Bill S.88, now Act 128, was passed in the 2010 legislative session and was allowed to become law without Governor Douglas’s signature. Among the provisions of the law were expansion of the Blueprint for Health and mandatory participation by hospitals and insurers. The act also requires the Department of Vermont Health Access to hire a director to create payment reform pilot projects. There are immediate cost-containment provisions applying to insurance companies and hospitals. Of interest, the minimum loss ratios from the Federal health reform legislation will apply to insurers and managed care organizations subcontracting to cover mental health and substance abuse treatment services.

There were some changes around disclosures and gifts from industry. For more information, see:  [http://www.leg.state.vt.us/docs/2010/Acts/ACT128sum.htm](http://www.leg.state.vt.us/docs/2010/Acts/ACT128sum.htm).

Perhaps most important, Act 128 calls for a study of three models for health care financing. The Health Care Reform Commission was tasked to recommend a consultant. A team headed by Harvard Economist William Hsiao, PhD, was selected and is studying Vermont's health care system now. The team will report to the Legislature early in 2011 with three options. The VPA Executive Committee believes Dr. Hsiao was the best possible choice, as he has years of international experience studying and designing health care financing systems. He designed the highly successful system in Taiwan. For the first time, we have a chance to create a true health care system in Vermont.

At the Vermont Medical Society meeting in early November, there was a presentation by Dr. Hsiao and Steven Kappel, his colleague on the team. There are more questions at this point than answers. The legislative, tax, and regulatory constraints, both at the federal and state levels, are sobering, requiring much crunching of data. The third member of the team is Jonathan Gruber, who has spent years developing computer models. The team must give the Legislature three models, one of which must be a government-administered single payer; one of which must be a public option to compete with private insurance plans; and a third, based on the principles and goals of the Act, that the consultant believes is the most practical and viable in Vermont. Dr. Hsiao appears extraordinarily thoughtful, balanced, and careful, and welcomes input from physicians. Allocation of resources and organization of practice could conceivably change, probably over a significant number of years. The effect of possible delivery system changes such as accountable care organizations is unclear. On the other hand, if case by case micromanagement of care were to disappear, that would be a tremendous improvement.
The Vermont Psychiatric Association has endorsed a publicly financed, single payer model as the best choice for Vermont. VPA’s Health Reform Task Force is co-chaired by Drs. Alice Silverman and Sue Deppe. Other members include Jonathan Weker, Peg Bolton, and our Executive Director, Valerie Lewis.

The election of Peter Shumlin for governor is a hopeful sign for the passage of single payer health care reform. The Legislature will determine whether single payer or any other significant health care reform has a chance of passage. If it passes, state leaders and our Congressional delegation will request necessary waivers from the Federal government. We hope to be able to act as soon as 2014, rather than waiting until 2017, as dictated by the new federal health care legislation. We believe that this is a once-in-a-lifetime opportunity to bring universal coverage to Vermonter.

Passing universal access through a single payer will not be easy. By sticking his snoot into the tent, this camel will probably get a nasty nosebleed from the insurance and pharmaceutical company lobbies. This is a crucial opportunity for us to educate our communities and legislators about what is really best for Vermonters. A single payer financing system would eliminate most of the insurance and managed care administrative burdens on clinicians, giving us more time to take care of people who desperately need care. It is the only way to salvage the dwindling psychiatric and primary care workforce in Vermont, and with it, access to care.

Please educate yourself. Physicians for a National Health Program has a fabulous single payer Q and A on its website, www.pnhp.org. And www.vermontforsinglepayer.org has a very informative website.

We would welcome your involvement or questions in this legislative session. Feel free to contact the VPA Task Force on Health Reform: Sue Deppe, MD, deppe@together.net, or 802.658.7441; or Alice Silverman, MD, alicehersheysilverman@gmail.com.

Consider writing letters to the editor of your local paper in support of single payer. The Vermont Workers’ Center at 802.861.4VWC or www.workerscenter.org, is circulating a petition for its “Health Care Is a Human Right” campaign. A number of psychiatrists have signed on and become members of the Workers’ Center, which has been mobilizing Vermonters to speak to this issue. For more on systems in other countries and how citizens feel about them, including Dr. Hsiao’s comments on Taiwan, see the PBS Frontline documentary Sick Around the World. Watch it online at: http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/.

