MARYLAND PSYCHIATRIC SOCIETY

MPS NEWS

Volume 28, Number 11 **Editor: Heidi Bunes** **March 2015**

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Deadline for submitting articles to *MPS News* is the 15th of the month preceding publication. Please email to heidi@mdpsych.org.

MPS News Design & Layout Meagan Floyd

The next MPS Council meeting will be Tuesday, **February 10** at 8PM in the MPS office.

President's Column

The Power of Language 2

As I approach the end of my tenure as MPS president, I can now safely confess that I spent my first two years on the Executive Committee in abject terror. I wasn't overly concerned that I wouldn't be able to handle the role itself; the process of serving on the Executive Committee provides a very useful apprenticeship and excellent mentoring, and I knew that I would have plenty of support from colleagues and staff. Rather, the fear which gripped me and often awakened me at 2am in a panic was that I had to produce a monthly column for this newsletter!

I went to medical school in Ireland, so like most non-US graduates, I began six years of training as a high school graduate, allowing only a schedule of basic sciences, pre-med and clinical studies. I had taken my last English class as a somewhat unsophisticated 17 year old high school senior, and therefore felt incredibly ill-prepared to write with any semblance of fluidity. In the light of that, I have tended to produce this column from an informative perspective, avoiding editorializing, and with the aim of keeping the membership informed about MPS activities, and to petition occasionally for your engagement and support.

Imagine my surprise, therefore, when the column that produced most positive feedback was the piece I wrote in November, regarding potential changes to the dangerousness standard in Maryland. I had inserted some of my own thoughts and concerns regarding the debate, and strangely, my comments were well-received! So now, perhaps unfortunately for my readers, the idea of expressing my personal opinion on an issue seems a tad less daunting, therefore I write today on a subject I feel very strongly about, and I make no apologies!!!

So much of how we view ourselves and our place in the world depends upon the language we use; how we speak to ourselves internally, how we express ourselves to others, and how we define the external world. We continue our shaping and re-defining through life. Think about medical school and residency; a large portion of our time there was spent in acquiring a whole new language to describe and define the disease states we were learning to recognize and treat. However, while necessary to our profession, I believe that this medical vernacular also allows us to distance ourselves from our patients and unfortunately to dehumanize them at times.

I can remember as an exhausted orthopedics intern (don't ask!), referring to somebody as "the hip in unit 2," and another person as "the diabetic neck fusion." It was a way of protecting myself from much of the misery I saw, which I had little emotional energy to deal with. Dublin is a small place, however, and sometimes that distancing became more difficult, as, for example, when I recognized the "terminal AIDS patient" as a well- known entertainer whom I had idolized as a teenager, or the "young lymphoma patient" as a friend from college.

This linguistic distancing became more pervasive and profound as I began my psychiatric residency. Somehow, it seemed perfectly fine to refer to a patient as "the female schizophrenic in room 6," and again, it allowed all of us as residents to deny that we could ever be that person. I prided

(Continued on next page)

myself on being compassionate and present for my patients, and yet I still defined them in terms of their illnesses, unaware of how limiting that was for me and for them. It wasn't until a close family member was diagnosed with a severe psychotic illness that I began to think more about how the very way in which we use the diagnostic words; how they themselves change the way think about our patients. Somehow, hearing a talented, attractive, young person whom I loved, say "I'm Bipolar," stopped me in my tracks. How many times had I limited my expectations, because I was seeing a patient only as the sum part of their diagnosis?

I've tried to be more aware of this "definition by diagnosis" phenomenon. I've found myself cringing as presenters even from august institutions such as NPR, who pride themselves on their political correctness, appear to have no problem identifying a person in a news story as a "chronic schizophrenic." Recently, I heard a reporter use the statement "she was bipolar" when describing a woman's difficulties in dealing with a particular bureaucracy. How must it feel to know that the world views you as simply a diagnosis? Can you imagine the outrage if they referred to somebody as the "cancer lady?"

Generally in the media, people are portrayed as having a medical illness, or struggling with it, fighting it, beating or overcoming it. It is viewed as an entity inflicted on the individual, not a full descriptive phrase or even worse, a noun. Why is it considered perfectly appropriate to declare somebody to be "a schizophrenic?" Our patients with Bipolar Disorder, or who fight Schizophrenia or who struggle with Autism all deserve the same respect we give any "medical" illness. The entire medical community needs to be aware of their own bias towards use of this language, and we as psychiatrists need to be on the forefront to effect its eradication.

So, please consider this to be my Andy Rooney moment. I present my views to you unapologetically, and fearlessly. There is, I admit, a self-serving component to my writing this article; I hope that one day, when I am referred to as "the old Alzheimer's lady in room 6," somebody will still remember me as a mother, spouse and psychiatrist.

Sally Waddington, M.D.

MPS Seeks Nominations for Lifetime of Service Award

At the March Council meeting, nominees will be considered for the Lifetime of Service Award to be given at the April 2015 MPS annual meeting. Council would appreciate member suggestions as to who should be selected.

The award is given annually to a senior MPS member who has shown a consistent, career-long pattern of unwavering dedication, commitment, and leadership to the organization. Other qualities to be considered include significant contributions to the mental health of our community through clinical work, teaching, administration, or research. View past recipients here.

Member nominations should be submitted no later than 5:00 p.m. March 5, 2015 for this year's award. Names and any supporting reasons you wish to include can be submitted by phone (410) 625-0232, email mps@mdpsych.org or postal mail Maryland Psychiatric Society, 1101 St. Paul Street, Suite 305, Baltimore, Maryland 21202-6407.

