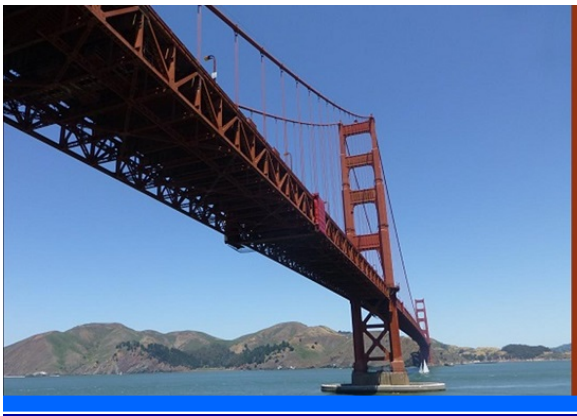

ARIZONA PSYCHIATRIC SOCIETY NEWSLETTER

Volume 4, Issue 2

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Greetings from the Newsletter Committee

Robin Reesal, MD, Newsletter Chair

June 2013

Welcome to the Summer edition of the APS Newsletter. Transition, wellness, and integration define the themes for this edition. We start off with introductory statements from our new APS President, Joanna Kowalik, MD, MPH. As an experienced and highly regarded child psychiatrist, she will enhance the Society with her thoughts and ideas. We look forward to her leadership.

Dr. Charlton Wilson, Chief Medical Officer of Mercy Care Plan, reviews the main points of the Mercy Maricopa Integrated Care plan. We thank him for opening our minds to interesting thoughts and ideas about future possibilities for Maricopa County.

Dr. Ann Negri, the Chief Medical Officer of CHOICES Network of Arizona, shares her outstanding academic career with us and tells us about one of her work passions the "Health for a Lifetime" program. This program integrates physical health with mental health.

Dr. Kathy Smith, an Assistant Professor of Psychiatry at the University of Arizona College of Medicine in Tucson, displays her high academic skills through her informative and useful article on mood disorders in the perinatal period.

Dr. Henry Brown, Chief Resident, shares his excitement for the Community Psychiatry rotation done with Dr. Andrew Mebane of the Southwest Network. Dr. Brown succinctly addresses daily hindrances to integration of medical and psychiatric care in the context of upcoming changes.

Johnson & Johnson Health Care Systems, Sophie Shen, introduces us to the complex area of Physician Quality Reporting System (PQRS). She skillfully details the multiple parts of this system and its effects on medical reimbursement.

The next section highlights the dedication and effort put forth by Drs. Stumpf, Kohlhepp, and Bastani to produce reports on the Arizona Medical Association House of Delegates Meeting and the American Psychiatric Association Assembly Representative Report from the APA Annual Meeting.

We close with reminders about educational events. The DSM-5 seminars start this summer, with limited availability in both Tucson and Phoenix. Do not miss out, enroll early.

On behalf of the Newsletter Committee, stay cool and have a relaxing summer.

Inside this issue:

President's Message

By Joanna Kowalik, MD, MPH, President

Arizona Psychiatric Society

Dear APS Member,

Thank you for your continuing support and participation in Arizona Psychiatric Society (APS). At the conclusion of the 2013 session of the American Psychiatric Association (APA) Annual Meeting, a new Officer starts tenure as President of the APS.

I am greatly honored and excited to begin my term as the President of the Arizona Psychiatric Society. I am eager to serve in this role but also very thrilled about all the things the organization is up to.
I first want to take the opportunity to thank our outgoing President, Tariq Ghafoor, MD, for all his excellent work over the last year. Dr. Ghafoor tackled a number of difficult challenges, including leadership in ongoing opposition to the psychologist prescribing legislation introduced in the Sunrise process, which was subsequently withdrawn. Overall, we had a very successful year, and I would like to commend him on his effective leadership and paving the way for what needs to happen next.

Arizona Psychiatric Society Executive Council depends heavily on its volunteer leaders, and we are grateful for those who are giving of their time and so deeply committed to advancing our profession.
As the President of APS, I will do my best to serve the needs of our profession, our members, and our community. The practice of psychiatry and the challenges we face are constantly changing, but we must admit this is a very exciting time for our profession. We are entering a new era of mental health parity, new-fangled CPT codes, innovative DSM-5 and the ongoing debate about the role of mental health in assuring safety and happiness of our citizens.

Moving forward, we recognize that we need to continue to build upon the transparency of APS so that members better understand what the Executive Council and the organization are doing. We recognize that our programs, website, publications, media communications, and other information outlets need to continue to work to be enhanced to increase the visibility of the organization and provide more real-time and relevant information. We are planning to focus on new strategies to improve and expand our capacity to serve you.

You are why the organization exists and we strive to reflect that in all we do. I hope you will stay engaged in what is happening throughout the coming year by attending APS events, volunteering to serve on committees and reaching out to us. I invite you to partner with us as we endeavor to advance the value and strength of our profession and to advance mental health care in our state.

Photos from the APS Annual Meeting

Dr. Joanna Kowalik, incoming President, thanks Dr. Tariq Ghafoor for his leadership at the APS Annual Meeting on April 13, 2013.

Dr. Payam Sadr presents the Howard E. Wulsin Excellence in Teaching Award to Dr. Martin Kassell.

For his outstanding efforts as APA Assembly Representative and to promote the interests of APS members, Dr. Ghafoor presented Dr. Jay Bastani with a Presidential Award. Other Presidential Award recipients: Dr. Robin Reesal for his contributions as Newsletter Chair, and Dr. Carol Olson for her advocacy efforts and leadership regarding psychologists prescribing.

APS Offering DSM-5 Workshops in Tucson and Phoenix: Register Today

Register today to attend "DSM-5: What you Need to Know to Transition from DSM-IV," Jointly Sponsored by the American Psychiatric Association and the Arizona Psychiatric Society, offered at your choice of dates and times, in Tucson on Saturday, July 27, 2013, from 9:00 a.m. to 1:15 p.m. (check-in beginning at 8:45 a.m.), and in Phoenix on Wednesday, August 14, 2013, from 5:45 p.m. to 10:00 p.m. (check-in beginning at 5:30 p.m.). The Arizona Psychiatric Society is pleased to offer this DSM-5 Workshop, with Dr. Ole Thienhaus and Dr. James McLoone as Faculty. These APS members and educators represented APS as attendees to the invitation-only APA Annual Meeting Train-the-Trainer Session on DSM-5. The training materials used by Drs. Thienhaus and McLoone have been developed by Drs. Black, Kupfer and Regier. Dr. Black is the author of "Study Guide to DSM-5," and Drs. Kupfer and Regier are the editors of DSM-5.

Register today! APS Members attend for a low member rate of $30 for the workshop. Space is limited. A full registration brochure is available at azpsych.org and is being mailed to all APS members.

