NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

JUNE 2022

River Arts District, Asheville

IN THIS ISSUE

Register Today!

NCPA Annual Meeting & Scientific Session

Sept. 29 - Oct. 2, 2022

Renaissance Hotel
Asheville, NC

www.ncpsychiatry.org/annual-meeting

We're Baaaack!

Mehul Mankad, M.D., D.F.A.P.A., Program Committee Chair

With great jubilation, the North Carolina Psychiatric Association is thrilled to offer the 2022 Annual Meeting in Asheville, North Carolina from September 30-October 2 IN PERSON! We will be back in our familiar stomping grounds of the Renaissance Hotel with all the bells and whistles that our members expect. We've also added some features from our virtual meetings that will enhance the overall experience for attendees.

As always, the Scientific Program Committee has worked for months to curate a group of speakers for the plenary sessions and workshop that will provide something for everyone. Being fortunate to live in a scholarly state, our local experts will all appear in person. Given the evolving landscape of psychiatry, we have dedicated time to the perspective of psychiatrists as leaders in mental healthcare. We are thrilled to host Department of Health and Human Services Secretary Kody Kinsley as our keynote speaker. We look forward to hearing from Julie Freischlag, M.D., Dean of Wake Forest School of Medicine and President of the American College of Surgeons, speak about physician leadership. Continuing the theme of leadership, you are stuck with yours truly, ***Mehul Mankad, M.D.,*** Chief Medical Officer of Alliance Health, speaking on the role of psychiatrists as Medical Directors.

Respecting the treatment domain, UNC faculty ***Mary Kimmel, M.D.,*** will update us in the area of peripartum psychiatry. ***Mina Boazak, M.D.,*** will share modern approaches to the treatment of adult ADHD. Duke faculty ***Jane Gagliardi, M.D., M.H.S.,*** and Duke resident ***Colin Smith, M.D.*** will share their original research on health equity for patients receiving emergency psychiatric services. ***Chris Aiken, M.D.,*** will return to present the top ten research findings of the year. Johns Hopkins University psychologist, Amanda Lattimore, Ph.D., will address the impact of social determinants of health on patients with substance use disorders.

This year's afternoon workshop will involve a deep dive into diverse telehealth approaches. Diego Garza, M.D., ***Nate Sowa, M.D., Ph.D., Manuel Castro, M.D., Nathan Copeland M.D., M.P.H.,*** and ***Elise Herman, M.D.,*** will discuss inpatient, outpatient, and consultation approaches to telehealth.

Our meeting would not be complete without the Sethi Award winner, Sophia Vinogradov, M.D. The award recognizes Dr. Vinogradov's extensive research dedicated to the understanding of cognitive retraining in schizophrenia and neuroplasticity-based interventions in psychosis and autism. She is Professor and Department Head of Psychiatry & Behavioral Sciences at the University of Minnesota Medical School.

The interesting lesson we have learned from our virtual meetings involves our national guest speakers. To provide the best national talent for our attendees, we have kept a few of our speakers in the virtual domain. We are pleased to offer University of Washington faculty Jurgen Unutzer, M.D., M.P.H., as

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Just A Repair Shop?

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

"There comes a point when we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in." This quote is attributed to Desmond Tutu, and it speaks to us in healthcare. We know that most of what determines health occurs outside of our offices and hospitals. In a recent editorial Donald Berwick, M.D., from the Institute for Healthcare Improvement, said, "Except for a few clinical preventive services, most hospitals and physician offices are repair shops, trying to correct the damages of causes collectively denoted 'social determinants of health.'"

Without giving short shrift to genetics, the conditions in which each of us grow up are significant social determinates of our health. Our citizens who lack access to quality healthcare, lack access to quality education, live in dangerous communities, have no economic stability, and/or live in communities with pollutants are likely to development chronic physical and/or mental health diseases. Dealing with these negative social determinants upstream will require significant policy changes—frequently through legislation.

Most of us do not want to become politicians to work on these issues, but we can help individual patients by asking about social needs and facilitate referral to social service agencies. Those primary care practices that care for Medicaid members are now required to screen patients for food, utilities/housing, transportation, and personal safety needs and make needed referrals. NCDHHS is working on a digital platform (NC CARE 360) to make this process easier. We can help our fellow physicians by doing the same in our practices. Most of our work will continue to be helping patients make repairs, but let's also help patients deal with social stressors.

