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President's Message

Joshua Nathan, MD



As the newly minted president for IPS, I am thrilled to write my first message to our members. I must begin with great appreciation

for our outgoing president, Danesh Alam, MD, for his wonderful work this past year. Among his significant accomplishments was creating a taskforce to facilitate coordination between IPS and the Illinois State Medical Society, a significant partner in legislative advocacy. Under his leadership, we also had a very successful IPS Annual Meeting, with an incredible turnout. This was especially significant due to our two special guests — Chair of the Illinois House Mental Health Committee, Representative Deb Conroy, and APA President Anita Everett, M.D. On a personal note, I have learned a lot about IPS leadership through observing Dr Alam throughout the past year.

Though I am humbled to be taking the helm, following in the path of so many great leaders, I am also enthusiastic about taking on the challenges that lie ahead. To say a little about myself, I have long realized that empathic and non-judgmental listening are more than just skills of our profession; they are my moral compass and the drivers of my passion and enthusiasm for creating fairness and equality in the world. In IPS in particular, I have found like-minded friends and colleagues, students and mentors. Together we overcome obstacles and find opportunities for making Illinois an even better place. These are exciting and frightening times, yet I remain hopeful as long as we are facing them together. Among

the major challenges are an ongoing opioid crisis, continued mental health disparity despite parity laws, and an alarming rate of depression and suicide among physicians. On the other hand, there is an Illinois House Mental Health Committee, a new wave of community involvement and advocacy in this country, and many allies fighting for better treatment of people with mental illness.

I would like to highlight one of the topics I will focus on as President: barriers to physician wellness. Empathy can help prevent burnout and is also impeded by it. Aware of that bidirectional relationship, I have become interested in physician wellness. Physicians, as is becoming increasingly recognized, are at notoriously high risk for burnout, depression and suicide. Moreover, I became dismayed last year when I renewed my medical license and saw that mental illness is singled out as a potential obstacle to licensure. I was further dismayed to learn of the onerous and punishing repercussions for sharing with our licensing board that one has suffered from a mental illness. Digging further, there is data that says these types of questions and consequences are a large part of what gets in the way of physicians addressing their own mental health. At a time when medical schools are trying to help students learn self-respect, self-reflection, and compassion for self, practicing physicians continue to die from suicide at high rates, and our regulatory bodies are contributing to the problem.

Fortunately, I am not alone in focusing on physician well-being. This was the focus of APA Immediate Past President Dr. Anita Everett during her tenure the past year. Dr. Altha Stewart

(Continued on pg 13)

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Psychedelics and Psychiatry: Past, Present and Future

Matthew Brown, DO, MBA, Psych Arts LLC, email: matt@drmatbrown.com

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Humans have had a relationship with psychedelics for thousands of years. Some of the earliest known evidence can be found in the form of cave paintings. Perhaps the most cited example is that of the “Bee Man Mushroom Shaman” found in an Algerian cave which dates back approximately 8,000-10,000 years, depending on the source. Even many of the world’s religions are said to have been influenced by psychedelic experiences. For example, the story of Moses and the burning bush is postulated to be in reference to Moses imbibing the fumes of an acacia tree which was known to have psychedelic properties. Additionally, there is compelling evidence that psychedelic mushrooms were used as a sacrament in early Christianity, as evidenced by much iconography of the fungus in various cathedrals throughout Europe that were built prior to the Spanish Inquisition. (Allegro, 1970 ; Brown & Brown, 2016; Brown & Espi-Forcen, 2017)

The more modern use of psychedelics in Western culture can be dated back to the work of Albert Hofmann, a chemist, who worked for Sandoz Pharmaceuticals. While in search of novel compounds that could be helpful in bleeding and heart conditions, he synthesized Lysergic Acid Diethylamide (LSD). The discovery of its psychoactive properties happened almost by accident in 1943 when Dr. Hofmann was exposed to the agent in his lab. About an hour after the exposure he started to feel odd and not like his usual self, so he decided to take the afternoon off and rode his bike home. During his bike ride he had many visual hallucinations that were not entirely unpleasant. This experience led him to wonder if the agent might hold promise in understanding matters of the brain. Passing this along to his superiors, Sandoz then sent out samples of this substance to universities in Europe for study (Brown & Espi-Forcen 2017).

One of these universities was in Prague, Czechoslovakia, where Dr. Stanislav Grof was studying in medical school. As part of his training he was enrolled as a subject and given LSD to see if it could help physicians in training more deeply understand their psychotic patients. Dr. Grof was intrigued by his experience. He trained to be a psychiatrist and psychoanalyst all the while engaging in research with LSD. His work with over 10,000 sessions with patients led to the discovery of the importance of serotonin in the brain, as well as the idea that anti-inflammatory agents may help decrease symptoms of mental illness. In the late 1960’s Dr. Grof moved to Maryland to continue his research at Johns Hopkins and then the University of Maryland, but unfortunately that

research was cut short by the Controlled Substances Act of 1970, which brought about the shutdown of almost all research on the use of psychedelic compounds in humans, despite mounting evidence of the potential benefits of these agents (Grof, 2001).

