THE PSYCHIATRIC SOCIETY OF VIRGINIA

VIRGINIA NEWS

A District Branch of the American Psychiatric Association

Fall/Winter 2010

A Message from the President

By Cheryl Jones, MD, DFAPA

The Word is Out!

Set in historic Williamsburg, VA, the 2010 PSV Fall Meeting at the Woodlands made history as well. Entitled *Get the Word Out: Challenges and Innovations of a New Decade in Mental Health Care,* the meeting was held on Saturday, September 11, 2010 from 8:00 am - 3:45 pm. We had one of the highest attendances of Fall Meetings with a total of 98 members and residents. The number of residents was also one of the highest at 22, with all medical schools in the state represented.

The meeting opened with an overview of the PSV. My vision for the year is to foster and populate the goals of the PSV as listed on our website.
They are as follows:

- **GOAL I:** To be truly relevant to our members;
- **GOAL II:** To promote advocacy and ethical care for the mentally ill;
- **GOAL III:** To foster science and the progress of psychiatry; and
- **GOAL IV:** To make a positive contribution to our communities.

These areas of focus are in alignment with the goals of the PSV and are areas which the Society membership identified as key to the psychiatric community in the upcoming years.

All of the presenters were experts in their field. The knowledge and scholarly acumen they imparted to the group was extraordinary. The society was pleased to have Dr. James H. Scully, Medical Director and CEO of the American Psychiatric Association and Dr. Annelle Primm, Deputy Medical Director and Director of Minority/National Affairs of the APA. Drs. Scully and Primm oriented us to the APA's position on a myriad of issues including global impact, professional education, advocacy, and government relations as it impacts the profession and the provider. Both Drs. Scully and Primm are renowned psychiatrists with many accolades. Both were certainly enthusiastic and approachable. They both expressed to me personally that the Society membership made them both feel welcome at the Psychiatric Society of Virginia.

Another historical point worth mentioning was that the meeting was held on September 11th. The group had a moment of silence acknowledging the lives lost on this date. This year also marked the fifth anniversary of Hurricane Katrina. It was fitting that the first topic was *Global Response: Lessons Learned and Challenges in the Future* presented by Dr. Primm. The Society asked the question, *How does the APA respond to global disasters that affect various cultures and ethnicities outside of the U.S. such as the earthquake in Haiti and more recently, in Chile?* Knowing that minority populations are disproportionally negatively affected, have we learned anything from Hurricane Katrina? The lecture focused on how to respond and measure outcomes in global disasters. The audience received a rare glimpse of how mental health professionals addressed disasters of epic proportions. The population from Hurricane Katrina was the focus. The components of DSM IC-Tr cultural formulation were discussed and how they can be useful in evaluation of a disaster-affected individual. The group discussion focused on the APA role as organizer of State liaisons. Our liaison is Dr. John Shemo from University of Virginia. Many of the audience members had not been introduced to this topic and learned about contacts at the APA level and in the State of Virginia.

Cheryl Jones, MD, DFAPA President

Another challenge facing the next decade is how the practice of psychiatry as a whole will buffet the changing landscape in terms of recruitment, teaching and retention of trainees; our place in new models of health care delivery; our role in advocacy for ourselves and our patients; our workforce and distribution of such; rules governing our continued education; and scope of practice to name a few. Dr. Scully's lecture, *Education: Residency and Beyond,* addressed the workforce and economic issues facing our patients and profession. Throughout the subsequent panel discussion, he continued to address other issues and more. At one point he described the

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A Message from the Editor


Kathleen M. Stack, MD, DFAPA

Validation and Diagnoses in Psychiatry

By Kathleen M. Stack, MD, DFAPA

I considered why being able to see or measure something can make it seem more real or valid. I do not doubt the diagnosis of schizophrenia, bipolar, PTSD etc. Yet, I recognize some release of inner tension in the validation of a mental health diagnosis with something scientific and measurable. This has happened in two recent reports.

First, there was the buzz on television and in the daily newspaper about the new blood test for Traumatic Brain Injury or TBI. While the scientific reports explained that this is preliminary data and a small study, the idea that there may be a blood test forthcoming to help with the diagnosis of TBI is very exciting to me. The prevalence of TBI in the active duty and veteran population is not yet known, but the prevalence in the active duty military is going to be higher than in past conflicts.

The current methods of evaluation are not completely effective. I often struggle when seeing patients long after the event. There are so many possible pre-existing and complicating factors. This is true in non-military populations as well. More studies are showing that the problem of TBI is also a valid concern in high school soccer, baseball and other previously considered "safe" sports. Something as definitive as a blood test would remove doubt about the origin of the symptoms. This would allow for any needed treatment and prevents the patient from being blamed or being seen as "faking."

This week, there was a *Medscape* article referenced in our *APA News Update* about a study which reported the development of a scan which "can identify people with PTSD with 95 percent accuracy." Once again, I was heartened by the idea that we will be able to move to an objective test for diagnosis.

One of the investigators in the PTSD study, Brian Engdahl, is quoted as saying "Beyond representing a step forward in evaluating treatments for PTSD, the finding also could help combat a stigma that prevents some patients from seeking treatment. The veterans themselves see what we've found, and many are relieved to see physical evidence of the emotional injury they have lived with all this time." He added, "This can reduce their self-blame, and it helps destigmatize this disorder."

I also feel professional validation when the traditional scientific method supports that there is measurable biological change specific to a diagnosis. Beyond that, I feel pride in the profession. I hold the belief that Psychiatry has valid diagnoses. This belief is often debated within and outside our profession. When this is validated by scientific methods, like patient testing by Dr. Engdahl, I feel relief. I look forward to further development in the area of diagnosis and then treatment. As a psychiatrist, I believe it is the science of our diagnoses which will move our specialty and our patients into the main stream of medicine.

Welcome New Members

Fellow

Chandrakant Patel, MD ..... Williamsburg, VA

General Member

Henrike Brinker, MD ..... Abingdon, VA
Ryan Ingram, MD ..... Virginia Beach, VA
Jonathan C. Lee, MD ..... Williamsburg, VA
Hasnain Maqsood, MD ..... Lexington, VA
Thomas R. Milam, MD ..... Roanoke, VA
Maxwell Senu-Oke, MD ..... Richmond, VA

Member in Training

Sara Abdijadid, DO ..... Bakersfield, CA
Ivona Bendkowska, MD ... Charlottesville, VA
Kirsten A. Butz, MD ..... Charlottesville, VA
Andrew J. Chambers, MD, JD ... Palmyra, VA
Nicholas D. Crall, MD ..... Columbus, OH
Bradley R. Grant, DO ..... Charlottesville, VA
Elionore Katz, MD ..... Virginia Beach, VA
Melanie M. Santos, MD .... Charlottesville, VA
Melissa L. Morton-Fishman, MD ... Roanoke, VA
Prem N. Pathak, MBBS ..... Richmond, VA
Elia Valladares-Juarez, MD ... Charlottesville, VA

Student

Nathaniel Cleveland ..... Danville, VA
Margaret Eason ..... Norfolk, VA
Jason McGrady ..... Radford, VA
Rajveer Sangera ..... Blackstone, VA
Kenneth Smith ..... Blacksburg, VA

The 2010 MSV Annual Meeting: A Healthcare Reform Summit

By Varun Choudhary, MD, MA
PSV Representative to the Medical Society of Virginia

The Medical Society of Virginia held their annual meeting this year at The Westfield Marriott in Chantilly from October 21-24. The prevailing theme of the meeting was *Healthcare Reform and Adaptation to the Change*.

