



NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. Patrick Sullivan Named as Inaugural Sethi Award Recipient

The Psychiatric Foundation of North Carolina is pleased to announce that Dr. Patrick Sullivan has been named the inaugural winner of the V. Sagar Sethi, M.D. Mental Health Research Award. The national award seeks to “honor a scientist for significant contributions to basic research in the neurosciences, psychology, or pharmacology at a molecular, cellular or behavioral level that has made, or is likely to make, a significant impact on clinical care.”

About Dr. Sullivan

Dr. Sullivan is the Ray M. Hayworth & Family Distinguished Professor of Mood & Anxiety Disorders at The University of North Carolina. He is also a professor in the Departments of Genetics & Psychiatry within the Carolina Center for Genome Sciences, and an adjunct professor in UNC’s Department of Epidemiology.

One of the highlights of his career has been the five years he spent in Christchurch, New Zealand. He and his wife, a clinical psychologist, both earned positions there in 1992. “It was a fantastic experience to see how psychiatry is different in another country. Psychiatric disorders are basically the same, but the symptom content can be different because of the culture.”

After his time in New Zealand, Dr. Sullivan spent several years at Virginia Commonwealth University working under Dr. Kenneth Kendler. He later came to The University of North Carolina in Chapel Hill where he has had the opportunity to establish a lab and assemble a team of 15 scientists.

It’s obvious that Dr. Sullivan is passionate about his work, which focuses on both locating genetic markers that cause psychiatric disorders and possible methods

for preventing them, and investigating drug treatments and their side effects relative to genetics as a way to help clinicians use drugs more safely.

“None of the stuff is ready for prime time; it’s not ready for the clinical phases just yet,” explains Dr. Sullivan. However, “I want people to understand that it’s very exciting right now. We are very hopeful that on the five year horizon, we’re going to have some ideas of the causes of these disorders and ways to prevent them.”

The Nomination

Dr. Sullivan’s nomination application was submitted by his colleagues at The University of North Carolina, Department of Genetics and the UNC Center for Women’s Mood Disorders. The nomination describes his work of discovering and understanding the genetic data with regard to psychiatric disease, including schizophrenia and bipolar disorder.

“It was a lovely surprise to hear that it happened,” Dr. Sullivan said when asked about his nomination.

In the nomination letter, Dr. Sullivan’s own research and collaborative efforts between more than 60 institutions from 19 countries has resulted in “groundbreaking work towards understanding the genetic underpinnings of psychiatric disease. This includes the demonstration of polygenic inheritance in several psychiatric diseases, clear overlap in the polygenic profiles of schizophrenia and bipolar disorder, and identification of copy number variants in these diseases.”



Patrick Sullivan, M.D.

Continued on next page...

Sullivan continued from cover...

His colleagues further explain, “These findings all have clear clinical significance. For example, the evaluation of genetic copy number variation in patients with mental retardation, autism, and psychosis is nearly ready for clinical implementation and promises to dramatically change the landscape of the field and clinical care. For schizophrenia, in an era where pharmaceutical companies have downscaled R&D, the PGC holds considerable promise to unlocking the underlying neurobiology of this devastating disorder. Such thorough understanding is the essential first step in influencing clinical implementation.”

About the Award

The V. Sagar Sethi, M.D. Mental Health Research Award was created with an endowment from Dr. Sethi, a practicing psychiatrist in Charlotte and a long-time member of the North Carolina and American Psychiatric Associations. The award includes a monetary prize and travel support to present a lecture at the NCPA’s 2012 Annual Meeting and Scientific Session in late September.



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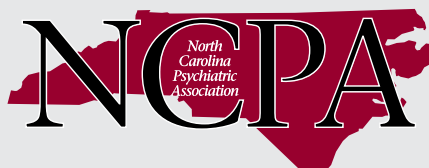
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The NCPA News is a publication of the NC Psychiatric Association, 4917 Waters Edge Drive, Raleigh, NC 27606.

To update your mailing address or if you have questions or comments about NCPA News, contact Kristin Milam, 919-859-0752 or kmilam@ncpsychiatry.org

From the President's Desk...

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

An organization is only as good as its members — and we know NCPA has great members. NCPA strives to provide the best possible service to its members. With this in mind, I would like to extend a personal invitation to every member to become involved in the North Carolina Psychiatric Association.

