

The Psychiatric Society of Virginia VIRGINIA NEWS

FALL

A District Branch of the American Psychiatric Association

2004

Yaacov S. Pushkin, MD, DFAPA



From the President of PSV

The relationship between economics and provision of psychiatric services is a critical one for patients, advocates and clinicians. Obviously, for those with resources, access to care is not a daunting issue. For those without, the equation is much different. In training, I wondered about this relationship of economics versus need—such powerful forces. Would economics rule need or vice-versa? How do these forces affect one another? The relationship is complex and involves, but is not limited to, available funding from government, managed care influences, private sector resources, facilities and staffing factors, care delivery methodology, community resources, advocacy, legislation and, unfortunately, stigma.

In recent years, we in Virginia have observed a decline in both state and private sector bed availability, precipitating a crisis in terms of access to acute/sub acute inpatient care for our sickest and most vulnerable patients. Patients, families, advocates, mental and general medical health professionals, ERs, general hospitals and, sadly, correctional facilities have witnessed first-hand the consequences of diminished acute care access. It is not uncommon to learn of no bed availability,

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on a given day or night, throughout large regions of the state with localities exasperatedly contacting one another over considerable distances in an attempt to locate a psychiatric bed. This issue has touched us all in Psychiatry. With reimbursement barely covering costs (if that), the private sector cannot absorb substantial indigent care. Under these

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circumstances, there is no incentive to convert private medical-surgical beds into psychiatric beds. Medical-surgical areas are also ill

equipped to provide a proper milieu for patients with symptomatic psychiatric disorders. Consequently, a number of private facilities around the state have closed beds. Unfortunately, this has all coincided with the state's own budget crisis and a reduction in state facility beds. There are no easy answers or quick fixes and no one factor or individual is to blame.

On the positive, advocates, private and public sector administrators, legislators, physicians and other mental health professionals as well as the state have begun weighing in on this issue. Within our own ranks, Richard Kaye has received distinguished recognition from the APA, with its Profile of Courage Award for his strong advocacy for proper access to care. Jim Reinhard, in his role as Commissioner of DMHMRSAS, has been leading reformative efforts to reinvest state resources into the community in hopes of promoting and effecting a preventive community care model.

The PSV has the capacity to develop a more integrated and potent response to this topic. Clearly, we need acute beds—both private and public. We need to be progressive in our thinking about community reinvestment. We need our legislators to understand the human toll and social cost of under appreciating and underresourcing the care of brain disorders. Why should the vital organ of the brain receive less acknowledgement and respect than other organs? We must increase our PAC activity to help forward our concerns. Within PSV, we have all sectors of Psychiatry represented—each having an opportunity to be involved. I invite our body to more formally engage in discussion in upcoming designated venues regarding these matters in order to strive toward tipping the economics-need equation more squarely in favor of our patients.

Sincerely,



Yaacov R. Pushkin, M.D.

The Wisdom of the Question

It is better to know some of the questions than all of the answers. —James Thurber

You know that children are growing up when they start asking questions that have answers. —John J. Plomp

I believe many of us went into Psychiatry because we are comfortable with questions. Ambiguity is something we constantly strive to clarify, but the uncertainty and the questions that inevitably surround human behavior does not throw us for a loop.

In *The Answer to How is Yes!* author Peter Block says we have stopped asking the important “why are we doing this?” questions and hide behind “How can we do this?” questions. Block states, “our culture, and we as members of it, have yielded too easily to what is doable and practical and popular. In the process we have sacrificed the pursuit of what is in our hearts. We find ourselves giving in to our doubts, and settling for what we know how to do, or can soon learn how to do, instead of pursuing what most matters to us and living with the adventure and anxiety that this requires.”

Block is right on target. There is a constant danger of losing sight of values, goals and our mission because the specific path to

that goal is not readily apparent.

In a world where change is happening at a dizzying pace and solutions to problems are needed yesterday, this talk of focusing on the right questions and not forking over the answers can drive some people over the edge.