Distinguished Fellowship

The MPS Distinguished Fellowship Committee will meet this month to consider members eligible to be nominated this year. APA Distinguished Fellowship is a national honor awarded to members who are outstanding, who have achieved true distinction in areas of expertise, and whose depth and scope of knowledge and breadth of skills are highly recognized. The MPS role is to nominate members for this honor. As part of its deliberation, the committee literally reviews every potentially eligible MPS member for potential nomination. The APA Membership Committee then reviews the applications of district branch nominees to ensure they are deserving of this national honor. Significant involvement in MPS and/or APA activities (such as participation on MPS committees) is a significant prerequisite for nomination. Also, Board certification is one of the requirements for obtaining Distinguished Fellowship status. More information is available at the bottom of this page on the APA website. If you have any questions, please contact Neil Warres, M.D., Chair of the Distinguished Fellowship Committee.

2015 MPS Annual Dinner

Thursday April 30, 2015 @ 6:00PM at Martin's West

Join us as we welcome Brian Zimnitzky, M.D. as 2015-2016 MPS President

Merle McCann, M.D. will become President-Elect & Jennifer Palmer, M.D. will become Secretary/Treasurer.

For more information or to register please click here!

February 10 Council Highlights

Executive Committee Report

Dr Waddington reported on a recent request to consider the **use of teleconferencing for Council meetings**. The MPS Bylaws were reviewed and they do not prohibit the use of teleconferencing. In checking with the District Branches, several use teleconferencing and even video/skyping because of distance and to be inclusive for members across their state. The Executive Committee discussed the use of teleconferencing and recommended that this option be reserved for Council members who would otherwise have to travel long distances to participate in the meeting. Requests would be decided on a case by case basis, and the minutes would reflect the use of teleconferencing. Teleconferencing participants would be counted for the quorum and allowed to vote on issues. Council concurred with the Executive Committee's recommendation.

Dr. Waddington discussed a bylaws change developed by the MPS Membership Committee that will be on the 2015 MPS ballot. In order to implement the change resulting from the APA's decision to begin **dropping members for non-payment of dues by March 31** starting in 2016, the MPS must change its timeline for dropping members in the MPS bylaws. She presented the proposed wording, which states that any member who fails to pay dues or other assessment for ten months shall be dropped from membership thirty days after verified contact by a member of the MPS Membership Committee, MPS leadership or MPS staff notifying the member of such proposed action. She also explained that because of the high postage for certified letters, the MPS will use three mechanisms for contacting members, with a certified letter as the last resort. Council concurred that the proposal be included on the ballot for a member vote.

Executive Director's Report

Mr. Hummel updated Council on the new MPS website and member database, including information being posted to the site, and database functionality and reports. He said that Advocacy Days were well attended. Our lobbyists arranged meetings with Senators and Delegates, including several of the newly elected members of the General Assembly. With so many new legislators, bills have been less prolific; therefore, many of the meetings were more of a "meet and greet" to familiarize legislators with the MPS.

Legislative Committee Report

Dr. Palmer described the MPS Advocacy Days and thanked everyone for participating actively. She explained that the MPS Legislative Committee and bill screeners have a conference call every Wednesday beginning at 7:00 PM during the legislative session. (Call 410-625-0232 if you are interested in becoming a bill screener.) So far the MPS has taken positions on the following legislation. [The links include a description of the legislation, bill sponsors, hearing dates, actual copy of the bill, crossfile information, fiscal notes, and committee actions.]

SB92/HB230- Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers-Repeal of Termination Date – This legislation is **SUPPORTED** by both MPS and MedChi as it removes the sunset provision for the assignment of benefits.

SB90/HB293- Guardianship, Advance Directives, and Surrogates - Disabled Persons and Mental Health Services – The MPS **SUPPORTS** this legislation with an amendment that seeks to have the 72 hour limit removed regarding a change for advanced directives. Instead, it is recommended that the person be declared competent before any such changes may be made. MedChi also supports with the amendment.

SB74/HB739- Task Force to Study Maternal Mental Health – The MPS and MedChi are overwhelmingly **SUPPORTING** this legislation. The Task Force will include a representative from both MPS and MedChi, as well as a representative of the Hopkins Woman's Mood Disorder Center.

HB3/no crossfiled SB- Prescription Drug Monitoring Program - Prescribers and Dispensers - Required Query – This legislation is **OPPOSED** by both MPS and MedChi, with Dr. Steve Daviss testifying against it. It would require physicians to always query the Prescription Drug Monitoring Program (PDMP) before dispensing or prescribing a monitored prescription drug to a patient. As the PDMP is not universally utilized in Maryland, and is in its infancy with some IT issues, these problems must be resolved before it is applied as this bill requires.

SB195/no HB crossfile- Mental Health - Voluntary and Involuntary Admissions - Assent and Certification by Psychiatric Nurse Practitioners – The MPS has sent a letter **OPPOSING** this legislation. The bar that has been established for the extreme measure of taking away a patient's civil liberties is that only two physicians, or a physician and a psychologist, may exercise this authority. We oppose expanding this authority to other members of the healthcare team.

