NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

DECEMBER 2016

Karen Tam / NC Health News

IN THIS ISSUE

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Hurricane Matthew - A Study in Disaster

Allan Chrisman, M.D., D.L.F.A.P.A. Chair NCPA Disaster Committee

Editor's Note: Just weeks after he returned from providing disaster psychiatry relief work in the flooded city of Baton Rouge, Louisiana, NCPA Disaster Committee Chair *Allan Chrisman* put this experience to work here in North Carolina. Hurricane Matthew, which originated as a named tropical storm on September 28, bulldozed its way across the Western Atlantic before becoming the first Category 5 Atlantic hurricane since 2007. Here is Dr. Chrisman's account of the chronology of a disaster and how our state and your association came together to respond.

On October 3, the governors of Florida and North Carolina declared a state of emergency. The next day, South Carolina Governor Nikki Haley recommended an evacuation for those residents living within one hundred miles of the coast. Interstate 26 in South Carolina eastbound between the coast and Columbia was reversed on Wednesday to facilitate movement away from the Lowcountry and Charleston areas. Evacuations of Cape Lookout National Seashore in North Carolina began this day as well. By October 4, North Carolina Governor Pat McCrory had ordered that evacuation be mandatory.

As the hurricane approached under the declared state emergency, citizens in the Outer Banks were evacuated, UNC Wilmington closed its campus, and local counties prepared for the impact of high tides, high winds and storm surge of four feet. However, just before coming to North Carolina as a tropical storm, Matthew turned outward to sea, giving the appearance of missing its major impact. Despite this favorable development, heavy rains of six inches per hour in a band from Jacksonville through Fayetteville to Raleigh created flash floods and river flooding greater than anytime in the past 22 years.

Thousands of people found themselves suddenly trapped in homes and cars during the torrential rains. Rescuers in Coast Guard helicopters plucked some of them from rooftops and used military vehicles to reach others, including a woman who held on to a tree for three hours after her car was overrun by flood waters. Thirty-eight school systems closed.

Princeville, a town of 2,000 that disappeared in the waters of the Tar River during Floyd in 1999, was evacuated Sunday as the river was expected to rise to 17 feet above flood stage.

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From the Editor

Drew Bridges, M.D., D.F.A.P.A

Book Recommendation: *An Unquiet Mind* by Kay Redfield Jamison

This edition's suggested book is one of those unique first person accounts of mental illness by someone who is also a mental health professional. This book is a candidate for any top five list of such writing.

In choosing books to recommend, I have three criteria. First, is the book well written? Second, is the story presented consistent with good psychiatric theory and knowledge? Lastly, can the reader learn from the work? *An Unquiet Mind* meets all three.

(As a reminder, Kay Redfield Jamison, PhD is a clinical psychologist who co-authored the textbook *Manic-Depressive Illness* with psychiatrist Frederick Goodwin in 1990. She founded UCLA's Affective Disorders Clinic before becoming Professor of Psychiatry at Johns Hopkins University School of Medicine, where she continues as the Co-Director of its Mood Disorders Center.)

Whether one is an experienced clinician or a novice, I think most professionals can be puzzled and often frustrated by the level of denial and resistance we encounter in patients. Perhaps the greatest strength of Dr. Jamison's writing is the way she explains her own fight against accepting treatment. She is eloquent and convincing in her description of trying to hold on to what she valued in her illness, and how her mind state was part of her identity.

NORTH CAROLINA Psychiatric Association news

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The NCPA News is a publication of the NC Psychiatric Association, 4917 Waters Edge Drive, Suite 250, Raleigh, NC 27606.
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Proactive Disaster Response Proves to be Effective

Tom Penders, M.D., D.L.F.A.P.A., President

This past October Hurricane Matthew ravaged Eastern North Carolina bringing high winds, torrential rains and flash floods. Historically high water levels bought dramatic flooding to many communities throughout the Coastal and Piedmont areas. Forty-three Americans lost their lives as a result of the storm, 28 were North Carolinians.

Such disasters have lasting effects on the large numbers of people affected. So, in addition to being a weather event associated with massive destruction, Matthew was also a traumatic event with extensive public health consequences for the mental health of the affected region.

Even before the storm struck the staff of NCPA was engaged through our Disaster Committee, under the leadership of its chairman, ***Allan Chrisman***. Coincidentally, Allan had just returned from volunteer duty with the Red Cross in Louisiana where he assisted in providing psychological first aid and other services to those displaced as a result of severe weather that took its toll there. Allan's commitments to provide support to those affected by the trauma of disasters had prepared him well to lead the effort of NCPA in working to help those addressing the needs of the thousands who had been displaced by Matthew. Allan has also led the organization's work that has provided the structure for a robust disaster response.

