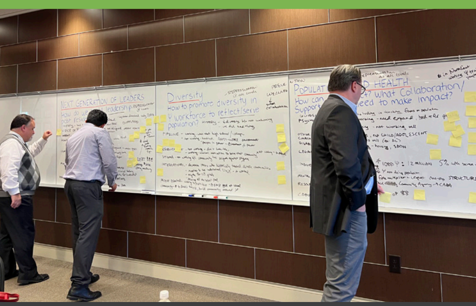
NORTH CAROLINA Psychiatric Association

news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

MARCH 2023



Top photo: NC Department Chairs and Training Directors participate in a facilitated discussion. Bottom photo: Michael Lang, M.D., Hiren Umrania, M.D., and Scott Klenzak, M.D. prioritize topics.

LEGISLATIVE UPDATE

The NC General Assembly began its long session in January. Legislation is moving too quickly for our print newsletter to have current information. To stay up to date, please look for our electronic newsletters and advocacy alerts for updates on legislation and important advocacy work we may be asking you to do.

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From left: Michael Zarzar, M.D.; Tyson Pankey, Ph.D, M.P.H.; Hiren Umrania, M.D.; Moira Rynn, M.D.; Marla Wald, M.D.; Scott Klenzak, M.D.; Robin Huffman; Ken Fleishman, M.D.; Ruth Benca, M.D., Ph.D.; Therese Garrett, M.D.; James Rachal, M.D.; Michael Lang, M.D.; Steve Buie, M.D.; Constance Olatidoye, M.D.; Lynneice Bowen, M.D.; Archana Kumar, M.D.; Sahil Munjal, M.D.; Samantha Meltzer-Brody, M.D., M.P.H.; Karon Dawkins, M.D.; Jennie Byrne, M.D., Ph.D.; Kalyan Muppavarapu, M.D.

NCPA HOSTS HISTORIC PSYCHIATRIC LEADERSHIP SUMMIT

What happens when a group of top psychiatry leaders get together for a day? Big ideas emerge!

In 2019, the North Carolina Psychiatric Association (NCPA) applied for an APA Innovative Grant to host a leadership summit for the Department Chairs and Training Directors from North Carolina's psychiatry residency programs. (At the time we applied for the grant, NC only had seven psychiatry residency programs.) The goals were to engage the academic centers with each other and the NCPA, to strengthen relationships, encourage collaboration, and elevate psychiatry. After a rigorous application process where NCPA had to demonstrate the significance of the project and the expected goals and outcomes, we were delighted to be selected!

We hit the ground running and distributed invitations to each of the seven programs on February 28, 2020. Then COVID hit, and we had to put our plans on indefinite hold as the world navigated the pandemic. Meanwhile, the mental health crisis continued to escalate, reinforcing the opportunity for psychiatry to take the lead to implement meaningful change.

Once COVID restrictions were lifted, planning for this historic gathering resumed, focusing on content that would be compelling enough for leaders to come. They did!

NCPA hosted the Psychiatric Leadership Summit on February 6, 2023, with representatives from the now-eight residency programs in the state, as well

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A MESSAGE FROM THE EDITOR

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

With the December 2022 edition of the NCPA print newsletter, I completed one year as editor. On behalf of myself and the NCPA staff I would like to thank all those who have contributed articles to the newsletter. The articles were varied and excellent. We appreciate your willingness to serve NCPA in this way. We also welcome other members to suggest story ideas or submit articles for future issues. Just contact me at info@ncpsychiatry.org.

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The *NCPA News* is a publication of the NC Psychiatric Association, 222 North Person Street, Suite 012, Raleigh, NC 27601.
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PRESIDENT'S COLUMN

THE YEAR IN REVIEW

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

This is the final article in my tenure as president of NCPA, and I thought it would be a good time to review the many positive events and challenges of the past year.

These last several years have required a great deal of perseverance both professionally and personally for each of us. As we move from the uniqueness of COVID to it becoming a part of our daily lives, there is a sense of a new normal. However, the tenacity we have as a specialty predates COVID.