Editor's Note: for more information about NC CARE 360, go to www.nccare360.org

NORTH CAROLINA Psychiatric Association news

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President's Column

Own Your Voice

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

As this year marches on there are many things on which we reflect! The past two years have created much difficulty for many. The strain on psychiatrists has been huge, with many changes in the way we carry out our profession. We have seen the rates of substance use increase, the rates of overdose deaths escalate, and the rates of depression and anxiety climb. The ability for people to access psychiatric care has declined, especially for children. To quote D***r. Samantha Meltzer-Brody***, "we are now dealing with the mental health tsunami." Others have spoken about the "second pandemic," referring to the mental health consequences of the COVID pandemic. We have known that psychiatric care has been undervalued for many years. Yet there has been steady, continuous work by NCPA members to provide care to individuals who need us.

There is a growing awareness of the need for psychiatrists to be involved in the overall care of individuals. We practice in different areas and in different settings, working in all of them to fulfill our mission statement—proving quality care people with mental illness. The more we engage in the house of medicine, strive to advocate for those who cannot advocate for themselves, foster diversity, equity, and inclusion, and unite to eliminate barriers for people who need our help, the more we impact the direction in which our profession moves. Now is the time for each of us to "Own Our Voice."

Through our tireless striving and partnering with other specialties we are seeing the frontiers of collaborative care opening up and renewed interest in this model. It is just the beginning, but the doors are now open. Collaborative care offers the possibility of more people having their mental illness identified and diagnosed, with many more people getting more appropriate care under the direction of a psychiatrist.

Such progress is the product of advocacy taking place at multiple levels—with physician colleagues, with state policy makers, with insurers, and with our national office. The more we engage in advocacy the more we can achieve. This is the value of owning our voice.

A number of NCPA committees have been impacting legislation at the state level. Their efforts have reshaped bills that otherwise would have created difficulties for the patients we treat. The Legislative, Public Psychiatry and Law, and Practice Transformation Committees have been helping members understand and manage legislation which impacts patient care.

Owning our voice has also led to inroads in diversity, equity, and inclusion. The Race, Ethnicity, and Equity Committee has been active since its creation in 2020 and recently developed a Diversity, Equity, and Inclusion Policy adopted at the April 2022 Executive Council meeting. The committee has set aggressive goals for the coming year to support and promote diversity and equity, as well as addressing the health inequities that have been highlighted in the COVID pandemic.

Owning your voice also means letting NCPA know of your needs and the support you seek as we continue to work to care for our patients and promote the continued growth,

development, and integration of our profession.

Over the past year, ***Dr. Alyson Kuroski-Mazzei's*** leadership has been invaluable. She continued to move our profession forward during difficult times as did ***Dr. Zachary Feldman*** before her. She has kept us on track and has continued to help foster the growth of our organization. It is with much appreciation that I send thanks her way. Let us continue the mission of addressing the needs of our patients and our profession by "Owning Our Voices!"

State Health Plan: Join in June

The NC State Health Plan will open its network for providers to enroll for a short period, through June 30, 2022. This BCBS-managed network covers approximately 700,000 NC residents, one of the country's largest risk pools, and pays 160% of Medicare. This is the only period in the year when current BCBS network providers can enroll to ensure their paid at this rate.

Visit www.shpnc.org/nc-state-health-plan-network to learn more and enroll.

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

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

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

Should payers and psychiatrists work together to develop value-based care?

Dr. Brundage:

Measurement-based care (MBC) and value-based payments in a private, outpatient, psychiatric practice – especially one that includes psychotherapy – evoke strong reactions. Using common scales like the Patient Health Questionnaire (PHQ-9), Quick Inventory of Depressive Symptomatology (QIDS-SR), or Hamilton Depression Rating Scale (HDRS) holds the promise of better outcomes for our patients. There is no universally agreed-upon way to implement measurement scales in small or solo outpatient psychiatric and psychotherapeutic practices. Still, so long as psychiatrists work with insurers, we will have to contend with the fact that this is the direction of managed mental health care. As such, it is in our best interest as advocates for ourselves and our patients to engage in dialogue with payers.

