NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

MARCH 2022

IN THIS ISSUE

Don't Forget to Pay Your Dues!

If you haven't already, make sure you pay your membership dues by the end of the 90-day grace period (March 31, 2022). Here are three ways you can renew today:

1. Pay online: www.psychiatry.org/PayDues
2. Pay by phone: (202) 559-3900
3. Send a check to:

   APA Membership Dept
   800 Maine Avenue, S.W.
   Suite 900
   Washington, D.C. 20024

Committing to Racial Health Equity in Psychiatry: Reckoning with Racism in Restraint Use

Colin Smith, M.D., Chief Resident, Internal Medicine-Psychiatry
Duke University Medical Center

"Every system is perfectly designed to get exactly the results it gets." – W. Edwards Demming

A genuine commitment to racial health equity in psychiatry requires proactive and intentional identification, and elimination of the roots of unjust differences in care perpetrated on minoritized communities. We have a duty to our patients, ourselves, and our profession to respond, especially when we are employing inherently coercive, forceful, and morally injurious interventions such as chemical and physical restraint.

Much of the literature evaluating disparities in emergency healthcare highlights inadequate medical evaluation and treatment for communities of color. It is well established, for example, that Black patients seeking care in emergency settings are less likely to be offered thorough evaluation for chest pain[1] or analgesia for musculoskeletal and abdominal pain[2] compared to their white counterparts.

But what about our use of physical and chemical restraints in psychiatry? Are we systematically and forcefully treating Black patients differently than white patients? Unfortunately, the answer is yes. A pair of recent observational studies evaluating over 900,0000 patient encounters demonstrate that Black patients are significantly more likely to undergo physical restraint than white patients in the general emergency department setting after adjusting for sociodemographic and clinical factors.[3,4] On the heels of these studies, our team analyzed nearly 13,000 encounters of patients, evaluated by an emergency consultation psychiatry service, and found that Black patients are also more likely to be injected with antipsychotics than white patients.[5] Lest we think the burden of these findings falls strictly on the shoulders of our emergency physician colleagues, preliminary results from an analysis of over 3,700 unique encounters in an urban med-psych unit show significantly higher rates of restraint and seclusion for Black patients than for white patients.[6]

> ***"Few problems have ever been solved by ignoring that they exist."***

What are we to make of these findings? Given the frankly racist practices that have pervaded the history of American medicine[7] and the common human phenomenon of implicit bias, it is illogical to suggest that racial bias does not play a role in our coercive treatment of Black patients presenting in distress.[8]

Although increasing diversity among physicians mitigates—but does not eliminate—implicit bias and prejudice,[9] people of color, and, in particular, Black individuals, still comprise a

...continued on page 7

ECU Department of Psychiatry and Behavioral Medicine Welcomes New Department Chair

Michael Lang, M.D., F.A.C.P., D.F.A.P.A.

Congratulations to NCPA member ***Michael Lang, M.D., F.A.C.P., D.F.A.P.A.*** on his recent appointment to Chair of the Department of Psychiatry and Behavioral Medicine of Brody School of Medicine, East Carolina University. Dr. Lang joined the faculty of the Brody School of Medicine in 2007 where he has supervised interns and residents. Dr. Lang has held a number of leadership positions, including Associate Residency Training Director of Internal Medicine/Psychiatry; Residency Training Director of Medicine/Psychiatry; section head of the Electroconvulsive Therapy Service; Vice Chair of the Department of Psychiatry and Behavioral Medicine; and Chief of Service for Psychiatry at Vidant Medical Center.

Dr. Lang steps into this role following ***Sy Saeed, M.D., M.S., D.L.F.A.P.A.*** who served as Chair of the Department of Psychiatry and Behavioral Medicine for the past 18 years. Dr. Saeed is the Director of the Center for Telepsychiatry at ECU and is the Founding Director of North Carolina Statewide Telepsychiatry Program (NC-STeP), a state funded program covering over 60 hospitals in the state. Dr. Saeed was named the 2019 recipient of the O. Max Gardner Award by the Board of Governors'. The honor pays tribute to one faculty member within the UNC System who, during the academic year, made the greatest contribution to the welfare of the human race.

NORTH CAROLINA Psychiatric Association news

EDITORS
Jillianne Grayson, M.D.
Art Kelley, M.D., D.L.F.A.P.A.

MANAGING EDITOR
Robin B. Huffman, Executive Director

ASSOCIATE EDITORS
Katie Cashwell, Communications Coordinator
Lana Frame, Membership Coordinator
Katy Kranze, Assistant Director

The *NCPA News* is a publication of the NC Psychiatric Association, 222 North Person Street, Suite 012, Raleigh, NC 27601.
To update your mailing address or if you have questions or comments about *NCPA News*, contact NCPA Staff, 919-859-3370 or info@ncpsychiatry.org.

President's Column

Collective Wisdom

Alyson R. Kuroski-Mazzei, D.O., M.R.O., D.F.A.P.A., F.A.S.A.M.

NCPA Mission: Promote the highest care for North Carolina residents with mental illness, including substance use disorders; advance and represent the profession of psychiatry and medicine in North Carolina; and serve the professional needs of its membership.

I write this in February, Black History Month, and I am reminded of the importance of harnessing our collective wisdom by bringing everyone's voice to the table. When we come together, we have a positive impact on our community culture and can support one another in more effective ways. With that, I would like to thank the entire NCPA Executive Council for their collective work on NCPA position statements, collaboration with other professional societies, and for the support each person gives to the profession of medicine and each other.

In our last Executive Council meeting, ***Dr. Samantha Meltzer-Brody*** facilitated a conversation about resilience. What came forth was centered around mindfulness, physician boundaries, network adequacy, and supporting our team members during these two years of a beyond-challenging pandemic. Even though we may be exhausted mentally, physically, and emotionally, it is important that we dig into our resilience as we see the light at the hopeful-end-of-the-pandemic tunnel.

We all experience stress and challenges, but how we handle our emotions can set us apart as physician leaders. When I was having a difficult time managing nurse staffing during the pandemic, it came to my attention that one can't control factors that are not directly under their attention. It was pointed out in an email from a HopeWay partner that, during these times, it can be helpful to make two lists: one list of things we can control and a second list of things that we can't control. In being mindful about what we can control, we can make actionable plans to overcome challenges and work through problems. The rest of it we just must let go as best we can. Resilience empowers us to accept and adapt to the most challenging situations and move forward. I love this quote from Martin Luther King, Jr.: "Faith is taking the first step even when you don't see the whole staircase.". There are times when we may need to leave the gap between what we can and can't control simply to faith.

