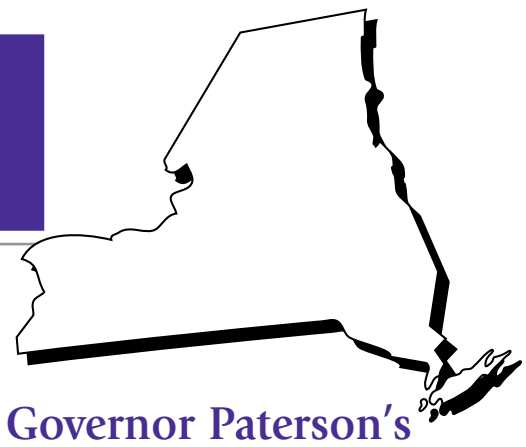
THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Spring 2009, Vol. 52, #1 • Bringing New York State Psychiatrists Together



President's Message:
APA Governance – A Real Issue for Members

By C. Deborah Cross, MD

C. Deborah Cross, MD

My President's Column for this issue will focus on the issue of APA governance and the role of the APA Assembly. Your first reaction may be to move on and read another more interesting or relevant article. However, I urge you to stay with me. APA governance is important to every member because APA governance determines how the APA addresses your needs.

The APA is presently governed by a Board of Trustees that includes 21 voting members – 4 elected national officers, 7 Area Trustees, the Speaker and Speaker-Elect from the Assembly, 3 former Presidents, 3 Trustees at large, an ECP Trustee at large, and an MIT trustee.

In addition to the BOT, currently we have an Assembly that includes 242 members with representation drawn from all district branches and state associations in the APA and from Early Career psychiatrists, Members in Training, Minority and Underrepresented Caucuses and Allied Organizations. The Assembly is the most representative component of the APA with grassroots membership participation.

In the face of the financial pressures due to reduced advertising from the pharmaceutical industry and the decision to reduce the role of the pharmaceutical industry in the APA Annual Meeting, at its March, 2009 meeting, the BOT recommended a 20% reduction in funding for the Assembly. This drastic reduction in funding for the Assembly can only be implemented by substantially reducing the functioning of the Assembly, member involvement in the governance of the APA and membership participation in the Assembly.

There are those in APA leadership who believe that the Assembly serves little purpose and should be drastically downsized or even eliminated. Cuts in the Assembly budget of the magnitude proposed by the BOT will only impair the Assembly's ability to function and provide additional support for those who believe the Assembly should be eliminated.

Despite the fact that the Assembly includes the broadest and most diverse range of APA members and interests, the Assembly is essentially an advisory body with no power to control APA activities. Despite its lack

[See **President** on page 2]

Legislative Report: Governor Paterson's 2009-2010 Executive Budget Proposal – Issues for the Mental Health System

By Richard Gallo, Barry B. Perlman, MD, and Seth P. Stein, Esq.

This edition of the Legislative Report will focus on the Governor's Executive Budget Proposal for the 2009-2010 fiscal year. Customarily, the Governor's annual budget proposal is released in January of each year, but due to the current financial situation, the Governor released the proposed budget in December 2008 in hopes of stimulating urgent action by the Legislature. In addition to proposed cuts in spending, the Budget Proposal also includes proposals for significant changes in the NYS Medicaid program that are intended to "reform" the program and generate savings. The Budget Proposal may be viewed on the Internet at: http://www.assembly.state.ny.us/comm/WAM/20081216/a158.pdf.

NYS Medicaid Drug Formulary

New York has established a Drug Utilization Review Board (DURB) which is charged with advising the Department of Health about which drugs from each class of medication should be included in the Medicaid formulary. Under the proposed statutory changes, the DURB will now be asked to recommend guidelines for specific therapeutic regimens for specific diagnoses that practitioners may prescribe without needing prior authorization.

In addition, a key change in the budget bill (Section 45(7), p. 81) eliminates the current right of the prescribing physician to override Medicaid prescribing restrictions. If this change is enacted into law, Medicaid will have final say about coverage for a particular drug, rather than the physician. Despite national outcry against the increasing role of bureaucrats in the relationship between doctors and patients, New York State is about to take a giant step in the wrong direction. NYSPA strongly opposes this change and reasserts its longstanding policy that generally-accepted medical practice must prevail over efforts to save costs.

Pharmacy Benefit Managers

The Budget Proposal also includes

[See **Legislative Report** on page 3]

Medicare E-Prescribing Incentive Program Offers Financial Awards for Providers

By Rachel A. Fernbach, Esq.

