NCPA North Carolina Psychiatric Association NEWS

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

*North Carolina Psychiatric Association* *Winter 2009-2010*

# CABHAs-A Move Toward Medical Leadership

Robin Huffman, Executive Director

Since late last fall, the State Department of Health and Human Services (DHHS) has announced its intention to "raise the bar" on quality by requiring a certain set of Medicaid services to be provided by a new type of agency. In order to provide Community Support Team, Intensive In-Home Treatment, Day Treatment, Case Management, and Peer Support services, an agency must be approved by the state to be a CABHA—a Critical Access Behavioral Health Agency. Required elements of a CABHA are a Medical Director, a Clinical Director, and a Quality Improvement/Training Director. These positions will be paid for through the rates being set for these services.

The resulting reaction has been strong and fierce. At the December meeting of the Legislative Oversight Committee (LOC) for Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS), Assistant Secretary for DHHS Michael Watson made the first public presentation on the CABHA. The room was packed with providers that loudly decried the requirement of hiring a psychiatrist, both because of cost and availability.

Some advocates and providers expressed concerns that this new requirement was being implemented too quickly, but were told that since the General Assembly last session had eliminated funding for Community Support services, the service definition that included case management, some replacement services had to be put in place for patients before July 1. DHHS concluded that, given the fiasco with the rampant overuse of Community Support, that some kind of clinical structure should be put into place to ensure that the services were ordered and delivered appropriately.

One of the official DHHS goals is "to ensure that mental health and substance abuse services are delivered within a clinically sound provider organization with appropriate medical oversight." Assistant Secretary Watson, in a meeting with physician leadership from NCPA in early March said, "The single biggest issue in this system is quality." Thus, the CABHA was born.

Despite the reasons and rationale for CABHAs, many legislators are fearful of the community reaction and wavering in their support.

**What Do the Critics Say?**

The outcry seems to be about reducing the number of agencies that provide services across the state. Some feel that small rural agencies are being targeted. Others seem to think that only agencies that become CABHAs will survive in this system, and therefore, feel pressure to apply to become a CABHA. Will there be a place for a small quality provider?

The Division, on the other hand, points out that many critics are missing the point. Division Director Leza Wainwright was quoted in the *Winston-Salem Journal* as saying, "These are services for adults with severe mental illness with a physical component. For every other illness, treatment delivered by a physician or supervised by a physician is considered essential. We do not believe that treatment for individuals with mental illness and substance-use disorders should be different."

**What Does NCPA Say About CABHAs?**

NCPA is publicly supporting the DHHS effort to improve clinical services and clinical accountability in the public mental health system, and said so at the January meeting of the LOC when NCPA Vice President John Gilmore was on the agenda to speak about CABHAs. In his remarks that day, and later in a radio interview on WUNC Radio, Gilmore countered the claims of a psycholo-

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*From the President......*

# A Vision for Public Psychiatry in NC

**Stephen E. Buie, M.D., D.F.A.P.A., President**

In January 2009, Department of Health and Human Services (DHHS) Secretary Lanier Cansler came to the Executive Council meeting and requested that NCPA put forth ideas about how to resurrect public psychiatry. The Access to Care Task Force put together a proposal to co-locate psychiatrists in Community Care of North Carolina (CCNC) primary care clinics across the state and for CCNC to provide care management for selected patients. The Task Force thought that this was a very cost effective approach at increasing access to psychiatric care across the state.

Most mental health care occurs in primary care offices, and putting psychiatrists in those offices would lower barriers to referral and treatment. We prepared a written document and on NCPA's Advocacy Day last June 10, presented a draft document to Secretary Cansler, Division of Medical Assistance (DMA) Director Craigan Gray, M.D., and various legislators. We met for two hours with **Michael Lancaster, M.D.**, Director of Clinical Policy for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and Chris Collins, of DMA and CCNC to present our ideas for the model. We formally presented our document to Secretary Cansler, along with NCPA's 2008 document advocating a clinical home for psychiatric patients, in July.

This week, we have been informed that CCNC is beginning a search for the leader of this psychiatric team and that there are plans to hire ten psychiatrists across the state to provide consultation to the 14 CCNC networks. Providing access to psychiatric consultation and direct psychiatric care in primary care settings across the state will be a tremendous benefit to the citizens of North Carolina.

In November 2009, the DHHS announced a new designation, the Critical Access Behavioral Health Agency (CABHA). The Department sought to consolidate the number of providers in order to improve the quality of care through this designation. CABHAs would be required to have either a half-time or full-time medical director, depending on the size of the agency, a clinical director and a quality assurance director. We are heartened by the Department's resolve to improve the quality of care for the seriously mentally ill by once again putting psychiatrists in a position of responsibility and authority. While the CABHA does not meet the ideal of the Psychiatric Clinical Home that the NCPA has championed, it does move in that direction.

Severe mental illness necessitating the multidisciplinary approach offered by a CABHA has a significant biological component, and providing a coordinated biopsychosocial treatment model will move us beyond the outmoded approaches of the last several years which have seen programs providing unnecessary community support services because that was the service they were selling. The role of the medical director will be to guide the treatment team in providing clinically necessary, evidence based treatments in a cost effective manner.

There has been an outcry among some of the providers, saying that a medical director is too expensive and is unnecessary. If they have so little understanding of these severe illnesses to say that psychiatric oversight is unnecessary, do we want our state and federal Medicaid funds supporting their services? Many of these agencies have already made the responsible decision and have either hired or are recruiting psychiatrists as medical directors. There are some who continue to protest, and I fear that their protests may derail this initiative for quality. My hope is that their complaints do not undermine this initiative for improved mental health care for the citizens of North Carolina.

During a brief encounter with Craigan Gray on Advocacy Day, he promised that he would work to rebuild services for the mentally ill. It appears to me that DHHS and CCNC are upholding that pledge. The two initiatives described form a foundation upon which a new system can be built. It greatly expands access to psychiatric care, breaks down some of the barriers between psychiatry and primary care, and improves the quality of specialized psychiatric care. To be on the brink of such an achievement in the current budgetary crisis is nothing short of remarkable. Secretary Cansler and his department are to be commended.

*The Governor's Institute on Alcohol and Substance Abuse and the NC Society of Addiction Medicine are offering:*

**Addiction Medicine 2010:**

**Building Bridges for the New Decade**

**April 23 & 24, 2010**

**Greensboro, NC**

Visit www.sa4docs.org

for the agenda and registration information

(**CABHAs** *continued from page 1*)

gist also on the agenda who questioned the need for CABHA medical directors. His presentation made several points:

- that the current system is fragmented and often fails to provide effective treatment,
- that the cornerstones of effective treatment are a good diagnostic assessment and treatment provided by an integrated team of professionals,
- that a transparent business model is needed to ensure that good small providers are not put out of business, and
- that fragmentation of the system has driven many professionals away who may be lured back to a strong, stable provider network.