Research in this area was mostly dormant or conducted underground for the next few decades. The new “psychedelic renaissance” started in the early 1990’s, by Dr. Rick Strassman at the University of New Mexico when he was studying the pineal gland and Melatonin. He postulated that the pineal gland must have some other use and found evidence to support that it may also produce a chemical called N,N-Dimethyltryptamine (DMT) which may explain many phenomena such as dreaming, near death experiences and even alien abduction stories. He was granted permission to study DMT in a group of healthy volunteers in a safety study.

Whereas Grof and Strassman deciphered the biochemical underpinnings of psychedelic drugs, we know now that these drugs’ therapeutic effect might also be related to their action in the amygdala. Moreover, new studies done with fMRIs have helped us understand the neuronal correlates in psychedelics. For instance, a study by Carhart-Harris revealed that LSD could expand the visual cortex and decrease connectivity between the parahippocampus and the retrosplenial cortex correlated with ego dissolution (Carhart-Harris, 2016). Thanks to these types of neuroimaging studies we can understand the importance of psychedelic science in the study of consciousness.

In the clinical setting, there is an increasing number of trials that explore the use of psychedelic medicines in patient care. Some of the first studies have been done with patients who have anxiety related to cancer or life-threatening diseases. This population can especially benefit from treatment with psychedelics, as they can enhance transcendence and decrease existential and eschatological anxiety. One of the first studies was done by Grob et al. in 2011. He gave psilocybin to 12 patients with advanced cancer and found significant reductions of anxiety in these patients with advanced cancer. In 2015, Gasser et al. conducted a similar study using LSD. More recently, Griffith et al. designed a double blind randomized cross over study (2016) involving 51 patients with cancer in which the placebo group was given a micro dose of psilocybin and the treatment group received a high dose of the drug. He found a dramatic reduction of anxiety and depressive symptoms and high remission rates in the

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treatment group. In this study, 6 months after the treatment, patients still had significant response and remission rates according to the anxiety and depression scales.

Psychedelics have been found helpful in the treatment of more than just cancer-related anxiety. A number of open label studies have found that psychedelics like psilocybin, LSD, ayahuasca and ibogaine are safe and potentially helpful in the treatment of tobacco, alcohol and opioid use disorders, depression, and obsessive-compulsive disorder. In addition, there are now a number of published subjective reports in scientific journals about patients who have found psychedelics helpful in the treatment of cluster headaches and eating disorders (Brown & Espi-Forcen, 2017).

An important aspect still in need of rigorous studies is the use of psychedelic micro dosing in the treatment of anxiety and mood disorders. Last year, we created a group through the social media platform: meetup.com called “Psychedelics and the Future of Psychiatry.” The group has enjoyed popularity in the community and has already gained more than 500 members from different disciplines including psychiatry, psychology, social work, nursing, sociology, art and music among others. Through this group we have met with individuals who have heard of or have personally used microdoses of psilocybin twice a week for the treatment of depression and anxiety with positive results. We believe there is an urgent need for good quality studies exploring

the role of microdosing in patient care. This treatment could have an important impact on the way we practice ambulatory psychiatry.

Within the last few years, there has been a resurgence of interest in psychedelic science and the potential to understand human consciousness, as well as the development of better neuropsychiatric treatments. Psychiatry must stay in tune with these new changes and demands to ensure that outstanding research and patient care continues. ■

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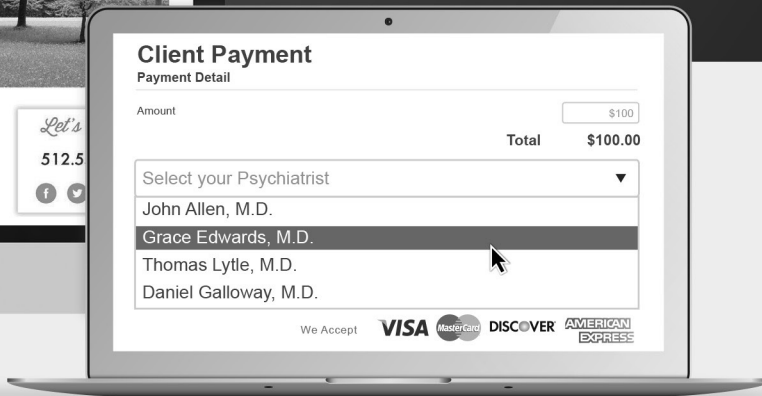
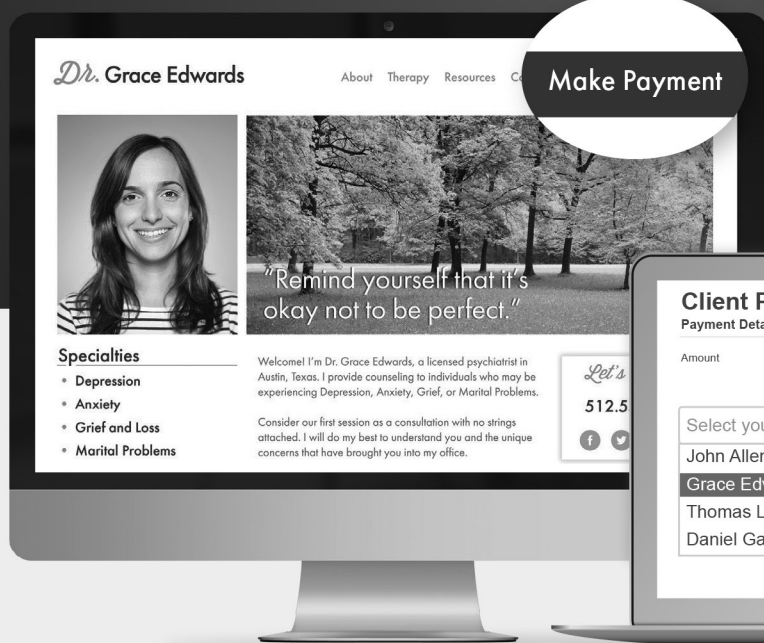
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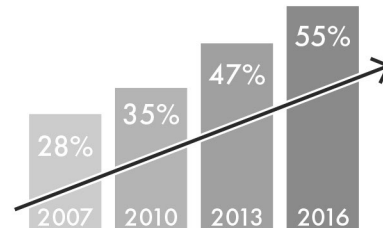
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APA Area 4 Legislative Institute

