NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

DECEMBER 2019

The NCPA conference room got a high-tech makeover to support video conferencing!

IN THIS ISSUE

Don't Forget to Pay Your Dues!

The deadline to pay your 2020 membership dues is December 31, 2019. Here are ways you can renew today:

1. Pay online:
   www.psychiatry.org/PayDues
2. Pay by phone:
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   APA Membership Dept
   800 Maine Avenue, S.W.
   Suite 900
   Washington, D.C. 20024

Breaking News: On November 19 (the week this issue was printed), NC DHHS announced indefinite suspension of NC Medicaid reform due to lack of funding from the NC General Assembly. NCPA will share more details as they become available on our website and in future electronic newsletters.

"State of the State" Update

Robin B. Huffman
Executive Director, NCPA

*Editor's Note: This column is excerpted from remarks shared with members at the NCPA Annual Business Meeting, September 21, 2019. *As this issue was going to press, NC DHHS announced that the planned Medicaid reform as described below is indefinitely suspended. The intention of the now-stalled reform effort as it relates to psychiatry is still newsworthy, although implementation is up in the air.*

State Health Plan

The best news to report this year is that, despite the battles between the health care community and the State Treasurer, psychiatry had a big win!

NC State Treasurer Dale Folwell has created a new State Health Plan (SHP) network, in addition to the Blue Cross Blue Shield NC (BCBSNC) network, for state employees. Intentionally or not, this new network is offering significantly higher reimbursement rates for most psychiatrists and mental health professionals who signed up for the Clear Pricing Project, which begins January 1, 2020.

NCPA gave much feedback and shared the Milliman report and other parity data last year to Treasurer Folwell. We argued that mental health expenditures were significantly below the national average, and that this underspend could be part of the reason for escalating medical costs.

We hope our behind-the-scenes work helped—and will continue to push—rate parity for psychiatrists!

Medicaid Reform*

On the first day of the NCPA Annual Meeting, NC DHHS Chief Medical Officer for Behavioral Health & IDD, ***Carrie Brown, M.D., M.P.H.*** gave a presentation about Medicaid Transformation. The good news in her presentation was that there is real intention to include psychiatry in general care for patients. Mental health care benefits will be part of the Standard Plan package being offered as part of this move to capitated Medicaid that is slated to begin next year. Care for people with severe, persistent mental illness, addiction, and developmental disabilities will continue to be carved out to the LME/MCO system that is currently in place, until 2021, when new Tailored Plans for this population will be established.

There is a real interest in getting psychiatrists back into Medicaid, especially enrolling now with the Standard Plans to care for those being seen in primary care practices.

continued on page 8...

From the Editor: Medicare for All — Pro, Con, or Other?

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

This newsletter issue includes our first attempt at a regular feature presenting contrasting opinions on important topics. (See pages 5 & 6.)

In reality, it is impossible to address "Medicare for All" as a binary choice. There are too many proposals that are variations on the idea. Furthermore, the most discussed plans are evolving as the election season goes forward.

The most discussed alternative to Medicare for All, generally known as the "public option" within the Affordable Care Act, also needs clarity from its proponents.

However, I think it is useful to present an overview of Medicare for All. We also offer an alternative idea from NCPA Immediate Past President ***Mehul Mankad, M.D., D.F.A.P.A.*** His perspective identifies some possible unintended consequences of sweeping change.

It should come as no surprise to members that the fate of Medicare for All has real implications for psychiatrists. Your NCPA leadership is aware that politics is not a spectator sport. Your involvement makes us stronger in our advocacy.

All readers are invited to respond to the ideas presented, either brief- or long-form commentary. We will publish replies in the March 2020 newsletter. Send an email to NCPA Communications Coordinator Kelly Krasula at kelly@ncpsychiatry.org.

NORTH CAROLINA Psychiatric Association news

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The *NCPA News* is a publication of the NC Psychiatric Association, 4917 Waters Edge Drive, Suite 250, Raleigh, NC 27606.
To update your mailing address or if you have questions or comments about *NCPA News*, contact NCPA Staff, 919-859-3370 or info@ncpsychiatry.org.

NCPA President's Column: Leadership in the Eyes of Past NCPA Presidents

Jennie Byrne, M.D., Ph.D., D.F.A.P.A.
President, NCPA

In our last newsletter, I addressed the challenges of leadership for residents and early career psychiatrists in the "rush hour of life." Thank you to everyone who reached out to say that my experience resonated!

After writing about the "rush hour of life," I realized that I knew very little about what it was like to be a late-career or retired psychiatrist in North Carolina. To get some perspective, I spoke with some past NCPA presidents who are in late stages of their career or retired from psychiatry. Thank you, Drs. ***Peggy Dorfman*** (1991-1992), ***Lesly Mega*** (1993-1994), ***John Wagnitz*** (1998-1999, 200-2001), and ***Erv Thompson*** (1999-2000)!

A common theme among the group was that none of them would have self-identified as a "leader" at the beginning of their career. They were all very interested in psychiatry and passionate about caring for patients, but none planned to go into administration or lead organizations. One quote that really resonated with me personally was, "I did not have a desire to be a leader, but I wanted to fix things."

All of the individuals I spoke with described different practice settings, varying from private practice to military service to hospitals to public psychiatry. In each setting, they found problems to be fixed, and set about fixing them!

In the process of looking for solutions and fixing problems, these psychiatrists became leaders. People looked to them to organize groups and get things done.

One leader said in retrospect, "Leadership came to me naturally," even though she didn't think about it at the time. Another theme from this group was their hard work ethic and their passion for the practice of psychiatry and for their patients. One psychiatrist admitted that it has been a hard "daily grind" for 30+ years, and other pointed out that "enthusiasm is important, and you must feel strongly about what you want to do."

Regarding future leadership roles in psychiatry, the group had mixed responses. Some clearly want to continue working in psychiatry in some fashion as long as they are physically able; others were feeling burnt out and ready to enjoy a retirement that did not include psychiatric practice. All agreed they would like opportunities to connect with younger psychiatrists, be a mentor, or support the NCPA community in some fashion.

From the female psychiatrists in the group, it was clear that having other women advocate for them helped them advance into leadership roles. All the leaders felt like the NCPA provided a good support for them over the years.

What was their advice to other psychiatrists in early or mid-career? Here are some of their tips:

- **Avoid Isolation:** Participate in meetings/committees/work-groups that are outside your comfort zone.
- **Manage Your Money:** Don't wait until late in your career to plan for retirement.

- **Identify Interests:** It is important to have interests outside of work so when you are ready to work less you have things you enjoy doing.
- **Get Comfortable with Change:** Many things will happen that are outside your control.
- **Get Involved:** Ask your employer for time and money to participate in NCPA and other leadership groups.

What did I learn from this group? Leadership evolves over time and looks very different for different people. Tolerance for change, a desire to fix things, a willingness to get involved are important traits for leaders in psychiatry. I also learned that our "senior" psychiatrists have a wealth of information and experiences to share — and they are gracious with their time and advice!

