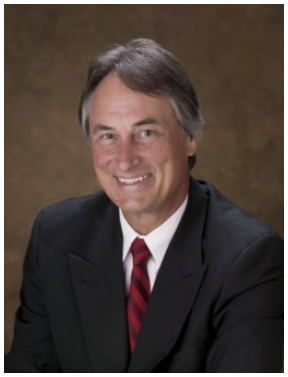
Academy of Medical Psychology

The AMP



OCTOBER 2012
VOL. 3 ISSUE 1

ACADEMY UPDATE FROM THE PRESIDENT

BY JERRY MORRIS, PSYD, ABMP

President's Column

By Jerry Morris, PsyD, MBA, MS (Pharm), ABMP, ABPP, ABBHP, NCSP, CCM, Board Certified Medical Psychologist

In my second year as the President of our Specialty and Society I'm humbled by the wonderful talent that has stepped forward to help us continue building the most important group in modern psychology. Dr. Caccavale has dedicate much volunteer time to put together a 10 course distance learning program approved by the board to help those psychologists who can't travel to complete a post doctoral graduate program in basic science and pharmacology or an approved CE program qualify for the academic part of specialty qualification. The board has approved this program and it will be loaded on our Web Site with a fair fee of $1,500 for AMP members shortly (see the Education section of the web site). Dr. Jack Wiggin's tireless service as Archives Editor, team member on oral examinations, board member leading the Government Relations Task Force, and in leadership on the AMP List.Serv is unbelievable. The work of the Board to establish the criterion and advertising to make our group a national Brand that is identified by psychologists and hospitals and healthcare facilities. Hospitals now regularly check with our central office to verify current board certification in the specialty of Medical Psychology for credentialing and privileging. Our leadership has acquired the first HRSA student loan forgiveness in psychology history at the post doctorate graduate borrowing level for a specialist working in a health manpower shortage area. We have a new, growing, and improved web site with lots of updates on science, the specialty, political and legislative issues and opportunities, and developing continuing education. We have weighed in on several national policy and practice issues and made the specialty's position clear.

These are exciting times in the specialty and several new specialists have qualified for board certifications during the last year and we have several applicants in the pipeline. We have established a set of essay questions that are approved for our oral examination and have established an item pool and a refined written examination which is administered online as an alternative option to the PEP or VERITAS.

We have added a state of the art software program for authors for submission of papers for consideration for the Archives (see: www.amphome.org and then in the left column click on "ARCHIVE-JOURNAL", and then click on http://amparchive.com/ojs/index.php/AMP (Authors will have to register and set an ID and Password).

We are mentoring and examining new specialists, and have welcomed Surloff, Cheri Ph.D., Barngrover, Susan, Ph.D,, Cole, Jeffrey D., Ph.D., Gary Padover, Ph,D, are welcome and refreshing specialists that have completed their extensive training, supervision, and oral and written examinations. We are exceedingly proud of the psychologists who take on the arduous task to become some of the most highly trained and skilled psychologists in America.

Soon we will own and deploy state of the art electronic classroom and education programs for our web site that will eventually make our specialty an "active learning community" and eventually an accredited distance learning system. We will become an accessible training site and system for aspiring specialists who can't leave their practice, hospitals, and healthcare community where they are saving lives, participating in the local healthcare fabric, and yet they are willing to master the foundation medical/psychological science and knowledge base, skill building preceptorships, and national examinations to become diplomats in Medical Psychology. We will become the special learning frame for our society members and our diplomats who wish to keep up on science, psychopharmacology, healthcare techniques, healthcare law and

(Continued on page 10)

New Jersey Assembly Bill 2419 regarding RxP

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. As used in this act:

"Board" means the State Board of Psychological Examiners established pursuant to P.L.1966, c.282 (C.45:14B-1 et seq.).

"Clinical experience" means a period of supervised training and practice in which clinical diagnoses and interventions are learned and which are conducted and supervised as part of the training program.

"Controlled dangerous substance" means controlled dangerous substance as defined in section 2 of P.L.1970, c.226 (C.24:21-2), and includes any substances listed in Schedules I through V of the federal "Controlled Substances Act," Pub.L. 91-513 (21 U.S.C. s.801 et seq.) as adopted by regulation of the Department of Health and Senior Services.

"Drugs" means drugs as defined in section 2 of P.L.1970, c.226 (C.24:21-2).

"Licensed practicing psychologist" means a licensed, practicing psychologist as defined in section 2 of P.L.1966, c.282 (C.45:14B-2).

"Prescribing psychologist" means a licensed practicing psychologist with a doctoral-level degree who: (1) has successfully graduated with a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution of higher education or has completed equivalent training to the postdoctoral master's degree approved by the board; (2) has passed an examination approved by the board that is relevant to establishing competence for prescribing, as described in section 3 of this act; and (3) has received from the board a certificate granting prescriptive authority, which is current and has not been revoked or suspended.

"Prescription" means prescription as defined in section 2 of P.L.2003, c.280 (C.45:14-41), and includes a controlled dangerous substance.

"Prescriptive authority" means the authority to prescribe, administer, discontinue, and distribute drugs, including controlled dangerous substances, recognized in or customarily used in the diagnosis, treatment, and management of a person with a psychiatric, mental, cognitive, nervous, emotional, or behavioral disorder, or other procedure directly related thereto, within the scope of practice of psychology in accordance with rules and regulations adopted pursuant to this act.

2. The board shall:

a. issue a certificate granting prescriptive authority, in accordance with applicable State and federal laws, to a licensed practicing psychologist with a doctoral-level degree, who meets the criteria specified in paragraphs (1) and (2) of the definition of prescribing psychologist in section 1 of this act;

b. develop and implement procedures for reviewing the education and training credentials for issuing such certificates in accordance with current standards of professional practice; and

c. prescribe, by regulation, a method for the renewal of prescriptive authority at the time of, or in conjunction with, the renewal of a prescribing psychologist's license pursuant to P.L.1966, c.282 (C.45:14B-1 et seq.). Each applicant for renewal of prescriptive authority shall present evidence satisfactory to the board, demonstrating the completion of 18 contact hours of continuing education instruction relevant to prescriptive authority during the previous two-year license period of the licensee.

3. A licensed practicing psychologist who applies for prescriptive authority shall demonstrate, by submitting to the board an official transcript or other official evidence satisfactory to the board, compliance with the following standards:

a. The psychologist holds a doctoral-level degree and has:

(1) completed a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution of higher education or training equivalent to the postdoctoral master's degree approved by the board. The postdoctoral master's degree in clinical psychopharmacology or equivalent training shall include a structured sequence of study in an organized program offering intensive didactic education, including the following core areas of instruction: basic life sciences, neurosciences, clinical and research pharmacology and psychopharmacology, clinical medicine and pathophysiology, physical assessment and laboratory exams, clinical pharmacotherapeutics, and research, professional, ethical, and legal issues.

