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NEWSLETTER

Winter 2019

ACLP — Psychiatrists Providing Collaborative Care Bridging Physical and Mental Health

President's Message

Growth Plans Show the Academy Is Flourishing and the Future Is Bright

— Rebecca Weintraub Brendel, MD, JD, FACLP

When I joined the Academy in 2003, there were about 750 members and about 325 meeting attendees. In the 15 years since, we became a subspecialty, underwent strategic restructuring of our Council and governance, introduced special interest groups (SIGs), changed management companies and executive directors, and hired a new editor and publisher for our journal . . . to name just a few of the changes.

We're not a small organization any longer.

Now, the Academy has grown to nearly 1,700 members and more than 1,000 attended the last annual meeting. We are vibrant and growing; we now have 19 SIGS with petitions for more pending—highlighting the vitality and accessibility of our SIGs as accessible ways for members to engage with colleagues in areas of interest.

For the fourth year in a row, our annual operating budget exceeds $1m. Over the last year alone, we underwent name changes for our subspecialty and the Academy, established a new audit committee, established transparency in committee and Board nominations and selections, and changed our bylaws to rename the Council to the Board of Directors, to reflect the leadership and operational demands required for an organization of our size. The Academy is flourishing and the future is bright.

With our success comes opportunity for continued growth, expansion of membership, and the potential for increased ability to define and solidify the future of our subspecialty in the interests of the patients we serve. Our inevitable work in this regard is just beginning. We are fortunate to continue to benefit from the exceptionally capable leadership of our executive director, James Vrac, and his staff at PAI Management. His invaluable stewardship continues to lead the Academy into the future. Staff efforts coupled with

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From
David Kroll, MD
Quality & Safety SIG

Hi, everyone.

I've been asked to provide a glossary of business- and quality-related vocabulary words in this special business-oriented issue of the *Newsletter* to help you decode quality dashboards and payment contracts. I hope it's helpful.

I received a little help on this one from Carol Alter, MD, FACLP, who leads the American Psychiatric Association's Committee on Quality and Performance Measurement—I think you'll see why I needed it by the time you get to MIPS!

So, let's get started—we have more for you from page 3 where we also collate extracts from my business columns to-date in *ACLP News* and give a sneak preview of what's yet to come.

Glossary of Terms

quality measurement (synonyms: performance measurement, or metrics): Any measurement that is used to assess the quality or performance of a product or service. Anyone can design a quality or performance metric for use on a personal or local level.

quality measure: This term usually describes a quality measurement that has been approved by CMS (Centers for Medi-

(terms continue on page 4)

the countless hours of volunteer work by the more than 200 Academy members who tirelessly serve on subcommittees, committees, and the Board of Directors, ensure our continued growth and success.

As 2019 program chair Madeleine Becker, MD, FACLP, and the Annual Meeting Committee are busy with early planning for the November meeting in San Diego, aptly themed "The Future of the Subspecialty," your Board is hard at work delivering for the present and sowing the seeds for the future.

As Dr. Becker's column (page 7) highlights, this year's meeting will bring exciting new programming, including a first-ever Saturday session culminating in a farewell luncheon reception—a perfect opportunity to bring the meeting to a formal close with ample opportunity for networking, final visits with colleagues new and old, and planning for a leisurely Saturday evening with new and old colleagues before departing from San Diego. Dr. Becker and I anticipate that this new format, recommended by our annual meeting consultation, will bring the meeting to an exciting and celebratory conclusion. Be on the lookout for further details in coming months!

The work of the Academy also continues with your SIGs hard at work with topical projects, preparing submissions for the annual meeting, including a new SIG mentorship track focused on providing opportunity for trainees and early career members to gain mentored experience presenting at our meeting. Our committees and task forces are moving ahead with our key priorities.

Highlights of the ongoing work of the Academy include work by the Communications Committee, under the direction of Sandra Rackley, MD, FACLP, to assess metrics of the new website use and the relative impact of different content included in our website. At the same time, the Branding/Marketing Task Force, headed by Terry Rabinowitz, MD, FACLP, is working to provide final recommendations for action to the Board at the June mid-year meeting following a successful strategic rollout of the Academy's new name. Dr. Rabinowitz has also taken the helm of the Journal Committee as the Academy engages consultation in preparation for the 2020 expiration of the contracts with the publisher and the editor-in-chief.

The Membership Committee, under the leadership of Maryland Pao, MD, FACLP, and Ann Schwartz, MD, FACLP, has worked to clarify criteria for Academy fellowship and awards. Please ask a colleague to join the Academy and they will encounter a streamlined membership process to facilitate becoming a member without delay or waiting periods. Just imagine, not too far in the future, the Academy is poised to welcome its 2000th member!

The successes of the Academy have led to the introduction of an Audit Committee, led by Bob Joseph, MD, FACLP, to bring the Academy up to present-day standards of oversight in reviewing the annual external audit report.

Under the leadership of Sherwood Brown, MD, FACLP, members of the Research & Evidence-Based Practice Committee have volunteered to assist the Annual Meeting Committee in evaluating oral papers and posters for inclusion at the annual meeting and developing support and programming for research development and production.

Finally, the great success of the Education Committee under the leadership of Paul Desan, MD, FACLP, is visible in the continued growing popularity of C-L psychiatry with trainees—this year saw a visible uptick in the number of positions for C-L fellowship filled in the Match.

"Just imagine, not too far in the future, the Academy is poised to welcome its 2000th member!"

Jim Rundell, MD, FACLP, continues at the helm of a multi-subspecialty workgroup of addiction, geriatric, and C-L psychiatry organizations and APA councils in these areas, to address creative recommendations and solutions for developing an adequate present and future workforce for our patients.

Other ACLP members participating on the task force are Dr. Schwartz, representing the Academy, and Sejal Shah, MD, FACLP, representing the Council on Consultation-Liaison Psychiatry of the American Psychiatric Association (APA). Finally, Tom Heinrich, MD, FACLP, continues to forge ahead as the Benchmarking Task Force gathers data and begins to synthesize their findings to assist C-L psychiatrists and C-L services in establishing productivity and full-time equivalent ranges for their services, taking into account volume and other practice factors.

As our work continues, James Vrac, president-elect Michael Sharpe, MD, FACLP, and I are busy at work to plan the mid-year board meeting and strategy planning session. The Academy last underwent strategy planning four years ago and is ready to plan for the next five to 10 years.

Critical areas of focus are likely to be on membership and implementation of recommendations from the membership survey, value of membership, communication with members, and effective engagement with other professional organizations.

In the interest of promoting effective working relationships with other professional organizations in psychiatry and beyond, ACLP will be the first psychiatric subspecialty organization to host a board meeting at the new APA headquarters at the Wharf in Washington, DC. The board has also approved exploring ACLP membership in the American Medical Association (AMA). Stay tuned for the exciting developments and strategy bound to come from the mid-year Board meeting in early June.

At the end of the day, the more things change, however, the more we hope some critical elements of membership continue the same as always. Specifically, as we grow bigger and stronger, we must all continue to maintain the collegiality and personal connections that have made the Academy the success it is today. I look forward to shepherding the Academy's continued growth and prosperity while continuing to embrace it as my ongoing professional home. As this year flies by, please do not hesitate to share your great ideas, big and small, to continue strengthening the Academy and our subspecialty.

Founder of ACLP's Quality & Safety SIG, David Kroll, MD, director of quality and safety for the Psychiatry Department at Brigham and Women's Hospital, has been leading new thinking on business issues in occasional articles for *ACLP News* for the past year.

Here we collate some of his thinking from past issues—and from articles yet to be published—and refer back to the full text should you want to explore the subjects further. Full *ACLP News* articles are under Member Resources on the website.

His argument is that, love 'em or hate 'em, it's better that we set meaningful, patient-centered quality and safety metrics for C-L—rather than leave it to others who may not have the same understanding.