The meeting kicked off with a full day Healthcare Information Technology course to help physicians understand recent advances in electronic medical records, electronic exchange of health information, and how to use technology to advance the practice of medicine. The purpose of this comprehensive educational session was to guide and educate physicians about the future requirements to increase efficiency mandated in the new health care law.

Daniel Carey, MD, FACC, FACP, the current president, noted in his opening keynote speech that medicine was currently at an important seminal moment in its history, and that it was vital to adapt to the forthcoming changes and use them as an opportunity to advance the mission of medicine. This seemed to be the prevailing tone of the educational sessions, meetings, and symposiums: adapt and accept the change or risk obsolescence.

Perhaps the most anticipated and most controversial session was held Saturday morning. *Health Care Reform: What Will it Mean for Virginia* featured keynote presentations from Joanne Grossi, Regional Director from the U.S. Department of Health and Human Services, as well as a discussion from The Honorable William Hazel Jr. MD, our current Secretary of Health and Human Services.

Ms. Grossi outlined the details, scheduled timeline, and implementation of the new health care law. She started her presentation by outlining the position that there existed a critical need for health reform: "46 million uninsured in America, $2.3 trillion spent annually on healthcare, 16% of our economic output tied up in the healthcare system, without reform by 2040 a third of economic output tied up in healthcare and 15% of GDP devoted to Medicare and Medicaid."

Ms. Grossi highlighted talking points and details of the new law, such as the limits placed on insurance companies, the extension of current parameters of health insurance, and the increased coverage provided in Medicare and Medicaid. She also briefly noted changes that were scheduled to be implemented in 2011. These included providing funding to states to assist with the mandate that all insurance companies submit justification to the state for all premium increases. There was also a requirement that 80% of premium dollars collected by insurance companies must be spent on "medical services" in small markets and 85% for large markets (Ms. Grossi noted that the term "medical services" had yet to be properly defined, and it would be an area that would be further clarified at a later time).

She further explained that there would be an increase in the number of "Primary Care Practitioners," as the law "provides new investments to increase the number of primary care practitioners, including doctors, nurses, nurse practitioners, and physician assistants."

Ms. Grossi concluded with a section called *Highlights for Physicians* to explain how the new law would affect doctors and hospitals providing care. She particularly elucidated the purpose of Accountable Care Organizations (ACO) that will be created by the government to regulate healthcare delivery. She described the ACO as the oversight committee that would "encourage hospitals and physicians to coordinate care for Medicare beneficiaries and to improve quality and reduce cost." She stated that reimbursements would be "tied to outcomes rather than volume," and that a "formal legal structure" would be required to implement this change so CMS would issue "guidance" or guidelines. With regard to hospitals, she briefly mentioned a "Hospital Readmissions Reduction Program" that penalized hospitals with high re-admission rates by withholding payment.

Dr. Bill Hazel then took the stage to make a more personal interpretation and explanation of Virginia's plan to implement health care reform. He admitted that he was in the unenviable position to prepare for these changes in a state that was very resistant to it. He expressed his opinion that healthcare reform was important and necessary as medicine was on an unsustainable course. He explained that our current national debt was out of control, and the current burden to each American taxpayer is $80,000; this would only worsen without reforming our current medical system.

Dr. Hazel touched upon Attorney General Cuccinelli's lawsuit against the government, stating that he did agree with the AG interpretation and he felt the mandate to purchase health insurance or pay a penalty would be found unconstitutional by Judge Hudson. He acknowledged, however, that it would make little difference since ultimately all healthcare lawsuits would be appealed to the Supreme Court, and the final decision would come within the next two years.

Dr. Hazel explained that a number of Task Forces had been created to explore different aspects of healthcare reform in order to create recommendations for implementation. These Task Forces included delivery of a healthcare group, a reimbursement/finance group, a healthcare workforce (scope of practice) group, an insurance reform group, and The Healthcare Information Technology Group.

One point that Dr. Hazel made specific to mental health was that Medicaid mandated changes would be instituted regarding coordination and collaboration of care between the Community Mental Health Boards (CSBs), hospitals, private practitioners, and ancillary care organizations such as group homes or foster homes. He did not go into details about this matter, just that there would be changes made on a systemic level. He also noted that nothing would be "off the table" with regards to "cost savings" ideas, and specifically cited the idea of a Medicaid Psychotropic Formulary that used generics with a "fail first" policy. He explained that this alone would result in a savings of $1.6 million.

Dr. Hazel concluded his presentation by reflecting on the interpreted theme of the meeting...that there was a paradigm shift occurring in medicine at this moment that was vital for the sustenance of organized medicine and the future of the country.

In The News

PSV Blue Ridge Chapter Update

By Joe Mason, MD, DFAPA

The Blue Ridge Chapter continues to host bi-monthly meetings. We're getting a good turnout of 20-25 people, a mix of physicians from private practice, with a few UVA residents and retired doctors from Westminster-Canterbury sprinkled in. The last speaker we had was Bruce Greyson, who is the Director of the Center for Perceptual Studies, a foundation within UVA dedicated to the study of reincarnation and near-death experiences. It was great! We hope to get more participation from UVA faculty, Region 10 and Western State, but it has been a steady group for this year.

Please join us in making a contribution to PSYCHMD-PAC by visiting www.psva.org.

New Clinic Opens in Hampton Roads

By Abbot Granoff, MD
Board Certified in Psychiatry

Loyola University Medical School, in the suburbs of Chicago, closed their Sexual Dysfunction Clinic last year after 39 years when the founder Domeena Renshaw, MD, psychiatrist, retired. There was no other Medical School based program like it anywhere in the country. I did my residency training at Loyola and rotated through the clinic. My wife, Ann, rotated through the clinic as my co-therapist.

We have always wanted to open a similar clinic in Hampton Roads since moving here and starting my practice in 1977. Last year, 2009, we started putting the pieces in place. Working with Dr. Renshaw over this past year, we finally put together a program and launched our Marital/Sex Therapy Clinic in August 2010. As a result, Hampton Roads now has the only (psychiatrist/co-therapist) team in the country offering Loyola style sexual dysfunction treatment. For further details please refer to our website: www.drgranoff.com/sextherapy.

WHERE ARE WE GOING?
THE FUTURE OF PSYCHIATRY AS I SEE IT

By Ram Shenoy MD, DLAFAPA

My interest in psychiatry was triggered by a tragic incident that occurred when I was working in a mental hospital in Trivandrum (currently Thiruvanandapuram), the capital of the Indian state of Kerala. I had just finished my residency in medicine and was looking for a job until I could finish my final examinations. I functioned as an internist and was very happy in the position. Halfway through my tenure there, I was asked to take care of a young man from a prominent family. He had a scholarship in a prestigious college in the city. He had a strong family history of Bipolar Disorder, then called Manic Depressive Illness. As was usual in those days, I was asked to administer ECT treatments to him. He improved remarkably well and I was planning to discharge him to his family within a week after the end of the series of ECT. I had to finish my exams and had to take a week long leave of absence, leaving my colleague instructions to have him monitored. I returned a week later and was told that he had left against medical advice when he found out that he had lost his scholarship because of missing many classes. I called his family and was told that he had committed suicide by jumping into a river. I was stunned and very upset. I blamed myself for not understanding the dynamics of what happened. I was ignorant about the functions of the mind. When I later left for the United States, I was determined to go into the field of psychiatry.

