



THE

IOWA

PSYCHIATRIST

VOLUME 18

NUMBER 2

SUMMER 2009

Suicide in Middle-Aged Adults: Renewed Attention to an Otherwise Forgotten Group

By Kija M. Weldon MS, Kimberly A. S. Merchant MA, Jess G. Fiedorowicz MD MS

Three times in 10 months, in an unsuspecting Iowa community, what started out as regular news coverage of allegations of improper or illegal activities involving middle-aged, professional men ended, suddenly and sadly, with each man taking his own life. Each time, in the shadow of suicide, a stunned community was left with ever-increasing questions and pain. Naturally, the community turned toward mental health professionals for answers. Why these men? Could their risk for suicide have been identified? While it would be presumptuous to respond to the first question here, the second question certainly merits at least general discussion. The young and elderly have long been noted to be at risk for suicide, however, clinicians may overlook that middle-age adults, particularly men, remain vulnerable.

Nationally, the lay media have also focused attention on suicide rates in middle-age adults as demonstrated by articles such as "Midlife Suicide Rises, Puzzling Researchers," published in the New York Times, and broadcasts such as "More Middle-Aged Adults Committing Suicide" on National Public Radio.^{1,2} Indeed, an estimated 32,000 people died from suicide in 2005, with approximately 15,000 of these occurring in middle-aged

adults.³ In addition, a recent article in the *American Journal of Preventive Medicine*, found an increase in the rate of suicide by 2.9% in men and 3.9% in women in whites 40-64 years of age from 1999 to 2005.⁴

The increased attention and close-to-home experience led us to examine the rates of suicide across different age groups over time. We accessed data from the Centers for Disease Control and Prevention (CDC) database, Web-based Injury Statistics Query and Reporting System (WISQARS).³ We compared data on crude rates from 1990, the first year such data was accessible, and from 2005, the most recent year available. We then averaged 3 consecutive years together for both the 1990 group and the 2005 group to improve the reliability of estimates. The overall pattern of suicide rates in different age groups has not changed dramatically from the early 1990's to mid 2000's as illustrated in Figure 1. There have been declines in the rate of suicides for 15-24 year old males, males age ≥ 65 years of age, and females ≥ 65 years of age. The rate of suicide in middle age males has increased slightly.

Based on this data, substantive changes in suicide risk for middle-aged adults do not appear evident. Further, while

Continued on page 4

Legislative Update



By Erika Anderson
Anderson
Legislative
Consulting

Every legislative session has a personality, a personality developed in part by the

challenges legislators are asked to address and the opportunities they leverage to move forward with priorities. A session is typically defined by either known challenges that developed over the interim that must be considered by policymakers, or by those that occur during the session that ultimately redirect focus and often redefine the personality of the session. The 2009 session was blessed with both scenarios.

On the first day of the 83rd General Assembly it was clear that rebuilding Iowa would be a top priority for the legislature after natural disasters in 2008 resulted in the designation of 86 counties as federal disaster areas. Not quite as clear, until the meeting of the state's Revenue Estimating Conference (REC) in March, was the anticipated impact of the national economic downturn on state revenue collections. When the REC came back with a mid-session answer that net General Fund revenues would be \$129.7 million less in the current fiscal year and \$269.9 million less in FY2010, both the Governor's and the Legislature's proposed budgets had to be re-tooled. This already arduous process was complicated by the enactment of the Federal American Recovery and Reinvestment Act of 2009 and the determination of how federal stimulus money received by Iowa should be used.

Despite all of this, the 83rd Iowa General Assembly ended five days earlier than the scheduled adjournment date and, not to be overlooked in the presence of high winds

Continued on page 5

Membership on the Move

NEW MEMBER IN TRAINING

Jeff Jacobson, DO
Julie Voelker, MD

NEW GENERAL MEMBERS

Thomas Brashers-Krug, MD, PhD, Iowa City
Anthony Miller, MD, Iowa City

UPGRADED TO GENERAL MEMBER

David Mair, MD, Iowa City
Afshin Shirani, MD, Iowa City

REINSTATED

Muhammad Chowdhry, MD,
Independence

INACTIVE STATUS

Michael Garvey, MD, Iowa City
James Pullen, MD, Des Moines

TRANSFER OUT

Stephanie Berg, MD, South Carolina
Alina Budu, MD, Texas
Michael Garvey, MD, Arizona
Stephanie Lopez, MD, Oregon
Alberto Sanchez, MD, New York
Stephen Zella, DO, Texas

Disclaimer

The advertisements, letters to the Editor, columns and articles published in this newsletter state the author's opinions and do not represent endorsement of those opinions by the Iowa Psychiatric Society. Information submitted by advertisers has not been verified for accuracy by IPS.



We have a dilemma in the state of Iowa concerning access to quality mental health care. Data suggests that the number of psychiatrists in the state is inadequate to meet the needs of our citizens unless significant changes occur. One solution two states have taken is to pass legislation which allows psychologists to prescribe psychotropic medications. During the 2009 legislative session, bills permitting doctoral-level psychologist to practice medicine have been introduced in ten other states. The additional training requirements and other details vary to some degree from proposal to proposal. New Mexico and Louisiana are the two states that allow psychologists prescribing privileges for psychotropic drugs

including Schedule II-IV medication.

I suggest that this approach to the access crisis is a 20th century idea and we should be using 21st century innovative approaches to improve access for mental health care. A more appropriate solution would be to utilize our current capacity in a more efficient manor by redesigning the process of healthcare delivery. We have already started with using telemedicine to expand psychiatric services for both children and adults to mental health clinics in rural Iowa.