SB162/HB451- Task Force to Study Regulation of Teletherapy – The MPS **OPPOSES** this bill because 1) there is already a Task Force on Telemedicine, we have a representative on that task force, and teletherapy could be folded into that existing task force; and 2) this proposed Teletherapy Task Force and the existing Telemedicine Task Force could develop two sets of criteria affecting psychiatrists. The criteria should be coordinated under one group. DHMH is opposing this legislation as is MedChi.

Continued on next page

Program and CME Committee Report
Dr Addison presented the brochure for *Women's Mental Health: Trauma, Mood Disorders & Resilience*. The event will be held at the Conference Center at Sheppard Pratt on Saturday April 18 from 8:30 am-3:15 pm. CME/CEU hours are 5.5. He noted the speakers, and reported that brochures have been mailed to MPS members, psychologists and social workers. Reservations are already coming in.

New Business
Dr. Aaronson closed the Council nominations for the Lifetime of Service Award and said that voting will take place at the March meeting. He reported that the Maryland Foundation for Psychiatry is seeking approval for a new member, Arthur M. Hildreth, M.D., for its Board of Directors. Council voted unanimously to approve Dr. Hildreth's appointment.

Maryland News

For Comment: 2016 Proposed Plan Certification Standards

The Maryland Health Benefit Exchange (MHBE) has proposed qualified health plan certification standards for 2016 and requests public comment prior to their consideration by the MHBE's Board of Trustees. They are also seeking comments on whether the MHBE Board should include as a voluntary standard for 2016 that issuers provide a quality improvement strategy as part of the certification process:

Quality Improvement Strategy - To obtain QHP certification, each issuer must implement a QIS, which is a payment structure that provides increased reimbursement or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities. A QHP issuer participating in the MHBE for at least two years will be required to implement and report information regarding a QIS. QHP Issuers must also submit data annually for activities that are conducted in relation to implementation of its QIS.

The public is invited to send comments to MHBE.publiccomments@maryland.gov no later than 5:00 p.m. on **Monday, March 9**.

2015-16 MPS Committees Forming!

Your energy and ideas can help the MPS effectively focus on issues that are important to you. Volunteer for MPS committees by returning the signup form included in the ballot mailing, calling the MPS office at (410) 625-0232, or emailing mps@mdpsych.org.

Maryland News

Parity Compliance Legislation Introduced in General Assembly

Cross-filed bills, SB586/HB1010 *Health Insurance - Federal and State Mental Health and Addiction Parity Laws - Report on Compliance*, are in play in the Maryland General Assembly. The sponsors are Senator Middleton in the Finance Committee and Delegates Kelly, Cullison, Morhaim, Penna-Melnyk, Reznik, and Rosenberg in the Health and Government Operations Committee. The bills would require health maintenance organizations, insurers, and nonprofit health service plans that offer specified contracts and health benefit plans to annually submit to the Maryland Insurance Commissioner a report certifying and outlining how these contracts and health benefit plans comply with the federal Mental Health Parity and Addiction Equity Act and state mental health and addiction parity laws.

One aspect embedded in the non-quantitative treatment limitations provisions of the legislation that has attracted the attention of the MPS and the APA is "network adequacy." A January 2015 study by the Mental Health Association of Maryland indicates that many psychiatrists listed on provider panels are not taking new patients, have moved, the phone number is not working, etc. Dr. Steven Daviss has testified on behalf of the MPS and MedChi regarding the issue of network adequacy as pertains to this legislation. The APA has also weighed in with letters from Dr. Saul Levin supporting both bills.

The federal Mental Health Parity and Addiction Equity Act prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. Patients cannot be denied insurance reimbursement when they reach a lifetime or annual spending cap imposed on mental health or substance use disorder care.

Online Physician Leadership Webinar

The Maryland Physician Leadership Institute, created by a grant to the Center from the Physicians Foundation, is offering a presentation by health care attorney and physician advocate, Alice G. Gosfield, Esq. Ms. Gosfield has a unique perspective on the physician mindset and the opportunities for leadership in this new era of health care reform. To view the free, one hour lecture, "Leadership in Health Care Change: Why Physicians?" which was presented at the Physician Leadership Summit at MedChi on November 2, 2014, follow THIS LINK. Please select "Show More" to see course objectives, disclosures, CME designation statement and evaluation form. CME credits have been awarded.

Maryland News

APA and MPS Advocate for Network Adequacy

On February 11, the APA and the MPS sent a letter to Governor Hogan and MIA Commissioner Redmer bringing attention to the very serious problem of access to mental health care, and in particular to psychiatrists, in Maryland's 2014 Qualified Health Plans ("QHPs") sold through Maryland Health Connection. It also highlighted the general need to ensure that all health plans meet network adequacy standards. The current situation results in higher health care costs for Marylanders and patients with untreated mental illnesses. Excerpts from the letter follow:

On January 26, 2015, the Mental Health Association of Maryland published "Access to Psychiatrists in 2014 Qualified Health Plans," which chronicles a study of the adequacy of the psychiatric networks in Maryland's four QHPs examining the accuracy of the provider directories and availability of the 1,154 psychiatrists in those directories to see patients within 45 days. The study results are devastating to those with mental illness or substance use disorders. Specifically,
• only 43% of the psychiatrists listed could be reached primarily because phone numbers were not working or incorrect, or the physician died, retired or relocated. (page 5)
• 19% of those who were reached were not actually psychiatrists although they were listed as such. {page 5)
• Less than 40% of the providers listed accepted the insurance of the company listing them as a participating provider. (page 6)
• Less than 18% of the psychiatrists listed were taking new outpatients. (page 6)
• Only 14% of psychiatrists listed and taking on new patients could see the patient in less than 45
days. (page 1)

