THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

FALL/WINTER 2012

A MESSAGE FROM THE PRESIDENT

Another Successful PSV Fall Meeting in Roanoke

W. Victor R. Vieweg, MD, DLFAPA President

Hard work by members and staff delivered an informative and entertaining meeting in Roanoke, September 21-22, 2012. Rizwan Ali, MD, our incoming president, was instrumental in finding local, regional, and statewide speakers.

The educational portion of the meeting started Saturday morning with a program moderated by Daniel P. Harrington, MD, Senior Associate Dean for the Virginia Tech Carilion School of Medicine, entitled "The Psychiatrist Joins Other Medical Providers in the Community." Colleen Kraft, MD, FAAP, Associate Professor of Pediatrics at the Virginia Tech Carilion School of Medicine and Research Institute, and Transitional Year Program Director at the Carilion Clinic in Roanoke, Virginia, discussed "The Primary Care Provider and the Psychiatrist in the Emerging Medical Home Model Community." Robert W. Johnson, MD, Psychosomatic Medicine, Inova Fairfax Hospital, and private practice in Northern Virginia who discussed "Connecting the Natural Networks." Tasks accomplished by both speakers included recognizing how behavioral health disorders affect chronic health conditions; assessing clinician comfort level as a primary care provider in screening, assessment, and treatment of behavioral health disorders; committing to incorporation of at least one behavioral health screen in your primary care practice; increasing awareness of the utility of systematically learning about their local community of health professionals; knowing about the availability of affordable tools for facilitating collaborative learning strategies to promote integrated care; and becoming aware of the possibility that their own innovative strategies in their own community may contribute to reducing barriers to care, lowering cost, and improving quality of care.



W. Victor R. Vieweg, MD, DLFAPA President

Sherif A. Meguid, MD, FRCPC, an Assistant Professor of Psychiatry at VCU, spoke about "Consultation by Psychiatrist with Other Disciplines of Medicine." Points covered included identifying issues that led to extending definition of Consultation & Liaison Psychiatry to embrace Psychosomatic Medicine; recognizing conditions and problems commonly leading other disciplines of medicine to seek help from C&L specialists; describing techniques that have been particularly helpful in this setting; and understanding approaches to avoid in this setting.

Noon lunch delivered a presentation by Dr. Harrington educating PSV members about Virginia Tech Carillion Research Institute and Virginia Tech Carillion School of Medicine. The high quality of medical students was the centerpiece of this talk.

The first afternoon session speaker was Anita Kablinger, MD, CPI, who spoke about "The Art of Psychopharmacology in the Treatment of Depression: Collaborative Opportunities including Antipsychotics" (see page 13). Points covered included differences between response, remission and recovery; prevalence of unremitted depression in the population; options for augmentation

Continued on page 5

PSV FALL MEETING REVIEWS ARE IN!

"Well organized, invaluable useful topics."

"The talks were clear and precise."

"Really wonderful conference."

SEE YOU IN 2013!

March 22-23, 2013
A Place for Psychotherapy
in Modern Psychiatry
Sheraton Park South
Richmond, VA

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Psychiatric Society of Virginia

2209 Dickens Road Richmond, VA 23230-2005 Phone: (804) 754-1200 Fax: (804) 282-0090 Email: psv@societyhq.com

www.psva.org

Letters to the editor and editorial contributions are welcome. Submissions may be sent to Jose Edwin Nieves, MD, DFAPA, or to Kathleen M. Stack, MD, DFAPA, via email at jose.e.nieves3@us.army.mil or to kathleen.stack@med.va.gov. Paid advertising is accepted on a first come, first served basis. To place your advertisement or to request a rate sheet, contact Beverly Bernard at PSV Headquarters via email at beverly@societyhq.com or by phone at (804) 565-6321.

A MESSAGE FROM THE EDITOR

UNINTENDED CONSEQUENCES: OPIATE ADDICTION

Kathleen M. Stack, MD, DFAPA



Kathleen M. Stack, MD, DFAPA

Both professional publications and the media as a whole report about the dramatic rise of prescription opiate use misuse and overdose. Excernts from the APA Dai

ate use, misuse and overdose. Excerpts from the *APA Daily* focused on the clear data showing that prescription painkiller abuse is on the rise.

Bloomberg News (6/26/12, Ostrow) reports, "Taking prescription painkillers without a medical need increased 75 percent from 2002 to 2010, and most users were men, according to the first study to look at who is likely to abuse the drugs and how often it occurs."

The UK's *Daily Mail* (6/21/12, Allen) reports that, according to research by the National Center for Health Statistics, "prescription painkillers have topped car accidents as the leading cause of accidental death in the US." According to the report, "the number of people dying from the pills has tripled since 1980, while the number of car accidents has dropped by one-and-a-half times since that year." In 2008, 41,000 Americans died from overdose while 38,000 died in road deaths. Meanwhile, "emergency department visits for prescription painkiller abuse or misuse have doubled in the last five years to nearly 500,000."

MedPage Today (6/26/12, Walsh) reports, "To see if this skyrocketing rate of fatal overdoses was accompanied by an overall increase in nonmedical use of these painkillers," researchers "analyzed data from the annual National Survey on Drug Use and Health. The analysis showed no increase in the number of people reporting any nonmedical use of prescription painkillers, or use on 1 to 200 days in the past year. But the total number of days of use rose by 35% to 612,829,084 in 2010 from 451,031,411 in 2002."

According to *Medscape* (6/26/12, Fox), the study's lead author "reports that during the study period, the rate of chronic (at least 200 days per year) nonmedical use of the drugs increased significantly (P < .05)."

There is much emphasis on the growing need for treatment, and programs for prescription monitoring. What is not in the reports above, or in others I have read, is a hypothesis of why this has happened. Certainly the causes of the dramatic increase in prescription opiate misuse are multi-factorial. There have been waves of different substances of abuse for hundreds of years.

As a physician, I could write another editorial about the "patient" who is now referred to as a "client" or "customer." As a psychiatrist, I could write about our culture view of pain. However, there is a different variable which I feel merits our attention. The increase in availability and misuse of prescription opiates seems to trail the accrediting bodies' particular emphasis on "the treatment of pain."

The idea of treating all pain based on patient report and avoiding under-treating pain is a laudable goal. The practice of treating everyone without emphasis or consideration of their history of addiction seems naïve. Concerns brought up by experts in the field were dismissed. With accreditation contingent on meeting these new standards, it became difficult for providers to do anything else.