The Basics of Medicare for All

Drew Bridges, M.D., D.L.F.A.P.A.
Past President, NCPA; Editor, NCPA News

The United States spends more money and receives poorer health outcomes than other countries, and leaves up to a third of citizens uninsured or underinsured. Extending coverage to all through the Medicare program is an attempt to address these shortcomings.

Democratic presidential candidate Bernie Sanders' plan is the most developed and most discussed proposal and will be the focus of this article. This version of "Medicare for All" is a complete replacement of all existing forms of coverage, with very minor exceptions. It replaces Medicaid, Medicare, private insurance, and other governmental programs with a new and more generous version of Medicare. New benefits include vision, dental, and some long-term care coverage.

Cost Structure

Patients will no longer pay premiums or have out of pocket expenses. Drugs will have minimal co-pays. New benefits and increased numbers of enrollees are paid for by higher taxes. Taxes will include a payroll tax for businesses, a household tax, and additional taxes on higher earners and wealthy people. On balance, the great majority of people will pay less for care.

Overall costs will go down due to more timely care. Fewer people will delay treatment or seek services at costly emergency rooms. Use of a single-payer will reduce administrative costs and corporate profits will no longer add to costs. Several analyses have estimated a $2–5 trillion-dollar savings as compared with the present system, but other analyses see considerably greater overall costs and less revenue generated by the proposed taxes.

Effect on Health Care System

The service delivery system will be more closely monitored by government regulations in order to control costs and eliminate disparities of care. Payment rates will be set for services. Doctors will almost certainly be paid less, but freed of significant administrative costs and paperwork due to elimination of multiple payers.

Effect on National Economy

The overall health care system is one-sixth of the economy. Medicare for all is a radical remake. No one can predict the overall effect on the general economy, but several points can be made. The payroll tax on businesses is anticipated to be one-half of costs for employers to provide coverage. Businesses, other than those in the health care business, will prosper. The household tax should be considerably less than the costs of premiums and out of pocket expenses, so most households will be better off. Cumulative taxes on higher income earners and otherwise wealthy will exceed current costs for those groups.

Businesses involved in the provision of medical services will be significantly disrupted, if not eliminated. Many involved in administrative roles in systems of care will lose their jobs, although some will be absorbed into the growing Medicare system. A single payer will enhance the development of technological tools for management of this new system, including electronic medical records and remote provision of services.

Effect on Psychiatrists

Not all private psychiatrists participate in Medicare. No one can anticipate what the effect will be on current practices with the loss of private insurers and gain of increased enrollment in Medicare. Our current public system of care for the most in-need, low-income patients may be better off with universal coverage.

Psychiatry's traditional struggle to achieve payment parity with other medical services will remain an issue. Intelligent advocacy will remain vital.

Alternative Plans

There are at least six reasonably developed alternatives that move in the direction of universal coverage, but stop short of the Sanders plan. These include a "Medicare at 50" and others accurately described as "Medicare for All Who Want It." However, none of these is as well developed and cost assessed as is the Sanders plan.

It is also fair to say that no other country serves as an obvious model for the U.S. to adopt. All have shortcomings. No other country offers a zero-out-of-pocket alternative.

Beyond Medicare for All

Mehul Mankad, M.D., D.F.A.P.A.
Immediate Past President, NCPA; Chief Medical Officer, Alliance Behavioral Health

As all physicians know, the United States' health care "system" is a bizarre combination of entitlement programs, commercial benefits, and an unfunded safety net. About nine percent of the population, or 28 million people, lack coverage.

When I was in medical school in the 1990s, the US was spending a staggering 10 percent of its Gross Domestic Product on health care. Other industrialized nations were achieving better health outcomes for less total expenditure. Fast forward to 2019, and our total expenditure approaches 20 percent.

Prior efforts to address the US health care crisis focused on providing some sort of coverage for the 28 million individuals who are currently uncovered. Will gap coverage, by enacting a "public option" of some sort, achieve the quadruple aim of 21st century health care? Will it improve quality, stabilize cost, increase access, and improve health care provider job satisfaction?

Medicare for All proposes to address the above dilemma of high cost and poor outcome through a national focus on quality. Mortality rates, disease burden, disability rates, hospital admissions, medical error rates, and disease-specific outcomes could all be addressed with a national strategy.

If we accept the economic upheaval of conversion of the US health care economy, then a transition to Medicare for all is consistent with health care as a right for all Americans. However, I have a slightly different take on this issue. It is important to preserve special programs for unique populations. These are programs that provide services above and beyond the current Medicare entitlement.

A Case to Preserve Medicaid, Indian Health, Veterans Affairs, and Other Special Programs

Before the term "Social Determinants of Health" existed, any experienced community psychiatrist could tell you that income, housing, education, and other demographic factors have a greater impact on a person's mental and physical health than the actual symptoms of their illness. For all of its challenges, the Medicaid system is more capable of serving less fortunate Americans than any other system in the US. Transportation to medical appointments, coverage of costly day treatment programs, and payment for long-term residential care are hallmarks of the Medicaid program that are not duplicated through Medicare.

While some populations are defined by income class or age, others are defined by unique factors. Currently, two million individuals receive health care through the Indian Health Service. The IHS funds health care in areas of the US that may be difficult to recruit. The IHS also provides culturally sensitive programming that specifically addresses the needs of the Native American population including Youth Regional Treatment Centers, a Methamphetamine and Suicide Prevention Initiative, and specialized health literacy campaigns.

> "94 million people, or more than a quarter of the population, receive care in special population programs. Unique services within these programs will not likely be preserved in Medicare for all."

Employing more than 300,000 in 170 hospitals and more than 1,000 clinics, the Department of Veterans Affairs provides services to one in 20 Americans. (Full disclosure: I worked for the VA for 15 years.) As with IHS, the VA has the ability to specialize in treatment that is either too costly or unavailable in the private sector. The penetration of psychotherapists specifically trained in evidence-based models for treatment of PTSD is much greater in the VA than anywhere else in the US health care system. Similarly, the VA serves as a clinical home for patients struggling with military sexual trauma, traumatic brain injury, and other injuries that would be hard to serve in the private sector.

Steps Forward

Achieving the quadruple aim of health care is much more likely with a coordinated approach. Replacing commercial health insurance with Medicare is one path forward. Subsuming programs for special populations under the Medicare umbrella may dilute their impact to a degree that compromises the ultimate goal of better health for all.

What Psychiatrists Need to Know About...

STOP Act (Update)

New Opioid E-Prescribing Requirement Begins Jan. 1

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

Since the public recognition of the devastative effects of the opioid epidemic, labeled a public health crisis in 2016, an enormous effort to combat the epidemic has been launched at every governmental and organizational level (local, state, federal — private and public). Efforts have been made in the prevention, treatment, and recovery from opioid use disorder. Multi-million dollar grants that have fueled these efforts are now showing signs of having an impact on this pernicious phenomenon.

