

THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

SUMMER 2013

A MESSAGE FROM THE PRESIDENT

The Patient Protection and Affordable Care Act

Rizwan Ali, MD, DFAPA
PSV President

Dear Colleagues,

Thank you very much for giving me the opportunity to serve as the President of the Psychiatric Society of Virginia this year. After a huge success at the Spring Meeting in Richmond, VA, we plan to move towards the east coast and have worked very hard to organize a fabulous program for you this Fall in Portsmouth, VA. As you all know, we covered psychotherapy in our Spring Meeting and invited some outstanding leaders in this field to talk about a rightful place of psychotherapy in modern psychiatry. Thank you for your participation. We expect the same enthusiasm and attendance in our Fall Meeting when we discuss the *Advances in Psychiatry Through Molecular and Genetic Research*. We have invited some highly-respected and well-known speakers to learn about these updates. Please make every effort to attend and bring other colleagues with you to make our Fall Meeting even more successful than the Spring Meeting.

I am honored to introduce to you our new officers who were elected recently by the PSV membership. I am confident that the next leadership will take our organization to even higher standards and will help us prepare to meet with the challenges of an ever-changing, brighter and exciting future. Please welcome Brian Wood, DO, FAPA (Roanoke),

President-Elect; Caroline V. Coster, MD (Richmond), Secretary; Varun Choudhary, MD, FAPA (Richmond), Treasurer; Maninder Singh, MD, DFAPA (Hampton), Member-at-Large (one year); Susan Waller, MD (Richmond), Member-at-Large (two year); and David Freeman, MD (VCU), Member-in-Training.

We are going through a great time of transitions. The billing and coding system was recently revised. It is being used and also reviewed for several needed improvements. With the release of the DSM-V, there will be big adjustments as practitioners adapt to many changes in the coming months. Another very important transition is the Patient Protection and Affordable Care Act (ACA) (also referred to as Obama-Care), which was signed into law on March 23, 2010 and will go into effect in January, 2014. Its implementation is going to be incremental and will be complete in 2022. When implemented, it may not be in its original form (like any other complex legislation), it will probably



Rizwan Ali, MD, DFAPA

Continued on page 14

SEE YOU THIS FALL!

PSV FALL 2013 MEETING

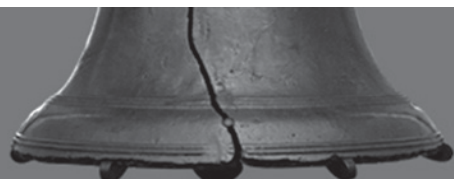
**Advances in Psychiatry
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September 20-21, 2013

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TRENDS IN MEDICAL STUDENT EDUCATION

By Greg Briscoe, MD; John Spollen, MD; Kathy Stack, MD;
 Lisa Fore Arcand, EdD; Edwin Nieves, MD

As clinicians, we face a flurry of changes in the medical world; so do teachers and learners in the medical student education arena. For example, medical student educators (MSE) have a responsibility to ensure that medical students have a uniform experience and all complete the same objectives.¹ Recent advances in technology have enhanced and extended the MSE's capacity to do so. That is, the recent release of Articulate Storyboard™ software allows a solo MSE to produce narrated clinical video cases, which combine real patient interviews and didactic instruction. Previously, this sort of production was prohibitively expensive for the average MSE. Consequently, a multi-institutional group from the Association of Directors of Medical Student Education in Psychiatry at (ADMSEP) has produced five peer-reviewed, publicly available, web-based clinical skills videos, with over 20 more in various stages of productions (<http://www.admsep.org/csi-eModules.php>). While studies are still underway, preliminary results are reflecting positive student education benefits. Hopefully, when the online library is completed, it will help ensure that students, regardless of where they do their clinical rotation, will all benefit equally in their exposure to patient pathology.

Somewhat analogous to the buzz of the practitioner level "patient centered medical home" is the emerging model of the longitudinal integrated clerkships (LIC) found in approximately 17 worldwide medical schools now. LIC programs are typically different from traditional, discipline-specific block clerkships in that students do not have discrete rotation blocks, but rather follow a cohort of patients through their clinical experiences in the core clinical disciplines. For example, if the student's patient has a surgical problem, he will view the surgery, follow-up after the surgery and also follow-up with the patient's primary care provider and/or other discipline providers, as necessary.