I suspect one of the reasons for this was that the research about pain treatment excluded those who had addictions. Also, the literature on under-treatment of pain was plentiful and clear. Only in the last few months has there been guidance from a trusted source.^{1*}

Clearly it is not the goal of health care providers, hospital systems or accreditation bodies to facilitate opiate abuse. I believe it is an unintended, unanticipated, if not

Continued on page 3

A LETTER FROM PSV PRESIDENT-ELECT

Dear PSV Members.

I am honored to serve this august organization (PSV) next year as President. It has been fourteen years since I completed my residency from the MCV/ VCU psychiatry program. During that training I not only learned some of the basics of psychopharmacology but also a foundation was laid for me to be a successful psychotherapist. I cherish those moments and my teachers who taught me how to understand human suffering at a deeper level through psychodynamic formulation. Now for the last seven years I have taught psychotherapy and psychodynamic formulation at a residency program in Roanoke, affiliated with UVA and VTCSOM. I think I have the most satisfying job in the world. Prior to psychiatry I was in pediatrics and as a pediatrician, I did enough pharmacology on a daily basis. I don't know about others, but my major pull towards psychiatry was because of the possibility of dynamic understanding of my patients and helping them through psychotherapy. Applying principles of empathy, rescue fantasy, transference and counter-transference in a treatment model always intrigued me. Due to a multitude of reasons, we as a group of physicians (psychiatrists) have drifted too far toward biological psychiatry and have left psychotherapy for psychologists and social workers. Monetary reason may be one pressing cause for this shift. Is it true that if we incorporate psychotherapy in our practice we will be financially disadvantaged? What is the rightful place in modern psychiatry from psychotherapy? Has psychotherapy lost its credibility due to lack of evidence? Or are all these myths created by the insurance companies and pharmaceutical industry? In March 2013, I am proposing that we address these important questions in our Spring meeting. Title, date and place are already set which is:

A Place for Psychotherapy in Modern Psychiatry

March 22 – 23, 2013 Sheraton Park South Richmond, Virginia Aims and Objectives:

- 1. To learn about the current status of psychotherapy in modern psychiatry its rightful place.
- 2. To learn about different models of psychotherapy in treatment of different psychiatric conditions.
- 3. To learn about the progress made in psychotherapy in this evidence-based psychiatry, 100 years after its birth.

There are several conditions effecting the mind; some respond effectively with pharmacology. Numerous are either partially treated or not treated at all by the medications. This seminar is organized to understand the facts and myths related to psychotherapy. Also to educate the audience, including practicing psychiatrists, residents and medical students, the need to evaluate patients from a holistic, bio-psycho-social perspective, which seems to dissipate in the conventional modern biological psychiatry.

In general, psychiatrists are shying away from incorporating psychotherapy in their treatment plans and relying heavily on medication management of their patients. Even after 100 years of its formal structure, psychotherapy offers a tremendous promise to patients at individual, couples and group levels. Nowadays, most of the talks are pharmaceutical sponsored or driven. Rarely, as psychiatrists do we gather to talk about progress in the field of psychotherapy and its usefulness in evidence-based current modern psychiatry. This seminar will help narrow that gap and will bring these two disciplines closer for the overall betterment of our patients.

One of the ambitious goals I seek as President next year, is to make PSV financially independent through ads and other marketing strategies, so that we don't have to rely on pharmaceutical support for our events in the future. You all can help me in this daunting endeavor by placing ads or asking your friends to place ads in our newsletters, in our programs during our fall and spring meetings and on our website.

With tons of excitement for the brighter future ahead of us and with my best regards to you,

M. Rizwan Ali, MD, DFAPA President-Elect, PSV

EDITOR MESSAGE CONT.

unpredicted, consequence of desire to end unnecessary suffering. However, fear of losing accreditation, which translates roughly into "unacceptable standard of patient care," may have helped set the stage on which the current prescription epidemic is playing out. References:

- 1. SAMHSA published "Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders" in their Treatment Improvement Protocol (TIP) series. This is free and can be ordered online www.samhsa.gov TIP 54.
- * Recommend it to a colleague in surgery, pain management or primary care.



Do you need help with your practice? Or are you interested in selling an active practice and retire? This is the best way to get the word out to fellow psychiatrists. PSV produces 3 issues of the *Virginia News* yearly.

Discounted Member Rates:

- Full Page Ad: \$350 or all three for \$262 each
- Half Page Ad: \$180 or all three for \$135 each
- Quarter Page Ad: \$90 or all three for \$67 each
- Eighth Page Ad: for \$50 or \$37 for all three.

For inquiries email Beverly@societyhq.com or call (804) 565-6321.

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE CHANGES FOR 2013 FROM THE APA

For 2013 there have been major changes to the codes in the Psychiatry section of the AMA's Current Procedural Terminology – the codes that must be used for billing and documentation for all insurers. These changes apply to any services provided beginning January 1, 2013.

- A distinction has been made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791).
- The psychotherapy codes have been simplified and expanded to include time with both the patient and/or family member. There are now just three timed codes to be used for psychotherapy in all settings (90832 - 30 minutes; 90834 - 45 minutes; 90837 - 60 minutes) instead of a distinction made by setting and whether E/M services were provided. When psychotherapy is done in the same encounter as an E/M service, there are timed add-on codes for psychotherapy (indicated in CPT by the + symbol) that are to be used by psychiatrists to indicate both services were provided (90833 - 30 minutes, 90836 - 45 minutes, 90838 - 60 minutes). The time for each psychotherapy code is now described as being time spent with the patient and/or family member, a change from the previous psychotherapy code times, which denoted only time spent face-to-face with the patient.
- In lieu of the separate codes for interactive psychotherapy, there is now an add-on code for interactive complexity, which may be used when the patient encounter is made more complex by the need to involve people other than the patient (90785). This add-on can be used with initial evaluation codes (90791 and 90792), with the psychotherapy codes, with the non-family group psychotherapy code (90853), and with the E/M codes when they're used in conjunction with psychotherapy services. Although it is expected this code will be used most frequently in the treatment of children, it can be used any time the interaction with the patient and/or family member is more complex than normal or when

For more information:

Contact the APA's Office of Healthcare Systems and Financing at hsf@psych.org or call the Practice Management HelpLine at 888-343-4671

other parties must be involved. The CPT manual includes specific guidelines as to what constitutes interactive complexity that should be understood before this add-on code is used. Documentation must clearly indicate exactly what that complexity was.