The pervasive skepticism that many of us have vis-a-vis payers often leads us to close off dialogue. Much of this skepticism is warranted, but our profession faces harm if more of us don't get out of our lanes. Dialogue with payers, or getting out of our lanes, often requires learning a new language. I recently encountered the term 'salary band' in a conversation about rates of COVID vaccination. The observation was that people in lower salary bands had lower rates of vaccination. Language matters. 'Salary band' whitewashes what we would otherwise call low wages. It disconnects us from considering the difficulties someone in a lower 'salary band' faces in taking time off work to get vaccinated, get transportation or recover. So, yes, we should engage but we must steadfastly pay attention to what is hidden in the language we use.

Dr. Bhalla:

In one word, yes! Healthcare policies – at the federal and state level together – can have a drastic impact on how we deliver health care. An understanding of how these policies can impact our practice is critical of strong mental health advocacy. Psychiatrists like Dr. Brundage need to be at the table when payers and policy makers try to enact change.

The shift to value-based care is the most recent trend in health care policy. It's likely here to stay, as value-based care has support from Republicans and Democrats policy makers alike. As all of us are keenly aware, we psychiatrists are a finite resource. Only some of the patients who need us can access our services because of important barriers to care. Value-based care – when well thought out and implemented appropriately – can be a useful tool to improve access to high quality behavioral health services to our patients.

Our field is special in so many ways from the rest of medicine. Since we do not have lab or imaging tests to measure disease severity, we rely on measurement-based care to measure behavioral health quality in value-based contracting. Under a value-based framework, payers should want patients to get high quality outpatient mental health services. Compared to other services, they're relatively low cost and can substantially reduce the amount of avoidable medical, surgical, and high-acuity services.

Without the collaboration and support of psychiatrists to help advise payers on how value-based care should be conceptualized, we run the risk of payers lumping mental health treatment into the same category as other medical care. Our services could succumb to pressures to cut costs – ignoring how treating the mind is an investment that can improve both mental and physical suffering.

While it may be a fact of life that there will always be some level of skepticism between payers and physicians, we owe it to our patients to work together to improve our quality of care.

In part three of the series, we will ask the question, "What impact would MBC/VBC have on the physician-patient relationship?"

NCPA Executive Council 2022-2023
Meet Your Newly Elected Officers

In March, NCPA members returned their election ballots, voting overwhelmingly to approve the slate of officers proposed by the Nominating Committee. The newly-elected officers began their terms at the conclusion of the APA Annual Meeting in New Orleans on May 25. Congratulations and thanks to the incoming NCPA officers and new Executive Council member for 2022-2023!

For a full list of Executive Council members, please visit the "About" section of the NCPA website: www.ncpsychiatry.org. Members with questions about the election process or interest in becoming more active in NCPA should contact staff for more information, info@ncpsychiatry.org.

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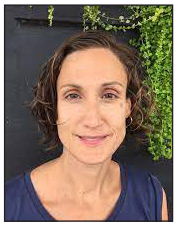
President

Constance Olatidoye, M.D.
President-Elect



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APA Assembly Representative

...*"Annual Meeting" continued from cover*

our speaker on integrated care/collaborative care, and UCLA faculty Timothy Fong, M.D., as our speaker on gambling disorder and non-substance addictions.

Our child psychiatry track, a popular destination for child and adult psychiatrists alike, will return. Amanda Lattimore, Ph.D., shares her data on national trends of addictions in youth. Amy Yule, M.D. of the AACAP Addictions Committee will focus her presentation on the assessment of substance use disorders in the context of youth with psychiatric disorders. Lucien Gonzalez, M.D., M.S. is an addiction trained pediatrician who will zero in on approaches to screening, psychoeducation and cultural responsiveness for children and adolescents.

Schedule subject to change any time.

While the scientific sessions are strong and timely, we realize that other benefits of this annual scientific conference are coming together, seeing old friends, meeting new colleagues, and networking over meals and drinks. We are placing member/attendee safety as a top priority so that the opportunity to socialize can be offered.

Registration is now open, visit www.ncpsychiatry.org/annual-meeting. Note that during registration we are asking attendees to agree to abide by safety standards that will be in place. More details about our social schedule will be available soon.

The Renaissance Asheville Hotel is currently taking reservations for the 2022 NCPA Annual Meeting. Make your hotel reservations today for the meeting to avoid overflow accommodations! Hotel reservations can be made now by calling the Renaissance Asheville Hotel at: 1-828-252-8211 or by visiting https://bit.ly/3Np0qfv. Mention that you are with the North Carolina Psychiatric Association to receive the group rate of $214. Reservations must be made by September 2 to receive the group rate.