Direct registration link for the July 27, 2013 Tucson DSM-5 Workshop is at:

http://aps-dsm5-tucson-072713.eventbrite.com

Direct registration link for August 14, 2013 Phoenix DSM-5 Workshop is at:

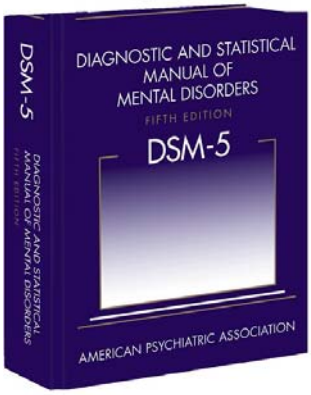
http://aps-dsm5-phoenix-081413.eventbrite.com

ACCREDITATION
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the Joint Sponsorship of the American Psychiatric Association (APA) and the Arizona Psychiatric Society. The APA is accredited by the ACCME to provide continuing medical education for physicians.

DESIGNATION
The American Psychiatric Association designates this live activity for a maximum of 4.0 AMA PRA Category 1 Credits ™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
DSM-5 cover is reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright 2013). American Psychiatric Association.

Photos (continued)

APS Annual Meeting attendees were engaged by the informative panel presentation and discussion by Judge Michael Jones, Dr. Jack Potts, and Attorney Charles Arnold on Arizona duty to protect.



APS Members Receive a Discount on APA publications-- Order your copy today at appi.org

An Introduction to Mercy Maricopa Integrated Plan (Mercy Maricopa)

A note to our readers: *Arizona's procurement law provides a procedure for losing bidders to protest awards. Magellan has protested the State's award of the Regional Behavioral Health Authority (RBHA) contract to Mercy Maricopa Integrated Care. That procedure also provides for the issuance of a stay while protests are considered. In this case, the stay limits the ability of Mercy Maricopa Integrated Care to communicate with the State. The stay does not prevent Mercy Maricopa Integrated Care, as a private company, from continuing to prepare for an October 1, 2013 launch.*

An Introduction to Mercy Maricopa Integrated Plan (Mercy Maricopa) (continued)

Charlton Wilson, MD, Chief Medical Officer
Mercy Care Plan

Dr. Wilson, is the Chief Medical Officer of Mercy Care Plan and has participated as a member of the development team and is assisting during the implementation of Mercy Maricopa Integrated Care.

Introduction

In the recent Maricopa Regional Behavioral Health Authority (RBHA) procurement, the State is seeking to better integrate physical and behavioral health with a particular emphasis on integration of care for those who are most at risk of poor outcomes from the current fragmented health system, individuals who have Serious Mental Illness (SMI). In this article, I will describe the new RBHA for Maricopa County, Mercy Maricopa Integrated Care (Mercy Maricopa), and identify some of the strategies that will be used to address integration. While there are many details about the new RBHA that are unique, three are particularly important:

- First of all, the State-selected plan is locally owned and operated and a not-for-profit, sponsored by two long-time health care organizations who are well-acquainted with Maricopa County residents' needs.
- Secondly, Mercy Maricopa will offer a new model designed to integrate behavioral health and physical health (acute care) for individuals with serious mental illness.
- And, lastly, the new RBHA will use technological solutions to facilitate data-sharing and care coordination, providing both members and providers tools to manage health care solutions.

Mercy Maricopa is sponsored jointly by Mercy Care Plan and Maricopa Integration Health System (MIHS). Mercy Care Plan, also a local nonprofit, has a 28-year history of providing innovative Medicaid managed care administration in the county and is sponsored by Dignity Health and Carondelet Health Network. MIHS is a county-wide public health care system that has been a health care safety net for the citizens of Maricopa County for 135 years. Other key components of Mercy Maricopa are its commitment to:

- Create efficiencies and reduce duplication in administrative oversight by contracting directly with providers;
- Facilitate member choice by offering multiple service delivery models;
- Incorporate family and peer voice and choice at all levels of the system;
- Enhance the role of peers and family members in supporting individuals in the community;
- Develop partnerships with peer and family-run organizations, universities and stakeholders.

Model of care

Mercy Maricopa will deliver integrated care to individuals with serious mental illness (SMI) through four distinct service delivery models, all of which currently are in place in some form:

- Whole Health Clinics (WHCs). Mercy Maricopa will contract with physical and behavioral health providers to provide co-located care in existing SMI clinics. By the end of the first year of the RBHA contract, Mercy Maricopa will expand Health Homes through further development of the integrated care teams, shared electronic medical records and shared, aligned financial incentives for participating practices. There currently are eight WHCs in Maricopa County.
- Patient Centered Medical Homes (PCMH). PCMH clinics will be operated in Federally Qualified Health Centers (FQHC) or FQHC look-alikes intended to serve members in the communities where they live. Mercy Maricopa will share electronically clinical and non-clinical data with all providers involved in the member's care through a health information exchange to further support care coordination.

- Patient Centered Health Care Homes (PCHCH). PCHCHs provide fully integrated physical and behavioral health services. Care coordination in this model is high-touch and utilizes innovative health information technology. The PCHCH model is based on standards established by the Utilization Review Accreditation Commission (URAC). Mercy Care Plan currently is contracted with several PCHCHs in Maricopa County.
- Virtual Health Homes. Mercy Maricopa will support members who have existing relationships with primary care physicians (PCPs) to continue receiving their physical health services with that provider. Our virtual health home model will allow members who prefer their current PCPs to continue receiving physical health care services in a traditional office setting.

In the first year, Mercy Maricopa will fund care coordinators at the provider level for all these entities, as well as provide centralized care coordination for members served by PCPs or specialty providers. By the end of the first year, the plan will transition its coordinators to provider sites to promote care coordination as close to the member as possible. In the second and third years of the contract, Mercy Maricopa will work with all stakeholders to embed care coordination activities in the functions of clinical teams.

Technological solutions

Technology plays a key role in Mercy Maricopa's model for coordinating between all providers involved in member care, as well as in communicating directly with members. These technological solutions will be phased in:

- Health Information Exchange (iNexx). Mercy Maricopa will transmit near real-time data to providers through its web-based Health Information Exchanges (HIE). iNexx is downloadable and connects to most Electronic Health Records systems and with Claimtrak. Mercy Maricopa intends to connect iNexx to the SMI clinics in the first year and then expand to other providers.
- Electronic Health Record Systems. Mercy Maricopa will maintain the current Claimtrak system at the SMI clinics during the first year, to maintain continuity of care and consistency in claims and encounter processing. The plan will work with providers not using the Claimtrak applications and who do not have existing electronic health records to identify solutions to meet their needs.
- iTriage. iTriage is a downloadable application that allows providers and members to communicate with each other, schedule appointment and make referrals. If integrated, the referral and member information can be directly imported from the provider's Electronic Health Record. iTriage currently is available to the general public and is being customized for the RBHA.
- Active Health Care Considerations. ActiveHealth will use extensive medical and pharmacy claims data to generate a single integrated member record and to monitor to avoid risk and optimize member care. The system will generate a targeted provider communication called a care consideration, which will include alerts indicating missed labs and preventive care appointments as well as informing the provider of potential risks. ActiveHealth currently is used by Mercy Care Plan.
- MyChart. Part of the Epic system used by MIHS, MyChart is an individual patient health record tool that will be available to members whose providers currently use Epic or elect to implement it as the Electronic Health Record.
- Web-based Member and Provider Portals. Mercy Maricopa will have HIPAA-compliant, secure web-based member and provider portals to promote dialogue and feedback and facilitate access to data. Data will be synchronized daily, allowing members to check eligibility, review benefits and prior authorizations and send secure emails to member services.
- Reporting Portal. Mercy Maricopa will implement a web-based reporting portal to allow ADHS/DBHS, AHCCCS and community stakeholders to view and run ad hoc reports.
- Provider Profiling. Mercy Maricopa will disseminate provider profiles to support sharing of essential clinical and member information that promotes quality efforts.

