NORTH CAROLINA Psychiatric Association news

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

MARCH 2014


IN THIS ISSUE



***ATTENTION ALL NCPA MEMBERS:***

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# Where to Place Prescription Cost in the Prescribing Equation

*Stephen I. Kramer, M.D., D.F.A.P.A.. Professor, Wake Forest School of Medicine; Medical Director, Adult Inpatient Psychiatry*

Three recent patient contacts prompted me to write this article. The first involved a patient who insisted on brand name medications only for all prescriptions, the second requested a generic version for a specific anticonvulsant because he felt the brand name was ineffective, and the third suggested that I manipulate the dosing instructions on the prescription so that what looked like a one-month supply would actually last for two. I had to revisit the question, what role should prescription costs play in prescribing practice?

Prescribing generic Central Nervous System drugs in the US saved $250 billion over a recent 10-year period. Yet the full story is not so simple because the potential savings is somewhat vitiated by the costs of illness relapse due to nonadherence or therapeutic inferiority. There are both acute effects on adherence and effectiveness as well as downstream effects on hospitalization, emergency department and crisis services, and accelerated outpatient follow-up visits. Of the 20 most expensive medications paid for by North Carolina Medicaid (generic medication prescription rate for all prescriptions has been 72 percent and for the last quarter of 2013, 79 percent), three are second-generation antipsychotics, three are stimulants, one is an antidepressant, and one is an antihypertensive adjunct of treatment for attention deficit and behavior problems in children.

The FDA approves generic drug formulations using World Health Organization guidelines for bioequivalence studies that fail to take into account a number of clinically relevant variables such as age, gender, BMI, smoking, general health status, and the specific illness. Theoretically, about 6 percent of patients switching from brand to generic will experience a clinically relevant change in the area under the curve pharmacokinetics. Inactive medication components or fillers may produce adverse effects, especially in those individuals with allergies, lactose intolerance and gluten intolerance. Further aspartame used in some drugs can worsen anxiety, affective and psychotic symptoms. Counterfeit medications sold on the Internet and across the national borders further complicate the picture. Three recent U.S. Supreme Court cases address generic drug marketing and disclosures to prescribers through the product label (Sorrell v. IMS Health, Inc, and Pliva, Inc. v. Mensing, both in 2011, and Mutual Pharmaceutical Co., Inc. v. Bartlett, 2013).

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# NCPA Member Appointed to NC Medical Board

***Debra Bolick, M.D., D.F.A.P.A.,*** has been appointed by Governor Pat McCrory to the North Carolina Medical Board. An official swearing in ceremony was held on Thursday November 21, 2013 at the office of the North Carolina Medical Board in Raleigh. The Medical Board exists to regulate medicine and surgery for "the benefit and protection of the people of North Carolina."

*Debra Bolick, M.D., D.F.A.P.A.*

Dr. Bolick is NCPA's Immediate Past President and currently serves as one of two Representatives to the American Psychiatric Association Assembly. She is also the Secretary/ Treasurer for the Psychiatric Foundation of North Carolina. Dr. Bolick is a former President of the Catawba County Medical Society.

Dr. Bolick earned her medical degree from the University of Colorado School of Medicine. She completed her internship and residency in psychiatry at the University of North Carolina School of Medicine. Dr. Bolick was previously in private practice in Hickory for 17 years. Since April 2010, she has been employed by the Veterans Health Affairs at the Hickory Community Based Outpatient Clinic, where she is a staff psychiatrist and Acting Section Chief of Outpatient Mental Health for the Hickory and Winston-Salem clinics.

Dr. Bolick resides in Hickory with her husband John. She has two grown children, Nicole and Troy.