I retook the Myers-Briggs personality inventory about a year ago during the Virginia Executive Institute and remembered that I am clearly an INFJ type (Intuition, Feeling, Perceiving type)—one who seeks meaning and connection in ideas, relationships, and wants to understand what motivates people. However I am aware that there is that other side of the quadrant, you “Sensing and Thinking” folks who tend to focus on the present and on concrete information gained from your senses and base decisions primarily on logic and objective analysis of cause and effect. You ST types, and thank God you are out there, will have to bear with me for just a moment.

Block is clearly also an INFJ personality type on the Meyers-Briggs inventory. But listen to what he says,

“We often avoid the question of whether something is worth doing by going straight to the question “How do we do it?”

When discussions are dominated by “How” we risk overvaluing what is practical and doable and postpone the questions of larger purpose. If we stay focused on the How questions, we risk aspiring to goals that are defined by the culture, by our institutions, by “that’s the way we’ve always done it” kind of thinking.”

One person put it this way. What do you do when you find yourself in a hole? The rationale thing to do is stop digging. But unfortunately we have all been guilty when something is not working to simply try harder . . . to dig faster—or figure out a way to dig cheaper or certainly more efficiently. If a business, or project, or relationship is failing we do more of what is not working. Einstein



said the definition of insanity is doing the same thing over and over again and expecting different results.

Block continues, “If we could agree that for six months we would not ask How, something in our lives, our institutions, and our culture might shift for the better. It would force us to engage in conversations about why we do what we do, as individuals and as institutions. It would create the space for longer discussions about purpose, about what is worth doing.”

It would also force us to act as if we already knew how—we just have to figure out what is worth doing. It would give priority to aim over speed. . . . we would be pulled into meaningful action, despite our uncertainty and our caution about being wrong.

Block, by the way is not talking about sitting on our hands or engaging in the “paralysis of analysis.” The book raises the question, “What are we waiting for? We have done plenty of visioning in our strategic planning efforts, and if we are waiting for more knowledge, more skills, more support from the world around us, we are waiting too long.

In fact, asking the How question is an expression of our fantasy for control and predictability. We think we can find predictability in the mastery, the knowing, and the certainty of doing something the right way. We think there is a right way, that someone else knows it (probably a consultant from another state) and that it is our job to figure it out. Again, the pursuit of “How” questions can act to avoid more important questions, such as whether what we are doing is important to us, rather than important to them.

Joe Flower wrote the following in a 1999 Physician Executive article entitled, “Living the Question.” He was talking about how the most successful fortune 500 company

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VIRGINIA NEWS

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We welcome letters to the editor and editorial contributions.

PSV Continues Aggressive Advocacy: Preview of 2005 General Assembly

Mental Health Parity

Organized psychiatry collaborated with Virginians for Mental Health Equity (VMHE) to provide supportive testimony for HB 294 (Ware, R-Powhatan), which provides that anorexia nervosa and bulimia nervosa are biologically-based mental illnesses under the law. Psychiatrist Bela Sood, a representative from NIMH, Miss Virginia Mariah Rice, and a Richmond family testified at the October 18 hearing Joint Commission on Mandated Benefits. The Commission will make its recommendation on the measure at its November 16 meeting.

Medicaid Preferred Drug List (PDL) and Access to Psychiatric Meds

PSV continues to play a key role in the fight to carve-out psychiatric medications from a restrictive formulary. We are working closely with DMAS administrators, members of the P&T Committee, and legislators to offer information about alternative approaches to improving care and reducing Medicaid pharmaceutical expenses. PSV leadership strongly opposes "fail first" and other policies that could disrupt Medicaid patients' access to medications. Yaacov Pushkin and Bela Sood testified at the October 6 public hearing on psychiatric medications.

Protection of Patient Records and Psychotherapy Notes

PSV is leading medicine's effort to ensure that physician psychotherapy notes in

Virginia enjoy the same protections they are afforded under HIPAA. We are working with the Attorney General's office to craft legislation that will restrict third party access to psychotherapy notes.

Psychologists' Attempts for Prescriptive Authority

This spring Louisiana joined New Mexico as the only states to authorize clinical psychologists, who meet certain training and supervision requirements, to prescribe medications although neither jurisdiction has fully implemented the new laws. These efforts are part of a national campaign by organized psychology to pursue prescriptive authority in all states. We do not expect such legislation during the 2005 Virginia General Assembly but we have noted increased political activity and contributing from the Virginia Psychologists Political Action Committee.

