NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

DECEMBER 2013

IN THIS ISSUE

ATTENTION ALL NCPA MEMBERS:

Are you receiving our twice-monthly e-newsletters in your email inbox?

Generally, we send an e-newsletter on the 2nd and 4th Tuesday of the month to all NCPA members with an email address on file with us. If you are not receiving an e-newsletter, but you use email, please contact us at info@ncpsychiatry.org or 919-859-3370.

Also, please add us to your safe-sender/email white list.

Final Rule Implementing Mental Health Parity Announced

On November 7, the federal government announced the long-awaited final rule that fully implements the Mental Health Parity Act, more than 20 years in the making. While there is much still to be gleaned from the 200-plus pages of the final rule's language, overall, mental health professionals and advocates, including the American Psychiatric Association and NC Psychiatric Association, applaud the rule's release and its more apparent features.

APA Response

The APA's President, Jefferey Lieberman, M.D., issued the following response after the final rules were made public:

"People with mental illness have long faced discrimination in health care through unjust and often illegal barriers to care. Today, the Obama Administration took a significant step toward eliminating those barriers by issuing a Final Rule for the Mental Health Parity and Addiction Equity Act of 2008. The Final Rule provides a crucial step forward to ensure that patients receive the benefits they deserve and are entitled to under the law. In addition to providing equal benefits for mental illness as physical illness, I am hopeful that there will be strong monitoring and enforcement at both the state and federal levels.

People with mental and substance use disorders have long suffered and fought hard for treatment coverage commensurate to that for medical and surgical care. Despite passage of the 2008 legislation, many insurance companies have manipulated its intent and purpose through vague medical necessity standards, lengthy approval procedures, bureaucratic delays in service requests, and complicated appeals processes. These maneuvers have unfairly denied patients the care they need, have paid for, and are due.

As we review the Final Rule, we look forward to a new chapter in mental health care that delivers on the promise of the parity law. APA will remain vigilant and continue working toward full equity for people with mental illnesses and substance use disorders."

Work Still Lies Ahead

States will play an increasingly important role in enforcement and implementation, and the APA and district branches like the NCPA need to be at the forefront of education, assistance and informing state officials about problems and processes that need resolution. Parity has been a long road; it is not yet over. The final rule is not the final word, and over the next year and more, APA and NCPA will continue to work with the federal and state agencies to ensure complete equity in the health system.

For more information, including parity history and the rule's full language, visit www.psychiatry.org/parity.

NCPA Slate Announced; Voting Begins in January

In early January, the NC Psychiatric Association will mail the 2014-2015 election materials, including the ballot and a return envelope, to all voting NCPA members. ***Electing leadership for the association is one of the most important duties of NCPA's membership base. Please read the election letter and ballot carefully and return 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. Once elected, the below slate of officers will begin their new terms at the close of the APA Annual Meeting in May;

NCPA's calendar runs from May 1 until April 30, annually. Please note, Burt Johnson, M.D., D.L.F.A.P.A., the incoming President, was previously voted into office on the 2013-2014 ballot as President-Elect.

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

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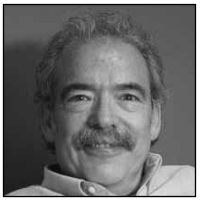

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NORTH CAROLINA Psychiatric Association news

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To update your mailing address or if you have questions or comments about NCPA News, contact Kristin Milam, 919-459-0752 or kmilam@ncpsychiatry.org.

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What Have We Done for You Lately?

Ranota T. Hall, M.D., D.F.A.P.A., President

"What have we done for you lately?" This may be a question you ask yourself about NCPA. What does your membership get you?

I have had an opportunity to put this question to practical use recently. As part of both Executive Council's and the Membership Committee's annual goals, we have taken the "show on the road."

Initially, Robin Huffman, Katy Kranze and—where possible—a local NCPA Executive Council member and I have been traveling to visit North Carolina's four teaching hospitals. Now at the halfway point, we have already determined that having the regional Councilor-At-Large in attendance is a must. Our intent has been to meet with each school's psychiatry residents so they get early exposure to NCPA—to "demystify" us as an organization , for lack of a better word, given many residents are not yet members. I have no illusions that the trainees await our arrival with the youthful exuberance of those waiting on the circus to come to town… but we do bring lunch.

So how can I impress upon them the value of joining their professional association at this point in their careers? I decided that they need to leave the meeting with something tangible, at least in the symbolic sense. Something useful. There are many things psychiatry residents need to learn before completing their formal training. On the road, I have about seven minutes to make the case that joining NCPA will help them; that joining NCPA will help them now, as well as later. So I asked myself the question: "What has NCPA done for them lately?"

To obtain my answer, I revisited the speech I gave at our annual meeting. Part of that speech included recounting my own personal "Psychiatric Family Tree." Let's call it "the genealogy" of my own education, which began when I first came to Duke to do my residency. I realized that there were myriad formal training experiences that shaped me and my skill set as a physician. In the end what I have lived by as a practicing psychiatrist were the words of wisdom from my supervisors. Advice to the trainee, that is what I decided had to be shared during my seven minutes. So I have been passing on these words, properly cited:

Dr. Hal Harris: *"You will be approached by many for jobs that you are not qualified for. Say no. No matter how much money they offer. Take a couple of years, consolidate your training and prepare for boards. Then you will be ready for the next step."* He also said, *"Don't be afraid to say no."*

Dr. Karen Wells: *"There is nothing wrong with labeling the problem."* Later, as I moved forward with my career and took on jobs with more administrative responsibility, she wisely shared, *"If you take this job just know that it will take three to five years to affect change."*

Dr. Charlie Keith: *"Ahhh, you just need to sit with this for a while. Be patient."* The back-story to this involved a very sick youth, an anxious trainee—me—and learning to "sit patiently" with my patient as they experienced something very difficult and frightening.