By Hossam Mahmoud, MD, MPH


The 2018 APA Area 4 Legislative Institute meeting took place on March 10, 2018 in Rosemont, Illinois. The annual meeting brings together representatives and members from different district branches (DBs) belonging to APA's "North Central" Area 4, which includes 14 DBs from 12 states: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

IPS members were joined by colleagues from the respective DBs. The Legislative Institute focused on legislative updates at the state and national level. The day started with briefings on Federal Affairs Update and American Psychiatric Association Political Action Committee (APAPAC) from APA Lobbyist, Mr. Mikael Troubh, and Interim Chair of the APA Division of Government Relations (DGR), Ms. Ashley Mild. The briefing identified APA coalition partners and other allied groups, summarized APA's recent achievements in federal affairs, explained the current "State of Play" in Washington D.C. and identified future risks and opportunities.

The keynote speaker was Representative Deb Conroy, Illinois State Representative for the 46th District. Representative Conroy discussed her work on advancing mental health and addiction treatment through her role as the Chair of the Mental Health Committee in the Illinois House. Representative Conroy reaffirmed her dedication to improving mental health in Illinois through ensuring parity implementation and enhancing awareness on mental health and substance use at the community level and legislative level.

Next the DBs provided state reports on recent challenges and achievements in mental health legislation. The reports were the basis for a discussion aimed at developing three goals for 2018-2019:

1. Working together to increase funding for APAPAC, to support APA's role in advancing mental health through political action at the Federal level.
2. Implementing an Advocacy Day in every state, to arrange for APA members from every Area 4 DBs to meet with their state elected officials, to advocate for mental health policy, patients and psychiatrists.
3. Ensuring the creation of a mental health committee in all Area 4 state legislatures to advance policies that enhance mental health and psychiatric services within the states.

The 2018 APA Area 4 Legislative Institute meeting was an excellent opportunity to network with colleagues in the Area, get updates on state legislatures and Capitol Hill, and learn from the experiences of other district branches. 



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Dr Frederick Sierles Awarded the Albert Nelson Marquis Lifetime Achievement Award

The IPS is proud to announce that our very own Dr. Frederick Sierles has been awarded the Albert Nelson Marquis Lifetime Achievement Award. This award was presented by Marquis Who's Who, which is one of the world's premier publishers of biographical profiles. Dr Sierles has an impressive record of accomplishments in the field of medicine and psychiatry, with several publications focusing on medical education. In addition to being involved in academics, Dr Sierles has been an active member of IPS, and we would like to congratulate him for this award.

More information about the Award and on Dr Sierles achievements is available at:

<https://dailytelescope.com/pr/frederick-s-sierles-md-presented-with-the-albert-nelson-marquis-lifetime-achievement-award-by-marquis-whos-who/49892>

IPS Member Survey 2017: Resources, Priorities and Future Directions

By Caroline Morrison, MD and Hossam Mahmoud, MD MPH

In 2017, IPS planned and implemented a member survey. The aim of the survey was to understand our members' priorities and interests and to explore what members value most about the work of IPS and their membership. This survey was also an opportunity for IPS to explore ways to engage, serve and support our members.

The survey was sent to all members, by email, over a period of two months, May to June 2017. The survey was sent three times with an additional reminder as part of the monthly Information Update.

Eighty-seven members responded, ranging from residents to seasoned members. Due to response rate and response bias, the data collected cannot be considered representative of all IPS members. However, the survey still provided a valuable look into some of our members' clinical specialties, their priorities, and their perceptions of IPS. Below are some of the data compiled based on the responses of IPS members and some tables summarizing the findings.

IPS Community

The responses reflect a wealth and breadth of experience and expertise among IPS members, across age groups, subspecialties and treatment modalities. This information is valuable, as it assists IPS in making appropriate referrals to members when contacted for certain treatments or subspecialists.

