NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

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IN THIS ISSUE

NCPA Wins Award!

The North Carolina Psychiatric Association District Branch received the APA's 2014 Communications Award for Innovative and Emerging Technology for the use of the Guidebook Event App at the 2014 Annual Meeting. NCPA previously received the APA's 2013 Communications Award for the Website category, following the association's 2013 redesign of www.ncpsychiatry.org.

New Workers' Comp Medical Fee Schedule Adopted

Improved Rates for Psychiatrists Start July 1

In February, the North Carolina Industrial Commission announced new rules that dramatically revised the state's Workers Compensation Medical Fee Schedule. The new fees for institutional services take effect April 1, 2015, and new fees for professional services are effective July 1, 2015.

The changes are the result of many years of negotiations among stakeholders, including physician groups like the North Carolina Medical Society and various state agencies that oversee the workers' compensation program.

Adopted in 1995, the old medical fee schedule had grown outdated and offered North Carolina physicians some of the worst reimbursements rates in the country, and much lower than other states in the Southeast. Low reimbursement rates limit physician participation and contribute to patient difficulties accessing care, while making workers' comp coverage more expensive for employers.

The updated fee schedule is seen as a universal win. According to the Industrial Commission's press release, the fee schedule "incorporates long needed revisions that will protect injured workers' access to healthcare while significantly reducing the overall cost of the workers' compensation system by establishing fair and reasonable fees for medical treatment." Analysis by the National Council on Compensation Insurance (NCCI) projects that the new Medical Fee Schedule will result in approximately $27 million in annual savings to the North Carolina workers' compensation system. This estimate is based upon 2013 written workers' compensation insurance premiums and self-insured employer data. These savings may continue to increase as North Carolina insurance carriers expand their workers' compensation premium base in response to the state's growing economy.

The Industrial Commission's Medical Fee Schedule rules are available online, http://bit.ly/1BPdym7.

Dr. Rahn Bailey Named Chair of Psychiatry and Behavioral Medicine at Wake Forest

In January, Wake Forest announced the appointment of ***Rahn Bailey, M.D., D.F.A.P.A.,*** as Chair, Department of Psychiatry and Behavioral Medicine, at Wake Forest Baptist Medical Center.

Known for his work in inpatient care, medical education, research and forensic evaluations, Dr. Bailey has experience creating and overseeing community-based programs, including those focusing on care for the traditionally underserved and patients with complex medical/psychiatric co-morbid diagnoses and conditions. Immediately prior to his appointment, Dr. Bailey served as chairman and professor of psychiatry at Meharry.

Dr. Bailey has served as president and a member of the board of trustees of the National Medical Association, president of the Tennessee State Psychiatric Association, and is currently the chair of the APA's Membership Committee.

Dr. Bailey is board certified in general and forensic psychiatry. He received his medical degree from the University of Texas Medical Branch at Galveston and completed his residency in psychiatry at the University of Texas at Houston, Texas Medical Center Affiliated Hospital, where he was chief resident. He completed a fellowship in forensic psychiatry in Yale University's Department of Psychiatry in New Haven, Conn.

NORTH CAROLINA Psychiatric Association news

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To update your mailing address or if you have questions or comments about NCPA News, contact Kristin Milam, 919-859-3370 or kmilam@ncpsychiatry.org.

The New Preferred Drug List for Psychiatric Medications

Burt P. Johnson, M.D., D.L.F.A.P.A., President

In early calendar 2015, the NC Division of Medical Assistance (Medicaid or DMA) updated its annual Preferred Drug List (PDL) that--for the first time--included psychiatric medications. Until the Governor signed the budget last summer, psychiatry had been essentially exempt from the PDL restrictions on drug prescribing.

This change came about as a result of the NC General Assembly, which lately has been turning more attention to the operations and future of Medicaid, putting into law a provision that, as of January 1, 2015, required DMA to save $1 million per month on the costs of psychiatric medications. The budget bill did not mandate a formulary, which is in effect what a PDL is, but it required the savings and included language that allowed managed care techniques to be used. NCPA has been advocating against such a plan for more than a dozen years.

The process to establish a psychiatric PDL moved quickly after the legislation became law. DMA had three to four months to come up with a plan, process it through the Physician Advisory Group, and publish it for the required public comment period. When this period ended, DMA moved in early November to obtain formal recommendations and approval at the public meeting of the DMA PDL Committee —composed of about 10 physicians from various specialties including myself as an NCPA representative. This was an hours-long public meeting designed to review each change to the Medicaid PDL so that it would be ready to go into effect by January 1, 2015.

An unusually large number of groups and individuals (including NCPA and some of our members) stood to speak at the public meeting November 4 to provide general feedback about the psychiatric PDL. Despite the sentiment against psychiatric medications being added, there was surprisingly limited feedback about specifics of the plan during the public comment period; the exception was specific feedback about Abilify Maintena, which led the PDL Committee to move it from non-preferred to preferred status. At the end of the day, DMA chose to go with a PDL for psychiatric medications.