Joining a committee is a great way to be involved with NCPA. Committee work helps steer NCPA's focus and positions on numerous efforts — that's why it's so important that all of our members are engaged and sharing their ideas and opinions.

Are you in private practice? The Practice Management Committee needs you! Are you working for a LME or CABHA? Please consider joining the Community and Public Psychiatry Committee. Are you a forensic psychiatrist? Then you might be interested in the Psychiatry and Law Committee. Perhaps you have a special interest in legislative affairs? Then the Legislative Committee should appeal to you. We also have committees on Cultural Diversity, Technology and Disaster.

Committees will be meeting during our upcoming Annual Meeting and Scientific Session in Wrightsville Beach on September 27-30. Please consider joining a committee that interests you, or even attend a committee meeting during the Annual Meeting to learn more about the process. Even if you are not able to volunteer your time, we value your insights!

Another way to be involved with NCPA is to share information with us. This year during the Annual Meeting and Scientific Session, we will survey attendees on the top issues facing our organization. These issues include health information exchange implementation, CPT code changes, insurance activity in the state, Medicare, integrated care, the NC public mental health system, maintenance of certification, telepsychiatry, and the corporate practice of medicine. Your input will provide direction for the NCPA in the year ahead. For those not able to attend the Annual Meeting, the survey will be posted on our website.

I encourage your involvement and participation in NCPA — help us provide you with an association that is effectively representing and engaged with its members! Please feel free to contact me directly with any questions or concerns; I can be reached at dbolickmd@charter.net.

Also, if you are attending the Annual Meeting, please take a moment to introduce yourself to me. The program committee has developed an outstanding weekend of lectures and workshops. Since we are meeting at the beach we will be turning our Saturday evening dinner into a seafood roast on the terrace, listening to the sounds of the ocean. Casual tropical attire is encouraged. Hope to see you there!

Are You Ready for the Annual Meeting & Scientific Session?

September 27-30, 2012 • Holiday Inn Resort • Wrightsville Beach, NC

If you haven't already registered for the 2012 Annual Meeting & Scientific Session, now's your chance! Registration is open for the meeting, Sept. 27-30 in Wrightsville Beach.

The 2012 Program Committee has put together an excellent line up of nationally-known speakers, such as Jay Scully, M.D. (APA CEO), Robert Ursano, M.D., Gabrielle Carlson, M.D., and Mark Pippenger, M.D., among others. The sessions include both a general psychiatry track and a child psychiatry track on Saturday; a Friday afternoon workshop will also focus on the 2013 CPT coding changes.

In addition to the up to 13.0 hours of *AMA PRA CME Category 1 Credits*™ offered, there will be plenty of opportunities to network with other attendees.

The Psychiatric Foundation of North Carolina will also be hosting a "Night At The Movies" fundraiser on Friday evening. Attendees will enjoy a red-carpet experience complete with champagne, dessert, and a screening of "A Dangerous Method." Tickets are available with a \$75 (individual) or \$100 (couple) donation to the Psychiatric Foundation of North Carolina. Due to the content of the movie, this is an adults-only event.

The onsite hotel room block has already filled up, but there are rooms available at two nearby hotels, the Hampton Inn Landfall and Shell Island Resort. For more information about the conference and hotel reservations, visit www.ncpsychiatry.org/2012annualmtng.html.

North Carolina General Assembly Permits Greater Information Sharing Between Health and Mental Health Providers

Mark F. Botts, Associate Professor of Public Law and Government, School of Government, UNC-Chapel Hill

Under a new state law that became effective Jan. 1, 2012, the North Carolina General Assembly allows mental healthcare providers to share client information with other mental healthcare providers without having to obtain client consent. To a lesser extent it also permits mental healthcare providers to disclose client information without client consent to other healthcare providers. And, the law relieves healthcare providers—those generally governed only by the HIPAA Privacy Rule—from having to follow the state confidentiality law that applies to mental health, developmental disabilities, and substance abuse (MH/DD/SA) services when healthcare providers receive client information from mental healthcare providers.

The state confidentiality law governing MH/DD/SA services, G.S. 122C-52 through 122C-56, applies to “facilities,” a term that, at first blush, might mislead some mental health professionals into thinking that the law does not apply to them. But, “facility” is defined broadly to mean any person, individual, firm, partnership, corporation, company, association, or agency at one location “whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.” Thus, the state confidentiality law applies to all MH/DD/SA service providers, including publicly-funded agencies and private practice clinicians.