David Kroll, MD

Business Route to Better Health

"C-L psychiatrists need to get on board with quality improvement. No one disputes that giving as many patients as possible the best possible outcomes for their health conditions is a good thing. But when you add in the idea that rigorous attention to standardized processes and clearly defining the desired outcomes in quantitative terms is the right way to go about improving outcomes in health care, you might lose a few people." —Dr. Kroll

Historical attempts to measure the quality—or "worth"—of a clinical service have often focused on metrics that don't really matter to patients, such as productivity benchmarks and so-called "meaningful use" of electronic health records.

Good intentions may exist behind these efforts, but they can waste time, and they haven't moved the needle on improving the product we deliver to patients—i.e., better health.

One reason they haven't been successful is that, for the most part, these process changes have been handed to clinicians by administrators in a "top-down" fashion. When administrators who do not practice C-L psychiatry make decisions about what signifies good quality in a psychiatry consult, they're probably going to get it wrong unless they solicit and seriously consider input from C-L psychiatrists.

If we're going to get administrators to listen to us, we need to have something to say. Specifically, we need to be able to tell them: "This is how we know whether this intervention by the C-L psychiatry team was successful, and we believe our patients would agree with us, and this is why, and here's what else we can do with our service to make the care in this hospital better." We also need to be able to prove it.

Rising costs of delivering health care have reached a crisis stage. Demonstrating that our interventions reduced the overall costs of care (e.g., through lowering the length of hospital stay, or reducing the likelihood of readmission) is one effective way to get our point across. Marking the extent to which short-term and long-term health outcomes have been improved by our care is another. If we can do both at the same time, we'll have a really strong argument.

Extracted from "Love 'em, or Hate 'em," *ACLP News,* May 2018.

Benchmarks for Staffing

"Adequately staffing psychiatry C-L services is critical to the success of hospital systems. Up to 40% of medical inpatients have psychiatric diagnoses, and C-L psychiatrists are needed not only to provide expert care for the ones with overt symptoms but also to help hospital teams manage behavioral health at the population level (including screening, policy development, etc.). This doesn't even include teaching obligations."—Dr. Kroll

How does a psychiatry C-L service director know whether there's enough staff to cover the needs of the hospital in the next month?

Consult volume varies day by day, and it's easy to mismatch this with staff availability when staffing must be determined in advance. Overstaffing wastes resources, dilutes productivity, and can lead to

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In this ISSUE:

@CL_Psychiatry

Business Issues (cont'd from p. 3)

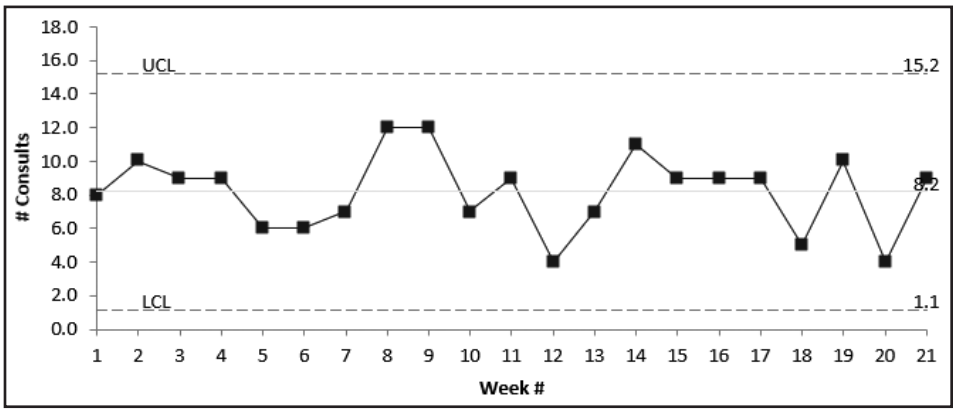
unnecessary frustration (for example, when vacation requests are denied). Understaffing, on the other hand, means not being available for patients.

In fact, short-term daily consult volume can be predicted—to an extent. Assuming that no major disruptions (such as a nearby psychiatric hospital closing, or a local volcanic eruption) are anticipated, the number of consults per day (or per shift) will almost always fall within a predictable range.

An easy way to illustrate this is to use a statistical process control chart, which is a tool that plots historical outcomes on an X-Y axis and calculates the maximum and minimum values that could be expected in the future under similar circumstances.

As an example, my institution (a relatively large one) plotted the number of new psychiatry consults assigned on Fridays over an approximately five-month period:

The center tracking line with squares is the mean (8) and the broken lines marked "UCL" and "LCL" are the Upper Control Limit (15.2) and Lower Control Limit (1.1), respectively.



From UCL and LCL alone, we can tell that it would be rare to receive >15 or <1 consult(s) on a typical Friday. Therefore, two psychiatrists on staff should expect to see between 0-8 consults (avg 4) each on a Friday; three psychiatrists, 0-5 (avg 2-3); and four psychiatrists, 0-4 (avg 2).

Depending on the psychiatrists' other responsibilities, eight consults may be too many or may be appropriate. One could also break this down by the half-day, the shift, or even the hour.

Extracted from "Statistical Chart Helps Manage Staffing Levels," *ACLP News,* September 2018.

Better Measures for Productivity

"A C-L psychiatrist's productivity, i.e., the volume of clinical work done per month or year, probably isn't the best way to measure his or her overall value to a hospital system. Volume does not equal quality, and the successes of psychiatric care delivery models that do not rely on traditional productivity measures, such as collaborative care and proactive inpatient consultation, are hard to ignore."—Dr. Kroll

C-L psychiatry service directors need to have some way of accounting for the work that their clinical staff do.

There are many good reasons to account for the work that's done, but perhaps the most important is that allocating resources and lobbying for more resources require objective data. Clinical productivity is one way to represent that data, and the fact that it is (usually) readily available, coupled with another fact that correlates (imperfectly) with revenue, makes it uniquely attractive for this purpose.

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Business Glossary (cont'd from page 1)

care and Medicaid Services) for use in a federal payment program (i.e., money is at stake). As a prerequisite for approval of a quality measure, validation research must be conducted in a range of clinical and administrative settings to ensure that it accurately and consistently captures the clinical process or outcome being targeted. Ideally, the use of a valid quality measure should not place undue burden on clinicians and should drive performance improvement by drawing more attention to the targeted process or outcome. Complete information can be found at https://qpp.cms.gov/

National Academy of Medicine quality aims: Effectiveness, efficiency, timeliness, safety, equitability, and patient-centeredness. These have been promoted by the National Academy of Medicine (formerly the Institute of Medicine) as appropriate targets for the development of quality measures. It is a good idea to consider them when conducting a quality improvement project at any level.

MACRA: The Medicare Access and CHIP Reauthorization Act of 2015. This legislation advanced the use of quality measures to determine reimbursement rates by CMS. One program created by MACRA was MIPS, and this is the part of it you are most likely to see if you are running a clinical service. On quality dashboards MIPS measures may be labeled as "MIPS/MACRA."

MIPS: Merit Based Incentive Payment System. MIPS applies to Quality Measures in four domains--quality, promoting interoperability (formerly known as "meaningful use"), improvement activities, and cost—to determine whether providers or health systems receive a payment adjustment (i.e., a penalty or bonus).

If you are working in a general hospital system (as C-L psychiatrists often are), your hospital system or physicians' organization should provide you with a list of the MIPS measures your service is responsible for. Several MIPS mea-

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Business Issues (cont'd from p. 4)

But how, exactly, does one set a productivity target? In theory, assuming money is important, the clinical productivity expected of a full-time clinical staff member should generate enough revenue to cover that staff member's costs (i.e., salary, benefits, and other fringe costs), whereas anything above that is bonus (for someone).

This is how a pure private practice works, and hospital departments in revenue-generating specialties may approximate this formula when constructing their own targets. But reimbursement for services is rarely guaranteed, it is rarely equal across locations and insurance carriers, and it is consistently lower for psychiatric care compared to other specialties. It would be hard to make this work for a C-L psychiatry service.

