NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SEPTEMBER 2022

IN THIS ISSUE

NCPA Annual Meeting & Scientific Session

Sept. 29 - Oct. 2, 2022
Renaissance Hotel
Asheville, NC

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www.ncpsychiatry.org/annual-meeting

988 Goes Live!

Therese Garrett, M.D., F.A.P.A., Co-Chair, NCPA Disaster Committee; Behavioral Health Medical Director, WellCare Health Plans

Across the nation, states and crisis lines have been preparing for the launch of 988, a 3-digit crisis line to divert mental health related crisis calls from 911. 988 provides easier access to crisis care, as the 1-800 National Suicide hotline number was not easily available when needed. 988 officially went live on July 15, 2022. Various mental health advocates are applauding 988, while others are asking us to consider its limitations.

REAL Crisis Intervention, located in Greenville, has managed and provided National Suicide Prevention Lifeline services to North Carolina residents in all 100 counties since 2012. With the transition to 988, the crisis line will continue to be handled by REAL Crisis, though with much easier access. So far, utilization has been substantially up, with a 142% increase in calls on Saturday July 16th compared to the average of calls received from the four Saturdays prior to the 988 launch.

The increase so far is averaging about 100 extra calls daily, with 48% of callers self-identifiying as first-time users of a crisis line. This provides North Carolina with the opportunity to impact, and hopefully save, many more lives. The most notable increase is in callers ages 45-54, with a 94% increase in callers. The text/chat line function has shown its highest increase and utilization with residents ages 13-24. REAL Crisis also provides backup to the National Suicide Prevention Lifeline. Prior to the 988 launch, REAL took 1230 backup text/chat crisis contacts in June 2022. This number decreased in July to 786 (through July 24th). This reduction is believed to be mostly due to the launch of 988, in all states, providing more overall coverage and thus less backup is needed.

Despite this laudable initial increase in crisis contacts, there remains wariness about the potential for 988 in our state and nationwide. Patient rights groups have raised concerns about the possible responses available through the Lifeline. Some with lived experience have concerns about the potential for Lifeline contact to lead to police contact and/or involuntary hospitalization. Though 988 is currently less trackable than 911, the move towards adding in geolocation features has others concerned about anonymity of the crisis line, as well as fears about being tracked, or police being sent to their homes. Against the backdrop of our collective reckoning with over-policing of Black, Indigenous, and people of color (BIPOC) individuals, there are fears about whether increased connection to crisis lines may increase contact between BIPOC individuals and law enforcement, despite the intent of diversion away from the law enforcement system.

However, if 988 can do as it hopes and resolve many crises without additional law enforcement interventions, then we may be able to reduce unnecessary law enforcement interactions with those in distress. Outcomes evaluation will allow us to see the impact of 988 in connecting individuals to other non-crisis mental health and commu-

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Don't Weather the Storm Alone

Visit the NCPA Disaster Resource Center

www.ncpsychiatry.org/disaster-resource-center

As we near the end of hurricane season, NCPA's Disaster Committee reminds you that there are numerous resources at your fingertips.

NCPA's website has a Disaster Resource Center, created by the Disaster Committee. Psychiatrists provide valuable medical experience and expertise for preparing and responding to disasters and mass traumas.

These resources are designed to help you and your patients following a disaster, and are updated as needed.

Topics and Resources include:

- Helping children cope
- Mass trauma
- Packing an emergency kit
- Handling medical disruptions
- And more links to APA, Red Cross, and the National Child Traumatic Stress Network

Visit the NCPA Disaster Resource Center today: www.ncpsychiatry.org/disaster-resource-center

NORTH CAROLINA Psychiatric Association news

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President's Column

All Roads Lead to Asheville in 2022

Michael Zarzar, M.D., D.L.F.A.P.A., President

It is with great pleasure that we will be gathering for the first in-person Annual Meeting since 2019. The Annual Meeting is a time when we can learn, spend time with colleagues, and reconnect with friends we have not seen in some time. That is especially true this year. This year's Annual Meeting carries significance beyond the usual positive reasons to attend. It is a time when we are seeing increasing awareness for the integral role of psychiatry in health care as we experience increasing rates of psychiatric illnesses. The growing acceptance of evidence-based collaborative care by insurance carriers will improve the care of individuals seeking treatment and is a positive way to expand access to psychiatric care.

NCPA continues to strive to represent the needs of all members. This year's Annual Meeting provides a venue to address those needs. The topics will apply for those in private practice, community psychiatry, academic psychiatry, and administrative psychiatry. ***Dr. Mehul Mankad*** and the Annual Meeting Program Committee have pulled together an excellent group of speakers for the various sessions. We will have updates on treatment areas such as peripartum psychiatry, substance use disorders, non-substance use addictions, adult ADHD, collaborative care, and telepsychiatry.

This is also a time to share thoughts, ideas, and perspectives in a collegial atmosphere as we deal with the many issues happening in various realms (legislative, legal, policy) that impact health care. At this Annual Meeting there will be sessions addressing themes of leadership, diversity, equity, and policy. We are privileged to have Kody Kinsley, Secretary of the NC Department of Health and Human Services, discussing the Future of Behavioral Health and Resilience in North Carolina.