Please designate the types of patients you treat. (check all that apply.)	Response Ratio (%)
Child	19.2%
Adolescent	34.9%
Adults	98.7%
Geriatric	53.0%

Areas of Expertise. (check all that apply.)	Response Ratio (%)
Addiction Psychiatry	25.6%
Affective Disorders	75.6%
Anxiety Disorders	67.5%
Child and Adolescent Psychiatry	24.3%
Developmental Disabilities	8.1%
Eating Disorders	10.8%
Forensic Psychiatry	18.9%
Geriatric Psychiatry	16.2%
HIV/AIDS Related issues	5.4%
Infant Psychiatry	2.7%
LGBTQ	8.1%
Neuropsychiatry	20.2%
Personality Disorders	28.3%
Psychotic Disorders	45.9%
Women's Mental Health	20.2%
Other	16.2%

Types of Treatment (check all that apply.)	Response Ratio (%)
Cognitive Behavioral Psychotherapy	33.3%
Electro-Convulsive Therapy (ECT)	18.0%
Repetitive Transcranial Magnetic Stimulation (rTMS)	15.2%
Vagus Nerve Stimulation (VNS)	2.7%
Family Therapy	19.4%
Group Psychotherapy	8.3%
Psychodynamic Psychotherapy	66.6%
Psychopharmacology	93.0%
Psychoanalytic Psychotherapy	12.5%
Psychoanalysis	5.5%
Other	8.3%

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IPS as a Resource

Most respondents regarded IPS as a voice for psychiatrists and patients and highly valued the legislative work of IPS. Most agreed that IPS effectively informs them about laws and regulations. Most respondents agreed that IPS promotes opportunities to network with colleagues and to meet with legislators and civic leaders.

It was striking to note that a large proportion of members strongly agreed or agreed that IPS is a voice for psychiatry (83%), that IPS has effective legislative efforts (78%), and that IPS informs members about laws and regulations (80%). The value that members associated with IPS advocacy and legislative work was more notable than the perceived educational opportunities and activities that IPS offers.

Please indicate your level of agreement with the following statements	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
IPS is a voice for psychiatry in Illinois.	49%	34%	16%	1%	0%
IPS is a voice for patients in Illinois.	35%	35%	27%	4%	0%
IPS is effective in legislative efforts.	33%	45%	18%	4%	0%
IPS effectively informs me about laws and regulations.	40%	40%	15%	5%	0%
IPS promotes opportunities to network with colleagues.	25%	43%	23%	85%	1%
IPS promotes opportunities to meet with legislators and civic leaders.	27%	39%	28%	5%	0%
IPS provides educational opportunities.	21%	44%	20%	15%	0%
IPS adequately connects me with APA initiatives.	31%	32%	24%	11%	3%

The Value of IPS Membership

Most respondents regarded their membership as beneficial and important to the profession, enhancing their credibility, especially with colleagues and with patients, providing networking and CME opportunities, and providing a voice in the development of healthcare policy. Again, when it comes to educational opportunities, only 8% strongly agreed that IPS provides CME opportunities.

Please indicate your level of agreement with the following statements. Being a member of the Illinois Psychiatric Society,...	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
is important to the profession.	57%	26%	14%	1%	1%
enhances my credibility with patients.	14%	17%	37%	28%	4%
enhances my credibility with colleagues.	16%	25%	42%	14%	3%
is expected by my colleagues.	9%	24%	37%	22%	8%
provides networking opportunities.	21%	35%	28%	15%	1%
provides CME opportunities.	8%	31%	38%	20%	3%
provides a voice in the development of health policy.	34%	35%	23%	7%	1%
has benefited me.	39%	24%	27%	8%	1%

Member Priorities

Members expressed significant agreement on the issues in which they would like IPS to focus. These included – in order of perceived importance – advocacy for the profession, ethics/peer review of professional standards, public perception of psychiatry and psychiatrists, healthcare reform, affordable continuing education, managed care, and practice management.

Of the following topics, please indicate how important each is to you and your practice and that you feel IPS should focus its resources on.	Most Important	Somewhat Important	Not Important
Advocacy for the Profession	83%	14%	3%
Affordable Continuing Education	32%	46%	12%
Ethics/Peer Review of Professional Standards	42%	55%	3%
Health Care Reform	53%	39%	8%
Managed Care	20%	56%	24%
Practice Management	21%	47%	32%
Public Perception of Psychiatry and Psychiatrists	72%	24%	4

Even though members reported that it is most important or somewhat important for IPS to focus on affordable continuing education (78%), the reported likelihood of attending training events was relatively low

What training or networking events would you likely attend if offered by IPS? .	Very Likely	Likely	Somewhat Likely	Unlikely	Very Unlikely
Suboxone training	57%	26%	14%	1%	1%
CME webinars	14%	17%	37%	28%	4%
CME 1/2-day conference	16%	25%	42%	14%	3%
Clinical "Updates" (e.g. mood disorders, therapies, forensic issues, etc.)	9%	24%	37%	22%	8%
Dinner with colleagues at a local restaurant with CME	21%	35%	28%	15%	1%
Dinner with colleagues at a local restaurant without CME (but with a speaker)	8%	31%	38%	20%	3%

(Continued on pg 16)



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Collaborative Care Codes Covered by Blue Cross Blue Shield of Illinois PPO

By Daniel Yohanna, MD

Collaborative care codes for the integration of behavioral health into primary care were approved by Medicare more than two years ago. Now, with the help of the Illinois Blue Cross Blue Shield (BCBS) Behavioral Health Medical Director and IPS member, Tom Allen, M.D. and the University of Chicago, BCBS of Illinois will now cover collaborative care codes for primary care physicians (PCP), effective January 1, 2018 with entities that they have contracted for this service.