Dr. Harold Carmel: *"It's all about safety and quality."*

They, in my opinion, were all correct. These words have been the foundation of how I have approached my own work as well as guided others. They serve as the "primordial soup" if you will, on how to be a medical leader. Know your limits; safety and quality first; be patient; be solution-focused; and say no when you need to without apology.

This year appears to be the year where we continue to have conversations about psychiatrists as medical leaders, about our need to reinforce our role as physicians first. Where better to start than with the trainees? How are they trained to lead the charge for quality care? How are their skills reinforced once out of training? If they are not the chief resident, who teaches them how to prepare to navigate complex groups of people and systems? To be a medical administrator? I suggest that being active in their professional society is one way to continue to learn these very necessary skills.

During the meetings with the residents we have shared a sample of the benefits one gets as a member: taking advantage of the opportunity to sit on a committee, chair a committee, or work on a task force helps solidify leadership skills. NCPA offers training programs such as the DSM-5 and CPT code events held over the past year. Access to senior psychiatrists and the NCPA staff can tap into resources that clarify questions about practice, policy and rule changes, legal issues and even job searches.

Our Councilors-At-Large are preparing to take on an even greater presence in their regions since they are a vital point of contact to assist

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What Psychiatrists Need to Know About... FRAUD AUDITS

Robin B. Huffman, Executive Director

There are few things as chilling to a psychiatrist as receiving an official letter from an entity that uses legal-sounding terms such as "after an investigation, we have found," "we received a patient complaint about billing practices," or "we require a plan of correction." Being informed in no-uncertain-terms that your office may have done something wrong is scary, even for those who are not faint of heart!

Last issue, we outlined the Medicaid quality "Gold Star" audits being conducted by the LME/MCOs. This issue we are highlighting more information about NC Medicaid (officially the Division of Medical Assistance or DMA) "Program Integrity" or "fraud" audits. While Gold Star reviews are the responsibility of the LME/MCOs to recognize quality providers, these reviews can trigger concerns that would require the LME/MCO to call for a DMA Program Integrity review.

If a situation gets escalated to this level, the first order of business is for DMA's Program Integrity Unit to collect information about the case or situation. If DMA has credible evidence of fraud, it will refer the situation to the Medicaid Investigation Division. It is possible, depending on certain factors, that payment for services provided to Medicaid patients could be suspended during this investigation phase. Suspension of payments does not automatically occur, but it could.

According to Patrick Piggot, DMA Chief of the Behavioral Health Review Section, 10 to 15 percent of behavioral health claims submitted to NC Medicaid are fraudulent claims. This is an alarming statistic, one that should put psychiatrists on high alert, particularly if an agency you are contracting with is performing the billing function. DMA anecdotal experience indicates that most of these fraud cases are primarily agency based, rather than in a psychiatrist's office or by a licensed independent practitioner.

Alarms should go off in your head if the agency does not or will not provide you with the EOBs for the billing they are doing on your behalf. According to Medicaid policy, physicians are responsible for their own bills; if a fraudulent claim is caused by your billing agent, the physician is still responsible.

Protections Against Fraud Accusations

- Ensure the service you have billed is reflected in your documentation.
- Accurately use the new Evaluation and Management (E&M) CPT codes. Get training on the appropriate use of the 99211-99215 series of codes that are designed to reflect the complexity of the patient's visit that day. With the elimination of the 90862 "medication management code," physicians need to be aware that every visit may be different and will require a different code. Auditors are looking for practices that choose a single higher-paying code and use it as a default code for everyone in their practice.
- Don't take others' word for how you should conduct your business practices. Talk to your colleagues. Check out the Medicaid website for the Clinical Coverage Policy that reflects your practice (8C is for outpatient treatment, 8A enhanced outpatient services).
- Make it a practice and expectation that you review the EOBs for services being billed on your behalf. Insist on it with any agency you work with.
- Know if and who may be billing "incident to" your Medicaid number. There are special requirements for incident to billing and your supervision of the staff seeing your patients.
- If you end a contract with a provider or leave an agency, notify Medicaid (and/or the LME/MCO) of the date that you are no longer providing services for that agency.
- You can—if concerned—contact either the LME/MCO or Program Integrity at Medicaid to request a report that lists entities who are submitting bills under your Medicaid NPI number.
- If you do use an E&M code, be sure you are documenting the key components: history, examination, medical decision making.

Reasoning for Documentation

- Communicate to other health care professionals.
- Reminder of what happened and what you did during the appointment.
- Justify care to third party payers.
- Create a basis for defense in a malpractice action.
- Remember if it isn't written, it didn't happen!

Documentation Tips

- Always put your credentials "M.D." behind your name when you sign off on your charts.
- Always sign and date each medical record.
- Include or specify the length of the appointment.
- Use specific, factual and objective language. Describe your thinking and reasoning behind diagnosis and treatment.
- Include past and present diagnoses and a treatment plan (including progress, compliance, change in diagnosis, medications, follow-up instructions).
- Know what is being billed under your provider number.
- More is better.

Action Steps

It is usually a good idea to call your medical malpractice carrier for advice whenever you have a question about a practice. Even if it is not a malpractice issue, your insurer should be there to help you mitigate your risk and may help advise you on things you should and should not do.

Acting on Suspicion of Fraud

As a profession, we are committed to minimizing fraudulent and abusive behavior in psychiatric care delivery, be it providing services that are not deemed medically necessary, billing for services that were not provided, or providing services by someone not credentialed to do so. We urge psychiatrists to provide strong medical leadership and work for the integrity of the delivery system. With the other mental health professional associations, NCPA has developed a resource for understanding fraud and abuse. It is found on the NCPA website and it details NC Medicaid's definitions of inappropriate care and how to report it in the state. Visit www.ncpsychiatry.org/fraud-abuse for more information.

