"Tips on Retiring, a Member's Experience"
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Four years ago at the first meeting of the MPS Retirement Committee, I told the group that I didn't believe I could ever retire because everyone I knew who might accept referrals of my patients was old enough to retire themselves. I had started my solo practice in 2002 after a previous 25- year career at an HMO and a few years in a small group practice. I had been gradually decreasing my patient panel by not taking new patients over a couple of years. I was working four days/week, seeing about 35 patients/week for a combination of psychotherapy and psychopharmacology, and had a panel of close to 100 active patients. I had gradually dropped out of private insurance networks and Medicare, billing for a few patients out of network and giving many patients reduced fees so that they could continue with me.

I had been enjoying my work but as the pandemic dragged on, and it became clear that I would not be returning to my office, I found it less satisfying. I also enjoyed being at home and felt the pull of other interests and activities. In June of 2021, I made the decision to retire by the end of June, 2022.

At the meetings of the Retirement Committee, I had listened to stories of others trying to find referrals for their patients and realized that I was faced with a daunting job. As my colleagues had recommended, I gave myself a year, planning for retirement in June of 2022. I vowed to myself to take this slowly and stay calm. I printed out a list of patients who had had a visit within the last year and added a few from the past who I knew might call and would want to know.

I began to tell my regular patients as I saw them. We processed the initial reaction to news, which ranged from "I'm so happy for you" to "What do you MEAN, you're retiring?" and everything in between. At that session or soon after, I asked them what they might need going forward. The answers seemed to fall into several categories:

- Wants ongoing psychotherapy and medication
- Not on medication, wants continuing psychotherapy
- Stable on medication; not interested in psychotherapy; Would be fine with PCP prescribing or very intermittent psychiatrist or psychiatric NP
- Needs more specialized care (geriatric, chronic pain, eating disorder)
- Wants (not always realistically) to finish psychiatric treatment and terminate

We also discussed whether they wanted to try to use their insurance to pay for care.

We began to talk about the reality of the referral situation and took inventory of what resources they might already have. These included:

- An organized care network (teaching hospital, HMO)
- A relationship with PCP or other specialist (e.g. neurologist)
- A psychotherapist (MSW, PhD) who might know other psychiatrists or NPs
- An insurance company with case managers or useful websites

Early in the process, I asked patients to investigate their own referral sources and set the expectation that this was going to be a difficult, frustrating process, worsened by the pandemic. They might have to make multiple calls and not hear back or sit on a waiting list for several months. Several patients were able to get referrals from their psychotherapists for other prescribers and many were able to transfer prescribing to their PCP. (There were surprises: some PCPs were very comfortable with a complicated regime; others were reluctant to continue even a low dose of lorazepam. I also discovered that many psychiatric clinicians were reluctant to continue ongoing benzodiazepine treatment, despite documentation of difficulties or side effects with other medications.)

I then started looking at my own resources. I had a few patients who were in intensive treatment and attached to me and would need an overlap with another clinician for a couple of months during the transition. I had been supervising a few NPs for many years and was able to refer two patients to one of them, and one to a close MSW colleague.

I then made a list of everyone I knew: mental health clinicians of all disciplines, primary care doctors and other specialists:

- Colleagues whose business cards I had collected at meetings for years
- Colleagues who had shared my office suites at my two private practice offices
- Colleagues from long ago at the HMO
- Colleagues in my address book and contact list

I emailed or called them all, asking if they or anyone else they knew had referral time. Whenever I talked with a colleague about a patient, I would let them know I was retiring and ask if they or anyone they knew might have availability. Whenever I talked with a friend inside or outside the profession, I did the same. For instance, when I met with my financial advisor about my retirement, his assistant had a good friend who was a social worker who had connections to a psychiatrist. A patient of mine was discharged from a psychiatric hospital and referred to a geriatric psychiatrist. That referral didn't work out, but I talked with the psychiatrist who has since taken three of my other patients. Two colleagues, one a PCP and one a LICSW, gave me suggestions of other people they had known, so I called those people as well.

I began to use the Psychology Today website myself. I found that patients had trouble navigating and choosing people from the site, while I could look through the bios and get a pretty good idea of who might be competent and appropriate. I began to email and call some of the more promising clinicians and developed of ongoing referral relationships with two NPs and one geriatric psychiatrist. I also found a couple of geriatric NPs who do home visits or consult to assisted care facilities. I found one through the website and another from the activities director of the facility.

By now, my list of patients began to have possible referrals penciled next to most of them, and I had a page of clinicians containing 15-20 MDs, NPs and a couple of MSWs who were ready to take patients.

When I asked a clinician about a referral, I said that it didn't have to be right away; that my patients could wait a few months for an opening. I took care to only refer one or two patients at a time. If those worked out, I might go back to the same clinician in a couple of months with another referral. I asked if the clinician would be willing to have a brief conversation with a patient, enough to say

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that it looked like a match, and then schedule a time for an intake. Other patients were able to secure a place on a waiting list. Large group practices and teaching hospitals kept waiting lists, often months long. I encouraged the patients to take a referral when it was offered, even if it meant transferring now, since the new clinician might not have time if they waited until right before I retired. Patients have been leaving when they felt comfortable with their new clinician, freeing up more of my time to call people and write treatment summaries when needed.

While most of my patients had been paying me out of pocket and were willing to continue this with a new clinician, I did not anticipate that younger psychiatrists and NPs would have higher fees than I had charged. I had not raised my fees in several years and had given patients reduced fees as I resigned from insurance networks. Most patients were willing to adapt, but some continued to look for practitioners with lower fees or insurance coverage.

I still have a short list of patients who have not found referrals. There seem to be several reasons:

- The patient lives out of town, having moved for COVID or other reasons. I have no connections to use, and the resources are even thinner than here. A few of these patients have found therapists but not prescribers. The situation is especially bleak in Florida.
- The patient is frail and elderly and is not able to arrange care herself and doesn't like the clinician I have found for her.
- The patient wants to use insurance with a limited network.
- The patient is young and procrastinating and might be moving, changing jobs, or getting married.
- The patient is adamant that they don't want to start with another therapist but despite needing to do so.

I have had to make peace with the knowledge that I won't get everything perfectly wrapped up before I go. A patient asked me yesterday, "But if I run out of meds after July 1, couldn't you just call them in?"

For the most part, I have enjoyed the process. I have met or remet several lovely people, found another NP to supervise after I retire, and made a couple of potential friends. I have worked hard, but the potential nightmare turned into a (COVID-style) social occasion over phone and email. I would advise clinicians planning to retire from solo practice to give themselves at least a year, try to empower their patients to do some of the work, and make peace with a "good enough" referral rather than a perfect match.

Recently moved or planning to move……

Remember to notify the MPS of any change in your mailing address or your email.

This will ensure that you don't miss any of the updates that the MPS provides during the month.