Through coordination with the administration of the American Psychiatric Association and staff of NCPA, Robin Huffman and Katy Kranze, initial coordinating meetings were held that laid the basis for setting objectives that focused the efforts of our Disaster Committee. Within hours work had begun to assist with supporting providers by collecting information about disruptions of services. Allan's guidance cautioned about the likelihood of limited access to supplies of maintenance medications. In conjunction with members ***Amba Jonnalagadda***, the recently appointed Medical Director for the Department of Mental Health, ***Burt Johnson***, Medical Director for the Trillium LME, staff worked to identify areas where volunteer members of NCPA could offer assistance. Robin's knowledge of the essential personnel throughout the state was invaluable in enabling a coherent and effective response.

Within days a special edition of the NCPA newsletter was published offering links to online information for providers and other affected individuals where advice about resources could be found. A webinar was offered online to our membership detailing the relevant issues involved consequent to Matthew's effects. The overall effort to address the damage of Matthew continues today and will likely continue well into the future.

The effort I have described was possible only as a result of years of the organizational work by NCPA to prepare a group capable of a response to natural or man-made disaster. The dedication of the staff and engaged membership in essential work such as this disaster response is only one reason that I have such admiration and pride to be associated with an organization that reflects the best that psychiatry and medicine has to offer.

These activities, of course, have occurred during a time when the usual business of NCPA continues to be ably administered. Efforts at advocacy at a time of rapid change in our profession, reorganization of our committee structure, attending to participation in a meeting of the National APA Assembly and regular service to its members continues on, uninterrupted by Matthew. NCPA shines every day. Recently it shined very much brighter.

Breaking News!

2017 Medicare Fee Schedule Released

New codes and improved rates are established to support the work psychiatrists and care managers perform in the collaborative care models. New "G codes" go into effect January 2017.

More details to come on NCPA website and E-News.

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Prescribing Stimulant Medications to Patients with Addiction Disorders

Elizabeth S. Stanton M.D., M.B.A., F.A.P.A., F.A.S.A.M.

This is the third and final article in a series by the NCPA Addictions Committee addressing prescribing for patients with Substance Use Disorders (SUDs).

One of the controversies that I face on an almost daily basis (as a psychiatrist treating mostly adults with SUDs) is how to assist my SUD patients who also present with either diagnosed or suspected ADHD.

The current data indicate that there is significant comorbidity (15%) of SUD and ADHD.[1] Additionally, the 2014 National Survey on Drug Use and Health indicated that 1.6 million people in the US age 12 and older reported using prescription stimulants for nonmedical uses, and approximately 600,000 are using illicit methamphetamines.[2] A confounding variable is that some patients will self-report the symptoms of ADHD in an attempt to obtain a prescription for stimulants when their prior history or current level of functioning does not appear to be consistent with their self-report.

The treatment paradigm that I use is to first focus on the disorder causing the patient the highest level of risk. Generally, in my patient population this means that I address the SUD, as patients may be referred to me with new legal issues, loss of jobs because of failed urine drug screens (UDS), a recent overdose, or a patient requesting help with their out of control addiction.

I work with the patient and often their families in stabilizing the addiction utilizing appropriate pharmacotherapy and psychotherapy with elements of Motivational Interviewing and CBT. I next address any comorbid mood, sleep, and anxiety disorders.

I initially postpone the topic of treatment/assessment of ADHD since there is much overlap in symptoms between many SUDs and ADHD.

I work with my patients to help them attain at least 6 months of sobriety prior to addressing the ADHD in terms of assessment or treatment. The literature supports this approach as there is only limited improvement in ADHD symptoms unless the SU disorder is stabilized first, and that there will be more modest improvement in both ADHD and SUD if the ADHD is treated once the SUD has been stabilized.[1]

An anecdotal advantage of this approach is that since I have been working with the patient for a longer period of time and have developed significant rapport, I will likely have collected more data regarding the patient's presentation for ADHD at this point in the treatment process. However, I still perform a thorough assessment, including a review of the records from previous clinicians, interview spouses/other pertinent collaterals, and utilize a validated ADHD self-report scale.

Lastly, in terms of the treatment paradigm, it is important not to forget to utilize all of our tools to assess our patients. This includes UDS, occasional pill counts, and use of the NC Controlled Substance Reporting System (NCCSRS). I utilize a UDS and the NCCSRS at the initial visit and periodically throughout the treatment. I continue to assess and treat the SUD utilizing medications (if indicated) and continue psychotherapy including elements of Motivational Interviewing or CBT, as both modalities are effective for these co-morbid disorders. I develop a treatment plan with my patient and include behavioral contracts outlining my expectations to continue on selected meds, and to continue in treatment with me. Given that the literature does not have consensus guidelines for the medication management of these individuals, I generally initially use nonstimulant medications as a first-line treatment.[3] Examples of these medications are Atomoxetine, Guanfacine ER, or Buproprion (off label use). If none of these appear to be efficacious, I then structure carefully monitored trials of long acting stimulants combined with the other tools mentioned previously. Also, if there are red flags during the treatment course, such as early refill requests, lost prescriptions, appearing intoxicated or impaired, missing appointments, etc., I then see the patient and their family and reassess what is needed to best meet their treatment needs.

