NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

MARCH 2020

NCPA has a new 2020-2023 Strategic Plan! Read about the three main goals on pages 4-5.

IN THIS ISSUE

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See page 15 or visit:
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Staying Focused in 2020 & Beyond

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

Psychiatrists face so many different issues: advocating for patients, staying current with data and literature, learning how to work on teams, operating a private practice…Prioritizing can be challenging in a rapidly changing environment where everything seems important. How is NCPA prioritizing the issues that matter most to members?

This year, NCPA Executive Council undertook the challenging task of developing a three-year strategic plan. With assistance from Tina Natt och Dag, Ph.D. of the NC Medical Society (NCMS), the Council held several strategic planning sessions using SWOT analysis to create the 2020-2023 NCPA Strategic Plan. We hope this plan reflects issues that are important to you!

Executive Council identified three priorities for NCPA in 2020-2023:

1. Advocate for our profession to relevant parties that our work as physicians is essential by promoting psychiatric leadership in key stakeholder groups, engaging in legislative advocacy, and highlighting psychiatry as an integral part of integrated care models.

2. Use NCPA resources to help members adopt and optimize new technologies.

3. Continuously learn about our members' changing needs to remain relevant, foster member engagement, combat isolation and burnout, and rekindle pride in the profession.

Prioritizing these three goals meant we needed to decide which other (important) goals to de-prioritize for the time being. I noticed that de-prioritizing was by far the most difficult part of our strategic planning sessions! If you are like me, you can relate to this challenge. How can we stay clear on our highest priority goals while there are so many other important goals, distractions, and emergencies?

Last year, I participated in the NCMS Healthcare Leadership and Management College. I expected to learn about management and finance, but I did not expect to learn so much about myself! I learned I was often lacking clarity of focus because I was not actively selecting and maintaining priorities. Instead, I was reacting to my environment.

More importantly, I was not actively de-selecting and de-prioritizing! I continue to work on de-prioritizing, and it continues to be challenging. If you are struggling with a similar issue, I encourage you to participate in coaching, leadership events, or even your own psychotherapy to address this issue. I have found that clarity of focus is a gift!

continued on page 9...

From the Editor: What are You Reading?

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

Few psychiatrists will encounter serial killers in their practices. The knowledge base and the work to identify and try to understand such individuals is one of those specialized endeavors that overlaps with the law enforcement world.

We should all, however, be conversant in a variety of forensic areas and have a basic knowledge of such topics. *The Killer Across the Table*, a book by John Douglas and Mark Olshaker is good entry level reading for those of us who have not invested time in becoming educated about "the criminal mind and violent predators."

Intended for a broad audience, this book is primarily a worthy work of historical processes. John Douglass, who holds a doctorate in education, pioneered the process of "profiling" for the FBI. In this work, he describes the techniques he developed through almost five decades of interviewing serial killers, including Charles Manson, "The Son of Sam Killer," and others.

This is not a textbook or a scholarly work, but it does address many of the concepts and questions common in our profession, such as the nature vs. nurture debate, and the central issue of the role of early attachment in adult behavior.

Many fiction writers, including the creator of the Hannibal Lecter character, and the producers of the *Mindhunter* Netflix series, used the descriptions and theoretical assumptions brought forth by John Douglass. While such stories are not a substitute for more rigorous clinical investigation in our work, the concepts pioneered by Douglass is information worth knowing.

NORTH CAROLINA Psychiatric Association news

EDITOR Drew Bridges, M.D., D.L.F.A.P.A.
MANAGING EDITOR Robin B. Huffman, Executive Director
ASSOCIATE EDITOR Kelly Krasula, Communications Coordinator

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2020-2023 NCPA Strategic Plan

Approved by NCPA Executive Council on February 1, 2020

Mission

Promote the highest quality care for North Carolina residents with mental illness, including substance use disorders; advance and represent the profession of psychiatry and medicine in North Carolina; and serve the professional needs of its membership.

Who We Serve

The North Carolina Psychiatric Association (NCPA) is a professional medical organization that represents more than 950 psychiatrists statewide; it is the district branch of the American Psychiatric Association.

Goal 1: Advocate for our profession to relevant parties that our work as physicians is essential by promoting psychiatric leadership in key stakeholder groups, engaging in legislative advocacy, and highlighting psychiatry as an integral part of integrated care models.

- Use NCPA to put psychiatrists front-and-center of state and local challenges to help solve state problems. For example, encourage psychiatrists to advocate for mental health in schools, become the leaders in advocating for our patients in the community, and develop relationships with local leaders.
- NCPA to identify evidence-based practices and serve as a platform for the distribution and implementation of these practices by psychiatrists across North Carolina (e.g. integrated care, and addiction treatment).
- Poll the membership about what legislative issues interest them (e.g. mental health parity, red flag gun laws, making conversion therapy illegal, getting private insurance to cover collaborative care).
- Develop an ongoing list/resource guide/meetings of organizations important for psychiatry to engage with.

