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President's Message

Danesh Alam, MD



Danesh Alam, MD

I am honored to be the next President of the Illinois Psychiatric Society (IPS) during the 80th year of our organization. I look forward to working alongside the IPS leadership to meet the mission of the organization.

First, I would like to thank Dr. Ryan Finkenbine for his commitment over the past year as president. Dr. Finkenbine provided strong leadership, not only looking at operational issues, but also making sure that we remained fiscally responsible. During his tenure, we went to a virtual office and also began work with our new lobbyist Betsy Mitchell. We are fortunate to have his continued support and involvement.

I am excited to work with our Executive Council, Dr. Joshua Nathan, President-Elect, Dr. Gaurava Agarwal, Treasurer, Dr. Susan Scherer, Secretary and the rest of our Council members. We are delighted to have several new Council members this year and are looking forward to their fresh perspective.

We continue to be confronted with a number of significant challenges:

- At the national level, we are in opposition to HR1628, the American Healthcare Act, (AHCA) and the MacArthur Amendment. These bills will negatively impact patients with mental illness and substance use disorders.
- Six of the nation's largest medical organizations, including the American Psychiatric Association, sent a letter to Senate Leaders expressing serious concerns about the proposed health care legislation and the secretive process

under which it is being drafted.

- Here at home, about one in four people living in Illinois, some 3 million people, are on Medicaid. Many risk losing care if Medicaid expansion in Illinois is eliminated. 1.2 million Illinois residents would lose coverage.
- The Medicaid financing provisions contained in AHCA will allow states to eliminate the state requirement for coverage of mental health services and reduce overall Medicaid funding by 25 percent over 10 years. If Medicaid expansion is eliminated, the state will lose \$3.1 billion in 2019 alone.
- The lack of a state budget at the time of this writing has had a devastating impact on virtually every aspect of mental health-care and substance use disorder in the state.
- A recent report reveals that the state of Illinois owes community mental health centers statewide over \$142 million in unpaid bills, a debt that is affecting the care of those struggling with mental illness and addiction.
- Idaho became the fifth state to pass a psychology prescribing bill. Iowa, New Mexico, Louisiana and Illinois being the other four states.
- Scope of practice issues continue to need our attention.
- The psychology prescribing bill is now with the Illinois Department of Financial and Professional Regulation which will put forward the rules in a few weeks. Once the rules are published we plan on initiating a work group to respond. We would like to ensure that the rules reflect both the spirit and content of the law.
- The Illinois Society of Advanced Practice Nurse Association introduced legislation that would have granted APRNs full

(Continued on page 8)

Improving Measurements, Outcomes, and Lives

Allen Doederlein, MD, President, DBSA and Cindy Specht, Executive Vice President, DBSA

The first priority for mental health treatment is ensuring that a person has a pathway out of crisis towards stability. However, all too often, this baseline stability can unwittingly remain as the end goal for long-term care. We at the Depression and Bipolar Support Alliance (DBSA) contend from our perspective of over 30 years representing the lived experience of people who have mood disorders that “stable” or “better” are not always synonymous with “well.”

If the goal of mental health treatment is to move beyond mere survival, we must address the symptoms of illness, but not at the exclusion of building wellness—wellness defined by the individual with overall quality of life in mind. Following are ways we at DBSA offer to raise the bar for treatment.

Evolve definition of success

To open up opportunities to thrive, we must raise expectations for treatment from crisis management and symptom reduction to wellness and resilience. Too often, when a person is out of immediate risk and able to function in most day-to-day activities, the assumption is made, by both clinician and patient, that treatment success has been achieved, and as such further steps aren't taken to facilitate complete well-being. While the person's condition may have improved greatly, they are still living with residual symptoms of their condition and are not living to their full potential. “Sight-raising” is vital to preventing relapse, lowering vulnerability to co-occurring conditions, and reducing suicide risk. DBSAAlliance.org/TargetZeroPodcast

Collaborate for better outcomes

When treatment plans are created jointly and in equal partnership between those with mental health challenges and the professionals treating them, individuals are more invested in, served by, and able to achieve those plans. Such collaboration fosters a transparent, dynamic approach that improves overall efficacy. Tools such as person-driven wellness plans and mood, symptom, wellness, and health trackers can be valuable assets in identifying both goals for, and progress towards, treatment that achieves both clinical and personal success. FacingUs.org

Broaden measurement

Often, traditional mental health scales don't capture the entire picture—they measure how ill a person is,

but not how well they are. An individual may have acceptable ratings on a traditional symptom scale and still have a significantly diminished quality of life—they may have poor family relationships, difficulty maintaining work, or simply feel that their life holds no greater purpose beyond existence. Conversely, a person may have some symptoms present, but feel that their life, while perhaps at times challenging, is fulfilling and meaningful.

In addition to measuring symptoms, we must also include measurements that address wellness, such as The World Health Organization's 5-point Well-Being Index (WHO-Five) self-evaluation, which asks a person to report on core positive aspects of overall well-being. DBSAAlliance.org/WHO-5.

Increase consideration of whole-health

The weight of mental health conditions negatively affects people who also have co-occurring conditions, which are frequent and diverse, ranging from diabetes to cardiovascular conditions to cancer. Choosing between effective treatment for a co-morbidity and mental health is counter-productive: individuals living with mental health conditions on average die 25 years sooner, not as a result of suicide, but as a result of myriad co-occurring conditions that can be exacerbated by and/or exacerbate mood disorders. Treating both mental and physical co-occurring conditions—recognizing and allowing for their complex interrelationships—is imperative to achieving optimal outcomes.

Empower with knowledge, self-directed tools, and support

Raising the bar for treatment starts and ends with hope and empowerment. Too often people with a mental health condition are told by others (and themselves) to limit their expectations. They are left feeling they will never live a full life. They feel their future is no longer in their control but rather in the fickle hands of fate. One of the best medicines a person can receive is to hear that while many components of their wellness journey may be out of their hands (like the way their body reacts to a particular medicine or therapy) many still are in their control. Learning as much as they can about their conditions is the first step in taking back control. Working in partnership with their clinicians on a plan that works towards achieving goals most important to them; implementing personal wellness strategies to support mental, physical, and emotional health; and

connecting with communities of support not only puts more control in their hands, but results in better outcomes—and lives.

About the Depression and Bipolar Support Alliance


DBSA is the leading national organization focusing on depression and bipolar disorder. Unlike other advocacy and education organizations, DBSA was created for and is led by individuals who themselves have a mood disorder. This first-person lived experience informs everything that we do.