In summary, treatment outcomes may be improved with the use of an integrated and step-wise treatment approach with this clinically challenging group of patients.

1 Wilens, TE, Morrison NR:Substance Use Disorders in Adolescents and Adults with ADHD:focus on treatment.Neuropsychiatry2012;2:301-312.

2. 2014 National Survey on Drug Use and Health@www.samhsa.gov/data. September 2015.

3.McGough M.D.,M.S.,James J.: Treatment Controversies in Adult ADHD. American Journal of Psychiatry173:10, October 2016.

Science to Practice: Using Your EMR as a Tool

Randy Grigg, M.D., D.L.F.A.P.A.

After listening to ***Sy Saeed's*** Top Ten Research Findings of 2015-16 at the NCPA Annual Meeting this year, I wanted to find a way to apply the new research findings. I realized that my Electronic Medical Record (EMR) could serve a vital role in helping my practice apply the information from some of the research findings. There were three studies that were particularly interesting that I decided to see if I could use their findings in my practice.

Relapse Prevention in Body Dysmorphic Disorder (BDD): Phillips et al. discovered that by prescribing escitalopram to patients with BDD you can prevent relapse. I decided this was an easy way to start applying the science to practice. Through the use of our EMR, I did a data query of all our medical records (more than 5,000 of them) by diagnosis. The good news is that this data search found three patients who had been treated in the office for BDD. The not so good news is that none of these patients were currently being seen in the practice. Had they been in treatment, I would have explored prescribing escitalopram for their BDD.

But what I learned is that our EMR allows this kind of search by diagnosis, which allows the psychiatrists in the practice to study their treatment protocols and outcomes. For example, psychiatrists with an EMR can search their databases for patients with a diagnosis of Alzheimers to consider the suitability of citalopram. (One of Dr. Saeed's Top 10 Research Findings was the "Effect of Citalopram on Neuropsychiatric Symptoms in Alzheimers Dimentia: Evidence from the CitAD Study". This study showed a reduction of such symptoms as anxiety, delusions, irritability/lability, and hallucinations.)

Measurement-Based Care of Major Depressive Disorder (MDD): In this study, Guo et al. compared patients with MDD receiving measurement-based care with standard treatment. They found that significantly more patients whose providers made decisions based on guidelines, HAM D and QIDS-SR, responded to treatment than those whose providers did not. Again, our EMR with its Patient Portal, allows for patients to complete screening tools and rating scales that are then available to the psychiatrist in the decision-making process for treatment and in evaluating possible treatment outcomes.

Clonidine in Prolonging Opioid Abstinence: Kowlczyk et al. found that clonidine reduces withdrawal symptoms and helps prolong abstinence in opioid use. This is another example of the value of using an EMR to adopt a new treatment modality. In this case, a data search by diagnosis and treatment can be initiated. Identifying patients in my practice with opioid dependence and studying their treatment could lead to a trial of clonidine in order to prolong opioid abstinence.

The point is that good research is being produced every year. By being able to identify a research finding that you may want to adopt and quickly being able to sort through all of your patients's diagnoses to see which ones may benefit from the new research, makes the process of applying the science in one's practice easier. Rather than relying on your memory the next time one of these patients appears in your office, you can use technology and your EMR to see how many of such patients are in your practice and proactively consider how to try the new science while the memory of the research finding is fresh.

NCPA wants to hear from you on your ideas and experiences in apply Science to Practice. Send your Science to Practice feedback or question to info@ncpsychiatry.org to be featured in the March Newsletter. To view the studies mentioned in this article, visit http://bit.do/SySaeed2016/

Member Notes...

Rahn Bailey, M.D., D.F.A.P.A. has been nominated for President-Elect in the 2017 APA National Election. Dr. Bailey is the Chair of Psychiatry and Behavioral Medicine at Wake Forest Baptist Medical Center. He is currently the Chair of the APA Membership Committee and serves on the NCPA Membership Committee.

He is board certified in general and forensic psychiatry. Dr. Bailey received his medical degree from the University of Texas Medical Branch at Galveston and completed his residency in psychiatry at the University of Texas at Houston, Texas Medical Center Affiliated Hospital, where he was chief resident. He completed a fellowship in forensic psychiatry in Yale University's Department of Psychiatry.

Dr. Bailey was the 113th President for the National Medical Association, and the President of the Tennessee Psychiatric Association shortly before transferring his membership to North Carolina.

Altha Stewart, M.D. has also been nominated for President-Elect. Voting begins in January.

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...Hurricane Matthew continued from cover

Three vehicle-related fatalities occurred in North Carolina in connection with rain produced by the storm. Twenty-five more deaths were later confirmed in the state, and 680,000 were without power. Interstate 95 in South Carolina and in North Carolina had to be shut down as a result of flooding. The North Carolina section didn't reopened until October 17.

After 10 inches of rain flooded the Lumberton area on September 28 from a different storm system, Matthew dumped another 10 to 14 inches. The Lumber River reached a record-breaking 24 feet in the south end of Lumberton. Robeson County schools did not reopen until October 31.

