SAN DIEGO PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

The San Diego Psychiatrist

February 2019

Executive Director Report

Michelle Gallice

Happy New Year! This year will be a special year for the San Diego Psychiatric Society as we celebrate our 60th year as a medical society. We are looking forward to a wonderful year ahead. We are hosting an extra special Installation Dinner for our new President in May and planning a wonderful year of CME programs and Resident-Fellow Membership events.

I hope you were able to join us for our first CME program of the year, which featured SDPS members Drs. Jonathan Meyer, Carla Marienfeld, David Printz, and Dhakshin Ramanathan. Thank you to all who joined us for this quality program.

Monday, March 18, 2019 will be the annual CPA Advocacy Day. Our residents will convene in Sacramento to meet with local and state representatives to present our views on key mental health legislation that is coming up for a vote.

On Saturday, April 27th, we stand strong with NAMI at their Annual Walk at Liberty Station. Join the San Diego Psychiatric Society team as a walker and/or helping us at our community table!

Our 60th annual Installation Dinner is on Friday May 31st at The Prado in Balboa Park. This special evening will celebrate past Presidents, special awardees and welcome our new President, Ben Hidy.

We welcome our new members and if you are interested in becoming more involved with us, come to one of our monthly council meetings and let us know what you'd like to do. Elections for the new year will be in March.

San Diego Psychiatric Society Council

Vanessa Lauzon MD - President
Ben Hidy, MD - President-Elect
Sanjai Rao, MD - Vice President
Jessica Thackaberry, MD - Secretary
Manny Garcia, MD - Treasurer
Larry Malak, MD - Immediate Past President
Rebecca Romero, MD - Councilor
Charles Ashbrook, MD - Councilor
Ronak Jhaveri, MD - Councilor
Jason Keri, MD - Councilor
Todd Young, MD - Councilor
Priti Ojha, MD - Councilor
Steve Ornish, MD - Distinguished Fellowship Chair
Chaitanya Pabbati, MD - Co-Communications Chair
DeeAnn Wong, MD - Co-Communications Chair
Maria Tiamson-Kassab, MD - APA Assembly Representative
Steve Koh, MD - Local Legislative Representative
Michael Takamura, MD - County Mental Health Representative
Anoop Karippot, MD - Child and Adolescent Chair
Tim Liu, MD - Early Career Representative
Priti Ojha, MD - Federal Legislative Representative
Ben Carron, MD - State Legislative Representative
Rob Myslin, MD - Uniformed Health Services Co-Representative
Savannah Woodward, MD - Uniformed Health Services Co-Representative
Eric Rafla-Yuan, MD - Resident Fellow Member Co-Representative
Stephanie Martinez, MD -Resident Fellow Member Co-Representative
Kristin Beizai, MD – Ethics Committee Chair
Michelle Gallice - Executive Director

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SCAM Against San Diego Physicians: Do NOT Give Out Your Medical License Number, DEA and/or NPI Number Over the Phone

San Diego County Medical Society

We have an urgent and important warning for all physicians about a **SCAM** being waged against San Diego County physicians. Scam artists are calling doctors at their offices claiming to be from the DEA and will ask for confirmation of the physician's MD#, DEA# and NPI# which they already possess. They then inform their targets that this information may have been stolen because it's been linked to illegal narcotics shipments. The target is told there is a warrant for their arrest but that they need to put up money to post a government bond.

The DEA is aware of this scam. They have issued the following statement:

> ***This has been an ongoing SCAM. DEA is aware that registrants are receiving telephone calls and emails by criminals identifying themselves as DEA employees or other law enforcement personnel. The criminals have masked their telephone number on caller id by showing the DEA Registration Support 800 number. Please be aware that a DEA employee would not contact a registrant and demand money or threaten to suspend a registrant's DEA registration.***

If you are contacted by a person purporting to work for DEA and seeking money or threatening to suspend your DEA registration, submit the information through "Extortion Scam Online Reporting" posted on the DEA Diversion Control Division's website, www.DEADiversion.usdoj.gov.

American Psychiatric Association Assembly Meeting

Larry Malak, MD and Barbara Weissman, MD
Area 6 Assembly Deputy Representatives

The November Assembly of APA Representatives began with a solemn moment of silence and recognition of for the victims of all the recent tragedies and violence in our country. Words by our speaker and CEO helped to mark the pain and division felt by so many in addition to the resilience of our communities we live and serve.

The APA Leadership spoke to the Assembly about a the financial health and status of the APA, PAC and Foundation. Of note, Area 6 Assembly members were contributing at a fantastic 94%. In addition, they highlighted a few of the special events going on around the Assembly, including a moving event at the Vietnam memorial to honor psychiatrists who served in the war. This was done the day prior to the Assembly and included the widow of one of the psychiatrists who participated with APA leadership in the wreath laying. This was set up in response to an action paper and was shown live on Twitter and will be produced into a video for the Assembly and website. The APA also had a lovely reception on Friday night and tour of the new APA headquarters followed by a PAC reception on Saturday night. A link to the Vietnam Memorial Ceremony can be found here: https://www.psychiatry.org/newsroom/apa-wreath-laying-ceremony

The APA Assembly Nominations Committee came up with a slate of candidates for Speaker and Recorder of the Assembly. For Speaker-elect, our current recorder Seeth Vivek and Joe Napoli from New Jersey will both run for election. For Recorder, the candidates are Mary Jo Fitzgerald, Vincenzo Di Nicola and our own Adam Nelson from Area 6. These candidates will make their way around the country to campaign and will make their way to Area 6 this winter before elections in early 2019.

In the work of the Assembly and our Area Council, one of the lengthier debates centered around the divestment of APA funds from fossil fuel investments. After discussion and debate, the Assembly voted to pass the paper and move the APA towards ending APA's investments in fossil fuel companies in an incremental, fiscally responsible manner. Additionally, the Assembly also supported Action Papers from Area 6 including work by Dr. Bob Cabaj's regarding the APA's participation in the WHO's essential medication list and doing regular reviews, Drs. Adam Nelson, Peter Forster, and Jessica Thackaberry's paper on increasing access to digital reports during the Assembly to reduce the amount of paper being used and Dr. Anish Dube's paper on care for immigrants and refugees at the border. In the end, the Assembly reviewed over a dozen position statements and over 20 action papers during a busy weekend of work.

The Assembly workgroups also met to conduct some of the important business of looking at Maintenance of Certification, Access to Care, Voter Turnout, Practice Guidelines and Public and Community Psychiatry. For a full recap, please see the Assembly Notes link below, created by Adam Nelson: https://app.box.com/s/3lnwr79s1r2m4s6pwcsnwkxez6sw6mo8

The Assembly Executive Committee met after the conclusion of the Assembly and will meet again in February. The full Assembly comes together during the APA Annual Meeting in May, this year in San Francisco. The action paper deadline is in March, so if you have any ideas for papers or positions that you think need an action paper or discussion at the APA Assembly, please contact your District Branch leadership or any Assembly Representative (including the authors above) so we can have your ideas heard!