The new Medicare electronic prescribing incentive program provides financial incentives for providers who engage in "e-prescribing." E-prescribing means transmitting prescriptions directly to a patient's pharmacy using electronic means, instead of using paper, a fax machine, or the telephone. The new incentive program was authorized by the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") and took effect on January 1, 2009. E-prescribing is currently optional for providers and pharmacies, but all Part D drug plans are required to provide e-prescribing support.

This article is intended to provide NYSPA members will a brief overview of the new e-prescribing incentive program. NYSPA has prepared a comprehensive guidance document outlining all aspects of the incentive program and how to participate that is currently available on the NYSPA website (www.nyspsych.org).

Highlights of the Program

- Medicare providers who successfully engage in e-prescribing can receive financial incentives of up to 2.0% of their fee schedule for 2009-2010, 1.0% for 2011-2012 and 0.5% for 2013.
- Providers who do not successfully engage in e-prescribing will be subject to a 1.0% reduction in their fee schedule in 2012, a 1.5% reduction in 2013, and a 2.0% reduction in 2014 and subsequent years.
- In order to transmit prescriptions electronically, providers must use qualified e-prescribing software, which requires a reliable, high-speed Internet connection.
- Providers may receive donations of e-prescribing software from hospitals,employers or drug plans.

Medicare providers who desire to participate in the e-prescribing incentive program do not need to sign up or otherwise register for the program.

[See **E-Prescribing** on page 4]

Proposed Changes to Sex Offender Program Reflect Current Economic Realities

By Rachel A. Fernbach, Esq.

Recently proposed amendments to the New York State Sex Offender Management and Treatment Act (SOMTA) indicate recognition of the significant financial burden that SOMTA has placed on the state mental health system. According to the Coalition of Behavioral Health Agencies, the New York State Office of Mental Health (OMH) is expected to spend a total of $38 million on sex offender management in 2008 and 2009. These amendments and other programmatic changes, included in Governor Paterson's 2009-2010 NYS Executive Budget Proposal, incorporate many of the recommendations made by NYSPA and other mental health advocates prior to the enactment of the law.

SOMTA, which went into effect in 2007, provides for post-incarceration, civil commitment of sex offenders deemed to suffer from a "mental abnormality." The act defines mental abnormality as a congenital or acquired condition, disease or disorder that affects the emotional, cognitive or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense and that results in that person having serious difficulty in controlling such conduct. Following a probable cause hearing and a jury trial, an individual adjudged to be a dangerous sex offender requiring confinement will either be detained in an OMH secure treatment facility or placed in the community under strict and intensive supervision and treatment (SIST), a program administered jointly by OMH and the Division of Parole.

Prior to SOMTA's enactment, NYSPA argued strongly against passage of the proposed civil confinement statute for a variety of reasons. First, NYSPA objected to the use of the term mental abnormality, which is not a psychiatric medical term, because it creates an inappropriate link between persons with mental illness and sexually predatory behavior. The use of "mental health" terminology to

[See **SOMTA Update** on page 6]

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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double-spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. *The Bulletin* is received by members of the American Psychiatric Association who belong to a district branch in New York State. *The Bulletin* is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. *The Bulletin* is published quarterly. Both classified advertisements and display advertisements are available. Please contact the editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

The opinions expressed in the articles or letters are the sole responsibility of the individual authors, and may not necessarily represent the views of NYSPA, its members, or its officers.

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FROM THE EDITOR'S DESK... By Jeffrey Borenstein, MD


Jeffrey Borenstein, MD

We are living through a time of great change. How we respond to the current challenges will affect our patients and our profession for many years. The Legislative Report focuses on the Governor's Executive Budget Proposal and how this will affect psychiatric care. The President's Message focuses on APA governance and proposed changes. The Area II Trustees Report shares the results of a survey which was sent to the membership.

We also report on the new Medicare electronic prescribing incentive program. We have a report on proposed changes to the Sex Offender Program. We have an article about web-based continuing medical education courses available through the NYS Office of Mental Health. In addition, we report on a comprehensive mental health website developed by NAMI-NYC Metro. Finally, we have the results of the Second Annual Resident Paper Contest. ■

LETTER TO THE EDITOR...