The year I started my residency, first at Central State Hospital and later at MCV, was the beginning of the golden age of psychiatry. I was offered a large stipend, due to the fact that I had transferred from internal medicine to psychiatry. Many of my colleagues had done the same. Many new medications and treatments had been introduced in the 1970s. Most of the emphasis was on psychotherapy and medications were considered to be an adjunct to the therapy. Those were the halcyon days of our profession. Medications were available but they had major side effects and we administered them with respect. Treatment was directed at the person and not the symptoms. Before HIPAA rules were introduced, I would not make a diagnosis without talking to the family or close friends or partners.

The turning point came in the 1980s when the second generation of antidepressants and antipsychotic agents were introduced for the treatment of psychiatric disorders. These medications were obviously less likely to cause overt side effects like tardive dyskinesia and the antidepressants were less likely to have fatal effects in overdoses. At one of the APA meetings, I remember one of the then famous psychopharmacologists proclaim that if we did not prescribe the second generation medications, we would be liable for malpractice claims. Alas, he spoke too soon. The malpractice claims for side effects like tardive dyskinesia pale in comparison to the claims for metabolic disorders and suicide that seem to happen with the newer medications.

Part of what I do in my retirement is peer review for Medicaid admissions in hospitals. I was shocked to see many patients diagnosed with schizoaffective disorder. Many of them were given the diagnosis without exploration of past history and information from the parents or staff of previous group homes or facilities. In my entire 35 years of practice, I have only made one diagnosis of schizoaffective disorder. I feel that the entity exists but is rare, as mentioned in a recent *British Journal of Psychiatry*. The patients that I reviewed who were diagnosed with schizoaffective disorder were on five or more medications, sometimes with more than one antidepressant and several antipsychotics. No reason for this massive polypharmacy was mentioned in most cases. The patient often was subdued and discharged or transferred to a State Hospital, where rational pharmacology is usually instituted and the patient recovers. I do not feel that this is a universal practice in psychiatry, but it is prevalent in many hospitals.

The field of psychiatry has mostly abandoned psychotherapy, relying on medications and by splitting treatment with therapists, who perform the psychotherapy. This is a prescription for disaster and for inviting litigation, unless one is fully aware of what the therapist is doing. Treatment is based on symptoms and not on the patient. The biggest gap of knowledge is in the treatment of development disorders including intellectual disability. Very few psychiatrists are trained in these conditions and often treat them without a clue as to how to approach the disorders. They are often over medicated, causing serious side effects. Behavioral treatment is ignored and there is no attempt to consult with the few psychiatrists who have experience in the field.

I am very pessimistic about how our field is going. It seems to be going from being a glorious profession with great understanding of the body and psyche to a mechanical machine which tries to emulate the other fields of medicine. We have to deal with long-term, sometimes lifetime disorders with patience, empathy and understanding of the human mind and body. If we do not do so, we will be like the lemmings of Norway, who jump into the ocean, probably with a full understanding that they will perish.

THE APA ASSEMBLY RULES COMMITTEE

By John P. D. Shemo, MD, DFAPA

The Rules Committee of the American Psychiatric Association Assembly is essentially a work group composed of representatives of each of the seven area councils, as well as representatives of the members-in-training, early career psychiatrists, minority and under-represented caucus, and the allied organizations. The Chair of the Rules Committee traditionally is the immediate past speaker of the Assembly. The members of the Rules Committee are appointed by the Area Councils or the other above-referenced constituent groups. They are of such diversity and are so directly "answerable" that it is hard to conceive of a coalition of Rules Committee members developing that which would have any

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MANAGED CARE LIAISON COMMITTEE: STATUS OF MENTAL HEALTH NET NEGOTIATION

By John P. D. Shemo, MD, DFAPA
Chairman, PSV Managed Care Liaison Committee

As Chair of the Managed Care Liaison Committee and in response to concerns expressed by PSV members, I have been attempting to engage in a dialog with Coventry/Southern Health/MHNet regarding their policies and procedures concerning authorization and reimbursement for psychiatric services. Southern Health and MHNet are both subsidiaries of Coventry Health Care. It is noted that in 2009, *Physicians Practice* ranked Coventry as the worst insurance company in the country in regard to business relations with physicians. Interestingly, in their recently published yearly article presenting these ranking, *Physicians Practice* changed their policy and only published those companies with the best ratings; no longer revealing which companies received the worst ratings.

In any case, on August 3, 2010, I did send the following letter of concern to Allen Wise, the CEO of Coventry.

> "As Chairman of the Managed Care Liaison Committee of the Psychiatry Society of Virginia, I am writing to express my concern/dismay/outrage as your subsidiary, Mental Health Net, continues, after July 1, 2010, to ignore what we view as both the spirit and even the letter of the mental health parity legislation that went into effect on the above-referenced date.
>
> Given the fact that Coventry is the parent company of Southern Health as well as Mental Health Net, with whom Southern Health is contracted, Coventry is, of course, ultimately responsible for the actions of its subsidiaries and vendors.
>
> Under parity legislation, health insurers are prohibited from requiring or imposing any limitations in coverage or authorization of care requirements on the treatment of psychiatric disorders that are not applied to all other medical illnesses. Obviously, such practices are continuing. While Mental Health Net recently rescinded their preauthorization requirements for CPT Code 90862, they did not do so for other treatment codes utilized by psychiatric physicians in providing care for their patients. The failure to facilitate combined treatment by psychiatrists – the integrated provision of both psychotherapeutic and psychopharmacologic modalities – we would contend is an ill advised clinical and business decision on your part, as such combined treatment is both more efficacious and ultimately more cost effective. But this is a discussion for another time.
>
> Going back to the central topic of this discussion, the failure of Mental Health Net to discontinue the requirement of preauthorization for psychiatric treatment using codes such as 90805, 90807, and 90846/47, when preauthorization is not required for E&M codes for the treatment of other medical disorders, or paradoxically, even when used by primary care physician to treat psychiatric disorders, is not acceptable. Two potential solutions are proposed.
>
> The first is simply that, in keeping with the intent of the mental health parity legislation, you instruct Mental Health Net to cease and desist in requiring any preauthorization reports or imposing any caps or limits on the treatment of patients with psychiatric diagnoses treated by psychiatrists that are not imposed on the treatment of all other patients with all other medical diagnoses.
>
> The alternative would be to allow psychiatrists in Virginia to utilize evaluation and management (E&M) codes for the reimbursement of the services they provide to their patients. We find it offensive to us and discriminatory towards our patients that we are the only group of physicians who provide cognitive services in direct patient care who are not "authorized" by your company to use any applicable CPT code. I would remind you that states such as New York have not only implemented legislation that in fact stipulates that any physician must be allowed by all insurers to utilize any applicable CPT code, but further ordered insurance companies who had not been allowing this to retroactively compensate psychiatrists for their past failure to do so.
>
> I am hopeful that we will be able to achieve a resolution to this matter that will both bring Coventry and its subsidiaries into compliance with the parity laws and end what would certainly seem to be discriminatory practices that have been and are injurious to persons with psychiatric illnesses."

