Mobile Bay Psychiatric Society NEWSLETTER

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Newsletter Vol. 1 Edition 2
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THE PRESIDENT'S CORNER

Dear Colleagues,

The COVID-19 pandemic has affected the delivery of psychiatric care across the world, In the US, most of the communities have experienced the impact on access to care, quality, and the way care itself is delivered. Outpatient care was transitioned to telehealth or phone only interviews, and now they are gradually transitioning in to in-person with appropriate precautions, and some adopted the telehealth model as permanent.

Inpatient psychiatry hospitals across the country faced with unique challenges in implementing CDC, state and local public health COVID 19 guidelines. Given the structure of a typical inpatient unit having common dining areas, recreational areas, two beds in each room with a shared bathroom, patients are free to move around and interact with other patients and staff on the unit. Some patient populations have limitation in understanding and adhering to some of the basic guidelines of frequent handwashing, maintaining distance, using face masks, need for quarantine due to active psychosis, mania, cognitive deficits.

Eastpointe hospital in Daphne, Alabama, part of Alta Pointe Health Systems, which provides acute adult inpatient psychiatric care for Mobile, Baldwin, Washington counties and surrounding populations in counties in south Alabama is faced with similar challenges. We as a team nursing staff, behavioral aids, social workers, physicians, environmental care, administrators were able to adapt quickly the guidelines of public health and American psychiatric Association using available resources.

We implemented the mandatory temperature checks, screen for upper respiratory symptoms, mask-wearing for everyone who enters the building, and established several stations for dispensing hand sanitizer. We implemented dining in rooms, no visitors, no group sessions, mandatory COVID 19 testing for patient transferring from other facilities, and screening and testing for at-risk or symptomatic patients coming from the community. We provided a surgical mask to all patients and encouraged them to use it when outside the room. We isolated patients who tested positive and quarantined to their room for 14 days. We implemented disinfecting the common arias in the unit, doorknobs, glass windows, phones, toilets more frequently every day.

Alta Pointe Health Systems is in the forefront of other psychiatric facilities in the country, with its advanced telehealth technology and equipment infrastructure at both inpatient and outpatient settings, which helped implement policies to reduce the risk of COVID 19 transmission without compromising patient care. We were able to do virtual family sessions, individual therapy sessions, physician rounding's, treatment team meeting involving physicians. We were able to conduct the involuntary probate court hearings virtually for patients who were exposed to or suspected of exposure to COVID 19.

As a part of the teaching hospital, we were able to provide medical students and resident physician the technology and tools needed to continue medical education virtually. They were able to continue their medical education and training without interruption by joining virtual rounds on the unit, treatment team meetings, and lectures while at home.

We had our share of difficulties in some areas, especially implementing social distancing, mask wearing and isolating the positive patient in the room for 14 days, as the patients were not able to understand due to their limited ability to comprehend directions as a result of their psychiatric illness.

So far, our hospitalized patients' haven't reported any COVID-19 related deaths and did not need transferring to the medical hospital due to COVID 19.

Praveen Narahari, MD, MS, FAPA
President Mobile Bay Psychiatry Society
Assistant Professor of Psychiatry,
Board Certified in American Board of Psychiatry and Addiction Medicine

Silexan

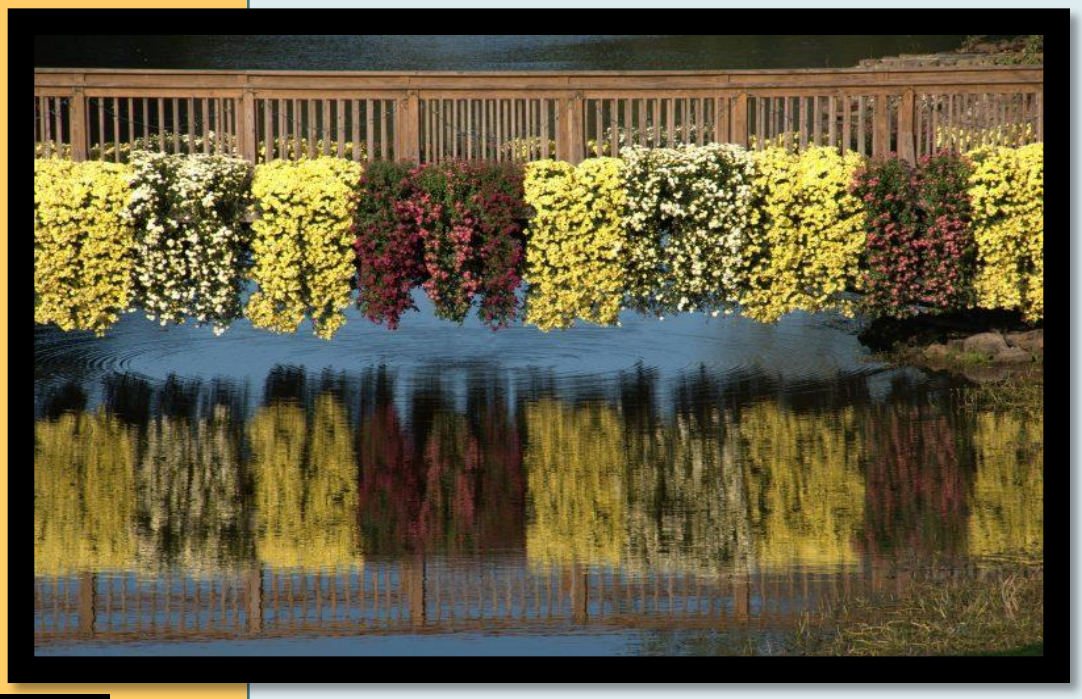
– an OTC that outperforms SSRIs for GAD??

