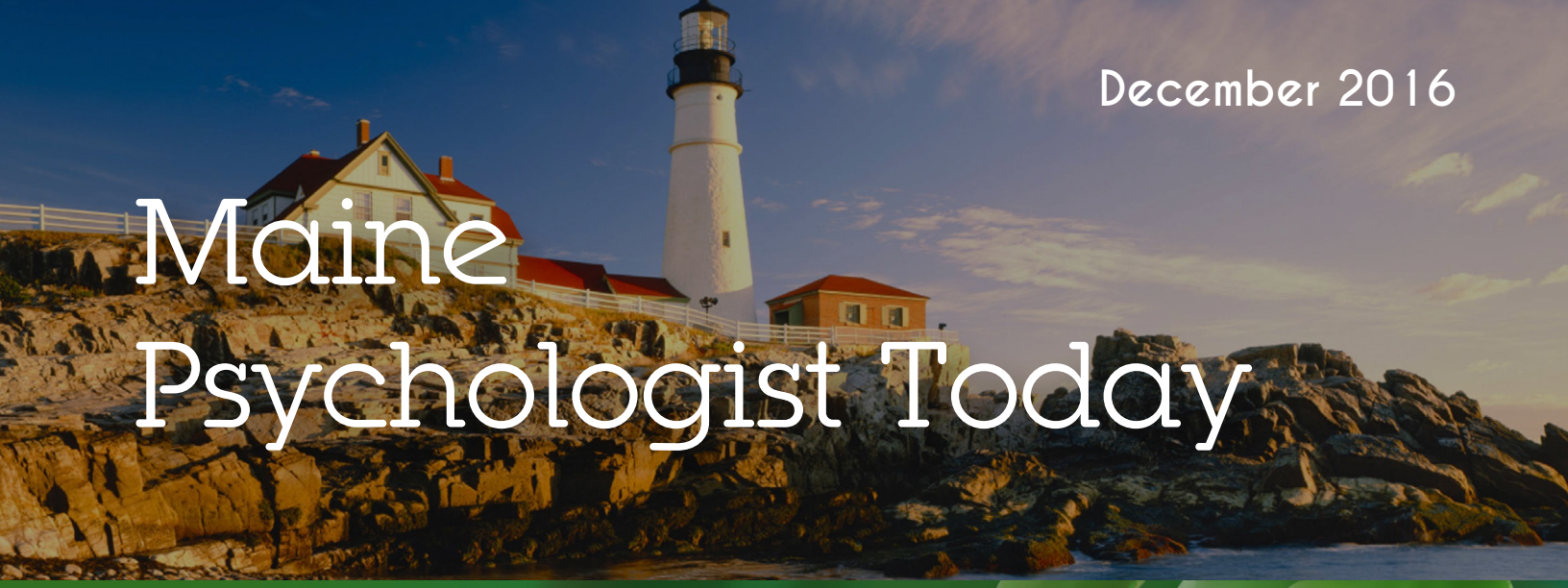

December 2016

Maine Psychologist Today

MAINE PSYCHOLOGICAL ASSOCIATION

Welcome to the Maine Psychologist Today, MePA's new online newsletter!

Notes from the President

2016 is coming to an end and we are gearing up for 2017! As we look ahead there are several areas MePA will be focusing on.

We are working to reenergize the Committee on Psychopharmacology. They will be working to provide you with information and resources on medication as well as trying to create opportunities for integration between you and primary care health providers.

Reimbursement Oversight Committee (ROC) is now being chaired by Tom Cooper. ROC is looking forward to working with insurance companies and regulators and passing that information on to you.

And, as always, we will be working with our Lobbyists to protect the interests of psychology in the legislative arena. We don't yet know what's coming, but last year we were successful in passing a moratorium on mental health cuts.

Please renew your membership and keep informed about what's going on in Maine that impacts you!!!!

Elise Magnuson, PsyD, LCSW

NEW

Welcome New Members

Michael Goldblatt, PhD
Falmouth
Retired

Michelle Kanga, PhD
Brunswick
Affiliate

Daniel Schwarz, MS
Portland
Affiliate

from the MePA Blog

Thoughts on Treating Grief

I was eating my lunch alone in the hospital cafeteria where I was a psychology intern, and was surreptitiously ease-dropping the conversation of two pastoral care counselors at the table next to me. At one point one said, with pride: "Today I got my patient from "anger" to "bargaining". That long-ago overheard statement has stayed with me and influenced my understanding and treatment of grief. Clients experiencing grief often come in with belief that the Keebler-Ross stages of grief, are like an obstacle course that must be traversed, hopefully as quickly as possible, in order to reach the final goal of "acceptance". I view grief as a part of a life in which we cycle around many of the same issues such as love, loss, triumphs, and disappointment, in hopefully ever widening circles of maturity and deeper understanding. We never leave it behind. We do not "get over" deep grief. Rather it is incorporated into the deepening of our identity. It is a dynamic process, which I believe was Kubler-Ross' original intent in her writings about the stages of grief.