Mr. Wise did not respond directly, but rather sent the letter to Peter Harris, MD, Medical Director of MHNet. Dr. Harris in turn sent the following response dated August 26, 2010:

> "This is in response to your letter to Mr. Allen Wise, of Coventry Health Care, Inc. ("CHC") regarding MHNet Specialty Services, LLC ("MHNet"), a wholly owned subsidiary of MNHet. Mr. Wise forwarded your letter to me for response. Specifically, your letter questioned MHNet's prior authorization criteria and standards. As described in further detail below, MHNet's prior authorization criteria and standards are in compliance with the Parity Regulations.
>
> Under the Parity Regulations, medical management standards (which would include prior authorization criteria and standards) are considered a Nonquantitative Treatment Limitation ("NQTLs") which is a limit affecting the scope or duration of benefits under the plan that is not expressed numerically. The Parity Regulations specifically distinguishes quantitative treatment limitations (a limitation expressed in a numerical value, e.g. annual limit of 50 outpatient visits) from NQTLs. The Parity Regulations indicate that NQTLs must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical benefits in the same benefit classification, "except to the extent that recognized clinically appropriate standards of care may

permit a difference.' [Emphasis added.] See 26 C.F.R. § 54.9812(c)(4); 29 C.F.R. §2590.712(c)(4); and 45 C.F.R. § 146.136(c)(4). Therefore, the Parity Regulations establish a different test to determine if NQTLs are compliant and allows variations to the extent that clinically appropriate standards support the variation.

MHNet, on behalf of Southern Health Services, Inc., any many of its other clients, requires prior authorization to determine the medical necessity of mental health and substance abuse benefits, including but not limited to, outpatient therapy. Such requirement is supported by clinically appropriate evidentiary standards based on recommendations made by experts in this field of practice. As a result, the Parity Regulations permit this requirement.

Pursuant to a change effective July 1, 2010, MHNet no longer requires prior authorization or makes a determination of medical necessity with respect to an initial assessment/evaluation for treatment of a patient by a provider. (Please note. MHNet will require prior authorization of these services only if a member's benefits are limited to treatment by a participating/contracted provider and the member wants to obtain treatment from a non-participating/non-contracted provider.) (CPT codes 90801, 90862, 99210, 99202, 99203, 99204, 99205, 99304, 99305, and 99306) or medications management (CPT code 90862). However, as noted above, MHNet requires authorization of outpatient therapy/treatment beyond the initial assessment. Therefore, procedure codes that may include a medication management component and therapy or other outpatient treatment of the patient continue to require prior authorization as described above.

For the reasons set forth above, MHNet believes that its prior authorization standards and criteria are in accordance and permitted by the Parity Regulations. I would like to discuss this issue and any other concerns you may have with MHNet. Therefore, I will contact your office to arrange a time for us to discuss that is convenient for you."

Following receipt of this letter I did have a cordial but frank telephone discussion with Dr. Harris on September 9, 2010. I did point out to him that the MCO that manages care for the State of Virginia employees did recently end preauthorization requirements for psychiatric treatment except for ECT in response to parity legislation. Thus, that MCO obviously, like the PSV, does not agree with Dr. Harris' argument. Following our discussion, he sent the following e-mail:

> "It was very helpful talking to you just now. I now have a much better appreciation of your concerns as well as the status of psychiatric care in Virginia. I'll need to do some further research and get back to you. If you don't hear from me within a few weeks please don't hesitate to contact me directly."

Also in August, another group in Charlottesville who was in contact with the faculty senate at the University of Virginia which is under contract for healthcare coverage with Coventry/Southern Health/MHNet, sent a copy of the above-reproduced letter to Mr. Wise to the human resources administrators at UVA. This group, in turn, received the following acknowledgement from the COO of UVA: "Thank you for the information. I understand your concern and we hear you." Shortly thereafter the University of Virginia did not renew their contract with Coventry, effective at the start of 2011.

After several weeks with no further response from Dr. Harris, I left messages at his office, but have had still no response. I will note that their system has been having a lot of turnover in medical director positions recently and I do not know if Dr. Harris even continues in his position. In any case, I have sent the following follow-up letter to Mr. Wise.

> "The Managed Care Liaison Committee of the Psychiatric Society of Virginia has received a reply to the letter we sent to you on August 3, 2010 from Peter Harris, MD, Medical Director at MHNet.
>
> I spoke with Dr. Harris by telephone on September 9, 2010. Following our discussion he did send me an e-mail stating that he would need to do some further research and would get back to me regarding the concerns expressed in our letter. He stated further "If you don't hear from me within a few weeks please don't hesitate to contact me directly." This was over six weeks ago. I did leave a message for Dr. Harris in the past week but have not received a reply.
>
> As you may be aware, the State of Virginia employees will no longer be subject to preauthorization requirements for psychiatric evaluation or treatment under their health insurance plan. We expect that the State of Virginia will find it difficult to support the continuation of insurance/managed care policies for other citizens of the Commonwealth which they do not find acceptable for State employees.
>
> We are requesting to know whether this response from Dr. Harris is fully endorsed by Coventry Health Care and if it constitutes Coventry's full response to the issues we raised in our above-referenced letter.
>
> Thank you in advance for your attention to this matter."

It is unclear how long this process will take, but the Psychiatric Society of Virginia does believe that we have an obligation to both our members and our patients to maintain pressure on the insurance industry to comply with both the letter and the spirit of parity legislation.

Poster Session, PSV Fall Meeting, September 10-11, 2011

The Psychiatric Society of Virginia had a very successful poster session at this year's Fall Meeting. Seventeen posters were accepted, representing all of the resident training programs in Virginia. Two guests from the APA; Annelle Primm, MD, MPH, and James H. Scully, Jr., MD, participated as judges, along with Mary Shemo, MD, DFAPA. They came up with a new and innovative approach to this task. Rather than having a first, second and third place, this year we have the best poster in three different fields. The three category winners are listed below.

Analysis of Systems Category

Using Electronic Medical Record Remote Data Access to Compare Inpatient Bed Utilization in the 12 Months Pre- and Post-Residential Substance Abuse Treatment

By Margarita Somova

The primary goal for the project was to record utilization of inpatient mental healthcare services in the 12 months pre- and post-admission to residential substance abuse treatment (RRTP) to determine if there is a change in inpatient utilization post-treatment. Electronic medical records within the Veteran Affairs (VA) System were reviewed utilizing the remote directory function. This allowed for inclusion of the eight VA hospitals in the Mid-Atlantic region which have inpatient mental healthcare units.

Based on results, RRTP treatment is positively associated with a decrease in both the number of admissions and days of care in the 12 months post-treatment. Utilizing the electronic remote data feature allows for a more thorough evaluation of mental health inpatient care in this veteran population.

Case Study Category

Catatonia as the Presenting Symptom in Systemic Lupus Erythematosus

By Sean D. Pustilnik

Catatonia is a syndrome of physical and behavioral abnormalities that can result from psychiatric, neurological, or medical illness. Although Systemic Lupus Erythematosus (SLE) is commonly known to cause neurological and psychiatric manifestations, it has only rarely been reported to cause the catatonic syndrome. In nearly all previously reported cases the diagnosis of catatonia was reported in patients with established diagnosis of lupus. We report a case where a woman with no known past medical history presented with catatonia that did not respond to standard treatment with benzodiazepines, suffered a long and complicated hospital course, and was eventually diagnosed with lupus. With initiation of treatment for lupus her symptoms of catatonia remitted. This case illustrates the importance of considering medical causes in the diagnosis and treatment of psychiatric disorders, especially the catatonic syndrome.