REGISTER NOW

www.ncpsychiatry.org/annual-meeting

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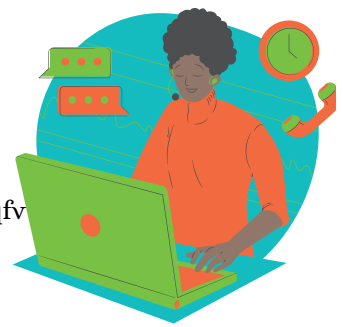

Zebra, Horse, or Zorse of Sorts? A Psychiatric Approach to Long COVID

Luciana Giambarberi, M.D.

Long COVID, also known as chronic COVID-19 and long-haul COVID, is defined as COVID-related symptoms lasting longer than four weeks after infection not otherwise explained by another diagnosis. Additionally, ICD-10 code "unspecified post-COVID conditions (U09.9)" was approved in October 2021. The unavoidable lack of standardization that arises in situations of new, rapidly-changing information, has led to confusion about long COVID symptoms among providers and patients alike. Naming a condition creates some structure for management and research, as well as context for our patients. However, post-viral and post-hospitalization syndromes are not new. There is still little known that is unique to long COVID, and long COVID symptoms can overlap or co-occur with other conditions. This article provides a brief psychiatric approach to common long COVID symptoms.

Establishing rapport with long COVID patients is essential and includes emphasis on validation and empathy. Long COVID patients may have experienced multiple forms of trauma, including healthcare-related, and some may still be uncertain about their diagnosis. The psychiatric evaluation should always include a thorough review of medical history, medications, and plans for further workup. This might consist of a complete blood count, comprehensive metabolic panel, electrolytes, hormone levels, medication levels, vitamin levels, urine analysis, urine drug screen, ECG, etc.

COMMON SYMPTOMS

Fatigue is one of the most common symptoms of long COVID, and it is associated with multiple etiologies. Fatigue is often encountered by psychiatrists as it relates to mood, anxiety, and sleep disorders. In the absence of a known psychiatric disorder, psychiatrists should communicate with the medical team for continued workup.

PATIENT CARE TIPS

- Avoid sedating medications.
- Consider activating medications.
- Refer to PCP/specialists as needed and keep an open dialogue.
- Refer to/provide psychotherapy (ex. behavioral activation, cognitive behavioral therapy).
- Review pertinent lab work and testing.

NEUROPSYCHIATRIC SYMPTOMS

Cognitive change, sometimes referred to as "brain fog," is another highly reported long COVID symptom. Patients have described examples of altered attention, executive function, and/or memory. As with fatigue, cognitive changes are associated with a spectrum of etiologies. In a psychiatric setting, subjective cognitive changes can often present as a result of untreated psychiatric disorders.

PATIENT CARE TIPS

- Primary cognitive disorders are best evaluated when comorbid psychiatric conditions are controlled or in remission.
- Consider a MoCA and/or neuropsychological testing.

Anxiety, depression, and PTSD are all symptoms of long COVID. These can present de novo or relative to other COVID stressors. COVID patients who received treatment in the ICU may experience post-intensive care syndrome (PICS). And some COVID courses are complicated by stroke, which itself can present with post-stroke psychosis, anxiety and depression. Therefore, patients with a history of COVID and stroke may benefit from additional psychiatric monitoring.

Secondary psychiatric symptoms can also manifest in long COVID patients. For example, **olfactory and gustatory abnormalities** are not treated by psychiatrists, but it is worth mentioning that the loss of these functions can contribute to anxiety and depression. Referral to sensory retraining therapy should be considered in long COVID patients.

Of note, mental health patients often forgo general medical care. Therefore, it is particularly important to ensure that long COVID patients have an established multidisciplinary team.

OTHER SYMPTOMS

Chest pain, shortness of breath, and dysautonomia (ex. POTS) have been reported as long COVID symptoms. While these symptoms may not be primarily psychiatric, they can correlate with anxiety or side effects of certain psychiatric medications.

Long COVID's multisystem involvement has emphasized the need for more comprehensive psychiatric care. Now, more than ever,

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Our Patients Who Commit Suicide: How Are We Handling It? How Are You Handling It?

