Southern California

PSYCHIATRIST

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President's Column

Ready-Made Resolutions

Curley Bonds, M.D.

As a New Year dawns, many of us will participate in the time honored tradition of making resolutions. Others may have trouble deciding what they should do to improve professionally or personally. 45% of Americans make resolutions, but only about 8 % are successful in keeping them.* To make your job easier, I'm providing a few ready-to-implement resolutions that you can adopt to get you off to a good start.

Go Digital!

I am always surprised by how many psychiatrists have not yet converted to electronic health records or EHRs. Most of us who work at large institutions were long ago forced to abandon paper charts in favor of electronic alternatives. Private practice physicians do not always appreciate how this transition can improve the quality of care they deliver. The cost of EHRs can be a disincentive, but in situations where third party revenue supports a practice, these tools will often pay for themselves by bringing greater efficiency and direct financial incentives.

The downside is that the initial transfer of records for existing patients over to a new platform and inputting demographic and basic diagnostic info can be a daunting task. Also, learning a new system and configuring it to meet your specific practice needs can take some time. But ultimately the benefits include the ability to create comprehensive notes that are legible, structured and designed to include all necessary elements. This can be invaluable in the case of legal threats or third party audits.

For providers who work from multiple sites, cloud based products allow easy access to patient charts from any location. Some products can be loaded onto a tablet or other portable system that will allow for concurrent documentation and the integration of standardized outcome measures during sessions. Skeptics may worry about losing ability to create rich descriptive narrative and about protecting the security and confidentiality of their records, but these concerns have been addressed by myriad products now available.

I worry about our specialty lagging behind others that would consider handwritten notes archaic. They also limit our ability to participate in the increasing need to send data in digital form to other health providers and systems. The digital revolution does not end with documenting clinical encounters, but it can allow billing, prescribing and simplified processes for prior authorizations. Most EHRs are customizable and are priced according to the size of the practice and the complexity of the product.

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The APA gives practical advice for choosing the right EHR in the Health Information Technology section of it's website. Click here for more info:

https://www.psychiatry.org/psychiatrists/practice/practice-management/health-information-technology/resources-choosing-the-right-ehr

Get Registered!

While the concept of a registry is unfamiliar to many psychiatrists, they have become increasingly important tools for other medical specialists in their quest to improve overall health outcomes. The APA website defines a clinical registry as an "organized system that collect data (reported by patients and providers) which are then used to better understand patient's health care history and experiences, as well as the quality of care they are being provided."

The field of oncology has been revolutionized by the ability to analyze large data sets that shed light on which patients are most likely to respond to which treatments. The APA has recently launched its own registry and is currently providing free access as a member benefit. One large perk is for those members who are required to participate in maintenance of certification (MOC) activities by the American Board of Psychiatry and Neurology. Simply participating in the APA registry will meet MOC Part IV requirements.

Imagine having at your fingertips a tool that would allow you to do practice based research and to compare your clinical outcomes to those of peers who have similar practices. There are several other benefits to participating in this important pilot project and I would encourage all members who are interested to investigate this resource. More information about the APA registry project is available at https://psychiatry.org/psychiatrists/registry.

Support Advocacy!

Perhaps the most important role of our professional organization is to be a voice for those who cannot speak for themselves. For a variety of reasons (stigma, cognitive impairment, and fear of social exclusion) the mentally ill often do not speak out on their behalf when it comes to policies that discriminate against them in the workplace or the healthcare market place.

Unlike other high profile illness like breast cancer and AIDs you rarely see large scale fundraising events, bike a thons or other public displays focused on raising awareness of individuals with mental illness. So our role as advocates is invaluable. This is why it is important for us to partner with other likeminded organizations that provide opportunities to raise money and awareness for these causes.

SCPS and NAMI have a longstanding partnership that is beneficial to both parties. Learning about proposed laws, educating elected officials and lobbying for positive change are examples of advocacy. Contributing to the APA or CPA political action committees is another way that we can help elect qualified legislators who understand the needs of our constituents. (For more on advocacy and fundraising data see this months Editors Column which follows this article).

Take Care of Yourself!