Although this service is only beginning to catch on, it is the most efficient way to bring behavioral health services for many patients seeking treatment for depression and anxiety in primary care settings, where many patients are seen for mental health treatment.

The codes will cover the initial contact with patients, follow up contact and additional time spent by the behavioral health case manager. An abbreviated definition of the codes from Medicare are as follows:

99492: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health

care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

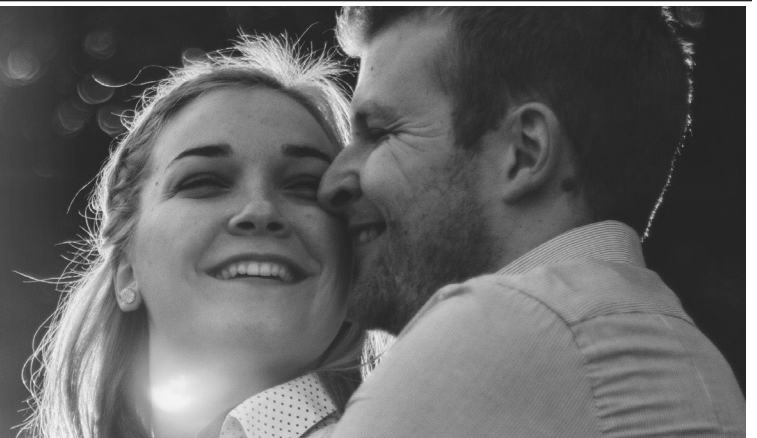
99493: Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

Note that the time described above includes the time the behavioral health care manager spends communicating with the patient by phone or in person, consulting with the psychiatrist and discussing the case and recommendations with the PCP. The coding would be completed by the PCP to account for the collaboration between the behavioral health care manager, the psychiatric consultant and primary care. Psychiatrists would be compensated by the PCP at a negotiated hourly rate.

This is a great step forward for collaborative care and we thank the APA committees for making this happen and IPS for moving it forward in Illinois. [▶](#)

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The Changing Landscape of Mental Health Treatment – A Three-Part Series on Telepsychiatry Part III: Overcoming Perceived Barriers

By Hossam Mahmoud, MD MPH

More evidence continues to support the efficacy, acceptability and feasibility of telepsychiatry. While more research is always reasonable, it is essential that we overcome the reluctance to implement telepsychiatry in the face of the current evidence.

Parts I and II of this series focused on answering common questions about telepsychiatry and on addressing common misconceptions that may dissuade psychiatrists from incorporating telepsychiatry into their practice. The third part will discuss approaches to overcoming some barriers to adopting telepsychiatry.

Destigmatizing the use of technology

Today the use of technologies is widespread, including use of the internet, smartphones, social media, electronic medical records and electronic prescribing. Therefore, the challenge is not necessarily training psychiatrists on the use of technology; rather, the challenge is to develop and normalize professional cyber environments, as distinguished from personal cyber environments, such as social media. As advocates for mental health and for our patients, we have years of experience fighting stigma associated with mental illness and with receiving psychiatric services. We should work within professional societies and with patient groups to destigmatize the use of technology in patient care, particularly the stigma pertaining to utilizing technology for patient communication. We need to continue to educate our patients and the public in general about the option of telepsychiatry, particularly for patients in rural areas and other hard to reach patients, such as those with limited mobility, high costs of travel, long travel time, and incarcerated patients.

Security Safeguards

Many psychiatrists continue to have concerns about patients' personal and health information, in the context of telepsychiatry, especially patient confidentiality and the risks of creating a digital paper trail that might be accessed by unauthorized users. However, many HIPAA-compliant platforms, electronic prescribing programs and electronic health record programs have become available in recent years. In addition to encryption technology, some programs have incorporated other levels of data security, including two-step verifications, biometrics and facial recognition.

Practice Challenges

Some psychiatrists express concerns that telepsychiatry can be an isolating method of practicing. While there are some models of telepsychiatry practice that can be isolating, applying collaborative care models can alleviate potential isolation. Accordingly, incorporating telepsychiatry into established in-person services allows psychiatrists to collaborate closely with the face-to-face treatment team. This has the potential to create a mutually supportive environment between the psychiatrist and the case managers, therapists, and other physicians.

Training and Education

Medical schools need to develop curricula that highlight the utility of telehealth, regardless of specialty. Furthermore, psychiatry residency training programs should incorporate telepsychiatry into their rotations, be it through developing their own telepsychiatry programs, building on existing programs or partnering with institutions and companies with expertise in telehealth. Regardless of whether they choose to incorporate telepsychiatry into their future practice, residents need to build skills, competence and experience in delivering services via videoconferencing. ■

For more information on telepsychiatry, please visit the APA Telepsychiatry Toolkit:

<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/telepsychiatry-toolkit-home>

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Including 20+ employer participants in several different areas of practice. Appetizers and drink tickets will be provided. Open to all IPS members.