Congratulations to Our 2018 Distinguished Fellows

Steven A. Ornish, MD
Chair, SDPS Distinguished Fellowship Committee

Distinguished Fellowship (DF) is the highest membership honor the APA bestows upon members. Distinguished Fellowship is awarded to outstanding psychiatrists who have made significant contributions to the psychiatric profession, are board certified, have no less than eight consecutive years as a General Member or Fellow of the APA and have demonstrated excellence in at least five of the following areas: 1) involvement in medical and professional organizations; 2) participation in non-compensated mental health and medical activities of social significance; 3) community volunteer work; 4) clinical excellence in direct patient care; 5) administrative contributions; 6) teaching contributions and 7) scholarly publications.

Each spring the DF Committee, composed of 12 Distinguished Fellows, meets to vet approximately 100 potentially eligible candidates from a list provided by the APA. After potentially qualified DF candidates are selected by the committee, a committee member is assigned to the candidate to "shepherd" them through the application process. The DF application takes approximately one to two hours to complete and three letters of support from DF Fellows are required.

I am pleased to report that all five of the Distinguished Fellow nominees who submitted applications in 2017 were awarded the honor of Distinguished Fellow: Drs. Nancy Downs, Jason Kornberg, David Lehman, David Gilder and Alvaro Camacho (posthumously).

Dr. Camacho's award will be presented to his children and their mother at this year's SDPS Installation Dinner. To the best of our knowledge, this is the first time the APA has granted a posthumous award, since Dr. Camacho's application was completed prior to his death.

SDPS is privileged to have many members who are Distinguished Fellows.

Machine Learning and Psychometrics

Ronak Jhaveri, MD
SDPS Councilor

Innovations in health care are leading our field to interesting new horizons. The art of the psychiatric interview was one of the earliest tools we had in treating our patients. Around 1950, we discovered our next era-defining tools with psychotropic medications. Currently, there are so many great ventures our colleagues are working on in diverse fields like neuroimaging, genotyping, pharmacology, etc. One question that I like to ask myself when I hear about some of the ground breaking work that is happening in

any field is "What is the timeline on this being available to everyone?"

There is one endeavor I see as being the first to "win the race" so to speak. It has the most expensive components, a user-interface tool (smartphone), in the hands of 68% of US population already. There are already an abundant amount of peripheral attachments and they are beoming more accessible and affordable at a steady pace. For example, my smartwatch knows when I am exercising and it knows when I am sleeping. It can estimate when I am in REM sleep and for how long. My scale at home checks my weight and estimates my percentage body fat. All of this data gets stored in apps that aggregate my information and provide me with charts and graphs and shows my trends towards healthier living. If only we had this access to this data from our patients, we would be better able to apply the scientific process to improving their quality of life and better understand which interventions to utilize.

So what is the greatest barrier to having access to this data integrated into our workflows? My first hunch would have led me to say the infrastructure isn't there, the code hasn't been written, and there is no secure way to handle this data. On closer look, it turns out we are the biggest barrier to change. In 2016, the first Apple CareKit approved mental health app (Start app) came and went without much public uptake. It put knowledge at this patient's finger tips, established digital crisis plans, reinforced and tracked medication adherence, collected real time PHQ-9 questions on a regular basis, and logged all this information securely in

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the app. This data then syncs with Apple's health app where information is aggregated with the user's other inputs (exercise, sleep, weight, at home EKG rhythm strip, etc.) and can then be securely transmitted to a designated provider at any time without creating a digital forum for medication management discussions. Personally, I welcome more useful objective data to determine what interventions to apply and to determine their efficacy after the fact.

As the future of treating the brain and the mind is leading us to robust individualized care plans, I believe an early stepping stone in our care delivery is going to be identifying 'low-hanging' objective data and letting our computers do the statistical analyses before a patient even walks through our doors. Given the digitally addicted world we are living in and the cost of getting an fMRI or genotyping for all of our patients; it's evident that the future tools of our field are already in our hands.

Member Spotlight

By Jason Keri

Name: Bruce Hubbard
Hometown: Wheeling, West VirginiaWhat was your pathway toward entering the mental health field? Although initially I majored in psychology in college, I elected to go to medical school, not necessarily to pursue psychiatry, but to broaden my life choice options.

And what drew you to psychiatry?
At Vanderbilt Medical School, I was mostly interested in plastic and reconstructive surgery. But then I had a clinical rotation in my fourth year on a psychopharmacology research unit headed by David Janowsky. That experience and Dave's tutelage dramatically and completely altered my career direction.

Tell us about your educational experience. Particular courses, experiences, teachers, supervisors/consultants that have been most formative?
Since I had a hobby of growing orchids, I looked for a training program in a warmer climate. When I interviewed at UCSD's nascent training program, Arnold Mandell promised my own research lab and a training program in an ideal climate for growing orchids. I was taken. Numerous mentors at UCSD shaped my development both personal and professional: Bob Nemiroff, Arnie Mandell, Lew Judd, Marc Schuckit, Dan Kripke, John Feighner, and many others. . .not to mention my peers and supervisees in the UCSD training program. Of particular importance in my training was a good balance between psychodynamic/ psychoanalytic and biological psychiatry. After three years as a full time faculty member at UCSD, I went into private practice.

SDPS UPCOMING EVENTS

FEBRUARY:
SDPS COUNCIL MEETING
8695 Spectrum Center Blvd. San Diego
2/12/2019 6:30pm – 8:00 pm

MARCH:
APA Advocacy Conference
Marriott Georgetown, Washington, DC
3/11/2019 – 3/12/2019

SDPS COUNCIL MEETING
8695 Spectrum Center Blvd. San Diego
3/12/2019 6:30pm - 8:00 pm

CPA ADVOCACY DAY
Halls of the Capital, Sacramento
3/18/2019

CICMAMH ANNUAL MEETING/ MANAGING CHANGE IN A CHANGING WORLD
Double Tree Hotel/Hazard Center
3/21 – 3/22/2019

APRIL:
SDPS COUNCIL MEETING
8695 Spectrum Center Blvd. San Diego
4/9/2019 6:30pm – 8:00 pm

NAMI WALK
NTC Park at Liberty Station
4/27/2019 8:00am-12 pm

MAY:
SDPS 60th Installation Dinner
The Prado in Balboa Park
5/31/2019

How has your training in psychiatry affected the following: your practice, your professional development, and other areas of life?
My practice over the past 44 years has been a balance of psychodynamic psychiatry and biologic psychopharmacology. I feel fortunate to have had solid training in the former by the many members of the San Diego Psychoanalytic Institute who volunteered their time as clinical faculty at UCSD. I have found that having psychodynamic training in my background is invaluable in formulating diagnoses and implementing treatment plans. I believe that my training as a physician and psychiatrist has allowed me the benefit of deeper and more meaningful relationships in general.