- Another change is that a new code has been added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (90840). This code was developed at the behest of the National Association of Social Workers, and it is expected that psychiatrists will generally use a high level E/M code when providing care for a patient in crisis. The CPT manual has guidelines as to what constitutes a crisis and permits the use of this code.
- Code 90862 has been eliminated, and psychiatrists will now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy add-on codes should be used along with the E/M code. (A new code, add-on code 90863, has been created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is not to be used by psychiatrists or other medical mental health providers).

For more information, please visit www.psych.org and click on the link under CPT Code Changes for 2013.

USE OF ANTISEIZURE MEDS

Dakshinamurty Gullapalli, MD Assistant Professor Salem Virginia Medical Center

Antiepileptic drugs (AED) are extensively used in the treatment of psychiatric disorders. They have been traditionally developed for their use in epilepsy based on animal models of epilepsy. However, clinically they are shown to have either negative or positive psychotropic effects. Currently several AEDs are used in psychiatric disorders. Neurotransmitters in the brain, apart from their effects on epileptogenicity, also have differential effects on mood, thought process and behavior. The psychotropic effects of AEDs are likely due to their multiple mechanisms of action mediated through the neurotransmitters. Antiepileptic drugs can, to some extent, be categorized into either having "sedating" vs "activating" profiles. The sedating AEDs tend to cause sedation, weight gain, impair cognition, and also have antimanic and anxiolytic effects. They can also potentiate depression. The main neurotransmitter responsible for this profile is GABA. Hence a sedating AED may be helpful as antimanic/mood stabilizer and anxiolytic along with untoward effects of cognitive disturbances and weight gain. Most of AEDs including valproate, carbamazepine, oxcarbazepine, gabapentin, levetiracetam and benzodiazepines fall into this group. On the other hand, AEDs with activating profile, show improved fatigue, cause weight loss, and have anxiogenic and antidepressant effects. Glutamate is primarily responsible for these effects. The AEDs in this group are useful for depression and weight loss but can precipitate anxiety. Felbamate and lamotrigine belong to this group. Few of the AEDs have mixed features common to both the categories and include topiramate and zonisamide.

AEDs also received warning labels from the FDA for increased risk of suicidal ideations. It is still not clear which specific group of patients or which AEDs carry higher risk than others; at the current time, all the AEDs in patients with or without epilepsy or mood disorders are all to be considered to have increased risk.

THE PRACTICE OF PSYCHOTHERAPY IN PSYCHIATRY

J. Edwin Nieves, MD, DFAPA

I am not so old to have forgotten how long it took to develop a "psychiatric ear." You have to "listen to the content and listen to the process" to become a psychiatrist, said Dr. John Gilliam. It took countless hours of listening to patients, watching videotapes with my classmates and early morning discussions of process notes with Drs. Mike Camp and Jack Russell to learn to identify defense mechanisms, read the body language and assess the ego development of a patient. In essence, the healthier the defenses and the more ego developed your patient was, the more a candidate for more interpretative therapy he/she would be. The more primitive the defenses, the more concrete or more "supportive" the therapy or medication eligible your patient would be. This transition, to learn to "think like a psychiatrist," happens around your third year of training.

Like all clinical skills, these require constant practice to remain fresh and in your mind. Still today, when seeing one of my outpatients I mentally keep track of defense mechanisms ("there is distortion") and venture a reflection ("do you really think that everyone at Wal-Mart knows such and such..."). While taking on additional administrative duties recently, I discovered that I have not been using them as much as I should. It became harder and harder to "listen to the content and listen to the process." Looks like I am not alone.

Recent reports show that the number of psychiatrists practicing psychotherapy has declined about 20% in the last 10 years with 48% of psychiatrists responding to a recent survey saying they used psychotherapy in their practice compared to 68% in 2002. To some extent, it seems that low reimbursement and the inability of some patients to pay for psychotherapy has contributed to psychiatrists moving more toward a medication management practice model but I think there are other issues as well.1,2 The current fragmentation of mental health services and roles has, in my opinion, placed many of us in a role of performing primarily diagnostic intervention. I commented in a previous column how each allied discipline performs their own evaluation while the psychiatrist, for the most part, sticks to a biological inventory of signs and symptoms. I do not know about others but I do not like that trend. Worst, I think this is what young psychiatrists are learning.

I recall a year or two ago, while conducting a mock board examination on a senior resident of one of our training programs, that the resident knew very little about depression in that particular patient. To be sure, the resident had completed a very good review of signs and symptoms and could identify the disease entity, but knew very little about the meaning of depression in that individual. I was very disappointed that I had not done a better job in providing a

better role model. All this talk of patient centered care is old news to us in psychiatry. We have always been trained to evaluate the strengths and weaknesses of the individual, as part of our diagnostic evaluation. The result of this evaluation will tell you what kind of therapy is the most appropriate for your patient - will it be group or individual? What kind of individual? Cognitive based? Supportive? Expressive? To be sure, this is very labor intensive. It is hard work, so I can understand why some colleagues have retreated from it, especially if not compensated, but I think that this an integral part of what makes a psychiatrist.

The trend of delegating and treating with fewer psychotherapy sessions will continue unless we teach the younger generation and continue to practice psychotherapy, claiming it as a part of our clinical domain. We can use rationalization as a defense mechanism to not get involved in this but I think we should. Altruism and anticipation, as you all recall, are much more mature defense mechanisms.

References:

- 1. M. Zoler "Less Than Half Psychiatrists Surveyed Practice Psychotherapy" Clinical Psychiatric News June 2012 Vol. 40 # 6 pp 1 & 3.
- 2. "Talk Does Not Pay, So Psychiatry Turns Instead to Drug Therapy" The New York Times 3/6/2011, www.nytimes.com accessed 6/27/2012.

PRESIDENT'S MESSAGE CONT.

or combination pharmacotherapy in the treatment of depression; and matching treatment options to patient signs/symptoms and corresponding brain targets.

Dr. Meguid returned for a second presentation entitled "Using Antiseizure Medications with Other Psychotropic Agents in Psychiatry." Points covered included identifying antiseizure drugs introduced by neurology and now used by psychiatrists; identifying antiseizure drugs such as Depakote that now have FDA-approval for psychiatric use; describing differences in how neurologists

and psychiatrists use antiseizure drugs; and recognizing potential drug interactions between standard psychotropic agents and anti-seizure drugs used in psychiatry.