Health plans have ready access to the claims data to know whether a physician is taking new patients and whether the physician is an active participant in the plan, but there is no evidence that they use their data to assure their network is sufficient to meet the consumer's needs. Plans can and should run the data on claims filed for each physician listed in their network on a quarterly basis. If a listed physician has not filed a claim in the past quarter, the physician obviously is not taking that insurance. Likewise, a small volume of claims should lead the carrier to question whether the physician is an active participant in the network and fairly included in the carrier's analysis of network adequacy. For plans that have an out of network benefit, the plan should run out of network claims data; a large volume of out of network claims means there are not sufficient choices in network because most patients would not voluntarily choose to pay out of pocket if the network in the plan was sufficient.

As you know, the state has the authority to require plans to verify the adequacy of their network and plans have the means to do it. APA respectfully requests that you require all exchange plans (indeed we recommend the state should require *all* insurance plans) on a quarterly basis to verify the adequacy of their network by publicly reporting (a) the number of claims filed by each psychiatrist listed in the network; and (b) publicly reporting the number of psychiatric claims paid on an out of network basis. Plans must then be required to update the network directories and their network adequacy analysis to remove those physicians that are not actively participating.

Appropriate treatment of mental health conditions will ensure overall health of the population and it will decrease the overall cost of medical care. As evidenced in the attached study by Milliman, spending on mental health care actually reduces the overall cost of health care for individuals and for the state.

Accordingly, APA asks that the state of Maryland ensure that: (a) citizens of the state get access to the mental health care for which they have paid, and (b) health insurance carriers are responsible for providing the resources promised to their customers. APA would like to work with the state of Maryland to make mental health care, an essential health benefit, available to all of its citizens.

New Behavioral Health Campaign

The Maryland Behavioral Health Coalition has launched a campaign to inform the public about the proposed budget cuts' impact on crucial healthcare services for Marylanders with mental health and substance use disorders. The theme is "Keep the Door Open." A new website launched in February. The problem of underfunding is effectively presented along with a call to action: Tell state legislators not to the shut the door on those who need help; there must be no more cuts to the behavioral health budget, and the 2% provider rate cut must be restored.

The website is accompanied by a Twitter campaign that had reached nearly 100K accounts as of February25. Join the campaign to keep the momentum going!

The Maryland Behavioral Health Coalition's February 25 rally in Annapolis was covered by several news outlets, including The Baltimore Sun, WTOP, and WYPR, among others.

APA Information

Record Requests Referring to ACA Risk Adjustment Formulas

The APA has received several calls from members who have received **letters from insurance plans or third parties requesting patient records** on behalf of insurance plans. Following is a potential response for member use that has been prepared by APA General Counsel.

Reason for the Letters. These letters are being sent so that insurers can comply with the requirements of the Patient Protection and Affordable Care Act (ACA). The ACA was concerned that insurers would cherry pick healthy individuals in an effort to avoid the cost of long term and serious illness. To offset that possibility, the ACA contains a "Risk Adjustment" formula that requires carriers who have fewer seriously ill members to make payments that will go to those carriers that have more seriously ill members so that in the end, the risk of loss due to covering serious illness is equitably shared by the insurance industry and there will be no benefit to discriminating against more complex individuals.

Why Patient Records Are Requested. To determine which carriers get paid and which will pay, the law requires carriers to report claims data to the state or to the Department of Health and Human Services. The carriers are responsible for ensuring that the data reported is accurate and therefore are conducting audits of their own data, which was originally derived from claims submission forms. Insurers have a record of the numbers of patients they paid claims for with X disease and that will be compared to how many consumers with X disease other insurers report. To ensure that the reporting is accurate, some insurers have hired audit firms that will review patient files to make certain that coding was correct and that, in the case of multiple diseases, all have been reported so that their company will accurately be placed in the correct grouping of those who pay because they have fewer seriously ill members or those who receive payment because they have more. These letters seek patient files in order to audit the data the insurance company has for the patients and make sure that their reports to the government will be accurate.

Your Responsibility. The answer to the question of whether the treating physician has to provide the data is different depending on the physician's status with the insurer and the patient's agreement with the insurer:

Participating physicians. Physicians who participate in the insurance network that is asking for the information need to check their contract to determine what documentation they are required to provide. It is likely that the agreement requires the physician to provide documentation when requested, but this could vary from contract to contract. In this situation, HIPAA allows a physician to provide the information to the insurance plan or to its "business associate."

Non-participating physicians. Physicians who do not participate in the insurer's network and have no contractual relationship with the insurer probably have no legal duty to the insurer and no obligation to respond to the insurer's request for information. Your patient, on the other hand, may have a duty to provide the information to the insurer under the terms of his/her plan and this may vary from plan to plan. Several options are reasonable in this circumstance.

a.Inform the patient of the request and reason therefore, and if the patient consents to providing the information, cooperate with the request.

b.Inform the entity making the request that they need to first secure the patient's permission for you to provide the records.

c.Wait for further communication from the requesting entity and then let them know that they need to contact the patient first for consent.

d.Wait for further communication from the requesting entity and ask them to provide in writing the statute, regulation, or contract that they believe requires you to provide the records.