When in Doubt

When in doubt about whether the services you or an agency you are affiliated with are being provided in the appropriate manner, ASK! Trust your instincts. If something doesn't feel quite right, it probably isn't. It is your responsibility to protect one of your most valued assets—your medical license!

AVAILABLE RESOURCES

Public Mental Health Records and Documentation Manual:
http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf

Medicaid Clinical Coverage policies outline the services, who is eligible to receive them, who is eligible to provide them and all the details related to medical necessity.

Basic Outpatient Services 8-C: http://www.ncdhhs.gov/dma/mp/8C.pdf

Enhanced Outpatient Services policy 8-A:
http://www.ncdhhs.gov/dma/mp/8A.pdf

...President's Column continued from page 3

members in areas that are immediate and most important to them. We also have shared that as trainees their registration to the NCPA annual meeting is covered and that there are opportunities for trainees at the national level as well.

Will all of this be enough to convince them to become members? I do not know. I suppose the best test is whether each of you, at this stage in your own careers feels that what NCPA does is of value to you. I do hope that if you are not on a committee or have never chaired one that you will make your presence known. It is important that we offer opportunities for members to be involved at the leadership level. You need to know you are as important to NCPA at this point in your career as the residents we have visited.

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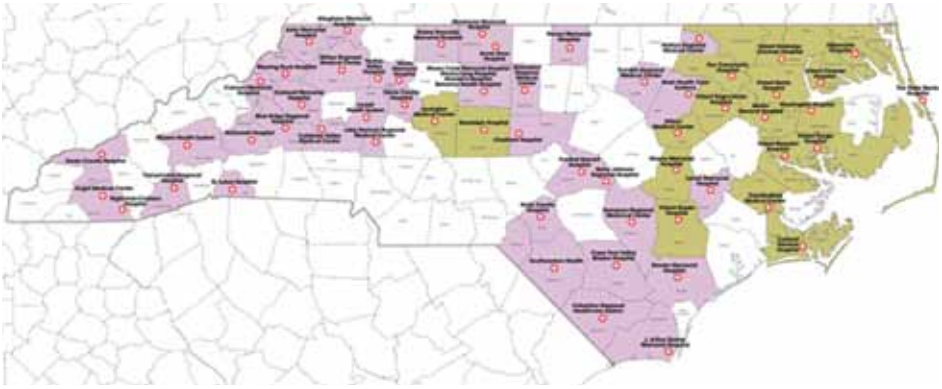
Statewide Telepsychiatry Program: NC-STeP

Sy Saeed, M.D., M.S., FACPsych, D.F.A.P.A., Professor and Chairman, Department of Psychiatry, Brody School of Medicine, East Carolina University; Director, ECU Center for Telepsychiatry and e-Behavioral Health

The N.C. Statewide Telepsychiatry Program (NC-STeP) was developed in response to Session Law 2013-360 directing the N.C. Department of Health and Human Services' Office of Rural Health and Community Care to "oversee and monitor establishment and administration of a statewide telepsychiatry program" (G.S. 143B-139, 4B). Telepsychiatry is defined in the statute as "the delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of two-way real-time interactive audio and video by a consulting provider at a consultant site to an individual patient at a referring site."

The vision of the Statewide Telepsychiatry Program is to assure that if an individual experiencing an acute behavioral health crisis enters an emergency department of a hospital anywhere in the state of North Carolina, he receives timely specialized psychiatric treatment through this program. Yet, the objectives go far beyond just taking care of the patient in the ED. The program will also facilitate enhancing community capacity for caring for people with mental illness. This program is about providing the best and evidence-based care to our patients regardless of where they may be located—large cities or small towns in North Carolina. Aside from helping address the problems associated with access to mental health care, NC-STeP also will help face a pressing and difficult challenge in healthcare delivery system today: the integration of science-based treatment practices into the routine clinical care.

ECU's Center for Telepsychiatry is the home for this statewide program that is anticipated to connect 60-80 hospital emergency departments across the state of North Carolina. The plan for NC-STeP was developed in collaboration with a workgroup of key stakeholders including representatives from universities in NC, hospitals/healthcare systems, North Carolina Hospital Association, NCPA, LME/MCOs, NC DHHS, and many others. The General Assembly has appropriated $2 million in 2013-2014 and 2014-2015 to fund the program ($4 million over two years).



The map above shows the current status of the program. The counties in gold below represent sites that are already up and running under the NC-STeP, whereas the counties in purple represent hospitals with EDs on the "waiting list" that have formally expressed interest in participating and subscribing to the service.

The Program builds upon two successful telepsychiatry programs in North Carolina:

1. The East Carolina University (ECU) Telemedicine Program has been in continuous operation since its inception in 1992, making it one of the longest running clinical telemedicine operations in the world. The Telemedicine Center provides the necessary support for conducting clinical telemedicine transactions, including scheduling, network operations, troubleshooting, training, and administrative assistance to those sites receiving medical services from ECU physicians and other healthcare providers. The support services of the Telemedicine Center have allowed the Department of Psychiatric Medicine at the Brody School of Medicine and the ECU Center for Telepsychiatry, to develop and expand a network of telepsychiatry services. Because of its experience and well-established program, the East Carolina University Center for Telepsychiatry and e-Behavioral Health (ECU Center for Telepsychiatry) was designated as the contractor to administer this statewide program.
2. Duke Endowment/Albemarle Hospital Foundation Telepsychiatry Project initially funded in 2010 by the Duke Endow-

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Attention Private Practice Medicare Providers: Important Information About Medicare Rates

PQRS—Physician Quality Review System—is a quality initiative that requires some documentation before the end of the year to avoid financial penalties to your practice.