Gerald Plovsky, M.D., D.L.F.A.P.A

Like many physicians, we care for patients who will die on our guard. But the death from a medical illness is fundamentally different than a patient who chooses to end his/her life by suicide. Medically ill patients may utilize physician assistance in U.S. states and other countries where it is legal or may at some point become exhausted and choose in a rational way to refuse care resulting in their death. Psychiatric patients with mood or psychotic disorders are understood to have an underlying illness that can impact their judgment and distort their perceptions, which then may usher in suicidal ideation and behaviors. Our role is to treat their illnesses and protect them with inpatient hospitalization if needed. All well-intentioned physicians respond to the death of a patient with the question: did I do my best in caring for my patient?

We psychiatrists, perhaps more than other physicians, have a more intimate relationship, a team-like partnership, with our patients. When a patient actively and independently ends his/her life, it results in feelings that they have abandoned this relationship producing a mixture of feelings. Then come the feelings from the patient's family towards us and our care, which is sometimes positive, sometimes not. Throw in a letter that appears one morning at your office from a legal firm sparking feelings of fear and dread. All of this can be overwhelming, and who do we process it with? A spouse, colleagues, friends, or staff? Actually no. The first thing your malpractice attorney will tell you is not to speak to anyone about the death for legal reasons. It is a setup for isolation, self-doubt, and emotional pain.

Psychiatrists are different than other physicians. Psychiatrists greatly value introspection and exploration of feelings, both in our patients and ourselves. We are a different breed, which is why we chose to specialize our medical training in the brain, the mind, and its emotions. We dare to look more closely at ourselves. We ask ourselves after a suicide if we have miscalculated and failed. We must remember that the illnesses we treat are extremely common and deadly. Of the top 10 causes of death, most are declining in frequency, except one: suicide, mostly from Major Depression, continues to escalate. From 1999 to 2018, suicides have increased 35%, and this statistic is continuing to rise.

Frequency of patient suicide for an individual psychiatrist is a dubious and ambiguous quality indicator. Many factors related to suicide rates are unrelated to the skill and competency of the psychiatrist. It is difficult for us or anyone to judge us based on our individual rate of suicide. For example, being new in a community you may be the new referral source for patients at the end of their illness journey after they have seen multiple providers and failed multiple treatments. We don't refuse to see patients because of a poor prognosis or due to a history of failed past treatments. Another factor may be their payor source. While suicides affect all socioeconomic levels, the patient population who can pay out of pocket or has good health insurance is different than the patient population on Social Security Medicare disability for depression.

Perhaps a first step to understanding the number of patients you have lost to suicide might be to have some sense of how you compare to your colleagues with similar practices. A recent survey of NCPA members in nonacademic outpatient practices suggests that it is not unusual to have six suicides by the third decade in practice. Regardless of the number of patient suicide cases a psychiatrist has, for any individual case there will likely be a need to process feelings. I think it would be advantageous for NCPA to identify psychiatrists who can be available to offer emotional support and counseling to psychiatrists dealing with their patients who commit suicide. This confidential physician-therapist relationship is legally acceptable and appropriate. This opportunity could be potentially very therapeutic for an unmet and unspoken need of North Carolina psychiatrists.

Editor's Note: If you are interested in continuing the conversation on this topic please contact us at info@ncpsychiatry.org.

APA Recognizes Honorees in New Orleans

Congratulations to the following NCPA members who have achieved Life Member status!

New honorees were formally recognized at the APA Annual Meeting in New Orleans in May. Please note, honorees listed below may hold additional distinctions other than those most recently awarded.

Life Member

Tedra Anderson-Brown, M.D.
Kristin Baker, M.D.
Joseph Balla, M.D.
Neil Dolan, M.D.
Celeste Good, M.D.
Danuta Jagla-Schudel, M.D.
Fred L. Jarskog, M.D.
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James Pawlowski, M.D.
William Price, M.D., M.P.H.
Beth Ridgway, M.D.
Margaret Rukstalis, M.D.
Annemarie Russell, M.D.
Randy Sellers, M.D.
Nilima Shukla, M.D.
Jeffrey Snow, M.D.
Odette Valder, M.D.

Distinguished Life Fellow Member

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Debra Bolick, M.D.
Donald Buckner, M.D.
Fred Caudill, M.D.
Ayesha Chaudhary, M.D.
Nancy Clayton, M.D.
George Corvin, M.D.
Carey Cottle, M.D.
Karon Dawkins, M.D.
Michael DeBellis, M.D.
Manish Fozdar, M.D.
Bradley Gaynes, M.D.; M.P.H.
Olivier Goust, M.D.
William Griffies, M.D.
Sarah Lisanby, M.D.
Erin Malloy, M.D.
Mark Mattioli, M.D.
Parish McKinney, M.D.
Robert Millet, M.D.
Rex Moody, M.D.
Ashwin Patkar, M.D.
Holly Rogers, M.D.
Linmarie Sikich, M.D.
Michael Smith, M.D.
Elizabeth Stanton, M.D.
Thomas Thompson, M.D.
Charles Vance, M.D., Ph.D.
Martin Williams, M.D.
Nicole Wolfe, M.D.
David Zarzar, M.D.
Richard Zenn, M.D.