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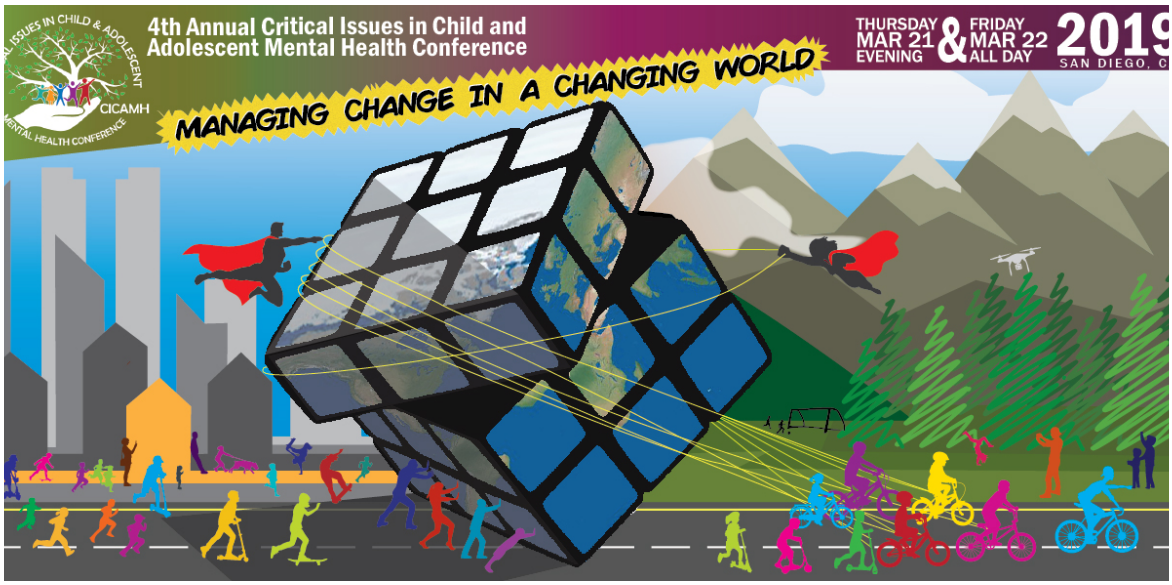
How else have you applied your psychiatric knowledge?
For many years I was extensively involved in forensic psychiatry as an expert witness, primarily in the civil courts, before this became a boarded subspeciality. I enjoyed this and considered it one of the best teaching jobs in the world! I have backed away from this now that there are numerous certified specialists to fulfill this need and because of the increasing demands of my clinical practice. I have continued supervising PGY-II residents in psychopharmacology at UCSD. I have always believed that community service is an obligation that all professionals should fulfill. I have served on the boards of non-medical non-profits. I have also served as Secretary for SDPS for nine years in the early 2000's and as Treasurer for many years and more recently for many years as Treasurer.

Tell us about your practice and with whom you are most interested in working:
My practice continues to be primarily in psychopharmacology. I have an outpatient practice only and enjoy working with all psychiatric diagnoses, but I mostly treat mood disorders. I have recently expanded my practice to include a psychiatric Physician's Assistant and a psychologist and am doing more and more telemedicine. We have recently added Transcranial Magnetic Stimulation for treatment of depression. Our treatment outcomes have exceeded expectations, I believe because we combine TMS with CBT and pharmacotherapy. Because of demand, we have just added a second Neurostar TMS machine and welcome referrals for this treatment modality.

How can potential patients contact you?
I may be reached at (619) 295-8005 or (619) 795-7434 or they may go to my website at www.brucehubbardmd.com.



Please Join Us March 21 and/or March 22

hursday March 21st 5:00 PM- 9:00 PM Dinner Conference

Managing Behavioral Health Problems Across Disciplines: How Can Pediatricians, Therapist and Child Psychiatrists Work Together

A Multidisciplinary Round Table Discussion of 2 Complex Clinical Cases
Exploring Opportunities and Challenges in Providing Collaborative Care

riday March 22nd 8:00 AM – 5:00 PM All Day Conference with Keynote Speakers and Breakouts

Managing Change in a Changing World

Keynotes and Breakouts
◆Immigration and Families ◆iGen- Generational Study of 11 million teens ◆Superhero Therapy◆
◆Sleep Disorders ◆Gender Non-Conforming Youth ◆Menstrual Disorders & Mental Health◆
◆Play Therapy for Emotional Regulation ◆School Threat Assessments◆
◆Insomnia ◆Grief Support ◆Unsheltered Youth◆

Thursday March 21st- $50.00 – Students $25.00 -Includes up to 3 Credits
Friday March 22nd - $99.00 – Students $50.00 –Includes up to 6 Credits
***Attend Both!* -$149 – Students $75- Includes up to 9 Credits**
(must present valid student ID at registration desk)
FEE Includes Parking, Food and CME/CE

Double Tree Hotel - Hazard Center
7450 Hazard Center Dr.
San Diego CA 92108

To Register please visit Register Online Easy & secure online registration
WWW.CICAMH.COM

For Full Agenda visit: www.CICAMH.com/#agenda For Speaker Bios visit:www.CICAMH.com/#Speakers

Longtime Psychiatry Chair Lewis Judd Dies at Age 88

December 21, 2018

When he stepped down in 2013, no one had – or has – served longer.

Lewis Lund Judd, who held the position of chair of the Department of Psychiatry in the UC San Diego School of Medicine for 36 years before stepping down in 2013 – an astounding 70 percent of the university's existence at the time – died December 16. He was 88.

Born in Los Angeles, Judd received his medical degree and training in adult and child psychiatry at UCLA. He served on the faculty at UCLA until 1970 when he was recruited by Arnold J. Mandell to the then-one-year-old Department of Psychiatry and two-year-old UC San Diego School of Medicine. The Department of Psychiatry at UC San Diego School of Medicine was the first in the country to be neurobiologically oriented. Judd would succeed Mandell as department chair in 1977.

Judd was an expert in biological psychiatry and clinical psychopharmacology — and a forceful advocate for pushing psychiatry beyond its decidedly charismatic, but often controversial, past to its empirical present as a data-driven, hard-charging neuroscience. He was an early and vocal leader of the idea that mental disorders, such as
depression, were the result of neurological and biological dysfunction, and argued that they could be effectively treated with appropriate, rigorously developed psychopharmaceuticals.

"Lew Judd was one of the giants of psychiatry and one of the leaders who transformed psychiatry into a rigorous science using genetics and imaging," said David Brenner, MD, vice chancellor, UC San Diego Health Sciences. "He built one of the greatest research departments in the world and trained the next generation of its leaders. He had amazing insight to anticipate areas of excitement and discovery and to invest in these areas."

As a young psychiatrist-in-training in the 1970s, Judd said the profession's emphasis still strongly emphasized the works of Sigmund Freud, Carl Jung and others. It involved exploring a patient's state-of-mind through talk, dreams, free association and fantasies. Successful psychoanalysis relied heavily upon the interpretive skills, imagination and charisma of the practitioner. "It was an art form," said Judd in 2013, not a science. The underlying biology of the brain was usually an after-thought.