**Articles, Photos, Commentary, Poetry, Whatever . . .**

**YOUR CONTRIBUTIONS ARE WELCOME!**

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A Greeting from Your VPA President

Hello, Colleagues,

I am very pleased to see our newsletter resuming, and appreciate the contributions from our colleagues around the state who are involved in research, advocacy, and providing clinical services. Our patients continue to face many challenges living and coping with psychiatric illness in an increasingly complex and demanding world.

I want to let you know about some upcoming VPA events and projects. We will be holding a “Mentoring Dinner” for UVM medical students, residents, and VPA members on December 16, 2010, from 6 – 8 pm in Burlington. Our goal is to share information about professional options post-residency and opportunities to develop mentoring relationships going forward. Many of you have signed up to be mentors and I am hoping you will be able to make the dinner. Final restaurant information will be sent out shortly.

We will also be advocating very actively at the Statehouse during what may prove to be a very significant year for health care reform. We may be reaching out to you to testify at key legislative hearings during the session and hope the legislators can hear from as many of you as possible. I have testified on several occasions and have been told that it is very helpful to legislators. We are also trying to arrange a media education workshop for VPA members. This is a training offered by APA to help us to be as effective as possible when testifying and/or advocating for our patients through other media venues. If we can arrange this, all members will be invited to attend and information will be sent out well in advance.

Finally, we are considering new software to make our website much more informative and user-friendly. We will keep you posted as things develop.

In closing, I want to wish you all happy and healthy holidays and hope to have the pleasure of meeting with you in person at our future events.

Best Regards,

Alice Silverman, M.D.

This just in . . .

On 23 November, a Federal Appeals Court in New York struck down Vermont’s 2007 law prohibiting the use of pharmaceutical prescribing data in marketing without physicians’ consent. The case is IMS Health, Inc., vs Sorrell, U.S. Court of Appeals, Second Circuit.

MARK YOUR CALENDAR . . .

16 December 2010, 6:00 pm, Mentoring Dinner (Burlington)
4 March 2011, 10:45 am, Gibbard Lecture and Award (FAHC)
SCHIZOPHRENIA TREATMENT RESEARCH PROJECT:
PARTICIPANTS SOUGHT FROM COUNTY AND BEYOND
The RA1SE Study at the Howard Center for Human Services

By Sandra Steingard, M.D.

The Howard Center for Human Services has been chosen as a site for a National Institute of Mental Health (NIMH) funded study of first episode schizophrenia treatment called the RA1SE: The Recovery After an Initial Schizophrenia Episode Early Treatment Program. I am the Principal Investigator (PI) and psychiatrist for the Howard Center site and Anne-marie Dubois, M.S.W., is the Program Director.

The PI for the overall study is John Kane, M.D., Chairman of the Department of Psychiatry at The Zucker Hillside Hospital, and Professor of Psychiatry at the Albert Einstein College of Medicine. Dr. Kane is an internationally-recognized schizophrenia researcher. The study coordinators are all leaders in the field of schizophrenia and early onset psychosis research.

The study includes 35 sites located at facilities across the country. They include clinics affiliated with academic centers and independent agencies. One unique feature of this study is that the randomization has been allocated by site, i.e., once a program was accepted as a site for the study, it was randomized to either active treatment or treatment as usual. The Howard Center was selected as one of the eighteen active treatment sites.

The treatment program we offer is called NAVIGATE. It includes individual psychotherapy, family therapy, supported employment, and pharmacotherapy. The primary hypothesis of the study is that NAVIGATE will significantly improve the quality of life of the individuals receiving this treatment, as compared to their peers receiving usual community care.

The psychotherapy portion of NAVIGATE is called Individual Resiliency Training (IRT). This is a manualized, cognitive/behavioral-based program. It includes standardized modules that are part of the core therapy, and additional modules that can be selected based on the goals of the individual receiving treatment. Core topics include education about the illness, relapse prevention, and resiliency development. Modules also address substance use and healthy living skills.

The family therapy portion of the program is also a manualized psychoeducation and cognitive behavioral-based treatment. It includes a standard program, with additional modules added as needed. Choice of modules is based on the needs of the individual patient and family.

The NAVIGATE supportive employment program is evidence-based, and is similar to services already in place at the Howard Center, though more focused on meeting the needs of patients early in the onset of symptoms. Each treatment plan is individualized. The primary goal is return to work or schooling.