Until Session Law 2011-314 (S 607) became effective this past January, the state confidentiality law generally required the client’s written authorization before a provider treating the client could disclose client information to another provider who was treating the same client. There was an exception to this rule: area MH/DD/SA authorities (also known as “local management entities” or “LMEs”) and their contracted service providers could share client information related to LME clients without client consent “when necessary to coordinate appropriate and effective care, treatment or habilitation of the client.” The new law expands this exception by making it applicable to all MH/DD/SA providers and their clients. Now, all MH/DD/SA providers may share confidential client information without client consent when necessary

to carry out treatment-related activities. (Providers of substance abuse services are still subject to the federal law governing substance abuse treatment records, 42. C.F.R. Part 2, which generally requires client consent for treatment-related disclosures to other providers.)

The new law also permits any MH/DD/SA provider that follows certain procedures to share confidential information with one or more “HIPAA covered entities or business associates” (for example, primary care providers, hospitals, home health, or specialists) when necessary to coordinate care and treatment of a client or to conduct “quality assessment and improvement activities.” These activities are defined to include “case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of” MH/DD/SA services. (In 2009, the North Carolina General Assembly amended the law to authorize MH/DD/SA providers and the Community Care of North Carolina Program to share client information without client consent for the same purposes.) While the client’s written consent is not required for this information sharing, before making such disclosures, MH/DD/SA providers must inform the client (or legally responsible person) that the provider may make such disclosures unless the client objects in writing or signs a non-disclosure form supplied by the provider. If the client objects in writing or signs the non-disclosure form, the disclosure is prohibited.

A third and perhaps less obvious but more consequential change to the state MH/DD/SA confidentiality law is one that relieves health care providers who are not “facilities” from having to follow the MH/DD/SA confidentiality law whenever they receive client information from MH/DD/SA providers. Before enactment of the law, a provider of general health care services that did not fall within the definition of “facility” would nevertheless have to follow the confidentiality law if the healthcare provider received MH/DD/SA client from another provider. The state confidentiality law attached to, and followed, the

Continued on page 11...

Bewilderment, Frustration, Opportunity in Private Practice

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

The seemingly endless evolution of North Carolina's mental health programs continues to bewilder and frustrate many private practice psychiatrists, at least for those who continue to treat Medicaid patients. The credentialing process by the newly formed MCOs is especially challenging if you do not have the administrative resources equivalent to that of an agency.

It is the rare psychiatrist who has a full understanding of the entities and processes that are known by acronyms of future reform -- FQHCs, ACOs, PCMHs, PDSA, CABHA, MCO/LME, CCNC, CPI, DDAF and more. Taking care of patients and earning a living is more than a full time job. Who has time for all that other?

Yet this writer believes that there is a real opportunity for private practice psychiatrists who wish to stay engaged with the Medicaid population. Furthermore, even if you are presently writing off Medicaid work, the time to read the rest of this article may be worth it.

The opportunity resides within the program known as Community Care of North Carolina (CCNC). Begun in the primary care world, physician directed, it is sometimes called a "Medicaid managed care" program. However, this is not your father's managed care. There are no people at the other end of the telephone line telling you what you can't do, or what you do that you won't get paid for.

Community Care of North Carolina began with the realization that 80 percent of costs come from 20 percent of the patients. And while some of this cost is not avoidable —some sick people just cost that much— there are others who roll up costs due to unsuccessful care.

Unsuccessful because it is uncoordinated, duplicated, and often delivered in sites that are the most expensive, such as emergency rooms.

The program found success with conditions such as asthma and diabetes mellitus and yielded remarkable savings. These successes were realized by enrolling primary care practices in networks that provided care management resources and expected physicians to practice with specific guidelines, in return for reimbursement by way of a per member per month payment in addition to the usual billing.

Community Care of North Carolina is now in its third year of adding mental health services to the program. It seeks to enroll private psychiatric practices in the program and make available to the practice a variety of resources, including case managers, pharmacy resources, and an information database that garners a wealth of patient information derived from paid Medicaid claims.

If you have read this far, please don't stop now, even if you are not impressed with the opportunity as described. Here's why: there is reason to believe that in North Carolina, enrollment of patients soon will not be limited to Medicaid but will include such private payers as BCBSNC and HealthChoice. Ultimately, the Community Care of North Carolina door may be the pathway of most mental health patients to your office.