To the Editor:

Dr. Debbie Cross's "President's Message" in the Winter 2009 issue (Vol. 52, #1) describes the complicated structure of APA governance very clearly, accurately and succinctly. Having served over the years at almost all levels I have, however, a couple of additional contributions. First, the ultimate authority is vested in the Board alone. The Board tends to be far more distant from the members than the Assembly, which is composed of Representatives elected by the members themselves from each of their District Branches. But the Assembly has no power, can advise and suggest but cannot act, and this results in a distance and a disconnect between the central APA authority and its membership at large. Transparency, accountability, and checks and balances are lacking, and full fiduciary responsibility is in question.

This is quite different from the governance model used by AMA, the Medical Society of the State of N.Y., other state medical societies, and the models used by APA's own two multi-District Branch state associations, Area 2 (N.Y.S. Psychiatric Association) and Area 6 (California Psychiatric Association). In those other models, ultimate authority lies in the larger, more representative governing body (e.g., the House of Delegates or the Area Council), That body meets once or twice a year so there is elected a smaller governing body (e.g., a board, council or executive committee) that meets far more frequently and governs in between. In general, however, the smaller body reports its actions to the larger body that can accept them or reject them. Thus transparency, accountability and checks and balances are built in. The APA model, however, makes for marked centrality and tends to a top-down situation where the smaller body makes its decisions and imposes its will on the members and their Representatives in the Assembly and Area Councils.

This has caused a good deal of difficulty in the past. For example, this lack of checks and balances led to the adoption of Medem, the former health care content dot.com, and to the former dysfunctional, wasteful and poorly administrated IT system, all costing millions of dollars of APA money. After much fuss, APA finally got on top of this and got it all turned around, but in the process the Board was going to rehire the administration that had produced the problems until the Assembly found out and confronted the administration. This resulted in a change of administration to the present one and things got much better. There is a new, effective administration in place now. Transparency, accountability and checks and balances had solved this and could well have prevented it beforehand.

Initiatives in this direction, for purposes of cost effectiveness, efficiency and true fiduciary responsibility to the members were the reasons for earlier attempts at changing APA's structure, such as the Key Biscayne Conference in 1975 and, more recently, the Sharfstein Workgroup's recommendations. Now, in the face of the present crises, such changes are more needed than ever.

Small central governance bodies can err, for who can't? The answer is democracy with transparency, accountability, and checks and balances, producing more inclusiveness and respect for the members, contributing to member morale, retention and recruitment.

Herb Peyser, M.D., D.L.F.A.P.A.
Assembly Rep, N.Y. Co. D.B.

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of legal power to determine APA policy, the Assembly has provided vital and necessary leadership by advocating for the interest of APA members. It was the Assembly that first initiated efforts to impose a freeze on APA dues increases; it was the Assembly that spearheaded efforts to secure revenue sharing for district branches and state associations; and it was the Assembly that first raised questions regarding APA finances and management that led to the resignation of the previous APA Medical Director. I am proud to report that Assembly representatives from New York assumed a leadership role in each of these three important actions.

In response to the need for financial retrenchment, the New York State Psychiatric Association unanimously approved a proposal to restructure and downsize APA governance by combining the current BOT and Assembly into a new unicameral governance body. This approach will generate savings in excess of what was recommended by the BOT and will establish a governance structure similar to the American Medical Association and the Medical Society of the State of New York.

In fact, over 30 years ago, in 1975, the BOT approved the Key Biscayne Conference recommendation for a unicameral governance model for the APA and submitted the proposal to the membership for adoption and the proposal was approved by a majority of members, but was not adopted because an insufficient number of members voted.

Under the NYSPA proposal, a new House of Delegates (combining the BOT and the Assembly) would include 114 members, a reduction of 149 individuals. This downsizing will generate substantial savings. However, these cost savings through downsizing will at the same time enhance the role and authority of members serving in the new House of Delegates because the House of Delegates will when it meets twice each year have the authority and responsibility to act on behalf of the APA. At other times, when the House of Delegates is not in session, authority for managing the APA will rest in an Executive Council that will function essentially as the current BOT.

In order to seek support for its reorganization proposal, NYSPA officers have submitted an resolution for consideration by the Assembly at its May, 2009 meeting that calls upon the Assembly to endorse the NYSPA proposal for consolidation of the BOT and Assembly into a single unicameral governing body; oppose any reduction in funding for the Assembly without an accompanying restructuring of APA governance that includes as its foundation a consolidation of the BOT and the Assembly in a single unicameral body and finally, direct the Speaker and Speaker-Elect as members of the BOT to pursue restructuring of the APA through consolidation of the BOT and the Assembly as set forth in the Area 2 proposal.