There is waste in our current delivery system with no-shows and cancelled appointment slots that go unfilled. Discharged patients from our inpatient psychiatric services are being readmitted within 30 days due to inadequate discharge planning or post discharge care. These often are simple access problems that can be corrected by better utilization of our current workforce. Creating more prescribers with markedly less medical training than our currently practicing psychiatrists, psychiatric nurse practitioners or mental health trained physician assistants is not an answer which leads to improved quality of care.

Last fall the Society canvassed our membership for their input on a strategy to address prior authorization (PA) for psychotropic medications paid for by Medicaid funding. The majority of those who responded favored working with the DUR Commission and DHS. A workgroup was assembled and has continued to meet with DHS on the PA issue. As noted in a companion article in this newsletter, PA for ten psychiatric medications will be initiated in mid June. Grandfathering in of current users of these ten medications is allowed. I personally am pleased with the outcome of this collaborative effort. Availability of all meds but not all preparations was maintained and cost saving to some degree has been attained.

A recent article in *Psychiatric Services* (ps.psychiatryonline.org, May 2009, Volume 60, No. 5, pp 601-606) evaluated the effect of containing prescription drug utilization by Medicaid programs in ten states. The study demonstrated that many patients had medication access problems. Those that did were 3.6 times more likely to have adverse events including emergency department visits, hospitalizations, homelessness, suicidal ideation or behavior, or incarceration. The study is not without some weaknesses but does support a need to monitor these efforts limit access and their resultant effect on our patient's well being. We need to maintain a place at the table for our workgroup to optimize our efforts to prevent harm as further changes are proposed to limit access. We give our thanks to the IPS members participating in the DUR workgroup.

Robert E. Smith, MD

FROM THE EDITOR

I was trying to be funny... I try a lot, but don't always succeed, or at least it's not always obvious. I intended for my last editorial to parody the relationship between pharmaceutical representatives and physicians while making what was otherwise a serious proposal. I'm afraid that not everybody picked up on my attempt at humor!

Just to set the record straight, I don't consider pharmaceutical representatives to be opportunists ready to do anything to make a sale and I don't consider physicians to be pathetic individuals without friends or cooking skills. I, for instance, make excellent sandwiches in my wife's absence, and I believe that my next attempt at making rice will be successful. I must admit, however, that since the last newsletter was published I have had an offer to bear my children. I thought that was very nice!



Anyway, in all seriousness, I do think it should be recognized that doctors, the media and the government have a tendency to talk about the pharmaceutical industry and their representatives as though they are evil - responsible for the cost of our health system and for elderly people having to eat cat food in order to afford their medicines. And this is not fair. Patented medications are certainly expensive, but the companies are only selling. Pharmaceutical representatives are only advertising. In the end it is doctors that are writing the prescriptions, and it is doctors who can keep the cost of medications, products and health care down.

Pharmaceutical representatives are people doing their jobs, many of them facing the scary prospect of downsizing and layoffs. And most of them are very nice people.

Next week I will be learning to use my sixth electronic medical record (EMR). I am part of the first generation of physicians out here who never had to use a paper chart. I have seen paper charts - as a resident at the VA I actually had to look at paper charts when I wanted to research a patient's history, but those piles of dead trees were enough to make me want to discount how important that history was!

Each EMR has its good and bad points. I hate the one I use now everyday, but it's good for billing. The one that I like best is IPR, the the University of Iowa's system - the one that's now being junked for another system. Apparently, only 10% of hospitals and 16% of primary care clinics use electronic medical records, so the fact that I'm now going to be using my sixth makes me think I must be pretty unique! I have no actual data to support that.

If you're making the most of your electronic medical software, you can be keeping records, ordering tests, writing and sending prescriptions, communicating with your office staff, scheduling and billing all from the comfort of your keyboard. I am predicting that the next innovation will allow me to feed my dogs remotely. Anyway, Dr. Steenblock and I were talking about electronic communication and record keeping at the IPS Spring Meeting and decided that we wanted to know more about how Iowa's psychiatrists are using electronic records and how they felt about them. So I'd like to call for everybody reading this to sit down and write a little about your how you've felt about your electronic medical record, e-prescribing or even your e-mail.

So... Epic, NexGen, IPR, Allscripts, Surescripts or whatever you're using, let's start sharing experiences with electronic records, electronic prescribing or whatever you're doing. Don't be shy - everybody's experiences are unique and if we can help each other avoid our mistakes, share in our successes or improve our practice, we'll all be better off!

Carver W. Nebbe, MD

Carver W. Nebbe, MD is a psychiatrist with the Thielen Student Health Center at Iowa State University and is pictured with his dog Teddy.

Suicide in Middle-Aged Adults Continued from page 1

attention is paid to suicide in adolescents and older adults, middle-aged adults remain at considerable risk of suicide. The Andreasen and Black *Introductory Textbook of Psychiatry* appropriately details suicide risk by age with the statement, “Rates for men increase steadily with age and peak after age 75; rates for women are curvilinear and peak in the late 40s or early 50s... three times as many men take their lives as women.”⁵ Yet, public health efforts and general publications have focused attention on risk for adolescents and the elderly. In one fairly typical article on suicide risk assessment, Frierson et al. state, “Suicide is most common in elderly people and adolescents.”⁶ Statements such as these may distort the actual data on suicide risk by age and even lead some to inappropriately consider middle-age as a protective factor.