In the last newsletter, I discussed the theme of "Own Your Voice." This theme continues to be vital as NCPA engages our members in important conversations. This June we held a member forum to offer a safe place to react to the recent Supreme Court Dobbs case ruling. While acknowledging various personal beliefs on the topic, members present stressed the need for independence of health care decisions and focused on the role of psychiatrists to support our OB-GYN colleagues challenged by these changes, to advocate as needed, and to provide support to each other and to our patients who may be struggling in the context of the decision. And by the time you read this, NCPA will have hosted another gathering of our members in our virtual Living Room for a discussion about the impact of patient suicides. These opportunities to collectively voice our opinions and concerns are a valued role of our professional association.

I hope you will join us in Asheville so that we can continue these conversations in person and share your insights with me, our Executive Council, and each other.

As we gather this year, we are fortunate that the advances in the understanding and management of COVID have enabled us to be able to come together. In the context of this understanding there will be some differences in the meeting events as we are monitoring the COVID projections. The Business Meeting Luncheon will be in the Grand

Ballroom to allow greater spacing between members in attendance. The Saturday night event will be a spread-out reception-style gathering, rather than a sit-down dinner. We were hopeful the smaller meal gatherings, such as our Women's Breakfast and a planned Race Ethnicity & Equity event, would be able to occur. The limited space and close quarters that are available for such gatherings would increase the risk of exposing individuals. Therefore, we will not be able to provide for those events at the hotel.

Based on recent CDC guideline changes, masking will be optional, and attendees are asked to be personally responsible for their health and safety. Safety supplies such as masks, testing kits, and hand sanitizer will be made available to attendees. NCPA will continue to monitor transmission levels and follow CDC guidance. We will continue to follow our previous decisions that were outlined in the registration materials: that registered guests attest that they are up to date with their COVID-19 vaccines at least 14 days prior to the meeting

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

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

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

What impact would Measurement-Based Care have on the physician-patient relationship?

Dr. Brundage:

Assigning value to the physician-patient interaction by an external source would not be therapeutic. Value must grow from within the treatment relationship and from the patient. I suspect that most patients and physicians want to decrease cost of treatment and improve quality of life. If the physician and patient determine that measuring with a validated scale will be useful in the treatment, certainly that would strengthen the relationship.

However, assigning monetary value to patient improvement would introduce an untenable tension into the physician-patient interaction. When compensation is tied to improvement, we objectify our patients. Instead of working with them we would work on them for financial incentive. Tethering compensation to level of improvement or speed of improvement would turn the profession into a commercial enterprise.

Undeniably, physicians earn a living by treating patients and money is a part of the treatment relationship from the beginning. But this arrangement contains the financial exchange and psychological meanings of money entirely within the physician-patient dyad. We have a third party involved in financial dealings. Even in the best of times, money evokes ambivalence and conflict. Payers motivated by profit – and dare I say greed – further complicate the meaning of money in the physician-patient-payer relationship. How can an insurance company, driven by and under the influence of greed, work with psychiatrists on broadly implementing Measurement-Based Care (MBC) for the patient's benefit? We must have open, iterative, and honest conversations that address the complex relationship of measurement and money for all involved.

Dr. Bhalla:

Studies have shown that the therapeutic relationship is equally, if not more, important than other factors like the physician's credentials or preferred style of therapy. Payers should not interfere with the relationship between the doctor and patient. Ideally, the role of payers should be a means of allowing patients access to high quality mental health physicians.

Measurement-Based Care (MBC) can enhance the therapeutic relationship – patients can participate in shared decision-making, are more informed/knowledgeable, are attentive to changes in their symptoms over time, and become aware of warning signs for relapse. MBC can help patients see improvements early on and build trust in their physician. MBC can also improve disparities by improving communication between physicians and patients from disadvantaged backgrounds.

Payers and physicians share the goal of easing patient suffering. While the motives are different, the goal is the same, nonetheless. Payers need to limit cost-cutting initiatives that come across as belittling to the patient-physician relationship – particularly in mental health treatment where the goal is to increase access to services rather than limit them.

In a value-based framework – from a purely economic standpoint – rational primary care physicians should value mental health treatment because untreated mental health treatment is a missed opportunity to decrease high-cost utilization. Payers can help the referral system function seamlessly by arming primary care physicians with tools to practice integrated and collaborative care. These can include technology, reimbursement, and quality measurement.

Quality measurement – particularly outcome measurement - is important because we as a scientific profession need to be able to objectively tell when our patients are improving. The research we have on therapeutic interventions is based on MBC, yet only 10% of physicians

...continued on next page

You Can Bring Psychiatric Expertise to Primary Care

Art Kelley, M.D., D.L.F.A.P.A., NCPA News Editor

Stigma about seeking mental health care still exists. Many, many patients who need psychiatric care never receive it. Care, when it is received, is frequently inadequate, especially regarding pharmacologic treatment. Behavioral health concerns among the US population are increasing, particularly since the beginning of the COVID pandemic. Primary care is bearing the brunt of this increase and, Psychiatry does not have the workforce to see all the patients needing care.

Fortunately, the evidence-based practice known as the Collaborative Care Model (CoCM) offers a way to approach the issues noted above by bringing our psychiatric expertise to primary care. More than 80 random controlled studies have demonstrated the effectiveness of this model in integrating behavioral health care into primary care. This team-based model adds a psychiatric caseload consultant and a behavioral health care manager to the primary care team. It aims to increase the identification of adult depression and anxiety disorders through measurement-based care, thereby improving patient outcomes. More recent studies are beginning to show its utility in the treatment of adolescent depression and anxiety, substance use disorder, PTSD, and bipolar disorder. CoCM can also lower medical costs, particularly on the physical health side.

