NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SEPTEMBER 2019

IN THIS ISSUE

Gun Violence is Public Health Crisis

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

"Our nation is in the midst of an epidemic of firearm-related injuries and deaths, and we must treat this as a public health crisis," said American Psychiatric Association President Bruce Schwartz, M.D. "We see the long-lasting mental health impact firearm-related violence and injury has on our patients every day, and it is time for us to come together as a nation to address this epidemic" (August 07, 2019, https://www.psychiatry.org/news-room/news-releases/apa-joins-call-to-action-to-prevent-firearm-related-injury-and-death).

The American College of Physicians (ACP) recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths. The ACP recently released a position paper expanding upon and strengthening its prior policies on firearm violence, reaffirming that "the medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths."[1]

The American Medical Association, the American Academy of Pediatrics, and the American College of Surgeons have also issued statements on firearm violence as a public health problem and have set priorities for reducing it (https://health.ucdavis.edu/what-you-can-do/a-public-health-problem.html).

What then are the statistics to support these assertions?

According to the Centers for Disease Control and Prevention, on average in 2017, 109 Americans died by firearm each day. There were 39,773 deaths by firearm in the United States in 2017. Nearly 60 percent (23,854) of firearm deaths in 2017 were suicides and 37 percent (14,542) were homicides. An additional 486 firearm deaths in 2017 were unintentional. Firearm homicide was the second leading cause of death for persons ages 15-24 years in the United States in 2017 and ranked in the top nine leading causes of death for those ages 1 to 44. Firearm suicide ranked in the top nine leading causes of death for those ages 10 to 54 in 2017.[2]

There is much finger pointing about the causes of gun violence. But to quote Jeffrey Swanson, Ph.D., a professor of psychiatry at Duke University, "I say as loudly and as strongly and as frequently as I can, that mental illness is not a very big part of the problem of gun violence in the United States."

"Only four percent of the violence—not just gun violence, but any kind—in the United States is attributable to schizophrenia, bipolar disorder, or depression (the three most-cited mental illnesses in conjunction with violence). In other words, 96 percent of the violence in America has nothing to do with mental illness."[3]

So how do we understand this situation and what needs to be done?

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From the Editor: Pro or Con?

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

Please consider a new idea for the newsletter. In a recent issue we presented a "pro or con" argument about an important clinical issue. Do we have the collective talent and interest to make this kind of article a regular feature?

The article could take any number of purely clinical issues, or legal and political items, as they affect the practice of psychiatry.

A first suggestion might be to present our view of "Medicare for All." I know that Medicare participation is not universal among our membership, and that replacing private insurance with Medicare would present challenges to those in private practice.

On the other hand, the reality of having to work with only one insurer might make Medicare more attractive. Payment rates would be another variable, among many. How much would Medicare, as we now know it, have to change to earn our collective enthusiasm?

Another issue might be the issue of prediction of violence, especially as it relates to recently proposed "red flag" gun laws.

As editor, I would be willing to take either side of the Medicare-for-All argument and research it, if I can find someone who would be willing to engage in a newsletter debate. Contact the NCPA office if you are willing to take this on.

NORTH CAROLINA Psychiatric Association news

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NCPA President's Column: Leadership in the "Rush Hour of Life"

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

Are you a psychiatry resident? Working at your first or second job?

Are you feeling the pressure of family planning and parental responsibilities?

Are you a caregiver? Supporting a partner or spouse?

Are you paying your student loans and facing piles of bills?

If you answered YES to these questions, you are likely feeling tired, overwhelmed, and confused. Leadership may sound like a nice concept that feels completely impossible in your reality. At the Executive Council meeting in June, I was fortunate to get feedback from some early career psychiatrists who were new to the council. They expressed frustration that the NCPA is out of touch with the concerns and priorities of young psychiatrists, and this was reflected in overly optimistic newsletter articles. Ouch.

While there are many reasons that the newsletter articles may be encouraging and focus on opportunities for psychiatry to positively impact policy, I think the criticism is reasonable. In these articles, NCPA leaders are looking to inspire and spread the word about the good work psychiatrists are doing in our state. The articles do not address the suffering, challenges, obstacles, pressures, and sheer exhaustion that young psychiatrists often face. Today, I would like to share my perspective on being an early career psychiatrist and what I believe leadership can mean in the "Rush Hour of Life."

When I was in residency on the Upper East Side in New York City, life was tough. A typical work week was 60 hours long for my non-physician friends, and about 80-100 hours long for residents. Thanks to a prolonged education and living expenses in NYC, I was buried in a mountain of debt. Maintaining a serious relationship was difficult, but I did manage to meet a wonderful partner and get married during residency. (Ask me about ridiculous wedding registry items selected during a sleepless overnight call in the ER.)