Minority Outreach Project (partnering with Legislative Black Caucus)

Through a grant, organized psychiatry sponsored a workshop and panel discussion that addressed mental health in minority communities. The session was held at the Virginia Legislative Black Caucus Annual Meeting on September 24 in Norfolk and addressed access to psychiatric care, stigma, availability of resources, and major disease. Thanks to Cheryl Jones (PSV Board Member), Ronald Forbes (Medical Director, Central State

Hospital), and Alex Taylor (Family Physician, Norfolk) for serving as panelists.

PsychMD PAC

Last year, PSV teamed up with the Northern Virginia Chapter of the Washington Psychiatric Society to form PsychMD PAC, the separate political arm for psychiatry. PsychMD surpassed its first year fundraising goal of \$7500. These funds are used to promote our agenda of a better system for psychiatric medicine, in the public and private sectors.

Organized Medicine's Agenda

Assignment of Benefits (AOB) and Fair Business Practices: Legislation would require health insurance companies to honor a patient's voluntary assignment of benefits to a physician. Physicians would have the ability to receive direct payment for services, which is currently enjoyed by dentists and oral surgeons in Virginia.

Increased Medicaid Reimbursement: Organized medicine will pursue across-the-board reimbursement increases for physicians.

Tort Reform: The Medical Society of Virginia and specialty societies continue to push lawmakers to support measures that would improve the availability and affordability of medical malpractice insurance.

For more information on any of these issues or to raise other concerns, please contact Cal Whitehead at cwhitehead@whiteheadconsulting.net.

Low-Cost Psychoanalysis & Analytically-Oriented Psychotherapy

The Psychoanalytic Training Institute of the New York Freudian Society offers reduced-fee psychotherapy and psychoanalysis in Charlottesville and Virginia Beach, VA; Washington, DC and its suburbs; and in Baltimore, MD.

Interested individuals may call 301-230-9884 in metro DC and VA or 410-727-9884 in Baltimore.



PSV IN THE NEWS

Please consider supporting the PSV Foundation. All donations can be sent to Sandra Peterson at the PSV office at PO Box 71656, Richmond, VA 23255-1656. Checks should be made payable to the PSV Foundation.

Mark Your Calendar!

Richmond Psychiatric Society Upcoming Meetings

All meetings will be held at the
Willow Oaks Country Club, 6228 Forest Hill Avenue
(804) 272-1451

Cocktails 6:30 pm
Business meeting and Dinner, 7 pm
Lecture/Q&A 7:30-9:00 pm.

SCHEDULE OF EVENTS 2004-2005

December 2 • Honorable John M. O'Bannon, M.D.
Legislative Issues

January 20 • Dr. Rochelle Klinger
Update on HIV

February • TBA

March 3 • TBA

March 3 • Dr. Prakash Masand

May 5 • Dr. Susan Kornstein, Professor, VCU/MCV
Women's Issues PMDD

May 5 • Dr. Eileen Ryan
Overview of the Juvenile Justice System

For more information contact:
Cheryl Jones, M.D. at (804) 675-5000 x2786 or
e-mail: richmondpsych@yahoo.com

Spring 2005 PSV Meeting
Friday & Saturday, April 15 & 16
Richmond Marriott West
4240 Dominion Blvd., Glen Allen, Virginia

To make room reservations
call 804-965-9500 by March 25, 2005.
Room rates are \$85 for a standard room plus tax.

Look for meeting brochures
in the mail sometime in March!
Hope to see you then!



Congratulations to PSV member Richard Kaye, DO



Dr. Richard Kaye has been selected to receive the 2004 American Psychiatric Assembly Profile of Courage Award for his courageous struggle against cuts to inpatient psychiatric beds in Virginia and against the shift of psychiatric patients from hospitals to jails.

This Profile of Courage award originated in 1996 in the Assembly to recognize an APA member, who at risk to her/his professional and personal status, has taken an ethical stand against intimidating pressure for the good of patient care and in keeping with APA Principles of Ethics.