Before we go further, I want to make sure that the definition of an RVU, or "relative value unit," is clear. An RVU is a standardized representation of the cost of a medical service used by Medicare, and it has three components. The component most clinicians are familiar with is the "work RVU," which corresponds directly to the billing code (or codes) that a clinician submits with each encounter. The other components, which represent practice expenses and the costs of liability insurance, are determined by factors beyond the individual staff clinician's control and can be put aside for the purposes of this article, but the three components are ultimately plugged into an algorithm that determines reimbursement by Medicare, based on Medicare's fee schedule for that year.

In many specialties, it is common to set an RVU target based on the expected revenue compensating for the costs of the clinical staff member. But such a target would be extremely difficult for a C-L psychiatrist to meet. Unlike transplant surgery, for example, C-L psychiatry is typically a "cost center" rather than a "revenue center" in the business of health systems—meaning it loses money, and the "business" chooses to "invest" in it for reasons other than generating revenue. The RVUs generated by a C-L psychiatrist will rarely be sufficient to offset costs.

Another way to determine a work RVU target is to consider how much clinical work you expect the psychiatry staff to do. If you think that a psychiatrist should staff two new consults and two follow-up encounters per half-day shift, for example, you could simply look up the Medicare fee schedule and add it up for the year:

[(2 * 3.29 (RVU for initial consult code 99254)) + 1.39 (RVU for follow-up code 99232)] x 8 (number of half-day shifts per week) x 48 (number of weeks on service) = 3594.24 for each full-time staff member (or full-time equivalent)

If you wanted your staff to spend more of their clinical time teaching or doing liaison work, you would set the bar lower; and you could set it higher if you wanted them to see more consults.

Extracted from "C-L Psychiatrists Need Better Measures for Productivity," *ACLP News,* November 2018.

Why We Need Money

"A new service line is never free. Even if you know that your project will save money in the end, somebody has to pay up front for some things or else the work will never get done. Maybe you need to hire new staff, or maybe you don't. Maybe you can do a lot of the work yourself. Maybe your meeting attendees can bring their own lunches. It's possible that you can accomplish this task without any real money ever changing hands. Still, it isn't free."—Dr. Kroll

Everything that transpires in the course of a workday costs something. Most of us think about costs in terms of concrete financial transactions: I give $1.50 to the cafeteria and receive a coffee in exchange. But that $1.50 underestimates my coffee's true cost.

If I spend 10 minutes walking back and forth from my office to the cafeteria, and five minutes waiting in line to pay, and my time goes for $138.64 an hour, the true cost of that coffee is closer to $36.

This assumes, of course, that I have no disposable downtime and wouldn't benefit from a break now and then. And I might be getting more than just coffee out of the transaction—I could simultaneously be using that

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Business Glossary (cont'd from page 4)

sures are applicable to psychiatric care in medical settings, and many more are applicable to primary care practices. Collaborative care is an example of a way in which C-L psychiatrists become involved with efforts to improve performance on MIPS measures. However, the list of MIPS measures you receive from your hospital system may still contain 0 items because "ownership" of these measures typically gets assigned to the primary team.

The APA maintains a list of which MIPS measures pertain to behavioral health, and it can be found at: tinyurl.com/apa-mips

outcomes measure: A measurement of a product or service's end result. On a service that provides psychiatric care, examples of outcomes measures might include depression symptoms after treatment, or suicide rates.

process measure: A measurement of adherence to a process that is thought to be consistent with producing a high-quality result. One might choose to measure a process rather than an outcome because processes can be measured in real-time, whereas the time lapse between process and outcome may be prohibitively long. Some outcomes are also multifactorial, and in those cases measuring only the outcome may not yield easily interpretable information about the service or product one is trying to evaluate.

patient-centered outcome: An outcome that patients actually care about.

measurement-based care (MBC): This term describes the use of symptom measurement tools (such as the PHQ-9) at regular intervals to inform treatment steps. The theory behind MBC is that it overcomes "therapeutic inertia" (the notion that prescribers are often slow to advance or discontinue treatment plans because it is not clear whether or not the patient is improving at the time of the encounter based on how he or she sub-

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Business Issues (cont'd from p. 5)

time to improve my relationship with a colleague, or I might need time to think about a problem with one of my patients.

Doing anything at all with your time requires you not to do something else. And yet, most of the time you only need to secure funding for projects that actually involve financial transactions.

Here's the basic formula:

Hourly staff cost = [(Annual salary + fringe)/(number of working weeks per year)]/(number of working hours per week)

Fringe refers to the costs associated with employing you that do not directly become part of your salary, like health insurance. Although overhead costs vary between employees and may not truly be proportional to your salary, the fringe rate is typically set by your institution and must be included in any budget calculation.

So, with a hypothetical salary of $200,000 per year, a fringe rate of 33%, an expectation of 48 working weeks per year, and 40 working hours per week, your hourly rate comes to:

[($200,000 + $66,000)/48]/40 = $138.54

I don't want you to start fretting over every wasted hour, but if you're trying to determine the staffing cost of a proposed new service line, this formula is how you do it. Then you simply add up the hours.

Extracted from
"What Do You Need Money For?",
ACLP News, January 2019.

Return on Your Investment

"An outcome that is important only to you, is only important if you can fund it yourself. Yes, you will be more motivated to succeed if you feel passionately about what your project can achieve, and internal motivation is a desirable thing. However, if you expect to ask someone else to pay for your project, you'll need to figure out what's in it for them."—Dr. Kroll

When you pitch a new service or project, prospective funders are looking for an ROI, or return on investment. ROI is calculated as follows:

ROI = (expected benefits – costs)/costs

This is usually reported as a percentage, and anything over 0 is considered a positive ROI. If I decide to measure length of stay (LOS) reduction, and I project that my new service will reduce LOS by four hours per patient on average, and I learn that my hospital system delivers inpatient care at an average hourly cost of $200, I can say that my project can expect to result in savings of:

$200/inpatient hour * 4 hours per patient * 3 patients per week * 52 weeks per year = $124,800 per year

Therefore, my ROI is ($124,800-$55,815)/$55,815 = 124% in the first year.

That's actually pretty good. Whether it's good enough to earn funding is up to your prospective funder, of course. Most institutions have something called a "hurdle rate," which is the minimum ROI they will consider eligible for funding. You may also be competing with other teams for a specific funding stream.

It is not a rule that your outcome has to be a financial benchmark, even though this makes for an easier calculation. Maybe your project will, in fact, result in a measurable health benefit for some patients. If that's the case, be prepared to prove that your project can deliver either a better health outcome at the same cost, or the same outcome at a lower cost, compared to the existing system.

Extracted from
an article to be published in the
March issue of *ACLP News.*

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"You are at an advantage from the outset if you argue your case using terms understood by the administrator you are seeking to convince—and confusion is avoided if you are both using the same definitions!"—Dr. Kroll

Business Glossary (cont'd from page 5)

jectively reports feeling that day) and facilitates reaching optimal treatment (or stopping an unhelpful treatment) in a more timely and decisive manner than usual care. A compelling body of research indicates that treatment strategies that use MBC (including collaborative care) lead to improved outcomes.

lean: This is an approach to quality improvement that focuses on eliminating waste within a system. Waste is all around you. Anything that is paid for and is not used is waste, including your time. Any time that patients spend in the health care system not recovering from their illnesses is also waste—for example, appointment lag times, or boarding in the emergency department for a psychiatric bed. Lean interventions improve efficiency, but because errors are usually the greatest source of waste, there is obsessive attention to eliminating errors wherever possible.

PDSA cycle: "Plan-do-study-act" cycle. It provides a structure for making rapid, iterative changes to a product or service in the context of a quality improvement project. The underlying idea is that no matter how well you plan, you will always encounter unforeseen problems when you try something new, and therefore it is necessary to make adjustments as you go. "Plan" refers to making a protocol. "Do" refers to trying out the protocol you came up with in the real world. "Study" refers to measuring how successful the plan was and what problems you encountered. "Act" refers to adjusting the plan for the next round in response to what you've learned from the first round. Repeat as many times as is necessary until you have a perfect product. This method contrasts with a research trial, in which the protocol must be specified in advance and typically doesn't change in response to real-time data.