Key partnerships

Mercy Maricopa will work with universities and community organizations to bring additional resources and expertise to the behavioral health system. These include: the Arizona State University Technical Assistance Center; other AHCCCS health plans; state agencies; university education programs; first responders; public housing authorities; Community Development Financial Institutions; the Arizona Employment Network Advisory Association and others.

An Introduction to Mercy Maricopa Integrated Plan (Mercy Maricopa) (continued)

Even before the State released its Request for Proposals for the RBHA, Mercy Maricopa's founders had begun to meet with community stakeholders, including provider groups, peer and family organizations and members, and incorporated their feedback into the proposal. Mercy Maricopa will continue to collaborate with and inform system stakeholders, using community forums, social media and other activities. Mercy Maricopa is committed to involve peer and family members in the governance of the RBHA.

Reimbursement of providers

Mercy Maricopa's Pay-for-Performance program will be aligned with the principles identified by key national organizations such as Substance Abuse and Mental Health Services Administration (SAMHSA), the American Medical Association, the American College of Physicians, the National Committee for Quality Assurance and the Joint Commission and CMS.

Meet Fellow APS Member: Ann Negri, MD

Ann M. Negri, MD
Chief Medical Officer
CHOICES Network of Arizona

Ann Negri, MD, Chief Medical Officer for the CHOICES Network of Arizona, has spent her entire medical career caring for those challenged with severe mental illness. Educated in medicine at Temple University School of Medicine, and trained in psychiatry at the University of Pittsburgh Medical Center, as well as the Western Psychiatric Institute. She is board certified and a Fellow and Distinguished Fellow through the American Psychiatric Association. Dr. Negri has built a prestigious career helping adults manage mental illness and substance abuse, and ultimately recover.

She has also found satisfaction in training new physicians in the field of psychiatry at the University of Arizona Medical School, and supports her profession through participation on peer review committees and as a consultant to the Arizona Medical Board.

While her involvement in her profession is vast and her commitment to treating her patients deep, one of Dr. Negri's proudest accomplishments has been her work with colleagues at CHOICES Network around a simple, but often forgotten idea: improving the physical health and long-term wellness for those with mental illness.

People with severe mental illness die on average 25 years earlier than the general population from preventable habits like cigarette smoking, as well as unmanaged chronic physical health conditions such as obesity, hypertension and diabetes.

One reason that people with serious mental illness are dying younger is that they often cannot access the best available health care due to socioeconomic barriers. In addition, more than 75% of people with severe mental illness are dependent on tobacco. People in this demographic also may be disproportionally affected because psychiatric medications can contribute to significant weight gain.

The high incidence of obesity-related illnesses in people living with mental illness, such as diabetes, has been identified as an epidemic within an epidemic. The good news is that common risk factors that lead to these physical health conditions are modifiable through simple lifestyle changes. Realizing the promise of such changes, Dr. Negri and the CHOICES Network team launched "Health For a Lifetime."

The Health for a Lifetime initiative promotes regular physical activity, healthy food choices and preparation, and collaboration with a "health coach" to stay on track as well as connect to resources about healthy habits. To participate in the program, individuals must be enrolled in the public behavioral health care system in Maricopa County, and obtain a medical release form from their general practitioner or internist.

Oftentimes, this can be the biggest hurdle to getting started in the program. Doctors who don't know much about the program may be hesitant to complete and sign the medical release form. It's important that doctors understand this is a simple wellness program, designed to support those with mental illness in an environment that they are used to coming to-their mental health clinic. All health coaches are trained and certified in wellness coaching, and the CHOICES medical team of psychiatrists, overseen by Dr. Negri, are very involved in monitoring and oversight of the program for their patients.

If you have questions, or would like to learn more about the program, please visit the CHOICES Network website at www.choicesnetwork.org and click on the Health for a Lifetime™ symbol on the homepage. You can also email CHOICES through our special Health for a Lifetime mailbox at healthandwellnessinquiries@choicesnetwork.org.

Promoting Wellness in Women: The Importance of Identifying and Treating Perinatal Mood Disorders

By Kathy W. Smith, MD
Assistant Professor, Psychiatry
University of Arizona College of Medicine, Tucson

Perinatal mood disorders, defined as mood and anxiety disorders in and around the time of pregnancy, are an important but often poorly understood area of mental health. Although mood and anxiety disorders are common in women in general, this risk is highest during the childbearing years. For example, boys and girls have equal rates of depressive disorders as children. However, at the time of puberty, this risk increases dramatically in girls, demonstrating a two times increased risk of 21.3% compared to 12.7% in males(1). These prevalence rates equalize again after the completion of menopause. And while mood and anxiety disorders are common in women, so is a pregnancy with 82% of women experiencing a pregnancy by the age of 44. Of these women, almost one-half will have an unintended or mistimed pregnancy(2,3,4).

In 2006, Cohen et al(5) published a well-designed, prospective, naturalistic study of 201 pregnant women who had a history of depression but at the time of enrollment were not depressed. During the course of their pregnancies, 43% of these women experienced an episode of major depression. When compared, the group of women who chose to discontinue antidepressant treatment had a relapse rate of 68% compared to 26% in the group of women who maintained their antidepressant treatment. This was an important study for many reasons, but most notably was that it revealed pregnancy was not "protective" from depressive disorders as had been commonly thought. This idea, that women would not, or should not, be depressed during pregnancy is one of the most challenging barriers for women who are pregnant to seek mental health treatment.

It is also known that up to 20% of women will experience an episode of postpartum depression and that women with a history of bipolar disorder are at particular risk, with a demonstrated recurrence of almost 71% during pregnancy(5) and a recurrence rate three times higher during the postpartum period compared to women with the disorder who are not pregnant(6). Anxiety disorders are also common and many studies demonstrate worsening of anxiety disorders during pregnancy(7,8,9).

Untreated depression during pregnancy is associated with many adverse outcomes including poor maternal weight gain, lower infant birth weight, and an increased risk of preterm deliveries(10). Additionally, untreated postpartum depression

has been associated with poor maternal health and with lower scores of gross motor control in infants, more crying and irritability and an increased risk of insecure attachment. Infants whose mothers are depressed have been shown to have a higher risk of physical abuse as well, and children have been shown to have more emotional or cognitive difficulties during the school years(11,12). Factors for women that increase the risk of developing perinatal mood disorders include a history of previous depressive episodes or a family history of depression, experiencing anxiety or depression during pregnancy, co-occurring stressful life events, limited social supports or difficult infant temperament(13). Fortunately, tools have been developed to help screen for and identify symptoms during the pregnancy or postpartum, such as the Edinburgh Postnatal Depression Scale. This 10-item self-administered questionnaire takes approximately five minutes to complete, and has been validated in many different languages to detect clinically meaningful depressive or anxiety symptoms(14).