The didactic portion of the education shall consist of at least 400 hours, as recommended by the American Psychological Association, to ensure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner; and

(2) obtained relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of qualified practitioners, including, but not limited to, licensed physicians or prescribing psychologists, as determined by the board; and

b. A prescribing psychologist shall pass an examination developed by a nationally recognized body, such as the American Psychological Association Practice Organization's College of Professional Psychology, and approved by the board.

4. a. A prescribing psychologist shall exercise prescriptive authority in accordance with rules and regulations adopted pursuant to this act.

b. A prescribing psychologist shall not issue a prescription unless the psychologist:

(1) holds a certificate of prescriptive authority which is current and has not been revoked or suspended; and

(2) has first contacted the physician of record of a patient to discuss the prescription.

c. Each prescription issued by a prescribing psychologist shall:

1) comply with all applicable State and federal laws and regulations relating to prescriptive authority; and

(2) be identified as written by a prescribing psychologist, in such manner as determined by the board.

d. A record of all prescriptions issued for a patient shall be maintained in the patient's record.

e. A prescribing psychologist shall not delegate his prescriptive authority to any other person.

5. a. A prescribing psychologist, when prescribing a controlled dangerous substance, shall file with the board in a timely manner the prescribing psy

chologist's Drug Enforcement Administration registration and number, and the State controlled dangerous substance license number, if applicable.

b. The board shall maintain current records of each prescribing psychologist with prescriptive authority, including the psychologist's Drug Enforcement Administration registration and number.

6. a. The board shall transmit to the New Jersey State Board of Pharmacy a list of prescribing psychologists. The list shall include, for each prescribing psychologist:

(1) the person's name;

(2) the identification number assigned to the person by the board; and

(3) the effective date of the person's prescriptive authority.

b. As a new certificate granting prescriptive authority is issued, the board shall update the list specified in subsection a. of this section by promptly forwarding to the New Jersey State Board of Pharmacy information specified in subsection a. of this section

c. The board shall notify the New Jersey State Board of Pharmacy, in a timely manner, upon termination, suspension, or reinstatement of prescriptive authority of a prescribing psychologist.

7. Pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the board shall adopt rules and regulations to effectuate the purposes of this act.

8. This act shall take effect on the first day of the seventh month next following the date of enactment, but the board may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill provides for certain licensed psychologists to prescribe medications.

As provided in this bill, the State Board of Psychological Examiners (board) shall issue a certificate of "prescriptive authority" to a licensed practicing psychologist with a doctoral -level degree, who: (1) has successfully graduated with a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution of higher education or has completed equivalent training to the postdoctoral master's degree approved by the board; and (2) has passed an examination approved by the board that is relevant to establishing competence for prescribing drugs.

"Prescriptive authority" is defined in the bill as the authority to prescribe, administer, discontinue, and distribute drugs, including controlled dangerous substances, recognized in or customarily used in the diagnosis, treatment, and management of a person with a psychiatric, mental, cognitive, nervous, emotional, or behavioral disorder, or other procedure directly related thereto, within the scope of practice of psychology in accordance with rules and regulations adopted pursuant to the bill.

Under the provisions of the bill, in addition to issuing a certificate of prescriptive authority, the board is mandated to develop and implement procedures for reviewing the education and training credentials for issuing such certificates in accordance with current standards of professional practice.

The bill provides that a licensed practicing psychologist who applies for prescriptive authority must demonstrate, by submitting to the board an official transcript or other official evidence satisfactory to the board, compliance with the following standards:

- The psychologist holds a doctoral-level degree and has:

--completed a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution of higher education or training equivalent to the postdoctoral master's degree approved by the board. The degree in clinical psychopharmacology or equivalent training must include a structured sequence of study in an organized program offering intensive didactic education, including the following core areas of instruction: basic life sciences, neurosciences, clinical and research pharmacology and psychopharmacology, clinical medicine and pathophysiology, physical assessment and laboratory exams, clinical pharmacotherapeutics, and research, professional, ethical, and legal issues. In addition, the didactic portion of the education must consist of at least 400 hours; and

-- obtained relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of qualified practitioners, including, but not limited to, licensed physicians or prescribing psychologists, as determined by the board.

A prescribing psychologist must pass an examination developed by a nationally recognized body, such as the American Psychological Association Practice Organization's College of Professional Psychology, and approved by the board.

The bill also specifies that:

- A prescribing psychologist shall exercise prescriptive authority in accordance with rules and regulations adopted pursuant to the bill;

- A prescribing psychologist shall not issue a prescription unless the psychologist holds a certificate of prescriptive authority which is current and has not been revoked or suspended; and has first contacted the physician of record of a patient to discuss the prescription;

- Each prescription issued by a prescribing psychologist shall:

--comply with all applicable State and federal laws and regulations relating to prescriptive authority; and

--be identified as written by a prescribing psychologist, in such manner as determined by the board;

- A record of all prescriptions issued for a patient shall be maintained in the patient's record;

- A prescribing psychologist shall not delegate his prescriptive authority to any other person; and

Continued on page 6

The Board announces approval of a new 10 course Online Continuing Education Cirtifiicate Program in Medical Psychology as an additional path to meet the science foundation requirements and psychopharmacology training to meet one of the requirements for Board Certification.

Cost is $1,500.

STATEMENT OF MENTAL HEALTH AMERICA ON SUPREME COURT'S DECISION UPHOLDING AFFORDABLE CARE ACT

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ALEXANDRIA, Va. (June 28, 2012) —Mental Health America today released the following the statement from Dr. David Shern, presidentandCEO, on the Supreme Court's ruling on the Affordable Care Act.

"The decision of the Supreme Court to uphold the Affordable Care Act Is a tremendous victory for the American public, including millions of individuals living with mental health and substance use conditions.

"The law represents an enormous step forward in our efforts to expand access to care for individuals with mental health or substance use conditions and in our advocacy for prevention of these conditions. Mental health and substance use conditions are among the most prevalent of health conditions, with the age of onset for these illnesses occurring in adolescence and young adulthood. Half of all people with a mental health diagnosis first experience it by age 14, but will not receive treatment until age 24. These delays have been importantly underwritten by historical discrimination in insurance coverage for mental illnesses and addictions. Owing in part to these delays in treatment, mental health and substance use conditions account for a greater burden of disease than any other illness class and constitute an important group of pre-existing conditions. The law's guarantee of coverage for people with pre-existing conditions will address these barriers, lower costs, end discrimination, and dramatically improve health outcomes.

"It is estimated that one-fifth to one-third of uninsured Americans have mental and substance use disorders. Of the estimated 32 million people who will gain coverage, about 4 to 6 million will have untreated mental illnesses or addictions. By including mental health and substance use services on the list of essential benefits that are to be covered in new plans offered to the uninsured beginning in 2014, the law recognizes how integral behavioral health is to overall health. And it extends the groundbreaking Mental Health Parity and Addiction Equity Act and its prohibition of discriminatory limits on mental health and substance use services to those plans. The expansion of Medicaid also requires those who are newly eligible to receive mental health and substance use services at parity with other benefits. State participation in the Medicaid expansion is therefore critically important. Since today's ruling allows states to opt out of the expansion without penalty to their current Medicaid programs, MHA affiliates around the nation will be working with their state governments to ensure state participation. The law also includes prevention, early intervention, and treatment of mental and substance use disorders as an integral part of improving and maintaining overall health.