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, 919-459-0752 or kmilam@ncpsychiatry.org.**

# The State of the Association... After We Took Our Show on the Road

*Ranota T. Hall, M.D., D.F.A.P.A., President*

I wait for inspiration each time I am asked to submit my newsletter article. I wish I could say that I have a compendium of ready-made topics to brush off and send to press, but it doesn't happen that way at all. I wait. And wait. For a sign (magical thinking). Something to spur me into action. Something that would remotely be of value to share. Fortunately this time of year in other circles, we are privy to an update on the State of the Union and State of the State. Therein lies my inspiration for this installment. In reality, it is time for the State of the Association update. Not necessarily a formal address but certainly an overview. This is particularly timely given this is my last newsletter article. It is a good time to reflect.

We are now well into the year. As I look back on the last several months, I realized that it is time for me to provide an update on our activities to date. Members should know that the initiatives we put in place earlier this year have continued with the dedication of committee chairs, members and our NCPA staff. At the onset, my goal was to strengthen our committee structure. It is my observation that great strides have been made by committee chairs in taking on a new process. Developing committee charters and work plans and reviewing them regularly has not been easy. I believe it has been informative.

We also have completed visits to all of the psychiatry training programs. It has been wonderful and energizing for me personally to meet the trainees and educate them about NCPA. Preparing for those visits meant I had to really think about how to convey the importance of our organization and how it may serve them as potential members. In the end, I came back to focusing on medical leadership. Each visit to each program emphasized the value of joining NCPA as a means of further exercising one's role as a medical leader through committee participation. I have noted the challenge we all faced when we finished training in terms of how to be a leader in a world when one was not specifically trained to do so. We are certainly looked to as a leader in our field whether we are associated with a small private practice, large group, an institution or large public sector entity.

It has become increasingly clear that NCPA offers the opportunity for psychiatrists to work toward solving problems and challenges that confront our profession and impact the patients we serve. This year, our plan to evaluate the effectiveness of our committee structure has ultimately highlighted a core strength of our organization. Careful review and goal setting has led to innovations within our organization. The visits to the psychiatric residency programs originated as a goal of our Membership Committee. Further, our Executive Council has a goal to strengthen the role of the Councilors at Large. Over the past several months our representatives have been taking steps to increase their presence and outreach to members within their regions. They were formally introduced during our Annual Meeting in Asheville and have been present at two of our four meetings with the training programs. A small stipend has been extended to each Councilor at Large to promote a local meeting as well.

An additional goal to improve our teleconferencing capabilities has improved communications by: allowing conference call capabilities and shared screens for committee meetings; reviews of work plans with committee chairs; and anticipated use for regional meetings or even town halls by the Councilors at Large. Our ability to use this technology increased participation in our February Executive Council meeting to include committee chairs who reviewed their own work plans.

We have also clarified the role and composition of the Technology Committee, which is seen as a key component of our organizational structure as we plan for the future. The Legislative Committee has also refined its membership and reorganized how it carries out activities to include representation from the Councilors at Large, policy committee chairs and members at large based on interest and expertise. Several committees are actively working on projects such as the Psychiatry and Law Committee's development of a draft Guns and Mental Health policy statement; the Health Care Delivery Systems Committee's work on the ACO Toolkit; and the Disaster Committee's successful and ongoing efforts to train members in disaster response. Our Community and Public Psychiatry Committee crafted language to submit

*Continued on page 8...*

# What Psychiatrists Need to Know About... MOC

*Larry Faulkner, M.D.,*
*President & CEO, APBN*

**The ABPN continuous Maintenance of Certification (C-MOC) Program helps keep you up to date on meeting MOC requirements.**

It's easier than ever to keep up with requirements of the Continuous Maintenance of Certification (C-MOC) Program of the American Board of Psychiatry and Neurology (ABPN). As of 2012, diplomates who certify or recertify are enrolled in the C-MOC Program. Diplomates who were certified prior to 2012, including lifetime certificate holders, may elect to participate in the program through their Physician Folio.