In Kinston, the Neuse River crested at 28.31 feet, a foot higher than the record set by Hurricane Floyd. In Greenville, the Tar River crested at 24.5 feet. Preliminary estimates indicate that roughly 100,000 structures were flooded across the state, and damage reached $1.5 billion.

Many animals died on densely populated commercial farms during flooding created by Matthew's rains. An estimated 1.7 million chickens, 112,000 turkeys, and 2,800 swine died according to the state Department of Agriculture and Consumer Services.

NCPA Prepares

In anticipation of this impact, NCPA actively prepared with a variety of efforts:

Collaboration with the Louisiana Psychiatric Association, which had just gone through a major flooding disaster, allowed the quick assembly of information on our website for professionals and the public to access aid from federal and state agencies. Materials on preparation and response to flooding were also posted.

On October 5, NCPA initiated the first of several requests to psychiatrists who had previously completed the American Red Cross (ARC) training in Fundamentals of Disaster Mental Health to pursue credentialing with the Red Cross for needed shelter work.

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October 10, NCPA convened a conference call with members of the Executive Council, the Disaster Committee, and medical directors of areas of the state public mental health system.

Amba Jonnalagadda, M.D., Medical Director/Clinical Policy Section DMHDDSAS, gave a report on flooding impact from her drive through effected areas. Updates also came from NCPA President ***Tom Penders, M.D.*** from Greenville, Goldsboro and Rocky Mount and ***Burt Johnson, M.D***. (Chief Medical Officer-Trillium) from Wilmington. This call included a general review of current plans for methadone and buprenorphine supplies, pharmacy openings and availability of psychotropic medications for emergency distribution for lost prescriptions and/or early refills, MCO crisis team availability for shelters and other hotspot locations, and collaboration with other physician organizations, Disaster Response Network of North Carolina, American Red Cross and state disaster mental health efforts including DMH/DD/SAS. Additional consideration was given for support to psychiatrists working in emergency rooms and inpatient units in area hospitals.

On October 14 the Disaster Response Task Force hosted a conference call for the ARC lead to give an update on the storm. During this call it was noted that the original ARC headquarters which had been originally situated in Wilmington was moved closer to the affected areas to Goldsboro, where it was further moved four times due to shifting flooded areas.

The following information came from ARC report: *Flooding continues to affect communities in Eastern NC along the Cape Fear, Neuse, Tar and Lumber Rivers and their tributaries. Overnight, almost 4,000 sought refuge in 65 shelters throughout the region. Evacuations are in effect in Spring Lake, Lumberton, Princeville, Kinston, Lenoir County, Vass and Goldsboro. A boil water advisory has been issued for Fayetteville, Johnston County, Sanford, Lee County, Spring Lake, and parts of Wayne County. As of 5pm, over 150,000 homes remained without power. Federal Emergency Management Agency says 66,080 households have reported losses from the storm.*

The descriptions above of the warning, impact and subsequent devastation caused by the flooding from Hurricane Matthew highlight both the unpredictability of hurricane paths and the unique features each particular storm brings to an area that can seem initially to be spared a direct impact only to experience a major disaster from flooding.

This flooding and its consequences are not rare. As noted by the National Traumatic Stress Network "in the United States floods on average kill approximately 127 people annually, making floods more deadly than tornadoes or hurricanes. Many of the fatalities are

electrocutions or accidents that occur after the floodwaters have subsided, and car-related incidents are responsible for almost half of the deaths. Floods may strike the same region repeatedly, resulting in recurrent stress for individuals residing in those areas.

"Although floods may not destroy buildings in the manner of tornadoes or hurricanes, the process of cleaning up mud and mildew filled houses can be emotionally overwhelming and fraught with health risks. Risks associated with the clean-up process include electrocution; infected skin wounds; injuries by wild animals; and illness from poor quality water, food, and indoor air. Cleaning one's home after a flood is an exhausting process, and this fatigue can lead to increased accidents. Losses in agricultural regions include livestock, crops, and farming equipment; thus, the secondary financial and emotional stresses associated with floods can last long after the waters subside."

"161012-Z-WB602-283" (CC BY-ND 2.0) by North Carolina National Guard

Lessons Learned

The enormity and rapidity of the impact of Hurricane Matthew on North Carolina far exceeded expectations of the disaster preparedness resources and capability. Initially, even with the early declared state of emergency, the expectation was that this could be handled within state resources. No outside ARC volunteers were mobilized, leaving the emergency response more limited.

While chaos and uneven distribution of resources in the initial response phase is not unusual, the rapid escalation of the flooding challenged the ability to perform rescue operations. The use of the National Guard and swift boat teams did allow for the successful rescues of over 1,500 people and animals. The subsequent pouring into the state of officials and volunteers was associated with very fluid levels of disorganization and high levels of stress for all concerned.