The importance of good psychiatric care-- which we deliver-- is being recognized. 18 years ago, ***Drew Bridges, MD*** and I helped form NCPA's Access to Care Task Force. This past year the efforts of a coalition that includes NCPA, NC Academy of Family Medicine, NC Pediatric Society, AHEC, CCNC, and NC Medicaid and its managed care vendors has resulted in the adoption of the IMPACT (or Collaborative Care) model across each of these groups. This evidence-based model has an essential role for a psychiatric consultant to assist primary care colleagues screen and treat common mental health disorders. Each of these partners are contributing to successful implementation of the model in the state. Dr. Shannon Dowler, Chief Medical Officer for NC Medicaid, has been instrumental in moving this forward, particularly in her work to secure reimbursement for the codes that support this model at 120% of Medicare rates. In July, BCBSNC began providing reimbursement for the model. NCPA held a celebration of these accomplishments with the groups involved at our 2022 Annual Meeting.

We were able to hold our first in-person meeting in three years! The ability to see everyone in person was a testament to the work of the NCPA staff, and the turnout was a reflection of our resilience. Many thanks to ***Dr. Mehul Mankad*** and the program committee for curating an outstanding program. Lessons learned from the prior two virtual annual meetings enabled us to feature several national speakers virtually, speakers who would not otherwise have been able to participate in that conference.

Younger leadership is stepping forward! A special edition of the NCPA Newsletter that will feature resident members has been approved by NCPA Executive Council. This summer edition will be led by residents and focused on DEI. It is heartwarming to see the next generation of leaders taking the initiative.

Psychiatry has led the way in innovation through the pandemic, and the changes persist. Telepsychiatry implementation during the pandemic allowed our patients to continue to receive the treatment they needed. The use of telepsychiatry continues and enables us to improve access for many individuals. See page 5 for more information about the end of the Public Health Emergency.

The Private Practice Committee was restarted this year, and we are fortunate to have ***Dr. Aarti Kapur*** and ***Dr. Carey Cottle*** chairing the group. We recognize the importance of private practice physicians in delivering care in our state and your importance to our association. I would encourage everyone to join and add your voice and perspective to the work of the committee.

There was a first-of-its-kind meeting of all the academic Department Chairs and Training Directors this spring, sponsored by NCPA. ***Dr. Jennie Byrne*** and NCPA staff envisioned this idea in 2019 and applied for an APA innovative grant, which we won. Planning for the event was postponed during the pandemic and finally took place this February. We are excited about continuing this leadership collaboration as psychiatry looks toward the future for our state.

There have also been difficulties over the past year, which our specialty is working to address.

The percentage of African American individuals practicing in our profession is woefully low. We have an active Race, Ethnicity, and Equity committee that is not only committed to helping lead hard conversations within our association, but which is also taking steps to reach out to a more diverse healthcare workforce pipeline. In March the REE Committee is traveling to a Student Professional Conference at NC A&T University to inspire students to consider medicine and psychiatry as a profession. It will take a conscious effort in all settings to create environments that support individuals coming into our field. This work needs to become part of the fiber of our daily lives in the profession.

There has been a rise in workplace violence in health care settings. We are all aware of the tragic death of June Onkundi, a nurse practitioner who was stabbed to death by a patient in a Durham clinic. The increase in workplace violence is a mirror of the general in-

continued on page 6...

What Psychiatrists Need to Know About... X-Waiver: What Will Change?

Eric Morse, M.D., D.F.A.P.A.
NCPA Addictions Committee

As an addiction psychiatrist who has been treating Opioid Use Disorder (OUD) for more than 20 years in both Opioid Treatment Programs (OTP), commonly known as methadone clinics, and Officed Based Opioid Treatment (OBOT), commonly known as Suboxone practices, I recently had to say good-bye to my X DEA number or "X-waiver" that I was assigned to in 2002. The DEA even emailed me an updated DEA certificate with the same date of issue and expiration that removed my X-waiver as if it never existed.

Under the DATA 2000 Act, MDs and DOs who wanted to treat opioid disorders with medications were required to take an 8-hour training course either in person or online and then submit proof of that training to be issued a DEA registration that replaced the first letter of their DEA number with an X. This number was required to prescribe buprenorphine for OUD to be filled at an outpatient pharmacy.

Under the CARA Act, PAs and NPs had to attend a 24-hour training to receive the X-waiver. The DATA 2000 Act placed various limits on the number of patients who could be seen. With passage of the Mainstreaming Addiction Treatment Act in December 2022, any medical provider with a DEA number can now prescribe buprenorphine for OUD, with no limits on patient numbers. In our OTP, where we use stock bottles of buprenorphine and never needed an X-waiver, we never had limits.

NOW THAT ANY MEDICAL PROVIDER CAN PRESCRIBE BUPRENORPHINE, WILL THEY?