In letters to DHHS Secretary Lanier Cansler last summer and meetings during the fall and winter with Assistant Secretary Watson and **Michael Lancaster, M.D.**, Division of MHDDSA Chief of Clinical Services, NCPA urged the adoption of a "clinical home" for psychiatric patients in the public mental health system. That idea was to ensure that patients had access to psychiatric care in acute situations and after discharge from a psychiatric hospital, as well as to provide safety net services to those without medical care. The development of CABHAs appears to move toward this clinical home model.

NCPA did give early feedback to the Division and the LOC, however, echoing concerns about the short time frame and offering other suggestions to stabilize the system. Most importantly, however, NCPA supports having true psychiatric medical oversight over systems of care that are designed for those who are truly ill and need medically appropriate care. Hiring a psychiatrist, however, cannot be "window dressing" for agencies.

## Watch Out!

One of NCPA's primary concerns is that psychiatrists (and the other physicians who get approval to serve as CABHA Medical Directors) may become employed at agencies that do not understand the role of medical leadership. As one NCPA officer put it, "Simply adding a medical director to a psychosocial rehabilitation agency does not create a transformed clinically based agency." The current DMHDDSA job description for the role states the Medical Director is responsible for the clinical care. Therefore, it is critical for psychiatrists to consider carefully any employment opportunity. If it looks too good to be true, it probably is. You need to be satisfied that the agency you work with is one that shares similar goals as yours and one with which you entrust your medical license.

As another NCPA member said in recent discussions about agencies that are resisting hiring the clinical staff necessary to become CABHAs:

> *"These are the same people that don't understand mental health treatment. They are the same ones who don't understand why they need licensed people to provide mental health services. They don't understand the medical component of mental health. They don't understand the bio, psycho, social model of care. This is exactly the reason that we must have Medical Directors to oversee the services provided by these organizations ... Their lack of understanding is the greatest argument for the need to have Medical Directors involved who do understand, so that people will get appropriate treatment that actually will make a difference in their lives."*

Before you sign on the dotted line, here are some questions you might want to ask any agency you are considering working with:

- **How long have you been in business? How long have you been providing these types of clinical services?**
- **Do the principles and owners have clinical degrees and backgrounds?**
- **What is the agency's treatment philosophy?**
- **How many licensed professionals do you have on staff? What are their licenses—LCSWs, PhDs, RNs? Is there Medical Director input into hiring and performance?)** *(Note: A "QP," qualified professional, is not an independently licensed clinician. You should expect a clinically informed agency to know the difference.)*
- **What types of services do you intend to provide as a CABHA?** *(Use your own clinical judgment as to whether the services they intend to offer are part of a real continuum, an attempt to provide a clinical home. Does the staff clinically match the services they intend to provide?)*
- **Tell me how you envision the role of the Medical Director.** *(Run, don't walk, away if the agency seems clueless about the clinical role of a psychiatrist or if they seem to want you only to write prescriptions or sign person centered plans. A true clinical home will want to involve you in developing their services and ensuring quality care.)*
- Ask them specific theoretical questions to gauge their true intent, such as: **"What would you want staff to do if a patient in your care needed a service that the agency doesn't provide?" "How willing are you to refer the patient out to the appropriate level of care, even if you 'lose' the business?" "Do you have referral agreements with other agencies in the area?"**
- **Do you have regular senior team meetings? Who attends?** *(The M.D. and Clinical Director should.)*
- **How do you handle internal monitoring of quality? How much time is spent on staff training? How do you envision the role of the Medical Director in these activities?**

(**CABHAs** *continued on page 7*)

# North Carolina News

## Medicaid Establishing a Preferred Drug List

The NC Department of Medical Assistance (DMA), which runs the state Medicaid program, has announced its plan to implement a Preferred Drug List (PDL) March 15. Preferred drug lists allow the state to restrict medications that can be prescribed for patients in the Medicaid program by requiring prior authorization for medications that are not considered "preferred." DMA is projecting target savings of $30-40 million, $10 million of which are savings to the state. It has been reported that the Department of Health and Human Services (DHHS) is trying to keep cost overruns in the Medicaid program capped at $250 million.

The PDL saves money for the state in a couple of ways. In establishing the list, the state will begin accruing revenue from supplemental rebates paid to the state by pharmaceutical manufacturers in order to have their medications included on the list. We are told "clinical and financial considerations" will be part of determining the drugs that will be included on the list. The greatest savings, however, are anticipated to be the barriers prescribers will have to overcome in order to prescribe a drug that is not on the preferred drug list.

When NCPA members first looked at the proposed PDL, there was some pleasure that the list was very inclusive of the psychiatric drugs. However, we were told at a meeting February 15 by DMA that the plan is that almost all prescription drugs will be included on the PDL initially, and that the list will be pared down in the coming weeks and months to "a more traditional PDL."

At press time, there is some question about whether psychiatric medications will be put on the PDL immediately. We have been informally informed by DHHS that psychiatric medications will not be on the list March 15, "until things are worked out." While special budget provisions were passed by the General Assembly last summer to allow for the establishment of a PDL, there is language in another section of the same bill that specifically prohibits prior authorization for medications used to treat mental illness and HIV AIDS. While the new PDL statute language exempts HIV AIDS drugs from being put on the PDL, that exemption was not included for psychiatric medications, thus creating a legal conflict.

DMA has a webpage devoted specifically to the PDL: http://www.ncmedicaidpbm.com/.

NCPA will continue to monitor this situation and asks for your feedback concerning this development.

## Joint Insurance Committee Meets with Commissioner of Insurance

NCPA member **Yvonne Monroe** and Executive Director Robin Huffman met with the NC Department of Insurance Commissioner Wayne Goodwin February 26, along with other members of the Joint Insurance Committee. In our first official meeting with the head of state DOI, our goals were to establish a relationship with the Commissioner, inform him of some of the issues related to mental health in the state, and request access to some of his key staff on certain issues. We were successful on all counts.

We talked about mental health parity and how DOI may be engaged on this issue as federal parity is rolled out in the state. We discussed issues related to noncompliance with the parity bill and our interest in DOI helping inform the state on its implementation. We discussed the adequacy of insurance panels and some of our concerns related to restrictions on panels, as well as our interest in offering assistance on issues related to mental health with the State Employee Health Plan and the state's new High Risk Pool. We even got around to initiating discussion about possible emergency declarations in the event of a pandemic that might limit patients' access to therapy and medical care.

We hope this is the first of regular meetings with the Department.

*Attending the Joint Insurance meeting with DOI February 26 were: **Yvonne Monroe, M.D.** (NCPA), Mary Hartsell (nursing), Sally Cameron (psychology), Commissioner Goodwin, Robin Huffman, Mary Beth Tobin (clinical social work), and Jack Register (social work).*

# Free Medications Available Statewide

North Carolinians who are unable to afford their prescription medicines can now get them for free. The program, administered by NC MedAssist, has created a mail-order central pharmacy to provide free brand name and generic drugs. The drugs are donated by participating pharmaceutical companies.