I continued to work extra hours doing clinical research, while knowing in my heart that I was never going to pursue my dream of becoming a researcher. As a resident, my son was born extremely premature and spent nine weeks in the NICU. While my grandmother was visiting NYC, she had a stroke, and I had to care for her in the ER. I then became pregnant with my second child at the same time I was completing residency, moving to North Carolina during the 2008 recession, and starting my first job. During the move, we were on a vacation with family when my grandmother had a heart attack in front of me and I did CPR. She lived another day before dying at the beach. My daughter was also born premature – spending two weeks in the NICU – and I had to return to work after nine days to pay our nanny bills.

I am sharing this story because I, like many of you, was in the Rush Hour of Life. What is the Rush Hour of Life? In the past, life events spaced out. You went to (much less) school, got married young, had

children young, and your children were grown just as you were starting to reach the peak of your career. Then you reached a solid professional plateau before your parents started to age and need care. You didn't typically have debt because only people with wealth went to college or medical school. Physicians were respected, well-paid, and autonomous members of society. The health care system seemed stable with minimal complexity. Psychiatrists were typically male and had a wife at home to take care of the household and family responsibilities.

Today it can all happen at once. You can be finishing your education, getting married, having children, paying debt, buying your first home, taking care of your parents, and trying to support a partner who is also working full-time with debt! This is why it is the Rush Hour of Life. When you are in the Rush Hour of Life, it becomes even harder to deal with the constant change and burdens of our current health care system. Despite all of these obstacles, our young psychiatrists persist.

I believe that if you are a young psychiatrist reading this article, you have already demonstrated leadership. You have chosen a difficult path to help some of the most fragile members of our community. You are often not paid as well as your physician colleagues. You may feel undervalued and disrespected in your health care system. You might be buried in a mountain of debt. You may wonder, "How can I be a leader?"

When young psychiatrists ask me for advice around leadership, here are the top five strategies I share:

1. Be a team leader. In most health care settings, the physician is asked to lead a health care team with nurses, PAs, med students, social workers, etc. Step up and lead your team. Do not do it all yourself! Focus on delegation and efficient use of everyone's time.

2. Lead at home and with your family. If you are in the Rush Hour of Life, there is no way that you can be responsible for 100 percent of the home and family tasks! This can be particularly difficult for female psychiatrists who feel social pressure to do it all. Delegation and efficiency can make a big difference.

3. Take ownership of your finances. Money is a painful topic, and physicians are notoriously bad financial managers. Negotiating the salary and terms of your current or next position can make a huge difference in your ability to feel like a leader rather than a cog in a machine.

> *"When you are in the Rush Hour of Life, it becomes even harder to deal with the constant change and burdens of our current health care system. Despite all of these obstacles, our young psychiatrists persist."*

4. Walk the walk. Behavior often speaks louder than words. Would you counsel your patients to stay in jobs that treat them poorly without speaking up to improve the workplace, without sleeping, without exercising, without eating well, and without advocating for themselves? Sometimes leading by example is the most difficult, but the most powerful type of leadership.

5. Get support from the NCPA! If your employer is not already doing so, ask them to sponsor your membership. Let us know if you need more talking points on how to negotiate for this employment benefit.

I hope that all the early career psychiatrists in the Rush Hour of Life feel supported by the team here at NCPA. Whether my story resonates with you or not, I value any and all feedback you have. Please email me at dr.jennie.byrne@gmail.com!

Member Notes...

Seamus Bhatt-Mackin, M.D., F.A.P.A., has joined the APA Psychotherapy Caucus Steering Committee. In this role, he will be working on a national level on projects related to psychiatrists doing psychotherapy including fostering supports for early career psychiatrists and bolstering psychotherapy training in psychiatry residencies.

Gary Gala, M.D., has been appointed interim chair of the UNC School of Medicine Department of Psychiatry.

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

What Psychiatrists Need to Know About... Cannabidiol

Cannabidiol: Managing High Expectations

Veronica Ridpath, D.O., Executive Council Resident-Fellow Member Representative (Atrium)
NCPA Addictions Committee Member

From vape pens to tinctures, supplements, relaxation gummies, and even a shot in your morning smoothie or latte, cannabidiol (CBD) is showing up everywhere. Evidence is sparse, but in a state without medical marijuana, patients want "the next best thing." How can we guide our patients on this sensitive subject while continuing to practice in an evidence-based manner?

What is CBD?