Dr. Kaye was presented with the award at the 2004 November Assembly Meeting at the J.W. Marriott Hotel in Washington, DC, on Saturday, November 6, 2004.

Congratulations to PSV members who have Obtained Life Status for January 1st 2005

Wesley B. Carter
Joan F. Hulley Liverman
Lenard J. Lexier
Roberto Luna
Bobby W. Nelson
Pannala J.M. Reddy
Carol A. Schreiner
Joel Silverman
W. Victor R. Vieweg



Virginia Legislative Black Caucus Foundation



PSV recently participated in and sponsored the Virginia Legislative Black Caucus Foundation event at the Norfolk Waterside Marriott.

In the picture from left to right:
Ronald Forbes, Sr., MD;
Cheryl Jones, MD
(PSV member);
Alex Taylor, MD,
Senator Louise Lucas
(D-Portsmouth)

Area V Council & APA Assembly Meetings

The combined Area V Council and APA Assembly meeting consisted of four days (November 5-7, 2004) of intensive activity. On a personal note, I remain indebted to Ram for the wonderful tutorial he has provided me on Indian culture, history and cuisine.

Financially, the APA is doing well. There has been a major turnaround and it is acknowledged that the oversight and insistence of the Assembly played a leading role in both the movement of the association to take the necessary financial measures to achieve solvency and in holding the central leadership accountable. This in turn led directly to changes in the central leadership.

The APA in the last fiscal year experienced a \$3.5 million increase in revenues, coupled with a \$2.8 million reduction in budgeted expenses. This allows us to end the year with a \$6.3 million surplus and currently has \$22 million in reserves. We have 29,114 dues-paying members. Only 17 percent of revenues are derived from member dues. The spring scientific meeting in NYC was very successful with high international attendance. It will be a real challenge for the upcoming scientific meeting in Atlanta in May to have a similar draw. The annual meeting and publications account for the vast majority of revenues. The latter can also be expected to trend downward pending the publication of DSM V, which will probably not occur until 2008.

The APA PAC did support 119 candidates in the recent congressional elections; 112 of these candidates won. Support was bipartisan with 52 percent Democrats and 47 percent Republicans. Collectively, 49.5 percent of the amount contributed went to candidates of each of the major parties. The APA will now cover the overhead costs of the PAC so 100 percent of contribution to the PAC can go to candidate support. The APA can do this since it is a C-6 corporation.

Around the country, there have been some recently passed laws or referendums. New York State passed a law proactively banning psychologist prescribing and also passed a confidentiality law aimed at insurance companies. They are not allowed to review patient records and can demand access to only eight pieces of data: patient name, date of birth, practitioner name, date of service, diagnostic code, procedure code, who besides the patient, if anyone, was

in the session, and a brief, few word description of the focus of the session, but with no details. It is noted that a reading of the Virginia law regarding physician disclosure to insurance companies has similar wording, with further detail occurring by exceptions. Obviously in Virginia the insurance companies have determined, based on their treatment request forms, that all cases are exceptions. It remains to be seen if the New York State legislature is more prone to enforce its legislative intent.

Meanwhile, Florida has passed a referendum mandating that any physician with three malpractice claims cannot have a license in Florida. If the Florida Supreme Court does not negate this referendum, there will be a major out-migration by many orthopedists, anesthesiologists, and obstetricians. Florida also passed a referendum (they call it an amendment) stating that after expenses, 90 percent of a liability award must go to the injured party. It is not clear if there will be an equal out-migration of Florida liability lawyers.

Ironically, while Florida voters passed every one of the referendums on their ballot this year, one stipulated that there would be significant limits on the future number of referendums.

As we are all aware, a bill allowing psychologist prescribing was passed in Louisiana. They are, however, looking at a stipulation that the psychologist would be required to obtain approval for any prescriptions from the primary care physician based on the assumption that the psychologist would not be able to make appropriate medical judgments on the interactions of psychotropic medications with other medications, or with the patient's comorbid medical conditions. If this stipulation is initiated, the primary care physician would then assume liability for any such adverse events.