Lastly, we should all make a commitment to improving our own health and wellbeing. Remember to make time for relaxation and to enjoy the wonderful lifestyle that makes Southern California one of the world's top vacation destinations. Take time to schedule a walk along the beach, a movie night or just some quiet time to snuggle up with a good book. Work to eliminate sources of stress and conflict in your life. If we don't take care of ourselves, we will not be able to provide quality care for others.

I sincerely hope that you have a healthy and prosperous 2017!

*Statistic Brain – data collected from University of Scranton. Journal of Clinical Psychology

Letter from the Editor

A Call to Action: Stand Up with SCPS for Mental Health Parity in 2017

Matthew Goldenberg, D.O.

"Some see things as they are and say why. I dream things that never were and say why not."

2016 has come to a close and 2017 begins with the promise of a new presidential administration and the hope of building on the gains of the recently passed and signed Comprehensive Addiction and Recovery Act (CARA). The new President, like all of his predecessors, has the power of the Bully Pulpit to bring light to issues and causes that otherwise might be lost in the dark.

Mental Illness and Addiction should be one of the issues that remains in the light. While Mental Illness affects 1 in 5 Americans every year, stigma continues to negatively impact those who are suffering and seeking treatment. The Parity laws included within the Affordable Care Act expanded Mental Health and Addiction benefits and protections to 62 million additional Americans. However, we must do more, as these gains do not make up for the tragic deficiency in access to quality Mental Health and Addiction treatment that face so many individuals in our country.

Consider this: suicide led to about 40,000 deaths in 2011 (nearly the same number of deaths as breast cancer). While Breast Cancer research received $258 Million Dollars that year for research, Suicide only received about $3 Million Dollars.

Or consider this: remember the ALS Ice Bucket Challenge? That effort helped to raise around $23 Million dollars for ALS research. By comparison, ALS accounts for about 7,000 deaths per year (compared to 40,000 from suicide).

The good news is that a lot of funding does come in for Mental Illness research. In 2015, depression, anxiety and schizophrenia research received a combined $787 Million dollars. A billion dollar budget might sound like a lot until you remember that 1 in 5 Americans are suffering and nearly 4% are suffering from a serious mental illness (a condition that severely impedes their day-to-day functioning).

The funding available for Mental Illness begins to feel inconsequential and insignificant when you compare it to Breast Cancer research dollars. In 2015, funding for Breast Cancer was close to $700 million dollars. (That does not include additional Billions for general Cancer research or research dollars for other types of Cancer.) Again, by comparison, breast cancer impacts 1-2% of Americans per year and around 12% of all American women over the course of their lifetimes (compared to mental illness which impacts about 20% of Americans every year).

I am in no way writing this to take anything away from the suffering caused by other conditions or to suggest we should decrease funding for breast cancer, or other research. I bring this up because I think we need MORE funding for Mental Illness and Addiction. We need more funding because our patients deserve it. We need more funding because Mental Illness and Addiction impacts 1 out of 5 Americans and millions of Americans can still not access or afford quality treatment.

The new President has the opportunity to build on the gains of the last Administration. We as Psychiatrists have the obligation to bring attention to and advocate for the Americans who need help. We are on the front lines, we see the suffering, we see the lack of access and we know how to solve these problems.

SCPS provides us the opportunity to be heard. Our voices are louder and more effective when we come together.

This month's Q and A with Erick Cheung M.D. helped me to remember how much is at stake and that helping those who cannot help themselves is at the core and is the history of the field of Psychiatry.

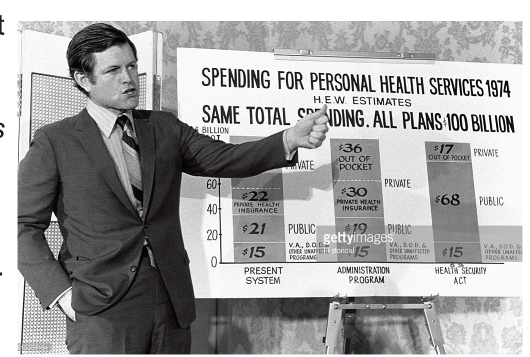
Many, if not all, of us did parts of our training at County Hospitals or Veterans Administrations. The experience of working with these vulnerable and underserved populations left a large impression on me and I suspect on you as well. You may just need to take the time to think back and feel the suffering, the desperation and lack of hope that many of the patients faced as they struggled and fought, for years in some cases, to find a Psychiatrist to help them.