Cannabidiol is one cannabinoid present in the cannabis plant that is credited for the "non-psychoactive" effects of cannabis use. In marijuana use, CBD mediates the intoxicant effects of THC and can reduce the paranoia and anxiety that some users experience. In fact, the rise of paranoia and adverse psychiatric effects associated with marijuana use can be linked to the increase in THC and reduction in CBD percentages found in marijuana seized from the streets.

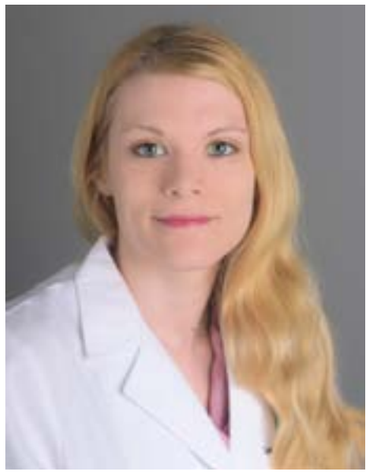
A release from the National Office of Drug Control Policy reported that between 1983 and 2008, the potency of THC in marijuana seized from the streets more than doubled. Does that mean that CBD stands alone as a treatment for anxiety? Not necessarily.

Touted as a panacea for psychiatric disorders, CBD marketing is reaching consumers and bypassing the clinical rigors of the FDA approval process. With the introduction of the 2018 Farm Bill, the growth of industrial hemp and the manufacture of products with less than 0.3 percent THC by weight has become legal at the federal level.

In North Carolina, CBD products are legal statewide. While available in a form that is strikingly similar to recreational marijuana, it is most popular in the various derivatives that conjure less the college dorm room and edge closer to the supplement industry.

The most popular method of ingestion is a sublingual extract taken as a drop under the tongue daily. CBD products are available either as full spectrum, which contain all the various cannabinoids of the hemp plant (including up to 0.3 percent THC), or a CBD isolate, which is in theory cannabidiol only. Without the watchful eye of FDA regulation, however, the contents of the bottle that consumers get may not be what the label describes.

The high potency CBD extracts, which can range up to $300 a bottle, can have no more CBD in them than the low potency extracts. Those



who pay extra for the pure CBD products due to concerns of drug testing at their jobs may be disappointed when drug screens show a positive for THC due to unscrupulous testing by the manufacturer and unreliable extraction methods. There have been seizures across the country for products that contain greater than the legal maximum THC percentage. Of the variety of extraction methods to obtain pure CBD, none is foolproof. Hydrocarbon extraction is by far the most common due to the low cost associated, whereas CO2 methods may be the most reliable but only available to established companies due to the high cost associated.

Medical Claims

With each new product comes a new and dubious claim. Psychiatric indications such as anxiety, depression, insomnia, bipolar disorder, PTSD, autism, schizophrenia, and even dementia are being marketed directly to patients without rigorous testing or even dose ranges. Pain and endocrine disorders are some of the newest targets. In fact, the FDA can't seem to send out cease and desist notices regarding medical claims as fast as companies can make them.

By April of this year, the FDA had sent out hundreds of warning letters regarding claims by newly formed companies stating that CBD could stop in vitro growth of cancer cells, stop progression of Alzheimer's disease, block central pain from fibromyalgia, and reduce withdrawal symptoms and rate of relapse in substance use disorders.

Currently, Epidiolex is the only FDA-approved CBD product on the market. Approved for two rare childhood seizure disorders, it is a CBD isolate available by prescription only. Available since 2018 in the United States, it carries approval for Lennox-Gastaut and Dravet syndromes as a second line treatment. Presently, it is being studied for applications in anxiety, psychotic disorders, and addictions. However, the research has not been conclusive. For patients who want to empirically try over-the-counter CBD for these indications, should we have concerns?

Absolutely. Often, patients who turn to CBD for psychiatric disorders are doing so to augment other psychotropic medications. As an inhibitor of enzymes CYP-3A4 and CYP-2D6, CBD increases serum concentrations of SSRIs, opioids, TCAs, benzodiazepines, antipsychotics, antiretrovirals, macrolides, some statins, and warfarin. This creates difficulties with targeting adequate dose ranges and puts patients at risk for complications and accidental overdose.

There are some case studies showing instances of hepatotoxicity at high doses. Physicians must be mindful of counseling patients on medication interactions, even if the hardline stance is to discourage CBD usage, as this information is not readily available to most consumers.

Harm Reduction Model

As psychiatrists, we will have patients coming into our offices both asking opinions about CBD and informing us that it will be part of the treatment plan whether we approve of it or not. It is important to understand that although the research is in its infancy, the marketing is in its prime. We can mitigate the damage by steering our patients towards reputable sources and understanding that controlling the variables may be the best options that we have. For patients who are substituting CBD products for marijuana, the benefit for psychiatric symptoms may be evident in the reduction of THC alone.

