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The Sequelae of COVID-19 for Psychiatric Patients and Options for Treatment

By Sheila Cooperman, MD

There have been a number of medical articles published over the course of the past two plus years on the post-acute consequences of COVID-19 infections. Several names have been coined: long COVID, long haulers, and Post-Acute Sequelae of COVID (PASC). An array of symptoms have been attributed to the aftermath of the infection as well: depression, anxiety, "brain fog," pain, headache, shortness of breath, and fatigue to list a few. As variants have emerged, there is some data that the "long hauler" symptoms differ with the type of the variant of COVID infection one contracted (1), the severity of the infection and predisposing conditions such as Diabetes Type 2, cortisol deficiency in those with respiratory-viral symptoms and possible reactivation of previous viral infections such as Epstein-Barr and Cytomegalovirus (2).

Akiko Iwasaki, Ph.D., Professor of Immunology and Molecular Cellular and Developmental Biology at Yale has been studying the underpinnings of Long COVID with the help of social media, according to Caroline Lieber's column at medicine.yale.edu dated 1/25/22.

Dr. Iwasaki has been monitoring a group, Survivors Corps. The group has been posting their experiences post-infection as well as their symptom response post-vaccination. Results from surveying the group indicate that 40% had their long hauler symptoms improve post-vaccination and 15% report a worsening of their symptoms. The research group has two hypotheses: (1) that the lingering symptoms may be due to a persistent viral infection and vaccination rids the body of the remaining virus with an improvement in symptoms, and (2) that for some patients there is an induction of cytokines with vaccination that leads to an improvement of symptoms post-vaccination but for others, vaccination induces a type of autoimmune reaction leading to a worsening of symptoms.

As research continues into what contributes to long COVID, psychiatrists may be faced with how

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President's Column

By Tobias Wasser, MD

"We've been particularly focused on the national children's mental health crisis and its impact on us here in CT."

CPS has been hard at work the past few months advocating on behalf of our field and our patients and I want to use this column as an opportunity to update you all on our efforts. We've been particularly focused on the national children's mental health crisis and its impact on us here in CT. These concerns existed before the pandemic, but like many things, the past two years have exacerbated an already growing problem. As emergency rooms have been overflowing with children and adolescents in crisis, with insufficient inpatient and community-based resources to meet the demand, we felt this was a timely and critical issue for the organization to address, particularly given the disproportionate impact of this crisis on those underserved in our communities. We have actively partnered with the leadership of the CT Council of Child and Adolescent Psychiatry (CCCAP), the local branch of the American Academy of Child and Adolescent Psychiatry (AACAP), to fight to improve the current landscape.

Fortunately, our state legislature also recognized this as a critical issue in this year's legislative session and demonstrated this by raising House Bill (HB) 5001, An Act Concerning Children's Mental Health. An expansive bill spanning more than 100 pages, HB 5001 calls for many improvements, including expanding telehealth to include mental health treatment for children, increased funding for child and adolescent fellowship positions, providing treatment for truancy instead of punishment, increasing the number of child and adolescent beds in a variety of settings, developing a protocol for transporting children in crisis to an urgent care center operated DCF, establishing grant programs for schools to hire more behavioral health staff, and a loan forgiveness program for those working in child and adolescent mental health.

In a public hearing held jointly by the Children's and Public Health Committees, CPS advocated strongly in support of HB 5001, with particular focus on the following areas:

- Increased funding to increase the number of fellowship slots for child and adolescent psychiatrists;
- Increased funding for and expansion of the Access Mental Health program, a pediatric collaborative care model for treating mental health conditions;

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We Desperately Need More Black Psychiatrists