Physician boundaries are traditionally countered by levels of perfectionism, competitiveness, and a strong work ethic. Yet, our collective wisdom shows that this can lead to burnout, depression, and anxiety. Thus, how can we support each other when these personality traits are hard wired? I believe it takes sharing our own experiences and learning from one another; making a point to have these conversations privately and publicly; and taking time to get to know each other personally. We are stronger when we break down silos and build trust that leads to mutual support. As network adequacy continues to be difficult, we must take care of ourselves in order to grow and mentor the physician leaders who will continue striving to increase access to care, deliver services that are equitable, and lead us through life's challenges.

During the NCPA Executive Council Meeting, Secretary ***Dr. Reem Utterback*** shared how she has tried to work with her patients and family to "take joy in the ordinary and not just look to the extraordinary." What a powerful exercise. This means not just looking towards that next vacation but finding joy in day-to-day life. As the pandemic has influenced many of us to think about our own mortality and that of our loved ones, I think it is safe to say that we need to make time to enjoy the small things in life while we are healthy. Many of us focus so hard on our work that our relationships, health, and wellness suffer. I am certainly guilty of this.

What are you going to do this week to prioritize you? I encourage each of you to make your own "treatment plan" that is unique to you and your needs. Work on making small changes that can ultimately improve your sense of joy and control. You will be stronger for it and so will our colleagues, our profession, and our patients.

Planning Underway for the 2022 Annual Meeting & Scientific Session

September 29 - October 2, 2022 | Renaissance Asheville Hotel

The Renaissance Asheville Hotel is now taking reservations for the 2022 NCPA Annual Meeting. The last day to make reservations in our discounted room block is September 2, but the block is expected to fill up before that cutoff date. So please make your reservation sooner than later! Visit www.ncpsychiatry.org/annual-meeting for more information and to reserve your room. Annual Meeting registration will soon. Be on the lookout for details!

NCPA is closely monitoring the evolving COVID-19 situation. Protecting the health and safety of our attendees is our priority. To this end, we're planning to follow industry-wide standards, as well as recommendations and requirements from federal, state, and local authorities. NCPA reserves the right to require additional precautions prior to and during the in-person event. More details will be shared soon.

A Dialogue about Measurement-Based Care as a Quality Measure in Psychiatry

Dhipthi Brundage, M.D. and Ish Bhalla, M.D., M.S.

Editor's Note: This is a summary of dialogue from the 2021 NCPA Annual Meeting session between *Dhipthi Brundage, M.D.* and *Ish Bhalla, M.D., M.S.* Dr. Brundage is a private practice psychiatrist in Durham representing a psychiatrist in practice. Dr. Bhalla is the Associate Medical Director of Behavioral Health Value Transformation at BCBSNC representing the perspective of a payer. Each author chose a side regarding the use of measurement-based care (MBC) in value-based payment arrangements. While both authors have mixed feelings about the question, they were asked to take a stance for the sake of conversation. This is the first installment of a three-part series.

What should be measured in VBC/MBC?

Dr. Bhalla:

I'll first spend some time defining what we mean by value-based care (VBC).

Simply put, value is defined as quality divided by cost. Something that is high value is also high quality and low cost. VBC is a concept that incentivizes the physician to either increase quality with fixed costs, decrease costs with fixed quality, or, preferably, increase quality while decreasing costs.

VBC has gained traction in physical health care over the past few decades. Primary care physicians have a panel of patients and payers who hold them accountable for improving their health given a fixed cost. There's an incentive to improve their patients' well-being without spending excessively on unnecessary tests. The idea is that physicians are given freedom to deliver care in ways that they're trained to, rather than worry about how to up-code their bills to payers. In this arrangement they would then be held accountable for quality measures.

Quality of healthcare can be divided into three categories: structural measures of capacity – like the availability of a board-certified PCP; process measures that focus on following evidence-based care like prescribing the right anti-hypertension medication; and health outcomes that measure the health of the patient like their actual blood pressure. VBC tends to focus on outcome measures so that physicians can decide themselves on how to improve their patients' well-being without the payer interfering.

Mental health has lagged physical health for value-based reimbursement. Some would argue that we don't have the same outcome measures as other medical disciplines. We have MBC such as the PHQ9 or GAD7 that have been shown repeatedly to be highly evidence-based, but few physicians use these tools in practice. We thus tend to focus on process measures like follow up after hospitalization or ED visits for mental illness, rapid access to mental health care services when needed, and appropriate use of highly evidence-based treatments like buprenorphine or clozapine.

Our field is moving towards holding physicians accountable for quality, but there is still work to be done to test which models will work best.

Dr. Brundage:

In addition to what we measure we must think deliberately about the act of measuring, who does the measuring, and how often we measure. We must be willing to discuss with our patients the meaning of measurement. Whether they use a validated scale or their clinical observation, psychiatrists generally watch for change in their patients. By operationalizing and concretizing this core practice, we could possibly ensure that we do not unwittingly become lax due to the day-to-day demands of clinical practice. Any type of systematic measurement should be tailored to the type of clinical practice, type of illness, severity of illness, and preference of the physician-patient dyad. If we implement a practice that does not account for these variables, we run the risk of getting bad data as physicians and are likely to simply check boxes to get through the paperwork.

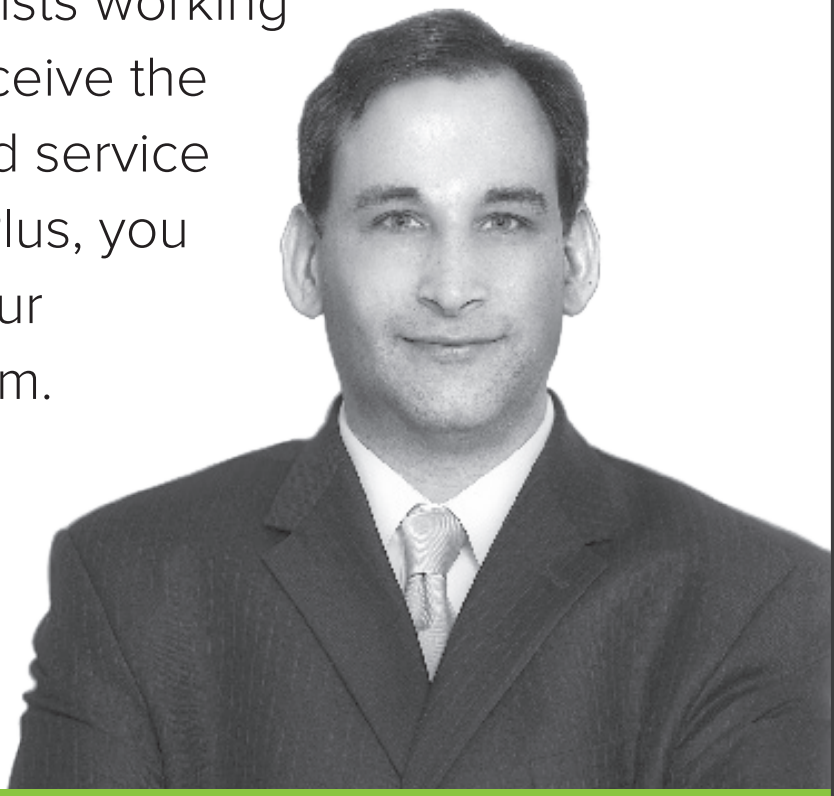
Certainly, following evidence-based measures makes sense when the evidence is robust. Studies such as STAR*D or CATIE fall into the category of robust studies. However, many studies are designed and conducted by pharmaceutical companies in ways that maximize indications for their drug.