The Physician Quality Reporting System (PQRS) is a CMS (Centers for Medicare and Medicaid Services) quality improvement program.

- Providers who serve Medicare patients MUST submit quality measures data to CMS.
- PQRS is switching from a financial incentive or bonus program to a program that imposes financial penalties for non-participation starting in 2013. (Actual penalties would be imposed in 2015.)
- To avoid the 2015 penalty of a 1.5 percent decrease in reimbursement a psychiatrist has only to report on one measure for one Medicare patient by the end of 2013.
- Providers are encouraged to fully participate in PQRS and can earn a 0.5 percent bonus on all of their Medicare charges if they report quality measures on 50 percent of more of their Medicare eligible patients.

Take Action in Three Steps:

1. Decide which measures to use and report on. While there are 259 measures provided by PQRS, there are 13 or so that are most relevant to psychiatric practice. CMS recommends reporting on at least three measures.
2. Determine the reporting method for sending PQRS data to CMS. Individual providers or group practice may choose to report using any of these four methods (the first two options are the most common ways of reporting information):
   - To CMS on their Medicare Part B claims (using the standard CMS 1500 claim form)
   - To a qualified PQRS registry (via a qualified Electronic Health Record)
   - To CMS via a qualified electronic health record (EHR) product
   - To a qualified PQRS data submission vendor.
3. Start collecting data.

For links to additional resources, including how-to's for the steps above, visit http://www.ncpsychiatry.org/pqrs.

State Government is Hiring Psychiatrists!

Central Prison Healthcare Complex in Raleigh, North Carolina, is seeking two psychiatrists for its new 216-bed Mental Health Facility. Duties of the positions include functioning as a psychiatric clinician responsible for providing psychiatric services to mentally ill inmates. Inmate patients are received into the healthcare complex from prisons throughout the state as well as county jails for the purposes of stabilization and treatment through implementation of individualized treatment plans.

Psychiatrists will join a multidisciplinary behavioral health team of psychiatrists, psychologists, social workers and other medical staff.

Positions include competitive state government salary and full benefits, including healthcare and malpractice insurance.

For more information, interested candidates should contact Bruce McKinney at Bruce.Mckinney@ncdps.gov or 919-743-2411.

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...Telepsychiatry continued from page 7

ment, to address the increased number of individuals with mental illness presenting to emergency departments in rural areas of eastern North Carolina. Since its inception, the program has demonstrated improved patient outcomes, with significant reductions in patient lengths of stay (LOS) as well as reductions in recidivism rates and reductions in involuntary commitments.

The Statewide Telepsychiatry Program will be dependent upon the ability of consulting and referring sites to share information safely and securely about the patients they are treating. As part of the contractual agreement, the ECU Center for Telepsychiatry will determine IT infrastructure and support to enable information sharing, and support scheduling, data collection and analytics needs. Through collaboration with participating entities, the ECU Center for Telepsychiatry is also developing the quality management and outcomes monitoring for the statewide program. All participating clinical providers will participate in a peer review process. They will also agree to meet quality and outcome standards and indicators.

The ECU Center for Telepsychiatry will create and maintain a one-stop web portal that coordinates and links to health information technology (HIT) functions required of the program. The portal will consist of separate but related technologies that will serve as the primary interface through which data is managed regarding patient encounters, including:

- Scheduling consultations and video conferencing equipment
- Exchanging clinical data for patient care and links to EMR data
- Supporting timely referrals
- Collecting encounter data for analytic needs of program managers and billing agents

The portal also will contain information about resources for participants, including hospitals, psychiatrists, and MCOs. The statewide telepsychiatry program includes the following required components: quality management, training, knowledge creation and dissemination; clinical providers, psychiatrists and others; infrastructure, sites, equipment, HIE, EMR, support, etc.; billing and collections; and web presence, schedules, protocols, algorithms, EMR, etc.

An advisory group made up of stakeholders from across the state will work with the Statewide Telepsychiatry Program to promote a comprehensive, collaborative and coordinated result among all partners.

Currently, there are 108 hospitals across the state with varying degrees of psychiatric coverage for their emergency departments; however, the majority of EDs do not have access to a full-time psychiatrist. Many times, behavioral health patients in crisis wait for hours—sometimes as long as days or weeks—for an appropriate psychiatric consultation after an initial ED determination of need. According to federal guidelines, 58 counties in North Carolina now qualify as Health Professional Shortage Areas due to a lack of mental health providers to meet population needs.

APA Launches HIPAA Privacy Rule Compliance Manual

Effective September 23, 2013, new HIPPA Privacy Rules were enacted, and physicians were required to conform their HIPPA practices to the new rules.

The APA has released an updated HIPAA Privacy Rule Manual, a Guide for Psychiatric Practices. This manual will help practitioners adopt the new HIPPA requirements.

The manual includes step-by-step instructions, checklists, template forms and patient notices, frequently asked questions, a thorough explanation of the regulations, and cross references to useful APA developed materials on issues including treatment of psychotherapy notes and "minimum necessary" disclosure standards. The manual is offered as a free membership benefit.

The manual, as well as other HIPAA resources, is available online at: www.psychiatry.org/practice/managing-a-practice/hipaa

Please note: access to many of the APA's online resources requires members to log into the website. Logging into the APA website may redirect you to the home page. To access the documents from the home page, click on the light blue "Practice" menu and then click on "HIPPA" on the left-hand side under "Managing a Practice."