The main lesson from this scenario was that local community resilience for disaster response is critical for successful mobilization and deployment of volunteers who are trained in Disaster Mental Health. Initial support to clients in shelters, and follow-up disaster mental health care using Psychological First Aid and Skills for Psychological Recovery based on CBT principles are vital to the sustained long-term recovery efforts of a community. Training in these skills is free and available online from the National Traumatic Stress Network.

Finally, joining the Disaster Response Network and/or the American Red Cross as a Disaster Mental Health volunteer before the next disaster is essential. During an actual time of disaster, the ARC and the Disaster Response Network will have limited capacity to train and process your credentials.

Feel free to contact me for any further questions or assistance in pursuing your volunteer interests.

Don't Forget to Deduct Your Dues!

As you prepare your tax documents in the New Year, remember that a portion of your APA and NCPA 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.

For your 2016 NCPA dues, all but 15 percent of your dues are tax-deductible (in other words, you may deduct 85 percent of your 2016 NCPA dues).

According to the APA, you may deduct 91 percent of your national 2016 dues (all but 9 percent) as a business expense.

The non-deductible amount represents the portion of dues that is used to pay for direct lobbying efforts, such as NCPA's paid lobbyist and the time that NCPA staff spends on lobbying efforts. Both of these figures are found on your APA dues statement.

If you need assistance determining the amount you paid in 2016 for your APA and NCPA membership, please email info@ncpsychiatry.org.

What Psychiatrists Need to Know About... MACRA

With the release last month of the government's final rule on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), reform of the Medicare payment system will soon be a reality, and APA wants to help participating members navigate this landmark transformation of the way physicians are paid for their services.

The move to "value-based payment"—reimbursing physicians on the basis of the quality and value of services they provide rather than the volume—has a long history, and APA members who are already participating in Medicare quality reporting programs may find the new system under MACRA not as different as they might imagine.

Still, the shift to value-based payment has gathered momentum, and MACRA, which replaces the flawed sustainable growth rate formula, represents a major commitment by the government to a new basis for paying physicians. Some quality reporting requirements under MACRA will begin as early as January 1, 2017, and physicians who don't comply could incur automatic penalties while missing out on possible incentives.

The new reforms apply only to physicians receiving Medicare payments and—crucially—only to those who see 100 or more Medicare patients enrolled in Part B. However, the value-based payment arrangements being embraced by the federal government are expected to be adopted in the private insurance market eventually, so even physicians who are not Medicare participants may want to follow them closely.

For that reason, APA is developing a variety of tools, including a web-based toolkit and webinar series, to make this transition as easy as possible. *Psychiatric News* and other APA communication channels will alert members as new items become available.

What should impacted members do to prepare for the reforms? First, they need to choose to be paid under one of two payment paths established under MACRA—the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs).

Importantly, however, there is a third option: decline to report under either MIPS or APMs and simply accept the penalties. It's important to understand that depending on their resources, Medicare patient load, and other factors, members may find that accepting the penalties may not be a bad option. APA administration is available to help members determine what course is best for them.

For those psychiatrists who are seeing a sufficient number of Medicare patients to be included in the new reforms and who choose one of the two new payment pathways, here's a brief breakdown:

MIPS: MIPS combines portions of three existing quality programs -- Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier. MIPS also adds a new category of Clinical Practice Improvement Activities. Physicians will receive payment adjustments based on measures of quality, resource use, advancing care information (the designation for use of electronic health records), and clinical practice improvement.

APMs: Physicians participating in accountable care organizations, networks of clinicians receiving bundled payment arrangements, or medical homes can choose to be paid under the APM option. Those who do so are exempted from MIPS and may receive more favorable financial incentives, including a 5 percent lump-sum bonus payment.

APA members who choose one of the two new pathways will be required to focus on quality and track and manage patient information in a new way while coordinating with other clinicians. To help members understand these new policies and available options, the Association will post new and updated materials on its Payment Reform and Quality Reporting site: www.psychiatry.org/MACRA

The APA MACRA Toolkit, now in development, may include the following resources:

- MACRA 101 Primer.
- Decision tree to help psychiatrists choose their payment pathway.
- Checklist and timelines to get ready for MIPS.
- Detailed information on MIPS reporting categories: advancing care information (use of EHRs), quality, resource use, and advancing care.
- Clinical practice improvement activities and resource use.
- Frequently asked questions.
- Special considerations and assistance for multisite practitioners and small and solo practices.
- Additional APA and other resources to help members prepare.

APA is also launching a webinar series to walk members through the nuts and bolts of these Medicare changes, including information on how they can be successful quality reporters and how to use the data to inform clinical practice. The webinar series can be viewed live or on demand on the APA Learning Center. Here are the tentative dates for the webinars:

- **Quality 101 Reporting:** This has already been recorded and is available now.
- **Final Rule Overview:** November 16, 2016
- **MIPS Quality Category:** November 30, 2016
- **MIPS Advancing Care Information Category:** December 7, 2016
- **MIPS Clinical Practice Improvement Activities Category:** December 14, 2016
- **Alternative Payment Models:** January 18, 2017

APA CEO and Medical Director Saul Levin, M.D., M.P.A., urges members to take advantage of APA's help. "The Medicare payment reforms in MACRA are upon us, and members may feel understandably apprehensive. That's why APA exists—to help its members. Our expert staff are here to guide members in navigating these reforms and making this transition as smooth and simple as possible. I urge members to go to our website and learn about the resources we are creating for you."