The use of age in the process of formulating a suicide risk assessment should be done with caution and with understanding of the available data rather than based on simple stereotypes. The targeting of suicide prevention efforts to adolescents and the elderly may have served in directing needed resources toward these groups, but may have diverted clinical and public health attention from middle-age adults. Therefore, while the current media attention may not be warranted based on the data, it should be welcomed toward recognizing this perhaps neglected yet at-risk demographic.

As clinicians we should recognize the complexity of suicide rates by age. Simplistic summaries of the data suggesting greatest risk for adolescents and older adults should be avoided. Current media attention will hopefully attenuate the implicit assumption of middle age as a protective factor. Suicide risk assessments should continue to be individualized and founded upon a

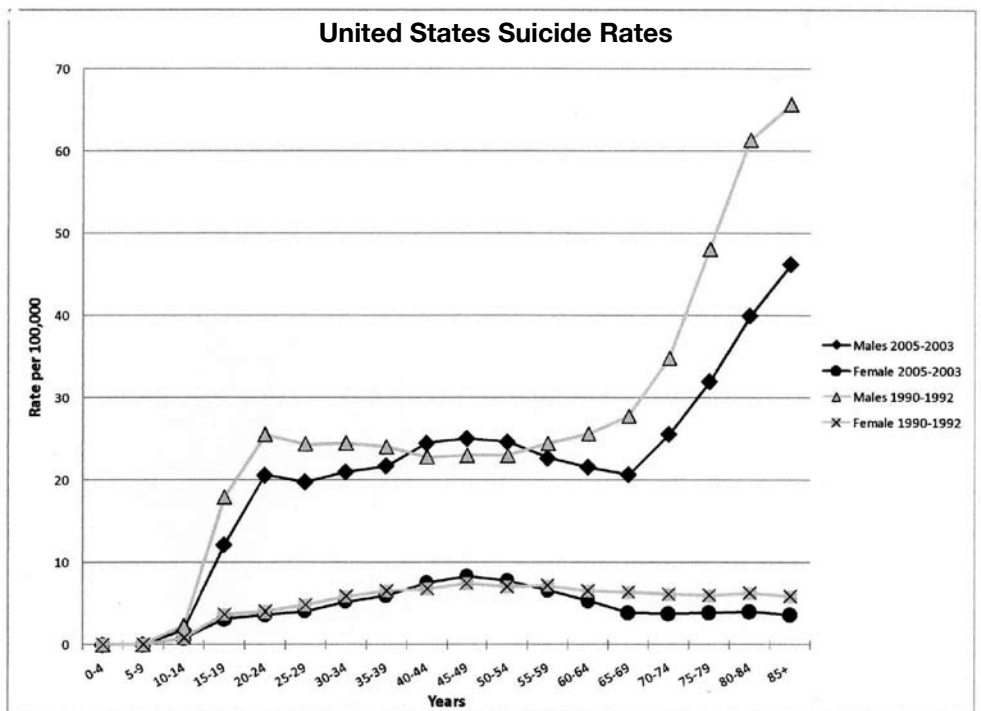


Figure 1. The pattern of suicide has remained constant from the early 1990’s to mid 2000’s, with a decrease in suicide rates in adolescent and elderly males.

rigorous assessment, with the hope that the decreased suicide rates seen for adolescents and the elderly will also become a trend for middle-age adults.

References

1. Cohen P. Midlife suicide rises, puzzling researchers. *The New York Times*. February 12, 2008. Accessed January 2, 2009.
2. Martin M. Report: More middle-aged adults committing suicide [transcript]. “Tell Me More.” National Public Radio. March 3, 2008. Accessed January 2, 2009.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/ncipc/wisqars. Updated 2005. Accessed December 20, 2008.
4. Hu G, Wilcox HC, Wissow L, Baker SP. Mid-life suicide: An increasing problem in U.S. whites, 1999–2005. *American Journal of Preventive Medicine*. 2008;35(6):589-593.

5. Andreasen NC, Black DW. *Introductory Textbook of Psychiatry*. 4th ed. Washington, DC: American Psychiatric Pub.; 2006.

6. Frierson RL, Melikian M, Wadman PC. Principles of suicide risk assessment. How to interview depressed patients and tailor treatment. *Postgrad Med*. 2002;112(3):65-6, 69-71.

Kija M. Weldon, B.S. is a third-year medical student at the Roy J. and Lucille A. Carver College of Medicine. She can be reached at kija-weldon@uiowa.edu.

Kimberly A. S. Merchant, M.A. is a Research Assistant II at the University of Iowa College of Public Health. She can be reached at kimberly-merchant@uiowa.edu.

Jess G. Fiedorowicz, M.D., M.S. is an Assistant Professor of Psychiatry at the University of Iowa. He can be reached at jess-fiedorowicz@uiowa.edu.

Legislative Update Continued from page 1

and waters, health care policy continued to be a top-five priority for both the General Assembly and the Governor. A few of the health-care highlights included:

Health Care Reform: Senator Hatch (D – Des Moines) sponsored the second consecutive year of legislative health care reform efforts. Senate File 389 was signed into law on May 19th and included a number of provisions such as: the creation of the Legislative Health Care Commission charged with developing a health care reform strategic plan, adding registered specialty health care providers and clinics to the voluntary health care services immune from civil liability, establishment of a health care workforce support initiative and shortage fund to help with the coordination and financial support of efforts addressing health care worker shortages in the state including those established by the bill – the medical residency training state matching grant program, the physician assistant mental health fellowship program, the health care professional incentive payment program, and the nursing workforce shortage initiative.