As with other evidence-based practices, the implementation and spread of CoCM has been difficult everywhere. But many members of NCPA have worked diligently to promote and implement this model in North Carolina. One major milestone came in 2018 when North Carolina Medicaid agreed to reimburse the CoCM codes, achieved in large part through the exceptional work of ***Jennie Byrne***, NCPA Past President, and our Executive Director, Robin Huffman.

Now we are on the threshold of another milestone: the launching of an initiative to implement the CoCM in a much broader way across North Carolina. Payers and the psychiatric, family medicine, and pediatric professional societies, with support from the state, are working to offer CoCM to primary care practices across North Carolina this fall. Very exciting news!

This initiative will not succeed unless NCPA members step up to serve as psychiatric consultants to the primary care practices that sign on. Many of us have been trained in the model and just need a refresher to get started. Right now, those who have been trained are the pool from which the consultants will be recruited. Do not be shy, alert

the NCPA office of your desire to serve. If you have not been trained but would like to serve, contact the NCPA office. There are ways to be trained. I use the word "serve" on purpose. This is an opportunity to bring your expertise in true service to your primary care colleagues and their patients with behavioral health disorders.

For further reading about the Collaborative Care Model scan the QR code using your smartphone's camera.

SCAN ME

..."Measurement Based Care" continued from previous page

report using measurement at all in clinical practice. This disconnect is bad for our field and can stifle research efforts and drug monitoring.

The physicians themselves don't necessarily need to test the outcome themselves. Some offices use clerical staff or technology platforms to gather the data. The health plans might be able to support this effort. But one way or another, measurement of outcomes is critical.

Promoting Mental Health Care Engagement: A Family-Level Cultural Approach

Mandeep Kaur, M.D., F.A.P.A., General, Child & Adolescent Psychiatrist, Cape Fear Valley Medical Center; Megan Blanton, MS, Graduate Student, Clinical and Counseling Psychology Ph.D Program, University of South Alabama; Ana-Maria Balta, D.O., General Psychiatry Resident, Department of Psychiatry and Behavioral Sciences, Eastern Virginia Medical School

Mental illness presentation and health-seeking behaviors are influenced by patient culture[1]. Often, within an identified ethnic, racial, or geographic cohort there are established cultural norms that the individuals share. Because of this, attempting to understand an individual patient by applying broad generalized knowledge about different cohorts can be ineffective. Adopting a family-level cultural formulation approach is very useful in promoting mental healthcare engagement as exemplified by the following clinical vignette.

A 14-year-old boy, K, immigrated to the U.S. with his parents two years prior to presentation because of a political insurgence in their home country. During the year prior to presentation, K's parents noticed that he became increasingly isolated, angry, and resistant to attending school. The school offered their usual supports, however, K's school attendance remained inadequate. Thus, referrals to Child Protective Services and subsequently to an outpatient adolescent psychiatry clinic were made. On psychiatric evaluation, K's symptoms included depressed mood, anhedonia, social withdrawal, irritability, anger outbursts, poor appetite, and poor sleep indicating diagnosis of Major Depressive Disorder. Posttraumatic stress from exposure to political instability and possibility of immigration trauma were ruled out. Marginalization, defined by low identification with the host culture along with one's culture of origin, was also explored[2]. However, based on K's relative ease with English acquisition, acceptable academic performance during the initial semesters, and reported circle of friends, marginalization was ruled out.

Despite medication trials, individual and family therapy, minimal improvement was noted. His parents had difficulty in applying the recommended behavior management techniques, e.g., use of contingency management plans. Medication adherence was also poor. After several sessions, his parents disclosed that K's mother had been diagnosed with cancer within the past year and was undergoing treatment. When asked about K's response to his mother's diagnosis, his parents revealed that they had not shared this with K. However, over the course of therapy, the clinician discerned that K had overheard his parents discussing this in their small apartment. The parents never discussed the mother's diagnosis with K since discoursing personal health issues with children remained taboo due to embarrassment in the family's culture.

After acquiring this information, clinicians concluded that the cultural norm of passive parenting, besides the additional stress of the mother's cancer diagnosis and treatment, were crucial reasons for his lack of progress. K's new treatment plan involved clinician facilitated intra-familial communication. K was enrolled in a day treatment program where he continued his education and received therapy. Gradually, improvement was noted in K's psychosocial functioning, correlating with the increased communication within the household.

Understanding both patient and provider culture is vital for effective outcomes

The above vignette may be a familiar experience to clinicians who work with culturally diverse patients: assessment targeted at identifying symptom onset, intervention designed to alleviate identified symptoms, confusion when it does not work, and eventual discovery of important missed cultural factors.

One way to ensure that clinicians are not missing data during intake and then filling in the gaps with their own culturally based assumptions is to utilize person-centered assessment using a structured interview such as DSM-5 cultural formulation interview (CFI). Composed of 16 open-ended questions this assessment can be administered in about 20 minutes by a trained clinician[3]. The CFI includes questions such as, "What do you think are the causes of your [PROBLEM]?" and "Are there aspects of your background or identity that make a difference to your [PROBLEM]?" Such questions would have provided K with opportunities to disclose that he had overheard his parents discussing his mother's diagnosis and revealed the communication dynamics in the family. Administering these questions to K's parents would have given clues that contin-

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Dr. Tharwani has over 27 years of psychiatry experience and specializes in Clinical Depression, Bipolar Disorder, Panic Disorder, Anxiety Disorder, Psychopharmacology, and psychotherapy.