Highlights from the 2013 Annual Meeting & Scientific Session

Once again the Annual Meeting and Scientific Session saw record attendance of psychiatrists, nurse practitioners and physician assistants who spent a weekend attending sessions, mingling with colleagues and taking in the beautiful sights of Asheville.

Business as Usual

The 2013 Program Committee assembled an impressive schedule of renowned speakers hailing from across the country, including many from within our own state borders. In addition to clinical presentations, attendees also heard from the Secretary of the North Carolina Department of Health and Human Services, Aldona Wos, M.D.

The annual business lunch hadrecord attendance with more than 100 NCPA members joining the Executive Council for a review of the association's financial status and reports, membership information and 2014 Executive Council nomination and election information. This year members also heard from committee chairs (or designees) about the status and goals of each committee for the year. If you were unable to attend the business lunch, but would like to review handouts and/or minutes from the meeting, please contact the NCPA staff at info@ncpsychiatry.org or 919-859-3370.

Members Honored

NCPA President ***Ranota Hall, M.D., D.F.A.P.A.*** announced four 2013 President's Awards over the weekend. "Every year, the president of the North Carolina Psychiatric Association has the privilege to honor those members whose service has gone above and beyond for the association, our members and the mental health field," said Dr. Hall. "It's my honor to continue this tradition and publicly recognize and thank this year's President Award winners."

The following members received 2013 President Awards:

- ***Nnenna Lekwauwa, M.D., D.F.A.P.A.*** for her service promoting a quality mental health system as Medical Director for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
- ***Venkata Jonnalagadda, M.D.*** for her service as NCPA's CPT Coding Expert, researching member inquiries and conducting training related to the 2013 CPT coding changes for mental health.
- ***Debra A. Bolick, M.D., D.F.A.P.A.*** for her service as the 2012-2013 President of the NC Psychiatric Association.
- ***Chris Aiken, M.D., D.F.A.P.A.*** for his service as the Program Chair of the 2013 NCPA Annual Meeting and Scientific Session.

The Psychiatric Foundation of North Carolina awarded two mental health research awards during the 2013 Annual Meeting & Scientific Session — the Eugene A. Hargrove, M.D. and the V. Sagar Sethi, M.D. Mental Health Research Awards.

Congratulations to ***Linmarie Sikich, M.D., D.F.A.P.A.***, the 2013, Eugene A. Hargrove, M.D. Mental Health Research Award recipient! The Hargrove Award seeks to honor an individual who has been recognized by colleagues for exceptional contributions to mental health research. The 2013 Hargrove Award focused on research related to child and adolescent mental health. Dr. Sikich is the principal investigator or sub investigator in more than 40 clinical research trials for children with autism spectrum disorders (ASD), early onset schizophrenia and pediatric bipolar disorder. She is an Associate Professor and Director of the Adolescent and School-age Psychiatric Intervention Research Program (ASPIRE) at the University of North Carolina School of Medicine.

Left to Right: ***Stephen Buie, M.D., D.F.A.P.A.****, President, Psychiatric Foundation of North Carolina;* ***Ranota Hall, M.D., D.F.A.P.A.****, President, NCPA;* ***Linmarie Sikich, M.D., D.F.A.P.A.****, 2013 Hargrove Award recipient; and Robin Huffman, Executive Director, NCPA.*

Congratulations to Charles Nemeroff, M.D., Ph.D., D.F.A.P.A., the V. Sagar Sethi, M.D. Mental Health Research Award recipient! The Sethi Award seeks to honor a scientist for significant contributions to basic research in the neurosciences, psychology, or pharmacology at a molecular, cellular or behavioral

*From Top: Poster winner **Anne Kelly, M.D.** and **Beth Pekarek, M.D., D.F.A.P.A.; John Gilmore, M.D., Stephen Kramer, M.D., D.F.A.P.A., Sy Saeed, M.D., D.F.A.P.A., and Holly Lisanby, M.D.; Ranota Hall, M.D., D.F.A.P.A.**, Secretary Aldona Wos, M.D., and Robin Huffman; Attendees during the Friday general session.*

Psychiatric Foundation at Work

The Psychiatric Foundation of North Carolina hosted its annual fundraiser on September 20. More than 50 guests hopped on LaZoom Comedy Bus Tours. All proceeds from the event benefited the Foundation, which among its other charitable goals provides complimentary registration for medical students and residents attending the Annual Meeting.

The Psychiatric Foundation is also the primary sponsor of the conference's poster session. This year more than 10 research posters were entered into the contest, and five posters and their authors walked away with awards. The Foundation and North Carolina Council of Child and Adolescent Psychiatry are pleased to announce and congratulate the 2013 poster session winners:

First Place: ***Anne Kelly, M.D.***, The University of North Carolina - Chapel Hill; additional authors: ***Brian B. Sheitman, M.D.***; Robert M. Hamer, Ph.D.; David C. Rhyne, LCSW; Robin M. Reed, M.D., MPH; Karen A. Graham, M.D.; ***Shane W. Rau, M.D., Ph.D.; John H. Gilmore, M.D.; Diana O. Perkins, M.D., MPH;*** Susan Saik Peebles, M.D.; Carol J. VanderZwaag, M.D.; ***L. Fredrik Jarskog, M.D.***

Second Place: Melissa Musec, M.D., East Carolina University; additional authors: Irene Pastis, M.D.; ***Michael Lang, M.D.***

Third Place: Xiaowei Sun, M.D., Ph.D., Duke University; additional authors: Robert Hamer, Ph.D.; ***Joseph McEvoy, M.D.***

People's Choice Award, sponsored by NAMI-NC: ***Joshua Pagano, D.O.***, East Carolina University; additional authors: ***Thomas M Penders, M.D.; Michael C Lang, M.D.;*** Zane S. Gooding D.O.