Produce Records Only to a HIPAA Covered Entity. If the letter you received is not from the insurer, but instead comes from a company claiming to be a business associate of the insurer, you should check with the insurer before providing records to confirm that the requesting company is actually the insurer's business associate. If the letter you received comes directly from the insurer with whom you contract and it represents that a third party is a business associate under HIPAA, it should be fine to provide the records to that third party.

ICU Program

The Partnership for Workplace Mental Health announced the launch of ICU, a program designed to decrease the stigma associated with mental health and foster a workplace culture that supports emotional health. ICU was developed by DuPont and delivered to their global workforce of 70,000 employees. The core component is a five-minute video that teaches employees about emotional health and how to appropriately connect with distressed coworkers who may need support. Visit the ICU program page to watch the video or review an implementation guide and tools for launch that can be tailored for each workplace.

Physician Burnout - Impact on Patients and Resources

A study in the February issue of the APA's *Psychiatric Services* reports that burnout among mental health professionals affects their work, including empathy, communication, therapeutic alliance, and engagement. Reducing professional burnout may have secondary gains in improving quality of services and patient outcomes.

A Medscape article expands on this study as it relates to physicians, including physician suicide. *Medscape Medical News'* recently released Physician Lifestyle Report 2015 shows that 46% of US physicians experience burnout, a rate that is up by 6% from 2013. The report also shows that burnout among psychiatrists runs at 38%.

Several helpful resources addressing the problem of physician burnout are available:

- Recognizing ongoing stressors in the lives of physicians across the lifespan, in 2011 the APA adopted a Position Statement on Physician Wellness as well as a resource document on the same topic.
- The American Psychiatric Foundation's Partnership for Workplace Mental Health publishes *Mental Health Works*, which included a 2012 article about a study at South Shore Hospital on ways to help their employees manage stress. The article begins on page 9 and includes a toolbox of stress management techniques that starts on page 11.
- California Public Protection & Physician Health has posted references for physician stress and burnout.
- University of Colorado and Colorado Medical Society developed a Work and Well-being Toolkit for Physicians. Page 20 has a Physician Burnout Symptom Checklist and page 22 has strategies to avoid burnout.
- In our state, the Maryland Physician Health Program assists physicians with impairments and concerns, including stress.

Loan Repayment Program Applications Now Being Accepted

The 2015 National Health Service Corps Loan Repayment Program application cycle **deadline is March 30** at 7:30 p.m. EST. This program provides loan repayment assistance to licensed primary care medical, dental, and mental and behavioral health providers who serve in communities with limited access to health care. There are both full-time and half-time service options. Available resources include the **APPLICATION AND PROGRAM GUIDANCE** and instructions on **HOW TO APPLY**.

From January 28 *Psychiatric News Update*

Medical Ethics Journal Provides Guidance

The new *AMA Journal of Ethics*, launched in February, offers insights into ethical decision making and the challenges medical students and physicians confront in their training and daily practice. The inaugural issue investigates professionalism, empathy and the role of the "hidden curriculum" in medical education. The *AMA Journal of Ethics* is actually the new name for AMA's online ethics journal, *Virtual Mentor*. The name change comes with:

- A refreshed website featuring expert commentaries and articles
- An easy-to-read monthly email summary of each issue
- Access to monthly ethics polls and podcasts on timely ethical issues

Medical student and resident physician issue editors suggest themes and solicit articles from ethics experts and experienced physicians. Upcoming issues will address the culture of medicine, treatment of autism, professional boundaries, health reform and patient care. The MEDLINE-indexed *Journal* is ad-free and open-access.

From February 2 *AMA Wire* post

HHS Plan for Improved Health Technology

On January 30, The HHS Office of the National Coordinator for Health Information Technology (ONC) released Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0, a proposal to deliver better care and result in healthier people through the safe and secure exchange and use of electronic health information. In addition, the ONC issued a report that identifies the best available technical standards for core interoperability functions.

The draft Roadmap, designed in concert with the Federal Health IT Strategic Plan 2015 – 2020, is based on building blocks that are needed to achieve interoperability:

- Core technical standards and functions;
- Certification to support adoption and optimization of health IT products and services;
- Privacy and security protections for health information;
- Supportive business, clinical, cultural, and regulatory environments; and
- Rules of engagement and governance.

Both the draft Roadmap and the Standards Advisory can be viewed at www.healthit.gov/interoperability. The public comment period for the Roadmap closes **April 3, 2015**. The public comment period for the Standards closes **May 1, 2015**.

Telemedical Liability

As with any medical practice, there are liability issues to be considered when using telemedicine technologies. Joseph McMenamin, M.D., an expert in legal medicine, gives insight on the potential liability climate resulting from use of telemedicine and outlines steps to minimize potential risk:

Define the minimum requirements to establish the doctor-patient relationship. This is crucial to determining whether the physician has a duty to the patient. The AMA's principles for telemedicine specify that a valid patient-physician relationship must exist before using telemedicine, through:

- A face-to-face examination, if a face-to-face encounter would be required in the provision of the same service in the real world
- A consultation with another physician who has an ongoing patient-physician relationship with the patient
- Meeting evidence-based practice guidelines on telemedicine regarding establishing a patient-physician relationship developed by major medical specialty societies

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care.

Determine who owns the huge amounts of data available to both patients and physicians. Now that patients have wearable technology, how are they sharing health data with their physicians? And what—if anything—are physicians required to do with that data?

