Assembly
May 13-15, 2016
Atlanta, Georgia
Assembly Meeting Materials

The schedule, agenda, action papers and items in **bold** will be the only items distributed ONSITE. Please review the materials ahead of the meeting and bring any hard copies of materials you would like to have during the meeting with you. Copies will not be available nor made in the Assembly Administration Office. We will have flash drives with the packet available for download onto your laptop and these will be available in the Assembly Administration Office.

Action items are highlighted.

PLEASE CLICK ON THE ITEM NUMBER TO VIEW THE ITEM

1. Remarks of the Board of Trustees
   - **1.A.1 Ratification of APA Bylaws: Ratification of the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws**
   - 1.C Treasurer's Report

2. Report of the CEO and Medical Director

3. Report of the Speaker
   - 3.A General Report
   - 3.B Reports of the Meetings of the Board of Trustees
     - 3.B.1 Summary of Actions, December 2015
     - 3.B.2 Draft Summary of Actions, March 2016

4. Report of the Speaker-Elect
   - 4.A General Report
   - **4.B Report of the Joint Reference Committee**
     - **4.B.1 Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses**
     - **4.B.2 Proposed Position Statement: The Role of Psychiatrists in Assessing Driving Ability**
     - **4.B.3 Proposed Position Statement: Patient Access to Electronic Mental Health Records**
     - **4.B.4 Proposed Position Statement: Trial and Sentencing of Juveniles in the Criminal Justice System**
     - **4.B.5 Retire 2005 Position Statement: Adjudication of Youth as Adults in the Criminal Justice System**
     - **4.B.6 Retire Position Statement: Infectious Disease Epidemics Including H1N1**
     - **4.B.7 Revised Position Statement: Sexual Harassment**
     - **4.B.8 Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders**
     - **4.B.9 Retain Position Statement: Any Willing Physician**

4.B.10 Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents
4.B.11 Proposed Position Statement: Integrated Care
4.B.12 Proposed Position Statement: Off-Label Treatments
4.B.13 Retire Position Statement: Patient Access to Treatments Prescribed by Their Physicians (*if the Proposed Position Statement: Off-Label Treatments is approved*)
4.B.14 Proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness
4.B.15 Retire Position Statement: A Call to Action for the Chronic Mental Patient (*if the Proposed Position Statement: Call to Action: Accountability for Persons with Serious Mental Illness is approved*)
4.B.16 Proposed Position Statement: College and University Mental Health
4.B.17 Retire Position Statement: College and University Mental Health (*if the Proposed Position Statement: College and University Mental Health is approved*)
4.B.18 Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research
4.B.19 Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness

5. Report of the Recorder
   - 5.A Draft Minutes of the October 30-November 1, 2015 Assembly Meeting
     - 5.A.1 Draft Summary of Assembly Actions, Fall, 2015
   - **5.B List of Members and Invited Guests**
   - 5.C Voting
     - **5.C.1 Voting Strength 2015-2016 – May 2016**
     - **5.C.2 Voting Strength 2016-2017**
     - **5.C.3 Audience Response System (ARS) Voting Instructions**
   - 5.D Report of the Assembly Executive Committee (AEC) meetings
     - 5.D.1 Report of the AEC meetings, Fall, 2015
     - 5.D.2 Draft Report of the AEC meeting, January, 2016
   - 5.E Action Paper Status (May & November 2015)

6. Report of the Rules Committee
   - **6.A Action Assignments and Reference Committee Rosters**
   - **6.B Consent Calendar**
   - **6.C Special Rules of the Assembly**

7. Reports From Assembly Committees – *Assembly Committees may submit reports onsite which may be included in onsite distributions*
   - 7.A Nominating Committee
   - 7.B Committee on Procedures
   - 7.C Committee on Public & Community Psychiatry
   - 7.D Committee of Minority and Underrepresented Groups
   - 7.E Committee of Early Career Psychiatrists
   - 7.F Committee of Resident-Fellow Members (*formerly Members-in-Training*)
   - 7.G Committee of Assembly Allied Organization
   - 7.H Committee on Psychiatric Diagnosis & the DSM
   - 7.I Awards Committee

8. Reports from APA Councils
    - 8.A Council on Addiction Psychiatry
    - 8.B Council on Advocacy and Government Relations
    - 8.C Council on Children, Adolescents and Their Families
    - 8.D Council on Communications
    - 8.E Council on Geriatric Psychiatry
    - 8.F Council on Healthcare Systems and Financing
    - 8.G Council on International Psychiatry
    - 8.H Council on Medical Education and Lifelong Learning
    - 8.I Council on Minority Mental Health and Health Disparities
    - 8.J Council on Psychiatry and Law
    - 8.K Council on Psychosomatic Medicine
    - 8.L Council on Quality Care
    - 8.M Council on Research

9. Standing Committees

10. Reports from Special Components – *Special Components may submit reports onsite which may be included in onsite distributions*
    - 10.A AMA APA Delegation
    - 10.B Work Group on Access to Care
    - 10.C Work Group on ASM/Foundation Initiatives
    - 10.D Work Group on Maintenance of Certification
    - 10.E Work Group on Metrics

11. Reports from Area Councils – *Area Councils may submit reports onsite which may be included in onsite distributions*
    - 11.A Area 1 Council
    - 11.B Area 2 Council
    - 11.C Area 3 Council
    - 11.D Area 4 Council
    - 11.E Area 5 Council
    - 11.F Area 6 Council
    - 11.G Area 7 Council

EXECUTIVE SUMMARY

Committee on Bylaws

The Committee on Bylaws met on August 6, 2015 via conference call, and referred the following proposed language to the Board of Trustees (BOT) at its October meeting in Arlington, VA. The proposal was approved. The full report is provided as **Attachment 1.**

Section 2.1. of the APA Bylaws:
(j) International Resident-Fellow Members. International Resident-Fellow Members shall be physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada who obtain written verification from the training program director. International Resident-Fellow Member status shall not exceed ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

ACTION 1: Will the Assembly vote to ratify the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws?

ATTACHMENT 1 - REPORT OF THE COMMITTEE ON BYLAWS

Chairperson: Rebecca W. Brendel, MD, JD
Members: Edyth P. Harvey, MD, Roger Peele, MD, Christopher Pelic, MD, Rudra Prakash, MD, JD and Sidney H. Weissman, MD
Administration: Margaret C. Dewar and Chiharu Tobita

At the July 2015 meeting, the Board of Trustees (BOT) voted to approve the recommendation of the Membership Committee, chaired by Dr. Rahn Bailey, to establish a new category of membership for international psychiatry residents, as follows:

"International Resident-Fellow Member: Physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, verified with a letter from the training program."

With the assistance of APA Assistant General Counsel, Ms. Shari Graham, the Committee on Bylaws drafted and completed the following proposed *APA Bylaws* language in August 2015:

Section 2.1. of the *APA Bylaws*:

(j) International Resident-Fellow Members. International Resident-Fellow Members shall be physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada who obtain written verification from the training program director. International Resident-Fellow Member status shall not exceed ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

This Bylaws language includes the membership application requirement of a written verification from the training program director, as indicated in the July 2015 report of the Membership Committee.

The Committee on Bylaws discussed and addressed the concerns noted by the Board of Trustees (BOT) and the Membership Committee that some countries do not have an accrediting organization for residency training programs similar to the ACGME. As a result, the length of residency and fellowship training in psychiatry varies by country. At least two medical societies allow international residents to be in the category for up to ten years. In accordance with the BOT and the Membership Committee, the *Bylaws* language states that an international resident is permitted to remain in the category for up to ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

The Board of Trustees voted to approve the proposed language at its meeting in October 2015.

ACTION 1: Will the Assembly vote to ratify the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws?

Item 2016A1 1.C
Assembly
May 13-15, 2016

AMERICAN PSYCHIATRIC ASSOCIATION
REPORT OF THE TREASURER
AT THE
Assembly Meeting
Frank Brown, MD, Treasurer

The Consolidated Financial Statements for the year ending December 31, 2015 are attached to this summary as *Appendix 1.* The consolidated statements include the financial activities of APA, APAF, APA PAC and the dormant APA Insurance Trust. The annual financial statement audit is nearly complete; however, until the final report is issued and approved by the audit committee in June, the numbers presented herein should be considered preliminary and subject to change.

Preliminary, Unaudited Financial Information

Consolidated Net Income – Year end statements show consolidated net income of $719K, which is lower than the $6.6M in net income during 2014, but is significantly better than the $7.2M net loss budgeted. The variance from 2014 to 2015 is attributable to a reduction in investment income from $7.9M to $901K due to changes in the stock markets.

American Psychiatric Association - Preliminary year end statements show an unrestricted operating net surplus of $1.9M, compared to the budgeted net loss the Board approved reserve utilization plan) of $3.2M. The positive variance was largely due to better-than-expected results from the DSM and budget savings from vacant positions.

Revenue Generating Activities produced $2.6M more in net revenue than was anticipated in the budget.

Membership Dues and Programs – End of year net revenue was $9.6M, which is $394K greater than the $9.2M budgeted. The better-than-budgeted results are due to higher than expected dues revenue; higher job classified ads; and slightly lower than anticipated membership expenses.

DSM Net Revenue -Net revenue was $9.3M, which was $2.2M greater than budgeted. DSM sales were $570K lower than budgeted; however, expenses were $2.7M lower than budgeted, mainly due to longer amortization of development costs than was anticipated in the budget. The $21M in development costs are now being amortized over 12 years instead of the 8 years included in the budget.

Miscellaneous net revenue was $340K and was not budgeted. The majority of this line item was made up of tax refunds from 2010, 2011 and 2012. APA pays unrelated business taxes on net advertising revenue.

Programs and Services Expenses were $9.5M, which was below budget by $1.9M, but $1.3M higher than 2014. The lower expenses were the result of vacant positions included in the budget.

Governance and Operations Expenses were $885K lower than budgeted based on vacant positions included in the budget in addition to lower than expected travel and meeting expenses.

American Psychiatric Association Foundation

Revenue Generating Activities – Unrestricted contributions totaled $400K, which was $118K lower than budgeted and $223K lower than 2014. Fundraising from the Corporate Advisory Council members and the Fundraiser at the APA Annual Meeting were lower than anticipated.

Programs and Services Expenses were $1.4M, which was $513K below budget, primarily in the Policy, Programs and Partnerships line item. The lower expenses were the result of vacant positions in the areas of Research and Diversity & Health Equity.

Statement of Financial Position

APA – APA is in a strong financial position with cash of $14.1M, investments of $73.2M and net assets of $81.1M. Cash and investments are both higher than the 2014 balances, as APA had positive net income, received an advance from the insurance company for the liability insurance program and reduced the outstanding advance to APAF.

APAF - APAF is in a healthy financial position with cash of $8.9 million, investments of $51 million and net assets of $59 million. Cash and investments are both down from 2014, as the assets were used to fund the foundation's net loss noted above.
Included in the $5.5M of temporarily restricted net assets is $1.2M in funds for the Stepping Up summit which took place last month. Summit expenses are expected to be around $950K.

American Psychiatric Association and Affiliates
Consolidated Statements of Financial Position
For the years ended December 31, 2014 and 2015

	2014	2015	Net Change
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$ 15,960	$ 23,032	$ 7,072
Accounts Receivable, Net	6,016	5,026	(990)
Pledges Receivable, Net	457	84	(373)
Grant Receivable, Net	126	151	25
Advances to Affiliates	1	-	(1)
Publications Inventory, Net	1,661	1,482	(179)
Prepaid Expenses and Other Current Assets	847	534	(313)
Total Current Assets	25,068	30,309	5,241
Investments in Marketable Securities	126,044	124,719	(1,325)
Property and Equipment, Net	2,249	1,798	(451)
Intangible	2,600	2,600	-
Development Costs	9,206	9,137	(69)
TOTAL ASSETS	**$ 165,167**	**$ 168,563**	**$ 3,396**
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	$ 10,453	$ 10,094	$ (359)
Dues Payable (DB & Other)	1,183	1,386	203
Deferred Revenue:			
Membership Dues	4,777	4,825	48
Grants and Contracts	-	-	
Other	7,358	10,464	3,106
Total Current Liabilities	23,771	26,769	2,998
Deferred Rent Liability	1,174	856	(318)
TOTAL LIABILITIES	**24,945**	**27,625**	**2,680**
NET ASSETS			
Unrestricted, Undesignated	36,027	44,125	8,098
Unrestricted, Designated	97,736	89,224	(8,512)
Temporarily Restricted	5,286	6,408	1,122
Permanently Restricted	1,173	1,181	8
ENDING BALANCE, NET ASSETS	**140,222**	**140,938**	**716**
TOTAL LIABILITIES AND NET ASSETS	**$ 165,167**	**$ 168,563**	**$ 3,396**

American Psychiatric Association
Statements of Financial Position
For the years ended December 31, 2014 and 2015

	2014	2015	Net Change
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$ 6,598	$ 14,067	$ 7,469
Accounts Receivable, Net	6,016	5,025	(991)
Grant Receivable, Net		27	27
Advances to Affiliates	1,637	358	(1,279)
Publications Inventory, Net	1,661	1,482	(179)
Prepaid Expenses and Other Current Assets	847	518	(329)
Total Current Assets	16,759	21,477	4,718
Investments in Marketable Securities	72,942	73,215	273
Property and Equipment, Net	2,209	1,788	(421)
Intangible	2,600	2,600	-
Development Costs	9,206	9,137	(69)
TOTAL ASSETS	**$ 103,716**	**$ 108,217**	**$ 4,501**
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	$ 10,074	$ 9,749	$ (325)
Dues Payable (DB & Other)	1,183	1,386	203
Deferred Revenue:			
Membership Dues	4,777	4,825	48
Grants and Contracts			
Other	7,358	10,334	2,976
Total Current Liabilities	23,392	26,294	2,902
Deferred Rent Liability	1,174	856	(318)
TOTAL LIABILITIES	**24,566**	**27,150**	**2,584**
NET ASSETS			
Unrestricted, Undesignated	24,856	27,202	2,346
Unrestricted, Designated	53,525	53,214	(311)
Temporarily Restricted	769	651	(118)
ENDING BALANCE, NET ASSETS	**79,150**	**81,067**	**1,917**
TOTAL LIABILITIES AND NET ASSETS	**$ 103,716**	**$ 108,217**	**$ 4,501**

American Psychiatric Association Foundation
Statement of Financial Position
($ in thousands)

	2014 Actual	2015 Actual	Net Change
ASSETS			
Current Assets			
Cash and Cash Equivalents	$ 9,330	$ 8,874	$ (456)
Accounts Receivable Net	-	1	1
Pledges Receivable	457	84	(373)
Grants Receivable, Net	126	124	(2)
Prepaid and Other	-	16	16
Total Current Assets	9,913	9,099	(814)
Investments in Marketable Securities	52,581	50,985	(1,596)
Property and Equipment, Net	40	10	(30)
Total Assets	**62,534**	**60,094**	**(2,440)**
LIABILIITES			
Accounts Payable and Accrued Expenses	379	345	(34)
Due to APA	1,619	336	(1,283)
Deferred Revenue	-	130	130
Total Liabilities	**1,998**	**811**	**(1,187)**
NET ASSETS			
Unrestricted, Undesignated	10,635	16,335	5,700
Unrestricted, Designated	44,211	36,010	(8,201)
Temporarily Restricted	4,517	5,757	1,240
Permanently Restricted	1,173	1,181	8
Total Net Assets	**60,536**	**59,283**	**(1,253)**
Total Liabilities and Net Assets	**$ 62,534**	**$ 60,094**	**$ (2,440)**

American Psychiatric Association and Affiliates
Consolidated Statement of Activities
For the Year Ending December 31, 2015
($ in thousands)

	2014 Actual	2015 Actual	2015 Budget*	Budget vs. Actual
Revenue Generating Activities				
Membership dues and programs	9,566	9,612	9,218	394
Publishing	3,939	3,283	3,456	(173)
DSM	9,523	9,346	7,194	2,152
CME and meetings	5,846	4,708	4,771	(63)
Unrestricted Contributions	822	635	518	117
Miscellaneous	8	340	2	338
	29,704	27,924	25,159	2,765
Programs and Services				
Policy, Programs & Partnerships	(6,079)	(5,980)	(7,604)	1,624
Federal Awards	(92)	(46)	-	(46)
Advocacy	(2,070)	(2,730)	(3,249)	519
Communications	(1,384)	(1,833)	(1,935)	102
Foundation Grants	(28)	(84)	(170)	86
	(9,653)	(10,673)	(12,958)	2,285
	(9,458)	(10,493)	(12,958)	
Governance and Operations				
Operations	(18,358)	(15,151)	(15,447)	296
Governance	(2,859)	(2,485)	(2,907)	422
	(21,217)	(17,636)	(18,354)	718
Net Operating Income	**(1,166)**	**(385)**	**(6,153)**	**5,768**
Investment income, net of management fees	7,941	901	(20)	921
Board Designated Fund Activities	(107)	(946)	(503)	(443)
Change in temporarily restricted funds	(95)	1,149	(554)	1,703
Net Income	$ 6,573	$ 719	$ (7,230)	$ 7,949

American Psychiatric Association
Statement of Activities
For the Year Ending December 31, 2015
($ in thousands)

	2014 Actual	2015 Actual	2015 Budget*	Budget vs. Actual
Revenue Generating Activities				
Membership dues and programs	9,566	9,612	9,218	394
Publishing	3,939	3,283	3,456	(173)
DSM	9,523	9,346	7,194	2,152
CME and meetings	5,846	4,709	4,771	(62)
Miscellaneous	8	340	-	340
	28,882	27,290	24,639	2,651
Programs and Services				
Policy, Programs & Partnerships	(4,527)	(4,684)	(5,822)	1,138
Advocacy	(1,875)	(2,550)	(3,249)	699
Communications	(1,384)	(1,833)	(1,935)	102
Foundation operations	(457)	(425)	(419)	(6)
	(8,243)	(9,492)	(11,425)	1,933
Governance and Operations				
Operations	(16,010)	(13,016)	(13,497)	481
Governance	(2,739)	(2,451)	(2,858)	407
	(18,749)	(15,467)	(16,355)	888
Net Operating Income	**1,890**	**2,331**	**(3,141)**	**5,472**
Investment income, net of management fees	4,282	513	-	513
Board Designated Fund Activities	(64)	(827)	-	(827)
Change in temporarily restricted funds	(102)	(98)	(65)	(33)
Net Income	$ 6,006	$ 1,919	$ (3,206)	$ 5,125

	2014 Actual	2015 Actual	2015 Budget*	Budget vs. Actual
Board Designated Funds				
Membership	104	(7)	-	(7)
Government Relations	-	(654)	-	(654)
Legal - Anthem	(168)	(122)	-	(122)
Legal - Health Parity	-	(44)	-	(44)
Total Board Designated Activity	**$ (64)**	**$ (827)**	**$ -**	**$ (827)**

American Psychiatric Association Foundation
Statement of Activities
For the Year Ending December 31, 2015
($ in thousands)

	2014 Actual	2015 Actual	2015 Budget	Budget vs. Actual
Revenue Generating Activities				
General Unrestricted Contributions	623	400	518	(118)
CME and meetings	-	(1)	-	(1)
Miscellaneous	-	-	2	(2)
	623	399	520	(121)
Programs and Services				
Federal Awards				
DDHE	$ (48)	$ (46)	$ -	$ (46)
Reseach	(44)	-	-	-
Library/Archives	(80)	(36)	(102)	66
Policy, Programs & Partnerships	(905)	(686)	(1,029)	343
Practice Research Network	(440)	(489)	(502)	
HIV Psychiatry	(127)	(85)	(149)	64
Foundation Grants	(28)	(84)	(170)	86
	(1,672)	(1,426)	(1,952)	513
Governance and Operations				
Operations	(1,891)	(1,710)	(1,531)	(179)
Governance	(120)	(34)	(49)	15
	(2,011)	(1,744)	(1,580)	(164)
Net Operating Income	**(3,060)**	**(2,771)**	**(3,012)**	**228**
Investment income, net of management fees	3,661	390	(20)	410
Board Designated Fund Activities	(43)	(119)	(503)	384
Change in temporarily restricted funds	7	1,247	(489)	1,736
Net Income	$ 565	$ (1,253)	$ (4,024)	$ 2,758

	2014 Actual	2015 Actual	2015 Budget*	Budget vs. Actual
Board Designated Funds				
Legacy	(43)	(53)	(453)	
Development	-	(66)	-	(66)
New Initiatives	-	-	(50)	50
Total Board Designated Activity	**$ (43)**	**$ (119)**	**$ (503)**	**$ (16)**

Report of the

CEO and Medical Director

to the

APA Assembly

May 13-15, 2016

Convention Center
Atlanta, GA

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EXECUTIVE SUMMARY

I am pleased to present the CEO and Medical Director's report for the APA President's year May 2015 – May 2016, which outlines the Administration's actions, activities, and accomplishments in the past year.

The APA Administration continues its progress toward full implementation of the Board's strategic initiative objectives within the organization's core areas:

- Advancing the integration of psychiatry in the evolving health care delivery system through advocacy and education.
- Supporting research to advance treatment and the best possible clinical care, as well as to inform credible quality standards; advocating for increased research funding.
- Educating members, patients, families, the public, and other practitioners about mental disorders and evidence-based treatment options.
- Supporting and increasing diversity within the APA; serving the needs of evolving, diverse, underrepresented and underserved patient populations; and working to end disparities in mental health care.

Reorganization of Healthcare Systems and Financing (HSF) and Quality Improvement and Psychiatric Services (QIPS) Divisions: Psychiatry is evolving in the new healthcare delivery systems and our strategic initiatives, along with the recommendations from the Board's Healthcare Reform Workgroup report highlighted the need for APA to advance our initiatives in new delivery models, reimbursement, as well as ensuring parity and equity in the delivery of mental health services. As a result, in order to meet these objectives, in December of last year, we internally reorganized both Healthcare Systems and Financing (HSF) and Quality Improvement and Psychiatric Services (QIPS), by creating three coordinated areas: 1) Reimbursement Policy, 2) Practice Management and Systems Delivery Policy and 3) Mental Health Parity Enforcement and Implementation Policy.

It is my hope that you will find this Report useful as it takes a comprehensive look back at on APA's achievements this year and as guidance for our continued work in the upcoming year.

ISSUE SUMMARIES FOR MAY 2015 TO MAY 2016

Ad Hoc Work Group on Healthcare Reform: Anita Everett, MD, chair of the third Healthcare Reform Board of Trustees Work Group, reported on the progress of the recommendations passed by the Board in March 2015. The report focuses on APA activities in the following areas: quality, integrated care, financing/reimbursement, research, workforce/education, and health information technology. Dr. Everett reported that all of the activities in the report are either ongoing or completed and now rest with a Council or Committee. The BOT agreed to sunset the work group and receive additional reports from the pertinent components at future JRC meetings.

Ad Hoc Work Group on Telepsychiatry: Jay Shore, MD, chair of the Board of Trustees Ad Hoc Work Group on Telepsychiatry, reported on their activities over the year and future recommendations for APA. The work group developed a toolkit for members with a series of videos on various aspects of telepsychiatry, including clinical, training, and policy considerations. They also planned and presented at both the annual meeting and IPS meetings. Other recommendations to the Board included: 1) the APA should take a leadership role in advocating for and educating about telepsychiatry at the national and state level to improve access to care (e.g. develop model state legislation, endorse the Interstate Medical Licensure Compact, support an extension of federal telemedicine license process); 2) the APA should collaborate with the American Telemedicine Association (ATA) on a joint telepsychiatry guideline; and 3) the APA should collaborate with the American Academy of Pediatrics (AAP) and the American Association of Directors of Psychiatric Residency Training Programs (AADPRT) on providing telepsychiatry education materials for residency training programs. The Board approved establishing a telepsychiatry committee under the Council on Healthcare Systems and Financing to continue the work group's effort.

American Psychiatric Association Headquarters: The APA's lease for its office space at 1000 Wilson Boulevard, Arlington, Va., expires December 31, 2017. This past July, the Board of Trustees voted to authorize the CEO/Medical Director to execute the lease for 800 Maine Avenue, SW, Washington, D.C. The agreement also includes an option, exercisable by the Board of Trustees, to purchase the leased space in 2020 and in so doing approve the terms of the purchase option, including the purchase and sale agreement that will govern the purchase of the property in 2020 if APA elects to exercise the purchase option in 2019/2020. The APA will move from Arlington to D.C. at the end of 2017.

American Psychiatric Association On Tour: During the APA Annual Meeting, the APA On Tour program will highlight the issue of human trafficking and its impact on mental health. Human trafficking is estimated to affect 20.9 million people worldwide. The majority of human trafficking survivors have mental health concerns, and 87% have had interactions with healthcare providers while being trafficked. This program, presented by a diverse group of panelists, provided an overview of human trafficking as well as diverse topics of particular interest to psychiatrists.

Congressional Briefings: On October 29, 2015, APA organized a congressional briefing reflecting interest and continued lobbying activity in addressing the pervasive criminalization of individuals suffering from mental illness. *Moving Mental Health Care from the Jails to the Community: Decriminalizing People with Mental Illness* was co-sponsored by partners including the Council on State Governments, National Alliance on Mental Illness (NAMI), the National Association of Counties, and the Major County Sheriffs' Association. APA President Renée Binder, MD and correctional psychiatry expert Robert Trestman, MD participated in the panel among other distinguished experts and individuals with salient personal experiences. The event was widely attended and praised for its focus and multidimensional representation of the issue.

On December 14, 2015, APA organized a congressional briefing reflecting interest and continued lobbying activity in repealing the Institutions of Mental Diseases (IMD) exclusion under Medicaid -- an outdated policy largely responsible for precipitating the shortage of psychiatric beds in the United States. The briefing was co-sponsored by NAMI and the National Association of Psychiatric Health Systems (NAPHS), and featured APA President Renée Binder, MD, Steven Sharfstein, MD, and Joe Parks, MD as presenters, along with Mark Covall, president and CEO of NAPHS. The event was well attended, and offered APA an opportunity further to engage Members of Congress interested in addressing the IMD exclusion -- most notably Representative Tim Murphy (R-PA).

Cultural Competence: APA's Cultural Competence webpage, "Best Practice Highlights for Treating 6 Diverse Patient Populations," is now available. The site features short video clips of prominent APA and M/UR caucus members including Rahn Bailey, MD, Maureen Van Niel, MD, Robert Cabaj, MD, Mary Roessel, MD, Albert Gaw, MD, and Lisa Fortuna, MD. The site also provides information on the demographics of various populations, historical information, and background on disparities and stigma to help viewers contextualize assessment and treatment.

DDHE is promoting three cultural competence programs for APA fellows during the 2016 annual meeting:

Diversity 3.0: From Fairness to Excellence
Presented by Marc Nivet, EdD, Chief Diversity Officer, AAMC
Monday, May 16, 1:30 - 3:00 pm, Room B409, Building B, Level 4, Georgia World Congress

Achieving Health Equity in Health Care Needs of Lesbian, Gay, Bisexual, and Transgender People
Presented by Harvey Makadon, MD, Director of Education and Training, Fenway Institute and American Psychiatric Fellow Jeremy Kidd, MD
Monday, May 16, 3:30 - 5:00 pm, Omni Hotel, Pine Room, Atrium Terrace Level, South Tower

Translating the Evidence for the Next Generation: Addressing Mental Health of Youth and Emerging Adults of Color
Presented by Lisa Fortuna, MD, MPH

Sunday, May 15, 2016, 8:00-11:00 am, Georgia World Congress, Room B, 313, Boston Medical Center, Boston University Medical School

District Branches/State Associations (DB/SAs): The APA's connection with DB/SAs is a vital component to the organization and membership outreach. The monthly webinars with DB/SA Executive Directors, is a key forum for discussing front-burner issues including but not limited to membership resources and recruitment, network adequacy, mental health parity, scope of practice, APA Administration updates, and upcoming conferences. The APA CEO/MD and Administration also met in person with the DB/SA Executives at the Annual and November meetings last year. Each of my chiefs shared current and future initiatives, opportunities for DB/SA involvement, and engaged in discussions about how the APA and DBs can work more collaboratively to serve our members. New this year, the DB/SA Executive Directors have also presented on issues important to their specific group. This open dialogue has helped to establish a better system to discuss ideas and identify opportunities so that the DB/SAs and the APA can create maximum value for its members.

DSM-5 Steering Committee: In March 2014, the Board of Trustees approved a report from a Board Work Group on updating of individual diagnostic categories as new data become available to support such changes. The report led to the establishment of a DSM Steering Committee which made recommendations to the Board in July 2015 on: 1) establishing criteria and format for submission of proposals to make changes, additions, or deletions to diagnostic criteria or categories for future revisions of DSM; 2) the creation of six DSM review committees that will review scientific proposals from the field; and 3) the creation of an "editorial committee" that can make changes to the DSM-5 criteria with the understanding that such changes will be reflected in an "updates" section of the DSM website and incorporated into print versions of the DSM-5 when feasible. The BOT approved all of the committee's recommendations. The Steering Committee is considering the relevant aspects of the process of reviewing proposals for changes, including the standards to be applied for review of proposals; the procedures for obtaining input from the field and other interested parties; how to handle non-empirically based requests for changes; and how best to roll-out the availability of the process to the field.

Fellowship Applications: The overall number of fellowship applications increased by almost **20%** for 2016, as compared to 2015, due to increased marketing and the streamlining of fellowships through DDHE. Applications for the APA Leadership, Diversity Leadership, Public Psychiatry, and SAMHSA Substance Abuse Minority Fellowships all increased by at least **40%**. The number of total fellowship applications has almost doubled as compared to 2013 submissions.

Number of Fellowship Applications Received	2015	2016
American Psychiatric Association Leadership Fellowship	16	31
Child and Adolescent Psychiatry Fellowship	42	31
Diversity Leadership Fellowship	20	32
Jeanne Spurlock, MD Congressional Fellowship	7	5
Public Psychiatry Fellowship	20	29
Resident Psychiatric Research Scholars	16	22
SAMHSA Minority Fellowship	44	45
SAMHSA Substance Abuse Minority Fellowship	2	4
Totals	**167**	**199**

In order to increase the visibility of APA fellowship programs, DDHE launched a Twitter account in November 2014. The goal of the Twitter account was to build an audience of relevant followers, build relationships, create awareness, and market new deliverables. In the last month, the APA fellowships twitter account has had 4,148 impressions (number of times users saw tweets on Twitter). DDHE plans to deliver 30 tweets a month and double the audience size by July 2016. Additionally, DDHE has started contributing blog posts on diversity related issues solicited from fellows, members, and community leaders. In the last 14 months, DDHE has published 15 posts on issues ranging from diversity to climate change and mental health connections.

International Update: The release of the APA Learning Center presented an opportunity for APA to better understand the psychiatric training and maintenance of certification processes outside of the United States. This understanding has proven to be useful when determining the supplementary and complementary benefits of the Learning Center to psychiatrists outside the United States and to APA international members.

A May 2015 meeting between APA leadership and the psychiatric organizations of Canada, the United Kingdom, Australia, New Zealand, and South Africa established the foundation for this exchange of knowledge and presented information about the psychiatric core competencies utilized in the respective countries. Including the CanMEDS framework utilized by Canada, the United Kingdom, Australia, and New Zealand and the European Framework for Competencies in Psychiatry (EFCP) in development by the European Board of Psychiatry, part of the European Union of Medical Specialists (UEMS). Further, the leadership of the World Psychiatric Organization provided insight on the psychiatric training and education needs facing other national psychiatric organizations.

This information combined with the mutual recognition agreement between the American Medical Association (AMA) and the UEMS European Accreditation Council for Continuing Medical Education (EACCME) allowing AMA PRA Category 1 activities, such as those offered by the Learning Center, to be eligible for conversion to ECMECs, the European equivalent of CME credits, provides further guidance on the potential impact of the Learning Center offerings.

Additionally, a reported growth in global mental health interest and inquiries has guided APA to review and communicate global mental health resources, training opportunities, and research and education programs in the United States that can foster this growing interest in psychiatry.

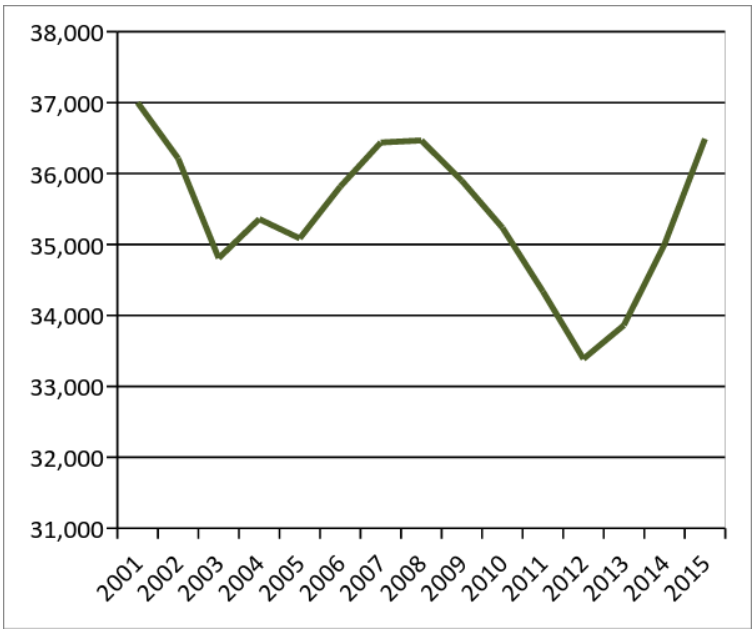
Joint Sponsorship Program: In March, the Board of Trustees approved a pilot program to expand services offered through the APA Joint Sponsorship Program. Richard (Rick) Summers, MD presented a proposal developed by the Council on Medical Education and Lifelong Learning and the APA Division of Education. The program will expand APA provided accreditation services for DBs, allowing them to host 20 online CME courses through the APA learning management system. Additionally, the Board approved having the Division of Education accredit up to 10 CME programs submitted by affiliated groups and five programs submitted by outside organizations. The pilot is approved for one year at which point it will be evaluated.

Member Webinar on Quality Reporting: APA hosted a webinar for members providing a comprehensive overview of the Physician Quality Reporting System (PQRS) to avoid the 2018 penalty in the 2016 reporting year. The webinar was led by Dan Green, MD, Medical Officer, CMS Division of Ambulatory Care, Center for Clinical Standards and Quality, who discussed how to report, choose measures, and avoid the 2% financial penalty on allowable Medicare Part B charges. Dr. Green reviewed the reporting criteria for 2016 as well as how to report without an Electronic Health Record (EHR) or qualified registry and identify appropriate measures. The webinar is the first of a series we have planned to educate our members on how to report to avoid future penalties as well as the move from PQRS to the Merit-based Incentive Payment System (MIPS).

Membership Trends and Benefits:

- Total Membership at the end of 2015 reached 36,490.

- Overall membership is at one of the highest points in 13 years.



- There has been a 7.8% increase in total membership from 2013-2015 (2,628 new members) and a 4.7% (1,244) increase in dues paying members.

The organization, as a whole, continues to build member benefits for each segment, improve delivery of those benefits to the members by updating systems like the website and LMS, and then promoting these benefits using various strategies and tactics. Over the past six months, the following have been created, updated, launched or have reached milestones.

- SET for Success**:** Dozens of free online courses designed to supplement and reinforce what RFMs are learning in the patient care setting and to help them prepare for the business side of medicine. Hot topics are included such as contract negotiations, buprenorphine and opioid dependence, DSM-5, and risk management, including confidentiality and the use of social media. The syllabus and courses can be viewed at www.psychiatry.org/SET.
- A Resident's Guide to Surviving Residency Training: Written to help RFMs with the day-to-day challenges of training, the Guide offers practical advice on more than 50 topics ranging from surviving on call and writing effective notes, to subspecialty training and negotiating their first job.
- RFM Handbook: Based on feedback from RFMs, the handbook was fully updated to be more engaging. It contains information about new/existing benefits, leadership and fellowship opportunities, awards and competitions, the APA's governance structure, and how APA policy is created.

- Building a Career in Psychiatry**:** Recently updated, this resource helps transitioning RFMs, and ECPs in their first few years of practice, to evaluate practice setting; get an overview of how health insurance works from the patient and physician perspective; understand medical liability and disability insurance; weigh whether to start, purchase or buy into a practice and how to value these options; techniques for marketing a practice; budgeting/retirement planning; and much more.
- Find a Psychiatrist: APA's FAP database is now the largest opt-in database of psychiatrists in the nation by far. Specifically valued by ECPs who are starting to build a patient base, the database now contains over 1,000 psychiatrists and growing. It is delivering value to members and patients and driving traffic to the website.
- Focus: Through more strategic promotion, the number of ECPs taking advantage of Focus as a benefit increased from 353 in January to more than 751 in December, which is a 113% increase. This is a big member benefit that has not been effectively promoted.
- Members Course of the Month: Each month, members are now provided free access to a paid CME course on a trending topic. This e-mail has one of the highest open rates and members have responded very positively. This also drives traffic to the learning management system (LMS) where members can look through paid courses.
- Risk Management courses: The APA partnered with the American Professional Agency (APA, Inc.) to create 9 risk management courses that are *AMA PRA Category 1 Credit™*. These *APA PRA Category I Credit* courses are offered free for members and also count towards the three hours required to receive a 5% discount on their professional liability policy. They can be found at http://www.psych.org/psychiatrists/practice/risk-management. These were in response to member comments about the desire for these resources.
    - PIP and Self-Assessment credits completed through the APA Learning Center now will automatically be conveyed to ABPN and, as in the past, are not subject to audit. This was a feature that the ECPs wanted and it was delivered.

- Lifelong Members' Page: For APA members in Life status, we have developed a dedicated webpage that aggregates resources and opportunities into one place. We have promoted the page and asked the general members in this category what other benefits they want the APA to provide. We have received good feedback and are now creating additional resources for them that will be added to this page.

The APA has created member toolkits to make it easier for leadership and members to communicate the member benefits of the APA to their colleagues, institutions, and mentees. Included in these toolkits are PowerPoints, talking points and handouts to assist members with formal presentations, informal group discussions, or one-on-one interactions with RFMs, ECPs, General Members and International Members. The toolkits are located at http://psychiatry.org/mybenefits/membership-outreach-toolkit.

Partnership with Chiefs of Police: Over the last several months, APA has met with the International Association of Chiefs of Police (IACP) to explore possible opportunities for collaboration. Our new partnership led to a plan to update IACP's 2010 white paper on police responses to persons with mental illness. IACP held a blue ribbon committee meeting in March to review, critique, and update the content of this 2010 report to reflect current policies and best practices. We will also be working with IACP to develop a companion document that will provide law enforcement agencies with specific, step-by-step guidance to officers on how to interact with individuals with mental illness.

Rebranding to Show a Unified APA: The CEO/MD and the Board started discussion on rebranding at the March 2014 BOT meeting, and on May 17, 2015, the new brand of the American Psychiatric Association was launched at the opening session of the Annual Meeting in Toronto. The brand was developed between December 2014 and March 2015, relying on extensive research among our leadership, membership, the Administration, District Branches and the public. The Board's goal in adopting the new brand was to demonstrate a consistent look and clear value to members about all that APA does, and to curb the competing marks, fonts, and colors evident in APA's then-current approach to branding. The rebranding is complete, now appearing on our journals, letterhead, business cards, facilities, and in use by all APA business unit as well as the Foundation. The APA will have new signs and a new look and feel at the Annual Meeting in Atlanta, Ga.

Registry: Changes to health care delivery as a result of the Affordable Care Act will require improvement in quality of care, while at the same time reducing costs. With an increasing national focus on quality and cost, the opportunity to leverage clinical registries to improve outcomes and appropriate utilization has never been greater. APA believes that the establishment of a registry will assist members in meeting these new requirements and is an investment for the future of the profession of psychiatry.

Establishing a registry will also help members comply with Physician Quality Reporting System (PQRS) and Merit-Based Incentive Payment System (MIPS) requirements and avoid penalties, which began in 2016 (2%) and will increase to 9% in 2022. A registry would also allow members to submit performance and practice data from the registry for Maintenance of Certification (MOC) Part IV credit. A registry will provide a national research database with aggregate de-identified data to help improve patient outcomes, develop new diagnostics and therapeutics, develop practice guidelines, identify gaps in care and inform APA educational programs, and support advocacy initiatives. It will also allow the APA to develop new psychiatric quality measures (with funding from CMS until 2019).

In March 2016, the Board of Trustees voted to proceed with development of a mental health registry and authorized funding for two years with reports back to the Board at each meeting. The registry will have a Registry Oversight Committee with representatives from various components, including the Assembly and others approved by the Board of Trustees. Registry development will begin immediately with implementation early in 2017.

State Advocacy Leadership Conference: After a 15-year hiatus, the APA held the State Advocacy Leadership Conference on October 23-25, 2016, in Hollywood, Fla. Forty-four DB/SAs participated in a robust discussion that featured panels of physicians and DB Executives sharing best practices regarding parity implementation and scope of practice advocacy. The conference also included a review of the new Scope of Practice toolkit (contains new talking points, fact sheets, infographics, media templates, and historical information) followed by a discussion about the resources available as part of AMA's Scope of Practice Partnership (SOPP). The keynote dinner speaker included Paul Gionfriddo of Mental Health America, and Andrew Sperling of NAMI was the opening session speaker the following day. In addition, conference participants were introduced to APA's four new State Regional Directors who are providing advocacy support to DB/SAs as requested.

Support Alignment Networks (SAN) Grant: In late September, APA received one of the Support Alignment Network (SAN) Grants from Centers for Medicare and Medicaid Services' (CMS) *Transforming Clinical Practice Initiative*. APA's overall goal for the grant is to train 3,500 consulting psychiatrists in collaborative care. We have partnered with the AIMS Center at the University of Washington to conduct the trainings, which will take place in person and online. The South Dakota District Branch recently conducted a training with 38 psychiatrists, residents, and medical students in attendance. We are offering three training sessions at the annual meeting with a total of 360 attendees. We launched our online modules in mid-January and over 100 psychiatrists have signed up to participate in this opportunity. We have reached out to the majority of the DB/SA executive directors regarding the recruitment of participants and many are becoming engaged with their local practice transformation networks in addition to seeking opportunities to incorporate these trainings into their respective meetings. We anticipate exceeding our one-year goal of training 500 psychiatrists by reaching approximately 600 in the first year.

In addition to creating the training infrastructure for the SAN grant, APA's Reimbursement Policy Department is working a "dual track" for payment of collaborative care. CMS has indicated they are interested in authorizing coverage for these services, publically stating that funding could begin as soon as January 2017. APA experts and staff have held a series of meetings with CMS officials to respond to questions and provide additional information. At the same time, a CPT coding proposal was put forward at the February meeting of the CPT Editorial Panel by the APA with support from the American College of Physicians and the American Geriatric Society. If approved, the codes will be sent to the AMA RVS Update Committee for valuation.

Veterans' Commission on Care and Military Efforts: In January, APA was invited to speak on mental healthcare and treatment before the Veterans' Commission on Care. The commission held informational hearings to examine veterans' access to health services and how to meet their needs more effectively. Jenny Boyer, MD, JD, PhD, spoke to the commission about the need for collaborative and team-based care, telepsychiatry, and ensuring that clinicians are providing the highest level of care. The commission also heard similar testimony from the American Psychological Association (ApA) and the National Association of Social Workers (NASW).

In addition, APA met with the Commandant of the Marine Corps four-star General Robert Neller to discuss collaborative efforts on mental health, including suicide prevention. The Commandant will speak at the Annual Meeting to discuss mental health needs of our service members, veterans, and family members.

Working to Support FDA's Reclassification of ECT: The FDA has proposed to reclassify ECT from a Class III (high risk) medical device to Class II (low risk) for use in treating severe major depressive episode (MDE) associated with major depressive disorder or bipolar disorder in patients who are treatment resistant or who require a rapid response due to the severity of their psychiatric or medical condition. This is a change that is largely supported by APA, though there are some concerns for the FDA to address to ensure there are not unintended consequences of adopting this proposal. Specifically, we recommended a class II designation also be given for catatonia, manic episodes (in bipolar disorder), schizophrenia, and schizoaffective disorder and that the patient population in each of these illnesses be limited to individuals with treatment-resistant psychiatric disorders and/or patients with life-threatening conditions related to their underlying psychiatric condition. We also recommended that the class II designation include ECT treatment for children and adolescents meeting the criteria for treatment resistance and in need of a potentially life-saving intervention for the conditions previously indicated and for MDE associated with major depressive disorder or bipolar disorder.

We urged psychiatrists to send comments to the FDA and also sent our own comments with appropriate nuances to address our concerns. In addition, we worked with other mental health groups, including the NAMI, American Academy on Child and Adolescent Psychiatry (AACAP), and Mental Health America (MHA), to submit individual and organizational comments. Throughout the comment period we also monitored opposition activities, which were intense and which prevailed in 2010, the last time this issue came up. FDA is currently reviewing the comments in order to make a decision on reclassification. It is not clear when a decision will be made.