The pioneer of this model in the U.S. was Harvard Medical School-Cambridge, and they have shown that students in the integrated clerkship "performed as well as or better than their traditionally trained peers on measures of content knowledge and clinical skills. CIC students expressed higher satisfaction with the learning environment, more confidence in dealing with numerous domains of patient care, and a stronger sense of patient-centeredness."²

However, other studies have found mixed data, i.e. UCSF authors compared traditional, longitudinal and hybrid curricula and found that "student performance on the U.S. Medical Licensing Exam Step Two (clinical knowledge) was equivalent across models."³ Worldwide, limited outcomes data "suggest that students who participate in these programs are more likely to enter primary care careers."⁴

The last topic we wish to discuss is that of recruitment of medical students into the field of psychiatry. Psychiatry is a shortage specialty, with critical shortages in general as well as child and adolescent psychiatry.⁵ According to the resident census data from the APA, the percentage of students entering psychiatry residencies upon graduation from U.S. allopathic medical schools since 2005 ranges from 1.7% to over 10%, so there is a large spread between the highest and lowest recruiting schools. Knowledge which factors are associated with higher recruitment rates may assist in developing strategies to increase recruitment of medical students into psychiatry. Previous reports have listed potentially relevant factors including graduating student debt, annual tuition for in-state students, percentage of international medical graduates in the school's psychiatry residency program, perceived strength of the department compared with other departments in the school and whether the behavioral science or clerkship director was the recipient of a teaching award.^{6,7}

A collaborative effort between the

Division of Education at APA and ADMSEP has begun to further evaluate potentially important factors. Last Fall education leaders in medical student education in psychiatry were surveyed concerning various factors that could be important. The factors that correlated with success were:

Psychiatry departmental and resident reputation and the attitudes towards psychiatry as a profession by non-psychiatry faculty and other students.⁸ So, Departments of Psychiatry with a better reputation and schools with less “anti-psychiatry stigma” appear to recruit more students into psychiatry. However, a simple cause and effect relationship is unlikely and there is still a lot of work to be done before we know how best to make psychiatry a more attractive specialty for medical students.

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JUNE BOARD BRIEFS

By Joe Mason, MD, DFAPA, Blue Ridge Chapter President

The PSV Board met on Saturday, June 22, 2013 in Richmond, VA to discuss current issues facing the society.

The Board looked at the list of APA General Members to identify who might be eligible to apply for Distinguished Fellow. It was agreed to encourage qualified members to apply. See box on page 8 in this newsletter for details.

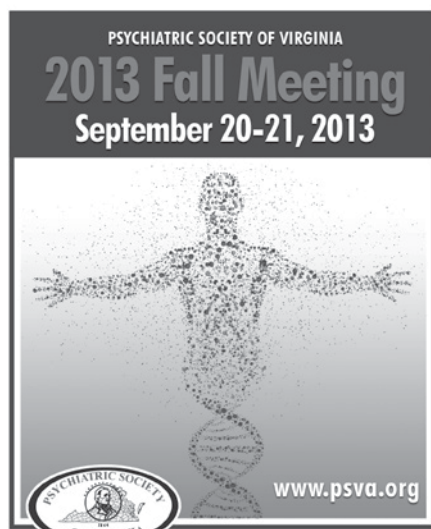
The PSV Board asks that you contact them if you are interested in applying for Distinguished Fellow at PSV@societyhq.com. The Distinguished Fellows Committee will be happy to review your qualifications prior to submitting an application.

Drs. Ram Shenoy and John Shemo continue to represent us in the APA Assembly and reported on the most recent meeting at the APA Annual Convention in San Francisco, CA. Dr. Shemo was unable to attend this meeting, the first time in many years due to his wife's illness, but submitted an action paper that was unanimously supported by the APA Assembly, yet was ignored by the APA board. The subject of the action paper was the need to amend the process for passing a referendum. This currently requires a quorum of voters, which is impossible to achieve and has not been met in any election in years. Dr. Shemo will present it again at the next assembly meeting.

Dr. Vic Vieweg, Immediate Past President, suggested an ad hoc committee be formed to discuss the future of psychiatry, as our profession attempts to adapt to the Affordable Care Act and the ever-expanding encroachment of the insurance industry on our ability to practice; the intent is to take a proactive approach and take a stance with legislators who determine policies that affect our profession. Please let us know if you are interested in being on this committee.

The PsychMD Political Action Committee fund is almost empty. PSV has an outstanding pair of lobbyists Cal Whitehead and Ralston King, who work hard for us. This coming November there will be elections for Governor, Lieutenant Governor, Attorney General and all 100 seats of the House of Delegates. Please consider contributing to PAC as every bit helps! <https://secure.societyhq.com/psv/PsychMD-PAC.iphtml>.

Dr. Becky Lindsay attended the APA's training for DSM-V at the APA Annual Convention. She will give a training session at our Fall PSV Meeting in Portsmouth. The meeting is Friday, September 20 and Saturday, September 21 and Becky's presentation will be Friday at 4:00 pm.



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INTEGRATION OF PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY: FROM RESIDENCY TO PRACTICE

Summary of a talk presented at the PSV Spring Meeting, March 23, 2013

By John R. Urbach, MD

Why should psychiatrists in 2013 need a reminder about the value of psychotherapy or the power of integrating it with medication treatment? Nearly four centuries ago Rene Descartes, the great philosopher, mathematician, and pioneer of the Scientific Revolution, promoted the concept of dualism, stating that the mind is a non-physical substance, associated with consciousness and self-awareness; he distinguished this from the brain as the seat of intelligence. He thus presented the “mind-body problem” in its modern form. His genius notwithstanding, Cartesian dualism appears to have been a blind alley, and findings in modern neuroscience do not support this view. The field now operates under the prevailing assumptions of physicalism, i.e., that all mental, emotional, and behavioral events must have a tangible substrate.