Be sure medical liability carriers cover telemedicine and data-related risks in policies. Telemedicine opens a door to a variety of medical liability risks that could go beyond tort claims. For example, non-tort risks include licensure, credentialing, privacy and security, reimbursement, deceptive trade practices, wrongful data collection and more.

Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and requirements as well as state medical practice laws, including laws concerning consent involving minors, prescribing, reproductive rights, end-of-life decisions and scope of practice. AMA principles call for physicians practicing telemedicine to maintain licensure in the state where the patient is located.

From February 11 *AMA Wire* post

For more on telepsychiatry, see the risk management article by PRMS on page 4 of the October 2013 *MPS News* or browse information on the APA website.

States Begin Considering Interstate Licensure

Eleven states have endorsed an interstate compact designed to facilitate medical licensure for physicians seeking to practice in multiple states. The Federation of State Medical Boards (FSMB) developed the compact, which was endorsed by the AMA in November. AMA is working with interested medical associations, the FSMB and other stakeholders to ensure expeditious adoption of the compact and the creation of an Interstate Medical Licensure Commission.

Already, legislators in 11 states—Iowa, Minnesota, Montana, Nebraska, Oklahoma, South Dakota, Texas, Utah, Vermont, West Virginia and Wyoming—have introduced the legislation. A new map highlights the growing support in state legislatures and includes links to the proposed legislation.

The compact is based on three key principles:
1.The practice of medicine is defined as taking place where the patient receives care, requiring the physician to be licensed in that state and under the jurisdiction of that state's medical board. This tenet aligns with the principles for telemedicine adopted at the 2014 AMA annual meeting.

2.Regulatory authority will remain with the participating state medical boards, rather than being delegated to an entity that would administer the compact.

3.Participation in the compact is voluntary for both physicians and state boards of medicine.

Among states that adopt it, the compact would act as an independent law and as a contract among the states to help ensure ongoing cooperation and adaptation.

From January 29 *AMA Wire* post

New Veterans' Mental Health Law

On February 12, President Obama signed into law the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, overwhelmingly passed by the House and Senate in the new Congress. APA's Dr. Paul Summergrad and Dr. Saul Levin witnessed the signing of this legislation, which is intended to reduce suicide and help veterans receive much-needed mental health care.

The Maryland Psychiatric Society
presents

Women's Mental Health: Trauma, Mood Disorders & Resilience

Saturday April 18, 2015
8:30 am-3:15 pm

The Conference Center at Sheppard Pratt

5.50 CME/CEU Hours

Registration is
$125.00 for MPS Members
and **$190.00 for Non-members**.

Fees are non-refundable.

For more information or to
REGISTER & PAY ONLINE:
http://womensmentalhealth.eventbrite.com

Register Now to Review Sunshine Act Payment Data in April

The second year of data submission in the Physician Payments Sunshine Act (also known as the "Open Payments" program) began last month, giving physicians the chance to register with CMS to review and dispute their financial interactions with medical device and drug manufacturers. Open Payments attempts to increase transparency and accountability in health care. If you haven't already registered in the agency's Open Payments portal, do so now in preparation to review and dispute data this spring. The AMA has taken an active role in guiding physicians through the review and dispute process, and providing talking points to explain the data to inquiring patients. [The APA has also been a valuable resource for information about this program by posting information online and helping members with the registration process.]

Medical device and drug manufacturers will have until March 31 to submit 2014 financial data, and CMS anticipates physicians will be able to review that data in April. In June, CMS plans to publish the 2014 payment data, and make updates to 2013 data.

From February 9 *AMA Wire* post

Notify MPS re Authorizations for Medications

The MPS Payer Relations Committee is collecting information from members about required prior authorization for generics, with the goal of showing insurance companies that it does not reduce costs. The information needed is the pharmacy management company, insurance company, medication, and why the prior authorization is needed. Please email the information to Laura Gaffney, M.D., Chair.

The committee also wants members to be aware of Maryland's step therapy law, which states that if a patient has been stable on a certain medicine for 3 months and the patient changes insurance, the insurance company is not allowed to require the patient to fail other medications before being prescribed the current medicine. This does not apply to Medicare D, Medicaid or self-insured employers. Members having problems with step therapy requirements should email Laura Gaffney, M.D., Chair, for assistance.

ABPN Response to ABIM Plans Re MOC

In a February 10 letter, the ABPN responded to the American Board of Internal Medicine's plans to make its MOC program more relevant for physicians. The ABPN noted that most of ABIM's plans are already in place in the ABPN MOC program, and stated it is planning no changes in its program requirements at this time. The letter included the ABPN's core beliefs underlying its MOC requirements:

- The vast majority of diplomates already pursue life-long learning.
- A collaborative approach to MOC.
- Avoid any potential conflict of interest in the MOC program.
- MOC requirements must not place an onerous burden on diplomates.
- It is crucial that diplomates select the specific MOC products that best fit their needs for self-assessment, CME, and performance improvement.
- It is important to recognize and give diplomates MOC credit for what they do already.
- The vast majority of diplomates should be able to pass MOC examinations.
- The ABPN must only report whether or not diplomates have met its MOC requirements.
- Diplomate attestation and random audit are acceptable methods to document performance in MOC.
- MOC fees must be reasonable.

The ABPN is looking for ways to improve its relevance and flexibility, and to reduce the burden it places on diplomates. They welcome recommendations in that regard.