American Psychiatric Association Foundation: Strategic planning is an important component that will help align board and staff on the mission and purpose/objectives of the Foundation, directing vigor toward the most appropriate projects and partners. The Foundation staff sent a request for proposals to firms with a due date of April 13. Interviews with the firms will begin shortly thereafter, with selection of the firm around the end of April. Board members will be identified and appointed to the strategic planning committee.

FRONT BURNER ISSUES FOR APRIL 2016

American Psychiatric Excellence (APEX) Awards: On April 18, 2016, the APA and APAF hosted an orange-tie event featuring the television series *Orange Is the New Black (OITNB).* The APEX Awards program celebrated those who have demonstrated the highest levels of mental health advocacy and who are working to reduce the number of Americans with mental illness in our prisons and jails. **Natasha Lyonne, Matt McGorry** and **Dascha Polanco** from *OITNB* joined us for a conversation about how the show has opened a window into the experiences and treatment of people with mental illness in

America's prisons and jails. Award-winning journalist **Cokie Roberts** hosted the 2016 APEX Awards. APEX awardees included U.S. Senator Al Franken, Minority Leader Nancy Pelosi and Florida state Sen. Miguel Diaz de la Portilla.

Featuring the "who's who" in psychiatry as well as celebrities, media, government officials, nonprofit partners, and participants in the Stepping Up National Summit, the APEX Awards was a can't-miss event for anyone who cares about improving treatment for people with mental disorders. The APEX Awards were presented at The Mayflower Hotel in Washington, D.C.

Collaborative Care Model Hill Briefing: On April 14, 2016, APA organized a congressional briefing reflecting interest and continued lobbying activity in promoting the Collaborative Care Model. The briefing featured APA President Renée Binder, MD, and Jurgen Unutzer, MD, MPH, MA, as presenters, along with David Roll, MD, a primary care practitioner from Massachusetts who has incorporated the evidence-based model into his practice. The event offered APA an opportunity further to engage Members of Congress interested in supporting the CoCM -- most notably Senator Ben Cardin (D-MD), Tom Carper (D-DE), and Patty Murray (D-WA).

Comprehensive Mental Health Reform: The Helping Families in Mental Health Crisis Act (H.R. 2646), introduced by Representative Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX), has bipartisan support with 186 cosponsors. Presently, Representative Murphy is working to find agreement within his caucus on several of the bill's more contested provisions, including the expansion of privacy exemptions under HIPAA for certain individuals with serious mental illness, a partial raise of the current Institutions for Mental Diseases (IMD) exclusion under Medicaid, and a way to offset the bill's overall expected cost of at least $5 billion. Energy and Commerce Committee Chairman Fred Upton (R-MI) has indicated some compromises will have to be reached between Representative Murphy and his colleagues before the bill is marked up by the full Energy and Commerce Committee. APA has joined other mental health stakeholders to press Representative Murphy and his colleagues on the committee to reach resolution on these issues so the process of enacting meaningful mental health reform can advance.

On the Senate side, the Health, Education, Labor, and Pensions (HELP) Committee reported out S. 2680, bipartisan mental health legislation that incorporated many core components of S. 1945, which Senators Bill Cassidy (R-LA) and Chris Murphy (D-CT) introduced as a companion measure to H.R. 2646. There is still some possibility that the Senate will consider this measure on the Senate floor this year, and incorporate non-controversial amendments on the decriminalization of individuals with mental illness, and substance use disorders.

APA remains fully engaged with all relevant offices and committees in both chambers. The Department of Government Relations (DGR) continues to articulate APA's top priorities in comprehensive mental health reform with key contacts.

MACRA implementation: In April 2015, the flawed Medicare sustainable growth rate (SGR) formula was repealed and replaced with the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA merges current incentive and penalty programs under Medicare into one known as MIPs and

encourages physician participation in alternative payment models. The law takes effect in 2019 but is based in many ways on 2017 physician performance. MACRA defers to the HHS Secretary in many key technical areas, thereby giving the Secretary significant discretion in implementing the law. AMA has convened a select group of specialties and state associations to tackle implementation where collaboration is possible, with APA participating at both the CEO and payment subject matter expert levels. APA submitted comments in response to CMS' November 2015 Request for Information (RFI) on MACRA implementation. Our comments focused on the critical need for measurement as part of any reimbursement framework to be based on solely psychiatry-relevant metrics. Advocating for relevant measurement within the opportunity presented by MACRA implementation is critical to addressing current and future challenges, including financial penalties, posed by multifold programs (e.g., the Health Information Technology (HIT) meaningful use program, the PQRS, etc.) that present challenges to the field of psychiatry due to lack of applicable measures and low EHR adoption in the field, among other reasons. Expansive efforts are currently underway at CMS with the development of the MACRA implementation proposed rule, which is expected in the spring or early summer. APA's Policy, Programs and Partnerships Division and DGR are working cross-functionally in preparation for CMS rulemaking and any necessary policy development, Capitol Hill engagement, and allied stakeholder collaboration.

Opioid Use: Both Congress and the Obama Administration are currently debating policies to combat the rise in opioid use across the country. The APA is actively engaged in ensuring that clinicians have ready access to several evidence-based interventions designed to treat addiction. The APA Administration is also spearheading a number of policy initiatives designed to reduce opioid use and encourage more physicians to treat addiction disorders. These initiatives include proposed legislative revisions to current buprenorphine prescribing caps, the promotion of and expanded access to Medicated Assisted Treatment, workforce incentives, and nationwide studies on opioid use, buprenorphine diversion, and barriers that discourage physicians from treating addiction disorders. The buprenorphine patient limits are also expected to be addressed in a Notice of Proposed Rulemaking from SAMHSA in the near future and APA will submit comments. Further, APA is one of more than 40 provider organizations that have announced commitments to address the opioid epidemic through providing physician training on appropriate opioid prescribing and medication-assisted treatment, endorsing the use of naloxone to reverse overdose, and promoting enrollment in and use of prescription drug monitoring programs. The APA is represented in periodic meetings convened by the HHS to discuss these organizational efforts and review progress.

State Affairs: The State Affairs team within DGR has been actively involved with DBs across the country, assisting them in various ways to help advance APA's advocacy priorities in state legislatures and with governors. Over this past year, the team has been actively involved in efforts to oppose psychologist scope-of-practice expansion, most notably in Hawaii, Iowa, Ohio, North Dakota, New Jersey, and New York. These efforts have largely focused on working collaboratively with DBs on utilizing a scope-of-practice toolkit developed by APA, which coordinates lobbying, communications, and partnership strategies aimed at killing scope-of-practice legislation, as well promoting alternatives to such legislation, including telepsychiatry utilization and integrated care. The State Affairs team has also been

actively working to promote APA's anti-discrimination policy in states, such as Georgia, Mississippi, Tennessee, and Missouri. We will continue to closely monitor and work on these issues.

With the conclusion of this report, I want to especially thank the Board, which has made many important decisions over the past year and has worked to elevate the APA and secure its future into the next few decades. I also want to thank the Assembly Executive Committee, Assembly, and all of the DB/SAs and their leadership (elected leadership and executive directors) for their concerted effort to engage membership and make a noticeably positive impact on patients and our members.

I look forward to another year of the APA growing, strengthening, and enhancing its position in the healthcare discussion. I also look forward to our continued journey together.

Respectfully submitted,

Saul Levin, MD, MPA
CEO and Medical Director

Report of the Speaker
May, 2016
Glenn A. Martin, MD

I have really enjoyed this past year as your Assembly Speaker. The Assembly serves a pivotal role in the functioning of the APA. We frequently serve as the canary in the coal mine, often recognizing emerging trends in psychiatry, regulations and technology before other structures in the APA and have been a strong stimulus for action. We host the M/UR caucuses and other sections and caucuses as well as our affiliated ACROSS member organizations. By our very size and diversity, consisting of a mélange of members from a multitude of backgrounds, ethnic, political, religious and others, coming from all over the US and Canada, and even further, working in the full range of private, public and academic settings, (and frequently all three), with accents, speaking styles and temperaments from across the spectrum, we provide a needed eclectic and sometimes idiosyncratic voice to help guide the APA leadership and administration. We can be unruly at times, even a tad unfocused but we are the incubator of ideas and leaders for our organization at the national and local level.

During the past year, we have addressed many important issues facing psychiatry. The Assembly voted unanimously to support a new Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia* an area of care impacting our most vulnerable patients which has been a focus of regulation and legislation that hasn't always been guided by a dispassionate evaluation of the science. Having played a key role in the completion of the DSM5 the Assembly remains focused on the future of that living document and launched a new Assembly Committee on DSM. Recognizing the ongoing national tragedy which is the criminalization of the mentally ill, we heard a compelling presentation and call to action at the Fall meeting from Dr. Paul Burton, Chief Psychiatrist at San Quentin State Prison.

We have established or continued key work groups on member issues including Maintenance of Certification, Access to Care, and Public and Community Psychiatry. We have worked to improve the functioning of the Assembly by establishing a workgroup to develop meaningful Metrics. And, despite the obvious political risk we have tackled some thorny issues of the organization of the MUR Caucuses as compelled by changes to District of Columbia incorporation laws. The members involved in these groups and those who volunteer (or are elected) to serve on key committees like AEC, Procedures, Rules, Nominating, Awards, etc., expand their Assembly member duties to include innumerable night and weekend meetings and calls. I thank each of them for their wisdom, their generosity and their ongoing dedication. They educate us all, improve our structure and inform our decision-making,

Just in November, we supported new or revised position statements on *Hypnosis; Tobacco Use Disorder; Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment; Telemedicine in Psychiatry*; *Substance Use Disorders in Older Adults; Bias Related Incidents* and voted to retain the 2007 Position Statement *Sexual Harassment.* After a period of budget compelled shrinkage we returned to an even more robust Assembly representation with the move to reinstate full attendance at the meeting, moving District Branch Deputy Representatives into full voting DB Reps. This was a result of a hard-fought but well-accepted reorganization that wouldn't have been possible without the goodwill and organizational skills of our previous Speaker Dr. Jenny Boyer, our Speaker-Elect Dr. Dan Anzia, the AEC and current and past Presidents of the APA, Drs. Binder and Summergrad.

For May 2016, our Assembly agenda includes 32 action papers, 19 position statements and one request for ratification of a bylaws change. The action papers address PIP Certification, Eliminating the Federal Parity Opt-Out, Standards for Inpatient Psychiatric Care, DSM, Ethics and other core issues of the association.

The Assembly continues to work to improve its functioning. Our meetings this year made concrete changes to the placement and labeling of microphones, seating arrangements within the room, timing changes to the agenda and more robust staffing and reporting from the reference committees. Our November meeting, held in a new venue over Halloween during the World Series overcame all those distractions to be by all accounts a fun, productive and memorable affair. I have no doubt that Dr. Anzia will continue our ongoing efforts at self-improvement while maintaining a needed and appropriate focus on finances.

We of the Assembly truly represent our members as they strive to practice the best medicine possible in settings and systems that don't always support that goal, while working with patients that society doesn't always treat with the dignity, respect and compassion they deserve. The Assembly serves the professional needs of our member psychiatrists and to a significant extent the needs of our patients and our society. When we do our job, hear and address our member concerns, propose solutions or at times simply sound the alarm and call for action within the APA governance system, we can feel proud. That is how I feel as I prepare to end my tenure as Speaker.

And so I will take this final opportunity to formally thank Drs. Anzia and Miskimen, the entire Assembly Executive Committee, our past, current and future APA Presidents, Drs. Summergrad, Binder and Oquendo, the APA administration and our CEO Dr. Saul Levin and of course Margaret Dewar, Allison Moraske and the entire Governance team for the encouragement, support, hard work and devotion.

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

FINAL SUMMARY OF ACTIONS
December 12-13, 2015

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
2.A	**Requests to Remove Items from the Consent Calendar** Items 7.A.9, 7.A.10, and 7.A.11 were removed	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar.	Chief Operating Officer • Association Governance
4.A	**CEO and MDO Report** The Board of Trustees approved transitioning the oversight of the APA Retirement Savings Plan from the Investment Oversight Committee to a Committee of employees, consistent with current standards and best practices.	CEO and Medical Director Chief Financial Officer Chief Operating Officer
4.B	**Mental Health Bills on Capitol Hill** The Board of Trustees authorizes the Administration to send a letter to Senator John Cornyn (R-TX) expressing strong support for the many provisions of S. 2002 that align with APA policy on criminalization of mental illness, but clarify our intention to continue working with him to better align certain provisions of the bill with APA policy, particularly the firearm-related provisions of the bill.	Chief of Government Affairs

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
5.A	**Minutes of the October 11-12, 2015 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its October 11-12, 2015 Meeting. **[cc]**	Chief Operating Officer • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Summergrad, Dr. Binder, and Dr. Oquendo. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
7.A.1	**Joint Reference Committee Report** The Board of Trustees **did not approve** the establishment of a Caucus of Korean American Psychiatrists under the Council on Minority Mental Health and Health Disparities. (Please see attachment #1)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Division of Diversity & Health Equity

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.2	**Joint Reference Committee Report** Will the Board of Trustees approve the 2016 George Tarjan Award nominee, Emmanual Cassimatis, MD. This action was removed. The award requires approval from the American Psychiatric Association Foundation Board.	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information)
7.A.3	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Jack Weinberg Award nominee, Constantine G. Lyketsos, MD MHS, DFAPA, FAPM, FACNP **[cc]** (Please see attachment #3)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Division of Diversity & Health Equity
7.A.4	**Joint Reference Committee Report** The Board of Trustees approved the 2015 Psychiatric Services Achievement Award nominees as detailed in attachment #4. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships
7.A.5	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Bruno Lima Award nominee, Kathleen Clegg, MD. **[cc]** (Please see attachment #5)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief Membership &RFM-ECP Officer • International Affairs

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.6	**Joint Reference Committee Report** The Board of Trustees approved that the chairperson of the APA*PAC* be appointed, ex-officio, as a corresponding member to the Council on Advocacy and Government Relations. *[Two Board members abstained from the vote.]* This would occur with the understanding that the APA*PAC* will include the chairperson of the Council on Advocacy and Government Relations as an ex-officio corresponding member to the APA*PAC* Board of Directors.	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Government Affairs • PAC and Grassroots
7.A.7	**Joint Reference Committee Report** The Board of Trustees **did not approve** the establishment of a Caucus on Infancy and Early Childhood under the Council on Children, Adolescents and Their Families. (Please see attachment #7)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Division of Diversity & Health Equity
7.A.8	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Human Rights Award nominee, Dr. David Satcher. **[cc]** (Please see attachment #8)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief Membership &RFM-ECP Officer • International Affairs

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.9	**Joint Reference Committee Report** Will the Board of Trustees approve the revised charge for the APA/Minority Fellowship Selection and Advisory Committee? (Please see attachment #9) **The Board of Trustees voted to refer the revised charge of the APA/Minority Fellowship Selection and Advisory Committee to the Joint Reference Committee.**	Chief Operating Officer • Association Governance • Joint Reference Committee Chief of Policy, Programs & Partnerships • Diversity & Health Equity
7.A.10	**Joint Reference Committee Report** Will the Board of Trustees approve the revised charge to the APA Public Psychiatry Fellowship Selection and Advisory Committee? (Please see attachment #10) **The Board of Trustees voted to refer the revised charge for the APA Public Psychiatry Fellowship Selection and Advisory Committee to the Joint Reference Committee.**	Chief Operating Officer • Association Governance • Joint Reference Committee
7.A.11	**Joint Reference Committee Report** Will the Board of Trustees approve the revised charge to the American Psychiatric Leadership Fellowship Selection Committee? (Please see attachment #11) **The Board of Trustees voted to refer the revised charge for the American Psychiatric Leadership Fellowship Selection Committee to the Joint Reference Committee.**	Chief Operating Officer • Association Governance • Joint Reference Committee

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.12	**Joint Reference Committee Report** The Board of Trustees approved that additional unnecessary interventions in psychiatry be determined under the premise that a new ABIM Foundation Choosing Wisely list will be developed by the Council on Quality Care and the Council on Research. (Please see attachment #12.A and #12.B)	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships
7.A.13	**Joint Reference Committee Report** The Board of Trustees approved giving the authors of the resource document, *Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model*, permission to submit the document for peer review and publication provided APA has the right of first approval.	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Research
7.A.14	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Hartford-Jeste Award nominee, Ilse R. Wiechers, MD, MPP, MHS. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Division of Diversity & Health Equity
7.A.15	**Joint Reference Committee Report** The Board of Trustees approved the 2016 John Fryer Award nominee, Mary Bonauto, JD. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Division of Diversity & Health Equity

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.16	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Irma Bland Award for Excellence in Teaching Residents nominees: Gordon D. Strauss, MD, Jessica G. Kovach, MD, Terrence A. Ketter, MD, David Lindy, MD, Anthony Edward Atwell, MD, Wioleta Mazurczak, MD, and Mary Helen Davis, MD. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Education
7.A.17	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Nancy C. A. Roeske, MD Certificate of Recognition for Excellence in Medical Education nominees: Rif El-Mallakh, MD, Ellen Gluzman, MD, Rona J. Hu, MD, Chloe Marie Leon, M.D., Julie Penzner, MD, Ashish Sharma, MD, Nina Freund, MD, and Richard Renka, MD. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Education
7.A.18	**Joint Reference Committee Report** The Board of Trustees approved the 2016 Adolf Meyer Award nominee, James W Dilley, MD. **[cc]**	Chief Operating Officer • Association Governance • Joint Reference Committee (For Information) Chief of Policy, Programs and Partnerships • Education
8.A.1	**Finance and Budget Committee Report** **APA Operating Budget:** The Board of Trustees approved the 2016 Operating budget as proposed.	Chief Financial Officer • Finance & Administration

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
8.A.2	**Finance and Budget Committee Report** **Foundation Operating Budget:** The Board of Trustees approved the 2016 American Psychiatric Association Foundation Operating Budget as proposed.	Chief Financial Officer • Finance & Administration APA Foundation
8.A.3	**Finance and Budget Committee Report** **APA Capital Budget:** The Board of Trustees approved the 2016 APA Capital Budget as proposed. *[One Board member abstained from the vote.]*	Chief Financial Officer • Finance & Administration
8.A.4	**Finance and Budget Committee Report** **International RFM's:** The Board of Trustees approved the proposed dues structure for International RFMs.	Chief Financial Officer • Finance & Administration Chief Membership & RFM-ECP Officer • Membership
8.A.5	**Finance and Budget Committee Report** **Education Joint Sponsorship Expansion:** Will the Board of Trustees approved the expansion of the CME joint sponsorship programs to include allied groups? **The Board voted to refer this action to the Council on Medical Education and Lifelong Learning with a report to the Board of Trustees by March, 2016.**	Chief Financial Officer • Finance & Administration Chief of Policies, Programs & Partnerships • Education

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
8.A.6	**Finance and Budget Committee** The Board of Trustees approved the use of the unrestricted (investment) reserve fund for the APA operating budget as follows: a) For Fiscal Year 2017, $3 million would be available to supplement operations. b) Beginning in Fiscal Year 2018, 50% of the unrestricted reserve investment income, calculated over the prior 3 year rolling average of completed fiscal years, would be available to supplement operations. (For example: for Fiscal Year 2018, the average Fiscal Years 2014, 2015, and 2016 would be used for the calculation).	Chief Financial Officer • Finance & Administration
8.C.1	**Membership Committee Report** The Board of Trustees approved the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report. *[BOT members from listed DBs recused themselves.]*	Chief Membership & RFM-ECP Officer • Membership
8.C.2	**Membership Committee Report** The Board of Trustees voted to approve the recommendation of the Membership Committee to partner with *Credible*, an affinity program that serves as an independent marketplace for student loans.	Chief Membership & RFM-ECP Officer • Membership

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
8.C.3	**Membership Committee Report** The Board of Trustees voted to approve the recommendation of the Membership Committee to revise the Guidelines for Election to Distinguished Fellowship as shown in Attachment F. *[One Board member abstained from the vote.]*	Chief Membership & RFM-ECP Officer • Membership
8.C.4	**Membership Committee Report** The Board of Trustees voted that the Members listed in Attachment G be approved for Fellowship and Life Fellowship. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.C.5	**Membership Committee Report** The Board of Trustees voted that the Members listed in Attachment H be approved for International Fellowship. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.C.6	**Membership Committee Report** The Board of Trustees voted that the Members listed in Attachment I be advanced to Distinguished Fellow or Distinguished Life Fellow. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.C.7	**Membership Committee Report** The Board of Trustees voted to approve the nominations listed in Attachment L for International Distinguished Fellow of the APA. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.C.8	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Members listed in Attachment O for failure to meet the requirements of membership. **[cc]**	Chief Membership & RFM-ECP Officer • Membership

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
8.C.9	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment P for International Membership. **[cc]**	Chief of Membership & RFM-ECP Officer • Membership
8.C.10	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment Q. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.D	**Nominating Committee Report** The Board of Trustees voted to accept the report of the Nominating Committee as presented.	Chief Operating Officer • Association Governance
9.A.1	**Speaker's Report** The Board of Trustees voted to approve the retention of the 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*. **[cc]**	Chief Operating Officer • Association Governance
9.A.2	**Speaker's Report** The Board of Trustees voted to approve the retention the 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*. **[cc]**	Chief Operating Officer • Association Governance
9.A.3	**Speaker's Report** The Board of Trustees voted to approve the Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution* - Joint Position Statement of the APA/AAAP. **[cc]**	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
9.A.4	**Speaker's Report** The Board of Trustees approved the Proposed Position Statement: *Substance Abuse Disorders in Older Adults*. **[cc]**	Chief Operating Officer • Association Governance
9.A.5	**Speaker's Report** The Board of Trustees approved the revised Position Statement: *Bias-Related Incidents.* **[cc]**	Chief Operating Officer • Association Governance
9.A.6	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *The Right to Privacy*. **[cc]**	Chief Operating Officer • Association Governance
9.A.7	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Interference with Scientific Research and Medical Care*. **[cc]**	Chief Operating Officer • Association Governance
9.A.8	**Speaker's Report** The Board of Trustees approved the revised Position Statement: *Hypnosis*. **[cc]**	Chief Operating Officer • Association Governance
9.A.9	**Speaker's Report** The Board of Trustees approved the retention of the 2010 Position Statement on *Posttraumatic Stress Disorder and Traumatic Brain Injury*. **[cc]**	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
9.A.10	**Speaker's Report** The Board of Trustees approved the retention of the 2010 Position Statement on *High Volume Psychiatric Practice and Quality of Patient Care*. **[cc]**	Chief Operating Officer • Association Governance
9.A.11	**Speaker's Report** The Board of Trustees approved the Proposed Position Statement on *Tobacco Use Disorder*. **[cc]**	Chief Operating Officer • Association Governance
9.A.12	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists.* **[cc]**	Chief Operating Officer • Association Governance
9.A.13	**Speaker's Report** The Board of Trustees approved the Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*. **[cc]**	Chief Operating Officer • Association Governance
9.A.14	**Speaker's Report** The Board of Trustees approved the Revised Position Statement on *Telemedicine in Psychiatry*. **[cc]**	Chief Operating Officer • Association Governance
9.A.15	**Speaker's Report** The Board of Trustees approved the APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*.	Chief of Policy, Programs, and Partnerships • Research

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
11.B.1	**Ad Hoc Work Group on Revising the Ethics Annotations** The Board of Trustees voted to approve the document currently titled, "APA Ethics Resource Document" with the understanding that the title will be changed and voted upon later at the December Board of Trustees meeting.	General Counsel
11.B.2	**Ad Hoc Work Group on Revising the Ethics Annotations** The Board of Trustees approved the previously titled "APA Ethics Resource Document" to "**APA Commentary on Ethics in Practice**".	APA General Counsel
11.C.1	**Distinguished Service Award Work Group** The Board of Trustees approved the recommendation of the Distinguished Service Award Work Group to award the 2016 Distinguished Service Award to Donna Norris, MD. **[cc]**	Chief Operating Officer • Association Governance
11.C.2	**Distinguished Service Award Work Group** The Board of Trustees approved the recommendation of the Distinguished Service Award Work Group to award the 2016 Distinguished Service Award to Steven Sharfstein, MD. **[cc]**	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
11.C.3	**Distinguished Service Award Work Group** The Board of Trustees approved the recommendation of the Distinguished Service Award Work Group to award the 2016 Distinguished Service Award to Daniel Winstead. **[cc]**	Chief Operating Officer • Association Governance
11.C.4	**Distinguished Service Award Work Group** The Board of Trustees approved the recommendation of the Distinguished Service Award Work Group to award the 2016 Organization Distinguished Service Award to the American Academy of Psychiatry and the Law (AAPL). **[cc]**	Chief Operating Officer • Association Governance
EX.1	**Support for Hawaii Psychiatric Medical Association** The Board of Trustees voted to approve a grant requested by the Hawaii Psychiatric Medical Association as unanimously recommended by the Committee on Advocacy and Litigation Funding and the Council on Advocacy and Government Relations.	Chief of Government Affairs CFO (for information)
EX.1	**Registries** The Board of Trustees accepted the recommended business case for a multi-illness, patient and provider entered data national mental health quality registry.	Chief of Policy, Programs, & Partnerships • Research • Quality Care

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
EX.2	**Registries** The Board of Trustees directs the Administration to continue to work with the appropriate consultants and APA components, including using focus groups, to develop and design a detailed business plan for the Board along with options and alternatives of types of registries that will work for APA and psychiatry, using up to an additional $30,000. *[Two Board members abstained from the vote.]*	Chief of Policy, Programs, & Partnerships • Research • Quality Care

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

DRAFT SUMMARY OF ACTIONS
March 19-20, 2016

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
2.A	**Requests to Remove Items from the Consent Calendar** Items 7.A.1, 7.A.4, 10.B.1, 10.B.2, and 10.B.3 were removed.	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar as amended.	Chief Operating Officer • Association Governance
5.A	**Minutes of the December 12-13, 2015 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its December 12-13, 2015 Meeting. **[cc]**	Chief Operating Officer • Association Governance
5.B.1	**Conflict of Interest Committee** The Board of Trustees voted to approve the revisions to the American Psychiatric Association's *Financial Statement, Disclosure of Affiliations and Conflict of Interest Policy* creating one comprehensive conflict of interest policy for the APA covering all APA entities including the DSM and Practice Guideline projects. **[cc]**	Chief Operating Officer • General Counsel • Association Governance
5.B.2	**Conflict of Interest Committee** The Board of Trustees voted to approve the revisions to the *Financial Statement, Disclosure of Affiliations and Interests Form* creating one overall form for all APA appointments. **[cc]**	Chief Operating Officer • General Counsel • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Summergrad, Dr. Binder, and Dr. Oquendo**. [cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
7.A.1	**Joint Reference Committee Report** The Board of Trustees voted to approve the submission of the Council on Research's manuscript on the clinical use of rTMS for depression management to the *American Journal of Psychiatry* for publication.	Chief Operating Officer • Association Governance • Publishing Chief of Policy, Programs and Partnerships • Research
7.A.2	**Joint Reference Committee Report** The Board of Trustees voted to approve the 2016 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Education nominees: Lourdes Dominguez, MD (Columbia University); Valier Houseknecht, MD (Wright State University – Boonshoft School of Medicine); Abigail Kay, MD (Thomas Jefferson University – Sidney Kimmel Medical College); Shirin Ali, MD (Columbia University); Eduardo Speiridion, MD (West Virginia School of Osteopathic Medicine); and Katherine Winner, MD. **[cc]**	Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships • Education
7.A.3	**Joint Reference Committee Report** The Board of Trustees voted to approve the 2016 Irma Bland Award for Excellence in Teaching Residents nominees: William C. Jangro, MD; Sander Markx, MD; James F. Luebbert, MD. **[cc]**	Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships (FYI) • Education

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
7.A.4	**Joint Reference Committee Report** The Board of Trustees voted to approve the revised JRC composition to replace the Immediate Past President with the APA Secretary and designate the two Assembly Representatives as the Assembly Recorder and the Immediate Past Speaker.	Chief Operating Officer • Association Governance
7.B	**2016-2017 Presidential Appointment Waivers** Will the Board of Trustees vote to approve waiving the composition requirement to allow an additional general member to hold a member position allocated for a member of the Board of Trustees on the Finance and Budget Committee for 2016-2018? **This action was withdrawn.**	N/A
8.A.1	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members listed in Attachment J for failure to meet the requirements of membership. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.A.2	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership all members who have not paid 2016 APA dues by the deadline of March 31, 2016. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.A.3	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members who will be dropped by their district branch if dues are not paid by the deadline. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.A.4	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment K for International Membership. **[cc]**	Chief Membership & RFM-ECP Officer • Membership
8.A.5	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment L. **[cc]**	Chief Membership & RFM-ECP Officer • Membership

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
8.C.1	**Tellers Committee Report** The Board of Trustees voted to approve the results of the 2016 Election. **[2 Abstentions]**	Chief Operating Officer • Association Governance
8.C.2	**Tellers Committee Report** The Board of Trustees voted to approve APA administration to dispose of the 2016 Election ballots immediately after the 2016 Annual Meeting.	Chief Operating Officer • Association Governance
8.D.1	**Elections Committee Report** The Board of Trustees voted to approve implementing the Videotaping Candidates Interviews Project for one more year and request that an effort be made to show its utility and provide additional feedback. **[1 Abstention]**	Chief Operating Officer • Association Governance Chief Communication Officer
8.D.2	**Elections Committee Report** Will the Board of Trustees vote to offer national and Board candidates an opportunity to distribute several emails per election cycle through the use of the APA-maintained listservers, consistent with all relevant laws, regulations, and members preferences? The APA will not release member emails directly to candidates. This does not limit other uses of email by candidates outside the use of APA resources. The Board of Trustees voted to refer the action to a Board *Work Group on Communications to members during the Election Cycle* Dr. Binder will appoint the work group in consultation with Drs. Oquendo, Martin and Anzia. The work group will report to the Board of Trustees in July 2016.	Chief Operating Officer • Association Governance Chief Communication Officer
10.A.1	**American Psychiatric Association Foundation [APAF]** The Board of Trustees voted to approve the APAF Board of Directors recommendation of the appointment of Dilip Jeste, MD, to the APAF Board of Directors for a term of three years, commencing in May 2016. **[cc]**	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
10.A.2	**American Psychiatric Association Foundation** The Board of Trustees voted to approve the APAF Board of Directors recommendation of the appointment of Karinn Glover, MD, to the APAF Board of Directors for a term of three years, commencing in May 2016. **[cc]**	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation
10.A.3	**American Psychiatric Association Foundation** The Board of Trustees voted to approve the APAF Board of Directors recommendation of the appointment of Dwight Evans, MD, to the APAF Board of Directors for a term of three years, commencing in May 2016. **[cc]**	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation
10.A.4	**American Psychiatric Association Foundation** The Board of Trustees voted to approve the APAF Board of Directors recommendation to extend the appointment of Judge Steven Leifman, to the APAF Board of Directors for an additional term of three years, commencing in May 2016. **[cc]**	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation
10.A.5	**American Psychiatric Association Foundation** The Board of Trustees approved a change in the APAF bylaws, section 4.4 increasing the size of the nominating committee from 3 to 5 and requiring 3/5 to be directors who do not serve in any elected ex-officio capacity. **[cc]**	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
10.B.1	**Awards and Fellowship** The Board of Trustees voted to accept and approve the following recommendations from the American Psychiatric Association Foundation Board of Directors. 1. The following awards and fellowships should be moved from APAF to APA since the source of funding is from APA: Adolf Meyer Award, Vestermark Psychiatry Educator Award, and Benjamin Rush Award Lecture, with the APA President-Elect responsible for appointing the selection committee. 2. The following awards and fellowships should be moved from APA to APAF since the source of funding is from APAF: Hartford-Jeste Geriatric Award, Fryer Award, American Psychiatric Leadership Fellowship, Public Psychiatry Fellowship, Child and Adolescent Psychiatry Fellowship, with the APAF BOD responsible for appointing the selection committee in consultation with the APA President-elect. 3. The presentation of the Agnes Purcell McGavin Awards (Prevention and Distinguished Career Achievement) and the Blanche Ittleson Award should be made at the most appropriate Child and Adolescent session or meeting, determined by the Administration in consultation with the Council chair. 4. The presentation of the Hartford-Jeste Award and the Jack Weinberg Award should be at the most appropriate Geriatric Psychiatry session or meeting, determined by the Administration in consultation with the Council chair. 5. The presentation of the Kempf Award should be at the most appropriate Psychiatric Division of Research session or meeting, determined by the Administration in consultation with the Council chair. 6. The presentation of the Isaac Ray Award should be at the most appropriate Forensic Psychiatry session or meeting, determined by the Administration in consultation with the Council chair. 7. The overseeing entity (APA or APAF) may replace a monetary honorarium with a plaque when funding is less than the equivalent of five years of the annual expenses for the award. At this point, the APA and APAF may consider securing external funding for an award or sunsetting the award when funds expire.	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships (FYI) • Diversity and Health Equity • Research • Education

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
10.B.2	**Awards and Fellowship** Since the following fellowships reside within APAF, the Board of Trustees voted to sunset the selection committees for the following fellowships: American Psychiatric Leadership Fellowship, Public Psychiatry Fellowship, SAMHSA Minority Fellowship. The new selection committees will be appointed by the APAF BOD chair in consultation with the APA President-Elect.	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation Chief of Policy, Programs, and Partnerships • Diversity & Health Equity
10.B.3	**Awards and Fellowship** Since the following awards reside within APAF, the Board of Trustees voted to sunset the selection committee for the following awards: Blanche Ittleson Award, Agnes Purcell McGavin Awards, Isaac Ray Award, Guttmacher Award, and Committee on Division of Research Awards. The new selection committees will be appointed by the APAF BOD chair in consultation with the APA President-Elect.	CEO and Medical Director Chair, APAF • American Psychiatric Association Foundation Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships (FYI) • Diversity and Health Equity • Research
10.B.4	**Awards and Fellowship** The Board of Trustees voted to approve the presentation of the Human Rights Award at the most appropriate International Psychiatry session or meeting, determined by the Administration in consultation with the Council chair. **[cc]**	Chief Membership & RFM-ECP Officer • International Affairs Chief Operating Officer • Association Governance
10.B.5	**Awards and Fellowship** The Board of Trustees voted to approve awarding up to five Distinguished Service Awards annually, which includes one organizational award. **[cc]**	Chief Operating Officer • Association Governance
10.B.6	**Awards and Fellowship** The Board of Trustees voted to approve awarding up to five Presidential Commendations annually. **[cc]**	Chief Operating Officer • Meetings & Conventions • Association Governance Chief of Policy, Programs, and Partnerships • Education

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
10.B.7	**Awards and Fellowship** The Board of Trustees voted to approve APA Legal Counsel to edit the APA Operations Manual to reflect the approved actions. **[cc]**	Chief Operating Officer • Association Governance General Counsel
11.A	**Ad Hoc Work Group on Telepsychiatry Report** The Board of Trustees voted to approve the establishment of a Committee on Telepsychiatry under the Council on Healthcare Systems and Financing to continue the work of the BOT ad hoc work group on telepsychiatry with the following proposed charge: Advise APA on policy, legislative and regulatory initiatives; develop educational tools for members on telepsychiatry; and develop resource documents for members on the use of telepsychiatry. [The committee will have the standard committee budget and conduct its business through email and teleconference]	Chief of Policy, Programs, and Partnerships Chief Operating Officer • Association Governance Council on Healthcare Systems & Financing
11.D	**DSM Steering Committee Report** The Board of Trustees voted to approve the "Criteria and Procedures for Submission and Review of Proposed Changes to the DSM," outlining the information required for proposals for making changes to *DSM-5* and the procedures to be followed (see attachment 1). **[cc]**	Chief of Policy, Programs, and Partnerships • Research Chief Operating Officer • American Psychiatric Publishing
13.A	**APA Joint Sponsorship Program Expansion** The Board of Trustees voted to approve a 12 month pilot expansion of the Joint Sponsorship Program that will allow for the addition of: • Up to 20 online programs, • Up to 10 affiliate programs, and • Up to five outside programs approved by the Council on Medical Education and Lifelong Learning (CMELL)	Chief of Policy, Programs, and Partnerships • Education

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
EX.1	**Editor of Psychiatric Services** The Board of Trustees approved the recommendation of the Search Committee to offer Lisa Dixon, M.D., the opportunity to be the next Editor of *Psychiatric Services*. **[cc]** [*The initial contract is for 3 years, with the possibility of two additional 5 year contracts*.]	Chief Operating Officer • Association Governance • American Psychiatric Publishing
EX.2	**Editor-in-Chief, Books** The Board of Trustees approved the recommendation of the Search Committee to appoint Laura W. Roberts, M.D., to be the next Editor-in-Chief, Books. **[cc]** [*The initial contract is for 3 years, with the possibility of two additional 5 year contracts*.]	Chief Operating Officer • Association Governance • American Psychiatric Publishing
EX.3.1	***Psychiatric Services* Editorial Board** The Board of Trustees voted to approve the appointment of Steven N. Adelsheim, M.D., to the *Psychiatric Services* Editorial Board for a four-year term on the *Psychiatric Services* Editorial Board to expire in May 2020. **[cc]**	Chief Operating Officer • Association Governance • American Psychiatric Publishing
EX.3.2	***Psychiatric Services* Editorial Board** The Board of Trustees voted to approve the reappointment of Roberto Lewis-Fernández, M.D., to the *Psychiatric Services* Editorial Board for a four-year term to expire in May 2020. **[cc]**	Chief Operating Officer • Association Governance • American Psychiatric Publishing
EX.4	**Medical Registries** The Board of Trustees voted to proceed with the continued development of the registry with funding from the reserves at up to a fixed amount over two years with the Board updated at each regularly scheduled Board meeting. In addition, the Board will direct the Administration to develop a plan to reduce expenditures or propose dues increases to cover at least 60% of the registry costs. **[2 Abstentions]**	Chief Operating Officer Chief of Policy, Programs, and Partnerships Chief Financial Officer

Agenda Item #	Title/Action Consent Calendar Items Notated by [cc]	Responsible Office/Component
EX.5.1	**Nominees to the DSM Review Committee** The Board of Trustees approved the appointment of the individuals to DSM Review Committees as noted in attachment Ex.5. **[cc]**	Chief Operating Officer • Association Governance APA General Counsel Chief of Policy, Programs and Partnerships • Research
EX.5.2	**Nominees to the DSM Review Committee** The Board of Trustees approved the appointment of the individuals to DSM Review Committees as noted in attachment Ex.5. **[cc]**	Chief Operating Officer • Association Governance APA General Counsel Chief of Policy, Programs and Partnerships • Research
EX.5.3	**Nominees to the DSM Review Committee** The Board of Trustees approved the appointment of the individuals to DSM Review Committees as noted in Attachment Ex.5, with the proviso that each commit to limiting their compensation related to pharmaceutical companies to no more than $10,000 per annum for the duration of their tenure on the DSM Review Committee as per the *Principles for Appointees to the DSM Steering Committee or Review Committees* (July 2014). **[cc]**	Chief Operating Officer • Association Governance APA General Counsel Chief of Policy, Programs and Partnerships • Research
EX.7	**DSM Research Materials Embargo** The Board voted to reaffirm and not to waive the current Archives Access Policy. **[1 Abstention]**	Chief of Policy, Programs, and Partnerships • Research Chief Operating Officer • American Psychiatric Publishing APA General Counsel
14	**New Business** The Board of Trustees voted to approve the Administrative and Investment Fiduciaries Agents for the APA 401K plan.	Chief Operating Officer • Human Resources Chief Financial Officer APA General Counsel

Item 2016A1 4.A
Assembly
May 13-15, 2016

Report of the Speaker-Elect
May, 2016
Daniel Anzia, MD

It has been my privilege to serve the Assembly and the American Psychiatric Association for this past year as Speaker-Elect, and to work with the Speaker, Dr. Glenn Martin, the Recorder, Dr. Theresa Miskimen, and Past Speakers Dr. Jenny Boyer and Dr. Mindy Young.

Beginning with the Assembly meeting at the end of October, 2015, the Assembly reorganization approved in May, 2015 took full effect. The reconstituted Assembly now includes at least two Representatives from every District Branch, with more from the larger District Branches and State Associations. All Representatives and Deputy Representatives of the Minority/Underrepresented Groups, the Early Career Psychiatrists, and the Resident and Fellow Members, and the Representatives of the Subspecialties and Sections are now full participants in both the November and May Assembly meetings. In this way, and by encouraging District Branches and State Associations allotted new Representatives to seek diverse representation, the Assembly has sought to further the APA's strategic goal of "supporting and increasing diversity within APA."

The Assembly Executive Committee carefully and thoughtfully attended to the financial aspects of this Assembly reorganization, aiming to balance the competing pressures of the effective functioning of the Assembly as the most diverse and representative voice of the APA membership within governance with the broader interests of members, such as the cost of APA operations and the value of work products. The Assembly has yet to complete our work to provide predictable and consistent support to the Area Councils for their functions, including full incorporation of Minority and Underrepresented Groups and Subspecialties and Sections, as well as the Resident and Fellow Members and Early Career Psychiatrists, in the meetings and functions of the Area Councils between Assembly meetings.

How the Assembly participates in the budget process of the APA, and especially in its own part of the budget process, has varied from year to year. Of course, the Assembly has members on the APA Budget and Finance Committee, and on the APA Board of Trustees, which has full fiduciary responsibility for the Association's finances. But budget processes for the Assembly could be clearer and more standardized. Several years ago the Assembly instituted an Assembly Committee on APA Budget Planning, which was intended to participate at an early stage of planning of each annual APA budget. Mostly for practical timing reasons, this function was soon left to the Assembly Executive Committee. At a minimum, the Assembly leadership and Executive Committee should have annual institutionalized processes for Assembly budget development, including review of prior year expenses, which will enable the Assembly to take appropriate accountability for its costs and value. I have been working with the APA Administration, especially the Chief Financial Officer and Association Governance, to lay the foundation for a more predictable and transparent process for the future, and hope to complete this work within my year as Speaker.

As Speaker-Elect, I have been the Vice Chair of the Joint Reference Committee (JRC), chaired by our President-Elect Dr. Maria Oquendo. I believe that the JRC has continued to improve its oversight and

coordination of the work of the APA Councils and Committees on behalf of the Board of Trustees and the Assembly. The Position Statements of the APA, most often drafted by the Councils, are shared accountabilities of the Assembly and the Board of Trustees. All finalized Position Statements are available on the APA website.

In November, 2015, the Assembly approved the following Position Statements (among others), all of which were subsequently approved by the Board of Trustees:

- Opioid Overdose Education and Naloxone Distribution
- Substance Abuse Disorders in Older Adults
- Tobacco Use Disorder
- Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment
- Hypnosis (Revision)
- Telemedicine in Psychiatry (Revision)

During the May, 2016 Assembly meeting the Assembly will have considered the following Position Statements (again among others):

- Emergency Department Boarding of Patients with Acute Mental Illness
- Patient Access to Electronic Mental Health Records
- Trial and Sentencing of Juveniles in the Criminal Justice System
- Equitable Access to Quality Medical Care for Substance Related Disorders
- Integrated Care
- Off-Label Treatments
- Call to Action: Accountability for Persons with Serious Mental Illness (Revision)
- College and University Mental Health (Revision)

The Assembly will also again be considering revision of the APA Position on Direct to Consumer Advertising.

As the Assembly develops metrics to track its outcomes and value, it is likely that one of them will involve the Assembly's many contributions to the APA's Position Statements. We also aim in other ways to further the APA's Strategic Goals. As a trial initiative during my upcoming year as Speaker, for each of the Assembly's two meetings I will issue a call for Action Papers aimed at one of the APA Strategic Goals.

I thank the Assembly for the opportunity to have served as Speaker-Elect, and I thank the APA Officers, the Board of Trustees, and the Administration for all their support. I look forward with enthusiasm to this coming year as Speaker.

Joint Reference Committee
Report to Assembly
May 2016

The Joint Reference Committee (JRC) refers the following actions to the Assembly for consideration. The summary of actions from the January 2016 JRC meeting may be found as attachment #20.

Item 4.B.1 Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses (JRCOCT158.A.1; JRCJAN168.A.2) (Please see attachment #4.B.1)
Will the Assembly approve the proposed Position Statement: *Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.2 Proposed Position Statement: The Role of Psychiatrists in Assessing Driving Ability (JRCOCT158.E.1; JRCJAN158.E.2; ASMMAY154.B.8; JRCJAN168.E.1)
(Please see attachment #4.B.2)
Will the Assembly approve the proposed Position Statement on *The Role of Psychiatrists in Assessing Driving Ability* and if approved, forward it to the Board of Trustees for consideration?