DBSA's vision is wellness for people with mood disorders, and we believe that an open and collaborative approach to treatment that accounts for the whole person allows people to achieve what they personally define as wellness. Our Scientific Advisory Board, made up of the nation's leading clinical and research experts on mood disorders, has contributed towards DBSA's long history of providing cutting-edge, interactive online tools and resources that allow individuals

to understand, choose, manage, and evolve their treatment plans.

Through our extensive online and print resources, more than 700 support groups, and nearly 300 chapters across the country, DBSA reaches over three million people each year with in-person and online peer support; current, readily understandable information about depression and bipolar disorder; and empowering tools focused on an integrated approach to wellness.

DBSA works to advance research and advocates at national and state levels for the rights of people living with, or affected by, mood disorders.

Ultimately, we at DBSA believe that our balanced, person-centered, wellness-oriented approach is what has allowed us to educate, empower, support, and inspire individuals to achieve the lives they want to lead for our now-30 years in existence. We hope you will learn more and work with us to raise the bar for treatment. DBSAAlliance.org 



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IPS Goes to Springfield . . . for Our Annual Advocacy Day

Joshua Nathan, MD, Assistant Professor of Clinical Psychiatry, Director, Mood and Anxiety Disorder Program, University of Illinois at Chicago

On a dreary April 5th day, Illinois Psychiatry Society general members, residents and attending physicians from all over Illinois had a successful and fun day in Springfield educating Illinois legislators about important pending medical legislation. We advocated for passage of two consumer protection bills, and against passage of one mental health regulatory bill. We met with our wonderful lobbyist Betsy Mitchell, who organized the day, including scheduling meetings with mental health champions Rep. Lou Lang and Rep. Sara Feigenholtz. We met with several representatives and senators throughout the day, and even had a brush with fame during a chance encounter with Miss Illinois. We ended the day with a cocktail hour of drinks and hors d'oeuvres for our group and legislator guests.

Hiking hither and thither around the Capitol and Stratton Building, we supported a bill to protect consumer access to medical care and a bill to strengthen mental health parity. With HB 311, the Network Adequacy Bill, we encouraged members of the Illinois General Assembly to vote in favor of requiring health plans to provide accurate provider information, to build sufficient provider networks, and to protect patients from care disruption when networks change. We strongly endorsed an amended HB 68, a bill sponsored by Representative Lou Lang (D), which revises the current mental health parity provisions of the Heroin Crisis Act in several ways. It expands the definition of mental illness as anything in the most recent version of the DSM or ICD diagnostic systems, clarifies that Medication Assisted Treatment medical necessity guidelines should be the same as ASAM criteria, details how the Illinois Department of Insurance and other agencies must enforce the law, and allows patients and providers to pursue action against plans for MH/SUD parity violations.



The IPS Group in front of the Capitol building on IPS Advocacy Day.



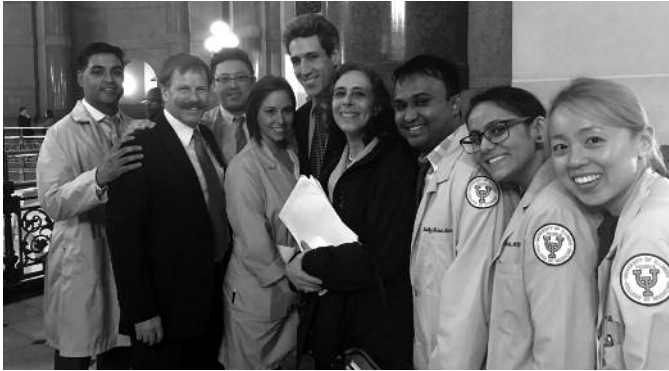
From Left: Krushen Pillay, DO; Alison Greenfeder-Weiss; Dena Oaklander; Joshua Nathan, MD; Tammy Tamayo, MD; Lauren Schumacher, MD

While getting in our steps around Springfield, we urged legislators to vote against HB 281, a bill sponsored by House Assistant Majority Leader Mary Flowers, which requires redundant regulation and compliance standards around the prescribing of psychotropic medication for foster children.

Over 40 members and resident-members participated in the daylong event, covering about 19 representative districts and 17 senatorial districts. Participants at IPS Advocacy Day in Springfield represented the following settings: private practice, academia, forensics, child and adolescent, and general practice psychiatry. They led 6 teams of resident-members from Rush, UICOMP, Northwestern, University of Chicago, University of Illinois at Chicago, Loyola Medical School, and Rosalind Franklin. Ryan Finkenbine, MD, Susan Scherer, MD, Jeffrey Bennett, MD, Arden Barnett, MD, Joshua Nathan, MD, and Meryl Sosa led the teams on our lobbying efforts.

Although our planned sit-down with Rep. Lou Lang and Rep. Sara Feigenholtz, organized by Ms. Mitchell, succumbed to the predictably unpredictable whimsy of a legislative session and was cancelled, our teams made the most of it, managing to meet with most of the legislators we intended. We even learned, during a break, by observing government in action from the Gallery as our elected officials in the House voted on bill after bill. The day ended with a meet and greet over drinks and appetizers at the IPS Advocacy Day Reception at Maldaner's Restaurant. Sen. Pat McGuire and Rep. Robert Pritchard paid us a visit to thank us for our efforts and learn more about IPS interests. Ryan Finkenbine, MD and the UICOMP residents got to meet with Rep. Feigenholtz after all, when she came a little later to the reception.

As always, we owe special thanks to Kristen Malloy for her coordination of the event, and to Meryl Sosa for her tireless and expert leadership and guidance. We also owe an extra thank you this year to lobbyist Betsy Mitchell, for



From Left: Jay Rawal, MD; Ryan Finkenbine, MD; Andrew Wang, MD; Amanda Vastag, MD; Senator Dan Biss; Meryl Sosa; Mashfig “Mishu” Mamin, MD; Priyanka Patel, MD; Alice Shin, MD

organizing meetings, for educating our group about the ways of Springfield, and for providing her timely political expertise to the whole event.

We had a great turnout and a wonderful time this year. It was, this year as every year, an exciting, educational, and meaningful day of advocating for health care and for psychiatry, for our patients and our communities. We hope we can get an even bigger crowd for next year, as there is certainly strength in numbers. 📱



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Chicago

The Department of Psychiatry at Rush University Medical Center in Chicago is recruiting for a full time academic clinical faculty member. This position offers teaching and clinical opportunities in a predominantly outpatient setting. Eligible candidates should be board eligible or certified and possess a strong clinical background with a broad range of mental disorders. The candidate will join the faculty of our interdisciplinary collaborative academic medical center, and supervise and teach residents, medical students and other trainees. Academic rank and salary will be commensurate with experience. Opportunities for participation in research and other academic or administrative functions may be available depending on candidates’ background and experience.