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NCPA Members Leading Unique, New Programs to Train More Psychiatrists

One part of the effort to provide better services to the mentally ill must be to grow the number of practicing psychiatrists. Two NCPA members are taking the lead in the establishment of new residency slots in key geographic locations in NC. These programs also feature unique training for the real needs of the present and future.

Steve Buie M.D., D.F.A.P.A. and ***Rodney Villanueva, M.D., F.A.P.A.*** describe below their efforts in Asheville and Charlotte respectively.

Focusing on Collaborative Care

Mountain Area Health Education Center (MAHEC) in Asheville is starting a community based psychiatry residency. The residency will have four positions each year and is participating in this year's match. The mission of the residency is to train psychiatrists who will provide psychiatric care to the rural areas of western North Carolina.

There will be an emphasis on training in collaborative care. Starting in the second year, residents will have one day a week in a MAHEC primary care clinic. They will spend part of their time providing primary care, supervised by a family medicine faculty member to deepen their medical knowledge base. The other half of their day in the primary care clinic they will serve as a psychiatric consultant for that clinic.

Other parts of the curriculum include inpatient psychiatry at three different regional hospitals, community based clinics for indigent patients with severe and persistent mental illness, work with an ACT team, a private practice type of outpatient clinic and psychiatric emergency room work.

Out of more than a thousand applicants, we have chosen 50 to interview; of that 50, we will choose four to start their residency in 2017.

In addition to the residency, Asheville has become a satellite campus of the UNC School of Medicine. Students move to Asheville for their third year and participate in a longitudinal integrated curriculum. This curriculum allows students to have faculty preceptors in family medicine, internal medicine, psychiatry, pediatrics, and obstetrics/gynecology. They spend one half day a week with these core preceptors and a half day every other week with neurology and cardiology preceptors. We started with four students in 2009 and are currently up to 22 students.

MAHEC has received funding to expand the medical school gradually over the next several years, with a long-term target of 44 medical students spending their third year in Asheville and surrounding communities. There will also be an MPH program starting as a collaborative project of MAHEC, UNC-Asheville and UNC- Chapel Hill.

Increasing Access

Carolinas HealthCare System (CHS) in Charlotte, NC is proud to establish the Sandra and Leon Levine Psychiatry Residency Program. The residency was established in 2015 through a generous gift from the Leon Levine Foundation to further the commitment of CHS and the Levine Foundation to increasing the accessibility of mental health services and education, as well as to address the growing need for behavioral health in the greater Charlotte area.

CHS welcomes Krystle Graham, D.O., as the program director. Dr. Graham comes to CHS from Georgia Regents University, where she served as the associate program director of their residency program. Rodney Villanueva, M.D., will serve as the associate program director with Dr. Graham.

The curriculum and rotations offer exciting opportunities to residents with some unique training experiences, such as rotations in CHS's psychiatric emergency department, (the only one of its kind in the region), telepsychiatry, and behavioral health integration. These experiences will be supported by a solid foundation in core didactic and clinical training, including outpatient, inpatient and consult-liaison services.

The first class of three residents will arrive in July 2017. Over 1,000 applications were received and 60 applicants will be interviewed.

Steve Buie is in private practice in Asheville, NC and an adjunct assistant professor of psychiatry at the University of North Carolina School of Medicine.

Rodney Villanueva is the Associate Program Director and Psychiatry Residency Program Co-Director at Carolinas HealthCare System.

Lives on the Hill

Rose Hoban

Dorothea Dix, the former state mental hospital in Raleigh, once formed a community where patients and professionals left the grounds together to attend plays at Memorial Auditorium, spend weekends at the beach, and go to football games at Carolina and Duke.

It was a place where one huge dining hall served meals and the other was used for bake sales; where space as a "treatment mall" was also used for as talent shows with remarkable performances by patients.

And it was a treatment center where eight people sometimes were required to hold down an anesthetized patient during electroconvulsive shock therapy.

These memories of decades past, some chilling and some charming, emerged on Sunday, October 16 as scores of people with connections to Dorothea Dix Hospital began to lay plans for its remembrance.

Former patients, volunteers, professionals and historians, they gathered at N.C. State University's Talley Student Union to take part in the North Carolina Health News project, *Lives on the Hill*. The ongoing effort seeks to spur discussion on how the hospital should be memorialized in the new park planned for more than 300 acres of the west Raleigh site.

"Thanks to Dix, and thanks to all the processes I went through and the work that I did, I can talk to people, I have a voice," former patient Eloise Brinson said in one of several videotaped oral histories presented during the event.

The table for an afternoon of shared memories was set with presentations by:

Mebane Rash, who spoke on the history of Dorothea Dix and mental-health reform in North Carolina. "The lives lived on this hill can and should inform public policy in the 21st century," she said.