Clinical Measurement of Treatment Category

Depression in Patients with Low Testosterone Levels

By Pavan Dontineni Venkata, MD: Sreekant Kodela, MD; Rizwan Ali, MD; Brian V Shenal, PhD

Major Depressive Disorder [MDD] is a significant cause of morbidity and mortality worldwide. There are several postulates associating MDD with various neuroendocrine abnormalities like hypothyroidism and hypogonadism. Age related decline in testosterone is associated with various nonspecific symptoms including depressive symptoms like anergy, amotivation, anhedonia, insomnia, sexual problems and decreased cognitive abilities. However this relationship is confounded by various factors including co-morbid medical illnesses, obesity, substance abuse, etc. and is thus complex. In our research, our objective was to test the presence and strength of association between depression and testosterone levels in a sample of veteran population who had their testosterone level checked in the last six months for various reasons. We compared the rates of depression in patients with low and normal testosterone levels. We also studied the presence of any association between hypogonadism and other variables like BMI, substance abuse, diabetes and other endocrine abnormalities.

Our study did not find any clear evidence of an association between MDD and low testosterone level. Though it did not reach statistical significance, there appeared to be an association between low testosterone, thyroid abnormalities and BMI. Review of literature suggests that attention should be paid to the select population like elderly males, patients with significant sexual problems or fatigue as main complaints and it is worthwhile to check the testosterone level. Low testosterone is easily treatable with replacement therapy and may aid in the treatment of depressive symptoms.

2010 Fall Meeting Poster Entries

1. **Jagadamba Pandit, MD**; Jim Poindexter, ANP; Antony Fernandez, MD; Akm Sulaman, MD: Hepatitis C in Recovering Opiate Addicts
2. **Sean Pustilnik, MD**; Alexandru Trutia, MD: Catatonia as the Presenting Symptom in Systemic Lupus Erythematosus
3. **Margarita Somova, MD**: A Case of Transient Psychosis, Possibly Due to Vasoocclusive Disease From Sickle Cell Anemia
4. **Pavan Venkata, MD**; M. Rizwan Ali: Role of Testosterone in Depression
5. **Benjamin Griffeth, MD**: Sociodemographic and Clinical Profiles of OEF / OIF Veterans Presenting to a Psychiatric Emergency Room
6. **Gagandeep Singh, MD**: Prevalence and Management of Insomnia in Patients Presenting to Psychiatric Outpatient Clinics
7. **Syed Raza, MD**: An Analysis of Disruptive Nocturnal Behaviors Using the PittsburghSleep Quality Index (PSQI-A) in Male Military Veterans with Post Traumatic Stress Disorder.
8. **William H. Cerrato, DO**: Analysis of Adverse Events on an Acute University Hospital Psychiatric Ward
9. **Taral Sharma, MD, MBA**; Champa H. Rajanna, MD; David W. Hartman, MD; Suzanna C. Jamison, PhD; Jon M. Sweet, MD; Susan P. Russell, NP: Substance Abuse in Primary Care: A Retrospective Analysis
10. **Jaclyn Crawford, DO, PGY2**: Likely case of Usher Syndrome Presents as Psychosis
11. **Roopa Sethi, MD**: Are Home Visits History?
12. **Robert Filler, BS**; Leslie Kryzanowski, MD; Antony Fernandez, MD: Treatment of Paraphilia in a Veteran with Bipolar Disorder and Vascular Dementia: A Case Report and Review of Literature
13. **Aidith Flores-Carrera, DO, LT, MC, USN**: Videophones: A Literature Review of an Underutilized Telemental Health Vehicle
14. **Kokil Chopra, MD**: A Case of Mania in a Patient with Systemic Lupus Erthematosus: Can Its Inflammatory Pathogenesis be Applied to Primary Mood Disorders?
15. **Martin Paspe Cruz, PharmD, CGP, BCPP**: Risk of Aseptic Meningitis with Lamotrigine
16. **Rabia Jaferi, MD**, Jessica Mess Cambell, MD: Reversible Hearing Impairment Causing Transient Audiotry Hallucinations In Patient with no Previous Psychiatric History.
17. **Neeta Kumani, MD**, Abigail Dwiggins: Movement Disorder in a Somatizizing Patient: A Case Report.

A Rational Approach to the Utilization of Atypical Antipsychotic Medications in Children Under Six

By Aradhana Bela Sood, MD, MSHA, FAACAP
Professor of Psychiatry and Pediatrics
Chair, Division of Child and Adolescent Psychiatry Medical Director, Virginia Treatment Center for Children Virginia Commonwealth University Health Systems

DMAS has been concerned about the patterns of use of atypical antipsychotic in children under the age of six. They have (under the auspices of their DUR board and advisors Drs. Shenoy and Dhillon) attempted to develop a protocol to oversee the use of this class of medications in young children. They are concerned about a) inappropriate use of atypical antipsychotics in this population; b) long term effects, and c) inadequate ongoing monitoring of key indices by prescribers.

I was asked to provide guidance to DMAS for the development of guidelines and eventual implementation of the guidelines for prescriptions of atypicals for very young kids. I believe this is a good opportunity for us to develop a rational and achievable approach that translates into the best and safest care for kids and families. To that end through the list-serves available we asked for input from AAP, AACAP members, Child Neurologists and PSV leadership anchored to the questions below. The rationale was to elicit feedback from practitioners who provide valuable service and form the child mental health service delivery system because of the paucity of child psychiatrists.

In crafting the protocol I consider it important to seek provider input that in part would inform the guidelines. Provider input will assist in guiding policies that are rational and when embedded in best practices will translate into good care for children and families. It is also hoped that the interactive model of child psychiatry oversight to provide input into decisions made to medicate this age group will shed light on the challenges and barriers that the field of providers face when diagnosing these subgroups of children requiring these medications. The interactive nature of the oversight will also provide an educational vehicle and help with work force training. The feedback has been overwhelmingly positive especially from pediatricians and child psychiatrists. In summary: In addition to using provider feedback and several quality indicators gleaned from national best practices, following are guiding principles:

a) Due to the vulnerability of the under six age group and the resulting complexities of diagnosis, the assessment of the phenomenology of psychiatric illness (in this age group that requires atypical antipsychotics) must reside with physicians with expert training in child mental health.

b) Recognizing the work force problems, we have to create processes that emphasize that any child requiring atypicals below the age of six must have an exchange of information between an expert consultant (child psychiatrist) and the prescriber (psychiatrist, pediatric neurologist, pediatricians) so that we can arrive at a reasonable diagnostic understanding which should inform prescribing practices. The absolute numbers are not so large that this cannot be achieved.

c) Prescribing of atypicals must be, in most cases, accompanied by therapist interface to address relevant treatments such as parent training, family therapy and individual work to provide additional scrutiny over psychopathology and its evolution. This assumption is based on the notion that such young SED kids with a need to be on atypicals should be in therapy. If the lack of therapy is secondary to lack of area resources, then this should become a local resource issue that should be discussed with stakeholders (e.g. public or private foundations/ officials) and must be developed.

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APA COMMITTEE REPORT: MINORITY AND UNDER REPRESENTED (MUR) COMMITTEE

By Antony Fernandez, MD, DFAPA
Deputy Representative
MUR Group- IMG (2010-2013)

APA is composed of a number of District Branches (DBs), representing Psychiatrists throughout the United States, Canada and Puerto Rico. The APA has divided the District Branches (DBs) into seven different distinct groups named Area Councils. Each Area Council serves as a forum to discuss business pertaining to the different DBs in the APA, as well as to nominate and elect an Area Council Chair and Deputy Chair both of whom represent the Area Council in the Assembly Executive Committee (AEC). In addition, the Area Council also nominates and elects an Area Trustee to the APA Board of Trustees (BOT).

The Minority and Under Represented (MUR) Committee is an Assembly Committee. All of the different Assembly Committees have specific tasks and their members are selected by an appointment process headed by the Speaker of the Assembly through the AEC, with the exception of the MUR Committee. The function of the MUR Committee is different, broader and most resembles the function of the Area Councils than that of an Assembly Committee.