Maggie McGauley, Faculty Recruitment
Margaret_McGauley@rush.edu
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IPS attends the NAMI Gala

On March 30, 2017, NAMI Chicago held the Light the Darkness Gala at The Geraghty. One of the awardees at the Gala was the IPS APA Representative and former President of the Illinois State Medical Society, Chicago Medical Society and IPS, Dr. Shastri Swaminathan who received the Community Health Advocate of the Year Award. At the event, the audience gave Dr. Swaminathan a standing ovation recognizing the tremendous work he has done for patients with mental illness and substance use disorders. Dr. Swaminathan is the Chair of Psychiatry at Advocate Illinois Masonic. Dr. Swaminathan gave a wonderful speech expressing his appreciation for the award and sharing some insight into his feelings regarding the work he does and the programs he has been able to create at the hospital. We would also like to thank Dr. Abdi Tinwalla and Wexford Health for funding a table at the event and including Ms. Sosa, APA Regional State Advocacy Director Amanda Blecha, Dr. Joshua Nathan, Dr. Chandan Khandai, Dr. Bianca Pullen, and Dr. Tara Thomas. 📱



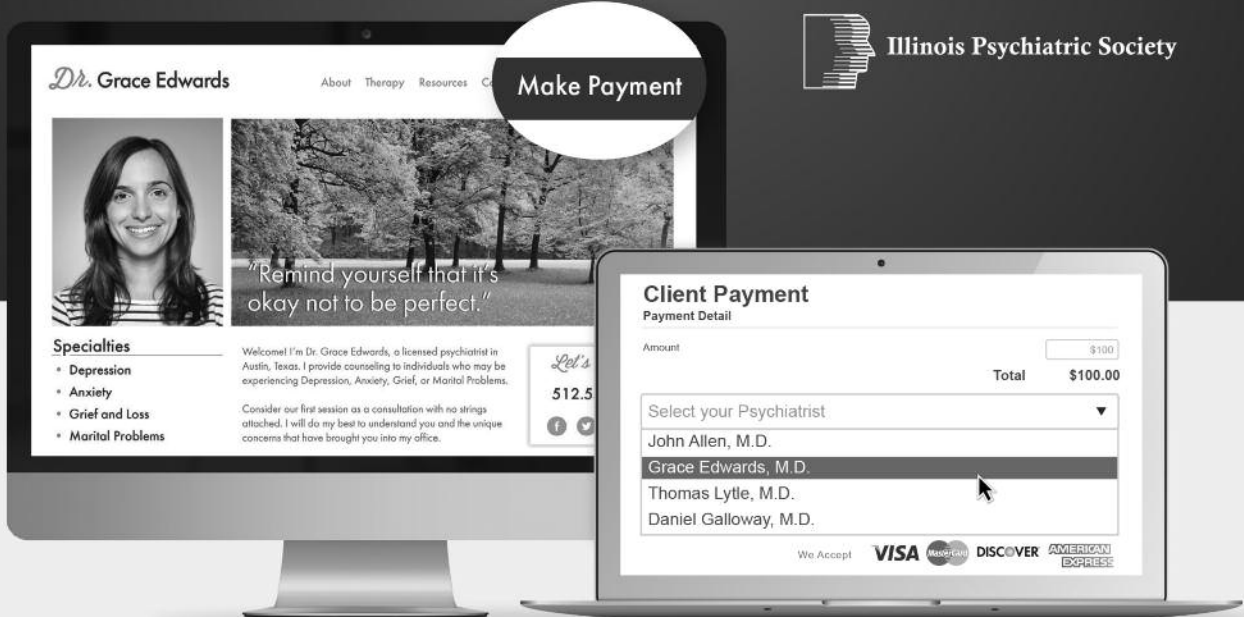
IPS Residents from left: Chandan Khandai, MD; Bianca Pullen, MD; Tara Thomas, MD

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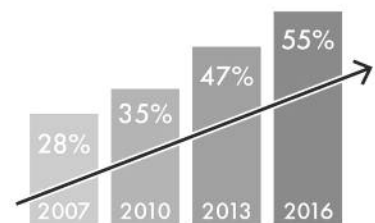
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Congratulations

Anita Rao, MD

Area 4 Deputy Representative

The Assembly Committee of Area Resident-Fellow Members (or ACORF) provides Assembly representation for members of the American Psychiatric Association who are enrolled in psychiatric residency and fellowship training programs. Committee members are elected by their Area Councils (seven in all), and serve two sequential one-year terms. Dr. Anita Rao (pictured above), of Northwestern University, was selected from an incredibly competitive field of applicants as the 2017-2018 Area 4 Deputy Representative serving the North Central Area including 12 states (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI). ACORF members serve on Assembly committees, including the Rules committee, Reference committees, the Assembly Executive Committee, and the Assembly Committee of Planning. 


Congratulations

Chandan Khandai, MD

William Sorum Assembly Resident-Fellow Member Award

The William Sorum Assembly Resident-Fellow Member (RFM) Awards were established in 1991 in memory of William Sorum, M.D., past Speaker of the Assembly. These awards honor a Resident-Fellow Member (RFM) and a District Branch

in each Area who has made the most notable progress in RFM activities, involvement, participation, or representation in the APA.

Chandan Khandai, MD (pictured below), is a rising PGY-4 at Northwestern and immediate past chair of the IPS Residents Committee. While Resident Chair, he reformed the Residents Committee by personally visiting most of Illinois residency programs, and recruiting representatives from all nine residencies. He also planned the first IPS Career Fair, which brought together over two dozen IL-specific vendors to talk with over 50+ resident, fellow, and early career members, and raised over \$10,000 for IPS. He led the first state-wide call to publicize APA national fellowships, and represented Illinois at the Area IV regional conference. He led the biggest IPS Advocacy Day yet, as well as met with both Senator Tammy Duckworth's office, and Dr. Elizabeth Salisbury Afshar, new Medical Director of Behavioral Health for the City of Chicago, to help residents get more involved in local and national advocacy. As Member-in-training Representative on the IPS Council, he helped organize the IPS Secret Shoppers network adequacy survey, as well as helped revise the state society website. He is currently serving as Chair of the APA Leadership Fellowship, as well as non-voting resident member of the APA Board of Trustees, while applying for a fellowship in consultation-liaison psychiatry. 




Congratulations

Katherine L. Wisner, MD

Katherine Wisner (pictured above), won the APA Award for Research in Psychiatry.

Established in recognition of a single distinguished contribution, a body of work or a lifetime contribution that has had a major impact on the field and/or altered the practice of psychiatry.