Fitzhugh Brundage, professor of history at the University of North Carolina at Chapel Hill, who used examples of the state's war memorials to address the day's central question: "How do we connect the past to the future?"

Jon Crispin, the Massachusetts photographer who discussed and showed images from "The Willard Suitcases." His project depicts belongings left behind by decades of residents at the Willard Asylum for the Chronic Insane in New York State.

"The connection between the staff and the patients were the main reason these cases weren't thrown away," Crispin said, noting that staff were too attached to the patients to throw away their belongings once they died.

Care Through Generations

Those connected to Dix told of how the community worked together like family, sometimes literally and at other times figuratively. Generations of staff lived in houses on the grounds, and patients and professionals worked together for decades at times.

"It was teamwork and it was a big family," said John Myhre, pharmacist at Dix from 1972 until 2009.

Myhre, who had been interviewed by NC Health News' team of videographers, also attended the event. Before the presentations, he said an account of Dix's legacy should include the research carried out there on a variety of medications including lithium. Trials were performed by drug companies and included informed consent on the part of participants, he said.

Major changes in medication practice for people with mental illness also took place during the latter years of the 20th century.

"When I first started they were giving monster doses of thorazine," a powerful antipsychotic drug, Myhre said. "A drugstore dose would be 25-50 milligrams four times a day. I saw lots of doses of 5,000 milligrams."

Questions Going Forward

The video interviews, portions of which were shown during the event, gave a broad range of opinions and facts about what informants had experienced at the hospital.

Following the viewing, about sixty people spent ninety minutes discussing a series of questions designed to get them thinking about what they feel is important in a memorial.

"One of the words that came up was it was a sacred space and place," said Karen Dunn, who runs the Club Nova clubhouse for people with severe and persistent mental illness in Carrboro. "For myself I think we should explore the possibility of a national monument, this place has national significance."

Others expressed that there was still grief over the closure of the facility.

"How do we become generative when we're still feeling punched in the gut," said NAMI NC head Jack Register. "We know that the questions around services are still there."

Give the Gift of Education This Year (& Beyond!)

The Psychiatric Foundation of North Carolina is a 501(c)3 organization and the charitable arm of the NCPA. The Foundation's primary goals focus on providing training, education and research that assist psychiatrists in offering the best possible care for patients.

One way the Foundation works toward this goal is by sponsoring psychiatric residents to attend the NCPA Annual Meeting & Scientific Session. This year, the Foundation paid the registration fees for 36 RFMs to attend the Annual Meeting and awarded three monetary awards for the Annual Poster Session. While continuing this tradition is a goal for both NCPA and the Foundation, the donations that fund their attendance have not kept pace. Are you able to make or increase your current contribution to sponsor a resident? As you consider your year-end donations to charitable organizations, please include the Psychiatric Foundation of North Carolina.

In addition to sponsoring residents, the Foundation also recognizes researchers who make outstanding contributions to the field of mental health research through the Eugene A. Hargrove, M.D. Mental Health Research Award and the V. Sagar Sethi, M.D. Mental Health Research Award. The Sethi Award was presented to Helen Mayberg, M.D. for her research on deep brain stimulation and the Hargrove Award was presented to Samantha Meltzer-Brody for her contributions to Women's Mood Disorders.

We were fortunate that this year both recipients presented a lecture at the NCPA Annual Meeting, and as a result, attendees benefit by learning directly from world-class researchers each year.

The Foundation was also honored to help sponsor the *Lives on the Hill* event in October. This event started the conversation to memorialize the legacy of Dorothea Dix.

Tax-deductible donations may be made online at www.ncpsychiatry.org/make-a-donation or by mailing a check to the Psychiatric Foundation of North Carolina, 4917 Waters Edge Drive, Suite 250, Raleigh, NC 27606.

Thank you 2016 Foundation Supporters!

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NCPA Announces 2017-2018 Slate of Officers

Voting begins in January

In accordance with NCPA's Bylaws, all voting members will receive election materials in January. Again this year, in an effort to make voting more convenient, we will offer electronic voting to all eligible members who have an email registered with NCPA. Electing leadership for the association is one of the your most important duties as a member of NCPA. Please read the election letter and ballot carefully and submit your anonymous vote by the deadline indicated in the voting materials.

Members of Executive Council serve staggered term limits to ensure a smooth transition of leadership each year. This slate includes President-Elect, Vice President, Secretary, two Councilor at Large positions and APA Assembly Representative.

President-Elect: ***Mehul Mankad, M.D., D.F.A.P.A.***

Vice President: ***John Santopietro, M.D., D.F.A.P.A.***

Secretary: ***Sonia Tyutyulkova, M.D., Ph.D.***

APA Assembly: ***Stephen Buie, M.D., D.F.A.P.A.***

Councilor At Large: ***Mary Mandell, M.D., D.F.A.P.A.***

Councilor At Large: ***James Rachal, M.D.***

Please contact the NCPA office with any questions, 919-859-3370 or info@ncpsychiatry.org.