The Council noted that input was received from the Council on Psychiatry and Law in the development of the statement and that the statement is consistent with the AMA guidelines on assessing driving ability?

Item 4.B.3 Proposed Position Statement: Patient Access to Electronic Mental Health Records (JRCOCT158.J.2) (Please see attachment #4.B.3)
Will the Assembly approve the proposed Position Statement: *Patient Access to Electronic Mental Health Records* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.4 Proposed Position Statement: Trial and Sentencing of Juveniles in the Criminal Justice System (JRCOCT158.J.3) (Please see attachment #4.B.4)
Will the Assembly approve the proposed Position Statement: *Trial and Sentencing of Juveniles in the Criminal Justice System* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.5 Retire 2005 Position Statement: Adjudication of Youths as Adults in the Criminal Justice System (JRCOCT158.J.4) (Please see attachment #4.B.5)
Will the Assembly retire the 2005 Position Statement: *Adjudication of Youths as Adults in the Criminal Justice System* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The 2005 Position Statement: *Adjudication of Youths as Adults in the Criminal Justice System* has been replaced by the proposed Position Statement: *Trial and Sentencing of Juveniles in the Criminal Justice System.*

Item 4.B.6 Retire Position Statement: Infectious Disease Epidemics Including H1N1 (JRCOCT158.L.2) (Please see attachment #4.B.6)
Will the Assembly retire the Position Statement: *Infectious Disease Epidemics Including H1N1* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The position statement is out of date as H1N1 is no longer an issue.

Item 4.B.7 Revised 2007 Position Statement: Sexual Harassment (JRCJUL158.J.2; ASMNOV154.B.9; JRCJAN166.15) (Please see attachment #4.B.7)
Will the Assembly approve the revised Position Statement: *Sexual Harassment* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The Joint Reference Committee revised the position so that the title and content were in parallel.

Item 4.B.8 Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders (JRCJAN168.A.1) (Please see attachment #4.B.8)
Will the Assembly approve the proposed Position Statement: *Equitable Access to Quality Medical Care for Substance Related Disorders*, and if approved, forward it to the Board of Trustees for consideration?

N.B. The JRC made a minor revision to the proposed position statement.

Item 4.B.9 Retain Position Statement: Any Willing Physician (JRCJAN168.B.1)
(Please see attachment #4.B.9)
Will the Assembly retain the Position Statement: *Any Willing Physician* and if retained, forward it to the Board of Trustees for consideration?

Rationale: Council members agreed that the intent of the statement is applicable to current issues concerning workforce and scope of practice.

Item 4.B.10 Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents (JRCJAN168.C.1) (Please see attachment #4.B.10)
Will the Assembly approve the revised Position Statement: *Psychiatric Hospitalization of Children and Adolescents* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The statement was revised as it was out of date, included inaccurate statements and did not highlight current concerns in the field. The Council has integrated the feedback and recommendations from the JRC into this version of the document.

Item 4.B.11 Proposed Position Statement: Integrated Care (JRCJAN168.G.1)
(Please see attachment #4.B.11)
Will the Assembly approve the proposed Position Statement: *Integrated Care* and if approved, forward it to the Board of Trustees for consideration?

Input on this position statement was provided by the Council on Psychosomatic Medicine, the Council on Healthcare Systems and Financing and its Work Group on Integrated Care.

Item 4.B.12 Proposed Position Statement on Off-Label Treatments (JRCJAN168.G.2)
(Please see attachment #4.B.12)
Will the Assembly approve the proposed Position Statement: *Off-Label Treatments* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.13 Retire Position Statement: Patient Access to Treatments Prescribed by Their Physicians (2007) (JRCJAN168.G.3) (Please see attachment #4.B.13)
If the proposed Position Statement: *Off-Label Treatments* is approved by the Assembly (see item 4.B.12), will the Assembly retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians* and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.14 Proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness (JRCJAN168.G.4) (Please see attachment #4.B.14)
Will the Assembly approve the proposed Position Statement: *Call to Action: Accountability for Persons with Serious Mental Illness* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.15 Retire Position Statement: A Call to Action for the Chronic Mental Patient (JRCJAN168.G.5) (Please see attachment #4.B.15)
If the proposed Position Statement: *The Call to Action: Accountability for Persons with Serious Mental Illness* is approved by the Assembly (see item 4.B.14), will the Assembly retire the Position Statement: *A Call to Action for the Chronic Mental Patient* and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.16 Proposed Position Statement: College and University Mental Health (JRCJAN168.J.1) (Please see attachment #4.B.16)
Will the Assembly approve the proposed Position Statement: *College University Mental Health* and if approved, forward it to the Board of Trustees for consideration?

N.B. this position statement replaces the 2005 position statement of the same name.

Item 4.B.17 Retire Position Statement: College and University Mental Health (JRCJAN168.J.1) (Please see attachment #4.B.17)
If the proposed Position Statement: *College and University Mental Health* is approved by the Assembly (see item 4.B.16) will the Assembly retire Position Statement: *College and University Mental Health* 2005 and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.18 Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research (JRCJAN168.L.1)
(Please see attachment #4.B.18)
Will the Assembly retain the Position Statement: *Conflict of Interests for Clinical Practice and Research* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.

Item 4.B.19 Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness (ASMMAY1512.S; JRCOCT156.13; JRCJAN168.K.1)
(Please see attachment #4.B.19)
Will the Assembly approve the proposed Position Statement: *Emergency Department Boarding of Patients with Acute Mental Illness* and if approved, forward it to the Board of Trustees for consideration?

Item 2016A1 4.B.1
Consent Calendar
Back-up (if removed): Reference Committee #1
Assembly
May 13-15, 2016

American Psychiatric Association
Position Statement

Title: **Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone With That Of Co-occurring Mental Illnesses**

Issue: The prevalence of Opioid Use Disorders (OUD) and the mortality from opioid overdoses continue to increase significantly in the United States. Buprenorphine is an approved and effective treatment for OUD, with special licensing requirements for the provider that prescribes it. Regional disparities in the supply of credentialed providers may impede access to care for many patients with OUD.
Patients with substance use disorders are twice as likely to suffer from a co-occurring mental illness as those without it and opioid use disorders are nine times more prevalent among patients with psychiatric comorbidities. While mental health comorbidities are associated with poorer outcomes, integrated treatment models have demonstrated improved quality of life, reduced illicit opioid use, and notable improvements in comorbidities, crime, and health costs. Recent and continuing changes in healthcare policy and cost prioritize the integration of evidence-based substance use disorders treatments into general medical settings.

For patients, access to treatment with buprenorphine is complicated due to the scarcity of buprenorphine waivered providers, low supply of opioid treatment programs, and the fact that general psychiatrists frequently opt out of providing buprenorphine treatment. In such cases, patients are often referred out to costly addiction treatment providers who typically offer medication with little or no wrap around services or no treatment at all for co-occurring mental disorders.

Position of the American Psychiatric Association:

1. The diagnosis and treatment of OUD are essential parts of psychiatric care. Patients with identified OUD should be educated about the condition and offered appropriate treatment.
2. The integration of care for OUD and co-occurring mental illnesses leads to improved patient care outcomes and should be practiced by general psychiatrists whenever possible.
3. Psychiatrists should be familiar with treatment options for OUD, manage uncomplicated patients with OUD, and seek consultation or referral with an addiction specialist for complicated cases.
4. Psychiatrists should complete training on the treatment of Opioid Use Disorder with buprenorphine and complete the additional licensing requirements to prescribe it.
5. In rural areas, consultation services with psychiatrists and addiction specialists should be made available via telemedicine to assist the local providers in treating complicated cases.

Background:
Over the past two decades, the prevalence of Opioid Use Disorders (OUD) has increased significantly in the United States [(1)]. While it is true that rates of heroin use have increased in many parts of the country, the most noteworthy factor driving these numbers is the dependence on narcotic pain medications [(2-5)]. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2013 national survey on drug use and health, 4.5 million Americans (1.7% of those older than 12 years old) were non-medical users of opioid pain medication, 289,000 or 0.1% of the overall

population used heroin in the past month and 681,000 or 0.2% used heroin in the past year. Overall, close to 2.5 million Americans meet diagnostic criteria for OUD [6]. Such trends correlate with mortality from opioid overdoses, whereby, in 2009, lethal overdoses from pain medications were reported four times more frequently than from heroin, a threefold increase since 1999 [5].

Effective treatments for OUD have been developed and are supported by the understanding that it is a chronic relapsing illness and aim at halting illicit opioid use. Medication assisted treatment using naltrexone, methadone, or buprenorphine is a very effective form of treatment for OUD. Buprenorphine is of particular interest in view of its less complicated prescribing and similar effectiveness compared to methadone [7]. Buprenorphine, a partial agonist at the *mu* opioid receptor, is a controlled Schedule III substance that was approved by the Food and Drug Administration (FDA) in October of 2002 for the treatment of OUD. Physicians can prescribe it after taking an eight-hour course and obtaining a special waiver [1].

Not unlike other substance use disorders, patients with OUD often suffer from co-occurring mental illnesses. In fact, SAMHSA estimates that 17.5% of those with a non-substance related mental illness have a substance use disorder, more than twice the rates among those who do not (6.5%). Similarly, 37.8% of those with a substance use disorder (7.7 million adults) suffered from a co-occurring mental illness, more than twice the rates among those without a substance use disorder (16.7%) [4]. In fact, heroin use is 9 times more prevalent among those with co-occurring mental illness (0.9 Vs 0.1%) [4]. Such findings bear clinical significance as dual diagnoses are associated with worse outcomes in terms of relapse rates, hospital admissions, aggression, imprisonment, homelessness, and infectious diseases such as HIV and HCV [8].

Individuals with co-occurring OUD and other mental illnesses have been shown to require more costly crisis oriented services including admissions to emergency departments, inpatient psychiatric units, and the criminal justice system [9]. Conventionally, such individuals receive treatment from at least two parallel systems: one for their OUD, often using buprenorphine, and another for their other mental illnesses. This parallel but non-integrated treatment approach undermines the benefits of an integrated treatment program.

Dual diagnosis treatment models have been developed to address the fragmentation of care for those with a SUD with a co-occurring mental illness. Such models appear to address the difficulties that patients could face by navigating separate health systems. These patients often get non-concordant opinions on recovery and are being excluded from one system because of their co-morbid disorder [8]. Multiple controlled studies have demonstrated improved outcomes in treatment models that rely on multidisciplinary treatment teams for a comprehensive approach to providing clinical and psychosocial services, as compared to non-integrated programs [8]. A longitudinal study comparing integrated treatment models to parallel models found that the former leads to improved quality of life, reduced symptoms of co-occurring mental illness, increased engagement in treatment and employment rates, and a reduction in substance use. This study also showed a reduction in positive drug tests, hospitalization rates and number of hospital days, felony or misdemeanor arrests, probation violation, and days of incarceration. In addition, the integrated model was found to be advantageous from a financial point of view as it led to overall reduction in expensive crisis-oriented services [10]. One study specifically investigated the effects of integrating buprenorphine treatment in patients with HIV and demonstrated improved outcomes in terms of continued substance use and compliance with treatment both for OUD and HIV [11].

For patients, access to treatment with buprenorphine often proves to be difficult as there is a lack of

buprenorphine providers. Currently, fewer than 3% of physicians in the US are licensed to prescribe buprenorphine [12]. Contributing factors include the required eight hours of training, the limits on the numbers of patients a provider can treat with buprenorphine at any given time, and the fact that it is not uncommon for physicians to opt out of buprenorphine treatment due to stigma, insufficient training, and lack of institutional support. A survey of buprenorphine providers in Washington State reported that psychiatrists constitute only 29.5% of the overall pool, and 0% in rural areas, where primary care physicians were virtually the only providers licensed to prescribe, leading to added hurdles for the treatment of complicated patients with dual diagnoses [13]. A recent national analysis of buprenorphine prescribing in the decade after it was approved by the FDA (from 2003 to 2013) found that while the number of prescriptions increased 13 fold (from 0.16 million to 2.1 million prescriptions), and that prescribing by primary care physicians increased from 6.0% to 63.5%, buprenorphine prescribing by psychiatrists decreased from 92.2% to 32.8% [1]. Many buprenorphine providers opt out of health insurance plans and patients end up in programs that charge fees that many cannot afford. As a result, many individuals relapse to the abuse of opiates. In urban areas, buprenorphine providers are four times more likely to work in a private practice setting rather than in a safety net setting where patients with OUD are more commonly receiving treatment, opposite the trend in rural areas [13]. A study examining empirically whether to separate treatment of SUD and psychiatric disorders found no evidence in support of having different providers, adding to the evidence for continued integrated care [14]. A survey of non-psychiatric physicians who received training to use buprenorphine revealed that almost three quarters were not prescribing it, and that a lack of mental health and psychosocial training and support was the most commonly reported barrier among those who prescribe and among those who do not prescribe buprenorphine [15].

References:

1. Turner L, Kruszewski SP, Alexander GC. Trends in the Use of Buprenorphine by Office-Based Physicians in the United States, 2003–2013. The American Journal on Addictions, 24: 24–29, 2015
2. Manchikanti L, Singh A. Therapeutic opioids: A ten-year perspective on the complexities and complications of the escalating use, abuse, and nonmedical use of opioids. Pain Physician. 2008;11:S63–S88.special issue.
3. Johnston LD, O'Malley PM, Bachman, et al. Monitoring the future: National results on adolescent drug use overview of key findings. http:// monitoringthefuture.org/pubs/monographs/mtf-overview2011.pdf
4. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
5. Calcaterra S, Glaz J, Binswanger IA. National trends in pharmaceutical opioid related overdose deaths compared to other substance related overdose deaths: 1999–2009. Drug Alcohol Depend. 2013;131:263–270.
6. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
7. MattickRP, BreenC, KimberJ, DavoliM. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.
8. Drake RE, Essock SM, Shaner A, et al. Implementing Dual Diagnosis Services for Clients With Severe Mental Illness. Psychiatric Services. 2001;52:469–476.

9. Drake RE, Bartels SJ, Teague GB, et al. Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease. 1993;181:606–611.
10. Mangrum LF, Spence RT, Lopez M. Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. Journal of Substance Abuse Treatment. 2006;30:79–84
11. Weiss L, Netherland J, Egan JE, et al. Integration of Buprenorphine/Naloxone Treatment into HIV Clinical Care: Lessons From the BHIVES Collaborative. J Acquir Immune Defic Syndr 2011;56:S68–S75
12. http://www.naabt.org/tl/buprenorphine-suboxone-treatment.cfm.
13. Kvamme E, Catlin M, Banta-Green C, et al. Who prescribes buprenorphine for rural patients? The impact of specialty, location and practice type in Washington State. J Subst Abuse Treat. 2013;44(3):doi:10.1016/j.jsat.2012.07.006.
14. Ramchand R, Griffin BA, Slaughter ME, et al. Do improvements in substance use and mental health symptoms during treatment translate to long-term outcomes in the opposite domain? Journal of Substance Abuse Treatment. 2014;47: 339–346
15. Hutchinson E, Catlin M, Andrilla CHA, et al. Barriers to Primary Care Physicians Prescribing Buprenorphine. Ann Fam Med. 2014;12(2):128-133.

Item 2016A1 4.B.2
Consent Calendar
Back-up (if removed): Reference Committee #1
Assembly
May 13-15, 2016

POSITION STATEMENT: THE ROLE OF PSYCHIATRISTS IN ASSESSING DRIVING ABILITY

BACKGROUND INFORMATION

The symptoms of psychiatric disorders, including major neurocognitive disorders (i.e., dementia), may in some cases interfere with the ability of patients to anticipate danger and avoid safety hazards, including those encountered while driving. Furthermore, the medications prescribed to ameliorate psychiatric symptoms may cause drowsiness and/or otherwise compromise the ability of patients to drive safely. Psychiatrists should therefore be aware of the possibility that their patients may be unable to drive safely and should be prepared to advise their patients and their caregivers that they should find alternatives to driving. Laws vary from state to state as to whether physicians, including psychiatrists, are obligated to inform the appropriate state agency if they believe that it is unsafe for their patients to operate a motor vehicle.

POSITION STATEMENT

The presence of a mental or neurocognitive disorder does not in itself signify impaired driving capacity. Nonetheless, persons suffering from mental disorders may experience symptoms that interfere with their ability to operate motor vehicles safely. Accurate assessment of the impact of symptoms on functional abilities usually is not possible in an office or hospital setting because such an assessment typically requires specialized equipment or observation of actual driving, which goes well beyond the scope of ordinary psychiatric care. However, psychiatrists may discover impairments affecting driving ability in the course of a comprehensive psychiatric evaluation, including an assessment of cognition.

Therefore, psychiatrists do have a role in advising patients about the potential impact of their illnesses and treatments on driving ability. When appropriate, psychiatrists should discuss with patients, caregivers, and family members symptoms of their patients' mental disorders that may substantially impair driving ability. Like all physicians, psychiatrists should warn their patients about the possible effects of medications, including psychotropic medications, on alertness and coordination. When clinically appropriate, medication with low potential for impairing driving ability should be chosen preferentially, taking into account the patient's driving requirements and habits.

Maintaining confidentiality in physician-patient relationships is important. At the same time psychiatrists should follow the laws in their state regarding reporting information on their patients' driving ability to the appropriate authority. Ultimately the responsibility for assessing driving ability resides with the Department of Motor Vehicles or other appropriate state agency. In states where reporting is not mandatory, reports made in good faith should be accompanied by immunity for psychiatrists from subsequent liability.

Developed by the Council on Geriatric Psychiatry

Item 2016A1 4.B.3
Consent Calendar
Back-up (if removed): Reference Committee #2
Assembly
May 13-15, 2016

Proposed Position Statement on Patient Access to Electronic Mental Health Records
Draft September 15, 2015

Systems that provide patients with online access to their mental health records should implement appropriate procedures and safeguards. These include:

(a) methods for ensuring that treating psychiatrists in the system are notified when patients access their records,
(b) methods for ensuring that information likely to result in harm to the patient or others will not be disclosed,
(c) methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed,
(d) methods for facilitating patients' comprehension of disclosed information, and
(e) methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist.

Background

"Health records" refers to evaluations, progress notes, discharge summaries, and other clinical documentation that is created by health professionals for the purpose of evaluation and treatment for a specific patient. As established by law, patients have a right to access their health records.[1]

Health care systems, including the Veterans Administration health care system, have begun to allow patients to access their treatment records online. This development has raised concerns.

In the past, patients' access to their medical information required physical access to a paper record. Typically, patient access would occur following a request to an individual psychiatrist or, in institutional settings, the medical records department. Medical records departments

[1] The HIPAA Privacy Rule provides an exception to patients' right to access for "psychotherapy notes." As defined by the Rule, psychotherapy notes are those notes made by mental health professionals documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. To qualify as psychotherapy notes, the documentation must exclude information regarding medication prescription and monitoring, counseling session start and stop times, the modalities of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. HIPAA-defined psychotherapy notes are not equivalent to psychotherapy progress notes - they are akin to process notes. State laws may grant patients the right to greater access; psychiatrists should familiarize themselves with the laws of their jurisdiction.

generally have followed the practice of obtaining the treating psychiatrist's approval prior allowing patients access. In many settings, the treating psychiatrist or a colleague would be present or available while the patient reviewed their information. These procedures provided an opportunity for the psychiatrist to review the available records, to restrict access to information as appropriate, and to be available to address questions, concerns, or emotional reactions that may arise.

The establishment of electronic medical records in some medical care systems has led to the availability of online access to personal medical records.

Patient access to information may benefit the therapeutic process in a number of ways:

- Online access provides a written source of information to patients about their care that can serve as valuable aid to memory. Patients can review the directions and other information from prior visits. This may lead to improvements in patient education and compliance.
- Access to the records provides an opportunity for patients to review documentation for accuracy and completeness.
- Ready patient access to records may promote active patient engagement in treatment. In reviewing the records, patients may gain a greater understanding of the information their psychiatrists have conveyed to them. The documentation may provide additional perspectives regarding their diagnoses, treatments, and treatment options. As a result, patients may have questions to discuss with their psychiatrists. Such discussions are important therapeutic opportunities that provide the psychiatrist with insight into their patients' hopes, fears, and concerns about their illness, treatment, and prognosis.
- Patients may use online access to facilitate the transfer of information from a past treatment episode to a new treating clinician. This may be an important as a means of providing continuity of care. Also, in emergencies, online access may be a means of conveying critical information.
- Online access to past records may be valuable to patients who have become estranged from care. Patients who review past treatment records may gain insight that will prompt them to seek ongoing care.

However, there are potential problems with online access to psychiatric records that require safeguards. These safeguards are discussed below:

(a) There should be methods for ensuring that treating psychiatrists in the system are notified when patients access their records

Electronic medical record systems with online portals enable patients to access their medical records, in any location, and at any time. As a result, psychiatrists may not be aware that their patients have accessed records. In some cases, patients may be affected by what they have read; their attitude toward treating psychiatrists and treatment may be changed. In the absence of notification of patient access, psychiatrists may miss the opportunity to clarify misunderstandings. As a result, the therapeutic relationship may be adversely affected. Psychiatrists should be notified when their patients access records.

(b) There must be methods for ensuring that information likely to result in harm to the patient or others will not be disclosed

Some patients may have extremely negative reactions to the recorded information to such an extent that their life or safety, or the life or safety of someone else, may be endangered. Medical records systems that permit online patient access should allow for this sort of sensitive information to be protected from viewing.

(c) There should be methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed

Patients may get inappropriate access to information. For example, a family member or other party may have given the psychiatrist information regarding the patient under the promise of confidentiality. Record systems that are accessible to patients should have the capability of blocking this information from viewing.

(d) There should be methods for facilitating patients' comprehension of disclosed information

Patients who access records may be confused by what they read or misinterpret documentation. Confusion may be lessened if the patient has ready access to online sources of information regarding psychiatric terminology and abbreviations commonly used in medical records. However, they may be no adequate substitute for a psychiatrist's explanation of the clinical notes and related documentation. The treating psychiatrists, of course, will be the best guides for their patients. Treating psychiatrists can explain their intents in writing the documentation and how they employed medical terminology and abbreviations in context. Systems should include information about abbreviations and terms. As previously discussed above, treating psychiatrists should be notified so that they can follow up with their patients to address any questions.

(e) There should be methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist

In some settings, it may be possible for inpatients to access their records during the course of hospitalization. Given the probability that psychiatric inpatients are acutely ill, and that the information accessed will include recent notes by psychiatrists, nurses, and other staff that may be disturbing to patients during acutely symptomatic periods, immediate access should not be routinely granted. As psychiatrists and other treatment staff are readily available, access should be granted by clinical discretion and, when deemed necessary, under the supervision of treatment providers. In cases in which there are disputes about access, resolution via mechanisms such as patients' ombudsmen, offices of patients' rights, or similar bodies should be available.

Documentation

If safeguards are not in place to prevent inappropriate access to information, clinicians may intentionally restrict the scope and detail of documentation to that which is minimally

necessary. As a result, allied caregivers and subsequent treating psychiatrists may not have access to a rich record of treatment. This unintended outcome may be prevented by ensuring that electronic health records provide a mechanism to maintain highly sensitive information in a domain that is not generally accessible to patients through online access. Documenters need to be sensitive about language and clinical descriptions within their documentation. Additional education about patient-sensitive documentation may be necessary.

Developed by the Workgroup on Access to Mental Health Records, Council on Psychiatry and Law. Grace Lee, MD (Chair), Elizabeth Ford, MD, Mark Komrad, MD, Steven Daviss, MD, Andrea Stolar, MD, Jenny Boyer, MD, Richard Milone, MD, and Brenda Jensen, MD.

Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System

Juvenile justice systems in the United States are undergoing substantial reform based on impressive advances in neurobehavioral understanding of adolescent development and on strong evidence regarding the effectiveness of developmentally grounded interventions. This body of knowledge has been summarized in a landmark report of the National Research Council (2013) and referenced by the Supreme Court in important decisions banning the juvenile death penalty (*Roper v. Simmons*, 2005) and severely restricting sentences of life without parole (*Graham v. Florida,* 2010; *Miller v. Alabama*, 2012). Despite these developments, statutes in many states permit or even require adolescents charged with crimes to be tried in criminal courts as adults, thereby becoming exposed to substantial terms of imprisonment

It is the position of the American Psychiatric Association that juvenile courts should have exclusive original jurisdiction in all cases in which individuals less than age 18 have been charged with a criminal offense. The law should presume that the youth will remain within the jurisdiction of the juvenile court unless the prosecution presents a clear and convincing case for transferring the case to the criminal court. Transfer should be permitted only if a youth is older than 14 at the time of the offense, has been charged with a violent crime, and the juvenile court finds, based on individualized consideration of all of the circumstances, that the youth poses a significant risk of further offending and has demonstrated that he or she is not amenable to treatment with the range of clinically appropriate services that should be available to the juvenile justice system.

Background:

Juvenile transfer laws, also known as waiver or certification laws, transfer an individual less than age 18 and charged with an offense from the juvenile court system to the adult criminal justice system for trial and sentencing. There are three main transfer mechanisms: (1) judicial waiver laws that permit or mandate judges to decide, in accordance with statutory criteria, whether a youth should be removed from juvenile court jurisdiction and tried in adult court; (2) concurrent jurisdiction laws that authorize prosecutors to file a case in criminal court; and (3) statutory exclusion laws that grant criminal courts original jurisdiction over juveniles who meet

defined criteria (e.g. specific crime type committed by a youth of a particular age). Transfer laws of all types expanded significantly during the 1980s and 1990s and played a significant role in placing increasing numbers of youth in the adult criminal justice system (Hockenberry and Puzzanchera 2014).

The vast majority of adolescents with antisocial behavior desist from criminal behavior as they enter adulthood. Even serious juvenile offenders demonstrate an increasing ability to control impulses, suppress aggression, consider the impact of their behavior on others, take personal responsibility for their actions, and resist the influence of peers between the ages of 14 and 25. (Steinberg, Cauffman, and Monahan 2015). Multi-faceted community interventions, both residential and non-residential, available to juvenile courts have been shown to reduce reoffending and to prodeuce remarkably large economic returns relative to their costs (National Research Council, 2013).

Potentially detrimental effects of transfer include a longer or harsher sentence than may have been experienced by the juvenile if maintained in the juvenile justice system, physical, sexual, or psychological victimization from adult inmates or correctional officers, and harmful disruptions in the youth's developmental progress and to the process of forming identity and a responsible, law-abiding person (Mulvey and Schubert 2012). In addition, many juveniles who are tried in adult court will have a higher recidivism rate when compared to similarly matched juveniles adjudicated in the juvenile justice system (National Research Council, 2013; Schubert et al 2010). Finally, transfer for less serious crimes may result in stigma combined with the substantial economic cost of housing juveniles with adult offenders.

References:

Graham v. Florida, 130 S. Ct. 2011 (2010)

Hockenberry S, Puzzanchera C. Delinquency cases waived to criminal court 2011. Juvenile Justice Bulletin: U.S. Department of Justice, December 2014

Miller v. Alabama, 132 S. Ct. 2455 (2012)

Mulvey AP, Schubert CA. Transfer of juveniles to adult court: effects of a broad policy in one court. Juvenile Justice Bulletin: U.S. Department of Justice, December 2012

National Research Council (Bonnie, R., Johnson, R., Chemers, B., and Schuck, J., eds). Reforming Juvenile Justice: A Developmental Approach. National Academies Press 2013

Roper v. Simmons, 541 U.S. 1040 (2005)

Schubert CA, Mulvey EP, Loughran TA, et al: Predicting outcomes for youth transferred to adult court. Law Hum Behav 34:460-75, 2010

Steinberg L, Cauffman E, Monahan KC: Psychosocial maturity and desistance from crime in a sample of serious juvenile offenders. Juvenile Justice Bulletin: U.S. Department of Justice, March 2015

APA Official Actions

Position Statement on Adjudication of Youths as Adults in the Criminal Justice System

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

The ostensible goals of transfer, or waiver, to the criminal justice system include: (1) deterrence of youth from committing crimes, (2) reduction in recidivism among youth who are transferred, and (3) improvement of public safety. However, instead of accomplishing their intended goals, waivers have seriously disrupted the lives of youth, and their families, especially those from minority communities. The federal government, in concert with states, should review and develop a strategy to reform current transfer/waiver practices. The general goals of such reform must be: to reduce the number of youth inappropriately transferred to the criminal justice system who could be better served by the juvenile justice system, to provide rehabilitation services that support the development of youth as valued members of society, and to ensure community safety. Reform should specifically include:

1. a moratorium on the expansion of eligibility criteria for transfer.
2. limiting transfer only to judicial discretion (or sole authority by judge).
3. an elimination of transfers for nonviolent offenders.
4. an elimination of transfer of first-time offenders.
5. the development of specialized facilities for transferred youth. Such facilities would include small living units that are secure and safe; programming that addresses the developmental, educational, health, mental health, religious, and other special needs of these youth; and
6. adequately staffed with qualified workers to ensure safety and specialized programming (Council of Juvenile Correctional Administrators, 2005).

APA Official Actions

Position Statement on Infectious Disease Epidemics Including H1N1

Approved by the Board of Trustees, May 2010
Approved by the Assembly, November 2009

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Developed by the Council on Research and Quality Care.

ISSUE: As the nation faces the onset of seasonal flu season and H1N1 continues to spread the APA acknowledges the increasing impact this will continue to make on the community. Many populations are vulnerable due to their situation, disease or socioeconomic position. Additionally individuals in schools and institutions are at additional risk due to their close proximity with each other.

POSITION STATEMENT:

With the infectious diseases such as H1N1 APA strongly supports:

1. Increased collaboration between psychiatry and primary care and public health to foster adherence, behavioral and medical interventions including psychiatric care for those exposed and infected.
2. Active and rapid planning for the special needs of vulnerable populations. In particular care and outreach is critically important for children; child and adult psychiatric patients, particularly those with chronic mental illnesses; those infected with HIV; schools; pregnant women; and the elderly.

The APA encourages psychiatrists and others to stay informed of the CDC guidelines and the vaccine recommendations in the statement.

Item 2016A1 4.B.7
Consent Calendar
Back-up (if removed): All Areas/Groups: Primary- Area 1, Secondary- ACROSS
Assembly
May 13-15, 2016

Position Statement on Sexual Harassment

Approved by the Board of Trustees, June 1992
Approved by the Assembly, May 1992
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA opposes and condemns all forms of sexual harassment ~~in the workplace;~~ and ~~further votes to~~ will advocate and lobby for legislative and judicial action to recognize and facilitate any necessary treatment for victims of sexual ~~workplace~~ harassment.

Revised by the Joint Reference Committee – January 2016

Item 2016A1 4.B.8
Consent Calendar
Back-up (if removed): Reference Committee #1
Assembly
May 13-15, 2016

Proposed Position Statement
American Psychiatric Association

Title: Equitable Access to Quality Medical Care for Substance Related Disorders

Issue: Persons with substance related disorders have often been excluded from both medical treatment and medical coverage by insurance companies due to false beliefs that (1) there is no efficacious treatment, and (2) providing medical coverage for substance related disorders on par with medical disorders would result in skyrocketing health care costs. Given the prevalence of substance related disorders and the morbidity, mortality and costs associated with them, they can no longer be ignored or excluded.

Position Statement:

- All substance related disorders are diagnosable mental illnesses for which effective treatments are readily available.
- APA opposes the exclusion of substance related disorders from legislation or programs that pertain to parity of insurance coverage, access to health care services, and quality of care.
- Access must be expanded to effective prevention and treatment for substance related disorders, including medication assisted treatment others, are not subject to the same restricted limits on access to and coverage of care as are substance related disorders.
- It is discriminatory and contrary to the scientific findings of the clinical, research, health economics and policy communities to exclude substance related disorder diagnoses and patients with these diagnoses and to limit access to effective behavioral and medication assisted treatments.

Background:

Roughly 21.6 million people ages 12 and over in the United States were classified with substance abuse or dependence in 2013.[(1)] There is a large body of evidence that confirms both the biological underpinnings of these illnesses as well as the high rates of Substance Use Disorder treatment success.[(2,3-9)] A 1996 report of the National Treatment Improvement Evaluation Study (NTIES) demonstrated that 12 months after treatment completion, there were substantial reductions in the use of substances as well as other gains in employment, declines in criminal activity, and decreases in alcohol and drug related medical visits.[(7)] Yet, only 4.1 million people (19%) received treatment for alcohol or illicit drug use problems and only 2.5 million people (12%) received treatment in a specialty setting in 2013, which represents a consistently large gap in the number of people needing treatment and those who receive it.[(1)]

In 2008, the US Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which required health insurers to provide equal coverage for mental health and substance use disorder (SUD) services and general medical services. It also prohibited health plans from using nonquantitative treatment limitations (NQTL) such as medical necessity, prior

authorization, and utilization review that are more restrictive than those used for medical/surgical health benefits. The Affordable Care Act (ACA) of 2010 added to that by expanding the parity requirement to Medicaid and Medicaid-managed plans, as well as state health insurance exchange plans. It also mandated that coverage for SUD treatment be included in health plans as an essential health benefit, equivalent to that provided for medical and surgical treatment. Historically, employers and health insurers have stated concerns about the implementation of parity regulations; that it would result in significant increases in healthcare costs.[10] While many studies exploring the effect of state-level parity mandates prior to MHPAEA have shown this not to be the case [2,11-14], a more recent study exploring the effect of the addition of NQTL have confirmed these findings. The study explored Oregon's 2007 state parity law, which is similar to MHPAEA in that it also limits use of NQTL for behavioral health that is not on par with medical and surgical services, and found that spending on drug abuse treatment was not associated with statistically significant spending increases.[15] Furthermore, a study that explored the effect of the MHPAEA on costs associated with treatment of SUD in a large health plan provider across 10 different states found only a modest increase of $9.99 per enrollee.[16]

While the effects of parity have not resulted in a significant increase in healthcare costs, neither has it resulted in an substantial increase in utilization of substance use disorder treatment services which is needed to close the aforementioned treatment gap [16-18], nor has it extended access to effective behavioral and medication assisted treatment for substance use disorders.[19] Another significant barrier to care is societal stigma and the internalization of that stigma by those who suffer from these disorders.[2] Such internalization may deter individuals from seeking care. On the other hand, legislation of full parity, as well as implementation of enhanced access to effective treatment including behavioral and medication assisted treatments, for those with both mental health and substance related disorders can send a strong message to the public that these are medical disorders for which effective and evidence-based treatments exist, and that these treatments are offered within a health care system that provides equivalent care for all disorders whether they be medical, surgical, or psychiatric, including all substance related disorders.

References:

1. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
2. Hennessy KD, Goldman HH. Full Parity: Steps toward treatment equity for mental and addictive disorders. Health Affairs. 2001;20:58-67.
3. Leshner Al. Addiction is a brain disease and it matters. Science. 1997;278:45-47.
4. Leshner AI. Science-based views of drug addiction and its treatment. JAMA.1999;282:1314-1316.
5. O'Brien C.P. A range of research-based pharmacotherapies for addiction. Science. 1997;273:66-70.
6. O'Brien C.P. Myths about the treatment of addiction. Lancet. 1996;347:237-340.
7. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. The National Treatment Improvement Evaluation Study: Preliminary Report: The Persistent Effects of Treatment - One Year Later, September, 1996.
8. McLellan AT, et al. Evaluating the effectiveness of addiction treatments: Reasonable expectations: Appropriate comparisons. Milbank Quarterly. 1996;74:51-85.
9. National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research-Based Guide, NIH Publication Number 99-4180, October, 1999.
10. Busch SH. Implications of the mental health parity and addiction equity act. AJP. 2012;169:1-2.

11. Sing M, Hill SC. The costs of parity mandates for mental health and substance abuse insurance benefits. Psychiatric Services. 2001; 52:437-440.
12. Kirschstein RI. Insurance parity for mental health: Cost, access, and quality. Final Report to Congress by the National Advisory Mental Health Council, NIH Pub no. 00-4787, Bethesda, MD: National Institutes of Health, June, 2000.
13. Sturm R, Zhang W, Schoenbaum. How expensive are unlimited substance abuse benefits under managed care? Journal of Behavioral Health Services and Research. 1999; 26:203-210.
14. Sturm R, Pacula RL. State mental health parity laws: Cause or consequence of differences in use? Health Affairs. 1999; 18:182-192.
15. McConnell KJ, Ridgely MS, McCarty D. What Oregon's parity law can tell us about the federal Mental Health Parity and Addiction Equity Act and spending on substance abuse treatment services. Drug and Alcohol Dep. 2012; 124:340-346.
16. Busch SH, Epstein AJ, Harhay MO, et al. The effects of federal parity on substance use disorder treatment. Am J Managed Care. 2014; 20:76-82.
17. Capoccia VA, Grazier KL, Toal C, et al. Massachusetts' experience suggests coverage alone is insufficient to increase addiction disorders treatment. Health Affairs. 2012; 31:1000-1008.
18. Wen H, Cummings JR, Hockenberry JM, et al. State parity laws and access to treatment for substance use disorder in the United States: Implications for federal parity legislation. JAMA Psychiatry. 2013;70:1355-62.
19. Pating DR, Miller MM, Goplerud E, et al. New systems of care for substance use disorders: Treatment, finance, and technology under health care reform. Psychiatr Clin N Am. 2012; 35:327-356.

Developed by the Council on Addiction Psychiatry

Item 2016A1 4.B.9
Consent Calendar
Back-up (if removed): All Areas/Groups: Primary- Area 3, Secondary- M/URs
Assembly
May 13-15, 2016

Position Statement on Any Willing Physician

Approved by the Board of Trustees, July 1995
Approved by the Assembly, May 1995
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA believes that treatment by a non-medical licensed professional cannot substitute for medical treatment by a physician.

Accordingly, the APA supports "any willing physician" legislation which requires any public or private third party payer, health plan, or organized system of health care (hereinafter referred to as "payer") to contract with any duly licensed physician who is willing to accept the payer's published criteria, terms and conditions for participation and payment for the medical treatment for which the payer is responsible.

However, the APA recognizes that the concept of patient freedom-of-choice and the concept of an affordable point-of-service option may be superior to "any willing physician" in their value to physicians and patients.

PROPOSED Final Draft Revision to Position Statement on Psychiatric Hospitalization of Children and Adolescents December 16, 2015

ISSUE:

In America today, many children and adolescents who suffer from mental health and behavioral disorders are not able to access appropriate mental health care due to the nationwide shortage of inpatient mental health services for their age group. Inpatient psychiatric hospitalization is often necessary to evaluate, acutely stabilize, treat and transition children and adolescent patients who present to emergency facilities in crisis. The CDC approximates that, each year, approximately one in five children in the United States experiences a seriously debilitating mental illness described as "serious deviations from expected cognitive, social, and emotional development". It is estimated that up to 12 million children in the U.S. under the age of 18 suffer from mental illnesses that include depression, anxiety, PTSD, mood disturbances, eating disorders, substance use, psychosis and suicidal ideation.

The nationwide shortage of inpatient mental health services for children and adolescents can be attributed to several factors including the overall decrease in psychiatric hospitals and long-term facilities from the 1960s to the present. Ninety five percent of public psychiatry beds available in 1955 were no longer available as of 2005. Currently, the majority of states in America have less than half the number of public psychiatry beds needed to serve community mental health needs due to the continued closing of inpatient units triggered by cost cutting measures by hospital systems. As a result, children and adolescents are often kept for long periods of time in Emergency Departments awaiting placement for long term or inpatient care. If an inpatient bed is found, these individuals may be sent to distant hospitals making it difficult for parents and families to visit, provide support and participate in the treatment process. More often, due to lack of facilities, children and adolescents are sent home with their families to wait for outpatient follow up. It is estimated that only 21% of children and adolescents receive care for their symptoms due to the lack of appropriate mental health facilities, and wait times often range from three months up to one year for assessment and treatment. Without appropriate inpatient psychiatric hospitals and adequate treatment facilities, many children and families do not receive appropriate intervention and treatment and are left to suffer from untreated and under-treated mental illness.

The consequence of untreated mental health illness in children and adolescents can be devastating for patients and their families. More adolescents die by suicide than all other natural causes combined. According to The Academy of Child and Adolescent Psychiatry, approximately 50% of students aged 14 and older with mental illness drop out of high school—the highest dropout rate of any disability group. 70% of youth in state and local juvenile justice systems have mental illness, with at least 20% experiencing severe symptoms. These youth are often diverted into the juvenile justice system for treatment and management of their mental illnesses due to a lack of alternative mental health care options which, consequently, can have numerous negative repercussions including worsening of mental illness and recurrent or long-term incarceration. These statistics attest to the importance of early intervention and treatment for all children and adolescents with mental illness symptoms. With additional inpatient and hospital-based resources, providers will be able to reduce the long-term sequelae of untreated mental health in the juvenile population.

APA POSITION:

It is the position of The American Psychiatric Association to:

1) **Advocate for the development of a full spectrum of appropriate, financially affordable, inpatient facilities and services for the diagnosis and treatment of children and adolescent in need of psychiatric care in the United States. These facilities are to include both psychiatric and general medical hospitals. Efforts should be focused on both increasing current inpatient services and also minimizing the current trend of closing existing units due to financial reasons.**
2) **Emphasize that the health of children and adolescents will be best served if primary treatment decisions such as admissions, medications, psychotherapy and appropriate disposition planning are the responsibility of a psychiatrist specialized in child and adolescent psychiatry whenever available.**
3) **Emphasize that, when possible, inpatient psychiatric hospitalization of children and adolescents should be provided close to their homes, so that their families may be included and participate during the treatment process**
4) **Work to provide parity in mental health treatment for all age groups by increasing mental health resources for children and adolescents and subsequently providing opportunities for early treatment and intervention to benefit young patients suffering from mental illness.**
5) **Work to educate the public and health care community that inpatient psychiatric care is necessary and justified when psychiatric illness severely affects a young person's safety or ability to function.**
6) **Address the shortage in Child and Adolescent Psychiatrists by recruiting psychiatrists-in-training and early career psychiatrists into specialized training**

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American Psychiatric Association

[Proposed] Position Statement on Integrated Care

January 2016

Issue: The American Psychiatric Association (APA) recognizes the well documented impact of untreated behavioral health conditions on outcomes, total healthcare expenditures and the patient care experience. Enhancing health care quality, access and value, including psychiatric services, requires employing new models of care with organized, proactive approaches to individuals' and populations' health. Patients with behavioral health conditions present in all sectors of the health care system and the APA can provide vital input in designing evidence-based approaches that provide comprehensive, high quality health care to the populations they serve while judiciously allocating precious healthcare resources.

It is the position of the APA that:

- Five Core Principles of Effective Integrated Care[1] are founded in the Wagner Chronic Care Model[2] and should serve as a guide for implementing and designing programs:

    1. Team-Based: Care is patient-centered and provided by teams using shared care plans. Effective teams in the primary care setting include at a minimum primary care providers, behavioral care managers and psychiatric consultants. Careful attention to cultural differences and change management are crucial to success.
    2. Population-Based: Patient populations are defined in advance, screened and triaged for targeted illnesses and/or health complexity, tracked in databases (referred to as registries), and followed for adherence and response to treatment. Caseloads are regularly reviewed for patients who have not followed-up and those who continue to have significant symptoms.
    3. Measurement-Based treatment to target: Outcomes are regularly measured using patient and illness-specific assessment tools (standardized when possible) and treatment adjustments made when improvement is not occurring. This is an iterative process until health stabilizes at a desired level (treatment to target).
    4. Evidence-Based: Treatments with evidence of effectiveness are used first, including evidence-based brief psychosocial interventions and/or pharmacotherapy proven to work in the primary care setting, followed by secondary and tertiary interventions if the initial treatment is ineffective.
    5. Accountability and Quality Improvement: Systems adopting the above elements track quality of care and outcome measures that allow for quality improvement and accountability during implementation and ongoing practice.

- In the Primary Care setting, the APA recognizes a model of integrated care known as the *Collaborative Care Model* (CoCM) as the most effective approach with demonstrated positive outcomes and cost containment across different mental health diagnoses and treatment locations[3]. This model enables enhanced access to the available psychiatric workforce to provide more optimal care outside of traditional psychiatric settings. There are other practice tested approaches that have merit but currently have a more limited

[1] http://aims.uw.edu
[2] Wager EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Q 1996; 74:511–544
[3] Archer J, Bower P, Gilbody S, et al: Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012;10:CD006525

research base. Utilization of blended models with adaptation to local practice conditions is common and may eventually merge with the CoCM model.