Katherine L. Wisner, MD, obtained her bachelor of science degree in chemistry and biology from John Carroll University in Cleveland, OH, her master of science degree in nutrition and medical degree from Case Western Reserve University. She completed a three-year postdoctoral fellowship in epidemiology at the University of Pittsburgh Graduate School of Public Health, a fellowship in professional ethics at Case Western Reserve University and a certificate for the Physician Leadership and Management Program at the Katz Graduate School of Business at the University of Pittsburgh. She also completed the Executive Leadership in Academic Medicine program. She is also board-certified in general and child and adolescent psychiatry. She is a distinguished life fellow of the American Psychiatric Association and a fellow of the American College of Neuropsychopharmacology. She is a past president of the Marce's International Society for Perinatal Mental Health and the inaugural President of the Perinatal Mental Health Society of North America. 

President's Message

(Continued from page 1)

independent practice, including full prescriptive authority, after completing additional clinical training under the supervision of either another APRN or physician. At the time of this writing, this legislation passed with significant changes largely due to the efforts of the Illinois State Medical Society.

We are fortunate to have Betsy Mitchell as our lobbyist. She has helped us monitor and impact over 130 bills in the legislature during the most recent session. I look forward to working with her, Dr. Ken Busch, the Chair of the Governmental Affairs Committee (GAC,) and the rest of the IPS GAC on many of these issues.

At the recommendation of our leadership we will continue focus on our current strategic goals:

- Increase member and non-member engagement
- Enhance our relationship with consumer, political and professional organizations
- Improve access to quality mental health care.

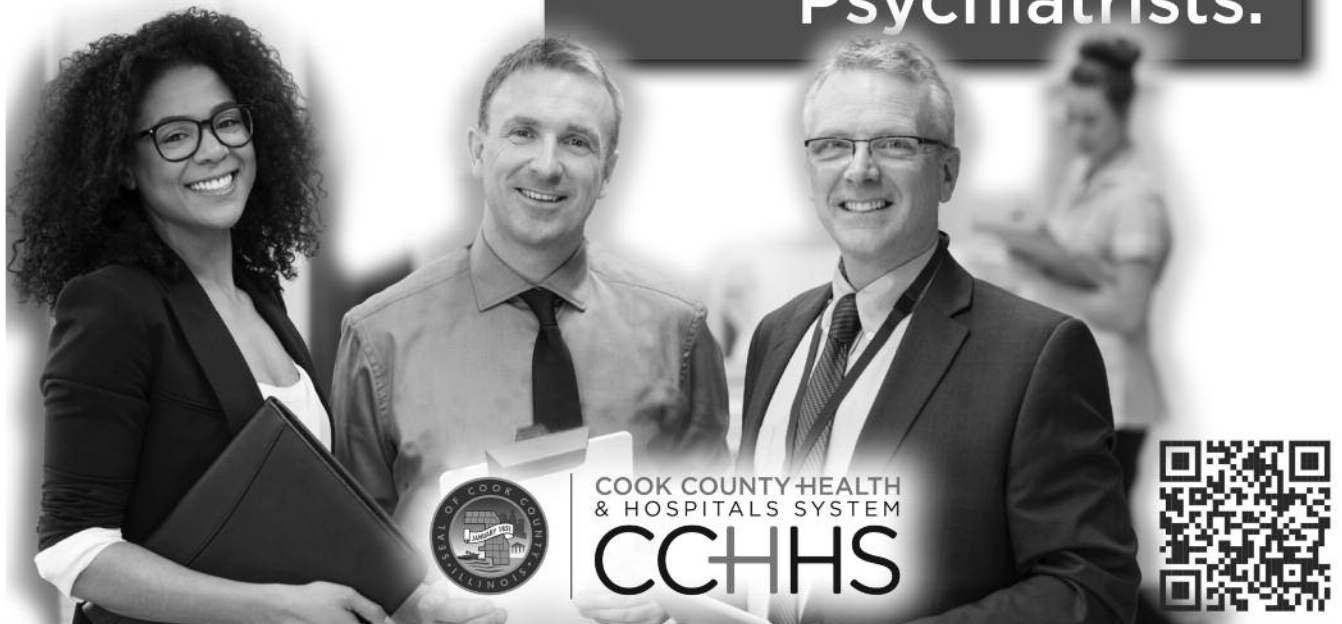
I would like all members and non-members to get involved in our organization and advocate for our patients and ourselves.

Please plan to join us at our upcoming events: Ravinia on August 6, 2017, Psychiatry Career Fair on October 12, 2017, and the Annual Meeting/Holiday Party and Awards night on January 27th, 2018. It is expected that Dr. Anita Everett, the President of the American Psychiatric Association will be the guest speaker at the January event.

We would love to hear from you. Please contact me directly at danesh.alam@cadencehealth.org or the IPS Executive Director, Meryl Camin Sosa, at msosa@ilpsych.org. 

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Residents' Corner

Life After Residency

Victor G. Patron, MD
Rush University Medical Center

The road to finding an ideal job after residency can be uncertain. Every training program has different approaches. In my residency program, conferences regarding contract negotiations are offered to staff. However, it is difficult to find the time to attend. Given the disparity between demand and supply of psychiatrists (at least for now), the job market is relatively comfortable for graduates if you are willing, in some cases, to sacrifice being in a cosmopolitan/urban area in exchange for a higher paygrade (Wyoming and Alaska have the highest mean salaries with 260K and 230K per year respectively). Although this data is openly available at the Bureau of Labor and Statistics, and is more widely evaluated by the yearly Medscape employment and salary report, not many residents take the time to go through it in order to have an effective and rational strategy when discussing job contracts. In fact, most psychiatry residents are not aware or do not hire someone to help negotiate their contracts.

I created three surveys to collect data and gauge what residents' expectations were after residency in the state of Illinois; one for residents who had signed a contract (10 residents), one for residents who had not signed a contract (10 residents), and one for residents who are going into fellowships (8 residents). All surveys were anonymous, with no questions disclosing the residency program. In many questions, multiple options could be selected (hence adding options might offer a value of >100%). The survey was conducted between March 3, 2017 and May 3, 2017 on an internet platform.

These are some of the most interesting findings:

- Only 30% of residents were coached on how to find a job.
- Only one in 13 residents said that they would do a fellowship if their student debt was lower.
- Residents want to go into private practice but still work in inpatient units. It might be difficult to find that balance in the city. Of those with contracts, most will work in government operated facilities and academic centers (80% and 60% respectively, with only 20% in inpatient units). The expectation from those doing fellowships and still seeking mainly to work in private practice and inpatient units (56% and 62% respectively). Research got a 0% across all categories. From those with contracts, 80% answered their practice will be in the suburbs, while fellows and those still seeking jobs (68%) wanted to stay in the city. 37% percent of all responders also wanted to work in the suburbs in academic and non-academic medical centers.
- **What about salary?** Employers make the initial offers and

not many residents negotiate. From those with a contract, in 100% of the cases the employer made the initial offer. One was able to negotiate the salary, two were not, and two said that the offer was good enough. Only one person said that the salary was less than expected but it would increase over time, two said better than expected and two said it was what they expected. From that group, no one hired a professional to negotiate their salary. The salary range for all of them was between 100K and 300K. Of those without a contract, two hired a professional to negotiate while five did not. The expected salary for those without a contract and fellows was between 200-250K for 50% and evenly divided above and below that mark. For those with a contract 40% were within that range and only 20% above.