This certainly fits with what we see in our practices every day. Psychotropic medications “change our mind” along with our brain, e.g. the delusional patient, reflecting back on how bizarre a past experience had been. Newer, and perhaps less familiar to us, is the notion that psychotherapy can, “change our brain” as well as our mind. Dr. Glen Gabbard heralded these findings in 2000, anticipating, “a new era of psychotherapy research and practice in which specific modes of psychotherapy can be designed to target specific sites of brain functioning.” Studies from 1996 on thyroid hormone (T4) levels in MDD patients showed that CBT treatment produced decreases in the latter, parallel to those from AD meds. In 2001, Nobel laureate Dr. Eric Kandel, claimed that, “Therapy has the potential, just as learning and memory do, to alter the brain’s functions at the gene level.” He predicted that new imaging techniques would support this view, and indeed data rapidly emerged. PET scan studies revealed higher baseline metabolism for MDD patients in the prefrontal cortex, caudate, and thalamus. Patients randomized to treatment with paroxetine or interpersonal psychotherapy showed parallel changes toward normalization. Similar findings were demonstrated with behavioral therapy of OCD.

In the past few years, functional magnetic resonance imaging (fMRI) has studied focal brain responses to both medication and psychotherapy. A 2012 study on hoarding disorder mapped focal differences in brain activation between patients and healthy controls asked to discard objects; the fMRI variations tended to normalize after a course of CBT treatment. Other intriguing fMRI studies noted changes of brain activation after short-term psychodynamic inpatient therapy for panic disorder, and in fronto-striatal activation after CBT for OCD. We have, in fact, witnessed an explosion of findings, with more than fifty major papers on the correlates between fMRI findings and psychotherapeutic interventions listed in Pub Med within the past three years.

For psychiatric residents and new practitioners, the

dilemma might be, “So which is better? If meds can change the mind as well as the brain, and psychotherapy can change the brain as well as the mind, then how do I choose?” Significant data has addressed these questions. A 2011 meta-analysis searched databases for all randomized control studies comparing CBT and pharmacotherapy, in adults with major depressive or anxiety disorders. This review summarized 21 papers on anxiety disorders (1,266 subjects), and 21 papers on depression (2,027 patients). CBT showed a statistically significant advantage over medications in panic disorder, while medications and CBT were “tied” in the treatment of depression. This analysis, and many other studies, imply that what is really better in the treatment of most anxiety and mood disorders is combined therapy.

A landmark 2000 study on the treatment of more than 600 patients with chronic depression revealed approximately equal response for those patients receiving nefazodone alone (55%) or a cognitive-behavioral analysis psychotherapy treatment (52%); those receiving a combined treatment demonstrated a remarkable 85% improvement. A 2008 study on childhood anxiety disorders followed 488 patients randomized to CBT, sertraline alone, combined sertraline and CBT, or placebo for a period of 12 weeks. The differences in outcome widened over the course of the study, and clearly showed the greatest benefit for combined treatment.

Diagnoses with documented benefit from integrated care include MDD-R, bipolar disorder, schizophrenia, bulimia, PTSD, and (in children) OCD. Some diagnoses for which the value of combined treatment remains less clear are OCD in adults, panic disorder, GAD, and dysthymia.

It is worth recalling what our “traditional” expectations are for each component of a combined therapy. Those for psychopharmacology include:

- Treating paralyzing, disruptive, and urgent symptoms/syndromes
- Decreasing hostility, impatience, distractibility, avoidance, that restrict ability to participate in other treatment
- Offering hope of a more rapid therapeutic response
- Providing a treatment option for patients who cannot or will not engage in psychotherapy

Psychotherapies facilitate:

- Rapport building and trust
- Recognizing dysfunctional patterns
- Understanding problems’ origins and perpetrators
- Defining an agenda for change
- Confronting fears and resistances
- Building self-esteem
- Resolving conflicts/thought-behavior barriers

- Gaining empathy/better interpersonal relationships
- Achieving more autonomy and self-awareness

If we then ask how psychotherapy can augment pharmacology, the following are among the benefits:

- Adds to brain changes produced by meds
- Addresses non-med factors (e.g., self-esteem, developmental issues, relationship problems, family role)
- Deepens rapport and patients' belief in recovery
- Addresses resistances, including med compliance, pessimism, masochism, authority conflicts
- Engages others in the therapeutic task; monitoring treatment, reducing acting out

There are other benefits to combined treatment, notably in the area of relapse prevention. Stopping meds is often a "calculated risk" and we know that for chronic or recurring conditions the relapse risks are high. After stopping completed psychotherapy, relapse rates are notably lower; adding a psychotherapy to continuing med use can increase remission times. This has been clearly demonstrated in studies adding CBT to medication treatment for MDD, for bipolar disorder, and more recently for other disorders.