I think it is fair to say that the new psychiatric PDL provides a wide latitude of available medications. It had been assumed by many that Abilify, reportedly the most costly DMA drug from any specialty, would be designated non-preferred. In fact, except for the long-acting Maintena form on the original list, it was not. At the PDL Committee meeting in early November, the Committee recommended shifting Maintena from non-preferred to preferred status. All of the newer oral antipsychotics —Fanapt, Latuda, and Saphris— were designated preferred, along with ADHD drugs Focalin and Vyvanse, two of the most expensive drugs for Medicaid. The biggest exception was Intuniv, at one point the third most expensive drug for DMA, which of note went generic in December 2014.

For some background, the national annual expense for pharmaceuticals is about $300 billion, of which $38 billion is spent on the principal psychiatric medications, antipsychotics ($18 billion), antidepressants ($12 billion), and ADHD drugs ($8 billion). While 70 percent or more of all prescriptions in the USA are for generic drugs, it has been widely reported that there are still large sums being spent as a result of prescriptions for brand name drugs when a comparable generic is available. Further the same exists for polypharmacy inconsistent with best practice guidelines (to give one example, children on three to five antipsychotics), and for receipt of antipsychotic, sedative, or anxiolytic prescriptions from

continued on page 14...

Current Status: Medicaid's PDL

- The PDL for atypical antipsychotics is slated to be implemented in May. Non-preferred antipsychotics can be prescribed after one trial of a preferred drug.
- For all other psychiatric medications, the DMA PDL is in place now and trials of two medications in each class must be attempted before a non-preferred drug is prescribed.
- A new DMA web-based prior authorization portal is now in place to expedite the process. Visit the Providers Tab on www.nctracks.nc.gov.
- A+KIDS is planned for reintroduction and implementation into NCTracks in May. More information will be in the April 2015 DMA communications.
- For your convenience, NCPA has compiled many resources and links related to the PDL online, www.ncpsychiatry.org/medicaid-pdl.

What Psychiatrists Need to Know About... Opting Out of Medicare

The NCPA office frequently receives questions from members who want to opt out of Medicare, but don't know how or who have opted out and aren't sure if they have done so correctly. When opting out of Medicare, a physician agrees to forgo treating Medicare patients (barring an emergency or urgent situation), unless the patient and physician have entered into a private contract.

For nearly 20 years, physicians have had the option to opt out of Medicare, instead choosing to treat Medicare patients under private contracts that allow for individualized fee schedules. Opting out of Medicare is a two-year commitment and comes with specific requirements that must be met and maintained; this action should be carefully considered prior to filing the necessary paperwork as it is not an appropriate option for many doctors. For example, physicians who work in a setting(s) where treating Medicare patients is part of their employment, should not opt out. Further, if there is a possibility for significant employment changes in the next two years, requiring the treatment of Medicare patients, opting out is probably not a good option.

The NCPA website, www.ncpsychiatry.org/medicare-resources, has in-depth Medicare resources, including affidavit and contract templates. The following general steps are necessary for opting out.*

Step 1: Notify Medicare of Opt-Out Status

- File an affidavit (a template is available on the NCPA website) with Palmetto GBA (North Carolina's Medicare Administrative Contractor, or MAC).
- **Resubmit opting out affidavit every two years.** Participating physicians must file their affidavits with at least 30 days before the first date of the next calendar quarter, with the affidavit showing an effective date of the first day of that quarter (i.e., 1/1, 4/1, 7/1, 10/1).
- Maintain affidavit on file in your office.

Step 2: Private Contracting

- Set up private contracts to continue treating Medicare patients (a template is available on the NCPA website).
- Maintain private contracts on file in your office. **Renew every two years**.
- Do not submit any claims to Medicare.

**NOTICE AND DISCLAIMER: Opting out has serious implications for your status, rights, and responsibilities as a Medicare provider. The information contained herein doesn't constitute legal advice nor should it be relied on exclusively. If you have any questions concerning these materials or opting out in general, please call the APA's Practice Management HelpLine, 1-800-343-4671, or the NCPA office, 919-859-3370.*

ESSENTIAL THINGS TO KNOW ABOUT OPTING OUT

- The first time you opt out of Medicare, there is a 90-day grace period during which you can change your mind about opting out. You just have to notify the Carriers you filed an opt-out affidavit with and refund any money you received from patients with whom you had private contracts that called for fees exceeding the Medicare-approved charges.
- Once you opt out of Medicare, you cannot see any patients under Medicare during the two-year period you have opted out for.
- If you have been seeing Medicare patients, once you have opted out, they will only be able to continue seeing you under a private contract. This means any payments from them to you will be out of pocket. Not only will Medicare not reimburse for your services, neither will any supplemental Medigap policies your patients have. Other secondary policies may or may not continue to reimburse the patient—generally, if they do, for no more than they would have if you were still a Medicare provider.
- If you mistakenly file a claim with Medicare during your opt-out period, or your patient does, and you are contacted by the Carrier with a request for an explanation, you must be certain to respond within the time period allotted. Otherwise, your opt-out status will be rescinded, and you will no longer be able to do private contracting. If this happens, you will once again be tied to the laws of Medicare, but Medicare will not pay for any of your claims that occur during your original opt-out period.
- Patients who reach Medicare age but are still employed and covered by their employers' insurance can choose not to enroll in Medicare Part B and will then not be Medicare beneficiaries for the purpose of their treatment by physicians.
- If a Medicare-eligible patient is covered under her employer's insurance, but chooses to enroll in Medicare Part B so that Medicare will serve as the secondary payer, you must still have an opt out contract with this patient or you will be bound to the Medicare-allowed fees (even though Medicare is not the primary payer).
- A new affidavit must be filed within thirty days of the date your old affidavit expires if you wish to maintain your opt-out status. New private contracts also need to be signed every two years.
- When a Medicare beneficiary signs a private contract with one physician, it does not mean Medicare will not cover medical services provided to the same beneficiary by others who have not opted out. This means that if an opted out physician refers a patient to a lab to have blood work done, or to another specialist who has not opted out of Medicare, the services the patient receives as a result of the referral will be covered by Medicare (if they are services that Medicare ordinarily covers).