On average, six North Carolinians die each day as a result of opioid overdose. For every death, there are multiples of other morbidities, including infection, fetal opioid withdrawal, financial loss, and relationship breakdown. For the first time in a decade, two observations point to progress made as a result of these efforts: a 25 percent reduction in opioid dispensing and a 6 percent reduction in fatal overdose rates. While the phenomena of opioid mortality continues to evolve as the result of resurgence of heroin use and introduction of the illicit fentanyl drugs, prescription opioids continue to be an important proportion of substances involved in the adverse consequences of the epidemic.

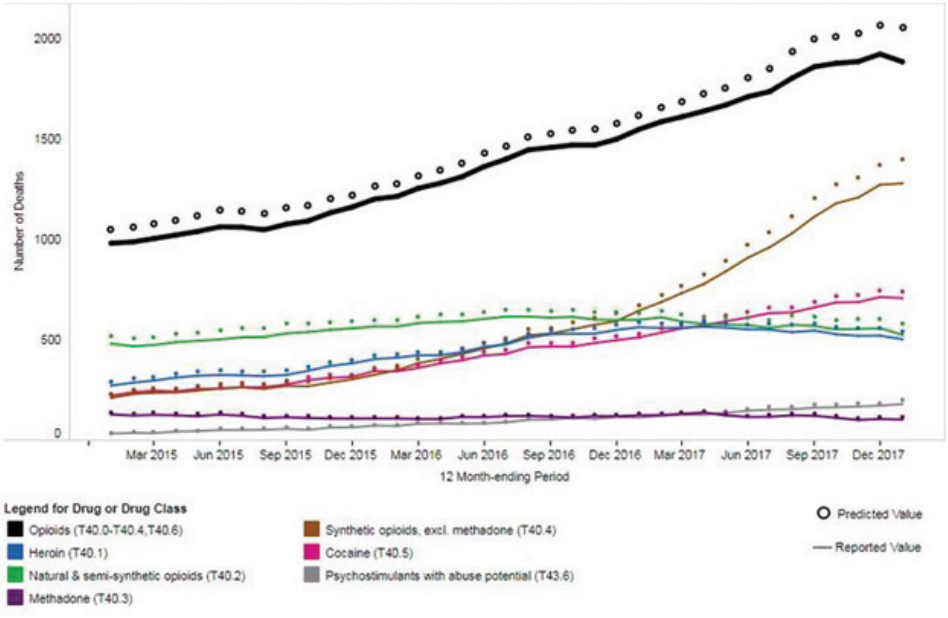


Figure 1. Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: North Carolina (March 2015–December 2017)
Source: CDC/National Center for Health Statistics

Among the most important initiatives has been a reevaluation of the role of opioids in the treatment of common painful medical conditions. Educational efforts nationally and throughout North Carolina have had the effect of changing practice patterns in the treatment and monitoring of risk in management of chronic pain. Many members of NCPA have been in the forefront of these efforts.

Among the changes that have made a difference are those in the legal and regulatory environment that are designed to provide guidelines and to establish guardrails for providers working with patients with chronic pain. One legislative initiative that has built on past successes is the Strengthen Opioid Misuse Prevention Act, or STOP Act (House Bill 243). This act, signed into law on June 29, 2017, with unanimous support in the NC legislature, is directed at preventing and reducing unsafe or inappropriate prescribing of opioid agents. The law also includes provisions intended to re-

duce the burden of unused opioid medications so frequently implicated in opioid related fatalities. Many of the provisions in the STOP Act have implications for prescribers and other health care professionals. Here, I will detail the provisions within this new law that are of importance for psychiatric providers.

Targeted Controlled Substances

The STOP Act applies to agents the law defines as "targeted controlled substances." Specifically, the law covers use of schedule II and III opioids and narcotics as specified in the NC Controlled Substances Act. Among these substances are the commonly used opioid analgesics and buprenorphine, used increasingly in the management of individuals recovering from opioid use disorders.

Prescribers Limit on Opioid Use

Among the provisions of the law that have direct effect on health care providers is the limit on the prescription of targeted substances prescribed for acute pain to five days or fewer. For post-surgical pain management, there is a limit of seven days. The law provides for follow-up prescriptions "as needed." Those dispensing targeted drugs (pharmacists) are not liable for filling prescriptions that violate limits. These provisions have been in effect since January 1, 2018. These provisions are directed at office or clinic-based care and do not extend to prescribing while patients are in hospitals, nursing homes, hospice, or residential care facilities.

The law now makes it mandatory that prescribers check the controlled substances reporting system (CSRS) before writing an initial prescription. In addition, for prescribing of targeted substances lasting more than 90 days, the CSRS must be reviewed before further prescriptions are written. When chronically prescribed, the CSRS must be checked at the end of each 90-day period. Documentation of the results of the findings from the CSRS must be recorded in the medical record. Prescribers will be subject to audit by NC DHHS. Violations of these provisions will be reported to the appropriate licensing board. Disciplinary actions are expected for violations.

Effective shortly after signing of the bill, physician assistants and nurse practitioners were required to consult with their collaborating physician before prescribing a targeted substance expected to last 30 days or more. The exact nature of the collaboration is not yet further defined in the law.

E-Prescribing of Targeted Drugs Beginning 2020

Effective January 1, 2020, all targeted drugs prescribed outside hospitals, nursing homes, hospice, and residential care facilities must be prescribed electronically. There is an exception for a provider who is having technical difficulties at the time of the prescription. Details of such failures must be documented in the record.

The provisions in the STOP Act may not directly affect many psychiatric providers. In part as a result of efforts by NCPA, commonly used psychotropic agents, such as stimulants used in the treatment of ADHD and benzodiazepines used for short-term treatment of excessive anxiety during periods of stress, are not considered targeted substances and not covered under the law.

Harm Reduction Provisions

The STOP Act also includes provisions that offer protections for individuals assisting in emergency interventions at the time of overdose. The law amends the NC Good Samaritan Law facilitating the distribution of naloxone by organizations under a standing order. Organizations are required to include "basic instructions and information" on how to administer naloxone. Organizations are largely immunized from liability that might arise out of such distribution. Other provisions encourage use of evidence-based public health interventions that have been shown to reduce harms associated with injection drug use. Previous language prohibiting "public funding" for syringe exchange is changed to "state funding," allowing cities and counties to fund these programs.

The STOP Act also includes a variety of provisions that regulate pharmacists dispensing of opioid drugs. These are designed to ensure accurate of reporting to the CSRS.

Hospice

Sponsors of the STOP Act recognized the need for efforts in disposing of opioid pills and capsules that are unused. For providers of hospice care, the law mandates education on the safe disposal of unused drugs to families and facilities.

The STOP Act is only one of a number of the important legislative approaches addressing the opioid crisis. These legislative approaches are only one of a number of efforts that appear to be having the effect of curbing the horrors of the opioid crisis.

To read a detailed summary of all STOP Act provisions, as prepared by the NC Medical Board, visit: https://ncmedboard.org/landing-page/stop-act.

...“State of the State”’ Update, continued from page 1

We are working hard to encourage primary physicians to use the new the Collaborative Care Model codes that NC Medicaid adopted. Talk to your primary care colleagues about being a psychiatry consultant for the model.