CLP 2019 program chair's message

THE FUTURE OF THE SUBSPECIALTY: 2019 MEETING IN SAN DIEGO

— Madeleine Becker, MD, FACLP

I hope that all of you enjoyed our November meeting in Orlando! The call for abstracts for our 2019 meeting in San Diego meeting has opened. Our meeting theme this year is "The Future of the Subspecialty." Submissions related to this theme will be especially welcome, but please send in all your great ideas!

Some highlights of the 2019 meeting:

The Updates in C-L Psychiatry course on **Wednesday** will be FREE with ACLP membership and registration for the meeting. The afternoon will offer multiple practical and interesting Skills courses.

We have an outstanding line-up of invited plenary guests who will speak on topics related to the theme of **The Future of the Subspecialty.**

In order to continue to highlight our SIGs' work, and to encourage submissions and presentations by Academy trainees and early career members, we are piloting a "SIG Mentorship Track" alongside of our regular submission track.

This process is designed to provide mentorship to our junior members, utilizing the expertise of some of our most senior Academy members.

The "SIG Mentorship Track" is a different submission process from the regular submissions. Each SIG may submit one submission to this special track. **You may also submit SIG-sponsored proposals to the regular call for abstracts and we hope you will!**

The meeting will end on Saturday afternoon after a morning of workshops and a grand closing session. This will be followed by an informal celebratory luncheon reception. I hope you will stay to join us for this event!

San Diego is a beautiful venue with many wonderful attractions nearby, including the San Diego Zoo, Sea World, as well as wonderful restaurants and shopping.

We look forward to receiving all of your submissions!

Business Issues (cont'd from p. 6)

Why Measure Quality

"Some C-L psychiatry services struggle to prove their worth to their own health systems. It may be easy to assume that your service is doing a good job when you've hired good psychiatrists and, generally, your patients and consultees seem happy with the consults they're receiving. And that's probably fair—your good psychiatrists probably are providing good care most of the time. It's also easy to point to research showing the ways in which C-L psychiatry services usually improve value for health systems by advancing health outcomes, lowering costs, or both. But academic research unfortunately doesn't move all listeners, and there is only one way to know for sure what the direct impact of your service is. That is by tracking outcomes."—Dr. Kroll

Tracking outcomes seems like an obvious step in any effort to assess quality or drive improvements in service delivery, but the field of C-L psychiatry has not come to an agreement regarding what outcomes should be measured, or how.

Several metrics have been proposed, and studied, including consult volume, consult type, consult response time, consultee satisfaction, patient satisfaction, patients' relatives' satisfaction, consultee concordance with recommendations, documentation elements, nurses' difficulty in caring for patients, global assessment of functioning scores, symptoms at follow-up, adherence to recommendations at follow-up, length of stay, utilization, and costs.

The first question we should ask ourselves is this: why do we want to measure quality in the first place? Is it to drive improvements in patient care? Quality measurement can be an effective tool for refining best practices and promoting adherence to those best practices at the local level. That is indisputably a good goal, but it is not the only one.

Another reason to measure quality is to prove our worth to hospital systems. C-L psychiatry services, no matter how good, can't operate without money, and most of us cannot generate that money by billing for clinical services (not if the clinical services are psychiatry consults, anyway). In order to grow (and therefore to care for a higher volume and complexity of patients), we may need to demonstrate the ways our work adds value for the health systems we serve.

A third reason to measure quality is to facilitate comparisons between services in different health systems—basically asking the question of whether service A is doing a better job than service B, as opposed to whether service A can do a better job this month compared to last month. This is not just about vanity. Comparisons can be used in a positive way to help set standards, and their usefulness in marketing and recruitment can be a powerful incentive for greater investment by health systems.

Extracted from an article to be published in a future issue of *ACLP News.*

ACLP SIG Updates

Bioethics

Co-chairs: Mary Ann Cohen, MD, FACLP; and Rebecca Weintraub Brendel, MD, JD, FACLP

Rotating Trainee and Early Career Psychiatrist Co-chairs: Anita Chang, DO (trainee, 2017-2020), Monika Chaudhry, MD (ECP, 2015-2018), Eric Rafla-Yuan, MD, (trainee, 2016-2019), and Andrew Siegel, MD (ECP, 2017-2020)

Interest in bioethical issues has markedly increased over the last year, with a current total of 345 Bioethics SIG members and high attendance at our ACLP Bioethics SIG symposia.

We will continue to work toward teaching psychiatrists and other clinicians of all specialties about Bioethics. In 2019, members are giving or planning to give lectures, grand rounds, courses, symposia, panels, and workshops at the annual meetings of the APA and ACLP and at other meetings.

Drs. Cohen, Aladjem, and Alfonso have proposed to the WPA Executive Council that the Bioethics SIG become a Section of the WPA. Drs. James Bourgeois, Becca Brendel, Talin Dadoyan, Cynthia Geppert, Michael Peterson, Laura Roberts and Saba Syed have expressed their interest in participating in this effort. We will continue to work on developing this section.

Bioethics SIG members are working to develop proposals for presentations on several of the many topics suggested at the last SIG meeting. These include, but are not limited to, unethical treatment of trainees, professionalism and the use of social media, ethical issues that arise with new technology and public information, and ethical issues involved with the care of persons in correctional facilities.

We are encouraging early career psychiatrists and trainees to participate in developing Bioethics SIG Symposia as well as contributing to articles in the ACLP C-L Psychiatry series in *Psychiatric News.*

The new link to our web page is: www.clpsychiatry.org/sigs/bioethics/

Early Career Psychiatrists

Co-chairs: Stephanie Tung, MD; and Jai Gandhi, MD

The Early Career Psychiatrists (ECP) SIG aims to create a network for, and provide support to, those entering the field of C-L Psychiatry. This group is open to trainees and faculty in their first 10 years of practice, and serves as an avenue for ECPs to develop greater expertise and integration into ACLP. The ECP SIG has attempted to utilize emerging technologies to facilitate peer guidance during a critical period of professional identity formation.

At the 2017 ACLP meeting, members of the ECP SIG requested events focused on mentorship. In response to feedback, members of the ECP SIG and ECP Subcommittee created and presented at two events at the 2018 ACLP meeting. A symposium entitled *Maximizing Mentorship Relationships Throughout Our Careers* was held and a workshop titled *Redefining Mentorship for the Early Career C-L Psychiatrist* was hosted. At these events, attendees were provided with insights on how to form and maintain mentorship relationships.

During the 2018 meeting, ECP SIG members explored potential means of improving communication within the group. The group voted to adopt use of the Slack application. Through this app, group members can help each other navigate challenges that arise from daily practice and share helpful resources or job postings.

When brainstorming about events for future ACLP meetings, ECP members sought informal venues for networking and career advising. Several trainees expressed interest in meeting senior members in the field, but noted that it can be intimidating to approach people from other institutions. Other areas of interest identified by the ECP SIG included financial aspects of clinical practice and the development of leadership and educational skills. At the conclusion of the 2018 meeting, Alan Hsu, MD, handed over his role as ECP SIG co-chair to Jai Gandhi, MD. Alan will remain involved in the ECP committee.

As we look ahead to CLP 2019 in San Diego, the ECP SIG has been brainstorming about several exciting events which we hope to share with you soon.

Emergency Psychiatry

Co-chairs: Allison Hadley, MD; and Scott Simpson, MD, MPH

The Emergency Psychiatry SIG was excited by another successful annual meeting marked by numerous original presentations and much networking by SIG members. SIG members led several great sessions and discussions, reflecting their diverse interests and expertise:

- Building unique service models for providing emergency psychiatric care.
- Managing challenging presentations including malingering and agitation.
- Treating toxidromes, from common to esoteric.
- Developing constant observation polices that save money, time, and lives.

The annual meeting has continued to grow as one of the most important academic venues for emergency psychiatry in the country.

With 400 members, the Emergency Psychiatry SIG has grown rapidly in the last several years and is the US' largest group of physicians focused on emergency psychiatric practice.