By Amanda Calhoun, MD, MPH, PGY-3

Last weekend, a racist shooting occurred in Buffalo, New York. The shooter left behind a racist ideology and specifically targeted a grocery store located in a Black community. I sat with my Black patient as he cried. His sobs made his entire body shake. Because he knew that this racist shooter was no extremist, but a representative of white people in America who harbor racist ideologies towards Black Americans. Many Black people don't feel safe anywhere in America, and for good reason. We are disproportionately targeted by brutality, not just among police and out in the community, but within the medical system as well. It was recently publicized that Cedars-Sinai Hospital has been sued for racist negligence after a Black woman died after a c-section. Her story is far from unique. Even Serena Williams recently shared her story about her near-death experience delivering her daughter, and her experiences of being ignored and dismissed by her medical team. As it stands, college-graduate Black women are more likely to die due to pregnancy-related complications than white women who never completed high school, in part due to racism of healthcare providers. Yet, these major issues are rarely acknowledged by my white supervisors, even though they are experts in processing and mentalization. They made space to process the events in Ukraine, and rightfully so, but the relentless racist violence towards Black Americans goes largely unacknowledged—except for by my Black supervisors.

"We desperately need more Black psychiatrists and Black leaders in the mental health field."

We desperately need more Black psychiatrists and Black leaders in the mental health field. We needed them yesterday. From the rising Black maternal mortality rates to the crisis of Black youth suicide, tied inextricably to racism and oppression, the Black American community is suffering, and we need Black psychiatrists and mental health professionals to process our fears, our grief, and our rage. Black psychiatrists are not just important for representation, they often bring a unique set of skills that is unmatched. A combination of lived experience of anti-Blackness, racism, and marginalization, a deep empathy for the lives of their minoritized patients as well as their white patients, and an enhanced expertise and scholarship in health disparities. Even more importantly, we need Black psychiatrists and mental health professionals in leadership positions throughout hospitals and academic institutions, to shape the narrative from a white-dominated lens and begin to include the narratives of minoritized individuals. We need Black leaders teaching our psychiatric education classes and we need Black therapy supervisors. Psychiatry has been and continues to be taught through the lens of the white person perspective, and Black people are often not accurately included in that lens. Most psychiatric research focuses on white populations. Clinically, there is no standardized training in how to help patients navigate racism. Colloquially, most professional conversations I have experienced center around white people. So, I was not surprised

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Surely, We Can Do Better Than This

By Steven Madonick, MD

On a recent Sunday afternoon, my wife Gayle and I met with her cousins to catch up for the first time since COVID-19 descended nearly two years earlier. They're from Danbury and we're from West Hartford, so we decided to meet halfway in Fairfield County. We met at a craft brewery named "Asylum." This struck me, an experienced psychiatrist, as a slightly odd name for a brewery. The four of us settled into a booth in a beautiful room with vaulted ceilings of tile and brick. We shared stories from our two years of coping with COVID since we had attended their wedding in February of 2020. I sipped my pilsner and looked out the window. I saw an expansive green campus with people jogging, walking their dogs and sitting with their families. The campus had many stately, columned edifices. I was overcome by a sense of de ja vu and unease.

Our server informed us that this large park-like campus was formerly Fairfield Hills Hospital, a state hospital for psychiatric patients. There were thousands of patients who spent much of their lives here until about 30 years ago. Suddenly, I felt as though I was sitting in somebody else's living room, uninvited. I knew too well what had happened to many of these people. Most no longer live on beautiful campuses. Sitting in this room made me think about what was lost when these patients were "deinstitutionalized." Indeed, they now often live in shabby single room occupancy hotels or group homes. Some are homeless or live in shelters. Others are incarcerated in jail or prison. Patients now cycle in and out of our modern-day asylums with about a five-day length of stay. My mind drifted and I was less interested in my drink.

We in psychiatry have known, without exception and for decades, how to promote the recovery of our patients with serious

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"We in psychiatry have known, without exception and for decades, how to promote the recovery of our patients with serious mental illness."

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"Good Faith Estimates" Are Bad Faith Contracts

By Christopher Hammel, MD, MPH

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In January, HR 3630, the No Surprises Act, went into effect. It contains its own potent surprise: that health care professionals, including solo psychiatrists, must deliver to patients a "good faith estimate" (GFE) of their full care and that health care professionals are liable for unpredicted costs. This currently applies to all new patients and to established patients with no insurance or with insurance they decline to use. In 2023, it will apply to all patients.