Non-members will not be admitted.

Thursday, October 18, 2018 | 6-8:30 pm
Rock Bottom Brewery | 1 West Grand Avenue |
Chicago, IL

For both the Attendee and Employer flyer
or for more info, visit <http://illinois.psychiatry.org>.

IPS Legislative Success

By Abhisek "Chandan" Khandai, MD, MS and Hossam Mahmoud, MD MPH

HB 5557: This bill was introduced by Representative Ann Williams, and the organization behind the bill was the Guardianship and Advocacy Commission. IPS opposed this bill because it would have prohibited patients in state-operated facilities from getting emergency ECT until there has been a court hearing and would have also created barriers to ECT for other patients. Dr. Kenneth Busch, who is a constituent of Rep. Williams, addressed the issues with her. In addition, given our positive relationship with Rep. Deb Conroy, Chair of the House Mental Health Committee, IPS reached out to Rep. Conroy to voice concerns about this bill. Consequently, Rep. Conroy reached out to Rep. Williams with her concerns, and the bill did not move forward. By working collaboratively, IPS effectively killed the bill.

Concurrently, IPS' Dr. Chandan Khandai contacted the Illinois Department of Human Services in order to provide invaluable information to counter the arguments made in favor of this bill. Below is Dr. Khandai's correspondence.

Dear Mr. Hostert,

Hope this email finds you well! My name is Chandan Khandai, and I'm a graduating psychiatry resident at Northwestern currently training in ECT. I wanted to follow up on some questions that you had regarding ECT, and HB 5557.

Regarding GAC's reasons why ECT should not be provided as an emergency treatment:

1. Patients need a medical evaluation for ECT

All patients require medical evaluation before any procedure. Psychiatrists are medical doctors. So I'm unclear as to the background behind this concern. Anytime I, or any other psychiatrist, recommends any psychiatric treatment— whether ECT, or medications- we perform a medical evaluation that takes into account both psychological and general medical concerns, and to assess the balance of risks and benefits. Every doctor does this, regardless of discipline, to make sure that the benefits of the procedure outweigh the risks.

2. Patients need an evaluation for anesthesia

ECT is done under general anesthesia. But so are many other procedures, that are also often done in emergency conditions. For example, if somebody needs an emergency surgery after a car accident, they would also need an evaluation by anesthesia to see if they would be safe for general anesthesia during surgery. Again, it comes back to weighing risks and benefits. As Dr. Dinwiddie pointed out in his letter, ECT is one of the safest procedures done under general anesthesia.

3. The hospital must make sure the patient hasn't had anything to eat

The reason why doctors have patients fast before surgery, is that when under general anesthesia, there is a lack of normal muscle tone, and any food or drink in the stomach could possibly be

regurgitated into the lungs- "aspiration." However, emergency procedures are often done all the time without strict fasting beforehand, again if the benefits of an emergency procedure under general anesthesia outweighs the risks from aspiration. And in practice, patients who receive emergency ECT often haven't eaten or drunk anything as part of the condition that required emergency ECT in the first place.

I wanted to also quickly share two cases, that I myself saw in just the past few months, where the patients and their families benefited immensely from emergency ECT:

- A 30s something gentleman from rural IL with Huntington's Disease had a horrible rapidly progressive version of the disease, where he became severely psychotic and heard Jesus telling him to kill himself. When he was in our medical hospital, he continuously attempted to choke himself, requiring ongoing medications for agitation and restraints (which itself is not good mentally or physically in the long-term). After discussing with his wife, we performed emergency ECT on him, which helped keep him alive and reduced his agitation.
- A 70s something gentleman from downtown Chicago was brought in by his family- no history of psychiatric disease, but he had a medical history of Lou Gehrig's Disease. He suddenly stopped caring for himself, and didn't speak, eat, or drink. He was peeing on himself and not responding even to his family. Again, after discussing with his family, we pursued emergency ECT, and were able to improve his clinical condition.

In both the above cases, emergency ECT helped save lives in patients. If we had waited for a court hearing (which practically takes at least 2-4 weeks), our two gentlemen would likely have died.


I hope this helps clarify any questions you may have; but if there is anything else that comes up, please feel free to reach out again to myself, Betsy Mitchell, and Ms. Sosa of Illinois Psychiatric Society. I can also e-connect you directly to senior ECT physicians such as Dr. Dinwiddie, who have decades of experience and can explain ECT far better than I. I just ask that the legislature not prevent physicians from exercising clinical judgment in cases where irreparable harm and death can be prevented through providing a safe and highly effective treatment.

Sincerely,

Abhisek Chandan Khandai, MD

Resident Psychiatrist, Northwestern

This is a large victory for mental health in Illinois, and it was largely based on three key roles that IPS played:

1. Providing ongoing scrutiny and review of mental health bills in Illinois
2. Developing and maintaining close relationships with Illinois legislators
3. Mobilizing quickly at multiple levels to advocate for mental health, patients and psychiatrists in Illinois. 