Child and Adolescent Award, sponsored by the North Carolina Council on Child & Adolescent Psychiatry: Vivek Anand, M.D. and Jose Bogantes, M.D., East Carolina University.

level. Dr. Nemeroff is the Leonard M. Miller Professor and Chairman of the Department of Psychiatry and Behavioral Sciences and Director of the Center on Aging at the University of Miami Miller School of Medicine in Miami, Fla. His research focuses on pathophysiology of mood and anxiety disorders with a focus on the role of child abuse and neglect as a major risk factor.

About the Hargrove Award

Dr. Hargrove, who died in 1978, was Director of the North Carolina State Department of Mental Health, Developmental Disabilities and Substance Abuse Services from 1958 until 1973. The Eugene A. Hargrove Mental Health Research Award (originally established by the North Carolina Foundation for Mental Health Research, Inc in 1980) is in commemoration of Dr. Hargrove's contributions to mental health care in North Carolina and his recognition of and support for research in the public mental health system. The Psychiatric Foundation of North Carolina now presents this award to an individual who has been recognized by colleagues for exceptional contributions in the field of mental health research.

About the Sethi Award

The V. Sagar Sethi, M.D. Mental Health Research Award was created in 2011 with an endowment from Dr. Sethi, a practicing psychiatrist in Charlotte and a long-time member of the North Carolina and American Psychiatric Associations. Applications for the award were required to meet the following criteria: significant contribution to basic research; research had a significant impact or is highly likely to have significant impact on clinical psychiatric care; M.D. or Ph.D. who is conducting active research in the United States.

*Left to Right, Front Row: Charles Nemeroff, M.D., Ph.D., 2013 Sethi Award recipient; **Ranota Hall, M.D., D.F.A.P.A.**, President, NCPA; **V. Sagar Sethi, M.D., L.M.**; and Robin Huffman, Executive Director, NCPA. Left to Right, Back Row: **John Gilmore, M.D.**, Director, Psychiatric Foundation of North Carolina; and **Stephen Buie, M.D., D.F.A.P.A.**, President, Psychiatric Foundation of North Carolina*

2013 Membership Report

New & Reinstated Members

Dena Armstrong, M.D.
Melanie Barrett, M.D.
Marica Bijelac, M.D.
Emily Boothe, D.O.
Gregory Brown, M.D.
Mark Chandler, M.D.
Kaleena Chilcote, M.D.
Shabbir Chowdhury, M.D.
Craig Cook, M.D.
Elizabeth Cox, M.D.
Ilona Csapo, M.D.
Dawn Fyler, M.D.
Gary Gala, M.D.
Charles Gammons, M.D.
Tesfa-Alem Gebremeskel, M.D.
Anisha Gulati, M.D.
Swaruparani Gullapalli, M.D.
Erik Gustke, M.D.
Lora Hart, M.D.
Gregory Helton, M.D.
James Horst, D.O.
Anoop Kalia, M.D.
Jessica Knight, M.D.
Archana Kumar, M.D.
William Lay, M.D.
Jessica Lay, M.D.
Norman Litchfield, M.D.
Keith Logan, M.D.
James Mattox, M.D.
Charles McCormick, M.D.
Rigardy Munoz, M.D.
Virginia O'Brien, M.D.
Sarah Parker, M.D.
Diana Perkins, M.D.
Punitha Rathnam, M.D.
Robin Reed, M.D.
Isabel Ross, M.D.
Jennifer Rucci, M.D.
Anna Shapiro, M.D.
Monica Slubicki, M.D.
Hans Stelmach, M.D.
Qionna Tinney Railey, M.D.
Shannon Tyler, M.D.
Susan Van Meter, M.D.

New Members in Training

Derek Ayers, M.D.
Avinash Boddapati, M.D.
Gregory Brown, M.D.
Hani Elwafi, M.D.
Anisha Gulati, M.D.
Nathan Harper, M.D.
Kim Johnson, M.D.
Bhavna Kaushik, M.D.
Anne Kelly, M.D.
Georgia Ketchum, M.D.
Nicholas Ladd, D.O.
Reina Maeda, M.D.
Sheila Maurer, M.D.
Sean Moran, M.D.
Katherine Nguyen, D.O.
Sarita O'Neal, M.D.
Heather Oxentine, M.D.
Joshua Pagano, D.O.
Raj Patel, M.D.
Punita Rathnam, M.D.
Abhinav Sharma, M.D.
Rebecca Silver, M.D.
Richard Smith, D.O.
Nathaniel Sowa, M.D., Ph.D.
Corneliu Stancui, M.D.
Archana Sugumar, M.B.B.S.
Melisa Tyndall, M.D.
Jasreet Uppal, M.D.
Mufida Wadhwania, M.D.
Laura Willing, M.D.

Members Transferring In

Maria Almeida, M.D.
Leah Fennell Barahona, M.D.
Ria Battaglino, M.D.
Tracy Benford Price, M.D.
Phyllis Bogard, M.D.
Crystal Bullard, M.D.
Nancy Clayton, M.D.
Cheryl Dodds, M.D.
Jeffrey Drexler, M.D.
Lance Feldman, M.D.
Predrag V. Gligorovic, M.D.
Mustafa Husain, M.D.
Israt Jahana, M.D., Ph.D.
Gail Kase, M.D.
Haesue Kim, M.D.
Kevin Lamm, M.D.
Dayna Lobraico, M.D.
Sarah Parker, M.D.
Michael Lee Pool, M.D.
Shaji J. Puthuvel M.D.
Margaret Rukstalis, M.D.
William Ryan, M.D.
Saka Salami, M.D.
John Santopietro, M.D.
Reshmi Saranga, M.D.
Richard Sarles, M.D.
Richard Smith, D.O.
Julia Triggs, M.D.
Liju Varghese, M.D.
Matthew Warren, M.D., Ph.D.
Junesik Yong, M.D.