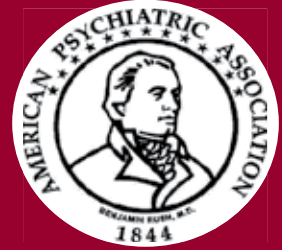
Here's one more "why" to consider: Community Care of North Carolina has a key seat at the table where many of the decisions about health reform are being made. You might want to pull up a chair.

It's that Time Again — Time to Renew Your Membership!

The North Carolina Psychiatric Association (NCPA) is a District Branch of the American Psychiatric Association. We represent 800+ physicians including NC Psychiatrists in training and in practice, and in practice settings from solo offices to hospitals and prisons. Our mission is to: Promote the highest quality care for North Carolina residents with mental illness, including substance use disorders; Advance and represent the profession of psychiatry and medicine in North Carolina; Serve the professional needs of our membership.

Your membership provides access to the members-only section of NCPA's website, inclusion in the Find A Doctor searchable database, exclusive networking events, advocacy from psychiatry's perspective so your voice is heard, practice management support, e-newsletter and print edition subscriptions, and more! NCPA's new staff members are ready to implement even more member benefits and make your ideas and suggestions a reality. For renewal information and a complete list of NCPA Member Benefits, visit www.ncpsychiatry.org/membership.html.

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Changes to Psychiatry CPT Codes: Getting Ready for 2013

Reprinted from www.psychiatry.org

Background

Almost all of the codes in the Psychiatry section of CPT (the 908xx series of codes) will be changing next year. We are not permitted to provide specific information about the new CPT codes that will be used for psychiatry services beginning in 2013 until they are published by the AMA this fall. However, starting right now, there are a number of things a practice can do to prepare for the code changes that will help you be ready when the new codes go into use.

The APA is aware that some psychiatrists have contracts with payers that limit the codes they will be reimbursed for to those in the Psychiatry section of CPT. We will be doing outreach to major payers to ensure that they are aware the codes are changing and will be making the necessary accommodations so there will not be a hold-up with reimbursement when the new codes go into effect.

Practical Steps

The one specific we are able to provide about the changes is that code 90862, pharmacologic management, will no longer exist in 2013. Even now, it is appropriate to use a medical evaluation and management (E/M) code (i.e., 99212 or 99213) in place of 90862.)

Start familiarizing yourself with E/M codes for medication management and other patient encounters that are not primarily for psychotherapy. Unlike the psychotherapy codes, which are almost all timed codes, E/M codes are generally chosen based on the complexity of the presenting problem, the intensity of the examination required, and the difficulty of the medical decision making involved (as well as the setting where the service takes place and whether the patient is new or established). There are, however, typical times attached to the codes, and coding can be based on time if more than half of the patient encounter was spent in counseling the patient and providing coordination of care.

The Centers for Medicare and Medicaid Services (CMS) has a well written guide to E/M coding available on its

website along with two sets of documentation guidelines for E/M coding – one from 1995 and the other from 1997. These guidelines are used by most payers when auditing E/M coding. The 1997 guidelines are the most appropriate ones for psychiatrists to use since they include a single-system psychiatric exam. We have posted an abridged version of the 1997 documentation guidelines (scroll to CMS Resources) on the APA website that just contains the information relevant to psychiatrists. The APA also has an online CME course that provides an introduction to E/M coding at www.apaeducation.org.

Contracts

You should review any contracts you have with insurers to see if they limit you to the current codes in the Psychiatry section of CPT (most of which will no longer exist in 2013). The APA will be contacting the major payers to alert them to the code changes, but it would also make sense for you to contact them to inquire about what will be done to revise the contract to accommodate the coding changes. Under HIPAA (the Health Insurance Portability and Accountability Act) all insurers are required to use the current CPT codes, which means they will be required to use the new coding schema and will need

to update any contracts to take into account the new codes that psychiatrists will be using and also to ensure that psychiatrists will be reimbursed for providing evaluation and management services as the Parity Act requires.

Conclusion

Since there may only be three months between when the new psychiatry CPT codes are made public and when they will go into effect, it's good to be doing everything you can to prepare for the changes now. Keep watching the APA website for new information and contact the Practice Management HelpLine—800.343.4671, hsf@psych.org—if you have any questions.

NOTE: NCPA will be presenting a 2-hour CPT Update workshop at the NCPA Annual Meeting on Sept. 28.