The SIG strives to ensure the Academy and C-L Psychiatry retain its leading role in the treatment of behavioral emergencies. Our members remain active collaborators with external organizations and are already preparing submission for the 2019 Annual Meeting!

HIV/AIDS Psychiatry

Co-chairs: Mary Ann Cohen, MD, FACLP; and Kelly Cozza, MD, FACLP

Rotating Early Career Psychiatrist Co-chairs: Kevin Donelly-Boylen, MD (2016-2019), Elise Hall, MD (2017-2020), David Karol, MD (2017-2020), Mallika Lavakumar, MD (2017-2020), Luis Pereira, MD (2017-2020)

The HIV/AIDS Psychiatry SIG has grown from 32 members in 2003 to 471 in January 2019! We will continue to work toward

teaching clinicians of all specialties about prevention and care of persons with HIV. In 2019, members are giving or planning to give lectures, grand rounds, courses, symposia, panels, and workshops at the annual meetings of the APA, EAPM, WPA, IPS, and ACLP.

At the 2019 APA Meeting:

- Drs. Mark Bradley, Mary Ann Cohen, Kelly Cozza, and John Grimaldi will present *New Directions in HIV Psychiatry: Prevention and Wellness in the Fourth Decade.*
- Drs. Marshall Forstein, Mary Ann Cohen, Fran Cournos, and Karl Goodkin will present *History of HIV Psychiatry: Psychiatric Response to the Epidemic.*
- Drs. Mary Ann Cohen, Jordi Blanch, Luis Pereira, and Ms. Getrude Makurumidze, BA, will present *HIV Stigma and Discrimination: Impact on Patients, Orphans, Families, and Prevention.*

Drs. Cozza, Nash, Reza, Alhjji, Jackson, and Lavakumar are developing an HIV C-L Psychiatry toolkit for teaching other physicians.

Drs. Bourgeois, Cohen, and others are developing a Clinical Manual of HIV Psychiatry. Members will contribute articles on HIV Psychiatry for the ongoing ACLP C-L Psychiatry series for *Psychiatric Times.*

Dr. Grimaldi (in collaboration with Dr. Cohen) will continue to select and annotate HIV articles for the ACLP "Quarterly Annotations" (under Education/Careers on the website.)

The web page is now at: www.clpsychiatry.org/sigs/hiv/

We welcome new members!

Integrative Medicine (Complementary & Alternative Medicine)

Co-chairs: Ana Ivkovic, MD; and Uma Naidoo, MD

We are very excited for this upcoming year and hope to have an even stronger Integrative Medicine presence at ACLP than in years past!

Our main order of business currently is to expand our SIG and recruit people who are interested in heading one of our three subgroups (understanding that overlap will be inevitable) which will provide a framework for our website, for the generation of a C-L-relevant integrative medicine bibliography, as well as for planning for CLP 2019:

- Mind-body Medicine (e.g., MBSRT, biofeedback, Tai Chi, yoga, exercise, etc.)
- Diet and Nutrition (e.g., dietary interventions, microbiome, macro- and micronutrients including deficiency states)
- Herbs and Supplements (including relevant drug interactions for C-L psychiatrists to be mindful of)

Military & Veterans

Chair: Eric Devon, MD

The Military & Veterans SIG enjoyed our first face-to-face meeting at the conference in Orlando last fall with an excellent turnout and lots of enthusiasm. As we turn towards the coming year, we have set our sights on a few topics, including but not limited to:

- Looking into branding ACLP as the "flagship" organization and conference for VA and DoD mental health providers.
- Improving collaboration with DoD.
- Finding ways to highlight VA strengths that may be generalized to civilian C-L practice, including such examples as unique integrated care models, TBI care, sleep disorders and the use of predictive analytics.

We are also open to collaboration with other SIGs on these and other topics, so please reach out!

Palliative Medicine & Psycho-Oncology

Chair: Jennifer Knight, MD, FACLP

It has been a great year for the Palliative Medicine & Psycho-Oncology SIG. We achieved our top priority in successfully nominating a speaker to be featured at CLP 2018: Steve Cole, MD, from UCLA.

Dr. Cole headlined as the opening plenary speaker at the meeting in Orlando, where he delivered a riveting and thought-provoking talk about the neural regulation of cancer. His talk informed us, as C-L psychiatrists, about how we can play a role in the discoveries and implementation of the ongoing breakthroughs in our field.

The 2018 meeting was also highlighted by several SIG-sponsored symposia where we continued to educate our colleagues about this C-L subspecialty.

We continue to make progress in developing a website, led by Alan Chu, MD, which will serve as an article bibliography and repository for other specialty-specific information for use by ACLP members, with article collection spearheaded by Eleanor Anderson, MD.

In this coming year, members of our SIG plan to submit additional SIG-sponsored symposia to other related organizations, including the International Psycho-Oncology Society and the American Psycho-Oncology Society. We also continue to discuss symposia topics for next year, with a focus on special populations.

A long-term goal is to continue to guide the future of our subspecialty through a published collaborative position statement. Finally, our current chair is now Jennifer Knight, MD, FACLP, of the Medical College of Wisconsin and specialist in Psycho-Oncology.

If anyone is interested in serving as a Palliative Care-oriented co-chair, please let Jennifer know.

Pediatric C-L Psychiatry

Co-chairs: Laura Markley, MD, FACLP; and Susan Turkel, MD, FACLP

The Pediatric C-L Psychiatry SIG is pleased to announce the launch of its new listserv; the email is pediatrics@list.apm.org.

Interested in joining the conversation? Subscribe via your Academy profile accessible on the Academy website. Only subscribers can post to the listserv.

We look forward to your contributions!

(SIG Updates continue on page 10)

SIG Updates (cont'd from p. 9)

Quality & Safety

Chair: David Kroll, MD

The Quality and Safety SIG held its first in-person meeting in November at CLP 2018. The meeting identified problem areas that our members would like to work on in the coming year, including:

- Difficulty proving the value of a C-L psychiatry service to hospital systems.
- Difficulty getting health systems to support projects that improve equitability of care.
- Lack of guidance on how to optimally use existing resources.

Our goal for 2019 is to submit at least one proposal to CLP 2019 that addresses one of these topics, which can provide an opportunity for those in the SIG to work together in a more formal capacity and to share best practices with the rest of the ACLP.

Our members are also happy to collaborate with other SIGs on their projects' implementation and measurement strategies.

Research

Chair: Jane Walker, MBChB, MSc, PhD, MRCPsych

The Research SIG is rapidly expanding and we really want to reach out to everyone involved in both research and quality improvement.

In 2018, we worked closely with the Research Committee to organize two new sessions at the annual meeting in Florida—*Getting Started in Research and Maintaining Momentum with Your Research*—as well as the now annual *Research for Researchers* session. We have had excellent feedback from both and Research SIG members are already planning sessions for the 2019 meeting program.

Women's Health

Co-chairs: Nancy Byatt, DO, MBA, FACLP; and Priya Gopalan, MD

The Women's Health SIG, with its many enthusiastic members, continues to promote collaborative projects across the country.

The SIG's resident members have collectively contributed to the ACLP "Quarterly Annotations" by summarizing the most current articles in the field of women's mental health. SIG members regularly publish update articles for the *Psychiatric Times* column for ACLP as well as in *Psychosomatics.* Columns on sexual health and lactation are in the process of being written by SIG members.

Since November's CLP 2018 in Orlando, members have been busy with important collaborations. Directly stemming from discussions at the SIG meeting, papers on trauma-informed care are being planned under the direction of Sarah Nagle-Yang, MD, and 11 people participated in conference calls to kickstart the project.

Based on SIG feedback, a conference call arranged for early February was to encourage collaboration between SIG members and to plan for CLP 2019.

The SIG website continues to provide a forum to recognize accolades earned by SIG members, to list WH-related talks at the annual meeting, and to provide reliable resources pertaining to WH for the ACLP community at large. The SIG also has an established listserv for improved communication.