Dakshinamurty Gullapalli, MD, Staff Neurologist at the Salem VAMC, spoke about "Use of Antiseizure Medications in Psychiatry" (see page 4). Points covered included understanding a general overview of anticonvulsants; describing the role of anticonvulsants in psychiatry; and recognizing the side effect profile of the anticonvulsant medicalizations.

Other features of this two-day program included a Friday Board of Directors Meeting followed by a reception with area legislators and exhibitors. Psychiatry resident exhibition winners were recognized at the Saturday Noon Luncheon.

PSV is looking forward to the March 2013 Richmond Spring Meeting focusing on advances in psychotherapy for the psychiatrist. This meeting will be organized by Rizwan Ali, MD, our incoming president.



PSYCHIATRIC SOCIETY OF VIRGINIA FAIL MFFTING

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Virginia College of Osteopathic Medicine (VCOM) Students, Residents and Alumni pose with Brian Wood, DO, FAPA (right), at the Annual Fall Meeting.

VCOM STUDENTS SHARE THEIR POSITIVE EXPERIENCES

Jana MacKercher (President) and Katie Webb (Vice-President) Psych-SIGN Club Officers

The PSV Fall meeting was a great experience for the second year VCOM students who were able to attend. Not only were we able to meet VCOM alumni, but we were also given the opportunity to meet several residency advisors. These advisors were very helpful in describing their programs and offering advice as we begin to plan for boards and clinical rotations. In addition, seeing the residents with their research posters was exciting for all of us, giving us a glimpse into the work we will be starting in the next few years. It was a great way to learn more about our future profession outside of the classroom while motivating us to keep up the hard work as our studies continue.

The presentation that seemed to stick out in our minds the most was Dr. Johnson's talk, "Connecting the Natural Networks." This new approach to effective communication between providers was exciting for us, as we hope that this system will be used widely when we begin to practice. Since our class began medical school, we have used similar forums and online postings to help each other succeed in our studies, and we felt that continuing these connections in the future will not only strengthen our skills, but offer the best care for our patients.

We would like to thank PSV and Dr. Wood for inviting us to the fall meeting, and look forward to attending future meetings!

MEETING HIGHLIGHTS



From left to right: Rajdip Barman, MD; Varun Choudhary, MD; Douglas H. Chessen, MD, DLFAPA; Ram Shenoy, MD, DLFAPA and his wife, Shobha, at the Friday night reception of the Fall Meeting in Roanoke, VA.



State Senator John Edwards with Helen Montague Foster, MD, DFAPA and her husband Thomas C. Foster.



Cindy Tunney of American Professional Agency and Anne Bizzarro of Neuronetics enjoy a cocktail with John P.D. Shemo, MD, DFAPA during the Friday night reception with exhibitors.

EARLY CAREER PSYCHIATRIST

Kelly Sullivan, DO Member-at-Large to the PSV Board of Directors

This is the second segment of a column written for newly graduating residents / early career psychiatrists. Whether looking for your first position as an attending out of residency or knowing when to leave some of your early positions can be daunting tasks. In transition to practice courses, residency attendings will often cite that you should remain in a position at least two to three years to show stability to future employers, but is this common practice? Now a year out of residency, close to half of my graduating class has already switched from their first position taken after graduation or are close to considering a change. Is this disillusion? Is this change in family/life status? From professional to personal reasons, there are a number of factors contributing to this new trend of rapid turnaround. Given there is so much offered about how medical students should evaluate prospective residency programs, should there not be greater discourse about how residents should select their first employer? If one could triage potential positions, the process may not start off as broad and expansive as it first appears. A first factor that needs to be ruled out or ruled in is one individual to every physician: personal and family preference. Location preference, whether it be that one wants to reside in a growing metropolis, a suburban mixture, or a rural community will be a strong limiting step and may increase or decrease employment opportunities due to lack or presence of strong physician competition. However, just as predicting are family wishes, if the desire of one's spouse is to return to a "home" city or for children to grow up in strong school district. If one's family is discontent or a strong inner calling is ignored, no matter how good the reputation of a company or how high a salary, change will likely be on the horizon. A second factor to consider is preferred type of practice, whether it be inpatient, outpatient, or a combination of both. All outpatient positions are becoming more scarce, outside of the public health and

community sectors, and these positions may also be becoming more scarce as private hospital systems are largely offering combination positions to ensure inpatient coverage and continuity of outpatient care. A third factor is preferred system of practice, whether in private, public, or academic sectors. In private practice one may have more say about patient population served, but service bonuses and finding collegial partners may be more motivating factors, whereas service for severely mentally ill and indigent populations may be more the mindset of those working in the community. Academic sectors may provide more of a protected middle ground, but salaries may be lower and pressures to research and publish are present. A final factor is how all of these interweave and create personal satisfaction, for if the physician is not content at work, the system where work is carried out can break down and the best position to benefit our patients is lost. Whether discrepancies with health care management, long work hours, or unbalanced call structures, these factors effect physician quality of life that can turn a vocational calling into a job that one decides to leave. In summary, is it possible to balance all these factors along with your principles? The emergence of integrated health care, meaningful use, and more universal electronic health record settings are all nuances that will unite all sectors and add more nuances to these factors that drive physician satisfaction. The best counsel would be to take a personal inventory of all these factors and to find employment in line with one's values and preferences. When interviewing, there are many enticements to distract from what may be unappealing and silence about political issues and business structure that may get glossed over in the details. Given that the rule now is that most graduates will change positions every few years, take time to review these issues and to see the position in its whole, system level to practicalities.

EARLY CAREER PSYCHIATRIST DUES UPDATE FROM THE APA

We appreciate your partnership as an early career psychiatrist (ECP) of the American Psychiatric Association (APA) and your local district branch/state association. And we have good news to share about your 2013 APA Dues rates. In response to concerns voiced by the ECP leadership, the Board of Trustees recently voted to change the graduated dues structure for ECPs. The revised rates for 2013 are shown below:

REVISED 2013 Dues Rates Approved 10/2012

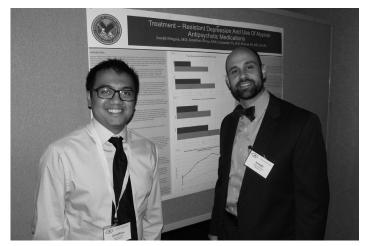
| | <u>US</u> |
|------------|-----------|
| GM Year 1 | \$105 |
| GM Year 2 | \$205 |
| GM Year 3 | \$260 |
| GM Year 4 | \$345 |
| GM Year 5 | \$430 |
| GM Year 6 | \$520 |
| GM Year 7+ | \$575 |

If you have already paid your 2013 dues at a higher rate, the difference will be credited to future dues. If you would prefer to have a refund, please call the APA to request one.