Diplomates must accomplish MOC requirements in three-year cycles or stages. Every three years, diplomates must document in their Physician Folio completion of the following:

- Continuous unrestricted medical license
- 24 CME credits of self-assessment (average eight per year)
- 90 Category 1 CME credits (including those from self-assessment)
- One Performance in Practice Unit
- Payment of annual MOC Program fee

While passing a cognitive examination is still required at least every 10 years, a diplomate's certification status is dependent upon fulfillment of all four MOC program components (Professional Standing, Self-Assessment and Continuing Medical Education, Cognitive Expertise, and Performance in Practice), along with annually logging completed MOC activities into ABPN's Physician Folios and payment of the annual MOC registration fee.

Instead of a single fee at the time of the MOC examination, participants in the C-MOC Program pay an annual fee. This fee covers participation in ABPN Physician Folios and includes one MOC cognitive examination in a 10-year period. Less than 10 years of participation or applying for a combined examination requires an additional fee.

The C-MOC Program is organized through the use of ABPN Physician Folios. Using the link at the top of the opening page of the ABPN website (www.abpn.com/folios), physicians can create accounts that will enable them to keep their demographic and license information up to date, track their MOC activities, locate ABPN-approved MOC products, stay apprised of any changes in the program, pay fees, and apply for examinations. Physicians must activate an ABPN Physician Folios account on the ABPN website to begin the MOC process and gain the benefits of the program.

## Modifying MOC

- As of 2012, the ABPN gives MOC credit for completing an ACGME-accredited subspecialty fellowship and passing an ABPN subspecialty examination. One three-year block of self-assessment, CME, and PIP requirements will be waived.
- Diplomates with "lifetime" certificates may now join the Continuous MOC Program in two ways: Passing the MOC examination and registering for the Continuous MOC Program, completing three years of required MOC activities, and passing the MOC examination within three years.

The American Board of Medical Specialties (ABMS) is reviewing MOC Program requirements for all 24 medical specialty boards. With input from all member boards, the ABMS is working to develop a new "MOC 2015 Standards" document. The ABPN will communicate any MOC Program changes to its diplomates as soon as this process is finalized. It is the hope of the ABPN that any changes to the program will be flexible and reasonable.

## Summary

The C-MOC Program will assist diplomates in complying with MOC requirements and time frames. The program will also facilitate the required annual recording of progress required of diplomates and reporting of diplomate participation to the ABMS.

There are several advantages C-MOC program participants gain:

- Annual fee instead of a larger fee at the time of application
- Personalized list of MOC activities that can be provided to employers, hospitals, licensing boards, and so on
- Reminders from the ABPN regarding MOC requirements that are due to be completed
- Easy-to-use system to track individual requirements
- Easy-to-use interface (ABPN Physician Folios)

We encourage you to activate your ABPN Physician Folio page at http://www.abpn.com/folios. The folios provide a place for diplomates to record their MOC activities and allow them to compare their MOC activities with the requirements for their MOC exam year. It's a personalized webpage that diplomates find very helpful for understanding MOC requirements.

Please note that if you were certified in 2011 or earlier, activate your folios account and refer to the ABPN 10-Year MOC Program on the ABPN website at www.abpn.com/moc_10yrmoc.html.

*Larry Faulkner, M.D., is president and CEO of the American Board of Psychiatry and Neurology. This article was reprinted with permission from Psychiatric News.*

**MOC 10 Year Timeline**

| Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Self Assessment** | 24 CME Credits of Self Assessment (Average 8/year) | | | 24 CME Credits of Self Assessment (Average 8/year) | | | 24 CME Credits of Self Assessment (Average 8/year) | | | |
| **Lifelong Learning CME** | 90 Category 1 CME Credits (including those from Self Assessment) | | | 90 Category 1 CME Credits (including those from Self Assessment) | | | 90 Category 1 CME Credits (including those from Self Assessment) | | | |
| **Cognitive Expertise** | | | | | | | | | Apply for Exam | Pearson Vue Exam |
| **Performance in Practice (PIP)** | 1st PIP Unit: 1 Clinical Module and 1 Feedback Module | | | 2nd PIP Unit: 1 Clinical Module and 1 Feedback Module | | | 3rd PIP Unit: 1 Clinical Module and 1 Feedback Module | | | |

Clinical Module: Review 5 cases in 1 category, compare with best practices, plan for improvement, repeat within 24 months.