Federally, the FDA did insist on a black box warning on SSRI's labeling for use with children and adolescents. The APA staff who monitored this stated that this move was based on "personal stories" in testimony rather than on careful review of the data. The APA is working with medical societies for Internal, Pediatrics and Family Practice to develop guidelines for SSRI use in children. The FDA has also insisted on metabolic syndrome warnings on all

atypical dopamine blockers despite the lack of evidence that this is a "class effect."

The parity law was extended by Congress. A parity bill that actually has at least some "baby teeth" has been passed by the Senate but cannot seem to get through the House of Representatives. A jail diversion bill has been passed by both Houses of Congress and awaits presidential signature.

A senator's college age son did recently commit suicide, leading Congress to rapidly make money available for suicide prevention programs in colleges. Interesting how politics works!

A number of action papers were considered by the Assembly. Currently there is a 30 patient limit on the number of patients that can be treated with Buprenorphine by either an individual physician or a physician group, regardless of the size of the group. An action paper was passed supporting the repeal of the extension of this limit to entire groups. A number of membership focused action papers were passed, including ones dealing with automatic membership transfers and upgrades as members geographically move or complete training programs. Another paper focused on making available the option of payment of dues by automatic monthly credit card debits. One paper passed which addressed expanding the criteria for bipolar disorder to account for presentation changes across the life span, especially regarding the diagnosis in children and adolescents. Robert Spitzer, M.D., actively supported this paper. Another action paper supported the Federal Trials Registry to make negative clinical medication trials more accessible. This was done with the recognition that, since all research protocols require prior FDA approval, false positive results are unlikely while there are a lot of reasons other than lack of efficacy that can lead to a negative trial result.

Finally, as a challenge to our non PSV member colleagues in Virginia, it is noted that our neighbor, West Virginia, has 190 psychiatrists in the state, 171 of whom are members. Only about 50 percent of Virginia psychiatrists are PSV members.

As always, Dr. Shenoy and I remain available to discuss local issues which may be brought to the larger APA Assembly forum, or to discuss the development of potential action papers.

PsychMD PAC Contributions Exceed First Year Goal!

Thanks to the psychiatrists below who gave generously to PsychMD PAC this past year. PsychMD PAC exceeded its first year goal by over \$1500 and has contributed over \$6000 to candidates who share our commitment to a better psychiatric care delivery system.

Please join us in our new campaign by making a contribution to your PsychMD PAC.

All listed contributors since August 2003.

Leadership Circle \$250+

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PsychMD-PAC ***The Political Voice for Virginia's Psychiatrists***

PsychMD-PAC raises money from Virginia psychiatrists to fund the General Assembly and statewide candidates with positions that promote a better environment for psychiatric care delivery.

Political contributions help offset the expenses of campaigns and allow psychiatrists to target our message to important decision-makers.

Without your support of PsychMD-PAC we cannot achieve our mission of educating candidates about our professional concerns.

Please accept my contribution of:

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Letters to Sentara's Medical Director

All three letters were addressed to Dr. Matthew Keats, Medical Director of Sentara

April 7, 2004

The Board of Directors of the Psychiatric Society of Virginia wishes to express our significant concern regarding current policies and procedures of Southern Health Services /Sentara Mental Health Management and your pharmacy managed care associates.

As you are aware, patients are being sent letters informing them of medication coverage denials based on reference to "FDA approval" regarding indications or doses. We think both that the issues you raise are inaccurate and misleading and that the process is inappropriately intrusive into the course of clinical care.