Combined treatment really exemplifies the special education and skill set of the American psychiatrist, and why we offer great potential value as diagnostic and treatment "integrators." We are uniquely suited to unite a medical, biopsychiatric, developmental and psychotherapeutic approach, yet often seem blocked from doing so. Rationales for avoiding psychotherapy in modern practice may include the following:

- Reimbursement issues (generating more income by brief med checks)
- Professional identity (disease model, biological perspective, treating more patients)
- Psychotherapy demands different skills (unpredictability, fewer algorithms, managing transference/counter-transference)

However, if psychiatrists abdicate the role of "integrator", don't we lose value? Many other physicians can and do prescribe psychotropic meds; many psychologists, social workers and others are skilled therapists, often more so than we; our greatest value may be recognizing the "whole picture" and intervening at multiple levels.

If we do embrace the integrative mission, then "who does what?" Psychiatrists practicing combined treatment must choose between a "one person" and "two person" (or multi-person) model of care. Providing both psychopharmacology and psychotherapy ourselves carries potential costs, e.g., income, skill sets, and the emotional demands of therapy. Benefits include a fuller awareness of the case, having fewer separate patients to track, and the professional satisfactions of diverse activity. The "two person" model may provide a less complete sense of the patient and complexities in coordinating care. However, such split treatment can provide more total clinician time and coverage, a wider choice of therapists, potentially better allocation of expertise, and the opportunity for collegial support and learning.

Even for psychiatrists who practice minimal psychotherapy, the notion of "dynamic psychopharmacology" represents an inescapable psychological intervention, to promote medication compliance and basic treatment rapport. Such issues as the meaning to the patient of taking medication, the tactful presentation of potential side effects, promoting treatment optimism, and capturing the "placebo effect" are implied in this approach. The placebo effect is real, has a significant and measurable clinical impact, and has even been demonstrated in PET scan studies; it thus behooves us as practitioners to harness it for the patient's benefit. Dynamic psychopharmacology can also allow us to:

- Confront both the sick role and the fear of being labeled
- Maintain some patient responsibility for recovery
- Clarify the outcome goals, i.e., becoming your "best possible self," not passive, indifferent, or emotionally flat

Over a 30-year period of training psychiatric residents, I have tried to promote our role as the best potential treatment integrators. The distilled version of that message is as follows:

- Training teaches treatment approaches somewhat separately, for the sake of clarity
- Clinical reality rarely presents such "pure" cases, but complex "mixtures" of difficulties
- Patients come to us just wanting to feel better. They do not carry labels identifying their ideal treatment
- Simple reductionism rarely provides a real treatment answer. Our brains are still more complex than the best computers. Yet even for computers, we pursue problems at different levels (hardware, software, application, format of inquiry)
- Symptoms can be viewed both as descriptive psychiatry (DSM) and as symbolic expression (psychodynamic meaning)
- Prescribing a medication conveys a psychological message to a patient as well as a pharmacologic effect
- There is not a "pill" for every human problem
- Problems without "pill" solutions may still be significant, debilitating, painful and open to relief
- There is not a psychotherapy for every human problem
- Problems without psychotherapy solutions may respond to "biological" interventions, general medical care, and a variety of lifestyle changes
- Patients coming to a psychiatrist may have no idea of what psychotherapy is or how it works; they need "informed consent"
- Many studies point to superior efficacy of "combined" or "integrative" treatments for a variety of disorders (Depression, GAD, Bipolar, etc). Learn to be an integrator in your care, and to value/collaborate with other MH professionals for the full benefit of your patients.

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APA ANNUAL MEETING OF THE ASSEMBLY IN SAN FRANCISCO

By Ramakrishnan S. Shenoy, MD, DLFAPA

My colleague, Dr. Shemo, could not make the meeting because of his wife's illness and we missed the astute information that only he could present.

The Assembly was very well done and the action papers were worked on without any major problems. Seven of the action papers were withdrawn by the persons who had authored the action paper. The most interesting paper was about the unsubstantiated idea that mental illness was the cause of violence. This was easily put down by a large majority. The most discussed issue was about the role of weapons in the community. Several papers were talking about this issue. Eventually, the four papers were amalgamated into one and won without problems.

Revitalization of the public perception of the APA and the psychiatric profession were adopted after an amendment. Another issue was that of a positional statement on the American Board of Psychiatry and Neurology (ABPM) Data Management Practices.

The DSM-V was initiated at the meeting and the Assembly passed an action paper to provide DSM-V to help teaching to district branches.

These were the major issues discussed:

- The meeting held in San Francisco was well appreciated by people from the USA and other countries.
- The venue of the meeting was good but the usual privileges, like having water, paper to jot our thoughts and giving correct information to the members attending the meeting were very poor.