When I was a young adult, both my parents died within a short time of each other. My grief was very much informed by the stage of life I was in: that of a young adult pulling away from the family of origin to form my own identity and new family. At the time, I mourned the loss of the opportunity that my parents and I could have an adult relationship that included more adult understanding and reciprocation. I still do mourn that. Yet my relationship to my parents' memories is almost as dynamic as it would have been had they lived. As I grow, I understand and appreciate their strengths and struggles in a way I never could have many years ago. My relationship to their death changes and deepens as I gain experience. In my practice I also encounter the changing nature of grief as clients mature. For example, I have seen a man whose father died when he was eighteen go into a deep depression over that loss when he was in his mid-thirties. He entered the military shortly after his father's death and was well taught to bury vulnerable emotions in order to perform in his profession. His "denial" lasted two decades. I have seen a widow of a successful man who mourned his death and extolled his virtues for thirty years before she allowed herself to feel her anger about his treating her with a casual disrespect reserved for someone he saw more as a prop than a partner. We are never done with grief. No one goes to a major family event: a wedding or birth or death of someone close without the stab of grief for those who are not there to share it. Our goal is to help our clients reach acceptance of their own emotional reactions rather than of the death itself.

One added thought about forgiveness in the grieving process. I have had many clients who feel the pressure to forgive a parent or other close family member who has treated them terribly when that person dies. I have heard the statement from people in the helping professions that forgiveness is good for the grieving person because it relieves them of a psychological burden. My response is "maybe". We see a population who has experienced many horrible actions at the hands of people who were charged with caring for them. Their anger towards the person who has died may be protective for them in avoiding repetitive abuse. I believe that lifting their self-imposed burden of needing to forgive is part of our job. The pressure to forgive may be viewed as an extension of the pressure not to acknowledge or speak about what was done. Forgiveness may come as a byproduct of deeper understanding, or it may not. Our goal is to help clarify the choices our clients make.

Arlene Brewster Ph.D.

New Law for Training for Mandated Reporters Now in Effect

LD 622 (now PL 407) requires all mandated reporters (this includes psychologists) to complete at least once every 4 years a mandated reporter training approved by the Maine Department of Health and Humans Services. The training, which can be completed online at this link: http://www.maine.gov/dhhs/ocfs/ec/occhs/documents/MandatedReporterOnlineAUG2016.pdf is comprised of a series of slides. At the end of the training, the mandated reporter completes a short quiz and then can print out a certificate of completion. The entire process takes about an hour.

MACRA: A Psychologist's Perspective on the Latest from Medicare

When it comes to MACRA, I don't yet know what the election of President Donald Trump means. Does it make my concerns irrelevant? Will MACRA be gutted or scraped along with the ACA? Or since it's the baby of separate and bi-partisan legislation, is it going to keep chugging along? Or somewhere in between?

IF it IS going forward, however, I believe we as psychologists are uniquely trained to evaluate and comment upon what it is proposing to do, because a core of our doctoral training is in research design and evaluation, how to review and critique both proposed and published research, analyses, and proposals, and how to provide guidance for and even watchdog-ing over mental health science.

And, so far, I am not only not impressed, I am very concerned. Let me acknowledge that I have NOT been very active at seeking and gathering information about MACRA, mostly relying on what information has been presented TO me. But that includes the MePA sponsored MACRA presentation last month (October 7, 2016), and I came away with that thinking that if this were a proposal to an IRB, there's no way I would be satisfied enough to go along with even a pilot study - much less an experiment - without considerable additional information about such basics as research supporting the underlying theoretical basis for the study, explanation about how research subjects would be protected from harm, and a statistical power analysis.

Because - from the information presented so far – I see no way this intervention has adequate power to actually detect a treatment effect - if indeed there really is one. And plenty of potential to do harm. And yet, the plan is to roll out MACRA – untested – on the entire nation. So, yes, I came away quite angry.

Anyway, several other psychologists at the presentation ("The Medicare Authorization and CHIP Reauthorization Act of 2015 (MACRA): What Does It Mean for You?" presented by Andrew Finnegan, Health Insurance Specialist with the Center for Medicare and Medicaid Services) asked me to share my thoughts regarding the presentation as well as a publication the presenter gave me to review. What follows comes from what I, therefore, sent out to MePA members on the MePA list-serve.