Process-based measures are also complicated in actual practice. We can measure the frequency with which patients have appointments after hospitalization or ED visits, but I have seen such measures completely miss the mark in ensuring that the patient attends the appointment. We can track the use of evidence-based medications, but that does not convey much about the patient's quality of life. Of course, a patient with schizophrenia could benefit from clozapine but the patient may not have the ability to get regular blood draws or suffers from side effects that are untenable. We would then treat and measure the disease but lose track of the human.

PART-TIME PRACTICE?

WE CAN COVER YOU

PRMS® ensures that psychiatrists working 20 hours per week or less receive the same unrivaled protection and service as those practicing full-time. Plus, you may be eligible to save on your malpractice insurance premium.



RICHARD STAGNATO, RPLU
ACCOUNT MANAGER
PRMS, 17 YEARS

More than an insurance policy

(800) 245-3333
PRMS.com/**PartTime**
TheProgram@prms.com

PRMS®
the psychiatrists' program®

Dr. Bradley Gaynes First NC Recipient of APA Senior Scholar Health Services Research Award

Who was your hero in medical school? "Everybody has one," according to ***Bradley Gaynes, M.D., M.P.H., D.F.A.P.A***. "My hero was the guy who created the stool guaiac test. It's a colon cancer screening and was created by an Ohio State University physician. No one knows who he was, but his research impacted the care of millions of adults. His research led to the standard of care that helped countless patients," Dr. Gaynes shared with NCPA.

Research scholarship with impactful implementation has been the marker of Dr. Gaynes' 25-year career and is the basis for being named the recipient of the American Psychiatric Association's 2022 Senior Scholar Health Services Research Award. The award recognizes sustained research accomplishments in mental health. The APA elaborated on the award in a recent statement: "The selection committee is made up of experts in the area of health services research and they evaluate the quality of the nominee's overall, sustained contribution to health services research that has resulted in a significant advance in the area of mental health." The first Senior Scholar Award was presented in 1991 and Dr. Gaynes is the 22nd recipient. He is the first psychiatrist in North Carolina to receive this award.

His research is centered in three primary efforts: assessing strength of evidence, operationalizing, and implementing. Dr. Gaynes explained, "My research aims to identify the highest quality, evidence based psychiatric data, to operationalize that data in to psychiatric and primary care settings, and then to disseminate the findings in clinics across the globe." A few highlights for Dr. Gaynes' research-centered career include lead investigator or co-investigator on 16 AHRQ-funded systematic reviews, co-investigator on a Task Force report on screening for depression in primary care, and lead investigator on several NIMH-funded projects studying measurement-based care to medically ill patients in sub-Saharan Africa.

What stands out among these highlights is that Dr. Gaynes' efforts have had such a far-reaching impact. Communities across North Carolina and the globe have benefitted from his research. Since 2017, Dr. Gaynes has been the Scientific Director of a U19 Global Mental Health hub in Malawi, which trains researchers in Malawi and Tanzania on how to design, disseminate, and implement mental health research projects. "Clinical management of depression in non-psychiatric settings works," noted Dr. Gaynes. "How do we then disseminate that care in places without resources? What are the effective strategies in low- and middle-income countries? Places like Malawi that have three psychiatrists need strategies to train researchers and providers in the implementation of depression screening and management. Even in North Carolina, rural communities often don't have referral resources. We need to send the psychiatrists in to the primary care setting."

Dr. Gaynes is a Professor of Psychiatry and the Associate Chair of Research Training and Education in the UNC Department of Psychiatry and a Professor of Epidemiology in the UNC Gillings School of Global Public Health. Most recently, he became the inaugural head of the department's new Division of Global Mental Health. A Distinguished Fellow of the American Psychiatric Association since 2004, his career clearly reflects his values as he works at the crossroads between psychiatry and public health, clinical trials research and mental health services research.

"The public health perspective asks us to identify what strategies will help the most people. It informs how we deliver care. To help the greatest number of folks, we need to look at primary care. Most people with mood disorders aren't comfortable going to mental health care providers, but they are going to their primary care providers" said Dr. Gaynes. "Thirty years ago, primary care didn't think depression treatment needed to be in their bailiwick. That has changed, and the identification of mood disorders is much better. The next wave of change needs to be in sustaining adequate care, dosing, and referrals. Psychiatry has a key role to play in that change and in leading the medical community to appreciate the role that mental health has in the expression of illnesses."

Dr. Gaynes has helped to usher in those changes through years of mentoring psychiatry residents and future mental health researchers. He has co-directed the grant-writing course for UNC's Clinical and Translational Science Award, directed UNC's Psychiatry Residents Research Track, and co-directed UNC's Junior Faculty Mentoring Program. In 2019, he won the AACAP Outstanding Mentor Award from the American Academy of Child and Adolescent Psychiatry for his work with Junior Faculty.

"When I was studying internal medicine in medical school, I

continued on next page...

Kody Kinsley Takes Oath as New DHHS Secretary

Governor Cooper appointed Kody H. Kinsley, to succeed Mandy K. Cohen, M.D., M.P.H. as NCDHHS Secretary beginning January 1st. Kody Kinsley, a native of Wilmington, served as the Chief Deputy Secretary for Health at NCDHHS and Operations Lead for NC's COVID-19 pandemic response. In this role at NCDHHS, Kinsley oversaw the state's response to the Opioid Epidemic; increased investments in services and supports for individuals with behavioral health needs and developmental disabilities; and has been a driving force behind North Carolina's COVID-19 pandemic response and vaccine distribution efforts.

Secretary Kinsley has engaged frequently with NCPA in the past, including meeting with Executive Council in 2019. In his first appearance at the Joint Legislative Oversight Committee for DHHS in February, Secretary Kinsley named behavioral health as one of his top priorities.