WELCOME TO OUR NEW MEMBERS

MEMBERS IN TRAINING

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Niketa Desai, MD Norfolk, VA
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Contact: Patricia H. Troy, CAE, Executive Director

The Senior Psychiatrists, Inc., formerly the APA Lifers, was recently granted Allied status by the American Psychiatric Association Assembly. This action paves the way for the newly formed organization to continue a strong presence within APA to address the interests and concerns of senior psychiatrists.

The Senior Psychiatrists will continue with the work of the APA Lifers, including sponsoring a workshop at the APA Annual Meeting, awarding the Berson Award (for contributions after receiving Life Member status), and mentoring. At the 2013 Annual Meeting, in addition to the workshop, they held their Annual Business Meeting and a well-attended reception sponsored by the American Professional Agency.

Membership as a Life Member of APA is required for membership in the Senior Psychiatrists. Paul Wick, MD, DLFAPA, of Tyler, Texas, is president.

Dues are \$50 per year and may be paid online at <http://seniorpsych.org>.

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PSV HELPS SHAPE MSV 2014 LEGISLATIVE AGENDA

By Cal Whitehead

PSV Advocacy Coordinator

The MSV Legislative Committee met on June 25 to consider seventeen proposals for the 2014 Legislative Agenda. Varun Choudhary MD, PSV Legislative Chairman and Treasurer, represented the Psychiatric Society of Virginia. Payor prior authorization reforms, advocated by PSV and the Washington Psychiatric Society for several years, were included in a proposed package of managed care practice modifications that will be recommended to the MSV Board of Directors for inclusion in next year's legislative agenda. Another major topic of discussion were proposals addressing public policy that dictated standards of care or protocol (e.g. mandatory ultrasounds, Lyme disease testing, radiologic screenings). The Committee ultimately advanced a proposal to the MSV Board that would create a multi-specialty workgroup to determine and develop recommendations outlining a structure for dealing with this type of legislative or regulation outside the political process and focused on science to reduce interference in physician-patient treatment decisions. The Committee members also engaged in a lengthy discussion about protecting the title "physician" from being used by non-physicians. The Committee will ask MSV Board and staff to further analyze different mechanisms that could ensure patients are not confused or misled by health care professionals' labels. The MSV Board of Directors will consider these items and additional information from staff research at its September 21 meeting in Richmond.

Please contact Cal Whitehead, PSV Advocacy Coordinator, for more information about these issues and other legislative questions at cwhitehead@whiteheadconsulting.net.



From left, PSV Legislative Chair and Treasurer, Varun Choudhary, MD, Kelly Williams Northam, State Senator Ralph Northam, MD, and Adam Kaul MD, PSV Past President.

WHY BECOME AN APA FELLOW

Being a Fellow is an honorary designation that was created by the APA Membership Committee and Board of Trustees to recognize early career members who have demonstrated allegiance to their profession and commitment to the on-going work of the Association. Most members who pursue Fellow status perceive it as one of the first steps to enhancement of their professional credentials. Fellows are recognized by their colleagues in the APA as a member of a very select group and are permitted to use the FAPA designation on all of their professional documentation. You do need to be board certified; you do not need a letter of recommendation. Fellow applications require review and comment from the member's district branch/state association and approval by the APA Membership Committee and Board of Trustees. All newly appointed Fellows are publicly recognized at the Convocation of Fellows and Distinguished Fellows, which is held every year during APA's Annual Meeting. Fellows receive a lapel pin as a symbol of their status and an embossed Fellow certificate to display with pride in their office.

**Fellowship applications submission
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IN THE NEWS

EVMS UPDATE

By William H. Lemley, MD, PGY-3

Eastern Virginia Medical School Psychiatry and Behavioral Sciences is excited to announce our new interns, Niketa Desai, Amer Khan, Kristen Nelson, and John Thurston for 2013 academic year as they begin their trek on July 1st.

As we welcome our new trainees with open arms, we say a bittersweet goodbye to our PGY-4 graduates as they move onward in their careers. Fortunately for us, three of our four graduates have decided to stay in the area to provide psychiatric care to the community and continue to take part in the teaching tradition.

Rabia Jafri, MD, who is interested in psychodynamic therapy, is joining Rock Landing Psychological Group, a group in Newport News, with the ultimate goal of having her own psychodynamic practice. She also plans to stay in touch with the EVMS program through teaching the residents as a member of the Community Faculty.

Abigail Dwiggens, MD has accepted a position as a Staff Psychiatrist with the City of Virginia Beach's Mental Health/Substance Abuse Division with Adult Outpatient Services. Her time will be divided between providing crisis stabilization services and outpatient psychiatric services.

Jessica Mees-Campbell, MD, our chief resident, plans to remain in the area with her family to practice adult psychiatry and will continue to be involved with leadership duties and resident teaching at EVMS and surrounding training facilities.

Neeta Kumari, MD, and her family have decided to relocate to the west coast, and will work in private practice at Riverside County Department of Mental Health in Riverside, CA.