Life Fellow Member

Vivian Campbell, M.D.
Karla de Beck, M.D.
Joseph Horrigan, M.D.
Darlene Ifill-Taylor, M.D.
Arlene Miller, M.D.
John Shin, M.D.
Ronald Waycaster, M.D.
Kyle Worsham, M.D.

Apply Now for Fellowship of the APA (F.A.P.A.) - Deadline September 1

Fellows of the APA (F.A.P.A.) are members of a select group dedicated to shaping the role of psychiatry in our healthcare system. Becoming a Fellow is an honor that reflects your dedication to the profession and is recognized by your peers as a mark of your leadership in the field of psychiatry. Learn more by scanning the QR code. Please let NCPA know if you are interested in becoming a Fellow by emailing info@ncpsychiatry.org.

SCAN ME

Member Notes

Venkata (Amba) Jonnalagadda, M.D., D.F.A.P.A., D.F.A.A.C.A.P. has been appointed Parliamentarian to the American Psychiatric Association Board of Trustees and Corresponding Member on the APA Council on Addiction Psychiatry. Dr. Jonnalagadda is the Associate Chief of Staff at the Durham VA Health Care System. Congratulations and thank you, Dr. Jonnalagadda, for volunteering your time and expertise for the benefit of the APA!

Stephen Wyatt, D.O., L.M., NCPA Addictions Committee Chair, will lead the newly-launched Addiction Psychiatry Fellowship this summer at Asheville-based Mountain Area Health Education Center (MAHEC). This fellowship is the first of its kind in North Carolina and one of fewer than 50 across the United States. The expansion of this critical healthcare workforce—psychiatric physicians trained to treat substance use disorders—comes at a critical moment. This fellowship aims to turn the tide on the staggering number of accidental overdose deaths in North Carolina.

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

"Could you please see this patient? He only speaks Spanish."

Xiomara Nieves-Alvarado, M.D.

I was born on the beautiful island of Puerto Rico. We speak Spanish, and we learn to speak English, but our culture very much speaks Spanglish. Growing up I was fortunate to have the chance to see the world since I was a toddler. My parents always wanted to be together and never left me with grandparents or babysitters when they had an event on the mainland. Little by little my dad was asked to travel to Europe, to Mexico, and his duties required him to be on the fly all the time. This gave me the opportunity to see different cultures before the boom of globalization, as well as to make friends everywhere I'd go, which I have kept.

When I started residency at Duke, I was very happy that the diversity of patients was such that one moment I would be talking to a person in English when suddenly, I would need a translator to speak Mandarin. My favorite was when I was called by a team because there was a Spanish -speaking patient and no one on the team spoke Spanish. I have never felt insulted in response to these requests. In fact, I find great meaning doing these interviews to make sure the entire context of the interview is well understood. Now, where is the challenge?

One challenge is determining how to communicate to my supervisor that I am not concerned about a patient's seemingly excessive use of religious content. I have heard translators emphasize to psychiatrists when a patient says, "Thanks to the Lord," "If God allows," "God sees everything," or "I just listen to God and live wholly." These sayings, in the raw translation, could be interpreted in so many ways. Now, when you ask the patients specifically about their thoughts, if God speaks only to them, or if God gave them special powers, or if they are God themselves, they mostly answer "no."

On the same note, when Hispanic patients say "Me quiero matar" (I want to kill myself), "Yo me queria morir" (I wanted to die), or "Matame" (Kill me), there may be no real intent of dying. These are used mostly as a figure of speech in embarrassing or painful situations. Lastly, some psychiatrists tend to use the affects and tones of the patient's relatives as part of their assessment of family dynamics and structure. Whereas that can be appropriate in many cases, it is important to consider how the field of medicine is seen in other countries. From my experience, Hispanics tend to be very patriarchal when it comes to medical evaluations, interviews, and medical recommendations. Usually, the doctor has the last word and that is what will be done. I have encountered this dynamic to be misleading to some American psychiatrists who may not recognize that families will not fight or question medical decisions or interventions. At times, they don't even ask. It is important to keep in mind that if family members don't ask for visitation hours or ways to be of help, it doesn't mean that they are not invested and emotionally affected.

