

# THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

WINTER 2008



James L. Krag, MD, FAPA  
PSV President

## ONE PRESCRIPTION AT A TIME

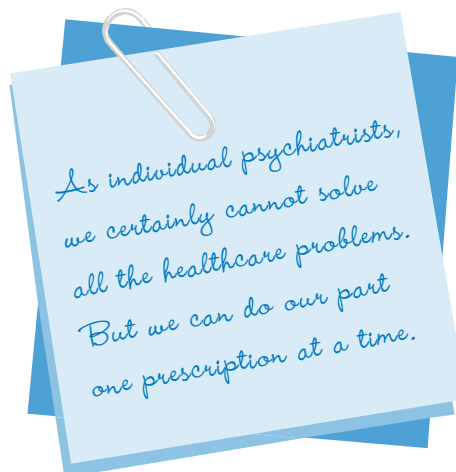
In this time of troubled finances and predictable cutbacks, we can expect to see more headlines like this one from a recent Associated Press article: Rising Cost of Medicaid Program Expected to Continue Upward." Medicaid's growing strain on federal and state budgets is unlikely to abate over the coming decade. But this is not unique to Medicaid. Costs of every form of health coverage have increased rapidly. This type of spending is unsustainable.

Healthcare has been one of the biggest issues of the 2008 presidential election. Even before there is a change in our national healthcare system, it is increasingly imperative that we as caregivers help alleviate at least some of the problems in the healthcare system by prescribing in a cost effective manner. Psychiatric medication is consistently a large portion of the cost in any insurance program. In 2002, olanzapine, risperidone and quetiapine were the first, second and fifth most costly of all 1,900 covered drugs for California's Medicaid program. When you write a prescription, how often do you think about the comparative cost of that medication? For some psychiatrists, it is anathema to consider cost when prescribing. The mere suggestion by a managed care company that we do so often brings psychiatric howls of protest. But why should it? Rather than complaining about restrictions on prescribing, we should be leading the way toward cost effective prescribing.

In our own households or offices, don't we consider cost when buying computers, cars or insurance policies?

If we are not cost conscious, we could become bankrupt due to overspending. And that is what our health care policies are facing.

As individual psychiatrists, we certainly cannot solve all the healthcare problems. But we can do our part one prescription at a time. For example, if we are seeing a person with depression, who for the first time needs an antidepressant, why would we not first prescribe a generic medication? A month's supply of fluoxetine 20 mg, paroxetine 20 mg, or citalopram 20 mg costs \$4, while Effexor 150 mg #30 costs about \$150 and Lexapro 10 mg #30 costs about \$100.



As we know, second-generation antipsychotics are among the most expensive medications to treat illness. (Risperidone (generic) 4 mg #30 costs \$355; Abilify 10 mg #30 costs \$460; and Seroquel 200 mg #60 costs \$515). And as expensive as these medications are by themselves, when used in combination, the monthly costs skyrocket. A recent article in BMC Psychiatry (Vol. 8, 2008) titled, "Cost of Antipsychotic Polypharmacy in the Treatment of Schizophrenia," states: "Despite consis-

## INSIDE THIS ISSUE

Message from the Editor .....	2
Depression NOS .....	3
In the News .....	4
APA Institute Report .....	5
"Heroes in the Fight" Awards .....	5
Fall Meeting Review & Poster Session Winners .....	6
Area V Council Meeting .....	7
Preserving the Cap—MSV .....	8
PSV Golf Gets Cooperative .....	8
Council on Minority Mental Health & Health Disparities .....	10
APA Assembly Report .....	11
APA Committee on Managed Care ..	13
Challenges of the 24/14 Initiative .....	14
Fall 2008 MSV Meeting Report .....	16

tent recommendations of antipsychotic monotherapy, antipsychotic polypharmacy is commonplace in the treatment of schizophrenia. The concomitant use of two or more antipsychotics has been reported to range between 13 and 60 percent, depending on the population studied, the year the study was conducted, the study method, the type of treatment site, and the duration of the study period. Our recent study using data from an observational noninterventional study found that over a one-year study period, only a third of the schizophrenia patients were treated predominantly with antipsychotic monotherapy, whereas 58 percent of schizophrenia patients had at least one period of antipsychotic polypharmacy lasting longer than 60 consecutive days." The Texas Medication Algorithm Project recommends at least

Continued on page 3

**President**

James L. Krag, MD, FAPA

**President-Elect**

Jose Edwin Nieves, MD, FAPA

**Secretary**

M. Rizwan Ali, MD

**Treasurer**

Adam T. Kaul, MD

**Newsletter Editors**

Jose Edwin Nieves, MD, FAPA

Kathleen Stack, MD, DFAPA

**Executive Directors**

Stewart A. Hinckley, CMP

Heather A. Spiess

**Association Manager**

Andrew Mann

**Membership Manager**

Kim Battle

**Financial Services**

David Vereen

**Director of Meetings & Conventions**

Kevin F. Johns, CMP, CAE

**Director of Information Technology**

Daniel Gainyard

**Manager of Corporate**

**& Educational Support**

Matt Van Wie

**Graphic Design & Publications**

Beverly V. Bernard



**Psychiatric Society  
of Virginia**

2209 Dickens Road  
 Richmond, VA 23230-2005

Phone: (804) 754-1200

Fax: (804) 282-0090

Email: psva@psva.org

[www.psva.org](http://www.psva.org)

Letters to the editor and editorial contributions are welcome. Submissions may be sent to Jose Edwin Nieves, MD, FAPA, or to Kathleen Stack, MD, FAPA, via email at jose.nieves@med.va.gov 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

## Knowledge and Responsibility

By Kathleen Stack, MD, DFAPA



Kathleen Stack, MD

Two different, but related, issues have been in the media recently which call our profession to examine current practices. One is related to funding, outcomes and publication of medication research, and the other is financial relationships between psychiatrists and pharmaceutical manufacturers.

In September, I saw the messages from Dr. Stotland, president of the APA, about the APA providing all requested information on financial dealings with pharmaceutical manufacturers for Senator Grassley. I agree with the idea of financial transparency, as it promotes fiscal responsibility in any institution. I admit I had not realized it was not already public information.

While I attended the Institute of Psychiatric Services in October, I had time to read the *Wall Street Journal* and the *New York Times*. Both carried articles of high profile psychiatrists who had reportedly not paid taxes or disclosed income earned as consultants, and owned large amounts of stocks in a pharmaceutical company. Those cited in the articles had earned or generated several hundred thousand to millions of dollars.

More recently I read the following:

In a letter to the editor of the *New York Times* (October 21, 2008), APA president Nada L. Stotland, MD, wrote that the *Times'* "Oct. 11 editorial, 'Drugs and Disclosure,' expressed fear that the integrity of medical research is being threatened by conflicts of interest and the manipulation of scientific data." According to Dr. Stotland, the APA shares the *Times'* "concerns and supports full disclosure and transparency." Dr. Stotland pointed out that "psychiatrists and patients have struggled with stigma for millennia." Yet, less than a month ago, "Congress approved, and President Bush signed, a landmark bill requiring coverage for care for mental disorders to be on a par with other medical conditions. It would be a tragedy if the possible misdeeds of a few were to undermine this historic achievement," Dr. Stotland concluded.