Election to Alpha Omega Alpha is an honor signifying a lasting commitment to scholarship, leadership, professionalism, and service. A lifelong honor, membership in the society confers recognition for a physician's dedication to the profession and art of healing. This year, the EVMS Chapter of the Alpha Omega Alpha Medical Society inducted Dr. Armin Ansari and Dr. Justin Petri for their contributions to this noble profession.

In other related news, Dr. Maria Urbano and Dr. Kathleen Stack were recipients of the 2012-2013 Irma Bland, MD Certificate of Excellence in Teaching Residents for their outstanding sustaining contributions to resident education as faculty of EVMS.

Along with our graduates, we are also proud to celebrate Dr. Purnima Gorrepati who recently left us at the end of her third year to start a two-year fellowship in child psychiatry at the University of Chicago. We wish her well.



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Call for Abstracts

PSV is calling all Medical Students, Residents and Fellows to submit abstracts for the Fall Meeting Poster Session. **Deadline for submitting abstracts is August 16, 2013.** PSV is especially interested in studies on suicide prevention. There is a \$500 prize available for the best study on suicide prevention. APA has also given PSV a grant to promote this activity. If your abstract is accepted you may be eligible for reimbursement of travel expenses. There are no registration fees for Members in Training.

For more information please visit the PSV website:

www.psva.org

Send questions to: psv@societyhq.com

VCU DEPARTMENT OF PSYCHIATRY

By Joel J. Silverman, MD

James Asa Shield, Jr., MD, Professor and Chair

We have just celebrated a very special day for our graduates with a recognition event for Dr. John Urbach after 28 years of service to the Department as Residency Training Director. Many of our former graduates attended one or all of the events. Dr. Deborah Hales, Education Director of the APA, was our special Grand Rounds speaker. Grand Rounds followed an early morning coffee and discussion of the development process of the DSM-V by Dr. Ken Kendler as well as a tour of our new McGlothlin Medical Education Building. A dinner at the Commonwealth Club closed out the daylong appreciation and recognition events. Five thousand dollars (\$5,000) was contributed to the Rindler/Urbach Fund for Resident Education. John continues to serve the Department as master teacher, clinician, mentor and trusted colleague.

This year we have another reason to celebrate. After over 50 years of offering the best in child and adolescent psychiatry, that we will be building a new state-of-the-art Virginia Treatment Center for Children in the near future. It is with humble appreciation to Mrs. Eva Teig Hardy, Mr. Bill Murray, Del. Dr. John O'Bannon, Gov. Bob McDonnell and the Virginia Legislature, that we will be able to realize the dream to replace the hugely outdated VTCC. Virginia's Legislature voted and the Governor signed, the bill to award \$56 million for the construction. We are in process of raising an additional \$15 million for programs and faculty recruitment for our department. We are now interviewing architects and design firms to find the one which will give us a great product.

Since the last newsletter, we have recruited new faculty and staff. Dr. Gerry Moeller is our new Professor and Chair of Addictions Psychiatry. Dr. Joel Steinberg joins as a Professor of Psychiatry in the Addictions Division. Both professors have illustrious backgrounds and are featured in our Spring newsletter. Drs. Moeller and Steinberg are establishing an fMRI Center to advance brain based research. This is a very important new research tool for our department and VCU. The Moeller-Steinberg recruitment was greatly facilitated by our Dean, Dr. Jerry Strauss.

RESIDENTS BREAKOUT SESSION AT THE PSV 2013 FALL MEETING

There will be a breakout session especially for Residents and Medical students after lunch on Saturday, September 21, 2013. This session is titled, *Life after Residency*. It will feature a panel of recently graduated psychiatrists discussing their experiences in finding a job. A frank discussion on the perils and pitfalls of finding a job in either public or private practice will take place. There will be lots of time for questions from the audience. There is no charge for Residents to attend.

VTC DEPARTMENT OF PSYCHIATRY

By Anita S. Kablinger, MD, CPI

Professor and Residency Training Director

Department of Psychiatry and Behavioral Medicine

Carilion Clinic-Virginia Tech Carilion School of Medicine

Over the past academic year, Virginia Tech Carilion Psychiatry has been a busy place!! Some of our residents were selected for prestigious honors and awards. Jennifer Wells, MD was selected by the VTCSOM class of 2014 for the Arnold Gold Foundation Humanism and Excellence in Teaching Award during the MS3 psychiatry clerkship. Dan Kline, MD and Taral Sharma, MD received the Virginia Laughlin Fellowship Award for excellence in psychodynamic psychotherapy. Aaron Clark, MD was awarded the American Psychiatric Association Diversity in Leadership Fellowship. Finally, graduating academic chief resident Taral Sharma, MD, MBA received the inaugural APA Resident Recognition Award at graduation.