This survey was by no means perfect; only 18 residents across the state answered it and some of the answers were time sensitive, but a few conclusions can still be drawn. Residents don't want to work in research, which is a problem if we consider how far behind psychiatry is compared to other medical fields. Of course, those research positions are being filled by other highly trained and smart professionals such as psychologists. Second, most residents do not negotiate their salaries and do not hire a professional to help them do so. One of the possibilities here is that graduating residents are satisfied with their offers. The survey included many other questions regarding factors influencing job decisions and staying in Illinois versus leaving the state. If you would like more information on other areas of the surveys or have any questions regarding the surveys, please send me an email at:

victor_g_patronromero@rush.edu 

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.

IPS Legislative Update

Betsy D. Mitchell, IPS Legislative Consultant


Overview of Non-Ending Session
Illinois has finally approved a budget after 736 days without a budget.

Last week, the Senate passed a budget and reforms. The Senate's package included an income tax increase and new taxes on many services (i.e. parking, storage, pest control, etc.). The Senate sent the package to the House for their consideration. Some of the bills included in the package were amended by the House and passed. Among them were procurement reform, local government consolidation, and school funding reform; however, in the end there was no vote on revenue or budget bills and discussions on those issues are to continue throughout June per instructions from Speaker Madigan.

So, what does it mean that Illinois is moving into a third year without a budget? Borrowing an analysis from Kevin Semilow at the Farm Bureau, the reality facing lawmakers includes: the state's current back log is \$14,503,854,421 and growing. Layoff notices continue to be sent out and programs closed. As reported at the most recent House Mental Health Committee hearing, numerous community mental health centers are struggling financially and some are shutting down. Universities are facing massive lay-offs and of course the elementary and secondary schools have no idea if they will be sent money to allow them to open their doors in this fall.

Highlights of Legislation Followed by IPS*:

- **HB 68/Lang -- Mental Health Parity** -- As amended in the House, HB 68 focuses on mental health by making revisions to the parity section of Heroin Crisis Act (HB1) enacted two years ago. There was a hearing on HB68 and it passed out of the Mental Health Committee, but did not make it past Second Reading in the House. Discussions around this bill are to continue.
- **HB313/Feigenholtz - Martinez -- APNs** -- ISMS made a final offer to the APNs which was accepted. The agreement allows for independent practice with a significant increase in post graduate educational and training requirements required. The agreement includes several other vital requirements. After the amendment, IPS was neutral on this legislation.
- **HB311/Greg Harris - Holmes -- Network Adequacy/Transparency** -- Introduced at the suggestion of ISMS, IPS supported this important legislation which passed both chambers and will now be sent to the Governor for his consideration. It will require insurers to keep directories up to date with regard to certain information regarding providers.
- **House Bill 1332/Fine - Morrison** -- Insurance coverage for eating disorders -- IPS supported this important legislation which passed and will now be sent to the Governor.
- **House Bill 3502/Conroy - Bush** -- With the House amendment to create the Advisory Council on Early Identification and Treatment of Mental Health, IPS supported this bill. The bill passed both chambers and will be sent to the Governor. IPS will begin seeking members who would like to serve on the Advisory Council.
- **HB 3904/Stratton - Bush** -- IPS supported this important bill to create a women's correctional services division within DOC. The bill passed the House but was amended in the Senate so it had to return to the House for concurrence, where it remains. Should it be considered during special session days in June, the bill will need a super majority to pass.
- **HB 2959/Fine - Biss** -- Prevents health insurance companies from denying health insurance based on pre-existing conditions. This is very important as the ACA goes away. This bill passed and will be sent to the Governor.
- **HB2907/Bellock - McGuire** -- Amends the Public Aid Code pertaining to telepsychiatry to not allow HFS to require that a physician or other health care professional be present in the same room as the patient for the entire time during the session. This legislation passed both houses and will be sent to the Governor.
- **SB1391/Harmon -- Creates the Psychology Interjurisdictional Compact Act** -- At the suggestion of IPS and ISMS, the sponsor accepted our amendment to the bill so that the Compact could only apply to clinical psychologists and not psychologists holding a prescribing license in any state. Following a committee hearing where IPS Past President, Dr. Arden Barnett attended and was prepared to testify. The bill was held on Third Reading in the Senate by the sponsor. IDFP asked for additional time to review the impact this compact would have on the Department.
- **Prescribing Psychologists Rules** -- IPS continues to watch closely for the release of the Illinois Department of Financial and Professional Regulations' **proposed rules for prescribing psychologists** in Illinois. This information is expected to be released at anytime. Stay tuned for additional information.
- **In-District Legislative Visits** -- Summer is the perfect time to **meet with your legislators** in their district office. Simply call for an appointment. For more information on contacting your legislators, contact IPS which will help you with talking points.

**For a complete list of all of the bills IPS followed this past session, contact IPS for additional information.* 

IPS Annual Meeting and Holiday Party

Meryl Camin Sosa, Esq.

On January 21, 2017, the Illinois Psychiatric Society held the Annual Meeting/Holiday Party at Maggianos in downtown Chicago. The event was well attended and members had a very good time. Dr. Peter Alahi was presented with the Excellence in Patient Care Award. Dr. Alahi is a Professor of Psychiatry at the University of Illinois College of Medicine in Peoria (UICOMP). He has served in several clinical and administrative positions throughout his career including having been the Regional Clinical Director of Regions 3 and 4 for the State of Illinois' Division of Mental Health, Medical Director for the Center for Medication Algorithms at UICOMP, and governing body member at McFarland Mental Health Center. He is currently the Outpatient Division Director in the Department of Psychiatry and Behavioral Medicine at UICOMP. Dr. Alahi has won numerous teaching and patient care awards and is currently responsible for outpatient clinical services where he oversees second through fourth year psychiatry residents in psychopharmacology and psychodynamic psychotherapy supervision at UICOMP. He also runs the electroconvulsive and Repetitive Transcranial Magnetic Stimulation.



From left: Bianca Pullen, MD; Representative Lou Lang; Louisa Olushoga, MD

The IPS was pleased to have Representative Lou Lang as the speaker for the event. Since being elected to the Illinois House of Representatives in 1988, Representative Lang has established himself as one of the Legislature's most effective leaders. Representative Lang has been a very big supporter of mental health and substance use disorder initiatives and now serves on the newly created House Mental Health Committee.