Attorney General Roy Cooper announced in January that a pilot program begun in March of last year to give low-income North Carolinians free access to needed prescription drugs has been expanded to serve residents statewide. "The growing number of uninsured in North Carolina—which currently is nearly one in five among us—face challenges every day in accessing medications that can improve their health status. The NC MedAssist program will greatly enhance the ability of low-income and uninsured people to access the medications they desperately need," said Pam Silberman, JD, DrPH, President and CEO of the North Carolina Institute of Medicine. The project was developed as a partnership with the Attorney General, the NC Association of Free Clinics, and NC MedAssist.

There are a number of psychiatric drugs available through this program, according to Howard Peckman, PharmD, MS, Pharmacy Manager-Clinical Policy, NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. They include:
Antipsychotics: Zyprexa, Haldol, Seroquel
Antidepressants: Cymbalta, Prozac, Nortioptyline, Trazadone
Other: Lithium, Depakote, Clonidine, Hydroxyzine

**Who is eligible to enroll in the program?**
North Carolina residents who are:
- Adults and children living at or below 200% of the Federal Poverty Level.
- Adults and children who do not qualify for: Medicaid, Veterans Administration or private health insurance.
- Medicare Part D participants who fall in the "donut hole" may be eligible after consultation with NC MedAssist.

**How can North Carolinians enroll in the program?**
Eligible North Carolina residents can enroll in the program by downloading an enrollment packet from the NC MedAssist website at www.medassist.org, or by calling 1-866-331-1348. Eligible North Carolina residents living in Forsyth, Stokes, Davie or Yadkin counties should enroll in the program by calling MedAid at 336-714-2359.

**How does the program work?**
Eligible North Carolinians can now enroll with NC MedAssist using one application form rather than applying with each drug company. The program has partnered with pharmaceutical companies such as Novartis, Eli Lilly and AstraZeneca to bulk ship drugs to one central location. The central pharmacy run by NC MedAssist keeps both brand name and generic drugs in stock, and can ship medications directly to participants' homes, making it quick and easy for people to get the medicines they need.

# NC Medical Board Updates Its Website and Database

While there has been much attention given to the NC Medical Board (NCMB) website and its expansion of public reporting of physicians' malpractice payment data, physicians may have overlooked the general expansion of physician data on the website. The new website went live early this year and appears to be designed to allow MDs to share more information that might be helpful to patients. The NCMB considers it "an opportunity for high-visibility, free marketing."

NCMB reports that on the old website, the licensee information pages got up to 3,600 "hits" daily. They anticipated that fewer than one percent of the 35,000 licensed physicians and physician assistants would have "reportable" malpractice payments when the system was to go live. They expect only a small fraction of licensees to have negative information of any kind.

Licensed physicians are reminded that there is certain information they are required to provide and update (such as addresses, malpractice claims, and continuing medical education—CME— reporting). In addition, however, physicians are encouraged to provide information such as practice hours, languages spoken, honors and awards, practice website, and insurance panel information.

NCPA sent a letter in January to the NC Medical Board President, Dr. George Saunders, expressing concerns that some of the information posted on the website created risk of identity theft by allowing the public to determine the physician's date of birth. In a recent communication from the Board, NCPA learned "At the request of the NCPA and others, we have removed the year of birth from the licensee information page." We were also reminded that physicians have access to the website 24 hours a day to edit their information, particularly whether they want their practice or home address to be the default address that is "published" on the website.

It is also worth mentioning that the Board has begun a new audit program to verify that physicians accurately report their CME hours. While there is no annual requirement for CME hours earned, MDs must document that they earn 150 hours over three years. Beginning in January, the Board is randomly selecting a percentage of licensees who renew each month to provide documentation of their CME hours reported during the license renewal process.

# NCPA Committee Develops Progress Note Templates for Members

**Yvonne Monroe, M.D.**, Chair NCPA Practice Management Committee

The documentation of medical procedures is changing. Since HIPAA went into effect, our patients can request and usually receive a copy of their medical record. With the internet and direct consumer advertising, more patients are aware that there are choices and want to understand their doctor's decision-making process. For years, our malpractice insurers have pushed us to thoroughly document. In response to the latter pressure, the Practice Management Committee designed a model progress note approximately five years ago. It was probably overly comprehensive. The format was predominantly fill-in-the-blanks. It takes too long to complete.

And then there are audits. In the past, insurance companies have audited a chart if there was a patient complaint about a doctor that pointed to possible fraud and abuse. In more recent years they sample notes from providers in high volume practices. With mental health reform of the past decade, Medicaid has increased their retrospective reviews to ascertain that services occurred and at the level that was submitted for payment. Certain patterns of practice/coding could trigger an audit by Medicare.

Now there are private companies that contract with The Centers for Medicare and Medicaid. These RACs (Recovery Audit Contractors) perform the auditing mandated by the Tax Relief and Health Care Act of 2006. By 2010, all 50 states must be covered by a RAC. Beginning in January 2010, Connolly Consulting, which has this hugely lucrative contract for approximately a quarter of the country, is "fully" operational in our state. The goal is to reduce improper payments within Medicare programs in order to contain costs. The bottom line is that if you are audited and your documentation does not support your CPT-4 code, then your procedure will be "down-coded," and you will be asked to pay back the difference. The RAC may ask for the 90801 and one progress note from 4-5 patients. Each progress note must "**stand alone**." Medicare expects a complete note on every visit. These are non-clinical reviewers. As has been the case, if any notes don't support the procedural code then there is an extrapolation formula that goes back three years. If interested, go to www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx.

With the help of a consultant, the Practice Management and Joint Insurance Committees, as well as several practice managers in the Triangle, have been informing the mental health professionals of NC of these changes. As a result, the NCPA Practice Management Committee overhauled its previous model progress notes for psychiatrists. There are three notes for your possible use. The notes are Medicare "compliant" as well as sufficient for malpractice liability purposes. You may want to review the notes, read the few pages in a recent CPT-4 manual about E&M codes (including the examples), and discuss the notes with a colleague to help clarify some of the items.

These documents are posted on the "Members Only" section of the NCPA website. (You need your APA member number and your password to access the page. Call the NCPA office if you need help.) The first template is a multipurpose form for follow-up, outpatient psychiatric/medical visits. Out of the three model notes, **this one is the only template to use if coding E&M services** (without a therapy component). The most frequent E&M services are 99213 and 99214.

The second template is for the usual, outpatient, specific psychiatric codes, including 90862, 90805, 90807, 90804, 90806, 90846, and 90847. You would not use this note for E&M services.

The third template is designed for outpatient individual or family therapy, without a medication or E&M component. The template can also be used by psychologists and masters' level therapists.

Please give the Practice Management Committee feedback on these forms and if they are helpful to your practice by contacting the NCPA office.

## Have You Been Targeted by a RAC?

The NCPA Practice Management Committee is very interested in hearing from members who have had experience with the new Medicare audits by Connally, the Centers for Medicare and Medicaid (CMS) Recovery Audit Contractor or RAC. Our Joint Insurance Committee has been following this issue and trying to develop resources to help our members. Documentation is key.

Please contact the NCPA office with any experience or information you can share about these RAC audits.