Our graduates for the 2014 academic year include Drs. Jagdeep Wander, MD, MS; Amara Chudhary, MD; Dan Kline, MD, administrative chief resident Michal Cieraszynski, DO, and Taral Sharma, MD, MBA. Dr. Cieraszynski, DO will be remaining on staff at the Salem VA Hospital. A formal graduation ceremony and reception was held at Hotel Roanoke. Our incoming Administrative and Education Chief Residents for the 2013-2014 will be Drs. Joseph Mingoia, MD and Adam Zavodnick, MD, respectively.

The Annual Departmental St. Albans Conference this year was held in January, 2013. We were fortunate to host Glen Gabbard as our honored guest speaker.

The first class of VTCSOM students has completed their third year clerkships and faculty evaluations have been very positive! The medical school is excited to have the very first class completing their fourth year in 2014 and look forward to great residency placements. VTCSOM was also selected to host a National Interprofessional Team Training Conference in 2014 – one of the trademark domains of the medical school curriculum.

A new residency interview process of psychiatry applicants was incorporated this past year as training programs began the all-in NRMP process. In this model, the applicants rotated through 11 interviewing stations – each of which highlighted various strengths of our program. This allowed for a more informative experience for the applicant while offering an opportunity for more faculty to interact with and assess each applicant.

Our program participated in the newly revised residency match process whereby no offerings of pre-matching candidates may be made by any participating residency program. We interviewed 74 people and ranked 55. We filled all eight resident positions through the match and accepted one additional candidate after the match, for a total of nine incoming PGY-Is for the 2013-14 year. All are US citizens and include four women and five men with two DO graduates.

We look forward to a great 2013-2014 academic year and hope to network with our fellow Virginian training programs and state meetings.

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EASTERN STATE HOSPITAL in beautiful Colonial Williamsburg, VA is hiring board-eligible/board-certified adult or geriatric psychiatrists and psychiatric nurse practitioners to work in the In-Patient Units.

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For immediate consideration, please submit your application online at <http://jobs.virginia.gov>

For further information, contact **Nelia San Jose-Carlson, MD (Medical Director)** at 757-253-4309.



MEDICAL DIRECTOR WANTED

Magellan Health Services has been contracted by Virginia's Department of Medical Assistance Services (DMAS) to be the Behavioral Health Services Administrator (BHSA) for members enrolled in Virginia's Medicaid/FAMIS Plus/FAMIS programs. Magellan is now seeking a board certified psychiatrist to serve as the Medical Director in our Virginia Care Management Center (CMC). The candidate must be licensed in Virginia, or be eligible for licensure in Virginia. The Medical Director provides oversight of a comprehensive medical policy implementation, utilization management services, and is responsible for developing and sustaining an interface with member forums and facilitates the delivery of appropriate care. The Medical Director plays a vital role in developing the clinical mission of the CMC and will have a direct impact on the quality of care for members in BHSA programs. Psychiatrists interested in exploring this opportunity should contact Kevin Palisi at (860) 507-1955 or email kjpalisi@magellanhealth.com. Apply online at <http://www.magellanhealth.com>.

EMPLOYMENT OPPORTUNITY CLINICAL DIRECTOR

Physician Program Manager III
Eastern Shore Hospital Center
Cambridge, Maryland

Eastern Shore Hospital Center is seeking a Board Certified Psychiatrist to serve as Clinical Director for an 80 bed, Joint Commission accredited psychiatric hospital operated by Maryland's Department of Health and Mental Hygiene.

This position is responsible for the overall quality of clinical services at Eastern Shore Hospital Center and provides supervision to clinical department heads. This position receives managerial supervision from the Hospital Chief Executive Officer. Job duties include direct supervision of all clinical services insuring compliance with Medical Staff Bylaws, Maryland Law, DHMH policies and procedures and Joint Commission standards; providing clinical-administrative supervision, leadership, and consultation to medical staff and insuring timely delivery of in-patient services to consumers having court involvement. We use a comprehensive electronic medical record system which includes pharmacy ordering, treatment planning, etc.

Please join us on the historic Eastern Shore of Maryland where you can enjoy sailing, crabs, beaches, quaint towns and the best of country living, with close proximity to Baltimore and Washington, DC. This facility is located in a designated Health Professional Shortage area. For further information and to apply for this position, go to www.jobaps.com/MD/jobs/dhmmh EOE

NEW PSV MEMBER BENEFIT

A new benefit to members is the job submission system, which allows a member to post an employment opportunity and have it show up on the website immediately for a period of 90 days. It also allows the person who posted the ad to go back and edit the details, or remove the submission entirely. The system can be accessed by going to the Member Section and clicking the "PSV Jobs Submission/Editing Page" link. The jobs that have been posted can be accessed via the Employment Opportunities subsection of the home page.

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Take the course online now at
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The focus of this online course is to educate clinicians, researchers and healthcare providers on the major changes from DSM-IV to DSM-V, including diagnosis-specific changes (e.g., criteria revisions) as well as broader, manual-wide changes (e.g., revised chapter ordering, use of dimensional assessments, integration of neuroscience and developmental material across the manual).