The message behind these examples is that it is critical to be able to recognize the difference in dynamics, to provide the opportunity to ask for thoughts, and to differentiate between exact words and figures of speech when we are evaluating our patients. Listen to the entire cultural context instead of focusing only on specific words. Hence, it is important to study history, to travel, and, if possible, to ask patients and families to describe where they come from and how have they done things in the past.

This is what I face every time I have a Hispanic or Latin patient on my case load. It demands much emotional presence that cannot be put into words because in the end it might as well be called an "instinct," but is not. It is not an instinct. It is an active search for patterns and among many individuals with similar demographics that leads me to make my assessment. This is what I understand as cultural competence and what I am continuing to work towards as I expand my knowledge and cultural experience.

...*"COVID" continued from page 6*

long COVID has brought the collaboration of medical specialties into the spotlight. As further information becomes available, we will continue to improve our approach to long COVID and gain confidence in its unique characterization.

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

SCAN ME

What Psychiatrists Need to Know About... Commercial Insurers and Collaborative Care Coverage!

BCBSNC Will Cover Collaborative Care Management Beginning July 1

July 1 will be a notable date for North Carolina healthcare. As of July 1, 2022, primary care settings that provide collaborative care services can bill Blue Cross Blue Shield North Carolina (BCBSNC) commercial plans using the Psychiatric collaborative care management services codes (99492, 99493, 99494, G2214).[1] BCBS commercial plans will join the ranks of the BCBS Medicaid Plan, Healthy Blue, which already cover collaborative care services. A new statewide CoCM Consortium led by NC Medicaid's Chief Medical Officer Shannon Dowler, M.D., reports that all other commercial insurers say they already cover these codes.

In a recent article outlining its CoCM model plans, BCBSNC made this statement: "Blue Cross NC will pay for collaborative care codes in a phased approach. The phased implementation will give all qualifying providers an opportunity to be reimbursed for CoCM on a fee-for-service basis, given that they have demonstrated their ability to deliver to key components of the CoCM (ie: registry, screening, case managers, psychiatric consultation in primary care)."

For a number of years NCPA and its leadership have been vigorously advocating for recognition of the CoCM model as one of the most highly researched, evidence-based practices for integrated care.

The announcement by BCBSNC follows a growing trend of activation of the CoCM CPT codes and adoption of this model across the state and country. In October 2018, for example, the CPT codes were activated by NC Medicaid and, shortly thereafter, NCPA and its partner professional organizations began its outreach around the CoCM model to commercial insurers. Legislation is being passed in other states to require insurers to cover CoCM.

Primary care settings are a "gateway" for many individuals with behavioral health care needs. The CoCM model provides a way for Primary Care Providers to clinically address the care of patients who screen positive for psychiatric conditions, in collaboration with a consulting psychiatrist and a care manager. The flexibility of the CoCM model allows psychiatrists to contract out a day or two a week to primary care agencies, practices, and clinics. This team-based care approach focuses on a new way to leverage psychiatric expertise to provide evidence-based management of behavioral health conditions in the primary care setting.

NCPA is working with NC DHHS leaders and staff as they develop technical assistance for primary care practices. This is huge progress in moving this model forward to provide for more screening and treatment of people in North Carolina with mental illness.

NCPA is receiving questions about how to find psychiatrists willing to become psychiatric consultants in the model. Interested in joining the Collaborative Care team? Check out the APA's webpage on Integrated Care; join the APA Collaborative Care "Community," led by John Kern from the AIMS Center at University of Washington, by emailing san@psych.org stating your interest; and if you feel you need a refresher course on the Collaborative Care Model, take the APA training course. In North Carolina, more than 150 physicians (127 psychiatrists and 29 primary care) have been trained in Collaborative Care by the APA. As the Collaborative Care Model moves into the North Carolina house of medicine, let's roll out the welcome mat by growing the psychiatric consultant pool!

To take the APA's CoCM Training Course, scan the QR code using your smartphone's camera.

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1 www.ama-assn.org/practice-management/cpt/learn-about-4-new-cpt-codes-bill-collaborative-care

Mental Health Equity Program of the UNC Department of Psychiatry

Tyehimba Hunt-Harrison, M.D., M.P.H.