Changing that mind-set would not be easy or quick. In 1988, for example, in a Q&A in Parade magazine, Judd was asked whether depression was "an act," that with just a "little willpower," according to the magazine's writer, a depressed person might "become cheerful again."

"It's a real disease, just as a heart attack is real," Judd countered. "Depression produces physical, emotional and thinking symptoms. Without treatment, depression can last for years and can even end in suicide. With treatment, as many as nine out of 10 people recover."

"Lew built this department by choosing independent investigators who could work together," said Igor Grant, MD, FRCP(C), professor and current psychiatry chair. "He sought breadth and depth. He wanted people who could further the idea of psychiatry as evidence-based medicine. He saw research as the key, and built a department that rose to become among the top three National Institutes of Health-funded psychiatry departments in the country.

"Another of his passions was the training of the next generation of academic and clinical psychiatrists and psychologists. Indeed, the majority of psychiatrists in practice in the San Diego region today were trained in the programs he fostered."

At the age of 57, Judd was named director of the National Institute of Mental Health (NIMH), the first active scientist to hold the job. He served as NIMH director from 1987 to 1990. During this time, Judd developed and launched multiple initiatives, including the National Plan for Research into Schizophrenia; the National Plan for Research in Child and Adolescent Mental Disorders; the National Research Plan to Improve Services for Individuals with Severe Mental Illness; and the momentous Decade of the Brain Research Plan.

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"This appreciation for the science of the human brain and mind exploded under his NIH leadership in the late 80s when he launched "The Decade of the Brain," said Sandra A. Brown, PhD, vice chancellor for research and
Distinguished Professor in the UC San Diego School of Medicine. "It was the transformative precursor to the BRAIN Initiative two decades later."

"The thing I'm most proud of is how psychiatry is becoming increasingly recognized as a real biomedical science," Judd said in 2013. "It used to be disdained. A broken mind wasn't as real as a broken bone. We lionized physical medicine, but dismissed brain biology, which has an enormous affect upon not just our behavior, but our bodies as well."

Judd authored more than 200 scientific publications and edited nine books and monographs.

He was a member of the Institute of Medicine, now known as the National Academy of Medicine. He received an honorary Doctor of Science from the Medical College of Ohio for national leadership in brain research. The American College of Physicians awarded him its William C. Menninger Memorial Award for achievement in the science of mental health. And he received the Distinguished Service Award from the American College of Psychiatry and the C. Charles Burlingame Award from the Hartford Institute of Living for meritorious contributions in education and research in psychiatry.

Judd was also a dedicated and talented clinician. He trained in psychoanalysis during his residency and provided psychotherapy and psychopharmacologic treatment throughout his career until his retirement. He was often called upon to consult on challenging patient conditions. He was always generous and available to help others.

Numerous national mental health advocacy organizations honored him, including the Distinguished Service Award for his contributions to national mental health research from the National Alliance for the Mentally Ill and the Award of Distinction from the National Mental Health Association for his leadership in child and adolescent mental disorders.

Judd was a Renaissance man: a runner, tennis player, avid reader of fiction and history, football devotee, lover of good food and wine, patron of the arts, loyal friend, devoted husband, father and grandfather.

He is survived by his wife, Patricia Judd, PhD, professor of psychiatry at UC San Diego Health; daughters Stephanie Judd, a clinical psychologist; Catherine Judd, a professor of English literature; and Allison Fee, an occupational therapist; sons-in- law Cliff Greenblatt and Frank Fee; and grandchildren Helena, Henry, Spencer, Miles and Jack.
He was predeceased by his brother, Howard Judd, a UCLA faculty member in the Department of Reproductive Medicine.

A tribute to Judd is planned in the late winter or early spring of 2019 in conjunction with celebration of the 50th anniversary of the founding of the psychiatry department. The Lewis L. Judd Recognition Fund has been established to help advance his ideas for better understanding and treating mental disorders. https://go.ucsd.edu/2QIhc0a. Contributions can also be made in his honor to the National Alliance for the Mentally Ill.

David A. Brenner
Vice Chancellor for Health Sciences at UCSD

Steven R. Garfin
Interim Dean, School of Medicine at UCSD

Igor Grant
Chair, Department of Psychiatry at UCSD

Free APA Member Benefit: Find A Psychiatrist Database

Find a Psychiatrist is a searchable database and centralized place for patients to find psychiatrists like you! If you are an APA member practicing in the US or Canada and are accepting new patients, please take a moment to Opt-In to be included. In order to do so, please visit psychiatry.org/fapoptin.

If you have questions or need help, contact AOA Customer Service: 1-888-35-PSYCH. As a member of the San Diego Psychiatric Society you can also opt-in to our own website directory. If you would like to have your information on the SDPS website please email your information to info@sandiegopsychiatricsociety.org. Please include: name, office address, up to 5 self-designated specialities, office website, and accepted insurance.

If you have any questions for the SDPS site, please call 858-279-4586.

Psychologists Writing Progress Notes?

November 19, 2018

APA responded to a CMS initiative to make changes to the documentation of patient care in psychiatric hospitals. APA supported CMS's proposal to have some medical professionals (NPs, PAs, CNSs) work collaboratively with psychiatrists to write daily progress notes, noting that the attending psychiatrist is always responsible for the overall care of the patient. However, APA opposed giving this authority to psychologists, as they do not have the appropriate medical training and are not licensed to evaluate and manage medical conditions. The Medicare final rule may be expected in early 2019.

Fighting the Stigma of Mental Illness Through Music

By Michele C. Hollow
Jan. 29, 2019
New York Times

When Ronald Braunstein conducts an orchestra, there's no sign of his bipolar disorder. He's confident and happy.

Music isn't his only medicine, but its healing power is potent. Scientific research has shown that music helps fight depression, lower blood pressure and reduce pain.

The National Institutes of Health has a partnership with the John F. Kennedy Center for the Performing Arts called Sound Health: Music and the Mind, to expand on the links between music and mental health. It explores how listening to, performing or creating music involves brain circuitry that can be harnessed to improve health and well-being. Dr. Francis Collins, director of the National Institutes of Health, said: "We're bringing neuroscientists together with musicians to speak each other's language. Mental health conditions are among those areas we'd like to see studied." Mr. Braunstein, 63, has experienced the benefits of music for his own mental health and set out to bring them to others by founding orchestras in which the performers are all people affected by mental illness.

Upon graduating from the Juilliard School in his early 20s, he entered a summer program at the Salzburg Mozarteum in Austria, and in 1979 became the first American to win the prestigious Karajan International Conducting Competition in Berlin.

His career took off. He worked with orchestras in Europe, Israel, Australia and Tokyo. At the time, he didn't have a diagnosis of bipolar disorder. But looking back, he can see that his disorder contributed to his success, and his talent masked the condition. "The unbelievable mania I experienced helped me win the Karajan," he said. "I learned repertoire fast. I studied through the night and wouldn't sleep. I didn't eat because if I did, it would take away my edge. My bipolar disorder was just under the line of being under control," he said. "It wasn't easily detected. Most people thought I was weird." He always sensed something was askew. When he was 15, his father took him to a doctor who diagnosed "bad nerves" and prescribed Valium.