I have subscribed to the Carlat Psychiatry Report for many years, and found it be fair and judicious in its approach to new developments in psychiatry. In the August 2020 issue, the editor Chris Aiken MD wrote an article about Silexan, an OTC which is a branded extract of lavender oil. I had never heard of it. He's prescribed it since 2016 to more than 500 patients for GAD and for MDD with anxious distress. Aiken tells us that the effect size for most of the medications used for GAD is poor – that the effect size for SSRIs, SNRIs, buspirone and pregabalin is in the "small" range (0.2-0.3), with benzodiazepines at 0.5. In one source I saw the effect size of buspirone is 0.17. In 1000's of medical records I reviewed at DDS, buspirone is a very popular anxiety med in family practice settings – and typically given as a prn.

Silexan is regulated as a prescription drug and licensed in 14 countries for anxiety. In a RTC (n=539) comparing Silexan to paroxetine and placebo, Silexan outperformed paroxetine (effect size 0.87). It has no known W/D effects, additive potential, or drug interactions. It is sold at Walmart and other pharmacies as Calm-Aid (Nature's Way) ($24/month for the 160 mg daily dose).

Is this too good to be true???

- Harold Veits, MD



Our mental health is important. Make some time for a little 'Self Care'.

Mum's the word at Bellingrath in November, when the Gardens are decorated with the 57th annual Fall Outdoor Cascading Chrysanthemums display, the nation's largest outdoor cascade chrysanthemums show.

The Horticultural Staff sets out the display in late October, and the chrysanthemums remain on display through the end of November.

REPORT FROM THE VA CLINIC IN MOBILE

There have been no significant changes at the Mobile VA clinic. We continue to use primarily video and telephone for communications during the pandemic but still have a number of patients coming into the clinic.

Contributed by Dr. Seth Strauss

REUNION 2020

50 Year Medical School Reunion – My Thoughts

Written By, Harold Veits, MD

I graduated from the University of Minnesota Medical School, Minneapolis, MN in June 1970. A 50th year reunion was planned in Minneapolis until Covid came along. Eventually a planning group set up a Zoom reunion for October 2020. There were almost 200 in my graduating class, less than 10% were women – which was common back then. I didn't know what to expect, but I signed up for the Zoom and attended. There were about 27 of us that attended – I was surprised at the small number. I wondered how many had died. Back then, we did everything alphabetically, so I became friends with T's and W's, and the one Y in the class. At least two S's showed up, but I didn't really know them back then. Less than half the class joined fraternities, but I never did – I lived at home and walked to campus. So, I expect that created less social opportunity. Some had become academics, and most of the attendees were in clinical practice. Somehow the topic of medical education came up, how it's changed, and the academics talked at length about that – about how selective medical schools had become. 2 or 3 of us tried to introduce re-connecting as human beings but that didn't take hold. Most were silent. They all looked pretty old, and nothing like the faces I remembered. I found the whole thing eerie.

Greetings colleagues and friends,

When I reflect back on my time in April 2018 when I was opening New South Psychiatry, I remember having 2 main concerns: Will I be able to financially support my business while meeting the needs of my patients and will I be able to successfully run a business with little experience? Well, the answer to both of those questions is yes, and with quite a lot of learning and growth. Little did I know that I would face an even greater challenge leading a six-clinician practice in a global pandemic during one of the busiest hurricane seasons yet. I have had to quickly adapt to the many changes that were required in order to successfully treat my patients while also maintaining their safety. Additionally, I had to "juggle" all of my clinicians' schedules while managing the financial aspect of the business. This can all be difficult during power outages, storm damage, and COVID-19. But I am fortunate to have a great office manager and support staff that help me tremendously. To further complicate matters, I had to quickly learn to be proficient with telemedicine, including proper documentation while finding the best platform to perform such tasks.