President's Message

(continued from page 1)

is carrying this mission forward into her term, as well. In the coming year, I am hopeful that IPS can address this issue in two ways. First, we will continue to target a major obstacle – the medical licensure applications and renewal application. Efforts thus far have been met with some success, with language changes that eliminate the request for psychiatric illnesses that have interfered with practice in the past. Second, the IPS Council has formed a team to develop a public service campaign aimed at both decreasing the stigma of depression among physicians and improving access to mental health care resources available for physicians.

In light of these efforts, I hope all our members and potential members appreciate the value of IPS. Through networking and advocacy functions, through newsletters and other outreach efforts, and through member participation and its very existence, IPS is – by nature – “anti-burnout.” By creating a community of psychiatrists, we are addressing the isolation and loss of control and autonomy that contribute to burnout. In addition, by linking with APA, IPS helps Illinois psychiatrists join the national community and benefit from national resources.

It is my pleasure to serve Illinois psychiatrists. 🇺🇸

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Legislative Update

Betsy D. Mitchell, MPA, IPS Legislative Consultant

Finally, the issue of mental health has risen to the top of Illinois' political agenda. This year there may have been more bills introduced in Springfield dealing with mental health than any other issue except education. IPS requested the introduction of two specific bills; one bill to provide for a uniform, electronic prior authorization form and another bill to increase the Medicaid rate for psychiatrists. Over the summer, please contact your legislators and discuss these two important bills:

HB5769/ Conroy (D, Villa Park) — After being introduced at the suggestion of IPS, this bill was negotiated with the Medicaid Managed Care Organizations (MCO) and the commercial insurers to create two task forces, one to create a uniform prior authorization form for MCOs and one to create a uniform prior authorization form for commercial insurers and for both forms to be allowed to be submitted electronically. Time ran out at the end of session to pass this bill but it is expected to be voted on and passed during the November legislative veto session.

HB 5285/ Feigenholtz (D, Chicago) — In 2015 Governor Rauner eliminated the Psychiatric Leadership Capacity Grants (PLCG) which were valued at \$27M. The grants were given by the State to community mental health centers to hire psychiatrists because the Medicaid reimbursement rates for psychiatrists were so low. In 2014, the State paid \$47M to psychiatrists. In 2017, after the PLCGs were eliminated, psychiatrists were paid \$21M. Also, the long budget impasse devastated mental health in Illinois. Over 2.5 million people in Illinois have a mental health condition, but only one-third can receive treatment. In addition, Illinois chose not to increase Medicaid rates to take advantage of matching federal funding. Furthermore, the State also did not include add-ons for CPT codes used by psychiatrists while the State included almost \$27M in add-ons for codes used by other mental health professionals. While telepsychiatry is beginning to improve access, it will not attract more psychiatrists to Medicaid. At the request of IPS, Rep. Feigenholtz introduced HB5285 to increase the Medicaid reimbursement rates for psychiatrists. Although a rate increase was not successful in getting into the budget, discussions on this vital issue continue. It is our hope that more legislators will see that without a rate increase, more and more patients in need of psychiatrists will not be able to access care. An increase in the Medicaid reimbursement rate for psychiatrists is the key to serving more in need.

In addition to our legislation, IPS engaged in many legislative discussions to develop good mental health policy for Illinois. Below please find a highlight of the bills that were passed by both the House and the Senate. These bills now await the Governor's consideration. Watch for future reports regarding the Governor's action on these bills.

Highlights of Legislation Passed By Both Houses and Awaiting Governor's Action:

SB 1707 HA3 — The Illinois House of Representatives passed Senate Bill 1707 with a strong bipartisan vote (106 to 9). This bill is the strongest mental health parity law in the nation and is the result of Kennedy Forum Illinois campaign over several years to improve parity law enforcement. This landmark legislation expands access to addiction treatment to help address the Opioid Crisis. Furthermore, among many other provisions, the bill prohibits prior authorization and step-therapy requirements, for FDA-approved medications needed to treat substance use disorders. It requires FDA-approved medications for substance use treatment to be on the lowest tier of formularies, prohibits the exclusion of coverage for court-ordered treatment and ensures a mechanism for ongoing monitoring of compliance with such measures. Also, the bill requires MCOs and commercial insurers to provide parity compliance analyses to the Illinois Department of Insurance and the Department of Health and Family Services.

HB 1853 — Psychology Inter-jurisdictional Compact Act Creates the Psychology Inter-jurisdictional Compact Act to allow Illinois to enter into a compact with other participating states for clinical psychologists. At the suggestion of IPS and with assistance from ISMS, language was added to the bill to amend the Clinical Psychologist Licensing Act to require that only clinical psychologists may participate in the new Psychology Inter-jurisdictional Compact Act. Should this legislation be signed into law, it will become effective on January 1, 2020. Following the adoption of our requested language, IPS was neutral on this bill.

HB 4096 — Medicaid-MCO-Preferred Rx List

Provides that beginning January 1, 2019 and continuing through January 1, 2022, HFS will require each MCO to list as preferred on the MCO's preferred drug list at least the same number, and no fewer, of drugs per drug class as are listed on the preferred drug list of the Illinois Department of Healthcare and Family Services (HFS). IPS supports this legislation.