The SIG will continue to provide opportunities to network and collaborate on projects. Please be in touch if you wish to be included in our listserv and, as always, with feedback, comments, or questions.

Sign up to a SIG—and make the most of your ACLP membership. New SIGs have come into being over recent times—such as the Quality & Safety SIG featured in this *Newsletter*—so why not take a look for a group that interests you?

ACLP SIG Member Counts

Bioethics	345
Cardiovascular Psychiatry	227
Community-Based PM Physician Practice Issues	205
Early Career Psychiatrists	431
Emergency Psychiatry	400
Global & Cultural	215
HIV/AIDS Psychiatry	471
Integrative Medicine (Complementary & Alt. Medicine)	99
Medicine & Psychiatry	614
Military & Veterans	79
Neuropsychiatry	501
Palliative Medicine & Psycho-oncology	389
Pediatric C-L Psychiatry	157
Psychological Considerations	251
Quality & Safety	68
Research	215
Telepsychiatry	313
Transplant Psychiatry	351
Women's Health	349

At Academy annual meetings, each SIG is provided meeting space and meeting time before the start of a conference day, and SIG-specific luncheon tables (above) offer more casual opportunities to network with those with similar interests.

ACLP Committee Updates

ANNUAL MEETING COMMITTEE

Oral Papers & Posters

Co-chairs: Janna Gordon-Elliott, MD, FACLP; and Dahlia Saad-Pendergrass, MD

The Oral Papers & Posters Subcommittee is excited about 2019!

In 2018, more structured guidance about Case Report abstracts was provided as part of the abstract submission process, and at CLP 2018 in Orlando we piloted a workshop where attendees practiced in a hands-on way their abstract-writing and poster-making skills.

In 2019, we will build off of these advancements by offering more practical tips during the abstract submission phase, and through the development of more educational materials relevant to abstract and poster preparation that may be used by our members and others attending our meetings.

Education is a core mission of ACLP—and at the heart of what we as C-L psychiatrists do every day. We're eager to be part of the process, along with the efforts of the Education Committee and our many other committees and members who promote scholarship and academic quality.

In addition to these goals for the year, our subcommittee is also looking to enhance what is already great about both the Oral Paper & Poster sessions at the annual meeting: most notably, the interactions between presenters and audience. We're looking forward to implementing innovative ways, utilizing the in-person sessions and the technology at our disposal, to disseminate our presenters' materials and encourage stimulating engagement and collaboration around ideas.

"The Future of the Subspecialty"

CLP 2019

San Diego, California

We look forward to reviewing all the submitted abstracts for Oral Papers & Posters for CLP 2019 this spring!

EDUCATION COMMITTEE

Interdisciplinary Education

Chair: Anna Ratzliff MD, PhD;
Vice chair: Liliya Gershengoren, MPH, MD

The Interdisciplinary Education Subcommittee is working on developing resources, including curriculum content, for how to enhance the ability of C-L psychiatrists to provide strong educational leadership for interdisciplinary teams.

Our brief guides for this content should be available on the website soon! We are interested in learning more about where our colleagues from other disciplines (nurse practitioners, psychologists, social workers and others) get their educational content related to C-L. If you have names of meetings or resources your teams use, please share with Anna Ratzliff: annar22@uw.edu

Online Education

Chair: Mary Jo Fitz-Gerald, MD, FACLP;
Vice-chair: Seth Powsner, MD, FACLP

The Online Education Subcommittee has been diligently working on obtaining CME for the 2018 Annual Meeting recordings. Our goal is to have eight hours CME available for the recorded Essentials Course Parts 1 & 2 and the *Aggravated About Agitation* workshop.

Prior to the meeting, committee members reviewed the slides for the Essentials Course and developed 8-10 questions. The questions were referenced by the slide number. During and immediately after the meeting, members viewed the recordings to add the slide timing as references. Members are currently cross-checking to verify the slide timings on the LLC site are accurate.

For those who didn't attend the meeting, the charge for the entire 25 hours recorded at the meeting (including the Essentials Course) is only $150. A real bargain! CME will be available shortly at a nominal cost.

The subcommittee also plans to obtain self-assessment credit for the Essentials Course and *Aggravated About Agitation.* Our long-range goal is to have more self-assessment credits online to help members and others prepare for board examinations and maintenance of certification. In the short-range, we hope to have a database of all the old self-assessments online available to members. This wouldn't be for self-assessment credit, but would be an additional resource for all members.

The Academy continued the practice of recording Clinical Pearls at the annual meeting. These are short, 5-10 minute presentations, of interest to C-L psychiatrists. The initial goal was to have the videos available for residents and fellows prior to seeing a patient. Have a consult on the agitated patient with TBI? Check out Brett Lloyd's TBI Clinical Pearl from 2018 under the website's Member Resources. If you're interested in contributing to these, please contact me at mfitzg@lsuhsc.edu

Other plans include improvements to the online education section and member resource section of the website. Subcommittee member, Lisa Rosenthal, references the monograph on "Aggression and Violence" in her presentation on agitation. We have a host of materials on both areas of the website.

As always, we welcome suggestions from members.

RESEARCH & EVIDENCE-BASED PRACTICE COMMITTEE

Chair: E. Sherwood Brown, MD, PhD, FACLP

I am honored to serve as chair of this committee following the outstanding leadership of Jeff Huffman, MD, FACLP. The Research & Evidence-Based Practice Committee strives to increase research and appreciation of evidenced-based medical care within ACLP. We want to increase the number of active researchers who are ACLP members and presenters.

Psychiatric illnesses within the context of medical illnesses and outpatient or inpatient

(Committee Updates continue on page 12)

Committee Updates (cont'd from p. 11)

clinical settings is an active area of research. Thus, ACLP has much to offer researchers. Inclusion of even more cutting-edge research and information on evidenced-based practice at the annual meeting would be of value to ACLP.

In collaboration with the Research SIG, we want to continue to develop the committee into a valuable resource for information on research and other scholarly activities for all ACLP members.

Last year's meeting saw a very large number of outstanding applications for awards selected by the overall committee and its subcommittees. The winners were truly outstanding. In addition, sessions and workshops developed by the committee were well attended. The 2018 meeting included research-oriented sessions and more are in the planning stages for this year's meeting. The committee looks forward to another excellent year in 2019.

Welcome *to our new members (July–December 2018)*

FULL MEMBERS

David Adson, MD
Pranayjit Adsule, MD
Erum Ahmad, MD
Peter Ajiboye
Olufunmilayo Akinola, MD
Bandar Althomali
Shilpa Amara
Sarah Andrews
Reji Attupurath, MD, MD
Nisha Baliga
Rebecca Bauer, MD
Kelly Blankenship, DO
Nora Burns, DO
Michael Bushey, PhD, MD
David Buxton, MD, FAPA
David Callander, MD
Gabriel Camara, MD
Mallory Cash, MD
Simriti Chaudhry, MD
Kristina Chechotka, MD
Rebecca Clendenin
Peter Coffman, MD, FAPA
Suki Conrad, MD
Roberto Cruz Barahona, MD
Piyush Das, MD, MBBS
Shalini Dave, DO
Vladimir Demidov, MD
Sameh Dwaikat, MD
Daniel Fishman, MD
Bethany Franklin
Jai Gandhi, MD
Mario Garcia
Eric Golden, MD
Luis Filipe Gomes Pereira, MS, MD
Simona Goschin, MD
Robert Gribble
Amy Grooms, MD
Raz Gross
Sasidhar Gunturu, MBBS, MD
Sameera Guttikonda, MD
Maria Harmandayan, MD
Michael Hawkins, MD
Stacey Heit
Lisa Henriksen
Agdel Hernandez Colon, MD
Alan Hines
Mario Hitschfeld, MD, MD
Patrick Hou, MD
Valerie Houseknecht, MD
Roger Huijon, MD
Timberly Humbert, MD
Jeffrey Iler, MD
Kevin Johns, MD
Nathaniel Johns
Pierre Joseph
Larkin Kao, MD
Saad Khan, DO
Timothy Kiong, MD
Susanna Kovari, MD
Joseph Kwentus