As 2020 has presented many challenges, my top priority during this time has always been my patient's health and stability. I knew if this focus continued, I would be alright. Looking back on those past obstacles and present state, I know I am here to support my community, as a physician, friend, colleague, citizen, and neighbor. We are in this together! Stay safe and strong. Hope will always prevail!

Peace,
Mark Haygood, DO, MS, FAPA
CEO New South Psychiatry, P.C

New South Psychiatry, P.C.

Can we take a step forward from the past?

Bogan Brooks, MD

Adjusting to the changes in psychiatry over the course of a career presents some interesting challenges and rewards. For example, on the first day of my internship, I was on an internal medicine service. The resident handed me a thick paper chart and said, "Figure out what's wrong with this patient." I looked at the attending's scribbled progress note from the previous day: "Naked in bed, but she knows me."

Another example, I began private practice even though insurers did not reimburse for psychiatric disorders at the same rate as non-psychiatric disorders. The community hospital's psychiatry inpatient unit featured a "therapeutic community." All psychiatrists in private practice in the community treated inpatients, saw out-patients, and performed C-L consults. When the hospital hired a managed care company to run the inpatient unit, the "therapeutic community" model was replaced by a "behavioral medicine" model. Medication management was "encouraged" and psychotherapy was "discouraged."

Managed care reviewers began to scrutinize progress notes, require prior authorizations, and decline payments. Psychiatrists were no longer known as physicians—we were known by the insurers as providers—and we were "encouraged" to join managed care provider panels. Refusal to join a panel was met with comments like: "We'll bring a bunch of psychiatrists up from Boston and put you out of business." We were "encouraged" to purchase computers with comments like: "Computers make writing chart notes and billing much easier."

After 14 years of this "encouragement," I left private practice for employment at a community mental health center where I flourished for several years with a hand-held Dictaphone, transcribed notes, and hand-written prescriptions. With the advent of electronic prescribing, my employer "encouraged" me to learn to type so I could learn to use a computer. I figured that if I had to learn how to type so I could use a computer, I might as well apply for a geriatric psychiatry fellowship because I found I enjoyed treating older adults. My post-fellowship employment was (and still is) at a community mental health center that is affiliated with a medical school. I have loved the combination of supervising psychiatry residents in a private practice clinic, teaching resident didactics, and directing a medical student clerkship. When the coronavirus pandemic hit, I began working from home and "seeing" patients via Zoom or via telephone visits. I also developed a virtual psychiatry clerkship. So, is it possible to take a step forward from the past? Probably not—we can only take a step forward from where we are now, which is in the midst of a pandemic—and while I don't know what our future careers as psychiatrists will look like, I can predict that our careers won't be boring.

The Future of Psychiatry

Ronald D. Franks, M.D.

Preamble (with emphasis on "amble"): A few weeks, Hal Veits learned that I would soon be retiring. He asked if I would do a column on the "Future of Psychiatry." for the newsletter. I was not sure that my crystal ball had any unique clarity on this subject. But, nonetheless, I obliged and offer the following.

Precision in Diagnosis. The human genome project has ushered in new, more precise means of diagnosing medical conditions that have previously relied mostly upon descriptive criteria. Using a series of signs and symptoms, usually coupled with laboratory tests, imaging, and histologic displays, we have come to categorize most human maladies. Increasingly, though, we are linking genetic and epigenetic perturbations within cells to diseases that will soon be re-categorized and regrouped based on cellular and sub-cellular metabolic processes and pathophysiology. Already, we are seeing cancer cells originating from different organs, with different histologies, responding identically to chemotherapy agents aimed at specific genetically controlled mechanisms within these cancer cells.

Thus, many common diseases will be reclassified and subclassified based on their genetically controlled functioning rather than syndromes and/or the apparent organ(s) from which they originated. Psychiatric diagnoses will be particularly benefitted by these advances. Descriptive categories will be dramatically altered as we subdivide, collapse, and eliminate current nomenclature with diagnoses linked to cellular functioning and response to therapeutics. The schizophrenias, and other psychiatric diagnoses, will finally be divided into subtypes defined by genetic and epigenetically controlled pathophysiologic processes. This advanced understanding of the underpinnings of psychiatric illness will allow us to more precisely determine medication selection combined with other treatments to substantially improve the prognoses of our patients.

Neurotransmitters. Over the past five years, we have seen a sharp increase in our understanding of glutamate and its role in modulating mood; even

suicidal preoccupation. The near future will become focused on understanding and regulating this neurotransmitter, much as the last four decades have focused on serotonin, dopamine, and norepinephrine. Further work on intrinsic opioid receptors and the reward pathways will give us greater efficacy in understanding addictions. Uncovering the pathophysiological response to psychological trauma will likely reveal new neurotransmitters, such as mitochondrial DNA, that will help us better manage response to stressful events.