New DHHS Secretary Kody Kinsley takes the Oath of Office on January 1, 2022.

..."Racial Equity" continued from cover

disproportionately small percentage of practicing psychiatrists.[10] Diversifying the workforce and developing evidence-based, trauma-informed training programs may help, but individual level interventions alone are insufficient.

The disproportionate use of coercive measures for Black patients in emergency psychiatry is a symptom of systemic racism and structural violence. Hyper-incarceration and police violence, endured for generations by minoritized communities, now extend into the clinical space and perpetuates stigma and justified mistrust.[11] Rectifying disparate restraint use on Black patients requires systemic change, such as increasing access to outpatient services and decriminalizing mental illness, in addition to reducing interpersonal bias in agitation management.

Systemic change stands to benefit patients and physicians alike. Restraints have not only been associated with aspiration, rhabdomyolysis, thrombosis, and posttraumatic stress symptoms in patients[12-14] but also serve as a morally injurious act for physicians and others involved, as evidenced by comments provided in a qualitative study assessing ethical conflict in management of agitation: "You don't have the space, you don't have the time, and you don't have the resources for these people. Now I don't have as much of a problem restraining them early. Of course, that comes with the philosophical question, 'What the heck is now wrong with me that I'm now okay with it?'".[15] Moral injury threatens to exacerbate the toll of injustice on minoritized communities, as trainee burnout in emergency psychiatry is negatively associated with plans to treat patients insured by Medicaid.[16]

If we are to achieve the racial health equity that many in psychiatry are calling for, then we must address the systems that perpetuate traumatizing and criminalizing communities of color. After all, few problems have ever been solved by ignoring that they exist.

For further reading and to view this article's references, scan the QR code using your smartphone's camera.

SCAN ME

..."Bradley Gaynes" continued from previous page

thought about my future and I couldn't imagine going home at night, at the end of a day of work, and reading about the liver," chuckled Dr. Gaynes. "But I could imagine going home and reading about human behavior and how that impacts a person's health and the people around them. Psychiatry felt like it appreciated the individual more fully. Treating individuals and overall communities has always been important to me."

The Senior Scholar Health Services Research Award winner is presented with a cash award and is invited to present a lecture at the American Psychiatric Association Annual Meeting, which will be held in New Orleans, LA from May 21-25, 2022. When asked what his lecture will address, Dr. Gaynes replied, "I hope to provide an example of how one can combine public health and medical perspectives to inform the delivery of mental health care."

Private Residential Treatment Facilities, It's Time for a Change

Kim J. Masters, M.D., F.A.C.P., D.F.A.P.A., D.F.A.A.C.A.P.

In my opinion

Editor's Note: At the November 2021 NCPA Executive Council meeting, a member communication was brought before the council that expressed concerns regarding abuse allegations in North Carolina adolescent Psychiatric Residential Treatment Facilities. A series of *USA Today* articles that was published in several state newspapers highlighted problems in these facilities, including several located in North Carolina. The member's letter prompted conversation among Executive Council members and the decision was made to appoint a joint task force with the North Carolina Council of Child & Adolescent Psychiatry to address the problem. The Joint Task Force has met several times, including a private meeting with DHHS. Their work is ongoing, and NCPA members will be hearing more from the Task Force in the coming months.

Dr. Masters, who does not serve on the task force, offered this opinion.

Speaking Out, Speaking Up

We all should speak out against the abuse of children and adolescents that is occurring in PRTFs (Psychiatric Residential Treatment Facilities) and group homes. Recent allegations of abuse of patients come from several reports. A *USA Today* investigation, reported in *The Fayetteville Observer*, found abuse history in 49 North Carolina PRTFs, including Strategic Behavioral Health in Charlotte and Eliada Homes in Asheville. The *Asheville Citizen Times* investigated allegations of abuse in Asheville-area PRTFs, Solstice East and Eliada Group Home. *New Yorker Magazine* reported on alleged abuses in many Teen Challenge group homes through America, which are "abusive shadow treatment facilities" for those in the juvenile justice system. Paris Hilton testified in *The Washington Post* against the Provo Canyon School in Utah.

While the North Carolina Psychiatric Association and the North Carolina Council of Child & Adolescent Psychiatry have a task force addressing the issues, it is important that we all inform ourselves about these abuses and find the proper venues to speak out about them.

Abuses of patients have been noted and confronted since at least 1794, when Dr. Philippe Pinel described patients' abuse by staff. Awareness of these abuses reach the level of public concern about every 25-30 years but attempts to stop the abuses have not been successful. In 1998, for example, the *Hartford Courant* investigated the death of 110 patients, including children in restraints.

The major perpetrators of the abuses most often are the poorly paid mental health staff, technicians, and residential health care specialists, who are responsible for direct care of patients. We should pressure facilities to make changes to recruiting, hiring, and adequately paying these direct care staff.

A Plea for Better Staffing

Having failed to stop abuse through regulations and training, we ought to deal with the abuse at its source: the line staff, behavioral health care technicians, residential councilors, etc. These are low-paying, high-risk jobs (average pay is 11-14 dollars/hour). Construction workers earn more, as do many other lower-risk employments.

The risks are twofold: being assaulted by patients and being terminated and referred to a state agency when a patient or family complains about inappropriate restraint and/or it is observed on video cameras that are present in most residential facilities. These staff members could earn more if they perform the same job in a hospital, because insurance reimburses hospitals at a higher daily rate than PRTFs or group homes.

The supervisory capacity of these staff is complicated in PTRFs funded by Medicaid. The mixing of the juvenile justice system's adolescent patients with those from the social service and mental health system puts a tremendous, if not impossible, load on staff. The result is frequent abuse (sexual, physical, and emotional) and bullying by the juvenile justice patients and staff, often due to their own experience and learned "strategy" in juvenile detention.

Who would then take a low wage, high risk job? Often, those who cannot get jobs elsewhere -- individuals who experienced the same environmental abuse and low educational opportunities of the patients. This situation would likely cause staff members under stress to abuse patients and override in-service trainings about 'seclusion and restraint alternatives.'

What Can We Do?