I have no problem with the stated goal of MACRA, which the presentation explained is to shift Medicare away from fee-for-service payment systems that pay "no attention to quality" so that MACRA will instead base payments to hospitals, practices, and practitioners for "quality and value." However, throughout the presentation, Finnegan and his slides seemed to be equating "quality and value" with a reduction in service utilization AND making the assumption that would occur because MACRA would be effective at motivating practitioners both to be more efficient and to provide more effective treatments.

And yet Finnegan repeatedly acknowledged that MACRA is not adhering to the scientific research on what has been shown to be effective in producing that motivation.
Finnegan explained that MACRA is relying on physicians being motivated by bonuses that they can earn under

MACRA – either through MIPS (Merit Based Incentive Payments System) or APMs (Alternative Payment Models (APMs) - more generous bonuses than the maximum of 2% that physicians have been able to earn under the current PQRS-based program/system. Only he had already shared that research strongly suggests bonuses of less than 15 to 20% are likely to be ineffective at engaging practitioners in the programs/behaviors that MACRA is counting on, and he went on to describe MACRA as a program that will fall far short of offering bonuses of that size – at least to the majority of practitioners and perhaps to any/all of them (us).

He presented slides about "How much can MIPS adjust payments" that showed those bonuses topping out at 4% during the first year of implementation (2019), rising to 5% during the 2nd year, 7% in the 3rd year, and 9% in "2022 and onward" – well below the 15 to 20% incentives he had just told us research has suggested will be necessary to motivate practitioners to engage adequately in the program.

I tried pointing out this means a) that MACRA is proposing to try to produce an effect with an intervention that research suggests will be inadequate to produce that effect and b) that he's trying to sell this idea to psychologists who are professionals for whom basic education and training includes research design and statistical analysis. Finnegan never did directly respond to those comments.

His presentation slides did show that MACRA will not only be implementing bonuses/incentives but also "downward adjustments" or penalties for practitioners who fall short of some median range of performance on MIPS criteria. And I noted that these penalties would mirror the bonuses (i.e., maxing out at a 4% penalty the first year and increasing to a 9% maximum penalty the 4th year and beyond) so that the cumulative difference in "Maximum Adjustments" would reach 18% in the 4th year of implementation.

So, I wondered aloud whether the plan is assuming that combination would be equivalent to an 18% bonus, even though it is actually a combination of incentives and punishments instead of just incentives. And I pointed out that the way he had described the incentive research he was asserting provided the theoretical basis for MACRA was entirely about bonuses – no mention of penalties or punishments. Again, Finnegan never directly responded to those comments.

Finnegan did, however, acknowledge that the MACRA program is effectively "robbing Peter to pay Paul" in an attempt to insure the plan meets revenue neutrality (per Congressional mandate). To that, I objected - if that is what is necessary to produce a revenue neutral result, MACRA is not betting/banking on its quality improvement program itself actually producing a main effect but is acknowledging that the intervention - as it is being implemented - may well produce NO financial efficiency/savings benefit, therefore needing a negative financial adjustment to counterbalance the additional expenses. Finnegan again never directly responded to those comments.

Now, let's address another concern I have regarding the information provided to us in that presentation regarding MACRA: WHO does MACRA actually offer those bonuses anyway. The presentation slides showed that "Clinical Psychologists" are among those who will NOT be included in the bonus program until at least year 3 of implementation (2021) while "Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists" are defined as "eligible professionals" (or EPs) to earn the bonuses starting in year 1 (2019).

In fact, clinical psychologists could even be completely locked out of earning such bonuses because – as one slide states, and Finnegan confirmed - the "Secretary MAY [emphasis added] broaden EP group to include others such as" clinical psychologists but is not mandated to do so. So - although we/psychologists might be relieved NOT to be subject to the reporting requirements and other demands of the program right away, I realized that means that "medical" practitioners (e.g., psychiatrists, psychiatric nurse practitioners) who prescribe medication and other "medical" interventions (e.g., ECT) could be earning thousands of dollars more per year while we/psychologists are getting nothing for doing just as much – if not more – to improve patient care and to reduce system costs.

Once again, we seem to be faced with a system designed to reward and entrench psycho-pharmacological interventions and discourage non-pharmacological interventions.

In summary, from what has been presented to me so far, MACRA seems potentially threatening to our profession and to the product that we are selling and – thereby – to the public we serve, potentially further reducing their access to evidence-supported interventions, while at the same at high risk of failing and producing increases in health care costs instead of reducing them.

When I posted the original version of this article, I did so in response to another MACRA post: Maine psychologist, Keith Cook, Ed.D, had entitled his, "They Seem to Be Flying the Plane While They're Building It." I explained that I think his title captured my concern, and I pointed out that when the Wright brothers and all those others were trying to develop heavier-than-air flying machines, they were only endangering themselves, not the general public.