Goal 2: Use NPCA resources to help members adopt and optimize new technologies.

- Reach out to members regarding implementation needs for adopting EHRs in their practices.
- Review, reorganize, and consolidate the resources on the NCPA website and develop a strategy to promote these tools to our members.
- Review current telepsychiatry state policy and information on the NCPA and APA websites. Organize these into a resource for members.
- Consider how to use technology to provide learning communities for NCPA members on these and other topics.

Goal 3: Continuously learn about our members' changing needs to remain relevant, foster member engagement, combat isolation and burnout, and rekindle pride in the profession.

- Create a Task Force to study and develop a plan for regional meetings across the state.
- Survey members regarding wellness, isolation and burnout.
- Bring in nationally known speakers to the annual meeting to address physician wellness.
- Use NCPA communication vehicles—print and electronic newsletters, social media—to share meaningful resources with members, such as inspirational stories, books, films, podcasts, etc.
- Based on the work of the Regional Meeting Task Force, schedule meetings to provide a local supportive clinical network, meet-up opportunities, and to identify local clinical concerns.
- Continuously communicate, share, and promote the work and accomplishments of NCPA to members.

A Point of Personal Privilege: We Haven't Forgotten You

Robin B. Huffman
Executive Director, NCPA

A few weeks ago, a note arrived in my office from the president of the recently reconstituted Charlotte Area Psychiatric Society. The note was to thank me for "coming so far out of your way to join us…" The week before, I had attended the group's dinner meeting to connect with psychiatrists in the region and to hear NCPA member and Chief of Behavioral Health for Blue Cross and Blue Shield of North Carolina, ***Kate Hobbs Knutson, M.D., M.P.H.*** speak on value-based care.

It was a group of around 25 psychiatrists. Some were NCPA members, some not. Some were employees of big health care systems, some not. One claimed to have practiced in the Civil War era, others were early career, mid-career, late-career. All were interested in seeing each other, catching up, and talking about providing good care for patients.

Dr. Hobbs Knutson encouraged questions and never got beyond the opening slide of her PowerPoint presentation. She spoke of her recent work in the public sector and about how to make case management more local and effective. She talked about the insurer's plan to pay higher rates for practices that can document quality care and good outcomes for a large percentage of their patients. She answered questions about how this new move to value was very different from the capitation contracts of the 1990s, where money was "saved" by cherry picking healthier patients and denying care to those who needed it.

She underscored that this move to value-based care is a boon for psychiatry, because health systems are finally understanding that solid investments in mental health care, primary care, and preventive care are needed to improve the health of our citizens. Then she grabbed a marker and graphed a continuum of patient severity that systems such as Intermountain Health are incorporating so that patients with severe mental illness have access to the specialized psychiatric care they need, while other members of the team are caring for those with milder mental health conditions.

Two days after the meeting in Charlotte, NC DHHS Secretary Mandy Cohen, M.D., M.P.H. spoke to a room of physicians at the NC Medical Society's Specialty Summit. She talked of the practice of medicine as a "team sport."

What struck me is that for many psychiatrists, the practice of medicine is solo. Unlike your primary care colleagues who have RNs, CNAs, and other caregivers in their practices, your office is likely to be staffed by a single person—you, the psychiatrist.

What is it that NCPA can do to help support you and the independent practice of psychiatrists, yet provide the connections and lifelines to keep your way of practice engaged in new payment systems?

How can NCPA help support psychiatrists who are in private practice and those in systems? How can we make sure that the move to value-based care doesn't inadvertently exclude private practitioners?

Earlier in this issue of the *NCPA News*, President Dr. Jennie Byrne outlines the newly approved three-year strategic plan for NCPA. The plan has three goals, which can be summarized as:

1. Advocating for the profession.
2. Using NCPA resources to help members.
3. Learning about our members' changing needs.

I know I am always saying this, but I need you to help me and the NCPA organization understand what your needs are so that we can help and support you. Don't make me guess!

Call me at 919-859-3370 or email me at rhuffman@ncpsychiatry.org. Tell me about your ideas for how NCPA can serve as a platform and a resource for you, your practice, and your patients.

Share YOUR "Bright Spots"

While psychiatrists improve patients' lives every day, it's important to shine light on special moments where your mental health care made all the difference.
Send your story to info@ncpsychiatry.org.

What Psychiatrists Need to Know About... Vaping

William F. Wright, M.D., F.A.P.A.
Addiction Psychiatrist & NCPA Addictions Committee Member

With a spike of related deaths, "vaping" has seemingly taken a meteoric rise in both the public and medical field's attention over the past year. Currently, the CDC reports the number of EVALI (e-cigarette/vaping associated lung injury) cases has hit over 2,700, with the associated death toll at 60. Despite the eye- and gut-catching news segments, it is still often difficult to walk in public without having to wade through a pall of vapor or see a plume of white haze escaping a car like a Cheech and Chong bit. From someone appearing to have a *Star Wars* cantina scene device attached to their lips, to a USB-looking fob, to an old-fashioned looking cigarette, what really is "vaping"?