APA members need a voice and representation that reflects the needs of our grassroots membership. A new House of Delegates to replace the current Assembly and BOT will preserve the best elements of the current Assembly, save money by reducing costs through downsizing and give those District Branch and State Associations a real voice in APA governance. ■

AREA II TRUSTEE'S REPORT By James Nininger, MD

James Nininger, MD

Spring 2009 Survey Results

Recently, a short survey was sent out to all members who have provided us with email addresses. The topics related to a number of issues important to our Association and on which I welcomed feedback prior to the March APA Board meeting. The results are provided below. I feel it is important that APA leadership has a sense of opinions on issues of concern to the membership. Communication between our DB Assembly Reps and membership (two-way) is one possible avenue for this but seems underutilized. Many of you, in addition to filling out the survey, provided related comments which were appreciated. If such brief "E-Surveys" (results were also able to be faxed) are not seen as too intrusive, I will plan to periodically tap willing members' views on pertinent issues through this method. Thank you. ■

A. Pharmaceutical company involvement with psychiatrists: APA is debating whether or not to decrease our involvement with Pharma along certain parameters. Pharma has cut back on advertising and sponsored symposia at the annual meeting due to financial concerns.

1. Do you feel APA should gradually try to
   28 Increase 159 Decrease
   65 Keep at same level
2. Should Pharma be allowed to serve meals at their sponsored symposia?
   21 Yes 132 No
3. Should your DB use Pharma support for their meetings (speaker and financing of food)?
   97 Yes 151 No
   Should the decision be left up to each DB?
   127 Yes 112 No
4. Should APA gradually try to decrease its financial benefits from Pharma:
   symposia?
   163 Yes 84 No
   advertising?
   134 Yes 113 No
   fellowships?
   134 Yes 109 No
   DB Committee meetings?
   167 Yes 68 No

B. Conflict of Interest

1. Should there be limits to absolute income or % of income received from pharmaceutical companies or health industry related companies or funds invested in such companies by members or only declaration of such potential conflict?

	Financial Limits	Declaration of Potential Conflicts of Interest
The APA Board	117 Yes 26 No	121 Yes 3 No
The APA Assembly	112 Yes 31 No	121 Yes 3 No
DSM-V Workgroups	120 Yes 22 No	121 Yes 3 No
Practice Guideline Workgroups	115 Yes 24 No	120 Yes 2 No
DB Council Members	102 Yes 33 No	115 Yes 5 No
Members at Large	95 Yes 36 No	104 Yes 11 No

C. Governance

1. Are you in favor of consideration of downsizing the APA Board, Assembly and Components?

APA Board?	Assembly?	Components?
91 Yes	99 Yes	95 Yes
54 No	47 No	42 No
83 No opinion	84 No opinion	86 No opinion

2. Are you in favor of considering a single representative body for the APA which would consist of a small Executive Committee with decision making responsibility embedded within a larger body of APA representatives?
   100 Yes 49 No 80 No opinion
3. Would you like to be in an email listserv with your Assembly DB Rep to provide two-way communication regarding relevant APA issues?
   135 Yes 93 No

Legislative Report continued from page 1

provisions (p. 88) that would revise rules regarding pharmacy benefit managers (PBM), companies that are hired by health plans to oversee and manage the prescription drug benefit offered by a health plan. PBMs frequently suggest that physicians "switch" a patient to a new medication, often for the financial benefit of the PBM or health plan rather than for the clinical benefit of the patient. The proposed change would require a PBM to notify the patient (or the patient's guardian) before contacting the patient's physician about switching medications. After notifying the patient, the PBM must provide the physician with clinical and financial information regarding the drug switch. Prescribers are encouraged to make a decision according to the best interests of the patient. However, this new rule will not apply to an attempt by the PBM to switch the patient to "a lower or equally priced therapeutically equivalent drug." The term "lower or equally priced" refers to the participant's co-payment or co-insurance amount. NYSPA is advocating for the deletion of this exception from the proposed law, which significantly weakens the patient protections it attempts to create.

Reducing the Influence of Drug Companies

The Budget Proposal includes provisions that would seek to protect physicians and other prescribers from the undue influence of pharmaceutical companies. Proposed laws would restrict gifts to physicians, impose disclosure requirements on the provision of "things of value" to prescribers, and limit the influence of drug companies and medical device manufacturers on continuing medical education.