I encourage you to write in. I will print letters to the editor and I want to share your voice and your option with our colleagues. I encourage you to join a NAMI walk, become active with SCPS or attend a Mental Health rally. Tell us what you are doing and what your colleagues could do to join you in your efforts if you are already actively fighting for Parity.

There are over 10 million souls living in Los Angeles County. That means that nearly 2 Million of them are suffering from Mental Illness and nearly half a million are suffering from serious mental illness. We must speak for them or their voices will not be heard.

I want to close, as I began, with a quote from Edward Kennedy who fought for Healthcare reform,

"The work goes on, the cause endures, the hope still lives and the dreams shall never die."



Source: Getty Images
Edward Kennedy lectures in front of a chart of health care spending. Kennedy was elected U.S. senator from Massachusetts in 1962.

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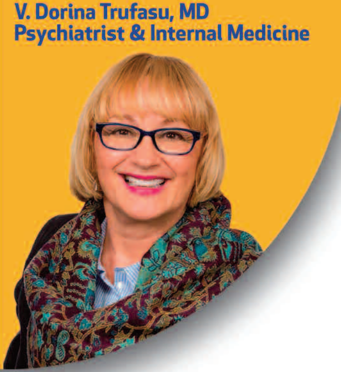

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An Experiment on a Vulnerable Population: Prop 64 and Adolescents

Scott R. Hunter, MD, MHS

This past November Californians voted to legalize recreational marijuana with more than 57% of the vote. Voter approval exceeded the state average in Los Angeles (58.4%) and Santa Barbara counties (61.1%), while Riverside (52.4%), San Bernardino (51.9%), and Ventura counties (55.0%) were somewhat lower but still had majority approval.

As early as 2011, the California Medical Association had announced its support for such legalization and accordingly, it publicly supported Proposition 64 in November. The California Psychiatric Association, however, was more cautious, and adopted a cautious "Neutral" position. The CPA outlined its divided stance in its Summer 2016 newsletter, citing "the important benefits of bringing order to the current unregulated marijuana industry," tempered by worry of the appearance "that psychiatrists are endorsing marijuana as harmless, when in fact there is great concern about risks to children and young adults, as well as those with psychiatric disorders."

The potential impact on children and young adults has often been cited by those opposed to the new law, officially known as the Adult Use of Marijuana Act. The bill's name suggests that its authors recognized the risk of appearing to endorse marijuana use by non-adults.

Long before the bill had earned its place on the ballot, the American Academy of Child and Adolescent Psychiatry opposed the legalization of marijuana in their 2014 Policy Statement, which reads in part:

> Legalization of marijuana for medicinal or recreational purposes, even if restricted to adults, is likely to be associated with (a) decreased adolescent perceptions of marijuana's harmful effects, (b) increased marijuana use among parents and caretakers, and (c) increased adolescent access to marijuana, all of which reliably predict increased rates of adolescent marijuana use and associated problems.

The statement goes on to summarize the known harmful effects of adolescent cannabis use, including addiction, worsening of co-morbid conditions, and impaired bio-psycho-social development. It concludes with the unequivocal statement: "as child and adolescent mental health advocates, AACAP opposes efforts to legalize marijuana." But AACAP's stance is also broad in that it supports the scientific study of cannabis's constituent compounds for therapeutic uses and includes specific language calling for decriminalization.

Dr. Kevin Gray, an author of AACAP's Policy Statement and current Co-Chair of their Substance Abuse and Addiction Committee, is a clinician and researcher focused on adolescent cannabis abuse at the Medical University of South Carolina. When reached for comment on California's new legislation, Dr. Gray defended AACAP's policy. He acknowledged his own bias, given the clinical population he serves, but also expressed serious concerns about what the future of legalization will look like.

Turning to the well-known history of the Tobacco Industry, Dr. Gray recalled that "100 years ago tobacco was not used that often because it was too harsh, but with the advent of the modern cigarette, the delivery and addictive properties were improved, opening it up to be mass marketed." The Control, Regulate and Tax Adult Use of Marijuana Act — the bill's extended official name — could allow history to repeat itself, but with a substance that even the staunchest supporters of legalization would agree is more dangerous for the developing brain.