"The law is already improving access to care and reducing costs. More than 2.5 million young adults who were uninsured have gained coverage because of the provision that allows them to stay on their parents plan till the age of 26. Most health plans cannot limit or deny benefits or deny coverage outright for a child younger than age 19 simply because the child has a "preexisting condition." Given the early age of onset, these provisions are critically important for children and young adults who have mental and addictive disorders. The parents of over 17.6 million children with pre-existing conditions no longer have to worry that their children will be denied coverage because of such a health problem. And in 2014, the law will prohibit insurance companies from denying coverage or charging more to any person based on their medical history. In addition, as a result of the law, 86 million Americans now receive coverage through their private health insurance plan for many preventive services without copays or deductibles.

"The law is providing Americans security, peace of mind and control over their health care. Now that the Court has spoken, it is time to end efforts to dismantle or repeal it which will not serve the public interest. It is time to stand up for the health and well-being of children, families and seniors and serve their interests."

Mental Health America (www.mentalhealthamerica.net) is the nation's largest and oldest community-based network dedicated to helping all Americans achieve wellness by living mentally healthier lives. With our more than 300 affiliates across the country, we touch the lives of millions—Advocating for changes in mental health and wellness policy; Educating the public & providing critical information; and delivering urgently needed mental health and wellness Programs and Services.

Contact: Sarah Steverman

(703) 797-2594 or email:

ssteverman@

mentalhealthamerIca.net

Seminal Psychologist Dr. John Caccavale retires from the Board after years of service. He receives a board accommodation for his tireless efforts on behalf of the specialty and professional psychology! The specialty is most greatful to this important figure in American Psychology! Dr. Caccavale is also the Executive Director of NAPPP!

AMP
ARCHIVES OF MEDICAL PSYCHOLOGY

Invitation to Join the Archives of Medical Psychology Team

Jack G. Wiggins, Secretary of AMP

The Academy of Medical Psychology received final approval of its trademark and logo of the Archives of Medical Psychology in November 2009. The Academy is in process of publishing the first online issue of its Archives of Medical Psychology as a member benefit. This new development by the AMP and ABMP Boards is not without new challenges that must be addressed to sustain this organizational momentum over long period of time. As Editor, pro tem, and Secretary of AMP I am acutely aware that this dual role cannot exist for long. It should be obvious to all that attempting combined the role of Secretary of the organization and Editor of this journal is beyond the capacities of any one individual. Even the role of Editor cannot be carried out without special assistance. Therefore, the Board of AMP and ABMP seeks your assistance in the editing and publishing of the Archives of Medical Psychology.

The Academy of Medical Psychology was founded as an organization of practitioners for practitioner interests through volunteerism. Service on the Board is an unpaid duty of psychologists dedicated to the advancement of Medical Psychology. Medical Psychology's goal is to enhance access to specialty behavioral health care that is in such short supply that it has been declared an emergency in some states and recognized by military and veterans' services as a critical shortage. State prisons have been designated as mental health shortage areas by HRSA and prisons in some states are in the hands of federal receivership. Thus, the Academy has a crucial role as practitioner organization in advocating for the health and safety of the public at large and the military and other governmental agencies designed to serve public needs. The advocacy role for public health service must be a primary mission of the Academy.

The Archives of Medical Psychology, on the other hand, is a repository of information that can serve this advocacy function of the organization and collect valuable new data for continuing education of members of the Academy. Editing of the Archives must be by people that have the necessary experience in medical psychology and the skills to carry out these functions. Editing also requires electronic communication skills for the actual publication of the Archives. The variety of the skills necessary for publication in the journal are unlikely to be found even in a complete Editor. Members of the Board of the Academy are already assigned specific tasks and duties within the organization and cannot be expected to contribute routinely in the editing and publishing of the Archives. Therefore, the Board has begun a search for members of the Academy to volunteer in the editing and publishing of the Archives and ask your personal support. The Board of AMP invites you to contribute your services to the Archives. We welcome AMP members with prior publishing experience and those with computer expertise who are willing to learn the rudiments of editing and electronic publishing. For further information contact Jack Wiggins at drjackwiggins@cox.net or 480 816-4214

Obesity: Cultural Trend, Genetics or a Disorder?

Rory Fleming Richardson, Ph.D., CEDS, ABMP

One of the greatest risks in the field of eating disorders is the risk of professionals succumbing to the impact of obesity, turning obesity treatment into a form of bulimia or bulimorexia by proxy (my term). Being overweight can have several causes. Compulsive eating is only one cause of obesity. Choice of life style, one's career, eating patterns (i.e., eating once a day, starving all day, eating late), continuously looking at images of people in the media who are thin and set a standard that is inconsistent with the continuous demand for money, metabolism and genetics. There are numerous components that need to be considered. To use the term "obesity" as a psychological diagnosis is wrong. Obesity is a result of combined factors. Eating disorders are created from the attempt to use food for emotional problem-solving, attempting to control basic survival responses and turning our bodies into the "perfect size" despite age, physical limitations or poor health behaviors. Obesity is a symptom but not the observable key factor in diagnoses.

Having worked with eating disorders that are present in not only younger patients but individuals who have relapsed as older adults into anorextic and bulimic patterns because of well meaning, but poorly trained healthcare workers referencing their body weight, the opportunity for both professionals and family members to become addicted to body image issues invites the development of by proxy addictions. In confronting this, it is difficult to get professionals to focus on the elements impacting patient's weight including failed back surgeries, chronic pain, the impact of medication on metabolism, and a life style that may sacrifice personal health care for the acquisition of money and status in their career.

If an individual is living an active, healthy life within their physical limits to the extent that pain problems (if present) are controlled, weight and fitness will be what it should. To have an unhealthy, more sedentary life style that may place an individual in a chair eight or more hours per day, attempts to control weight with pills, liposuction, liquid diets and other methods is inviting the development of bulimia and eating disorders. Historically, use of laxative herbs were used to lose weight. Is this not another form of bulimia? With thirty years recovery from bulimia and now being just short of 60 years old, the invisible epidemic of eating disorders and weight obsession continues to impact individuals of all ages, genders and income levels.

Historic $3 Billion Settlement Reached With GlaxoSmithKline

Global health care giant GlaxosmithKline LLC (GSK) agreed to plead guilty and to pay $3 billion to resolve its criminal and civil liability arising from the company's unlawful promotion of certain prescription drugs, its failure to report certain safety data, and its civil liability for alleged false price reporting practices, the Justice Department announced today. The resolution is the largest health care fraud settlement in U.S. history and the largest payment ever by a drug company.