There are effective treatments for perinatal mood disorders and ideally involve a multidisciplinary approach to care. Increased social support and sleep are important, as well as interpersonal psychotherapy or cognitive behavioral therapy. Bright light therapy, acupuncture, exercise and omega-3 fatty acids have also been shown to be helpful. For moderate to severe depression, psychopharmacology should also been considered(14).

Determining a treatment course is an individualized discussion for each woman and her family. Unfortunately, stigma and a lack of awareness of how to identify and treat these disorders are significant barriers for women to seek and receive help. Ideally, the best course is for women who have a history of mood or anxiety disorders, or are currently taking psychotropic medications, to consult with an expert before becoming pregnant. After a thorough psychiatric evaluation, a balanced discussion of the risks of untreated illness for both mother and her baby, as well as the risks of treatment options including psychopharmacology, can occur. Many studies have now been published examining the risks and benefits of psychotropic medications during pregnancy or while breastfeeding and practice guidelines are available to help clinicians determine the best course (15,16,17,18,19).

Mood and anxiety disorders during pregnancy and in nursing mothers are an important area of women's mental health and are a major public health issue. Given the known risks and frequency of untreated mental health issues in women, an understanding of how to assess and screen for these disorders in this vulnerable population is critical. By detecting and treating these issues sooner rather than later, the morbidity and mortality of untreated illness can be significantly minimized and provide for the best possible outcomes for mothers and their families in our community.

Footnotes

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Wellness from the Resident Perspective: The Community Psychiatry Rotation

By Henry Brown, DO
Banner Good Samaritan Regional Medical Center
Resident PGY-4, APS Member-in-Training

Earlier this year, while on my Community Psychiatry rotation as a resident of Banner Good Samaritan, I had the pleasure of working with the patients and all of the members of the treatment team of the Saguaro Clinic at Southwest Network (SWN). The Lead Psychiatrist, Andrew Mebane, MD as well as the rest of the staff made it such a great experience that I decided to apply and will be working for SWN at the conclusion of my residency.

At times, when working with patients, I am amazed and inspired by the human ability to persevere and triumph in spite of the severity of an individual's psychiatric pathology and multiple life-difficulties they face on a regular basis. Often compounding this scenario is the many tasks of daily life, which are considered minor nuisances to most of us, but can be a daily struggle to many in this population. The upshot is that there are many opportunities to provide relief via relatively simple solutions. For example, the current system already assists patients with getting to and from appointments, getting prescriptions, as well as coordination of medical care. Yet, in spite of the tremendous efforts put into ensuring great care, difficulties still arise. Patients will see a Psychiatrist, but not their PCP or vice versa. Throw in a medical specialist and then it can really get complicated. The patients, like most of us, are busy trying to get through the day, but life has a tendency to be complicated. None of us enjoy spending the time and effort trying to coordinate different aspects of our medical care and the patients of the Community Psychiatry population are certainly no different.

Integration of healthcare in the Community Psychiatry setting has been driven by the passing and implementation of 'The Affordable Care Act' (which will go into full effect 2014). Healthcare integration for the Community Psychiatry setting has great potential. The overall intended goal is a familiar one, one we have heard many times before, i.e., to improve quality and lower costs. But, to paraphrase former House Majority leader Nancy Pelosi: We will have to implement it first to find out if it works.

As Psychiatrists, we are in many ways ahead of the curve. Our diagnoses and treatments are intrinsically based on a biopsychosocial model. And, the Community Psychiatry setting is geared towards maximizing the psychosocial aspect of treatment for those that cannot do so on their own. Hence, the use of case managers, social workers, peer support, group therapy and more, all under one roof. And yet, there is still the difficulty that is encountered by the average patient, and which is even more challenging for the Community Psychiatry patient, that is addressing regular medical care (which is the "bio" part of the model). Healthcare integration will hopefully be one of the sorely needed puzzle pieces that will help resolve these challenges.

I am looking forward to being part of the coming change in healthcare, which I anticipate and expect will include many improvements (and hopefully few setbacks). I am optimistic that we can all use our 'human ability' to persevere and triumph in spite of the severity of the psychiatric pathology and multiple other difficulties that may be part of our health care system.

Advocacy Update: Introduction to Physician Quality Reporting System

By Sophie Shen

Introduction of PQRS

Over the past few years, Medicare has created several physician incentive programs to tie provider pay to higher quality, lower-cost care. These programs-the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Electronic Prescribing

Incentive Program (eRx)-have focused on gathering physician quality data and encouraging the use of information technology. PQRS is a voluntary program that establishes financial incentives and penalties for eligible professionals based upon their ability to report data on quality measures (selected from a predetermined list) to CMS for professional services furnished under Medicare Part B.

Starting as a temporary program in 2007, under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), the PQRS program was made permanent and increased PQRS incentive payments to 2 percent for successful participation in both the 2009 and 2010 program years(1). Currently, PQRS allocates incentives and penalties solely based on whether eligible professionals (EPs) successfully submit a report and not on quality-related outcomes. As a result, as long as EPs satisfactorily report the required quality measures, they can earn a full incentive payment. To fulfill the requirements of PQRS, participating providers must choose the measures they wish to report, select a reporting period and reporting option, document patient visits, and finally submit their data to CMS. Once they have submitted this information, there are three possible outcomes(2):

1. If CMS deems the submission "satisfactory," then the provider (or group) receives an incentive payment.
2. If the submission is not "satisfactory" but nevertheless does meet the minimum bar for participation-set in the 2013 final rule as successful reporting performance on one measure- the provider's payment is not altered (they will receive neither an incentive nor a penalty).
3. If the provider fails to participate in PQRS at all, then he or she will be subject to a downward payment adjustment.

Changes under Health Care Reform

Several PQRS program changes were included in health care reform legislation enacted in 2010. The Affordable Care Act (ACA) requires the implementation of timely feedback and the establishment of an informal appeals process by 2011. The ACA also calls for PQRS payment penalties starting in 2015(3). The 2013 Medicare Physician Fee Schedule finalized an incentive payment of 0.5% of an EP's total allowed charges for services to be paid in the year following the reporting period for satisfactory participation in PQRS. This year will be the final year that this reporting incentive is offered under PQRS. After 2014, reporting incentives will be replaced by "payment adjustments"-penalties administered to subsequent Medicare reimbursement. Although providers will not be penalized for non-reporting until 2015, the data used to assign those penalties will be collected during the 2013 reporting period. Thus, EPs who do not satisfy PQRS reporting requirement in 2013 will be subject to a negative 1.5% penalty in 2015.