Strikingly absent from the proposals is a requirement that drug companies obtain the permission of the prescriber before the prescriber is solicited regarding his or her prescribing practices. Without this extra layer of protection, drug manufacturers will continue to target physicians to urge them to prescribe certain products based on detailed knowledge of the doctor's prescribing pattern and which enhance the manufacturer's profit goals. The only way to prevent drug companies from attempting to improperly influence physician decision-making is to deny drug companies access to physician prescribing data. NYSPA urges adding language that would prevent the sale or distribution of physician-specific prescribing information and patterns to drug manufacturers.

Proposed Budget Cuts for Hospitals

Finally, NYSPA wishes to point out another possible threat to the mental health delivery system. Unexpectedly, the proposed OMH budget shows a small increase for 2009-2010. However, this increase is insignificant when one recognizes the broad role played by Article 28 licensed facilities, such as hospitals, in providing mental health services throughout the state. Even when hospital Departments of Psychiatry remain profitable or at least break even, the hospital may be severely and adversely impacted by the Budget Proposal, which severely reduces Medicaid rates. The consequence may be the closing of institutions which are important providers of mental health services to the communities they serve.

We last encountered a similar threat to the mental health system when confronted with the recommendations of the "Commission on Health Care Facilities in the 21st Century," also known as the "Berger Commission," back in 2006. Fiscal data presented at that time indicated that Article 28 facilities account for an enormous percentage of mental health services provided in New York. For example, Article 28 facilities provided services representing 48% of funds expended for inpatient care and 40% of funds expended for outpatient care. NYSPA wants to make sure that legislators are aware of this pressing concern when they consider changes to the Medicaid reimbursement scheme later this year. ■

Richard Gallo is the NYSPA Government Relations Advocate. Barry B. Perlman, M.D., is Chair of the APA Committee on Government Relations and Immediate Past President of NYSPA. Seth P. Stein, Esq., is the NYSPA Executive Director and General Counsel.

Web-based Continuing Medical Education Courses Available through New York State Office of Mental Health

By Veronica Hackethal MD, MSc., Bureau of Evidence Based Services and Implementation Sciences, NYS Psychiatric Institute/OMH

People with serious mental illness die 25 years earlier than the general population, according to The National Association of State Mental Health Program Directors (NASMHPD). Not only does this population have higher rates of cardiometabolic risk factors, but they have low rates of treatment for the risk factors and medical conditions that they have. Baseline data from the CATIE study revealed worrisome rates of non-treatment among those with schizophrenia who also have diabetes (30.2%), hypertension (62.4%), and dyslipidemia (88.0%). Increasingly individuals with serious mental illness are being recognized as a high risk population for diabetes and heart disease. For example, the Canadian Diabetes Association has included schizophrenia in its list of independent risk factors for the development of type 2 diabetes.

Web-based Continuing Medical Education (CME) courses are now being made available as part of the New York State Office of Mental Health (OMH) and Department of Health collaborative effort to improve psychotropic prescribing practices. This three year initiative was rolled out in Fall 2008 and focuses on two quality concerns: psychotropic polypharmacy and the use of antipsychotics with high or moderate risk of metabolic side effects for individuals with cardiometabolic risk factors. In support of this initiative, these CME courses include video presentations by top leaders in the field. The courses provide a review of the research detailing the extent of the problem, an explanation about the development of the quality improvement indicators, as well as clinical case examples and treatment recommendations.

While these courses have been developed for prescribers, their content is available to all at no cost over the internet. Other clinicians and staff who would like to learn more about psychotropic polypharmacy and cardiometabolic effects of certain antipsychotics are invited to view these videos.

These web-based CMEs are accredited by the Medical Society of the State of New York. No industry funding was provided for their development. Currently three CME courses are available. The first two cover cardiometabolic risk and psychotropic medication separately in adults and in youth. The third covers psychotropic polypharmacy. Each course lasts roughly an hour, followed by a multiple choice quiz. Maximum accreditation is 1.25 AMA PRA Category 1 credits for the youth course, and 1.00 AMA PRA Category 1 credits each for the adult cardiometabolic and for the psychotropic poypharmacy courses.