I am suggesting that when we psychiatrists work in these PRTFs and group homes, we should:

- Be involved in advocating for higher pay, and in promoting/hiring of behavioral line staff with the educational and

...continued on page 13

The Pitfalls of Wellness Programs and What We Can Do About It: A Resident Perspective

Shilpa Krishnan, D.O. PGY-2 at Atrium Health Sandra and Leon Levine Psychiatry Residency
Laura Williams, D.O. PGY-3 at Cape Fear Valley Residency Program

"Burnout" is often the term used to describe the mental exhaustion that health professionals face, sometimes manifested as depersonalization and low sense of professional efficacy. According to the Medscape 2021 Physician Burnout and Suicide Report, 41% of psychiatrists reported burnout; across all specialties the rate was 42%.[1] Among resident physicians in particular, existing data shows a significant prevalence of mental distress. A national study of U.S. internal medicine residents from the 2008-2009 academic year showed an overall burnout rate of 51.5%.[2] A more recent systematic review of resident physicians done in 2015 found an overall prevalence of a major depressive episode among residents to be 28%.[3]

The COVID pandemic has created additional stresses, emotional exhaustion, and dissatisfaction. Residency, by its very nature, is difficult; residency during a pandemic is even harder. For residents, healthcare workers, and all hospital employees infected with COVID, they experience the stress of the infection, and then the stress of returning to work while recovering. Their colleagues experience pressure to keep up with the workload as COVID spreads. This stress, this pressure, continues to mount as it seeps through hospital systems. The stress is palpable at every level of care and a stressed leadership affects all those beneath them.

As of early January, we are faced with not just the normal stressors of residency, or the "normal" stressors of the pandemic, but the mounting stressors of government systems that increasingly treat healthcare personnel as expendable. Facebook groups consisting of healthcare workers are filled with posts and memes using humor as a defense mechanism to show just how much the CDC guidelines have made employees feel disposable. And we cannot fault the administration or the hospital for just following federal guidelines.

Naturally, the conversation turns to wellness – a word that we value in psychiatry and try to emphasize the importance of to our patients. Perhaps more than most specialties, we care for both the bodies and minds of our patients. But we are also physicians, notorious for, "do as I say, not as I do." Nationwide, it's estimated that roughly 300-400 physicians die by suicide every year.[4] A 2013 study using data collected from the United States National Violent Death Reporting System found that physicians who died by suicide were less likely to have received mental health treatment compared with non-physicians who took their lives.[5]

Dr. Pamela Wible, activist, and author of *Physician Suicide Letters—Answered*, has stated that medical education is "a profoundly dehumanizing experience and it's drilled into you: 'Do not show your heart or tears to anyone, ever again.'" To be fair, we have turned a major corner away from the "work until you drop" mentality that was seen for decades within medical education. In recent years the Accreditation Council for Graduate Medical Education (ACGME) has made a push to encourage and prioritize wellness in medical schools and residencies more than ever.

As a result, wellness initiatives within residency programs have grown in the last several years. Consisting largely of lectures on improving wellness, scheduled group activities, and creating so-called "wellness committees," these initiatives aim to reduce overall stress. The programs are conducted with good intention, and sure, it is nice every now and then to participate in a yoga session or attend an organized social event. However, these initiatives are not what physicians are asking for and do not provide a solution. The Medscape 2021 Physician Burnout and Suicide Report shows that physicians do not want more education on the importance of wellness, sleep, diet, mindfulness, etc. The top four recommendations made by physicians are: 45% want increased compensation to avoid financial stress, 42% want more manageable work and scheduling, 39% want respect from administration/colleagues/staff, and 35% want increased control and autonomy.[1]

These wellness initiatives as they are currently conducted, do not address more severe forms of mental illness that many residents suffer from. There are resident physicians who have major depression, bipolar disorder, substance dependence, anxiety with panic, post-traumatic stress, obsessive compulsive disorder, and may even experience episodes of psychosis. We are all human after all. Unfortunately, the stigma of mental illness among physicians persists. For fear of consequence, residents often do not disclose their struggles with mental illness to peers, faculty, or program leadership. This is true within psychiatry as well; for as much as

...continued on page 13

Psychedelics, It's Not the 60s Anymore

Steve Prakken, M.D.

As a curious and experimental child of the 1960s, I have always had a bit of a fascination with the potential use of psychedelics in psychiatry. Noticing the recent resurgence of interest in this topic, I began to explore it, and realized I have been living under a rock. The new research completely surprised me, so let me share what I found.

First, what are we referring to when using the terms "psychedelic" or "hallucinogen"? The word "psychedelic" (from the Greek "mind manifesting") refers to an agent with indescribable effects on consciousness, perception, emotion, and self-awareness. The term "hallucinogen" describes a type of psychedelic which causes frank hallucinations, such as LSD, psilocybin (magic mushrooms), mescaline (peyote), and DMT (ayahuasca). The current research on psychedelics includes two additional agents that tend not to give such frank hallucinations, but which have similar effects on the psyche. These are Ketamine, a dissociative anesthetic, and MDMA (ecstasy), representing a group called empathogens (generating empathy) or entactogens ("touching within").

Research beginning in the 1950s and 1960s showed promise for using hallucinogens to treat depression in end-of-life care and alcohol use disorder (AUD). This research stopped in the late 1960s due to cultural and regulatory factors. In the 2000s interest rose again following double-blind, randomized clinical trials showing hallucinogen use giving short- and long-term positive changes in mood, life satisfaction, anxiety, depression, and substance use disorder.[1] Research expanded quickly, and studies now indicate that classic hallucinogens can have benefits in the treatment of depression, anxiety, OCD, acceptance of life-threatening disease, and tobacco or AUD.[2]

Hundreds of other trials are looking at these agents in a wide range of psychiatric and medical conditions. Ketamine is currently FDA approved for the treatment of treatment-resistant depression. MDMA has shown promise in PTSD, AUD, and Autism Spectrum Disorder. Currently, phase III trials are underway for MDMA treatment in PTSD, and Phase I and II trials are underway for Psilocybin and LSD treatment of depression and anxiety. Notably, treatment effects are shown to be as strong or stronger than current therapies and tend to be long term.[3]

Treatment protocols with hallucinogens usually consist of pre- and post-intervention sessions, bookending a monitored use of hallucinogen, most commonly with one to two treatment episodes. Pretreatment is focused on clarifying "set" (mind set) and "setting" (the environment that the event will occur in). The guided setting can be individual or group. The post-treatment is a therapeutic session(s) used to integrate the material from the event.