PMIC Inpatient Benefits: A new paragraph was added to Iowa Code section 135H.3 requiring group insurance to pay for medically necessary inpatient benefits and prohibiting exclusions or denials for those children diagnosed with a biologically based mental illness and meeting medical assistance criteria for admission to a Psychiatric Medical Institution for Children (PMIC). (Senate File 478. *See also:* Senate File 236 relating to PMIC services and cost-based reimbursement.)

Mental Health Parity: Despite statewide grassroots efforts, positive polling numbers, and legislative leadership, the mental health and substance abuse parity bills supported and passed by both the House and Senate Human Resources Committees stalled on the debate calendars and were never brought to the floor for debate. Mandated health care coverage for prosthetics (HF311)

and oral chemotherapy medications (SF 478), however, were passed by the General Assembly.

Stipends for Psychiatrists: Receiving a decrease in total funds available, but maintained in the Health & Human Services Appropriations for FY10, were the stipends created in 2007 to help address the mental health professional shortage through financial support to psychiatrists serving as medical directors in community mental health centers. In the upcoming year, four \$40,000 stipends will be available (total appropriated \$163,6000) whereas in FY09 five stipends were funded. House File 811 has not yet been signed by the Governor who does have line-item veto authority for this and other appropriations bills.

Federal Dollars: House File 820 allocates to state agencies, programs, and projects federal funds made available to the state through federal grants, block grants, and stimulus dollars. Included in these allocations: \$13.4 million in substance abuse prevention and treatment block grants, \$3.5m in community mental health services block grants, \$1m in preventative health and health services block grants, and additional dollars to the state mental health institutes in Cherokee, Clarinda, Independence, and Mt. Pleasant.

Veterans Prescription Drug Coverage: Senate File 440 directs state health care facilities and the state Department of Veterans Affairs (VA) to identify residents' eligibility for benefits through the US Department of Veterans Affairs. Eligible residents must be allowed to access any prescription drug benefit included and the health care facility should assist residents in accessing prescription drugs for which they are qualified. The state Department of Inspection & Appeals, the VA, and the Department of Human Services are directed to identify barriers to residents in accessing these benefits and are required to assist health care facilities in adjusting procedures for medication administration to comply with Iowa Code 135C.31A.

Donner Dewdney, MD Celebrated 40 Years of Service to Kids

In April, IPS member Donner Dewdney, M.D., Orchard Place's in-house child psychiatrist, celebrated his 40th anniversary at the Psychiatric Medical Institute for Children. The celebration dinner took place in the gymnasium where Dr. Dewdney spent many hours playing noontime basketball with staff members and colleagues.

Dr. Dewdney started Des Moines' first private practice in child psychiatry. He founded the children's psychiatric program at Iowa Lutheran Hospital and continues to serve there as director of inpatient behavioral services. He is writing a book about his work with psychotic children and still works three days a week at Orchard Place.

Congratulations Dr. Dewdney for you 40 years of service to more than 7,000 kids in central Iowa!

Psychiatrists Invited to Share Concerns

The Iowa Psychiatric Society is sponsoring meetings this summer in Sioux City, Des Moines, Waterloo, Iowa City and Davenport for all psychiatrists (members and non-members) to discuss how IPS can assist them to enhance their practice and improve services in their communities.

This program is funded through a grant from the American Psychiatric Association to engage psychiatrists in the activities of the Society. A brief update on APA and IPS programs will be followed by a dialogue on some of the current trends in psychiatry: the shortage of psychiatrists, scope of practice, telepsychiatry, the judicial system, the shortage of beds and fiscal challenges.

Please watch your mail for a special invitation or call the IPS office for more details.

On Consulting with an Iowa Physician Undergoing a Medical Malpractice Lawsuit

By David E. Drake, D.O.

I know of few threats that are more anxiety producing for physicians than the possibility of a medical malpractice lawsuit. Forced to deal with attorneys who will focus on our alleged failings and oversights, we come face to face with an arena that is not our own – in depositions and court room interrogations – having to respond to inquiries about our every action, thinking, and documentation even when our best efforts were put forward.

In some cases, negligence may be involved, while in others, a bad outcome may be a result of a complicated morass of factors outside our control.

Very recently I had the good fortune to work with an Iowa physician who asked to meet with me in consultation in my role as psychotherapist in my private practice office. The time was just following news that his records from a case had been requested by the attorney for a former patient. The outcome of a treatment had not been what anyone had wanted or predicted. My new physician patient wanted to be prepared for what might lay ahead – depositions, expert witnesses both for and against, and the especially dreaded possibility of going to trial.

For psychiatrists the risk for a lawsuit has been between 5 and 7% over at least the last decade or so. In the article “Malpractice distress: Help yourself and others survive”, Sara C. Charles, M.D., Profess of Psychiatry (emerita) from the University of Illinois College of Medicine in Chicago wrote that “No nationwide reporting system tracks the incidence of medical malpractice claims, but industry experts suggest a claim is leveled against 7% of psychiatrist each year. The risk is higher for other medical specialists: a recent survey by the American College of Obstetricians and Gynecologists found that 89% of practicing ObGyns had been

sued at least once in their careers. Because a claim usually takes several years to resolve, a substantial number of physicians - - including psychiatrists – are involved in litigation at any one time.” (Vol 6, No. 2/ February 2007 from Current Psychiatry, pp 23-24).