Each lecture is preceded by an introduction by Dr. Lloyd Sederer, OMH Medical Director. Dr. Jeffrey Lieberman (Columbia College of Physicians and Surgeons/New York State Psychiatric Institute), and Dr. Robert Findling, (Case Western University) also provide introductory remarks. The adult cardiometabolic video is presented by Dr. John Newcomer (Washington University School of Medicine, St. Louis). Dr. Newcomer is a leading expert in psychopharmacology and has published numerous articles about cardiometabolic complications related to certain antipsychotics. The youth cardiometabolic video is presented by Dr. Christopher Correll, who specializes in pediatric psychopharmacology at Albert Einstein Medical College, NY. The polypharmacy course is presented by Dr. Alexander Miller, Professor of Psychiatry at the University of Texas Health Sciences Center at San Antonio.

Future CMEs are currently being planned, and will soon begin development. ■

The videos and CMEs can be accessed at:

Cardiometabolic (Youth):

https://psyckesmedicaid.omh.state.ny.us/Common/CardiometabolicYouth.aspx

Cardiometabolic (Adult):

https://psyckesmedicaid.omh.state.ny.us/Common/CardiometabolicAdult.aspx

Psychotropic Polypharmacy:

https://psyckesmedicaid.omh.state.ny.us/Common/PolypharmacyCME.aspx

E-Prescribing continued from page 1

However, prior to participating in the incentive program, the provider must obtain and implement a computer software system that has e-prescribing functionality. An e-prescribing system can be implemented in two ways. First, a provider may sign up with an e-prescribing service provider and access its e-prescribing system via the Internet using a secure user name and password. Or, a provider can purchase e-prescribing software in the form of a CD-Rom from a software vendor and then download the software to a computer hard drive. Both options will require the provider to have in place a reliable, high-speed Internet connection.

The e-prescribing incentive program will be operated on a calendar year basis with the first reporting period being January 1, 2009 to December 31, 2009. Participating providers must report all qualifying e-prescribing no later than two months from the end of the reporting period.

How to Participate

After a qualified e-prescribing system is put in place, the provider reports an e-prescribing quality measure (a G-code) on the Medicare Part B claim form. To be a "successful e-prescriber," the G-code must be reported on at least 50% of applicable cases during the reporting period.

The following is an abridged list of procedure codes that are eligible for the incentive: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244 and 99245.

NYSPA is aware that several outpatient office codes were omitted from the above list, including pharmacologic management (90862), initial nursing facility care (99304-99310), domiciliary services (99324-99327) and home services (99341-99350). We have brought this fact to the attention of the APA and are working to ensure that these additional denominator codes be included in the e-prescribing measure.

In order to be eligible for the 2009 incentives, a psychiatrist's estimated allowed Medicare Part B charges for the above-listed procedure codes must be equal to at least 10% of their total Medicare Part B allowed charges. That amount may be changed in future years.

To report the e-prescribing measure, participating providers will use one of three new G-codes:

G8443 If the provider used a qualified e-prescribing system for all of the prescriptions generated during the encounter

G8445 If the provider had a qualified e-prescribing system, but didn't generate any prescriptions during the encounter

G8446 If the provider had a qualified e-prescribing system but the prescription was transmitted via paper or telephone due to special circumstances.

The e-prescribing incentive amounts are equal to a percentage of an eligible provider's fee schedule amount during the reporting period. The incentive amounts for successful e-prescribers are 2.0% in 2009 and 2010, 1.0% in 2011 and 2012, and 0.5% in 2013. Conversely, Medicare providers who do not engage in e-prescribing will be subject to a financial penalty starting in 2012, as follows: in 2012, a 1.0 % reduction in fee schedule; in 2013, a 1.5% reduction in fee schedule; and in 2014 and subsequent years, a 2.0% reduction in fee schedule.

MIPPA provides a "significant hardship exception," which permits HHS, on a case-by-case basis, to exempt an eligible professional from the penalty if compliance with e-prescribing would result in a significant hardship. An example of a significant hardship is an eligible professional who practices in a rural area without sufficient Internet access.

Many NYSPA members who are sole practitioners or members of small group practices may currently be exempt from the Medicare requirement to submit claims electronically because they are a small provider with fewer than ten full-time employees. However, at this time, there is no similar exemption from e-prescribing for small providers. Therefore, even if a provider is exempt from submitting claims electronically to Medicare, the provider may still be subject to a penalty for failing to successfully e-prescribe. As such, in order to avoid future reductions in Medicare fees, psychiatrists are well advised to familiarize themselves with e-prescribing and the available software products and work to implement e-prescribing within their practice as soon as practicable.