HB 4146 — Patient Rights-Transition

During an enrollee's plan year, the bill prohibits a health care plan from removing a drug from its formulary or negatively changing its preferred or cost-tier sharing unless, at least 60 days prior to making the formulary change, the health care plan provides notifications to prescribing providers, as well as to current and prospective enrollees. The provider may certify that coverage of the drug is medically necessary for the enrollee. In this case, the health care plan shall authorize coverage for the drug based solely on the provider's assertion that coverage is medically necessary and prohibits the health care plan from making certain modifications to the coverage related to the covered drug. If signed into law, the bill becomes effective immediately. IPS supports this legislation.

HB 4165 — CMS-DHFS-ACA Protections

Prohibits Illinois from applying for any federal waiver that would reduce or eliminate any protection or coverage required under the Patient Protection and Affordable Care Act (ACA) that was in effect on January 1, 2017, including, but not limited to, any protection for persons with pre-existing conditions and coverage for services identified as essential health benefits under the ACA. If signed into the law, the bill becomes effective immediately. IPS supports this legislation.

HB 4936 — MENTAL HEALTH PROFESSIONAL

Requires HFS to seek Federal approval of an amendment to the Illinois Title XIX State Plan for the purpose of allowing a person who has completed a psychiatric training certification program from any branch of the U.S. Armed Forces and who has at least one year of experience in a mental health setting to be recognized as a mental health professional and be able to practice as such in Illinois. IPS did not support this bill.

HB 4949 — Consumer Fraud-Mental Health Ads

Amends the Consumer Fraud and Deceptive Business Practices Act to make it an unlawful practice for any person to engage in misleading or false advertising or promotion that misrepresents the need to seek mental health disorder or substance use disorder treatment outside of the State of Illinois. IPS supports this bill.

HB 5109 — Behavioral Health Loan Repayment

Creates the Community Behavioral Health Care Professional Loan Repayment Program to be administered by the Illinois Student Assistance Commission, beginning July 1, 2019. The bill provides for loan repayment assistance, subject to appropriation, to eligible mental health and substance use professionals, including

psychiatrists, practicing in a community mental health center in an underserved or rural federally designated Mental Health Professional Shortage Area. IPS supports this legislation.

HB 5111 — Behavioral Health Workforce

Creates the Behavioral Health Workforce Education Center Task Force Act.

SB 904 — Workers Comp & Physicians

Introduced at the suggestion of ISMS, the bill requires a provider to bill an employer directly and that the employer or the insurer must send to the provider an explanation of benefits. Requires employers and insurers to pay interest to providers for services if the bill is not paid promptly. Authorizes providers to bring legal action in circuit court to enforce the payment procedures for services. Requires the Director of Insurance to adopt rules to ensure that providers have the opportunity to comply with requests for records by employers and insurers. Imposes penalties upon employers and insurers that fail to comply. If signed by the Governor, the bill becomes effective immediately. IPS supports this legislation.


SB 2446 — Tele-Psychiatry

Requires HFS to reimburse psychiatrists and federally qualified health centers for mental health services provided by psychiatric advanced practice nurses to Medicaid patients via tele-psychiatry. If signed into law, the bill becomes effective immediately.

SB 2609 — Psychotropic Electroconvulsive

Provides that psychotropic medication or electroconvulsive therapy may be administered pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act over the objection of the recipient if the recipient has not revoked the power of attorney or declaration for mental health treatment as provided in the relevant statute. If signed into law, this bill becomes effective immediately.

SB 2951— Early Mental Health Act

Creates the Early Mental Health and Addictions Treatment pilot programs to be implemented throughout Illinois and to take into consideration area workforce, community uniqueness, and cultural diversity. Requires HFS to develop a pilot program aimed at providing community-based mental health treatment tailored to the needs of young people. IPS supports this legislation. 

IPS Mind Matters

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IPS MIND MATTERS

IPS Member Survey 2017: Resources, Priorities and Future Directions

By Caroline Morrison, MD
and Hossam Mahmoud, MD MPH


(Continued from pg 8)

Future Directions

This set of data demonstrates that IPS members value their membership and the actions and activities of IPS. IPS Council has been examining the data in order to ensure that member input is taken into consideration as future strategies and activities are planned.

IPS will continue to serve as a referral source to connect patients to psychiatrists who are able to provide needed services across Illinois. IPS will continue to work with members, APA, other medical societies and advocacy groups to advocate for mental health, patients and psychiatrists. In addition, IPS will continue to organize educational and

professional development conferences to address the needs and interests of our members. Concurrently IPS will work on tailoring such activities to appeal to a larger segment of our members and to enhance efforts to communicate to members about educational opportunities.

Finally, members are urged to contact IPS for feedback and suggestions, regarding member benefits, social events, educational activities, and other areas of interest. Please contact Ms Meryl Sosa at: msosa@ilpsych.org 

SAVE THE DATE!

IPS WOMEN'S BRUNCH

Sunday, October 21, 2018 | 10:30 am
East Bank Club | Chicago, IL

More Information Coming Soon!