The APA is committed to providing you with timely and useful benefits that will help you make advances in your psychiatric career and your patient services.

Here are a few examples of benefits available to you as a member:

- New benefit for ECPs! Free FOCUS Journal Online (savings of \$308) a comprehensive review of current clinical practice based on the content outlined by the ABPN recertification exam. Call APA to start your subscription for 2013 (1-888-357-7924).
- Free subscriptions to The American Journal of Psychiatry, Psychiatric News, and the new Psychiatric News Alerts daily postings on breaking news of interest to psychiatrists.
- Earn CME credit and fulfill MOC Part 4 requirements by participating in free Performance in Practice (PIP) Physician Practice Assessment Tools (free for members, \$399 for non-members).



Joseph Mingoia, MD & Jonathan Olivas, MD from Virginia Tech Carilion School of Medicine with their First Place poster "A Review of Atypical Antipsychotics and their use in the Augmentation of Treatment Resistant Depression."

2012 Fall Meeting Poster Winners

FIRST PLACE:

A Review of Atypical Antipsychotics and their use in the Augmentation of Treatment Resistant Depression

Joseph T. Mingoia, MD; Jonathan C. Olivas, MD; and Rizwan Ali, MD

ABSTRACT:

Until recently, lithium has been the most well researched augmentation agent for unipolar major depressive disorder without psychosis. A variety of alternative methods have been identified. Atypical antipsychotic agents were first recognized as augmentation agents in treatment refractory depression in 1999. Recent investigative thrusts involving atypical antipsychotic agents have resulted in a growing amount of data that bolster earlier findings of their ability not only to augment treatment refractory depression but also to elicit a more rapid onset of action and sustained treatment duration. The advent of a new era has begun and in this review new treatments that have been approved by the FDA in treatment refractory depression are described.

SECOND PLACE:

Telepsychiatry in the Emergency Department: Improving Access and Increasing Efficiency in the Care of Psychiatric Patients

AUTHOR:

Mark D. Kilgus, MD, PhD

Chair, Department of Psychiatry and Behavioral Medicine Carilion Clinic, Virginia Tech Carilion School of Medicine

THIRD PLACE:

Nicotine Replacement Treatment in Patients with Comorbid Medical or Psychiatric Problems During Substance Use Rehabilitation

AUTHORS:

Stephanie Peglow, DO & Kathleen P. Decker, MD, Hampton VAMC, Eastern Virginia Medical School

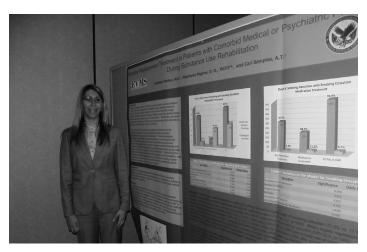
THIRD PLACE:

Hepatitis C in Recovering Opiate Addicts Jennifer Smith, MD; Ashley Ertel, MSW; Antony Fernandez, MD; Akm Sulaman, MD

MEETING HIGHLIGHTS



Rick Seidel, MD presenting on behalf of Second Place poster winner, Mark D. Kilgus, MD, PhD.



Stephanie Peglow, DO, with EVMS tied for Third Place with her poster titled "Nicotine Replacement Treatment in Patients with Comorbid Medical or Psychiatric Problems During Substance Use Rehabilitation."



Jennifer Smith, MD, with VCU Health Systems, Tied for Third Place with her poster "Hepatitis C in Recovering Opiate Addicts."

AN UPDATE ON THE DEPARTMENT OF JUSTICE SETTLEMENT AGREEMENT

Adam T. Kaul, MD, FAPA PSV Past President

As many of us are aware, on August 23rd this year, Judge Gibney approved and



Adam T. Kaul, MD, FAPA PSV Past President

entered a revised settlement agreement regarding the Department of Justice and the Commonwealth of Virginia. This agreement notes that the Commonwealth will provide additional waiver slots for individuals with intellectual disabilities. It also notes that, per Virginia Code § 37.2-837(A)(3), the settlement agreement does not require closure of the Training Centers, and that individuals will have a right to remain at a Training Center, if their authorized representative choses. Per Commissioner James Stewart, in a letter dated September 27, 2012, to individuals residing in Training Centers and their authorized representatives, the Commonwealth continues its plan to close four Training Centers, beginning with Southside Virginia Training Center by June 30, 2014. Northern Virginia Training Center will close by June 2015, and Southwestern Virginia and Central Virginia Training Centers will close by June Of 2018 and 2020, respectively. Commissioner Stewart also writes that "if after all attempts to engage an individual and his or her authorized representative in discharge planning are not successful, and a community home is not chosen, individuals residing in a training center that is scheduled for closure will be transferred to another state-operated training center within three months prior

to the training center closure date."

DBHDS and area CSB's are preparing for these pending closures as they will represent a significant shift in delivery of care and safety nets for the community. An increase in private and public resources will need to be identified and implemented, at every level of care from routine to crisis treatment, in all areas of medical and ancillary supports for these individuals.

DBHDS has a page on its website which describes the agreement and outlines many of the areas of need regarding resources and planning for the pending transitions. It can be found at www.dbhds.virginia.gov/settlement.htm.