Sadly, probably not, but they should. Stigma abounds, especially, in the medical community. It wasn't until my Addiction Psychiatry Fellowship at the University of Maryland that I learned how effective and easy using medications for OUD (MOUD, which include naltrexone, buprenorphine, and methadone) was. Even so, fewer than 10% of prescribers received their X-waivers and less than 40% of X-waivered prescribers ever wrote for buprenorphine. Even with restrictions dropped in response to COVID when any prescriber could prescribe buprenorphine without an X-waiver if you submitted an intent to train, very few prescribers did.

WHICH "NEVER X-WAIVERED PRESCRIBERS" WILL MOST LIKELY START PRESCRIBING BUPRENORPHINE NOW?

Buprenorphine prescribing is becoming the standard of care in emergency medicine when OUD is diagnosed. "But I do not have an X-waiver" is no longer an excuse! The same is true for nursing homes, jails, prisons, hospitals, and substance use rehabs. On April 5, 2022, the US Department of Justice published a statement that people who suffer with an OUD have the ADA right to remain on their MOUD. I have filed my share of ADA complaints on behalf of my patients on www.ADA.gov since then.

SHOULD ALL PSYCHIATRISTS PRESCRIBE BUPRENORPHINE?

In my opinion, yes, just like any other psychiatric medicine that treats a mental disorder. You read, learn, and prescribe as you see the need for it. You can at the very least, prescribe a few days' worth of the medication and refer the patient to an OBOT or OTP. Not doing so, puts your patient at a much higher risk of overdosing. We are in an epidemic. All of us should consider the adage "if you are not part of the solution, you are part of the problem."

WHERE CAN I LEARN MORE ABOUT PRESCRIBING BUPRENORPHINE?

In addition to the AAAP, ASAM and APA websites, you can read TIP 63 or the Quick Start Guide on the

SAMHSA.gov website. Alternatively, call or email me and I can help you. Help is also available through the NC Star program, directed by ***Robyn Jordan, M.D.***, an NCPA member.

WHAT SHOULD I DO BEFORE PRESCRIBING BUPRENORPHINE?

Besides taking a thorough history and documenting like any other patient, I suggest doing a urine drug test. I buy instant drug test cups online for $3 a cup if you buy more than 25 of them. If you plan on seeing a patient more than once for buprenorphine, you may want to work with a send-out lab to do confirmatory testing when a patient contests a result or says they are using something that is not in the test cup (like certain Benzos or Fentanyl).

WHAT IS A STANDARD DOSE OF BUPRENORPHINE?

The national average is about 12 mg a day. The usual dose range is 8 – 24 mg a day, but 16 mg is the usual starting dose. Most patients have tried it off the streets and can tell you what they need. If that number is between 2-24 mg a day, most buprenorphine prescribers will start there. Most buprenorphine prescribers will usually see people weekly until they pass their drug test, then add a week between visits up to 4 weeks.

WAIT, IF EVERY PRESCRIBER STARTS PRESCRIBING BUPRENORPHINE, WON'T THAT PUT DR. ERIC MORSE OUT OF BUSINESS?

Yep, probably. Please put me out of business!

MIGHT THERE BE UNINTENDED CONSEQUENCES OF REMOVING THE X-WAIVER?

I worry that medical schools and residency programs that were insisting that their graduates do the X-waiver training, will stop training on MOUD especially if the funding for it stops. Will SAMHSA maintain the buprenorphine medical provider locator? I also worry that lower quality prescribers, especially online services (go Ryan Haight Act, go!), that were previously limited to 275 patients per prescriber will far exceed that number, and the DEA and Medical Boards will not be able to track the buprenorphine prescriptions as easily. I am a big believer in lowering barriers and improving access to care so long as there is still some quality to the care.

Eric Morse, M.D. is an addiction and sports psychiatrist with a private practice and Opioid Treatment Program clinic.

This article and its references can be found by scanning the QR code with your smart phone.

PUBLIC HEALTH EMERGENCY TO END MAY 11

The federal Public Health Emergency (PHE) is scheduled to end of May 11, 2023, which will create changes to how healthcare has been delivered these past three years. Under the PHE, a number of restrictions were lifted to help patients receive services; many of the pre-pandemic rules will go back into place when the PHE ends. For example, health care professionals will be required to use a HIPAA-complaint software for telehealth, and DEA requirements will revert back to seeing a patient in person (at least once) if being prescribed controlled substances and procuring DEA registration in any state where they are prescribing controlled substances.