> *"It is important to understand that although the research is in its infancy, the marketing is in its prime."*

The first brand on the market was Charlotte's Web, which has been consistently evaluated by independent laboratories and found to be within acceptable margins of error for dosing. While it may be too soon to recommend CBD for any particular indications, knowing sources and dosing can help to remove variables. Sublingual extracts can give a more consistent dose range than vaping or ingested products. As with all supplement or substance use, keeping an open line of communication with patients is the most important key to treatment success.

Veronica Ridpath, D.O. is a third-year psychiatry resident at Atrium Health in Charlotte. A native of rural South Carolina, Dr. Ridpath attended medical school at the Edward Via College of Osteopathic Medicine in Spartanburg, SC. Actively involved in NCPA, she is a Resident-Fellow Member Representative on Executive Council and serves on the Addictions Committee. She plans to pursue a fellowship in Addiction Psychiatry and continue to work in education and advocacy.

Accountable Care Communities: Addressing the Drivers of Health Through Multi-Sector Partnerships

Brieanne Lyda-McDonald, M.S.P.H., Project Director, NC Institute of Medicine and
Adam Zolotor, M.D., Dr.P.H., President & CEO, NC Institute of Medicine

In the United States, we pay about twice as much for health care as all other developed countries and have among the worst health. With continued growth in cost, declining life expectancy, and a rapid shift to payment for value rather than payment for volume (in Medicaid and private insurers), the time could not be more ripe for Accountable Care Communities (ACCs).

Research on the factors that affect health outcomes shows that access to, and use of, medical care is only one of many factors that influence health and well-being. Traditional health care is designed only to provide (and pay for) clinical care, not to address the other drivers of health that affect health outcomes, e.g., social and economic factors, health behaviors, physical environment, and the policies and programs that influence these factors (see Figure 1). Because clinical care and genetics each account for only 20 percent of the variation in health outcomes, these other drivers must be addressed to improve health and well-being.[1]

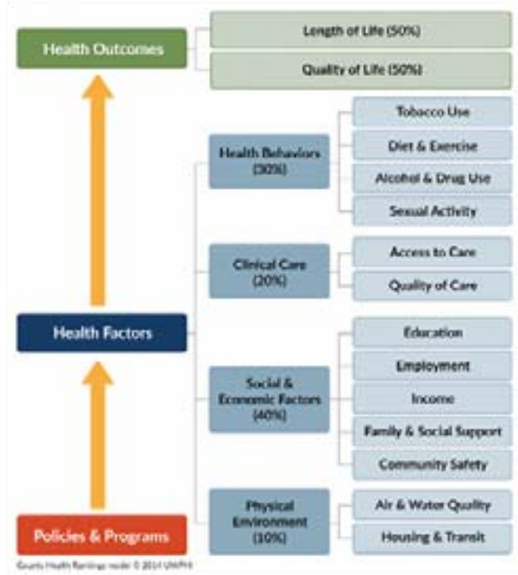


Figure 1. Drivers of Health that Affect Health Outcomes. Source: County Health Rankings model, 2014. http://www.countyhealthrankings.org/what-is-health

One strategy that has shown promise in bridging the gap between health care and social service providers is the ACC model, a regional multisector partnership sharing responsibility for coordinating and financing efforts to address multiple drivers of health. ACCs bring together traditional health care with its focus on preventing and treating illness, community-based partners whose focus is on creating the conditions necessary for good health and well-being, and those who purchase and pay for health care.

ACCs acknowledge that communities have a shared responsibility to ensure the health and well-being of all members of the community. ACCs seek to fulfill this shared responsibility through cross-sector collaboration that most often includes community members, businesses, the education, housing, and transportation sectors, the health care delivery system, public health, and human services organizations. ACCs can improve the health and well-being of communities by developing shared goals, systems, and sustainable funding among partners.

To that end, in 2018 the North Carolina Institute of Medicine convened a Task Force with funding from the Kate B. Reynolds Charitable Trust and The Duke Endowment to develop recommendations to support the creation of ACC models across the state. The Task Force was chaired by Mandy Cohen, M.D., M.P.H., Secretary for the North Carolina Department of Health and Human Services; Miles Atkins, Mayor of the Town of Mooresville and Director of Corporate Affairs & Government Relations at Iredell Health System; Reuben Blackwell, President & Chief Executive Officer of Opportunities Industrialization Center, Inc. and City Council Member in Rocky Mount, NC; and Ronald Paulus, M.D., former President & CEO of Mission Health System. They were joined by 56 other task force and steering committee members, including legislators, state and local agency representatives, service providers, and community representatives.