A slang term in the common lexicon, vaping refers to the use of an electronic cigarette whereby a battery-powered heat source "vaporizes" a liquid solution (e-liquid, "juice," "e-juice," or "vape juice") for inhalation. Some e-cigs are disposable, but most are reusable by replacing the e-liquid in the form of a "pod," "cartridge," or "juice." This aerosolized liquid is typically composed of propylene glycol, glycerin, flavoring, nicotine, and other additives. (Sometimes the propylene glycol is solely replaced with vegetable glycerin, and sometimes nicotine is not an ingredient.) Other additives can include diacetyl and vitamin E acetate. (More on this particle goodie later.)

The umbrella term for these devices outside of the vaping industry is e-cigarettes. The government refers to them as "electronic nicotine delivery systems" (ENDS). Four main vaping apparatuses exist:

1. "E-cigarettes" resemble traditional cigarettes down to a brown "filter" mouthpiece.
2. "Pocket vapes" are smaller, more portable, and designed for ease of use (resembling USB drives). They are popular among teens and young adults, as they are easy to hide/conceal.
3. "Vape pens" look like a cylindrical pen with a mouthpiece.
4. "Box mods" have a larger battery and adjustable settings for those "advanced" in vaping.

To activate these vapes, some require nothing more than drawing or inhaling on the mouthpiece end, while others require depressing an activation button. As it sounds, these devices are as variable as bongs and can be nearly as open to personalization and modification (even with illicit substances, i.e., marijuana and black-market accessories). In order to achieve aerosolization of the liquid, a temperature between 200-400 degrees Fahrenheit is required. As mentioned, these devices require a battery to power the heating element.

But what about the nicotine? The nicotine unit levels in e-juice are typically: zero, 3mg, 6mg, 12mg, and 18mg; although, there have been some products with as high as 36mg. In contrast, a traditional cigarette can contain between 6mg to 28mg of nicotine. However, due to the burning process and the level of entropy in the universe, the typical inhaled amount of nicotine per cigarette ranges from 1.1-1.8mg, amounting to roughly 22-36mg of nicotine inhaled per standard pack of 20 cigarettes. Therefore, admittedly, if one were to utilize only one refill of e-juice per day, they would inhale less nicotine than a typical pack of cigarettes.

Vaping seems to have appeared overnight, as compared to conventional cigarette smoking. Humans have used tobacco products since they were discovered by indigenous and Mesoamerican peoples of the Americas as far back as 8,000 years ago. Cigarettes using wrapped paper became popular in the 17th century. Patents for electronic vaporizer-type devices were first filed in the 1930s. Chinese pharmacist Hon Lik created the modern and commercially successful e-cigarette look in 2003, but they did not seriously hit the market until 2007. Since Juul was introduced in 2015, it has amassed 75% of the market, sitting at a reported value of $38 billion (yes, billion). Juul has cornered the market in the 15-17 age range,

as teens are 16 times more likely to use Juul than adults.

With lower nicotine concentration and less chemicals ("cancer toxins") in e-cigarettes, aren't they healthier and safer? Although research is just now coughing up some data, early studies have found increases in chronic coughs, bronchitis, asthma diagnoses, impaired pulmonary immune cell function, link to murine (lung/bladder) cancer, and mixed findings on cardiovascular issues. There is also concern that carbonyl compounds (exposure to e-cig solvents to high heat) have been associated with increased risks for blood clots and atherosclerosis. As mentioned, there are also nearly 3,000 lung injury cases and 60 deaths attributed to e-cigarettes.

The current hypothesis via the CDC is that vitamin E acetate, found in many black-market, illegal, or street e-juices also containing THC, is the culprit. Other ingredients, compounds, or reactions contribute, but there is no way to confirm at present with available data. It is believed the vitamin E acetate causes a chemical-like burn in the lungs, leading to injuries. Therefore, the FDA has recommended not to purchase any vaping device, product, or e-juice from the street, as well as to avoid using THC oil or modifying store-bought devices. The use of these devices with THC as an adulterant or as an outright administration mechanism despite these health injuries and deaths is highly concerning. E-cigarettes have not yet proven to be efficacious as an aid for smoking cessation, although more studies are needed. At present, there is no FDA approval for e-cigarette devices for aiding tobacco/nicotine cessation.

Over 14.5 million people are using e-cigarette devices, with nearly half of users coming from those 18 and under. After many years of steady decline, the current tobacco/nicotine use is at the highest rate we have seen in this age group in nearly two decades. Juul has targeted children as young as third grade by funding summer camps, visiting schools, and paying community and church groups to distribute their materials. However, 63% of younger populations were found unaware that these devices contain nicotine. The rate of high school seniors using e-cigarettes has doubled in two years' time. Roughly a third of adolescents perceived e-cigarettes as less harmful than typical cigarettes, while nearly three fourths of those currently using e-cigarettes felt they were less harmful than regular cigarettes. Young folks who smoke e-cigarettes are four times likelier to start smoking a traditional tobacco cigarette, and those who start vaping are more than three times likelier to use marijuana than their peers. One in 10 North Carolina high school students report having vaped marijuana.