Solo practitioners or small group practices may find the cost of implementing an e-prescribing system to be prohibitively expensive. As a result, it is anticipated that drug plans, hospitals and other employers may donate computer hardware, software and training services to providers who elect to e-prescribe. In addition, the National ePrescribing Patient Safety Initiative

[See **E-Prescribing** on page 6]

SECOND ANNUAL RESIDENT PAPER CONTEST

By Seeth Vivek, MD

We are pleased to report that the Second Annual Resident Paper Contest was very successful. We received 21 submissions and NYSPA would like to thank all participants.

First Place was awarded to Celine Hamilton, M.D. for her paper entitled "Suicide Prevention: The suicide risk assessment and inpatient psychiatric hospitalization." Dr. Hamilton presented a summary of her paper at the NYSPA Spring Area II Council Meeting on March 28, 2009, at the La Guardia Marriott Hotel. Dr. Hamilton received a plaque and a cash prize of $500.

Second Place went to Abigail Dahan, M.D. for her paper entitled "A Proposed Role for the Psychiatrist in the Treatment of Adolescents with Type 1 Diabetes." Third place was awarded to Sophia Wang, M.D. for her paper entitled "Cardiovascular Risk & Memory in Non-Demented Elderly Women." Dr. Dahan and Dr. Wang each received a plaque.

Herb Peyser, M.D., Aaron Satloff, M.D., and James Nininger, M.D. served as judges for the competition.

The following is a list of all other participants, each of whom will receive a certificate of participation:

Abigail Dahan, M.D., Celine Hamilton, M.D. and Glenn Martin, M.D.

Chadi Abdallah, M.D.
Community Integration and Associated Factors Among Older Adults with Schizophrenia

Lada Alexeeno, M.D.
Extrapyramidal symptoms associated with antidepressants -a review of literature and analysis of spontaneous reports

Jafar Bozorgmehr, M.D.
Role of Reactive Oxygen Species in Depressive Disorder

Binu Chacko, M.D.
Case Report: Discovering the identity of a lost autistic adolescent using a form of facilitated communication

Jonathan T. Horey, M.D.
Comparison of Substance Use Milestones in Cannabis-and Cocaine-Dependent Patients

Saira Hussain, M.D.
Increases in C Reactive Protein May Predict Recurrence or Clozapine-Induced Fever

Fayaz A. Ibrahim, M.D.
Successful Aging in Older Adults with Schizophrenia: Prevalence and Associated Factors

Khwaja Khusro, M.D.
Neuroleptic Induced Parkinsonism: A Case Report

Maria Mendoza,, M.D.
N-Desmethylclozapine: Is there Evidence for its Antipsychotic Potential?

Elissa Miller, M.D.
A Review: Depression and Treatment Outcomes in United States College Mental Health Since 1990

Navin A. Natarajan, M.D.
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NAMI-NYC Metro Develops Comprehensive Mental Health Website

By Rachel A. Fernbach, Esq.

The National Alliance on Mental Illness of New York City, Inc. (NAMI-NYC Metro) announced in February the launch of a new website that will provide an online clearinghouse of mental health information for families, consumers and professionals in New York City. The New York City Network of Care for Behavioral Health (www.nycnetworkofcare.org) will provide information, communications and advocacy for those navigating the sometimes complicated mental health system. One central goal of the website is to make sure there is "no wrong door" for those seeking to obtain mental health care and treatment in the city of New York.

The website offers a comprehensive directory of behavioral health service providers available in New York City as well as peer-reviewed articles, information on housing, insurance coverage, mental health disorders, pending legislation and advocacy efforts, and daily news articles from around the world addressing mental health, mental retardation and developmental disabilities, and substance abuse issues.

In praise of the project, Michael Hogan, New York State Commissioner of Mental Health, said "The Network of Care web site promises to help transform mental health care in New York City. Never before have so many state and local resources been pulled together, and the ability to house personal wellness plans online will mark a significant step forward in helping to improve quality of care. I greatly appreciate the leadership of NAMI-NYC Metro to bring the Network of Care to New York City."

Wendy Brennan, Executive Director of NAMI-NYC Metro, added "NAMI-NYC has always offered New Yorkers support and guidance through our telephone helpline, and now everyone can have access to this information 24 hours a day on one web site. Network of Care offers one comprehensive resource that can help people navigate New York City's complex mental health system. We often hear people say they feel lost in the system, and now Network of Care will help them take back some degree of control."