The NCIOM ACC Task Force made 24 recommendations, spanning a broad range of issues from the readiness of organizations and systems to partner to funding mechanisms and priorities for sustainability. The recommendations are described in detail in the NCIOM's report, *Partnering to Improve Health: Developing Accountable Care Communities in North Carolina*. A second product of the Task Force is a starter manual for communities interested in forming cross-sector partnerships to address health-related social needs. Existing coalitions and partnerships across the state are prime candidates for developing their efforts further to become an ACC-style model. The NCIOM is continuing efforts to get the word out about this concept and is actively seeking opportunities to present to communities, trade organizations, local government officials, and others.

The work of the Task Force comes at a time when the North Carolina Department of Health and Human Services (NC DHHS) is working on a vision to "optimize health and well-being for all people by effectively stewarding resources that bridge our communities and our healthcare system."[2] To do this, NC DHHS has created a statewide framework for healthy opportunities that includes:

1. Developing standardized screening questions for unmet resource needs,
2. Supporting the development of NCCARE360, a web-based resource platform,
3. Geographic mapping of social drivers of health indicators,
4. Building infrastructure to support the recommendations of the Community Health Worker Initiative,
5. Implementing Medicaid transformation through Medicaid Managed Care, and
6. Testing public-private pilots of ACC-style models focused on individuals enrolled in Medicaid.[3]

These initiatives will be instrumental in helping to develop or support ACCs throughout the state, in particular the standardized screening questions and NCCARE360 resource platform. The screening questions ask about food, housing/utilities, transportation, and interpersonal safety, the nature of the needs, and whether help is wanted.[4]

Prepaid Health Plans participating in Medicaid managed care will be required to use these questions to screen their members for needs. NC DHHS is encouraging health and social service providers throughout the state to integrate these questions into their daily practice or service provision. The NCCARE360 resource platform is being developed with the goal of "mak[ing] it easier for providers, insurers and human services organizations to connect people with the community resources they need to be healthy."[5]

Medicaid Healthy Opportunities Pilots will allow NC DHHS to test an ACC-style model with a population enrolled in Medicaid and utilize Medicaid funding to pay for health-related social services.

Developing sustainable ACCs throughout North Carolina will be a complex effort. If done effectively, these models for collective action could go a long way to address the health-related social needs of community members and improve population health into the future.

There is plenty of blame to go around for the high cost of health care and the poor health outcomes we face (insurers, health systems, providers, pharmaceutical companies, and consumers all bear some responsibility).

It is imperative as we re-align incentives to value rather than volume, that we understand what drives health, partner with agencies who have the non-traditional expertise we need, and develop clinic practice models and financial models.

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...”Gun Violence is Public Health Crisis,” continued from page 1

Nina Vinik, director of the Joyce Foundation’s Gun Violence Prevention & Justice Reform Program, said, “First, there’s no ‘silver bullet’ that will end gun violence. We need a comprehensive approach that includes stronger gun laws, community-based solutions, and more attention to the root causes of violence” (http://www.joycefdn.org/programs/gun-violence).[4]

Based on a survey of researchers, these top five recommendations were identified:

1. Enact federal Extreme Risk Protection Orders (ERPO), or Gun Violence Restraining Orders (GVRO), and support state adoption of these measures. Extreme risk protection laws allow families and law enforcement to petition a court to temporarily remove guns from those considered at high risk to themselves or others. An ERPO prohibits individuals in crisis from purchasing or accessing firearms and requires them to relinquish any guns they possess while the order is in effect.
2. Extend firearm restrictions and prohibitions to dating partners, ex-partners, and known domestic violence offenders; and to those guilty of violent misdemeanors.
3. Require universal background checks.
4. Enact permit-to-purchase laws, which require prospective gun buyers to apply directly to a state or local law enforcement agency to obtain a license or permit before purchasing a firearm. This also gives law enforcement more time to conduct thorough background checks.
5. Three-way tie:
   - Research and expand community-based interventions to prevent violence.
   - Address larger social issues and root causes, such as poverty, early childhood education, and the climate of hate.
   - Reduce gun trafficking by providing more funding for ATF and increasing inspections of gun dealers.

Since the 2012 shootings at Sandy Hook Elementary School, there have been 2,098 mass shootings in the United States–shootings in which four or more people, excluding the shooter, were shot in a single event (Gun Violence Archive, as of June 12, 2019).