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Member Notes

Ish P. Bhalla, M.D., M.S. and ***Nora Dennis, M.D., M.S.P.H.*** were published in Psychiatric Services 73:6, June 2022. Their article is entitled, *You Get What You Pay for: The Case for Value-Based Payments in Psychiatry*.

The following bio lines were inadvertently admitted from the June 2022 edition of NCPA News. Thank you to these writers for their contributions to the newsletter!

Zebra, Horse, or Zorse of Sorts? A Psychiatric Approach to Long COVID
Luciana Giambarberi, M.D.
Assistant Professor, Psychiatry and Behavioral Medicine
Assistant Professor, Neurology
Atrium Health Wake Forest Baptist Medical Center

"Could you please see this patient? He only speaks Spanish."
Xiomara Nieves-Alvarado, M.D.
PGY-3, Duke University Medical Center

Our Patients Who Commit Suicide: How Are We Handling It? How Are You Handling It?
Gerald Plovsky, M.D., D.L.F.A.P.A
Adult and Geriatric Psychiatry
Triad Psychiatric & Counseling Center

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

2022 Incoming APA/APAF Fellows

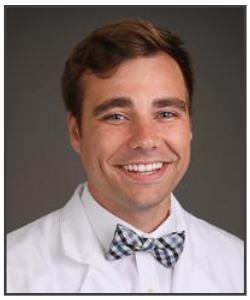
The APA offers eight unique Fellowship opportunities to psychiatry residents. Through these fellowships, residents are given opportunities for experiential learning, training, and professional development that will help them become leaders in the field of psychiatry. In addition, APA/APAF Fellows get exclusive opportunities to be a part of APA leadership councils and network with APA members from around the country. Nearly 100 fellowship positions are awarded each year. NCPA is proud to recognize the seven residents-fellows members awarded APA/APAF Fellowships this year.

Laila Hussain, D.O.
Diversity Leadership Fellowship
PGY-3, Campbell University - Cape Fear Valley Medical Center

Reginald Johnson, M.D.
Diversity Leadership Fellowship
PGY-2, University of North Carolina, Chapel Hill

Anthony Kulukulualani, M.D.
SAMHSA Minority Fellowship
Child and Adolescent Psychiatry Fellowship, University of North Carolina, Chapel Hill

Enioluwafe Ojo, M.D., M.P.H.
Diversity Leadership Fellowship
PGY-2, University of North Carolina, Chapel Hill



Gregg Robbins-Welty, M.D., M.S.
Leadership Fellowship
PGY-4, Duke University Medical Center

Andrew Tuck, M.D.
Correctional Public Psychiatry Fellowship
PGY-4,Duke University Medical Center

Rick Wolthusen, M.D., M.P.P.
Public Psychiatry Fellowship
PGY-3, Duke University Medical Center

Status Change: From Resident to Attending

Abraham Bombeck, M.D., Attending Psychiatrist, Cherokee Indian Hospital

Following my recent graduation from MAHEC's Psychiatry Residency Program in Asheville, NC, I am three weeks into my first position as an attending psychiatrist at Cherokee Indian Hospital. During the course of residency my curiosity steadily grew about the process of transitioning from a resident to an attending psychiatrist. Conversation with fellow residents revealed they had similar thoughts. I hope to answer some of the questions that arose in these conversations, in so far as they were answered by my experiences over the last year.

After loading up mountains of student loan debt in medical school, it was a relief when early into my 4th year of residency, I began to receive email from physician recruiters. Here at last was growing evidence that I had a skill set which was in demand and which suggested I would likely get a job post-residency. Supervisors were also starting to have discussions with me about positions within their departments, while gauging my level of interest regarding working with them following graduation. With several potential job options available, I narrowed the field down using a recommendation of a mentor who suggested I consider three primary factors - the job itself, location, and compensation.

Initially I planned to take a job at the hospital where I had done the majority of my inpatient training. A series of administrative changes then occurred at the hospital as it transitioned from a non-profit entity to a for-profit corporation. This led to significant alterations in the psychiatry department that made it unclear how things would look going forward. Through much of this uncertain period I still intended to take a position at this particular hospital. My situation changed after receiving a call from the behavioral health medical director at Cherokee Indian Hospital. He shared about their department's growth and invited me to do a site visit to see their new facility and to meet staff. Additionally, he encouraged me to consider a position with their organization. Based on the positive experience I had working with Cherokee Indian patients during a second-year rotation, as well as the variety of work settings the job would offer (inpatient, outpatient, and OTP), I knew it would be a good fit.

A salary was negotiated, and I took this information to a consultant who specializes in assessing salaries, benefit packages, pensions, and loan repayment opportunities for physicians. His rates struck me as exorbitant at the time, but he ended up making suggestions that led to savings that far surpassed his fee. The information he provided indicated that the jobs I was considering would have essentially the same level of compensation once all of their financial aspects were considered. Despite the long commute from Asheville, the position at Cherokee would fit in well with my family's schedule. Given this factor, the job's variety, and the opportunity to work with a rural patient population, I accepted the position.