I, of course, agree with Dr. Stotland, as do all of us. However, I wonder if the way research, researchers and institutions are funded may be a part of the problem. I am no expert in this area, but my basic understanding is that academic institutions usually require researchers in psychiatry to obtain grants or funding for their research projects. Part of all of the researcher's salary and the salary of study coordinators and staff working on the project are dependent on these funds. Grants may or may not be awarded, but investigation of medications supported by pharmaceutical companies could be a more steady funding resource than grants. I would speculate that institutional practices would include taking a portion of the funding for overhead, administrative support, infrastructure, etc. In other words, if they are "successful" in bringing in funds, responsibility and expectation of continuing to be able to do so are likely to increase. The continued employment of those you supervise and the status and income of the researcher, their superiors and institution may be dependent, in part, on the ability to continue to generate revenue. These series of compromises may lead to a conflict of interest.

Now, if the results of the drug study are equivocal and the decision is to stop the study early, are those preliminary results even publishable? Do you refuse to accept funds for the next two to three years to continue using a new design or a

*Continued on page 13*

# DEPRESSION NOS, ANYONE?

By Elizabeth Kamin, MD

I first became fascinated by the field of psychiatry as a curious teenager browsing through my father's books on Freudian theory. I found the idea of an unconscious world of drives and motives both eerie and compelling. Indeed, most of us are initially drawn into psychiatry by this same lure. Then, during our training we began to study and memorize symptom-based diagnostic criteria so that we may have a practical means by which to classify and treat our patients. But have we become so immersed in this diagnostic quagmire that we are losing hold of our roots?

Freud first used the term "neurosis" to represent emotional, behavioral, and physical ways in which unconscious conflict is expressed. This term was officially eliminated as a diagnostic category from the DSM III under the leadership of Dr. Robert Spitzer. The DSM task force felt that psychodynamic terms were vague and implied an etiology that could not be scientifically verified. They instead implemented a categorical, multi-axial system based on reportable symptoms to improve and standardize psychiatric diagnosis. While this system may serve its intended purpose, it does not fare quite as well when used as a tool for conceptualizing patients or teaching future psychiatrists.

I have many opportunities to interact with medical students on their psychiatry rotations. As part of my teaching, I often question them about their diagnostic understanding of a patient we have just seen. The students will attempt to integrate memorized diagnostic criteria with what they have observed in order to conceptualize the patient. This usually culminates in a confused expression, and a question such as, "What, again,

is schizoaffective disorder?" I then explain the patient's symptoms in dynamic terms of ego strengths and functioning on a continuum from neurotic to psychotic. The students' expressions brighten with understanding and enthusiasm. They are now able to conceptualize what they see by addressing what cannot be directly observed.

Fortunately, in my residency program, the psychodynamic model is frequently used as a teaching tool. We are required in our oral board preparation course to give a case presentation using dynamic concepts to include ego strengths, ego functions and defense patterns. We then formulate two separate lists of differential diagnosis; one using psychodynamic principles and one using DSM IV criteria. The diagnoses generated using a dynamic model focus on the patient's functional status, including reality testing abilities and affect tolerance. Diagnoses based on a DSM model often focus solely on affect, as in depression NOS. Most reasonable clinicians would agree that the dynamic diagnoses offer more information to guide the appropriate choice of medications and therapy—not all depressed persons are alike. Using this method, we as residents are learning to see the patient behind the diagnosis.

As tomorrow's psychiatrists, we are in a uniquely challenging position. Though psychiatry has a rich history rooted in psychoanalytic theory, there exists an understandable desire to standardize and classify mental illness according to a medical model. But we should not ignore or discard highly useful theoretical constructs in order to accomplish this. Instead, we must use our integrative skills to balance classical theory with new information and modern demands.

---

*Continued from page 1*

two trials of second-generation antipsychotic monotherapy as well as a trial of clozapine before combination treatment is used. The clinical benefits of antipsychotic polypharmacy are unclear and poorly documented, and polypharmacy increases antipsychotic treatment costs at a time of growing budget constraints across systems of care. Unless we as psychiatrists do a better job managing the costs of treatment, our patients may lose access to these valuable medications.

We need to consider the cost of medication as a personal issue when prescribing, as if we were spending our own money. And we as a profession should be seen as leaders in promoting cost effective prescribing rather than waiting to have the economy force this on us.

There are other ways to help maintain quality care while reducing costs of treatment. The title of the Fall PSV Meeting was Making Our Voices Heard. In the morning, we heard from two individuals about effective ways of helping people with mental illness become more self-sufficient as they take more personal responsibility for their illness. Over 80 psychi-

atrists attended the meeting and listened as Derrick Abney, a man proud of his progress in recovery from bipolar disorder and addiction, speak about The Impact of the Recovery Movement on Clinicians. This was followed by John Oteneasek, who continues to receive treatment for schizophrenia, and who is Director of REACH (Recovery Education and Creative Healing), speak about his work training others with chronic mental illness how to develop a Wellness Recovery Action Plan (WRAP). Both speakers were well received and are examples of programs we as psychiatrists can promote as ways to help people not only become more stable and well but also to help reduce overall costs of care for them. It is a win/win situation.

The afternoon portion of the meeting was focused on how we as psychiatrists can better make an impact on both state and federal legislation. The Spring 2009 PSV meeting is being coordinated by our President-Elect, J. Edwin Nieves, MD, and will continue the focus on better understanding of how health care policy will affect the future of psychiatry.





# IN THE NEWS

## SUSAN G. KORNSTEIN, MD, TO RECEIVE JEWISH WOMEN INTERNATIONAL'S 2008 WOMEN TO WATCH AWARD

Jewish Women International (JWI) has selected Susan G. Kornstein, MD, as a 2008 Women to Watch honoree for her work as a pioneer in women's health.

Kornstein is a professor of psychiatry and obstetrics/gynecology at Virginia Commonwealth University (VCU). She is co-founder and executive director of the VCU Institute for Women's Health, a groundbreaking center for treatment, research, education, community outreach and the promotion of female leadership in science and medicine. Kornstein, an internationally known researcher in depression, is Editor-in-Chief of the *Journal of Women's Health* and president of the International Association for Women's Mental Health.

Kornstein's Institute demonstrates just "how much has changed since I started out. Women's health is much more of a priority on the national health care agenda," she says. "But a lot of work still needs to be done."

Kornstein is one of ten exceptional Jewish women from across the United States who will receive the 2008 Women to Watch award. In addition to appearing in the fall issue of *Jewish Woman*, the women will be honored at an annual celebration that includes a gala luncheon, awards ceremony and dynamic honorees' discussion panel. This year's event will take place December 8, 2008, at the Hilton Washington.

"Women to Watch honors extraordinary leaders," says Loribeth Weinstein, executive director of JWI. "Jewish women make crucial contributions in their professions, their communities and in society at large, and this award truly accentuates their impact."

## PSV LEADS IN VHA CAUCUS AT THE INSTITUTE OF PSYCHIATRIC SERVICES

By J. Edwin Nieves, MD

During the recent IPS meeting in Chicago, the Veterans Health Administration (VHA) psychiatrists caucus met under the leadership of PSV member, Antony Fernandez.