This same writer, Dr. Sara Charles, wrote in 2001 that “More than 95% of physicians react to being sued by experiencing periods of emotional distress during all or portions of the lengthy process of litigation. This may begin immediately on being served with the complaints by a sense of outrage, shock, or dread about the personal and financial effects of the eventual outcome. This is the first reaction in a series that is similar to those that accompany any major life event. Feelings of intense anger, frustration, inner tension, and insomnia are frequent throughout this period.” (“Coping with a Medical Malpractice Suit”, West J Med 2001; 174:55-58)

And while I have worked with other physicians who have undergone or were undergoing malpractice lawsuits, this particular physician was most helpful to me in understanding what each of us is potentially up against when that request for medical records comes from an attorney’s office for the purpose of a possible lawsuit.

This physician, whom I will refer to as ‘Dr. J.R.’ (not the real initials) did research on the subject himself. And while not an OB/ Gyn specialist, found the DVD, “From Exam Room to Courtroom: Navigating Litigation and Coping with Stress” put out by The American College of Obstetricians & Gynecologists to be a very helpful resource. J. also found the works of Eckhart Tolle, author of A New Earth: Awakening to Your Life’s Purpose and The Power of Now, in his writings and CD’s to be helpful in getting him back to living in the moment and less fearful obsessing about what could develop as the potential lawsuit unfolded.

Dr. R found the retaining of a personal attorney as very important – an attorney to make sure that his other attorney hired by his malpractice insurance company had his interests in the forefront – and not just those of the insurance company. And although this expense was out-of-pocket I dare say he would never have thought of doing it otherwise in retrospect. I wrote of this that “A personal attorney is somewhat like a second opinion. Such an attorney may be much better in determining insurance questions, additional coverage and so forth. A personal attorney can also provide peace of mind if one imagines bankruptcy or other often exaggerated fantasies.”

Dr. R.’s experience and advice is helpful, I believe, for each of us to hear. What follows are some highlights from what he wrote, when I asked him to reflect on what helped him to get through this ordeal:

Develop a support system of empathizers – spouse involvement and shared updates are important, however avoid making your spouse/significant other your sole confidant.

Seek professional consultation and schedule regular appointments.

Most physicians are super achievers and conscientious to a fault...therefore an accusation of negligence conjures up incompetence, carelessness, and possible shame. The picture of an accused physician taking the back stairs and avoiding the elevator and meetings is painfully true. It is import for the physician not to isolate.

Reduce your work schedule to allow research into your case. Subsequent articles and notes to be written up and shared with defense attorneys is something positive which can be done and may lessen unproductive obsessing.

Continued on page 7

Schedule meals, trips, and pleasurable activities in which you would normally participate in a time of low stress. Be physically active and meditate and/or pray.

Remind yourself of the innumerable circumstances in which you have acted wisely and carefully and undoubtedly avoided complications for your patients.

Reflect not only on the good you have done for nearly all your patients but also on the positives you have provided for your family and friends.

And remember, as with everything else, 'this too shall pass'.

My former patient, Dr R, taught me about what each of us can face and how each of us, as physicians, can find that place within that speaks to focusing on what's important and discerning the facts that exist. Dr JR would reflect, after listening to Eckhart Tolle, that how for the present moment he was doing just fine – he had a roof over his head, he had food, and friends and family to be thankful for. And while the temptation to look at all the 'what ifs' were there, he was often able to get beyond that and learned to trust in his insurance-provided and personal attorneys to help him get through this. Doing his own homework on his case seemed to allow Dr R to be a contributing part of his defense team, rather than being stuck in a role as a victim.

It was my good fortune and honor to have consulted with Dr R through this process. As it turned out, his case did not go to trial and a settlement ensued. He was much relieved. Dr. R now meets with medical students to teach them about surviving a medical malpractice lawsuit themselves.

David E. Drake, D.O., FACN, DFAPA, Clinical Professor of Psychiatry at Des Moines University, is a psychotherapist/relationship consultant and psychiatrist in solo private practice in Des Moines. He can be reached at 515.288.8000 and at ddrakedo1@qwestoffice.net

Post-Graduate Conference and IPS Fall Meeting

Friday October 16, 2009

Celebrating the 90th Anniversary of Psychopathic Hospital



State of Iowa 1919 – Law for State Psychopathic Hospital Law: “An Act to establish a state psychopathic hospital especially designed, equipped and administered for the care, observation and treatment of persons who are afflicted with abnormal mental conditions; and providing for method of hearing complaint as to persons so afflicted and commitment following such hearing, and making appropriation for the establishment of such a hospital”.

Dr. Paul E. Huston documented the early history of the Iowa State Psychopathic Hospital in Palimpsest, 54(6), pp. 11-27 and 55(1), pp. 18-30. In his writings, he indicated that the psychopathic hospital movement in the early 1900's had “three chief demands in the field of mental medicine which could not be readily met by the state hospitals. These needs were 1st Temporary Care, 2nd Research, and 3rd Teaching”. We are now 90 years after the state law which laid the foundation for construction of the old psychopathic hospital and a Department of Psychiatry which would be integrated within the College of Medicine (now the Carver College of Medicine) and the Hospital of the State University of Iowa (now University of Iowa Hospital and Clinics).

These three needs are still being met for the State of Iowa.

The Fall Post-Graduate Conference co-sponsored by the Iowa Psychiatric Society and the Department of Psychiatry will celebrate the 90th anniversary of this institution and trace its history on October 16, 2009 at the Marriott Convention Center in Coralville, IA. Speakers will include former and present faculty members, as well as others influenced in their careers by Dr. Robert G. Robinson, Professor and Chair of the Department of Psychiatry, who is the longest serving Chair since establishment of the Department of Psychiatry. The CME event will be followed by a reception and dinner the same evening. All former faculty, residents, and other associated with the department are invited and are encouraged to attend.