E-cigarette/vaping companies have learned a lot of valuable tricks from their old uncle – traditional tobacco cigarettes – in marketing to young people. From the tobacco company playbook: use celebrities (actors, musicians, and now social media "influencers") to hock your product [check], use rugged men/glamorous women in advertising schemes [check], sex sells…always [check], sponsor sports and music festivals [check], use flashy cartoons reminiscent of good ol' Joe Camel [check], and use sweet flavors that don't remotely resemble cigarette smoke [double check].

The PATH study has shown a prime implication for such high numbers of both youth and young adult use of vapes is "they come in flavors I like." The FDA reports 97% of youth vapers used a flavored e-cigarette within the past month. The most common and popular Juul flavors among middle- and high school-aged individuals were "Cool Mint," "Mango," and "Fruit Medley." The popularity of non-tobacco tasting flavors, the continued presence of nicotine in most vaping products (especially Juul), and the heavy-handed advertising all tilt towards younger folks. In January 2020, the FDA banned mint and fruit-flavored cartridge-based e-cigarette flavorings. It did not ban sale of menthol or tobacco flavors, as well as other types of e-liquid. (Remember from earlier, e-juice can also come in refillable tanks and packaged in small liquid vials.) In addition, the president signed legislation in December 2019 to raise the federal minimum age of all tobacco products (including cigarettes, cigars, and e-cigarettes) from 18 to 21.

These measures are potentially good starts in attempting to put the proverbial vapor back into the pod. But quite a bit of help on the ground is also needed to ensure the genie does not come back out fulfilling the three wishes of death, injury, and addiction.

Our youth's vulnerable prefrontal cortex is still in the oven, and as we know, still needs some cooking until it's done in their mid-20s. Therefore, the health care community, and especially we psychiatrists, need to once again champion the cause of education and prevention to turn back the vaporizing horde of e-cigarette users. Perhaps inform them their Juul is just a tech-refurbished reboot of the old Joe Camel cigarette days.

Editor's Note: Due to space limitations, this article with cited references is available on the NCPA website at www.ncpsychiatry.org/vaping. You may also email info@ncpsychiatry.org for a copy.

Ethics Document: Confidentiality Key in Responding to Reviews

Mark Moran
Reprinted with Permission from Psych News

Multiple negative reviews, especially if they repeat the same complaint, may signal a need to thoughtfully explore why the complaints are happening and make changes.

"He was late for the appointment, seemed distracted and uninterested in what I had to say, and never made eye contact."

In the age of the internet, everyone and everything are fair game for criticism: log onto Yelp or a similar online review portal, and you are likely to see that your favorite hotel, restaurant, or landscaping service has at least one scorching bad review, along with the glowing ones.

Physicians, including psychiatrists, are no exception, and any number of websites—such as HealthGrades.com, Vitals.com, or RateMD.com—provide patients a venue for rating their doctors. Any physician, especially one with a large caseload, is liable to run across at least one bad review.

"It's a common concern," said Charles Dike, M.D., vice chair of the APA Committee on Ethics and associate professor of psychiatry in the law and psychiatry division at Yale University. "People are aware of these rating venues, and even physicians who have never felt themselves victimized by a bad review worry about it."

But responding to bad online reviews can be especially tricky for psychiatrists, who have a bedrock ethical commitment to patient confidentiality. A new resource document published by the APA Committee on Ethics seeks to provide some guidelines for when and how to respond to negative reviews and—perhaps more importantly—when not to respond.

Dike said a crucial takeaway from the resource document is that psychiatrists cannot respond to a negative review in any way that might publicly disclose that the individual is or ever was a patient. And anything published online is "public."

"If you indicate publicly that you are or were the person's psychiatrist, you have broken the law and acted unethically," Dike said.

But a second, equally important takeaway is not to overreact to one bad review. "Doctors take their roles seriously and tend to believe they are doing a really good job," Dike said. "Even one complaint can be quite damaging and demoralizing. But we have to caution them not to overreact in the moment to one bad review. It can be extremely hard to just watch these reviews online and not feel like there is a form of redress."

In cases where the identity of the reviewer is obvious, and the psychiatrist wants to respond, Dike urges psychiatrists to take the discussion offline. "You might have the opportunity to respectfully address the individual's concerns in the privacy of your office, being careful not to come across as confrontational," he told Psychiatric News.

As the resource document states, "Where possible, the psychiatrist may work together with the patient to formulate concrete steps to alleviate concerns and preserve the therapeutic relationship. Entering these conversations from a place of compassion and empathy impresses upon the patients that their treatment experience will improve.

Oftentimes, acknowledging and addressing the issue that resulted in a negative review leads the reviewer to voluntarily remove or revise the review on their own."