## From the Chief of Clinical Policy

Michael Lancaster, M.D., D.F.A.P.A.

# Medical Director in the Critical Access Behavioral Health Agency

By now you may have heard about the new CABHAs (Critical Access Behavioral Health Agency). These new comprehensive agencies are being developed to provide mental health and substance abuse services to consumers across North Carolina. One of the main features— and most controversial— is the requirement that there be a medical director in each of these agencies. Many of the psychiatrists in North Carolina are being contacted to consider either a half-time (50% only) or full-time medical position in one of these agencies. This is an opportunity for psychiatrists to be active participants in the development and provision of services for our most at-risk populations, to join the network of community psychiatrists, and to improve the clinical quality of our behavioral health system.

The role of medical director requires a psychiatrist or an MD with ASAM certification and, in exceptional circumstances, other MDs with experience with the population served. We are hoping many psychiatrists will consider this new opportunity to provide clinical oversight and direct service in these new provider agencies. In this way we will strengthen the clinical provision of services throughout our system.

These positions are not "token" positions. They are not created for your signatures on forms, but are meaningful roles in a system that is struggling for clinical leadership as we transition in an environment of recovery oriented practices. The role of the psychiatrist will be to help implement best practice models and promising practices of care in all service areas. The clinical team required in the CABHA will consist of a clinical director and a quality manager who, together with the psychiatrist, will direct clinical services for the population served. The goal of this collaborative effort is to provide services of high clinical quality, founded in best practice models of care, available to all of our citizens across the state.

Consider this opportunity as a meaningful contribution to our mental health system and the individuals who depend on that system. Consider carefully any agency that you explore as a possible employer of your services, and ask questions that will assure you of the critical nature of your role, the mutual respect in the organization, and shared expectation to provide high quality services. If you are interested in exploring this new opportunity for service, more details and a job description for the medical director position are posted on the division website (http://www.ncdhhs.gov/mhddsas/). Also, please do not hesitate to contact me (michael.lancaster@dhhs.nc.gov) to discuss this medical director opportunity if you have additional questions or comments. ⚘

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(**CABHAs** *continued from page 3*)

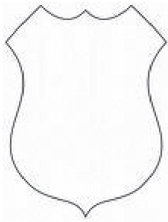
- **Does your agency's medical malpractice insurance cover my work as a Medical Director (in addition to my clinical work)?**

## Value of a Medical Director

NCPA applauds the return to a more medically driven and clinically focused public sector mental health system. "CABHAs should be caring for those who have severe mental illnesses as well as chronic medical illnesses, serving as a medical home, a place where care for these patients is coordinated. Physician leadership is essential in managing the complex care of those patients. They have psychiatric illnesses that have to be understood and managed within the context of their medical illnesses, and only a psychiatrist has the training to do so." This statement is from one of several documents NCPA has written and shared with policy makers that can be found in the Members section of the NCPA website. These include the documents "Value of a Medical Director," "Duties of a Medical Director," and "Questions You Should Ask." Other DHHS and Division documents and memos related to CABHAs are also on the website. Look also for the "From the Chief of Clinical Policy" column by Dr. Lancaster on this page of the newsletter.

Many in NCPA believe that the de-medicalization of North Carolina's mental health system is responsible for much of its recent failings. The move of the DHHS Secretary and Assistant Secretary to return psychiatrists and other licensed mental health professionals to the system may indeed transform our public mental health system into one that can claim clinical quality and clinical accountability. ⚘

# ALERT—State Law Enforcement Using New Form



***Has This Happened To You?***

*A law enforcement officer comes into your practice, shows a badge and produces a document he claims requires you to turn over confidential patient records. Worse yet, he states that this document overrides any HIPAA regulations and that "all the other doctors" are turning over the protected health information you are refusing to release.*

This was the scenario for at least one NCPA member recently, who refused to release the patient information and complained to the NC Department of Justice about the aggressive nature of the agent and the use of a document that could be misleading to unsuspecting physicians.

The NCPA is writing a formal letter to Department of Justice about the SBI's use of its "Law Enforcement Request for Protected Health Information" document. NCPA wants to make sure members are aware of this form and of the responsibilities you have as psychiatric physicians. The NCPA member called his medical liability insurance company, PRMS, The Psychiatrists' Program, which shared the following article for us to publish.

## Myths and Misconceptions: When Investigators Come Knocking

**Q.** A police detective recently came to my office demanding to see a patient's record. When I expressed reluctance to give him access to my patient's psychiatric record, he became threatening, asserting that I would be holding up his investigation if I did not comply. It was only after he assured me that HIPAA required me to release records to government investigators that I let him look at the record. When I later mentioned to a colleague how intimidating this detective was, my colleague said she believed that my cooperating with the police by allowing access to the record was improper. Wasn't I right to cooperate with police?

**A.** Regardless of how intimidating a government investigator is – whether from the police, the FBI, the Department of Homeland Security, etc. – a psychiatrist's obligation to maintain the patient's confidentiality always exists.

***Your confidentiality obligation precludes you from even confirming the person is a patient.*** As stated in the APA Annotations to the AMA Principles of Medical Ethics (2006), "Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care…A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion…"

***Proper legal basis for the release is always required.*** The legal basis for the release of patient information could take one of many forms, including:

- An authorization signed by the patient,
- A valid court order,
- A valid subpoena,
- An exception to confidentiality (such as mandatory child abuse reporting, or the safety of patient or others), or
- A law that requires such release (such as a state law requiring physicians to release treatment information to the medical examiner upon request).

***HIPAA is not a sufficient basis to disclose psychiatric information to investigators.*** Under HIPAA's Privacy Rule, there are only two mandatory disclosures – 1) to the patient and 2) to the Department of Health and Human Services for enforcement. All other disclosures, including those to investigators, national defense inquiries, etc. are permissive disclosures – not required disclosures. So psychiatrists need to evaluate the request in terms of other ethical and professional obligations, which are usually much stronger in restricting access to patient records than the Privacy Rule's floor of confidentiality protections.

***Recommended response to any investigator or government official who is seeking access to a patient's psychiatric record:*** "While I wish to cooperate, any information I might have would be confidential, so please put your request in writing and cite your authority / provide the legal basis that allows you access to the information; upon receipt of that information, I will process your request promptly." Note that if the requesting party actually is entitled to access your information, the valid legal basis for the release can generally be provided easily. Once you receive that written request with the applicable authority for the release, psychiatrists should consult with their risk manager or personal attorney.

***Never turn over the original record.*** Even when provided with a proper legal basis for the record – such as a patient's authorization for the release, only a copy of the record is to be released. This is true even if the investigator insists that the original must be disclosed.

*This article was used with permission from The Psychiatrists' Program, the APA-endorsed Psychiatrists' Professional Liability Insurance Program. The Psychiatrists' Program is committed to providing its members with excellent customer service. Program participants who wish to discuss this or other risk management issues, please contact the Risk Management Consultation Service (RMCS) helpline at (800) 527-9181 from 8:30 a.m. to 5:30 p.m. ET Monday through Friday.*

# NAMI North Carolina Offers Support in Tough Times

During a time when so many cuts are being made in the mental health community, NAMI North Carolina continues to offer natural supports that will help these individuals who have lost so many of their services.