Please mark your calendar for this exciting and informative celebration. Learn some of the history of the hospital and the department; reconnect with other former residents who have trained within the department; meet present and former faculty members of the department; and have a great day and evening of reminiscence.

Telehealth Psychiatric Services: Improved Access in Iowa

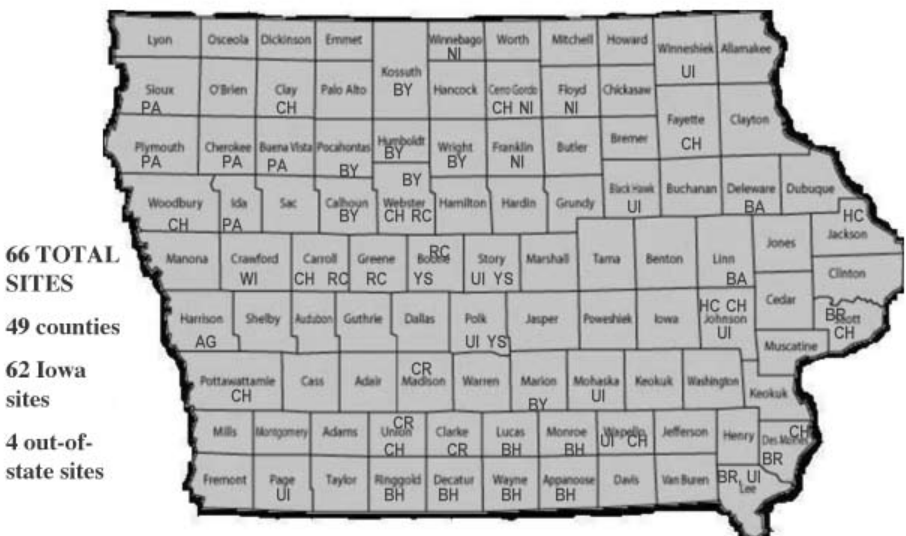
Many stakeholders have indicated a shortage of behavioral health professionals in the state. According to the Iowa Department of Public Health's Primary Care Office, 81 of Iowa's 99 counties are identified as mental health shortage areas. Access to needed services is of high priority to those involved in the behavioral health care system, particularly access to psychiatric services. Thanks to the Iowa Community Reinvestment program, today Iowa Plan enrollees in rural and underserved areas of the state have better access to services to address their mental health needs. What initially began in 14 Child Health Specialty Clinics across the state has now expanded to a current total of 66 sites in 49 counties and includes 4 out-of-state locations. There are now 22 Iowa Plan providers engaged in providing psychiatric telehealth services and more who have expressed interest.

Program Highlights

In November, 2008, Magellan Behavioral Care of Iowa issued a Telehealth Application, allowing providers to apply for project funding in order to implement telehealth psychiatric services according to a prescribed model. The community reinvestment funding covered equipment installation and technical support as well as a lump sum payment for a minimum number of service units to include initial evaluations, medication management, and care coordination. As is the standard for all psychiatric care under the Iowa Plan, the Telehealth Psychiatric Service Standards require Iowa-licensed clinicians no matter their location.

Through lessons learned with the Child Health Specialty Clinics, it was determined that in order to effectively provide telehealth psychiatric services, a care coordination piece was absolutely necessary. The service requires that

Iowa Expanding Access to Psychiatric Services Telehealth Locations



AG	Community Memorial Hospital (Alegent)	BY	Berryhill Center
BA	Backbone Area Counseling Center	NI	Mental Health Center of North Iowa
BH	Behavioral Health Centers of Southern Iowa	PA	Plains Area Mental Health Center
BR	Bridgeway	RC	Richmond Center
CH	Child Health Specialty Clinics	UI	University of Iowa (including 8 other providers)
CR	Crossroads Mental Health Center	WI	West Iowa Community Mental Health Center
HC	Hillcrest	YS	Youth and Shelter Services

a nurse provide various coordination services including assessing whether the consumers are comfortable with telehealth, organizing and preparing information for the psychiatrist, following up on prescription orders, assisting the consumer and family with other issues, collaborating with other providers, and anything else to coordinate appropriate care. This service is reimbursable through the Iowa Plan

Chris Okiishi, M.D., child psychiatrist participating in the Iowa telehealth program, and strong advocate for the use of telehealth in psychiatric services, has said, "What has been amazing to me is how quickly families adapt to the technology—within seconds, it's as if we were in the same room...and for me, it's very good to be able to be in Sioux City at 9:00, Ottumwa at 9:30, and Fort Dodge at 10:00, all without having to put any additional gas in my car."

Key Program Components

Technology: Webcams and secure computer technology make services accessible in sites across the state, allowing behavioral health professionals to provide services to individuals in various locations without having to travel to be seen in person.

Access: Telehealth technology is now in place in 62 sites across Iowa and continues to expand.

Services: The standards and models for care remain the same through telehealth as they would be face to face and the care coordination service enhances the experience of Iowa Plan consumers.

Outcomes and Satisfaction: Consumers will be asked to complete self-report outcomes assessments and to report on their satisfaction with the service in order to assess the experience of care.

MIT Reflections of a Day on Capitol Hill

By Eric Johnson, DO

In February, I served as the IPS delegate to APA's 2009 Advocacy Day. The advocacy events took place from February 8 to 11, and this was a busy and exciting time on Capitol Hill! That very week, the 111th Congress was debating and ultimately passed the "economic stimulus act" (American Recovery and Reinvestment Act of 2009). I was one of 105 APA members from across the country to take part in the APA's comprehensive advocacy program, organized by the Division of Government Relations, and including a wealth of educational and action opportunities. The first days were spent in training and preparation, and the visit culminated with appointments with our legislators. My request for meetings was accepted by the offices of Senator Harkin, and Representatives Loesback and Braley.