(The document also cites statistics from an article on a business website about responding to negative Yelp reviews, stating that a third of negative reviews are positively revised "when you take the time to respond to the upset customer.")

Multiple Negative Reviews? Take Notice.

What about when a psychiatrist is receiving a number of bad reviews from different sources, many of which appear to register similar complaints?

In that case, it may be time to take notice. "If there are many complaints similar in nature, this represents an opportunity for the physician to reflect on his or her practice, thoughtfully explore why the complaints are happening, and attempt to change one's approach," Dike said.

It is possible that a review may contain factual inacuracies, in which case review sites typically have protocols and procedures for removal of such material. But even then, caution is advised.

According to the resource document, "If making use of the relevant procedures would require the psychiatrist to reveal any confidential information, including whether the person posting the materials was or was not treated by the psychiatrist, the psychiatrist is prevented from using them by both the legal duty to protect patient privacy (for example, under the Privacy Rule of the Health Insurance Portability and Accountability Act [HIPAA]) and the physician's ethical duty to not reveal a patient's personal or health information without the patient's explicit, informed permission."

Finally, there are ways for physicians to be proactive about patient feedback. By encouraging patients to post reviews, physicians may be able to populate a website with enough positive reviews to dilute the impact of one or two negative reviews. Alternatively, they can solicit feedback in a nonpublic venue.

The resource document also recommends the following:

- **Provide mechanisms for patients to submit feedback directly to their psychiatrist** (for example, paper surveys that can be handed to the receptionist or slipped into a locked survey box in the waiting room, or electronic tablets in the waiting room that link directly to a patient satisfaction questionnaire). This approach fosters open communication between the psychiatrist and patient and allows them to discuss grievances directly before escalating to an online commentary.
- **Post information in waiting rooms instructing patients on how to submit online reviews about their experience** (for example, "If you would like to publicly review the service we provided, please go to [link], where you can do so anonymously").

These solicitation practices are ethical "so long as the same information and opportunity to comment is given to all patients without coercion, and no patient is directly asked to provide a review," according to the document.

Ultimately, Dike said, patient feedback can improve one's practice. "Physicians need to really know how their patients feel about their experience," he said. "If enough patients have an opportunity to express their opinion, that can provide real data to reflect on your practice and make constructive improvements."

Editor's Note: To access the APA Resource Document about responding to negative online reviews, visit: http://bit.ly/apareviewguide.

..."Staying Focused in 2020 & Beyond," continued from page 1

Are you looking for other ways to develop your leadership? Here are a few ideas:

1. Join an NCPA committee or task force.
2. Join the NCMS to partner with our physician colleagues.
3. Consider applying for the NCMS Leadership College. (There are several tracks.)
4. Attend the NCPA annual meeting. Better yet, volunteer to help on the planning committee.
5. When public comment is asked by DHHS – answer! If too complicated, you can always email the NCPA office and we will forward them on your behalf.
6. Join a caucus of the APA, which include: State Hospital, VA, IDD, Religion, Rural, College Mental Health, Integrative, MOC, Global, Climate Change, American Indian, Asian-American, Black, Hispanic, International Medical Graduates, LGBTQ, Women.
7. Complete FREE online CME for the Collaborative Care Model so you are trained in this valuable new way to practice psychiatry.

Are you interested in helping NCPA with any of our strategic goals for 2020-2023? Please reach out to the NCPA office. We would love your help! It has been my honor to be your President this year. I look forward to working with the next group of NCPA leaders as we shape the future of psychiatry in North Carolina.

HRSA Grants Improve Child Psychiatry Access in North Carolina

Kenya Caldwell, M.D.
Duke Second-Year Child and Adolescent Psychiatry Fellow

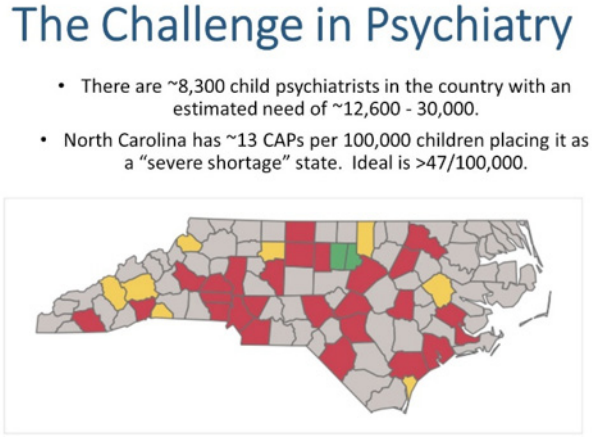
It is no secret that trying to get an appointment with a psychiatrist is a difficult task. There is an increasing demand for psychiatric services and a chronic shortage of psychiatrists. And this is even more of concern when trying to access child psychiatry.