**Connection Support Group:** A support group led by an individual living well with mental illness for individuals living with mental illness. NAMI Connection groups offer a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. Each group is run by two trained facilitators, meets for 90 minutes a week, is offered free of charge, follows a flexible structure without an educational format, does not recommend or endorse any medications or other medical therapies and are confidential - participants can share as much or as little personal information as they wish.

**Peer to Peer:** A nine week program where individuals living with mental illness can learn from one another about how to live well with their illnesses. Participants come away from the course with a binder of hand-out materials, as well as many other tangible resources: an advance directive; a "relapse prevention plan" to help identify tell-tale feelings, thoughts, behavior, or events that may warn of impending relapse and to organize for intervention; mindfulness exercises to help focus and calm thinking; and survival skills for working with providers and the general public.

**In Our Own Voice:** A weekend training that teaches individuals to present their stories of how they have coped with the effects of their illness and that recovery is possible. What better way to advocate for better services then to tell how these services have helped people living with mental illness survive across the state.

For more information on these programs, to make a referral, or to find if there is a class or program near you please contact the NAMI North Carolina office at 800-451-9682 or mail@naminc.org.

# APA Honors NCPA Members

The APA announced in December members who have been singled out for achievement as new "Distinguished Fellows" in addition to other honorees. The NCPA is proud of the significant number of our members who have been honored by the APA. If you recognize any of your colleagues listed, please take the time to congratulate them on their outstanding achievement. These members will be recognized at the NCPA Annual Meeting in October in Wrightsville Beach.

**Distinguished Fellows**
Donald T. Buckner, M.D.
George P. Corvin, M.D.

**Fellowship**
Mohammad Abu-Salha, M.D.
Moira F. Artigues, M.D.
Thomas Walter Brown, M.D., JD
John D. Hall, M.D.
James N. Kimball, M.D.
Alan Metz, M.D.
Thomas M. Penders, M.D.
Haresh Tharwani, M.D.

**Distinguished Life Fellows**
Joseph DeVeaugh-Geiss, M.D.
John J. Haggerty, M.D.
Eric W. Peterson, M.D.
Gary Peterson, M.D.
Jean G. Spaulding, M.D.
Ervin M. Thompson, M.D.

**New 50-Year Distinguished Life Fellows**
Marcelino Amaya, M.D.
Mario Perez-Reyes, M.D.
Nicholas Stratas, M.D.

**New 50-Year Life Members**
Dennis Carmichael, M.D.
Xaver Franz Hertle, M.D.

**Life Member**
Lawrence A. Champion, M.D.
Leslie M. Forman, M.D.
Arthur E. Kelley, M.D.
Praful C. Mehta, M.D.
Mary Lou Melville, M.D.
Stephen L. Oxley, M.D.
William J. Ryan, M.D.
V. Sagar Sethi, M.D.
Marshall J. Stein, M.D.
Frank W. Stevens. M.D.

# The Psychiatrist and Facebook

Nadyah Janine John, M.D., Child and Adolescent Psychiatry Fellow, Brody School of Medicine

The expansive use of the Internet for email, instant messaging, blogging forums, and picture- and video-sharing sites is beginning to pose some ethical questions for the medical professional. Facebook, one of the more popular online networking sites, has been a topic of discussion in the medical field.

On Facebook, you create a profile with personal information, messages, blogs, pictures and videos on your web page. Using the Facebook online directory (now consisting of over 350 million active users worldwide), you search for friends, family and business associates and request to "friend" them so that your web pages are now linked. Your information can then be seen by your friend. With the use of appropriate privacy settings, your information may also be shared with, or hidden from, your friends' friends or networks that you join on Facebook.

A CNN report touches on some of the controversies of physician use of Facebook.[1] For the patient who "friends" his physician, benefits can include quick answers, refills or appointments. For the physician, drawbacks may include the sense of being on-call twenty-four hours daily, poor insurance reimbursement for this service, and the potential blurring of the professional and private persona.

Society expects medical professionals to embody altruism, integrity and trustworthiness.[2,3] The private persona of a medical professional may not always exude professionalism. Before the Internet, such instances may have been forgotten with memory, shielded with the destruction of a paper picture or contained by the limited number of persons witnessing the event. On the Internet, personal information - ideas, thoughts, pictures and videos - can be shared more easily, instantaneously, and is potentially available to a much larger and possibly unintended audience. A 2008 study suggested that nearly two-thirds of medical students, as well as a growing number of residents have a personal profile and regularly use Facebook.[4] A recent study in JAMA 2009 explored the battle that medical schools are having with online posting of unprofessional content (violations of patient confidentiality, profanity, explicitly discriminatory language, depiction of intoxication and sexually suggestive material) by their medical students.[5]

Psychiatrists have historically been taught diligence about their personal information because of the potential impact on therapeutic relationships. The personal information that is typically shared with a "friend" on Facebook is just the information that professionals are taught to filter carefully from our psychotherapy patients for risk of contaminating the transference process.

In May-June of 2009, 170 psychiatrists in the state of North Carolina completed a survey about their attitudes towards online social networking sites like Facebook. Almost half (48.9%) of responders reported having an online social networking account. There was no clear difference between account holders and non-account holders with respect to their gender, their patient population (child and adolescent, adult or geriatric) or their therapeutic approach (medication management, psychotherapy, even combination of medication management or no intervention) in practice. Preliminary results showed that account holders felt that the most significant risk of having an account was patient transference. It is unclear how frequently patients had attempted to view their psychiatrist's account, but 1-in-8 account holders reported being contacted by a patient via their online social networking account.

Facebook does provide the ability to alter privacy settings for the entire account, as well as specifically for individual pieces of information. Information can be shared with only friends, certain networks or certain individuals. In the 2008 study of medical students and residents, only one third (37.5%) of accounts were made private. In this study of North Carolina psychiatrists, over 60% of account holders had "Friends Only" privacy settings, and almost 10% did not know what their settings were. Although 24.6% of non-account holders report not having an account because of the risk of patient access to their personal information, they tended to be less fearful of transference problems and more fearful of counter-transference overall. However, only 1.2% of account holders reported using their account to browse patient profiles.

New technology is not inherently dangerous. There can be benefits to online social networking sites for psychiatrists like professional networking via the AACAP Facebook page. The rapid advancements in technology and information sharing possibilities, however, insure that medical professionals will have to deal with the boundary and professionalism issues posed. Education about the potential risks and benefits, and technical choices that influence their likelihood of occurrence is a key strategy to maximize the utility of new technologies.