Members Transferring Out

Frank Angotti, M.D. (West Virginia)
Meera Balasubramaniam, M.B.B.S. (New Jersey)
Dinesh Benjamin, M.D. (Ontario)
Sandra Blakney, M.D. (New York)
Youngue Chen, M.D. (Virginia)
James Christensen, M.D. (Minnesota)
Jessica Derreberry, M.D. (Pennsylvania)
Todd Derreberry, M.D. (Pennsylvania)
Kwanna Hayes, M.D. (Georgia)
Steve Herrin, M.D. (Illinois)
Suzanne Kerns, M.D. (South Carolina)
Jose Ribas Roca, M.D. (Massachusetts)
Gardy Rigaud, M.D. (Florida)
Dana Rosca, M.D. (Northern California)
Mohan Sridaran, M.D. (South Carolina)
Sandarsh Surya, M.D. (Georgia)
Laura Wakil, M.D. (Southern California)
Garth Watkins, M.D. (Central California)
Steven Zuchowski, M.D. (Nevada)

Members Notes...

Christopher Myers, M.D. **will represent the NC Psychiatric Association in the 12th class of the NC Medical Society and its Foundation's Leadership College. The elite program allows physicians and physician assistants to excel as leaders within organized medicine, hospitals, health care systems, medical staffs, group practices, and in the public policy arena.**

We want to hear from you! **To submit an item for Member Notes, please email the NCPA member's name, photo (if available) and details to info@ncpsychiatry.org.**

Marijuana Use Trends and Psychiatric Disorders

Thomas Penders, M.S., M.D., D.L.F.A.P.A., NCPA Addictions Committee Chair

This is the first in a series of articles by the NCPA Addictions Committee designed to review the current status of the science that may inform opinion as each member considers their stance on changes in public policy and legislation relating to cannabis.

History

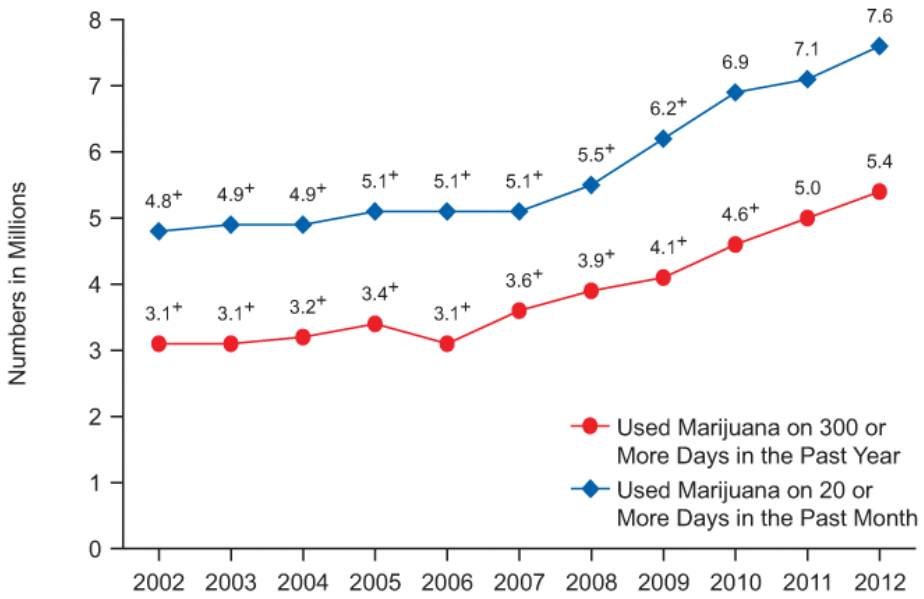
The Hemp Plant, Cannabis sativa, is among the oldest known to humankind. Evidence for its use as a source of fiber for clothing, rope and in the production of parchments can be traced to Central Asia 12,000 years ago. The word "canvas" is derived from cannabis. Throughout human history extracts of the cannabis plant have been used as medicine for a variety of conditions such as muscle spasm, nausea and nervous disorders. Its introduction into Western medicine is attributed to an English Army Surgeon, William O'Shaughnessy who used cannabis extracts while in India during his appointment as Physician and Director of Telegraphy with the East India Company in 1844. Cannabis plants accompanied the settlers who arrived at Jamestown in 1607. During colonial times, and continuing for the next 300 years, extracts of the cannabis plant had been used by physicians and the public for treatment of a variety of musculoskeletal, digestive and nervous conditions. Various nostrums including extracts of cannabis were freely available to the public unregulated and widely used in popular cures.

The first effort to control the sale of cannabis products, the Marijuana Tax Act, became federal law in 1937 over the objections of the American Medical Association. Over the remainder of the century increasing regulation by federal and state governments culminated in inclusion of cannabis as a schedule I drug with high abuse potential and no accepted medical use by the Controlled Substances Act of 1970. Despite this, very limited numbers of individuals have received medical marijuana as part of a tightly controlled compassionate use program administered by the National Institute of Drug Abuse.

Recent Use Trends

Each year researchers from the Department of Social Sciences at the University of Michigan survey about 50,000 secondary students about their use of alcohol and illicit drugs. In 2012, about half (49 percent) of high school seniors reported the use of an illicit drug. For 10th and 8th graders, the figure was 37 percent and 15 percent. In the vast majority of cases the drug reported was marijuana. Strikingly, about 1 in 15 12th graders indicated that they used marijuana on a daily basis last year. Among adults in America, despite a leveling off of the prevalence of illicit drug use in general, about 7 percent of the US population use marijuana at least monthly, a figure that has grown each year out of the past five. Among high school age children, marijuana use in the past month exceeds use of tobacco products.