2016 Membership Report

New & Reinstated Members

Luis Betancourt, M.D.
Nathan Carter, M.D.
Wilson "Sid" Comer, M.D.
Asa Cordle, M.D.
Halimena Creque, M.D.
Erikka Dzirasa, M.D.
Mary Edmondson, M.D.
Martha Evans, M.D.
William Fox, M.D.
Randy Gergel, M.D.
Zane Gooding, D.O.
Priscilla Hidalgo, M.D.
Noel Ibanez, M.D.
Charla Jones, M.D.
Gisela Knebl-Kohn, M.D.
Jonathan Leinbach, M.D.
Dwight Lynse, M.D.
Mitushi Mishra, M.D.
Leslie Montana, M.D.
Stacia Moore, M.D.
Stephen Panyko, M.D.
Punitha Ratham, M.D.
Jennifer Rucci, M.D.
Adamu Salisu, M.D.
Hadia Shafi, M.B.B.S.
Sacheen Shrestha, M.B.B.S.
Nilima Shukla, M.D.
Vikram Shukla, M.D.
Bryan Smith, M.D.
Alyssa Thompson, M.D.
Douglas Waldrep, M.D.
Joseph Zanga, M.D.

New Resident-Fellow Members

Jonathan Allan, M.D.
Gregory Arthmann, M.D.
Sayanti Bhattacharya, M.D., M.S.
Christian Bjerre Real, M.D.
Ryan Brown, M.D.
Kenya Caldwell, M.D.
William Cecil, D.O.
Sanjai Dayal, M.D.
Brett Fornell, M.D.
Ramez Ghanbari, M.D., Ph.D.
Brandon Harsch, M.D.
Nicole Helmke, M.D.
Veronica Hocker, M.D.
Elizabeth Hoffman, M.D.
Laura Iafrati, M.D.
Hyun Hee Kim, M.D.
Michael Kritzer-Cheren, M.D., Ph.D.
Erik Larrson, M.D.
Lisa Lindquist, M.D.
Pranjal Mann, M.D.
Michael Marchese, M.D.
John Marigliano, M.D.
Nicholas Mischel, M.D., Ph.D.
Sagarika Nag, M.D.
Rebekah Nash, M.D., Ph.D.
Marta Olenderek, M.D.
Cecilia Ordonez Moreno, M.D.
Megan Pruette, M.D.
William Scheidler, M.D.
Naveen Sharma, M.D.
Phillip Smith, M.D.
Lucia Smith-Martinez, M.D.
Heather Spain, M.D.
Elijah Wilder, D.O.

Members Transferring In

Ronee Aaron, D.O.
Nicole Aho, M.D.
Andrew Alkis, M.D.
Tarek Aziz, M.D.
Charles Berlin, M.D.
Erin Dainer, M.D.
Rami Dieb, M.D.
Gina Duncan, M.D.
William Griffies, M.D.
Rabiya Hasan, M.D.
Dale Hindmarsh, M.D.
Chinedu Iheagwara, M.D.
Angela Kallis, M.D.
Mandeep Kaur, M.D.
Andrew Klise, M.D.
Alyson Kuroski-Mazzei, D.O.
Robert Lucking, M.D.
Jacob McGrath, M.D.
Robert McIntire, M.D.
Larry Nelson, M.D.
Michael Newberry, M.D.
Peter Oliver, M.D.
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Fathima Reyman, M.D., M.P.H.
Jeffrey Simon, M.D.
Jagannath Subedi, M.D.
Anne Taylor, M.D.
Benjamin Williamson, M.D.
William Wright, M.D.
Syeda Younus, M.D.
Richard Zenn, M.D.

Members Transferring Out

Michael Arena, M.D. (MA)
Erica Arrington, M.D. (WV)
Avinash Boddapati, M.D. (NY)
Douglas Conrad, M.D. (SC)
Sherry Dubester, M.D. (VA)
Lance Feldman, M.D. (SC)
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Heather Oxentine, M.D. (GA)
Atul Pande, M.D. (CA)
Shaji Puthuvel, M.D. (GA)
Catherine Rogers, M.D. (MS)
Anna Shapiro, M.D. (NY)
Charlie Swanson, M.D. (VA)
Allie Thomas-Fannin, M.D. (IN)
Jaspreet Uppal, M.D. (NJ)
Nicholas Wisnosky, M.D. (NY)
Suzanne Yoder, M.D. (KY)

NORTH CAROLINA
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North Carolina Psychiatric Association
A District Branch of the American Psychiatric Association

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Submit your nominations for the 2017 V. Sagar Sethi, M.D. Mental Health Research Award now! Nominations must be submitted before the January 15, 2017 deadline. Submission criteria and instructions are available online, www.ncpsychiatry.org/sethi-award.

Calendar of Events

December 11, 2016
NCPA Executive Council
NCPA Office Building

December 14, 2016
Addictions Committee
Conference Call

December 23, 2016 - January 2, 2017
NCPA Office Closed