In addition to the criminal and civil resolutions, GSK has executed a five-year Corporate Integrity Agreement (CIA) with OIG. The plea agreement and CIA include novel provisions that require that GSK implement and/or maintain major changes to the way it does business. "Our five-year integrity agreement with GlaxoSmithKline requires individual accountability of its board and executives," Inspector General Daniel R. Levinson said. "For example, company executives may have to forfeit annual bonuses if they or their subordinates engage in significant misconduct, and sales agents are now being paid based on quality of service rather than sales targets."

NJ Bill 2419 continued fro m page 3

} A prescribing psychologist, when prescribing a controlled dangerous substance, shall file with the board in a timely manner the prescribing psychologist's Drug Enforcement Administration registration and number, and the State controlled dangerous substance license number, if applicable.

The board is required to maintain current records of each prescribing psychologist with prescriptive authority, including the psychologist's Drug Enforcement Administration registration and number, and is to transmit to the New Jersey State Board of Pharmacy a list of prescribing psychologists. The list, which would be updated, as necessary, shall include, for each prescribing psychologist: the person's name; the identification number assigned to the person by the board; and the effective date of the person's prescriptive authority. In addition, the board must notify the New Jersey State Board of Pharmacy, in a timely manner, upon termination, suspension, or reinstatement of prescriptive authority of a prescribing psychologist.

The bill provides for rulemaking by the board and has a delayed effective date of the first day of the seventh month following enactment, but allows the board to take anticipatory action in advance as necessary for implementation of the bill.

Jeff Cole, PhD, ABMP

Diplomate

Clinician

Academic

Clinical Academic Supervisor

Psychopharmacology Researcher

Forensic Clinical Psychologist

Is Elected to the Board of Directors of AMP/ABMP

Congratulations Dr. Cole

Dr. Jack Wiggins: Editor

Call for Manuscripts

The Archives of Medical Psychology will begin its fourth year in January 2013. The Archives is accepting submissions for that issue now. We welcome original articles of interest to readers of medical psychology. For information about requirements for submission of articles go to www.amphome.org and click on Journal Archives in the left-hand column or simply type in Archives of Medical Psychology on Google.

Editor at drjackwiggins@cox.net.

AMP
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Heath Care and Science Page

Antidepressants and the Elderly: Research on antidepressants has a long hx of problems: Using a 3 point differential on HAM-D scale as indication of efficacy, claiming they rise to "effective treatment for depression" if there is a 50% improvement in a few of the targeted symptoms of the large syndrome, discounting the data from the nearly 2/3ds of subjects with no response and of drop outs due to side effects, failing to subtract placebo to indicate a less than 15% improvement or general spontaneous remission over time rates from the Response Rate, and verbal descriptions with implicitly and explicitly indicate that the medication technique is a scientifically validated "stand alone, or first line treatment" rather than a simple, albeit a small effect, technique in a Depression Treatment Plan! Keep that in mind as you review this research summary from a study appearing in a major medical journal: http://www.amphome.org/images/userfiles/File/Antidepressants Are Effective for the Treatment of Major Depressive Disorder in Individuals Aged 55 Years or Older2(1).pdf

The Kaiser Family Foundation's interactive Medicare Health and Prescription Drug Plan Tracker ; http://healthplantracker.kff.org/ now includes 2012 data about plan enrollment and market penetration for both Medicare Advantage plans and stand-alone Medicare prescription drug plans. The update also adds 2012 data on Medicare Advantage quality ratings.

With the 2012 updates, the online tracker now allows users to monitor trends for Medicare Advantage plans since 1999 and for Medicare drug plans since their inception in 2006. It provides detailed information at the county, state and national level for Medicare Advantage plans, and at the state and national level for stand-alone prescription drug plans. The tracker can be used to graph, map and analyze data over time and by geographic region.

Multiple Sclerosis Tutorial: http://www.cmeinstitute.com/neurologyreports/MS/NR2/section.asp

Healthcare Reform Law and Your State: http://www.healthcare.gov/law/resources/index.html

Placebo Science Explained: http://www.youtube.com/watch?v=v_feOG94IAs&feature=youtube_gdata_player

http://www.youtube.com/watch?v=Zihdr36WVi4&feature=youtube_gdata_player

Agency for Healthcare Quality Research (AHQR) Update on Antidepressants: http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageacion=displayproduct&productID=1143&ECem=120730

Exercise: Treatment for Depression in CHD:http://www.amphome.org/images/userfiles/File/Exercize_Treats_Depression_in_CHD.pdf

New Body Type Index Predicts Death in the Obese: http://www.medscape.com/viewarticle/767714?sssdmh=dm1.803855&src=nldne

Proton Pump Inhibitors: Dangers- Hip Fractures. Proton-pump inhibitors (PPIs) are a group of drugs whose main action is a pronounced and long-lasting reduction of gastric acid production. They are the most potent inhibitors of acid secretion available today. The group followed and has largely superseded another group of pharmaceuticals with similar effects, but different mode-of-action, called H_2-receptor antagonists. These drugs are among the most widely-selling drugs in the world and are generally considered effective.[1] The vast majority of these drugs are benzimidazole derivatives; however, promising new research indicates that imidazopyridine derivatives may be a more effective means of treatment.[2] High dose or long-term use of PPIs carry a possible increased risk of bone fractures.[3]**Proton-pump inhibitors** (**PPIs**) are a group of drugs whose main action is a pronounced and long-lasting reduction of gastric acid production. They are the most potent inhibitors of acid secretion available today. The group followed and has largely superseded another group of pharmaceuticals with similar effects, but different mode-of-action, called H_2-receptor antagonists. These drugs are among the most widely-selling drugs in the world and are generally considered effective.[1] The vast majority of these drugs are benzimidazole derivatives; however, promising new research indicates that imidazopyridine derivatives may be a more effective means of treatment.[2] High dose or long-term use of PPIs carry a possible increased risk of bone fractures.[3]

Clinically used proton pump inhibitors: Omeprazole (brand names: Losec, Prilosec, Zegerid, ocid, Lomac, Omepral, Omez)

- Lansoprazole (brand names: Prevacid, Zoton, Monolitum, Inhibitol, Levant, Lupizole)
- Dexlansoprazole (brand name: Kapidex, Dexilant)
- Esomeprazole (brand names: Nexium, Esotrex)
- Pantoprazole (brand names: Protonix, Somac, Pantoloc, Pantozol, Zurcal, Zentro, Pan, Controloc)
- Rabeprazole (brand names: Zechin, Rabecid, Nzole-D, AcipHex, Pariet, Rabeloc. Dorafem: combination with domperidone[*citation needed*]).

Revaprazan

January 31, 2012 — A new study strengthens the association of long-term use of proton pump inhibitors (PPIs) with increased risk for hip fracture in postmenopausal women, particularly those who smoke.