(**Facebook** *continued on page 11)*

(**Facebook** *continued from page 10*)

*Further information about the survey of North Carolina psychiatrists and Facebook will be reviewed and prepared for publication at a later date.*

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**When:** May 1, 2010
**Where:** Dorothea Dix Campus
**Time:** 9:00am check in - 10:00am start time

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# APA/Federal News

## Health Reform Passes!

As the *NCPA News* was going to press, the primary domestic agenda item of the Obama presidency, reform of the US health system, had passed the House and was heading for the President's signature. More information about this major change and how it will impact health care and the delivery of mental health services in North Carolina will be posted as it becomes available.

## APA 2010 Election Results

The Board of Trustees reviewed the report from the Committee of Tellers during their March meeting and accepted the results of the 2010 APA Election. The official results are posted below. More information can be found on the APA website.

**APA National Election Results**

| | |
|---|---|
| President-Elect | John Oldham, M.D. |
| Treasurer | David Fassler, M.D. |
| Secretary | Roger Peele, M.D. |
| Area 3 Trustee | Brian Crowley, M.D. |
| Area 6 Trustee | Marc David Graff, M.D. |
| MIT Trustee-Elect | Sarah Johnson, M.D. |

**APA National Elections Online Voting**

| Yr. | % Voter Turnout | Yr. | % Voter Turnout |
|---|---|---|---|
| 2010 | 31% | 2005 | 34% |
| 2009 | 31% | 2004 | 31% |
| 2008 | 31% | 2003 | 36% |
| 2007 | 29% | 2002 | 35% |
| 2006 | 32% | 2001 | 37% |

## Medicare Rate Cuts May Be Postponed Until October

In early March, the Senate approved H.R. 4213, a jobs bill that also postpones the pending 21% cut in Medicare payments to October 1, and extends a small payment increase for psychotherapy services. The House is expected to pass the bill. Congress has already approved several delays in the cut, which was otherwise to have gone into effect on January 1.

In particularly welcome news for APA members, the bill also includes a one-year extension of the temporary 5% bump in payment for psychotherapy services. The payment bump was approved as part of the "MIPPA" bill in 2008, but expired on January 1, 2010. The 5% bump would apply to calendar year 2010 services, and would be retroactive to January 1. APA lobbyists have lobbied hard for this extension, which is also included in the Senate-passed health reform bill now pending a House vote.

## How Is Parity Working?

The APA wants to know what is happening in North Carolina as federal mental health and addiction parity begins to be implemented across the nation. While provisions were intended to go into effect January 1, 2010, the federal rules had not been promulgated, leaving some issues in confusion. The final rules will go into effect July 1.

The law requires that any group health plan that covers more than 50 employees and offers mental health and/or substance use disorders coverage must provide that coverage with no greater financial requirements (that is, copays, deductibles, annual or lifetime dollar limits) or treatment limitations (number of visits) than the predominant requirements that it applies to substantially all medical/surgical benefits.

In order to inform NCPA/APA members, the APA has created a web site to monitor the implementation of parity and make certain that health insurers covered by the act are providing benefits in compliance with the law. The APA is asking NCPA members to let it know if you have any problems or concerns about a health plan's mental health coverage in relation to parity. Because of special provisions in the new rules that could be favorable to psychiatry (such as banning insurers from differentiating between mental health care and general medical and surgical care for both "quantitative" and "non-quantitative" treatment limits) psychiatrists are encouraged to report practices that are burdensome to them, such as undue prior authorization requirements, "fail-first" policies, or low reimbursement rates. APA Director of the Office of Healthcare Systems and Financing Irvin "Sam" Muszynski, J.D. raises the possibility that such practices may be addressable under the new rules.

Go to the website to learn more about the act, our state's parity law, and to report concerns and questions. The website is www.mentalhealthparitywatch.org. Information is also available by phone at (866) 882-6227.

## Consult Codes Update

The Centers for Medicare and Medicaid Services (CMS) has announced that Medicare will no longer reimburse for the outpatient and inpatient consultation codes (99241-99245 and 992510 – 99255). This does not mean that they will not pay for consultations, but rather that consultations must be reported

(**Legislative** *continued on page 13*)

using different codes.

CMS has advised physicians to use the appropriate new patient, initial hospital care or initial nursing facility care evaluation and management (E&M) code for the designated setting. What you would formerly have billed as an office consultation should now be billed as an office or other outpatient visit for the evaluation and management of a new patient (99201-99205). An inpatient consult should now be coded using the initial hospital care codes (99221-99223). A consult occurring in a nursing facility should now be coded using the initial nursing facility care codes (99304 – 99306). And, finally, any consultations done as a home service should be coded as a home visit for the evaluation and management of a new patient (99341-99345). If you have been using 90801 for your consults, you can continue to do that.

The APA is hearing concerns from members that there is no real match to the consult codes in the inpatient initial visit codes (99221-99223). While there are inpatient consult codes that provide for problem-focused histories and examinations (99251& 99252), as would be demanded by many referrals dealing with specific issues, the lowest level initial inpatient E/M code calls for a "detailed or comprehensive" history. Some Medicare contractors (MACs) are advising clinicians to use a subsequent hospital visit code (99231or 99233) when the history and examination are problem focused, while others are directing them to use code 99499 (unlisted E/M service) when this situation occurs; others have yet to provide any guidance. Currently the APA reports that Cigna, the carrier for North Carolina is specifically directing its clinicians not to bill 99499 but to bill the "appropriate" E/M code (which may prove very difficult under the circumstances). However, Palmetto, the MAC that NC is transitioning to, says to bill 99499. NCPA will be looking for more guidance from the APA in coming weeks and months.

The APA also reports that while consulting physicians are still expected to document appropriately and communicate their findings to the doctor who referred the patient to them, they are no longer obligated to provide a written report to the referring clinician, which the consultation codes require.

As with all evaluation and management services, the specific code selection should be based on the standard evaluation and management guidelines. The guidelines can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf .

It is important to note that the CPT consultation service codes are not being eliminated, it is just that CMS will no longer reimburse for these codes for Medicare patients. It is unclear if private payers will follow suit. The APA's Office of Healthcare Systems and Financing is monitoring how private insurers are responding to this new Medicare policy. Although it appears that many companies are still paying for the consult codes, several seem to be eliminating them over the next few months, and it's reasonable to believe that they will follow Medicare's direction. Please call the APA's Managed Care Help Line, 1-800-343-4671, if you have any questions. Here is the link to the complete article on the APA website: http://www.psych.org/Departments/HSF/MedicareMedicaid/2010-Consult-Codes.aspx

# What Is Your Opinion on APA's Draft Report on Ties with Industry?

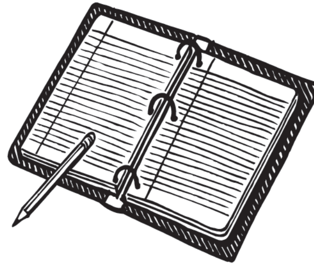
The APA Assembly will be considering a number of issues and reports at the May meeting. The NCPA Executive Council, at its meeting February 7, voted to endorse one of those reports—"Draft Report of the APA Workgroup on Relationships between Psychiatrists and the Pharmaceutical and Medical Device Industries." Council is interested in the opinions of NCPA members on this report. You can find the report at http://www.ncpsychiatry.org/members/2009%20draft%20Appelbaum%20report%20on %20relationship%20to%20industry.pdf – you will need to log into the Members' only section of the NCPA website with your APA number and password. (Call the NCPA office if you need help with this.)