The billing conversation and treatment agreement are the standard of practice, which should be sufficient, but are not under the new law, and the documentation requirements are burdensome and compel uncompensated labor. But these pale in comparison with the real problem: GFEs create a black hole of liability in the form of, ironically, a surprise bill.

The GFE requires that we estimate the next 12 months of care costs, including (effective 2023) outside services such as laboratory studies, imaging, and psychological testing. Solo practitioners are required to somehow obtain these costs and keep them up to date on a live basis, a straightforward impossibility. If we are inaccurate by more than $400, the patient can pursue arbitration, which, if successful, transfers to us any expense above our estimate. A single unpredicted hospitalization could result in a surprise bill for the referring psychiatrist that would shutter most practices. While one could try to provide an updated GFE, it is not difficult to imagine an arbitrator determining that this undermines the GFE's purpose.

The phrase "good faith estimate" is thus an oxymoron: It is no estimate, and it cannot be made in good faith. It is a binding contract based on the impossible expectation that we are able to read the future. And if we botch our crystal ball reading, a patient, or the patient's insurer, can take us to the bank.

Many new patients vacillate, and the GFE, which we are plainly incentivized to overestimate, is gasoline for that fire. Some of them will cancel, and we will then see them in the emergency department instead of the office. Even if they engage, the GFE compromises it: Good psychiatric treatment involves a process of discovery that often leads to unexpected results. We learn early in training that assumptions are dangerous. Because the GFE requires us to make and rely on prejudgments, it may be impossible to practice good psychiatry and be in compliance with the law. Further, the GFE creates a perverse incentive for psychiatrists when patients get sicker because we must now consider whether we predicted the additional costs. If not, we have a Sophie's choice: Don't treat or do and risk our livelihoods.

The original purpose of the law was to prevent surprise billing, already a nonissue in outpatient psychiatry. Its actual functions are to make us pay for patients' care and to rob us of autonomy. It forces us to price our services like a retail product, when we are more like sculptors: we know when to use our tools, and our hands remember the clay, but nobody can guess how the fire will change the glaze. It precludes individualized treatment Unsurprisingly, the law was heavily lobbied by the insurance industry, particularly Anthem Blue Cross/Blue Shield, which filed almost three times as many lobbying reports as the next-

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Sequelae of Covid-19

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to assess and best help their patients who may have a worsening of their psychiatric and/or physical symptoms because of their infection. Fortunately, there are several options here in Connecticut. The following list is not exhaustive but can be used as a resource.

Yale Post COVID-19 Recovery Program indicates that patients can be referred by their inpatient or out-patient providers and that they will have an initial evaluation by a pulmonologist, a physical therapist and/or an occupational therapist. Their cognition, cardiovascular status, sleep will be assessed. Yale-New Haven Children's Hospital Winchester Center will evaluate children and adolescents.

UConn Long COVID Recovery Center will see patients who are referred by their primary care provider after 8 weeks of persistent symptoms and their care will be coordinated with specialists.

Hartford Health Care COVID Recovery Center has a multidisciplinary approach.

Stamford Health COVID 19 Recovery Program is housed in their Center for Integrative Medicine and Wellness Center that includes pain management (non-opiate), lifestyle medicine, and evaluation of diet.

Further studies may inform evidence-based treatments and interventions for Post-Acute Sequelae of COVID leading to the improved health and wellbeing of patients.

References:

Moyer, M, Long Haul COVID Cases Could Spike After Latest Wave, Scientific American, 2/3/2022.

Su et. Al, Multiple Early Factors Anticipate Post-Acute COVID-19 Sequelae, 2022, Cell 185 881-895, Elsevier. https: doi.org.10.1016/j cell.2022.01014.