The meeting was well attended with representation from Maine, Illinois, Virginia and other states. Top on the agenda was VHA recruitment of new staff. During the last few years, there has been an increase in the development of new mental health initiatives and programs across the VHA. Telemental

health, suicide prevention and recovery are among them. Each one of these has also required recruitment of new staff. Caucus members discussed different approaches for improving recruitment and expediting the process of credentialing and hiring.

Other topics discussed were familiar to some of the PSV members: involuntary treatment statutes and limitation in bed space capacity. Some local trends of steering veterans to veterans administration hospitals brought up the discussion of "citizens first."

## WELCOME TO OUR NEW MEMBERS

### GENERAL MEMBER

Satish Annadata, MD, MPH..... Blacksburg, VA  
 Bush Kavuru, MD .....Roanoke, VA  
 Huma Khalil, MD ..... Manassas, VA  
 Rais A. Khan, MD.....Springfield, VA  
 Rafael G. Semidei, Sr.....Austinville, VA

### MEMBER-IN-TRAINING

William Cerrato, DO ..... Richmond, VA  
 Yongyue Chen, MD, PhD ..... Richmond, VA  
 Thomas J. Cummings, Jr., MD.....Arlington, VA  
 Stephen G. Cunningham, MD ..... Norfolk, VA  
 Richard S. Hamilton, DO ..... Norfolk, VA  
 Priscilla C. Hidalgo, MD..... Charlottesville, VA  
 Linda M. Jasperse, MD ..... Richmond, VA  
 Kevin M. Lamm, MD ..... Norfolk, VA  
 Meredith S. Lee, DO..... Charlottesville, VA  
 Lady A. Martinez Fernandez..... Charlottesville, VA  
 David R. Meyer, DO ..... Charlottesville, VA  
 Vladimir Prem, MD ..... Norfolk, VA  
 Rachna S. Raisinghani, MD ..... Charlottesville, VA  
 Maria R. Santa Cruz, MD..... Charlottesville, VA  
 Roopa Sethi, MD .....Roanoke, VA  
 Aisosiya A. Simmons, MD, MPH .....Portsmouth, VA  
 Gagandeep Singh, MD .....Roanoke, VA  
 Margarita I. Somova, MD ..... Norfolk, VA  
 Jacob A. Treskovich, MD..... Charlottesville, VA  
 Ross A. Yaple, MD ..... Glen Allen, VA  
 Michelle E. Zavage..... Charlottesville, VA

APA President Nada Stotland, MD, MPH, with PSV Association Manager Andrew Mann, at the District Branch Leadership Conference in Washington, DC on Friday, November 7, 2008.



# REPORT ON THE APA INSTITUTE OF PSYCHIATRIC SERVICES 2008 IN CHICAGO

By Ramakrishann Shenoy, MD

The annual Institute of Chicago was held early October in Chicago at the Palmer House Hilton. It was inaugurated by Dr. Nada Stotland, the current APA President. In contrast to the main APA meeting, the Institute is more informal and the attendees include all health care personnel including psychologists, social workers, trainees and psychiatrists. The theme this year was Recovery and there was a large contingent of professionals who belonged to the Recovery movement including a few who were former or current recipients of mental health services.

The keynote speaker, a Congressman from Chicago, could not attend because of the special session of Congress on the economic stimulus, and the Executive Director of the AMA made the inaugural address. He spoke about the health care plan of both then-candidates for President. He saluted the APA for the hard work in getting the parity bill passed and for getting rid of the discriminatory 50 percent reduction for psychiatric services imposed by Medicare. This reduction will be gradually eliminated starting in 2010.

The awards ceremony distributed several awards to outstanding MITs in many medical schools in the nation. PSV member and former president, Ram Shenoy MD, received the Frank Menolascino Award for his work with the intellectually disabled. His oration was on "Intellectual Disability Throughout the Life Cycle." There were several symposia, including subjects such as suicide prevention, PTSD, community care of the mentally ill, autism and other topics.



*Ramakrishann Shenoy, MD, DLFAPA, receives the Frank Menolascino Award for his oration on "Intellectual Disability Throughout the Life Cycle."*

## "HEROES IN THE FIGHT" AWARDS PRESENTED: PROFESSIONALS RECOGNIZED FOR THEIR LEADERSHIP IN THE MENTAL HEALTH FIELD

By Cal Whitehead, PSV Government Relations Coordinator

Voices for Virginia's Children, the Psychiatric Society of Virginia (PSV), NAMI Virginia, the Virginia Federation of Families, the Virginia Association of Community Services Boards (VACSB), and Mental Health America Virginia (MHAV) presented "Heroes in the Fight" awards to recognize heroes who provide care and support for children and adults with mental illness and their families. Heroes in the Fight is a recognition partnership program established by Eli Lilly and Company.

The following awards were presented at a dinner ceremony in Richmond at the Science Museum of Virginia on September 23.

### Community Supporter

The Honorable William Fralin, member of the House of Delegates representing portions of Roanoke City, Roanoke County, and Botetourt County, was recognized for his important contributions to eliminating the devastating practice of parents being forced to relinquish custody of their children with mental health needs solely in order to receive treatment. "Delegate Fralin's persistence over several years introducing legislative proposals and even requesting an opinion from Virginia's Attorney General were instrumental in eliminating custody relinquishment in Virginia," said Mary Dunne Stewart, Policy Director at Voices for Virginia's Children.

### Individual Psychiatrist

Dr. Aradhana "Bela" Sood is actively engaged in all aspects of Virginia's children's mental health system. She is Division Chair in the Department of Child Psychiatry at VCU Medi-

cal School and is the Medical Director at the Virginia Treatment Center for Children. As the premier child psychiatrist in Virginia, Dr. Sood was appointed by Governor Tim Kaine to serve on the Independent Review Panel following the Virginia Tech tragedy in 2007. Dr. Sood champions the involvement of families in mental health policymaking. She regularly makes presentation to family and professional groups at conferences in Virginia and nationwide. She is an effective policy advocate for children and their families and has advocated directly with state lawmakers and the Governor to encourage increased resources for children's mental health services. "What stands out most about Dr. Sood is her overwhelming commitment to all aspects of children's mental health — clinical care, teaching, policy, and child advocacy," said Dr. John Morgan, Executive Director at Voices for Virginia's Children.

### Health Care Professional (two awards)

Dr. Brian Meyer, a child and adolescent psychologist, is a professor in the Department of Psychiatry at VCU Medical Center and was formerly the Executive Director of the Virginia Treatment Center for Children. Dr. Meyer was recognized for ongoing advocacy on behalf of children with mental health problems and their families. Dr. Meyer has worked directly with legislators explaining the intricacies of a complicated mental health system, has testified before legislative committees, delivered workshops to parents at conferences geared to engaging family members, and been a guest columnist in the *Richmond Times-Dispatch*. "Dr. Meyer brings a great deal of energy and

*Continued on page 14*

# FALL MEETING REVIEW

By Bernard M. Williams, MD

What a great meeting at Virginia Beach and what a landmark subject for our discussion. Several of our presenters explained their more recent efforts to take charge of their mental illnesses and to help others with similar illness as a part of treatment, rehabilitation and recovery. To have our patients with severe mental disease to form organizations to take further responsibility for their outcome, is a special and significant move forward and a great help in our treatment program efforts, public as well as private.

And thanks to those in our leadership who brought these new ideas before us. Deinstitutionalization brought on by anti-psychotics and lithium finally has more meaning and hope.