PPIs can affect fracture risk by increasing secretion of gastrin, inhibiting calcium absorption, and altering osteoclast function. Use of these drugs to treat indigestion increased when they became available over the counter in the United States in 2003. In May 2010, the US Food and Drug Administration issued a warning about the possible link between extended PPI use and hip fracture and requested further information.

The new study, published online January 31 in the *British Medical Journal*, adds information from nearly 80,000 women to the body of data. Hamed Khalili, MD, from Massachusetts General Hospital, Boston, Massachusetts, and colleagues examined data from the prospective cohort Nurses' Health Study, which provided information on lifestyle and dietary risk factors. The study, which began in 1982, assesses participants by questionnaire every 2 years.

Use of PPIs increased nearly 3-fold from 2000 to 2008 among the 79,899 women in the study, from 6.7% to 18.9%. The researchers documented 893 hip fractures over 565,786 person-years of follow-up. Absolute risk for hip fracture among the women who regularly used the drugs for at least 2 years was 2.02 events per 1000 person years compared with 1.51 events per 1000 person years among women who did not take the drugs.

The risk for hip fracture among women who used PPIs for 2 or more years was 35% higher (age-adjusted hazard ratio, 1.35; 95% confidence interval [CI], 1.13 - 1.62). The association held up after adjusting for body mass index, physical activity level, calcium intake, and use of other drugs that can affect fracture risk, such as bisphosphonates, thiazide diuretics, corticosteroids, and hormone replacement.

Hip fracture risk correlated with PPI use over time. "Compared with non-users, the fully adjusted hazard ratios of fracture were 1.36 (1.12 - 1.65) for women with two years' use of PPIs, 1.42 (1.05 - 1.93) for four years' use, and 1.55 (1.03 - 2.32) for six to eight years' use," the researchers report. However, the risk returns to normal for women who have ceased taking the drugs for at least 2 years.

Smoking history stood out among the risk factors considered. Fracture risk rose by more than 50% for women who currently smoke or did so previously (fully-adjusted hazard ratio 1.51 [95% CI, 1.20 - 1.91]). By contrast, the authors found no association between PPI use and fracture risk in never smokers (fully-adjusted hazard ratio 1.06 [95% CI, 0.77 - 1.46]). The researchers suggest that the inhibition of calcium absorption from smoking may act synergistically with PPIs to increase fracture risk. The reason for PPI use did not affect fracture risk.

Strengths of the study, according to the investigators, include its prospective design, large sample, and analysis of several putative confounding risk factors. A limitation is that the study did not include brands and dosages of the PPIs. The researchers conclude that "regular use of PPI was associated with increased risk of hip fracture among postmenopausal women, with the strongest risk observed in individuals with the longest duration of use or with a history of smoking."

The authors have disclosed no relevant financial relationships.

BMJ. Published online January 31, 2012.

^ "Follow The Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain". The Kaiser Family Foundation. March 2005.

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FOR IMMEDIATE RELEASE Contact: CMS Public Affairs Thursday, February 2, 2012 (202) 690-6145

Health reform law saves $2.1 billion for 3.6 million Americans with Medicare

New data show average American with Medicare to save nearly $4,200 through 2021 thanks to health reform. http://www.amphome.org/images/userfiles/File/Health reform law saves(1).pdf

PEOPLE WITH MEDICARE SAVE OVER $4.1 BILLION ON PRESCRIPTION DRUGS THANKS TO THE HEALTH CARE LAW

18 million with Medicare also receive free preventive services in the first seven months of 2012

As a result of the Affordable Care Act – the health care law enacted in 2010 – nearly 5.4 million seniors and people with disabilities have saved over $4.1 billion on prescription drugs since the law was enacted, Health and Human Services (HHS) Secretary Kathleen Sebelius announced today. Seniors in the Medicare prescription drug coverage gap known as the "donut hole" have saved an average of $768.

In addition, during the first seven months of 2012, the new health care law has helped nearly 18 million people with original Medicare get at least one preventive service at no cost to them.

"The health care law has saved people with Medicare over $4.1 billion on prescription drugs, and given millions access to cancer screenings, mammograms and other preventive services for free," said Secretary Sebelius. "Medicare is stronger thanks to the health care law, saving people money and offering new benefits at no cost to seniors."

The health care law includes benefits to make Medicare prescription drug coverage more affordable. In 2010, anyone with Medicare who hit the prescription drug donut hole received a $250 rebate. In 2011, people with Medicare who hit the donut hole began receiving a 50% discount on covered brand-name drugs and a discount on generic drugs. These discounts and Medicare coverage gradually increase until 2020 when the donut hole is closed.

The health care law also makes it easier for people with Medicare to stay healthy. Prior to 2011, people with Medicare had to pay extra for many preventive health services. These costs made it difficult for people to get the health care they needed. For example, before the health care law passed, a person with Medicare could pay as much as $160 for a colorectal cancer screening. Thanks to the Affordable Care Act, many preventive services are offered free of charge to beneficiaries, with no deductible or co-pay, so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.

In 2012 alone, 18 million people with traditional Medicare have received at least one preventive service at no cost to them. This includes 1.65 million who have taken advantage of the Annual Wellness Visit provided by the Affordable Care Act – over 500,000 more than had used this service by this point in the year in 2011. In 2011, an estimated 32.5 million people with traditional Medicare or Medicare Advantage received one or more preventive benefits free of charge.

For state-by-state information on savings in the donut hole, please visit: http://www.cms.gov/apps/files/donut-hole-data-chart.pdf

For state-by-state information on utilization of free preventive services, please visit: http://www.cms.gov/apps/files/preventive-data-chart-first-seven-months-2012.pdf

GlaxoSmithKline Hit with 3 Billion Fine for false advertising, selling medications for unapproved interventions:
http://www.amphome.org/images/userfiles/File/GlaxoSmithKline_3_billion_drug_settlement.pdf

Continued from page 1

regulation, , and multidisciplinary team treatment theory and survival skills.

Finally, while many psychological societies are declining, are in turmoil, are experiencing financial struggles, and have morale and political turmoil-we have none of these things. We, by definition, are different, special, and not intended for a fractionated segment of psychology. We are a lean and efficient homogenous gathering of like psychologists who are either interested in Medical Psychology, or in achieving diplomate status in Medical Psychology. We don't want everyone, we are more than psychopharmacologists, physiological psychologists, health psychologists, neuropsychologists (thought we value and study many of these areas of knowledge and psychological work). We are Medical Psychologists preparing or prepared to do all of the interventions that use psychological and medical knowledge relevant to our patient's care in the world's healthcare facilities and hospitals and in practices that support these facilities and institutions.

I am proud to have served with the very talented board, specialists, and society members during the last two years. We have added new board and work group members during the last year that I hope are studying, learning, serving, and preparing to replace me and carry the torch forward! More are welcome to step forward and begin the process of contributing to our system and moving up in leadership. Contact me and I will find a place for your talents and volunteerism in the society!