> Feel free to email questions or comments to Dr. Kaul at: atkaul@hotmail.com

WELCOME TO OUR NEW MEMBERS

| DISTINGUISHED FELLOW | Tora Tany | | |
|---------------------------------------|--|--|--|
| Kenneth Miller, MDPortsmouth, VA | Zees Anth | | |
| DISTINGUISHED LIFE FELLOW | | | |
| Miriam Koller Pizzani, MDRichmond, VA | Inna Nori | | |
| FELLOW Adı Tro | | | |
| Donna Carmosky, MD | Moh Jose Gun | | |
| GENERAL MEMBER SI | | | |
| Alfredo Cervantes, MD | Nao Matt Suln Sher Shar Loui Will Nish Niki Utta Ubh | | |
| MEMBER IN TRAINING | | | |
| Andrew Alkis, MD | Ann Jenn Tina Sara Zia Ifeyi Micl Chri | | |

| Toral Desai, MBBS | Charlottesville, VA |
|--------------------------|---------------------|
| Tanya Dutta, MD | Richmond, VA |
| Zeeshan Farugui, MD | Richmond, VA |
| Anthony Forgey, MD | Charlottesville, VA |
| David Freeman, MD | |
| Inna Garber, MD | |
| Norrieve Gibson, MD | |
| Jennifer Gomberg, DO | |
| Adreanne Gringas, MD | Charlottesville, VA |
| Troy Hoff, PhD | Richmond, VA |
| Mohammad Huzaffar, MD | Richmond, VA |
| Josepha Iluonakhamhe, MD | Charlottesville, VA |
| Gunit Kaur, MD | Glen Allen, VA |
| Sharad Koirala, MBBS | Richmond, VA |
| David Lekberg, Jr., MD | Richmond, VA |
| Naomi Lian, MD | Roanoke, VA |
| Matthew McEachern, MD | Charlottesville, VA |
| Sulman Mirza, MD | |
| Sherin Moideen, MD | Richmond, VA |
| Shameem Momin, MD | |
| Louis Nardelli, DO | |
| William Oetgen, MD | Charlottesville, VA |
| Nishant Parikh, MD | |
| Nikita Patel, MD | Norfolk VA |
| Uttam Raheja, MD | Ashburn VA |
| Ubha Rayamajhi, MD, MPH | Norfolk VA |
| Kimberly Reese, MD | Richmond VA |
| Anne Richardson, MD | Richmond VA |
| Jennifer Smith, MD | |
| Tina Thakrar, MD | |
| Sarah Thayil, MD | |
| Zia Uddin, MD | |
| Ifeyinwa Utah, MBBS | |
| Michael Vallania, MD | |
| Christine Whitehead, MD | |
| Christine Willeneau, WiD | |



J. Edwin Nieves, MD, DFAPA and James Krag, MD, DFAPA Past Presidents of PSV

The Foundation is the PSV's tax-exempt 501(c)3 organization. For many years Drs. Doug Chessen and Stan Jennings led and promoted the Foundation. Their contributions and devotion to causes of interest to the Psychiatric Society of Virginia, will be hard to emulate. We are happy to announce that at a Foundation virtual meeting on October 30, 2012, Dr. Ram Shenoy agreed to be the Foundation President for the next three years. During this meeting, we discussed the importance of enlisting PSV membership contributions to the Foundation. Foundation contributions are tax deductible and members are encouraged to contribute no matter the amount. The importance of foundation financial transparency was also discussed, and President Dr. Ali suggested that Foundation financial statements become part of our board standard reports. In addition, Dr. Rizwan Ali asked that PSV Foundation Bylaws, returns and other relevant information be made public on our website. These suggestions were welcomed by all members and adopted.

In recent years, one of the main areas of support for the Foundation has been the psychiatric residents' participation and research efforts. We intend to continue and expand that support in coming years.

Dr. Shenoy has been a proponent of suicide prevention for many years and during his tenure as our Foundation President he will be putting particular focus on how the Foundation may better promote suicide prevention and awareness. With that in mind, the PSV will have a "Call for Posters" for the 2013 Annual Fall Meeting centered on this item. Suggested topics for submissions include:

- Literature review
- Prevention
- Co-morbid conditions
- Patient and Family Education
- Other relevant areas related to this important aspect in mental health

Dr. Shenoy and the Foundation Board are also looking at ways to help retiring physicians make use of the tax-deductible nature of the Foundation to lessen their tax burden at age 70.5 as they are required to disperse 401K savings. And for all PSV members the Foundation can become a regular way to give back within our own community of psychiatrists. We ask all PSV members to be regular annual contributors to the Foundation.

Other active Foundation Board members are Doug Chessen, MD, J. Edwin Nieves, MD, Rizwan Ali, MD, and Adam Kaul, MD

The PSV Foundation will have a breakfast table at the Annual Spring Meeting, March 23, 2013. All interested members are encouraged to join us for breakfast.



Mira Signer, MSW Executive Director National Alliance on Mental Illness (NAMI) Virginia

Are you passionate about supporting people with mental illness and their families? Do you want to make a difference in your community and in Virginia? Consider serving on the Board of Directors for NAMI Virginia, the state office of the National Alliance on Mental Illness.

Each year the NAMI Virginia Board of Directors Nominating Committee seeks nominations of qualified individuals to serve on its Board of Directors. NAMI Virginia's mission is to promote recovery and improve the quality of life of Virginians with mental illness through support, education, and advocacy. Board members are responsible for governance and financial stewardship, as well as representing and advocating for the mission, goals, and programs of NAMI Virginia. Board members are responsible for advising, governing, overseeing policy and direction, and assisting with the leadership and general promotion of NAMI Virginia, so as to support the organization's mission and needs.

Each year there are approximately three to five vacancies for the Board. The length of one term for a board member is three years, commencing at the Annual Meeting. Self-nominations are acceptable. Nominations received will be reviewed by the Nominating Committee and then a proposed slate of nominees is forwarded to the membership for consideration. As a grass-roots organization, our members vote on candidates to fulfil the Board vacancies. Deadlines and the nomination form are not yet available, but as soon as they are, they will be published on our website (www.namivirginia.org) and circulated widely to members and partnering organizations such as the Psychiatric Society of Virginia.

NAMI Virginia seeks a diverse mix of committed candidates. It is preferable for nominees to have personal experience with mental illness, either as a person in recovery, or due to a family member or loved one who has experienced mental illness, or a professional in the field. Familiarity with NAMI, our programs, and public policies is beneficial. It is critical for nominees to have an interest in mental health issues in general, as well as compassion for the experiences that people with mental illness face. It is expected that all Board members be members of NAMI. You can join by going to www.nami.org/join; there is a 100% giving policy on the Board. The Board of Directors has identified several areas of specific need that would benefit the Board in better carrying out their responsibilities including finance; fundraising and development; and public relations and marketing.

When the deadline to submit nominations becomes available we will alert our friends at PSV. In the meantime, please consider whether you or someone you know would be a good candidate for the NAMI Virginia Board of Directors.