NCPA does have several concerns with Medicaid reform: the bumpy road to capitation, the move from fee for service to “value based care,” the assumption that primary care will be able to take care of patients with mental illness and addiction, and making sure psychiatrists are paid well enough to participate in the plans and be part of whole person care. Those are the things we are working on!

Medicaid Expansion

Medicaid expansion has been one of NCPA’s legislative priorities this year. The NC General Assembly has been stalled since the Governor’s veto of the state budget—primarily over the battle for expanding Medicaid. House Bill 655 (a version of Medicaid expansion) passed out of the House Health Committee. It is not an ideal bill, but it is something! By the time you read this, we will know if any progress was made. *(Note: H655 did not pass.)*

Other Insurers

After many years of closed doors, BCBSNC has asked to attend meetings with NCPA and our members to discuss issues related to inclusion in their network, value-based care strategies, and outcome measures. We welcome these discussions with their new Chief Medical Officer for Behavioral Health, NCPA member ***Kate Hobbs Knutson, M.D.***, and the opportunity to build a new relationship with the Blues.

We are still working to convince BCBSNC and other insurers to offer parity rates to psychiatrists.

Health Information Exchange

Psychiatrists may not realize it, but until we stepped in and helped get legislation passed this spring, psychiatrists were mandated to be connected to the state HIE by June 2018 (for Medicaid) and June 2019 (for State Health Plan and other state reimbursements). As proclaimed in earlier editions of *NCPA News*, House Bill 70 passed, extending the deadline for connection until June 2021 for psychiatrists.

Here is the question I need to pose to you, our members: how will NCPA manage the competing interests of protecting patient privacy at all costs vs. engaging collaboratively with other physicians and sharing information? Help us work on these issues.

Scope of Practice

These issues are pervasive. NCPA walks a fine line between embracing the work that other health professionals do in our system, while promoting the expertise that psychiatrists bring to the team and identifying services only psychiatric physicians should perform.

NC temporarily lost its only physician in the General Assembly. Greg Murphy, M.D. has replaced the late Congressman Walter B. Jones in Washington. Anesthesiologist Perrin Jones, M.D. has been appointed to Dr. Murphy’s seat. What will it take to encourage our physician member(s) to run for the state legislature? “We need more doctors in the House” (and Senate)!

Psychiatrists as Leaders

On October 4, the NC Medical Society inaugurated its 166th President. We believe this is the first psychiatrist in this role in history! I am fond of saying that ***Palmer Edwards, M.D., D.F.A.P.A.*** is poised this year to reconnect the head to the body in the house of medicine!

For the first time in history these past few years, the NC Medical Board has had not one, but two, psychiatrists serving at the same time. NCPA members ***Debra Bolick, M.D., D.F.A.P.A.*** and ***Amba Jonnalagadda, M.D., F.A.P.A.*** have both been lauded for their good work on the Medical Board. In exciting news, we learned that Dr. Jonnalagadda will become President of the Board next year.

There are so many other things to talk to you about, telepsychiatry, clinically integrated networks, and the like; but I think one of the key roles of NCPA is building relationships—with Governor Cooper, with members of the NC General Assembly (both sides of the aisle), with NC DHHS and its Divisions (NC Medicaid, the Division of Mental Health Development Disabilities & Substance Abuse Services, Division of Rural Health, Division of Public Health), with the NC Medical Society and other medical associations, and with the NC Department of Insurance. So much of the work I do and the association does is related to building working relationships with policy makers.

My message and challenge to you is that it is going to take every single one of us to help keep our system on track, to help improve the care for your patients, to help make psychiatric medical care affordable and available.

Your voice, your involvement, your ideas, your challenges, and your suggestions help guide your Executive Council, your NCPA staff, and your contract lobbyists as the health care system changes from its traditional fee-for-service system to one that tries to incentivize physicians to keep people well. Help us help you!

Palmer Edwards, M.D., D.L.F.A.P.A. Inaugurated as 166th NC Medical Society President

On October 4, ***Palmer Edwards, M.D., D.L.F.A.P.A.*** was sworn in as the North Carolina Medical Society's 166th president. To NCPA's knowledge, he is the first psychiatrist to ever serve in this role.

Dr. Edwards has a long history serving the house of medicine and NCPA, including as NCPA President from 2006-2007. In addition, he served as Chair of the NCPA Ethics Committee from 1999-2002, and as NCPA's delegate to the NC Medical Society House of Delegates.

"In a year when the American Medical Association president is a psychiatrist and integrated and collaborative care are taking center stage, the North Carolina Psychiatric Association is proud to have a psychiatrist connecting the head to the body in the North Carolina house of medicine," said NCPA President ***Jennie Byrne, M.D., Ph.D., D.F.A.P.A.***

Dr. Edwards is a graduate of the Wake Forest University School of Medicine, and completed both his adult psychiatry residency and child and adolescent psychiatry fellowship at Vanderbilt University.

He is board-certified in adult psychiatry and child and adolescent psychiatry. In addition to his private practice, he is a clinical associate professor in the Wake Forest

University School of Medicine's Department of Psychiatry and Behavioral Medicine and a psychiatric consultant to the Wake Forest University School of Medicine's Adult Medicine Clinic.

Samantha Meltzer-Brody, M.D., M.P.H. New Chair of the UNC Department of Psychiatry

In August, the UNC School of Medicine announced the appointment of ***Samantha Meltzer-Brody, M.D., M.P.H.***, as Assad Meymandi Distinguished Professor and Chair of the Department of Psychiatry, effective October 1.

Dr. Meltzer-Brody brings a wealth of clinical, research, and administrative experience to the position. She is Founder and Director of the NC Perinatal Psychiatry Program of the UNC Center for Women's Mood Disorders. Her focus is on the epidemiologic, genetic, and other biomarker models of perinatal depression, as well as novel ways to deliver psychotherapy to perinatal women. Her work has impacted treatment of women from Chapel Hill to Sub-Saharan Africa. She established the international postpartum depression consortium (PACT) and is co-investigator of the PPD ACT app, a smart phone study that is a large, international genetic study of postpartum depression and postpartum psychosis. She has also served as the academic principal investigator of the brexanolone clinical trials. In March, brexanolone became the first drug to receive FDA approval for the treatment of postpartum depression.

Dr. Meltzer-Brody also founded Taking Care of Our Own, a resource for physician well-being and burnout prevention. She currently serves as Executive Medical Director of the UNC Well-Being Program.

Earlier this year, Dr. Meltzer-Brody received the APA's 2019 Alexandra Symonds Award in recognition of outstanding contributions and

leadership in promoting women's health and the advancement of women. She was also recipient of the Psychiatric Foundation of NC's 2016 Eugene Hargrove Award for her exceptional contributions in the field of mental health research.

Changes to Involuntary Commitment, Form

Major changes to involuntary commitment procedures went into effect October 1. Senate Bill 630, strongly supported by the NC Hospital (now Healthcare) Association, became law in April 2018. Input from psychiatry was woven into some aspects of the statute, but pressure to divert people with mental illness from hospital emergency rooms was a driving force. Here's what psychiatrists need to know:

1. There is a new Involuntary Commitment Form to be used: https://www.ncdhhs.gov/ivc

2. The list of mental health professionals who are allowed to conduct the first "QPE" exam was broadened to include Licensed Professional Counselors.