CMS offers its Maintenance of Certification (MoC) Incentive Program, starting in 2012 and scheduled to end in 2014. This program provides board-certified professionals with an opportunity to earn an additional incentive payment of 0.5% of total allowed charges through PQRS by participating in a qualified MoC program "more frequently," or at least once more, than required for certification.(4) CMS is allowing flexibility in the interpretation of "more frequently" since frequency is dependent upon specialty and must be determined in relation to its designated requirements. Eligibility for the MoC incentive is contingent upon participation in PQRS. By participating in both programs, the total potential 2013 bonus increases to 1% of total allowed charges. MoC incentives are currently scheduled only through 2014. Putting everything together, the table below shows the maximum incentives and penalty providers will receive under PQRS from 2007 to 2016 and beyond. In 2011, average bonuses were $1,059/individual and $9,863/practice(5).

Medicare Physician Quality Reporting System Incentives and Penalties(6)

Incentive or Penalty (payment adjustment)
2007 1.5% subject to a cap
2008 1.50%
2009 2.00%
2010 2.00%

The ACA authorized incentive payment through 2014
2011 1.00%
2012 0.50%
2013 0.5% if no MoC, 1% if MoC (performance year for 2015 penalty)
2014 0.50%

2015 -1.50% Penalty (payment adjustment)
2016 -2% Penalty (payment adjustment)

Individual Reporting Option Mechanisms and Requirements

Reporting mechanisms differ depending on whether an Eligible professional chooses to participate under the individual reporting option or group practice reporting option (GPRO). Those who elect the individual reporting option may submit data on select measures or measures groups through a claims-, registry-, or EHR-based reporting system. Each individual measure corresponds to a specific clinical procedure. A "measures group" is a set of four clinically related measures, which may only be submitted via claims- or registry-based reporting. Each eligible professional must satisfactorily report on at least 80 percent of eligible instances for at least three measures or report on a 20-patient sample (if reporting measures groups) to qualify for the 2013 (7)PQRS incentive payment.. Review the following supporting documentation for specific criteria to satisfactorily report on these two options.

2013 PQRS Measure Sets for Individual Reporting (8)

Measure Sets: Total
Individual Measures: 259,241 of which are reportable via claims and/or registry
Measure Groups: 22

Measures Related with Behavioral Health

American Psychiatric Association listed measures that may be most pertinent to psychiatry(9), but others in the complete list of PQRS measures and specifications for 2013 may apply to individual practices(10).

Group Practice Reporting Option (GPRO) Mechanisms and Requirements

As of 2013, groups of two or more eligible professionals using a single Tax Identification Number (TIN) that self-nominate as a GPRO can report PQRS measures via web-, registry-, and administrative claims-based methods. CMS plans to allow group practices to report PQRS measures through their EHRs, much like individual EPs can. However, because CMS wishes to make sure that this reporting option properly aligns with its meaningful use (MU) incentive program, it will not be available until 2014 at the earliest(11). As a result, groups that are interested in avoiding penalties in 2015 must make sure to successfully report at least one applicable measure to CMS during the 2013 reporting period. It is extremely important to remember that provider organizations interested in participating in PQRS' GRPO in 2013 will need to self-nominate for the GPRO by October 15, 2013. If a group practice fails to self-nominate by this date, it will be subject to a negative payment adjustment in 2015. Only groups that elect to report via the administrative claims-based method are exempt from this requirement.

The same incentive and penalty structure applies to group practices that elect to participate in the GPRO as applies to individuals (i.e., up to a 1.0 percent incentive for 2013 if a group also qualifies for MOC reporting and a -1.5 percent penalty for 2015).However, under the GPRO, payment adjustments are calculated based on the group practices' total estimated allowed Medicare Part B charges for the reporting year. GPRO participation is optional, and groups are only eligible for PQRS incentives if they self-nominate to participate in the GPRO. However, once this decision is made, the group must take action to avoid the PQRS penalty. Furthermore, once a group is selected to participate in the GPRO, individual professionals in the group must relinquish their right to participate in the PQRS as individuals (i.e., a physician cannot earn an incentive as part of a group practice and as an individual). If a group practice selected for the GPRO is disqualified from the program during the reporting year (e.g. due to a change in TIN), individuals in that group would be permitted to participate in the PQRS as individuals for the remainder of the reporting year.

Reporting Criteria to Avoid the 2015 PQRS Payment Adjustment

For 2015 and subsequent years, a penalty will be applied to total allowable Medicare charges if an eligible professional or group practice does not satisfactorily submit data on quality measures for the applicable reporting period. Individual eligible professional and group practices participating in GPRO can avoid the 2015 PQRS payment adjustment by meeting one of the following criteria.

Reporting as an Individual (12)

* Meet the criteria for satisfactory individual reporting for the 2013 PQRS incentive;
* Report only 1 applicable measure or measures group using the claims, registry, or EHRbased reporting mechanisms; or
* Elect to be analyzed under the administrative claims-based reporting mechanism by October 15, 2013

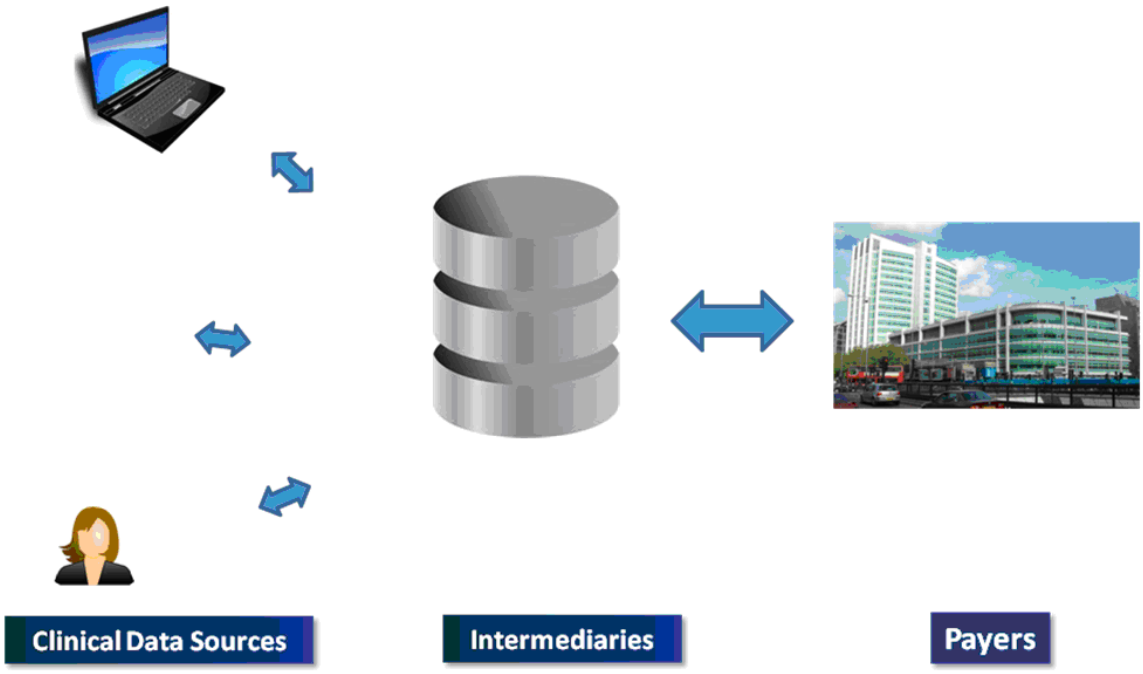
Reporting as a Group Practice (13)

There are 3ways that a group practice may avoid the 2015 PQRS payment adjustment:
* Meet the criteria for satisfactory reporting for the 2013 PQRS Incentive under the GPRO;
* Report 1 applicable measure or measures group using the registry or GPRO Web Interface reporting mechanisms in 2013; or
* Elect to be analyzed under the administrative claims-based reporting mechanism in 2013.This election must be made when the group practice self-nominates to participate in the GPRO.