I had the pleasure of thanking these 3 legislators for their support and co-sponsorship of last year's landmark mental health parity act (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008). However, we urged members of Congress to not yet consider the job done. Employers have indicated that substantial time will be needed to implement the parity requirement into their insurance



Eric Johnson, DO and Representative Loesback plans. APA is urging the departments of Health and Human Services and the Treasury (the two departments charged with implementing the law) to quickly release the regulations under consideration.

Health Information Technology was another key issue highlighted by the APA this year, and was quite timely due to the fact that the stimulus act includes a significant amount of money directed to it. APA had a clear message for Congress - electronic psychiatric records should be maintained with the highest level of privacy and security possible, and this should not be an area to "cut corners".

Another major accomplishment of the recent Congressional session was the reduction of the discriminatory Medicare copay for outpatient mental health services to 20 percent. A continued message this year was to urge Congress and the Obama administration to ensure that psychiatric

care is covered on an equal basis with other types of care under any proposals to reform health care.

A highlight for me was a keynote address delivered by Gordon Smith, who was defeated in a re-election bid last November as a senator from Oregon. He remains a staunch APA ally and sponsor of the 2004 suicide-prevention law named after his son who had taken his own life. He presented a moving speech and acknowledged the lack of understanding that elected officials have for mental illness treatment, often until it affects them directly. "Your job is to make sure that mental health is not put on the back burner", Smith said.

The 110th Congress provided landmark legislation for individuals with mental illness and their care providers, and there is momentum for further healthcare reform. Advocacy efforts have played a key role. My appreciation for this process, as well as PACs, has grown significantly and I am eager to utilize my advocacy "training" at the state level.

Eric Johnson, DO, is currently a fourth year resident at the University of Iowa, Department of Child Psychiatry. Dr. Johnson serves as the MIT Chair on the IPS Executive Council.

Prescriptive Authority For Psychologists in Iowa?

Did you know that last month's Iowa Psychological Association's spring meeting featured a session by a New Mexico psychologist who was promoting prescriptive authority for psychologists? It was titled "The Time is Now." Were you aware that several states bordering Iowa, including Missouri, Wisconsin and Illinois have had recent legislative initiatives promoting this concept? These developments prompted the Iowa Psychiatric Society to initiate a survey of members to determine how high a priority this issue should be, and the responses clearly indicated that this is a concern of the utmost importance to psychiatrists in Iowa. Thus, the Iowa Psychiatric Society will vigorously oppose any proposals of this type.

But we need your support. The IPS Political Action Committee *IPPAC* is asking psychiatrists (both members and non-members alike) for contributions so that we can proactively lay the groundwork to advocate for the best psychiatric care possible in Iowa. Please don't delay; it is in the best interest of our patients and our profession.

IPPAC's goal is to raise \$3000 by December 2009. If every IPS member gives \$25 we would exceed our goal. Contributions are not limited to \$25 and larger donations are encouraged to help us meet our goal. To donate, please fill out the form below.

2009 *IPPAC* CONTRIBUTION FORM

Name: _____

Home Address*: _____ City: _____ State: _____ Zip: _____

Phone: _____ Contribution: \$ _____

* State law requires we use our best efforts to collect and report the name, mailing address of individuals who contribute to *IPPAC*.

Make check payable to *IPPAC* and send to: *IPPAC, 2643 Beaver #338, Des Moines, IA 50310*

Note: *IPPAC* can accept only personal checks. No corporate contributions can be accepted.

Medicaid To Require Prior Authorization Of Ten Mental Health Drugs

Effective June 15, 2009 the Iowa Medicaid Enterprise will require prior authorization for the following ten mental health medications: Abilify Dismelt, Invega, Pristiq, Risperdal M-Tab, Zyprexa Zydis, Luvox and Seroquel XR.

Grandfathering: Non-preferred drugs will require prior authorization for new users only. The change in drug status to non-preferred will only stop pharmacy claims from paying for “new users” or those members that have not had the drug previously paid by Medicaid. If the member does not have a history of the requested drug in the Medicaid paid claims system, a prior authorization will be required. Established users will be grandfathered by the point of sale (POS) system. The POS system will look back 180 days for paid claims for the specific drug and allow members to continue to get the same drug without restrictions. All strengths of the grandfathered drug will be included in the grandfathering. This grandfathering process will remain in place for the duration of the member’s eligibility.

Prior Authorization Process: Prior Authorization (PA) Forms are located at www.iowamedicaidpdl.com. A decision will be made within 24 hours of the request. The average time is 2-3 hours and the prescriber will be notified by fax of decision with dates of authorization if approved..

Denied Authorizations: If the initial request is denied, the pharmacist and physician will be faxed and the patient sent a letter. The pharmacist may use up to a 72-hour override one time if PA can not be immediately received. The physician can call the Provider Help Desk to speak to the pharmacist that reviewed the request.

A physician can fax a second request giving additional clarifying medical information. If the second request is denied, it can be referred to the IME Medical Director for further review and discussion. If deemed necessary by the Medical Director, it will

be referred to a consulting board certified psychiatrist.

Formal Appeal: A formal appeal must be made within 30 days. The Department of Human Services determines if the appeal is eligible for a hearing. If approved, it will then be heard by an administrative law judge and the decision is issued typically in less than 90 days.