The pharmacotherapy is somewhat flexible. Psychiatrists are provided with information and treatment guidelines regarding evidence-based pharmacotherapy for first episode schizophrenia but are not confined to a particular algorithm. COMPASS, a shared decision-
making program, is also offered. Prior to each appointment, the participating patient enters data into a computer program on subjects such as current symptoms, goals for the visit, and medication side-effect management. That information is immediately available to the psychiatrist and is incorporated into clinical decision-making at that appointment. Research in other settings has found that shared decision-making can enhance the doctor-patient relationship, and is associated with improved medication adherence and positive patient attitudes toward treatment.

We are currently recruiting participants for the RA1SE project. Anyone between the ages of 18 and 40 who is experiencing psychotic symptoms and has used antipsychotic medication for less than four months, or not at all, is eligible for enrollment. We are seeking patients who appear to be experiencing symptoms consistent with a first episode of schizophrenia, but we understand that many adults experience a slow emergence of symptoms and may have had some psychotic symptoms for years before seeking treatment. We are also aware that the diagnosis of schizophrenia can be difficult. We recruited two individuals within the first week of the study, and are hoping to recruit at least sixteen more participants within the next eighteen months. We anticipate that most people who enroll in the study will be eligible to participate in the Community Support Program, including case management and eligibility for affiliated housing and other CSP services, although this is not required by the study.

We are recruiting primarily in Chittenden County but would be pleased to discuss the study with potential participants from other parts of the state, and with mental health professionals interested in making referrals. Please contact Dr. Sandra Steingard, 802.488.6211, or Ms. Annemarie Dubois, 802.488.6241, if you have questions or would like to discuss a referral.

This is an extremely exciting study for both the Howard Center and Vermont. Our population center is smaller than most of the other programs chosen for the study and we were honored to have been selected. We believe that our early recruiting success reflects an unmet service need in our state and the potential of the RA1SE program to help.

OFFICIAL PROJECT DESCRIPTION
The Howard Center for Human Services is part of the National Institute of Mental Health sponsored Recovery After an Initial Schizophrenia Episode (RA1SE) Early Treatment Program research project. RA1SE seeks to fundamentally change the trajectory and prognosis of schizophrenia through coordinated and aggressive treatment in the earliest stages of illness. It is designed to reduce the likelihood of long-term disability that people with schizophrenia often experience. It may also reduce the financial impact on public mental [health] systems caused by this chronic illness.

RA1SE is being conducted by two independent research teams: the Feinstein Institute for Medical Research in Manhasset, NY, and the Research Foundation for Mental Hygiene at Columbia University in New York, NY. This project has been funded in whole or in part with federal funds from the American Recovery and Reinvestment Act of 2009 and the National Institute of Mental Health, National Institutes of Health, United States Department of Health and Human Services, under Contract No. HHSN271200900020C.

Sandra Steingard, M.D., Medical Director
The Howard Center for Human Services, Burlington, Vermont
Psychiatrists must complete all of these requirements in order to maintain board certification with ABPN.

**ABPN Maintenance of Certification (MOC)**

By Peg Bolton, MD

Those of us who took our initial psychiatry boards after 1994 have had to pass a cognitive (written) examination every ten years in order to maintain ABPN certification. The ABMS is now phasing in a more broad-based process for psychiatry and other specialties that includes four parts. Psychiatrists must complete all of these requirements in order to maintain board certification with ABPN. This process is called Maintenance of Certification (MOC).

The four required tasks for MOC include: a cognitive exam, performance in practice (PIP) activities, professional standing, and self assessment/lifelong learning. I will summarize these four areas briefly, and encourage you to go to the website, www.abpn.com, for official information. The new requirements for recertification will phase in over a number of years. The ABPN website includes a grid that indicates what is required for each re-certification year. As an additional incentive, CMS plans to encourage participating Medicare physicians (regardless of whether they are subject to the recertification process) to engage in the PIP portion of MOC by offering a slight increase in reimbursement.

The cognitive exam will continue to be a staple of MOC. Psychiatrists can prepare for it through review courses, CME, and specialty journals such as FOCUS, which is sponsored by the APA for MOC preparation.

The PIP is new. It requires the ABPN-certified psychiatrist (diplomate) to solicit evaluations from peers and patients and to perform a practice improvement-oriented chart review. These requirements are for “clinically active” diplomates. At most, the diplomate will have to perform three PIP segments (including chart reviews and patient/peer feedback modules) in a ten year period. The forms for the PIP evaluation of the diplomate are found on the APBN website.

Psychiatrists have raised concerns about the potentially problematic impact on the therapeutic relationship caused by asking patients for PIP evaluations.