Guest Speaker, Representative Lou Lang, Deputy Majority Leader, Illinois General Assembly

Representative Lang passed the first parity law in Illinois and then in 2015 passed HB1, The Heroin Crisis Act, which also included a 40-page provision on parity that reflected the federal parity regulations. The bill was based on recommendations by a task force and bipartisan hearings. The bill passed the House unanimously and passed the Senate. The Governor vetoed the bill based on his contention that the state could not afford the provisions of the bill, especially the section that requires Medicaid to provide coverage of opioid abuse including Medication Assisted Treatment (MAT) with no limitation regarding the length of time patients can receive MAT, the type of MAT and prior authorization cannot be required. This was the only bill that the legislature overrode the Governor's veto on.

Representative Lang spoke about his plan to revamp the




Peter Alahi, MD (middle) accepting his Excellence award with Ryan Finkenbine, MD and Daniel Yohanna, MD

mental health system in Illinois. As part of this process, Representative Lang plans to hold several bipartisan hearings during the summer on issues related to the mental health system including a hearing on substance use disorders. Other hearings may include topics such as the criminal justice system and child and adolescent mental health. During this session, Representative Lang introduced HB 68 which would revise the parity provisions in HB1 to further clarify requirements that insurers must comply with to meet the federal parity requirements. During the hearings, Rep. Lang wants to hear from members regarding problems with the industry. He is aware that higher reimbursement rates for psychiatrists are needed. He wants persons with mental illness and substance use disorders to receive treatment rather than going to jail. He also shared that it took five years to pass the Compassionate Use of Medical Cannabis Pilot Program. During the year the bill passed, he was told by 93 members that they were for the bill, but when it came time to vote, only 53 legislators voted for the bill. Politics often trumps public policy.

Not only did members find Representative Lang's talk



educational but inspirational as well. We want to thank Representative Lang for his wonderful presentation.

We would also like to thank our four sponsors for the event: Wexford Health Sources Inc.; PRMS The Psychiatrists Program; American Professional Agency, Inc., and Allergan. 

Thresholds and Others Aim to Reduce the Severity of First-Episode Psychosis

Marc Fagan, VP, Clinical Operations & Youth Services at Thresholds

Imagine if we could stop the symptoms of psychosis in its tracks and avoid long-term mental health treatment. That's exactly the goal for Thresholds in Chicago and dozens of First-Episode Psychosis providers nationwide. Psychosis affects 3% of the population.

Specialized treatment for people experiencing early signs of psychosis has been gaining steam across the United States largely due to strong clinical outcomes and Federal investment in services. Other countries have demonstrated successful outcomes for years, but the United States' multi-payer healthcare system has made it complicated to implement nationally. In 2008, The National Institute on Mental Health (NIMH) launched its RAISE (Recovery After Initial Schizophrenia Episode) project, consisting of studies that examined the impact of Coordinated Specialty Care services for people in their earliest phases of psychosis

(<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>).

The success of the RAISE trials led to heavy Federal investment in Coordinated Specialty Care, requiring states to utilize 5% of their Mental Health Block Grant set-aside for early intervention services. This investment increased to 10% in 2016. The success of these initiatives are marked by a number of indicators, but the main premise is that the earlier someone with symptoms of psychosis gets the right help, the better the long-term outcomes. These benefits diminish the longer someone goes without the right treatment.

Illinois started its FIRST.IL initiative in 2016, supporting 11 organizations state-wide to provide Coordinated Specialty Care (CSC) for First-Episode Psychosis. Thresholds MindStrong leads the way in this area, with services in both Chicago and nearby DuPage County.

CSC is a recovery-oriented, specialized approach for people in their early phases of experiencing psychosis. In line with other evidence-informed CSC services nationwide, Thresholds MindStrong employs a multi-disciplinary team of clinicians working together with the client and his or her family to individualize the treatment approach. Referrals come from hospitals, primary care physicians, schools, counseling centers, and other health service providers targeting clients

(Continued on page 16)

Optimizing Medical Management for Mothers with Depression (OPTI-MOM)

Katherine L. Wisner, MD, MS,

*Norman and Helen Asher Professor of Psychiatry and Behavioral Sciences and Obstetrics and Gynecology
Director, Asher Center for the Study and Treatment of Depressive Disorders
Northwestern University Feinberg School of Medicine*

Major Depressive Disorder (MDD) is one of the most common complications of pregnancy, with 7.5% of women having a new episode during the 9 months of gestation and 6.5% with an episode in the first 3 months after birth. Suicide accounts for 20% of deaths in postpartum women and it is the second leading cause of mortality in the first postpartum year. Pharmacologic treatment during pregnancy most commonly includes the SSRI drugs sertraline, fluoxetine, and citalopram/escitalopram. However, data to inform the SSRI dose requirements across pregnancy and after birth are lacking, and modern pharmacogenomic tools have rarely been applied. In addition to the large inter-individual variability in drug response in non-gravid patients, pregnancy induces alterations in the activity of several cytochrome (CYP) 450 isoenzymes. CYP3A4, 2D6 and 2C9 activities are increased, and doses of drugs metabolized by these CYPs must be increased to avoid loss of efficacy. In contrast, CYP2C19 activity decreases and dose reductions are needed to minimize toxicity for drugs metabolized by this CYP. We must provide the optimal drug doses across the changing milieu of pregnancy to maximally reduce disease burden while minimizing adverse effects.

We have been fortunate at Northwestern to bring a novel resource to Illinois. We were awarded a grant from The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), to study the changes in plasma concentrations of SSRI across pregnancy and postpartum. The overarching aim is to develop evidence to construct guidelines for the optimal dosing of SSRIs in pregnant women. The progressive changes in plasma SSRI and metabolite concentrations across pregnancy and after birth will be determined in 200 women. In addition, serial evaluations of depressive and anxiety symptoms and side effects will be obtained at monthly intervals to evaluate their association with plasma concentrations. We will investigate the impact of genomic variability on inter-individual differences in SSRI dosing, plasma concentrations and pharmacodynamics during pregnancy, with a focus on genes involved in the metabolism and elimination of SSRIs (CYPs), drug transporters responsible for SSRI access to the central nervous system, and genes encoding critical SSRI targets involved in therapeutic efficacy.