The Academy welcomes the following new members who joined during the period July 1–December 31, 2018:

Rahul Lauhan, MD
Jacqueline Levin
Kathleen Levy, DO
Pamela Lopez, MD
Christopher Martin, MD
Earl Mauricio, MD
Tess McTestface, CAE, MD
Aaron Meyer, MD
Debra Miller
Michael Miller
Donovan Moncur, MD
Cristina Montalvo, MD
Carmen Monzon, MD
Adnan Mufti
Lama Muhammad, MD
Rebekah Nash, MD, PhD
Aniceto Navarro, MD
Scott Nichols, MD
Julie Owen, MD
Jeremy Parker, MD
Suesan Pedersen, MD
Elizabeth Prince, DO
Seema Quraishi
Christopher Racine
Michael Rancurello, MD
Sonia Riyaz, MD
Lilian Scheinkman
Simon Sidelnik, MD
Jonathan Smith, MD
Christine Stanson
Claudia Suardi, MD
Joji Suzuki, MD
Thida Thant, MD
Paul Thisayakorn, MD
Michelle To, MD
Maria Vicente-Prado
Bryce Wininger, MD
Laura Worrel
Hwa Ling Yap
Sahab Yaqubi, MD

ASSOCIATE MEMBERS

Ileen Aiken, NP
Jaime Biava
Warren Black
Laura Crawford, PMHNP
Mufeed Hamdi, PhD, MSc, MBChB
Gabriele Harrison, PMHNP
Suzanne Kodya, MA
Sarishma Lal, NP, BSN, PMHNP, APRN, RN
Yit Shiang Lui, MSc, MRCPsych, MBBS
Matthew McWeeny
Rachel Molander
Chi Onwuli, DNP
Elizabeth Smith

RESIDENT MEMBERS

Noha Abdel Gawad
Aspen Ainsworth, MD
Saleh Aldahash, MD
Ibrahim Alfurayh
Zubair Ali
Shada Aljishi
Maher Almatrafi
Yekaterina Angelova
Ramon Aragon, MD
Ludmila Aramian, MD
Joseph Baldwin
Diya Banerjee
Alissa Bauer
Abdualla Ben Ammer, MD
Jessica Berthelot
Janet Charoensook
Nithya Cherukuru
Joy Choi
Kaitlin Clifford
Andrew Coulter
Andrew Cruz, MD
Matthew Dandois
Erin Dean, MD
Anna Lisa Derrien
Mercy Eigbike, MD
Brenna Emery
Nkemka Esiobu
Zelde Espinel
David Fipps
Cecilia Fitz-Gerald
Adam Fusick
Mounika Ganguly, MD
Thomas Gethin-Jones
Laura Gibbons, MD
Devin Greene
Alecia Greenlee, MD
Samuel Greenstein, MD
Andrew Halls, MD
Brandon Hamm, MS, MD
Sabeen Haque, MD
Daniel Helman
Alyssa Hickert
Bo Hu
Nafiha Islam
Samuel Jackson, MD
Aleksandr Kaipov
Anna Kim
Shivani Kumar
Catherine Lee, MD
Erica Lensink
Idris Leppla
Mimi Levine
Lisa Linde
Brady Lonergan
Jahaira Lopez-Pastrana
Spencer LunBeck, MD, BS
Avneet Madan
Elizabeth Madva
Selena Magalotti
Lauren Mahoney, MD
Charles Manchee
Ashaki Martin
Amalia Martinez
Roopa Mathur, DO
Ruth McCann
Aum Memon, MBBS
Caitlin Meyer
Mona Mojtahedzadeh, MD
Jessica Molinaro, MD
Carey Myers
Romy Nehme
Julia Novikov, MD
Jessica Obeysekare
Lindsay O'Brien, DO
Daniel Olson
Anne Owens
Victor Patron Romero, MD
Sara Powers
Maria Prom
David Puissant, MD
Houssam Raai
Aimy Rehim
Nafisa Reza, MD
Yingying Rezmovits
Alexandra Roque-Saldana
Anna Shapiro, MD
Matthew Sheehan
Meghan Sheehan, MD
Todd Simmons, MD
Akriti Sinha, MD
Shazadie Soka
Lauren Solometo
Emily Sorg
Meredith Spada, MD
Benjamin Stacy
Timothy Steinhoff, MD
Michael Strong
Laura Suarez Pardo, MD
Deepika Sundararaj
Shariff Tanious, MD
Erica Taylor
Maya Todd
Mark Toynbee
Jennifer Trinh
Christian Umfrid
Brian Wasserman
Jessica Whitfield
Helena Winston, MD
Sita Yerramsetti
Jeffrey Zabinski, MD
Mohsin Zafar
Roberta Zanzonico

MEDICAL STUDENTS

Sonya Bakshi
MacKenzie Brigham
Chelsea Cosner
Gabriel De Leon
Memphis Diaz Garcia
Sara Elchehabi
Ioulia Furman
Christopher Galbick
Lissa Garcia
Lissa Garcia Segui
Eric Garrels
Timothy Genovese
Hiroe Hu
Abby Jessell
Ashleigh Johnson
Jeena Kar
Elizabeth Kim
Sun Kim
Katherine Kruckenberg, BA
Joseph Legan
Carlos Leiton
Grace Masters
Elizabeth Meller
Joseph Merkel
Tabish Riaz
Adrienne Rosenthal, MBA
Taku Saito
Ahmed Sandhu
Shawn Sedgh
Akshaya Selvamani
Jason Smith
Omar Soubani
Clair Sulerzyski
Haily Valles
Haley Vertelney

REFINED ELIGIBILITY CRITERIA FOR HACKETT AWARD

Aimed at nomination and selection of the most outstanding among us

The eligibility criteria for selecting candidates for the Academy's highest honor—the Eleanor and Thomas P. Hackett Memorial Award—have been reviewed and revised by the ACLP Board.

ACLP president Rebecca Weintraub Brendel, MD, JD, FACLP, says the updated criteria "create transparency and clear guidance for nominations and selections for this highest Academy honor." She adds: "The Board hopes that these refined criteria lead to the nomination and selection of the most outstanding colleagues for their vital contributions to the Academy and our subspecialty."

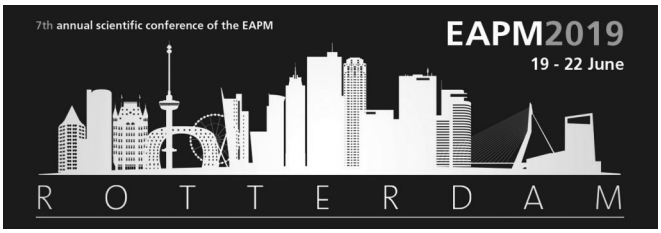
The Hackett award is presented each year to an Academy member. Previously, the criteria were that the award winner had demonstrated distinctive achievements in C-L training, research, clinical practice, and leadership.

The updated award criteria are:

- The nominee must have been a full member of ACLP consecutively for the past 10 years.
- The nominee must have achieved Fellow status within ACLP.

Register Now for the European Conference

June 19-22, 2019, in the Netherlands



Keynote lectures at this year's EAPM annual conference will question whether integration of mental and physical care remains only a dream and will describe how mental states can be incorporated into the somatic symptom mix to make value-based health care possible.

EAPM is a strategic partner of ACLP.

Keynote speakers are:

ACLP president-elect Michael Sharpe, MD, FACLP, also EAPM vice-president, is a hospital psychiatrist highly experienced in integrated care. Dr. Sharpe is head of the Oxford Psychological Medicine Centre and leads the multi-morbidity theme of the Oxford Collaboration for Leadership in Applied Health Research and Care.

Jim van Os, MD, professor of Psychiatric Epidemiology, is described by EAPM as a "pop star" in Psychiatry. With a focus on patient-centered and personalized care, Dr. van Os is especially interested in contextual and psychosocial influences on symptom formation. He is medical manager at the Brain Center Rudolf Magnus, Utrecht University Medical Center.