It is also my pleasure to be a member of our Foundation, which recognizes the importance of inviting residents to join us in fostering the best interest of those people with mental illnesses.

For pictures of the Fall Meeting, please visit PSV's website ([www.psva.org](http://www.psva.org)).



## Comments About

*Making Our Voices Heard*

*"Nice meeting."*

*"Grass roots organization."*

*"Everything was GREAT!"*

*"This was a well-organized, well-run program/meeting."*

## SECOND ANNUAL POSTER SESSION WINNERS

Congratulations to the residents who participated in the Psychiatric Society of Virginia second annual scientific poster session during the fall annual meeting in Virginia Beach. There were a total of 19 posters submitted from medical schools across Virginia.

The top winners out of 19 posters were: Eloise Weeks, MD, who won first place, Ama Arthur-Rowe, MD, who won second place, and Laura E. Dauenhauer, MD, who placed third.

Congratulations also goes to the faculty advisors and co-authors for both posters from the McGuire VAMC.

### First Place

Eloise Weeks, MD; Steven Carter, FNP; Cheryl Jones, MD; Antony Fernandez, MD, presented: *The Richmond VAMC Story: Challenges of the 24/12 Initiative*

### Second Place

Ama Arthur-Rowe, MD; Alva Carter-Kershaw, MSW1; Antony Fernandez,

MD; Cheryl Jones, MD; and Victor Viewig presented: *A Recovery Based Program for Smoking Cessation in Military Veterans-Richmond VAMC Study*

### Third Place

Laura E. Dauenhauer, MD; Bruce Cohen, MD; and Preeti Chauhan, MD presented: *Factors that Influence ECT Referrals: A Survey of Virginia Psychiatrists*

All of the participants are listed below.

## Residents Research Symposium Posters

1. Arthur-Rowe, Ama; Carter-Kershaw, Alva; Fernandez, Antony; Jones, Cheryl; Viewig, Victor  
*A Recovery Based Program for Smoking Cessation in Military Veterans – Richmond VAMC Study*
2. Carr, Gregory  
*Effectiveness of Psychotherapy via the Internet*
3. Chopra, Kokil; Nieves, J. Edwin  
*Mass Murders and Serial Killings and Obscure Part of Psychiatry*
4. Cowan, LCDR George L  
*Markers of Rapid Systemic Decline in a Young, Male Patient within Six Months Onset of Anorexia Nervosa Behaviors*
5. Cunningham, Stephen; Nieves, J. Edwin  
*Recruiting Members for the Next Generation of the PSV*
6. Danelisen, Daliborka; Lynch, John; Benesek, John; Fernandez, Antony  
*A Psycho-Educational Approach to Improving Partner Relationships in Veterans with PTSD*
7. Dauenhauer, Laura E; Cohen, Bruce; Chauhan, Preeti  
*Factors that Influence ECT Referrals: A Survey of Virginia Psychiatrists*
8. Kamin, Elizabeth; Nieves, J. Edwin  
*A Resident's Perspective on Treatment Risks for the Seriously Mentally Ill*
9. Lafrenaye, Jonathan; Cruz, Martin P.  
*Extrapyramidal Symptoms in Non-Psychotropic Medications*
10. Lobraico, LT Dayna T.  
*Post Traumatic Stress Disorder on US Troops Returning From Combat*
11. Mahmood, Aamir  
*Impact on Long Acting Methylphenidate on Routine Driving of Young Adults with ADHD: Three Case Reports*
12. Malloy, Jessica; Jones, Cheryl; Fernandez, Antony; Ford, Gary; Lape, Lori; Brown, Bertina; Depriest, Andrea; Morris, Nikita; Williams, Mark  
*Reduction of Recidivism and Cost After Implementation of a MHICM Program at Richmond VAMC*
13. Cowan, LCDR George L.; Nasky, LT Kevin M.  
*Research Proposal: Sertraline-Induced False Positive Drug Screens for Benzodiazepines: A Retrospective Analysis*
14. Nasky, Kevin; Hines, Neil; Simmer, Edward  
*The USS Cole Bombing: Analysis of Preexisting Factors as Predictors for Development of Posttraumatic Stress Disorder*
15. Roaf, Amanda; Crow, Frank; Fernandez, Antony  
*Continuity of Care In A Veterans Administration Medical Center Substance Abuse Treatment Program – The Richmond Experience*
16. Sachs, Matthew  
*Discovering Relationships Between Patient Agitation and the Occurrence of Snowfall*
17. Singh, Maninder  
*Residents as Patient Educators*
18. Somova, Margarita  
*Seeing Through the Blind*
19. Weeks, Eloise; Carter, Steven L.; Jones, Cheryl; Fernandez, Antony  
*The Richmond VAMC Story: Challenges of the 24/14 Initiative*



# REPORT TO PSV AREA V COUNCIL MEETING — NOVEMBER 6, 2008

## APA ASSEMBLY MEETING — NOVEMBER 7–9, 2008, WASHINGTON, DC

By John P. D. Shemo, MD, DFAPA and Ram Shenoy, MD, DLFAPA  
PSV Assembly Representatives

The Area V Council Meeting was held just prior to the Assembly Meeting over the four days from November 6 to November 9, 2008. As usual, the agenda was lengthy and fast paced. Ram and I were lead or secondary authors on four action papers. I additionally served on the Reference Committee on Professional Values, as well as the Rules Committee and the Practice Guidelines Steering Committee.

The recent election was obviously a key focus. As always with change, there are both opportunities and potential dangers, as would have been the case whichever way the election had gone. Unfortunately, the dangers occur early and can be rapid, while the opportunities are slower to develop and require a lot of nourishing. Due to the ill health of Senator Byrd of West Virginia, Senator Reid is pushing for Senator Inouye of Hawaii to move into the critical role as Chairman of the Appropriations Committee. Senator Inouye's long-term chief of staff is a psychologist who is the country's leading proponent of psychologist prescribing. While all psychologist prescribing bills that were introduced in state legislatures were defeated this past year, these bills keep being reintroduced each year as they only have to pass once. It is unclear what influence will be exerted from Washington on this issue. As even a strongly Democratic member of the Assembly warned: "Democrats love non-physician providers." He pointed out that Senator Inouye is a big advocate of expanding the scope of practice for anyone who wants it.

On the positive side, we have had successes on Capitol Hill this year. The discriminatory reimbursement rate for outpatient psychiatric codes will slowly be eliminated under Medicare between now and 2014. It is expected that this will lead to the use of more psychiatric diagnostic codes in primary care. Cur-

rently, primary care physicians will diagnose "fatigue" rather than "depression" so they can be paid by Medicare at an 80 percent, rather than a 50 percent, rate.

The Mental Health Parity Bill, after years of rejection under strong pressure from the insurance lobby, finally passed, primarily because the Kennedy/Domenici Parity Bill was used to move the \$700 billion bank/Wall Street bailout bill back and forth between the House and Senate — a fascinating study in how our government works.

Additionally, the APA has done a lot of work with the business community in the past year to help them understand why/how psychiatric treatment for their employees is in their own best interest.

It is expected that health care reforms in the new administration will probably be incremental, starting with universal health coverage for all children. The biggest impediment, of course, is the fact that the government, especially after the bailout, has no money. Hawaii last year did implement a universal coverage for children program, but had to abandon the program after only eight months, as so many people who had family coverage under their employment-based insurance dropped the family coverage so their children would be eligible for the state-sponsored coverage.