In the United States, 77% of counties are underserved. And while there are approximately 8,300 child and adolescent psychiatrists, the estimated need is between 12,600 to 30,000 (Harris, 2018). In North Carolina, 84 of our 100 counties are considered mental health professional shortage areas (North Carolina Telepsychiatry Program, 2018), and 64 of our 100 counties do not have a child psychiatrist (Practicing Child and Adolescent Psychiatrist - North Carolina, n.d.).

To treat the 2.3 million children age 18 and under in North Carolina, only Durham and Orange counties have a "mostly sufficient supply" of child psychiatrists. Surprisingly, included in the "severe shortage" category is Wake County, which has the highest number of child psychiatrists but not enough to cover the nearly 250,000 children that reside within the county. Also, among the most populous states, North Carolina has the second largest rural population in the United States (Practicing Child and Adolescent Psychiatrist - North Carolina, n.d.).

Further, major depression in adolescents increased 52% from 2005-2017, and in the outcome of suicide, mental illness has become the leading medical cause of death among children and adolescents in North Carolina and the United States (Twenge, Cooper, Joiner, Duffy, & Binau, 2019). The need for mental health treatment in kids has grown substantially.

What does this mismatch of supply and demand mean? Predictably, it translates to significant delays in treatment, decreased quality of treatment, and higher costs. For our patients, it means waiting months to see a psychiatrist, travelling many miles to see a psychiatrist, less evidence-based psychotropic prescribing, and poorer outcomes. For us, the specialty workforce, it means cramped schedules, shorter appointments with patients to review their clinical information, less time to collaborate with the the treatment team, and earlier burnout.



Map Source: https://www.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home

So how do we address the mismatch? As many of us are aware, primary care providers are the first line for patients with behavioral health concerns. In pediatrics, 85% of all psychotropics prescribed to children are by pediatric primary care providers (Southammakosane & Schmitz, 2015). Further, 75% of children with psychiatric disorders are seen in a primary care setting and up to 50% of all those visits to pediatric providers involve behavioral, psychosocial, and/or educational concerns (Ford, Steinberg, Pidano, & Meyers, 2006).

However, in a survey by the American Academy of Pediatrics, 65% of pediatricians reported they do not have adequate training to recognize and treat mental health conditions. Unfortunately, the clinicians that are most called upon to manage the mental health of children report they aren't trained to do so. In 2003, Massachusetts recognized

these challenges and implemented a novel intervention, a telephonic psychiatric consultation line serving as a pediatric access program. This phone line, called the Massachusetts Child Psychiatry Access Program (McPAP) serves as a type of integrated care model within pediatrics. It allows pediatric primary care providers an opportunity to consult with a care manager or child psychiatrist about patient mental health concerns in real time.

At the heart of this program is an opportunity to provide education and training in managing mental health conditions in primary care. Indeed, when McPAP started, 8% of providers in Massachusetts thought they could meet the mental health need of their patients, and after a few years enrolled in McPAP, 60% thought they could meet the need. Now, McPAP is able to cover 1.5 million kids with just six teams (Straus & Sarvet, 2014).

Since that time, child psychiatry access programs have grown across the nation. According to a recent study conducted by the RAND Corporation, child psychiatric telephone access programs appear to increase the number of children who receive mental health services (Stein, Kofner, Vogt, & Yu, 2019), and these programs have led to more appropriate prescribing and decreased costs related to psychotropic medications. Access programs have improved outcomes by utilizing the available workforce and changing the model in which care is delivered.

In early 2018, Duke Integrated Pediatric Mental Health through a partnership with Cardinal Innovations, one of the state's LME/MCOs, started the North Carolina Psychiatry Access Line (NC-PAL) based on the McPAP model. Initially, this program was designed to provide telephone consultation to pediatric primary care providers in six central and rural counties – Franklin, Granville, Halifax, Person, Vance and Warren. In these six counties, NC-PAL provided consultation and referral resources to more than 40 practices covering 60,000 children aged 18 and under. The pediatric providers were able to connect to a care manager immediately and receive a response within at least 30 minutes from the child psychiatrist.

In the first two years of NC-PAL, 100% of pediatric providers utilizing NC-PAL reported satisfaction with the program, 60% felt there was a reduction in the need for immediate or a higher level of care, and 94% felt their ability to care for their patients with mental health conditions improved.

From the success of NC-PAL's early work and substantial support from the state and North Carolina Psychiatric Association, North Carolina applied for and was awarded a grant from Health Resources and Services Administration (HRSA) in the fall of 2018 to expand NC-PAL state-wide over the next five years with a focus on the development of mental health consultative infrastructure and educational programs across North Carolina.

Through a novel telephone access program for our primary care partners in North Carolina, psychiatrists are providing integrated care solutions to the state's mental health challenges.

Through a second HRSA grant in partnership with University of North Carolina, NC-PAL has expanded its consultative infrastructure to include a perinatal mental health component that will focus on the original NC-PAL counties. Through a novel telephone access program for our primary care partners in North Carolina, psychiatrists are providing integrated care solutions to the state's mental health challenges.