By Jerry Morris, PsyD, MBA, MS(Pharm), ABMP, ABPP, ABBHP, NCSP, CCM, Board Certified Medical Psychologist

Emerging Practice Trends

By APA Government Relations staff

Sept. 13, 2012—;Starting Jan. 1, all mental health providers must use new CPT® code numbers for psychotherapy when billing insurance carriers, including Medicare. The fundamental services underlying these new codes will not change. This transition is a result of the Centers for Medicare and Medicaid Services (CMS) Five-Year Review of the psychotherapy codes conducted by the American Medical Association (AMA).

The APA Practice Organization (APAPO) has represented the psychology practitioner community in the process for more than two years, but has been unable to report on much of the ongoing work because of strict confidentiality requirements. As information is made available to the public, we will assist practitioners in understanding and making the transition to the new codes. The 2013 Medicare reimbursement rates for these new codes will be released in early November.

All mental health professionals including psychologists, psychiatrists, nurses and social workers delivering psychotherapy services will use the same applicable codes for psychotherapy, though psychiatry will change how they bill for medical services.

The changes are minimal. For example, the most frequently billed service by psychologists, 90806 (45-50 minute psychotherapy), will become 90834 (45 minute psychotherapy). Use of a particular psychotherapy code and reimbursement for that service will not differ depending on whether the service is provided by a physician or a psychologist. The code numbers and descriptions for psychoanalysis, family psychotherapy (with and without the patient), multi-family group psychotherapy, and group psychotherapy will not change in 2013.

Some specific key code changes include:

(Continued on page 12)

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Join the Most Sought After Specialists in the Emerging Era of Integrated Care

Affirmations to Diplomates: Our society is a growing and vibrant specialty representing the highest trained and most relevant psychologists in America to the emerging healthcare system. During the next year, our specialty will appear in The National Psychologist, The Psychology Times, and in various APA Scientific and Professional Journals. We represent specialists and those interested in Medical Psychology across America. We are setting standards in our field and influencing practice standards with governmental agencies. We are becoming recognized by states and practitioner associations. We are developing integrated care and hospital practices, becoming leaders in prevention and lifestyle management, and our specialists are being asked to present at national physician societies and professional workshops. We prescribe complex psychological treatments, recommend and/or prescribe psychotrophic medications, treat addictions, and establish treatment and prevention for patients with chronic illnesses such as obesity, diabetes, hypertension, asthma, etc. **You are a member of an important psychological and healthcare specialty!**

Emerging Practice Issues continued from page 10

From the Center for Substance Abuse Research, University of Maryland, College Park — -September 24, 2012

Thus far in 2012, more that one-half of U. S. States have had media reports of Buprenorphine misuse of diversion

There were a total of 186 media reports of buprenorphine misuse or diversion from January 1 to August 31, 2012, according to an update of an informal analysis first conducted by CESAR in 2011 (see *CESAR FAX*, Volume 20, Issue 33). The most common types of media reports were of persons possessing (56%) or selling (25%) buprenorphine, often along with other drugs such as prescription opioids and benzodiazepines, marijuana, heroin, and cocaine. There were also reports of smuggling into correctional institutions (14%), diversion by theft and fraud (8%), and use by children (3%). More than one-third (35%) of the media reports involved other drugs and approximately one-fifth (19%) involved other crimes, including trafficking of other drugs, burglary, and robbery. Massachusetts had the highest number of media reports (39), followed by New York (24), Maine (19), Pennsylvania (15), Kentucky (14), and New Hampshire (14). Below is a list of the 27 states and one territory that had at least one buprenorphine media report in the first eight months of 2012, the total number of media reports per state, and a brief description of one of the media reports. The full list of media reports is available online at www.cesar.umd.edu.

Selected Articles from U.S. States Reporting on Buprenorphine Misuse or Diversion, January-August 2012

(N=186 media reports in 27 States and 1 Territory) **State Total # of Articles Example Article Subject Example Article Description** AK 1 possession Man arrested for possession of methadone, Xanax, and Suboxone. ("Alaska Department of Public Safety Issues Trooper Dispatches," *Targeted News Service*, 6/6/12)

AL 1 possession Woman found in possession of Suboxone when arrested for distribution of methadone and hydrocodone to undercover officer. ("Woman Arrested on Drug Counts," *Chattanooga Times Free Press*, 1/21/12)

CA 5 possession Two people found to be in possession of Suboxone pills after being arrested for felony drug sales. ("Meth, Pot, Heroin Found at Eureka Home Today," *Eureka Times Standard*, 4/11/12)

CO 1 death Man died with cocaine, Xanax, Subutex and alcohol in his system; buddies drove around with him dead in car and used his credit cards. ("2 Colo. Men Get Probation in Real-Life 'Weekend at Bernie's' Case," *Gannett News Service*, 3/9/12)

CT 3 possession, selling Man charged with possession of 40 grams of powdered cocaine, 4 oxycodone tablets, 1 Suboxone tablet, and 3 Suboxone strips. ("Drug Probe Leads to Arrest of West Haven Man," *New Haven Register*, 7/11/12) DE 1 possession Two men charged with possession of 125 grams of heroin, 10 Suboxone films, 40 hydroxyzine pills, 19 grams of marijuana, and three shotguns. ("Drug Arrests In Angola by The Bay," *Cape Gazette*, 6/1/12)

FL 1 use by child Two persons charged with giving two children Buprenorphine. ("Two Charged with Giving Drugs to Children," *Northwest Florida Daily News*, 6/7/12)

IN 6 smuggling into jail/prison Correctional officer smuggled 80 Suboxone strips and 280 grams of marijuana into prison. ("Prison Guard Catches Coworker Trying to Smuggle Drugs," *The Herald Bulletin*, 2/24/12)

KY 14 diversion Home burglary in which a wallet, cell phone and Suboxone strips were stolen. ("Brief: Woman Reports Assaults, Thefts," *The Daily Independent*, 8/13/12)

MA 39 possession Woman charged with drug trafficking and possession of marijuana, heroin, and Suboxone. ("DA: Falmouth Woman Deals Drugs with Baby in Car," *The Associated Press State*

ME 19 selling Suboxone tablets, heroin, and drug paraphernalia found in home of man arrested for drug trafficking. ("Southwest Harbor Man Gets 9 Years for Dealing Drugs," Bangor Daily News, 6/7/12)

MN 1 possession Woman charged with possession of 8 tablets of Suboxone and methamphetamine. ("Minneapolis Firefighter from Coon Rapids Sold Meth Out of Fire Station, Court Papers Say," St. Paul Pioneer Press, 3/28/12)

MS 5 selling Man sold Suboxone to an undercover police officer. ("Two Arrested for Separate Drug Sale Cases," Picayune Item, 3/28/12)

NC 1 possession, selling Three women arrested on prostitution charges also charged with possession and selling of marijuana, morphine, alprazolam and Suboxone. ("Police Bring Prostitution Charges," Times -News, 5/14/12)

NH 14 selling Man charged with sale of Suboxone. ("8 Arrests Made in Nashua Drug Sweep in Wake Of Probe," The Union Leader, 5/31/12)