It was also pointed out that the new administration will probably push for electronic medical records even more vigorously than did the Bush Administration. This could be crippling for solo practitioners due to the expenses involved. Some think that this, in fact, is a vehicle to force physician practice consolidation. In any case, the gravest danger of electronic medical records is that all data on patients, which has been downloaded into the system at the expense of the practitioner, will be available to over 6,000 government and insurance entities, all of

which are exempt from confidentiality restrictions under HIPPA.

New York, which already has a law that specifically forbids the introduction of any bill in their state legislature that would allow psychologist prescribing, has now also passed a law that any physician can use any CPT code applicable to the services they provide, and insurance must reimburse for these codes. Thus, in New York, the insurance and managed care companies can no longer dictate what codes a given specialty can or cannot utilize.

Issues of the APA budget were also discussed at length. Revenues are down by about \$4 million, largely due to decrease in support from the pharmaceutical industry, but revenues have also been cut by about \$4 million. It is costing a lot of money to respond to Senator Grassley's "requests" for information on APA financing. There have been staff cuts at the central office, with about a nine percent staff reduction. There is no fat — the question is, what muscle and bone can we do without? The projected publication date for DSM-V is 2012. So far, the DSM-V project is under the projected budget of \$21 million.

There was a fascinating presentation to the Assembly by an Al-Qaeda specialist on the faculty at West Point regarding the transition of Al-Qaeda from a terrorist organization that uses the media to a media organization that promotes terrorism. This then led to a discussion of the broader concept of how to win a war without fighting a war.

Due to space limitations, we will not go into detail on the specific action papers considered by the Assembly in this Session.

As always, Ram and I are both willing and eager to bring the concerns of PSV members to the attention of the APA.

# PRESERVING THE CAP—MEDICAL SOCIETY OF VIRGINIA

By Cal Whitehead, PSV Government Relations Coordinator

In the summer of 2007, the Medical Society of Virginia (MSV) began focusing on the medical malpractice cap, in anticipation that plaintiffs' attorneys would introduce legislation to repeal or increase the cap either during the 2008 session of the General Assembly or certainly in the 2009 session.

On July 1, the cap matured at \$2 million, ending a decade of annual increases. However, that date does not mark an end to the cap itself; it will remain in place at the \$2 million level unless legislation is passed to change it. MSV's goal will be to work to maintain the cap at its current level.

Aggressive plans are in place to protect the cap, and by extension Virginia's Birth Injury Fund (BIF). MSV's policy staff is conducting extensive research into the impact of the cap—as well as the potential impact of losing it.

Within 10 days of the end of the 2008 session, MSV staff began drafting a detailed working document that will be used to help navigate the society in the formulation of a medical malpractice cap game plan. The document was then reviewed by MSV's board of directors, executive committee and Medical Liability Advisory Group (MLAG). This plan will

guide the society not only through next year's session, but it will serve as an invaluable tool for 2010 and the years to follow. Going forward, MLAG will focus its efforts on exploring possible policy options and scenarios, prioritizing those options and forwarding them to MSV's board of directors for its consideration.

MLAG is chaired by Daniel Carey, MD and includes the following members:

- Zerline E. Chambers-Kersey, MD
- Paul M. Colopy, MD
- Siobhan S. Dunnavant, MD
- David A. Ellington, MD
- Thomas W. Eppes, Jr., MD
- E. Claiborne Irby, Jr., MD
- H. Lee Kanter, MD
- Edward G. Koch, MD
- Russell C. Libby, MD
- Michele A. Nedelka, MD
- Sterling N. Ransone, Jr., MD
- E. Mark Watts, MD

As Dr. Carey has noted, the strength that can be derived from tapping the resources of MSV's policy, communications and government affairs teams, as well as membership, the MSV Alliance, the MSV Foundation, the MSV Insurance Center, VAMPAC and personal commitments from the MSV board, will greatly enhance the society's ability to achieve a favorable outcome.

There are several ways you can help protect the cap. Organize visits with your legislators in their home districts before the General Assembly session convenes (MSV can help coordinate these efforts). Write, call or email your legislators to share your stories of how keeping the cap at \$2 million will help ensure a stable malpractice market for health care providers. Talk to local chambers of commerce and community groups about the potential consequences of increasing the cap. Maintain your MSV membership to support our advocacy efforts. And consider purchasing your insurance through the MSV Insurance Center. The center's profits help support MSV advocacy efforts on your behalf.

## HOW TO GET INVOLVED

*If you wish to become involved with the effort to maintain the medical malpractice cap, please contact:*

### Amy Hewett

Assistant Director of Political Advocacy  
phone 804-377-1036  
e-mail [ahewett@msv.org](mailto:ahewett@msv.org)

— OR —

### Keith Hare

Director of Government Affairs  
phone 804-377-1031  
e-mail [khare@msv.org](mailto:khare@msv.org)

## PSV GOLF GETS COOPERATIVE!

By W. Stanley Jennings, MD, DFAPA

A glorious morning greeted our golfers for the fall PSV golf outing. Red Wing Lake Golf Course was in magnificent condition. There was only one thing that was missing to make this a perfect tournament. Our reigning champion, the fabulous and charismatic Dr. Larry Conell, had been forced to return to Harrisonburg and could not play. The golfers reasoned that any victory under the circumstances would feel hollow.

They chose to play together against the course to achieve the best score they could as a team. Led by the equally fabulous and quite possibly the best golfer on

earth, Ed Goldenberg, the team set out with a singular common purpose and achieved an arguably perfect (depending on how one set their goals) even par on the front nine.

It was then that Dr. Ed had to leave. Displaying his gift of leadership, he spoke to the remaining players some words of encouragement as they set out without him. These words were the stuff that make sports legend. If only we had recorded those words to sustain us in the future. But as he left, the players chose one golf ball and named it simply "Ed" to play in his memory. It was as if Ed had

never left. When help was needed, they called on Ed and he delivered for them.

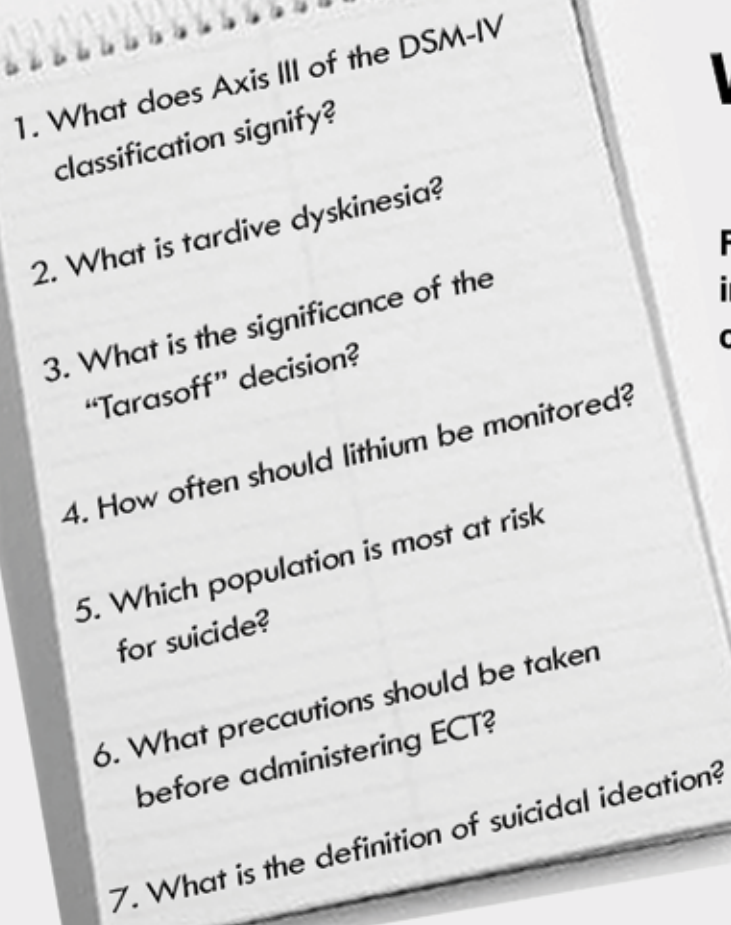
Ed made four birdies on the back nine that day to lead the team to finish with an unprecedented better than perfect 68. That is the stuff of sports legend: *That is why they keep score. When the going gets tough, the tough get going. Quitters never win, winners never quit. The cream always rises to the top.*

