife, mother, and breast cancer survivor. If each of those elements is not tended to, I am in no position to address the needs of my patients. Secondly, we should recognize our accomplishments as physicians and acknowledge when the system does work, because despite all the brokenness that exists there are people we have helped. Finally, let us allow the brokenness and failed systems to propel us forward rather than keep us stagnant. Let us use our platforms of research, writing, involvement in state and national organizations, and taking part in Illinois State Advocacy Day (April 5, 2017) to make our voices heard and propose solutions to continuing problems. We are powerful with a unique perspective as young trainees. Granted, change does not come about in one day or even one year but we have a responsibility to never give up trying. We have sacrificed many things to be here (time, money, relationships) all because of our desire to help people. We should not lose sight of that conviction amongst the challenges. Let us work to retain some aspect of our childhood excitement. 📖

If you are a resident and would like to submit a column for the next Residents' Corner, please email kmalloy@ilpsych.org. Whether it's a topic you would like to see get more attention, or an experience you would like to share, this is your forum.

Medicare to Start Paying for Collaborative Care Models

Daniel Yohanna, MD; Co-Chair IPS Access to Care Committee

Beginning this year, the Centers for Medicare and Medicaid Services (CMS) will begin payment for Psychiatric Collaborative Care Services provided under the direction of a treating physician or other qualified health care professionals during a calendar month. These are substantially different types of payments as they are paid directly to the treating primary care physician responsible for the care of the patient who in turn will reimburse the psychiatrist and pay behavioral health case managers for assessments, and establishing, implementing, revising and monitoring the care plan. Behavioral case managers can also provide other brief, reimbursable interventions.

The health care professional definition includes advanced practice nurse and physician assistant. A behavioral health case manager refers to a clinical staff person with a masters or doctoral level degree in behavioral health. An episode of care begins when the treating physician refers the patient to the behavioral health case manager and ends when goals are achieved or failure to meet the goals necessitating a referral to a psychiatrist or when there is a break in treatment lasting more than 6 months. This brief article outlines the activity of the **APA Committee on RBRVS, Codes and Reimbursement** that has been working on the

Collaborative Care Model (CoCM) codes with CMS and the AMA to define and value them.

The behavioral health care manager can continue to provide and bill for other services including psychiatric evaluation, psychotherapy, family psychotherapy, group therapy and other services just as before but codes for services reported must be outside the time used for CoCM.

So what work constitutes Psychiatric CoCM codes?

994X1 Initial Psychiatric CoCM required elements:

- Outreach to and engagement in treatment for a patient directed by the treating physician or other qualified health care professional;
- Initial assessment of the patient including administration of validated rating scales with the development of an individualized plan;
- Review by the psychiatric consultant with modification of the plan if recommended;
- Entering patient into a registry and tracking patient's follow-up over time with appropriate documentation and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence based

Type of Service	Total Duration of Collaborative Care Management over Calendar Month	Codes
Initial-70 minutes in the month	Less than 36 minutes	Not reported separately
	36-85 minutes	994X1
Initial plus additional increments up to 30 minutes	86-116 minutes	994X1 X 1 and 994X3 X 1
Subsequent -60 minutes in the month	Less than 31 minutes	Not reported separately
	31-75 minutes	994x2
Subsequent plus each additional increment up to 30 minutes	76-105 minutes	994X2 X 1 and 994X3 X 1

TABLE A: New codes for CoCM are for the initial assessment by the Behavioral Case Manager, follow-up care and additional time spent in each are shown above.

CPT	Description	Work RVUs	Non Facility PE RVUs	Facility PE RVUs	Malpractice RVUs	Final total Non-Facility RVUs	Final Total Facility RVUs	Payment/patient billed non-fac	Payment Patient Billed Fac
994x1	Initial 70 minutes	1.70	2.17	0.70	0.11	3.98	2.51	\$142.84	\$90.08
994x2	Subsequent 60 minutes	1.53	1.89	0.63	0.10	3.52	2.26	\$126.33	\$81.11
994x3	Additional 30 minutes	0.82	0.97	0.34	0.05	1.84	1.21	\$66.04	\$43.43

TABLE B: CoCM pay rates


techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

994X2 Subsequent Psychiatric CoCM elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participating in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;


- Provision of brief interventions as noted above;
- Monitor of patient outcomes with validated rating scales; relapse prevention planning and preparation for discharge from active treatment.

Please refer to Table B above to see just how much CoCM will pay.

We encourage members to participate with primary care in a collaborative model through contracting for hourly service as a consultant. There will be work done locally and nationally to assure that these CPT codes are covered by private insurance. Coverage for Medicaid patients will be uncertain until the federal portion of Medicaid coverage is clarified and state’s decide what will be covered. If you have questions, feel free to contact the IPS committee on Access to Care. 

If you are having problems with the Risk Evaluation and Mitigation Strategy (REMS) system for monitoring Absolute Neutrophil Count (ANC) for patients on Clozapine, please read on:

We have been getting complaints that Walgreens and CVS will not look up results in the REMS system so the physician’s office has to fax a copy to the pharmacy for them to dispense medications. This has added to our work load since we have to put results into the REMS system and still notify the pharmacy by fax like we did before the system was put into place. Smaller pharmacies have the capability to do this; why not all the pharmacies?