- In Critical Care/Medical/Surgical settings, the APA supports the use of evidence-based models of care to improve total health outcomes, reduce admissions, readmissions, and lengths of medical/surgical hospitalization, and to promote health stabilization in inpatients with medical complexity.
- In the Public Mental Health sector, the APA will advocate aggressively for efforts to develop effective models to address the physical health disease burden and subsequent 20-30 year mortality gap experienced by psychiatric patients with serious mental illnesses ("reverse integration"). Successful models are emerging that include nurse care managers and an emphasis on health behavior change in a behavioral health home setting. There is a responsibility to monitor and address chronic medical conditions associated with mental illness and psychotropic medications. The APA will support the efforts of psychiatrists to utilize their full range of medical training to oversee the total health needs of patients.
- The APA must be at the forefront of supporting the development of best practices in integrated care. Psychiatrists utilize unique skills among behavioral health professionals, including knowledge about the interaction of medical and behavioral conditions. This approach supports effective patient-centered care and the ability to successfully treat psychiatric symptoms in the face of comorbid medical/surgical conditions. As a result, the APA will marshal its resources in education, research and advocacy to prepare psychiatrists for new roles in providing patient-centered outcome changing integrated health care.
- The APA will work with relevant payer, stakeholder and health systems to find sustainable reimbursement strategies, consistent with the requirements of Mental Health Parity and Addiction Equity Act (MHPAEA), for the essential processes and functions of evidence-based models of integrated care services including quality outcomes, timely access, and related performance measures.

Author(s): Lori Raney, MD and Eliot Sorel, MD (primary); APA Workgroup on Integrated Care and Council on Healthcare Systems and Financing

Adoption Date:

Item 2016A1 4.B.12
Reference Committee #2
Assembly
May 13-15, 2016

American Psychiatric Association

[Proposed] Position Statement on Off-Label Treatments

January 2016

Issue

Management of a patient's clinical care by third party payers (both public and private) has infringed on physician autonomy and clinical decision-making authority. This is especially problematic when prescribing drugs for off-label use. Management techniques, including additional administrative hurdles and financial penalties for patients, open the door for sub-optimal care.

Position Statement

The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an off-label[i] indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA encourages the use of the current drug compendia recognized by the Centers for Medicare and Medicaid Services (American Hospital Formulary Service-Drug Information, Gold Standard Inc. Clinical Pharmacology Compendium, National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Thomson Micromedex DrugDex® Compendium, Thomson Healthcare DrugPoints® Compendium) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses; APA further affirms that when the prescription of a drug or use of a device represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate off-label uses of drugs on their formularies.

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[Footnote] [i] The FDA describes off-label use of approved drugs as "when a drug is used in a way that is different from that described in the FDA-approved drug label…New uses for these drugs may have been found, and often medical evidence supports the new use. But the makers of the drugs have not put them through the formal, lengthy, and often costly studies required by FDA to officially approve the drug for new uses."

For example, the drug is:

- Used for a different disease or medical condition.
- Given in a different way (such as by a different route).
- Given in a different dose.
- Given for a different patient population (e.g., age, gender)
- Given to patients with conditions for which the drug is contraindicated (e.g. specific medical conditions, pregnancy)
- Given in combination with another drug or drugs that are contraindicated in the label

Authors: Joseph Mawhinney, MD and Susan McLeer MD (primary); Council on Healthcare Systems and

Financing

Adoption Date:

Position Statement on Patient Access to Treatments Prescribed by Their Physicians

Approved by the Board of Trustees, July 2007
Approved by the Assembly, May 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA further affirms that when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate "off-label" uses of drugs on their formularies. The APA recommends the following:

Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses

1. APA reaffirms the following policies:

a. A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion;

b. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy; and

c. APA encourages the use of three compendia (AMA's *Drug Evaluations**; *United States Pharmacopeia-Drug Information*, Volume I*; and *American Hospital Formulary Service-Drug Information*) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.)

Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers

2. APA strongly supports the need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.

3. APA supports the dissemination of independently derived scientific information about unlabeled uses by manufacturers to physicians, if the independent information is provided in its entirety [including comprehensive results of relevant clinical trials], is not edited or altered by the manufacturer, and is clearly distinguished from manufacturer-sponsored materials. Dissemination of information by manufacturers to physicians about unlabeled uses can be supported under the following conditions:

a. **For Reprints** of independently derived articles from reputable, peer-reviewed journals, the following criteria must be met:

   i. The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published;

   ii. The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;

   iii. The journal should be recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national psychiatric societies;

   iv. The journal must be indexed in the *Index Medicus* of the National Library of Medicine;

   v. The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors;

   vi. When the subject of the article is an unlabeled use, or the article contains information that differs from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA-approved professional labeling with the reprint;

   vii. If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the reprint, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.

b. **For Reprints of monographs or chapters from the three compendia** (AMA's *Drug Evaluations*; *United States Pharmacopeia-Drug Information*, Volume I; and *American Hospital Formulary Service-Drug Information*) named in federal statutes for determining the medical acceptability of unlabeled uses, the following criteria must be met:

i. The monograph or chapter should be reprinted in entirety by the publisher of the compendia, and the reprints then sent to the requesting industry sponsor;

ii. The reprints of the monographs or chapters should not be altered in any way by the industry sponsor;

iii. The industry sponsor disseminating the reprint of the monograph or chapters should disclose that the reprint includes information that has not been approved by the FDA and should attach a copy of the FDA-approved professional labeling with the reprint.

c. **For Complete Textbooks** the following criteria must be met:

i. The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook;

ii. The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof;

iii. The reference text should be generally available for sale in bookstores or other distribution channels where similar texts are normally available and should not be distributed only or primarily through drug, device, or biologic firms;

iv. The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text;

v. Specific product information (other than the approved package insert) should not be physically appended to the reference text.

d. **For Proprietary Information** indicating that a drug is ineffective or unsafe when used for a specific unlabeled indication, manufacturers should report to the FDA and share with all physicians all of the proprietary information.

e. **For Continuing Medical Education (CME) activities and information**:

i. The FDA should continue to support principles in the FDA Draft Policy Statement on Industry-Supported Scientific and Educational Activities (Fed. Reg. 1992; 57:56412-56414); the FDA Draft Policy Statement acknowledges the importance of relying on professional health-care communities, rather than the FDA, to monitor independent provider activities;

ii. The FDA should continue a policy of regulatory deference for industry-supported CME activities conducted by organizations accredited by the Accred-itation Council for Continuing Medical Education (ACCME), state medical societies, and specialty societies such as the American Psychiatric Association (APA), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.

4. APA strongly supports the responsibility of physicians to interpret and put into context evidence received from all sources [including pharmaceutical manufacturers], before making clinical decisions (i.e.., prescribing a drug for an unlabeled use).

Improving the Supplemental New Drug Application (SNDA) Process

5. APA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. APA strongly encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, APA and other medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in populations with mental disorders , are submitted and acted upon in a timely manner. Specific recommendations include:

a. **User fee legislation should be re-authorized** to ensure that the FDA has the necessary resources to act on all efficacy supplements within six months of submission;

b. **The SNDA process should be streamlined** as much as possible without compromising the requirements for substantial evidence of efficacy and safety;

c. **Legislation should be enacted** that provides extensions of marketing exclusivity for a product to manufacturers who conduct supplemental research [i.e., Phase IV studies] and submit efficacy supplements gaining FDA approval for additional indications; the legislation should place a limit on total length of extended marketing exclusivity;

d. **For drugs no longer under patent and for which generic versions are available**, the FDA, other governmental agencies (e.g., the National Insti-tutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organiza-tions, the APA and other medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements based on relevant research findings will be submitted to and acted upon by the FDA in a timely manner.

Encouraging Clinical Research in Child and Adolescent Psychiatry

7. APA urges pharmaceutical manufacturers and the FDA to work with the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American College of Neuropsychopharmacology and other experts in pediatric medicine to identify those investigational drugs that should have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products.

Item 2016A1 4.B.14
Consent Calendar
Back-up (if removed): Reference Committee #5
Assembly
May 13-15, 2016

American Psychiatric Association

[Proposed] Position Statement
The Call to Action: Accountability for Persons with Serious Mental Illness

(Adapted from the Position Statement: A Call to Action for the Chronic Mental Patient)

January 2016

REVISED BY JRC – January 2016

Issue: Failure to meet the needs of persons with serious mental illness, including persistent mental illness, early presentation of mental illness, and comorbid substance use disorders, remains a national crisis.

Serious mental illness spans all ages, genders, and sociocultural groups. It includes a wide variety of diagnoses, including psychotic disorders, mood disorders, anxiety disorders, neurodevelopmental disorders, neurodegenerative disorders, traumatic brain injury, and substance-related syndromes. Obstacles to recovery are everywhere. State hospital closures, community hospital downsizing, and the absence of essential community systems are driving forces behind poor outcomes, homelessness, and increasing social costs. Poor quality of care, social disadvantage, and adverse health behaviors lead to premature mortality in this population. Life expectancy of persons with serious mental illness is decreased by as much as 20 years compared with otherwise similar groups without mental illness.

Ensuring appropriate treatment, rehabilitation, and opportunities for recovery of persons with serious mental illness is ***a public health responsibility***. Federal, state, and local governments must be accountable for ensuring access to comprehensive assessment, treatment, and evidence-based care. Psychiatrists have a unique role and responsibility for developing strategies to address these challenges.

Position: The American Psychiatric Association shall work with psychiatrists, other physicians, and professionals, communities, and partners to achieve the best possible clinical outcomes, functioning, and quality of life for persons with serious mental illness. Priorities and strategies include:

1. **Ensuring access to all levels of effective and efficient care and treatment.**

   Services shall be:
   - Person-centered and recovery oriented, fostering self-sufficiency, independence, and positive self-worth.
   - Culturally and linguistically sensitive.
   - Available to persons across the lifespan.

- Available to persons of all social, cultural, ethnic, racial, gender, sexual orientation, economic backgrounds, and population densities.
- Provided in the least restrictive setting appropriate to the person's needs.
- Overseen in a meaningful way by a physician, preferably a psychiatrist.
- Reimbursed by all health insurances (including Medicare and Medicaid) and provided by all health systems (including the Veteran's Administration).
- Adequately funded.

Services shall include but not be limited to:

- Comprehensive diagnostic assessments of psychiatric, substance use, and physical health, taking into consideration the impacts of psychosocial factors (such as homelessness, poverty, trauma, gender, and sexual orientation).
- Comprehensive plans of care and treatment based upon comprehensive and timely assessments.
- Follow-up assessments of sufficient frequency and duration.
- 24-hour emergency assessment and care, inpatient care, transitional care, respite care, clinic-based outpatient care, and therapeutic day care.
- Proactive crisis prevention with prompt and appropriate crisis intervention and stabilization, available and accessible at all times.
- Integrated psychiatric and substance use disorder care and treatment.
- Evidence based treatments (such as Assertive Community Treatment, supported employment, peer support, ECT, and DBT).
- Access to a comprehensive formulary of psychotropic medications.
- Comprehensive case management and functional support services.
- Support for education, socialization, and rehabilitation.
- Home-based, school-based, and community-based programs.
- Prevention and early recognition and intervention programs.
- Engagement of family and other primary supports, including the financial, social, and behavioral health resources to do so.
- Full spectrum housing from structured residential care to independent living.
- Full spectrum employment from supported employment to long-term, independent, and sustainable employment.
- Benefits counseling and coordination including assistance to the uninsured and underinsured.
- Review of social security eligibility to better reflect disability and to foster transition to sustainable employment.

2. Coordinating and integrating medical and psychiatric care.

Care and treatment shall be coordinated with primary care providers to alleviate the burden of medical illness, so the life spans of persons with serious mental illness will not be compromised or shortened because of inadequate or inadequately integrated services. Coordination shall include comprehensive care management services.

3. **Ensuring interagency coordination of federal, state, and local: human service, health, and criminal justice agencies.**

   An individual's transition between levels, locations, and jurisdictions of care and treatment shall be seamless. Funding shall follow individuals through transitions.

4. **Enhancing education and training at every level of potential intervention.**

   Elements shall include but not be limited to:
   - Family engagement and participation in education.
   - Peer support knowledge and skill development.
   - Educational opportunities for students and trainees in all relevant fields.
   - Interdisciplinary and cross-discipline training.
   - Medical student and resident training in primary care, specialty care, and emergency care.
   - Reaching out to community partners and other interested stakeholders.
   - Opportunities for academic career development.
   - Partnerships of state health authorities, medical schools, and academic medical centers.
   - Training of psychiatric residents and early career psychiatrists regarding administrative and leadership roles in the public/community sector.
   - Availability and accessibility of adequately trained and supervised psychiatrists and other practitioners, at all levels of education and training, to meet clinical and social service needs.

5. **Increasing research about serious mental illness and the individuals it affects.**

   Research shall include epidemiology, etiologies, treatments, comorbidities, prevention, outcomes, interdisciplinary management, and service delivery.

6. **Eliminating discrimination against persons with serious mental illness by informing the public, elected leaders, and community leaders that any individual with serious mental illness may be meaningfully integrated into their community**.

   Individuals with serious mental illness, family members, professionals, paraprofessionals, and interested others shall inform the public, elected leaders, and community leaders about what must be done to overcome the discrimination, stigma, and obstacles of meaningful community acceptance and integration of persons with serious mental illness.

Authors: Laurence Miller, MD, Isabel Norian, MD (Primary), APA Assembly Committee on Public and Community Psychiatry, in consultation with the APA BOT Workgroup on Healthcare Reform, American Association of Community Psychiatrists, and the Council on Healthcare Systems and Financing and its Workgroup on Integrated Care.

Adoption Date:

Am J Psychiatry 136:5, May 1979

Position Statement: A Call to Action for the Chronic Mental Patient

This statement was approved by the Assembly at its October 1978 meeting and by the Board of Trustees at its December 1978 meeting upon recommendation of the Ad Hoc Committee on the Chronic Mental Patient. It was prepared by the Ad Hoc Committee on the Chronic Mental Patient.[1]

THERE IS no more urgent concern than the needs of the chronic mentally ill who suffer from severe, persistent, or recurrent mental illnesses with residual social and vocational disabilities. As a result of the deinstitutionalization programs of the past decade and the continuing growth of high-risk populations that generate chronic illness, the problems associated with the care of these patients constitute a national crisis. The Conference on the Chronic Mental Patient, sponsored by the American Psychiatric Association in collaboration with the President's Commission on Mental Health, was held in Washington, D.C., January 11-14, 1978, and addressed the striking inadequacy of care, treatment, and rehabilitation of this group, estimated to number over one million Americans.

The chronic mentally ill are of all ages, including children, and have a variety of diagnoses.[2] They may reside in community or institutional settings. Such patients must be distinguished from those individuals who may be receiving various forms of psychotherapy for mental disorders without attendant long-term disabilities. The chronically ill have a host of special and unique problems including extreme dependency needs, high vulnerability to stress, and difficulty coping with the demands of everyday living, resulting in difficulty securing adequate income and housing and holding down a job.

The term "chronic mentally ill patient" stigmatizes persons so designated and obscures their diversity and potential for improvement. It is not a desirable appellation because of its implication of hopelessness and progressive deterioration but has been used in this report because of its historical and current use in the literature and by the profession and because of its descriptive clarity. While these people have a chronic illness that requires medical and psychiatric attention over a long period of time and are, therefore, appropriately called patients, it is equally important to recognize them as persons with continuing disability. This disability concept carries the positive implication that a psychosocial rehabilitation approach should complement any treatment provided.

Successful programs for helping the chronically ill patient offer a continuum of residential and nonresidential services to ensure that care is tailored to meet individual needs and to provide easy access and reentry to services and responsiveness to crises. Such programs use the skills of persons with an interest in and knowledge about chronic mentally ill patients. They provide thorough monitoring and balance active outreach with the encouragement of self-sufficiency and independence. They also encourage interagency cooperation and referral and serve as patient advocates. They have effective vertical (e.g., up higher governmental levels) and horizontal (e.g., across to other community agencies) structures. Sensitivity to incremental degrees of progress, economic stability, accountability, and responsibility are also essential features of effective programs.

Obstacles to effective delivery of services to the chronically mentally ill are monumental. They include the attitudes of patients, families, communities, community leaders, and professionals; the lack of an integrated community support system; fragmentation of federal programs; the absence of unified funding; the failure to designate responsibility for treatment, care, and rehabilitation of the chronically ill patient; widespread discrimination in employment, ambulatory care funding, zoning, etc.; and conflicting and/or limiting federal and state regulations.

POLICY STATEMENT

To address the needs of the chronic mentally ill, a national public policy must be adopted. This policy must include the following:

1. *Public sensitivity and financial commitment to a system of opportunities and services.* A systematic approach to caring for the chronic mentally ill must include at a minimum active case-finding and outreach; 24-hour emergency and crisis stabilization services; functional evaluation; medical and psychiatric care; training in skills of everyday living; so-

[1]The Ad Hoc Committee on the Chronic Mental Patient included John A. Talbott, M.D., chairperson, James T. Barter, M.D., Maurice Laufer, M.D. (deceased), W. Walter Menninger, M.D., Arthur T. Meyerson, M.D., Mildred Mitchell-Bateman, M.D., Lucy Ozarin, M.D., John P. Spiegel, M.D., and Harold Visotsky; Dr. Richard Duke, Dr. Z. Erik Farag, Dr. Henry Foley, Dr. Eli Ginzberg, Dr. Sam Keith, Dr. David Mechanic, Ms. Judith Turner, and Ms. Jane Yohalem were consultants, and Donald Hammersley, M.D., and Sam Muszynski, M.S.W., represented APA staff.

[2]In this report, the population we are concerned with are primarily those suffering from major psychoses, e.g., chronic schizophrenia, chronic recurrent affective disorders, etc. For reasons of simplicity and expeditiousness, the term, as used in this report, does not include persons suffering from alcoholism or drug abuse or the mentally retarded.

cialization; an array of specialized living arrangements; subsistence, prevocational evaluation, clinical work adjustment programs, and subsidized transitional and permanent full- and part-time work opportunities that are meaningful and feasible; and assistance to families—all of which are monitored and managed in accordance with individual needs. In addition, provision should be made for indirect services such as community consultation, community education, community organization, and interagency collaboration. The system should recognize that some patients, while chronically disabled, are only partially disabled and can function in supportive situations. The system should be designed to promote growth and sustain functioning to the maximum degree feasible for each individual and should be directed toward patients who voluntarily request assistance.

2. *Designation of clear responsibility for providing services at appropriate levels of government.* The assurance of care, treatment, and rehabilitation of the chronically mentally ill is a national public health responsibility. Thus, every level of government bears some responsibility to assure adequate services to this population.

The federal government should have the responsibility for defining eligibility; identifying and assuring levels of benefits; funding services under national health insurance or categorical programs; establishing regulations ensuring access to services, quality care, and cost effectiveness; and monitoring program implementation. The state government should assume responsibility for statewide planning, approval of local plans consistent with that statewide plan, supplementary funding and benefits, standards, and program monitoring within the state. At the local level, appropriate organizational entities should be responsible for local planning and integration of services for the chronic mental patient, administering and/or managing those services either directly or by contract, and evaluating programs.

3. *Full civil rights for the chronically mentally ill.* There should be no discrimination against the mentally ill. The right to adequate treatment in the community and to confidentiality must be guaranteed. Chronic mentally ill patients should have full access to medical, legal, educational, vocational, occupational, and housing services and opportunities. These services and opportunities to the mentally ill should be provided in settings that allow the maximum independence consistent with the patient's needs.

4. *Reform of funding mechanisms.* These should be designed to remove incentives toward more restrictive forms of care, to remove discrimination against the chronically mentally ill, and to assure their access to health, human service, rehabilitation, and housing programs. Funding should also increase the availability of vitally needed services such as active outreach, crisis stabilization in the normal environment, diminution of symptomatic behavior, remediation of functional skills, meaningful daytime activities, long-term supportive work opportunities, and case management.

5. *The same policy and implementation requirements* for classes of service, levels of care, and accountability that are required of public and private, state and local health systems and facilities should be applied to programs run directly by the federal government (i.e., the Veterans Administration and Public Health Service systems).

6. *Social and cultural factors.* There should be an equitable allocation of mental health resources in the community to citizens from all social, economic, and racial (ethnic) backgrounds and population densities. All services delivered must be adapted to meet the cultural values and perceptions or needs of various ethnic, minority, and subcultural groups.

7. *Utilization of families.* Wherever possible, patients' families should be involved in their treatment and care rather than depending on more expensive and less caring substitutes. While women in the home have traditionally assumed the caretaking responsibility, changing roles suggest that their presence can no longer be taken for granted; there must be adequate financial, social, and mental health supports available when families assume such responsibility.

RECOMMENDATIONS

Psychiatry's Role in the Care of Chronic Mentally Ill Patients

Since care of the chronic mentally ill patient is a major health concern to the public, it is incumbent on psychiatrists and other physicians to take an active role in attending to the needs of this population. Even though psychosocial problems may predominate, the medical and psychiatric needs of the chronic mentally ill require vigilant monitoring. In addition, psychiatrists have a responsibility in the development of comprehensive services for the chronic mentally ill and should be involved at all levels of program planning, public education, training, and research related to preventive care and rehabilitative services.

The American Psychiatric Association should take the lead in undertaking programs to elevate the prestige and value of work with chronic mentally ill patients. Portions of the scientific programs of annual meetings, regional meetings, and district branch scientific meetings should be devoted to this population. Research should be sponsored and groups working with this population should be encouraged. APA should also take steps to encourage psychiatrists and others to monitor the quality of care administered to the chronic mentally ill patient population by their peers.

The prestige and status of psychiatrists who work in programs with chronic mentally ill patients will be enhanced by affiliation with medical school departments of psychiatry; teaching and/or clinical assignments at medical schools by psychiatrists who work with the chronic mentally ill; clinical and supervisory assignments by faculty of academic departments to programs for chronic mentally ill patients; continuing medical education programs held at the site of programs for chronic patients by medical schools and APA district branches; academic appointments for psychiatrists working in programs for the chronic mentally ill patient; and a referral system involving private psychiatrists, which will ensure continuity of care.

Community Education

1. All involved consumer, professional, paraprofessional, and governmental bodies should mount a coordinated education and lobbying program, using professional communication expertise (lobbying, marketing, community education) to inform the public about the chronic mentally ill and how to meet their needs.

2. Community education must be oriented toward increasing the visibility and status of programs directed to chronic mental patients.

3. A major effort should be undertaken to develop a constituency for the chronic mentally ill patient population.

4. District branches should make an effort to include the subject of care and treatment of the chronic mentally ill in both their community and scientific programs.

Research

There must be a continuing emphasis on research in the area of chronic mental illness, including epidemiology, etiology, therapy, outcome, and effective service delivery. In addition, new efforts should be undertaken to clarify the conditions under which family care is helpful or harmful; to ascertain the rate and nature of problems faced by the (current) deinstitutionalized population as compared with the (formerly) institutionalized chronically ill population; to study the criteria for deinstitutionalization and for various types of group maintenance, including continued hospitalization; to define and refine the tasks, skills, and process of case management; and to reexamine the issues relating to confidentiality. Uniform data collection regarding the size, composition, and service needs of the chronic population at the local level is needed to help identify special problems and needs and to improve program planning and monitoring. Another fruitful area for research is the prevention of chronicity, especially in children and adolescents as well as in the aging.

Training

1. Training programs should be expanded or established for persons, including family members, in the skills appropriate to the needs of the chronic mentally ill.
2. Current professional training programs, including psychiatric residency programs, should be modified and reoriented toward an interdisciplinary focus to enhance the capacity of professionals to treat and care for the chronic mentally ill patient. Persons who have been working in chronic care settings should be retrained to be able to function within a community/rehabilitation model, nursing homes, and geriatric facilities, as well as in programs that help patients in strength assessment and the acquisition of the skills of everyday living.
3. Funding is required to implement the above retraining provisions and provide incentives for state governments to carry out this statutory responsibility where necessary. Consideration should be given to mechanisms whereby psychiatric residents could "pay back" the money spent on their training by serving in shortage areas (e.g., state hospitals).
4. Psychiatric residency training programs should be encouraged to include training for more chronic mentally ill patients than the 10 specified in the residency training guidelines, as well as to include training in administration and planning. Consideration should also be given to a new subspecialty—rehabilitation psychiatry.
5. A program for volunteer case aides should be established to promote local volunteer mobilization around the chronic mentally ill patient.
6. Training programs should be established for medical students and primary care physicians, especially those working in emergency settings, to focus on the special treatment needs of patients with chronic mental illness, since these patients have a higher incidence of medical illness and are often resistant to medical care due to their mental disability. Such programs should include experience with ambulatory chronically mentally ill patients, with particular emphasis on appropriate and inappropriate psychopharmacological medications, the concomitant social and vocational disabilities, and the full array of ambulatory treatment programs necessary for chronically ill patients.
7. The establishment of guidelines for training and career development of psychiatrists involved with program planning for and treatment of chronic mentally ill patients should be encouraged. A study of psychiatrists currently working in this area may offer data relevant to the development of successful educational experiences and career pathways.

Continuity and Provision of Services

1. Barriers should be removed to assure chronic mentally ill patients access to a full range of medical, psychiatric, rehabilitative, income maintenance, social, employment, and related opportunities and services appropriate to their needs in the least restrictive setting.
2. The system of care should be continuous between institutions and local programs, and there should be well developed systems for interservice program referral. It is necessary to establish and support case management to enable the chronically ill patient to use and benefit from community resources and programs. Such management should be based on a comprehensive treatment and management plan; the patient, and if possible the family, should be involved in the planning and delineation of responsibilities. Before extensive programs of case management are undertaken, however, there is a need to define the role, responsibility, and function of care, fixing of responsibility, and linking of hospitals with community services. Interagency linkage should be encouraged through inducements and sanctions written into legislation, regulations, and procedures. Adequate resources should be provided for case management functions, and funding should allow for an adequate period of time for training staff and establishing information systems, etc., to phase in such a system.

Financial Needs

The financial recommendations that follow include consideration of cost savings resulting from the shift of chronically ill patients from higher cost institutional programs to lower cost community alternatives. Attention to the ways in which financing mechanisms perpetuate higher cost care can prevent escalating and outrageous costs for programs serving chronic mentally ill patients. Some evidence exists that high quality integrated programs based on a least restrictive but full service model are no more costly than state hospital incarceration.

1. Programmatic funds should, as a long-term goal, flow from the federal to the state level and be earmarked for the chronic mentally ill patient where possible. This includes monies currently administered in the Departments of Health, Education, and Welfare, Housing and Urban Development, Labor, etc. Thus, a specified share of welfare, housing, rehabilitation, health, and mental health dollars would be directed to this population either on a capitation or index of need basis. These monies would be allocated to local communities or agencies only if programs were accountable in relation to the chronic mentally ill patients' needs for service.
2. On the federal level, structures should be created to provide oversight, both by Congress and the executive branch, of legislation and regulations affecting the needs of chronic mentally ill patients. A comparable structure should be established on the state and local levels.
3. The Department of Health, Education, and Welfare should perform a national survey of Medicare and Medicaid eligibility requirements, benefit services, and reimbursement schedules. This survey would elucidate current inequities and help establish national parity.
4. Chronic mentally ill patients are entitled to full participation in the health care system. Medicare, Medicaid, and

future national health insurance should not single out the chronic mentally ill as a class or discriminate against them in any way. This is especially important regarding private psychiatric care, which is often less costly than that provided by institutions.

5. Medicare, Medicaid, and future national health insurance benefits should include a full range of inpatient, day treatment, and outpatient services encompassing periodic medical and psychological evaluation and treatment, resocialization, and rehabilitation. In all future funding, there should be differentiation between health services (e.g., evaluation, diagnosis, medical, and psychiatric treatment) and social and supportive services (e.g., escort services, housing, etc.).

6. Any future national health insurance should also include cost effective but positive financial incentives to encourage professionals to care for the chronic mentally ill patient, so that the existing disincentives to providing long-term care are reversed.

7. Financing of psychiatric and human services should be modified to remove fiscal disincentives (e.g., Medicare restrictions on ambulatory care) and unnecessarily restrictive or debilitating settings or forms of care, such as inpatient hospitals or nursing homes.

8. All federally funded comprehensive community mental health centers should be required to provide comprehensive services to the chronically ill mental patient as one of the mandated essential services.

9. A federal technical assistance program, along the model of the agricultural extension program, should be developed to help localities develop appropriate programs for chronic mentally ill patients.

10. Funding mechanisms should encourage states and localities to move individuals out of the human services system into mainstream community life through rehabilitative programs.

11. Priority should be given to proposed systems ensuring that money follows chronic mentally ill patients, either through a voucher system that would enable patients to buy any or all necessary services or by some other mechanism.

12. There is agreement on the following points regarding recommendation 13 in the Preliminary Report of the President's Commission on Mental Health (advocating establishment of a class of intermediate care facilities for mental patients under Medicaid): there is a current *shortage of federal and state funding* for community living arrangements for the mentally disabled; there is a need for a *continuum* of types of living arrangements, offering varying degrees of supervision and support; funding policies should promote a planned, accountable *system* of living arrangements within each state and local planning area; there is a critical need for improved methods to *link* special living arrangements with nonresidential treatment, rehabilitation, and support services; and it is vital to recognize that appropriate living arrangements are *necessary* but not sufficient in meeting the needs of the mentally disabled.

Based on these areas of agreement, it is recommended that additional resources for community living arrangements for the mentally disabled be made available through earmarking federal and state housing and social service funds.

With respect to the advisability of specific federal funds for intermediate care facilities for the mentally ill, while we support the intent of the proposal, we believe that no such facilities should be established, because specific federal funding for a particular class of facilities will result in overdevelopment of one type of residential arrangement at the expense of other types, it will detract from the availability of adequate resources for essential nonresidential rehabilitation and support services, it will interfere with developing flexible local systems based on community needs, and it will be more expensive than a policy that would limit use of medical funds to more narrowly defined medical needs and would support housing arrangements from nonmedical resources.

13. Provisions of Supplemental Security Income legislation and procedures should be modified to replace the current disincentives against patients' returning to productive employment with positive incentives; e.g., allowances should be made for patients' rehabilitation potential.

Administrative Issues

As a long-term goal, the federal government should take responsibility for leadership and advocacy of care for the chronic mentally ill patient; establish policy and ensure consistency in all relevant agency policies; set basic programmatic guidelines and regulations; establish minimal care and accountability standards; issue guidelines setting forth broad parameters for the ulitization of funds; provide strong incentives and bonuses for care of the chronic mentally ill patient in the community; stimulate collaboration among agencies involved in policy planning and program implementation; develop technical assistance and disseminate information concerning the chronic mentally ill patient; develop criteria for determination of local government's ability to assume planning, management, and service operation responsibility and to establish programs for those localities without sufficient capacity to provide training, assistance, and funding to attain an acceptable level; and provide assurances that any jurisdictional level that has oversight/coordination responsibilities (and has reduced or eliminated its service operations) maintains the necessary staff expertise to carry out its responsibilities in the areas of planning, licensure, etc.

State governments should carry out the leadership, patient advocacy, and planning functions on a statewide basis for distribution of federal monies; supplement federal funds with state monies; and designate local authorities to have programmatic responsibility. They should also establish and provide assurances that coordination mechanisms are in place and operating to ensure chronically ill patients' access to appropriate support programs, develop appropriate standards for programs on a state level, establish regulatory/guideline appeals mechanisms, provide services for specific populations when it is not feasible for any other entity to assume this function, and monitor local service operations.

Local authorities should designate specific local entities to perform program activities; coordinate the planning and provision of services; hold local entities accountable for these services; establish entitlement for chronic mentally ill patients to relevant support systems; ensure nondiscrimination; ensure maximum consumer (public and nonprofit) participation; and provide local entities with formal authority over support-system resources such as welfare, rehabilitation, etc., applicable to this population.

Local entities should be the final common pathway for program funding directed toward providing the chronic mentally ill with a holistic integrated program based on the least restrictive, rehabilitative model with appropriate medical-psychiatric input. Local entities eligible for designation as the authority responsible for chronic mentally ill patients should include both public and nonprofit facilities.

The immediate goals should include the following:

1. Oversight mechanisms should be established at the fed-

eral level; examples are a select committee in Congress comparable to the Select Committee on Aging, and an executive branch equivalent, which would oversee federal legislation and regulations applying to chronic mentally ill patients.

2. Each state mental health authority should designate a single person/office to assume primary responsibility for acting in behalf of, planning, and supporting services for chronic mentally ill patients. Such person/office should develop knowledge about all potential federal and state programs that may provide funding and/or services for chronic mentally ill patients and transmit that knowledge to appropriate mental health service providers. Further, that person/office should review legislation, appropriations, and rules and regulations and should serve as an advocate for policies that will enhance services for chronic mentally ill patients.

3. Each state should produce a plan which guarantees that the needs of the chronically ill population will be provided for. Such plans should fix responsibility within each local planning area with a single community agency that assumes the role of convener, catalyst, coordinator, community organizer, and advocate for meeting the full range of needs of chronic mentally ill patients. The type of agency that can best assume this role may vary from community to community, depending on what is available. In all cases, it is essential that such responsibility be clearly assigned and recognized.

4. Clinical integration should be done by the local area health or mental health planning body independent of any care delivery system of its own that might represent a competitive interest. This also applies on the state level.

5. Accountability is a critical element to assure that the services promised are actually delivered. Evaluation of these services must be consistent and equally applicable to all service providers. Efforts should be made to limit the costs and bureaucracy of the evaluation process—possibly by utilizing the Health Systems Agency structure or an equivalent—and to encourage a positive attitude in enforcing accountability; i.e., evaluators should be oriented toward helping recipients satisfy not only regulatory requirements but also toward improving services, in addition to identifying service deficiencies and threatening penalties. Affirmative approaches to quality of life and social and vocational disabilities should be a primary objective.

6. Rather than building a whole new network of programs and services, the emphasis should be on the development of staff and facilities for the chronic mentally ill patient, making use of existing functions and resources, including the family whenever possible, and restructuring and reordering such programs in ways that better meet the needs of the chronic mentally ill patient. The development of new approaches and capacity should be encouraged at the local level, and technical assistance should be provided to enable this.

7. States should be discouraged from developing new state-operated facilities for chronic mentally ill patients and should phase down present facilities over time. While states must assure an adequate supply of facilities to meet the needs of chronic mentally ill patients, in order to encourage the local development of programs these facilities should not be state operated.

8. The federal government should eliminate any state or regional options in the utilization of essential federal funds, e.g., Section 8 of the Housing Law of 1975, and establish mechanisms whereby states and localities may appeal restrictive regulations.

Civil Rights

There should be federal legislation or regulations to accomplish the following:

1. *Prohibit discrimination against chronic mentally ill patients in vocational rehabilitation, employment, and education.* Specifically, Title VII of the Civil Rights Act of 1964 should be amended to prohibit "unjustified" discrimination in employment on the basis of handicap. In addition, there should be vigorous enforcement of Sections 503 and 504 of the Rehabilitation Act of 1973, federal legislation to encourage the hiring of the mentally handicapped (either through bonuses or tax incentives), and assurance that the severely and chronically mentally disabled are served by vocational rehabilitation agencies. Also, the concept of equal job opportunity should be applied to women in both institutional and community rehabilitative and vocational programs.

2. *Prohibit discrimination against chronic mentally ill patients in housing.* Specifically, Title VIII, Fair Housing, of the Civil Rights Act of 1968, should be amended to prohibit discrimination in housing on the basis of handicap. The Department of Housing and Urban Development should promulgate regulations to encourage states and localities to allocate additional Section 196 funds to develop more group care facilities, and to make additional Section 8 rental assistance funds available to mentally disabled persons living in group homes.

Federal legislation should be enacted encouraging the private market to provide housing to the mentally handicapped and conditioning receipt of federal revenue sharing or other funds to states having a plan for the development of community care and community residencies for the mentally disabled.

3. *Endorse the right to adequate treatment for both voluntary and involuntary patients in the hospital and the community, in the least restrictive setting consistent with individual treatment needs.* This includes the establishment of a mechanism whereby the patient may object to any aspect of his/her treatment plan, including transfer to another facility or to the community.

4. *Protect confidentiality, while allowing access to relevant information for legitimate treatment, planning, and research needs.* Centralized records should contain the minimum amount of information needed to meet the patient's future treatment needs, with access to records limited to a "need to know" basis, and patients should have the right to consent to the release of particular items of information from their records for time-limited periods, revocable by the patient. Stringent protection should govern access to treatment records, and stringent criminal penalties should be mandated for misuse of information included in records. Insurance claims (private and governmental) should be reviewed by a claims review system in which physicians would review patients' records without their names attached.

5. *Develop and fund an advocacy system independent of service providers to help ensure the implementation of patients' rights.* This system should either be part of the protection and advocacy system created by the Developmental Disabilities Act or should be modeled on that system.

6. *Prohibit zoning discrimination against the mentally ill by requiring that receipt of revenue sharing, housing, and other federal funds be predicated on the absence of exclusionary zoning laws or regulations in an area.*

7. *Enact a "Bill of Rights" for mentally disabled persons residing in the community.*

Item 2016A1 4.B.16
Consent Calendar
Back-up (if removed): Reference Committee #3
Assembly
May 13-15, 2016

American Psychiatric Association
Position Statement on College and University Mental Health

Approved by the Council on Psychiatry and Law, September 12, 2015*

The need for mental health services on college and university campuses is increasingly recognized. Many students enter college already taking psychiatric medications and most colleges report that the number of prescriptions written at their student health and counseling centers has grown in recent years (National Survey of College Counseling Centers, 2015). Mental health visits are among the most frequent types of healthcare visits among college students (Turner and Keller, 2015). Further, most colleges report increasing numbers of students with histories of binge drinking, substance abuse, and severe psychopathology (Center for Collegiate Mental Health, 2015). Suicide is the second leading cause of death in college students (Blanco et al, 2008). Attending college is often very stressful for young adults, especially when faced with intense academic pressure to perform. Stressors also include separation from parents and other family members and the ongoing process of forming one's personal identity. In addition, several psychiatric disorders begin during late adolescence and early adulthood, highlighting the importance of early identification and treatment during this time.

Strong evidence shows that mental health problems adversely affect rates of graduation among college students (Hunt et al., 2010). Unfortunately, however, utilization of mental health services varies greatly among colleges (Lipson, et al, 2015). Many college students do not have ready access to psychiatric services or do not take advantage of the services that are available to them. Most community colleges do not have student health or counseling services at all. Many college students continue to lack health insurance. Moreover, students who leave home for college typically also leave their adolescent health care providers and do not successfully negotiate a transition to new providers who understand the special needs and vulnerabilities of young adults. (IOM, 2014)

It is the position of the APA that:

1. All colleges and universities, including community colleges, should have an established arrangement for timely access to psychiatric evaluation and treatment and other necessary and appropriate mental health services for all students in need of them. All colleges without student health programs should have the capacity to provide screening and referral for mental health services. Every student health program should make arrangements for access to an employed or consulting psychiatrist or for referral to a local private psychiatric practitioner or community clinic. Arrangements should be in place for psychiatric care to be coordinated in an appropriate manner with care delivered by the student health service or counseling center. Psychiatrists should have the opportunity to participate in assessment and treatment planning to a degree commensurate with their clinical responsibility.

* This Position Statement replaces the 2005 statement by the same name

2. A treating psychiatrist should not serve as a decision-maker regarding academic matters, including withdrawal from classes or from school, due to the potential conflict of interest between the academic mission of the university and fidelity to the welfare of the student. A treating psychiatrist should serve in a consultative capacity in academic decisions, but the final decisions should rest with those not involved in the direct health care of students.

3. All colleges and universities should either require or strongly encourage students to have comprehensive health insurance coverage, especially for mental health and substance abuse treatment, and should assist students to obtain coverage if they are not insured. Psychiatric problems arising while students are enrolled should be treated on or off campus adequately and at parity with any other health problems.

4. Colleges and universities should provide students, parents and staff with easily accessible and culturally sensitive orientation, and ongoing education, regarding health and wellness. Particular attention should be paid to mental health literacy, including recognizing mental health problems and understanding appropriate interventions, including how to respond to disturbing behavior or apparent distress, whom to contact and how to access services both for routine care and for urgent and emergency interventions. Colleges should implement comprehensive programs to reduce suicide risk, prevent alcohol and substance use problems, and reduce sexual assault and respond compassionately to its victims.

5. Colleges and universities should work with community partners and state, federal agencies (such as NIMH, NIDA, SAMHSA) and college MH focused non-profits (such as JED Foundation and Active Minds) to educate the public regarding challenges and risks related to young adulthood, the prevalence of mental disorders among young adults, the importance of recognizing and responding to signs of distress and strategies for stress management and resiliency.

6. Protection of confidentiality and trust in the treatment relationship are especially important for college students. Colleges are relatively self-contained communities and college students transitioning from adolescence to adulthood are growing into their sense of themselves as independent individuals. At the same time, parents also have a strong interest in being involved in their children's health care -- even when their child has become an adult, legally speaking. In rare cases involving students who present a risk of harm to themselves or others, the university administration also has a strong interest in being aware of the student's status. The primary regulations governing privacy in college mental health settings are FERPA, HIPAA, state confidentiality statutes, and codes of professional practice. Clinicians and college officials should encourage young students who may be still dependent on their parents emotionally and financially to share appropriate information with them and seek their support when clinically indicated. Even in case of student's refusal to contact the parent, the perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations. The federal laws and regulations, including updated guidance on FERPA, generally provide an adequate framework for thoughtful clinical decision-making and allow disclosure to university officials and parents when there is genuine concern about the students' safety or the safety of others.

7. Indiscriminately requiring students with mental health problems to take a medical leave can exacerbate students' mental health conditions and adversely affect their self-esteem, and it also

violates the American with Disabilities Act. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the risk of violence to self or others cannot be managed safely in the school environment, but students should have appropriate due process protections in these determinations. Students' safety prior to returning to college should be determined by a mental health care provider on a case-by-case basis.

REFERENCES

Blanco C, Okuda M, Wright C, Hasin DS, Grant BF, Liu SM, Olfson M., Mental health of college students and their non-college-attending peers: results from the National Epidemiologic Study on Alcohol and Related Conditions. Arch Gen Psychiatry. 2008 Dec;65(12):1429-37. doi: 10.1001/archpsyc.65.12.1429.

Center for Collegiate Mental Health. 2014 Annual Report (2015, January). (Publication No. STA 15-30) http://ccmh.psu.edu/wp-content/uploads/sites/3058/2015/02/2014-CCMH-Annual-Report.pdf (accessed: 6/29/2015)

Gallagher RP. National Survey of College Counseling Centers 2014. The International Association of Counseling Services, Inc. Monograph Series No. 9V. http://www.collegecounseling.org/wp-content/uploads/NCCCS2014_v2.pdf (accessed 6/29/2015)

Hunt J, Eisenberg D, Kilbourne AM. Consequences of receipt of a psychiatric diagnosis for completion of college. Psychiatric Services. 2010;61:399–404.

Institute of Medicine (IOM), Investing in the Health and Well-Being of Young Adults (Bonnie RJ, Stroud, C, and Breiner, H, eds, 2014)

Lipson SK, Gaddis SM, Heinze J, Beck K, Eisenberg D., Variations in Student Mental Health and Treatment Utilization Across US Colleges and Universities. J Am Coll Health. 2015 May 5:0. [Epub ahead of print]

Turner JC, Keller A., College Health Surveillance Network: Epidemiology and Health Care Utilization of College Students at U.S. 4-Year Universities. J Am Coll Health. 2015 Jun 18:0. [Epub ahead of print]

Developed by the Council on Psychiatry and Law

APA Official Actions

Position Statement on College and University Mental Health

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

A Presidential Task Force on Mental Health on College Campuses was appointed by the American Psychiatric Association (APA) in 2005. An earlier group, the 1972 APA Task Force on College Mental Health, issued a statement focusing on the need for psychiatrists working in college settings to understand the special nature of work in colleges. While we agree with the general thrust of these comments, changes in both psychiatric practice and the college student population necessitate a new policy statement:

The need for mental health services on college and university campuses is increasing. More students enter college already taking psychiatric medications and most colleges report increases in medications being prescribed at their mental health services. Further, most colleges report seeing increases in students with binge drinking, substance abuse, and severe psychopathology. Suicide is the second leading cause of death in college students. Going to college is often very stressful for late adolescents when faced with more intensive grade pressure, separation from parents and friends, and the continuing formation of one's identity. In addition, several disorders begin during late adolescence and early treatment is necessary.

There are institutional benefits to providing excellent mental health care on college and university campuses. Data show that treatment for mental health problems results in higher rates of student retention and graduation.