As it currently stands, once the PHE ends patients will be required to been seen in-person to initiate medication for opioid use disorder, including buprenorphine. In December, SAMHSA proposed a new rule that would permanently extend the ability to treat patients without an in-person requirement, and in February the DEA proposed a rule that only a 30-day supply can be prescribed without an in-person evaluation. We will keep members informed of any policy changes.

Other changes when the PHE ends will include:

- Those with private insurance will no longer receive eight free at-home COVID tests each month, but those on Medicaid will be able to access at-home COVID tests until 2024 under the American Rescue Plan.
- In NC, an estimated 300,000 people will lose eligibility for health care coverage under Medicaid.

Many states and insurers have made permanent changes to telehealth, which are no longer linked to the PHE. The Consolidated Appropriations Act of 2023 extended telehealth flexibilities for Medicare patients, including postponing in-person requirements until at least the end of 2024.

The end of the PHE is complex and still evolving. The NCPA and APA are working to create resources for psychiatrists to expect regarding the end of the PHE.

For the most up to date information and additional resources scan the QR code.

MEMBER SPOTLIGHT
SAHIL MUNJAL, M.D.

ASSISTANT PROFESSOR AND PSYCHIATRY RESIDENCY PROGRAM DIRECTOR, ATRIUM WAKE FOREST BAPTIST HEALTH DEPARTMENT OF PSYCHIATRY

Sahil Munjal, M.D. was born and raised in New Delhi, India, the son of two physicians. He completed his medical training at the University College of Medical Sciences in New Delhi. His residency in general psychiatry was completed at the New York Medical College at Westchester Medical Center and Lenox Hill Hospital where he served as Chief Resident from 2016-2017. He then completed a Consultation-Liaison Fellowship at Yale University. He joined the faculty of Wake Forest University School of Medicine in 2018. Twice since then he has received the department's Loretta Y. Silvia Teaching Award from the residents and fellows.

CONVERSING AT THE DINNER TABLE

Dr. Munjal's interest in psychiatry was sparked in his teen years by dinner conversations with his father, a pulmonologist, and his mother, a gynecologist. Both spoke of the many patients in their practices with mental health issues who because of stigma, refused to seek help from psychiatrists. From these conversations he began to appreciate the influence of mental disorders on physical illnesses. Little did he know that his growing fascination with the intersection of mental health and physical health would become the North Star for his career as a psychiatrist.

EXCITED BY CONSULTATION-LIAISON WORK

Dr. Munjal is energized by the complexity of patients with physical and mental health co-morbidities. He frames their issues as a puzzle to be solved for their benefit. He particularly enjoys the collaborative work with physical health colleagues in their care for hospitalized patients, saying it keeps him "on his toes" regarding all of medicine. Since residency he has continuously provided C/L services to HIV specialty clinics, which has satisfied and increased his desire to help patients by solving complex clinical issues while providing training to medical students and residents. Given these interests, he believes working in an academic setting is perfect for him.

COMBINES CONSULTATION LIAISON SKILLS WITH THE COLLABORATIVE CARE MODEL (COCM)

Since 2019, Dr. Munjal has served as a consulting psychiatrist in the Atrium Wake Forest Baptist HIV clinic. Working in fidelity to the Collaborative Care Model (CoCM) he consults with a team of clinicians on the treatment of mental disorders in patients suffering with HIV. Using universal screening and evaluation the clinic identifies patients with depressive and/or anxiety disorders and refers them for caseload consultation. He notes, though, that other mental disorders are regularly diagnosed, sometimes requiring referral to psychiatric clinics in the community. When asked if the CoCM, mostly used in primary care at present, can be valuable in specialty clinics, he replies "absolutely."

Member Spotlight is a new column, where we feature the outstanding work of NCPA members. If you are interested in nominating a member, email info@ncpsychiatry.org.

..."Year in Review" continued from page 3

crease in violent crime in our society. We all know that people with psychiatric illness are more likely to be victims of crime than perpetrators of crime. However, the uptick in violence in health care settings requires that we are cognizant of the need to intervene. We need to support our peers, colleagues and the frontline staff (nurses, front office staff, techs, etc.) as we work to promote safe environments. (Expect to hear more about this as NCPA works to present a special conference on this topic this fall.)