Daily or Almost Daily Marijuana Use in the Past Year and Past Month among Persons Aged 12 or Older: 2002-2012



+ Difference between this estimate and the 2012 estimate is statistically significant at the .05 level. Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

In 2012, 7.6 million persons aged 12 or older used marijuana on 20 or more days in the past month, which was an increase from the 5.1 million daily or almost daily past month users in 2007 (Figure 2.15). The number of daily or almost daily users in 2012 represented 40.3 percent of past month marijuana users.

After alcohol and tobacco, marijuana is regularly reported to have the highest rates of dependence and abuse in national surveys. In 2011, 4.2 million individuals qualified under DSM-IV TR for a diagnosis of cannabis abuse or dependence. Individuals with diagnosed mental disorders use marijuana at rates that are seven times those who do not have a mental disorder. Among patients in treatment for psychiatric disorders there is a tenfold increase in marijuana use disorders as compared to the general population. These statistics underline the important observation that patients in psychiatric treatment are more likely to use, tend to use more and are more likely to become dependent on this widely available substance.

Public Attitudes and Legislative Changes

Public attitudes and views of the dangerousness of cannabis are changing. This has had an important effect on public policy and legislation related to the use of marijuana. Over the past decade about half of our states have either decriminalized or greatly reduced the penalties for possession and use of small amounts of cannabis products. Two states, Colorado and Washington, have passed legislation providing for legalization for recreational purposes, and in 21 states where it has been made available for "medical purposes," use appears to be rapidly expanding fueled by robust cottage industries in provision of numbers of products that include cannabis. Today there are a few countries that derive the majority of their tax revenue from sales of legal cannabis.

Paradoxically, arrests for possession and sale of marijuana have trended upwards recently with an average of 100 individuals detained per hour nationally as reported by FBI statistics. This is occurring despite the announcement by the U.S. Department of Justice that they would not prosecute those using cannabis within the legal structure of the laws of those states. Canada has recently approved an expansion in a regulated system of marijuana culture that has an estimated revenue potential of $1.3 billion according to executives of Tweed, a corporate producer of medical marijuana. It is estimated that over the next decade there will be 500,000 users of the product among our northern neighbors.

Legal Status in North Carolina

Here in North Carolina where use of small amounts of marijuana remains a class 3 misdemeanor, a bill to downgrade this to a summary offense was defeated in the past legislative session. The ACLU has recently reported a dramatic disparity in the prosecution of users of marijuana. In North Carolina 50 percent of those prosecuted have been African American. The future of the legal status of this curious plant is now under intense scrutiny. Opinions on public policy range from support for full legalization to continue restriction and control.

In North Carolina House Bill 84 "Enact Medical Cannabis Act" received a rare negative report and is dead for the 2013-2014 session. News reports indicated that legislators were being "harassed" by constituents almost all of whom were in favor of passage. Groups advocating availability of medical marijuana have been formed and are growing in our state. The listing of marijuana as a schedule I drug under the Controlled Substances Act defining it as a substance with no currently accepted medical use and a high potential for abuse is a source of increasing controversy.

Cannabis as Medications

Since the discovery that THC is the active ingredient in smoked marijuana there has been research interest at both a clinical and basic science level in the use of cannabis as a potential therapeutic agent. Discovery and elaboration of the endogenous endocannabinoid system and its role in modulating stress in health and disease promises to provide insights into therapeutic applications for a variety of problems such as treatment of pain, obesity, muscle spasms and seizures. Additionally, growing information is pointing to deleterious effects of cannabinoids. Multiple studies have now demonstrated increased risk for development of schizophrenic-like psychosis among youth who are regular users of smoked cannabis.

The accumulated body of evidence relating to the positive and negative health effects of marijuana has great relevance for the current debate about liberalizing availability of cannabis products. The NCPA Addictions Committee will present clinical information for our members.

Coming Up in the Series...

- **Marijuana and Psychosis**
- **Pharmacology of Cannabis and Its Psychoactive Agents**
- **Cognitive and Developmental Effects**
- **Medical Marijuana: Evidence, Accepted Indications and Current Use**
- **The Endogenous Cannabinoid System: Potential for Intervention in Psychiatric and Addictive Disorders**

NORTH CAROLINA
Psychiatric
Association

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

4917 Waters Edge Drive, Suite 250
Raleigh, NC 27606
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www.ncpsychiatry.org

Calendar of Events

December 12, 2013
Medical Forum
NC Council of Community Programs 2013
Conference & Exhibits
(full conference runs Dec. 11-12th)
Pinehurst Resort, Pinehurst, NC
Online Registration:www.nc-council.org

February 20-21, 2014
2014 Clinical Update &
Psychopharmacology Review
McKimmon Center, Raleigh, NC
www.southernregionalahec.org/ContinuingEd/clinicalupdate14.html

Support the Psychiatric Foundation of North Carolina!

As you are planning your end of year charitable contributions, please consider a donation to the Psychiatric Foundation of North Carolina. Your gift helps support psychiatric residents and medical students to attend the NCPA Annual Meeting and Scientific Session, sponsors the Residents Poster Session, and helps support the NC Psychiatric Association.

If you have a colleague that you'd like to honor or remember, making a donation in his or her name is a perfect way to honor their achievements or continue the memory of a colleague or friend who has passed away.

All donations are tax-deductible. Please consider donating today! Forms are available online, www.ncpsychiatry.org/foundation.

Thank you to our 2013 Foundation Supporters!

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