Existing studies of the effect of pregnancy on SSRI

plasma concentrations are limited. The data suggest that the concentration to dose (C/D) ratios for sertraline, Fluoxetine (FLX), and Citalopram/Escitalopram (CIT/esCIT), decrease in the second half and decline even more dramatically in the third trimester, presumably due to increased hepatic metabolism. However, the degree to which these changes affect depressive symptom relapse has not been elucidated. Our study will fill this major gap in the literature. Previous studies show:

Sertraline. Sertraline is extensively metabolized by the following CYP450 enzymes: major pathway, 2B6; minor pathways, 2C9, 2C19, 2D6, 3A4/5. In six women, our team examined plasma C/D ratios that were collected at 20, 30, 36 weeks gestation, at delivery, and 2, 4-6 weeks and 3 months after birth. The mean C/D ratios for sertraline decreased by an average of 60% between 20 weeks and delivery, which reflected increased drug metabolism. The C/D ratios of sertraline at 12 weeks postpartum were similar to those in early pregnancy.

Fluoxetine. CYP2D6 is the primary enzyme that metabolizes fluoxetine (FLX). 3A4 and 2C9 play a moderate role, and 1A2, 2B6, 2C8 and 2C19 also contribute. Our team evaluated the C/D ratios of FLX in seventeen women. The C/D ratios decreased in the final trimester of pregnancy and returned to pre-pregnancy levels by 12 weeks postpartum. A significant negative relationship between depression scores and FLX drug concentrations was observed, which suggests that lower FLX concentrations resulted in higher depressive symptom levels.

Citalopram. Citalopram (CIT) is a racemic mixture of S- and R-CIT, with only the S-enantiomer having biological activity. Two compounds are marketed as antidepressants (CIT =Celexa, and esCIT=Lexapro). The overall metabolism is through three CYPs: 2C19, 3A4 and 2D6. We studied three pregnant women treated with CIT and two treated with esCIT. In four of five subjects, the C/D ratios for drugs decreased between 20 weeks gestation and delivery, which again reflects increased drug metabolism.

Major Point: If the non-pregnant dose is continued during pregnancy, the plasma concentrations will decline across pregnancy and women are at risk for recurrence, particularly in the second half of pregnancy. Clinically, our team is referred many women whose SSRI “lost efficacy” around mid-pregnancy due to declining plasma

concentrations. The dose must be increased, which captures the previous level of efficacy, usually within a few days to a week. We recommend monitoring women with a standard quantitative depression measure (PHQ-9, IDS-SR 16 or 30, EPDS) at monthly intervals and providing patients with education about the potential for the need for dosage increase to sustain plasma levels. In our OPTI-MOM project, we will explore the role of CYP polymorphisms and their effect on plasma concentrations across pregnancy in a pharmacogenomics component of the study.

For your interest:

PHQ-9


http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

IDS-SR

<http://www.ids-qids.org/>

EPDS

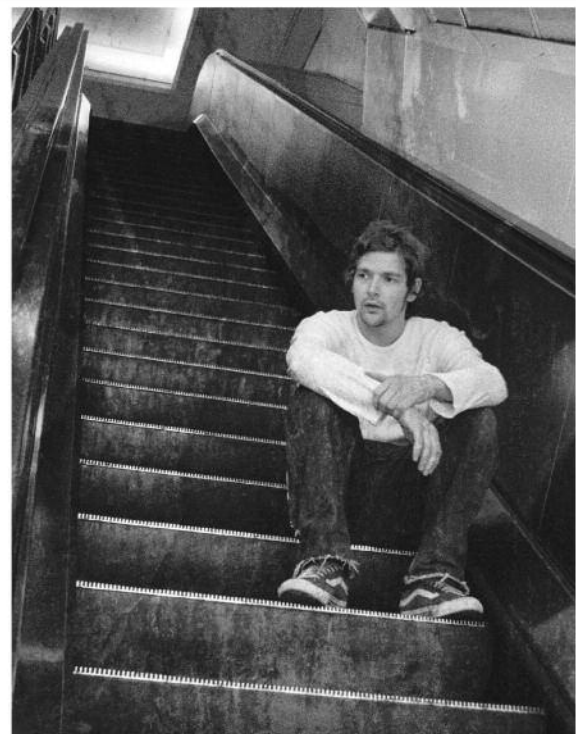
<http://nj.gov/health/fhs/postpartumdepression/pdf/PPD-Edinburgh-Scale.pdf>

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4. Avram MJ, Stika CS, Rasmussen-Torvik LJ, Ciolino JD, Pinheiro E, George AL, Wisner KL. Rationale and design for an investigation to optimize SSRI antidepressant: Treatment for pregnant women with depression. *Clin Pharmacol Ther* 2016;100:31-33. 

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Thresholds

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within the first 18 months of symptom development.

Intake and assessment: The MindStrong team responds to callers within 1 business day to start the assessment process. Because many people in this early phase are hoping to get into services as soon as possible, the MindStrong Access Coordinator schedules in-person assessments quickly, either in the office or in the client's home. The coordinator then links the client with the rest of the MindStrong team to draw out the treatment schedule.

Individual Therapy and Coaching: One of the key therapeutic approaches is Individual Resiliency Training (IRT) used successfully in multiple CSCs, including the RAISE study. IRT integrates elements of cognitive-enhancement and cognitive behavioral therapy, psycho-education, and motivational interviewing in order to increase client competency in coping with psychotic symptoms effectively, decreasing distress and substance use, improving relational health, and addressing overall wellness, including nutrition, weight, and exercise.

Medication: The medication regimen is determined through shared decision-making between the client and the MindStrong Advanced Practice Nurse or Psychiatrist, who is well-versed in treating people with psychosis. Using the philosophy of "starting low and going slow," the prescriber works together with the client and the MindStrong team to monitor main and side effects throughout the treatment process and in conjunction with the other CSC services.

Family Education and Support: Family involvement in treatment is key to preventing subsequent psychotic episodes. MindStrong provides essential family psycho-education and promotes heavy involvement from the family regardless of client age. Because some families also thrive better when connecting with others with similar experiences, MindStrong also offers Multi-Family Groups on regular intervals.

Supported Employment and Supported Education: Without support, psychosis often significantly derails clients from school and work. Thresholds is well-known for its research and practice in the Evidence-Based Individualized Placement and Supports (IPS) model of supported employment. The MindStrong Vocational Specialist assists clients to stay in or return to work or school, while helping clients successfully maintain their career goals.

Care Coordination: MindStrong helps clients weave services together, and maintain connections with primary health providers, leisure activities, and other community resources.

Peer Leadership and Peer Support: Clients often benefit from connecting with others who had similar experiences. MindStrong offers peer connection and also assists clients in their later stages by helping them develop peer leadership skills.


MindStrong provides its services to people 14-40 years old, but research demonstrates that the average age of psychotic onset is in young adulthood. Similarly, most serious mental illnesses begin in the young adult years. Despite this, young adults are the least likely age group to engage in mental health services. That's why the MindStrong teams in Chicago and Westmont also have a sister team called Emerge.