Medicare News

Possible EHR Incentive Program Changes in 2015

CMS intends to implement changes that would help to reduce the reporting burden on providers, while supporting the long term goals of the program. Responding to input from health care providers and other stakeholders, CMS is considering the following changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- Shortening the 2015 reporting period to 90 days to address provider concerns about their ability to fully deploy 2014 Edition software
- Realigning hospital reporting periods to the calendar year to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other quality programs
- Modifying other aspects of the programs to match long-term goals, reduce complexity, and lessen providers' reporting burden

These changes will not be included in the pending Stage 3 proposed rule. For more information, read Dr. Conway's blog, CMS intends to modify requirements for Meaningful Use, or visit the EHR Incentive Programs website.

PQRS Payment Adjustments & Providers Who Rendered Services at IDTFs

Participation in the PQRS program is at the individual National Provider Identifier (NPI) level within a Tax Identification Number (TIN). Eligible Professionals (EPs) who worked for more than one organization during the 2013 PQRS program year (January 1 through December 31) had to meet the reporting requirements for each TIN under which he or she worked to avoid the 2015 PQRS payment adjustment for each TIN, or for each specific TIN/NPI combination. Beginning January 1, 2015, EPs who did not meet the PQRS reporting requirements during the 2013 program year will receive a 1.5 percent cut to all of their Part B Medicare reimbursements. CMS previously issued guidance that EPs who rendered services at independent diagnostic testing facilities (IDTFs) would be eligible, but not able, to participate in PQRS due to their billing methodology. However, CMS has now determined that these EPs **are** eligible and able to participate in PQRS. For more information, click here.

PQRS Booklet Released

"The 2013 Physician Quality Reporting System (PQRS)" booklet provides in-depth education on PQRS, including important changes for the 2013 PQRS, 2015 payment adjustment, and more.

2015 Medicare Telehealth Services

CMS updated its "Telehealth Services" Fact Sheet, which describes services that can be furnished to Medicare beneficiaries via a telecommunications system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, billing and payment for the originating site facility fee, resources, etc. Several psychiatric services became eligible for telehealth coverage this year.

CMS Extends Meaningful Use 2014 Reporting Deadline

CMS announced on February 25 that physicians participaing in the meaningful use electronic health record (EHR) incentive and penalty program will now have until March 20 to attest to meaningful use for the 2014 reporting year. The previous deadline was February 28. "CMS extended the deadline to allow providers extra time to submit their meaningful use data," the agency said in a news release. According to CMS data released in mid-December, more than 50 percent of eligible professionals will face payment penalties next year because they could not fulfill the requirements of the burdensome program. The AMA has advocated for improvements to the program, which are summarized in the post.

From a February 25 *AMA Wire* post

Register for Physician Quality Reporting Programs: Reporting Once in 2015

On Wednesday, **March 18 from 1:30 to 3 PM**, a provider call will give an overview of how to report once across various 2015 Medicare Quality Reporting Programs, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, Value-Based Modifier (VM), and Medicare Shared Savings Program. This presentation will help providers wishing to report quality measures one time during the 2015 program year and maximize their participation in the various Medicare quality reporting programs in order to avoid the 2017 PQRS negative payment adjustment, satisfy the Clinical Quality Measure (CQM) component of the Medicare EHR Incentive Program, and satisfy requirements for the VM, avoiding the VM payment adjustment. A Question and Answer session will follow the presentation. This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (refer to the call detail page for more information). Register early; space may be limited.

CLASSIFIED

EMPLOYMENT OPPORTUNITIES

The University of Maryland Medical System (UMMS) is looking to fill several psychiatry positions. The University of Maryland Medical Center (UMMC) Midtown is looking for a Psychiatry Chair; UMMC is looking for a full time community child and adolescent psychiatrist and a full time consulting liaison faculty; Union Hospital, UM Upper Chesapeake Health and UM Baltimore Washington Medical Center are all looking for experienced full time psychiatrists. For more information visit our website www.ummsphysician.jobs or contact Jill Albach at jillalbach@umm.edu. UMMS is an Equal Opportunity Employer.

PSYCHIATRIST - full or half time, independent contractor position with well-established & growing multidisciplinary practice. Spectrum Behavioral Health is an Annapolis area private practice with three desirable locations, congenial colleagues and comprehensive administrative support. For more information about SBH, visit our website: www.spectrum-behavioral.com. To discuss this opportunity, please call Barbara Usher, Operations Administrator, at 410-757-2077 x7121 or email barbara.usher@spectrum-behavioral.com.

PSYCHIATRIST NEEDED- Full or Part Time. Private practice in Towson without hassles. Full administrative support. No insurance contacts. Flexible hours. Plenty of patients. Contact Abdul Malik, M.D. at 410-823-6408 x13 or email to Drmalik.baltimore@gmail.com

Psychiatrist wanted for behavioral health Organization in Baltimore. Adult population served. Clinical responsibilities include evaluations and psychopharmacology management. Buprenorphine services offered by the clinic, but not a necessary requirement for hire. Full or Part-time employment. Send CV to: University Psychological Center, Inc. Attn: Clark J. Hudak, Jr., Ph.D. Requirements: Active individual Malpractice insurance (1-3 million) and Valid License, DEA, CDS.