Feedback Module: Solicit feedback from 5 peers & 5 patients, refer to core competencies, plan for improvement, repeat within 24 months.

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... Prescription Costs continued from cover

Psychological, attitudinal and behavioral elements also contribute to the degree that very ill patients become fearful of differently-colored, -shaped or -packaged refills from the pharmacy, leading to non-adherence. Even generic–to-generic changes may be clinically unsettling for this population.

Extended release bupropion manufactured by Teva failed the FDA's own bioequivalence study after years of consumer and prescriber complaints regarding bupropion generics. Similar difficulties have been identified with clozapine generic and brand comparisons.

However, the overwhelming majority of generic medication substitutions for brand alternatives work very well for our patients. The first-generation antipsychotics, older antidepressants, and most benzodiazepines are only available in generic forms.

Of course, drug selection is the first step in writing the prescription. Are the newest agents, generally more expensive than others, actually superior to the older ones? Head-to-head effectiveness and side effect profiles are limited, though some meta-analyses are available to help guide drug selection. Potential drug interactions and medical comorbidities will also shape medication selection. Restrictive formularies, unique to each patient's insurance plan, can further dictate drug choice. Large retail chains and a growing number of smaller pharmacies have $4 and $10 lists of prescription items.

The 90-day supply request saves out of pocket expense for the patient but safety concerns and uncertain titration schedules make this less appealing for most clinicians when initiating a new agent. In general, a larger supply of a smaller dose of medication (e.g. 90 capsules of 30 mg) will cost less than a smaller supply of two different prescriptions (e.g. 30 capsules of 30 mg and 30 capsules of 60 mg) of the same drug, each aimed to produce the same daily dose of medication (90 mg). Surprisingly, the reverse is true for some medications.

Complex polypharmacy exaggerates the cost of care when unhelpful agents are not discontinued. Prematurely adding adjuvant and potentiating agents adds to prescription costs, clouds the assessment of the patient's response to treatment, and threatens patient safety.

Our more significantly ill patients require closer monitoring when going from one medication form to another, including generic to another generic substitution.

As key members of the health care team, we have a duty to the patient—which is always the primary one—and a responsibility to society as stewards of limited health care dollars, especially related to an underfunded public sector, to thoughtfully address the two with every prescription.

*Editor's Note: Choosing Wisely®, an initiative of the American Board of Internal Medicine (ABIM) Foundation, is a resource "to help physicians and patients engage in conversations to reduce overuse of tests and procedures, and support physician efforts to help patients make smart and effective care choices." (http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx)*

*The recommendations of the American Psychiatric Association to the Choosing Wisely® initiative can be accessed at: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association. They include—among other suggestions-- rethinking the use of atypical antipsychotics as a first-line intervention for insomnia in adults.*

# APA Announces 2014 Members Approved for Fellowship, Life Status

**Congratulations to the following NCPA members who have achieved fellowship, distinguished fellowship, and/or life member status!**

**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."**

***Distinguished Fellow***
**Samina A. Aziz, M.D.**
**Paul Anthony Buongiorno, M.D.**

***Distinguished Life Fellow***
**Richard W. Brunstetter, M.D.**
**Robert G. Crandall, M.D.**
**Kenneth G. Schooff, M.D.**
**Jeffrey Garland Brantley, M.D.**
**Douglas Howard Finestone, M.D.**
**Sally C. Johnson, M.D.**
**Philip H. Lavine, M.D.**
**Linda Bick Mundle, M.D.**
**Philip Thoppil Ninan, M.D.**
**William George Ryan, M.D.**
**Octavio Salazar, M.D.**
**Marvin Stanley Swartz, M.D.**
**Richard Harry Weisler, M.D.**