3. Those who can conduct the evaluation will now be called "Commitment Examiners."

4. Patients can now be seen in non-hospital settings, which include mental health clinics that do not have physicians available to examine and do medical differential diagnoses.

5. As a nod to the reality that a substantial number of people present with psychiatric symptoms that are caused by physical conditions, a health screening must be conducted as part of the commitment exam. This screening is included on the IVC form and Mental Health Commitment Examiners will be allowed (although not required by statute) to perform the Health Screening.

6. Clinics may have medical professionals onsite to do the health screenings. The statute says, "A health screening shall be completed, conducted by a first commitment examiner or other individual who is determined by the area facility, contracted facility, or other location to be qualified to perform the Health Screening and in conjunction with the first examination."

7. NC DHHS Chief Medical Officer for Behavioral Health & IDD, ***Carrie Brown, M.D., M.P.H.***, has worked hard to create a Health Screening for these non-medical settings with questions and "decision trees" with prompts to get patients emergency medical care when certain symptoms are identified. It is not perfect from a medical perspective, but we hope this new form will help get patients the care they need.

8. There are a number of other changes in the statute, including that each county must create a transportation plan. The statute recommends not using shackles for children under the age of 10.

There are several resources for information on these changes. NC DHHS has set up an IVC resource page with links to all the forms (which are now "fillable" PDFs), written and video instructions for the new forms, FAQs, and other helpful information. You can visit this resource page at https://www.ncdhhs.gov/ivc. If you have questions about any of the changes and/or forms, you may contact the Department at IVCCommunication@dhhs.nc.gov.

The NC Healthcare Association, likewise, has created a resource page to assist hospitals and others in navigating the new IVC changes. The website address is https://www.ncha.org/ivcbill/.Please contact NCPA with your thoughts and experiences with these changes!

HEALTH SCREENING

A health screening (N.C. G.S. § 122C-3(16a)) does not constitute a medical evaluation† and should be completed at the same location as the first examination or by utilizing telemedicine equipment and procedures (N.C.G.S.§ 122C-263(a1)).

☐ **Check box & sign to attest that the health screening is being replaced by a medical evaluation†** skip to Section III

Signature _____ Printed Name, Credentials, Date & Time _____

Vital Signs

BP _____ HR _____ RR _____ Temp _____ Date & Time _____

If person taking vitals is different than person completing this form, sign/print name & credentials below:

_____

Please note the red box above! *If you—a physician—are doing the commitment exam, there is no need to complete the separate Health Screening section of the new IVC form. The physician must check the box and sign on page 2, saying that a medical exam was done. The new IVC law allows a patient to have the first exam by a therapist and NEVER see a doctor for up to 7 days. The Health Screening is trying to prevent this scary prospect by making sure someone is being told when to rush a person to the emergency room to address a medical emergency.*

"Duty to Report" Requirement Now in Effect

The N.C. General Assembly recently passed House Bill 228, an Act to Modernize the NC Medical Board (NCMB). The Act includes several provisions that affect licensed medical professionals, including a new legal obligation to report certain misconduct by any individual licensed by NCMB. This new "duty to report" provision (N.C. Gen. Stat. §90-5.4) went into effect October 1, 2019.

Specifically, the law obligates any individual licensed by NCMB to report:

1. Sexual misconduct involving a patient by a licensee.
2. Fraudulent prescribing, drug diversion, or theft of any controlled substances by a licensee.

Medical professionals need not have definitive evidence of misconduct to make a report. The law specifies that licensed medical professionals should submit a report if they "reasonably believe" that misconduct has occurred. Licensees who report suspected misconduct in good faith are granted civil immunity.

NCMB has created a new online form to receive reports from health care professionals or institutions:

https://www.ncmedboard.org/landing-page/licensee-duty-to-report.

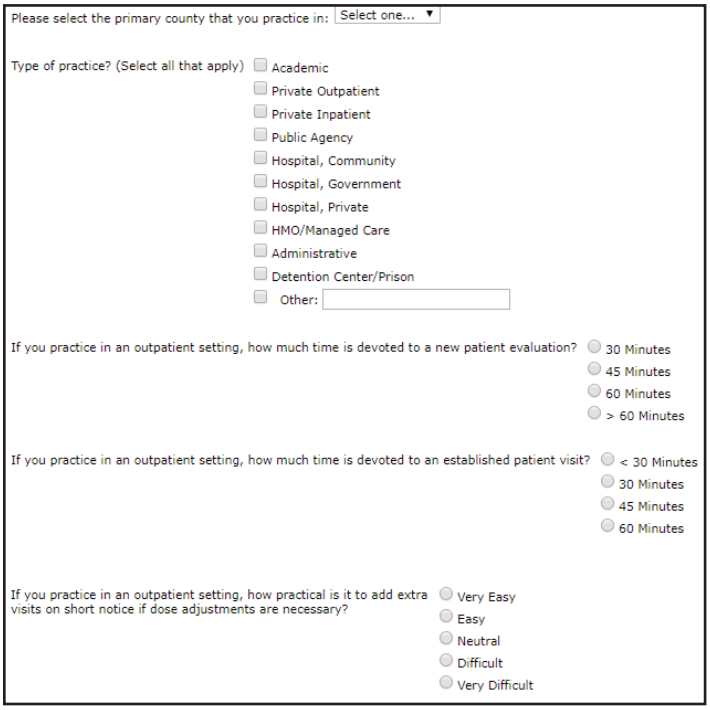
The form may be used to report information required by statute, or to report any other concern the reporting individual believes NCMB should investigate. This page also includes FAQs and other information to help licensees understand their reporting obligations under the law.

Clozapine Prescribing Habits Survey

Ten years ago, NCPA surveyed members regarding clozapine use and prescribing habits. Since then, clozapine remains underutilized despite ample evidence showing benefits for treatment-resistant schizophrenia, patients with chronic suicidal thoughts/behavior, as well as self-injurious and aggressive patients.

Developed by ***Ted Zarzar, M.D.***, this survey seeks to understand factors that influence clozapine prescribing habits. It should only take about five minutes to complete. Dr. Zarzar and ***P.G. Shelton, M.D., F.A.P.A.*** represent NCPA on the NC DHHS Drug Utilization Review committee.

To take the short survey, please visit: https://bit.ly/342Dzjt. (The link is also posted on the NCPA homepage.) Thank you for your participation!



NCPA Annual Meeting & Scientific Session

"Leaders, Educators, and Influencers"

Thank you to everyone who attended the 2019 NCPA Annual Meeting and Scientific Session in Myrtle Beach! It was wonderful to reconnect with familiar faces and meet new members. We couldn't have asked for more perfect weather, which put the cherry on top of a fantastic weekend at the beautiful Marriott Grande Dunes!