Thank you, Ed. You are the man!





# Can your claims examiner pass this test?

- 
1. What does Axis III of the DSM-IV classification signify?
  2. What is tardive dyskinesia?
  3. What is the significance of the "Tarasoff" decision?
  4. How often should lithium be monitored?
  5. Which population is most at risk for suicide?
  6. What precautions should be taken before administering ECT?
  7. What is the definition of suicidal ideation?

**We can!**

**Find out if your malpractice insurer's claims examiners can answer these questions.**

**If they fail this test, it's time for you to give us a call!**

We speak your language. You won't have to explain psychiatric terminology to us. Our claims staff has more experience handling psychiatric liability claims than any other in the world.

For more than 20 years, we have handled over 15,000 files involving psychiatrists. Of course, we hope you never have a claim. But, when the unfortunate does occur, you want to make sure you have experts on your side.



Endorsed by the  
AMERICAN  
PSYCHIATRIC  
ASSOCIATION

## **The Psychiatrists' Program**

***Professional Liability Insurance Designed for Psychiatrists***

**Call: (800) 245-3333, ext. 389 ~ E-mail: [TheProgram@prms.com](mailto:TheProgram@prms.com) Visit: [www.psychprogram.com](http://www.psychprogram.com)**

# THANK YOU

We would like  
to thank our  
exhibitors for the  
PSV Fall 2008 Meeting

## *Making Our Voices Heard*

Cavalier Hotel  
Virginia Beach, VA  
September 26–27, 2008

### SILVER LEVEL EXHIBITORS

AstraZeneca  
Wyeth Pharmaceuticals

#### EXHIBITORS

Bristol-Myers Squibb  
Centra Health  
Eli Lilly & Company  
Forest Pharmaceuticals  
Janssen Pharmaceutica  
Jazz Pharmaceuticals  
Pfizer, Inc.  
Rockingham Memorial Hospital  
Sepracor  
Takeda Pharmaceuticals  
Welligent, Inc  
Wyeth Pharmaceuticals

## WANTED

### GUEST WRITERS

Want to write an article for the  
spring issue of *Virginia News*?



Feel free to submit  
ideas or articles  
to the editor at  
[PSV@societyhq.com](mailto:PSV@societyhq.com)

## REFLECTIONS ON BEING A MEMBER OF THE COUNCIL ON MINORITY MENTAL HEALTH AND HEALTH DISPARITIES



By Asha Mishra, MD, DFAPA  
Chair, Committee on Women of the APA

As a member of the Committee on Women of the APA, I am privileged to be a member of the Council of Minority Mental Health and Health Disparities. My colleagues on this council are Chairs of the Committee on Black Psychiatrists, Hispanic Psychiatrists, Asian American Psychiatrists, Native American Psychiatrists, Gay, Lesbian and Bisexual Psychiatrists, International Medical Graduates, some Minority Fellows, several corresponding members, a liaison from the American Association of Community Psychiatrists, along with Annette Primm from the Office of Minority and National Affairs. Our fearless leader is Sandra Walker with Alison Bondurant, the APA staff liaison. The council meets twice a year, in the fall and at the annual meeting.

This September was my first time sitting on the Council and getting to experience a firsthand awareness of the many facets of minority and mental health disparities. Being there, you realize how much work goes on behind the doors and how dedicated the individual members on this team are, and yet we have so many health disparities to deal with.

Throughout the two-day meeting, we were bustling with activity and visits from our APA president, Dr. Nada Stotland, Medical Director, Jay Scully and some assembly reps. At the fall meeting, tasks were assigned, component workshop submissions were finalized, and selection process for the awardees was undertaken so that the council could forward the names to the APA leadership for any and all the awards that are associated with the individual committees. So much work, so little time!

As I sat there, I pondered the tasks assigned to my committee. I felt energized by what is happening at the Dis-

trict Branches around Diversity Initiatives and efforts around reducing disparities in health care. I drifted off into issues related to the Committee on Women as I somberly gulped down what I had discovered in the course of my tasks, that out of 125 departments of psychiatry in the USA, only 12 are chaired by women psychiatrists. Out of 181 psychiatry residency training directors, only 65 are women. And, finally, despite the context of knowing that of late, about half the medical school class is women, and only 34.6 percent of APA members are women. (Not to mention, women still make 70 cents to every dollar that a man makes.)

It got me wondering if we indeed had broken through the glass ceiling or not? And why, after having had a few female APA presidents and known many of the women in leadership roles at their organization or jobs, I am sitting there still wondering about a glass ceiling? Is it the ceiling that is shatterproof, or is it that we women are choosing to not assume leadership roles? What holds us back? Or is it that we really do not want to be leaders and do not particularly care about our voices being heard about our choices or on behalf of our patients?

I believe that voids do not exist in nature, so if we do not claim our rightful place at the head of the line, in leadership roles, somebody else surely will. So I came back wanting to ask each and every one of women psychiatrists this question: What will it take for us to become more involved in our organization, in our advocacy and work towards parity, elimination of barriers to care, elimination of disparities in health care, and finally, in the elimination of barriers to even more women and minorities in leadership roles? What will get us more involved in our district branch work and in our APA by becoming and staying on as APA members?

# APA ASSEMBLY AND ASSOCIATED ORGANIZATIONS REPORT

By Ramakrishnan Shenoy, MD

The APA Assembly session preceded the APA convention. The meeting was brought to order by Speaker Jeffrey Akaka in the Washington Convention Center on Friday, May 3, 2008. This was Dr. Akaka's last session as speaker. He was succeeded by Ron Burd, MD, from North Dakota. The Assembly had a rather hectic schedule with 30 action papers, one report on Assembly and Board of Trustees relationship, and several speeches by VIPs. Of note were Senator Akaka, Junior U.S. senator from Hawaii and the Vice-President of the AMA.

In the election for replacing the retiring Speaker-elect and the Recorder of the Assembly positions, Gary Weinstein, MD, of Kentucky and Bruce Hirschfield of Maryland won respectively. Area Council V was well represented, and the new leaders John O. Gaston, MD, of Georgia, Chair, and Scott Benson, MD, Deputy Chair of Florida did an admirable job.