Based on the findings from new studies, the understanding of the mechanism of action (MOA) of these agents has moved from a simple 5-HT2A receptor agonist theory to something much more complex. Effects are now seen at multiple serotonergic receptors, on modulation of downstream signaling proteins, for dopaminergic and glutamatergic activity, and on immunomodulation and neurotrophic factors. Ketamine's MOA may be mTORC1 modulation rather than NMDA antagonism, and MDMA (an amphetamine derivative) may add oxytocin and vasopressin release to 5HT, NE, and dopamine effect.[3,4]

One of the compelling questions regarding the MOA of psychedelics is, "Would the outcomes be the same if the substance was given when unconscious?" In other words, is the experience itself (commonly reported to be "life changing") as important as the direct drug impacts? The subjective psychedelic experience is quite unique in the therapeutic world and the question of consciousness as a required part of the MOA is under study.[5]

Risk associated with long term exposure to hallucinogens has focused on the drug ayahuasca. Studies show ayahuasca users having lower levels of depression and confusion, and higher "agreeableness," openness, life quality and reduced lifetime AUD. Short term adverse events (AEs) for hallucinogens have been negligible in controlled settings, but in uncontrolled settings fear reactions can lead to disorganized and dangerous behaviors and emergence of latent psychiatric disorders. MDMA has a higher risk profile, with evidence for potential binge use and neurotoxicity, though there is conflicting data.[4]

In short, the research on psychedelics is rapidly evolving, with early outcomes indicating benefits for several psychiatric diseases (notably treatment-resistant ones), with surprisingly positive and long-lasting effects. This early work also implies that, in controlled settings, hallucinogens are relatively well tolerated with few AEs. It is an exciting time in the research and understanding of medical and psychiatric use of psychedelics; ongoing larger trials will help

...continued on next page

Executive Council Approved Cannabis Position

On January 30, 2022, the North Carolina Psychiatric Association Executive Council approved NCPA's Position on Cannabis. This position was crafted by a work group of the NCPA Addiction Psychiatry Committee in response to the frequency with which cannabis bills are being introduced to the North Carolina General Assembly, and out of concern for the medical rhetoric used in connection with cannabis products.

NCPA recognizes that its members hold a variety of viewpoints related to cannabis and cannabis use. We have been asked for our stance on the issue based on the latest research. NCPA staff are in the process of sharing this new policy with stakeholders and interest groups. A summary of a few key points can be found below; the complete NCPA Position on Cannabis can be read on the NCPA website at: www.ncpsychiatry.org/cannabis

- The North Carolina Psychiatric Association is in favor of decriminalization of cannabis.
- NCPA does not see evidence in the current literature supporting the use of cannabis to treat psychiatric illnesses, and, in fact, there is evidence cannabis will worsen some mental health disorders.
- NCPA is concerned the poor evidence for medicalization of cannabis may result in the increased incidence of associated cannabis use disorders in North Carolinians.
- NCPA strongly recommends safeguarding adolescents from greater availability of this substance.
- Any tax revenues generated by legalizing cannabis should be used in part for treatment, research, collection of population data, and to study public health impact and the impact on adolescent use initiation.

Member Notes

Harold Kudler, M.D., D.L.F.A.P.A. was appointed as Adjunct Professor of Psychiatry at the Uniformed Services University in Bethesda, Maryland.

To submit an item for Member Notes, please email the NCPA member's name and details to info@ncpsychiatry.org.

..."Psychedelics" continued from page 10

clarify the safest way forward to integrating these novel compounds into clinical treatment.

SCAN ME

For further reading and to view this article's references, scan the QR code using your smartphone's camera.

APA Announces Honorees

Congratulations to the following NCPA members who have achieved American Psychiatric Association's Distinguished Fellowship and Fellowship status! New honorees will be formally recognized at the APA Annual Meeting in May. Please note, honorees listed below may hold additional distinctions other than those most recently awarded.

Distinguished Fellow

Scott Klenzak, M.D.
Justin Schechter, M.D.

Fellow

Iverson Carter, M.D.
S. Therese Garrett, M.D., M.P.H.
Victoria Payne, M.D.
Alyssa Thompson, M.D.

Distinguished Fellowship is awarded to outstanding psychiatrists who have made significant contributions to the psychiatric profession in at least five of the following areas: administration, teaching, scientific and scholarly publications, volunteering in mental health and medical activities of social significance, community involvement, as well as for clinical excellence. Distinguished Fellow is the highest membership honor the APA bestows upon members.

Fellow status is an honor that reflects dedication to the work of the APA and signifies allegiance to the psychiatric profession.

Please let the NCPA Fellowship Committee know if you are interested in becoming a Distinguished Fellow or a Fellow by emailing info@ncpsychiatry.org.

What Psychiatrists Need to Know About... The No Surprises Act

The No Surprises Act, a new federal regulation, had provisions that went into effect January 1, 2022. The act is intended to provide financial protections to patients and reduce the likelihood that patients may receive a "surprise" medical bill by requiring providers to inform patients of an expected charge for a service before the service is provided.

This legislation focuses on emergency services and out-of-network providers at in-network facilities. However, there are sections that apply to ALL healthcare providers, and NCPA members should be aware of the provisions with which they will be expected to comply. The most significant change for psychiatrists providing care in the outpatient setting is a new requirement to provide a Good Faith Estimate (GFE). **Beginning January 1, 2022, under the No Surprises Act, uninsured patients and commercially insured patients who choose not to use their benefits are entitled to a Good Faith Estimate of charges from psychiatrists and other health care providers before scheduled services.**

The APA has submitted comments to Centers for Medicare & Medicaid Services regarding the regulations issued to implement the No Surprises Act and expressed concern that the law could have unintended results for both patients and providers. Here are some FAQs from the APA.

Q: Who am I required to provide a Good Faith Estimate to?

A: At the present time, the requirement for a Good Faith Estimate applies to these three categories of patients:

- Patients who do NOT have health insurance of any kind
- Patients who DO have health insurance that would pay for all or part of treatment, but who DECLINE to use their insurance for the cost of treatment.
- Patients who are shopping for care.

The Good Faith Estimate requirement is not currently being enforced for insured patients, but it is expected to eventually apply. Patients with Medicare or Medicaid insurance are not entitled to a Good Faith Estimate.

Q: What is expected of me if my patient has insurance, but I do not accept their insurance payment?

A: You will be expected to provide the patient with a Good Faith Estimate. This patient would be considered "self-pay" and, therefore, qualifies to receive a GFE starting January 1, 2022.

Q: When do I need to begin providing these estimates to my patients?

A: You should provide a Good Faith Estimate to all your current patients (uninsured, self-pay, or patients who are shopping for care) and new patients (uninsured, self-pay, or patients who are shopping for care) starting January 1, 2022.

The law also requires that these patients (in the three categories) receive a new notice every year or if your fees change.

Q: Is a Good Faith Estimate binding?

A: The information provided in the Good Faith Estimate is only an estimate, and a patient's final bill may differ from what is included in the good faith estimate. There is no penalty if you overestimate the costs. The American Psychiatric Association (APA) recommends that if in doubt, you should overestimate expected charges.