The Network of Care is currently available in fourteen different languages making it accessible to many different groups of New Yorkers. The web site was jointly developed by NAMI-NYC Metro and Trilogy Integrated Resources, LLC, a California company that creates information-based web sites in the health and social services fields ("Trilogy"), along with participation from city and state agencies and other mental health organizations. Trilogy will provide ongoing maintenance for the site.

"While there are many mental health resources for New York City residents, tracking down the right mental health care can be a challenge, " noted Adam Karpati, M.D., Executive Deputy Commissioner for Mental Hygiene at the New York City Department of Health and Mental Hygiene. "We thank NAMI-NYC for providing New Yorkers with this important resource, which will help connect people to the services they need."

NAMI-NYC Metro, one of the largest NAMI affiliates, is a grassroots organization that provides support, education and advocacy for families and individuals of all ethnic and socio-economic backgrounds who live with mental illness. NAMI-NYC Metro can be reached at www.naminycmetro.org. ■

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is making free e-prescribing software available to all prescribers in the United States, via its website www.nationalerx.com.

However, donation of such items to prescribers might pose a conflict with federal fraud and abuse laws prohibiting the receipt of non-monetary remuneration by health care entities that bill Medicare and Medicaid. To eliminate this potential conflict, HHS has implemented new exceptions, or safe harbors, under the federal physician self-referral law and anti-kickback law.

New York State Information

The New York State Medicaid program requirement that all prescriptions for brand drugs include the terms "dispense as written" and "brand medically necessary" in a handwritten form is in direct conflict with e-prescribing initiatives. Efforts are ongoing to resolve this issue and other similar issues around the country.

Governor Paterson's 2009-2010 NYS Executive Budget Proposal authorizes the New York State Medicaid Program to provide financial incentives to prescribers ($.80 per dispensed prescription) and pharmacies ($.20 per dispensed prescription) who engage in e-prescribing. NYSPA will provide additional information regarding the Medicaid incentive program as it becomes available. ■

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achieve a social and political result only further deepens the stigma currently associated with mental illness. In addition, NYSPA noted that proposed costs associated with the sex offender program would be unsupportable and would likely swallow up funds earmarked for other important mental health services. Regrettably, this prediction is quickly becoming fact.

Third, rather than house sex offenders in already overtaxed OMH residential treatment facilities, NYSPA encouraged the use of an outpatient treatment model, similar to programs operating successfully in several other states. Finally, NYSPA urged that the sex offender program be housed under the Department of Corrections rather than under OMH because it is a problem of the correctional and criminal justice system and not the mental health system.

NYSPA is pleased that the Governor's Budget Proposal includes changes to the sex offender program that directly address concerns and challenges expressed by NYSPA prior to the enactment of the statute. The proposed changes are as follows:

- Under current law, respondents awaiting a jury trial are housed in OMH facilities. A proposed amendment to Section 10.06 of SOMTA would instead permit respondents to remain in prison or on parole pending a trial date, thereby reducing additional financial burden on the mental health system.
- A proposed amendment to Section 10.08 of SOMTA would allow respondents to make an "electronic appearance" in court by means of video conferencing technology, thereby reducing transportation and security costs.
- The Governor suggests shifting treatment for sex offenders away from an inpatient psychiatric model towards treatment models that require lower staffing ratios, for example, the outpatient treatment model currently in place in Texas.
- The Governor suggests a reduction in planned staff by 217 jobs, saving $11.7 million.
- The Governor suggests a three-year delay in any significant statutory investments, including implementation of the "SHU law." The SHU law, signed into law in January, 2008, limited the use of solitary confinement for inmates with severe psychiatric illnesses and mandated the creation of new residential mental health units (RMHU) as well as additional training and assessments. However, this three year delay will not apply to changes required by the 2007 Disability Advocates, Inc. (DAI) legal settlement, which includes additional funding for special treatment beds, transitional immediate care beds and RMHUs. According to the Governor's Office, postponing the effective date of the SHU law "would allow additional time to determine the effectiveness of the programs and funding associated with the DAI settlement before expansion of these new services" and would postpone the hiring of 86 new staff.

The Governor's Office estimates that the proposed changes will result in $23 million in savings in 2009-2010 and $33 million in savings in 2010-2011, however, work still needs to be done to ensure that funding for vital and necessary mental health services is maintained. ■

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