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As his career progressed, things started to unravel, and his behavior grew increasingly erratic. He was given a diagnosis of bipolar disorder at age 35. His manager dropped him as a client, and he was fired from a conducting job in Vermont. It was there he met Caroline Whiddon, who had been the chairwoman of the Youth Orchestra Division of the League of American Orchestras. She had been given a diagnosis of depression and anxiety disorder more than 20 years earlier, and had played French horn professionally, which she described as “a notorious instrument that’s known for breaking people.”

Mr. Braunstein reached out to her about creating an orchestra that welcomed musicians with mental illnesses and family members and friends who support them. “I never thought I’d go back to playing French horn again,” she said. “Ronald gave me back the gift of music.” Mr. Braunstein called his new venture the Me2/Orchestra, because when he told other musicians about his mental health diagnosis, they’d often respond, “Me too.” Since the term #MeToo is now associated with sexual assault cases, people sometimes ask if the orchestra is connected to that cause. “It gives us an opportunity to explain that we were founded in 2011,” in Burlington, Vt., “before the Me Too movement began,” Ms. Whiddon said.

In 2014, a second orchestra, Me2/Boston, was created. In between, in 2013, Mr. Braunstein and Ms. Whiddon got married. Each orchestra performs between six and eight times a year. Each has about 50 musicians, both amateur and professional, ranging in age from 13 to over 80, and they rehearse once a week. New affiliate ensembles in Portland, Ore., and Atlanta follow similar schedules. Mr. Braunstein gives free private lessons to those who want to polish their skills.

Me2/Orchestra is a nonprofit, and the musicians are all volunteers. Ms. Whiddon raises money through an annual letter-writing campaign to cover expenses, with support from more than 100 donors. “When we perform at a hospital, center for the homeless or correctional facility,” Ms. Whiddon said, “the cost of that performance is covered by corporate sponsorships, grants or donations from individuals, so the performance is free to those who attend.”
Participating in Me2/Boston allowed Nancy-Lee Mauger, age 55, to pick up the French horn again. The note on the rehearsal door — “This is a stigma-free zone” — made her feel welcome.

Ms. Mauger had played French horn until her mental illness made it impossible to perform. She has diagnoses of dissociative identity disorder, post-traumatic stress disorder and depression. “In 2009, I was playing a Christmas Eve gig,” she said. “It was at the same church, with the same quintet, choir and music that I had played every Christmas Eve for 15 years. This particular night felt different. I had trouble focusing my eyes. At one point, I could not read music or play my horn.” It lasted about two minutes, and she thought she was having a stroke. In fact, it was her mental illness. “I learned that little parts of me would come out and try to play my horn during gigs,” she said. “The problem was that they didn’t know how to play. This became such an obvious problem that I quit.”

Now, after four years of intensive therapy, she is able to play again.At each performance, a few musicians briefly talk about their mental illnesses and take questions from the audience. “Instead of thinking people with mental illnesses are lazy or dangerous, they see what we’re capable of,” Mr. Braunstein said. “It has a positive effect on all of us.”
Jessica Stuart, now 34, stopped playing violin in her mid-20s when she was diagnosed with bipolar disorder. “Joining the Me2/Orchestra in Boston in 2014 was the first time I had played in years,” she said. “I cannot count the ways the orchestra helps me. It has allowed me to overcome the shame I felt about living with mental illness. I no longer feel I have to hide an important part of my life from the rest of the world.”

Jessie Bodell, a 26-year-old flute player who has borderline personality disorder, said he finds rehearsals fun, relaxed and democratic. He noted that unlike most orchestras, Me2 doesn’t have first, second or third positions. “There isn’t an underlying, tense, competitive feeling here,” he said. “We’ve seen when you sing or

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play an instrument, it doesn't just activate one part of your brain," said Dr. Collins of the National Institutes of Health. "A whole constellation of brain areas becomes active. Our response to music is separate from other interventions such as asking people to recall memories or listen to another language."

Partnering with Dr. Collins on Sound Health is Renée Fleming, the renowned soprano and artistic adviser to the Kennedy Center. "The first goal is to move music therapy forward as a discipline," she said. "The second is to educate the public and enlighten people about the power of music to heal." So far the initiative is investigating how music could help Parkinson's patients walk with a steady gait, help stroke survivors regain the ability to speak, and give cancer patients relief from chronic pain.

"The payoff," Dr. Collins said, is to "improve mental health. We know music shares brain areas with movement, memory, motivation and reward. These things are hugely important to mental health, and researchers are trying to use this same concept of an alternate pathway to address new categories of mental disorders."

Missing a Great Colleague and an Outstanding Friend

Bernardo Ng, MD

I have been an SDPS member since 1992, but since moving to Imperial County in 1994, it became increasingly harder to join the society's activities because "I did not have the time." So, this is not the first time I got invited to collaborate with the SDPS newsletter, but I recall not ever doing it, again because I was "too busy."

Well, on this occasion "I did make the time," given the unique situation of Alvaro Camacho's passing. As most of you know,"Al" as he liked to be called, was found dead due to a self-inflicted wound in his office at Sun Valley Plaza, in Imperial California on 9/23/2018. It had been a relaxing Sunday morning, until I got that call… it was a local psychotherapist who had gained privileged information that made her wonder about Al's safety.

After listening to her concerns, I asked her to call the local police department, while I drove to the office. Unfortunately, her call came too late, because Al was already dead. The ensuing hours of shock, disbelief, dismay, and uncertainty, were finally over when the detective of the homicide division stated that there was no evidence of foul play and that it was very likely the coroner would rule it as a suicide. I am still perplexed with my first reaction, wondering how should we handle such development. I was there with my girlfriend and senior staff, and we were all worried about "protecting" Al, and how the word "suicide" would mark his reputation.

Things cleared up as the detective shared a "personal story," – he told us about his line of work, and how in spite of being accustomed to seeing dead bodies in the worst conditions, he freaks out when his 6-year-old boy comes to him with a tiny cut in his finger. As I listened, it hit me, we work so hard to fight against the stigma of mental illness and educate about how mental illness can strike just anyone, and this time was one of our own, and I did not know how to react. At the same time, it crossed my mind, how frequently we argue about how unprepared police officers are in mental health matters, well, he explained how different it is when "it hits home" and how hard it is to make decisions. It inevitably comes like a cold shower, when someone so close dies by suicide, even worse if this is a psychiatrist. Then he said it, in a gentle yet categorical way, "the only thing to say is that - pending the coroner's report - it was a suicide," and it finally made sense in my mind.

While the scene was being processed and his body removed, I talked to the psychotherapist who talked to his children and their mother the same day; I also called Steve Koh, who diligently called UCSD and APA's leadership. At the same time my administrator identified a specialized crew to clean his office.