As my year is coming to an end, I can say it has been a great privilege to serve as the president of NCPA. I have been a member of this professional association for more than 30 years and have been proud of the patient-centered focus of our organization. I look forward to ***Dr. Constance Olatidoye***, a wonderful individual and a thoughtful leader, taking the role of President following the national APA meeting in May. I would also like to give a huge shout out to our NCPA staff who enable us to be the strong organization we are: Robin Huffman, Katy Kranze, Lana Frame and Anna Godwin!

LESSONS FROM A PRITE FELLOWSHIP

Malcolm Vaught, M.D.

Medical residency presents numerous opportunities to expand one's clinical knowledge and engage in activities that reflect (and simultaneously cultivate) professional and personal interests. In my case, teaching has been a passion of mine for many years. In some ways, it even paved my path in medicine and has led me to who I am now as a resident-physician. That said, I was given a tremendous privilege in becoming a PRITE Fellow in 2021.

[PRITE Fellowships offer four residents from across the country the opportunity to serve as Members of the PRITE Editorial Board, where they participate in the question-writing process by developing an assigned number of questions and then editing and referencing exam items.]

Residents of all training levels are familiar with taking standardized exams. However, very few are privy to how these tests are created. Being a PRITE Fellow has given me the unique opportunity to be a pioneer in distributing medical knowledge pertaining to some of the most groundbreaking studies in psychiatry, as well as convey fundamental concepts for resident learning and clinical practice. As someone who genuinely values medical education and the training of future physicians, being a PRITE Fellow has helped me cultivate skills as a clinician and teacher. The position has allowed me to meet and learn from leaders in the field of psychiatry and academic medicine. It has given me the chance to engage in meaningful discussions with individuals who share my passion for teaching and helping our field and its members grow. I'm also lucky enough to have made some good friends along the way!

As global events occur and society changes, mental health has truly taken massive strides over the last decade. I am proud to be part of a team that assists in teaching and guiding fellow residents across the nation as we adapt to the ever-changing world in which we live.

Malcolm Vaught, M.D. is a psychiatry resident at Cape Fear Valley Health.

APA ANNOUNCES 2023 HONOREES

Congratulations to the following NCPA members who have achieved Distinguished Fellowship, Fellowship, 50-Year member, and/or 30-Year member status! New honorees will be formally recognized at the APA Annual Meeting in San Francisco in May. Please note, honorees listed below may hold additional distinctions than those most recently awarded.

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Malcolm McLeod, M.D.
Praful Mehta, M.D.
Barry Ostrow, M.D.

30-YEAR MEMBERS

Moira Artigues, M.D.
Mary Berg, M.D.
Lea Kirkland, M.D.
Rigardy Munoz, M.D.

Members who achieved "Distinguished Fellow" status did so by invitation and have been recognized for making significant contributions to psychiatry; as the APA describes, "Excellence, not mere competence, is the hallmark of a Distinguished Fellow."

"Fellow" status is an honor that reflects a psychiatrists dedication to the work of the APA and signifies allegiance to the psychiatric profession. If you are interested in learning more or being considered for one of these honorary titles, please reach out to the NCPA Fellowship Committee by emailing info@ncpsychiatry.org.

The APA also recognizes the extraordinary achievement of 50-year members and beginning in 2022, recognizes those who have reached Life Member status after 30-years of qualifying membership (excluding membership as a medical student).

DIVERSITY IN SLEEP PATTERNS

Sushrusha Arjyal, M.D.
NCPA Race, Ethnicity, and Equity Committee

Sleep is an essential phenomenon that plays a crucial role in renewing our energy, consolidating our memory, and improving our overall physical and mental growth. Among sleep disorders, insomnia is the most common. Studies show that approximately 30-40% of adults in the United States suffer from insomnia, the prevalence being higher in females.[1] Officially, the aggregate of symptoms, including sleep disruption, delay in onset of sleep, intermittent awakenings during the night, and waking up early in the morning, is defined as "insomnia" provided that it leads to significant functional impairment during the day.[2]

As a psychiatrist and a sleep specialist, I frequently see patients with insomnia. However, it is not uncommon to see patients with other sleep disorders who have subsequently developed insomnia over time. It significantly impacts their daily life, mental health, functionality, and relationships.

To understand insomnia, we need to understand sleep. Sleep is a dynamic phenomenon that can vary from one night to another. Sleep can depend on what we do during the day and what we don't. Sleep patterns can vary with time, season, age, and our daily activities. A regular bedtime, waking up time, moderate exercise, eating a healthy diet, a good bedroom environment and temperature are essential for good sleep.