It is the position of the APA that all colleges and universities should:

1. have an established arrangement for timely access to necessary and appropriate psychiatric services for all students in need of mental health services. Such arrangements may include employed and/or consulting psychiatrists, as well as referral arrangements with local private practitioners. Arrangements should be in place for care to be coordinated in an appropriate manner.
2. ensure that psychiatrists have authority commensurate with their responsibility. This should include significant participation in assessment and treatment planning for students served in college and university mental health settings.
3. assure that the treating psychiatrist role is clearly separated from the role of psychiatrist as practitioners, hospitals, university health services and/or community mental health centers. When students are referred out of their student health systems, care should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts.
4. offer health insurance coverage programs to students that provide comprehensive coverage for mental health, including substance abuse treatment.
5. provide students, parents and staff with easily accessible and culturally sensitive orientation information and ongoing education regarding wellness, general health, and mental health issues (including information about accessing emergency services). This should include problems associated with re-entry of students who have had to interrupt their education.
6. educate student health personnel about recognition of mental health problems.
7. have comprehensive suicide risk reduction and substance abuse prevention programs.
8. establish clinically informed policies that are responsive to and consistent with the ADA (Americans with Disabilities Act).
9. work with psychiatric residency training programs to increase educational opportunities in college and university mental health services. Consideration should be given to the establishment of post-graduate fellowship programs in college psychiatry.
10. work to educate the public as to the challenges and risks related to the college years, in partnership with the appropriate agencies (such as NIMH, NIDA, SAMSA).
11. work toward de-stigmatization of psychiatric illness and helping young people and their families make thoughtful choices about college.
12. support the expansion of research endeavors around college mental health issues and exploration of factors relating to prevention and resiliency.

Prepared by the Task Force on College Mental Health, May, 2005; revised by the Council on Children, Adolescents & Their Families, September 2005; and revised by the Joint Reference Committee, October 2005

Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research

Approved by the Board of Trustees, December 2010
Approved by the Assembly, November 2010

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

The APA, as a professional medical association, joins with other medical specialties in promoting, supporting, and advocating, as its primary interest, the highest level of evidence based practice, ethically based and scientifically valid research, and quality continuing education for the benefit of patients, the profession and society. As a medical specialty, we affirm our support of the Institute of Medicine report [*Conflict of Interest in Medical Research, Education and Practice*].

Members involved in clinical practice, education, research, and administration must be diligent and aware in identifying, minimizing, and appropriately managing secondary (personal) interests (financial, contractual, career-centered) that may inhibit, distract, or unduly influence their judgment or behavior in a manner that detracts from or subordinates the primary interest of patients and may be perceived by some as undermining public trust.

Principles and Guidelines

The following situations, contexts, and associations have been noted to be of special concern, both by accumulated evidence and heightened public focus. Accordingly, members should exercise vigilance, caution, and strive for the prevention of conflict whenever possible.

A. Gifts and meals often accompanied by product endorsement and promotional literature may influence physicians' decisions about prescriptions, laboratory tests, or procedures.

B. Contact with pharmaceutical representatives represents marketing and should be distinguished from balanced education and critical scientific information as a basis for prescribing. Samples and starter packets may influence decisions to prescribe products that have equivalent and less costly alternatives.

C. Conflict of interest ethical principles and ongoing studies should be integrated parts of continuing medical education, including distinguishing marketing and promotion from balanced, scientific clinical evidence.

D. Consulting arrangements with industry should be based on a substantive contribution and commensurate compensation.

E. Constructive collaboration with industry for research of new products and public education for the benefit of the community should not be discouraged. However, funding should be commensurate to the research and reflect active participation and documented remuneration. The role of the member in a scientific publication or sponsored information document should be specifically and accurately acknowledged.

F. Physicians have a continuing responsibility to review the scientific and clinical evidence base on newly developed treatment options and incorporate new options for the patient populations they treat.

This policy was developed by the Assembly Conflicts of Interest Work Group. The principles and guidelines in this document are derived from the Institute of Medicine report:

Lo B, Field MJ, Institute of Medicine, Committee on Conflict of Interest in Medical Research, Education, and Practice: Conflict of Interest in Medical Research, Education, and Practice. Washington, DC: National Academies Press, 2009. (www.nap.edu/catalog/12598.html)

Item 2016A1 4.B.19
Consent Calendar
Back-up (if removed): Reference Committee #4
Assembly
May 13-15, 2016

American Psychiatric Association

Proposed Position Statement
Title: Emergency Department Boarding of Patients with Acute Mental Illness

Issue:
Individuals with acute mental illness are increasingly seeking psychiatric care in emergency department (ED) settings. This situation is, in part, a culmination of a failure of states and localities to invest adequately in preventive mental health and substance use services, coupled with reductions in inpatient and crisis services. The inability or failure to access lower levels of care, such as outpatient services, respite care and subacute services, has led patients and families to seek more expensive emergency care during decompensated states. There are few psychiatric emergency services nationwide dedicated to the evaluation and treatment of patients during an exacerbation. Care is more often being provided by emergency medicine physicians who generally have received little training in the evaluation and management of psychiatric disorders. As a consequence, the default treatment disposition typically becomes psychiatric admission for these patients. Unfortunately, over the years, the number of psychiatric beds has been reduced, leading to a backup of patients in emergency departments awaiting an inpatient psychiatric bed. This is particularly true for the most vulnerable psychiatric populations, including children and adolescents, developmentally disabled individuals, and persons with serious and persistent mentally illness.

Once a patient has been evaluated and is awaiting disposition, the patient is considered to be "boarded" in the ED. The wait for boarded patients can be hours, and even days to weeks. During this time, there is often little active psychiatric treatment available. Furthermore, environmental factors in the ED may result in further exacerbation of underlying psychiatric symptoms.

APA Position:

Prolonged boarding of patients with acute mental illness in emergency departments leads to inadequate care, may be harmful, and is unacceptable. All efforts should be made to help place each patient at the appropriate level of psychiatric care. When boarding is unavoidable, the emergency department should ensure that the patient is receiving active, appropriate, and humane mental health treatment in a safe setting with periodic re-evaluation for any emerging physical health problems. Depending on the needs of each patient, this treatment may include appropriate interventions for agitation and other acute symptoms, supportive therapy, and initiation of medications for their primary mental illness. Attention should also be paid to patient comfort and the ED staff should provide regular updates for the patient and family. All emergency settings should have access to psychiatrists, on-site or via telepsychiatry, to assist in conducting an adequate evaluation and in providing optimal care.

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Council on Psychosomatic Medicine

Adoption Date:

American Psychiatric Association

Background
Title: Emergency Department Boarding of Patients with Acute Mental Illness

With "deinstitutionalization" of psychiatric patients in the 1960s, and the advent of managed care starting in the 1980's, the emphasis of caring for persons with mental disorders shifted toward community-based treatment facilities, both inpatient and outpatient, and largely away from state-run facilities. This has led to market forces determining the total number of inpatient psychiatric beds in a given state, rather than population indices. The end result has been a trend towards decreasing beds, which worsens when there is an economic downturn such as with the recent recession.

More patients are seeking mental health care in emergency departments (EDs). The annual number of ED visits from 1996 to 2006 has increased from 90.3 million to 119.2 million,[1,2] with 6 to 10% of patients presenting for mental health concerns.[3,4] Mental health visits have been found to be 42% longer than non-mental health visits. In the same study, the mental health visits demonstrated a higher rate of inpatient admission (24% versus 12%), higher rates of transfer (16% versus 1%), and higher percentage of self-pay or charity care (22% versus 16%). Furthermore, the duration of time spent in the ED was especially long for patients who required transfer to a different facility or with a diagnosis of significant mental illness or substance use disorder.[5]

The term "ED boarding" is subject to interpretation, as there is not one agreed upon definition. Some have described it as remaining in the ED for four additional hours after the decision is made to admit.[6] Others define it as a stay in the ED exceeding 24 hours.[7] Nolan and colleagues went further in their definition to an actual description. "Boarding describes ED patients whose evaluation is complete and for whom the decision has been made to either admit or transfer, but for whom there is no available bed."[8] These patients may be kept in the emergency department, in ED hallways, or sent to inpatient medical floors or other "improper placements" while awaiting an appropriate psychiatric bed. This can apply to both voluntary and involuntary patients.[8] And finally, the Joint Commission has defined boarding as "patients being held in the emergency department or another location after the decision to admit or transfer has been made."[9] One thing that is clear with each definition is that ED boarding is a term used for all patients that are awaiting hospitalization, not only those with a mental health

condition. Though, one survey revealed that 11% of all ED patients boarded but 21.5% of all psychiatric ED patients boarded and odds of boarding for psychiatric patients were 4.78 (2.63-8.66) times higher than non-psychiatric patients.[8]

The extent of boarding is not clear because of the lack of an agreed upon meaning to the term. In 2008, The American College of Emergency Physicians surveyed ED directors regarding psychiatric boarding ("Psychiatric and Substance Abuse Survey"). They surveyed 1400 emergency department directors, of which 328 responded. In this survey, 79% of respondents reported having psychiatric patients boarding in their emergency department;55% of emergency department directors reported boarders on a daily or at least multiple day per week basis;62% reported that there are no psychiatric services involved with the patient's care while they are being boarded prior to their admission or transfer.[6] Average boarding times vary but published average ranges are from 6.8 hours[10] to 34 hours.[11]

ED Boarding of psychiatric patients is caused by multiple factors, only one of which is the frequently cited inpatient bed shortages. Inpatient unit closures, bed reductions, delays in discharge for already admitted patients as they wait for outpatient services to become available all contribute to decreasing numbers of available psychiatric beds.[12] The hesitation of private hospitals in accepting manageable public health patients is a factor. Though lack of available beds is an issue, it is far downstream in patient care. Other causes are related to lack of sufficient funding and care at lower levels (such as intensive outpatient services, crisis stabilization units, and respite). Of the respondents to the ACEP survey, 23 percent replied they have no community psychiatric resources available and 59 percent had no substance abuse or dual diagnosis patient services available.[6]

Once in the ED, there is also a lack of available mental health resources and psychiatric clinicians to evaluate and treat patients.[13] Timely, active treatment in the ED setting can avoid the need for some admissions. Additionally, other factors may include lack of ambulances willing to provide transport,[14] time spent handling pre-authorization from insurance carriers and other managed care hurdles, lack of insurance or having public insurance,[13] absence of alternative placement options aside from admission,[15] patient characteristics such as homelessness,[13] and concerns about liability issues by evaluating emergency clinicians.[16] Iatrogenic worsening due to less than optimal conditions in the ED can be a factor. Finally, characteristics of boarded patients include higher rates of psychotic disorders, personality disorders, and those that require physical restraints/seclusions (i.e. those with substantial illness burden).[17] These characteristics may make placement difficult.

ED boarding costs the system, other ED patients, as well as the individual patient. The average monetary cost to an ED to board a psychiatric patient has been estimated at $2,264.[4] Other than the

direct monetary costs, the system becomes less efficient. ED Boarding in general contributes to reduced availability of emergency staff, longer wait times for patients in waiting rooms, increased patient frustration, reduced ED capacity, increased pressure on staff, increased rates of patients who leave without being seen, longer inpatient stays, lost hospital revenue and consumption of ED resources.[4,8,12,15] For providers, boarding is also associated with a higher degree of stress, greater risk of adverse events, and lower levels of reported patient satisfaction. [10]

Costs to the individual patient are numerous. The ED environment can be loud and chaotic, which may exacerbate underlying conditions or agitation.[12] Resulting anxiety or agitation may require medications or additional interventions such as restraint or seclusion.[18] These patients require increased use of ancillary support (such as security officers, safety attendants) and have increased risk of elopement.[4] The ED also lacks the therapeutic milieu, programming, and consistent provider teams available on inpatient psychiatric units.[17] Additionally, emergency physicians and nurses may carry negative attitudes towards psychiatric patients that affect the treatment they provide and may lead to adverse outcomes.[18] In fact, a major concern about psychiatric boarding is that there is often minimal to no active treatment for the psychiatric condition. As noted previously, 62% of ED medical directors responding to the ACEP survey reported that there are no psychiatric services involved with the patient's care while they are being boarded prior to their admission or transfer.[6]

There have been many different proposed solutions to include opening of more inpatient beds, increased mental health resources in EDs, emergency telepsychiatry, establishing crisis stabilization units, as well as increasing funding to outpatient mental health services. Allen et al have described the many beneficial effects of specialized psychiatric emergency departments.[19] Most recently, Zeller and colleagues published a study on the use of regional psychiatric emergency services to divert patient from EDs and inpatient units and to allow for directed psychiatric care.[20]

References

1.Pitts, Stephen R. *et al*. Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary. National Health Statistics Report, No. 7, August 6, 2008.

2. McCaig, Linda, Burt, Catharine. National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary. *Advance Data from Vital and Health Statistics*. National Center for Health Statistics, No. 355, 2003.

3. Larkin GL, Claassen CA, Emond JA, et al. Trends in U.S. Emergency Department Visits for Mental Health Conditions, 1992-2001. Psychiatric Services. 2005; 56(6):671-77.

4. Nicks BA, Manthey DM. The impact of psychiatric patient boarding in the emergency departments. *Emerg Med Int*. 2012; 2012: 306-8.

5. Slade EP, Dixon, LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv*. 2010; 61: 878-884

6. American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey 2008 [internet]. Available from http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf. Accessed August 28, 2015.

7. Stefan S. Emergency Department Treatment of Psychiatric Patient: Policy Issues and Legal Requirements. Oxford University Press: United States, 2006.

8. Nolan JM, Fee C, Cooper BA, et al. Psychiatric boarding incidence, duration, and associated factors in the United States emergency departments. *J Emerg Nurs*. 2015; 41:57-64.

9. The Joint Commission. Care of psychiatric patients boarding in EDs. An advisory on safety and quality issues. 2014. Available from http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_One_April_20142.PDF. Accessed August 28, 2015.

10. Weiss AP, Chang G, Rauch SL, et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. Annals of Emergency Medicine. 2012;60(2):162-171.

11. Tuttle GA. Access to psychiatric beds and impact on emergency medicine. Chicago, IL: Council on Medical Service, American Medical Association; 2008.

12. Bender D, Pande N, Ludwig M. A literature review: psychiatric boarding. Prepared for Office of Disability, Aging and Long-Term Care Policy by Lewin Group. Washington DC, US Department of Health and Human Services. 2008. Available at http://aspe.hhs.gov/basic-report/literature-review-psychiatric-boarding. Accessed August 28, 2015.

13. Chang G, Weiss A, Kosowsky JM, et al. Characteristics of Adult Psychiatric Patients With Stays of 24 Hours or More in the Emergency Department. Psychiatric Services. 2012;63(3):283-286.

14. (The Joint Commission. Care of psychiatric patients boarding in EDs. An advisory on safety and quality issues. 2014. Available from http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_One_April_20142.PDF. Accessed August 28, 2015).

15. Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room “boarding” of psychiatric patients. Health Aff (Millwood). 2010; 29:1637-1642.

16. Appelbaum PS. “Boarding” psychiatric patients in emergency rooms: one court says “no more”. *Psychiatric services*. 2015; 66(7): 668-70.

17. Simson SA, Joesch JM, West II, and Pasic J. Who’s boarding in the psychiatric emergency service? *West JEM*. 2014;15(6):669-74.

18. Zun L. Pitfalls in the care of the psychiatric patient in the emergency department. *J Emerg Med*. 2012; 43(5): 829-35.

19. Allen MH, Forster P, Zealberg J, Currier G. APA TASK FORCE ON PSYCHIATRIC EMERGENCY SERVICES: Report & Recommendations Regarding Psychiatric Emergency & Crisis Services. 2002.

20. Zeller SJ, Calma NM, Stone A: Effect of a dedicated regional psychiatric emergency service on boarding and hospitalization of psychiatric patients in area emergency departments. Western Journal of Emergency Medicine 15:1-6, 2014.

Joint Reference Committee
January 24-25, 2016
DRAFT SUMMARY OF ACTIONS

As of March 14, 2016

N.B: *When a **LEAD** Component is designated in a referral it means that all other entities to which that item is referred will report back to the **LEAD** component to ensure that the LEAD component can submit its report as requested in the JRC summary of actions*.

JRC Members Present:
Maria Oquendo, MD: JRC Chairperson; APA President-Elect (stipend); Salaried at Columbia and NYSPI; royalties from suicide severity rating scale; NIMH; Neuropsychology; Suicide Research; husband's compensation includes stock from Bristol Myers Squibb
Daniel Anzia, MD: JRC Vice Chairperson; APA Speaker-Elect (stipend); 80% employed at Advocate Lutheran Health and Hospitals Corporation; Spouse and father of Advanced Practice Nurses
Jenny Boyer, MD: Department of Veterans Affairs – salaried; small private practice; State Medical Board of Oklahoma
Saul Levin, MD, MPA: CEO/Medical Director – APA salary; Chair of the APAF Board of Directors
Theresa Miskimen, MD: Robert Wood Johnson School of Medicine – salaried; Rutgers University Health Care; State of NJ - psychiatrist leading the involuntary medication panel review for three state hospitals
Hector Colon-Riviera, MD: Resident Fellow – SAMHSA fellow; Boston Medical Center

Excused:
Gail Robinson, MD
Paul Summergrad, MD

Observers:
Joseph Napoli, MD – Area 3
William Greenberg, MD – Area 3
David Scasta, MD – Assembly ACROSS

JRC Administration:
Margaret Cawley Dewar – Director, Association Governance
Laurie McQueen, MSSW – Associate Director, Association Governance

APA Administration:
Yoshie Davison, MSW – Chief of Staff
Kristin Kroeger – Chief, Policy, Programs, & Partnerships

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
2	Review and Approval of the Summary of Actions from the October 2015 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the October 2015 meeting?**	The Joint Reference Committee approved the draft summary of actions from the October 2015 meeting.	Shaun Snyder, JD Margaret Dewar Laurie McQueen	Association Governance
3	**CEO/Medical Director's Office Report** Updates on Referrals			
3.A	Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U; JRCJUN156.15) The Joint Reference Committee requested that the APA Administration send a letter to the Veterans Administration to address the concerns raised in the Assembly action paper. Per the email sent to the JRC on December 4, 2015, The APA Administration, through research and staff discussions across divisions (Government Relations, Healthcare Systems and Financing and the Office of the General Counsel), determined that barring the discovery of certain evidence, it was premature to address this topic with the VA at this time. The APA Administration's recommendation to the JRC is twofold: (1) that we educate psychiatrists employed by the VA on potential parity violations from third party payers that require vigilance and potential reporting and (2) encourage action through the appropriate internal channels (e.g., the regional business units and the VA Office of the Inspector General) since there are empowered actors in place within the VA who are highly interested in any taxpayer money that is not being utilized.	The Joint Reference Committee thanked the CEO for the updated information. It was noted that the APA Administration will implement the recommendations from the CEO's office.	CEO/MDO Office	N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
4	Referrals to the JRC from the Board of Trustees			
4.A	<u>Revised Charge to APA/SAMHSA Minority Fellowship Selection and Advisory Committee</u> CHARGE: The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee serves in an advisory capacity to the staff in monitoring and evaluating the program in terms of meeting objectives and the impact on training programs. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor. BACKGROUND In the Fall of 2015, the Council on Medical Education and Lifelong Learning (CMELL) was asked by Francis Lu to consider expanding the charge of fellowship selection committees to ensure that each fellow received at least one mentor. An edit was introduced into the charge of each fellowship which required the selection committee to identify a mentor for each fellow. This mentor would be in addition to any other mentors a fellow might receive as part of their fellowship. CMELL is (and remains) supportive of connecting fellows with as many mentors as possible. When the BOT reviewed the proposal, longstanding inconsistencies between the fellowships were noted and it was felt that the charges of the fellowship selection committees could benefit from further evaluation, standardization, and synchronization across experiences for fellows.	The Joint Reference Committee referred the charge of the three fellowship selection committees (items 4.A, 4.B and 4.C) to the APA Administration for comprehensive review in which the APA Administration will: • Seek input form relevant stakeholders including selection committee chairs, related components and councils, and current/previous fellows • Review and standardize appointment process for selection committee members and terms of appointment • Update the charge of the fellowship selection committee, including mentorship selection, and ensure that the charge of each selection committee is standardized. • Standardize timelines for application review and fellow selection • Delineate the roles of the APA Administration members in implementing the programs • Clarify the relationship of the selection committees with relevant Councils and Components • Ensure the appropriate approvals are in place with respect the appropriate funding entities (APA/APAF) The Administration will report back to the JRC in Fall 2016.	Saul Levin, MD, CPA	CEO/MDO Office Report to Joint Reference Committee - October 2016 **Deadline**: October 5, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
4.B	Revised Charge to APA Public Psychiatry Fellowship Selection Committee CHARGE: The APA Public Psychiatry Fellowship Selection Committee is composed of five members appointed by the APA President for three-year terms. It has representation from the IPS Program Committee, APA Public Psychiatry alumni, and three members at large. The committee is not authorized to meet in person except at the APA Annual Meeting. The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor.	Please see item 4.A		
4.C	American Psychiatric Leadership Fellowship Selection and Advisory Committee CHARGE: The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor. The purposes of the APA Public Psychiatry Fellowship are (1) to heighten the awareness of psychiatric residents of the many activities of psychiatry in the public sector and of the career opportunities in this area and (2) to provide experiences that will contribute to the professional development of those residents who will play leadership roles within the public sector in future years. The APA Public Psychiatry Fellowship program provides support for outstanding residents in psychiatry to participate in APA components and attend the APA Institute on Psychiatric Services (IPS). Funds for travel, hotel, and out-of-pocket expenses are provided. During the IPS, special functions are held to recognize and honor current fellowship recipients, and activities are scheduled to augment and enrich the educational opportunities of this meeting. During the fellowship term, the Fellows are given the opportunity to plan and present a series of workshops to be presented at the next IPS. The fellowship encourages all fellows to attend the APA Annual Meeting; however, no fellowship funding is provided for this purpose.	Please see item 4.A		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
5	**Report of the Membership Committee**			
5.1	Referral Update Changing ECP Status to 8 Years Following Completion of Training (ASMMAY1512.N; JRCJULY15 6.11) The Membership Committee did not fully understand the benefits of extending ECP status by one year. The paper referenced mentorship and leadership opportunities, so giving the opportunity to serve as the ECP representative to the Assembly to more members would be a benefit. APA offers a complimentary online subscription to FOCUS, which is a benefit that would then be extended to an additional 850 members at a potential cost of $336 per subscription were these members to purchase a subscription. An analysis of the paid subscriber list for FOCUS, shows that there are currently 52 members in their 8th year after training who subscribe, so a more realistic cost is the loss of these paid subscriptions which is $17,472). Of the voting members present, three were in favor, three were opposed, and three abstained from voting.	The Joint Reference Committee referred the action paper back to the Membership Committee to determine if they could clarify and delineate their position regarding the extension of ECP status from 7 to 8 years if financial benefits were not extended and there was revenue neutrality between the 7th and 8th year of ECP status for the Association.	Jon Fanning, MS, CAE Susan Kuper	Membership Committee Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
5.2	Senior Psychiatrists (ASMMAY1512.CC; JRCOCT154.C) The committee supports the recommendation to appoint a work group comprised of members from the Board of Trustees and the Assembly and include senior psychiatrists. The work group would be charged with exploring mechanisms to best meet the needs of senior psychiatrists and make recommendations within one year. It was noted that there has been considerable concern among many senior members that they would like to "give back" at this stage of their careers but that APA has not had an appropriate place for them within the organization. It is recommended that the work group include Resident-Fellow Members and Early Career Psychiatrists to bring a different dynamic and diversity to the discussions. And having a diverse representation of member segments could lead to more collaboration and mutually beneficial partnerships between older and younger members. There was also a suggestion to include Pat Troy to participate in the work group, in her role as the Executive Director of the APA Lifers. It was suggested that the following information would be helpful in any future decision-making • Percent of members in Life status under the age of 65 (9.5%, 817 of 8,645 total members in Life status) • Percent of members 65 or older not in Life status (25.8%, 2,719 of 10,541 members 65+; includes Inactive Members/Fellows and International Members/Fellows; 736 or 7% of members 65+ are General Members, Fellows, or Distinguished Fellows on track to reach Life status) • Breakdown of current occupational status (current information not available) • Data from formal surveys of senior psychiatrists, especially regarding their interests in and feedback on APA (not aware of any recent surveys to this member segment) • APA's vision on the role of senior psychiatrists In response to the last bullet requesting information about the APA's vision on the role of senior psychiatrists, the CEO and Medical Director's Office reported that the APA is approaching the needs of senior psychiatrists like it does other segments in an effort to build member value. Based on feedback from senior psychiatrist leaders and general members, APA will launch a new webpage in mid-December that is dedicated to this segment. The page will include both new and existing resources, and ways to stay involved. Moreover, similar to other segments, the APA is asking leaders to identify any gaps that exist and then trying to identify experts on those topics to create products that are meaningful to general members of that segment. These resources will be promoted via e-mail in the first quarter of 2016. APA is also looking at sessions given at the 2016 Annual Meeting to expand educational opportunities.	The Joint Reference Committee referred the item back to the Membership Committee and requested that they use a sub work group of the Membership Committee to include a representative from the Board of Trustees and the Assembly and a Senior Psychiatrist. The sub work group is asked to address the issues and needs raised in the action paper.	Jon Fanning, MS, CAE Susan Kuper	Membership Committee Status Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6	**Assembly Report**			
6.1	<u>Access to Care Provided by the Department of Veterans Affairs</u> (ASMNOV1512.A) Action paper 12.A asks: That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans. That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans. That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA. **Will the Joint Reference Committee refer action paper 12.A: Access to Care Provided by the Department of Veterans Affairs to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.A *Access to Care Provided by the Department of Veterans Affairs* to the Council on Advocacy and Government Relations (LEAD) and the Council on Healthcare Systems and Financing. A report back is requested for the June 2016 JRC.	Jeffrey Regan Deana McRae Kristin Kroeger Becky Yowell	Council on Advocacy and Government Relations (LEAD) Council on Healthcare Systems and Financing Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.2	Prior Authorization (ASMNOV1512.D) Action paper 12.D asks that the APA explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization. **Will the Joint Reference Committee refer action paper 12.D: Prior Authorization to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.D *Prior Authorization* to the APA AMA Delegation for development of an appropriate resolution for submission at the AMA House of Delegates.	Kristin Kroeger Becky Yowell	APA AMA Delegation Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
6.3	Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Support Product (ASMNOV1512.E) Action paper 12.E asks: That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting. **Will the Joint Reference Committee refer action paper 2015A2 12.E: Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Support Product to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.E *Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Support Product* to the Council on Quality Care (LEAD) and the Council on Research. The Joint Reference Committee requested that they explore the feasibility of such a product including researching what is currently available and creating a standard process by which to evaluate the products currently on the market.	Kristin Kroeger Samantha Shugarman, MS Philip Wang, MD, Dr.PH Jennifer Shupinka	Council on Quality Care (LEAD) Council on Research Status Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.4	<u>Payer Coverage for Prescriptions from Nonparticipating Prescribers</u> (ASMNOV1512.F) The action paper 12.F asks: 1) That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and 2) That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and 3) That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and 4) That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists. **Will the Joint Reference Committee refer action paper 12.F: Payer Coverage for Prescriptions from Nonparticipating Prescribers to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.F *Payer Coverage for Prescriptions* from Nonparticipating Prescribers to multiple entities as follows: • Items 1 & 4 to the APA's Policy Department; • Item 2 to the Division of Government Affairs; • Item 3 to the Council on Healthcare Systems and Financing	Kristin Kroeger Jeffrey Regan Becky Yowell	APA Policy Department Division of Government Affairs Council on Healthcare Systems and Financing Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.5	<u>APA Support for NIMH Funding of Clinical Research</u> (ASMNOV1512.G) Action paper 12.G asks that the APA shall: 1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget. 2. The APA will advocate the implementation of the recommendations of the White Paper. **Will the Joint Reference Committee refer action paper 12.G: APA Support for NIMH Funding of Clinical Research to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.G *APA Support for NIMH Funding of Clinical Research* to the Council on Research and the Division of Research. The JRC requested an interim update in June 2016 and a full report in October 2016. Given that a new Director of NIMH will begin in July 2016, it was thought that there may be additional information and/or direction regarding the NIMH's research agenda at that time.	Kristin Kroeger Philip Wang, MD, Dr.PH Jennifer Shupinka	Council on Research Division of Research Interim Update to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016 Report to the Joint Reference Committee – October 2016 **Deadline**: October 5, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.6	<u>It is Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fair to Comply with Parity</u>? (ASMNOV1512.H) The action paper asks: That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting. The Ethics Committee review will specifically address at least the following questions: 1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law? 2) If an insurance company policy or the review standards that guide a psychiatrist reviewer's decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer? 3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law? The Assembly voted to refer action paper 12.H to the Council on Healthcare Systems and Financing. **Will the Joint Reference Committee refer action paper 12.H: Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity? to the Council on Healthcare Systems and Financing for input or follow-up?**	The Joint Reference Committee did not approve referring action paper 12.*H Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?* to the Council on Healthcare Systems and Financing. The Joint Reference Committee noted that the Assembly did not act to pass or fail the action paper and instead referred it to the Council on Healthcare Systems and Financing. The JRC was unclear as to the purpose of the referral and what would happen to a response from the Council. It was noted that the author requested and received an opinion from the Ethics Committee on this issue.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.7	Strengthening the Role of Residency Training to Improve Access to Buprenorphine (ASM NOV1512.I) The action paper asks that the DSM Steering Committee explore adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5. **Will the Joint Reference Committee refer action paper 2014A2 12.I: *Strengthening the Role of Residency Training to Improve Access to Buprenorphine* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.I *Strengthening the Role of Residency Training to Improve Access to Buprenorphine* to the Council on Medical Education and Lifelong Learning.	Kristin Kroeger Tristan Gorrindo, MD	Council on Medical Education and Lifelong Learning Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
6.8	Equality in Permanent Licensure Policy (ASMNOV1512.K) The action paper asks: That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards. That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure. **Will the Joint Reference Committee refer action paper 12.K: *Equality in Permanent Licensure Policy* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.K *Equality in Permanent Licensure Policy* to the Council on Medical Education and Lifelong Learning (LEAD) Council on International Psychiatry re: IMG issues (SECONDARY)	Kristin Kroeger Tristan Gorrindo, MD Ricardo Juarez, MS	Council on Medical Education and Lifelong Learning (LEAD) Council on International Psychiatry (SECONDARY) Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.9	Partial Hospital Training in Psychiatry Residency (ASMNOV1512.L) Action paper 12.L asks that the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency. **Will the Joint Reference Committee refer action paper 12.L: Partial Hospital Training in Psychiatry Residency to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.L *Partial Hospital Training in Psychiatry Residency* to the Council on Medical Education and Lifelong Learning.	Kristin Kroeger Tristan Gorrindo, MD	Council on Medical Education and Lifelong Learning Report to the Joint Reference Committee - June 2016 **Deadline**: May 23, 2016
6.10	Advocating for Medicaid Expansion (ASMNOV1512.N) Action paper 2015A2 12.N asks: That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion (2); That a status report and recommendations be made to the Assembly at the May 2016 meeting. **Will the Joint Reference Committee refer action paper 2015A2 12.N: Advocating for Medicaid Expansion to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.N *Advocating for Medicaid Expansion* to the CEO/MDO Office and the APA Administration and requested a report to the Assembly in May 2016 and a report to the Joint Reference Committee in June 2016.	Saul Levin, MD, MPA Jeffrey Regan	CEO/MDO Division of Government Affairs Assembly – May 2016 **Deadline**: March 24, 2016 Report to Joint Reference Committee – June 2016. **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.11	Systems to Coordinate Psychiatric Inpatient Bed Availability (ASMNOV1512.O) Action paper 12.O asks that the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care. **Will the Joint Reference Committee refer action paper 2015A2 12.O: Systems to Coordinate Psychiatric Inpatient Bed Availability to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.O *Systems to Coordinate Psychiatric Inpatient Bed Availability* to the Council on Quality Care (LEAD) and the Council on Healthcare Systems and Financing.	Kristin Kroeger Samantha Shugarman, MS Becky Yowell	Council on Quality Care (LEAD) Council on Healthcare Systems and Financing Report to Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
6.12	Making Access to Treatment for Erectile Disorder Available Under Medicare (ASMNOV1512.P) Action paper 2015A2 12.P asks: That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner. That the Council on Advocacy and Government Relations and the Council on Healthcare Systems and Financing advocate, along with other professional societies and advocacy groups, for legislation to allow access to the full array of medications, mechanical therapies, and other treatments for Erectile Disorder which are currently excluded from coverage under Medicare. **Will the Joint Reference Committee refer action paper 12.P: Making Access to Treatment for Erectile Disorders Available Under Medicare to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee did not refer the action paper 12.P: *Making Access to Treatment for Erectile Disorders Available Under Medicare* to a component(s). The Joint Reference Committee noted that the action paper does not fit within the APA's strategic goals and initiatives and the necessary prioritization of the current work to implement these goals.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.13	<u>Senior Psychiatrist Seat on the Board of Trustees (BOT)</u> (ASMNOV15A2 12.R) The action paper asks that asks: 1. Create a Senior Psychiatrist seat on the BOT. 2. The Senior Psychiatrist Trustee would be elected by the Life Members. The Assembly voted to refer Action paper 2015A2 12.T to the Joint Reference Committee. **Will the Joint Reference Committee refer action paper 12.R: Senior Psychiatrist Seat on the Board of Trustees (BOT) to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee discussed the issues presented within the action paper. The JRC recognized the need to provide APA members at all levels opportunities to actively participate in the Association's work. It was noted that the members of the Board of Trustees do not represent anyone or any particular segment of the organization. The Administration will assist the Membership Committee sub work group (see item 5.2) to assess access to opportunities for senior psychiatrists (Leadership opportunities on the Board of Trustees and Assembly; component appointment; Awards; access to benefits; etc) to ensure that such opportunities are equitable for all members. The JRC recommended that a communication from the APA leadership to the APA senior psychiatrists be drafted relaying the efforts to date and future plans.	Saul Levin, MD, MPA Jon Fanning, MS, CAE	CEO/MDO Office
6.14	<u>Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices</u> (JRCJUL158.B.1/ASMNOV154.B.5) The Assembly voted to refer the Position Statement to the Joint Reference Committee to assign to relevant bodies to draft a more meaningful position statement on DTC Advertising. The draft position statement should be presented to the Assembly in November, 2016. **Will the Joint Reference Committee refer the AMA's 2010 Position Statement: *Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred this item to the Council on Quality Care and requested that the Council draft a new position statement on Direct to Consumer Advertising. The Council is asked to obtain feedback and input on the draft statement from the Council on Advocacy and Government Relations and the Council on Communications.	Kristin Kroeger Samantha Shugarman, MS Jeffrey Regan Deana McRae Jason Young James McCarty	Council on Quality Care Council on Advocacy and Government Relations Council on Communications Report to Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.15	<u>Retire 2007 Position Statement: Sexual Harassment</u> (JRCJUL158.J.2/ASMNOV154.B.9) The Assembly voted to retain the 2007 Position Statement: *Sexual Harassment* as the Assembly felt the position is still relevant and includes the recommendation for necessary treatment and recognition of the need for treatment. **Will the Joint Reference Committee refer Position Statement: *Sexual Harassment* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee revised the position statement and recommended that the Assembly approve the revised Position Statement: *Sexual Harassment* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
7	**Council Assessments**			
7.A	Council on Psychiatry and Law	The Joint Reference Committee accepted the Council's 3-year assessment and thanked them for their work. The JRC noted that the Council provided a very detailed and clear report.		
7.B	Council on Quality Care	The Joint Reference Committee accepted the Council's 3-year assessment and thanked them for their work.		
8.A	**Council on Addiction Psychiatry** Please see item 8.F for the Council's report, summary of current activities and information items.			
8.A.1	<u>Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders</u> **Will the Joint Reference Committee recommend that the Assembly vote to approve the proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Equitable Access to Quality Medical Care for Substance Related Disorders*, and if approved, forward it to the Board of Trustees for consideration. Please note the minor JRC revision to the proposed position statement.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.A.2	Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-occurring Mental Illnesses **Will the Joint Reference Committee recommend that the Assembly vote to approve the proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-occurring Mental Illnesses, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement on *Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone* with that of Co-occurring Mental Illness to the Assembly and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.B	**Council on Advocacy and Government Relations**			
8.B.1	Retain Position Statement: Any Willing Physician **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement: *Any Willing Physician*, and if retained, forward it to the Board of Trustees for consideration?** Rationale: Members agreed the intent of the statement is applicable to current issues concerning workforce and scope of practice.	The Joint Reference Committee recommended that the Assembly retain the Position Statement: *Any Willing Physician*, and if retained, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B.2	Referral Update Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G; JRCJULY156.6) **Will the Joint Reference Committee request from the Assembly (Assembly Executive Committee) clarification of the action paper, including a definition of the problem being addressed?** The Council on Advocacy and Government Relations discussed the JRC referral of Action Paper, "Timely Reimbursement for Psychiatric Treatment" (ASMMAY1512.G). The Council examined the correlation of the timeliness of payment systems and increased participation in plans by psychiatrists, as presented in the Action Paper. Members offered feedback related to reimbursement systems and relative practicality in solo/private practices compared to larger healthcare settings. The Council—agreeing with the comments from the Council on Healthcare Systems and Financing—found the Action Paper does not clearly define its objective or provide a clearly understood outcome for resolution. Through unanimous consent, the Council seconded the recommendation of the Council on Healthcare Systems and Financing and recommended the Action Paper be returned to the authors for further clarification.	Dr. Anzia informed the Joint Reference Committee that the Assembly Executive Committee reviewed the action paper to clarify the paper's intent. They consulted with some of the original authors and Information received from the authors indicated the intent was to ensure that the APA would be involved in efforts to improve physician payment via a card linking the medical record, the cloud and payment systems. Similar systems have been vetted or are already in use in Europe. The Joint Reference Committee thanked Dr. Anzia for the clarification and recommended that the APA Administration reach out to HHS' Office of Coordination to determine what, if anything, the U.S. Government may be doing on this front. It was also recommended that the AMA be approached to ascertain their position and if indicated consider developing a resolution for the AMA House of Delegates.	Saul Levin, MD, CPA Kristin Kroeger	APA Administration CEO/MOD Update to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
8.C	**Council on Children, Adolescents and Their Families**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.C.1	Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Psychiatric Hospitalization of Children and Adolescents*, and if approved, forward it to the Board of Trustees for consideration?** Rationale: The statement was revised as it was out of date, included inaccurate statements and did not highlight current concerns in the field. The Council has integrated the feedback and recommendations from the JRC into this version of the document	The Joint Reference Committee recommended that the Assembly approve the revised Position Statement: *Psychiatric Hospitalization of Children and Adolescents*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.C.2	Parent Medication Guide on Autism **Will the Joint Reference Committee recommend that the Board of Trustees approve the Parent Medication Guide on Autism?** Parent medication guides, jointly produced by APA and the American Academy of Child and Adolescent Psychiatrists, are resources to help parents understand medication safety issues. The autism guide is the latest in the series, which include guides on ADHD, bipolar disorder in children and adolescents, and childhood and adolescent depression. The entire collection is available at http://parentsmedguide.org.	The Joint Reference Committee recommended that the Board of Trustees approve the *Parent Medication Guide on Autism*. It was noted that this document was not APA Policy. **1/29/16** N.B. Since the JRC reviewed the document, the AACAP has made revision to the *Parent Medication Guide on Autism.* These revisions will be reviewed by the Council on Children, Adolescents and Their Families and then the JRC in order that this document be forwarded to the Board of Trustees at their March 2016 meeting.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman/Laurie McQueen	Board of Trustees – March 2016 **Deadline**: February 24, 2016
8.D	**Council on Communications** No action items	The Joint Reference Committee thanked the Council for their verbal report.		
8.E	**Council on Geriatric Psychiatry**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.E.1	Proposed Position Statement: Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Role of Psychiatrists in Assessing Driving Ability* and if approved, forward it to the Board of Trustees for consideration?** The most recent draft of this position statement revision was created with input from the Council on Psychiatry and the Law. When last reviewed by the JRC, it was suggested that reformatting might be in order. As of this writing, we are trying to determine if this has been accomplished.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Role of Psychiatrists in Assessing Driving Ability* and if approved forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.E.2	Referral Update – no action needed Principles of End of Life Care for Psychiatry (2001) (JRCJAN158.E.3) The Council is working on this project with the Council on Psychosomatic Medicine. The creation of the first draft was delayed due to the illnesses of several members of the workgroup. As of this writing, a conference call is planned for January to move this project forward.	The Joint Reference Committee thanked the Council for the update.		
8.F	**Council on International Psychiatry** Please see item 8.F for the Council's report, summary of current activities and information items. The council does not have any action items.	The Joint Reference Committee thanked the Council for their verbal report.		
8.G	**Council on Healthcare Systems and Financing** Please see item 8.G for the Council's report, summary of current activities and information items.			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.1	<u>Proposed Position Statement: Integrated Care</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Integrated Care, and if approved, forward it to the Board of Trustees for consideration?** Input on this position statement was provided by the Council on Psychosomatic Medicine, the Council on Healthcare Systems and Financing and it's Work Group on Integrated Care.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Integrated Care* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.2	<u>Proposed Position Statement on Off-Label Treatments</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Off-Label Treatments*, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Off-Label Treatments* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.3	If item 8.G.2 is approved, <u>Retire Position Statement: Patient Access to Treatments Prescribed by Their Physicians</u> (2007) **Will the Joint Reference Committee recommend that the Assembly retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians*, and if retired, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that. if the proposed Position Statement: *Off-Label Treatments* is approved by the Assembly, the Assembly should then vote to retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians* and forward to the Board of Trustees for a similar vote on retirement.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.4	Proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *The Call to Action: Accountability for Persons with Serious Mental Illness*, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Call to Action: Accountability for Persons with Serious Mental Illness* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.5	If item 8.G.4 is approved: Retire Position Statement: A Call to Action for the Chronic Mental Patient **Will the Joint Reference Committee recommend that the Assembly retire the Position Statement: *A Call to Action for the Chronic Mental Patient*, and if approved forward it to the Board of Trustees to consideration?**	The Joint Reference Committee recommended that the proposed Position Statement: *The Call to Action: Accountability for Persons with Serious Mental Illness* be referred to the Assembly for review and possible retirement. If the Assembly retires the Position Statement: *A Call to Action for the Chronic Mental Patient*, it will then be forwarded to the Board of Trustees for retirement.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.H	**Council on Medical Education and Lifelong Learning** Please see item 8.H for the Council's report, summary of current activities and information items. The council does not have any action items	The Joint Reference Committee thanked the Council for their verbal report.		
8.I	**Council on Minority Mental Health and Health Disparities**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.1	Referral Update – no action needed Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H; JRCJULY156.7) The council's Work Group on Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault held conference calls on October 20 and November 17. The work group is currently conducting a literature review and is researching nationwide protocols and requirements for mental health care to victims, roadblocks to access to care, funding issues, and legislation related to sexual assault. A draft rape resource document, prepared by work group chairperson Dr. De Faria, was completed. Because the Council on Psychiatry and Law felt that the documents needed additional work (more references and focus on psychiatry), it is now re-circulating among work group members for editing and expansion.	The Joint Reference Committee thanked the Council for the update.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.2	Referral Update – no action needed Impact of Global Climate Change on Mental Health (ASMMAY1512.L; JRCJULY156.9) The Work Group on the Impact of Global Climate Change on Mental Health has examined bibliographies and references (including APA Position Statements related to climate change) as well as a recent publication on the destruction of Hurricane Sandy. Dr. Rao (WG Chairperson) held consultations with a number of psychiatrists interested in this issue for their perspectives. The Work Group recommends that APA develop a position statement on the psychiatric impact of climate change. The Committee on Psychiatric Dimensions of Disasters would be the appropriate component to write the statement in view of its expertise. Feedback from the Council, the Committee on Psychiatric Dimensions of Disasters and the Council on International Psychiatry on this issue is provided in the attachment.	The Joint Reference Committee referred the item to the Council on Research and its Committee on Psychiatric Dimensions of Disasters. The Committee is asked to develop a position statement on the psychiatric impact of climate change including the effects of climate change on minority populations.	Kristin Kroeger Philip Wang, MD, Dr.PH Jennifer Shupinka Ricardo Juarez, MS	Council on Research Committee on Psychiatric Dimensions of Disasters Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
8.J	**Council on Psychiatry and Law**			
8.J.1	Position Statement: College and University Mental Health **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *College and University Mental Health*, and if approved, forward it to the Board of Trustees for consideration?** N.B. this position statement replaces the 2005 position statement of the same name.	The Joint Reference Committee recommended that the Assembly approve the Proposed Position Statement *College University Mental Health* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.2	Resource Document: College and Mental Health and Confidentiality **Will the Joint Reference Committee approve the Resource Document College Mental Health and Confidentiality?** N.B. this resource document replaces the 2009 resource document of the same name.	The Joint Reference Committee approved the Resource Document *College and Mental Health and Confidentiality.*	Jon Fanning, MS, CAE	APA Administration
8.J.3	Referral Update – no action needed Location of Civil Commitment Hearings (ASMMAY1512.V; JRCJULY156.16) The Civil Commitment Workgroup, chaired by Dr. Elizabeth Ford, has had many email discussions and a conference call. The workgroup has reached out to the author of the action paper for clarification and is now currently working on a draft position paper. A draft copy will be sent to the JRC for review in June.	The Joint Reference Committee thanked the Council for this update and noted that a draft may be received by the Joint Reference Committee in June.	Jeffrey Regan Lori Klinedinst/Vincent Pacileo	Council on Psychiatry and Law Report to Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
8.J.4	Referral Update – no action needed Physician Assistance with Dying Work Group After their joint meeting with the Committee on Judicial Action, Council on Geriatric Psychiatry, and the Ethics Committee, the Council on Psychiatry and Law created a workgroup on Physician Assistance with Dying. The workgroup has been meeting by conference call and is currently reviewing requests from District Branches and collecting information.	The Joint Reference Committee thanked the Council for the update. Dr. Hoge noted that Dr. Anfang is chairperson of the Work Group and given the complexity of the issue, development of recommendations or work product may take longer to complete than originally thought. The goal is to develop a resource document and it is hoped that a draft will be ready for review in 6 months.	Jeffrey Regan Lori Klinedinst/Vincent Pacileo	Council on Psychiatry and Law Report to Joint Reference Committee – October 2016 **Deadline**: October 5,, 2016
8.K	**Council on Psychosomatic Medicine**	The Joint Reference Committee thanked the Council for their verbal report.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.K.1	<u>Proposed Position Statement: Emergency Department Boarding of Individuals with Psychiatric Disorders</u> (JRCOCT156.13) (Please see attachment) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Emergency Department Boarding of Individuals with Psychiatric Disorders, and if approved, forward it to the Board of Trustees for consideration?** Background: The number of individuals with acute mental illness who are seeking psychiatric care in emergency department (ED) settings is increasing. This is due in part to the inadequacy of mental health resources in the community, including both inpatient and outpatient services. Given the long wait times and inadequate care that patients receive, the APA Assembly passed an Action Paper in May 2015 in an effort to address this situation. The position statement was developed as a result of the Action Paper, with the goal to increase the visibility of the problem and identify solutions to improve patient care. Dr. Kim Nordstrom was the lead author of the position statement. The statement was reviewed by the Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Emergency Department Boarding of Individuals with Psychiatric Disorders*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly - May 2016 **Deadline**: March 24, 2016
8.L	**Council on Quality Care**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.1	Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement: *Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research*, and if retained, forward it to the Board of Trustees for consideration?** Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.	The Joint Reference Committee recommended that the Assembly retain the Position Statement: *Conflict of Interests for Clinical Practice and Research*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly - May 2016 **Deadline**: March 24, 2016
8.L.2	Retain Position Statement: Psychotherapy **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement: *Psychotherapy*, and if retained, forward it to the Board of Trustees for consideration?** Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.	The action item was withdrawn.	N/A	N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.3	Retain Position Statement: Patient-Physician Covenant **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement*: Patient-Physician Covenant*, and if retained, forward it to the Board of Trustees for consideration?** Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.	The action item was withdrawn.		
8.L.4	Retain Position Statement: Confidentiality of Medical Records and Physician Right to Privacy Concerning His/Her Own Health Record **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement: *Confidentiality of Medical Records and Physician Right to Privacy Concerning His/Her Own Health Record*, and if retained, forward it to the Board of Trustees for consideration?** Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.	The Joint Reference Committee referred the position statement *Confidentiality of Medical Records and Physician Right to Privacy Concerning His/Her Own Health Record* to the Council on Psychiatry and Law for revision.	Kristin Kroeger Jeffrey Regan Lori Klinedinst/Vincent Pacileo	Council on Psychiatry and Law Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
8.M	**Council on Research**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.1	Revised Position Statement: Atypical Antipsychotic Medications **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Atypical Antipsychotic Medications* and if approved, forward it to the Board of Trustees for consideration?** Rationale: The statement is still relevant, but the Council is recommending that this statement be revised slightly for language and clarity. Edits to language also include those made in response to concerns expressed by the JRC at their October meeting that called for stronger wording against the off-label use of antipsychotic medications, such as for the inappropriate management of sleep.	The Joint Reference Committee referred this position statement to the Council on Geriatric Psychiatry for their feedback to the Council on Research prior to the June 2016 report deadline. The JRC requested that the Council on Research refocus the issue statement. Dr. Anzia may provide some suggested language to the Council.	Kristin Kroeger Ranna Parekh, MD, MPH Sejal Patel Philip Wang, MD, Dr.PH Jennifer Shupinka	Council on Geriatric Psychiatry Council on Research Report to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
8.M.2	Request to publish: Manuscript on clinical use of rTMS for depression management **Will the Joint Reference Committee recommend that the Board of Trustees approve the submission of the Council on Research's manuscript on the clinical use of rTMS for depression management to the *American Journal of Psychiatry for publication?*** N.B. This paper was developed primarily by members of the Council's Workgroup on Diagnostic Markers and Treatment in collaboration with the National Network of Depression Centers (NNDC) rTMS Task Force. The entire Council has reviewed and provided feedback. They would like to submit this manuscript to the American Journal of Psychiatry.	The Joint Reference Committee recommended that the Board of Trustees approve the submission of the Council on Research's manuscript on the clinical use of rTMS for depression management to the *American Journal of Psychiatry* for publication.	Shaun Snyder, JD Margaret Dewar Laurie McQueen/Ardell Lockerman	Board of Trustees - March 2016 **Deadline**: February 24, 2016
9	**Awards**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
9.A	2016 Nancy C.A Roeske Certificate of Recognition for Excellence in Medical Education **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Education nominees: Lourdes Dominguez, MD (Columbia University); Valier Houseknecht, MD (Wright State University – Boonshoft School of Medicine); Abigail Kay, MD (Thomas Jefferson University – Sidney Kimmel Medical College); Shirin Ali, MD (Columbia University); Eduardo Speiridion, MD (West Virginia School of Osteopathic Medicine); and Katherine Winner, MD?**	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Education nominees: Lourdes Dominguez, MD (Columbia University); Valier Houseknecht, MD (Wright State University – Boonshoft School of Medicine); Abigail Kay, MD (Thomas Jefferson University – Sidney Kimmel Medical College); Shirin Ali, MD (Columbia University); Eduardo Speiridion, MD (West Virginia School of Osteopathic Medicine); and Katherine Winner, MD.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman/Laurie McQueen	Board of Trustees – March 2016 **Deadline**: February 24, 2016
9.B	2016 Irma Bland Award for Excellence in Teaching Residents (Please see attachment 9.B) **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 Irma Bland Award for Excellence in Teaching Residents nominees: William C Jangro, MD; Sander Markx, MD; James F Luebbert, MD**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 Irma Bland Award for Excellence in Teaching Residents nominees: William C Jangro, MD; Sander Markx, MD; James F Luebbert, MD.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman/Laurie McQueen	Board of Trustees – March 2016 **Deadline**: February 24, 2016
10	JRC Revised Composition **Will the Joint Reference Committee recommend that the Board of Trustees approve the revision to the Joint Reference Committee as detailed in attachment #10?**	The Joint Reference Committee recommended that the Board of Trustees approve the revision to the composition of the JRC to replace the Immediate Past President with the APA Secretary and name the two Assembly Representatives as the Assembly Recorder and the Immediate Past Speaker.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman/Laurie McQueen	Board of Trustees – March 2016 **Deadline**: February 24, 2016