Then came Monday, all staff had been summoned to meet sharply at 8:00 am, to process the unfortunate event and collectively decide on how to carry on that

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day. There was a lot of crying, disbelief, and a sense of guilt for not having noticed that something was wrong with him, and at the same time trying to figure out a culprit for his deed. His staff was reached as well and a plan developed.

Then it felt as if time ran faster than usual, there were patients to be seen; attorneys involved; his office closed early; we programmed grief support groups; and then the phone calls… a cascade of calls came in, follow up calls with the police department, the local newspaper, local colleagues, friends we had in common locally and abroad; and at the same time the e-mails. I received communications from different cities, states, and countries, the recurring question was "is it true?"

The following days, were extremely busy, and it became very clear to me that in spite of almost 30 years of continuous work in the field of psychiatry, one is never ready to lose a friend and colleague to suicide. Every article read and every lecture attended on suicide risk and prevention, suddenly appear insufficient, distant, and meaningless.

By the middle of the week I was in Mexico City attending the WPA annual congress. Among the various people I met and knew Al, I shall underscore Maria Oquendo. Besides being our friend, she is an expert in suicide. Talking to her was so uplifting and reassuring, and left me with the certainty that Al must have been ill and went untreated, or at best insufficiently treated, as she said "in our profession there are people with such intellectual and emotional reserve, that unfortunately mask their ailment…"

Upon return there came the funeral, keeping on with the Catholic tradition, we had mass at the Calexico church of Our Lady of Guadalupe. I thank Joel Dimsdale, Steve Koh, Mounir Soliman, and Denisse Chavira for attending, who were a refreshing presence, in the persistent turbulence that the friends and family, kept experiencing. During the dinner thereafter, Denisse helped me understand yet something else. She had taken it upon herself to print copies of all articles published by Al as a gift to his children. I have no idea of how many in total, but she mentioned that we were coauthors in most of them. In a way, that explained the many calls that came my way, right after his death, and slowly ceased.

As the memory of Al's premature death settles in in my mind and my heart, one thing keeps bugging me. I wonder, how he made time to direct the mental health services of the largest primary care clinic system in Imperial county, keep a private practice, go to graduate school and do a postdoc, publish articles in high impact journals, be a parent of two beautiful children, do public speaking, earn awards, be the percussionist of a local band, be voluntary faculty for UCSD… and yet, he did not make the time to take care of his health. As the days go by, I have worked on developing the habit of asking myself if I am making the time to take care of my health. Are you…?

Long-Term Care Funding for Doctors: Do You Know These 5 Options?

January 11, 2019
Kevin B. O'Reilly
News Editor
American Medical Association

Funding long-term care expenses has emerged as a top financial concern for physicians, according to AMA Insurance Agency Inc.'s "2018 Report on U.S. Physicians' Financial Preparedness." But nearly 70 percent of physicians do not have insurance coverage in place for themselves. Of physicians without coverage, 36 percent have said they plan to self-fund, while another 33 percent said they aren't sure how they'll handle a potential long-term care expense.

I recently spoke with J. Michael Hegwood to learn more about the options available to physicians when it comes to funding their long-term care. Hegwood is assistant vice president of brokerage marketing at AMA Insurance and has worked in the financial services industry for 30 years.

O'Reilly: You've often written and talked about the dilemma physicians face when it comes to long-term care. What do you mean by that?

Hegwood: Given the nature of their work, physicians understand better than the general population the importance of being able to fund their long-term care. And while our research shows that funding long-term care is among the top three financial concerns for physicians in their 40s or older, many physicians still don't have a plan in place for how they will do that.

O'Reilly: What might be some contributing reasons that many physicians don't have a concrete funding plan?

Hegwood: I think there are several factors at play. One is figuring out where it makes most sense to invest. What if you purchase coverage and don't end up needing care? You could be spending a lot of money on something you'll never use. On the other hand, if a long-term chronic health issue were to occur, it may be very costly—so purchasing coverage would make sense. Understanding your funding options can help you make the best decision for your financial and health situation. There are three traditional funding options as well as two newer, more flexible options physicians should be aware of.

O'Reilly: You've mentioned one option already—self-funding. What are the pros and cons to that approach?

Hegwood: As you might expect, this option is typically a possibility for those who have the financial means to pay for it themselves because it can become very expensive. When self-funding, you're essentially taking on 100 percent of the risk—which means the entire burden of paying for long-term care falls to you.

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On the upside, if you don't ever need long-term care, you've paid $0 for the coverage. But if you're confined to a nursing home facility care for four years, you might be tagged with a $400,000 bill for a private room. The self-funding solution may work well for those with a great deal of financial resources, as well as those with a good history of family health. But be prepared, because the burden of payment is entirely on you.

O'Reilly: What about the other traditional funding options?

Hegwood: In the general U.S. population, Medicaid is the primary payer for long-term care services. But Medicaid isn't typically an option for physicians. Because it is a social health care program for those with lower incomes and very limited assets (usually less than $2,000), you would have to spend down your assets to qualify.

It's also important to know that Medicare, unlike Medicaid, will not cover long-term care expenses. It may cover some of the initial expense, but it was never intended or designed to support long-term care.
The other traditional option for funding long-term care is long-term care insurance, which rose to popularity in the 1990s and 2000s. Long-term care insurance plans help you shift the risk to a third party—an insurance company.

In exchange for the payment of premiums, long-term care insurance policies promise to pay benefits for custodial, intermediate and/or skilled care. When you apply for coverage, the insurance carrier determines your rates based on the policy features selected as well as your age and health status. The younger and healthier you are, the better your rates. Benefits from these plans are generally triggered when an insured is unable to perform any two of the activities of daily living: feeding, toileting, dressing, grooming, bathing and transferring. Long-term care insurance is a great concept, but some early generations of these plans were not priced adequately as a result of poor underwriting and cost projections.

These pricing flaws have resulted in some hefty premium increases for existing policyholders. For instance, in the summer of 2018 one insurer received approval from state regulators to raise long-term care insurance costs by an average of 58 percent on some of its policies.

For those who stop paying the premium, they'll lose all the benefits and get nothing. Or they could pay the hefty premium increases and never need the coverage —and again, no cash would be paid out. But some people have benefited greatly from these plans, protecting their family from what might have otherwise been a financially catastrophic event for them.

O'Reilly: You mentioned new funding options that provide more flexibility are available now. Do they address some of the issues you've described with the traditional funding options?

Hegwood: Yes, alternative funding options have emerged in recent years. Two of the most common ones are hybrid or linked-benefit plans and long-term care riders, which can be attached to a traditional life-insurance policy. In hybrid plans, the policy will pay benefits to cover long-term care expenses if you need long-term care. If you don't need the coverage, the plans are designed to pay out another benefit—typically in the form of a death benefit.

Many of the early hybrid plans required the insured to reallocate existing assets to fund the policy premium—which could require a substantial deposit of $50,000 or more. Those with the means to self-fund were some of the early adopters of these plans, simply because they had the ability to pay that initial premium. They were able to transfer part of the risk to an insurance company while still guaranteeing a benefit would be paid whether or not they needed the long-term care.