Recent Efforts to Streamline Data Input to PQRS

Several medical specialty societies(14) have been urging the administration and Congress to allow provider participation in qualified clinical data registries to count towards PQRS requirements. As part of American Taxpayer Relief Act of 2012 (i.e. Fiscal Cliff Law), physicians (and other eligible professions included in the PQRS) will gain a new option for meeting PQRS reporting requirements beginning in 2014-participate in a "qualified" clinical data registry--"For 2014 and subsequent years, the Secretary is required to treat an eligible professional as satisfactorily submitting data on quality measures under the PQRS program if, in lieu of reporting PQRS quality measures, the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry for the year,"(15) The new law offers four specific considerations to guide development of the requirements for a "qualified" registry:
* Transparency of data elements, risk models, and measures
* Submission of data with respect to multiple payers
* Provision of timely performance reports at the individual participant level
* Support for quality improvement initiatives for participants

CMS intends to examine ways that clinical registries could be used to satisfy meaningful use requirements, and looked for public input on the concept in past few months as part of a request for comments on the development of criteria for "qualified" registries. Below is a graphic that describes the framework.(16)



CMS Call for New Measure Inclusion for PQRS

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures for the Physician Quality Reporting System (PQRS) program for future years. This "Call for Measures" runs from May 1, 2013 through July 1, 2013.CMS seeks a quality set of measures that are outcome-based rather than clinical process measures and fall into one of the National Quality Strategy (NQS) priorities that work to address known measure and performance gaps. The priorities can be found in the fact sheet and on the webpage about the Call for Measures. To access the measures list and related materials, click on the "Measures Codes" page in the left-hand column of the CMS PQRS website at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

Footnotes:

1. Analysis and Payment of PQRS, CMS, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html, last accessed on May 28, 2013
2. Update on Medicare's Physician Incentive Programs, 2012 http://www.advisory.com/~/media/Advisory-com/Research/PPR/White-Papers/26046-Update-on-Medicares-Physician-Incentive-Programs.pdf, last accessed on May 28, 2013
3. PQRS overview, American Medical Association, http://www.ama-ssn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-quality-reporting-system.page
4. 2012 Physician Quality Reporting System: Maintenance of Certification Program Incentive Made Simple http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PQRS-MOC-Made-Simple.pdf
5. Testimony of Kavita Patel, May 14,2013, Finance Committee, http://www.finance.senate.gov/imo/media/doc/Kavita%20K%20Patel%20Senate %20Finance%20Testimony%20FINAL.pdf
6. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html, last accessed on May 28, 2013
7. 2013 Physician Quality Reporting System (PQRS): Registry Reporting Made Simple, April 2013 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_SatisfactoryReporting-Registry_041813.pdf
8. Physician Quality Reporting System (PQRS): Updates for 2013. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_WhatsNewPQRS_PMBR_02012013.pdf, last accessed on May 28, 2013
9. American Psychiatric Association, Physician Quality Reporting System (PQRS) http://www.psychiatry.org/practice/managing-a-practice/medicare/physician-quality-reporting-system-pqrs
10. Measures Codes for PQRS, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
11. PQRS overview, American Medical Association, http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-quality-reporting-system.page
12. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/PQRS/Downloads/2013_WhatsNewPQRS_PMBR_041813.pdf
13. The same as above
14. American College of Cardiology, National Coalition on Health Care, The American Association of Neurosurgeon
15. Federal Register Volume 78, Number 26, February 7, 2013, Medicare Program; Request for Information on the Use of Clinical Quality Measures (CQMs) Reported Under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs. http://www.gpo.gov/fdsys/pkg/FR-2013-02-07/html/2013-02703.htm
16. Qualified Clinical Data Registries a Data Intermediary Model meeting slides. May 3, 2013, Office of National Coordinator.

Report from the ArMA House of Delegates 2013

APS Delegates to ArMA:
Michael Stumpf, MD, DFAPA, and
Elizabeth Kohlhepp, MD, DFAPA

The Arizona Medical Association (ArMA) held its Annual Meeting and House of Delegates at ArMA, 810 West Bethany Home Road in Phoenix, on Friday, June 1, and Saturday, June 2. Delegates to ArMA from your Arizona Psychiatric Society are Michael Stumpf, MD and Elizabeth Kohlhepp, MD.

Incoming ArMA President is Thomas Rothe, MD, who is a Family Practitioner in Tucson. Jeff Mueller, MD, who is an Anesthesiologist at Mayo, was voted President-Elect. Our APS Past-President, Gretchen Alexander, MD, was elected to be an At-Large Member of the ArMA Executive Committee.

Several Resolutions which could affect Psychiatry were debated.

Three Resolutions concerning gun rights/gun safety and individuals with mental disorders were debated. A Resolution calling for increased gun violence research, increased funding for psychiatric treatment, increased education regarding Arizona laws for psychiatric treatment including involuntary treatment for individuals dangerous due to mental disorder, and better reporting to the National Instant Criminal Background Check System (NICS) of individuals who are statutorily required to be reported, was sent to the ArMA Executive Committee.

A Resolution regarding elimination of Absolute Immunity for Physician Expert Witness Testimony was debated. We pointed out that Expert Witness testimony includes not only physicians hired for testimony in malpractice cases, but also psychiatrists who might be giving Expert Testimony in cases regarding commitment for involuntary treatment, or testimony in child custody cases, and that we likely would not favor losing immunity for good faith testimony regarding our patients. The Resolution was referred for further study.

A Resolution calling for restoration of funding for Graduate Medical Education was well supported.

A Resolution calling for increased research for medical uses of marijuana was supported.

A resolution calling for increasing the legal standard in malpractice cases from "preponderance of the evidence" to "clear and convincing" was supported.

APA Assembly Representative Report from the APA Annual Meeting

Jay B. Bastani, MD, DLFAPA, Arizona APA Assembly Representative

From the Assembly
The Assembly of the American Psychiatric Association meeting precedes the Annual Scientific Meetings held in May annually. Both were held at the Moscone Convention Center, San Francisco CA. The Area VII Council met at 7 AM for an hour each day to review the assigned APA Position Papers and Action Papers. The Assembly was called to order by Dr. Scott Benson and the usual housekeeping items were cleared such as quorum, prior minute's approval, recognition of members and guests.
The floor was given to Carolyn Draznick MD Acting President of the Connecticut Psychiatric Society (CPS). She gave a presentation on the APA's response to Newtown, Connecticut School shooting event. CPS has had a series of natural disasters and had already begun to organize a disaster response program. Dr. Draznick and Dr. Kahn drove to Newtown right after the tragedy to talk to the Red Cross about how they could help. Over the next weekend, they found that almost a hundred mental health professionals had come to volunteer their services. She organized the volunteers into treatment teams with four hour shifts. Unfortunately those who were not licensed in Connecticut and were not officially trained by

the Red Cross could not participate ("my way, your way and then there is the Red Cross way"). On just one day (the Sunday after the event) more than a hundred mental health professionals provided counseling for 300 residents of the town including first rescuers. In the following months, more than 150 members of CPS volunteered to provide free service to those affected. She attributed the promptness of CPS response and coordination of the effort to their Disaster Response Plan.