NCPA will be offering a CPT Coding Workshop for psychiatrists and practice managers on December 7, 2012 in Greensboro. Registration details will be available shortly.

An Epidemic of Opiate Deaths – Psychiatry’s Response

Thomas M. Penders M.D., F.A.P.A., Brody School of Medicine, East Carolina University

Historical Background

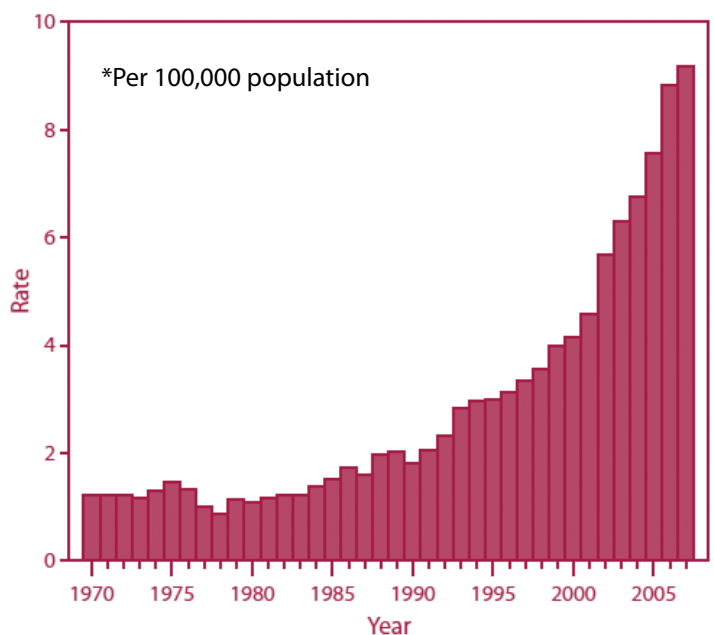
The use of opium and its derivatives for analgesia and sedation is as old as recorded history. Poppy seeds have been found in association with remains of early ancestors of man from the Neolithic age. The earliest recorded medical documents mention the beneficial effects of opiates in the treatment of various conditions described by Mesopotamian, early Egyptian and other physicians from ancient cultures. The property of offering predictable pain relief while sparing cognitive faculties make the opiate drugs rather uniquely positioned in modern formularies. Opioid drugs also have a rather powerful capacity for development of psychological and physical dependence. A sizable number of those exposed to these agents develop a pattern of compulsive use. Consequently, modern societies have developed a rather ambivalent posture toward these substances, cultivating their use as pharmaceuticals while, at the same time, sanctioning their use as recreational drugs.

At the turn of the nineteenth century opium nostrums were widely available over the counter and without prescription. Concern about their widespread compulsive use was among the factors leading to initial federal legislation regulating their availability. The Harrison Act of 1914 represented the first government response to regulation of drug use. It was passed primarily in an effort to restrict availability of opiates. For the first eight decades of this century concern about development of addiction served to limit the use of these agents to relief of acute pain following injury or surgery or to situations involving suffering associated with terminal illness. Also, physicians were apprehensive about prescribing outside of these indications as many physicians had been prosecuted under federal legislation for drug trafficking when doing so.

Reconsideration for Chronic Non-cancer Pain

Until the mid-1980s use of opiate analgesics were generally confined to short courses. In 1985 a group of physicians at Sloan-Kettering in New York, working with terminally ill cancer patients, observed that, despite development of physical dependence, there was a low rate of addictive use in this population. At that time Portenoy and others published a series of 38 cases describing use of opioid analgesics for non-malignant chronic pain. Among these observations were that two-thirds required less than 20 morphine equivalents per day, none more than 40 mg per

day. They observed acceptable analgesia with little evidence of toxicity. Only two patients in this group attempted to escalate their dosages. These individuals were the only two in the series with a past history of substance abuse. The authors concluded: “opiate maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse.” This seminal observation came at a time in the history of American Medicine when concerns were being raised from within and outside the profession that chronic pain, a common and growing complaint in primary care, was being under treated. These observations and conditions touched off a nationwide debate about the appropriateness of the use of opiate agents in the treatment of chronic non-cancer pain. The controversy fueling this debate continues to the present. Compassionate physicians and experts have responded by expanding the utilization of these agents in the treatment of several common chronic pain syndromes including headache, low back, pain, fibromyalgia, osteoarthritis and many orthopedic syndromes. This expansion was supported largely by evolving expert opinion that there was a proper role for the use of opiates



