CPNP Announcements

INTERVIEW WITH INCOMING CPNP PRESIDENT JULIE DOPHEIDE

During the 2013 Annual Meeting, the Mental Health Clinician was able to spend a few minutes with the incoming president for the 2013-14 year, Julie Dopheide, Pharm.D., BCPP. Dr. Dopheide received her Doctor of Pharmacy degree from the University of Nebraska and subsequently completed a psychiatric pharmacy residency at the University of Southern California (USC) in Los Angeles (LA), California. Currently, Dr. Dopheide is an Associate Professor at USC and has faculty appointments to both the School of Pharmacy and the School of Medicine. She practices at the LA County Medical Center and also serves as the director of a PGY-2 psychiatric pharmacy residency. In this capacity, she also provides Medication Therapy Management services at the Center for Community Health, a primary care clinic which acts as a safety-net for people in the Skid Row district of LA. Dr. Dopheide has over 50 publications to her credit, and has a particular interest and expertise in pediatric psychopharmacology, which also includes work on the Pediatric Psychotropic Guidelines Development team for LA County. Throughout her approximately 25 years of practice, she has been involved in varying capacities with numerous pharmacy organizations, including CPNP, the CPNP foundation, the American Society of Health-Systems Pharmacy (ASHP), the California Society of Health-Systems Pharmacy (CSHP) and the American Pharmacists Association (APhA).

How did you become involved in CPNP?

I was a founding member of CPNP. However, when CPNP was first getting started, I was unsure if I wanted to join. At the time, many individuals, including me, felt that the pharmacy profession was too fragmented. We already had a number of organizations within pharmacy, and I felt maybe we should just try to continue to influence the already existing organizations.

So how do you view this decision to form CPNP now? Specifically, what unique role does CPNP play in the world of clinical pharmacy practice?

I am glad that we formed CPNP as a separate organization. There are two things that CPNP does particularly well, which another organization would have difficulty accomplishing. Firstly, the Continuing Education (CE) is very necessary. None of the other national meetings in pharmacy provide CE at a high level which is specifically related to psychiatry and neurology topics. Secondly, our networking is better for our members, because it is more specific to our field. So in these ways, we fill a need that wouldn't be met otherwise. However, I still feel that we need to show solidarity with the other pharmacy organizations (ASHP, APhA, ACCP, etc.) to demonstrate a united front to achieve our common goals such as provider status.

How did you become involved in the leadership of CPNP?

As a founding member of CPNP, I have been involved in service to the organization from the beginning. I was really able to get involved, when my mentor, Glen Stimmel, was President. He was able to recommend my appointment to several committees. Since then, I've served on a number of committees including the Resident and New Practitioner Committee, the Recertification Committee, the Review Course Editorial Board and the Consumer Relations Committee (when it was known as the NAMI Relationship Management Group). CPNP has grown tremendously since my early involvement and now it is easy to volunteer for a committee or project through cpnp.org.

At the Town Hall Meeting, the goals for 2013-14 year were laid out by yourself and outgoing President Rex Lott. These goals are listed below. What ideas do you have for implementing these goals throughout the upcoming year?

1. Launch a new 3-year strategic plan that is both aggressive and attainable.
   a. To accomplish this, we just have to plan it and make it happen. We already have the wheels in motion for many of our initiatives, so we just have to continue to build on our momentum. Specifically, our work groups for the Strategic Plan have already met and are drafting "SMART" objectives for our goals of Synergy, Membership Value, Quality of Care and Connections. SMART stands for **S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-based.
2. Become active participants in defining the future of our profession through government affairs.
   a. This is going to be accomplished in two ways. First, we will continue to work with our lobbyist, Carrie Potter, to advocate for psychiatric pharmacists to be reimbursed providers of direct patient care in diverse health systems including medical homes. Secondly, our membership needs to take an active role in

learning how Comprehensive Medication Management (CMM), the patient care process endorsed by CPNP, is different from Medication Therapy Management (MTM) and how both have their place in the care of patients. (For more information, go to cpnp.org, click on Government Affairs and see what's available in the CMM toolkit.) CPNP will continue to update these tools to keep members abreast of new developments and new resources. Look for a CMM webinar coming soon to cpnp.org.

3. Reinforce and increase awareness of CPNP membership benefits.
   a. Getting individuals involved in CPNP is best done through individual relationships. If each member can find one or two other colleagues to encourage involvement and/or mentor in this way, the entire organization will benefit from the fresh ideas and creativity that new involvement brings. Rex or I or one of the other members of CPNP Leadership can stand up on the stage and encourage people to get involved. But as individuals, we are much more likely to respond if someone we know personally asks or encourages us to get involved in CPNP.

IT TAKES A VILLAGE OF VOLUNTEERS TO PLAN AND IMPLEMENT AN ANNUAL MEETING

With 495 attendees, nearly 30 hours of educational programming, 130+ scientific posters and over 30 speakers, you know that the CPNP Annual Meeting takes a lot of manpower to successfully implement.

Kudos go out to the dozens of volunteers who put in countless hours before the meeting and on-site to make this huge event go off seamlessly. From our programming committees to our posters and awards committee, we have tried to recognize everyone making a contribution to this year's successful Annual Meeting below (Table 1).