Essential Things to Know about Opting Out courtesy of the APA, http://www.psychiatry.org/practice/managing-a-practice/medicare/opting-out-of-medicare.

Member Notes

Jack Bonner III, M.D., D.L.F.A.P.A., received the American College of Psychiatrists' Distinguished Service Award for significant achievements and leadership in the field of psychiatry.

Venkata "Amba" Jonnalagadda, M.D., F.A.P.A., Councilor at Large, has been appointed to the North Carolina Medical Society Ethical and Judicial Affairs Task Force for 2015.

Marvin Swartz, M.D., D.L.F.A.P.A. received the APA's Isaac Ray Award for outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence.

We want to hear from you... please don't be shy about sharing your news or your colleagues' news!

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

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LEADERS IN PSYCHIATRIC MEDICAL LIABILITY INSURANCE

North Carolina State Health Plan Adds Applied Behavioral Analysis Coverage

On January 1, 2015, the State Health Plan (SHP) began providing coverage for Applied Behavior Analysis (ABA) treatment for members who have been diagnosed with Autism Spectrum Disorder (ASD) and meet certain other criteria. Information about coverage can be found in the benefits booklets posted on the State Health Plan web site at: http://shpnc.org/myMedicalBenefits/ppo/default.aspx.

Age and Diagnosis Requirements

Coverage for ABA treatment is only available to members who are younger than 26 years of age and have been diagnosed with Autism Spectrum Disorder.

Diagnostic Evaluation Requirements and Acceptable Diagnostic Tools

Coverage is only provided if the member is diagnosed with ASD by a licensed physician (M.D. or D.O.) or a licensed doctoral-level clinical psychologist (Ph.D. or Psy.D.) based on a comprehensive face-to-face diagnostic evaluation using a clinically validated tool recognized by ValueOptions (the Mental Health Case Manager for the State Health Plan). A list of acceptable diagnostic and screening tools recognized by ValueOptions can be found at: http://www.cdc.gov/ncbddd/autism/screening.html. The diagnostic evaluation does not require prior approval.

ABA Provider Requirements

When a SHP member meets the age and diagnosis requirements listed above, the State Health Plan will provide coverage for, ABA treatment that is supplied either by (a) a properly licensed health care provider, or (b) a board-certified analyst who is supervised by a properly licensed health care provider. For purposes of coverage under the State Health Plan, the following types of health care providers may supply or supervise the supply of ABA treatment: psychiatrists licensed as a M.D. or D.O.; licensed doctoral-level clinical psychologists; developmental pediatricians licensed as a M.D. or D.O.; licensed clinical social workers; psychiatric mental health nurse practitioners and psychiatric mental health clinical nurse specialists; licensed psychological associates; licensed professional counselors; certified fee-based practicing pastoral counselors; and licensed marriage and family therapists. When ABA treatment is supplied directly by one of these provider types, those services are covered only if the provider is currently licensed in the state in which the ABA services are supplied and the provision of ABA treatment is within the scope of practice covered by the provider's license in that state.

The State Health Plan will only cover ABA treatment that is supplied by in-network providers (i.e., providers who are in-network with Blue Cross and Blue Shield of North Carolina or with the Blue Cross and Blue Shield Association through the BlueCard program and who meet the Plan's provider requirements).

ABA Authorization Requirements

The State Health Plan requires authorization from ValueOptions prior to the start of any new ABA treatment or continuation of any ongoing treatment after the initial authorized period.

The first request for authorization submitted to ValueOptions by the treating or supervising provider should include:

- the date of the diagnostic evaluation;
- the results of the diagnostic evaluation;
- the name and credentials of the diagnosing provider;
- the name of the tool used in the evaluation, and
- the clinical formulation of the diagnosis.

Authorization requests must be submitted to ValueOptions using an ABA review form (initial or concurrent). Those review forms can be found at: http://www.valueoptions.com/providers/Clinforms.htm

The above link also includes ABA Provider Progress Report Guidelines.

All requests for authorization and any additional information that may be requested must be faxed to 877-320-0269 unless otherwise instructed.

For more information including ABA Medical Necessity Criteria, and Authorization Codes, visit www.valueoptions.com/providers/Network/NC_State_Health_Plan_PPO.htm.

The information found in this article is reprinted from the State Health Plan section of the ValueOptions website, www.valueoptions.com.