These lifestyle changes can be challenging for people who are struggling in different aspects of their life. I have personally treated patients who suffer from sleep disruption because they commute two or more hours, work night shifts or frequently travel across different time zones. Other patients include those too anxious and stressed about their lives that the bedroom provides little or no comfort: single parents with full time jobs or caregivers who cannot afford seven hours of sleep and are exhausted but "too wired" to sleep. Such patients go to bed and lay there for hours because "their mind seems to be going at 100 miles per hour" - their brain tries to work constantly like "a hamster in the wheel" at bedtime and it drives their sleep miles away.

In these cases, I educate patients about sleep hygiene, giving up excessive caffeine, and the adverse effect of alcohol and other substances on sleep. I also discuss pharmacological managements, but these measures prove to be less than ideal at times, perhaps due to the fact that insomnia is a symptom that can be affected by several other factors than just poor sleep hygiene.

Studies support the fact that significant variations in work hours can contribute to disruptions in sleep. People who work more than 40 hours a week tend to have disrupted sleep compared to people who work less than 40 hours. Other factors found to be predictors of sleep disruption include being a caregiver, lacking social and emotional support, and having multiple physical and mental health issues.[3]

"SLEEP IS A DYNAMIC PHENOMENON THAT CAN VARY FROM ONE NIGHT TO ANOTHER. SLEEP CAN DEPEND ON WHAT WE DO DURING THE DAY AND WHAT WE DON'T.

Sleep and prevalence of insomnia can also vary between races. Several studies have shown that there is a significant disparity in sleep patterns between different races. A study in Chicago showed that there is a deficit in sleep duration in African-American, Hispanic, and Asian participants compared to White participants. The study was conducted after adjusting for apnea-hypopnea index (AHI), gender, age, education, work schedules, body mass index (BMI), smoking status, depressive symptoms, and other comorbidities like hypertension and diabetes mellitus.[4]

Furthermore, it would be an oversight not to consider the challenges in accessing mental health care. Sleep issues and mental health care are fundamentally intertwined. Providing more access to mental health care and proper treatment of mental illnesses like depression, mania, and hypomania can lead to better sleep in individuals and vice versa.

The use of substances can be detrimental to sleep. Access to proper detoxification centers and rehabilitation will give sleep specialists an opportunity to work on bringing individuals more or less back to their normal sleep patterns. The lack of access to proper treatment leads to frequent relapses, which also hinders the overall treatment of insomnia in individuals.

Lastly, we should talk about financial challenges in treating patients with sleep disorders. Sleep studies, especially in lab studies, tend to be expensive. I have had patients who are already struggling financially who decide to skip or postpone their sleep studies as they focus on saving for other medical expenses. Sleep studies are essential to treat disorders, including but not limited to sleep apnea, periodic limb movement disorders, narcolepsy, and others as they frequently present with overall sleep disruption. Treating them is important to treat their overall sleep.

In conclusion, sleep and sleep disorders do not exist in isolation. Educating patients about sleep hygiene can have a significant impact if we are able to simultaneously address the different factors adversely affecting their sleep. Often, I succeed in treating insomnia by educating my patients about their bedtime, avoiding the use of electronics, avoiding excessive caffeine and alcohol, and even working towards quitting smoking. However, insomnia is a problem that is deeply embedded and co-exists with other medical and psychological problems. Prognosis is deeply affected by social, cultural, and financial aspects of the individual and is adversely affected by these constraints. Increasing attention to these other aspects affecting sleep and focusing on education on sleep will be a step forward towards improving overall physical and mental health. I do have hope that someday, with collective effort, we will be able to achieve this milestone.

Sushrusha Arjyal, M.D. is an Assistant Professor of Psychiatry and Behavioral Sciences and an Assistant Professor in the Department of Neurology at Duke.

This article and its references can be found by scanning the QR code with your smart phone.

LET ME TELL YOU ABOUT A *HELL OF A BOOK*

Megan Pruette, M.D.

I just finished reading one *Hell of a Book* that had all the beauty of great literature- engaging plot, thought provoking narration, and use of story to navigate important societal questions. To put the icing on the cake, the author is from our very own state, North Carolina. This *Hell of a Book* is a must-read for NCPA members.