For mass shootings, the following is recommended:

1. Ban assault weapons, large capacity magazines, and bump stocks.
2. Expand enactment of Extreme Risk Protection Order (ERPO) laws.
3. Improve and increase funding for threat assessments.
4. Require universal background checks.
5. Enact permit-to-purchase laws, which require prospective gun buyers to apply directly to a state or local law enforcement agency to obtain a license or permit before purchasing a firearm.
6. Repeal the Protection of Lawful Commerce in Arms Act (PLCCA), which protects firearms manufacturers and dealers from being held liable when they act negligently.

Nearly two-thirds of all gun deaths in the United States are suicides.

For firearms suicides, the following is recommended:

1. Establish federal Extreme Risk Protection (ERPO) law and support adoption in the states.
2. Require safe storage of firearms, such as child access prevention laws.
3. Support public awareness campaigns and community outreach to educate the public about the risk of gun availability for suicide.
4. Impose a mandatory waiting period between purchase of a weapon and taking possession of it.
5. Improve and increase funding for mental health services and research on suicide prevention.
6. Enact permit-to-purchase laws, requiring prospective gun buyers to apply directly to a state or local law enforcement agency to obtain a license or permit before purchasing a firearm.

What can we do in our own practices?

Fortunately, there are a number of ways for psychiatrists to directly address risks and dangers of gun ownership. The University of California, Davis has a website called “What to Do, which lists information and has handouts (https://health.ucdavis.edu/what-you-can-do/additional-materials.html).

I am posting these resources on the Disaster Resource Center section of the NCPA website and will give a brief summary here:

1. Ask your at-risk patients about firearms. No law prohibits you from asking when it is clinically relevant to the patient or someone else’s health.
2. Counsel at-risk patients about firearm risk and safety.
3. Take further action when your patient or someone in your patient’s home is at extreme risk or going through a crisis.

Allan Chrisman, M.D., D.L.F.A.P.A. serves as chair of the NCPA Disaster Committee. He is an associate professor-emeritus of psychiatry in the Duke University School of Medicine.

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Psychiatrists Get a Windfall with New State Health Plan Network

When the State Health Plan (SHP) rolls out its new benefit year in January 2020, psychiatrists who signed onto the new "State Health Plan Network" by the July 1, 2019 deadline will receive new and higher reimbursement rates than they previously experienced when treating SHP patients in Blue Cross Blue Shield's Blue Options network.

North Carolina State Treasurer Dale Folwell intended to implement a new network with rates indexed to Medicare as part of his "Clear Pricing Project," which he announced last fall for state employees, teachers and retirees. This network was designed to replace Blue Cross Blue Shield's Blue Options network for SHP covered lives beginning in January 2020.

In the intervening months, a standoff ensued between the SHP and the North Carolina Healthcare Association, with only a few rural hospitals agreeing to the new "Clear Pricing Project." As a result, the SHP was forced to back down from the plan for its separate network.

Instead, it will utilize both the new SHP network and the Blue Options network for its covered lives. In a letter to providers, the SHP confirmed its intention that providers who signed the new network contract would be reimbursed at the rates outlined in that contract.

The rates for physicians were set at 160 percent of Medicare rates. This puts psychiatrists at rates on par with other phyicians, perhaps for the first time ever in the SHP.

NCPA is continuing to stay in close communication with the leadership at the SHP and in the Treasurer's office to ensure that the new network and the new rates will continue to be in effect for our members who signed onto the new network.

We are also interested in receiving members' feedback regarding any possible problems with billing and claims payment that might arise as a result of being part of both networks. Please keep us informed by emailing info@ncpsychiatry.org.

For more information on the Clear Pricing Project, visit this website: https://www.shpnc.org/state-health-plan-clear-pricing-project.

Member Alert: Callers Masquerading as North Carolina Medical Board Seek Personal Data

Telephone scammers are getting more sophisticated. Recently, the North Carolina Medical Board (NCMB) learned that scammers are spoofing the Board's main telephone number to make their calls appear legitimate.

Scammers typically threaten loss of the target's professional license if personal or financial information is not provided. Be advised:

- NCMB does NOT contact licensees by telephone to give notice of pending action, and does not demand payment or sensitive information by phone, such as DEA number or NPI number.
- If you receive a suspicious phone call, hang up. Do not release any personal information.
- If you have questions, email info@ncmedboard.org or call 1-800-253-9653. *(Editor's Note: Please also let the NCPA office know if you have any questions by emailing info@ncpsychiatry.org.)*

Please encourage your colleagues to be aware and cautious!

https://www.ncmedboard.org/resources-informationprofessional-resources/publications/forum-newsletter/notice/scam-alert-callers-masquerading-as-ncmb-seek-personal-data

Don't Miss This Year's NCPA Annual Meeting — There's Still Time to Register!