The MUR Committee is composed of two elected members from each of seven different Caucuses. These groups are the American, Alaskan and Hawaiian Natives Caucuses, the Asian American Caucus, the Caucus of Black American Psychiatrists, the Gay, Lesbian and Bisexual Psychiatrist Caucus (GLB), the Hispanic Caucus, the International Medical Graduates Caucus (IMGs) and the Women Psychiatrist Caucus, for a total of 14 voting members. Each of the seven caucuses forming the MUR Committee represents a different and distinct group in many ways, resembling the diversity of the different District Branches (DBs). Each caucus, according to their individual guidelines, elects a President, an Assembly Representative and an Assembly Deputy Representative.

The Representatives each have one vote in the Assembly and will have all of the privileges of any other Representative of the Assembly. The Deputy Representative will have all the privileges of any District Branch Deputy Representative of the Assembly. The responsibility of the Representative will be to provide a report to the minority group after each Assembly meeting regarding all issues considered and the Representative's vote on those issues that come up for voting. The regular reports of the Minority/Underrepresented Groups to the Assembly reflect on an ongoing basis on the problems and progress in solving the problems that affect Minority/underrepresented psychiatrists and the patient populations they reflect.

The MUR Committee Chair is nominated and elected by the MUR committee members from among the seven Caucus Assembly Representatives and Deputy Representatives. They also function as the 14 members of the MUR Committee, in a manner resembling how the Area Councils nominate and elect their respective Area Council Assembly Representative and Deputy Representative. The MUR Committee Chair represents the MUR in the Assembly Executive Committee.

The APA Board of Trustees (BOT) passed a resolution cancelling the voice-only seat occupied by the Black Psychiatrists in the BOT. The Board of Trustees (BOT) passed a motion in March, 2009 establishing a BOT MUR voting seat to be occupied by the MUR Committee Chair. Some concern has been expressed that the position should be occupied as a result of a nationally contested election using similar rules to those existing for the election of other Trustees to the Board. The BOT has not implemented the above stated resolution, waiting for recommendations on how best to achieve a fair nomination and election process to elect the MUR Trustee. The Area Council Trustee candidates are nominated by the Area Council and the election is carried out through the vote of all the Area Council DBs membership.

Several modifications have been suggested and are in the process of discussion within the committee and the APA. One suggestion is to have the Assembly MUR Committee become the "MUR Caucus Area Council" and cease to be an Assembly Committee. This MUR Caucus Area Council as proposed will adopt the same general structural guidelines as stated in the APA Operations Manual (OM) for the seven existing Area Councils and adapt them to the specific needs of all the seven Caucuses in question, with their expanded responsibilities in the Minority Caucus Area Council thus formed. The MUR Area Council as proposed will follow the same guidelines as the seven Area Councils, to elect their Reps to the Assembly AEC and to elect the MUR Trustee with specific adjustments to be developed to accommodate the individual Caucus peculiarities and fairness in representation.

Whatever the outcome of the negotiations, the APA as an organization in transition and it remains to be seen how the concerns of the constituent members are best addressed. I welcome comments and suggestions from readers.

MEDICAL SCHOOL NEWS

UVA Update

Clinical Research in Residency Training: A Group Approach

By Meredith Lee, D.O., PGY-3

Imagine twelve very distinct personalities in one room trying to accomplish a common goal. While this may sound much like jury duty, this is how the 3rd year psychiatry residents at University of Virginia in Charlottesville, VA are spending one hour weekly learning about clinical research. The common goal: trying to design a research protocol as an entire class. This is the concept behind UVA's weekly research seminar developed by Dr. Anita Clayton. Since 1994, the third year Psychiatry residents at UVA have participated in a yearly seminar which meets one hour per week for the duration of the PGY-3 year. The purpose of this seminar is to spend one year, as a class, to brainstorm ideas and develop a research project from start to finish. The components of the seminar are as follows:

1. Orientation to clinical research: The first month of the seminar is to help residents understand the value of clinical research and "demystifies" the process of conducting clinical research.
2. Selection of a research topic: The next 2-3 months are spent brainstorming about clinical problems and producing a list of possible research ideas.
3. Design the research protocol: The following 2-3 months are spent developing the design of the research protocol, developing primary and secondary hypotheses, and learning principles of inferential statistics and sampling methods.
4. Preparation of IRB protocol: Residents split the task of writing the protocol, consent form, and summary study schedule over a 4 month period.
5. Preparation for data collection: The final portion of the seminar spends 1-2 months designing clinical research forms, designing computerized databases for the study, and learning research techniques such as the Structured Clinical Interview for DSM.

While the first year of the research seminar is conducted during the PGY-3 year of residency, residents may continue the project through their PGY-4 year if needed to recruit subjects and collect data.

As someone who worked in the clinical research industry for 5 years prior to attending medical school, I was skeptical of how beneficial this seminar would be as a learning experience. I have never really enjoyed group projects during medical school and tend to think it is easier to work on projects independently. I previously was very interested in conducting

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Eastern Virginia Update

By Stephen I. Deutsch, MD, PhD
Ann Robinson Endowed Chair in Psychiatry
Professor and Chairman, Department of Psychiatry and Behavioral Sciences
Department of Psychiatry and Behavioral Sciences

I am delighted to have this opportunity to summarize several exciting developments within our Department. Most importantly, this column also provides me with an opportunity to thank publically our outstanding faculty and administrative support staff.

I would like to begin by welcoming Drs. Tuesday Burns, Justin Petri and Potter Henderson, who have joined our Department over the past year. Dr. Burns is already actively involved in several specialized clinical initiatives, including therapeutic brain modulation and the clinical challenges of depression presenting during pregnancy. Dr. Petri has assumed primary teaching responsibilities on our inpatient residency training unit within Sentara Norfolk General Hospital, in addition to developing special programs in Community Psychiatry and Student Health. Dr. Henderson is a child psychiatrist, who will work to create a program in Child and Adolescent Psychiatry. Importantly, Drs. Burns, Petri and Henderson are actively participating in teaching and clinical supervision with our medical students and residents.

I am also very pleased that Dr. Paul Sayegh has agreed to create a Division of Education within our Department that will address Psychiatry's contribution to the undergraduate medical school curriculum and define the didactic and clinical experiences of our residents. The practice of the 21st century psychiatrist must be informed by developments in genetics, functional brain imaging, neurochemistry and psychopharmacology, in addition to traditional diagnostic and psychotherapeutic modalities.

Consistent with the goal of developing special programs that can only be found within academic health centers, I am very pleased with the enormous progress that Dr. Maria Urbano has made with the program that she directs for adolescents and young adults with autism spectrum disorders. Dr. Urbano has already evaluated more than 20 persons with autism spectrum disorders within this transitional period of their lives (i.e., leaving or about to leave the educational system and losing eligibility for "entitlements" to a variety of specialized services while transitioning to "independent" living). Dr. Urbano is working with this underserved population and has identified an inventory of resources that may facilitate the successful transition of her patients into independent living status. Importantly, the infrastructure of her program will be able to support complementary research and teaching activities, including clinical trials of novel medications and

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UVA Update

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clinical research as a practicing psychiatrist, but have been overwhelmed by all the hard work it entails. However, after spending the past 3 months in the research seminar, I realize two things: how beneficial the research seminar is and how my attitudes are slowly changing about the feasibility of developing and conducting a study.