Other plenaries at the conference—in Rotterdam, the Netherlands, on June 19-22—will reflect on models of integrated care in different populations, and how patients themselves can be involved in their own care.

Parallel sessions will cover a range of topics from integrated complexity care to momentary e-health assessment.

Joint ACLP-EAPM preconference

The preconference (on Wednesday, June 19) is a joint venture between EAPM and ACLP. It will focus on physiological and psychological pathways of psychosomatic syndromes.

Together, European and American scientists will give an impression of the body-brain crosstalk and how psychological adversity impacts functional somatic conditions and, vice-versa, how somatic conditions influence affective wellbeing, says conference chairman Carsten Leue, MD.

EAPM Travel Award

EAPM is offering 10 travel awards to younger researchers who submit an abstract for the conference. The award includes €300, a year's membership of EAPM, and the conference registration fee.

Conference venue

In the vibrant heart of the city of Rotterdam is the World Trade Centre Rotterdam, which houses the Postillion Convention Centre WTC Rotterdam. This iconic building is one of the few buildings that survived World War II bombing of Rotterdam.

Hotels and the convention center are walking distance from Rotterdam Central Station where the fast train from Schiphol Airport (Amsterdam International) arrives. It takes approximately 20 minutes to get from the airport to Rotterdam.

Complete details of the EAPM conference—including program, venue, awards, and registration—are at www.eapm2019.com

- The nominee must be able to demonstrate active presentations at Academy meetings AND active volunteer service.

  Examples of active presentations at Academy meetings include: serving as a moderator, speaker, or discussant for a preconference course or general session; or serving as the lead presenting author for a poster or oral paper session. Examples of active volunteer service may include service on the Board of Directors, a committee, subcommittee, or taskforce, or service as a chair, co-chair, or vice-chair of a special interest group.
- Nominees must have demonstrated significant contributions to advancing the field of C-L Psychiatry.
- Nominee must demonstrate excellence in each of the following four categories:
  - o Education
  - o Scholarship / Research
  - o Clinical Excellence in C-L Psychiatry
  - o Leadership in C-L Psychiatry within AND outside the Academy.
- Three letters of recommendation attesting to achieving excellence in these four categories must support the award; and, collectively, the letters of recommendation should support all four categories.
- Recipients must commit to giving a lecture at the same annual meeting as the award is presented.

See how to nominate for the Hackett award under About ACLP > Awards on the ACLP website.

THE MOST POPULAR ARTICLES FOR DOWNLOADS & CITATIONS

***— Ted Stern, MD, FACLP, editor-in-chief,* Psychosomatics**

Psychosomatics, the ACLP's journal, remains a strong voice for our society and for the field of C-L Psychiatry (a.k.a. psychosomatic medicine). It is the vehicle for publication of review articles, original research reports, perspectives, case reports, and letters to the editor.

The number of citations of articles published in *Psychosomatics* has been rising steadily and the impact factor is now 2.54. Moreover, full-text views of our published articles have increased by approximately 25-fold over the past seven years.

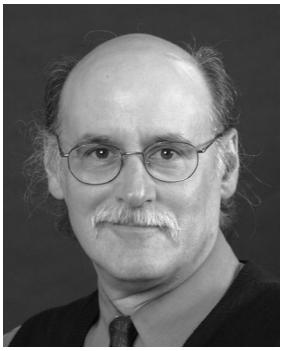
Among the most frequently downloaded articles are reviews on:

- QTc prolongation and torsades de pointes (Beach et al)
- Post-partum depression screening tools (Ukatu et al)
- Antidepressants and the risk of hyponatremia (De Picker et al)
- Wernicke-Korsakoff syndrome (Isenberg-Grzeda et al)
- The neuropsychiatric complications of glucocorticoid use (Dubovsky et al)
- Autoimmune encephalopathy (Oldham)
- The Stanford Integrated Psychosocial Assessment of Transplantation (Maldonado et al)

And, the most frequently cited recent articles include:

- A review of microthinking about micronutrients (Moroze et al)
- Toxicities associated with NBOMe ingestion (Suzuki et al)
- Opioid use after orthopedic surgery (Suzuki et al)
- Collaborative care models for the treatment of psychiatric disorders in medical settings (Huffman et al)
- Demoralization and depression in patients with cancer (Tang et al)
- The syndemic of HIV and trauma (Brezing et al)
- Psychotropic-induced hyperprolactinemia (Ajmal et al)

Our processing time remains swift. The time from submission of an article to our first decision is 6.7 days, while the time from submission to a final decision is 16.5 days! Moreover, once a manuscript has been accepted for publication it is published online in less than two weeks, and printed in the journal, on average, within four to six months. This rapid review relies to a large extent on timely and practical advice from our reviewers; know that your efforts are much appreciated.



Ted Stern, MD, FACLP

Members of the ACLP should also remember that they are provided with free access to related titles *(General Hospital Psychiatry* and the *Journal of Psychosomatic Research)* published by Elsevier.

Recent initiatives include access to Mendeley Stats (formerly MyResearchDashboard.com) that provides authors with an easy view of article downloads and a citation history (via Mendeley.com), and PlumX Metrics. PlumX metrics track scholarly output engagement in five different categories (usage, captures, mentions, social media, and citations) using a color-coded "Plum Print."

Usage includes information on clicks, views, and downloads, among other items. Captures includes indicators such as bookmarks, favorites, and reference-manager saves, indicating that someone wants to return to that work. Mentions includes activities, such as blog posts, news mentions, comments, and reviews of the work. Social media tracks tweets, shares, and Facebook likes that reference research. Citations offers information on traditional citation indexes (e.g., Scopus) and citations that help indicate societal impact (e.g., Clinical or Policy Citations).

None of this would be possible without you—the members of the Academy, the reviewers of articles submitted to *Psychosomatics,* and the readers of *Psychosomatics.* With your help and support, our journal, will continue to grow its sphere of influence related to the core missions of the Academy—clinical care, education, and research at the interface of psychiatry and other disciplines.

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"The Future of the Subspecialty"

LAST WORD: From executive director James Vrac, CAE

We all make assumptions—even sometimes when we should know better.

It's good then to be pulled up and made to think twice.

That's what Lisa Rosenthal, MD, FACLP, does for us so effectively in her "clinical pearl"— one of four new vignettes, where ACLP members talk to camera about their specialist interest, now on our website.

It joins our growing online resource of knowledge and experience in specialty clinical areas—a must-read for all C-L psychiatrists.

Dr. Rosenthal's special interest is schizophrenia and cardiovascular disease. People with schizophrenia have an elevated risk of death and shorter life expectancy than their peers who do not have schizophrenia. Yet, they are offered the same treatments and same standards of care as their peers only about 50% of the time.

"How do people with schizophrenia die?" asks Dr. Rosenthal. "People with psychiatric illnesses share the same major causes of death as everyone, particularly in higher-income countries. Cardiovascular disease is the No. 1 killer, and it is the same for patients with severe mental illness."

About 30-40% of the elevated mortality in psychotic disorders is due to suicide and injuries from accidents; but 60-70% is due to medical illnesses, the vast majority of which are cardiovascular. These patients are also 7-10 times more likely to die of respiratory illnesses than their peers without schizophrenia.

So, why aren't patients with schizophrenia offered standard treatments and standard quality of care for their medical illnesses? Dr. Rosenthal describes how some clinicians assume people with schizophrenia will not adhere to treatment plans.

Such evidence may exist for patients with psychiatric diagnoses such as severe depression, but studies show that people with schizophrenia may actually have *better* adherence than their peers who do not have schizophrenia.

In other words, we shouldn't allow assumptions to be made. Instead: "We need to advocate for the holistic treatment of patients with psychotic disorders," says Dr. Rosenthal.

The difference we can make is significant. At present, schizophrenia decreases longevity by as much as 20 years.

ACADEMY OF CONSULTATION-LIAISON PSYCHIATRY

Winter 2019
NEWSLETTER

***ACLP** — Psychiatrists Providing Collaborative Care Bridging Physical and Mental Health*