The book is *Hell of a Book* by Jason Mott. The novel goes between the narrator, a man on a book tour grappling with his past traumas, and a young boy growing up black in the south experiencing traumas. Mott's ability to accurately portray the experience of someone struggling with their past is profound. The narrator has "a condition"-- at times also described as "an overactive imagination"-- making his narration a perfect example of "an unreliable historian." The reader is put directly into this man's experience of the world, sometimes questioning what is real and not real, sometimes trying to disappear into an alcoholic stupor, sometimes being incredibly charming while wooing women, but always doing whatever it takes to keep the past in the past.

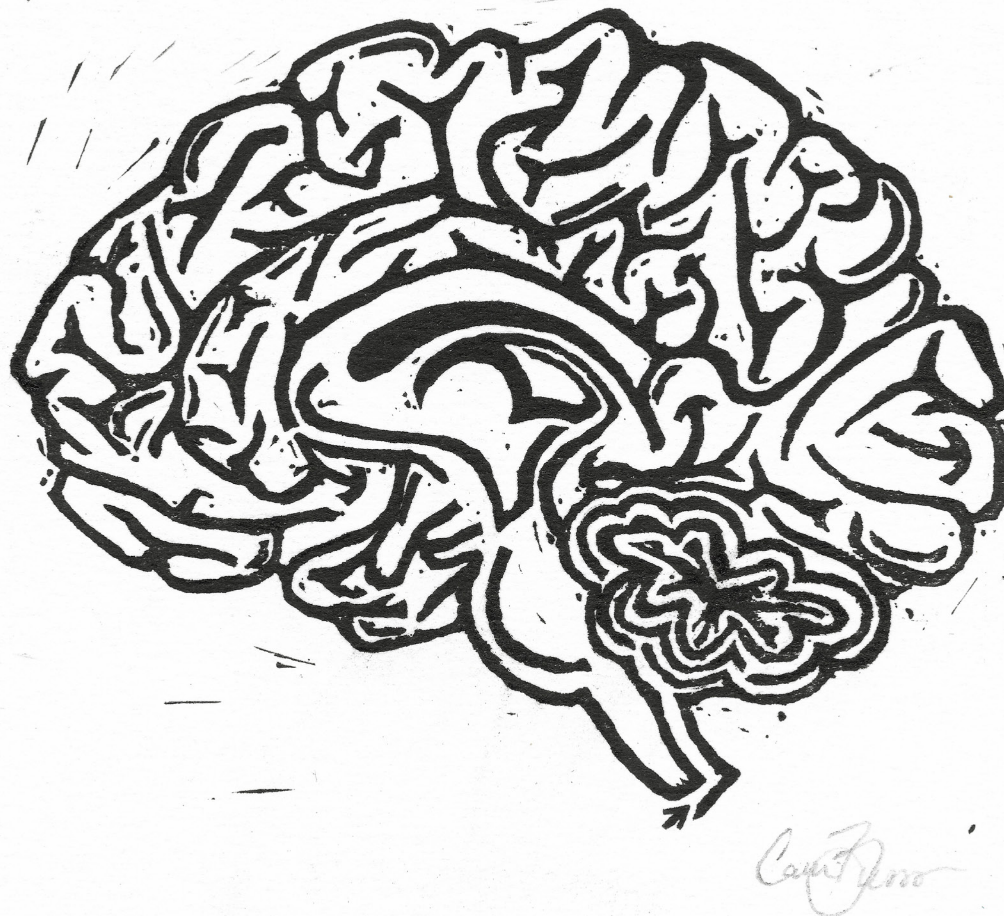
Reading *Hell of a Book* felt like I was seeing a patient in my office. At first, there is no information, everything is "fine," their childhood was "great," etc. Then details come, but they are fuzzy and don't quite make sense. The timing is off, the people aren't right, there are huge holes, and a growing sense that something in the past is very wrong. Finally, it all comes out, all the horrors of what happened, the story becomes more cohesive, there is more perspective, understanding, and healing.

In addition to being a chilling portrayal of trauma, *Hell of a Book* grapples with issues of race, particularly in the south. The narration gives a first-person account of growing up black in the south- the fear of the police, the love and strength of family, the grief, and the internalization of societal narratives. Race, the subtle and not so subtle ways it affects the psyche, are the foundation of the book. The author tackles these timely issues not through preaching or overt statements, but through his narration and experience of the characters. Mott creates a book in which race is omnipresent, although rarely the main act, allowing the reader to experience the ubiquitous and relentless nature of racial trauma.

Megan Pruette, MD is a Clinical Assistant Professor at UNC where she treats patients in an outpatient clinic and in the NC prison system.