Through MACRA, Congress seems to be either conducting a very flawed experiment on the American public or practicing medicine upon them without a license, either way acting well outside of their areas of expertise, and imposing something completely counter to the concept of: above all else, do no harm.

Perhaps I am wrong. Perhaps I am misinterpreting things. Perhaps I am unaware of information that would convince me otherwise. But based on what I have so far been presented, I not only cannot support MACRA going forward, I am also wondering if perhaps we as a profession should be actively opposing it. NOT only (or even primarily) for our own interests but for the protection of our patients (and their families and the general public).
I look forward to being shown otherwise, but until I am... If I were on an IRB, and this proposal had been submitted for my review, I believe it would be unethical NOT to object and insist that adequate support be presented before researchers be allowed to move forward. So that is what I am doing now – starting with this article - and will continue to do – until/unless provided adequate information to show otherwise.

About the author:

Dr. Gordon Street, Ph.D. is the co-founder of Anxiety Solutions of Northern New England, PLLC which is located in Raymond, Maine, where he lives with his wife and two daughters. Dr. Gordon and his wife, Dr. Lee Fitzgibbons, founded Anxiety Solutions, a private practice dedicated to providing evidence-guided approaches for anxiety disorders, 12 years ago. They met while working at the Center for Treatment and Study of Anxiety in Philadelphia, where they were part of the team conducting clinical effectiveness research on Prolonged Exposure for PTSD, Exposure and Response Prevention for OCD, and group CBT for generalized social phobia. Dr. Street's contribution included research design, statistical analysis, and database management. This is Dr. Street's second career. He spent 12 years as a TV news reporter in Tennessee, specializing in education and other child-related issues.

Welcome New Committee Chairs

President Elise Magnuson has announced that Tom Cooper, PsyD has been named the new Chair of the Reimbursement Oversight Committee and Susan Lichtman Maataoui, PhD will be the new Chair of the Continuing Education. The Reimbursement Oversight Committee has been an advocacy presence in MePA for a decade-working to assist members with problems of reimbursement and access to services for their clients. Dr. Cooper will be taking over from long-time Chair Linda Monahon, Ph.D. and Dr. Maatooui will be replacing John O'Brien, Ph.D. "We are delighted that Dr. Cooper will be assuming the helm of this very important Committee within MePA. He has shown that he has the skills necessary to work with both insurers and regulators in this ever-changing market, and Dr. Maataoui, who served as President of MePA a decade ago, brings a great deal of insight and experience to the position. We welcome them both!"

New Law for Training for Mandated Reporters Now in Effect

The 128th Maine legislature will convene early in January to begin the business of passing a biennial budget and dealing with as many as 1,400 bills that are being submitted by legislators. The Maine House of Representatives is still in control of the Democrats, who have elected Rep. Sara Gideon of Freeport as the next Speaker of the House. The Senate remains in the control of the Republicans who have re-elected Sen. Michael Thibodeau of Waldo County as President of the Senate. The majorities in both houses are slimmer than they were in the last legislature, so bipartisan cooperation will be more important than ever to get any serious business done, especially on the budget.

Assignments to the 17 joint standing committees will be announced later this month. There will be changes in all committees because a number of legislators are not returning, either because they were up against term limits, chose not to run again, or were defeated at the polls. We expect to begin seeing bills in print in the next couple of weeks. We know there will be bills to make changes to the recreational marijuana initiative passed by the voters, and inevitably there will be bills dealing with the opioid epidemic, welfare, mental health and a host of other issues.

However, Cahill & Company will be reviewing every bill for a possible impact on the psychology profession. We will be working in concert with your executive director and legislative committee to formulate MePA positions when appropriate. I encourage all members of MePA to get to know their local representative and senator, and to be prepared to respond in the event MePA asks you to contact them regarding a bill of importance to your profession or the people you serve.

Best wishes for the holidays.

Bob Howe and Pam Cahill
Howe, Cahill & Company

At-home Continuing Education Offerings

Can't make it to a MePA workshop? Pressed for time? Check out the MePA At-home Continuing Education Offerings at members.mepa.org

MePA's Newest Committee: Focus on Psychopharmacology

MePA's newest committee is comprised primarily of psychologists who have received an advanced degree in Psychopharmacology. The new group's charges are to respond to the members' need for resources and information prescribed medication, and to work on opportunities for integration between psychologists and primary care health providers. We anticipate the Committee will be doing some continuing education, and additionally will be providing some informal education for members. With their existing linkages with some physicians already in place, they also hope to offer new and existing members valuable expertise on how to make those professional connections. If you would like more information about the committee or are interested in joining, contact Tom Collins at mepacollins@gmail.com.

Renew Your MePA Membership at members.mepa.org. Login and click on your name. The renewal option will appear.