PQRS Resources, Assistance Available

Have you received a letter from CMS regarding a negative payment adjustment from the Physician Quality Reporting System (PQRS)?

Alliant Quality, the QIN-QIO (Quality Innovation Network-Quality Improvement Organization) for Georgia and North Carolina, is your resource for quality improvement and successful reporting to CMS pay for performance (P4P) and reporting initiatives. They can help you understand the PQRS requirements, the "new" Physician Value Based Modifier program, report successfully, and avoid future payment adjustments. And the technical assistance and educational services are free to you! You need to enroll with them to receive their services.

To get started with the enrollment process, please complete a brief online assessment, and a team member will follow-up with you within seven days. The assessment can be found online at http://svy.mk/1BBGQjU. For questions, contact Tara McAdoo, Task Lead for Physician Initiatives with Alliant Quality, tara.mcadoo@alliantquality.org or (678) 527-3673.

APA Announces 2015 Honorees

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

Distinguished Fellow
Stephan Baum, M.D.
Daniel Bradford, M.D.
Brian Andrew Farah, M.D.
Manish Fozdar, M.D.
Winston Earl Lane, M.D.
Omar Manejwala, M.D.
Mehul Mankad, M.D.
John Santopietro, M.D.
Philip Spiro, M.D.
Pamela Wright-Etter, M.D.

Distinguished Life Fellow
Art Kelley, M.D.

Fellow
Aaron Albert, M.D.
Seamus Bhatt-Mackin, M.D.
Thomas Boeker, M.D., Ph.D.
Leslie Bronner, M.D.
Jennie Byrne, M.D., Ph.D.
Vivian Campbell, M.D.
Fred Caudill, M.D.
Charles Dunham, M.D.
Lance Feldman, M.D.
Zachary Feldman, M.D.
Nadyah John, M.D.
Venkata Jonnalagadda, M.D.
Nadiya Kaesemeyer, M.D.
Arlene Miller, M.D.
Jennifer Pennell, M.D.
Shane Rau, M.D., Ph.D.
Alicia Romeo, M.D.
Saka Salami, M.D.
Binoy Shah, M.D.
Amy Singleton, M.D.
Sarah Wells Slechta, M.D.
An'Drea Taylor, M.D.
Kellie Tolin, M.D.
Reem Utterback, M.D.
Saima Zia, M.D., M.P.H.

Life Member
E. Drew Bridges, M.D.
Patricia Campbell, M.D.
Regina Carroll, M.D., L.F.
Peter Clagnaz, M.D., L.F.
Helen Courvoisie, M.D.,
George Dornblazer, M.D.
Jeffery Fahs, M.D.
Masoud Hejazi, M.D.
Patricia Hill, M.D.
Mukesh Kamdar, M.D.,
Stephen Kramer, M.D.
Malti Mehta, M.D.
Roger Perilstein, M.D.
Donald Russ, M.D.
David Smith, M.D.
Jane Steiner, M.D.
Margery Sved, M.D.
Ronald Vereen, M.D.
Krishna Verma, M.D.

50 Year Member
John Boswell, M.D.
Bret Burquest, M.D., P.A.
Salvador Cefalu, M.D.
Roy Ehrlich, M.D., PC
Eugene Lawlor, M.D.
William Van Fleet, M.D.

A Point of Personal Privilege...

Robin B. Huffman, Executive Director

March 6 marked my 15-year anniversary with the North Carolina Psychiatric Association. Fifteen years! Fifteen years of advocating for psychiatrists, lobbying for quality care for patients, staffing NCPA committees, fielding insurance questions, sitting in legislative hearings, meeting with insurers, planning annual meetings, and responding to the media. Fifteen years of new faces around the Executive Council table, of witnessing practices grow and flourish, of members changing career paths and renewing excitement for their life work, of watching members' children grow up.

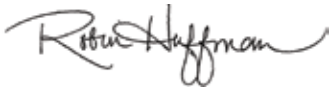
And in fifteen years, I have borne witness to the inherent goodness of people, the true caring of our members for the work they do, the quiet good deeds of some of our members as they live and work in their communities. I have always considered myself fortunate to have found such a satisfying vocation with such good people.

Last month, I was reminded again of the wonderful psychiatrists I work with and the care they practice, and I feel compelled to risk writing about it.

When NCPA's member ***Mohammad Abu-Salha*** experienced the most wrenching tragedy that can befall a parent, one that continues to play out on the national stage, NCPA was inundated with calls from members. The first let the NCPA office know that one of our members was impacted by the tragic shooting in Chapel Hill. Then came the calls asking what NCPA was going to do to help. Member ***Rick Weisler***, who has responded to national natural disasters in the past, offered to provide some emergency backup coverage for the practice. ***Allan Chrisman***, who chairs NCPA's disaster committee, sprang into action as well, initiating emails to our membership, unearthing resources for our members, and attending community meetings. He is assisting the N.C. Disaster Response Network in its work to support the community impacted by the tragedy. ***Kumari Verghese*** organized and provided emergency backup coverage to the practice as well. Other members sent flowers for the family to our office, volunteered for backup patient coverage as needed, and made donations to the fund honoring the three young people. The presidents of the NCPA and the APA issued a joint statement of condolence and a call for justice. I attended the funeral prayer service. Others have assisted, offered support, and visited the family.