For the past two months, the twelve of us and our leaders, Dr. Anita Clayton and Dr. Veronica Harsh, have spent one hour weekly in a room brainstorming, debating, and trying to come up with a good research question. We have discussed all kinds of potential research topics from the effects of the Virginia Prescription Monitoring program on prescribing practices in the psychiatric setting to evaluating the efficacy of risperidone vs. lithium in borderline personality disorder. We brainstormed over 30 different ideas, narrowed the topic list to our top 4 choices, and voted for our favorite.

I am not sure if other residency programs use a 'group approach' for training residents about clinical research. Per Clayton and Sheldon-Keller, this approach offers several advantages including 1) being less intimidating for residents; 2) allowing for flexibility in demands on individuals while maintaining the momentum of the project; 3) operating within an organization that is familiar to residents; 4) encouraging a cooperative approach to research as a team which prepares residents for research projects in the 'real world'.

Overall, this experience has been a positive one thus far. Not all of us agreed on the final research topic, but we all had a chance to vote for our favorite ideas. We each played a role in suggesting possible research ideas, performing a literature search to see what data already exists for those topics, and discussing pros and cons of each of the potential research questions.

While it is still early in the seminar and we have not yet started developing the research design, I am excited to see what my classmates and I will complete at the end of the year. I look forward to working with my peers to achieve a common goal: a completed research study and potential publication. Even though we spend uncountable hours reading research articles as medical students, residents, and eventually practicing physicians, there has always been something frightening and intimidating about taking on a research project. With the help of Drs. Clayton and Harsh, as well as my eleven classmates, the concept of developing a study is not so scary anymore.

Reference:
Clayton and Sheldon-Keller. The design and evaluation of a group research experience during psychiatric residency training. *Academic Psychiatry*, 25:1, 2001: pps. 68-76.

Eastern VA Update

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integrated psycho/social/vocational interventions designed to promote successful outcomes.

The Therapeutic Brain Modulation program within the Department that is co-Directed by Drs. Tuesday Burns and Serina Neumann is aligning a novel treatment modality with research and teaching interests. The ability to deliver transcranial magnetic stimulation in an academic health center invites inquiries for inter-Departmental collaborations, such as exploring the effectiveness of this intervention in special populations, including pregnant women with major depression and dermatologic patients with complaints of chronic itch. Also, the influence of this intervention on inflammatory mediators that may participate in the pathophysiology of major depression are additional opportunities for collaborative research that can only be pursued within an academic health center.

I was also gratified with the selections of Drs. Paul Sayegh and Maria Urbano as two of our region's "Top Docs" by Hampton Roads Magazine.

Dr. David Spiegel continues to be extremely productive with several seminal publications in the Consultation and Psychosomatic literature over the past academic year. Importantly, Dr. Spiegel has expanded his consultation services in Sentara Norfolk General Hospital, improving the care of our patients, enriching the learning experiences of our trainees, and forging stronger collaborative alliances with other Departments throughout the medical school and hospital.

Our training programs in all Mental Health disciplines continue to be over-subscribed with applicants, consistent with their excellence. Moreover, our administrative staff must be acknowledged for their continued commitment to the community, as reflected in their participation in a major evening benefit for the homeless.

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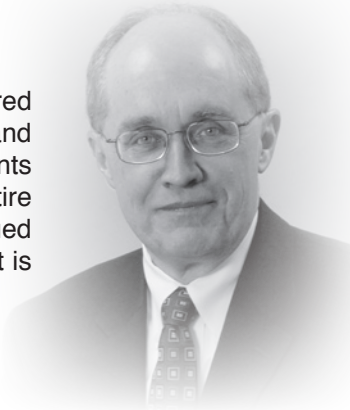

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President's Message

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political landscape with the statement "There are not sides, only trenches." This underscored APA's efforts in government relations to make sure we are part of the conversation as healthcare delivery changes with the advent of the Medical Home and the Healthcare Reform.

Some salient observations were that the need for physicians is ill-defined because according to the Institute of Medicine 1996 survey there seems to be a surplus of specialists versus primary care physicians. However, there exist different ideologies on the definition of "need." "Need" may be best defined as need for "services" and the aspects of a healthcare system will then define supply, demand and thus surplus. Thus, depending on the model the U.S. might need 2,989 psychiatrists or 358,696 psychiatrists as of a study based in 1997. The data was interesting in that he broke down the distribution of total physicians in the U.S. as a whole, by State, by specialty and further presented data on the interplay between wages and the Gross Domestic Product. In addition, APA does not truly have a definitive number of psychiatrists because Boards of Medicine allow physicians to self-designate. As of 2008, there were 954,224 physicians and 40,904 were psychiatrists or 4.2% of all physicians. Psychiatrists have average salaries of $154,000 per year. This varies by state, but is comparable to the mean for all physicians which is around $165,000. As of 2006, the study found that psychiatrists were the third specialty (under pulmonary and infectious disease) to achieve the largest increase in compensation.

His concluding observations were that continued economic expansion seems assured as population growth continues to exceed official estimates. Demand for Specialty Services is increasing while demand for Primary Care physicians is plateauing. The average physician work effort is decreasing while opportunities for non-primary care physicians to provide primary care and lower complexity specialty will grow. (This relates to the Medical Home Models, i.e. blood pressure routine checks and management). The newer models of care ensure that more physicians will be needed to provide higher complexity specialty services and to integrate care (medical home or team based models). If there is a lack of physicians to provide services that are demanded, patients will look to other health professions (nurse practitioners).

The discussion of topics continued during the Resident panel discussion. This was one of the most exciting and meaningful aspects of the meeting. A panel consisting of an Early Career Psychiatrist and Residents in various levels of training gave an experiential view of psychiatry and practice at their current level. Dr. Scully responded to challenges facing these individuals and accepted feedback from the audience. This made for a lively discussion. The Residents participating were Danielika Danelison, PGY4 from Medical College of Virginia and Aidith Flores-Carrera, Naval Academy and Member-in-Training Board representative. Dr. Stephen Cunningham, Member-at-Large (one year) was the Early Career Psychiatrist and graduate of Eastern Virginia Medical School. Topics such ACGME mandates, continuing education, and how the APA interfaces with these requirements were some of the topics. The inclusion of Residents in the Fall meeting was important to the Planning Committee. Helping Residents understand how the APA will benefit them as Residents and as Early Career psychiatrists will encourage membership at the local and National levels.

The Resident Symposium was founded by Dr. Edward Nieves, Past President. It has been hugely successful. This year there were 17 entries. On behalf of the PSV, I would like to acknowledge and thank the attending/faculty mentors who assisted these residents in making these entries possible. The PSV Foundation has supported expenses of the Symposia. Your donations to the Foundation make similar opportunities possible for the residents. This activity serves to fulfill GOAL III: To foster science and the progress of psychiatry. Thanks to all resident participants! Everyone is a winner!

The afternoon session turned our attention to *Innovations and Challenges of a New Decade in Mental Health*. Innovations in technology, such as telemedicine, are becoming more relavent. Could this technological innovation be the answer to rural communities and help with shortages of psychiatrists? Would scope of practice discussions be impacted? The membership received an opportunity to review advances and challenges of telemedicine with two keynote speakers. Tony Graham and Varun Choudhary are experts in this field. We were treated to a historical overview of the development of the field. Dr. Graham focused on rural areas and practice. The technical aspects were discussed, as well as ethics and outcomes. Dr. Choudhary utilizes telemedicine in his forensic practice. We discussed licensure issues if the practice extends state to state.