Many Policy experts agree that public health priorities are taking a backseat to industry interests as marijuana becomes legalized. UCSF's Center for Tobacco Control Research and Education published an analysis of the Adult Use of Marijuana Act in early 2016, concluding that it was "written primarily to create a new business and only include[s] minimal protections for the public that are unlikely to prevent public health harms caused by the burgeoning marijuana industry." It continues: "Evidence from tobacco and alcohol control demonstrates that without a strong public health framework, a wealthy and politically powerful marijuana industry will develop and use its political clout to manipulate regulatory frameworks and thwart public health efforts to reduce use and profits." It may

be coincidental that spending on the Yes on 64 Campaign dwarfed the opposition: $15.9 million to $1.1 million.

Searching for clues as to how legalization and the marijuana industry will affect marijuana consumption, many have looked to Colorado and Washington where voters legalized marijuana in 2012 and legal sales officially began in 2014. In particular, trends in adolescent use have been watched closely, but eagerness to see results has led some in the media to make spurious claims. As recently as December 21, the Washington Post ran the headline, “After legalization, teen marijuana use drops sharply in Colorado.” While it is true that the rates of marijuana use by 12-17 year-olds decreased from 2013-14, to 2014-15, the decreases were not statistically significant, nor did they control for national trends in use, which incidentally also decreased during that time.

The Post article, and so many others like it, is at best misleading and at worst outright propaganda for those wishing to further (or hinder) the cause of legalization, as there is barely enough data at this point to sufficiently draw conclusions about the impacts of legalization on adolescent use. Readers should remain skeptical of such unsystematic reports.

There is one early rigorous analysis that was published online December 27 in JAMA Pediatrics. Cerdá, Wall, Feng *et al.* compared attitudes and rates of marijuana use before and after legalization and found that perceived harmfulness decreased 14.2% and 16.1% among Washington eighth and tenth graders respectively, while use increased 2.0% and 4.1%. These differences were significant when compared with states that did not legalize marijuana over the same time period. No significant differences were observed in Washington twelfth graders, nor were there any significant differences in perceived risk or use for all three age groups in Colorado.

These results are fairly consistent with decades of data from the Monitoring the Future study that have clearly identified an inverse relationship between perceived risk of use and rates of use. Permissive public policy and aggressive marketing threaten to tip the balance further and increase marijuana use among adolescents and young adults. While the results of the Cerdá study should be considered cautiously given that the states are less than three years into legalization, it is also demonstrates that impacts across states will differ, and other states’ data may therefore have limited utility.

Furthermore, market forces at play for Colorado’s 5.5 million people or Washington’s 7.2 million may substantially differ for California’s 39.3 million. The marijuana industry is still in its infancy, and we can only guess at the power and influence that commercial interests will yield when exposed to much larger markets. The reality is that marijuana use rates are highest in young adults, and those tasked with marketing marijuana products will attempt to maximize exposure in young people. And as Dr. Gray observed, “The adolescent brain is so primed for addiction, they are the perfect target market.”

Even with Colorado, Washington or other states as examples, it is far too soon to determine the full impact of legalization. As Dr. Gray says, “It’s a massive naturalistic experiment, driven by forces other than the interest of public health.” In the meantime, we have every reason to be wary and continue to provide education to our patients and to the public about the risks of marijuana use, as we can expect to be confronted with distortions and half-truths about a substance we know is harmful to youth.

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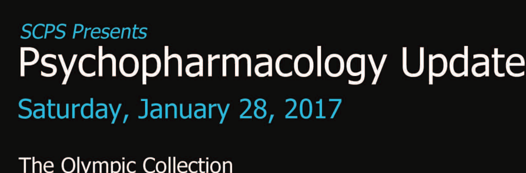

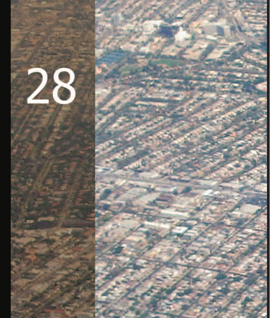

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Phillip J. Resnick, M.D., Professor of Psychiatry, Case Western Reserve University, School of Medicine.