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
11	Old Business 2016 Jacob Javits Award Will the JRC recommend that the Board of Trustees approve the 2016 Jacob Javits Award nominee, US Representative Tim Murphy R-PA?	The Joint Reference Committee deferred action on the 2016 Jacob Javits Award nominee until the June 2016 Joint Reference Committee meeting.	Shaun Snyder, JD Margaret Dewar Laurie McQueen Jeffrey Regan Deana McRae	Joint Reference Committee - June 2016 **Deadline**: May 23, 2016 Division of Government Affairs - FYI

Draft Minutes of a Meeting of the Assembly
American Psychiatric Association
Omni Shoreham Hotel, Washington, DC
October 30-November 1, 2015

Welcome and Introductions

Dr. Glenn Martin, Speaker of the Assembly, called the 83rd meeting of the Assembly of the American Psychiatric Association (APA) to order on October 30, 2015, at the Omni Shoreham in Washington D.C. Dr. Martin and the other Assembly officers welcomed the new members of the Assembly. Dr. Martin referred to his report (3.B) concerning the meetings and final summary of actions of the Board of Trustees.

1. Remarks of the Board of Trustees

Report of the APA President

Dr. Renée Binder, APA President addressed the Assembly. She reinforced the need for the APA to be involved in the issue of jails and prisons and the decriminalization of people with mental illness. Dr. Binder attended a congressional briefing on this topic which included representatives from law enforcement, NAMI, and correctional psychiatrists. In addition, the APA is co-sponsoring a conference called the "Stepping Up Initiative" with National Association of Counties which is designed to help communities to reduce the number of people with mental illnesses in U.S. jails and prisons.

Dr. Binder spoke about the newly established American Psychiatric Excellence (APEX) Awards which will be April 18, 2016 in Washington, DC. The awards will be a chance for APA to honor and recognize those who are "working to support humane care and effective treatment for individuals with mental disorders". She encouraged members of the Assembly to attend or contribute to the event. Dr. Binder concluded her remarks by thanking Dr. Martin and the Assembly for its hard work and responding to questions from the audience.

Report of the APA President-Elect

Dr. Maria Oquendo, APA President-Elect, began her remarks by having members of the Assembly serving on APA components stand, introduce themselves and identify the component(s) on which they serve. She emphasized the need for the Councils and the Assembly to work together before action papers are forwarded to the JRC. Improved coordination will help the papers be expedited through the APA. Dr. Oquendo concluded her remarks by answering some questions from the Assembly.

1.C Report of the APA Treasurer

Dr. Frank Brown, Treasurer, presented his report to the Assembly. The APA's net income year-to-date is $8.3 million, compared to $14.4 million the same time last year. The difference is

due to decreased sales of the DSM-5 and the decrease in Annual Meeting attendance, both of which were anticipated and factored into the budget. The annual budget is -$3.2 million. The net assets are $87.5 million compared to $79.2 million last year. The American Psychiatric Association Foundation's net income is $700,000 compared to $100,000 the same time last year. The annual budget is -$4 million. The net assets are $61.3 million.

Membership revenue is $11.3 million, non DSM publishing is $10.6 million and CME revenue is $9.4 million. Unrestricted operating income is $5.9 million and non-operating income is $2.4 million. Dr. Brown completed his report by updating the Assembly on the APA's investment portfolio and the positive health of the APA/APAF reserves which are at $134 million.

2. Report of the Chief Executive Officer and Medical Director

Dr. Saul Levin, CEO and Medical Director, addressed the Assembly. He began by thanking the Assembly Officers as well as the Assembly itself for its hard work. He also thanked the APA Administration. Dr. Levin gave an update on the recent IPS meeting in New York City, which had a record 1,600 attendees. The APA hosted a state advocacy conference in Hollywood, Florida which had participation from 44 states. The conference focused on the Mental Health Parity and Addiction Equity Act (MHPAEA) and scope of practice. The APA has created a toolkit on scope of practice which is available for APA members on the APA website at: http://www.psychiatry.org/about-apa/meet-our-organization/district-branches/unsafe

Dr. Levin updated the Assembly on the APA's work on parity enforcement. Through the APA's lawsuit against Anthem, New York State Psychiatric Association's lawsuit and ruling against United, the APA has highlighted the need for companies to evaluate their insurance carriers to ensure they are complying with parity. Dr. Levin also reminded the group about the new electronic form to register Pharmacy Benefits complaints available on the APA website.

The APA received a four-year, $2.9 million Transforming Clinical Practices-Support Alliance Networks (SAN) grant from the Centers for Medicare and Medicaid Services (CMS). The grant provides support for APA to train 3,500 consulting psychiatrists to work in a collaborative model. Dr. Levin thanked Ms. Kroeger and her team for their work in drafting the successful grant proposal.

Dr. Levin concluded his presentation by updating the Assembly on the status of APA's potential involvement in creating a registry and answering some questions from Assembly members.

4. Report of the Speaker-Elect

Dr. Daniel Anzia, Speaker-Elect, referred the Assembly to his Joint Reference Committee Summary of Actions and Draft Actions Report (4.A and 4.B).

5. Report of the Recorder

Dr. Theresa Miskimen, Recorder, determined if a quorum was present by asking if representatives from the following District Branches were in attendance: Connecticut Psychiatric Society, New Hampshire Psychiatric Society, Vermont Psychiatric Association, Mid-Hudson Psychiatric Society,

Northern New York District Branch, Nebraska Psychiatric Society, Wisconsin Psychiatric Association, South Carolina Psychiatric Association, Tennessee Psychiatric Association, Psychiatric Society of Virginia, Colorado Psychiatric Society. Connecticut Psychiatric Society, New Hampshire Psychiatric Society, Vermont Psychiatric Association, Wisconsin Psychiatric Association, South Carolina Psychiatric Association, Tennessee Psychiatric Association, Psychiatric Society of Virginia, and the Colorado Psychiatric Society had representation at the meeting. Hearing no further responses from the named District Branches, Dr. Miskimen declared a quorum of the Assembly.

Dr. Miskimen referred to her report in Section 5, items A-C, of the backup materials. She asked that the Assembly approve the minutes of the May 15-17, 2015 Assembly meeting (5.A).

Action: Will the Assembly vote to approve the minutes of its May 15-17, 2015 Meeting?

The Assembly voted to approve the May 2015 Assembly Minutes.

6. Report of the Rules Committee

Dr. Jenny Boyer, Chair of the Assembly Rules Committee, referred the Assembly to the Rules Committee report and explained the role of the Rules Committee. Item 6.A included the action assignments to reference committees and other Assembly groups. Dr. Boyer presented Item 6.B, the consent calendar, and asked if any member of the Assembly wished to add or remove an item. Items 4.B.3, 4.B.5, 4.B.9, and 12.S were removed from the consent calendar.

Action: Will the Assembly vote to approve the Consent Calendar with items 4.B.3, 4.B.5, 4.B.9 and 12.S removed?

The Assembly voted to approve the Consent Calendar with items 4.B.3, 4.B.5, 4.B.9 and 12.S removed.

Dr. Boyer presented Item 6.C, Special Rules of the Assembly. These are the usual rules governing debate in the Assembly. The Rules Committee moved that the Assembly adopt the *Special Rules of the Assembly* for this meeting.

Action: Will the Assembly vote to adopt the Special Rules of the Assembly for this meeting?

The Assembly voted to adopt the *Special Rules of the Assembly* for this meeting.

7. Reports from Assembly Committees

7.A Nominating Committee

Dr. Jenny Boyer, Chair of the Nominating Committee, thanked the committee members for their work and also thanked all members who expressed interest in running for Assembly office. The candidates for 2016-2017 are:

Speaker-Elect:

John de Figueiredo, M.D., Area 1

Theresa Miskimen, M.D., Area 3

Recorder:

James R. (Bob) Batterson, M.D., Area 4

David Scasta, M.D., Area 3

A motion was made from the floor to close nominations as follows:

Action: Will the Assembly vote to accept the candidates for the 2016-2017 Assembly election?

The Assembly voted to accept the candidates for the 2016-2017 Assembly election.

7.B Committee on Procedures

The Committee brought the following item forward to the Assembly for approval.

Action: Will the Assembly vote to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component"?

The Assembly voted to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component".

8. Reports from APA Councils

APA Council Reports may be found in the backup materials.

10. Reports from Special Components

10.A AMA APA Delegation

Dr. Carolyn Robinowitz recognized members of the Assembly who participate and contribute to the AMA. She stated that the section council on psychiatry represents not only the APA but also other psychiatric groups such as child and geriatric psychiatry. Many psychiatrists have taken leadership positions within the AMA, such as Dr. Jeremy Lazarus, Past President of the AMA as well as Past Speaker of the Assembly, and Dr. Patrice Harris who has been re-elected to the AMA Board of Trustees as chair-elect. In addition, Dr. Jack McIntyre, Past President of the APA, is running for AMA Board of Trustees. Dr. Robinowitz encouraged the Assembly to join the AMA, promote AMA membership and participation in the local medical societies.

American Psychiatric Association Political Action Committee [APA*PAC*]

Dr. Charles Price, Chair, APA*PAC,* presented a report to the Assembly. Dr. Price stressed the importance of donating to the APA*PAC*. He noted that 100% of the Assembly Executive Committee (AEC), members of the Council on Advocacy and Government Relations, and the APAPAC Board had donated to the APA*PAC*. The goal is for the Assembly to also reach 100% participation to help the APA demonstrate its leadership support of the APA*PAC*. Dr. Price concluded his presentation by recognizing some of the members who have donated in excess of $1,000 to the APA*PAC*.

Assembly Profile of Courage Award

Dr. Melinda Young, Awards Committee Chair, presented the Assembly Profile of Courage Award to Dr. Steven Sharfstein, Past President of the APA, in recognition of his leadership in highlighting the ethical concerns about any participation of psychiatrists on interrogation teams. In addition, the Assembly noted his active participation in developing a formal position by the APA which states categorically that psychiatrists shall not participate in torture.

Paul Burton, M.D.: Out of Sight, Out of Mind: The Mass Incarceration of American Mental Illness

Dr. Paul Burton, Chief Psychiatrist at the San Quentin State Prison, addressed the Assembly on the incarceration of the mentally ill. Dr. Burton noted that there are 2.2 million people incarcerated in the United States and approximately 16% have a serious mental illness. Nationwide, about 15% of the prison inmates are prescribed psychiatric medications.

Dr. Burton stated that, due to closures, jails and prisons have become more like state psychiatric hospitals which are certainly not ideal settings for mentally ill individuals with 10 times more individuals with severe mental illness in jails and prisons than in state hospitals nationally. Dr. Burton emphasized the need for improved access to community treatment, robust outreach to law enforcement to improve police relations with the mentally ill, and monitoring of the "tough on crime" laws.

Dr. Burton explained that San Quentin has created anger management groups and parenting groups which have helped change the culture of the prison so that inmates who previously may have shunned mental health services are now receiving some mental health care. He stressed that there is a need for more psychiatrists in the prisons but noted also that the shortage of psychiatrists nationwide also has an impact on the prison system.

Report from the American Psychiatric Association Foundation

Dr. Saul Levin, MPA, (Chairperson of the APAF Board of Directors and Chief Executive Officer and Medical Director of APA) and Paul Burke (Executive Director of APAF) reported on the recent activities of the American Psychiatric Association Foundation (APAF). The Foundation has a number of ongoing programs including the *Partnership for Workplace Mental Health and Typical or Troubled*?® and the *School Mental Health Education Program*. In addition, the Foundation, along with the National Association of Counties and the Council of State Governments Justice Center, will be hosting a Stepping Up Summit April 17-19, 2016, which will focus on helping to decriminalize people with mental illness. The new American Psychiatric Excellence (APEX) Awards will be presented on April 18, 2016. The Foundation is also hosting a benefit on May 14th at the Georgia Aquarium during the Annual Meeting in

Atlanta. Dr. Levin and Mr. Burke concluded their remarks by again stressing the importance of donating to the Foundation.

11. Reports from Area Councils

Reports from Area Councils may be found in the backup materials.

12. Action Papers

Please refer to the Summary of Assembly actions.

13. Unfinished Business

Please refer to the Summary of Assembly actions.

14. New Business

Please refer to the Summary of Assembly actions.

Adjournment - The meeting adjourned at 11:00 am on Sunday, November 1, 2015.

_____

Respectfully submitted,
Theresa Miskimen, MD
Assembly Recorder

Assembly
October 30-November 1, 2015
Washington, D.C.

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A2 4.B.1	Retain 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*	The Assembly voted, on its Consent Calendar, to retain the 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016 Membership & ECP-RFT Trustee
2015 A2 4.B.2	Retain 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*	The Assembly voted, on its Consent Calendar, to retain the 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.3	Proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities*	The Proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities* was withdrawn by the Council on Psychiatry and Law as the draft position statement is still being finalized.	FYI- Joint Reference Committee, January 2016
2015 A2 4.B.4	Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP*	The Assembly voted to approve the Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.5	Reaffirm APA's Adoption of the AMA's 2010 Position Statement: *Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices*	The Assembly voted to refer the Position Statement to the Joint Reference Committee to assign to the relevant bodies to draft a more meaningful position statement on DTC Advertising. The draft position statement will be presented to the Assembly in November, 2016.	Joint Reference Committee, January 2016
2015 A2 4.B.6	Proposed Position Statement: *Substance Abuse Disorders in Older Adults*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Substance Abuse Disorders in Older Adults*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.7	Revised Position Statement: Bias-*Related Incidents*	The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Bias-Related Incidents*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.8	Retire 2007 Position Statement: *The Right to Privacy*	The Assembly voted, on its Consent Calendar, to retire the 2007 Position Statement: *The Right to Privacy*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.9	Retire 2007 Position Statement: *Sexual Harassment*	The Assembly voted to **retain** the 2007 Position Statement: *Sexual Harassment*	Joint Reference Committee, January 2016
2015A2 4.B.10	Retire 2009 Position Statement: *Interference with Scientific Research and Medical Care*	The Assembly voted, on its Consent Calendar, to retire the 2009 Position Statement: *Interference with Scientific Research and Medical Care*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 4.B.11	Revised Position Statement: *Hypnosis*	The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Hypnosis.*	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.12	Retain 2010 Position Statement on *Posttraumatic Stress Disorder and Traumatic Brain Injury*	The Assembly voted, on its Consent Calendar, to retain the 2010 Position Statement: *Posttraumatic Stress Disorder and Traumatic Brain Injury*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.13	Retain 2010 Position Statement on *High Volume Psychiatric Practice and Quality of Patient Care*	The Assembly voted, on its Consent Calendar, to retain the 2010 Position Statement: *High Volume Psychiatric Practice and Quality of Patient Care*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.14	Proposed Position Statement on *Tobacco Use Disorder*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Tobacco Use Disorder*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.15	Retain Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.16	Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*	The Assembly voted to approve the Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 5.A	Will the Assembly vote to approve the minutes of the May 15-17, 2015, meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the May 15-17, 2015 Assembly meeting.	Chief Operating Officer • Association Governance
2015 A2 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2015A2, 4.B.3, 4.B.5, 4.B.9 and 12.S were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2015 A2 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2015 A2 7.A	The Assembly voted to accept the report of the Nominating Committee.	The Assembly voted to accept the report of the Nominating Committee. The slate of candidates for the May 2016 Assembly election is as follows: Speaker-Elect: John de Figueiredo, M.D., Area 1 Theresa Miskimen, M.D., Area 3 Recorder: James R. (Bob) Batterson, M.D., Area 4 David Scasta, M.D., Area 3	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A2 7.B.1	Will the Assembly vote to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component"?	The Assembly voted to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component".	Chief Operating Officer • Association Governance
2015A2 8.L.1	APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*	The Assembly voted unanimously to approve the APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*.	Board of Trustees, December, 2015 FYI: Chief of Policy, Programs &, Partnerships • Quality Care
2015A2 12.A	Access to Care Provided by the Department of Veterans Affairs	The Assembly voted to approve action paper 2015A2 12.A which asks: That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans. That the APA correspond with the Secretary of the Veterans Administration (VA), Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans. That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA.	Joint Reference Committee, January 2016
2015A2 12.B	Directions to the Area Nominating Committees	The Assembly voted to approve action paper 2015A2 12.B which asks that: Areas should have the latitude to nominate more than two candidates. The Procedures Committee should be asked to change the language accordingly.	Assembly Executive Committee, January 2016 APA Nominating Committee (for information)
2015A2 12.C	New Names for Psychiatric Conditions	The Assembly did not approve action paper 2015A2 12.C.	N/A
2015A2 12.D	Prior Authorization	The Assembly voted, on its Consent Calendar, to approve action paper 2015A2 12.D which asks that the APA explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.E	Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product	The Assembly voted to approve action paper 2015A2 12.E which asks: That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.	Joint Reference Committee, January 2016
2015A2 12.F	Payer Coverage for Prescriptions from Nonparticipating Prescribers	The Assembly voted to approve action paper 2015A2 12.F which asks: That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.	Joint Reference Committee, January 2016
2015A2 12.G	APA Support for NIMH Funding of Clinical Research	The Assembly voted to approve action paper 2015A2 12.G which asks that the APA shall: 1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget. 2. The APA will advocate the implementation of the recommendations of the White Paper.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.H	Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?	The Assembly voted to refer action paper 2015A2 12.H to the Council on Healthcare Systems and Financing.	Joint Reference Committee, January 2016
2015A2 12.I	Strengthening the Role of Residency Training to Improve Access to Buprenorphine	The Assembly voted to approve action paper 2015A2 I which asks that the APA liaise with ACGME/Residency Review Committee (RRC) to promote Buprenorphine training during general adult psychiatric residency training.	Joint Reference Committee, January 2016
2015A2 12. J	Need to Gather Information on Physician Health Program (PHP) Performance	The action paper was withdrawn by the author.	N/A
2015A2 12.K	Equality in Permanent Licensure Policy	The Assembly voted to approve action paper 2015A2 12.K which asks: That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards. That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.	Joint Reference Committee, January 2016
2015A2 12.L	Partial Hospital Training in Psychiatry Residency	The Assembly voted to approve action paper 2015A2 12.L which asks that the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.	Joint Reference Committee, January 2016
2015A2 12.M	Addressing the Shortage of Psychiatrists	The action paper was withdrawn by the author.	N/A
2015A2 12.N	Advocating for Medicaid Expansion	The Assembly voted, on its Consent Calendar, to approve action paper 2015A2 12.N which asks: That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion. That a status report and recommendations be made to the Assembly at the May 2016 meeting.	Joint Reference Committee, January 2016
2015A2 12.O	Systems to Coordinate Psychiatric Inpatient Bed Availability	The Assembly voted to approve action paper 2015A2 12.O which asks that the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.P	Making Access to Treatment for Erectile Disorder Available Under Medicare	The Assembly voted to approve action paper 2015A2 12.P which asks: That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner. That the Council on Advocacy and Government Relations and the Council on Healthcare Systems and Financing advocate, along with other professional societies and advocacy groups, for legislation to allow access to the full array of medications, mechanical therapies, and other treatments for Erectile Disorder which are currently excluded from coverage under Medicare.	Joint Reference Committee, January 2016
2015A2 12.Q	Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations	The paper was not moved by the author.	N/A
2015A2 12.R	Senior Psychiatrist Seat on the Board of Trustees (BOT)	The Assembly voted to refer action paper 2015A2 12.R to the Joint Reference Committee.	Joint Reference Committee, January 2016
2015A2 12.S	Need for Position-Specific Email Addresses for Leadership Roles in the APA	The action paper was withdrawn by the author.	N/A
2015A2 12.T	Election of Assembly Officers	The Assembly voted to approve action paper 2015A2 12.T which asks that the Assembly Procedural Code be rewritten to make the election of Assembly officers based on a majority vote with each voting member of the Assembly casting one vote.	Assembly Executive Committee, January 2016
2015A2 14.A	Revised Position Statement on *Telemedicine in Psychiatry*	The Assembly voted to approve the Revised Position Statement on *Telemedicine in Psychiatry*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016

MEMBERS AND INVITED GUESTS
ASSEMBLY
May 13-15, 2016
As of 4-28

ASSEMBLY EXECUTIVE COMMITTEE

Speaker	Glenn Martin, M.D.
Speaker-Elect	Daniel Anzia, M.D.
Recorder	Theresa Miskimen, M.D.
Immediate Past Speaker	Jenny L. Boyer, M.D., J.D., PhD
Past Speaker	Melinda Young, M.D.
Parliamentarian	John Wernert, III, M.D.
Area 1 Representative	A. Evan Eyler, M.D.
Area 1 Deputy Representative	Manuel Pacheco, M.D.
Area 2 Representative	Seeth Vivek, M.D.
Area 2 Deputy Representative	Jeffrey Borenstein, M.D.
Area 3 Representative	Joseph Napoli, M.D.
Area 3 Deputy Representative	William Greenberg, M.D.
Area 4 Representative	James R. Batterson, M.D.
Area 4 Deputy Representative	Bhasker Dave, M.D.
Area 5 Representative	Laurence Miller, M.D.
Area 5 Deputy Representative	Philip Scurria, M.D.
Area 6 Representative	Joseph Mawhinney, M.D.
Area 6 Deputy Representative	Barbara Weissman, M.D.
Area 7 Representative	Craig F. Zarling, M.D.
Area 7 Deputy Representative	Charles Price, M.D.
M/UR Representative	Linda Nahulu, M.D.
RFM Representative	Sarit Hovav, M.D.
ECP Representative	Mark Haygood, D.O.
ACROSS Representative	David Scasta, M.D.
CEO and Medical Director	Saul Levin, M.D., MPA

DISTRICT BRANCH REPRESENTATIVES

Area 1

Connecticut Psychiatric Society
John M. DeFigueiredo, M.D., Representative
Reena Kapoor, M.D., Representative
Brian Keyes, M.D. ,Representative

Maine Association of Psychiatric Physicians
Julie Pease, M.D, Representative
James Maier, M.D., Representative

Massachusetts Psychiatric Society
Patrick Aquino, M.D., Representative
John Bradley, M.D., Representative
Gary Chinman, M.D., Representative
Michelle Durham, M.D., MPH, Representative
Marshall Forstein, M.D., Representative

New Hampshire Psychiatric Society
Robert Feder, M.D., Representative
Isabel Norian, M.D., Representative

Ontario District Branch
Leslie Kiraly, M.D., Representative
Renata Villela, M.D., Representative
Shery Zener, M.D., Representative

Quebec & Eastern Canada District Branch
Vincenzo Di Nicola, M.D., Representative
Judy Glass, M.D., Representative

Rhode Island Psychiatric Society
Paul Lieberman, M.D., Representative
L. Russell Pet, M.D., Representative

Vermont Psychiatric Association
Jaskanwar Batra, M.D., Representative
Lisa Catapano-Friedman, M.D., Representative

Area 2

Bronx District Branch
Robert Neal, M.D., Representative

Brooklyn Psychiatric Society, Inc.
Ramaswamy Viswanathan, M.D., Representative

Central New York District Branch
Darvin Varon, M.D., for Marvin Koss, M.D., Representative

Genesee Valley Psychiatric Association
Aaron Satloff, M.D., Represenative

Greater Long Island Psychiatric Society
Frank Dowling, M.D., Representative
Meenatchi Ramani, M.D., for Laura Kunkel, M.D., Representative
Scott Krakower, D.O., for Deborah Weisbrot, M.D., Representative

Mid-Hudson Psychiatric Society
Leon Krakower, M.D., Representative

New York County District Branch
Kenneth Ashley, M.D., Representative
David Roane, M.D., Representative
Shabnam Shakibaie Smith, M.D., Representative
Gabrielle Shapiro, M.D., Representative
Felix Torres, M.D., Representative
Henry Weinstein, M.D., Representative

New York State Capital District Branch
Russell Denea, M.D., Representative

Northern New York District Branch
Kishor Sangani, M.D., Representative

Queens County Psychiatric Society
Adam Chester, D.O., Representative

West Hudson Psychiatric Society
Nigel Bark, M.D., Representative

Psychiatric Society Of Westchester County, Inc
Richard Altesman, M.D., Representative

Western New York Psychiatric Society
Norma Panahon, M.D., Representative

Area 3

Psychiatric Society of Delaware
Gerard Gallucci, M.D., Representative
Ranga Ram, M.D., Representative

Maryland Psychiatric Society, Inc
Steven Daviss, M.D., Representative
Annette Hanson, M.D., Representative
Robert Roca, M.D., MPH, Representative

New Jersey Psychiatric Association
Lily Arora, M.D., Representative
Charles Blackinton, M.D., Representative
Charles Ciolino, M.D., Representative

Pennsylvania Psychiatric Society
Mary Anne Albaugh, M.D., Representative
Kenneth M. Certa, M.D., Representative
Sheila Judge, M.D., Representative
Melvin Melnick, M.D., Representative
Jyoti Shah, M.D., Representative

Washington Psychiatric Society
Elizabeth Morrison, M.D., Representative
Roger Peele, M.D., Representative
Eliot Sorel, M.D., Representative

Area 4

Illinois Psychiatric Society
Kenneth Busch, M.D. Representative
Linda Gruenberg, D.O., Representative
Lisa Rone, M.D., Representative
Shastri Swaminathan, M.D., Representative

Indiana Psychiatric Society
Heather Fretwell, M.D., Representative
Brian Hart, M.D., Representative

Iowa Psychiatric Society
Carver Nebbe, M.D., Representative
Robert Smith, M.D., Representative

Kansas Psychiatric Society
Donald Brada, M.D., Representative
Matthew Macaluso, D.O., Representative

Area 4 (*continued*)

Michigan Psychiatric Society
Denise Gribbin, M.D., Representative
Lisa MacLean, M.D., Representative
William Sanders, D.O., Representative

Minnesota Psychiatric Society
Dionne Hart, M.D., Representative
Maria Lapid, M.D., Representative

Missouri Psychiatric Association
James Fleming, M.D., Representative
Sherifa Iqbal, M.D., Representative

Nebraska Psychiatric Society
Jennifer McWilliams, M.D., Representative
Syed Qadri, M.D., Representative

North Dakota Psychiatric Society
Ronald Burd, M.D., Representative
Gabriela Balf-Soran, M.D., for Kevin Dahmen, M.D., Representative

Ohio Psychiatric Physicians Association
Jonathan Dunn, M.D., Representative
Brien W. Dyer, M.D., Representative
Karen Jacobs, D.O., Representative
Eileen McGee, M.D., Representative

South Dakota Psychiatric Association
Ammar Ali, M.D., Representative
William Fuller, M.D., Representative

Wisconsin Psychiatric Association
Clarence Chou, M.D., Representative
Michael Peterson, M.D., Representative

Area 5

Alabama Psychiatric Society
Daniel Dahl, M.D., Representative
Paul O'Leary, M.D., Representative

Arkansas Psychiatric Society
Molly Gathright, M.D., Representative
Eugene Lee, M.D., Representative

Florida Psychiatric Society
John Bailey, D.O., Representative
Debra Barnett, M.D., Representative
Louise Buhrmann, M.D., Representative
Elias Sarkis, M.D., Representative

Georgia Psychiatric Physicians Association, Inc
Howard Maziar, M.D., Representative
Joe L. Morgan, M.D., Representative
Sultan Simms, M.D., Representative

Kentucky Psychiatric Medical Association
Mary Helen Davis, M.D., Representative
Mark Wright, M.D., Representative

Louisiana Psychiatric Medical Association
Mary Fitz-Gerald, M.D., Representative
Mark Townsend, M.D., Representative

Mississippi Psychiatric Association, Inc
Maxie Gordon, M.D., Representative
Sudhakar Madakasira, M.D, Representative

North Carolina Psychiatric Association
Samina Aziz, M.D., Representative
Debra Bolick, M.D., Representative
Stephen Buie, M.D., Representative

Oklahoma Psychiatric Physicians Association
Harold Ginzburg, M.D., Representative
Shreekumar Vinekar, M.D., Representative

Puerto Rico Psychiatric Society
Sarah Huertas-Goldman, M.D., Representative
Michael Woodbury-Farina, M.D., Representative

Area 5 (continued)

South Carolina Psychiatric Association
David Beckert, M.D., Representative
Edward Thomas Lewis, III, M.D., Representative

Tennessee Psychiatric Association
James Kyser, M.D., Representative
Rodney A Poling M.D., for Valerie Arnold, M.D., Representative

Texas Society of Psychiatric Physicians
Debra Atkisson, M.D., Representative
A. David Axelrad, M.D, Representative
Daryl Knox, M.D., Representative
J. Clay Sawyer, M.D., Representative

Society of Uniformed Services Psychiatrists
Elspeth Ritchie, M.D., Representative
James West, M.D., Representative

Psychiatric Society of Virginia, Inc
Rizwan Ali, M.D., Representative
Adam Kaul, M.D., Representative
John Shemo, M.D., Representative

West Virginia Psychiatric Association
T.O. Dickey, M.D., Representative
Daniel Elswick, M.D., Representative

AREA 6

Central California Psychiatric Society
Robert McCarron, D.O., Representative

Northern California Psychiatric Society
Robert Cabaj, M.D., Representative
Peter Forster, M.D., Representative
Adam Nelson, M.D., Representative
Raymond Reyes, M.D., Representative

Orange County Psychiatric Society
Richard Granese, M.D., Representative

San Diego Psychiatric Society
Maria Tiamson-Kassab, M.D., Representative

Area 6 (continued)

Southern California Psychiatric Society
Lawrence Gross, M.D., Representative
Larry Lawrence, M.D., Representative
Mary Ann Schaepper, M.D., Representative
Simon Soldinger, M.D., Representative

Area 7

Alaska Psychiatric Association
John Pappenheim, M.D., Representative
Alexander von Hafften, M.D., Representative

Arizona Psychiatric Society
Gurjot Marwah, M.D., Representative
Payam Sadr, M.D., Representative

Colorado Psychiatric Society
L. Charolette Lippolis, D.O., MPH, Representative
Patricia Westmoreland, M.D., for Alexis Giese, M.D., Representative

Hawaii Psychiatric Medical Association
Iqbal Ahmed, M.D., Representative
Leslie Gise, M.D., Representative

Idaho Psychiatric Association
Charles Novak, M.D., for Zachary Morairty, M.D., Representative
James G. Saccomando Jr., M.D., Representative

Montana Psychiatric Association
Krista David, M.D., Representative
Joan Green, M.D., Representative

Nevada Psychiatric Association
Philip Malinas, M.D., Representative
Dodge Slagle, D.O., Representative

Psychiatric Medical Association of New Mexico
Brooke Parish, M.D., Representative
Reuben Sutter, M.D., Representative

Oregon Psychiatric Association
Amela Blekic, M.D., Representative
Annette Matthews, M.D., Representative

Area 7 (continued)

Utah Psychiatric Association
Jason Hunziker, M.D., Representative
Louis A. Moench, M.D., for Stamatios Dentino, M.D., Representative

Washington State Psychiatric Association
James Ethier, M.D., Representative
Matthew Layton, M.D., PhD, Representative
Brian Waiblinger, M.D., Representative

Western Canada District Branch
Ian Forbes, M.D., Deputy Representative
Adel Gabriel, M.D., Representative
Adeyinka Marcus, M.D., Representative

Wyoming Association of Psychiatric Physicians
Stephen Brown, M.D., Representative
O'Ann Fredstrom, M.D., Representative

EARLY CAREER PSYCHIATRISTS (ECP) REPRESENTATIVES

Area 1
Gwendolyn Lopez-Cohen, M.D., Representative
Simha Ravven, M.D., Deputy Representative

Area 2
Anil Thomas, M.D., Representative
Maria Bodic, M.D., Deputy Representative

Area 3
Rajeev Sharma, M.D., Representative
Reena Thomas, M.D., Deputy Representative

Area 4
Jacob Behrens, M.D., Representative
John Korpics, M.D., Deputy Representative

Area 5
Justin Hunt, M.D., Representative
Mark Haygood, D.O.,* Deputy Representative

Area 6
Steve Koh, M.D., Representative
Lawrence Malak, M.D., Deputy Representative

Area 7
Joshua Sonkiss, M.D., Representative
Jason Collison, M.D., Deputy Representative

* Also listed with the Assembly Executive Committee

MINORITY/ UNDERREPRESENTED GROUPS

American Indian, Alaska Native and Native Hawaiian Psychiatrists
Linda Nahulu, M.D.,* Representative
Mary Roessel, M.D., Deputy Representative

Asian-American Psychiatrists
Francis Sanchez, M.D., Representative
Kimberly Yang, M.D., Deputy Representative

Black Psychiatrists
Stephen McLeod-Bryant, M.D., Representative
Rahn Bailey, M.D., Deputy Representative

Hispanic Psychiatrists
Jose De La Gandara, M.D., Representative
Oscar Perez, M.D., Deputy Representative

International Medical Graduate Psychiatrists
Nyapati Rao, M.D., Representative
Antony Fernandez, M.D., Deputy Representative

Lesbian, Gay and Bisexual Psychiatrists
Ubaldo Leli, M.D., Representative
David A. Tompkins, M.D., Deputy Representative

Women Psychiatrists
Maureen Van Niel, M.D., Representative
Judith Kashtan, M.D., Deputy Representative

* Also listed with the Assembly Executive Committee

RESIDENT-FELLOW MEMBER (RFM) REPRESENTATIVES

Area 1
Loreen Pirnie, M.D., Representative
Rebecca Allen, M.D., MPH, Deputy Representative

Area 2
Subhash Chandra, M.D., Representative
Jeremy Kidd, M.D., Deputy Representative

Area 3
Jessica Abellard, M.D., Representative
Nazanin Silver, M.D., MPH, for Raul Poulsen, M.D., Deputy Representative

Area 4
Sarit Hovav, M.D.,* Representative
Matthew Kruse, M.D., Deputy Representative

Area 5
Candes Dotson, D.O., Representative
Hannah Scott, M.D., Deputy Representative

Area 6
Alexis Seegan, M.D., Representative
Jonathan Serrato, M.D., Deputy Representative

Area 7
Kelly Jones, M.D., Representative
Robert Mendenhall, D.O, Deputy Representative

Resident-Fellow Member (RFM) Mentor
Elie Aoun, M.D.

* Also listed with the Assembly Executive Committee

ASSEMBLY COMMITTEE OF REPRESENTATIVES OF SUBSPECIALTIES & SECTIONS (ACROSS)

Area 1

Academy of Psychosomatic Medicine
David Gitlin, M.D.

American Association of Community Psychiatrists
Jeffrey Geller, M.D., MPH

American Academy of Psychiatry & Law
Debra Pinals, M.D.

American Academy of Psychoanalysis
Eric Plakun, M.D.

Area 2

American Academy of Child & Adolescent Psychiatry
Warren Ng, M.D.

American Group Psychotherapy Association
C. Deborah Cross, M.D.

Association of Family Psychiatrists
Gregory Miller, M.D.

Area 3

American Association of Psychiatric Administrators
Barry Herman, M.D.

American Society for Adolescent Psychiatry
Richard Ratner, M.D.

Association of Gay and Lesbian Psychiatrists
David Scasta, M.D.*

Southern Psychiatric Association
Mark Komrad, M.D.

Area 4

American Academy Addiction Psychiatry
David Lott, M.D.

American Academy of Clinical Psychiatrists
Donald Black, M.D.

American Association for Emergency Psychiatry
Kimberly Nordstrom, M.D., JD

American Psychoanalytic Association
Prudence Gourguechon, M.D.

American Association for Social Psychiatry
Beverly Fauman, M.D.

Area 5

Senior Psychiatrists, Inc
Jack Bonner, M.D.

Area 6

American Association for Geriatric Psychiatry
Daniel Sewell, M.D.

* Also listed with the Assembly Executive Committee

PRIVILEGED GUESTS OF THE ASSEMBLY

BOARD OF TRUSTEES OFFICERS

President	Renée Binder, M.D.
President-Elect	Maria Oquendo, M.D.
Secretary	Altha Stewart, M.D.
Treasurer	Frank Brown, M.D.

AREA TRUSTEES

Area 1	Jeffrey Geller, M.D., MPH
Area 2	Vivian Pender, M.D.
Area 3	Brian Crowley, M.D.
Area 4	Ronald Burd, M.D.
Area 5	R. Scott Benson, M.D.
Area 6	Melinda Young, M.D.*
Area 7	Jeffrey Akaka, M.D.

TRUSTEES

Trustee	Paul Summergrad, M.D.
Trustee	Jeffrey Lieberman, M.D.
Trustee	Dilip V. Jeste, M.D.
Trustee-at-Large	Anita Everett, M.D.
ECP Trustee-at-Large	Lama Bazzi, M.D.
RFM Trustee	Ravi Shah, M.D., MBA
RFM Trustee-Elect	Stella Cai, M.D.
M/UR Trustee	Gail Robinson, M.D.