As this program grows, funding beyond the HRSA grant will be necessary for the program to be sustainable. In September 2018, and with herculean efforts from NCPA and President ***Jennie Byrne, M.D., Ph.D., D.F.A.P.A.***, NC Medicaid approved primary care practices to use reimbursement codes to treat Medicaid patients using the collaborative care model. This is a step in the right direction to provide funding for integrated care models. However, in order to fully meet the needs of North Carolinians, we must pursue further support from governmental and commercial payers to expand evidence-based mental health services in integrated care models that will ultimately lead to reduced costs to the health system and improved health amongst the citizens of North Carolina.

NCPA will continue to serve as an advocate for the expansion of integrated care models and to place psychiatry and psychiatrists front-and-center in solving the state's health care challenges.

Editor's Note: As part of an advocacy elective, Dr. Caldwell has been working alongside NCPA Executive Director Robin Huffman and the association's contract lobbyists on legislative issues and advocacy initiatives. Due to space limitations, this article with cited references is available on the NCPA website at www.ncpsychiatry.org/hrsa. You may also email the office at info@ncpsychiatry.org for a copy.

Resident Spotlight: Gender-Affirming Care Is Mental Health Care

Eric Tran, M.D.
MAHEC PGY-2 Resident

In 2016, the Williams Institute estimated that in the United States, 1.4 million adults identify as transgender, which represents 0.6% of the overall population. In 2017, the Institute reported that 150,000 youth aged 13-17 also identified as transgender, about 0.7% of the population. These numbers are more than double what they reported in 2003, probably because more people are comfortable identifying as transgender. Because such an identity is still quite stigmatized, these are still likely underestimates--even the 2016 report's upper bound is close to three million.

I bring up these numbers to say a simple sentence: transgender and gender non-conforming people live everywhere. As an extension, transgender and gender non-conforming people needing somatic and mental health care are everywhere. For example, in the 2016 report, North Carolina is #16 for proportion of transgender people, outranking states like New York or Massachusetts. Another 2016 Williams Institute Report showed that 36% of the country's transgender population and 35% of the country's LGBT population reside in the South. In just two years at my residency in rural Western North Carolina, I've provided mental health care for dozens of transgender people in a variety of settings.

In addition, multiple studies have shown that transgender people suffer from disproportionate rates of mental health issues. The Campaign for Southern Equality recently released results from the largest survey of LGBT Southerners. Of the transgender responders, 80% reported having experienced depression, compared to the national average of just under 10%. Anxiety and suicidal thoughts and self-harm were also similarly higher in transgender respondents.

Because of the extent of these disparities and how likely we are to care for transgender and gender nonconforming people in our careers, psychiatrists have both a duty and an opportunity to provide competent and meaningful care to this population.

Several professional organizations have guidelines and best practices. For example, the APA document, "A Guide for Working With Transgender and Gender Nonconforming Patients," includes best practices, basic terminology, and templates for writing letters to insurers and surgeons for gender-affirming procedures. Cleveland Clinic Consult QD wrote "Working with Transgender Adolescents: A Primer for Psychiatrists," which includes screening for gender dysphoria and exploring age-appropriate treatment referrals. The Fenway Institute's National LGBT Health Education Center has a plethora of self-led modules about a variety of topics in transgender health.

Being transgender does not inherently cause mental health issues, but it is rather a result of cultural stigma. This extends to the healthcare world. In the Campaign for Southern Equality report, only half of transgender respondents felt comfortable seeking care, and more than half reported delaying care "sometimes, often, or always" due

to concerns regarding their identity. So, in addition to these guidelines, I think there are philosophical ideas or ethos we can adopt to better welcome and care for transgender populations.

First, we can approach our clinical interactions as opportunities for therapeutic interactions. This can begin before we even meet our patients. Are there signs of an affirming practice in the waiting room (safe space stickers, brochures for LGBT resources, directions to a gender-neutral bathroom)?

Do the intake forms allow patients to mark their identified gender and name; if so, do you have a chance to review them before calling their name out loud?

Calling someone by their birth name (sometimes called "deadnaming") or incorrect pronouns can be a form of psychological violence that can color the entire interaction. Even if there are fields on my intake form, I make it a habit to

ask patients what they would like. As an example, I say: "Hello, my name is Dr. Eric Tran. I use he/him/his pronouns. What would you like me to call you?"

Related, we can regard gender-affirming care as mental health care. Using someone's correct gender and name doesn't just avoid violence. It allows us to affirm that their identity is legitimate and being taken seriously. We often think of gender transition in terms of hormone replacement therapy and surgical intervention. But often before that, people may transition socially, which can involve using pronouns of identified gender, using a different name, and/or wearing clothing associated with identified gender.

Recognizing and respecting these earlier efforts can be a form of validation for all patients. And should someone like to transition with hormones or surgery, we can point them in the right direction if they don't already have a provider. I know multiple other residents and attendings in the family medicine program who are either practiced in or want to learn about medical transition. Local LGBT resources, such Tranzsmission in my area of the state, will sometimes list trans-competent providers, as well. Given that gender affirming treatments have been correlated with positive mental health outcomes, I see this as not only as being in our wheelhouse, but also one of our duties.