As an example, we will address the issue of your practice of denial of doses of Lexapro over 20 mg per day based on "FDA approval." As we know you are aware, the FDA's role is to regulate pharmaceutical company advertising and marketing and it is not primarily to regulate physician prescribing. The FDA itself has opined that physicians should use the current medical literature and clinical experience in making prescribing decisions. We refer you to the Code of Federal Regulations (CFR) or, more concisely, to the first page of the Foreword to the Physicians' Desk Reference (PDR). The decision to seek FDA approval for a medication indication is an economic decision made by the pharmaceutical company and not a scientific decision. Since side effect issues powerfully delay or block the FDA approval process, pharmaceutical companies typically will go to the FDA with the lowest dose range that separates adequately from placebo to meet efficacy criteria since this is the dose at which they will have the lowest side effects. Research studies also, as you know, have often extensive exclusion criteria so that complicated patients with the target disorder are excluded. Thus, the patient populations in most studies have moderate ranges/duration of symptoms. Finally, measures of efficacy in these studies generally involve response and not remission. For example, in depression studies, a response is defined as a 50 percent drop in the score on a rating scale such as the Hamilton Depression Scale. If a patient starts at a score of 30, they will be rated as having a response if the score drops to 15. A patient with a Hamilton Depression Scale score of 15 is still very impaired. In direct consequence, when a medication is used in clinical practice outside research populations, the bell-shaped curve of doses tends to shift to the right, sometimes considerably, as physicians are faced with treating both sicker and more complicated patients, and attempt to treat to an end point of remission and not just response. Your evocation of "evidence based medicine" as a justification for inadequate treatment of patients is flawed by the reality that at this point in time the evidence is flawed, again based on the fact that most research is not done under "real life" conditions and is economically rather than scientifically driven. It is a misuse of a valid and legitimate concept.

We object vigorously also to your use of "fail first" policies. Such "cookie cutter" approaches negates to patients the value of having experienced physicians who are able to make seasoned judgments about what is or is not in a patient's best interest for a variety of interacting reasons. An example would be your insistence that patients "fail" on stimulants before they can be given Atomoxetine.

The Board of Directors of the Psychiatric Society of Virginia finds policies such as these, especially when directed at specialists such as psychiatrists, to be shortsighted and discriminatory towards our patients. We would point out that it is just these kinds of policies that are being addressed in the RICO lawsuits being conducted currently in federal court. It is noted that two of the managed care defendants have already opted to "bow out" by settling out of court.

The Board of Directors of the Psychiatric Society of Virginia requests that such policies not be implemented now or in the future without input from this organization which represents the physicians responsible for the care of psychiatric patients.

July 6, 2004

The Managed Care Liaison Committee of the Psychiatric Society of Virginia wishes to express significant concern regarding the new fee schedule for professional services from Sentara Mental Health Management. Our concerns are several:

The level of your fee schedule remains woefully inadequate. It is out of line with fee schedules provided in other states for similar services. It is well short of the fee schedule provided by the federal government under Medicare. As you may be aware, your reimbursement rate for 90807, for example, is only 69.7 percent of the Medicare rate.

We are concerned about your continued devaluation of psychiatric psychotherapy. This devaluation is all too well demonstrated by your significantly regressive reimbursement rate for adequate length sessions for patients, ignoring the data on the superior outcomes associated with combined treatment. We additionally note that you do not reimburse at a higher rate for 90807 than for 90806, again ignoring the standard set by the federal government under Medicare guidelines. Further, we note that you seem to set a \$2.00 value on medical school since you set this differential rate in the reimbursement between 90807 provided by a psychiatrist and 90806 provided by a psychologist (whose reimbursement rates we also think to be inadequate). We would remind you that overhead costs of a psychiatric medical practice, including the cost of education, liability insurance, and continuing education requirements to maintain professional certification, is significantly higher than similar costs for mental health professionals.

We wonder why, on a percentage basis, master's level mental health professionals and psychologists were given larger increases than physicians. For example, for 90807/90806, psychiatrists were given no increase, while psychologists were increased by four percent and master's level mental health professionals were increased by almost eight percent.

As you are no doubt aware, nationwide, 54 percent of psychiatrists no longer contract with any managed care organization, and the more the physician attempts to provide comprehensive psychiatric treatment, the less they can viably afford to accept MCO contracts. This, of course, deprives MCO patients of high quality specialty care. We cannot help but wonder if this is, in fact, the "hidden agenda" of these reimbursement policies.

We await your response to these enumerated concerns.

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Letters continued from page 8

October 25, 2004

The Managed Care Liaison Committee and Board of Directors of the Psychiatric Society of Virginia sent letters on April 7, 2004, and July 6, 2004, addressing concerns raised by our membership regarding current policies and procedures of Sentara Mental Health Management and/or your pharmacy managed care associates. On April 10, 2004, you sent an e-mail to then PSV President J. Gregory Fisher, MD, DFAPA, expressing a willingness to discuss the concerns addressed in the first of these letters. Dr. Fisher responded on that same day, but no further dialogue occurred. There has to date been no formal reply to either the first or second letters.