Psychiatrists have raised concerns about the potentially problematic impact on the therapeutic relationship caused by asking patients for PIP evaluations.
from it, despite the nature of our clinical practices.

To complete a PIP module, the diplomate obtains the feedback from peers and patients, makes a plan for practice improvement, and re-queries them (or different peers and patients) to determine whether the plan has been effective. Detailed information about how to complete the PIP segments is available on the website.

The professional standing requirement is satisfied if the diplomate holds an active and unrestricted license to practice medicine in at least one state, commonwealth, territory, or possession of the United States, or province of Canada.

The self-assessment portion must be done using an ABPN-approved instrument. A list of these can be found at the ABPN website. When the new MOC process has been fully phased in, psychiatrists will need to complete one self-assessment instrument in years 1 – 3 and another in years 6 – 8. The lifelong learning portion will require completion of 150 approved CME credits in the first 5 years of a 10 year block and 150 credits in the second 5 year interval. Please refer to the website grid to see what will be required to re-certify in your recertification year.

It is my understanding that the ABPN will not be collecting documentation of these activities from every diplomate, but will audit some diplomates when they apply to take the recertification exam. The ABPN website www.abpn.com has the official information about the MOC requirements. I will be happy to talk to anyone interested in this process about what I know, and try to find answers to what I don’t know.

SAVE THE DATE: GIBBARD LECTURE IS FRIDAY, 4 MARCH 2011

By Debra Lopez, MD

The 2011 Bruce A. Gibbard Memorial Lecture will be Friday, 4 March 2011. The program, sponsored by the UVM Department of Psychiatry & held at FAHC in Burlington, will include a Grand Rounds lecture to begin at 10:45 am, and an afternoon workshop from 1:00 to 3:00 pm.

Our speaker this year is Nancy McWilliams, Ph.D., a fabulous speaker and beloved teacher and clinician. Dr. McWilliams is the author of several books that are now standard textbooks in many psychiatry & psychology training programs. These include Psychoanalytic Psychotherapy: A Practitioner's Guide (Guilford, 2004), Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process (Guilford, 1994), and Psychoanalytic Case Formulation (Guilford, 1999).

The morning presentation, entitled, "What Happened to our Shared Understanding of Mental Health?", will address a paradigm shift in conceptualizations of mental health and the implications of such a shift for treatment and mental health policy. The afternoon seminar will examine "Clinical Implications of Assessing Overall Mental Health: Treatment of Paranoid Patients as a Case in Point". Here, Dr. McWilliams will review psychoanalytic theory and research on paranoia, emphasizing its origins in humiliation, and will discuss treatment recommendations.

The Gibbard Lectureship Committee is very excited about this speaker & program! Details will be sent to VPA members soon. If you would like to nominate a VPA Member to be considered for the Bruce Gibbard Award (to be announced at the Lecture), please do so by 31 December 2010. Contact Dr. Lopez at 802.864.7496.
The overarching project goal is to help at-risk veterans get on the road to recovery, rather than becoming incarcerated or homeless.

MHISSION-VT (pronounced “mission Vermont”) is a SAMHSA-funded jail-diversion project that is designed to assist in coordinating services for veterans with substantial mental health recovery needs, particularly those at risk for homelessness or incarceration. This article describes the MHISSION-VT program and provides contact information for interested psychiatrists and their patients.

Vermont psychiatrists are often challenged by the complex mental health and social support needs of military veterans returning home from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as previous conflicts. Veterans often present with psychiatric symptoms referable to service-related stressors, combat-related mental illness, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), co-occurring substance abuse, and other chronic disorders.

These heavy symptom burdens threaten to devastate the lives of many veterans and their families. In addition, both the healthcare needs of at-risk veterans, and the unfortunate involvement of many in the correctional system, are increasing the cost to society on behalf of this vulnerable group. Veterans whose addiction disorders or other psychiatric illnesses go unrecognized, and therefore undiagnosed and untreated, too often spiral into encounters with law enforcement and, eventually, the correctional system. Many also become homeless.

Veterans with greater symptom burdens are often the least able to advocate for themselves and to access needed recovery services. Lack of integration of available health and support resources further compounds this difficulty. The University of Vermont Center for Clinical and Translational Science (UVM-CCTS) MHISSION-VT Project is designed to help bridge these gaps. MHISSION-VT (Mental Health Intergovernmental Service System Interactive Online Network for Vermont) helps to identify at-risk veterans, intercept them prior to the occurrence of irrevocable involvement with the criminal justice system, and connect them with an appropriate array of service and treatment options. MHISSION-VT is not a treatment or service provider; the project facilitates inter-agency communication on behalf of troubled veterans and other at-risk adults, in order to help them obtain services and treatment. The overarching project goal is to help at-risk veterans get on the road to recovery rather than becoming incarcerated or homeless.