Of the 30 action papers submitted and discussed, 19 were passed by the Assembly, one with an amendment, 3 were defeated, 2 withdrawn and 3 moved to the consent calendar. The Assembly could not reach a consensus on the Board Assembly relationship and after a long and heated debate, this was tabled.

Of interest was the enthusiasm and involvement of the Members-in-Training (MITs), who submitted several papers and added to the discussion.

This time, the reception hosted by the APA Foundation was held at Union Station, a historical venue. Several hundred people participated, and awards were given to leaders in innovative care. These included both members of the APA and non-members. The reception for the various medical schools for their alumni followed the pattern set in San Diego in 2007, where most medical schools pooled their resources and held a joint reception in the Washington Convention Center.

I would be deficient in my report if I failed to report that the APA Convocation featured Dr. Oliver Sachs as the chief speaker. Dr. Sachs spoke about the role of music in a person's life and also shared his "affliction" with musical hallucinations. It was a very interesting and informational speech. Patty Duke was the chief guest of the APA Foundation's program, "Conversations." She spoke to a record audience about her trials and tribulations with bipolar disorder.



Institute of Law,  
Psychiatry and Public Policy,  
University of Virginia

## UPCOMING PROGRAMS

Please visit  
[www.ilppp.virginia.edu](http://www.ilppp.virginia.edu)  
for registration, continuing  
education, and other  
information.

You may also email  
[ilppp@virginia.edu](mailto:ilppp@virginia.edu)

<b>January 15-16, 2009</b>	<b>Applying Forensic Skills to Juveniles</b> ILPPP Faculty • Charlottesville, VA
<b>February 13, 2009</b>	<b>Assessing Risk for Violence with Juveniles</b> ILPPP Faculty • Charlottesville, VA
<b>April 17, 2009</b>	<b>Paraphilias, NOS – Rape and Coercion – Current Controversies</b> Dennis Doren, PhD • Charlottesville, VA
<b>April 24, 2009</b>	<b>Assessing Malingering and Waiver of Miranda Rights</b> Richard Rogers, PhD • Charlottesville, VA
<b>April 27 - May 1, 2009</b>	<b>Juvenile Forensic Evaluation: Principles and Practice</b> ILPPP Faculty • Charlottesville, VA
<b>May 22, 2009</b>	<b>Forensic Mental Health Symposium: Assessing the Risk for Violence in Community Settings</b> Charlottesville, VA John Monahan, PhD - University of Virginia Alec Buchanan, PhD, MD - Yale University Li-wen Grace Lee, MD - New York State Office of Mental Health

*Presented by The University of Virginia Institute of Law, Psychiatry and Public Policy. Supported by and in collaboration with Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services & Office of the Attorney General, Commonwealth of Virginia.*





## Without the right tools, what are the odds of success?

Many people who depend on public assistance are denied access to the most effective tools and treatments for mental illness. Instead of benefiting from newer, safer treatments, they are often forced to change medicines or wait for authorizations. Worse yet, some must go through a “fail-first” treatment in which they are first required to use older, cheaper medications, regardless of what is considered to be the most effective treatment.

The effects of such unsettling treatment patterns can be dramatic, triggering a pattern of deterioration that can be marked by unemployment, hospitalization, imprisonment, and even homelessness.

That’s why Eli Lilly and Company continues to support open and unrestricted access to all available treatments for mental illness.

**We believe that, to improve the odds of recovery, mental health professionals and their patients must be given the right tools.**

[lillyforbetterhealth.com](http://lillyforbetterhealth.com)

MG46550-B PRINTED IN USA COPYRIGHT ©2008, ELI LILLY AND COMPANY. ALL RIGHTS RESERVED.

*Lilly*  
Answers That Matter.

# APA COMMITTEE ON MANAGED CARE

By Anthony L. Pelonero, MD

Our American Psychiatric Association has an impressive array of Standing Committees, Councils and Component Committees comprised of APA members and staff. These committees cover a wide range of topics that are of importance to psychiatrists. (An online component directory is available to APA members in the Members Corner of the APA website: [www.psych.org](http://www.psych.org).)

In 2006, I was invited to speak with the Committee on Managed Care, and in 2007 I was pleased to become a corresponding member of the committee. Because managed care has an important influence on the practice of psychiatry and the increasing numbers of patients receiving medical care in an organized setting, the Committee on Managed Care has been charged with several tasks, including ongoing examination of the practice environment regarding managed care, making recommendations and developing position statements on a variety of managed care issues, review psychiatrist's concerns about managed care, and other assignments.

Serving on this component committee also affords the members an opportunity to stay abreast of important issues related to medical practice, as we are often privileged to have one or more speakers address the committee. In September 2008, the component committees met in Washington, DC. Robert Plovnick, MD, the Director of the Department of Quality Improvement and Psychiatric Services of the American Psychiatric Association, spoke on performance measures and pay for performance. Information was shared on groups that are working on standardizing specifications for quality measures in psychiatric care. Development of quality measures of medical practice is happening in many specialties, and these organizations will contribute to how high quality psychiatric practice is defined and measured in the future. Examples of the organizations leading these efforts include:

- Physician Consortium for Performance Improvement. The APA is represented on this group that is developing sample quality measures.
- National Quality Forum: a national membership organization with a national strategy for quality measurements and reporting. Twelve measures have been endorsed by the Ambulatory Care Performance Measure Project including measures on Major Depression, Bipolar Disorder, ADHD and Substance Use Disorder.
- Physicians Quality Reporting Initiative: a voluntary pay-for-reporting program sponsored by CMS. Measures are reported using administrative claims.
- Hospital-Based Inpatient Psychiatric Services: a Joint Commission effort to measure processes and outcomes of inpatient psychiatric services. Example measures are assessments of violence risk, substance use disorder, and trauma and patient strengths. Also, hours of restraint and seclusion use, antipsychotic polypharmacy, discharge assessment and aftercare recommendations shared with the next level of care.
- Pay for performance programs: not an organization, but PFP programs have been important in the development of performance measures of care.

The committee is also planning the annual workshop it provides at the APA Annual meeting. The 2009 workshop is tentatively titled "Healthcare Reform and the Implications for Managed Care" and several speakers are lined up to cover topics such as healthcare systems, e-prescribing, telemedicine, physician profiling, changes to psychiatric practice, and the impact on patients.

It has been very interesting to serve on the committee, especially to see the APA in action. There are many hundreds of members contributing their time and talent for the organization and to the field of psychiatry. To see this firsthand has been impressive, and has heightened my admiration for our organization.

---

*Continued from page 2*

new compound? Do you start over looking for another source of revenue for you and your institution? Do you then accept funding from a competitor of the company which has supported your research for the last two to three years? Do you fail to find the funds to keep your staff employed? The more I thought about this, the more grateful I was that I did not have to shoulder those responsibilities.

I am not suggesting that the psychiatrists named in the article are not responsible for their behavior. I am suggesting that if a person's livelihood and that of co-workers depended on ANY funding source, one would give great consideration before discarding it. Also, can we be so naive as to suggest that any company would advertise that their product did not work? Would we expect that of any other business?

We are on the brink of a sea of change in funding for mental health care. This is spectacular. However, as far as I know, we are not at that same point in research funding.