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David L. Fogelson M.D., Clinical Professor of Psychiatry at the David Geffen School of Medicine and the Resnick Neuropsychiatric Institute at UCLA

Choosing Wisely in Mental Health: What Should You Do in Treatment?
Gray Norquist, M.D., M.S.P.H., Professor and Vice-Chair Emory Dept. of Psychiatry and Behavioral Sciences; Chair, APA Council on Quality Care

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Get to Know Your 2016-2017 SCPS Board Members:
A Brief Q+A with SCPS Treasurer Elect, Erick Cheung M.D.

This is the third in a series of conversations with 2016-2017 board members. We hope you enjoy getting to know a little more about Treasurer Elect, Erick Cheung M.D. We thank our Board Members for their time and participation!

1) What initially sparked your interest in the field of Psychiatry?

I hope this isn't too cliché. In college, I was majoring in the fields of neuroscience and psychology. That itself didn't really dictate that I was going to be a psychiatrist, I thought about being a teacher, *maybe* a neurologist or a neurosurgeon (just to be cool), but honestly med school sounded like a pretty awful idea. Then I went to Paris for a half year, where I was studying Surrealistic art and poetry. Turns out this is what really ignited my fundamental interest in the human condition… like, what is free will? What is truth? What is mind and what is body? Where, how, and what is human consciousness? In my senior year at UCSD, I went on a goose chase writing a full-blown undergrad thesis on human consciousness… and the rest is history.

2) How has field changed or been different than you initially imagined?

Before going to medical school, I worked for some psychiatrists in an outpatient office, doing the dirty work like prior auths, calling med refills, hounding insurance companies for payment. I remember one of the guys working 10-hour days, doing 15 minute med management visits, never taking a lunch, maybe just stopping here and there to eat a spoonful of peanut butter and some red vines that one of the drug reps had dropped off. I thought that was crazy, but it was really my first impression of psychiatry. By the way, I still despise doing prior auths.

3) Tell us about the area of psychiatry in which you practice or your practice setting?

I am a full time faculty member at UCLA Department of Psychiatry in Westwood. I was lucky to inherit the role of medical director of psychiatric emergency consultation services at our main Hospital on the UCLA campus. I attend on the emergency psychiatry service, and enjoy a diversity of outpatient clinical work including adult outpatient and transplant psychiatry. By far, my most enjoyable clinical work is the 6-10 hours of individual psychotherapy that I do weekly, mostly in a transference-focused framework. My new gig is running quality improvement projects for our psychiatric hospital.

4) What motivated you to become more active with SCPS?

I joined the board of SCPS when I was a resident, and have been in various positions ever since then, most recently secretary and treasurer elect. My engagement with organized medicine goes back to medical school, when I experienced the birth of my social conscience. Our country was at war in Iraq, Howard Dean was running for President, and pretty much in the second week of med school I started leading grassroots activism and medical student campaigns for universal healthcare. The point was to do something to address the crisis and plight of the uninsured. We marched on the capital of New York with a 70-foot long banner (went to school right down the street at Albany Medical College).

So, I grew up a bit, and got elected to serve as the medical student chair to the Association of American Medical Colleges, on a platform of access to care, and later working on issues of conflicts of interest, criminal background checks, medical school indebtedness, NRMP data, and other issues. Ever since then, I have had a deep understanding and appreciation for organized medicine and the critical role that it plays in advocating for our profession and our patients.

5) Where do you hope to see the field of Psychiatry go in the next 20 years?

We (American society) just spent the last 60 years de-institutionalizing patients and shutting down psychiatric hospitals. There were legitimate wrongs to right, back then. But now we are bearing the consequences, with an utter lack of sufficient acute care resources to address patients in mental health crisis and emergencies. Patients languish in emergency rooms for days, vying for an ever-shrinking number of hospital beds. Worse, for those beds that do exist, my personal impression is that the average standard of care leaves much room for improvement. In the next 20 years I hope that we will have hit the low point, such that we will see a re-building of acute care services that deliver high quality / high value care, within a mental health and legal system that truly supports it.

SEVERAL IMPORTANT LEGAL DEVELOPMENTS

By Daniel H. Willick, J.D., Ph.D.
December 29, 2016

There have been several recent legal developments impacting psychiatry, which I describe below.