September 19-22, 2019 | Marriott Grande Dunes | Myrtle Beach, SC
Earn Up To 13.5 Hours *of AMA PRA Category 1 Credits*™

In just a few weeks, the 2019 NCPA Annual Meeting will kick off in Myrtle Beach, South Carolina at the beautiful Marriott Grande Dunes Resort & Spa. We hope you will be there! If you haven't already registered, there is still time. Online registration is fast and easy. **Visit www.ncpsychiatry.org/annual-meeting and click on the "Register Now" button.** The deadline for general registration is Tuesday, September 17. After that date, walk-in registration rates will apply.

The theme of this year's meeting is "Leaders, Educators, and Influencers." The Program Committee, chaired by ***Moira Rynn, M.D.***, chair for the Department of Psychiatry and Behavioral Sciences at Duke, has secured many top-notch speakers, drawing heavily on the research talent and psychiatric expertise right here in North Carolina in addition to other prestigious out-of-state institutions. Attendees will have the opportunity to earn up to ***13.5 hours of AMA PRA Category 1 Credits™.***

In addition to the many educational sessions, there will also be plenty of time to network and socialize with new and old colleagues, alike, throughout the weekend. We are excited to offer several evening receptions and other events that we hope you will enjoy!

On Thursday, please join us at our Welcome Reception to connect with your fellow meeting attendees and wind down from your day of travel. Joseph Kaizer and Esther Kim, M.D. candidates in the Wake Forest School of Medicine hoping to specialize in psychiatry, will perform their classically trained violin and cello music. They will also speak briefly about their work to found the WFSOM Musical Outreach Committee, which aims to provide music as therapeutic treatment. (See the June issue of the *NCPA News* to learn more about them!)

On Friday evening, we are adding a brand-new Networking Reception, sponsored by Novant. Whether you are seeking a new position or looking for the right candidate to hire, you won't want to miss it.

On Saturday, we are really kicking things into high gear! After spending your morning in either the General Psychiatry Track or Child and Adolescent Psychiatry Track hearing from our excellent speakers, get ready for a high-energy party unlike anything you've ever seen at the NCPA Annual Meeting!

The first thing to know is that we are starting the evening festivities one hour earlier than in recent years, so that our attendees with young children will be able to participate.

From 5:00-6:00, please plan to attend the Resident Poster Session Reception, sponsored by Novant. Enjoy drinks and hors d'oeuvres while viewing research posters presented by residents from across North Carolina's seven psychiatry residency programs. Yes, seven!

Then, we encourage you to show off your best Hawaiian shirt at our Poolside Dinner Party! Rather than a seated dinner, we invite you and your family to mix and mingle in a casual, fun atmosphere by the hotel's fabulous pool and feast on a delicious Calabash seafood buffet. And thanks to our friends at Monarch, the South Sea Dancers will dazzle you with their traditional Polynesian dancing. You'll even get to learn a few hula moves yourself. There will also be a photo booth, caricature artist, and lawn games that all ages will enjoy. This is sure to be the highlight of the weekend!

We can't wait to see you there! In the meantime, feel free to contact the NCPA office if you have any questions about the Annual Meeting. Please call 919-859-3370 or email info@ncpsychiatry.org.

Get ready for a special, not-to-miss performance by the South Sea Dancers during Saturday's Poolside Dinner Party!

Program Schedule

Please note, this agenda is subject to change at any time. To view the most current schedule of educational sessions and social activities, please visit: *www.ncpsychiatry.org/scientific-schedule.*

Thursday, September 19

2:00-6:00 pm	NCPA Registration Opens
2:00-5:00 pm	NCPA Executive Council Meeting

Evening Events

6:00-7:30 pm	Welcome Reception (Casual Attire)
7:30-8:30 pm	Product Theater, Hosted by Alkermes

Friday, September 20

7:00-7:55 am	Registration Opens, Visit Exhibit Hall & Continental Breakfast
7:00-7:55 am	US Army Civilian Corps Focus Group Breakfast (By Invitation Only)
7:55-8:00 am	Welcome Address, Jennie Byrne, M.D., Ph.D., D.F.A.P.A., NCPA President
8:00-9:00 am	*Reflections on Race, Medicine, and Psychiatry*, Damon Tweedy, M.D.
9:00-10:00 am	*NC Medicaid Transformation: Challenges and Opportunities*, Carrie Brown, M.D., M.P.H., NC DHHS Chief Medical Officer for BH & IDD
10:00-10:30 am	Break with Exhibitors
10:30-11:30 am	*Disaster Psychiatry: Past, Present, Future*, Allan Chrisman, M.D., D.L.F.A.P.A.
11:30-12:30 pm	*Addressing the Impact of Trauma on Children from Brain to Clinic to Policy*, Lisa Amaya-Jackson, M.D., M.P.H.
12:45-2:00 pm	Women in Psychiatry Lunch, Tina Natt och Dag, Ph.D., M.A., Executive Director, Kanof Institute for Physicians Leadership, NC Medical Society
2:00-2:30 pm	Break with Exhibitors
2:30-4:30 pm	*Practical Advice for Making Electronic Health Records and Other Practice Management Software Work for YOU*, Zachary Feldman, M.D., F.A.P.A., Aarti Kapur, M.D., and Margie Satinsky