We do plan to include these letters in an upcoming edition of the Psychiatric Society of Virginia Newsletter and think it only fair to again offer you the opportunity to formulate a response, which would also be included in the Newsletter.

We have noted that in your e-mail to Dr. Fisher you mentioned that Sentara Mental Health Management may in fact have limited “influence and input into the decision making process” related to some of these concerns. The Board of Directors would in this case appreciate learning the identities of the decision makers so we can more appropriately direct our concerns.

We hope you fully understand that the direction of these concerns to you is in your administrative capacity and is certainly not directed to you as a professional colleague.

November 1, 2004

Dear Fellow Psychiatric Society of Virginia Member,

Sentara Behavioral Health Services and I appreciate having the opportunity to respond to the concerns raised in the two letters sent from the PSV’s Managed Care Liaison Committee. In order to provide a full and thoughtful reply to these concerns, my SBHS colleagues and I spent a good deal of time and effort to craft our response. As a result, the letter is approximately six pages long and, understandably, would not fit in the PSV newsletter due to space considerations.

I strongly encourage you to go to the PSV’s website to read our response. While it may not resolve all of the concerns raised in the Managed Care Committee’s two letters, I am hopeful that it provides clarification and perspective on these important issues.

Yours truly,

Matthew Keats, MD MMM

Medical Director, Sentara Behavioral Health Services

For a copy of the response letter go to www.psva.org.

The Wisdom continued from page 2

leaders make decisions in this fast paced world:

“... while the time allowed for decision-making is so much shorter, the uncertainty built into each decision is much greater. As a result, especially in the industries and sectors that are deepest in change, people try to structure their decisions differently. They give up on predicting. Instead of making irrevocable moves, they think in terms of buying options.

Instead of restructuring their business from top to bottom, they do a lot of little things. They make a minority investment in some company with an emerging technology. They license a technology. They form a strategic partnership with someone who is trying out a new business model. They hire a few people to try out something new. They give a few people in the company the permission and resources to set up an experiment. They feed the new thing, see how it grows. If it works, they feed it more. If it doesn’t, they can it and move on to the next thing. They live in the question.”

I think there is wisdom in this. If we are waiting for a specific roadmap that clearly outlines, step by step answers to the the

question, “How do we transform a mental health system that is in shambles”—we will be waiting a long, long time.

In Virginia’s mental health service system, we have been able to make some significant progress by eating this elephant one bite at a time. The service system still needs much work—it is not transformed—but pilot projects have been working, reinvestment projects have proven that alternatives to traditional inpatient beds can, in some cases, serve more people, even more effectively. We have added PACT teams, added crisis stabilization units, formed Jail diversion teams, trained law enforcement officers in CIT (Crisis Intervention Teams), etc.

I believe we have the expertise and know many of the answers already. That is, if we continue to ask the important “Why” questions—and not just go straight to the “how can we do it today” questions. Focusing on the immediate answers that solves today’s crisis—such as figuring out how to get someone in a traditional “secure” inpatient bed—or how to find more of those beds—can deter us from asking important “why” questions.

Questions, such as:

- Why are putting our resources primarily in

one area rather than another?

- Why are we focusing solely on “disease models” rather than adding “recovery models”?
- Why is it so easy to identify, define and focus on illness and disability as opposed to wellness and resiliency?
- Why is it so hard to listen to consumers who are telling us they want less paternalistic, unilateral, and often coercive medical interventions and more collaborative, empowered, self-determined health care choices?

I will just end this column with a question, O.K?

The important thing is not to stop questioning. Curiosity has its own reason for existing. One cannot help but be in awe when he contemplates the mysteries of eternity, of life, of the marvelous structure of reality. It is enough if one tries merely to comprehend a little of this mystery every day. Never lose a holy curiosity.

—Albert Einstein (1879-1955)

VIRGINIA NEWS

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