Please send your comments to rhuffman@ncpsychiatry.org, so that Robin Huffman can share your opinions with NCPA's representatives to the APA Assembly—Drs. **Debra Bolick** and **Amy Ursano**.

# DSM-5 Draft Criteria Available Online

The draft criteria for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* are available online at http://www.dsm5.org. The site provides a forum to accept comment on proposed changes. Comments will be accepted through April 20. Update to the draft criteria will be made based on comments and field trials before DSM-5 is published in 2013.

# Clinical Viewpoints



**Column Editor: Sy Saeed, M.D., M.S., D.F.A.P.A.**

The *Clinical Viewpoints* is our regular column that reviews topics and viewpoints of interest to clinicians. The daily demands of clinical practice often leave little time for browsing journals and balancing viewpoints. It's our hope that this column may fill some of this gap. The column is sponsored by the North Carolina Psychiatric Association's Clinical Committee. One of the charges of the Committee is to facilitate discussion about issues of clinical significance. We hope to highlight some of these discussions in this column.

In this issue's column our focus is on the serotonin syndrome, a potentially life-threatening drug reaction that can result from therapeutic or illicit drug use, intentional overdose, or inadvertent interactions between drugs. As Dr. Wagnitz summarizes in this article, the serotonin syndrome is not an idiopathic drug reaction but a predictable effect of excess serotonergic agonism of CNS receptors and peripheral serotonergic receptors. This serotonin excess produces a spectrum of clinical findings which can range from barely perceptible to lethal. In presenting this column to our members, our objective is to alert fellow psychiatrists to the potential risks of the serotonin syndrome and the need to monitor all current medications, prescription or OTC, for potentially serious interactions.

We welcome opinions and thoughts pieces from our members and we hope to include these discussions not just in the newsletter but also in the members' section of our website.

## What is it...?

**John G. Wagnitz, M.D., D.L.F.A.P.A.**

- A disorder virtually unknown to an estimated 85% of physicians.
- In 2004, the Toxic Exposure Surveillance System reviewing cases from office-based practices, emergency rooms and in-patient facilities found significant toxic effects in 8,187 persons leading to 103 deaths.
- Although more recent data is difficult to obtain, it can be hypothesized, in our current pandemic polypharmacy prescribing environment, the incidence can only increase!

**A Review Referencing Three Articles…**

"Serotonin syndrome is a condition caused most often by the concurrent use of two or more agents that enhance synaptic serotonin levels. It is characterized by a triad of clinical changes – cognitive, neuromuscular and autonomic. Symptoms can develop within two hours of an increase in the synaptic level of serotonin." [1]

"Patients with mild manifestations may present with subacute or chronic symptoms whereas severe cases may progress to death. The serotonin syndrome is not believed to resolve spontaneously as long as precipitating agents continue to be administered." [2]

"Mental status (cognitive) changes include agitation, confusion, delirium, hallucinations, hyperactivity, hypervigilence, hypomania and pressured speech. Neuromuscular changes include hyperreflexia, increased muscle tone, restlessness, rhabdomyolysis, rigidity, shivering, spontaneous / inducible / ocular clonus, and tremor. Autonomic changes include diarrhea, mydriasis, fever, flushing, increased bowel sounds, increased respiratory rate and tearing, hypotension or hypertension and sweating. The hallmark sign for clinically significant serotonergic toxicity is considered to be clonus." [3]

**"Causative Agents:**

Serotonin syndrome most commonly occurs when a patient takes two or more drugs that affect the serotonin system through different mechanisms. Mechanisms include increased serotonin production, inhibition of serotonin reuptake, increased serotonin release, inhibition of serotonin metabolism, increased serotonin release, and stimulation of serotonin receptors. Some drugs affect serotonin through more than one mechanism.

- "Increased serotonin production: The dietary supplement l-tryptophan, a serotonin precursor has been implemented in serotonin syndrome.
- "Inhibition of serotonin reuptake: Examples include chlorpheniramine, cyclobenzaprine (Fexeril), dextromethorphan (Robitussin DM), methadone, pentazocine (Talwin), SSRI's, sibutramine (Meridia), St. John's wort (Hypericum perforatum), tramadol (Ultram, others), trazodone (Desyrel), tricyclic antidepressants, and venlafaxine.
- "Inhibition of serotonin metabolism: This category largely includes monoamine oxidase inhibitors isocarboxazid (Marplan), phenelzine (Nardil), selegiline (Eldepryl), and tranylcypromine (Parnate). Linezoid (Zyvox) and methylene blue also inhibit monoamine oxidase.
- "Increased serotonin release: Examples include dextromethorphan, meperidine, methadone, methylenedioxymethamphetamine (MDMA, ecstasy), and mirtazapine (Remeron).
- "Stimulation of serotonin receptors: Examples include

(**Clinical** *continued on page 15*)

(**Clinical** *continued from page 14*)

buspirone (Buspar), lysergic acid diethylamide (LSD), meperidine, lithium, metoclopramide (Reglan), dihydroergotamine (D.H.E. 45), and triptans (sumatriptan, etc.).

"Serotonin syndrome can also occur when the elimination of a serotonergic drug is altered. For example, some SSRIs can inhibit the metabolism of tramadol by CYP2D6 inhibition, perhaps increasing serotonergic activity." [3]

**Comments…**

In my current work environment, with EMR and electronic prescribing I am fortunate to have at my disposal a listing of all current medications being prescribed by any provider within our system. When I write a new, or renew an old, psychotropic prescription, a reminder instantly pops up if there is a known potential for interaction with another medication. Also in this delivery system, I practice in a location with two primary care providers on site who are concurrently treating most of my patients. In order to minimize potential for addiction, they are under an administrative directive to first try less addictive medications. Thus many of my patients come to me on tramadol (Ultram®) or similar analgesics. Looking up potential interactions with psychotropic medications, there is almost nothing in the pharmacopeia that can be prescribed without risk of serotonin syndrome! The primary care providers at my location have been very cooperative trying to work out alternatives but I am sure other providers have a difficult time understanding the problem even when it is called to their attention.

A few months ago I posted a question about psychiatrists' experiences with serotonin syndrome on a psychopharmacologic list serve to which I belong. Although many were aware of it, all but one minimized it as anything of concern. The one individual, however said if others had experienced seeing their patients being treated in an emergency room with the throws of that syndrome they would and should be quite concerned. (Interestingly since those comments were posted, another posting proposed the combined use of tramadol with an SSRI to "boost" serotonin for treatment of cases of treatment-resistant depression. The overwhelming response was to avoid that temptation!)

I am writing this article to alert fellow psychiatrists to the potential risks of the serotonin syndrome and the need to monitor all current medications – prescription or OTC for potentially serious interactions.