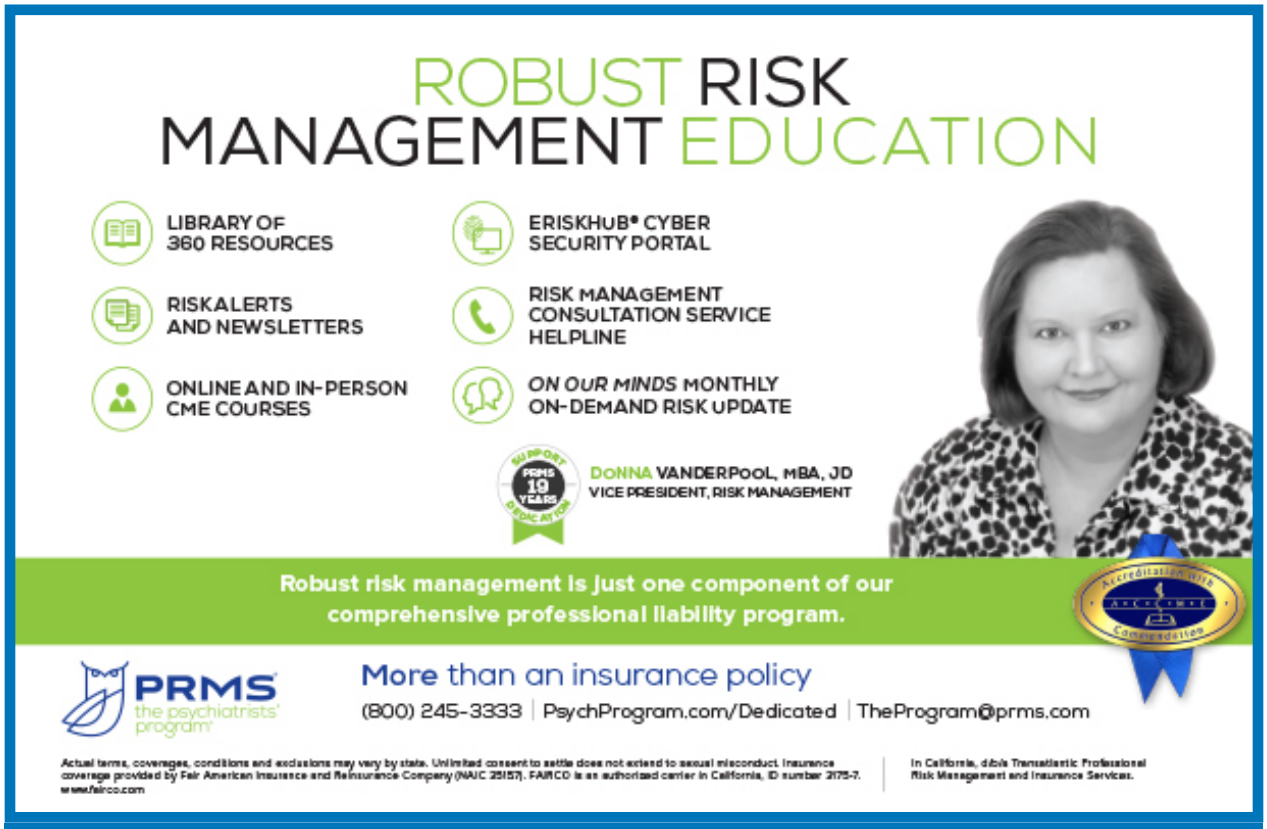
The other option I want to highlight is the long-term care rider, which carriers are now beginning to offer as part of their traditional life insurance policies. These riders provide access to living benefits in the form of an accelerated benefit provision, in which the insured can tap into 50–90 percent of the policy's death benefit before actually dying. The amount paid under an accelerated benefit provision tends to vary from company to company, but there are numerous competitive plans to choose from. The general premise is this: When a policyholder uses the living benefits, there's an offset to the original death benefit. In addition, these riders add flexibility to the coverage as well as to the premium payment schedule, making them a very attractive option for many people.

Just like the original hybrid plans, these riders create a scenario in which a benefit is always paid if the insurance remains in effect. As a result, this has become an increasingly popular way for many people to fund their potential long-term care expenses.

O'Reilly: How can physicians figure out which funding option will be the best fit for their families?

Hegwood: Your financial adviser or insurance broker should be able to help you compare and select the right funding plan for you. This person should be able to help you compare the different plans available to you, and think through health and financial factors particular to your family's situation. If you don't have a financial adviser already, AMA Insurance's Physicians Financial Partners program provides access to a nationwide network of independent, local and experienced financial professionals who can help you reach your unique financial planning goals—including funding long-term care. These professionals have undergone a comprehensive due-diligence process by AMA Insurance, which has been serving physicians for 30 years.

The most important thing is to talk to your family and financial advisor, and put concrete plans in place today so you can look toward the future with confidence.



https://www.psychprogram.com/campaigns/dedicatedresources.html

Welcome to Our New and Returning Members!

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Michael McCarthy, MD, PhD
Lama Muhammad, MD
Ruby Shandilya, MD
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Eric Tung, MD

What's New at the APA

APA called for a vigorous appeal to a Federal judge's ruling striking down the Affordable Care Act. U.S. District Court Judge Reed O'Connor in Texas ruled the ACA unconstitutional without the requirement of an enforceable individual mandate after Congress repealed the tax penalty associated with it. The Affordable Care Act has provided coverage to roughly 2.8 million Americans with substance use disorders and 1.3 million Americans living with serious mental illness. You can read APA's full statement opposing the ruling here, and APA's joint-statement with America's Frontline Physicians here.

January Course of the Month: Levels of Care in Adolescents with Substance Use Disorders
The transition from childhood to adolescence and subsequently adulthood are unique developmental periods with significant changes in social networks and interactions. Adolescence and early adulthood are the peak times for initiation of substance use disorders, particularly tobacco, marijuana, prescription drugs, and alcohol. Learn the considerations for determining the level of care and the use of behavioral approaches for treatment.

New CME module on *Central Appalachia and the Opioid Epidemic*
APA's Division of Diversity and Health Equity has recently published a CME module on Central Appalachia and the Opioid Epidemic. Attempts to understand the opioid epidemic have repeatedly engaged with constructions of multiple "cultures" such as the Appalachian culture, substance use culture, psychiatric/health care culture, and political policy culture. This CME module will explore and critique these cultures which are considered integral to the opiate epidemic in Appalachia and the way these cultures impact Appalachian mental health. You can learn more and access the module here.

Understanding Culture's Impact on Psychiatry – CME Module on Cultural Formulation Interview (CFI) Now Available
APA's Division of Diversity and Health Equity has published a CME module on Cultural Formulation Interview (CFI). The goal of this module is to increase awareness of the impact of culture on the practice of psychiatry and to describe current research in cultural psychiatry. Presented in pulse-learning activity (PLA) form, this module provides information on the CFI's development, utility, and implementation into regular clinical practice.