The MHISSION-VT project has been undertaken collaboratively by UVM-CCTS, the Vermont Department of Mental Health, and the Vermont Agency of Human Services, with funding provided by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). It is part of a wider program at CCTS designed to develop and transfer novel technologies in support of clinical science. MHISSION-VT helps connect disparate information systems and systems of care (e.g., the VA Office of Rural Health, local mental health agencies, veterans’ support groups, public and private treatment service providers and clinicians, law enforcement, the courts, and the Vermont Department of Corrections) by enabling information sharing and fostering decision support strategies. Now in the second year of the
grant, MHISSION-VT is creating process-based tools, technologies, and dissemination of research in order to promote the identification, screening, assessment, and diversion of these at-risk persons from the criminal justice system to evidence-based treatment and supports via the Sequential Intercept Model. Though the focus of the project is improvement in information sharing and service coordination, MHISSION-VT also facilitates transportation to help participants access services.

MHISSION-VT is currently deployed in Chittenden County, and will be expanded to the rest of Vermont in 2011-2012. Psychiatrists with an interest in this program can find information at www.mentalhealth.vermont.gov/initiatives, or may contact the Department of Mental Health at 802.241.2601.

The following graphic summarizes the MHISSION-VT architecture for integrating disparate referral sources and service and treatment options.
HIGHLIGHTS OF APA ASSEMBLY, NOVEMBER 2010

By Alice Silverman, MD, and Peg Bolton, MD

The APA Assembly was most noteworthy for the passage of an Action Paper addressing ethical guidelines for dealing with the pharmaceutical industry. This was particularly significant in that previous iterations of the guidelines had met with much opposition and division in the Assembly and were rejected. The Area 1 Council, of which Vermont is a part, played an important role by urging the rest of the Assembly to accept the recommendations of a representative group of leaders from the Assembly, understanding that some members wished for more explicit guidelines and some preferred less. A copy of the Action paper will hopefully be available on the APA website with some navigation and will likely be publicized in the near future. Any VPA member who would like to see the version approved by the Assembly may contact Alice Silverman, MD.

Unfortunately, the two Action Papers submitted by Vermont at the Assembly failed. The first had to do with privacy of electronic health records and urged the APA to advocate for federal funding to explore the feasibility of patient-controlled encryption. This technology has been researched by VPA member Dr. Stuart Graves, who has played a major role in educating VPA members, the VMS, and other relevant state and APA committees on this promising innovation. Although there was a significant effort made to educate the Assembly about this issue, we were not successful mostly due to a lack of understanding about patient-controlled encryption.

Our second Action paper asked APA to provide assistance to district branches in the form of research and letters of support, if requested, to assist in their legislative efforts towards health care reform, a very timely issue in our state. The Action Paper won by a small margin on the floor of the Assembly but then failed when a call for a “vote by strength” was requested. A vote by strength multiples each representative’s vote on the Assembly floor by the number of APA members that person represents. In that case, we lost by a small margin.

The final issue of note relates to an Action Paper that passed calling for the formation of an APA–ABPN task force to look at new maintenance of certification (MOC) guidelines that many Assembly members believed to be onerous, expensive, and potentially problematic. Some patients would be asked directly to evaluate the psychiatrist as part of the performance in practice part of the MOC process. In particular, there were concerns that certain practice settings (forensic as an example) make requesting an evaluation from the patient inappropriate. Other concerns related to asking the patient to do something for the doctor and the impact that might have on the therapeutic relationship.

A note from Dr. Bolton: As this is my last Assembly meeting, I will be passing the baton to Evan Eyler, MD, who will be taking over as the Vermont representative to the APA Assembly. I am sure she will keep us posted as to MOC and other issues as they arise. Any VPA member can initiate an Action Paper that can be brought to the Assembly for consideration. If you have an issue that you would like to raise, please contact Evan or any member of the Executive Committee for help in formulating it according to the guidelines for writing effective Action Papers.

A new Deputy Representative to the APA Assembly is needed. If you might be willing to serve, please contact VPA President, Dr. Alice Silverman, at alicehersheysilverman@gmail.com.