I took two weeks off following residency and found the break adequate, though I know others who took anywhere from one to four months off before starting jobs. My first few weeks as an attending have felt similar in many ways to starting a new rotation during the fourth year of residency. I feel confident in my clinical decision making. The greater challenge is figuring out work flows and getting to know treatment team and staff members. Most importantly, I am getting to know my patients, which remains my ultimate source of meaning in this profession.

Editor's note: *Practice Management: The Basics* is an online resource for APA members, which includes a section on Starting Out. Scan the QR code using your smartphone's camera.

SCAN ME

..."President's Column" continued from cover

unless there is a qualifying medical or religious reason. Unvaccinated attendees will attest to a negative COVID test within 72 hours of admittance to the Annual Meeting. As the event nears, we will provide further guidance to attendees.

The Annual Meeting will provide the opportunity to gain insight into the ways in which we can support positive progressive change for the future of psychiatry in our state. The way psychiatric care is delivered is rapidly changing. Since NCPA last gathered in-person, we have seen advances in telepsychiatry and the expansion of Collaborative Care, to name just two changes. These advances require that we continue to advocate for true, full parity of coverage of psychiatric conditions. We are traveling down new roads and those roads lead us first to Asheville. See you there!

What Psychiatrists Need to Know About... Contracting with Tailored Plans

North Carolina will launch the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan December 1, 2022, as part of the General Assembly mandated move from a predominantly fee-for-service delivery system to managed care.

NC Medicaid will transition approximately 150,000 beneficiaries who need services for a severe mental health disorder, severe substance use disorder, intellectual/developmental disabilities (I/DD) or traumatic brain injury (TBI) to coverage provided by regional Behavioral Health and I/DD Tailored Plans (Tailored Plans). This move is part of the state's embrace of whole-person, integrated care and is designed to ensure that physical health needs of patients with serious illness are addressed. Through the RFP process, all the existing Local Management Entity/Managed Care Organizations (LME/MCOs) were approved to become Tailored Plans—Alliance, Eastpointe, Partners, Sandhills Center, Trillium and Vaya. There is also an Eastern Band of Cherokee Indians (EBCI) Tribal Option for primary care case management.

Tailored Plans offer a comprehensive benefit package, including physical health, pharmacy, behavioral health, IDD/TBI, and long-term services and supports (LTSS) services.

Beneficiaries enrolled in Tailored Plans may choose or will be assigned to a primary care provider (PCP) and a Tailored Care Management (TCM) provider. TCM is a fully integrated, longitudinal care management service available to all Tailored Plan beneficiaries. TCM providers, including certified Advanced Medical Home Plus (AMH+) and certified Care Management Agencies (CMAs), will develop a comprehensive care plan for all TCM participants and will coordinate all physical and behavioral health, substance use services, home and community-based services and other supports. This service adds a layer of additional health supports for those who may have not been receiving adequate physical health care.

Psychiatrists will serve critical functions in Tailored Plan networks, including providing the highest level of psychiatric care for Tailored Plan beneficiaries with severe mental health conditions and substance use disorders, as well as those with I/DD and TBI diagnoses. Psychiatrists will provide senior clinical oversight and consultation for TCM providers, participate in TCM care teams, advance population health, provide psychiatric consultation in integrated care settings, and participate in the development of Tailored Plan clinical practice guidelines. Access to psychiatric care is essential for Tailored Plan members to live their lives in fully integrated settings that promote their overall wellbeing.

Your primary care colleagues may not be accustomed to participating in Medicaid plans for the behavioral health population, but they will play an important role providing critical medical homes for Tailored Plan beneficiaries who often experience a complex combination of behavioral and physical health conditions. NC Medicaid is encouraging all primary care providers to participate in the Tailored Plan provider networks. Tailored Plans have the option to contract directly with primary care providers or to partner with a Standard Plan to contract with primary care providers.

Find Tailored Plan contact information using the QR Code to the right. It is important to contract with multiple, if not all, networks who serve beneficiaries in your community so that existing patients and their families can remain in network.

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Find more contracting information and a map of Tailored Plan catchment areas using this QR Code.

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Key Tailored Plan Dates

Aug. 15, 2022 – Beneficiary Choice Period begins. Enrollment Broker begins mailing Enrollment Packets to beneficiaries, and beneficiaries can choose a PCP and Tailored Care Management provider by contacting their Tailored Plan.

Sept. 15, 2022 – Last day for PCPs to have fully executed contracts with Prepaid Health Plans (PHP) for inclusion in PCP Auto-Assignment.

Oct. 14, 2022 – Last day for beneficiaries to choose a PCP and Tailored Care Management provider before auto-assignment.

Post Oct. 14, 2022 – PCP and Tailored Care Management Provider Auto-Assignment for beneficiaries who have not chosen a PCP or Tailored Care Management provider.

Dec. 1, 2022 – Behavioral Health I/DD Tailored Plans launch.