A year flanked by the devastation of the coronavirus and the public outcry over the murders of Ahmaud Arbery, Breonna Taylor, and George Floyd, 2020 provided an intense beam of light onto inequities and injustices that have plagued healthcare access and outcomes for communities of color since before the birth of this nation. With the increased appreciation for the necessity of mental wellness and quality healthcare for the good of both individuals and society, there has also been heightened awareness of the disparities that contribute substantially to poor outcomes for many whom clinicians are to serve. Even in North Carolina, with medical and industry giants, there are gaping holes that must be eradicated in our efforts to justly meet the needs of all our communities. The Mental Health Equity Program (MHEP) of the UNC Department of Psychiatry was envisioned in 2020 to do just that.

MHEP's vision is a simple, straight forward statement: All in need of mental and behavioral healthcare will have high-quality and meaningful clinical experiences across the continuum of care.

Admittedly, this is not a novel idea, but neither are its shortcomings in its actual implementation. For this simple statement to transform from mere words for marginalized communities, there needs to be increased awareness that is directly coupled with action steps to remove the persistent inequities and barriers to high-quality mental health care provision. The MHEP's mission is to accomplish this ideal via a multi-pronged and phased approach that intentionally targets the factors that impact access and outcomes. This is accomplished via strategies that prioritize advocacy, community engagement, multi-disciplinary collaborations, data-driven interventions, and a culturally centered focus.

Although a new program, we have been very actively learning from stakeholders, identifying resources and strengths (including the engaged leadership of our department's chair, ***Samantha Meltzer-Brody, M.D., M.P.H.***), and attending to areas for departmental improvement. This second year of MHEP is dedicated to building sustainable partnerships with community stakeholders (i.e., faith leaders, Indigenous communities, historically black colleges and universities, etc.) and improving the health equity education of our workforce. In the summer of 2022, we will launch two educational programs for general psychiatry residents: 1) the Mental Health Equity Track with two second year general psychiatry residents taking a deeper dive into understanding issues and developing solutions towards equity and 2) a novel four-year curriculum program that integrates a health equity lens throughout the residency's didactics and clinical spaces. Simultaneously, we are developing trainings for our faculty to enhance their provision of informed healthcare and trainee supervision. In addition to improvements targeting our current workforce, we are also engaging in marathon efforts to increase the future workforce's diversity for both clinical and research teams. Although current priorities are centered on addressing inequities based in race and ethnicity, MHEP also recognizes the combined impacts of intersectionality and the disparities effecting other marginalized communities.

The MHEP is only at the beginning of the journey towards improved mental healthcare for all. Thankfully, we are not alone in this work. Our department has numerous faculty, staff, and trainees engaged in the mission via research, work groups, and educational programming. Fortunately, this is a time ripe for change and our dynamic team has the determination to drive the momentum forward.

Dr. Hunt-Harrison is a Child & Adolescent Psychiatrist and Associate Professor in the Department of Psychiatry at UNC Chapel Hill School of Medicine. She serves as the Vice Chair of Mental Health Equity and Community Engagement of the UNC Department of Psychiatry.

Submission Period Open for 2022 NCPA Poster Session

The Psychiatric Foundation of NC will host this year's Resident Poster Session on Saturday, October 1 at the 2022 Annual Meeting & Scientific Session in Asheville, NC. To encourage participation, there will be four monetary awards from the Psychiatric Foundation of North Carolina and the North Carolina Council of Child and Adolescent Psychiatry.

Residents from all eight psychiatric residency programs across the state are invited to submit abstracts and posters relevant to any aspect of adult or child/adolescent psychiatry, including clinical treatment, research, training, service delivery, administration, etc. We would love to have all the programs represented! Submission deadline is July 15. To submit an abstract visit www.ncpsychiatry.org/poster-session.

NORTH CAROLINA
Psychiatric
Association

Calendar of Events

June 11, 2022
NCPA Executive Council Meeting

July 15, 2022
Annual Meeting Poster Session
Submission Deadline
www.ncpsychiatry.org/poster-session

September 29-October 1, 2022
NCPA Annual Meeting & Scientific Session
Renaissance Hotel, Asheville
Registration Now Open!
www.ncpsychiatry.org/annual-meeting

Early Bird Registration Ends July 31st!

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

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

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

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

Advertise with NCPA

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