While there are no words to adequately convey the range of emotions many of us feel, I am struck by comments made by Dr. Verghese, describing the prayer service we attended. "We were beyond words to see the outpouring of support from their faith community and people from all faiths... The way they handled grief and the strength through faith that we witnessed was nothing like I have ever seen."

I am saddened by the loss of Razan Abu-Salha, Yusor Abu-Salha, and Deah Barakat. I am encouraged, however, by the support expressed by NCPA members for their colleague and his family and by the conversations we are having about diversity, honoring others' cultures, and seeking ways to connect. I trust this care and concern will continue to build within our community and within the NCPA that I am honored to work for.



The Social Costs of Marijuana, the Most Frequently Used Illegal Drug in the World

Heather N. Oxentine, M.D., PGY-3 resident at the Brody School of Medicine at East Carolina University, is a Resident Fellow Member Representative on NCPA's Executive Council. Thomas Penders, M.S., M.D., D.L.F.A.P.A., Associate Professor at the Brody School of Medicine at East Carolina University, is NCPA's Vice President and Addictions Committee Chair.

This is the sixth in a series of articles by the NCPA Addictions Committee designed to review the current status of the science that may inform opinion as each member considers his or her stance on changes in public policy and legislation relating to cannabis. Please note: due to space limitations, references cited are available online at www.ncpsychiatry.org/marijuana-series or by calling 919-859-3370.

The possession, sale or use of marijuana or products of the cannabis sativa plant had been, until recently, a violation of federal and state laws. The World Health Organization estimates that about 147 million people or 2.5 percent of the world population consume cannabis annually[1]. In 2012, it was estimated that about 12.1 percent of the population over age 12 in the United States had used marijuana within the prior year. Estimated street prices for marijuana in the United States are estimated to range from $10-12 per gram as of 2013[2].

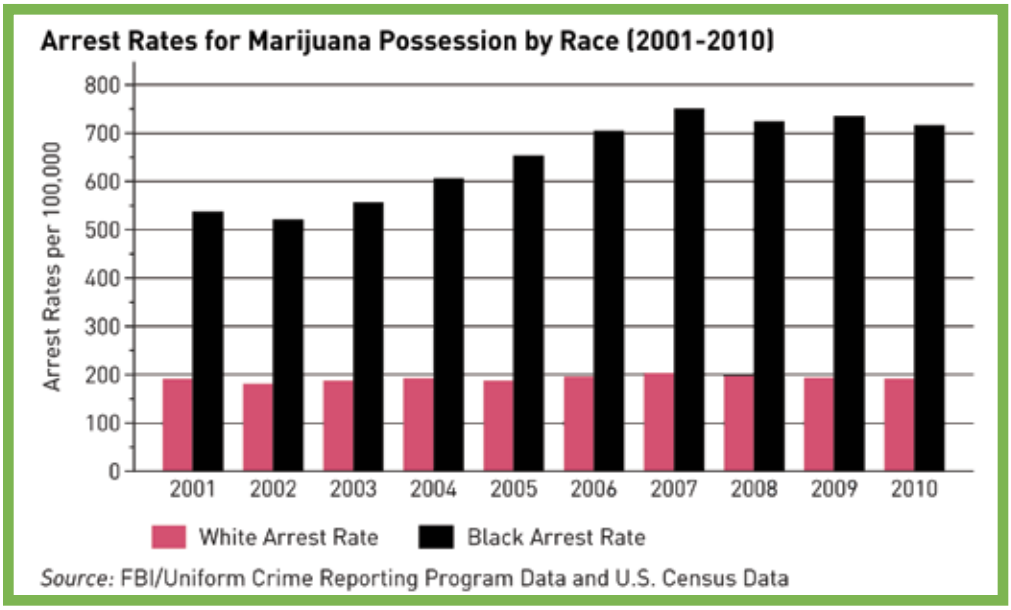
Marijuana-Related Incarceration

In 2012, 42 percent of drug arrests in the United States were for possession of marijuana and 5.9 percent were for the sale or production of marijuana[3]. Specifically, 749,825 individuals were arrested in the US for a marijuana law violation, and of those, 658,231 (roughly 88 percent) were arrested for possession solely[4]. In North Carolina law, enforcement made 20,983 marijuana arrests in 2010 (the 10th most in the nation), and marijuana possession arrests accounted for 53.6 percent of all drug arrests in North Carolina during that year[5]. Sixty-two percent of marijuana possession arrests in 2010 were of individuals 24 years old or younger and more than 34 percent were teenagers or younger[6]. Of interest, the United States accounts for 5 percent of the world's population and accounts for 25 percent of the world's prison population[7].

Costs to Law Enforcement and Taxpayers

It has been estimated that the total national cost of enforcing marijuana possession laws is approximately $3.613 billion annually. In 2010, it was estimated that states spent $1.747 billion policing marijuana possession arrests, $1.371 billion adjudicating marijuana possession cases, and $495 million incarcerating individuals for marijuana possession[5]. The documentation of racial differentials in the arrests and prosecution of marijuana related violations has been a source of considerable controversy.