NJ 2 possession Man charged with possession of Suboxone and heroin after motor vehicle stop. ("Police Blotter," Glen Rock Gazette, 8/31/12)

NM 6 smuggling into jail/prison Woman charged with attempting to smuggle 59 strips and 5 tablets of Suboxone to an incarcerated individual. ("Woman Charged with Attempt to Smuggle Drugs at Las Cruces Prison," Las Cruces Sun-News, 8/27/12)

NY 24 selling Woman charged with selling Suboxone and oxymorphone, for which she was prescribed. ("Niagara Police & Courts," Buffalo News, 6/22/12)

OH 3 possession Man in possession of 6 grams of marijuana, 11 Xanax pills and 1 Suboxone pill after intoxicated driving traffic stop. ("Police: Children, Drugs Inside Car During OVI Stop," Dayton Daily News, 7/28/12)

PA 15 possession, selling Man arrested for possession and sale of Suboxone and DMT. ("Erie County Man Arrested Following Search of Suspected 'DMT' Drug Lab in Girard," States News Service, 1/11/12)

Puerto Rico 1 smuggling into jail/prison Woman attempted to smuggle 30 Suboxone pills, 100 Suboxone strips, and 13 grams of marijuana into federal detention center. ("Visitor Arrested for Attempting to Smuggle Contraband into Metropolitan Detention Center," Justice Department Documents and Publications, 3/19/12)

.RI 4 possession Two charged with possession of Suboxone, as well as possession of heroin, marijuana, and receiving stolen goods. ("Detective Bureau," US State News, 3/9/12)

TN 2 diversion, selling Woman charged with using TennCare benefits to purchase Suboxone and then selling to an undercover agent. ("Overton County Drug Round-Up Includes TennCare Fraud Charges," States News Service, 2/14/12)

VA 7 selling Two charged with distribution of Suboxone and crack cocaine. ("Bristol, VA Grand Jury Returns More Than 100 Drug Charges," Bristol Herald Courier, 5/23/12)

VT 1 use by child Man pled guilty to child cruelty after one-year-old daughter swallowed Suboxone pill that he had bought illegally. ("Vt. Dad Admits He Left Out Pill, Baby Swallowed It," The Associated Press State & Local Wire, 3/12/12)

WA 3 possession Man arrested on drug charges and trafficking in stolen property after his home was searched and police found Suboxone, heroin, marijuana, mushrooms, firearms and stolen property. ("Drug Trade Cleaned Up in S-W," Skagit Valley Herald, 3/23/12)

WV 3 possession 90 Suboxone pills found as part of seizure of more than 7,100 prescription pills. ("Officers Seize Cache of Pills: Drug Unit Detectives Nab More Than 7,100 Prescription Pills in Separate Traffic

SOURCE: CESAR search of LexisNexis Academic database for “All News” in the “United States” with the terms “buprenorphine,” “Suboxone,” “Subutex,” “Butrans,” or “Buprenex.” Only articles describing misuse or diversion were included. Only one article per news report/incident was included. If two unrelated incidents were reported in one article (e.g., “Police Beat” articles), each incident was counted individually. The state listed is the state in which the incident occurred.

New Codes Continued from page 10.....

1. Outpatient and inpatient psychotherapy codes will be replaced by a single set of codes that can be used in both settings.
2. The new psychotherapy codes will have specified times rather than ranges:

• 30 minutes, not 20-30 minutes

• 45 minutes, not 45-50 minutes

• 60 minutes, not 75-80 minutes

3. The single psychiatric diagnostic evaluation code will be replaced by two codes: one for a diagnostic evaluation and the other for a diagnostic evaluation with medical services.

Information about Medicare payment rates associated with the new codes is expected to be released in early November when CMS publishes the final Medicare fee schedule for 2013.

NextWave Pharmaceuticals announced FDA approval of its drug Qullivant XR

October 1, 2012 — The US Food and Drug Administration (FDA) has approved a once-daily liquid medication for the treatment of attention -deficit/hyperactivity disorder (ADHD).

In a news release, drug manufacturer NextWave Pharmaceuticals announced FDA approval of its drug Qullivant XR (methylphenidate hydrochloride), the first once-daily, oral-suspension medication for the treatment of ADHD.

According to the company, the central nervous system stimulant is the first extended-release, once-daily liquid ADHD medication on the market. It helps control ADHD symptoms within 45 minutes of administration and lasts for 12 hours.

"The approval of Quillivant XR fills a void that has long existed in the treatment of ADHD. We routinely see the struggles of patients who have difficulty swallowing pills or capsules. Having the option of a once-daily liquid will help alleviate some of these issues while still providing the proven efficacy of methylphenidate for 12 hours after dosing," said Ann Childress, MD, president of the Center for Psychiatry and Behavioral Medicine, Las Vegas, Nevada, who was also an investigator in a clinical trial that tested the drug.

The company notes that the drug's efficacy was evaluated in a randomized, double-blind , placebo-controlled, crossover, multicenter classroom study of 45 children with ADHD.

Quillivant XR is a federally controlled substance (CII) because of its potential for abuse and/or dependence.

The drug is expected to be available in pharmacies in January 2013.

Coming Soon!

New Online Training Program That Satisfies Basic Science Component of Board Certification

Medical Psychology Certificate Program Information

The Medical Psychology Professional Certificate Program requires the completion of 10 courses for a total of 300 hours. The program is consistent with the model curriculum guidelines for optional training in medical psychology developed by the Acaademy of Medical Psychology. Individuals who require CE hours for the course, should request this in writing. CE credit is provided by the National Alliance of Professional Psychology Providers. NAPPP is an APA approved sponsor of continuing education and maintains responsibility for the program and its contents. The entire program is completed online. Enclosed is a detailed recitation of the required courses.

Please Note: The Professional Certificate in Medical Psychology will not meet the academic prescribing requirements for those states that now allow prescriptive authority for psychologists. This is a training program for those seeking specialized training in medical psychology as optional training to qualify for the diplomate in Medical Psychology offered by the American Board of Medical Psychology.

Psychologists who enroll in the certificate program are expected to complete one course every five to six weeks. Courses are taken in a specific order as detailed in the course descriptions.

Tuition

Tuition is $1500 for AMP or NAPPP members and $1700 for non-members. NAPPP membership can be obtained at www.nappp.org. AMP membership can be obtained at www.AMPhome.org.

Tuition Reimbursement

Should a participant wish to terminate from the program or request a refund of the program tuition, the following schedule of reimbursement shall apply:

1. Before registering for the program: 100% reimbursement.

2. There will be no reimbursement after 3 courses have been completed. Requests for reimbursement must be made in writing.

Application Process

An application form is provided at the end of this document. You will need to mail a filled out application together with a copy of your doctoral degree and current license to practice. When the information in your application is verified, you will be asked to remit the tuition fee and be directed to the program site. There, after registration, you will have access to the materials and the first course. All students may be required to participate in scheduled conference calls with the mentor for the course.