The Federal Government's Final Rule on Non-Discrimination in Health Programs and Activities

The U.S. Department of Health and Human Services issued a final rule on May 18, 2016 prohibiting discrimination against a variety of protected classes of patients treated by physicians. Physicians who are subjected to this rule must have posted a notice regarding their non-discrimination practices by October 16, 2016. The notice should include "tag lines" in the top 15 languages spoken by individuals with limited English proficiency in the state where the physician practices. Guidance from the federal government regarding physicians subject to this rule and on the steps to be taken to comply with this rule may be found at:
www.hhs.gov/civil-rights/for-individuals/section-1557/

and guidance from the AMA may be found at
https://www.ama-assn.org/sites/default/files/media-browser/public/AMA-Fact-Sheet-Section-1557-Final.pdf

SB 1174 Regarding Medical Board Investigations of Physicians Prescribing Psychotropic Medications for Minors in the Foster Care System

On September 29, 2016, the California Legislature enacted SB 1174, which amended Business and Professions Code Sections 2220.05(a)(7) and 2245; and amended Welfare and Institutions Code Section 14028. This law requires the California Department of Healthcare Services and the California Department of Social Services to share prescribing data with the Medical Board of California for the purpose of Medical Board review and possible prosecution of excessive prescribing of psychotropic medications for children in foster care. The Medical Board has already been collecting such information for over one-and-one-half years. Psychiatrists who prescribe psychotropic medications for children in foster care should immediately confer with their malpractice insurer and legal counsel for advice on the appropriate manner to cooperate with the Medical Board if they are contacted by the Medical Board regarding care that they have provided to foster children. Such investigations involve issues of confidentiality and privilege, which are presently being contested in the courts. There is much controversy over the prescribing of psychotropic medication for children in foster care with some newspapers contending that psychiatrists are engaging in improper and dangerous prescribing, notwithstanding Court and County oversight of such prescribing before the enactment of SB 1174.

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Council Highlights December 8, 2016

Mary Read, M.D., *Secretary*

The meeting was called to order shortly after 7:00pm by Dr. Curley Bonds

Introductions were made around the table as we had three residents as visitors at the meeting

A gift was then given to Mindi Thelen for her 25 years of dedicated and exceptional service to SCPS

The minutes from the previous meeting were approved

President's report

Bylaw Amendment Considerations

RFM representation on Council: A long discussion was held about changing the bylaws from having two resident/fellow (RFM) voting members on Council to having one voting member from each residency program in the SCPS region. A motion was passed to place on the March ballot a proposed bylaw change proposing two minimum voting RFM members for the Council and a maximum of one per residency program (7-8). There was more discussion of how these members would be chosen or elected but there was no clear conclusion as to method.

Santa Barbara and Ventura Council representation: There has not been a Santa Barbara representative coming to Council for over 10 years. A discussion was held about consolidating the Santa Barbara and Ventura councilor positions to provide representation to both areas. There was some concern about adding multiple RFM voting members and simultaneously cutting an area representative. The possibility of moving it to another area that might be underrepresented like the Inland Empire was raised. The matter was referred to the bylaws committee for further discussion and they will bring it back to Council.

CPA Council Report (Dr. Bonds)

Dr. Arroyo spoke about what might come with the new Federal administration. There is no consensus. Some areas of concern are the reestablishment of high risk insurance pools that might exclude some of our patients; retraction of Medicaid expansion; the Healthy Families program may be compromised. Fortunately our state government is committed to maintaining services.

Other issues are the likelihood of a psychologist prescribing bill in this current bill cycle. CPA will continue to support the already existent NP and PA programs as the most reasonable pathways to sufficient education for furnishing medications. There is also an effort following from SB 1174 to exclude foster children from access to care though the intent was to protect the children. There have been 80 cases of foster children statewide who have been identified as receiving medications outside of parameters and these regimens will be examined by the Medical Board. Dan Willick provided context for the difficulties physicians can face in Board investigations whether or not there is any problem found with patient care.

Regarding CPA

Mindy Young reported that APA membership is up 2.5% and the budget is in good shape.

John Fanning from the office of the CEO spoke about the contract between APA and APA Inc. and how problems arise when DBs have contracts with PRMS.