EDUCATIONAL OBJECTIVES:

- List the primary significant changes in the classification of and diagnostic criteria for mental disorders from DSM-IV to DSM-V
- Discuss some of the major clinical modifications that might be needed to implement the major changes in DSM-V
- Describe some of the important research implications resulting from changes in DSM-V
- Transition from DSM IV to DSM-V in a work setting.

CREDITS:

- American Psychiatric Association provides 6 hours **AMA PRA Category 1 CME Credit™** for physicians.

REGISTRATION FEES:

- APA members - \$199
- APA MITs - \$99
- Nonmembers - \$249

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MSV PARTNERSHIP FORMED

The Medical Society of Virginia Foundation (MSVF) has partnered with Frontier Health to develop Evolve, a pilot clinical leadership program. Funded by a grant from The Physicians Foundation, this unique new program aims to position clinicians for leadership in an ever-changing environment where collaboration is the new norm.

What is Evolve?

Evolve is intended for clinical teams so the program will involve collaboration between a physician and another clinical partner. It encourages pairings between physicians, nurses, nurse practitioners, physician assistants, physical therapists and other providers and can take up to 20 clinical teams. Participants will have the chance to identify a population health issue they are dealing with in their practice setting that they would like to solve.

How does it work?

Evolve features a blend of in-person and asynchronous online activities including presentations from national experts, informal discussions and case studies, online learning discussions, videos and organized video conferences. Tentative topics include: Patient Protection and Affordable Care Act (PPACA) and health reform, leadership styles, preSPIKES communication model, basic financial fluency, ePatients, participatory medicine, mHealth, eVisits and more!

How can I participate?

Evolve is a seven-month program so all applicants must be willing to commit to the duration of the program. There is no cost to participate. Applications will be accepted until all available spaces are filled.

Accepted applicants will be asked to sign a letter of commitment upon enrolling in the program and must have a moderate understanding of technology, including the ability to participate in online discussion communities and video conferences.

These are the tentative dates and locations where this program will take place:

- **Session 1** – Engage: October 11 - Richmond, VA, MSV headquarters
- **Session 2** – Dollars and Sense: November 6 - Richmond, VA, MSV headquarters
- **Session 3** – Infinity and Beyond: December 5 - Richmond, VA, location TBD
- **Session 4** – Teachback: April 3 - Richmond, VA, location TBD

Applications will be reviewed on a rolling basis. Please apply today if you are interested in re-thinking traditional structures and working together with rising clinical leaders from around Virginia. Teams may apply directly to Frontier Health at fhc.bz/evolveapp.

Questions?

If you have any questions or would like additional information about Evolve, please visit <http://evolvenow.io> or contact Amy Swierczewski at aswierczewski@msv.org or (804) 377-1053.

President's Message

Continued from page 1

be repealed, modified, and altered while the rules and regulations are being written down by the stakeholders and the Department of Health and Human Services.

Irrespective of some of its shortcomings, like not addressing important issues such as the liability insurance system, it promises several good things. It has been hailed by some as the most important healthcare legislation since the enactment of Medicare and Medicaid in 1965. As the name suggests, it aims to ensure affordable health insurance to all U.S. citizens and also to reduce growth in healthcare spending.

It is an extensive document which is written on 974 pages and has ten sections. Some of the main features as I understand are as follows:

1. It does not replace the fee for service model, private insurance, Medicare or Medicaid.
2. It will add millions of people into the insured population.
3. It will increase the revenue of the hospitals, health insurers and the healthcare providers.
4. Everyone admitted to the hospital will be insured so hospitals will not have to provide free care to the uninsured.
5. It will give seniors access to cheaper drugs, free preventive care, reform Medicare Advantage plans and close the Medicare Part-D donut hole.
6. It will make it illegal for the insurers to charge women different rates than men.
7. It will eliminate the pre-existing condition exclusion by the year 2017, so there will be no exclusion even for the high-risk patients.
8. The states will be asked to expand Medicaid so as to insure the currently uninsured.
9. Every state in the union will have to set up electronic health care exchange where people will be able to compare the cost and coverage and shop for the best policy for themselves.
10. The plan is to cut \$716 billion of waste from Medicare and reimbursements to private Medicare Advantage plans and to reinvest it into healthcare reform.
11. The fees for the primary care and Medicaid services will be increased.
12. Medical Home Model of Care will be promoted where a team led by the primary care physician will care for patients in the community with emphasis on preventive care and management of chronic diseases in the outpatient setting.

Evidently, things are going to change and it is better for us as physicians to start thinking about adjusting the way we practice medicine. We do not need to agree with the bill but we need to start reading and discussing it, because it is going to affect our lives very soon. Medical organizations like AMA and APA are already engaged as the rules and regulations explaining and implementing this law are being written. Let's stay together and united in these unprecedented times of changes in healthcare in this country. Visit our PSV website and send suggestions and comments. Participate in discussions and volunteer your time. Write articles in our newsletters and attend every meeting possible. Contact me with your comments or questions at rizwan7094@yahoo.com. Thank you again.

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