The weekend was full of top-notch CME lectures by leading NC experts, business meetings, networking opportunities, and social events. A highlight was the third annual Women in Psychiatry event, which was held as a lunch this year (pictured bottom left). Nearly 80 women participated in the leadership session presented by Tina Natt och Dag, Ph.D., Director of the Kanof Institute for Physician Leadership at the NCMS Foundation.

We are so pleased that many members decided to make it a family beach weekend and bring their spouses and children. That made Saturday night's poolside, luau-themed dinner party all the more fun (pictured top and bottom right). The night was complete with Hawaiian dance entertainment, lawn games, caricature artists, and a photo booth!

This year's meeting had the highest turnout of psychiatric residents ever. This is due in part to the recent addition of three new residency programs across the state (bringing the total to seven), meaning that resident attendance will only continue to climb in years to come! On pages 14–15, one of our Wake Forest residents, ***Kayla Lyon, M.D.***, shares highlights of her experience at the meeting.

Mark your calendar for next year's meeting, which will be the first weekend of October in Asheville. If you have any ideas for how we can make the meeting even more exciting and worthwhile for members to attend, please share them with our NCPA office by emailing info@ncpsychiatry.org.

RESIDENT POSTER SESSION

This year, a record 22 research posters were presented, and the judges awarded four prizes:

Psychiatric Foundation of NC Awards

1st Place: Ramez Ghanbari, M.D., Ph.D. (Duke): *Development of a Real-World Ketamine Database Registry: Centers of Psychiatric Excellence*

2nd Place: Kayla Lyon, M.D. (Wake Forest): *Alcohol Intoxication by Novel Distillation of Hand Sanitizer in a Hospitalized Patient*

3rd Place: Neha Naqvi, M.D. (Wake Forest): *To B12 or Not to B12? A Case Report on Cobalamin Deficiency and Acute Onset Visual Hallucinations in an Elderly Male*

NCCCAP Award

1st Place: Alexandra Bey, M.D., Ph.D. (Duke): *Automated Video Tracking Biomarkers of Social Interaction Correlate with Children's Autism Symptom Severity and Observer Ratings of Joint Engagement*

HONOREES

- ***Allan K. Chrisman, M.D., D.L.F.A.P.A.*** (pictured top left) was recipient of the APA's 2019 Bruno Lima Award in Disaster Psychiatry. As a disaster mental health educator, researcher, leader, and responder (and Chair of NCPA's Disaster Committee), Dr. Chrisman's contributions to the psychiatric care of victims of disasters across North Carolina and around the world have served to strengthen mental health systems and the communities they serve.

- ***Andrew H. Miller, M.D.*** (pictured bottom left) was recipient of the V. Sagar Sethi, M.D. Mental Health Research Award. The award honors a scientist for significant contributions to basic research in the neurosciences, psychology, or pharmacology. Dr. Miller also gave a lecture on his research, "The Emerging Role of the Immune System in Depression and Other Psychiatric Disorders."

During the NCPA Business Meeting, awards were presented to members who have made positive contributions to the NCPA and to the mental health field in 2018-2019. Honorees included:

- ***Mehul Mankad, M.D., D.F.A.P.A.*** for service as the 2018-2019 NCPA President

- ***Chris Myers, M.D., D.F.A.P.A.*** for dedication, exceptional service to the Association, and stewardship of NCPA resources as Treasurer, 2015-2020

- ***Moira Rynn, M.D.*** for service as the 2019 Annual Meeting Program Chair

BY THE NUMBERS

297 Total Attendees

Residents & Med Students **56**

13.5 CME Hours

Speakers **17**

51 Sponsors & Exhibitors

Resident Spotlight: The Wake Forest "Clump" Takes on the NCPA Annual Meeting

Kayla Lyon, M.D.
Resident-Fellow Member Representative (Wake Forest), NCPA Executive Council

From the moment that my peers and I began planning our trip to the NCPA Annual Meeting in Myrtle Beach, the excitement in our department became infectious. Questions began to swarm. "Do they really sponsor our conference fees?" "Is there a poster presentation session?" "Can we all be away from the clinic at the same time?"

Along with a few others from the department, all seven residents of the PGY-3 class from Wake Forest were ultimately able to attend the conference. The department lovingly refers to our class as our self-imposed title, "the clump," due to our instant and resilient cohesiveness that began the day we all met. So as any good "clump" would do, we carpooled to Myrtle Beach and rented a house a few blocks from the resort that would allow us to stay together with our spouses and children for the long weekend. As we all arrived, it was clear that this weekend would be an experience that would leave a lasting impression on our lives.

The seven Wake Forest PGY-3 psychiatric residents and their families enjoying down time in Myrtle Beach.

When we stepped on the property of the beautiful Grand Dunes Resort, we all felt so excited and welcome to be there. It was as if we had checked in to meeting of hundreds of our closest friends. Our day on Friday was filled with enrichment for our future careers. Our minds were challenged with a discussion on Medicaid transformation, and we were all inspired and urged to do more for our communities by the disaster work in psychiatry that Dr. ***Allan Chrisman*** presented.

In the afternoon, I was honored to moderate the panel discussion on practical advice regarding the implementation of electronic health records and other software in psychiatric private practice. Not only did the panel provide attendees with a printed list of questions that should be asked of any potential company providing these services, but they also spent a considerable amount of time addressing questions from the audience and allowing non-panelists to share their experiences with others. This valuable session proved to fill a gap in practical learning that most residency programs simply do not impart. It is only because of meetings like this that such material can be effectively shared among peers.

Saturday morning was spent absorbing knowledge on risks of benzodiazepines, novel psychiatric treatments, depression in dementia, and the coexistence of trauma and substance abuse. On Saturday evening, many of my colleagues and I presented our research in the Resident Poster Session. I enjoyed presenting my own case report, titled "Alcohol Intoxication by Novel Distillation of Hand Sanitizer in a Hospitalized Patient." I even included a demonstration of the distillation procedure that drew observers of all ages and served to illustrate the ingenuity that our patients possess. At the recommendation of several conference attendees, I plan to publish my case, which is something that I may have never done had I not had the venue for my poster presentation and the intellectual support of reviewers within NCPA.

Dr. Kayla Lyon and her daughter.

It was fascinating to discuss ongoing research and simply to make personal connections with my fellow North Carolina psychiatry residents. I was even able to catch up with some of my former attendings and upper-level residents from medical school. I was inspired by

Dr. Lyon and fellow Wake Forest resident Dr. Neha Naqvi presented their research posters in the Resident Poster Session. The Psychiatric Foundation of NC awarded Dr. Lyon 2nd place and Dr. Naqvi 3rd place.

the brilliant minds that will soon be the newest psychiatrists in our state.

The Poster Session concluded with us moving outside to what was certainly the highlight of the entire weekend: the awesome poolside dinner and luau. Along with our families, we all had an amazing time socializing, dancing, and watching incredible performances from the entertainers. The relaxed atmosphere proved to be just what we all needed to unwind after all of our intellectual activities throughout the conference.