Resources: www.iowamedicaidpdl.com, PA Help Desk 877-776-1567 or 515-725-1106 (local).

Criteria for Prior Authorizations:

Abilify Dismelt, Invega, Pristiq, Risperdal M-Tab, and Zyprexa Zydis will become *nonpreferred* and *require prior authorization through the Modified Formulations PA* as follows: Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation of a recent trial and therapy failure with the original parent drug of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Luvox CR and Seroquel XR will become *nonpreferred* and continue to require prior authorization through the *Extended Release PA* as follows: Payment for the extended

release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Pexeva will become *nonpreferred*. Current prior authorization criteria for non-preferred drugs is: Payment for a non-preferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.)

Metadate CD and Ritalin LA will become *nonpreferred* and will continue to require prior authorization through the *ADD/ADHD/Narcolepsy agents PA* as follows: Prior authorization is required for ADD/ADHD/Narcolepsy agents for members 21 years of age or older. The category includes amphetamine salt combos, atomoxetine, dexamethylphenidate HCl, dextroamphetamine, lisdexamfetamine, methamphetamine HCl, methylphenidate HCl, and modafinil. Prior approval shall be granted if there is documentation of one of the following: Attention deficit disorder, Attention deficit hyperactivity disorder, Narcolepsy and Other FDA approved indications.

Drug Name	Drug Status on the PDL	PA Form to Use
Abilify Dismelt	Non-Preferred with Conditions	Modified Formulations
Invega	Non-Preferred with Conditions	Modified Formulations
Luvox CR	Non-Preferred with Conditions	Extended Release Formulations
Metadate CD	Non-Preferred with Conditions	ADD/ADHD/Narcolepsy Agents
Pexeva	Non-Preferred	Non-Preferred
Pristiq	Non-Preferred with Conditions	Modified Formulations
Risperdal M-Tab	Non-Preferred with Conditions	Modified Formulations
Ritalin LA	Non-Preferred with Conditions	ADD/ADHD/Narcolepsy Agents
Seroquel XR	Non-Preferred with Conditions	Extended Release
Zyprexa Zydis	Non-Preferred with Conditions	Modified Formulations

Can your claims examiner pass this test?

1. What does Axis III of the DSM-IV classification signify?
2. What is tardive dyskinesia?
3. What is the significance of the "Tarasoff" decision?
4. How often should lithium be monitored?
5. Which population is most at risk for suicide?
6. What precautions should be taken before administering ECT?
7. What is the definition of suicidal ideation?

We can!

Find out if your malpractice insurer's claims examiners can answer these questions.

If they fail this test, it's time for you to give us a call!

We speak your language. You won't have to explain psychiatric terminology to us. Our claims staff has more experience handling psychiatric liability claims than any other in the world.

For more than 20 years, we have handled over 15,000 files involving psychiatrists. Of course, we hope you never have a claim. But, when the unfortunate does occur, you want to make sure you have experts on your side.



The Psychiatrists' Program

Professional Liability Insurance Designed for Psychiatrists

Call: (800) 245-3333, ext. 389 ~ E-mail: TheProgram@prms.com ~ Visit: www.psychprogram.com



Iowa Psychiatric Society
 PMB 338
 2643 Beaver Avenue
 Des Moines, Iowa 50310-3909

PRSR STD
 U.S. POSTAGE
PAID
 Des Moines, Iowa
 Permit No. 5297

Return Service Requested

INSIDE

- Page 1** - Suicide in Middle-Aged Adults
Legislative Update
- Page 2** - President's Letter
- Page 3** - Letter from the Editor
- Page 5** - Donner Dewdney, MD Honored
- Page 6** - On Consulting with an Iowa Physician
Undergoing a Medical Malpractice
Lawsuit
- Page 7** - IPS Fall Meeting
- Page 8** - Telehealth Psychiatric Services: Improved
Access in Iowa
- Page 9** - MIT Reflections of a Day on Capitol Hill
Prescriptive Authority For Psychologists
in Iowa?
- Page 10** - Medicaid To Require Prior Authorization of
Ten Mental Health Drugs

ON THE MOVE

IPS & PSYCHIATRY

IPS Psychiatry on the move

Dr. Loren A. Olson, MD was awarded the NAMI Exemplary Psychiatrist award by the National Alliance on Mental Illness (NAMI) National at a special breakfast hosted by NAMI during the 2009 American Psychiatric Association's Annual Meeting on May 19, 2009 in San Francisco, California.

Dr. Olson was nominated for the award by NAMI of Greater Des Moines based for his "tireless" work, referencing a Christmas Eve emergency in 2006, when he made a house call 25-miles away from his home to make sure his client was safe.

Iowa District Branch, American
Psychiatric Association

Robert E. Smith, MD
President

Karen Loihl
Executive Director

Carver W. Nebbe, MD
Editor

To provide ideas or information
contact:

Iowa Psychiatric Society
 PMB 338
 2643 Beaver Avenue
 Des Moines, IA 50310-3909
 Phone: 515-633-0341
 Fax: 515-277-6030
 E-mail: iowapsych@mchsi.com

CMES / PROGRAMS

EVENTS

- October 3, 2009.....NAMI Iowa Walk, Des Moines
- October 8-11, 2009APA Institute on Psychiatric Services, New York
- October 15, 2009.....IPS Executive Council Meeting, Iowa City
- October 16, 2009.....IPS Fall Conference, Iowa City
- May 22-27, 2010APA Annual Meeting, New Orleans