Contact the Access to Care Committee through Kristen Malloy (kmalloy@ilpsych.org) if you have experienced a problem dispensing clozapine. 

Guns, Rights, Safety & Stigma

(Continued from page 5)

to disclose such information for fear of anything from social repercussions to loss of potential job prospects. The Psychiatric Times reported in an article in December of 2016 that the AMA is pushing for State Medical Boards to stop asking applicants for licensure about history of mental illness and focus only on current impairment by mental health and addiction. This is welcome news, especially for those who want to seek help for mental health issues but are afraid of the consequences.

The debate will rage on about gun control laws, but it is our duty as psychiatrists to stay informed, considerate and proactive. While there is a very clear and urgent need for better gun laws, we must also be mindful of how these laws are implemented and how effective they may be while simultaneously preserving the rights of our patients and combating stigma.

UPDATE:

On Feb 16, 2017 the United States Circuit Court of Appeals for the 11th Circuit concluded that doctors could not

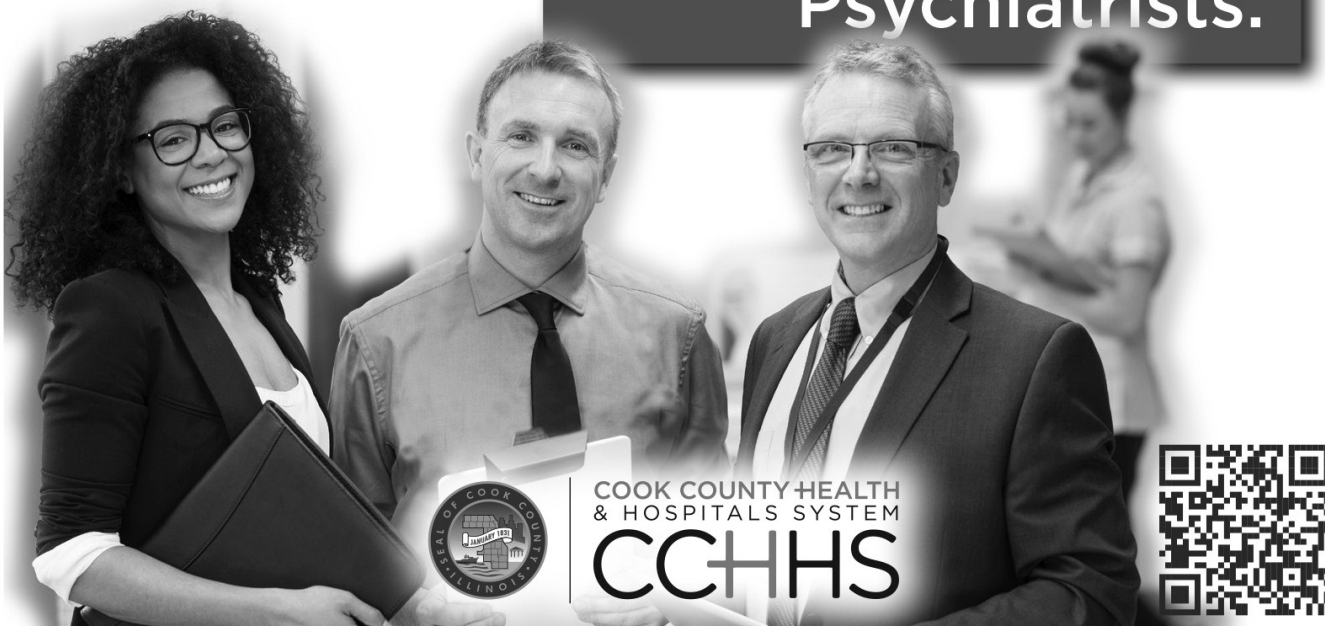
be threatened with losing their license for asking a patient if they owned guns and for discussing gun safety, because doing so would be a violation of their First Amendment right to freedom of speech. This overturns the previously mentioned 2011 law that prevented doctors in Florida from talking to their patients about gun laws.

References:

- <http://alert.psychnews.org/2016/12/court-ruling-may-increase-role-of.html>
- <http://smartgunlaws.org/gun-laws/policy-areas/consumer-child-safety/minimum-age/>
- <http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx>
- <http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.68102>
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- <http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.6b8>
- <http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.7b26>
- <https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>
- <https://www.nytimes.com/2017/02/16/us/florida-doctors-discuss-guns-with-patients-court.html>

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Save the Dates:

IPS Advocacy Day

Wednesday, April 5, 2017

Please RSVP and watch for more information in the IPS e-blasts!

Contact Kristen Malloy at kmalloy@ilpsych.org to register.

Dear IPS members,

We are honored and excited to serve as IPS co-editors. We encourage IPS members to submit psychiatry-related papers to IPS for publication in Mind Matters. Please forward your submissions to kmalloy@ilpsych.org. We look forward to hearing from you!

Sincerely,

Firas A. Nakshabandi, MD
 Michelle John, DO, MPH
IPS Newsletter co-editors

IN MEMORIAM:

Frank W DeLaurentis, M.D. (Orland Park, Ill.)