BREAKING NEWS

NC Medicaid Tailored Plans Implementation Delayed Until October 1, 2023



BRAIN MAZE: START HERE (2023)

Linocut on paper

Nina (Cami) Burruss, M.D. is a PGY-3 psychiatry resident at UNC who will be starting her Child and Adolescent Fellowship at Johns Hopkins in July. *Brain Maze: Start Here* is a reflection on the complexity of psychiatry training. In this piece, an incomplete maze mirrors the often ambiguous nature of psychiatric care while also referencing the importance of play (especially when working with pediatric patients). The detailed nature of this print allows viewers to reflect on the intricacies of each patient encounter. Additional work can be found at camiburruss.com.

..."Leadership Summit" continued from cover

as NCPA's President, President-Elect, Vice President, Executive Director and team.

Dr. Jennie Byrne facilitated the day-long event, leading us through discussion of priorities this group could tackle for the greater good. Participants spent the morning dissecting what is and is not working in each practice setting and corner of the state. In the afternoon session, the department chairs and training directors split into groups and were asked to think more future and action oriented. Issues discussed included moral injury (not physician burnout), promoting diversity in the workforce, population health, payors, "all treatment matters—not just pills," social determinants of health/mental health, settings without physician leadership, how to teach leadership, continued mental health stigma, rural health, and quality of care.

The Summit generated big ideas on ways to encourage psychiatrists to stay in North Carolina post residency to help with the workforce shortage, reduce the boarding of patients in emergency rooms, staff beds at the state psychiatric hospitals, increase reimbursement rates, and regularly engage this group of leaders to continue to improve patient care in the state. Specific plans were made by the training directors to commit to quarterly meetings. A big idea to engage all the programs/systems on a joint legislative initiative is currently being explored. This was truly a historic meeting for all the psychiatry programs and NCPA to come together to meet to advance psychiatry in a noncompetitive way. The momentum that was generated was palpable, and it will be exciting to see the progress we can make after coming together.

The takeaways from the meeting that were shared the with the attendees are:

STRONGER TOGETHER

We all work in a highly fragmented healthcare ecosystem. Psychiatrists, like other clinicians, are on the frontlines and historically have had difficulty finding bandwidth to collaborate on statewide goals. As NC Department of Psychiatry Chairs, we are stronger together. We came together for an all-day retreat on Monday 2/6/23 to find ways to work smarter together to benefit our patients, our providers, and our communities.

SUSTAINING OUR WORKFORCE

Treating mental illness and substance use disorders is hard work. Our workforce was struggling pre-pandemic, and the last few years has seen a tidal wave of new mental health needs. We need to address burnout, moral injury, salary and service parity, student loans, and other forces that threaten to further diminish our workforce.

FORCE MULTIPLIERS

We currently have about 1,000 psychiatrist members in North Carolina and we need them to impact a population of 11 million people. Given that approximately 5% of the population suffers from mental illness, that is a ratio of 1000:550,000 or 1 psychiatrist for every 550 people in need of care. We must invest in force multipliers so that our psychiatry expertise can benefit the entire population. Given the workforce shortages in NPs and PAs, we must double down on evidence-based population health models of care like the Collaborative Care Model.

SMART LEGISLATION CAN HELP

We are looking to actively partner with our colleagues in the NC General Assembly to rapidly develop and iterate solutions for treating mental health in our state. It is not enough to work harder, we must work smarter together.

PART-TIME PRACTICE?
WE CAN COVER YOU

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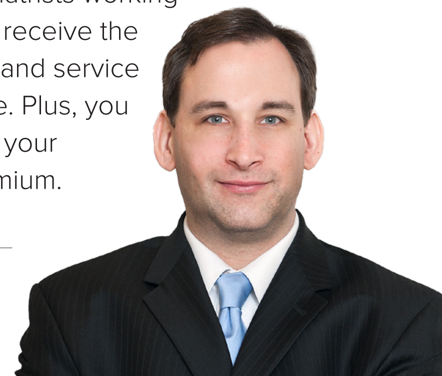

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NORTH CAROLINA
Psychiatric
Association

Save the Date

North Carolina Psychiatry Reception
APA Annual Meeting
Sunday, May 21

CALENDAR OF EVENTS

April 29, 2023
Executive Council Meeting
Raleigh; 10am

May 19-21, 2023
APA Assembly Meeting
San Francisco

May 20-24, 2023
APA Annual Meeting
San Francisco