The release of the DSM-5 was an event coinciding with the Scientific Meeting. The book sales are already ahead of projection and it was heading up the Amazon best seller list during the Assembly meeting.

Jay Scully MD, APA Medical Director, gave a brief presentation which will be in the Journal of the American Psychiatric Association regarding the present state of the APA. Attendance at the current Annual meeting is anticipated to be the best of the past 5 meetings. Dr. Scully announced that his replacement as Medical Director and CEO will be Saul Levin, MD, MPA. Dr. Levin was recently appointed the Interim Director of the District of Columbia Department of Health and will assume his new post this fall. Membership is up for the first time in years. CPT codes have been a big focus. Dr. Scully recommended that everyone use this link to stay up to date: www.psychiatry.org//cptcodingchanges. Insurance companies use CPT changes as a way to reduce rates and services that psychiatrists can provide. There were problems with no payment for psychotherapy and excessive review of some E&M codes, among others. There were particular issues with WellPoint, and discussions with United Healthcare and ValueOptions. The lawsuit against Anthem/WellPoint got a lot of attention from other insurance companies. The board has been very active in supporting parity implementation. The recent Vermont court decision was the first decision on parity. It was favorable to mental health Parity because the Court found that an insurer had to show that there is a clinically appropriate reason for not following parity. Jay Scully said that APA has responded to Assembly position papers on improving information technology to stay in touch with members, and he announced the anticipated release of the APA mobile app in the third quarter of this year. He sees a big challenge ahead is defining what good psychiatric care is and how to recognize it since as a profession we define the standards of care

Dr. Fassler, APA Treasurer, presented some preliminary budget data. Preliminary year-end statements show an unrestricted operating net deficit of $5.1M, compared to the budgeted deficit of $585K (part of a plan to spend down reserve funds in certain parts of the APA). The negative variance was largely due to a reduction in revenues from publishing and meetings, as well as an increase in pension expenses. Unrestricted Revenue was less than budget by $6.7M. Publishing revenues were almost $4.7M less than anticipated, primarily due to DSM IV sales falling off in anticipation of the release of DSM 5. Last year's Annual Meeting was approximately $1.5M below budget. Overall, compared to the prior year, revenues were $4.2M less, due primarily to the decline in publishing revenues. End of year membership revenues were $9.5M, which is $164K below budget.

Dr. Ron Burd, Chair of the Committee on RBRVS and the Codes and Reimbursement, reported on the status of APA coding efforts. The current status was reviewed, with an emphasis on current problems with payers, hopeful resolution of CMS' concerns leading to finalization of values for the codes (Jan 2014), and direction of further coding initiatives and activity. He said that there is still work to be done getting the RUC or relative values for the psychotherapy add-on codes.

Action Papers and Position Statements:

At this meeting the Assembly voted on action papers and position statements covering topics from an APA position statement on violence and mental health to a recommendation that an electronic version of DSM-5 be made available as a member benefit.

The position statement on violence and mental health issues received unanimous support from the Assembly. An Assembly Reference Committee was devoted entirely on Friday evening to creating this document with the support from many experts. It was an impressive example of collegiality where diverse points were presented and the document created. Other Position statement asked the APA to distribute referendums with the Annual Dues mailing statements in order to get a better response rate from members rather than wait for the Election ballot. A position paper regarding Detained Immigrants with Mental Illness was passed. As part of that position statement, the APA Assembly expressed deep concern about the lack of adequate attention towards the mental health needs of detainees and made recommendations for screening and treatment. A position statement regarding Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment of Care of All Patients was approved by the Assembly. The position statement on the Use of Medical Marijuana for PTSD was endorsed. The statement opposed using medical marijuana in the treatment of PTSD on the grounds that there is no adequate evidence of beneficial effects.

An action paper passed made a recommendation that the APA liaison with ABPN regarding the MOC exam timing. This change in timing would allow those who take their exams early to have more than a ten-year period before taking the next exam.

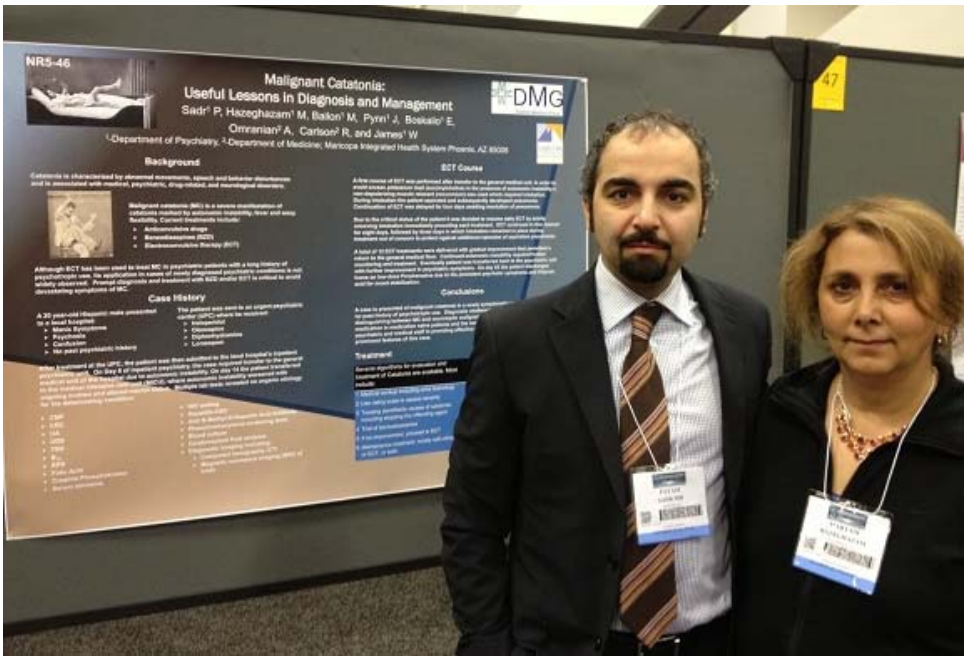
The Assembly requested that residency training programs with a high percentage of residents who are members of the APA (programs that achieve Bronze Club or higher status) gain access to Psychiatry Online at a rate that is half the cost of the existing discounted subscription rate for residents. The Assembly endorsed a vigorous program to revitalize APA public relations efforts in order to communicate both the importance of mental health and the need to address barriers to treatment that prevent access to good quality mental health care (including parity violations by insurers).
The APA was asked to contact the ABPN to address concerns about applicant data collection and data management practices. The goal is to make sure that ABPN handles applicant data in a manner that ensures privacy and confidentiality.
An Action Paper passed recommended an electronic version of the full text of DSM-5 be made available as a free benefit of APA membership. The Assembly voted to recommend the ACGME adds a requirement for residency training on the management of potentially violent patients for psychiatry residents to the curriculum.
An action paper was passed that asked the APA to begin development of a resource document on human trafficking.
The Assembly voted to support the AllTrials petition campaign to insist that data from all clinical trials be made available to clinicians, rather than allowing sponsors to publish only selected (presumably more favorable) clinical trial results.
The APA was asked to apply to be a Non-Governmental Organization (NGO) at the United Nations so that APA could provide testimony to the UN on issues of importance to psychiatry.
The Assembly voted to allow APA district branches and areas to offer access to electronic communication services for APA election candidates.
There were two other speakers invited by the Assembly to address: Jeremy Lazarus MD President of the AMA and Paul Pendler, VP Employee Assistance and Work-Life Program, J.P. Morgan Chase and Company.
The final work of the Assembly was election of Jenny Boyer MD as the new Speaker-Elect and Glen Martin MD as Recorder of the Assembly. Melinda Young MD will become the Speaker of the Assembly.