The State of North Carolina spent roughly $55 million enforcing marijuana possession laws in 2010[6]. Many jurisdictions have begun to soften the penalties for possession of small quantities of cannabis and focus on imprisonment for those who traffic the drug on the black market. With the amounts being spent annually on enforcing marijuana laws, some proponents for legalization suggest these amounts could potentially be saved annually if marijuana use was legalized and taxed like tobacco. An analysis from 2005 performed by Jeffrey Miron estimated that if the U.S. >>



NAMI NC Names New Executive Director

The North Carolina chapter of the National Alliance on Mental Illness (NAMI NC) has named a new Executive Director: Jack Register, MSW, began in January filling the vacancy created by Deby Dihoff's retirement at the end of 2014. Register is a former NAMI NC board member and brings advocacy experience to the position. He has previously worked as a university professor in social work at the University of North Carolina – Greensboro and as the government relations director for the North Carolina chapter of the National Association of Social Workers. NAMI NC Board President Mike Mayer, Ph.D. says, "Jack will bring leadership and creativity to NAMI NC's programs and a deep sense of commitment to our mission."

were to legalize marijuana it would save $7.7 billion in law enforcement costs and generate as much as $6.2 billion annually if marijuana were taxed. A U.S. study from 2006 demonstrated that cannabis was the No. 4 value crop, and even No. 1 or 2 in many states including California, New York, and Florida averaging $3,000/lb. placing production at a value of $35.8 billion[8].

Recent Legalization

In 2012, Washington and Colorado became the first states to officially legalize cannabis under state law[9]. At a federal level, marijuana is still considered illegal and is classified still as a Schedule I substance under the Controlled Substances Act, which classifies these substances as having high potential for dependency and no accepted medical use. In August 2013, the U.S. Department of Justice issued a revised memorandum to federal prosecutors making it clear that marijuana is still an illegal drug under the Controlled Substance Act (CSA) and will continue to be strictly enforced, specifically naming eight priority enforcement areas. It also addresses the need for state and local authorities to continue to enforce the regulatory efforts at their end as well[10]. Distribution and use of marijuana remains today a violation of federal law. This includes use of medical marijuana, or the use of cannabis and its constituent cannabinoids such as tetrahydrocannabinol (THC) and cannabidiol (CBD) for medical therapy.

In 1996, California passed Proposition 215 which made the state the first in the union to allow for the medical usage of marijuana. Currently, 23 states, the DC, and Guam have passed medical marijuana laws[9].

In 2014, North Carolina passed HB 1220 (Epilepsy Alternative Treatment Act) which allows for use of product with low THC/high CBD (cannabidiol oil) in those with intractable epilepsy. The bill authorizes neurologists registered with the Intractable Epilepsy Alternative Treatment Pilot Study to dispense hemp extract acquired outside North Carolina to treat children with intractable epilepsy. The main purpose of the bill was to allow families who have traveled to Colorado to obtain the hemp extract to return back to North Carolina and legally continue the treatment. The bill also encourages the University of North Carolina at Chapel Hill, Duke University, Wake Forest University, and East Carolina University to research hemp oil[11].

Research on the drug has been difficult to conduct since the plant is illegal in most countries. The cannabis that is available for research studies in the U.S. is grown at the University of Southern Mississippi and controlled by the National Institute for Drug Abuse[9]. With the recent legalization of medical marijuana in numerous states, many questions are being raised including how to regulate its recommendation, dispensing, and registration of approved patients.

New concerns with legalization include "drugged driving," which is considered operating a motor vehicle while under the influence of marijuana or other drugs, which can lead to drivers being charged with DUIs similarly as one would with alcohol. In Colorado, impaired driving is considered five nanograms of active THC per milliliter of whole blood. THC has been shown to be associated with poorer driving performance, longer response times, and slower driving speeds. Several studies have actually shown an increase in crash risk in drivers using cannabis. One study found that between 1999 and 2010, the number of drivers testing positive for cannabinol involved in fatal vehicular accidents had tripled[12]. Recent statistics from 2013 in Colorado show 36 persons testing positive for cannabis alone (5.7 percent) involved in fatal crashes[13]. Prospective monitoring of numbers of accidents, fatalities, and DUIs should provide a measure of the harm associated with liberalization of public policy related to marijuana.

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Using Social Media in a Professional Setting

Jennie Byrne, M.D., Ph.D., F.A.P.A., is in private practice in Chapel Hill and currently serves as the NCPA Technology Committee Chair.

The Technology Committee has developed several resources for NCPA members curious about expanding their professional web presence, including answering the question, "Why should I use social media?"

Your patients are using social media. Whether you like it or not, your patients are using social media to communicate, connect, and learn. If you want to reach them, you have to use the same media they are using.

You can reach a large number of people quickly. Social media is a good way to spread the word quickly and broadly. For example, you can post a blog about depression on 3 social media sites and within a few hours, it may be viewed hundreds of time. As an example, I wrote a blog on "The Myths of Psychiatry," which has been viewed more than 1,300 times. I have a video on conflict resolution that has been viewed more than 23,000 times on YouTube!