Information About Examinations

Final examinations are required in every course. All examinations will require outside research as many of the examination questions do not come directly from the reading materials. We utilize this procedure for several reasons. First, this is a post doctoral program. The subject matter is in many ways very different from that studied for your doctoral degree in psychology. It is more technical and requires a very different approach. The expectation that examination questions directly mirror reading materials would, in fact, not prepare psychologists for medical psychology practice where decisions, many times, must be made without prior information.

Second. Psychologists typically work in solo practices. Psychology differs from other professions in that psychologists are trained to understand and interpret research results. This is what makes us different in the ways we recommend medications and eventually prescribe psychotropics. One way to address the issues that differentiate medical psychologists from others is to focus and prepare the practitioner to research issues and problems. This skill is essential, particularly if one is in solo practice. Students, therefore, can expect that final examinations will require extra work. It is part of what it will take to become a medical psychologist.

Grading Policy

In order to earn full credit for a course, participants must obtain a 75% passing grade for the course.

In conclusion, we hope that this explains the examination process and the reasons underlying the philosophy associated with our testing. Students will have ample time to research every examination question as the final product is what counts. Should additional information be needed, please contact Dr. Jerry Morris at cmhcjerry@sbcglobal.net.

Grievance Procedure

We are fully committed to conducting all activities in strict conformance with profession's ethical principles. We comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants.

Course Descriptions

1. **COURSE TITLE: Introduction To Medical Psychology Practice**

COURSE DESCRIPTION:

This course provides an in-depth introduction to medical psychology. It provides the teaching materials that are the foundation for the entire program. Moreover, the wide array of subject coverage is designed to allow the student to begin implementing what has been learned upon completion of the course, should a student decide to do so.

2. COURSE TITLE: Cardiovascular Anatomy and Function

COURSE DESCRIPTION:

This course provides an introduction and overview of the cardiovascular system. There are several videos that provide hand-on learning about this most important human system. There is a complete cardio tutorial that will ensure that on the completion of the course, a high degree of comfort with this typically non-psychological subject will be achieved.

3. COURSE TITLE: Hepatic Anatomy, Function & Diseases

COURSE DESCRIPTION:

This course is an in-depth presentation of everything that a medical psychologist needs to know and understand about the hepatic system. Having a good working knowledge of hepatic function and the diseases associated with hepatic illness is essential when working in an integrated healthcare setting. Knowledge of hepatic function is particularly important for patients who are on medications. The course materials include several video presentations.

4. COURSE TITLE: Respiratory Anatomy, Function & Diseases

COURSE DESCRIPTION:

This course provides an introduction to the anatomy, function and diseases of the respiratory system. Many times patients who are experiencing breathing problems are wrongly diagnosed with having an anxiety disorder. This course provides clinicians with a working knowledge to distinguish respiratory dysfunction and illness from other disorders

5. COURSE TITLE: Renal Anatomy, Function & Diseases

COURSE DESCRIPTION:

This course is an in-depth presentation of the information that a medical psychologist needs to know and understand about renal function and illness. Having a good working knowledge of renal function and the diseases associated with dysfunction is essential when working in an integrated healthcare setting. Knowledge of renal function is particularly important for patients who are on medications. The course materials include several video presentations

6. COURSE TITLE: Basic Pharmacology

COURSE DESCRIPTION:

This course provides foundation of pharmacology. Drug-drug interactions, adverse drug events, and reducing prescribing errors receive particular attention.

7. COURSE TITLE: Clinical Medicine In Practice

COURSE DESCRIPTION:

Focus of this course is on the use of medications and physical illnesses typically encountered in the clinical practice of medical psychologists. Topics covered include: when medications are appropriate, assessment protocols, risks and rewards when using medications and controlling adverse events.

8. COURSE TITLE: Physical and Laboratory Assessment

COURSE DESCRIPTION:

Topics covered include: body functions and systems affected by disease, performing physical assessments and other types of examinations, how to read blood panels, and other assessments used in

medical practice. This class will prepare participants to evaluate lab tests commonly used in medical practice so that the medical psychologists can effectively understand and communicate with other healthcare professions.

9. COURSE TITLE: Introduction To Pharmacotherapeutics

COURSE DESCRIPTION:

This course covers clinical application of psychotropic medications to the treatment of major mental disorders. Major drug classes: Anxiolytics, Antidepressants, Neuroleptics, Mood Stabilizers, Hypnotics, and drugs that treat side effects from these medications are presented in detail. Pharmacological effects, diagnostic and indicators for use are discussed along with when not to prescribe. Research on these medications and drug classes receive particular attention including placebo response and gender and ethnic responses to medications

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PROGRAM APPLICATION

Professional Certificate Program in Medical Psychology

Name: _____ Date:_____

Address_____City_____Sate:_____ Zip Code: _____

Telephone:_____ Cell: _____Email:_____

Degree: PhD___ PsyD ___ EdD__ School Doctorate was earned:_____ Date: ___/___/_____

State(s) where licensed: _____License Number(s): _____

Is your license current: Yes_____ No_____ Are you now under investigation for any ethical or criminal complaint? Yes___No___

Can you briefly describe your practice? _____

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Do you have any formal training in Medical Psychology? Yes_____ No _____ If yes, please detail your training:_____

Please explain why you desire to obtain training in medical Psychology?

This application and copies of your doctoral degree and current license to practice should be scanned and emailed to Dr. Jerry Morris at cmhcjerry@sbcglobal.net.

After reviewing your application, you will be contacted and required to submit your tuition payment before proceeding to formally enter the program.

ABMP is most grateful to Diplomate Dr. John Caccavale who has authored the original 10 courses of the certificate program. The program will be placed in a state of the art online education program and format that will be come and evolving and growing program that will accommodate new science and learning andteaching methods as they develop!

ACADEMY OF MEDICAL PSYCHOLOGY

Academy of Medical Psychology
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Nevada, MO 64772

E-mail: cmhcjerry@sbcglobal.net

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of the American Board of Medical Psychology

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The AMP

American Board of Medical Psychology

AMP's new journal needs specialty editors and authors. Help us have a great place to keep our specialists aware of emerging practice issues, science, and opportunities. Volunteer! Sign up for the Journal at http://amphome.org/.

ANNOUNCEMENTS FROM YOUR EDITOR

Dear membership:

There are indeed many important articles in this issue of the Academy of Medical Psychology Newsletter. From the victories being won toward limited prescriptive authority, to the ever– growing presence of the Academy it in the areas of education and training, advocacy and practice, and a growing membership, the excitement about our specialty continues to grow. The program application for Professional Certification Program in Medical Psychology on the previous two pages is reasonably simple and user friendly. Encourage your colleagues to consider being a part of a vital health care movement. If you have questions or concerns, please feel free to contact me at OzarksCarge@yahoo.com for any reason.

Ward M. Lawson, PhD, ABPP

Ward M. Lawson, PhD, ABPP
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