The figure above shows the rate of unintentional drug overdose deaths in the United States during 1970–2007. In 2007, approximately 27,000 unintentional drug overdose deaths occurred in the United States, one death every 19 minutes. Prescription drug abuse is the fastest growing drug problem in the United States. The increase in unintentional drug overdose death rates in recent years has been driven by increased use of a class of prescription drugs called opioid analgesics. Source: National Vital Statistics System. Available at <http://www.cdc.gov/nchs/nvss.htm>.

in these settings and that concerns relating to addiction had been overblown by government regulators. Research demonstrating effectiveness in improving quality of life or functional capability in patients with chronic non-cancer pain has been slow in arriving. The potential risks of sustained long-term use remain undetermined.

Expanding Opiate Prescribing

The prescription of opiate analgesics in this large patient group has quadrupled in the past decade. There has been an explosion in the prescription of these agents for many chronic painful conditions. The CDC reports that in 2010 enough opiate analgesic units were dispensed to provide analgesia to every American adult for a month.

During this same time period there has been an increase in the average prescription dose of opiates escalating from the 20 to 40 mg equivalent described by Portenoy to an average dosage morphine equivalent today that is just shy of 100 mg equivalents. There has been a recognition that a significant minority of patients maintained on such regimens are using these drugs aberrantly, or in ways other than specified by prescription. Between 30 and 90 percent of patients maintained on maintenance opiates for chronic non-cancer pain are also today taking benzodiazepine drugs concurrently. Many patients with chronic mental illness and those with past and current histories of substance use disorders are also maintained on opiate analgesics for treatment of co-occurring chronic pain syndromes. Perhaps more alarming is the dramatic increase in non-medical use of these drugs by those for whom they have never been prescribed.

Overuse, Abuse and Accidental Overdose

Concurrently, during the last decade there has been a parallel increase in the numbers of deaths from inadvertent overdoses of opiates, frequently in combination with depressant drugs. Over the past decade the death rate from accidental overdose of prescription analgesics has quadrupled, now exceeding the death rates complicating use of heroin and cocaine combined. In a growing number of states, opiate deaths exceed those of motor vehicle accidents.

These facts are part of what is recognized as an urgent public health problem. State and federal agencies have mobilized to counter what now appears to be an easy availability of opiates coupled with an incomplete appreciation of their dangers. The last Monitoring the Future survey of recent

high school graduates documented that 12 percent had used a narcotic pain reliever for other than medical reasons in the past year.

Psychiatry's Response

Among the constructive responses to encourage a more balanced calibration of the use of opiate drugs has been educational efforts supported by Community Care of North Carolina. Educational sessions to primary care physicians have been held throughout the state, many provided by members of NCPA, emphasizing the need for careful evaluation and use of non-opiate alternatives for treatment of chronic non-cancer pain. Additionally, use of the Controlled Substance Reporting System and urine drug screening has been well received by those practicing in areas where chronic opiate therapies are being prescribed. While

“Over the past decade the death rate from accidental overdose of prescription analgesics has quadrupled...”

these efforts have had some impact, recognition remains that the evidence base supporting efficacy and lack of harm for the use of narcotic analgesics in many specific populations with chronic non-cancer pain has not kept up with the collective prescribing practices.

A recent literature search of publications covering the consequences of long term use of opiate drugs for patients who also are being treated for schizophrenic disorder yielded nothing. When recently asked about the effect that use of opiate drugs might have on patients with bipolar disorder the usually encyclopedic Robert Post responded with: “It doesn’t sound like a very good idea.” The large literature on co-occurrence of depression and chronic pain fails to address the issue of risks of opiates in a population with high risk for suicide.

The dilemmas involved in providing compassionate care to patients suffering with chronic pain syndromes informed by a very limited evidence base will need to be addressed if we are to make further impact with a growing problem that is resulting in widespread loss of life. NCPA’s Addictions Committee is now considering alternatives for providing a constructive response to the dilemmas of providing effective care to those with chronic pain while limiting the individual and societal harm associated with increased chronic opiate prescribing. At a time when integration of psychiatric and primary care medicine has clearly demonstrated its value, psychiatry has a unique opportunity to make an important contribution to an effective reply to the “opiate epidemic.” Ψ

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From the Executive Director...