You can reach a new audience. Perhaps you are interested in seeing a certain group of patients or maybe you want to increase your psychotherapy cases. You can target your social media posts to reach these people who might otherwise not know about you. It is a good way to break out of a rut and try something new.

You can educate your community. This is perhaps one of the best things about social media. You as a psychiatrist are an expert, and it is an easy way for your voice to be heard. There is so much misinformation online and on social media, you can really help your community by providing accurate and timely information.

You can market your skills. Social media is a great way to market your expertise and skills. Even better, you can do this by educating your community at the same time. You don't need to give specific advice, but you can talk about your skills and help people understand how you, as a psychiatrist, can help them.

There are sophisticated filters to help protect privacy. Many psychiatrists are worried about using social media because they feel they will lose their privacy. Most social media channels now have "professional" channels where you do not need to post any personal information at all. Also, there is a sophisticated set of filters so that you can control how much information you release on social media.

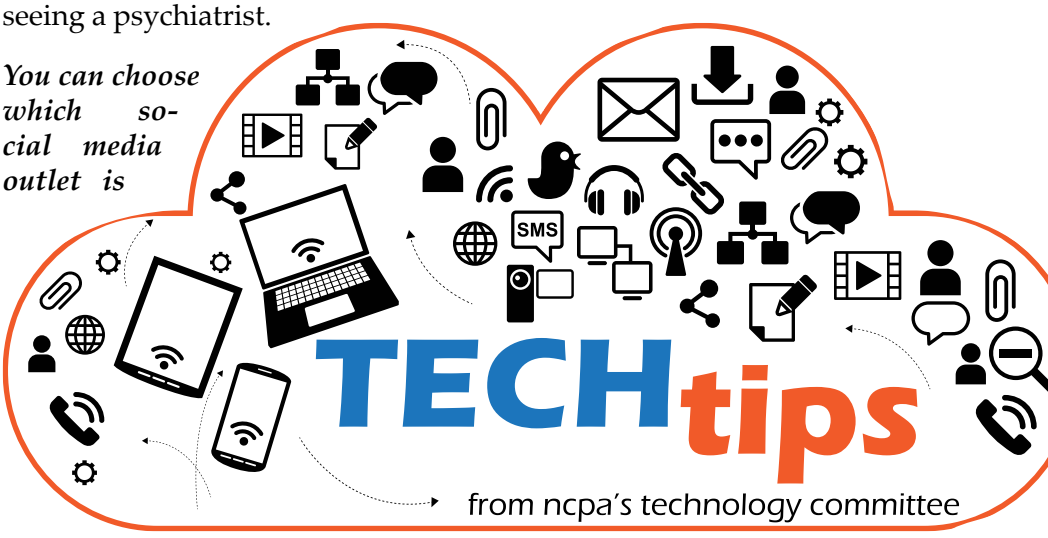
Patients can "interview" you online. This is a wonderful use for social media, the patients can read your words and watch your videos and "interview" you before they even call your office. This is a great way to encourage patients to seek treatment and remove stigma of seeing a psychiatrist.

You can choose which social media outlet is most appropriate for you. There is an ever-growing number of social media channels and you can pick the ones that work best for you. You *do not* need to participate in all social media channels. For example, you may want to use YouTube for videos, but skip Facebook. You may like LinkedIn because it is considered more "professional," or you may want to use Twitter to reach a younger demographic. It all depends on your needs and preferences.

For more tips on social media, building a professional web presence, and more, visit NCPA's new online Video Library, www.ncpsychiatry.org/video-library.

Your medical malpractice carrier can also provide insights from a risk management perspective. Tech Tips should not be considered legal advice.

If you are interested in joining the Technology Committee, email info@ncpscyhiatry.org.



...President's Column continued from page 3

multiple prescribers concurrently. In the case of Medicaid, those are dollars collected from taxpayers, so we all have an interest in using these funds parsimoniously.

There is literature on the subject of psychiatric formularies, the conclusions of which are that institution of formularies can lead to treatment interruptions and greater expenditures for resultant ED and hospital treatment that exceed money saved by reduced costs of medications.

There have been various other efforts to optimize the appropriate use of psychoactive drugs ranging from the Controlled Substance Reporting System for use of controlled substances, to the A+KIDS program introduced in North Carolina in 2012. A+KIDS ("Keep It Documented for Safety") was a mandatory program that required prescribers of antipsychotics to children in the NC Medicaid program to register their patients and provide clinical information, as well as documenting safety monitoring in order for pharmacies to fill the prescriptions. What was found was this intervention resulted in a greater adherence to evidence-based practices and decreased prescription of antipsychotics to children. This also resulted in savings for Medicaid. A similar result was obtained in a separate study in Missouri where the intervention was simply the reading of educational materials to physicians whose use of psychotropics had triggered a quality indicator.

Of interest is the report from the managers of the A+KIDS program that the transition to DMA's new NCTracks computer system caused the A+KIDS program to become inoperable over a year ago, and that usage practices for antipsychotics in children and adolescents in NC gradually returned to the patterns that existed before the institution of A+KIDS.