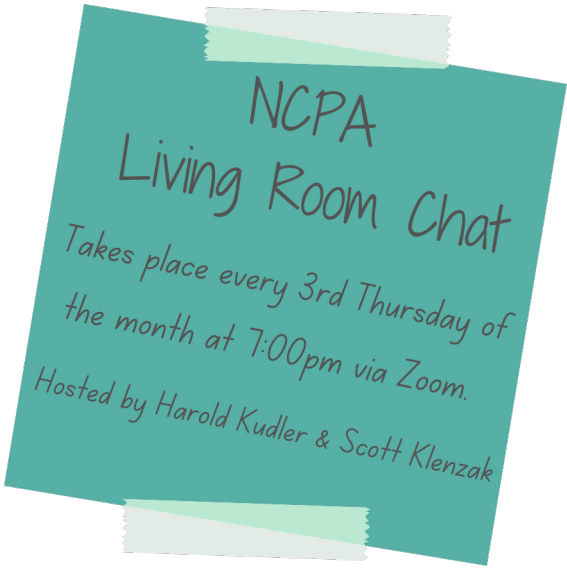
Terms and Definitions

Advanced Medical Home Plus (AMH+): Deliver both primary care services and tailored care management services.

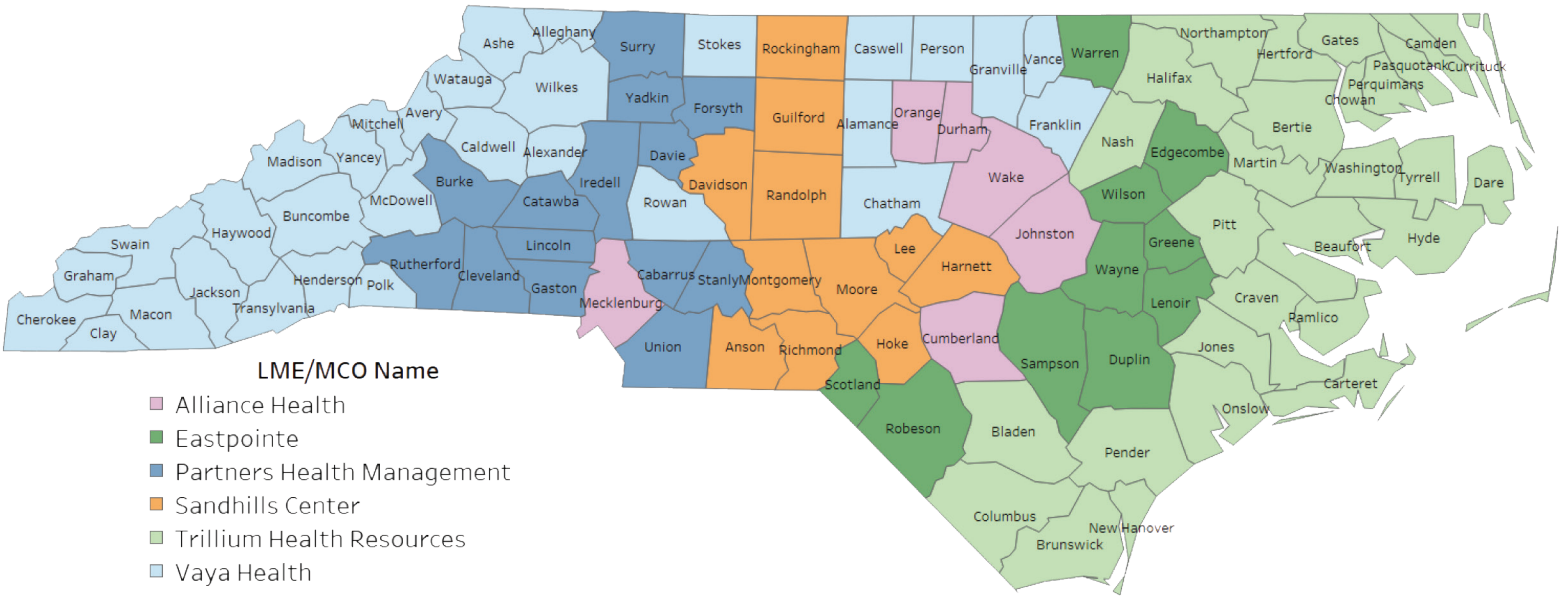
Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan (Tailored Plan): An integrated health plan for individuals with significant behavioral health needs and I/DDs.

Care Management Agencies (CMAs): Deliver behavioral health, substance use, intellectual and developmental disability, and/or traumatic brain injury services and tailored care management services.

Tailored Care Management (TCM): Fully integrated, longitudinal care management services for beneficiaries enrolled in Tailored Plans. Tailored Care Managers must provide a comprehensive care management assessment and develop a person-centered care plan or individual support plan which coordinates all physical health, mental health, substance use disorder, home and community-based services and supports, and pharmacy services. TCM can be provided by an AMH+, a CMA, or directly by qualified Tailored Plan staff.



Regional Behavioral Health and Intellectual/Developmental Disability Tailored Plans - Projected County Alignments at Tailored Plan Launch for December 1, 2022



...”988” continued from cover

nity supports. No matter the size of the impact, we do need to continue to advocate for further investment. Improvements are needed in simplification and ease of access to crisis services, while increasing opportunities for outpatient, community based, and natural supports where we live and work.

Other concerns come from professionals uncertain as to whether the safeguards that 988 have which are currently less than 911, will be adequate to protect those who are at imminent risk. Currently, calls are routed based on caller area code, rather than on the actual location of the caller. Thus, for someone who has kept an out of state area code, while living in NC, their call could be routed to an out of state location. A crisis call clinician answering their call may not have the best information for any local North Carolina resources. Additionally, infrastructure is not currently in place to provide geolocation of calls. Thus, if someone calls in acute crisis, standing on top of a building or with a gun in hand, and hangs up, there is no easy way to track them down, in contrast with 911. The nuance of explaining to our patients when to call 988 vs 911 requires that psychiatrists understand the pros and cons of the various ways to access crisis and emergency services.