Psychiatry and Psychotherapy. Once the bedrock of psychiatry, psychotherapy will continue to become less and less a part of our practices. Economics will continue to play a major role in shifting this treatment modality to non-physicians. Likewise, the interest of residents in learning the complexities and skills of psychotherapy will continue to wane. With psychiatry adhering more to the medical model, coupled with advances in pharmacology and other therapeutics,
psychiatrists will become ever more indistinguishable from other specialties of medicine.

Practice Settings. Increasingly, psychiatry will be integrated into the practice of primary care. Value-based reimbursements for care, which will include responsibility for the overall health of populations of patients, will require comprehensive team-based approaches practiced within primary care patient homes. Psychiatrists will be critical to achieving that goal, becoming directly involved in the treatment of twenty-five percent or more of primary care patients. But, if we are to reach societal mandates of increased access and quality of health care at reduced cost, our psychiatric interventions will be necessary in the case management of patients at an even greater percentage, especially for those with chronic illness. Subspecialists within psychiatry will consult as needed to these primary care patient homes, just as with other subspecialties in medicine. Psychiatrists' salaries will increasingly be based on health outcomes.

Optimism. The future is a bright one for psychiatry. For our patients, the stigma of mental illness will continue to fade in response to our advances in understanding the biological basis of psychiatric disorders. So, where do the neuroses fit in?

This is Brad Sadler

of Southern Psychiatry Associates. I know we've all been dealing with one of the more major public health crises of our lifetime. It's been an incredible time of stress for patients and providers. I have not had a vacation since the beginning of the year. I've had multiple crisis's in my practice and we are overwhelmed with work at this point. My practice very quickly went to a full telemedicine arrangement and I've only seen one patient in the office since March. My staff has more or less been on TeleMed as well -although some of my NP's have opted to see a few patients in office.

I have been eagerly watching the vaccine trials unfold - hoping for an end to this stress both for my staff and for the patients I take care of. Over the summer my wife noticed an Ad for a vaccine trial. She filled out the form and then I did. We got a call a few days later and we were asked a few questions and apparently, we answered them in a way that we were able to participate in the trial. They wasted no time and later that week were at the Clinic research facility who was employed by Pfizer to carry out the vaccine trial.

I hadn't really ever been in a trial before so it was interesting to see how it all worked. We are blinded to whether or not we received the vaccine - although I'm fairly certain I received placebo and my wife got the 'real deal'. Neither one of us had any symptoms except she had an achy arm for a few days. The vaccine was given in two shots three weeks apart. Each time we came in we were given a COVID-19 test. We came back for a third visit where they drew blood - presumably to look for antibodies. Of note, the contracted company is not blinded to who gets the vaccine or not and they accidentally left my folder uncovered which confirmed my suspicion of being in the control group.

Once a week we log into an app and tell them whether or not we have symptoms of COVID-19. We are paid some for our participation. We got approx. 100 dollars per office visit and we get 5 dollars per week to fill out the illness diary. We were able to get our flu shots but they had to be at least 14 days after we received our injection from the trial. If a vaccine becomes available before the trial and we plan on getting it - we are to let them know and they may either unblind us at this point or drop us from the study they are not sure.

Overall, it's been uplifting to participate in this. I often talk with my patients about it as a way to show my faith in science and to give them hope that this burden we are all sharing right now will eventually come to an end. To be honest, of course my initial haste to sign up for the vaccine trial was probably mostly because of my own worry and anxiety of contracting the illness. I've had some serious infectious disease infections in the past and have a lot of anxiety about being exposed to this virus and have no interest in taking my changes with the roll of the dice. The virus has already killed one of my fraternity brothers age 44 with three children. Even though, I'm certain i got the placebo I continue to participate out of duty to science and to help push us forward on the path of recovery and my patients have been really happy that I'm doing this to get us back to normal.

Of note, my wife is a teacher and the children are back in the classroom so she remains the most at-risk person in our family. I'm happy that she may have gotten the vaccine.

I hope everyone stays safe and healthy. Go Science!!
Bradley Sadler MD

In Memoriam
Bernard "Bud" Bergman

I learned yesterday that Dr. Bergman died in late January, in Panama City Florida. Bud was a graduate of Emory in Atlanta, where he was AOA, and did his psychiatry residency as well, both adult and child.

He came to Mobile in the late 1990's to work at Alabama Psychiatric Services, where I met him when I started working there in December 2000. I got to know him as a friend and colleague – he loved patient care. Some years later he moved to Panama City Florida where he worked for Life Management, the MHC there, for several years. We continued to be in touch, and I saw him at meetings. I found him to be modest, humorous, and a great conversationalist – he was very bright.

He will be missed.