## QUESTIONS OR COMMENTS?

*PSV welcomes your comments, questions and feedback about this editorial.*

*Please send your letters to:*

*Mail* Psychiatric Society of Virginia  
2209 Dickens Road  
Richmond, VA 23230-2005

*E-mail* [psva@psva.org](mailto:psva@psva.org)

*Fax* (804) 282-0090

# INNOVATIONS IN SYSTEMS REDESIGN TO ADDRESS CHALLENGES OF THE 24/14 INITIATIVE: AN OUTPATIENT MENTAL HEALTH SERVICE PARADIGM (THE RICHMOND VAMC STORY CONTINUES...)

By Eloise Weeks, MD; Steven L. Carter, FNP; Cheryl W. Jones, MD; Antony Fernandez, MD; Psychiatry Services, Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, Virginia and Department of Psychiatry, Virginia Commonwealth University, Richmond, Virginia

Across the US, healthcare systems struggle to achieve the goals of accessibility to healthcare and continuity of care. They face obstacles such as inefficient triage systems and overwhelming demand for patient visits. To confront this problem within the Veterans Health Administration (VHA), the VHA has worked with the Institute for Healthcare Improvement (IHI) to apply advanced clinic access for patients to both primary care and specialty care clinics so that veterans receive the care they need, when and where they want it. As of August 2007, the VHA nationwide was challenged with an initiative to reduce delays in access to care to within a single day for mental health outpatient screening and within 14 days for complete new patient mental health evaluation. This initiative is called the Systems Redesign 24/14 Initiative. Systems Redesign (SR) is a patient-centered, scientifically-based set of redesign principles and tools that enable staff to examine their health care processes and redesign them.

The following SR redesign applications were applied:

- Updated and implemented our Service Line Agreement
- Redesigned our Consultation template to reflect and compliment changes in the Service Line agreement to create an efficient referral tool for primary care and specialty Clinics
  - Improved efficiency of our Consultation process by screening consultations
- Discontinued inappropriate consultations with “curb-side” interventions

- Implemented Intake Clinics to provide access
- Implemented Same Day Access Clinics within the profiles of 90% of providers
- Implemented Saturday hours to increase access
- Implemented Urgent Care Clinic to provide access for crisis intervention
- Submitted and acquired approval for additional 2.5 FTE designated for 24/14 Initiative
- Hired Locum Tenens physicians to fill service line gaps in FTEE

The efficiency of the redesigned model is evidenced by a reduction in the mean days to complete the consultations from 30±6 days to 11.6 days. Systems redesign applications were successful as evidenced by improved access, improved efficiency, and implied decreased cost. Overall improved quality was evidenced by patient satisfaction scores. Of 472 responses, 80% of the respondents rated the service delivery as very good to excellent.

Our systems-based interdisciplinary model emphasized liaison and collaboration. It is the goal of the service to mitigate barriers to access with the provision of holistic care in a seamless fashion. Yet, it is the attainment and maintenance of this goal that ultimately enhances satisfaction and healthcare outcomes for the veteran and his family. Continuous forecasting and contingency planning is essential to the continued balancing of supply and demand.

*Continued from page 5*

enthusiasm to both his clinical and policy work and inspires his colleagues and students to fight for children’s mental health improvements through all available channels. Helping children who are the most vulnerable has been the guiding principle of Dr. Meyer’s career,” said Mary Dunne Stewart.

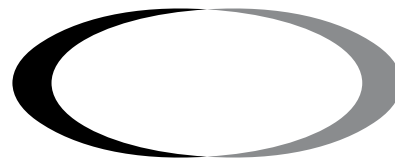
Dr. Robert Cohen has had a long and distinguished leadership career in children’s mental health, as a program manager, state department official, researcher, hospital director, medical school administrator, program creator, public policy advocate and champion of system reform. “Dr. Cohen has performed heroically in many ways, but most notably in his dedicated and highly influential work to improve the public child mental health system. He was one of the first, 20 or more years ago, to recognize and document the gaps and failures in the system and to advocate effectively for system reform,” said Dr. Morgan. Dr. Cohen has championed reforms and enhancements in many settings to benefit children with emotional disturbance. “Perhaps most telling, Dr. Cohen is a hero to the many families he has touched through

his dedicated service. He has never lost sight of the tremendous stresses on, and strengths of, family members struggling to cope with serious emotional problems in their child and frustrating deficiencies in the service system,” said Dr. Morgan.

## Shenandoah Valley, VA

**PSYCHIATRIST**—Harrisonburg, Virginia. Rockingham Memorial Hospital (RMH) is seeking a board certified/board eligible psychiatrist to join a well-established hospital-owned practice. Outpatient and inpatient care. Current call coverage 1:5. Competitive salary and benefits package including year-end bonus package, malpractice, health, dental and life insurance, 403B retirement plan with employer contribution, CME allowance, relocation assistance and much more. Contact Jenny Hansbrough at 540-433-4439 or at [jhansbro@rhcc.com](mailto:jhansbro@rhcc.com).





**MEDICAL DOCTOR**  
**A S S O C I A T E S**

100% Employee-Owned

## **Accessible**

**Here today. Here to stay.**

### **Meet one of the owners**

For the past 17 years, Bernie has made providers and clients' needs her top priority. Whether it is a placement or a staffing solution, Bernie is available.

Bernie is ACCESSIBLE.

**Bernie is an MDA owner**

**National and International Opportunities**

**800.780.3500 x.2136 [www.mdainc.com](http://www.mdainc.com)**



THE PSYCHIATRIC SOCIETY OF VIRGINIA

## VIRGINIA NEWS

2209 Dickens Road  
Richmond, VA 23230-2005

### REPORT ON FALL 2008 MSV MEETING

*By W. Stanley Jennings, MD, DFAPA*

The fall 2008 MSV meeting was held in the context of the banking financial crisis, which seemed to overshadow most of the proceedings. Other than that, the primary issue before the society was the upcoming challenge to the medical malpractice \$2 million cap, which is due to expire in 2009.

New legislation sponsored by trial lawyers is expected but will likely be offered as late as possible to prevent us from having time to lobby against it. Therefore, what we actually will face is unknown at this time.

The most interesting new presentation was the results of MSV branding efforts. The consultants presented aspects of an ad campaign around the theme of "Nobody understands the medical needs of patients better than their physician." MSV advocates for greater control of medical care by physicians. The MSV slogan is "The power of physicians working together."

The PSV-sponsored resolution "Physician workforce for mental health services" was spoken for by our lobbyist Cal Whitehead, with no dissent expressed. No specific action would be taken on this resolution, as MSV is already on record as acknowledging the inadequacy of the mental health budget to meet the needs of our Commonwealth.

Save the Date!

PSYCHIATRIC SOCIETY OF VIRGINIA

## 2009 Spring Meeting

*Transitioning from the* **March 27-28, 2009**  
**Crowne Plaza**  
**Richmond, VA**

**Current to the Future**  
*Practice of Psychiatry*

Visit [www.psva.org](http://www.psva.org)  
for Program Updates

### Position Available Virginia Beach Area

Virginia licensed Psychiatrist to join a large multi-disciplinary group of providers with several locations in the Virginia Beach area. Excellent compensation and benefits. Fax resume to: Christian Psychotherapy Service, (757) 497-1327 or call (757) 490-0377.