Jewish Community Services (JCS), is a non-profit human services agency that provides programs and services to support meeting basic needs for economic sufficiency; living independently; achieving mental health and competence; and feeling supported by and connected to the Jewish community in ways that are meaningful. JCS is seeking a Part-Time Psychiatrist for our outpatient mental health center. Job Skills/Qualifications: Conduct psychiatric evaluations and medication management. Experience: Psychiatrist, Psychiatric Resident or Fellow, Child and adolescent experience a plus. Education: MD; Licensed in Maryland, DEA certification, liability insurance. Fax your resume and cover letter to 443-200-6108 or apply directly : https://home.eease.adp.com/recruit/?id=10157231

The **Center for Eating Disorders** has the following available positions:
Inpatient/Partial Hospitalization Attending Psychiatrist will lead a multidisciplinary treatment team in the assessment and care of patients with eating disorders. This unique practice opportunity combines the excitement of an academic environment with training of fellows, post-doctorate psychologists, social work interns and University of Maryland residents. MD license required.
Outpatient/IOP Attending—Services to be provided will include Evaluations, Level of Care Assessments, and Pharmacological Management. Opportunity to provide Individual, Group and Family Therapy. One position includes leading a multidisciplinary treatment team for an Intensive Outpatient Program. MD license required.
Eating Disorder Fellowship In partnership with University of Maryland, the Center for Eating Disorders is offering one-year fellowships starting July 1, 2015 on an inpatient/partial hospitalization unit. Training goals include 1. Develop comprehensive understanding of diagnostic criteria, etiology and co morbidity of patients with eating disorders. 2. Develop ability to complete diagnostic assessments on patients with eating disorders. 3. Develop individualized treatment plans providing recommendations for psychopharmacologic, individual, group and family therapy as well as determination of level of care indicated. 4. Develop competency in management of a multidisciplinary treatment team on an Eating Disorder Inpatient/Partial Hospitalization Unit. Opportunity to sign on upon completion of fellowship. The positions are available to start July 1, 2015.
Please fax resume to 410-938-5250, or mail to: Steven Crawford, M.D., 6535 N Charles St, Suite 300, Baltimore MD 21204. You may also email your resume to scrawford@sheppardpratt.org.

The Johns Hopkins Hospital Community Psychiatry Program is recruiting a board eligible/board certified adult psychiatrist to work full-time in their outpatient program. The program uses a multidisciplinary approach to provide care to those with a wide range of psychiatric disorders. Applicants may be eligible for the Maryland State Loan Repayment Scheme (SLRP). For more details please contact Dr. Bernadette Cullen, Director, Community Psychiatry Program at 410-955-5748 or email: bcullen@jhmi.edu.

REMEMBER TO VOTE!

The **2015 MPS election begins March 1!** Returned ballots must be postmarked no later than March 31, 2015. Candidate biography information is available online this year. Please click here!

Sheppard Pratt
PHYSICIANS, P.A.
PART OF THE SHEPPARD PRATT HEALTH SYSTEM

WEEKEND PSYCHIATRISTS

Either Towson or Ellicott City, Maryland

Sheppard Pratt is seeking psychiatrists to provide inpatient, weekend services on either our main campus in Towson or on our campus in Ellicott City, Maryland. This position can be configured as a part time or full time position, depending on the number of weekends the psychiatrist desires to work. Both adult and child psychiatrists are needed.

Qualified candidates must possess a current license to practice in Maryland at the time of appointment. Sheppard Pratt offers a generous compensation package and is an equal opportunity employer. To inquire about these positions, please contact Kathleen Hilzendeger, Director of Professional Services, 410-938-3460 or khilzendeger@sheppardpratt.org.

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Or email CV to dawn@mhmcareers.com

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INPATIENT PSYCHIATRISTS

Both Adult and C&A Psychiatrists are Needed

Towson, Maryland

Sheppard Pratt is currently recruiting for psychiatrists to provide inpatient services on several units on our main campus in Towson, Maryland about twenty minutes north of Baltimore's Inner Harbor. Based on psychiatrist preference, these positions can be paired with assignments in the partial hospital or in crisis evaluation services.

Sheppard Pratt is seeking psychiatrists with an orientation to time effective treatment, sensitivity to managed care referrers and a focus on quality care in a clinical setting with active training programs. Board certification and advanced specialty training are highly preferred. Sheppard Pratt offers flexible, competitive compensation and benefit plans and is an equal-opportunity employer.

Please contact Kathleen Hilzendeger, Director of Professional Services, at 410-938-3460 or khilzendeger@sheppardpratt.org.

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MEDICAL DIRECTOR

ADOLESCENT RESIDENTIAL TREATMENT CENTER

TOWSON, MARYLAND

Sheppard Pratt is recruiting a Board Certified Child Psychiatrist with experience in treating the severely mentally ill adolescent within a psychiatric residential treatment facility (PRTF) setting. Responsibilities include leading a multiple discipline team and providing the assessment and management of adolescents placed in intermediate to long term residential care and special education. The patient population includes individuals with multiple psychiatric disorders including severe mood dysregulation, PTSD, impulse control disorders, conduct and learning disorders, and mild developmental disorders. Additional responsibilities may include the supervision of psychiatry residents and/or fellows.

The Medical Director is the leader of the clinical team and responsible for the quality of care and the oversight of all clinical activities for the program. Qualified candidates must have leadership experience. Qualified candidates must possess a current license to practice in Maryland at the time of appointment. Board Certification is highly desired. Sheppard Pratt offers a generous compensation package, comprehensive benefits and is an equal opportunity employer. For more information, please contact our Director of Professional Services, Kathleen Hilzendeger, at 410 938-3460, email khilzendeger@sheppardpratt.org.

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