A new patient-provider dispute resolution process allows uninsured or self-pay patients to challenge any bill from a provider that exceeds by more than $400 the amount listed for the provider or facility in the GFE.

Q: What else do I need to know about the No Surprises Act?

A: Insurers will be held accountable to paying for care delivered by an out-of-network provider when the insurer's provider directory incorrectly included the practitioner as being in network. NCPA members may already be noticing that insurers are requesting professionals to update their practice demographic information more often. We suggest members document their updates to insurers.

The APA has provided a summary of the key requirements of the No Surprises Act on their website (https://bit.ly/36AJzGh), Good Faith Estimate templates, and a detailed list of what information is required in a Good Faith Estimate. If you have any questions or concerns, please contact us at info@ncpsychiatry.org.

...”Burnout” continued from page 9

we, as mental health providers, empower our patients and attempt to destigmatize mental illness in the general population, a culture of stigma and silence persists within our community of practitioners.

Considering all of this, what are possible “wellness” solutions? We propose three ideas here.

1. Destigmatize mental illness. As resident physicians, disclosing emotional distress to faculty and program leadership should not count against us. It is imperative that there exists a safe space within every residency program for residents to speak up when they are struggling, without judgment or fear of consequences, personal or professional. Though national bodies such as the ACGME and AMA ask residents annually about wellness through online surveys, these questionnaires can be burdensome and often do not directly lead to sustainable solutions.

2. Shift away from a “work horse” driven model to a work-life integration model. Many hospitals across the country have a resident-dependent care model. In contrast, imagine a residency program/curriculum that prioritizes resident education. It would consist of a robust workforce of attending physicians and faculty members. It would allow flexibility for residents to obtain varied clinical experiences, explore professional interests, engage in scholarly activities, and be invested in didactic education. It would allow time for doctors’ appointments and taking sick days. It would create a work-life integration that is key to maintaining wellness.

3. Provide necessary mental health and psychiatric services. It is crucial that residents have access to mental health care. With any residency, we would argue this is true. But with psychiatry residency, given the unique emotional weight of patient interactions and psychotherapy training, it is critical. Furthermore, for psychiatry residents, it is not enough that therapy be encouraged; rather, psychotherapy from a licensed professional should be incorporated within the program curriculum itself. Certain North Carolina psychiatry residency programs, such as Atrium Health in Charlotte, pay for their residents to receive psychotherapy for one year. Having residents be therapy patients themselves not only allows for improvements in one’s own mental health, but also expands emotional awareness and insight into the therapeutic process. Having it integrated into training removes the fear and anxiety that one will be viewed negatively for seeking help.

These are necessary steps to take. However, there also needs to be major changes far above the hospital level. We have been bred in this culture of work, work, work – go, go, go. To maintain a healthy mind and body, the culture needs to change – and physicians are demanding it.

For further reading and to view this article’s references, scan the QR code using your smartphone’s camera.

SCAN ME

...”PRTF’s” continued from page 8

emotional background to help patients.

- Promote line staff interactions (instead of just watching and recording) with patients in the form of DBT-S type social skills groups. I recommend Marsha Linehan’s DBT Skills Training Manual, Second Edition. This manual and workbook is structured into four groups of mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance skills.
- Promote other evidenced based treatments in PTRFs and group homes, instead of coercive, group consequence and made up abusive ‘treatments.’
- Watch video clips of restraints and seclusions of all patients who undergo these procedures.
- Support the involvement of families in the care of their children in PTRFs, Guardian ad litem, and social workers.

For further reading and to view this article’s references, scan the QR code using your smartphone’s camera.

SCAN ME

Starting Your Own Practice

Jillianne Grayson, M.D.

Starting your own practice is a daunting but exciting task. There are many benefits and drawbacks. Right out of Fellowship, I knew I wanted to start my own practice. Psychiatry, unlike other medical specialties, has very little overhead, which made opening a private practice a viable option.

One of the great advantages of having your own practice is that you can customize the patient's experience. For example, I personally prefer a long intake (2-3 hours). Having your own practice allows you to break the intake into several visits for those patients who cannot tolerate a long intake (ADHD patients come to mind). There is also a sense of freedom and autonomy to choose the hours you prefer working and when you can go on vacation.

With the freedom and autonomy come some drawbacks. There is a additional personal responsibility without partners to cover for you while on vacation or away from the office for personal reasons. This means that, unless you find another provider to cover you during these times, you need to be on call, checking messages, and consistently getting back to patients in a timely manner.

You also must have a sense of and an interest in the business aspects of private practice. I did not have these skills when starting my practice, so I started by Googling and talking to mentors. I was disappointed by how few resources there were, so I developed my own checklist. Below are the six steps I went through to establish my business. There are no conflicts of interest, and I am not affiliated with any of the businesses listed below. These are my personal opinions.

1. Finding Office Space

Office space should be one of the first things you find. You need a business address for almost everything else on this list. You can consider subletting office space with other providers. Some psychiatrists start this way and work part time, covering a variety of ER/CL shifts while their practice is growing. I started this way but within a month, as my practice grew, I quickly realized I needed my own space.

There is much to consider: commute, ideal location for patients, accessibility to public transportation, ease of parking, aesthetics of the waiting room and your office, and privacy for patients.

2. Business Basics

Your practice name, corporate structure, tax number, bank accounts, and whether to hire an accountant should be your next focus.

- Consider what type of corporate structure you want (PLLC, S corporation, C corporation); there are various tax benefits and drawbacks to each, and lot of information regarding this subject can be found online.
- In North Carolina, register first with the NC Medical Board as a PLLC and then with the Secretary of State.
- Register with the federal government to obtain an EIN number, tax identification number or employer identification number.
- Get a business bank account and credit card to track expenses, ideally as soon as possible.
- Consider hiring an accountant. I use QuickBooks™ and I hired an accountant who can help me produce profit/loss statements and file my taxes.

3. Insurance and Billing

One of the biggest decisions you will need to make is whether you are going to take insurance or be an out of network provider. I personally decided to be an out of network provider, mainly to have more freedom in how I practice, and worry less about billing and coding. If you chose to have a strictly direct pay practice, be sure to opt out of Medicare. As an out of network provider, you can either submit claims for patients who have insurance or provide them superbills that allow them to submit claims on their own. I provide superbills and have partnered with an app called Reimbursify™, which helps patients submit out of network claims.

If you choose to accept insurance, there is no requirement to take all insurances. If you decide to apply to a panel, it can take months to be empaneled depending on the insurance company. You must complete questionnaires, verify your licenses, insurance, and hospital privileges; and review and sign a contract that contains their reimbursement rates. While it may seem like insurance companies have all the power, it is important to note that there is some room to negotiate fees and referral circumstances as many insurance companies need psychiatrists on their panels to ensure they have network adequacy.