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Advanced Telepsychiatry (ATP), a Roanoke, VA based psychiatric/telepsychiatric practice, is currently seeking Board Certified or eligible Adult and Child psychiatrists for exciting full-time and part-time telepsychiatry positions. Preference is given to those holding a VA license. Candidates holding a license in a neighboring state are also encouraged to apply.

ATP telepsychiatrists have the option of working from home, following a brief training period in our new medical office. Our outstanding management and support staff allows our psychiatrists to focus on what is most important: patient care. ATP offers all the benefits and camaraderie of working in a large company setting, combined with the financial rewards of private psychiatric practice.

Employment benefits at ATP include:

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ATP is willing to sponsor H1 for eligible candidates.

For immediate consideration, please email your CV and 3 references to info@atpsych.com

VCU DEPARTMENT OF PSYCHIATRY UPDATE

Joel J. Silverman, MD, DLFAPA James Asa Shield, Jr., MD, *Professor and Chair*

I am delighted to announce that Dr. Gerald Moeller, Professor of Psychiatry at the University of Texas in Houston, will be joining our Department of Psychiatry as Chair of Addictions early next spring. Dr. Moeller is an expert in fMRI brain imaging of Addictions. He will be continuing this outstanding research at VCU. We hope he will be bringing a number of his colleagues with him to add greater strength to our Addictions Division and to addictions education, research and treatment at the University and in the region.

We welcome Dr. Moeller, his wife, Melissa and two children and look forward to a long and productive association with them.

Dr. Michael Rao, President of Virginia Commonwealth University, recently hosted his first Presidential Symposium. We were thrilled that he chose Children's Mental Health as his topic. Drs. Ken Winters, Peter Jensen and Patrick Tolan joined us in exploring the subject, "Unraveling the Mystery of Children's Mental Health: From Brains to Behavior." This event was attended by over 225 childhood specialists and families from Virginia. Most encouraging was Dr. Rao's talk on the importance of psychiatry to the community, to the University, to research and to our patients across the Commonwealth. It is wonderful to have a highly supportive University President. Drs. Leslie Kimball-Franck, Julie Linker, Ross Yaple and Robert Cohen lead the breakout workshops with Tess Searls, RN, Vivian Mann, LCSW and Sue Geller, MA.

Drs. Jim Levenson, Ananda Pandurangi and I have just returned from our annual teaching collaboration with our colleagues at the Post Graduate Institute of Medical Education and Research in Chandigarh, India. We had a great collaboration with our colleagues providing psychiatric education to medical students and faculty at Baba Farid University of Health Sciences, Faridkot, Punjab and Government Medical College in Chandigarh. In addition, we facilitated work around medical education with the faculties of all these institutions.

We are delighted that one of our faculty, Dr. Joel Moran, is President of the Richmond Psychiatric Society. Members of our clinical faculty were also elected to all positions within the organization and include: Drs. Elliott Spanier (President-Elect), Mimi Pizzani (Secretary), David Markowitz (Treasurer) and Lynne Foreman and Sherman Master (Counselors).

Our department was pleased to be involved in the recent NAMI Walk where significant support was raised to advance psychiatric research. Our department's t-shirt was designed by resident David Freeman and won Second Place in the t-shirt contest.

We are celebrating the 50th year of the Virginia Treatment Center for Children and will soon be celebrating the 100th birthday of the Department of Psychiatry at VCU. We deeply appreciate all of the support we receive from our colleagues and the community.

THE ART OF PHARMACOLOGY IN TREATING DEPRESSION

Anita S. Kablinger, MD, CPI Professor and Residency Training Director Department of Psychiatry and Behavioral Medicine Carilion Clinic-Virginia Tech Carilion School of Medicine

Depressive disorders are common and, unfortunately, account for a significant proportion of disability among the population. There are multiple diagnoses that a psychiatrist should consider when evaluating a patient with depression including Major Depressive Disorder, Bipolar Disorder, Depression Secondary to a General Medical Condition, Substance-Induced Depression and Dysthymia. It is important to develop a working hypothesis as well as a differential to ensure the right course of treatment and appropriate goal for recovery. These different illnesses require specific treatment options and have differing prognostic outcomes. If the first course of treatment implemented is ineffective or does not lead to remission, it may be that a misdiagnosis has occurred rather than the development of treatment-resistance. For example, there is a high rate of misdiagnosis in Bipolar Depression (about 35%) and patients treated for MDD instead, often resulting in symptoms lasting for approximately 10 years before the correct diagnosis and treatment are initiated.

Identifying subtypes of depression is also important for the appropriate selection of pharmacological agents. Postpartum-onset, atypical depression, melancholia and delusional features all predict different courses of illness and may respond preferentially to certain pharmacological agents. Medical conditions often implicated in the etiology of depression include endocrine disorders such as hypothyroidism or Cushing's disease and nutritional impairments like B12, folate or vitamin D deficiencies. Depression is also very common in those with chronic pain, diabetes and cardiac disease. Alcohol, sedatives and other prescription medications may contribute to mood problems and temporal history of moods and medications is warranted.

The goal of treating those with



Anita S. Kablinger, MD, CPI

depression is complete remission and recovery. Many treatments were FDA-approved based on leading to a 50% reduction in symptoms, referred to "response." Remission requires a complete resolution of symptoms and resuming normal functioning. This latter outcome often requires weeks or months and once achieved is known as recovery. Aggressive pharmacological management is imperative for achieving remission and recovery but is frequently not used in the primary care environment where most patients with depression are seen and treated. The following terminology may be helpful as you evaluate and monitor patients with depression:

Non-response: <50% decrease in HAM-D (Hamilton depression scale) Response: Good enough response that a change in treatment is not necessary Remission: Two consecutive asymptomatic months (HAM-D <7) Recovery: >Six months remission Treatment-resistant: partial response to treatment Treatment-refractory: no response to treatment; symptoms unchanged or

An extensive pharmacological evaluation must include discussion of the following: duration and dose of medications used in the past or for the current episode, adverse events or sensitivity of

the patient to past medications, the effect of the medications on symptoms and the patient's perception of the medication (which influences potential response). There are multiple models of treatment resistance or refractoriness in treating depression but, in general, the psychiatrist should consider adequate trials of an SSRI or SNRI first followed by potential treatments with a TCA or atypical antidepressant (mirtazapine, bupropion, trazodone). The most common reasons for lack of remission include nonadherence to medications, inadequate duration (should be six to eight weeks total) and not titrating to the maximum dose. Patients may be very sensitive to medications (perhaps slow 2D6 metabolizers) or require "the kitchen sink" approach to get better (perhaps extensive metabolizers or genetic predisposition).