Synthesizing these two points, I urge us to think of our practice of medicine as allyship to transgender communities. This can involve recognizing where we can and do not need to take a role in our patients' care. In terms of taking action, we can know and cite the literature that gender affirmation leads to better mental health outcomes for transgender people. This may be to other providers, to parents, or insurers. I care for several adolescents who self-harm, and I've discussed with their parents and providers that helping them achieve a body they like may also help them want to preserve it.

> ***I urge us to think of our practice of medicine as allyship to transgender communities.***

In terms of not taking action, I think we should consider when we are acting as gatekeepers. Guidelines for gender affirmation will often mention referral to psychiatry; this more as an attempt to link people to care due to high rates of untreated mental health issues and not necessarily to screen for conditions that preclude transition. (As discussed above, transition can help mental health outcomes.) In some circumstances, such as surgery, we may be required to assess competency, but overall our role as gatekeeping should be minimal.

We are very likely to care for transgender people in our careers. We will likely see people on a continuum in their journey. But regardless, holding the spirit of gender-affirming, person-centered practice will guide us towards competent, effective care.

Eric Tran, M.D. is a resident physician at the Mountain Area Health Education Center (MAHEC) in Asheville, NC. He volunteers with Youth Outright and Campaign for Southern Equality. He is also a poet, and his debut book of poetry, the Gutter Spread Guide to Prayer *will be released in March 2020. For more information about the book, visit: https://www.autumnhouse.org/books/the-gutter-spread-guide-to-prayer/.*

Editor's Note: Due to space limitations, this article with cited references is available on the NCPA website at www.ncpsychiatry.org/lgbt. You may also email info@ncpsychiatry.org for a copy.

APA Annual Meeting: April 25-29, Philadelphia

PRMS Professional Risk Management Services
Duke Psychiatry & Behavioral Sciences
Duke University School of Medicine
HopeWay
UNC School of Medicine
Department of Psychiatry
ECU Brody School of Medicine Department of Psychiatry and Behavioral Medicine
Cape Fear Valley Health
MAHEC
UNC Health Care
Network Physician Recruiting
Novant Health
Cone Health
Wake Forest Baptist Medical Center
Atrium Health
North Carolina Psychiatric Association

NC Psychiatry Reception

During the APA Annual Meeting

Sunday, April 26
7:00-9:00 pm

RSVP: http://bit.ly/4262020

APA Announces 2020 Honorees

Congratulations to the following NCPA members who have achieved Distinguished Fellowship, Fellowship, and/or Life Member status! New honorees will be formally recognized at the APA Annual Meeting in Philadelphia in April. *Please note, honorees listed below may hold additional distinctions other than those most recently awarded.*

Distinguished Fellow

Nadyah John, M.D.
Venkata Jonnalagadda, M.D.
Aarti Kapur, M.D.
Alyson Kuroski-Mazzei, D.O.
Pheston "PG" Shelton, M.D.

Fellow

Matthew Conner, M.D.
Jennifer Ingersoll, M.D.

Life Member

Pamela Baker, M.D.
Lawrence Beasley, M.D.
B. Steven Bentsen, M.D.
Preetinder Brar, M.D.
Scott Cunningham, M.D.
Anthony DiNome, M.D.
Gregory Dray, M.D.
David Gittelman, D.O.
Therese Hueholt, M.D.
Doreen Hughes, M.D.
James Jenson, M.D.
Beverly Jones, M.D.
David Krefetz, D.O.
K. Ranga Krishnan, M.B.B.S.
Gary Leondhardt, M.D.
David Manly, M.D.
Michael Newberry, M.D.
Lucy Preyer, M.D.
Deborah Ross, M.D.
Sy Saeed, M.D.
James Walsh, M.D.
Magdalena Wojdynska, M.D.

NCPA Presents 2020

Annual Meeting & Scientific Session

Asheville, NC | Oct. 1-4

Early-Bird Registration Open

Until April 1, members get first dibs (before non-members & exhibitors) on the limited room block at the Renaissance Asheville Hotel. Check your email for the group reservation link, and book your room today. Don't miss out on staying in the heart of downtown and enjoying all the city has to offer. While you're at it, go ahead and register for the meeting at the early-bird rate!

http://bit.ly/ncpsych20

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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

April 1, 2020
Last day to early book your room at Renaissance Asheville for the 2020 NCPA Annual Meeting before hotel block opens to non-members.
Visit: http://bit.ly/NCPA2020

April 19, 2020
(Note: Sunday meeting)
Executive Council Meeting
NCPA Conference Room
Raleigh, NC

April 25-29, 2020
APA Annual Meeting
Philadelphia, PA

April 26, 2020
NC Psychiatry Reception
(at APA Annual Meeting)
RSVP: http://bit.ly/4262020