Writing clear policies on payment is something that you need do ahead of time. Be sure to have a no-show policy. Because your billing is time-based, if a patient does not show, you do not get paid. Patients are less likely to no show if your policy states they will be charged for

...continued on next page

...”Practice” continued from previous page
the visit. Determine whether you are going to charge for administrative tasks outside of appointment times. Some providers bill for this in 15-minute increments. I opted to build administrative costs into my regular fee schedule. (Editor’s Note: please see page 12 for more information on the No Surprises Act)

Billing is one of the hardest parts of owning my own practice. As physicians, it is in our nature to help people, and asking for and collecting money is very unnatural to me. As an out of network provider, I had to practice stating my fees out loud before I was able to say them to patients. Some providers who take insurance opt for an administrative assistant to help them file claims.

4. Marketing

Part of marketing will be through your website, business cards, and networking with other professionals in the area. Your website is how patients will find you. Get it up and running as soon as possible. There are several hosting services that help you develop a website; I went with Google™. Patients want to see who you are. I have received lots of positive feedback from patients about the pictures on my website and how they felt more comfortable coming to the first session because of them. Business cards are a must, but many people also have QR codes. I opted to have a business card with a QR code, from hihello™, that links to my iPhone’s contact card (iPhone’s version of a business card that can be shared across platforms).

Don’t forget to update your member profile with NCPA! NCPA’s website has a “Find A Doctor” feature for the public to locate psychiatrists near them who are accepting referrals. Be sure to add your board certifications, areas of practices, and click the box that says you are accepting referrals. There is even a place for you to add your website or upload a photograph. A number of potential patients call the NCPA office every week trying to find a psychiatrist and even more use the website.

5. Malpractice and General Liability Insurance

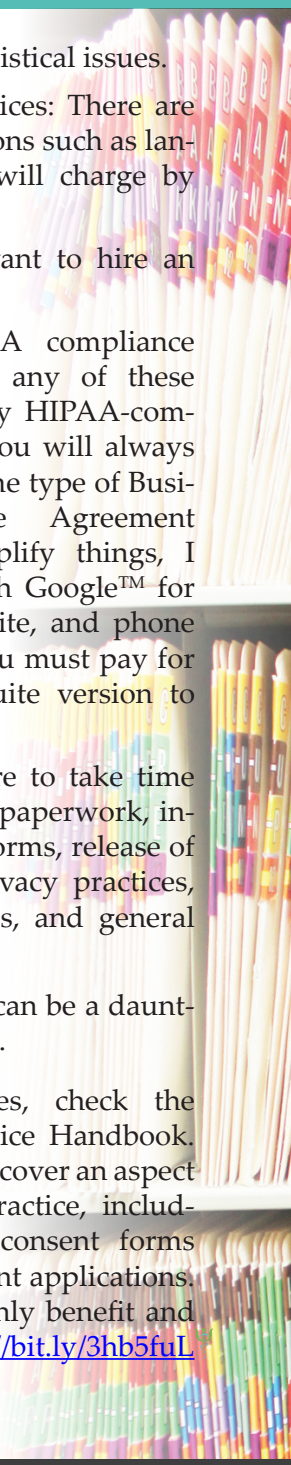
If you have a physical location for your practice, you will need general liability insurance. Of course, don’t open your practice without malpractice insurance. There are two categories to choose from: claims-made and occurrence policies. Claims-made policies are cheaper, particularly at first, because they only cover issues while the policy is in place. You typically need to purchase a tail policy if/when you cancel your policy. An occurrence policy is more expensive upfront because it covers the time in question even after the policy has terminated so you do not need to purchase tail insurance. Many professional associations such as APA and AACAP work with insurance companies to provide discounts.

6. Other matters to consider:

- Phone: Many people choose to get a separate office phone or even an office cell phone. I found it was easier to get an internet-based phone number. There are many phone options, including some that are HIPAA compliant such as iplum™.
- Fax: I think Doximity™ is the best option: it is free, HIPAA-secure, and can be received on an app on your phone.
- Email: Note that Gmail™ email is not end-to-end encrypted, so using it alone it is not HIPAA compliant. However, there are add-ons that make it compliant. I utilize a patient portal for all health-related topics and only use email for logistical issues.
- Translation services: There are a variety of options such as languageline that will charge by the minute.
- Whether you want to hire an administrator
- Consider HIPAA compliance when selecting any of these services. For any HIPAA-compliant service, you will always need to sign some type of Business Associate Agreement (BAA). To simplify things, I chose to go with Google™ for my email, website, and phone service. Note you must pay for the Google™ suite version to have a BAA.
- Lastly make sure to take time on your patient paperwork, including intake forms, release of information, privacy practices, payment policies, and general practice policies.

Opening a practice can be a daunting but exciting task.

For more resources, check the APA’s Online Practice Handbook. Each of the chapters cover an aspect of establishing a practice, including templates for consent forms and staff employment applications. This is a member-only benefit and can be found: https://bit.ly/3hb5fuL



REMEMBER TO DEDUCT YOUR DUES!

As you prepare your tax documents, remember that a portion of your dues are tax-deductible as a business expense. Likewise, if your employer covers the cost of your membership, the company is entitled to the tax-deduction.

NCPA 2021 Dues: You may deduct 94 %

APA 2021 Dues: You may deduct 93 %

The non-deductible amount represents the portion of dues that is used to pay for direct lobbying efforts.

NORTH CAROLINA
Psychiatric
Association

It's Time to Update Your NCPA Member Profile and Referral Info!

In the past year, have you: moved your home or office, started a new job, accepted new patients, transitioned to telemedicine, all the above?

Log into your NCPA member profile (www.ncpsychiatry.org/login) to update your contact info and enroll in our "Find a Doctor" search tool. Or, if you've previously enrolled but are no longer accepting new referrals, please log in to note that change!

If you need assistance, give us a call at 919-859-3370 or send us an email at info@ncpsychiatry.org.

Calendar of Events

April 6, 5:30 - 6:30 pm
Practice Transformation Committee

April 7, 6:00 - 7:00 pm
Race, Ethnicity and Equity Committee

April 21, 7:00 - 8:00 pm
Living Room Chat

April 30, 9:00 - 11:00 am
Executive Council

May 5, 6:00 - 7:00 pm
Race, Ethnicity and Equity Committee

May 12, 5:30 - 6:30 pm
Addictions Committee

May 19, 7:00 - 8:00 pm
Living Room Chat

May 21-25, 2022
APA Annual Meeting - New Orleans, LA