Despite any limitations, the 988 rollout is a significant step forward for putting mental health further in the public eye and for reducing barriers to access to crisis supports. North Carolina, in addition to supporting the implementation of 988 with a $3.3 million grant from SAMHSA, has legislated the inclusion of $1.3 million into the annual state budget for long term support of the 988 crisis line. 988 is an exciting new addition to the resources available in North Carolina, and we look forward to seeing its successes!

*Statistics on recent 988 usage from Disaster Response Network 988 report on 7/24/22 and state 988 workgroups on 7/26/22.

...”Cultural Approach” continued from page 6

gency management plans were not a good fit for this family (e.g., K’s mother was exhausted from cancer treatment) or cultural practices (e.g., K’s parents traditionally did not assume an assertive parenting role).

In addition to considering the role that patient culture plays in mental health care engagement, it is equally important to consider the role that clinicians’ cultural beliefs play. This ability to critique one’s beliefs and examine one’s cultural identities is a practice referred to as “cultural humility” by the National Institutes of Health. Failure to practice cultural humility can cause clinicians to unconsciously treat patients differently based on race or other cultural factors in a phenomenon known as implicit bias[4]. A nationally representative study reported that Hispanics, Blacks, and Asians are significantly more likely than Whites to feel that their doctors look down on them and the way of their living[5]. Therefore, current cross-cultural education is moving beyond traditional cultural sensitivity and multiculturalism training and aims to build cultural humility among healthcare professionals.

Increasing healthcare system capacity for cultural humility

Cross-cultural education efforts such as training in assessment protocols such as the DSM-5 CFI[3], the Cultural Formulation assignment model[6], and curricula involving cultural humility-focused participatory learning activities[7] are emerging strategies that promote effective cross-cultural care. Additionally, utilizing cultural humility focused participatory learning activities among medical residents (including home visits) has been found to increase attentiveness to their patients’ perspectives and social context[8]. Even an hour of training on the CFI has been shown to significantly improve psychiatric residents’ self-reported cultural competence3. Finally, studies have shown that providing spiritually integrated care is beneficial[9]. Therapists may suggest seeking out communication with patients’ religious leaders to promote communication and trust in the treatment process.

Broadly, tailored approaches to increasing healthcare engagement and promoting intra-familial communication is vital. Healthcare providers need to become informed of their patients’ family values, establish trust to promote open discourse, and provide educational material in their native language. With these approaches, healthcare professionals can increase patient engagement and lessen the cultural and ethnic disparities in health-seeking.

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

SCAN ME

NC PSYCHIATRIC ASSOCIATION
ANNUAL MEETING
RENAISSANCE ASHEVILLE HOTEL
SEPT 29 - OCT 2, 2022
13.5 AMA PRA CATEGORY 1 CREDITS™

FIVE REASONS TO ATTEND THE NCPA ANNUAL MEETING

It is not too late to reserve your seat for the NCPA Annual Meeting, taking place September 29 - October 2, 2022 at the Renaissance Asheville Hotel. Below are five reasons to attend the NCPA Annual Meeting this year:

1. Time with colleagues, IN-PERSON! This will be our first in-person meeting since 2019, and we are thrilled by the opportunity to gather with colleagues! This is your chance to share photos of your kids and grandkids, network for that next job opportunity, swap business cards (better get some printed!), remember how short/tall your fellow members are, discover new services and products in our Exhibitor Hall, and clink a glass with former classmates. There is perhaps nothing sweeter than that feeling of being together after so much time apart. We hope you can join us!

2. Receive Continuing Education Credits! This live activity has been designated by the APA for a maximum of *13.5 AMA PRA Category 1 Credit*™ and will feature nationally known speakers, outstanding plenary sessions, workshops on timely topics in psychiatry, and engaging panel discussions. Better than a weekend with 13.5 hours of Netflix! Topics for the Scientific Sessions include Social Determinants of Health, Medical Leadership, Approaches to Telehealth, Adult ADHD, Adolescent Substance Use, Peripartum Psychiatry, and more.

3. Experience NCPA's first-ever live-streamed presentations! Taking the best of what we have learned from the last two years of digital presentations, the 2022 Annual Meeting will include two lectures with live question and answer sessions with west coast psychiatrists, Dr. Jürgen Unüzter and Dr. Tim Fong. This is an incredible opportunity to learn from leaders in the collaborative care model (Unützer) and non-substance addictions (Fong). NCPA is pleased to utilize a virtual platform to provide affordable and accessible continuing education credits.

4. Connect with psychiatric residents who are impacting the field of psychiatry. Did you know there are now eight psychiatric residency programs across North Carolina? Do you know what those residents are researching, practicing, learning, and treating? The Resident Poster Session will be held Saturday evening during the Annual Meeting and is an opportunity to showcase the many aspects of residency training and the important care that these psychiatric trainees are doing not just in the future, but NOW.

5. Hear from a top state official! The Annual Meeting opens with a keynote presentation from Kody H. Kinsley, Secretary of the NC Department of Health & Human Services, appointed to the cabinet position by Governor Roy Cooper. Secretary Kinsley's presentation is entitled, *The Future of Behavioral Health and Resilience in North Carolina*. Secretary Kinsley was sworn into office in January and has identified behavioral health and resilience as a priority area of focus. He led operations for a behavioral health care service provider early in his career in western NC and worked at a high level in the federal government before moving back to his home state to take a leadership role in the Division of MH/IDD/SUD. We are eager to hear from this state leader with such broad experience and responsibility in behavioral health.