Emerge is a "program without walls," providing a young adult-specific array of services in one's home or community. Focusing on the transition to adulthood, Emerge accepts clients with a wide array of mental health needs (including those that don't qualify for First Episode Psychosis) by providing individual, group, and family therapies, supported employment and supported education, medication monitoring, peer support, and connection to primary healthcare. Recent Emerge outcomes demonstrated that 75% of clients remained out of psychiatric hospitalization and 96% either achieved or maintained stable housing.

Thresholds relies on a thorough research and program evaluation regimen for both lines of service. The team has been involved in numerous nationwide studies, publications, and presentations in order to push knowledge translation and next levels of research in the early intervention field.

Recent studies indicate that people often go approximately 74 weeks before engaging in treatment like CSC. As a result, an integral part of the MindStrong teams is to regularly reach out to community providers, parent groups, hospitals, schools, doctors, and other stakeholders to educate them on recognizing symptoms of psychosis and make referrals to a team as soon as possible.

There are 11 organizations across Illinois providing First Episode services within the FIRST.IL initiative, and the Illinois Division of Mental Health soon will have a website available with contact information for your nearest provider.

To learn more about Thresholds MindStrong and Emerge in Chicago and Westmont, call 773-432-6555, email YoungAdult@thresholds.org, or visit the website at www.Thresholds.org/MindStrong. 

Patients Need Your Help to Enforce Mental Health Parity

With all the recent discussion of the future of the Affordable Care Act (ACA), members have asked about the impact of the ACA's destiny on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

MHPAEA is a separate statute that applies to large group employer plans (+50 people), Medicaid managed care arrangements and nonfederal government plans that do not opt out. The ACA expanded MHPAEA to Medicaid expansion plans, Exchange Plans and to the individual and small group markets. Right now, MHPAEA impacts almost all insurance products on the market, and your patients need your help in dealing with possible parity issues and ensuring access to care.¹ What can you do?

1. Work with your patients to recognize potential parity violations and complain when they experience one.

One of the most common things APA has heard from regulatory authorities is that violations don't exist because no one is complaining! Twenty states, including Illinois, have been granted money by the federal government to enforce parity in the state. Regulators need to hear from you to know where to look for problems. You must not be silent.

Here are some potential parity violations²:

- A. **Pre-authorization** including blanket preauthorization requirements for all mental health or substance use disorder (MH/SUD) services, treatment facility preauthorization requirements not applied to medical/surgical services, or more stringent medical necessity review or prescription drug preauthorization requirements than those applied to medical/surgical services;
- B. **Fail-first protocols**, requiring an individual to fail to achieve progress with a less intensive form of treatment before a more intensive form is covered;
- C. **Probability of improvement** requirements, for example, offering coverage of continuing treatment only if improvement is demonstrated or probable;
- D. **Written treatment plans**, requiring treatment plans completed by specified professionals, within a certain time, or on a regular basis where similar requirements are not applied equally to medical/surgical coverage;
- E. **Other** limits or exclusions, including:
 - Excluding chemical dependency services in event of noncompliance,
 - Excluding coverage for residential treatment,
 - Geographical limitations on MH/SUD services not

- imposed on medical and surgical services, or
- Facility licensure requirements not imposed on medical/surgical facilities.

Each of these is explained in detail here:

<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

If you or your patients experience these issues, go to this consumer portal, and complain.

<https://www.hhs.gov/mental-health-and-addiction-insurance-help>. Federal authorities have assured us that there are benefits experts available to help with the problem and/or steer people to the right place.

2. Help your patients ask for documents from their insurance plan when their care is denied.

Substance Abuse and Mental Health Services Administration (SAMSHA) recently issued a new consumer rights publication that specifies what documents patients are entitled to get from their plans, if they ask, when their MH/SUD care is denied. It is important to get further information from the plans and SAMSHA has made clear that the patient is entitled to information both on the MH/SUD side of the plan and from the medical/surgical side of the plan to determine if MH/SUD is treated differently. These documents include: the plan's medical necessity criteria, utilization review standards, and its analyses performed to verify whether the plan complies with MHPAEA. We suspect that many plans do not actually do the required analysis under MHPAEA and therefore cannot comply. SAMHSA's Consumer Rights publication provides for discovery from the health plan a wealth of information and patients need to take advantage of it. See, SAMHSA's publication here:

<http://store.samhsa.gov/shin/content/SMA16-4992/SMA16-4992.pdf>. If you need assistance once a document request is made and the documents are produced or not produced, please contact Maureen Bailey at m Bailey@psych.org.

3. Do not substitute a consumer complaint to enforcement authorities for an appeal.

Patients have only a limited amount of time to appeal a denial of a claim. Filing a complaint with a regulatory agency is not a substitute for an appeal. Help your patient appeal denials and include in the appeal a claim that the action may violate MHPAEA. Also include in the appeal a request for the documents in the SAMSHA publication above. Many denials are reversed on appeal, particularly when the appeal

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Congratulations

2016 APA/IPS Distinguished Fellows, Fellows and Life Members!

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Mental Health Parity

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advances to the external stage and an independent third party. Don't give up, when the patient's claim is not appealed, the plan wins.

4. Post the APA's parity rights poster in your office.

This poster clearly and simply explains the parity law and the steps to take when a violation is suspected. Share the link with colleagues. The poster can be found here <https://psychiatry.org/File%20Library/Psychiatrists/Practice/Parity/Parity-Poster.pdf>


5. Tell APA about your experiences.

APA is in regular contact with state and federal authorities tasked with enforcing the parity laws and they need feedback about patients' experiences getting MH/SUD care which may implicate the parity laws. If APA is able

to collect sufficient data, APA can better relay to the authorities what is working and not working with parity enforcement. Contact mbailey@psych.org.

For patients, parity means reasonable access to care. For psychiatrists, it means the ability to practice medicine without unnecessary interference so that you can spend your time in patient care rather than intentional hurdles to block care. Psychiatrists have made substantial gains in making parity a reality, but it requires vigilance and your participation. Keep up the good work!

¹ Currently, broad bipartisan support for parity remains and the outlook for the parity extensions under the ACA depends on what repeal and replace does.

² It can be complex to demonstrate an actual parity violation, but there is no need for you to do the legal analysis. You should report any of these potential violations to the enforcement authorities. 

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is published by the Illinois Psychiatric Society, a District Branch of the American Psychiatric Association. Views expressed by various authors are not necessarily those of the IPS

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ips mind matters

Save the Dates:

IPS Career Fair

October 12, 2017

Rock Bottom Brewery, Chicago, IL

IPS Annual Meeting/Holiday Party and Awards Night

January 27, 2018

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

Congratulations!

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Loyola University	Silver
McGaw Medical Center of Northwestern University	Bronze
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