Table 1. 2013 Annual Meeting Volunteers

Allen, Shari	Elliott, Ellie	McKee, Jerry R.
Argo, Tami	Fang, John	Melton, Sarah T.
Bean, Jennifer	Fischer, Michael	Moore, Troy A.
Bishop, Jeffrey R.	Fowler, Jill	Narayanaswamy, Sudha
Brandt, Nicole	Franklin, Martin	Nussbaum, Abraham
Brennan, Jessica	Frick, Lara	Overman, Gerald P.
Burghart, Steven M	Goldstone, Lisa	Park, Susie H.
Butte, Atul	Hall, Beth M.	Perry, Paul
Canning, Jacquelyn	Hamner, Mark	Popish, Sarah
Cates, Marshall E.	Kattura, Rania	Raskind, Murray
Cather, Jessica	Kelly, Deanna L.	Reynoldson, Jill
Chavez, Benjamin	Kelsoe, John	Ross, Clinton
Chen, Jack J.	Kemp, Michael	Schneiderhan, Mark
Christopher, Melissa	Kirkwood, Cynthia K.	Shea, Shawn
Clauson, Kevin	Lakey, Susan L.	Smith, Tawny L.
Cobb, Carla	Leckband, Susan	Sonne, Susan
Cunningham, Julie	Levin, Gary M.	Stevenson, James
DiPaula, Bethany	Lott, Rex S.	Stimmel, Glen
Dishman, Ben	Lovell, Amy C	Straley, Craig
Dopheide, Julie A.	MacLaren, Robert	Thomas, Christopher
Dugan, Sara E.	Malhotra, Jodie V.	Williams, Kelly
Ehret, Megan J.	Manejwala, Omar	Zeier, Katy

WHAT THE 2013 ANNUAL MEETING PROVIDED ME…

One hundred percent of our attendees completing their Annual Meeting survey indicated that they would highly recommend the CPNP Annual Meeting to their colleagues. When asked to provide examples of what they will do differently in their practice as a result of participating in this activity, attendees shared the following:

Looking back, not only did I meet some great new friends and colleagues at the annual meeting, I also flew home with the missing piece to a clinical puzzle that serendipitously greeted me upon my arrival. Most of us are aware of valproic acid-induced

hyperammonemic encephalopathy, but I know I am speaking for myself when I say urea cycle disorders do not frequently pop into my head, at least not prior to the clinical pearls presentation "Don't Forget Urea Cycle Disorders." Thanks to recognizing the role of an underlying urea cycle disorder in precipitating VPA-induced encephalopathy, I was able to intervene for a patient that was both rapidly declining and stumping every treatment team in the hospital from neurology to infectious disease!

I'll be more confident on advising therapies for bipolar, delirium and detox from drugs of abuse. I'll definitely put an effort to upgrade my CBT skills to deal with patients. Now I know how much I didn't know about new antidepressants and I what I have to study.

Many of the sessions have made an impact on me and what I plan to do in my practice. For example, I will use this evidence to support the policy I am writing for the use of opioids in pregnant women, I will work with the MDs to come up with better treatment plans for people with schizoaffective disorder, I know more about the data now for lurasidone to support its use in our patients, and in general just knowing more about what's being done outside of my facility is always nice.

I am leaving the meeting more knowledgeable of drugs on the horizon. I also have a better understanding of what other clinicians do to formulate their treatment plans, algorithms, and practice habits. As always, an extremely welcomed and valuable meeting.

As a result of this meeting, opioid addiction treatment recommendations will be updated at our facility and I will evaluate protocol for elderly and antipsychotic use. I will assess potential to use additional data as part of overall decision making.

I have already shared several presentations with other pharmacists at my practice site and changed my prescribing practice of prazosin.

The keynote speaker's (Dr. Shawn Shea) information on the medication interest model is a life changing opportunity. I am very excited to pursue more education in this area.

Will approach the discussion of LAIs with patients differently. Will also approach my discussion with providers about evidence-based medicine differently after attending the academic detailing first session.

Will be able to better recommend treatment for delirium. Will begin using the topics discussed in the medical interest model when talking with patients.

Don't miss out on all of these valuable take-aways that have impact long after the meeting. Make plans now to join us April 27-30, 2014 in Phoenix, Arizona.

MENTAL HEALTH CLINICIAN AUTHOR AND REVIEWER RECOGNITION

The Mental Health Clinician editorial board would like to thank the 170+ individuals who contributed to Volume 2 (2012-2013) as authors and peer reviewers (Table 2). These contributions help the MHC promote good practices in neuropsychiatric pharmacotherapy to an ever-expanding audience.

CPNP members can indicate their interest in peer review through their volunteer profile, and any mental health professional can contribute to the publication through an open submission.

Table 2. MHC Volume 2 Contributors

Abrams, Mary Ann	Davis, Erica	Henderson, Crystal	McGrane, Ian R.	Reddy, Tara
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JUNE 2013 MEMBER NEWS

CPNP members Julie Dopheide, Megan Ehret, and Charles Caley, and the University of Connecticut collegiate chapter participated in the Schwarting Symposium at the University of Connecticut.

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