***Fellow***
**April H. Morciglio, MD**
**James W. Scott Wallace, M.D.**
**Jane P. Gagliardi, M.D.**
**Keith H. McCoy, M.D.**
**Kimberly M. Bush, M.D.**
**Leah A. Fennell Barahona, M.D.**
**Matthew E. Holmes, M.D.**
**Mojeed A. Akintayo, M.D.**
**Paritosh R. Chowdhury, M.D.**
**Peter P. Buonaccorsi, M.D.**
**Robert J. McHale, M.D.**
**Shannon Alligood Tyler, M.D.**
**Terra Caudill, M.D.**
**Theresa A. Yuschok, M.D.**
**Tushar Thakre, M.D., Ph.D.**

***Life Fellow***
**Leslie M. Forman, M.D.**
**Thad Jones Barringer, M.D.**
**David Watterson Branyon, M.D.**

***Life Member***
**J. Gray McAllister, III, M.D.**
**Trevor G. Williams, M.D.**
**John A. Ascher, M.D.**
**Manjusri Chatterjee, M.D.**
**Thomas Howard Clay, M.D.**
**Claire Virginia Cooper, M.D.**
**James Cameron Garbutt, M.D.**
**Joseph Lawrence Godfrey, M.D.**

*...President's Column continued from page 3*

to DHHS in response to the Medicaid Advisory Committee request for comments. This is only a small overview of what our committees and chairs have accomplished.

All committee charters and work plans are posted on our website for members to view. It is my hope that upon reviewing, members may identify a committee of interest and become engaged with that committee. I have posed this as an opportunity to the trainees. As an opportunity to participate in NCPA in a "hands-on" manner and to begin to exercise leadership as a member of a committee and, at some point, a chair of a committee or taskforce. We have a wealth of knowledge and skill within our organization. I believe strongly that there are members with skill sets we need who have remained on the perimeter. It is my hope that you will come forward and share those strengths and skills on one of our committees. I am unable to visit you individually as I have done with the training programs, so please consider this your invitation.

In sum, the state of our Association is strong and getting stronger. Ultimately it is you, our members who will lead us into the future. I have enjoyed the opportunity to represent you and want to extend a special thank you to the committee chairs, committee members, the NCPA staff and Robin for your dedication and willingness to take on new challenges. It has been a pleasure to serve.

# Marijuana and Psychosis

*Diana O. Perkins, M.D., M.P.H., D.F.A.P.A., is Professor, Department of Psychiatry, University of North Carolina, Chapel Hill; Medical Director, Outreach and Support Intervention Services.*

*This is the second 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 their 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.*

Marijuana use, especially a pattern of use that begins during early adolescence, or heavy use in late adolescence or early adulthood, has emerged as an environmental risk factor for the development of psychosis, increasing risk about 4-fold (1-5). This means that about 4 percent of heavy or early marijuana users will develop schizophrenia, compared to about 1 percent of the general population. Thus marijuana may increase risk of schizophrenia, but only in persons who have a biological vulnerability. These studies also suggest that, given current rates of marijuana use, marijuana likely plays a causal role in about 10-14 percent of all cases of schizophrenia (6).

Interestingly, at the first episode of psychosis the "kind" of schizophrenia associated with marijuana use is characterized by less severe negative symptoms and cognitive impairments (7, 8) as well as an earlier age of onset (9). It is currently unclear if these differences in presentation are due to marijuana exerting some therapeutic benefit, that the type of schizophrenia where marijuana is a risk factor is a more benign disorder than the type of schizophrenia that develops for other reasons, that obtaining marijuana use requires intact social skills, or some other confounding factor. However, once schizophrenia develops continued use of marijuana is associated with relapse, re-hospitalization, and worse functional outcomes (10, 11). For this reason substance abuse treatment is a critical component of the care of persons with schizophrenia who use marijuana.