After notification of the imminence of a psychiatric PDL, the NCPA requested several interested members to pull together a potential alternative to a formulary. The proposal was presented to DMA during the public commentary panel for the PDL. This proposal recommended that rather than imposing a psychiatric formulary, which the evidence suggests can be detrimental, Medicaid instead put in place a web-based prior authorization module analogous to A+KIDS. With this, if a psychiatrist (or a physician from another specialty prescribing a psychotropic medication) wished to prescribe outside a set of guidelines based on principles of efficacy, adherence, efficiency, and side-effect monitoring, prior authorization would be required. However, there would be an automatic and immediate approval of the request, with the only requirement being to go online and enter the requested information. This proposal was turned down as being non-implementable in the time left before January 1, 2015, but Medicaid leadership agreed to meet with NCPA representatives for further discussion.

The proposal gave examples of practices that might require prior authorization:

Quality of Care Concerns – Efficacy

- Antipsychotics as monotherapy for depression.
- Antipsychotics as treatment for anxiety disorders (not approved by the FDA).
- A second antipsychotic prescribed by a non-psychiatrist for any reason.

Quality of Care – Adherence

- Unnecessary multi-daily dosing of psychotropic medications (once daily dosing, or splitting larger >>

Compassionate Care Beyond Life: Releasing Records After The Death of a Patient

Samina Aziz, M.B.B.S., D.F.A.P.A, is in private practice in Raleigh and currently serves as NCPA's Secretary, Membership Committee Chair, and Ethics Committee member.

One of the questions we encounter in the span of our careers is confidentiality of medical records after the death of a patient. This is simple if the patient has a release of information in place or has left clear guidelines and much more complicated if the death is sudden, whether due to natural causes, an accident or even suicide.

The APA's guidelines indicate that it is ethical to preserve the patient's confidentiality, but that we should be mindful of our legal obligations. According to HIPAA (Health Insurance Portability and Accountability Act) a patient's right to confidentiality continues after death. It poses a dilemma because if every one of our patients thought confidentiality ended with their demise, many a therapy session would play out differently. It is the nature of our work that we are the keepers of many secrets.

This is a nuanced question, and the way to approach it may be the same way we approach any request for records from any patient. Why is the information sought, who has the right to receive this information, and how do we release this information in a manner that is not harmful to the patient?

The simplest of these to tackle may be who has a right to the information. In North Carolina that is the executor of the patient's estate or next of kin. If there are multiple next of kin, as in the case of surviving siblings in absence of spouse, or surviving parents of a deceased child, it is advised that the court appoint one of these to act as the executor, and the records may then be released to that person.

Why the information is being sought is more complicated. Particularly in the case of a suicide, a spouse or child may desire a greater understanding of the illness, which may not be addressed by records and may lead to further confusion and suffering. Many therapists and psychiatrists have chosen to meet with families to answer general questions without compromising confidentiality and have found that offers relief. Herein may lie the ethical dilemma and where each request may require attention and the balancing of legal obligations and the principle to first do no harm.

Records may also be requested by attorneys if there are concerns about malpractice, and it is then advised to consult your own malpractice insurance carrier about guidelines in such a circumstance.

The NCPA Ethics Committee investigates, processes, and resolves complaints charging members of the NCPA with unethical behavior or practices, according to the APA Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.

Decedents Frequently Asked Questions. (n.d.). Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/faq/decedents/index.html

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pills, should be the objective for both adherence and efficiency goals).

- Use of higher than FDA-approved doses.
- Use of very low dose (sub-therapeutic) antipsychotics as sleep aids.

Quality of Care – Side Effect Monitoring

- Use of an antipsychotic for any reason greater than six months without obtaining laboratory measures to monitor for diabetes.

More Efficient Use of Resources

- Initiating treatment with a branded drug when a similar generic drug is available and offers comparable clinical advantages.

NCPA is taking Medicaid up on its offer to meet with senior Medicaid physician and pharmacist leaders to pursue the goals of its proposal. This will include discussion of which of the recommendations could be incorporated into the Medicaid computer system so it would recognize potential variations from best practices and allow development of a prior authorization module analogous to A+KIDS. This is not likely to lead to immediate results, but NCPA's long-term goals are to link quality of prescribing to reduced use of formulary restrictions. Certainly the above recommendations for quality prescribing are worthy of everyone's consideration.

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Meeting Disclosure
The Accreditation Council for Continuing Medical Education (ACCME) has mandated that all speakers must disclose any affiliation with a commercial organization, which is supporting the CME activity or whose products, research, or services may be addressed in their presentations. Having an interest in or affiliation with any corporate organization providing support for a program does not prevent a speaker from making a presentation, but the relationship must be made known in advance to the audience in accordance with the Standards for Commercial Support of Continuing Medical Education of the ACCME.

Calendar of Events

April 25, 2015
NCPA's Review of Systems: A Practice Workshop
McKimmon Center, Raleigh, NC

May 15-17, 2015
APA Assembly
Toronto, Canada

May 16-20, 2015
168th APA Annual Meeting
Toronto, Canada
Register Online: annualmeeting.psychiatry.org

June 2015
Registration Opens for NCPA's
2015 Annual Meeting & Scientific Session
Winston-Salem, NC | October 1-4, 2015