Unsurprisingly to those that know us best, "the clump" also stepped out to the beach on several days to enjoy a much-needed vacation and escape from the walls of our hospital and offices. Some of our newest family members even enjoyed the sand and ocean for the first time in their lives.

Our weekend concluded with what was surely a "grand finale" in Dr. ***Sy Saeed***'s presentation of "Top 20 Research Findings of 2018-2019 for Clinical Psychiatry." Dr. Saeed managed to compact all of this valuable information into an hour and a half of digestible pearls, curated for our practical knowledge. It was a great summation of the things we had learned from the weekend, and it provided some guidance for what we may look forward to in future psychiatric research.

"The clump" packed up our belongings and ate a seafood lunch by the water to conclude our weekend together before heading back home and to work the next day. We shared our experiences, newfound knowledge, and excitement with our entire department, and we hope to bring even more of the department along with us next year.

On behalf of all the residents who attended this year's Annual Meeting, I would like to sincerely thank those members of the NCPA who have donated to the Psychiatric Foundation of NC in order to sponsor our attendance. The knowledge, professional connections, and overall sense of well-being that I gained from this experience will undoubtedly shape my future practice as a psychiatrist in North Carolina. I hope to also sponsor residents for this meeting, as I feel that it was among the most valuable experiences of my residency.

Support the Next Generation of Psychiatrists

Psychiatric Foundation OF NORTH CAROLINA

The Psychiatric Foundation of North Carolina is a 501(c)(3) organization and the charitable arm of NCPA. The Foundation's primary purpose is to support training, education, and research to assist psychiatrists in offering the best possible care for patients. One way the Foundation accomplishes this is by sponsoring the registration fees for all psychiatric residents who attend the NCPA Annual Meeting & Scientific Session. At this year's meeting, NCPA welcomed 56 residents and medical students from each of the seven training programs across North Carolina. 14 still need a sponsor!

As you make your year-end donations to charitable organizations (or determine how to satisfy your retirement account Required Minimum Distribution), please consider including the Psychiatric Foundation of NC. Every dollar helps!

In addition to general donations, the Foundation accepts Tribute or Memorial donations to honor a loved one, friend, or colleague. Tax-deductible donations may be made online (credit card) at www.ncpsychiatry.org/make-a-donation or by mailing a check (payable to the Psychiatric Foundation of NC) to 4917 Waters Edge Drive, Suite 250, Raleigh, NC 27606.

"What Has NCPA Done For Me Lately?"

Robin B. Huffman
Executive Director, NCPA

Most psychiatrists don't think about calling the NCPA office when they have an issue, a question, or a situation that comes up in the course of doing business. Every so often, we get a call for help finding a referral for a patient who is moving. Other times, it's a question about an article in our newsletter.

But one of the values of NCPA membership is that we have long-standing relationships with entities across the state, so we can help you figure out what to do when complicated situations arise. We like hearing from members and trying to help!

I have been working for NCPA for nearly 20 years, and recently I had one of those moments that keeps me motivated at this job.

A psychiatrist called me at the end of the day about a patient medication situation his office nurse had been working on all week. The insurance company had approved the new drug, but when the patient tried to fill it at the pharmacy, it was denied. There were days of phone calls back and forth, with the insurer blaming the pharmacy, and the pharmacy blaming insurer.

"It worked! You are a lifesaver...literally! Thank you so much."

-Carey Cottle, M.D., D.F.A.P.A.

(Greensboro)

But at the end of the day, a patient with active suicidal thoughts was not getting the medication his doctor thought he needed. What could be done?

I got off the phone and contacted the NC Department of Insurance for help. After a series of emails and phone calls into the night, the insurer notified us the next morning that the claim had been processed. A few days later, we had to revisit the issue regarding refills, but eventually the situation worked out.

This is the gratifying work I get to do. Most importantly, this is the power of what organized psychiatry can do together! Let's use this power to make it a another great year for psychiatrists and your patients!

Remember to Deduct Your Dues!

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

NCPA 2019 Dues: You may deduct 94 percent. (In other words, all but 6 percent of your North Carolina dues are tax-deductible.)

APA 2019 Dues: You may deduct 96 percent. (All but 4 percent of your national dues are tax-deductible.)

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

If you need assistance determining the amount you paid in 2019 for your APA and NCPA membership, please send an email to info@ncpsychiatry.org.

Member Notes...

Debra Bolick, M.D., D.F.A.P.A. has been appointed to the Board of the APA Political Action Committee. This bipartisan federal PAC supports candidates committed to assuring the health and wellbeing of individuals suffering from mental health and substance use disorders. She recently completed two terms of service on the NC Medical Board.

Please send us your news!
Email your name and details to info@ncpsychiatry.org.

Classified Advertisement

Recruiting a psychiatrist to join well-established group in Raleigh

Raleigh Psychiatric Associates, established in 1978, is seeking a psychiatrist to join our team. Our practice is 100% pay at time of service; no need to join insurance panels. One of our eight psychiatrists is entering semi-retirement, providing an immediate patient base.

Enjoy the autonomy of setting up your own practice:

- Set your own hours
- Schedule as much time as you need for new patients and returns
- Set your mix of psychotherapy and medication management

Utilize the advantages of being part of a group practice:

- Support from colleagues with a variety of subspecialty expertise
- Strong referral base to build a practice quickly
- Administrative support including scheduling and billing
- Group retirement and insurance benefits

For inquiries, please email Dr. Rhonda Stahl at stahl@raleighpsych.com.

Three Easy Ways to Renew Your NCPA & APA Membership:

1. Pay online:
   www.psychiatry.org/PayDues
2. Pay by phone:
   (202) 559-3900
3. Send a check to:
   APA Membership Dept.
   800 Maine Avenue, S.W.
   Suite 900
   Washington, D.C. 20024

We look forward to serving you again in 2020!

Are you missing out on new patients?

Update Your NCPA Member Profile & Enroll In Our

Find A Doctor Search

The NCPA office receives daily calls from people looking for a local psychiatrist! If you are currently accepting referrals, make sure you are enrolled in the search tool and your practice information is up to date.
Log into your profile at https://ncpsych.memberclicks.net/login

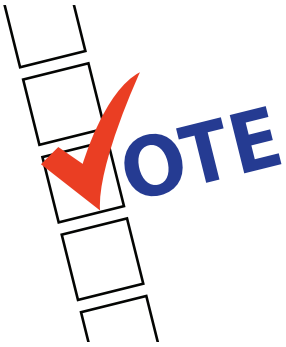
(If you need assistance, call the NCPA office at 919-859-3370.)

NCPA & APA 2020 Elections: Electronic Voting Opens Thursday, January 2

2020 is a big year for voting, so why not get some good practice in January? Starting Thursday, January 2, you'll be able to have your say on who will become the next leaders in psychiatry at both the state and national levels. Your leaders shape these organizations, so make sure your voice is heard!

For the first time, the voting periods for the NCPA and APA elections will coincide, meaning it is easier than ever to cast your votes!

On January 2, you will receive an email with your NCPA voting materials, including information on this year's candidates and your unique voting link.