FELLOWS

APA/SAMHSA/Diveristy Fellow	Uche Achebe, M.D.
APA/Leadership Fellow	Misty Richards, M.D.
APA Public Psychiatry Fellow	Raj Loungani, M.D., MPH
Minority Fellow	TBD

DISTRICT BRANCH PRESIDENTS, PRESIDENTS-ELECT & EXECUTIVES

standing invitation

* Also listed with Assembly Executive Committee

PAST SPEAKERS OF THE ASSEMBLY

Jenny L. Boyer, M.D., JD, PhD*	2014-2015
Melinda Young, M.D.*	2013-2014
R. Scott Benson, M.D.	2012-2013
Ann Marie T. Sullivan, M.D.	2011-2012
Bruce A. Hershfield, M.D.	2010-2011
Gary S. Weinstein, M.D.	2009-2010
Ronald Burd, M.D.	2008-2009
Jeffrey Akaka, M.D.	2007-2008
Michael Blumenfield, M.D.	2006-2007
Joseph Ezra V. Rubin, M.D.	2005-2006
James E. Nininger, M.D.	2004-2005
Prakash N. Desai, M.D.	2003--2004
Albert Gaw, M.D.	2002–2003
Nada Stotland, M.D., MPH	2001–2002
R. Michael Pearce, M.D.	2000–2001
Alfred Herzog, M.D.	1999–2000
Donna Marie Norris, M.D.	1998–1999
Jeremy Allan Lazarus, M.D.	1997–1998
Roger Dale Walker, M.D.	1996–1997
Richard Kent Harding, M.D.	1995–1996
Norman A. Clemens, M.D.	1994–1995
Richard M. Bridburg, M.D.	1993–1994
G. Thomas Pfaehler, M.D.	1991–1992
Edward Hanin, M.D.	1990–1991
Gerald H. Flamm, M.D.	1989–1990
John S. McIntyre, M.D.	1988–1989
Irvin M. Cohen, M.D.	1987–1988
Roger Peele, M.D.	1986–1987
Fred Gottlieb, M.D.	1984–1985
Harvey Bluestone, M.D.	1983–1984
Lawrence Hartmann, M.D.	1981–1982
Melvin M. Lipsett, M.D.	1980–1981
Robert O. Pasnau, M.D.	1979–1980
Robert J. Campbell, III, M.D.	1978–1979
Daniel A. Grabski, M.D.	1977–1978
Irwin N. Perr, M.D.	1976–1977
Miltiades L. Zaphiropoulos, M.D.	1975–1976
Harry H. Brunt, Jr., M.D.	1971–1972
John S. Visher, M.D.	1970–1971
Robert S. Garber, M.D.	1963–1964
Mathew Ross, M.D.	1956–1957

* Also listed with Assembly Executive Committee

Voting Strength by State for the
Fall 2015 and May 2016
Assembly Meeting

The Assembly shall be composed of Representatives selected by the District Branches/State Associations; a Representative and Deputy Representative from each Minority/Underrepresented Group; a Resident-Fellow Member Representative and Deputy Representative from each Area; an Early Career Psychiatrist Representative and Deputy Representative from each Area; a Representative from each Assembly Committee of Representatives of Subspecialties and Sections (formerly AAOL); and the Assembly Executive Committee.

At its May 2015 meeting, the Assembly approved the APA Assembly Reorganization. Each state will have Assembly Reps according to a formula below.

The Central Office will use the report that was run on December 31, 2014 to determine the voting strength for the November 2015 and May 2016 meeting.

District Branch Representatives are eligible to be apportioned according to the following formula:

Numbers of Voting Members	Reps
450 or less*	2
451-900	3
901-1350	4
1351-1800	5
1801 or more	6

*California and New York District Branches have 1 Representative for District Branches with 450 or less, with the larger District Branches using the above formula.

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Alabama Psychiatric Physicians Association	251	2
Alaska Psychiatric Association	64	2
Arizona Psychiatric Society	389	2
Arkansas Psychiatric Society	133	2
Bronx District Branch	160	1
Brooklyn Psychiatric Society, Inc.	306	1
Central California Psychiatric Society	374	1
Central New York District Branch	134	1
Colorado Psychiatric Society	425	2
Connecticut Psychiatric Society	686	3
Delaware, Psychiatric Society of	99	2
Florida Psychiatric Society	1084	4
Genesee Valley Psychiatric Association	149	1
Georgia Psychiatric Physicians Association, Inc	609	3
Greater Long Island Psychiatric Society	530	3
Hawaii Psychiatric Medical Association	172	2
Idaho Psychiatric Association	56	2
Illinois Psychiatric Society	985	4
Indiana Psychiatric Society	321	2

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Iowa Psychiatric Society	190	2
Kansas Psychiatric Society	197	2
Kentucky Psychiatric Medical Association	271	2
Louisiana Psychiatric Medical Association	304	2
Maine Association of Psychiatric Physicians	171	2
Maryland Psychiatric Society, Inc	683	3
Massachusetts Psychiatric Society	1566	5
Michigan Psychiatric Society	739	3
Mid-Hudson Psychiatric Society	66	1
Minnesota Psychiatric Society	424	2
Mississippi Psychiatric Association, Inc	149	2
Missouri Psychiatric Association	436	2
Montana Psychiatric Association	50	2
Nebraska Psychiatric Society	149	2
Nevada Psychiatric Association	147	2
New Hampshire Psychiatric Society	129	2
New Jersey Psychiatric Association	844	3
New Mexico, Psychiatric Medical Association of	141	2
New York County Psychiatric Society	1859	6
New York State Capital District Branch	153	1
North Carolina Psychiatric Association	855	3
North Dakota Psychiatric Society	49	2
Northern California Psychiatric Society	1005	4
Northern New York District Branch	39	1
Ohio Psychiatric Physicians Association	925	4
Oklahoma Psychiatric Physicians Association	208	2
Ontario District Branch	753	3
Orange County Psychiatric Society	246	1
Oregon Psychiatric Physicians Association	388	2
Pennsylvania Psychiatric Society	1498	5
Puerto Rico Psychiatric Society	139	2
Quebec & Eastern Canada District Branch	405	2
Queens County Psychiatric Society	251	1
Rhode Island Psychiatric Society	237	2
San Diego Psychiatric Society	323	1
South Carolina Psychiatric Association	356	2
South Dakota Psychiatric Association	77	2
Southern California Psychiatric Society	1009	4
Tennessee Psychiatric Association	306	2
Texas Society of Psychiatric Physicians	1128	4
Uniformed Services Psychiatrists, Society of	337	2
Utah Psychiatric Association	161	2
Vermont Psychiatric Association	112	2
Virginia, Psychiatric Society of	570	3
Washington Psychiatric Society	852	3
Washington State Psychiatric Association	492	3
West Hudson Psychiatric Society	102	1
West Virginia Psychiatric Association	174	2
Westchester County, Psychiatric Society of	399	1

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Western Canada District Branch	503	3
Western New York Psychiatric Society	148	1
Wisconsin Psychiatric Association	374	2
Wyoming Association of Psychiatric Physicians	24	2

Voting Strength by State for the
November 2016 and May 2017
Assembly Meeting

The Assembly shall be composed of Representatives selected by the District Branches/State Associations; a Representative and Deputy Representative from each Minority/Underrepresented Group; a Resident-Fellow Member Representative and Deputy Representative from each Area; an Early Career Psychiatrist Representative and Deputy Representative from each Area; a Representative from each Assembly Committee of Representatives of Subspecialties and Sections (*formerly AAOL*); and the Assembly Executive Committee.

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1351-1800	5
1801 or more	6

*California and New York District Branches have 1 Representative for District Branches with 450 or less, with the larger District Branches using the above formula.

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Alabama Psychiatric Physicians Association	250	2
Alaska Psychiatric Association	66	2
Arizona Psychiatric Society	390	2
Arkansas Psychiatric Society	127	2
Bronx District Branch	147	1
Brooklyn Psychiatric Society, Inc.	302	1
Central California Psychiatric Society	391	1
Central New York District Branch	129	1
Colorado Psychiatric Society	427	2
Connecticut Psychiatric Society	691	3
Delaware, Psychiatric Society of	107	2
Florida Psychiatric Society	1117	4
Genesee Valley Psychiatric Association	152	1
Georgia Psychiatric Physicians Association, Inc	624	3
Greater Long Island Psychiatric Society	497	3
Hawaii Psychiatric Medical Association	169	2
Idaho Psychiatric Association	52	2
Illinois Psychiatric Society	971	4
Indiana Psychiatric Society	337	2

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Iowa Psychiatric Society	168	2
Kansas Psychiatric Society	205	2
Kentucky Psychiatric Medical Association	265	2
Louisiana Psychiatric Medical Association	307	2
Maine Association of Psychiatric Physicians	166	2
Maryland Psychiatric Society, Inc	673	3
Massachusetts Psychiatric Society	1531	5
Michigan Psychiatric Society	735	3
Mid-Hudson Psychiatric Society	60	1
Minnesota Psychiatric Society	432	2
Mississippi Psychiatric Association, Inc	150	2
Missouri Psychiatric Association	442	2
Montana Psychiatric Association	52	2
Nebraska Psychiatric Society	152	2
Nevada Psychiatric Association	155	2
New Hampshire Psychiatric Society	133	2
New Jersey Psychiatric Association	846	3
New Mexico, Psychiatric Medical Association of	159	2
New York County Psychiatric Society	1773	5
New York State Capital District Branch	150	1
North Carolina Psychiatric Association	847	3
North Dakota Psychiatric Society	48	2
Northern California Psychiatric Society	1014	4
Northern New York District Branch	40	1
Ohio Psychiatric Physicians Association	943	4
Oklahoma Psychiatric Physicians Association	228	2
Ontario District Branch	838	3
Orange County Psychiatric Society	247	1
Oregon Psychiatric Physicians Association	401	2
Pennsylvania Psychiatric Society	1436	5
Puerto Rico Psychiatric Society	135	2
Quebec & Eastern Canada District Branch	388	2
Queens County Psychiatric Society	254	1
Rhode Island Psychiatric Society	241	2
San Diego Psychiatric Society	336	1
South Carolina Psychiatric Association	381	2
South Dakota Psychiatric Association	80	2
Southern California Psychiatric Society	978	4
Tennessee Psychiatric Association	309	2
Texas Society of Psychiatric Physicians	1204	4
Uniformed Services Psychiatrists, Society of	332	2
Utah Psychiatric Association	164	2
Vermont Psychiatric Association	104	2
Virginia, Psychiatric Society of	586	3
Washington Psychiatric Society	862	3
Washington State Psychiatric Association	497	3
West Hudson Psychiatric Society	103	1
West Virginia Psychiatric Association	190	2
Westchester County, Psychiatric Society of	392	1
Western Canada District Branch	502	3
Western New York Psychiatric Society	139	1

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Wisconsin Psychiatric Association	392	2
Wyoming Association of Psychiatric Physicians	24	2

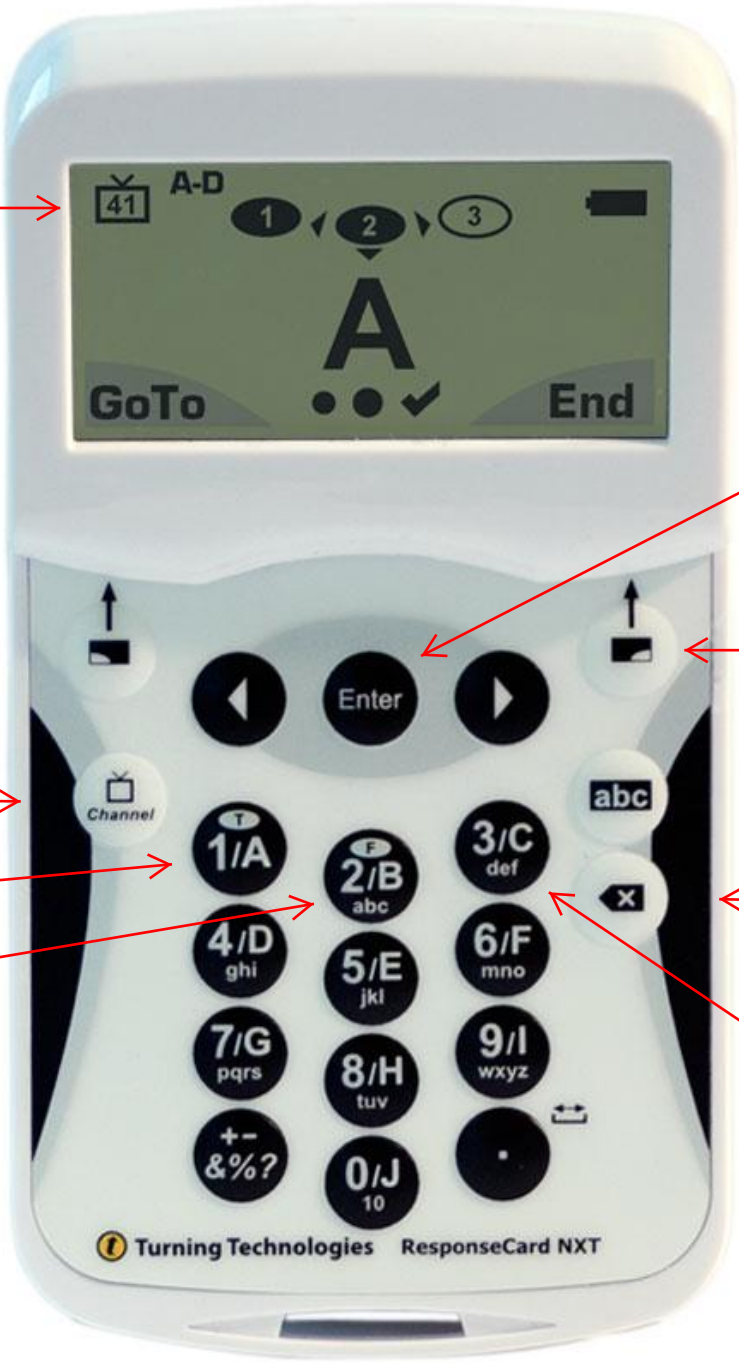
Item 2016A1 5.C.3

Voter Instructions for "Standing Vote" with ARS devices

*Before voting, please make sure that your clicker/response card/ARS device is on "**Channel 41**".*

Please turn on your clicker by pressing "Enter". The Channel should be displayed on the top left corner of the screen.

To change the Channel, please press the "Channel" button, enter the numbers "4" and "1", and then confirm your entry by pressing the button on top right corner (which will be displayed as "OK"). Once the Channel is changed, you should see a checkmark ✓ on the bottom of the screen.



To submit your vote:

- Press "A" for Yes, "B" for No, and "C" for Abstain.
- Press "Enter" button to submit your vote.

<u>Please note</u>: You can enter/submit your vote as many times as you want, but the system will only accept one response per one device. The last response entered/submitted will be recorded as the final vote.

Assembly Executive Committee
FINAL REPORT
Friday, October 30, & Sunday, November 1, 2015
Omni Shoreham, Washington, DC

Glenn Martin, MD,Speaker
Daniel Anzia, MD, Speaker-Elect
Theresa Miskimen, MD, Recorder
John Wernert, MD,III, Parliamentarian
A. Evan Eyler, MD, Area 1 Rep
Manuel Pacheco, MD, Area 1 Dep Rep
Seeth Vivek, MD, Area 2 Rep [A]
Jeffrey Borenstein, MD, Area 2 Dep Rep
Joseph Napoli, MD, Area 3 Rep
William Greenberg, MD, Area 3 Dep Rep
James Batterson, MD, Area 4 Rep
Bhasker Dave, MD, Area 4 Dep Rep
Laurence Miller, MD, Area 5 Rep
Philip Scurria, MD, Area 5 Dep Rep
Joseph Mawhinney, MD, Area 6 Rep
Barbara Weissman, MD, Area 6 Dep Rep
Craig Zarling, MD, Area 7 Rep
Charles Price, MD, Area 7 Dep Rep
Linda Nahulu, MD,M/UR Rep
Sarit Hovav, MD, RFM Rep
Mark Haygood, D.O., ECP Rep
David Scasta, MD, ACROSS Rep
Jenny Boyer, MD, Immediate Past Speaker
Melinda Young, MD, Past Speaker
Saul Levin MD, MPA, CEO and Medical Director

Guests:
A. David Axelrad, MD, Chair, Assembly Committee on Procedures (*Friday*)

Administration:
Margaret Cawley Dewar, Director of Association Governance
Allison Moraske, Senior Governance Specialist, Assembly
Colleen Coyle, JD, APA General Counsel (*Friday*)
Rodger Currie, Chief of Government Affairs (*Friday*)
Yoshie Davison, Chief of Staff
Jon Fanning, Chief of Membership & RFM-ECP Officer (*Friday*)
Shari Graham, JD, Assistant General Counsel (*Friday*)
Kristin Kroeger, Chief of Policy, Programs, and Partnerships
Ranna Parekh, MD, MPH, Director, Division of Diversity and Health Equity
Shaun Snyder, JD, Chief Operating Officer
Philip Wang, MD, DPH, Director of Research (*Friday*)
Jason Young, Chief Communications Officer (*Friday*)

Friday, October 30, 2015

1. **Call to Order and Opening Remarks** — *Dr. Martin*
Dr. Martin welcomed the Assembly Executive Committee and guests to the meeting. The members then introduced themselves and disclosed any potential conflicts of interest.

2. **Approval of Report of AEC meeting, July 2015**
MOTION APPROVED: The AEC voted to accept the report of the Assembly Executive Committee from July 2015.

3. **Remarks from the Speaker-Elect** — *Dr. Anzia*
Dr. Anzia noted that the Assembly would be voting on the draft APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*. Area 4 is the primary reviewer and the RFM Committee is the secondary reviewer. The leadership of the Practice Guidelines and the Assembly liaisons to the Steering Committee on Practice Guidelines held a conference call to discuss the revisions and address any concerns. Dr. Anzia also announced that Dr. Laura Fochtmann, Vice-Chair of the Guideline Writing Group, will be attending the Assembly and can visit Area Council meetings, if needed. Dr Martin

reminded the AEC that the vote on the Practice Guideline would be an up or down vote, with no editing allowed from the floor.

4. **Remarks from the Recorder** — *Dr. Miskimen*
Dr. Miskimen reviewed the Assembly voting process and requested that the Area Councils review the process during their upcoming Area Council meetings.

The procedure for calling for a vote by strength had been adjusted during the previous Assembly reorganization. Dr. Martin stated that the procedure will continue as written and that the Assembly Committee on Procedures will review and make necessary changes.

5. **Remarks from the CEO and Medical Director** — Dr. Levin
Dr. Levin began by thanking Drs. Martin, Anzia, and Miskimen for their hard work and support. He updated the AEC on the congressional briefing held on October 29th that focused on the national epidemic of the criminalization of people with mental illness, noting that Dr. Binder spoke at the briefing. Dr. Levin also spoke about the recent State Advocacy Leadership Conference in Hollywood, Florida, thanking Drs. Martin, Miskimen, Young, and Price for attending. He noted that 48 states were represented and the feedback was very positive.

Dr. Levin announced that CMS awarded APA one of the *Transforming Clinical Practices-Support Alliance Networks (SAN)* grants. This is a four-year $2.9 million grant, and as a Support and Alignment Network, APA will train 3,500 psychiatrists to expand their quality improvement capacity, learn from one another, and reach common goals of improved care, better health and reduced cost.

Dr. Levin concluded his remarks by reporting that the recent Institute of Psychiatric Services (IPS) meeting in New York City was successful, with good attendance.

6. **Review of Assembly Agenda** — *Dr. Martin*
The AEC reviewed the Assembly agenda. Dr. Martin explained that the Reference Committees will be creating reports on their recommendations. The reports will be distributed Saturday morning for use/discussion during the Area Council meetings.

7. **Reports of Assembly Component Chairs**

A. Rules Committee — *Dr. Boyer*
Dr. Boyer outlined the work of the Rules Committee prior to the Assembly meeting. She also reviewed the draft consent calendar with the AEC. Dr. Boyer explained how the Special Rules had been modified to clarify the process of moving an action paper as well as how direct referrals of an action to the Board of Trustees will be handled by the Assembly.

B. Awards Committee — *Dr. Young*
Dr. Young announced that APA Past President Dr. Steven Sharfstein will be receiving the Assembly Profile of Courage Award on Sunday morning. Dr. Sharfstein is receiving the award in recognition of his organizing APA's strong stand against the participation of psychiatrists on American government interrogation teams, his resolute stand on psychiatrists' and physicians' profound ethical obligation to patients; his willingness to stand firm in the face of opposition by the nation's military and civilian leadership, his participation in developing a formal position of the APA stating categorically that psychiatrists should not participate in the commission of torture or participate directly in the interrogation of persons held in custody, and his work to change APA ethical guidelines to explicitly oppose such practices.

C. Committee on Procedures — *Dr. Axelrad*
Dr. Axelrad noted that there will be one action coming forward from the Committee on Procedures on incorporating the Assembly Committee on the DSM into the *Procedural Code of the Assembly*.

D. Assembly Nominating Committee — *Dr. Boyer*
The Assembly Nominating Committee had several candidates interested in running for Assembly office. The Committee will meet Friday evening to finalize the slate of candidates which will be announced Saturday afternoon during the third plenary.

8. **Area Councils/Assembly Groups**
The AEC discussed items the Area Councils and Assembly Groups should review during their meetings. In addition to the action papers, the Practice Guideline and the process of votes by strength should also be reviewed. It was requested that Area Councils assign mentors to new Assembly members and also notify the Assembly Officers promptly of any issues of concern that are discussed during the Area/Group meetings.

9. **New Business/Other Issues**
The Work Group on APA Fellows Participation in the Assembly presented its report to the AEC. The work group recommended that The work group recommends that the mentorship program offer 10 positions annually on the Assembly for which Fellows can apply, that participation may be one or two years, depending on the length of the fellowship (some being one and some two year fellows) and Fellow interest, that the program involve participation in the May Assembly only (not November), that the Fellows have voice only (no vote), and that this program be created as a two year pilot with a decision about the program being made after the two years.

The AEC had a number of follow up questions for the work group and further discussion will occur at the AEC meeting on Sunday afternoon.

Sunday, November 1, 2015

10. **Review of Assembly Business and Actions: Action Papers** — Drs. Martin, Anzia and Miskimen
The AEC reviewed the passed Assembly actions and the draft action assignments. When the papers are reviewed by the JRC in January, it will be requested that high priority be given to action paper 12.F: *Payer Coverage for Prescriptions from Nonparticipating Prescribers* and 12.K: *Equality in Permanent Licensure Policy*.

11. **Hotel/Meeting Feedback**
Dr. Martin requested that the AEC provide feedback on both the hotel and general meeting issues.

Plenary
- Add floor speakers to the center of the dais
- Have veteran Assembly members sit near the RFMs
- Label the floor microphones (*Pro, Con, Procedural Matters*) differently to make it clear which side is being called on by the Speaker

Area Councils
- Microphones are needed in Areas 3, 4, 6, and 7
- Areas 3 and 6 requested larger meeting rooms
- At Area Council meetings, encourage members to attend the work group meetings Saturday afternoon

General Hotel
- Omni Rewards points credit even if the room is on the APA master account
- More directional signage
- Color hotel map distributed prior to the meeting and available at the meeting

Association Governance and the Meeting and Conventions Department will work with the hotel on these issues.

12. **New Business/Other Issues**
The Work Group on APA Fellows Participation will present an updated report to the AEC at its meeting in Charleston in January.

13. **Closing Remarks** — Dr. Martin
Dr. Martin thanked the AEC for its hard work. He also thanked the APA Administration and requested that the thanks of the AEC be extended to both the staff and volunteers in Association Governance.

14. Next Meeting: **January 22-24, 2016, location: The Mills House, Charleston, South Carolina**

15. Adjournment

American Psychiatric Association
Assembly Executive Meeting
Charleston, South Carolina
January 22-24, 2016
Draft Report

Assembly Executive Committee Members:

Glenn Martin, MD, Speaker
Daniel Anzia, MD, Speaker-Elect
Theresa Miskimen, MD, Recorder
John Wernert, III, MD, Parliamentarian
A. Evan Eyler, MD, Area 1 Rep
Manuel Pacheco, MD, Area 1 Dep Rep
Seeth Vivek, MD, Area 2 Rep
Jeffrey Borenstein, MD, Area 2 Dep Rep [A]
Joseph Napoli, MD, Area 3 Rep
William Greenberg, MD, Area 3 Dep Rep
James R. Batterson, MD, Area 4 Rep
Bhasker Dave, MD, Area 4 Dep Rep
Laurence Miller, MD, Area 5 Rep [A]
Philip Scurria, MD, Area 5 Dep Rep
Joseph Mawhinney, MD, Area 6 Rep
Barbara Weissman, MD, Area 6 Dep Rep [A]
Craig Zarling, MD, Area 7 Rep
Charles Price, MD, Area 7 Dep Rep
Linda Nahulu, MD, M/UR Rep
Sarit Hovav, MD, RFM Rep
Mark Haygood, DO, ECP Rep
David Scasta, MD, ACROSS Rep
Jenny Boyer, MD, Immediate Past Speaker (*via speakerphone*)
Melinda Young, MD, Past Speaker
Saul Levin, MD, MPA, CEO and Medical Director

Administration:
Margaret Cawley Dewar, Director of Association Governance
Allison Moraske, Senior Governance Specialist, Assembly
Jessica Hopey, Senior Governance Coordinator
Yoshie Davison, Chief of Staff
Kristin Kroeger, Chief of Policy, Programs, and Partnerships
Colleen Coyle, JD, APA General Counsel (*via speakerphone*)
Shaun Snyder, JD, Chief Operating Officer (*via speakerphone*)

Call to Order of the Assembly Executive Committee – *Glenn Martin, MD*

A. Introductions

Dr. Martin welcomed the AEC to Charleston and had everyone introduce themselves and disclose any potential conflicts of interest.

B. Approval of the Fall, 2015 AEC Report

MOTION APPROVED: The Assembly Executive Committee voted to approve the report of the Assembly Executive Committee from the Fall, 2015 meetings.

Report from the Speaker – *Glenn Martin, MD*
Dr. Martin highlighted some items from the December Board of Trustees meeting. The Board of Trustees approved the APA 2016 budget as well as the American Psychiatric Association Foundation budget for 2016. In addition, the Board approved an ethics resource document titled "APA Commentary on Ethics in Practice". The Board also discussed registries and accepted the recommended business case for a multi-illness, patient and provider entered data, national mental health quality registry.

The AEC reviewed the two action papers assigned to the committee at the Fall Assembly meeting.

Action paper *12.B: Directions to the Area Nominating Committees* asks that: *Areas should have the latitude to nominate more than two candidates. The Procedures Committee should be asked to change the language accordingly*.

The AEC will have the Assembly Committee on Procedures develop language to amend the *Procedural Code of the Assembly* to incorporate the changes outlined in the action paper. The language will be discussed and voted on at the May 2016 Assembly meeting.

Action paper *12.T: Election of Assembly Officers* asks that: *The Assembly Procedural Code be rewritten to make the election of Assembly officers based on a majority vote with each voting member of the Assembly casting one vote.*

The AEC will have the Assembly Committee on Procedures develop language to amend the *Procedural Code of the Assembly* to incorporate the changes outlined in the action paper. The language will be discussed and voted on at the May 2016 Assembly meeting.

Report from the Speaker-Elect – *Daniel Anzia, MD*
Dr. Anzia reported that the JRC will be meeting immediately following the AEC meeting. The Assembly voted to refer one position statement (*Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices*) and thirteen action papers to the JRC. The JRC continues to stress the accountability of APA components to both the Assembly and the Board of Trustees. Dr. Anzia also noted that there will be a number of position statements coming forward to the Assembly for approval in May. Dr. Martin encouraged thoughtful discussion of draft position statements by Assembly members at the Area Council level.

Report from the Recorder – *Theresa Miskimen, MD*
Dr. Miskimen reviewed the Fall Assembly *Survey Monkey* results with the AEC. The total number of respondents was 122, which is the highest response rate on record. The survey consisted of 10 questions, six of which used a rating scale, with the remaining four being open-ended questions related to the acoustics of the venue, the perceived benefit of participation in Assembly proceedings, the quality of action papers and recommendations for improvement . There were favorable responses to the reference committee format, in terms of both the discussion format and written report summarizing the testimony and the rationale for changes, the presentation by Dr. Paul Burton on correctional psychiatry, and the use of the new microphone labeling system of "Pro", "Con", and "Procedural Matters". The open ended questions showed that many in the Assembly feel that the action papers, while improving, should still focus more on relevance and demonstrate the author's homework was done before action paper submission. Dr. Miskimen stressed the importance of Assembly members bringing information related to current APA/psychiatric issues back to their DBs for discussion and follow-up.

Report from the APA CEO and Medical Director – *Saul Levin, MD, MPA*
Dr. Levin began his remarks by thanking Drs. Martin, Anzia, Miskimen, and the AEC for their support and hard work. He also thanked the Governance staff and the Chiefs for their hard work. Dr. Levin explained the transition process in DGR and that Jeff Regan will be interim Chief of Government Affairs until a replacement for Rodger Currie is secured.

Dr. Levin thanked Dr. Eyler and Area 1 for their work in helping APA identify HIPAA violations. Dr. Levin has frequent conference calls with the District Branch Executive Staff and encouraged the AEC to thank their individual DB Executive Staff for their hard work at both the branch and APA level.

The APA is closely monitoring the national elections. While the nominees are not yet known, APA is already working on identifying members who are willing and able to be involved in advising the transition team of the newly elected President on mental health issues.

The deadline to vote in the APA national elections is February 1st. Dr. Levin encouraged everyone to view the videos of the candidates on the APA website and asked the Areas/Groups to encourage voting.

The APA received a four-year, $2.9 million Transforming Clinical Practices-Support Alliance Networks (SAN) grant from the Centers for Medicare and Medicaid Services (CMS). The grant provides support for APA "to train 3,500 psychiatrists to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health and reduced cost." Dr. Levin thanked Ms. Kroeger and her team for their work in drafting the successful grant proposal.

Discussion on Dual Representative Roles

The AEC discussed the composition of the Assembly, specifically those Assembly members who serve on both the Assembly and the APA Board of Trustees.

MOTION APPROVED: The Assembly Executive Committee voted to request that the Assembly Committee on Procedures modify the *Procedural Code of the Assembly* to reflect that members of the APA Board of Trustees cannot be permanent DB/ACROSS/ECP/MUR/RFM Representatives or Deputy Representatives, that a Trustee can serve as an Alternate Representative on a case by case (but not permanent) basis, and that the Area Representative/Deputy Representative cannot be a District Branch Representative. [*Dr. Young recused*]

Area Council Structure and Financing

The AEC reviewed the purpose and composition of the Area Councils outlined in the *Procedural Code of the Assembly* to ensure that the Procedural Code includes all information and procedures to support effective Area Councils. They also compared the language against the strategic priorities of the APA.

In addition, the AEC discussed the Area Council block grants and asked individual Areas officers whether they believe the Area Council is sufficiently funded for its required activity. This included discussion of which positions are (or are not) funded to attend the Area Council meetings, including DB Executive Staff, legislative representatives, and whether the Areas pay for substitute members. In order to help better track meeting costs, the AEC requested a report which shows a breakdown in airfare costs. The Administration will work with ATC Travel Management to obtain these reports.

Dr. Martin requested each Area give a rough estimate on how much additional funding they need to accomplish Area Council meetings (as currently structured).

Area 1: </= $5,000 (current block grant amount: $15,650)
Area 2: </= $3,000-$5,000 (current block grant amount: $30,650)
Area 3: </= $5,000 (current block grant amount: $9,650)
Area 4: </= $3,000-$4,000 (current block grant amount: $34,650)
Area 5: </= $5,000 (current block grant amount: $32,150)
Area 6: </= $5,000 (current block grant amount: $21,150)
Area 7: </= $17,000 (current block grant amount: $43,650)

Drs. Martin, Anzia, and Miskimen will review these requests during the Assembly budget review process.

Assembly Committees & Work Groups Reports

Assembly Awards Committee – *Melinda Young, MD*
Dr. Young briefly reviewed the list of Assembly awards. Two awards have not yet been awarded:

- *Assembly Award for the DB and Area with the Highest Percentage of Voting:* an award for the Area and District Branch with the highest percentage of votes in the APA national election.
- *Assembly Award for Excellence in Service and Advocacy*: to recognize activities by women that promote mental health and reduce stigma related to psychiatric illness, particularly on behalf of women and members of disadvantaged population groups.

Dr. Young encouraged the AEC to discuss these and the other Assembly awards at their upcoming Area Council meetings.

Assembly Committee on Psychiatric Diagnosis and the DSM
Dr. Martin reminded those Areas and Groups that have yet to submit an appointment (Areas 1, 2, 3, ACROSS, M/UR, RFM) to please do so. Once the roster of the committee is complete, Dr. Martin will appoint a Chair.

Access to Care – *Joseph Mawhinney, MD*
The work group, along with the Council on Healthcare Systems and Financing, is developing an access to care toolkit. In addition to reviewing the status of previously approved access to care action papers, Dr. Mawhinney is planning to write an action paper on developing a position statement on out-of-pocket costs.

Maintenance of Certification (MOC) – *James R. Batterson, MD*
Dr. Batterson, along with Drs. Anzia and Levin, will be attending APA/ABPN leadership meeting in Chicago at the end of the month. A critical issues forum is scheduled for mid-April to discuss new and creative ways of doing MOC. Dr. Batterson requested that the AEC email him pertinent questions and suggestions that he can bring to the meeting.

Metrics – *John Wernert, III, MD*
The objective of the metric work group is to develop some measureable outcomes and metrics for Assembly leadership. The work group met at the Assembly in the Fall and developed two primary issues of focus for the group:
1: Identify the extent to which the Assembly work impacts the APA by reviewing APA actions from the last five years to determine which items were generated by the Assembly.
2: That the Assembly helps the APA identify APA leadership.

The work group will meet again in May and make recommendations to the AEC.

M/UR Bylaws – *Glenn Martin, MD*
The M/UR Bylaws work group consists of Drs. Anzia, Martin, Nahulu, Colleen Coyle, Margaret Dewar, and is staffed by Allison Moraske. The objective of the group is to develop the minimum necessary language to be added to the *Procedural Code of the Assembly* that needs to be included in the governing documents of the M/UR caucuses, similar to the model bylaws document used by District Branches. The initial areas of concern are: membership, elections, M/UR Trustee nominations, and the M/UR Trustee election. The work group will be following up with the M/UR caucuses directly to address these issues.

Preliminary Discussion of the May 13-15, 2016 Assembly

The AEC reviewed the draft Assembly schedule. Dr. Martin indicated he may want to extend the meeting time of the AEC on Friday morning, depending on what is coming forward for the AEC to review ahead of the Assembly meeting. Dr. Martin is contemplating some speakers for the plenary sessions. It was requested that reports from groups such as the APA*PAC* and AMA be shortened.

Written reports summarizing the actions of the Reference Committees, which was started at the Fall Assembly, will continue, with some tweaking to the format. Governance staff will look into the possibility of using the APA Annual Meeting app to keep track of the activity in the Reference Committee meetings.

The action paper deadline is **March 24**. The Excel cost estimate worksheet has been revised by both the Finance Department and Governance to show the cost breakdown of the papers more clearly. This form, and other action paper information is available online at Action Paper Central: http://www.psychiatry.org/network/assembly/action-paper-central.

Unfinished Business

APA Fellows Participation in the Assembly
Dr. Zarling submitted a revised report from the work group to the AEC. The recommendations from the revised report include that interested fellows partner with a member of the Assembly Committee of Residents and Fellows (ACORF) that participates in the Assembly meetings, collaborate with their ACORF peers in the writing and review of action papers, and to discuss their experiences and impressions with their fellowship peers at fellowship business meetings and/or during regularly held monthly fellowship conference calls.

MOTION APPROVED: The Assembly Executive Committee voted to accept the report of the Work Group on APA Fellows Participation in the Assembly.

New Business

Assembly Committee of Resident-Fellow Members
Dr. Hovav reported that the Chair of the Assembly Committee of Resident-Fellow Members (ACORF) often has difficulty obtaining the names of the new ACORF members each year, mainly due to the fact that the Area Council have different processes/timeframes for appointments. The AEC decided that the deadline for submitting rosters for both the RFMs and ECPs would be May 1st. In addition, Dr. Martin requested that ACORF discuss issues surrounding the RFM election process and report back to the AEC in May at which time the Assembly Officers will decide if a formal work group should be formed.

Action Paper ASMMAY1512.G: *Timely Reimbursement for Psychiatric Treatment*

Action paper ASMMAY1512.G: *Timely Reimbursement for Psychiatric Treatment* was referred to the Council on Government Relations by the JRC. The Council discussed the paper and recommended the action paper be returned to the authors for further clarification. As such, the Council is asking the JRC to request clarification from the AEC. In order to provide the JRC with an update at the meeting, Dr. Miskimen followed up with the authors of the action paper.

Adjournment

Upcoming Meetings:

Assembly, May 13-15, 2016, Atlanta Georgia
Assembly Executive Committee, July 22-24, 2016, Minneapolis, MN
Assembly, November 4-6, 2016, Omni Shoreham, Washington, DC

"What's Happened to my Action Paper?"
From the APA Assembly Recorder
Updated March 1, 2016

Assembly Action Date	Lead Author	Title	Past Actions	Next Action/Status Update as of February 2016 : JRC and AEC meeting
May 2015 12 C	Mawhinney	Developing an Access to Care Toolkit	Referred: Council on Healthcare Systems and Financing (CHSF)	Communications plan is being developed including having a web presence. This includes work by the author, the CHSF and the Division and Council on Communications.
May 2015 12 D	Mawhinney	Compendium of Access to Care Action Papers and Position Statements	Referred: CHSF	Communications plan is being developed. This includes work by the author, the CHSF and the Division and Council on Communications.
May 2015 12 E	Mawhinney	Access to Care Survey	Referred: CHSF	Communications plan is being developed. This includes work by the author, the CHSF and the Division and Council on Communications.
May 2015 12 F	Mawhinney	Level of Service Intensity Instrument	Referred: Council on Quality Care (LEAD, items 2 and 3); CHSF; Office of Healthcare Systems and Financing (items 1 and 2)	CHSF suggested that a special APA WG should be consider to take on this project.
May 2015 12 G	Daviss	Timely Reimbursement for Psychiatric Treatment	Referred: CHSF (LEAD); Council on Advocacy and Government Relations (CAGR) and report back to JRC Reviewed JRC: January 24, 2016	JRC referred to: Office of the CEO Report back to JRC: June 2016
May 2015 12 H	Dunn	Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault	Referred: Council on Minority Mental Health and Health Disparities (LEAD); Council on CHSF (item 3); Council on Psychiatry and Law Report back to JRC: January 2016 Develop Position Statement	Update from Council on Minority Mental Health: the council assigned a WG to research the issue and develop resource documents/work in progress.
May 2015 12 J	McDougall	Fostering the Next Generation of Leaders within the APA	Referred: Chief RFM-ECP Office; Director of the Division Diversity and Health Equity; Director of Education; APA Foundation Report to JRC October 2015	The Administration also solicited feedback from the CMELL. Summary: there are various activities and proposal set for the next several years to address this issue.

"What's Happened to my Action Paper?"
From the APA Assembly Recorder
Updated March 1, 2016

May 2015 12 L	Torres	The Impact of Global Climate Change on Mental Health	Referred: Council on Minority Mental Health and Health Disparities (LEAD); Council on Communications; Council on International Psychiatry; Committee on Psychiatric Dimensions of Disasters Reviewed JRC: January 24, 2016	WG recommends that the APA develop a position statement on the psychiatric impact of climate change. JRC Referred to the Council on Research and its Committee on Psychiatric Dimensions of Disasters to develop a position statement. Report back to JRC: June 2016
May 2015 12 M	Gourguechon	Promoting Military Cultural Knowledge among Psychiatrists	Referred: Council on Medical Education and Lifelong Learning (CMELL-LEAD); Division of Government Affairs; CAGR; Council on Quality Care; Council on Minority Mental Health and Health Disparities; VA Caucus Report back to JRC: October 2015	CMELL is to develop of a position statement with the various councils including CAGR and the Council on Quality Care.
MAY 2015 12 N	Hovav	Changing ECP Status to 8 Years Following Completion of Training	Referred: Membership Committee; Finance and Budget Committee Reviewed JRC: January 24, 2016	JRC referred back to Membership Committee for position clarification. Report back to JRC: June 2016.
May 2105 12 O	McLeod-Bryant	Improving APA Support of the Mental Health of African American Males	Referred: Division of Diversity and Health Equity; Division of Education; Council on Minority Mental Health and Health Disparities	Report back to JRC: June 2016
May 2015 12 S	Bolick	Emergency Department Boarding of Individuals with Psychiatric Disorders	Referred: Council on Psychosomatic Medicine (LEAD); CSHF; Council on Psychiatry and Law; CAGR Report back to JRC: October 2015	Council on Psychosomatic Medicine (LEAD) developed a position statement with other Councils. JRC referred to: Council on Communications to be involved in communications campaigns related to this issue including consequences of diminishing mental health funding and repercussions on bed availability.
May 2015 12 T	Fleming	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior	Referred: Division of Education and CMELL (LEADS); Council on Children, Adolescents and their Families Reviewed JRC: October 2015	JRC reassigned the AP from CMELL to the Council on Children, Adolescents and Their Families and requested that they form a WG on this topic. Implementation: Division of Education.

"What's Happened to my Action Paper?"
From the APA Assembly Recorder
Updated March 1, 2016

MAY 2015 12 U	Ginzburg	Parity in Payment, Parity in Policy Implementation	Referred: Department of Government Affairs; CHSF (LEAD); the Office of the CEO Reviewed JRC: January 24, 2016	The APA administration will implement recommendations from CEO 's office as discussed with the VA Caucus Leadership.
May 2105 12 V	Sonkiss	Location of Civil Commitment Hearings	Referred: Council on Psychiatry and Law (LEAD); CAGR Report back to JRC: October 2015 Develop Position Statement Reviewed JRC: January 24, 2016	Update by Council on Psychiatry and Law: Civil Commitment WG is developing a position statement that will be forwarded to the JRC Report back to JRC: June 2016
May 2015 12 W	Weker	Reconfiguring the Health Care Percentage of the GDP	Referred: CHSF Reviewed JRC: October 2015 JRC referred back to CSHF for review and feedback. Reviewed JRC: January 24, 2016	CHSF point person and the author are set to review the AP for further clarification and understanding of the action. Report back to JRC: June 2016
May 2015 12 Y	Aoun	Mental Health leave in Colleges	Referred: Caucus on College Mental Health via the Council on Children, Adolescents and their Families Report back to JRC: October 2015 Position statement to be presented to JRC January 2016 Reviewed JRC: January 24, 2016	JRC recommended that the ASM approve the proposed position statement *College University Mental Health* an if approved, forward to the BOT for consideration. If approved it will replace the 2005 PS of the same name.
MAY 2015 12 CC	Bonner	Senior Psychiatrists	Referred: BOT, July 2015 Reviewed by BOT: July 11, 2015 BOT voted to refer to the JRC Reviewed JRC: January 24, 2016	JRC referred to Membership Committee to review by a sub work group of BOT, ASM and Senior Psychiatrists representatives. Report back to JRC: June 2016
NOV 2015 12 A	Ginzburg	Access to Care Provided by the Department of Veterans Affairs	Reviewed JRC: January 24, 2016	JRC referred to: CAGR (LEAD) and CHSF. Report back to JRC: June 2016

"What's Happened to my Action Paper?"
From the APA Assembly Recorder
Updated March 1, 2016

NOV 2015 12 B	Peele	Directions to the Area Nominating Committees	Reviewed AEC: January 22, 2016	The AEC will have the Assembly Committee on Procedures develop language to amend the Procedural Code of the Assembly to incorporate the changes outlined in the action paper. The language will be discussed and voted on at the May 2016 Assembly meeting.
NOV 2015 12 D	Peele	Prior Authorization	Reviewed JRC: January 24, 2016	JRC referred to: APA AMA Delegation
Nov 2015 12 E	Daviss	Ad Hoc WG to Explore the Feasibility of Developing an Electronic Clinical Support Product	Reviewed JRC: January 24, 2016	JRC referred to: Council on Quality Care (LEAD) and the Council on Research. Report back to JRC: June 2016
NOV 2015 12 F	Daviss	Payer Coverage for Prescriptions from Nonparticipating Prescribers	Reviewed JRC: January 24, 2016	JRC referred to: Items 1 and 4: APA's Policy Department Item2: Div of Gov Affairs Item 3: CHSF Report back to JRC: October 2016
NOV 2015 12 G	Plakun	APA Support for NIMH Funding of Clinical Research	Reviewed JRC: January 24, 2016	JRC referred to: Council on Research and the Div of Research Interim update due June 2016 Full report due October 2016
NOV 2015 12 H	Plakun	Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Stds Fail to Comply with Parity?		ASM referred: CHSF
NOV 2015 12 I	Abellard	Strengthening the Role of Residency Training to Improve Access to Buprenorphine	Reviewed JRC: January 24, 2016	JRC referred to: CMELL Report back to JRC: June 2016
NOV 2015 12 K	Hovav	Parity in Permanent Licensure Policy	Reviewed JRC: January 24, 2016	JRC referred to: CMELL (LEAD) and the Council on International Psychiatry (secondary) Report back to JRC: June 2016
NOV 2015 12 L	Madakasira	Partial Hospital Training in Psychiatry Residency	Reviewed JRC: January 24, 2016	JRC referred to: CMELL Report back to JRC: June 2016

NOV 2015 12 N	Fleming	Advocating for Medicaid Expansion	Reviewed JRC: January 24, 2016	JRC referred to: CEO Office and the Division of Government Affairs Report back to ASM: May 2016 Report back to JRC: June 2016
Nov 2015 12 O	Granese	Systems to Coordinate Psychiatric Inpatient Bed Availability	Reviewed JRC: January 24, 2016	JRC referred to : Council on Quality Care (LEAD) and the CHSF Report back to JRC: June 2016
NOV 2015 12 P	Vivek	Making Access to Treatment for Erectile Disorder Available under Medicare	Reviewed JRC: January 24, 2016	JRC did not refer AP
NOV 2015 12 R	Geller	Senior Psychiatrist Seat on the BOT	Reviewed JRC: January 24, 2016	JRC referred to: CEO Office for follow up
NOV 2015 12 T	Scasta	Election of Assembly Officers	Reviewed AEC: January 22, 2016	The AEC will have the Assembly Committee on Procedures develop language to amend the Procedural Code of the Assembly to incorporate the changes outlined in the action paper. The language will be discussed and voted on at the May 2016 Assembly meeting.