Evening Events

5:00-6:00 pm	Product Theater, Hosted by Sunovion
5:00-7:00 pm	NCCCAP Social (Bumstead's Pub, 400 Mr. Joe White Ave., Myrtle Beach)
6:00-7:00 pm	Networking Reception, Sponsored by Novant (Business Casual Attire)

Saturday, September 21

7:00-7:55 am	Registration Opens, Visit Exhibit Hall & Continental Breakfast
7:00-7:55 am	NCCCAP Business Meeting & Breakfast (NCCCAP Members Only)
7:00-7:55 am	CMO Breakfast (All Chief Medical Officers of the state facilities and LME/MCOs invited to meet with Carrie Brown, M.D., M.P.H.)

General Psychiatry Track

8:00-9:00 am	*Benzodiazepines: Risks, Benefits, and Accidental Deaths*, Chris Aiken, M.D., D.F.A.P.A.
9:00-10:00 am	*Challenges in Delivering Novel Treatments in Depression: Glutamate, Ketamine and Beyond*, Phil Ninan, M.D., D.L.F.A.P.A.
10:00-10:30 am	Break with Exhibitors
10:30-11:30 am	*The IDEAS Study & Depression in Dementia*, Venkata Ravi Chivukula, M.D., M.P.H., F.A.P.A.
11:30-12:30 pm	*Trauma and Substance Use: A Tangled, Interlocking Web*, William Wright, M.D., F.A.P.A.
12:45-2:00 pm	NCPA Business Meeting (NCPA Members Only)

Child & Adolescent Psychiatry Track

8:00-9:00 am	*Intersection of Race & Politics: Meeting the Mental Health Needs of Racial Minority Youth*, Melvin Oatis, M.D.
9:00-10:00 am	*Mental Health & Depression Disparities in Black Youth*, Alfiee Breland-Noble, Ph.D., MHSc
10:00-10:30 am	Break with Exhibitors (Exhibit Hall Closes After)
10:30-12:30 pm	*Bridging the Gap: Overcoming Barriers & Promoting Resiliency in Racial Minority Youth (Panel Discussion)*, Melvin Oatis, M.D., Alfiee Breland-Noble, Ph.D., MHSc, and Phillip Murray, M.D., M.P.H.

Evening Events

5:00-6:00 pm	Resident Poster Session Reception, Sponsored by Novant
6:00-8:00 pm	Poolside Dinner Party, Entertainment Sponsored by Monarch (Casual Attire)

Sunday, September 22

7:00-7:55 am	Registration Opens, Visit Exhibit Hall & Continental Breakfast
8:00-9:00 am	*Immunotherapeutic Interventions for the Treatment of Depression and other Psychiatric Disorders*, Andrew Miller, M.D., 2019 V. Sagar Sethi Mental Health Research Award Winner
9:00-10:00 am	*Rapid Acting Ketamine and Esketamine: Changing the Neurobiology of Depression*, Steven Szabo, M.D., Ph.D.
10:00-10:30 am	Break/Check Out of Hotel
10:30-12:00 pm	*Top 20 Research Findings of 2018-2019 for Clinical Psychiatry*, Sy Saeed, M.D., M.S., FACPsych
12:00 pm	Meeting Adjourns

Accreditation Statement: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and the North Carolina Psychiatric Association (NCPA). The APA is accredited by the ACCME to provide continuing medical education for physicians. **Designation Statement:** The APA designates this live activity for a maximum of 13.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NORTH CAROLINA
Psychiatric
Association

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

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Calendar of Events

September 17, 2019
General Registration for NCPA Annual Meeting Ends; Walk-In Pricing Begins Sept. 18

September 19-22, 2019
NCPA Annual Meeting
Marriott Grande Dunes
Myrtle Beach, SC

October 3-4, 2019
NCMS LEAD Conference
Raleigh, NC

October 17, 2019
NCPA Addictions Committee Meeting (By Phone)

November 9, 2019
NCPA Executive Council
Raleigh, NC

November 15-17, 2019
APA Assembly
Washington, DC