There is going to be a registry to help members with MOC Part 4 requirements

The APA Foundation and PAC would like more contributions. We had a short side discussion about a possible article for the newsletter explaining the differences amongst all of these funds

Candidates for national APA offices came to speak. Altha Stewart from Memphis, on faculty at UT and Rhan Bailey who is Chair at Wake Forest spoke. Dr. Bonds noted that both are good candidates and either way we will have an African-American president elect.

APA is supportive of states fighting non-MD prescribing bills but there is some debate of how much and how quickly to step in and help.

Dr. Gross then spoke about the internet portal to make changes to the DSM5 that went live this week. He will send out more information to Council.

CPA council forwarded names to APA for APA representatives from Area 6

CMA resolutions discussed and several supported

Legislative affairs: CPA filed an amicus brief supporting the right of sexual offenders to retain confidentiality in psychotherapy. National Association of Social Workers is joining in this case.

Collaboration between APA Foundation, National Association of Counties, and County Association of Justice to fight the criminalization of mental illness on January 18-19 is looking for another 6-8 people to participate. Contact Randall Hagar if interested.

President Elect's Report (Dr. Simpson)

Nominating Committee: All offices for next year have candidates: Dr. Red for president-elect; Dr. Rees for Treasurer; Dr. Amy Woods for Secretary and others for Councilor positions currently. There are two contested Councillor elections.

Treasurer's report (Dr. Cheung)

Dr. Cheung went over the reports sent out with the Council documents. Nothing unexpected.

Membership Report

Three new members were approved. Ara Darakjian, Omar Farooqi, and David Ngo

Legislative Report (Drs Soldinger and Read)

Dr. Soldinger covered the highlights of the newly passed (12/7) 21st Century Cures Act that moves forward several of Representative Tim Murphy's initiatives strongly supported by APA. It is meant to facilitate coordination of fragmented resources, address the critical mental health work force shortages and strengthen enforcement of mental health parity among other goals.

Scope of practice bills are in play all over the country. Podiatrists, optometrists, psychologists, and others are moving to expand their scope of practice. As many as 17 states are considering bills to allow non medically trained people to practice medicine usually with very little additional education.

The California season to propose bills has just opened so we are actively monitoring bills coming in.

In other legislation, a bill passed last year to have a pilot psychiatric bed registry in 10 contiguous northern California counties that will display information about the availability of acute psychiatric beds. There is possible legislation next year to add crisis stabilization, residential mental health and residential substance use disorders treatment bed

AB 1300 was defeated last year but Emergency department boarding of psychiatric patients remains a serious problem statewide so there is an ongoing collaboration with Cal ACEP (American College of Emergency Physicians) to develop a framework to address one cause – the lack of onsite ability to detain for purposes of transport to LPS designated facilities.

Program Committee (Dr. Gales)

Dr. Gales and the committee are planning a training in primary care to include cardiology, GI and endocrine. This is planned to be an update of current standard of care as well as illnesses that can present as psychiatric disorders.

AMA report

Dr. Lymberis provided us with an extensive report that had been emailed out to SCPS Council. Dr. Bonds pointed out some of the highlights and recommended reading the report for further detail

New Business

Dr. Silverman brought up a concern that Blue Shield is sending letters to psychiatrists requesting chart reviews. One of her friends quit the panel when she was asked for the charts of 30 patients. Dan Willick referred us to Civil Code 56.104 for the law governing these transactions and advised having the patient sign a release in these instances

The CPA's AMA and CMA reports are available for review here:
https://simplebooklet.com/16winternewsletter#page=0

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. . . . Oscar Pakier, M.D., M.D. (2017)
San Gabriel Valley/Los Angeles-East . . . . Anita Red, M.D. (2019)
Roderick Shaner, M.D. (2018)
Santa Barbara . . . . Anish Dube, M.D. (2019)
South Bay . . . . Michelle Furuta, M.D. (2019)
South L.A. County . . . . Ricardo Restrepo, M.D. (2019)
Ventura . . . . Julia Krankl, M.D. (2019)
West Los Angeles . . . . Zoe Aron, M.D.(2019)
. . . . Sophie Duriez, M.D. (2017)
. . . . Zeb Little, M.D. (2018)
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