Join the Disaster Psychiatry Task Force!

Dr. Jay Bastani has agreed to lead a Task Force in connection with preparing a Disaster Psychiatry Plan for the Arizona District Branch. If you are interested in contributing to this important and timely effort, please contact Teri (602-347-6903, teri@azmed.org).

APS Members at the APA Annual Meeting in San Francisco

Four of Arizona's newest Distinguished Fellows celebrate and enjoy the breathtaking views of SFO (clockwise from rear left, Dr. Richard Gottlieb, Dr. Mary Nowlin and daughter Kamilah Sarah Smith, Dr. Elizabeth Kohlhepp, Rich Myers and Diane Mann (guests of Dr. Gary Grove), and Dr. Gary Grove. Also recognized in the 2013 Convocation were newest Arizona Distinguished Fellows Drs. Carlos Carrera, Michael Cleary, and Mariam Cohen.



Drs. Payam Sadr and Maryam Hazeghazam presented a poster on Malignant Catatonia at the APA Annual Meeting.

Many APS members enjoyed the education, celebration, and collegial opportunities at the APA Annual Meeting in San Francisco in May. Thanks to these APS members for sharing their photos with us and allowing us a chance to celebrate them in the Newsletter! We welcome the submission of your photographs as well.

Are You Ready to Take the Next Step in Your Career?

Being a Fellow of the APA is an honorary designation to recognize members who have demonstrated allegiance to their profession and commitment to the ongoing work of the APA and their District Branch. Members who pursue Fellow status see it as one of the first steps towards enhancing their professional credentials. Members who apply and are approved in 2013 will be invited to participate in the Convocation of Fellows and Distinguished Fellows during the 2014 APA Annual Meeting in New York City. The deadline for submitting a Fellowship application is September 1, 2013. Visit http://psychiatry.org/join-participate/member-benefits/becoming-a-fellow for information or contact Teri (teri@azmed.org, 602-347-6903) for assistance.

The deadline for 2013 nominations for Distinguished Fellows is passed. However, if you would like more information on Distinguished Fellow nominations, please contact Teri for the guidelines and assistance on evaluating the criteria for nomination. The deadline for completed Distinguished Fellow nominations (which must be submitted and endorsed by the District Branch) is July 1st of each year, and the review and preparation process takes some advance work, so it is never too early to get started on this worthy distinction.

Kaffe Klatch on Summer Hiatus - Will Resume in September

The Thursday, June 27th Kaffe Klatch, was the final session for the summer. Kaffe Klatch will resume on its regularly scheduled 4th Thursday of the month in September, graciously hosted by Dr. Martin Kassell at his home. All ages are welcome! If you would like to join a reminder mailing list for the Kaffe Klatch group, please contact Teri. Come and enjoy this collegial exchange of tips, tricks, and insights.

APA Resources for You: DSM-5 Online Course, Depression Awareness in the Workplace, and Dues Reminder

DSM-5

Additional information and reference materials on DSM-5 are available to the general public online at http://www.psychiatry.org/practice/dsm/dsm5. On this page, you will find links to articles in Psychiatric News, fact sheets, and videos that explain the new organization and features of the DSM-5 and the diagnostic differences between DSM-IV-TR and DSM-5. From this webpage, you can view the DSM-5 Table of Contents; view and download online assessment measures; learn more about the insurance implications of DSM-5; and watch the DSM-5 Press Briefing at the APA Annual Meeting in San Francisco, May 18, 2013. Please check this webpage frequently for updated information.

Additional CME opportunities on DSM-5 are available at http://www.apaeducation.org, including the online version of the DSM-5: What You Need to Know Master Course from the 2013 APA Annual Meeting in San Francisco. The online version is available at a discounted rate for APA members and comes complete with slide handouts and DSM-5 fact sheets. Earn up to 6 AMA PRA Category 1 CME Credits™ for Physicians or Certificate of Attendance (coming soon, the online course for psychologists, social workers, certified counselors, addiction counselors and registered nurses, offering CE credits).

Partnership for Workplace Mental Health Introduces Initiative on Depression Awareness

Partnership for Workplace Mental Health™
A program of the American Psychiatric Foundation

The Partnership for Workplace Mental Health has introduced **RIGHT DIRECTION**, an initiative to help employers raise awareness about depression in the workplace. The partnership collaborated with Employers Health, a national employer coalition based in Ohio, in the development of Right Direction, which gives employers tools and resources to conduct worksite education.

Right Direction encourages companies to invest in their workforce to gain healthier, more productive employees, as well as achieve decreased disability costs, less turnover, and better retention of employees. Right Direction is unique in that it provides a step-by-step tool to destigmatize depression in the workplace and help employees function better both in and out of work. Information about depression in the workplace, and resources needed to combat this growing area of concern, can be found at http://rightdirectionforme.com. A free tool kit called a Field Guide is also available from Right Direction or through the Partnership for Workplace Mental Health.

ACT NOW--DON'T LET YOUR MEMBERSHIP EXPIRE!

The deadline for paying current-year APA membership dues is June 30. Membership dues must be paid by June 30 or your membership will automatically expire on that date (unless members are enrolled in the APA Scheduled Payment Plan). Renew your dues online or enroll in the Scheduled Payment Plan (http://www.psychiatry.org/join-participate/becoming-a-member) to pay your membership dues by credit card in monthly, quarterly, biannual, or annual installments - with no interest or service fee.

If your e-mail or mailing address have recently changed, please contact Teri Harnisch (teri@azmed.org, or 602-347-6903) to update the same.

If you are interested in contributing an article to the Newsletter or have a topic that you would like addressed, please contact us. The Fall Newsletter theme will incorporate Ethics.

Have a safe and relaxing summer--stay cool! Hope to see you at a DSM-5 Workshop. Be on the look-out for an Annual Meeting Planning Survey (your chance to let us know what you would like planned for 2014).

APS Newsletter Committee: Robin Reesal, MD, Chair; Elizabeth Kohlhepp, MD, DFAPA; and Gretchen Alexander, MD.

Arizona Psychiatric Society

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