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[posted 11/10/2008]

*Dr. Wagnitz is currently working in a primary care clinic in Hamlet, NC. He recently served as the Medical Director at Sandhills Center LME. He currently Co-Chairs the Access and Health Services Committee and is a member of the MH Committee of NCMS and Past President of NCPA. He is a founding member of the American Association of Community Psychiatry.*

*Dr. Saeed is Professor and Chairman, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University and the Chief of Psychiatry at Pitt County Memorial Hospital in Greenville, North Carolina. He is the current Chair of the NCPA's Clinical Committee.*

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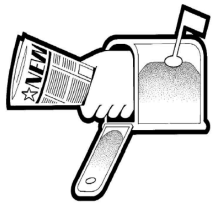

# MEMBERS IN THE NEWS

## ANNOUNCEMENTS!!

The Eye Movement Desensitization and Reprocessing International Association (EMDRIA) Board of Directors has elected **Gary Peterson, M.D., D.L.F.A.P.A.** as Secretary for 2010. EMDRIA is a 4000 member professional non-profit association for EMDR practitioners and researchers. EMDR is an information processing psychotherapy for treating many symptoms, especially those associated with trauma.

Peterson has been selected by his peers for his subspecialty expertise for "Best Doctor's in America" for 2010-11.

Peterson is the current Chair of the NCPA Technology Committee. He is a psychiatrist in private practice at the Southeast Institute in Chapel Hill.

## Meeting Notes

You are invited to a Town Hall Meeting on Mental Health, Developmental Disability, and Substance Abuse Services sponsored by The Coalition.

The Coalition will host a series of town hall meetings on MH, DD, & SA services across the state. These listening sessions will:

- Provide a briefing on the current budget cuts and future budget outlook
- Offer an opportunity to share your opinions about MHDDSA services and supports; in person, in writing, or online
- Update you on how to make a difference on these issues

**TIME:** All meetings are from 6:30 to 8:30 PM.

**DATES & LOCATIONS:**

March 30 – **Greensboro**, Guilford College, Dana Auditorium

April 13 – **Fayetteville**, Southern Regional Area Heath Education Center (SRAHEC)
1601 Owen Drive

April 19 – **Asheville**, Mountain Area Heath Education Center (MAHEC), 501 Biltmore Ave

Late April – **Durham**, TBA

Please see www.thecoalitionnc.org for updates.

**Executive Council:**
Saturday, April 24 and Sunday June 27 in the NCPA Conference Room, 10:00 am. Committee Chairs and interested members are also invited. RSVP.

**Budget Committee:**
Monday, April 12 Conference Call, 9:00 am.

**Access to Care**:
Tuesdays, April 27, May 25 & June 22 in the NCPA Conference Room, 4:00 pm, please RSVP.

**Psychiatry and Law Committee:**
Fridays, April 24 & June 4 in the NCPA Conference room, 1:00 pm, please RSVP.

NAMI Family-toFamily Education Program offers a few 12-week class series to help family members understand and support their relatives with serious mental illness. Classes are limited to 25; registration is required. Upcoming dates and locations can be found on the NAMI website at: www.naminc.org.

## NCPA Dues Deductibility Statement

NCPA dues are not deductible as a charitable contribution for federal income tax purposes, but may be partially deductible as a business expense. NCPA estimates that **6%** of your membership dues for 2009 are allocable to lobbying activities of the NCMS, and therefore are not deductible for income tax purposes.

## Membership Report

**Please welcome the following new, reinstating and transferring members.**

**New & General Members**
Jeremy Revell, M.D., Topsail Beach

**Transfer In**
Terrence Clark, M.D., Candler
Thomas Sibert, M.D., Winston-Salem
William Wheeler, M.D., Hurdle Mills
Melanie Johnson, M.D., Winston-Salem
Mehul Mankad, M.D., Durham
Ilona Csapo, M.D., Brevard
Benjamin Weinstein, M.D., Hickory

**Member-in-Training Applications**
Gregory Caudill, M.D., WFU

**Transfer Out**
Gregory Weiss, M.D., FL
Suzanne Sutherland, M.D., MI
Andrea Hawk, M.D., SC

***Keynote Speaker named...***

## Hagop Akiskal, M.D.

He will talk about "Temperament, Bipolar Spectrum, Suicidality and Creativity" in addition to a workshop on "Principles of Caring for Bipolar Patients and Their Families."

***Plan on attending the***

**2010 NCPA/NCCCAP**
**Annual Meeting & Scientific Session**
**September 30th-October 3rd**
**Holiday Inn SunSpree, Wrightsville Beach, NC**

*In addition, NCPA will be celebrating it's 75th Anniversary!!*

## EXECUTIVE COUNCIL

President ........ Stephen E. Buie, M.D., D.F.A.P.A
President-Elect ........ B. Steven Bentsen, M.D., D.F.A.P.A.
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Assembly Representative ........ Amy Ursano, M.D.
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........ Dan Johnston, M.D., Elizabeth Pekarek, M.D.
MIT Representatives ........ Nadia Charguia, M.D., William De Lay, M.D.
........ Bryan Smith, M.D., Monica Slubicki, M.D.
NCCCAP Representative ........ Mark Carroll, M.D.
NCMS Reps ........ Steven Bentsen, M.D., D.F.A.P.A.,
........ Warren Pendergast, M.D., D.F.A.P.A
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Executive Director ........ Robin B. Huffman
Membership Coordinator/Office Manager ........ Cindy Hartman
Administrative Assistant ........
Clinical Consultation Specialist ........ Karen French, R.N.

## COMMITTEES

**Constitutional Committees:**

Budget ........ Ranota Hall, M.D.
Constitution and Bylaws ........ Charles R. Vance, M.D.
Ethics ........ Diana Antonacci, M.D., D.F.A.P.A.
Fellowship ........ Elizabeth Pekarek, M.D.
Membership ........ Arthur Kelley, M.D.
Nominating. ........ Stephen I. Kramer, M.D., D.F.A.P.A.
Tellers ........ Peter Rosenquist, M.D., D.F.A.P.A.

**Other Committees:**

Access to Care Task Force ........ Margery S. Sved, M.D.
Addiction Psychiatry ........ David A. Ames, M.D.
CAMP Veterans Task Force ........ Denisse Ambler, M.D.
Clinical Committee ........ Syed Saeed, M.D.
Community and Public Psychiatry ........ Randall Purdy, M.D.
Cultural Diversity ........ John Shin, M.D.
Legislative ........ John H. Gilmore, M.D.
Practice Management ........ Yvonne L. Monroe, M.D.
2010 Program ........ Chris Aiken, M.D.
Psychiatry and Law ........ Peter N. Barboriak, M.D.
Public Affairs and Publications ........ .
Technology ........ Gary Peterson, M.D.
NCPA Representative to CIGNA/Medicare ........ James S. Williford, M.D.
NCPA Representative to State Employees & Teachers' Comprehensive Health Plan ........ Jackson A. Naftel, M.D.

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***Do you need to update your mailing address & phone? Please let us know.***

**NCPA Annual Meeting September 30 - October 3, 2010 !**

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