The brain's own cannabinoid system, termed the endocannabinoid system, is a key regulator of neurotransmitter release (including dopamine, GABA, and glutamate) and neuronal plasticity (12). The endocannabinoid system is now known to regulate recovery of the endocrine and autonomic nervous system from stress, immune system function, and energy balance. The endocannabinoid system also plays key roles in neurodevelopment. Marijuana contains multiple cannabinoids, with the main cannabinoid delta-9-tetrahydrahydrocannabinol (THC). THC is a "partial agonist" at cannabinoid receptors in the brain, and thus activates these receptors. THC is a prime suspect to explain the impact of marijuana on psychosis, based on evidence that THC administration induces a transient psychosis in healthy persons as well as persons with schizophrenia (10). This idea has led to trials of cannabinoid receptor antagonists, such as rimonabant, in schizophrenia, that unfortunately have failed thus far to show clinical benefits (13).

Cannabis also contains cannabidiol (CBD), which is reported to have anti-anxiety and antipsychotic effects, and to protect against the psychosis-inducing effects of THC (14). CBD appears to have very weak effects on cannabinoid receptors, but has been shown to influence the metabolism of the body's own cannabinoid, anandamide, increasing anandamide levels. A recent 4-week double-blind clinical trial in 42 patients with acute psychosis compared CBD to amisulpiride (an antipsychotic available in Europe) (15). In this study CBD was comparable to amisulpiride in reduction of total, positive, and negative symptoms, and was not associated with extrapyramidal side effects, weight gain, or prolactin elevation. CBD treatment was also associated with elevations in blood levels of anandamide, and change in anandamide levels were highly and significantly correlated with symptom change. The authors advance the intriguing theory that anandamide is protective against psychosis, and that cannabidiol mechanism of action is to interfere with anandamide metabolism and thus boost anandamide levels.

In summary, marijuana contains a complex mixture of potential active compounds, with THC and CBD seeming to have opposing effects relative to psychosis. Use of marijuana in childhood or adolescence, or heavy use in young adulthood appears to increase risk of schizophrenia by about 4-fold, with THC the likely culprit. The impact of increasing use of marijuana in adolecents together with the increasing concentrations of THC relative to CBD in strains of marijuana raise concerns that the relative contribution of marijuana to development of schizophrenia could increase in the future. The endocannabinoid system is emerging as an intriguing treatment target in persons with schizophrenia, with CBD in particular showing early promise as an effective drug.

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Medical professional liability policies can vary widely from one company to the next. It is important for psychiatrists to know the full – and accurate – story on a policy. Whether it is reviewing the difference between occurrence and claims-made policies or explaining how another policy might leave the doctor with an uninsured risk, I have done my job when I help psychiatrists evaluate their options to make the right choice.


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# ACO Toolkit Now Available for Psychiatrists

*Michael Zarzar, M.D., D.F.A.P.A., is the chair of the Health Care Delivery Systems Committee, formerly called the Access to Care Task Force.*

After months of work and years of interest in collaborative care, NCPA has helped develop a resource guide for psychiatrists to learn more about Accountable Care Organizations (ACOs). The North Carolina Medical Society Foundation received a grant from the American Medical Association to develop a series of toolkits for physicians as the country begins to move toward a new era of health care delivery systems and resulting changing reimbursement strategies. The ACO Toolkit is a national document developed right here in North Carolina. As a specialty psychiatry is starting to be valued as people begin to recognize what we have said for many years—good psychiatric care helps improve patients' lives, reduce health care costs overall, and improve efficiency of health care delivery.

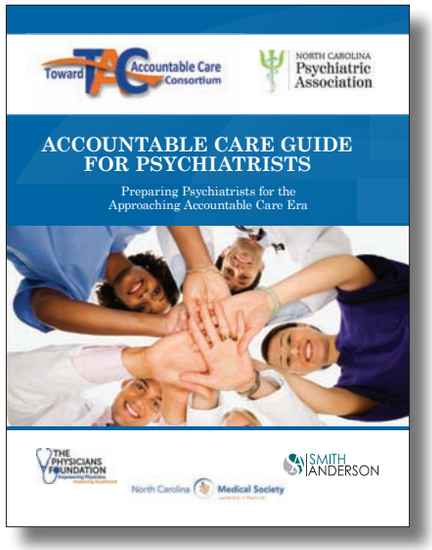
NCPA was one of the early groups asked to write a toolkit for physicians as a part of this endeavor. The toolkit is now available online and can be accessed through the NCPA and NCMS websites. This transition is coming as our country moves ahead with changes in the way health care is delivered. An ACO model for Medicaid physical health was recommended last month to the NC Medicaid Reform Advisory Group. As with all changes, this carries uncertainty, but also opportunities.