Learning Objectives of the Module:

- Understand the basis of the impact of culture on the practice of psychiatry
- Learn the foundational basics of the DSM-5 Cultural Formulation Interview
- Identify and appreciate situated aspects of culture beyond typically categorized fields such as ethnicities, languages, sexual orientation, military service, etc.

You can learn more and access the module here.

Transgender Mental Health Pulsed Learning Module
APA's Division of Diversity and Health Equity has published a new CME module on Transgender Mental Health. This CME activity evaluates the current literature on various health and clinical aspects of the transgender populations. Using a pulsed learning format via email, participants will be provided with a series of multiple-choice questions to be completed over time. The questions are also designed to evaluate central features of social determinants of health in transgender youths and adults. You can access the course here.

Trouble Finding a Doctor? New Digital Portal Aims to Make It Easier In California

By Cathie Anderson
January 09, 2019
Sacramento Bee

If you've ever tried to use your insurer's online directory of health care providers, there's a good chance that you've been frustrated by an error or two: It says a doctor is accepting Medicare patients. Not! Or, it says an obstetrician is accepting new patients. Nope! Such errors will significantly decline in California, leaders of a key health care industry trade group said Tuesday, if providers and health plans adopt a one-stop digital shop that the organization developed in collaboration with insurers, providers, suppliers and other key stakeholders.

The Integrated Healthcare Association announced the debut of its Symphony Provider Directory, which will allow health care practitioners to access a dashboard where they can update all their information and submit it to all insurers at one time. Insurers, on the other hand, will be able to easily import those updates for all their system providers. "This is much more than a complex IT project," said Dr. Jeffrey Rideout, the association's president and chief executive. "This is an industry-wide commitment to improve the health care system in California. IHA's role is to drive alignment and establish an effective and sustainable platform that supports the complex needs of health plans, providers and ultimately health care consumers."

Although Symphony is called a directory, its aggregate database will be accessible to consumers only through the health plan websites. Eyal Gurion, IHA's senior vice president for strategic initiatives whose worked on the Symphony project for the last 18 months of his time, says he'll continue to work to ensure the project's successful adoption.

"The first thing we did was pretty extensive market research with all the plans and providers and purchasers that we work with to really understand what this needs to look like for this to work and add value,"

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Gurion said. “After building (Symphony), we worked with three of the largest plans in California – HealthNet, Anthem and Blue Shield – and roughly 6,000 providers, both provider organizations and small independent practices across the state, to make sure that (it) operates the way it should.” Providers and insurers put Symphony through its paces in 2018, making suggestions for improvements and additions.

Errors in medical directories are common all around the United States. In fact, the U.S. Center for Medicare and Medicaid Services reviews directories for a third of its Medicare Advantage plans every year. Between November 2017 and July 2018, it found that 48.7 percent of directories had at least one error. That figure has hovered close to 50 percent over the last three years.

When consumers find errors, the report stated, they begin:
▪ To question the accuracy of the number of providers in the Medicare network.
▪ To lose trust in the integrity of Medicare administrators and the system.
▪ To worry that their care needs may not be met.

Federal officials said Medicare would study ways to encourage a collaborative industry approach to create a centralized database that all providers could update and where all plans could access information. California legislators made that idea appealing to industry in 2015 when they passed legislation requiring health plans to establish online provider directories and update the information at least once a week.

Senate Bill 137 allows insurers to terminate contracts or deny payments if, within a mandated period, a provider doesn’t respond to requests for updated information. Insurers also may face penalties if they knowingly relied upon inaccurate information for their directories.
But this isn’t solely about complying with the law for Sachin Gangupantula, who co-owns a medical practice in Modesto. It’s about ensuring that consumers know that providers are open for business, he said.

“If you look at the last three years of the Affordable Care Act and what it has done, it has introduced so many new patients into the system,” he said, “and a lot of people are coming for the first time into the health care market, and they don’t know exactly where to look for physicians or what to look for.
“If we’re not doing a good job of providing information correctly, I fear that we will just lose the patients all over again.”

After Gangupantula opened up Valley Diabetes & Obesity, he said, he was overwhelmed by how many requests he received for updated information but also how many different ways those requests came to him: Some large health plans began requiring their providers to use their online portals to update their information. Others contracted with companies that had developed online directory software that would send them updates. Many continued to rely upon faxes, U.S. mail or emails to collect information.

Gangupantula runs business operations while his wife and co-owner, Dr. Gopika Gangupantula, is the sole practitioner there. Their practice opened in March 2017, and he didn’t understand why he was so often receiving requests for updated information until he read SB 137. He assigned himself the challenge of verifying the practice’s information with insurers because he didn’t want to reduce the amount of time staff had for patient care.

He was still struggling with managing the updates when he went to an industry conference in early 2018. There, he ran into representatives from Gurion’s team at the Integrated Healthcare Association. They told him about their effort to ensure health care practitioners could update their information once and easily update it with every health plan they served. “I said, ‘Whoa! This is exactly what I need as a small practice, and I can imagine how big of a problem it would be for a larger practice with hundreds of physicians,’ ” Gangupantula said.

He gave them his contact information and told them he would be happy to help in any way he could. They later asked him to participate in a soft launch of the software they had developed for physicians.

“I actually provided them with a lot of feedback on the functionality and the usability aspect of it, just because I have a background in engineering,” Gangupantula said. “We’ve had at least two occasions where we all came together – all of the soft launch partners as well as all of the payers. Together, we were able to talk through the entire process and what is involved and what are the best things we’ve seen so far and what we can improve.”

One such improvement, he said, was ensuring that the dashboard showed providers which health plans they contract with at each insurer. This was important, Gangupantula said, because each insurer has many products, names sound alike and so administrators might have to look up contracts for each update. “Compare all of the confusion we have now with having one single interface available to all practices,” he said, “and it shows us, ‘Hey, here are the two contracts you have with a payer.’ It shows you the information they have on you, and if you want to change any of it, you update it. ... It’s one step, literally one portal.”

Gurion said providers and insurers will receive automated reminders or alerts when information information must be updated. Symphony will be free to providers in 2019, Gurion said, and pricing has not yet been determined for 2020. It will be based upon the number of practitioners in each group.

The online system was developed with a $50 million payment from Blue Shield of California, funds that the

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insurer said it would provide as part of an agreement it negotiated with the California Department of Managed Health Care to be able to acquire Care1st Health Plan. The staff at Integrated Healthcare Association already have a large physician practice group and insurer interested in getting Symphony at their organizations, Gurion said, and professional associations and societies are standing ready to help spread the word about it. Education will be really crucial, he said, and the staff plans to lead sessions for big practice groups and at industry conferences.

"We have a pretty robust outreach and education plan," Gurion said. "We have 100,000 physicians in California – MD's and DO's – but online directories include a much broader group of providers. It's physicians. It's behavioral health professionals. It's dentists. Essentially everything offered through a health plan product needs to be included in the directory, and we estimate just in California, we have 200,000 to 250,000 practitioners and providers in California that need to be reached."

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