Robin B. Huffman, Executive Director

We are heading into some exciting times at NCPA. We always look forward to the NCPA Annual Meeting and Scientific Session. It is invigorating to see more than 150 psychiatrists networking, catching up with old friends, meeting new colleagues for the first time, and engaging in the work of the association.

But there is more to celebrate as well. Here at the NCPA office we have new staff, new ideas, new energy, and a renewed commitment to provide timely information, help, education and service to our member psychiatrists!

Katy Dorman joined NCPA in June to serve as our membership coordinator. In addition to working closely with our members, Katy will also coordinate the NCPA Annual Meeting and handle day-to-day operations. Katy is familiar with the work our members do, having spent the past two years working in a Raleigh psychiatric office.

Kristin Milam came on board in July as our communications director. In this role, she will work to increase communications with our members, including

developing content for the NCPA website, newsletters, e-newsletters and other publications. Kristin comes to the Association from the NC ABC Commission where she served as the Education & Training Director and prior to that, the NC Department of Insurance where she was the Director of Public Information.

You will get to meet Katy and Kristin when you come to the NCPA Annual Meeting later this month. We hope you will have a minute to talk to with all of us and to share YOUR ideas for NCPA. At the committee meetings on Sept. 27, and the business luncheon on Sept. 28, we want members to help us set our priorities for the coming months and years. We want to hear from you on the issues you think are critical for your professional association to engage in.

It is my greatest hope that, with this talented team and with your feedback, NCPA will provide even better service, information, and support to you, our members.

Information Sharing continued from page 4...

client information as it was transmitted from the mental healthcare provider to the healthcare provider, even if the healthcare provider was not a “facility” under the state law. For example, this healthcare provider’s obligation to apply and follow the state confidentiality law would arise if a mental health professional disclosed client information to the healthcare provider under any one of the several specific circumstances where state confidentiality permits such disclosure: with client consent, in a medical emergency, pursuant to an advance instruction for mental health treatment, or when a physician refers a patient to a mental health professional. Although some healthcare providers may not have known it, the receipt of such information meant the healthcare provider was required to apply the state law confidentiality law to the MH/DD/SA information and not further disclose it except as permitted by that law.

Now, “a HIPAA covered entity or business associate receiving confidential information that has been disclosed pursuant to G.S. 122C-53 through G.S. 122C-56 may use and disclose such information as permitted or required” by the HIPAA Privacy Rule. See G.S. 122C-52(b).

For healthcare providers who are accustomed to following only the HIPAA Privacy Rule, this is significant because the Privacy Rule permits information sharing in many circumstances where G.S. 122C would not. There is, however, one caveat. When the healthcare provider receives client information from a MH/DD/SA provider for purposes of quality improvement activities or coordinating treatment (because the client did not opt out of the disclosure after being informed that such disclosures would be made unless the client objected in writing), the statute prohibits the information from being “used or disclosed for discriminatory purposes including, without limitation, employment discrimination, medical insurance coverage or rate discrimination, or discrimination by law enforcement officers.” See G.S. 122C-55(a7). (This notice and opportunity to object is not required when MH/DD/SA providers disclose information for care coordination and quality assessment and improvement purposes to the Community Care of NC networks, whose information sharing is governed by a separate statutory provision.) Ψ



N.C. Psychiatric Association
4917 Waters Edge, Suite 250
Raleigh, NC 27606
www.ncpsychiatry.org

Are you joining us in September? We hope so!

2012 NCPA Annual Meeting & Scientific Session

September 27-30, 2012 | Holiday Inn Resort in Wrightsville Beach, NC

visit www.ncpsychiatry.org/2012annualmtng.html

What's Inside:

From the President's Desk

page 3

State Confidentiality Statute Update

page 4

2013 CPT Coding Changes

page 7

The Opiate Epidemic

pages 8-9

NCPA's New Staff

page 11

Calendar of Events

September 27-30

Annual Meeting & Scientific Session
Holiday Inn Resort • Wrightsville Beach
www.ncpsychiatry.org/2012annualmtng.html

December 7, 2012

NCPA CPT Coding Workshop
Sheraton Greensboro & Koury
Convention Center • Greensboro
Additional Details Coming Soon!!

March 21-22, 2013

Clinical Update and
Psychopharmacology Review 2013
Cape Fear Botanical Garden • Fayetteville