Approximately one-third of patients do not respond to initial antidepressant treatment regimens and as much as one-third of depressed people become treatment-resistant. The STAR-D study is an important classical trial for all psychiatrists to read, illustrating that many patients require methodical and sequential trials of different antidepressant classes before success is achieved. It also demonstrates that combinations of medications (two antidepressants with differing mechanisms of action) or augmenting agents (medications that are not antidepressants alone but boost the effect of antidepressants) may be necessary. Consider combinations of SSRI with bupropion or mirtazapine with an SNRI, thus attending to all the potentially important neurotransmitters involved in depression. Augmenting agents including atypical antispsychotics, lithium, T3 or m-folate are also good choices for your armamentarium depending on patient profiles, co-morbid medical issues and family history. As the teaching goes, "go big or stay at home" - aggressive treatments should be the normal approach to treating depression and longitudinal care is the way to achieve success with your difficult patients!

worse



IN THE NEWS

PRESCRIPTION DRUG ABUSE FORUM – A LOCAL SUCCESS!

Carolyn McKann

Deputy Director for the Virginia Prescription Monitoring Program

Substance Abuse Free Environment, Inc. (SAFE), a community coalition that addresses youth tobacco, alcohol and other drug use in Chesterfield County, Virginia, sponsored a prescription drug abuse forum on Saturday, September 22, 2012 at John Tyler Community College's Chester campus. The Psychiatric Society of Virginia provided breakfast for the forum, which was attended by approximately 130 healthcare professionals, primarily prescribers and pharmacists.

The forum featured five speakers covering all areas of the substance abuse problem, including outpatient management of opiate dependence and the pathophysiology of addiction. Attendees heard from state law enforcement who gave an overview of abuse and arrest trends in the Chesterfield area, and from a local attorney who specializes in defending prescribers who have found themselves having to defend their actions and/or practice patterns before the Board of Medicine. The Virginia Prescription Monitoring Program (PMP) concluded the forum with an overview of the PMP and how to use it as a resource in clinical practice.

The need for such forums has been well established, as the CDC states that prescription drug abuse now causes more deaths in the United States than abuse of cocaine and heroin combined. Studies also show that young people who first misuse a prescription drug usually obtain the substance free from a friend or relative's home medicine cabinet. The DEA, in conjunction with local law enforcement agencies, has held five National Drug Take-Back Days which have been hugely successful, collecting from 121 to 276 tons of unwanted prescription drugs nationwide at each event. Saturday's forum furthered SAFE's mission of engaging the community to work together to prevent substance abuse. SAFE is extremely grateful for the support offered by the Psychiatric Society of Virginia!

EASTERN VIRGINIA MEDICAL SCHOOL

Stephanie L. Peglow, DO Member-in-Training to the PSV Board of Directors

Eastern Virginia Medical School Residents and Students were excited about carpooling to Roanoke, Virginia for the Fall Conference of the Psychiatric Society of Virginia. With most of us in one car and the posters in the other we set off with only minor barriers including dragging road debris and a general lack of coffee. Our MSIV Erik Johnson made us proud, presenting his poster "Refractory Schizo-Obsessive Disorder Responsive to Electroconvulsive Therapy" based on a patient he observed on his MSIII psychiatry rotation. Bill Lemley presented "Use of Smartphone Apps in Teaching Medical Students," doing an excellent job presenting his first poster. Stephanie Peglow presented "Nicotine Replacement Treatment in Patients with Comorbid Medical or Psychiatric Problems During Substance Use Rehabilitation." We were honored to be supported by PGY3's Ubha Rayamajhi and Purnima Gorrepatti who attended the meeting as well.



UPCOMING EVENT

Christine J. Truman, MD

The Tidewater Perinatal Mental Health Consortium is dedicated to ensuring all new mothers receive information about perinatal mood and anxiety disorders, as well as establishing a support group at every Virginia birthing hospital. The Consortium fully supports these goals.

In an effort to continue to improve knowledge regarding recognition, diagnostic and treatment strategies, and provision of social support for women with perinatal mood and anxiety

disorders (PMAD) in the Tidewater/Hampton Roads area, the Second Annual Mental Health in Pregnancy and Beyond Conference will be held on February 1, 2013, at the Hampton Roads Convention Center. This one-day conference features plenary and break out sessions given by speakers at the forefront of the field including faculty from Johns Hopkins University, Virginia Commonwealth University, and the University of North Carolina. Please visit www.MHpregnancy.org or www.postpartumVA.org for a full conference agenda.

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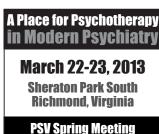
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LEGISLATIVE UPDATE

The Psychiatric Society of Virginia government relations team continues to work on an array of issues that include support for a Medicaid reimbursement increase (3% and inflation factor) and opposing licensure of naturopaths, as well as monitoring of unknown scope of practice issues.

PSV representatives are also currently working closely with the Virginia College of Emergency Physicians (VACEP) on screening/clearance "medical guidelines" for professionals and facilities. Both PSV and VACEP are outlining protocols to ensure physician-to-physician communication when disagreements occur between emergency departments and receiving psychiatric facilities. Finally, the

Virginia Department of Behavioral Health and Disability Services continues to work to comply with the DOJ settlement. This includes the closing of four state training centers by 2020. The cost of placing patients into community settings is expected to be a budget concern during the upcoming General Assembly.

The Medical Society of Virginia's Annual Meeting took place from Thursday, November 1 to Sunday November 4 in Williamsburg. PSV President-Elect M. Rizwan Ali, MD

(Roanoke) attended as PSV Delegate. Ralston King and Cal Whitehead (PSV Government Relations) also attended. MSV's House of Delegates met for final approval and endorsement of new policies.

Please SAVE THE DATE for PSV's White Coats on Call on Tuesday, January 29, 2013. White Coats on Call is hosted by the Medical Society of Virginia for the Commonwealth's physicians to come to Richmond during the General Assembly Session and

advocate on broad health care issues and specialty-specific matters. Lunch will be provided and we encourage all those able to attend, even if you are only able to join for half a day.