Save the Date
Annual Business Meeting

Tuesday, 6/21/22
5-7 p.m.
Millpond Gatherings
Northford, CT

Legislative Report for 2022

By Carrie Rand-Anastasiades

"This year the main priority of the General Assembly was children's mental health."

The 2022 session was a fast and furious one, commenced and completed in just over 90 days. In addition to the brief time period, the lingering effects of the COVID pandemic created yet a new twist to how it progressed. The beginning of the session was completely virtual with all public hearings and committee meetings held online. During the latter part of the session individuals were allowed in the building but only on the first and second floors, and meetings moved to a hybrid in person and virtual format. If you are not familiar with the State Capitol, the Senate is located on the third floor, so there was no public access to those legislators while business was conducted. In addition, the House of Representatives continued to allow remote voting from individual legislators' offices. The restricted access made it incredibly difficult to lobby. Business was still conducted via email, text and phone calls, which is not ideal.

This year the main priority of the General Assembly was children's mental health. With the pandemic wreaking havoc and ten plus years of budget deficits eviscerating mental health services, CT was left without infrastructure to help those children in need of assistance. The legislature passed three omnibus bills meant to augment current systems and institute new ones. They funded the initiatives with $30 million of recurring State Funds as well as approximately $15 million in Federal money given under the American Rescue Plan. All these bills passed both chambers overwhelmingly and were signed by Governor Lamont.

The first bill passed, entitled AAC Children's Mental Health, dealt with a multitude of topics. They include the establishment of child and adolescent psychiatrist grant programs (to aid the recruitment and retention of psychiatrists) mandated coverage for intensive evidence-based services for children and adolescents, and integrated delivery of behavioral health and primary care services (collaborative care model CoCM). It also prohibits prior authorization for acute inpatient psychiatric services, extends telehealth services, and requires studies regarding reimbursement rates and parity. The bill extends the number of psychiatric beds at CT Children's Medical and establishes a pilot program in Waterbury that allows an FQHC to administer intensive outpatient services.

The second bill, AAC Childhood Mental and Physical Health Services in Schools dealt with wage supplements for childcare programs, grant programs for school social workers, psychologists, counselors and nurses. The bill also expanded school-based health centers as well as the services they provide, and it tackled teacher retention and recruitment.

The third bill, AAC Expanding Preschool and Mental and Behavioral Services for Children makes mobile crisis response services available 24 hours a day, 7 days a week. It required DCF to use funds to help families with the costs of mental health services and treatments for their children and expedited the licensure process for physicians seeking to practice in multiple states.

Although all three of these bills make significant strides in children's mental health, more still needs to be accomplished to address the deficiencies that still exist, not only for children but also for adults. We are excited to have the multitude of programs roll out so we can capitalize on what is working in the community and then continue to direct our focus and advocacy on what can be done to move psychiatric treatment in CT to the next level in 2023.

News from the APA

American Psychiatric Association Announces Launch of PsychPRO 2.0 Mental Health Registry

Washington, D.C., April 13, 2022 — The American Psychiatric Association (APA) announced today the launch of PsychPRO 2.0, a next-generation technology platform for the PsychPRO mental health registry offering enhanced options for engaging with patients, tracking outcomes, and streamlined data collection for quality reporting.

The PsychPRO mental health registry was created so that psychiatrists could help lead national efforts to improve clinical research and the quality of care, ease administrative burdens on individual physicians, help them meet maintenance of certification (MOC) requirements and reduce overall costs for mental health care delivery.

"The migration to the new technology platform will enhance the already robust benefits of the PsychPRO mental health registry," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "PsychPRO 2.0 will help psychiatrists and hospital systems better navigate a rapidly evolving health care landscape and help track and achieve optimal outcomes for our patients. It truly is the registry of the future."

PsychPRO 2.0 is designed with flexibility and scalability in mind, and has increased reporting capabilities, standardized data inputs, various options for collecting patient reported data and a pricing structure that encourages participation from a greater number of clinicians and health care systems.