Last, but certainly not least, Dr. Pandurangi took us through a tour of neuroscience to the current age of the machine. Are medications for depression going to be a thing of the past? What a fabulous lecture from a world renowned researcher! Innovation in pharmacology and neurosciences are spawning not only new medications and medication delivery systems but also new devices such as trans-cranial magnetic stimulation. His lecture entitled, *Neural Circuitry in Depression* explored the neural basis of emerging neuro-modulation therapies including trans-cranial magnetic stimulation (TMS), Vagal Nerve Stimulation (VNS). Cutting edge research such as retinal stimulation techniques was also discussed. The demystification of the technology will serve to encourage incorporation of these new technologies into practice. Dr. P, as he is fondly known at Medical College of Virginia, was very optimistic about the future of psychiatry. He stated that there will be procedures and non-pharmacological interventions to be performed that will enhance our repertoire of treatments and serve to enhance our specialty practice and thereby our demand as specialists, and subsequently our income.

Before I close, I would like to take the opportunity to recognize Cal Whitehead, our PSV Lobbyist. Cal has labored hard to make certain that the interests of PSV membership are represented in legislative spheres. Scope of practice issues are at the forefront. Last year, he led the effort in helping us defeat a psychologist prescribing study. He ensures our views on Mental Health Reform Legislation are heard. He oversees

The MCV/VCU residents had a great time at the PSV Fall meeting in Williamsburg. It was wonderful to meet and share experiences with other psychiatry residents from Virginia and to attend educational lectures. It was also exciting to exhibit posters and participate in the panel discussion with Dr. Scully.

trends in state budget funding for mental health and lobbies for increase. He alerts us to failed or carried over Bills and gives us opportunities to represent the PSV as experts.

While we members often dialogue about these issues, it is appalling that Cal announced at the Fall Board meeting that our MD PAC was basically empty. What is the significance of this? Cal stated that psychologists have basically many more funds available to lobby than we. In a tough economic time when opinions about healthcare and dollars are reeling from left to right, we must ensure we can be at the table to have our views heard and push through legislation. We cannot do that without funds!

By definition, the PsychMD-PAC is a fund that raises money from Virginia psychiatrists to fund General Assembly and statewide candidates in their fight to promote a better environment for psychiatric care delivery. Political contributions help offset the expenses of campaigns and allow us to target our message to decision makers. At the Board meeting, Cal challenged the Board members that he would match the amount they gave with his own money. This is unprecedented! Cal believes so strongly in the need to fund the PAC he is giving back a portion of his own salary to keep our membership at the bargaining table. Cal's salary is paid by the PSV and not the PAC Stewart Hinckley of Ruggles pledged the same to the Board! I implore all members to give to the PsychMD-PAC. Donations are accepted via the APA dues renewal form, at the PSV meetings or by mail to the PSV (form is on website, www.PSVA.org). Make checks payable to PsychMD-PAC. GOAL II is to promote advocacy and ethical care for the mentally ill. The PsychMD-PAC seeks to fulfill this goal. Cal is there when we cannot be. Support your PsychMD-PAC!

In closing, I would like to thank you for your confidence in my leadership as President. I want to thank everyone from Ruggles (Andrew Mann, Matt Van Wie, Stewart Hinckley, Kim Battle and all of the others) because there is a lot of work behind the scenes to make a successful meeting. I would like to thank all of our exhibitors as well. See you all in the Spring!

THE APA ASSEMBLY RULES COMMITTEE

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viable agenda to overstep or abuse the powers since such a coalition would essentially need to be unanimous. The Committee is charged with reviewing all new business and action papers to be presented to the Assembly in the upcoming Assembly meeting. These meetings are held twice a year. There is a deadline set for the submission of action papers to allow sufficient time for review by the Rules Committee. An action paper can be submitted after the deadline as "new business" from the floor, but will only be considered if the issue is of pressing importance and/or has come up after the above-referenced deadline. The committee then holds several evening conference calls to discuss assignment of the action papers and other agenda items.

Action papers are written by individuals or small groups who have delineated a concern that they think should be addressed by the Assembly. The committee reviews these papers to assign them to various assembly groups for further review and refinement. The committee can recommend that they be put on the consent calendar, in which case they are "automatically" passed with acceptance by the Assembly of the consent calendar. Any single member of the committee or the Assembly can move that an item put on the consent calendar be taken off for full review and vote by the Assembly, and this request by a single member will be honored. Given this ability of any member to put an action back on the agenda, the committee tends to only put actions on the consent calendar that they truly believe to be non-controversial.

Actions not put on the consent calendar are assigned to various levels of review and refinement. Most are assigned to reference committees composed of representatives from the area councils, MITs, ECPs, MURs, and allied organizations. The five reference committees are assigned papers thought to be relevant to their specific areas of interest. These include: advocating for the patient, advocating for the profession/work force issues, supporting education/training/career development, defining/supporting professional values, and enhancing the scientific basis of psychiatric care/governance issues. At the Reference Committee meetings, the writer of the paper presents their rationale for moving their paper. Any Assembly member may attend these committee meetings and question/challenge the aspects of the paper. Following the meeting, the committee can vote to refer the paper "as written" to the Assembly, can recommend that the paper be rejected, or can present a revision of the original paper based on the debate that occurred in the meeting. The author of the paper can accept the committee revisions or move that their original paper be considered. The Assembly then votes to either accept or reject the revised paper. If the revised paper is rejected by the Assembly, the Assembly then votes to accept or reject the original paper.

Some papers are sent for review by various designated groups within the Assembly structure such as the MITs or ECPs. Like the Reference Committees, they review the paper with input from the authors and make a recommendation to the Assembly to either accept or reject the paper. Again, the original author can still move that the full Assembly vote on a paper that has been

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THE PSYCHIATRIC SOCIETY OF VIRGINIA
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THE APA ASSEMBLY RULES COMMITTEE

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rejected or revised by committee. Some papers felt to have very broad implications can be assigned to two or more area councils for review.

The Rules Committee may decide that an action referred for consideration be rejected if it is thought to be unprofessional in content or language. This is a rare event. Virtually all Assembly members have had long tenures on their District Branch Boards of Directors and have held offices in their District Branches. Typically, they have also held tenures in other professional organizations, and well understand the need for civility even in the face of disagreement.

I am currently in my third two-year term as the Area V Representative on the Rules Committee. While this assignment is very labor intensive, I have found it interesting and rewarding. The function of the Rules Committee is critical in establishing the flow of the deliberative process that will allow the full Assembly to consider and contribute to a lot of work in the three days of the Assembly meeting. This, in turn, is the mechanism by which the APA can be maintained as a member-driven organization.

In conclusion, I wish to remind all PSV members that they are entitled to sit in as observers at all Assembly meetings and that Ram and I are always open to suggestions and feedback regarding potential action papers to be brought by the Virginia Delegation to the Assembly floor.

A RATIONAL APPROACH...

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d) Widespread education and dissemination of standard (nationally recognized) best practice guidelines (from AACAP and other organizations like the Texas algorithm for children in the welfare system) must be available to all CAPS and other disciplines who prescribe these medications to young children. We already have guidance on these issues through current AACAP endorsed parameters. Let us use them to inform our day to day practice. CAPS can lead the way and serve as consultants to our colleagues when they are less than clear about diagnosis or the best approach to the presenting illness. As we utilize this approach, gradually the knowledge base concerning the phenomenology of childhood disorders will increase, best practice treatment interventions will become more available to all providers and it will not require such scrutiny.

Let us use this opportunity to work together to enhance care and prevent iatrogenic illnesses in this vulnerable population. If the process works like it is intended, it will be a win-win for children/families, providers as well as payors.

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