To learn more about the meeting, view the speaker line up, or register visit www.ncpsychiatry.org/annual-meeting or scan the QR code using your smartphone's camera. Register before September 19 to receive general registration rates; after that date, walk-in registration will apply.

SCAN ME

In the coming weeks, NCPA staff will be sending registered attendees information on how to access electronic handouts, invitations to special events, safety information, and more. In the meantime, if you have any questions, please call 919-859-3370 or email info@ncpsychiatry.org. See you in Asheville!

Accreditation and Designation Statement This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Psychiatric Association (APA) and the North Carolina Psychiatric Association. The APA is accredited by the ACCME to provide continuing medical education for physicians.

The APA designates this live activity for a maximum of *13.5 AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

SCIENTIFIC AND SOCIAL SCHEDULE

THURSDAY, SEPTEMBER 29

2:00pm - 6:00pm	Registration Opens
2:00pm - 5:00pm	NCPA Executive Council Meeting
5:30pm - 7:00pm	Welcome Reception

FRIDAY, SEPTEMBER 30

7:45 am - 8:00am	Welcome Remarks Michael Zarzar, MD, NCPA President
8:00am - 9:00am	***The Future of Behavioral Health and Resilience in NC*** Secretary Kody Kinsley
9:00am - 10:00am	***Thinking Beyond the Biomedical - How Structural and Social Determinants Impact Substance Use*** Amanda Latimore, PhD
10:30am - 11:30am	***Leading to Uplift: Through COVID-19 and Beyond*** Julie Freischlag, MD, F.A.C.S., F.R.C.S.E.d(Hon), D.F.S.V.S.
11:30am - 12:30pm	***Improving Population Health Through Integrated Behavioral Health Care*** Jürgen Unützer, MD, MPH, MA
12:45pm - 2:15pm	NCPA Business Meeting
2:30pm - 4:30pm	***Inpatient, Outpatient, & Consultation Approaches to Telehealth*** Elise Herman, MD; Diego Garza, MD; Nate Sowa, MD, PhD.; Nathan Copeland, MD, MPH
4:30pm - 5:45pm	Sponsored Dinner, Hosted by Neurocrine Medical Affairs
5:45pm - 6:45pm	NCPA Networking Reception Sponsored by HopeWay
6:30pm - 8:00pm	NCCCAP Reception

SATURDAY, OCTOBER 1

7:00am - 7:55 am	NCCCAP Business Meeting
8:00am - 9:00am	**CONCURRENT TRACKS**
General Track:	***Modern Approaches to the Treatment of Adult ADHD*** Mina Boazak, MD, MMCi
Child Track:	***Supporting Whole Child Health in NC: Priority Behavioral Health Initiatives*** Charlene Wong, MD
9:00am - 10:00am	**CONCURRENT TRACKS**
General Track:	***Psychiatrists as Medical Directors: Calling or Capitulation?*** Mehul Mankad, MD
Child Track:	***The Structural, Social, and Intergenerational Determinants of Youth Substance Use*** Amanda Latimore, PhD
10:30am - 11:30am	**CONCURRENT TRACKS**
General Track:	***Peripartum Psychiatry: Supporting Family Mental Health During a Critical Time of Development*** Mary Claire Kimmel, MD
Child Track:	***Co-occurring Psychiatric and Substance Use Disorders in Adolescents and Young Adults*** Amy Yule, MD
11:30am - 12:30pm	**CONCURRENT TRACKS**
General Track:	***Gambling Disorder and Nonsubstance Addictions*** Tim Fong, MD
Child Track:	***Culturally and Developmentally Responsive Approaches to Pediatric Substance Use*** Lucien Gonzalez, MD, MS, FAAP
5:00pm - 6:15pm	Resident Poster Session Reception Sponsored by MindPath
6:15pm - 8:00pm	Dinner Party

SUNDAY, OCTOBER 2

8:00am - 9:00am	***Cognitive Retraining in Schizophrenia*** Sophia Vinogradov, MD
9:00am - 10:00am	***Racial Inequities in Physical and Chemical Restraint Use in Emergency Psychiatry*** Jane Gagliardi, MD, MHS and Colin Smith, MD, MScGH
10:30am - 12:00pm	***Top 10 Treatment Updates from the Past Year*** Chris Aiken, MD
12:00pm - 12:05pm	Closing Remarks

This schedule is subject to change at any time leading up to the conference.

NORTH CAROLINA
Psychiatric
Association

Calendar of Events

September 29, 2022
NCPA Executive Council Meeting
Renaissance Hotel, Asheville

September 29-October 2, 2022
NCPA Annual Meeting & Scientific Session
Renaissance Hotel, Asheville
www.ncpsychiatry.org/annual-meeting

Walk-In Registration Rates Begin Sept. 19!

NCPA Living Room Chat
3rd Thursday of Every Month
7:00-8:00pm
via Zoom

It's Time to Update Your NCPA Member Profile & 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.

Advertise with NCPA

Whether you're seeking a new position or recruiting for new employees, NCPA has an advertising solution for you! Visit www.ncpsychiatry.org to see our current postings and rate information; NCPA members are eligible for special advertising discounts.