The new platform will help APA build on existing efforts to implement an infrastructure to develop models of care, such as Learning Health Systems and Quality Networks. These models

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President's Column

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- Removing barriers to care and increased access to telehealth;
- Continued efforts toward enforcement of mental health parity.

We also suggested the following additions and revisions:

- Reshaping the 10-year loan forgiveness proposal toward a loan assistance model with shorter-term incentives to recruit and retain psychiatrists in CT;
- Urged the committee to provide financial incentives for hospital and health systems to build beds for child and adolescent mental health treatment;
- Supported increased compensation for psychiatrists employed by state agencies caring for the most ill and underserved individuals (e.g., DCF, DDS, DMHAS, DOC).

The public hearing started at 9am on Friday 2/25, but went long into the night, not finishing until almost 2am on Saturday 2/26. Along with testimony I submitted on behalf of CPS, several psychiatrist members of CPS and CCCAP provided both written and oral testimony either as individuals or on behalf of other healthcare organizations in our state, including Tichianaa Armah (CPS Secretary), Paul Bryant (CPS Treasurer), Sheila Cooperman (CPS Past President), Paul Desan (CPS Past President), Frank Fortunati, Javeed Sukhera, and Cynthia Wilson (CCCAP President). All who testified were well-received by the legislature and were wonderful advocates for our field and patients.

There is still more to come and more work to be done. The bill will undergo additional revisions before hopefully being signed into law, much of which will occur between my drafting this update and the publication of our newsletter. We hope you all will stay interested, involved, and that these efforts can serve as a model for the important impact we can all make for our patients when we work together.

"There is still more to come and more work to be done. The bill will undergo additional revisions before hopefully being signed into law…"

We Desperately Need More Black Psychiatrists

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that none of my white supervisors acknowledged the racist shooting in Buffalo, because I am used to issues that center Black people being minimized, even silenced.

Sure, there have been some committees and task forces that have occurred since the murder of George Floyd in 2020, but they are often led by the same individuals who perpetuated the racial hierarchy pre-2020 with no training or expertise in racism and its effects on minoritized populations. If we are truly committed to rectifying the racism inherent in the psychiatric field, historically and currently, we need to start investing in the pipeline of Black psychiatrists. White people hold the vast majority of academic leadership positions in psychiatry, and that needs to change. We need to revamp psychiatry and have a more equitable spread of individuals in leadership, across racial and ethnic backgrounds, which reflects our patient population. We need to start investing in programs, starting in early childhood, that fund Black and other minoritized children to go into the medical field, and in particular the mental health field. We need to continue to invest in outreach programs that empower Black children and other minoritized children to pursue medicine in the first place. We need to start investing in not just recruitment, but retention of Black medical students and psychiatry residents. We need investment in resources that help Black students and residents to combat the racism they experience in the medical field. We need interventions for reporting racism and protocols as well as policies that hold individuals accountable for racist behaviors. We need protection from retaliation once individuals do report racist events.

At very least, it would be nice if all my supervisors had acknowledged the Buffalo shooting—the deadliest shooting of 2022, which happened to also be racist.

Good Faith Estimates

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highest organization. Now we stand before them blindfolded, and the GFE is their machine gun: They will use it to justify coverage denials, suppress reimbursement rates, force patients to pursue arbitration at our expense, and coerce us to refer to their preferred providers, and then hold us liable for unanticipated costs (itself an anticipated outcome of seeing specialists). All of these possibilities leave our practices vulnerable to a fatal surprise bill. The GFE is a leap forward on the familiar journey toward annihilating physician autonomy and solo private practices. Patients and psychiatrists alike should be alarmed that the Centers for Medicare and Medicaid Services has made our work more burdensome and precarious during a period of unprecedented need for mental health care and burnout of health care professionals. The law was intended to prevent health care executives from looting patients in extremis, but its true consequence will be that they loot us instead. An exception must be made for outpatient psychiatry.

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News from the APA

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are sought out by health care systems across the country who are seeking to improve the quality of care they offer and maximize their impact in their communities in the most cost-effective way possible.