*"ACOs (Accountable Care Organizations) are viewed as the future way in which care will be delivered, and as the structure through which reimbursement will be determined. ACOs are a component of the Affordable Care Act, intended to reorganize the way medical treatment is delivered and reimbursed. The design of care delivery is primary care based with the active participation of all necessary specialty medical resources, leading to a comprehensive team approach that seeks to improve the quality of care and experience of the patient while lowering costs."* This avenue may provide ways in which services that previously were not reimbursable will now be able to be covered (e.g. direct or phone consultation to the primary care physician without seeing the patient).

The ACO guide is just that—a guide. It does not dictate or direct the way in which to be involved in those changes. It helps to understand the changes and provides options. There are many ways in which psychiatrists can be involved as health care changes in the future—the important aspect of this is being aware of the changes that are coming. Examples of involvement range from relationships in which a psychiatrist can serve as a consultant to primary care, a referral relationship with primary care, to integrated care with primary care among others. This will involve community, private practice, and academic psychiatry.

NCPA's Health Care Delivery Committee is now shifting its focus to working on practical education about how ACOs will impact us as a specialty and how to prepare for the coming transitions. This article cannot capture all the information available in the ACO guide, which includes general sections on ACOs, reimbursement through ACOs (different from fee for service), and a section specific to psychiatrists.

As we have been told in multiple meetings, it is not if, but when the




changes will happen. The more educated we are about the changes, the more impact we can have on the changes and turn uncertainty into opportunity. We encourage everyone to become familiar with the ACO guide as it provides useful information to prepare for the impending changes.

The ACO Toolkit is available via a link on the NCPA homepage, www.ncpsychiatry.org; scroll down to the NC Psychiatric News box and click the "Just Released" link.

### *Submit Your Nomination for the Hargrove Award Today!*

**The Psychiatric Foundation of North Carolina is now accepting nominations for the Eugene A. Hargrove, M.D. Mental Health Research Award. Nominees should be North Carolina residents with an M.D. or Ph.D. who are actively conducting PTSD and/or TBI research. Nominations should be submitted by June 15, 2014.**

**For additional nomination information, visit www.ncpsychiatry.org/Hargrove-Award.**

NORTH CAROLINA
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**North Carolina Psychiatric Association**
*A District Branch of the American Psychiatric Association*

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## Drugged Driving

Results of a recent survey published in the American Journal of Epidemiolgy find that between 2005 and 2009, a third of fatally injured drivers tested positive for non-alcoholic drugs, the most common being cannabis. In 2010, 1 in 8 fatalities was associated with cannabis compared to 1 in 20 in 1999. Over the same period, numbers testing positive for alcohol have remained stable at 40 percent.

Brady JE and Guohua LI. Trends in Alcohol and Other Drugs Detected in Fatally Injured Drivers in the United States, 1999-2010. American Journal of Epidemiology. 2014, online ahead of print.

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# Calendar of Events

**Saturday, April 5, 2014**
**NCPA Executive Council Meeting**
**NCPA Conference Room, Raleigh, NC**

**May 3-7, 2014**
**167th APA Annual Meeting**
**New York, NY**
**http://annualmeeting.psychiatry.org**

**Saturday, May 17, 2014**
**Medical Directors' Network Symposium**
**Friday Center, Chapel Hill**

**September 25-28, 2014**
**NCPA Annual Meeting & Scientific Session**
**Wrightsville Beach, NC**
**Registration Details Coming Soon!**
**www.ncpsychiatry.org/2014-AnnualMeeting**