NCPA Election Slate

Electronic voting will be available for all eligible members who have an email address registered with NCPA. Electing leadership for the association is one of your most important duties as a member of NCPA. Please read the election letter and ballot carefully and submit your anonymous vote by the deadline indicated in the voting materials.

Some members of Executive Council serve staggered terms to ensure a smooth transition of leadership each year. This year's slate includes President-Elect, Vice President, Treasurer, two Councilor at Large positions, and two APA Assembly Representatives (one of them an additional representative because of our growing membership).

President-Elect:
Alyson Kuroski-Mazzei, D.O., F.A.P.A.

Vice President:
Michael Zarzar, M.D., D.F.A.P.A.

Treasurer:
Elise Herman, M.D., F.A.P.A.

Councilor At Large (Eastern Region):
Michael Smith, M.D., D.F.A.P.A.

Councilor At Large (North Central Region):
Aarti Kapur, M.D.

APA Assembly Representative:
Steve Buie, M.D., D.F.A.P.A.

APA Assembly Representative:
Scott Klenzak, M.D.

APA Election Slate

The APA Nominating Committee, chaired by Immediate Past President Anita Everett, M.D., reports the following slate of candidates for the APA's 2020 Election. This slate is considered public, but not official, until the Board of Trustees approves it at its December 2019 meeting.

President-Elect:
David C. Henderson, M.D.
Henry A Nasrallah, M.D.
Vivian B. Pender, M.D.

Treasurer:
Ann Marie T. Sullivan, M.D.
Richard F. Summers, M.D.

Trustee-At-Large:
Frank Clark, M.D.
Mark Komrad, M.D.
Michele Reid, M.D.

Area 2 Trustee:
James P. Kelleher, M.D., M.B.A.
Glenn A. Martin, M.D.

(Note: NCPA members are not eligible to vote for this category.)

Area 5 Trustee:
Jenny Boyer, M.D., Ph.D., J.D.
Philip L. Scurria, M.D.

(Note: NCPA members are eligible to vote for this category. Area 5 represents the South & Puerto Rico, which includes North Carolina.)

Resident-Fellow Member Trustee-Elect:
Mariam Aboukar, D.O.
Aatif Mansoor, M.D.
Sanya Virani, M.D., M.P.H.

All candidates and their supporters are encouraged to review APA's Election Guidelines. Candidates' photos and the addresses of their personal websites will be published in the December 20 issue of *Psychiatric News*.

APA voting members may cast their ballots from January 2 to January 31, 2020. For more information, visit the election section of the APA website or email election@psych.org.

2019 Membership Report

New & Reinstated Members

Ronee Aaron, D.O.
Kerry Balentine, M.D.
Michael Clark, M.D.
Stuart Downie, M.D.
Susan Therese Garrett, M.D.
Bradley Gaynes, M.D., M.P.H.
Diana Graham, M.D.
Shelley Holmer, M.D.
Harold Hong, M.D.
Justine Jerrett, M.D.
Jennifer Kemper, M.D.
John Latz, Jr., M.D., M.S.
Kondal Madaram, M.D.
Alison Manning, M.D.
Kevin Marra, M.D.
Michael Mefford, M.D.
Samantha Meltzer-Brody, M.D., M.P.H.
Clemence Nyandjo, M.D.
Sarita O'Neal, M.D.
Stephen Panyko, M.D.
Elena Perea, M.D.
Anne Richardson, M.D.
Eric Semeko, M.D.
Takahiro Soda, M.D., Ph.D.
Satish Vallabhaneni, M.D.
Marla Wald, M.D.
Matthew Weingard, M.D.
Sophia Weiqing Yuan, M.D.

New Resident-Fellow Members

Mai Bedair, M.D.
Christine Beran, M.D.
Sean Butterbaugh, M.D.
Yamna Channa, M.B.B.S.
Austin Cook, M.D.
Lori-Ann Daley, M.D.
Nicholas DePriest, M.D.
Ivan Escobar Roldan, M.D.
Sarah Evans, M.D.
Niloufar Farid, M.D.
Adam Fijtman, M.D.
Katie Gaffney, M.D.
Greer Gunther, M.D.
Syeda Haider, M.D.
Haseeb Haroon, M.D.
Karim Hebishi, M.D.
Ashleigh Johnson, M.D.
Luke Johnson, D.O.
Kyung Eun (Daisy) Kim, M.D.
Sarah Kirk, M.D.
Bryan Lao, M.D.
Audrey Martinez, M.D.
Joseph Maxwell, M.D.
Andrea McMahon, M.D.
Danielle Meola, M.D.
Michael Morledge, M.D.
Benjamin Morrell, M.D.
Lauren Morris, M.D.
Ayumi Nakamura, M.D.
Xiomara Nieves Alvarado, M.D.
Mary Kelsey Norris, M.D.
Fredrik Palmer-Picard, D.O.
Laura Paschall, M.D.
Amrish Pipalia, M.D.
Katherine Pollard, M.D.
Sree Readdy, D.O.
Alison Riehm, M.D.
Syeda Rizvi, M.D.
Gregg Robbins-Welty, M.D.
Elizabeth Shaffer, M.D.
Joe Shortall, D.O.
Levent Sipahi, M.D.
Ryan Slauer, M.D.
Jessica Steinsiek, M.D.
Cameron Strong, M.D.
Anna Tommasini, D.O.
Stanley Traylor, D.O.
Jayson Tripp, D.O.
Andrew Tuck, M.D.
Kevin Turek, M.D.
Luhan Wang, M.D.
Laura Williams, D.O.
Kristi Mae Wragg, M.D., M.S.W.

Members Transferring In

Ngu Aung, M.D.
Rebecca Bottom, M.D.
Frinette Checo, M.D.
Yongyue Chen, M.D.
Luciana Giambarberi, M.D.
Hristos Karanikas, D.O.
Steven Koehl, D.O.
David Krefetz, D.O.
Patricia Mathew, D.O.
Michelle Maust, M.D.
Courtney McMickens, M.D.
Jacqueline Norman, D.O.
Matthew Petrilli, M.D.
Thomas Sneed, M.D.
Benjamin Stacy, D.O.
Adare Yanagihara, M.D.

Members Transferring Out

LeTonia Adams, M.D. (SC)
Sanju Adhikari, M.D. (VA)
Jessica Allen, M.D. (SC)
Kammarauche Asuzu, M.D. (CT)
Brian Casey, M.D. (KY)
Ranota Hall, M.D. (DC)
Amy Newhouse, M.D. (MA)
Kathleen Richards, M.D. (PA)
Philip Schmitt, M.D. (RI)
Gregory Weiss, M.D. (VA)
Robert Wilson, M.D. (FL)

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
P 919.859.3370
www.ncpsychiatry.org

Calendar of Events

December 12, 2019
NCPA Addictions Committee
NCPA Conference Room
(Raleigh) & By Phone

December 21, 2019 - January 2, 2020
NCPA Office Closed
Happy Holidays!

December 31, 2019
Deadline to Pay 2020 NCPA & APA Membership Dues
www.psychiatry.org/PayDues