"Hackensack Meridian Health is excited to partner with the APA in utilizing PsychPRO," said Ramon Solhkhah, M.D., M.B.A., Founding Chair of the Department of Psychiatry & Behavioral Health at Hackensack Meridian School of Medicine. "With a strategic focus on psychiatric quality, our plan to utilize PsychPRO and its many new functions will extend our capacity to implement a data driven approach to help ensure the highest quality patient care."

To find more information on the PsychPRO mental health registry, including pricing and how to sign up, visit the APA's PsychPRO registry page, or contact press@psych.org.

American Psychiatric Association Launches New Maternal Mental Health Effort Aimed at Identifying Clinician Training Gaps

Washington, D.C., April 11, 2022 — A recent study in Psychiatric Services documented that 51% of pregnant women with a major depressive episode did not receive any mental health treatment. Untreated mental illness is risky for pregnant mothers and their babies, and although the topic is generally under-researched, safe pharmacological and non-pharmacological treatments for pregnant women do exist. A new effort from the American Psychiatric Association (APA), led by Diana E. Clarke, Ph.D., managing director of research and senior epidemiologist/research statistician, will gauge psychiatrists' and other mental health clinicians' experience with and attitudes around treating pregnant women with mental and substance use disorders and identify training gaps.

The initiative, Mental Health Needs Assessment in the Management of Perinatal Psychiatric Disorders, is supported by a $447,209 grant from the CDC Foundation. As part of the initiative, APA will perform a needs assessment via focus groups of women with mental and substance use disorders before, during, or up to two years postpregnancy. It will also survey and hold focus groups and a panel discussion with mental health professionals who treat pregnant women.

"Maternal health, and particularly maternal mental health, is an issue that has taken a back seat for far too long in the United States," said APA President Vivian Pender, M.D. "This effort will help us better understand where our opportunities are to ensure pregnant mothers have access to the psychiatric care they need, which will lead to improved mental health outcomes for moms and their babies."

A 20-member advisory panel of psychiatrists and other mental health clinicians with expertise in maternal mental health has been assembled to inform the project. "This is an important initiative, and I am thrilled that representatives from many mental health professional organizations and diverse backgrounds are participating on the panel to ensure a robustly informed process," said Dr. Clarke. The project aims to update and expand existing recommendations for the mental health care of pregnant women; develop a perinatal psychiatric care toolkit for clinicians; and to formulate educational and training recommendations for behavioral health clinicians to better serve this population.

"" 'Maternal health, and particularly maternal mental health, is an issue that has taken a back seat for far too long in the United States,' said APA President Vivian Pender, M.D."

We Can Do Better Than This

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mental illness. Medication and therapy are often important. Access to basic needs such as healthy food, shelter and income are also key. Connection to family and social reintegration are necessary because isolation and loneliness impair the restoration of mental health. Critically, full recovery, and not just the absence of illness, requires the restoration of purpose. Reintegration into the community, cultivating interests, hobbies, work, education, meaningful relationships and a renewed sense of hope for the future, are crucial. If we know all of this, why is full and successful recovery from serious mental illness not the norm? Why do so many of our patients remain chronically ill?

For many years, psychiatrists filled leadership roles in mental health organizations. This was true in long term inpatient facilities and in the first community mental health centers. These physicians understood what was necessary for recovery from serious mental illness. They were able to bring together the various biological, psychological and psychosocial elements at the right time and place to make a crucial difference in the lives of those recovering from serious mental illness. Today, such clinicians and their unique skill sets are viewed solely as a cost in a never-ending cost-benefit analysis. Psychiatrists with a decade of postgraduate education, years of clinical training and a wealth of experience are now often relegated to medication management or a limited role in the decision making at organizations responsible for promoting the recovery of patients with serious mental illness. The result is a mental health system without clear medical and clinical leadership. It is said that every system produces the results that it is designed to produce. Unfortunately, our clinically rudderless and leaderless system all too often perpetuates chronic mental illness.

Surely, we can do better than this.

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