Respectfully submitted by Theresa Miskimen, MD
APA Assembly Recorder

Rules Committee Report

Draft Action Assignments – as of 4/26

Reference Committee Rosters

Reference Committee 1 — Advancing Psychiatry

Meets: Friday, May 13, 3:00 PM-6:00 PM, 2016, Room A312, Level 3

Presents: 2nd Plenary, Saturday, May 14, 10:30 AM- 12:00 PM

Roster:

Robert Roca, M.D., MPH, Area 3, CHAIR
Marshall Forstein, M.D., Area 1
Adam Chester, M.D., Area 2
Prudence Gourguechon, M.D., Area 4
Mark Wright, M.D., Area 5
Richard Granese, M.D., Area 6
Dodge Slagle, D.O., Area 7
Loreen Pirnie, M.D., RFM
John Korpics, M.D., ECP
Kimberly Yang, M.D., M/UR
Mark Komrad, M.D., ACROSS

Assignments: 4.B.1, 4.B.2, 4.B.8, 12.A, 12.B, 12.C, 12.D, 12.E, 12.F

cc	2016A1 4.B.1	Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with That of Co-occurring Mental Illnesses
cc	2016A1 4.B.2	Proposed Position Statement: The Role of Psychiatrists in Assessing Driving Ability
cc	2016A1 4.B.8	Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders
	2016A1 12.A	Performance in Practice Certification by the American Psychiatric Association
	2016A1 12.B	Standards for Inpatient Psychiatric Care
	2016A1 12.C	APA Position Statement on Mental Health Hotlines
	2016A1 12.D	Supporting the WACP Position Statement on Migrant Crisis Around the World
cc	2016A1 12.E	Eliminate Federal Parity Opt-Out
cc	2016A1 12.F	Making Access to Treatment for Erectile Disorder Available Under Medicare

Reference Committee 2 — Supporting Research

Meets: Friday, May 13, 3:00 PM-6:00 PM, 2016, Room A313, Level 3

Presents: 2nd Plenary, Saturday, May 14, 10:30 AM- 12:00 PM

Roster:

Mary Ann Schaepper, M.D., Area 6, CHAIR
Lisa Catapano-Friedman, M.D., Area 1
Aaron Satloff, M.D., Area 2
William Greenberg, M.D., Area 3
Lisa Rone, M.D., Area 4
James Kyser, M.D., Area 5
Iqbal Ahmed, M.D., Area 7
Candes Dotson, M.D., RFM
Maria Bodic, M.D., ECP
TBD, MD, M/UR
Beverly Fauman, M.D., ACROSS

Assignments: 4.B.3, 4.B.12, 4.B.13, 12.G, 12.H, 12.I, 12.J, 12.K, 12.L, 12.M

cc	2016A1 4.B.3	Proposed Position Statement on Patient Access to Electronic Mental Health Records
	2016A1 4.B.12	Proposed Position Statement: Off-Label Treatments

	2016A1 4.B.13	Retire Position Statement: Patient Access to Treatments Prescribed by their Physicians
	2016A1 12.G	Providing Recordings of Individual Presentations from the APA Annual Meeting
	2016A1 12.H	Third Party Coverage of Medication Found to Be Beneficial to an Individual Patient
	2016A1 12.I	Pharmacists Substituting Medications with Similar Mechanisms of Action
	2016A1 12.J	Eliminate Out Of Pocket Cost Barriers to Care for Patients with Severe, Persistent and Recurrent Disabling Mental Disorders
	2016A1 12.K	Coding Suicidal Ideation
	2016A1 12.L	Exercise: Too Little, Too Much
	2016A1 12.M	Inclusion of Racism in ICD-10-CM and DSM 5

Reference Committee 3 — Education& Lifelong Learning

Meets: Friday, May 13, 2016, 3:00 PM-6:00 PM, 2016, Room A314, Level 3
Presents: 3rd Plenary, Saturday, May 14, 2016, 1:00 PM- 3:15 PM

Roster:

Jacob Behrens, M.D., ECP, CHAIR
Shery Zener, M.D., Area 1
Henry Weinstein, M.D., Area 2
Sheila Judge, M.D., Area 3
James Fleming, M.D., Area 4
Debra Atkisson, M.D., Area 5
Robert McCarron, MD, Area 6
Matthew Layton, M.D., Area 7
Kelly Jones, M.D., RFM
Ubaldo Leli, M.D., M/UR
Jack Bonner, M.D., ACROSS

Assignments: 4.B.16, 4.B.17, 12.N, 12.O, 12.P, 12.Q, 12.R, 12.S, 12.T

cc	2016A1 4.B.16	Proposed Position Statement: College and University Mental Health
cc	2016A1 4.B.17	Retire Position Statement: College and University Mental Health
	2016A1 12.N	Improving Electronic Medical Record (EMR) – Information Technology (I.T.) Toolkit
	2016A1 12.O	Direct to Consumer Advertising
	2016A1 12.P	Improving the Efficacy of Prescription Drug Monitoring Programs
	2016A1 12.Q	Develop an APA White Paper on the Use of Patient Information Discovered in Targeted Internet or Social Media Searches
	2016A1 12.R	Encouragement of Senior Psychiatrists to Maintain Active Membership in APA
	2016A1 12.S	Enhancing Ethical Knowledge of APA Members
	2016A1 12.T	Mandatory Competency Testing for Senior Psychiatrists

Reference Committee 4 — Diversity & Health Disparities

Meets: Friday, May 13, 2016, 3:00 PM-6:00 PM, 2016, Room A315, Level 3

Presents: 4th Plenary, Sunday, May 15, 2016, 8:00 AM- 11:30 AM

Roster:

Kenneth Certa, M.D., Area 3, CHAIR
Reena Kapoor, M.D., Area 1
Felix Torres, M.D., Area 2
Dionne Hart, M.D., Area 4
Eugene Lee, M.D., Area 5
Alexis Seegan, M.D., Area 6
Linda Nahulu, M.D., Area 7
Jessica Abellard, M.D., RFM
Lawrence Malak, M.D., ECP
Maureen Van Niel, M.D., M/UR
Gregory Miller, M.D., ACROSS

Assignments: 4.B.11, 4.B.19, 12.U, 12.V, 12.W, 12.X, 12.Y, 12.Z

cc	2016A1 4.B.11	Proposed Position Statement: Integrated Care
cc	2016A1 4.B.19	Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness
	2016A1 12.U	Psychiatrist Involvement in Medical Euthanasia and Physician-assisted Suicide of the Non Terminally Ill
cc	2016A1 12.V	A Psychiatric Response to Human Trafficking
	2016A1 12.W	APA Takes a Neutral Stand on Physician Aid in Dying
	2016A1 12.X	Disapproval of the Detention of Central American Asylum Seeking Children and Families in Need of International Protection
	2016A1 12.Y	Develop an APA Position Statement Regarding the Ethical Tensions Faced by Psychiatrists Serving as Third Party Utilization Management Reviewers under the Parity Law
cc	2016A1 12.Z	US Joint Statement on Conversion Therapy

Reference Committee 5 — Membership & Organization

Meets: Friday, May 13, 2016, 3:00 PM-6:00 PM, 2016, Room A316, Level 3

Presents: 4th Plenary, Sunday, May 15, 2016, 8:00 AM- 11:30 AM

Roster:

Melvin P. Melnick, M.D., Area 3, CHAIR
Paul Lieberman, M.D., Area 1
Ramaswamy Viswanathan, M.D., Area 2
Brian Hart, M.D., Area 4
John Bailey, M.D., Area 5
Lawrence Gross, M.D., Area 6
Amela Blekic, M.D., Area 7
Matthew Kruse, M.D., RFM
Gwendolyn Lopez-Cohen M.D., ECP
TBD, MD, M/UR
Jeffrey Geller, M.D., ACROSS

Assignments: 4.B.4, 4.B.5, 4.B.14, 4.B.15, 12.AA, 12.BB, 12.CC, 12.DD, 12.EE, 12.FF

cc	2016A1 4.B.4	Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System
cc	2016A1 4.B.5	Retire Position Statement: Adjudication of Youths as Adults in the Criminal Justice System
cc	2016A1 4.B.14	Proposed Position Statement: Call to Action: Accountability for Persons with Serious Mental Illness
cc	2016A1 4.B.15	Retire Position Statement: A Call to Action for the Chronic Mental Patient
	2016A1 12.AA	Enhancing the Retention of Resident Fellow Members (RFMs) Who Have Received APA Funding Following the End of their Terms
cc	2016A1 12.BB	Utilization of DSM-5 Terminology in APA Publications and Communications
	2016A1 12.CC	Increasing the Opportunity for Involvement of Resident Fellow Members (RFMs) and Early Career Psychiatrists (ECPs) in the APA Assembly
	2016A1 12.DD	Allow Deputies to Vote
	2016A1 12.EE	Increasing Members' Involvement in APA Policy
cc	2016A1 12.FF	APA Referendum Voting Procedure

Area Council and Assembly Group Action Assignments

Presents: 4th Plenary, Sunday, May 15, 2016, 8:00 AM - 11:00 AM

Assignments: 1.A.1, 4.B.6, 4.B.7, 4.B.9, 4.B.10, 4.B.18

	2016A1 1.A.1	Ratification of the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws All Areas/Groups: Primary – Area 4, Secondary – Area 7 ***Note**: This will voted on during the 3rd Plenary, Saturday, May 14, 2016, 1:00 PM- 3:15 PM
cc	2016A1 4.B.6	Retire Position Statement: Infectious Disease Epidemics Including H1N1 All Areas/Groups: Primary – Area 5, Secondary – ECPs
cc	2016A1 4.B.7	Revised Position Statement on Sexual Harassment All Areas/Groups: Primary – Area 1, Secondary – ACROSS
cc	2016A1 4.B.9	Retain Position Statement: Any Willing Physician All Areas/Groups: Primary – Area 3, Secondary – M/URs
cc	2016A1 4.B.10	Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents All Areas/Groups: Primary – Area 6, Secondary – Area 1
cc	2016A1 4.B.18	Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research All Areas/Groups: Primary – Area 2, Secondary – RFMs

Assembly Rules Committee
DRAFT Consent Calendar

To provide time for discussion and debate on many issues on the agenda, the Assembly has approved using a Consent Calendar at its meetings. Placement on the Consent Calendar does not imply that an issue is not of prime interest or importance, but rather that it is perceived to be non-controversial, routine, for information (perhaps to another component), or an administrative matter.

When the Consent Calendar is brought to the floor of the Assembly, any member may request removal of any item for debate, for individual action, or for information. Members may have suggestions for additions to the Consent Calendar when it is presented for a vote.

The remaining items are voted on en bloc. Items removed are then taken up in the order in which they appear on the agenda schedule.

A. Does any member of the Assembly wish to add any item to the Consent Calendar?
B. Does any member of the Assembly wish to remove any item from the Consent Calendar?
C. Will the Assembly vote to approve the remaining items on the Consent Calendar?

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cc #1 **2016A1 4.B.1** Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone With That Of Co-occurring Mental Illnesses
If removed: **Reference Committee #1**

cc#2 **2016A1 4.B.2** Proposed Position Statement: The Role of Psychiatrists in Assessing Driving Ability
If removed: **Reference Committee #1**

cc#3 **2016A1 4.B.3** Proposed Position Statement on Patient Access to Electronic Mental Health Records
If removed: **Reference Committee #2**

cc#4 **2016A1 4.B.4** Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System
If removed: **Reference Committee #5**

cc#5 **2016A1 4.B.5** Retire Position Statement: Adjudication of Youths as Adults in the Criminal Justice System
If removed: **Reference Committee #5**

cc#6 **2016A1 4.B.6** Retire Position Statement: Infectious Disease Epidemics Including H1N1
If removed: **All Areas/Groups:** Primary – Area 5, Secondary – ECPs

cc#7 **2016A1 4.B.7** Revised Position Statement on Sexual Harassment
If removed: **All Areas/Groups**: Primary – Area 1, Secondary – ACROSS

cc#8 **2016A1 4.B.8** Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders
If removed: **Reference Committee #1**

cc#9 **2016A1 4.B.9** Retain Position Statement: Any Willing Physician
If removed: **All Areas/Groups**: Primary – Area 3, Secondary – M/URs

cc#10 **2016A1 4.B.10** Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents
If removed: **All Areas/Groups**: Primary – Area 6, Secondary – Area 1

cc#11 **2016A1 4.B.11** Proposed Position Statement: Integrated Care
If removed: **Reference Committee #4**

cc#12 **2016A1 4.B.14** Proposed Position Statement: Call to Action: Accountability for Persons with Serious Mental Illness
If removed: **Reference Committee #5**

cc#13 **2016A1 4.B.15** Retire Position Statement: A Call to Action for the Chronic Mental Patient
If removed: **Reference Committee #5**

cc#14 **2016A1 4.B.16** Proposed Position Statement: College and University Mental Health
If removed: **Reference Committee #3**

cc#15 **2016A1 4.B.17** Retire Position Statement: College and University Mental Health
If removed: **Reference Committee #3**

cc#16 **2016A1 4.B.18** Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research
All Areas/Groups: Primary – Area 2, Secondary – Area 6

cc#17 **2016A1 4.B.19** Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness
If removed: **Reference Committee #4**

cc#18 **2016A1 12.E** Action Paper: Eliminate Federal Parity Opt-Out (see action paper packet)
If removed: **Reference Committee #1**

cc#19 **2016A1 12.F** Action Paper: Making Access to Treatment for Erectile Disorder Available under Medicare (see action paper packet)
If removed: **Reference Committee #1**

cc#20 **2016A1 12.V** Action Paper: A Psychiatric Response to Human Trafficking (see action paper packet)
If removed: **Reference Committee #4**

cc#21 **2016A1 12.Z** Action Paper: US Joint Statement on Conversion Therapy (see action paper packet)
If removed: **Reference Committee #4**

cc#22 **2016A1 12.BB** Action Paper: Utilization of DSM-5 Terminology in APA Publications and Communications (see action paper packet)
If removed: **Reference Committee #5**

cc#23 **2016A1 12.FF** Action Paper: APA Referendum Voting Procedure (see action paper packet)
If removed: **Reference Committee #5**

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Special Rules of the Assembly

1) There will be a maximum of three minutes for each presentation during debate.

2) The author or presenter has priority in making statements.

3) The Speaker will attempt to solicit a balance of pros and cons.

4) The Speaker will entertain a motion for the question when it is felt that there has been sufficient debate, both positive and negative on the motion.

5) A Reference Committee model is being used as an alternative to Area Council review for some Action Papers. The Rules Committee will select the papers to be processed in this way. The Reference Committee will be selected by the Speaker from nominees submitted by the Area Councils, the ECP Committee, the RFM Committee, the M/UR Committee, and the ACROSS Committee, to equalize participation as much as possible. Council Chairs may be appointed as non-voting participants in the Reference Committees. The Reference Committees may modify or combine Action Papers. Their recommended actions will be distributed in time for discussion in the Area Council meetings before being brought to the floor.

6) Presenters of reports should be limited to spelling out clearly the title and identification of the report, giving a short summary of the salient points if necessary, calling for action if indicated, and being available for questions from the floor.

7) New Business should be kept to a minimum, particularly if the issue is already reflected in another Action Paper on the Agenda that was emailed before the meeting.

8) The author will move his or her paper. The Reference Committee will give a report of recommendations to approve, not approve, amend, or otherwise act on the paper. If the Reference Committee proposes amendments, they will move them en bloc as an amendment by substitution, which does not require a second or acceptance by the author. The discussion will be on the amendment by substitution. Two additional levels of amendment will be permitted to this amendment by the Reference Committee. At the end of the discussion, if the Reference Committee's wording with any passed amendment fails, then discussion will revert to the original paper.

9) The question of direct referral of an Action Paper to the Board of Trustees will be divided and handled as a separate motion following passage of the Action Paper, even if direct referral is included in the Action Paper's "Be it Resolved." The Reference Committee's input regarding the direct referral motion will be taken into consideration. Debate on this motion will be limited as to timeliness and thus the appropriateness of a direct referral.

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ACORF REPORT – MAY 2016

Sarit Hovav, MD, Chair

We say goodbye to our Area RFM Reps and our Mentor!

Area 1 – Loreen Pirnie

Area 2 – Subhash Chandra

Area 3 – Raul Poulson (RFM Dep Rep)

Area 4 – Sarit Hovav

Area 5 – Candace Dotson

Area 7 – Kelly Jones

Area 6 – Alexis Seegan

ACORF Mentor

ACORF REPORT – MAY 2016

Sarit Hovav, MD, Chair

Updates:

1. **New Email addresses:**
    a. Each Area RFM Rep/Dep Rep now share an email address for official correspondence for assembly information and ACORF official emails.
        i. area1rfm@gmail.com, area2rfm@gmail.com, area3rfm@gmail.com, area4rfm@gmail.com; area5rfm@gmail.com; area6rfm@gmail.com; area7rfm@gmail.com
        ii. This will assist future Chairs and Mentors in proper communication with the incoming Dep Reps from the beginning as it is expected that the outgoing Area RFM Reps, as well as the Area Reps will supply the email to the incoming Dep Rep. Further, it will help clear personal emails of the heavy load of ACORF shared files on the Google Drive that will accumulate over the years.
        iii. At this time, there are folders on Google Drive with all monthly agendas, monthly minutes, forms, procedural codes, RFM resources, information from the Board of Trustees, and other valuable information.
        iv. Having access to the email address will automatically give access to all these files.
        v. Contacts on the emails will no longer need to be re-created, saving time for the RFMs to communicate quicker with the DBs in their area.
2. **Election Results:**
    a. New ACORF Chair for 2016-2017: Matt Kruse
        i. Chair should continue to be reached at acorfchair@gmail.com
    b. New Mentor for 2016-2017: Sarit Hovav
        i. Mentor should be reached at acorfmentor@gmail.com
    c. New DSM Committee member: Rebecca Allen, contact rebecca.mae.allen@gmail.com
3. **First time that an Exit Survey was done via Survey Monkey (7 respondents):**
    a. Will you be a resident, fellow, or ECP next year?
        i. ECP (4)
        ii. Fellow (1)
            1. Child/Adolescent
        iii. Resident (2)
    b. Will you be APA member next year?
        i. Yes (all)
    c. 2 will not have an active role in the APA but wish they did. Comments below:
        i. No role but wish I did (2)
            1. Will continue involvement in RI DB
            2. Switching districts/Areas will be interesting but hope to be involved
        ii. Yes, will have an active role (4)
            1. Running for Area 6 ECP Dep Rep
            2. Will be ACORF Mentor

3. Will be RFM Rep (again)

iii. 1 did not respond

d. Did you enjoy ACORF so far?
   i. Yes, Can't wait for May Assembly (6)
      1. Sarit has done an awesome job, incredibly organized
   ii. No (0)
   iii. Was OK (1)
e. What was the best part of being in ACORF? (6 responded)
   i. Friends, networking
   ii. Meeting motivated, intelligent and driven fellow residents. Being able to play an active role in where the direction of psychiatry is heading
   iii. To get to know other people
   iv. Having the opportunity to network and learn from some of the best and most proactive psychiatrists in the field
   v. Meeting new people, learning how the assembly works, getting involved
   vi. Networking and lasting friendships
f. What was the worst part of being on ACORF? (6 responded)
   i. Time commitment (2)
   ii. None
   iii. Nothing productive, except 1-2 action papers. A lot of new rules and regulations and making it more complicated for no obvious gain
   iv. There weren't really any "worst" parts. It was overall very helpful and a great learning experience
   v. The beginning – very confusing about terms/rules (maybe the handbook clears some of that up) and it can be intimidating to ask questions
g. What would you like to see changed for the years to come in the way ACORF is run?
   i. Run just fine (4)
   ii. Other (3)
      1. Take stance in larger issues
      2. Reminder e-mails with the conference phone number and passcode on the day of meetings would be helpful. I realize we're adults, but we're also very busy. I think this would have improved meeting attendance. Also, the new email address is a bit annoying. However, this may not be an issue to those who aren't accustomed to receiving emails on their personal accounts.
      3. Run well, more explanation of acronyms at the beginning/awareness of lack of knowledge

4. First dinner at the May Assembly to include PsychSIGN, ACORFers, Assembly Committee of ECPs, PsychSIGN members, RFMT/E, and previous members of those from the past couple of years. Some APA staff will also be joining us. The dinner will be Friday May 13 at Livingston Restaurant and Bar. Our hope is that these mixed events will continue and create a closer relationship between these groups to create a better networking and social structure with increased opportunities for mentoring.

Report of the Assembly Awards Committee

Assembly District Branch Best Practice Award

This award recognizes a District Branch for exemplary standard practices and/or innovative programs in areas such as member services, communications, financial management, government affairs, and meetings/education, with a special interest in practices and programs that hold potential for replication by other District Branches.

The Assembly Awards Committee met via conference call to consider the candidates for this award and selected **the Psychiatric Society of Virginia**, based on their development of a free membership app for mobile devices which could be used as a marketing tool and a means of delivering time sensitive information to members, as the winner of 2016 District Branch Best Practice Award.

Honorable mentions were given to, in alphabetical order, **North Carolina Psychiatric Association**, for their development of a first-ever Advocacy Fellowship for an interested RFM and the **Society of Uniformed Services**, for the development of a meeting presented in both in-person and webinar format to address their distant and world-wide membership.

Resident-Fellow Member Mentor Award

This award is given to APA members who advocate for and mentor future psychiatrists. The nominations are solicited by RFMs and the Assembly Committee of Resident-Fellow Members select one member per Area each year. The 2016 winners are:

Area 1: A. Evan Eyler, M.D.
Area 2: Deborah Cabaniss, M.D.
Area 3: Debra Koss, M.D.
Area 4: James R. (Bob) Batterson, M.D.
Area 5: Mary Fitz-Gerald, M.D.
Area 6: Brenda Jensen, M.D.
Area 7: Iqbal Ahmed, M.D.

Assembly Award for Excellence in Service and Advocacy from the Women of the Assembly

This award was established by the Assembly for a female member of the APA whose work exemplifies excellence in clinical mental health care combined with service to members of an underserved minority community.

The APA Women's Caucus selected **Mary Hasbah Roessel, M.D.**, to be the first recipient of this award.

Dr. Roessel is a Board certified psychiatrist practicing in Santa Fe, New Mexico. She has worked for 25 years in her psychiatric practice primarily with Indigenous peoples of the southwestern USA, Alaska, and

British Columbia. She is currently the Deputy Representative for the American Indian, Alaska Native, and Native Hawaiian Psychiatrists, a caucus of the Assembly Committee of Minority/Underrepresented (M/UR) Groups. .

Assembly Award for the District Branch and Area with the Highest Percentage of Voting

The Assembly Award for the District Branch and Area with the Highest Percentage of Voting will be awarded by the APA Assembly for the first time this year.

The award is intended to encourage APA members to participate in APA national elections and to annually distinguish the District Branch and Area achieving the highest percent of voting in the national election.

The District Branch with the highest percentage of voting in the national election is the **Wyoming Association of Psychiatric Physicians** with 33%.

The Area with the highest percentage of voting in the national election is **Area 3** with 23%.

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Summary of Activities
Council on Addiction Psychiatry

- The National Institute on Drug Abuse (NIDA) will present the featured research track at the 2016 APA Annual Meeting. The track was planned in collaboration with NIDA's leadership and will feature symposia, workshops, and a lecture by NIDA Director, Nora Volkow, MD.

- The council frequently provides consultation to APA's Division of Government Relations regarding proposed legislative and regulatory initiatives that address the epidemic of prescription drug and heroin addiction and increased access to medication assisted treatment. Recently the Council provided input on a proposed rule on the confidentiality of substance abuse treatment records, 42CFR Part 2. It will also assist APA in developing comments on a proposed regulation regarding changes in the patient limits for buprenorphine prescribers.

- A workgroup comprised of representatives of the Council on Addiction Psychiatry and the Council on Psychiatry and Law has met several times to focus attention on Physicians Health Programs. In March, the group met with the leadership of the Federation of State Physician Health Programs, which serves as a resource for information, helps establish monitoring standards, accumulates data on State PHP programs and laws that govern them, etc. The group discussed state-to-state variations in structure, services offered, referral processes, funding sources, processes for access and appeals, and privacy concerns.

  The Workgroup is developing two position statements. The Council on Addiction will focus on the elements and protections that should be included in any Physician Health Program. The Council on Psychiatry and Law will focus on issues of due process.

- With the financial support of the National Institute on Drug Abuse, the Council on Addiction Psychiatry and Council on Medical Education continue efforts to identify, evaluate, and make widely available curriculum on substance use disorders that can be used to guide and augment the didactics curriculum of general psychiatry residency training programs in accordance with ACGME program requirements. A workgroup of key medical education influencers was established and meets frequently to advance this work. This group will identify and assess the scope and quality of existing open-source SUD curriculum, design and implement mechanisms to make the curriculum available to all residency training programs, execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors, identify gaps in the existing curriculum with the goal of developing curriculum to address them in a future initiative, and develop and implement mechanisms to evaluate the project.

- A council workgroup on tobacco use disorder continues to meet every 4 to 8 weeks. The group will present a symposium and a workshop at the APA Annual meeting and is planning additional presentations for the Institute on Psychiatric Services. Additionally, it is compiling resources, writing blog posts, and planning a video, all of which will be available on APA's website.

- Council's leadership and administration liaison continue to be active participants in an AMA Task Force to Reduce Opioid Abuse. The group's approximately 30 members include representatives of State medical associations, as well as medical specialty associations. The group has developed several statements, including ones addressing increased access to naloxone and the use of prescription drug monitoring systems. The chair of the Task Force, Patrice Harris, MD, is the Chair-Elect of the AMA and also an active APA member and former member of the APA Board of Trustees. She recently brought the concerns and recommendations of the Task Force to the National Governors' Association and the National Prescription Drug and Heroin Summit .

- APA continues to present webinars once or twice a month on behalf of the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT). They offer free continuing medical education credit and attract large numbers of participants. All webinars are recorded and can be accessed at www.psychiatry.org/psychiatrists/practice/professional-interests/addiction-psychiatry/pcss-mat-archive . The program's dedicated website is www.pcssmat.org

- The Providers' Clinical Support System for Opioid Therapies (PCSS-O) is a SAMHSA-funded initiative that includes 13 partner organizations, among them APA, American Academy of Addiction Psychiatry (lead), American Medical Association, American Academy of Neurology, American Academy of Pediatrics, American Academy of Pain Medicine, and the American Dental Association. APA contributes to the program by presenting webinars and developing online clinical case vignettes with self-assessment. The focus of the program is the appropriate use of opioids to treat chronic pain and the recognition and treatment of opioid use disorder. The dedicated website is www.pcss-o.org

- The Council has developed several position statements that will be reviewed at its May meeting and then forwarded to the JRC and Assembly for consideration and approval.

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS
ASSEMBLY REPORT, MAY 2016

Barry B. Perlman, M.D., Chairperson

The Council on Advocacy and Government Relations was established in May 2009, as part of the reorganization of APA councils and components. The Council was consolidated to include the charges of the Council on Advocacy and Public Policy, the former Committee on Government Relations, and the former Committee on Mental Health Care for Veterans and Military Personnel and their Families. The Council also absorbed some of the charges of the former Council on Social Issues and Public Psychiatry. The Committee on Advocacy and Litigation Funding was retained as a corresponding committee.

The Council continues to serve as the APA's coordinating body for all legislative and regulatory actions involving the federal and state governments. Activities include analyzing problems and anticipating needs for policies and strategic planning. Recent examples include Council work on internet-based psychiatric bed registries, expanding the utilization of telehealth to promote patient monitoring services in Medicare, and evaluating proposed modifications to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Comprehensive Mental Health Reform

Through the end of the year, momentum has continued to build for Congressional action to enact meaningful reform to the federal government's management and financial support of mental health and substance use services. The Helping Families in Mental Health Crisis Act (H.R. 2646), introduced by Representative Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX), continues to gain bipartisan momentum with 186 cosponsors. Murphy is working to build support overall and forge agreement on a set of core provisions. The Senate is considering a similar bipartisan comprehensive reform bill, Mental Health Reform Act of 2015 (S.1945), introduced by Senators Bill Cassidy (R-LA) and Chris Murphy (D-CT). Both bills include a number of important provisions that align with APA policy priorities, such as clinical leadership in the coordination and oversight of federal mental health resources, addressing the psychiatric workforce shortage, and promoting stronger mental health parity enforcement.

Last month, the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee favorably reported the bipartisan Mental Health Reform Act of 2016 (S. 2680), sponsored by Chairman Lamar Alexander (R-TN), Ranking Member Patty Murray (D-WA), Senator Bill Cassidy, M.D. (R-LA), and Senator Chris Murphy (D-CT). The legislation contains a number of favorable provisions to psychiatry including the establishment of a Chief Medical Officer within SAMHSA, a SAMHSA strategic plan with a focus on SMI and mental health workforce development, and stronger coordination of federal mental health and substance use disorders resources, among other provisions. The recent action in the Senate Health, Education, Labor, and Pensions Committee—and anticipated action in the Senate Judiciary Committee—will potentially lead to consolidations of several bills into one mental health package for consideration on the floor of the Senate.

APA remains engaged with relevant members of Congress through direct lobbying and grassroots contact, as well as third party partnerships, in order to drive APA's agenda forward through enactment of bipartisan comprehensive mental health reform. The Council continues to work closely with the APA Administration for political and policy feedback regarding comprehensive mental health reform since the effort began over three years ago.

Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights

The Council has continued their work in amending APA's 1996 endorsement of the Principles for the Provision of Mental Health and Substance Abuse Treatment Services. The original document was developed by nine major mental health professional organizations, including the American Psychiatric Association, American Nurses Association, American Psychological Association, and National Association of Social Workers. The group's objective was to define patients' bill of rights, inclusive of the right to know: benefits available; extent of professional expertise; treatment options; contractual limitations; appeals and grievance procedures and guaranteed confidentiality. In conjunction with the Council of Healthcare Systems and Financing, the Council has been assigned the responsibility for updating this significant policy model, providing substantive work for consideration by the Joint

Reference Committee. The position statement will be a useful resource for APA members as well as patient advocacy.

Scope of Practice

The start of the 2016 state legislative sessions brought a new and innovative strategy for dealing with psychologist scope of practice battles in the states. With the introduction of the new APA regional state government affairs team and the creation of the Unsafe Prescribing toolkit, the 2016 legislative sessions kicked off with major bills being introduced in Hawaii, Iowa, New Jersey, New York and Ohio (with threats of introduction in California). The APA Administration, working closely with the Council and APA membership, has injected a new sense of urgency in defeating inappropriate scope of practice measures sought by psychologists. Nationwide, legislation has continued to focus on allowing psychologists to gain prescriptive authority while -short-cutting‖ the education and training necessary to maintain patient safety. APA has been simultaneously broadened the conversation to promote evidence-based alternatives to pervasive mental health access challenges (e.g., expansion of collaborative care models in states with rural health challenges, telepsychiatry implementation, and parity enforcement). It is important to note that as a result of the passage of a prescriptive authority bill in Illinois in 2014, the American Psychological Association continues to -step up‖ their efforts to gain such authority in many states and APA expects active legislation in numerous states in 2017.

CALF Grants

Originally created in 2002, and re-established in 2009, the Committee on Advocacy and Litigation Funding is charged with reviewing requests, typically from district branches and state associations, for financial support of projects that involve legislation, litigation, and advocacy. The Committee makes recommendations regarding funding through the Council on Advocacy and Government Relations and the Joint Reference Committee to the Board of Trustees and programs coordinated activity by other APA components, District Branches, and State Associations.

With increased legislative activity, the Council has worked with the APA Administration in ensuring support to eligible and approved DB/SAs as they seek to bolster their advocacy apparatus.

APA*PAC*

The APA Political Action Committee (APAPAC) is governed by a Board of Directors that is composed of 13 APA members. Chaired by Corresponding Council member Charles Price, M.D., APAPAC is the bipartisan political voice of the APA and enables APA to invigorate its patient and professional advocacy activities by supporting candidates for federal office with political contributions. The APAPAC works to ensure the election of members of Congress who share mutual principles and goals with APA and who stand up for psychiatry's position during the legislative process. Another extremely important role of the APAPAC is to educate other members of Congress as to why they should support positions vital to our patients and our profession.

In 2015 APAPAC had one of its most successful fundraising years on record, raising $253,000. APAPAC also saw the average contribution rise from $154 in 2014 to $181 in 2015. With an average participation rate of just 4.5% since 2008, APAPAC will focus on raising this percentage in 2016. This participation rate ranks among the lowest of all medical specialty PACs, and increasing the number is vital to the PAC's future success. APAPAC's goal for individual contributors in 2016 is 1,776, which would be a 15% increase in participation and bring the participation rate above 5%. As of March 31, 2016, APAPAC has received contributions from 648 individual donors (37% of the 1,776 goal).

Summation

The Council on Advocacy and Government Relations, in conjunction with the Department of Government Relations, provides valuable expertise on a number of critical issues impacting APA membership. Opportunities and challenges to advancing the legislative goals of the APA will continue into 2016. APA is well-positioned to work with leadership on both sides of the aisle, particularly in the committees most relevant to our legislative agenda. As dynamic issues related to the practice of psychiatry have emerged and evolved over the last year, the members of the Council have served as key advisers to the Department of Government Relations and the Board of Trustees on pressing national priorities impacting psychiatrists and their patients.

Item 2016A1 8.C
Assembly
May 13-15, 2016

Council on Children, Adolescents and Their Families
REPORT TO THE ASSEMBLY

The Council wishes to report that:

- The Council held a conference call on April 13, 2016, at 7PM EST. The call primarily focused on cyber bullying, resident fellow announcements, APA on Tour – Impact of Human Trafficking on Mental Health, and discussion of the May Agenda. The said agenda items were discussed; however the Council will address the topics at length in May. Tatiana P. Claridad, Program Manager and newly appointed staff liaison, attended the call to introduce herself.

- The Council is looking forward to collaborating with other Councils on the topic of human trafficking. In partnership with the Council of Minority Mental Health, both councils plan to address the topic of at risk youth and determine deliverables addressing this issue. Details on this project are being collected.

- The Council will meet in conjunction with the 2016 Annual Meeting in Atlanta on Monday, May 16, 2:30PM-5:00PM at the Omni Atlanta Hotel at CNN Tower, Cottonwood, M1, North Tower.

- The College Mental Health Caucus, which is supervised by the Council, will meet on during the 2016 Annual Meeting on Monday, May 16, 2pm-5pm, Omni Atlanta Hotel at CNN Center, Magnolia, M2, North Tower.

Item 2016A1 8.D
Assembly
May 13-15, 2016

Council on Communications Assembly Report

Executive Summary:

The Council on Communications currently has three independent initiatives ongoing: establishment of a new awards committee that will reform the process for awarding and subsequently overseeing the Member Communications Award; the establishment of a Task Force on Innovation aimed at cataloguing and tracking new devices or apps designed to support or augment the practices of psychiatrists, as well as those aimed at patients; developing new communications polices for internal and external APA communications designed to encourage full brand compliance and unified messaging across all APA divisions. These efforts are currently ongoing.

Five action papers were also referred to the council recently. See the "**Referral Updates**" section below for a list of those action items and the council's responses to them.

Action Items:

The Council on Communications currently has no action items to refer to the APA Assembly.

Referral Updates:

Action 12.C: Developing an Access to Care Toolkit:

The Council on Communications recognizes the concern of the author, and feels compelled to point out that the broad scope of position statements and other parity resources produced by APA are readily available for download on Psychiatry.org through the **APA Policy Finder tool**. Using this tool, APA members and the general public can enter a term such as "parity," which will return all position statements and policy documents relating to that topic in PDF format for easy download. Additionally, the Psychiatry.org currently has a standalone webpage dedicated to parity and parity resources that can be viewed at www.psychiatry.org/parity.

Action 12.D: Compendium of Access to Care Action Papers and Position Statements

The Council on Communications submits that a compendium of parity resources available to both members and the general public already exists in the form of a dedicated web page which can be accessed at www.psychiatry.org/parity. From here, users can access a wide range of resources, including position statements, an APA-produced "parity poster" in both English and Spanish, and guides for members and non-members on how to file parity complaints or report non-compliance. Additional APA policy on parity is easily searchable and available for download through psychiatry.org's Policy Finder tool.

Action 12.E: Access to Care Survey

The Council on Communications believes that there is little to gain in spending APA resources (monetary & staff hours) on a "parity survey," and that such a survey would be surplus to requirements in patient advocacy work. The Council submits that APA resources would be better spent promoting existing parity resources, all of which are easily available online at www.psychiatry.org/parity.

Action 12.L: The Impact of Global Climate Change on Mental Health

The Council on Communications recognizes the concerns of the author, and will review any position statements that are produced by the Council on Psychiatric Dimensions of Disasters as a result of the action.

Action 12.S: Emergency Department Boarding of Individuals with Psychiatric Disorders

The Council recognizes the issue behind this action paper as one that plagues every specialty in the profession of psychiatry. The Council wishes to point out that public education and government advocacy on this issue are of paramount importance to affecting real change. The Council resolves to support and offer feedback to any position statements or other resources that are produced by the Council on Psychosomatic Medicine, the Council on Healthcare Systems and Financing, and the Council on Advocacy and Government Relations as a result of this action.

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Attachment 1: Minutes from the Council on Communications February Conference Call

The following Council members were present on the call: Chairman Arshya Vahabzadeh, M.D.; Carol Bernstein, M.D.; Stephen Allison, M.D.; Gail Saltz, M.D.; Lloyd Sederer, M.D.; Lara Cox, M.D.; Steven Chan, M.D.; Ayana Jordan, M.D.; Chuan Mei Lee, M.D.; and Amanda Harris, M.D.

The following APA staff were present on the call: Jason Young, Chief Communications Officer; Glenn O'Neal, Director of Corporate Communications and Public Affairs; Amanda Davis, Deputy Director of Corporate Communications and Public Affairs; Ryan Vanderbilt, Director of Integrated Marketing; Cathy Brown, Executive Editor of Psychiatric News and Director of Member Communications; and James Carty, Corporate Communications Specialist.

The conference call began at 3:30 pm ET and the council unanimously approved the minutes of the last council call, held on February 26, 2016.

The call began with Young offering APA communications updates to the council. Young gave the council an update of APA's efforts to combat scope of practice legislation in Hawaii, and said that APA has conducted a statewide poll to help understand why voters agree or disagree with the proposed legislation.

Young and O'Neal also gave an update on APA's efforts to establish a mental health registry. O'Neal noted that the focus groups had been completed, with both patients and doctors participating. The final

report showed that physicians were overwhelmingly in support of a registry, while patients came around to the idea after receiving more information about what a registry is, and how issues like privacy would be handled. The main takeaway is that more education and understanding is needed for patients and the general public about the nature of a mental health registry and how it would function.

Davis gave an update on the APEX Awards. She informed the council that Cokie Roberts would emcee the event, which would honor television show Orange is the New Black. Davis noted that APA is in conversations with stars of the show to appear at the event. Davis said that APA has also extended invitations to lawmakers and members of Congress to accept awards.

Young asked the council members if they had ever seen OINTB, and what their thoughts on the program were. A few council members had seen it before, and most thought it was a good show.

Council Chair Vahabzadeh then asked if most of the money raised for the event had come from donors or members. Young responded that the APEX awards are in their first year, and could grow over time. Young said that the event is not likely to realize its full potential in its first year, and at this point is more of a "friend-raiser," aimed at fostering relationships with outside groups that are likeminded with APA on the issue of mental illness in US prisons. Invitations have been aimed at country officials and judges and other people who can affect change.

Vahabzadeh then asked about outreach to journalists for the event. O'Neal responded that the run of show was not fully realized before, but now is. Targeted outreach to journalists will begin soon, including those who cover mental health and society.

Lara Cox asked about if any other cast members had been considered, such as Uzo Adubo. Young responded that Adubo was APA's first choice, but had a scheduling conflict and could not attend. Young noted that with Roberts, Kohan and possibly others, some very powerful women are involved in the APEX awards this year.

Young gave a brief update on the Annual Meeting. The APA's brand is now fully implemented after the rebranding that took place in May 2015. 2016 will mark the first year that the medical mind will be fully implemented at an annual meeting. Speakers at the event will include Atul Gawande, Supreme Court Justice Stephen Breyer, and CDC head Tom Frieden.

Vahabzadeh led the council in a discussion of action papers that had been referred to the council by association governance.

The following papers were reviewed:

Action 12.C: Developing an Access to Care Toolkit:

Action 12.D: Compendium of Access to Care Action Papers and Position Statements

Action 12.E: Access to Care Survey

Action 12.L: The Impact of Global Climate Change on Mental Health

Action 12.S: Emergency Department Boarding of Individuals with Psychiatric Disorders

Council discussion centered on the action papers dealing with parity resources (Actions 12.C, 12.D, and 12.E) ended in the resolution that many of the resources requested by the author already exist and is easily searchable, and that creating a toolkit for that issue would be a redundant and onerous administrative task.

The council had a dubious response to Action 12.L, which deals with climate change. Council members questioned the urgency of the topic, noting that there are many more pressing concerns that resources can and should be devoted to, such as the topic of Action 12.S. They did, however, agree to offer feedback on any document produced by the action should it be requested of them.

The council recognized the serious nation of Action 12.S, which deals with Emergency Department Boarding of people with psychiatric disorders. The council noted that this is an issue that effects many doctors, even those who are not psychiatrists, and needs to be addressed immediately. The council pledged to assist the furtherance of this action to the best of their ability.

The council held a discussion on direct to consumer advertising. Most council members seemed opposed to the practice, and pledged to offer feedback and advice to any document that would be produced in regards to that issue in the future.

The council adjourned at 4:30 pm.

ADDENDUM: Communications Policies Call on 3/26/16

The communications policy work group held a brief call to discuss the outline for an APA communications policies document.

The following staff were present on the call: Jason Young, Glenn O'Neal, Amanda Davis, James Carty.

The following council members were present on the call: Arshya Vahabzadeh, Ayana Jordan.

Jordan presented an outline document that offered a comprehensive plan for drafting APA communications policies aimed at establishing best practices for both internal and external communications.

The document was well received, and Young noted that the only thing missing was a piece on communications related to APA Elections.

The work group pledged to present the outline to the council at the next council call.

Council on Geriatric Psychiatry

The Council focuses on the complex needs of older adults and stands at the interface of psychiatry with other medical specialties. It recognizes that integration of care is vital to the well-being of our patients. The Council accomplishes its goals by initiatives related to education, research and clinical care in geriatric psychiatry.

Guideline on the Use of Antipsychotics to treat agitation and psychosis in patients with dementia: The Council continued reviewing and providing feedback to the Practice Guidelines Steering Committee. The Council was impressed by the effort made by the Guidelines group to create a document built on the foundation of the existing evidence and adherent to IOM rules. The input of the Council focused on ensuring that the Guidelines would prove useful to our members in the field.

Council is working on the following position statements:

- **Role of Psychiatrists in Long-term Care Settings**- The JRC asked the Council to review an existing position statement entitled "Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia". The Council suggested retiring this position statement but strongly supports the need for a statement emphasizing the importance of high quality mental health care services in the long-term care (LTC) setting. The Council is therefore developing a new statement focusing on the specific role of psychiatrists in systems where LTC services are provided by multidisciplinary teams in which psychiatrists may serve principally as consultants or supervisors. The statement is expected to be ready in May 2016 for submission to the JRC.

- **Precepts of Palliative Care:** A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Psychosomatic Medicine is working on the statement. The draft statement will be sent to the members of the both councils for review by end of April.

The Council reviewed following position statement and action papers and provided feedback.

- **Position Statement on Atypical / Second Generation Antipsychotic Medications**

The JRC requested that the Council on Geriatric Psychiatry review this statement to ensure that it aligns with the APA Practice Guidelines on Atypical Antipsychotics for use for Dementia. The Council reviewed the draft and provided comments. The statement indicated that there are no data on efficacy of atypical antispychotics in dementia. The Council feels that it is not correct to say there are no data on the efficacy of antipsychotics in dementia. There are indeed studies showing efficacy. The problem is that many of these studies also show serious adverse side effects, making their use controversial. The fact that using them in dementia is off label does NOT mean that there are no efficacy data. The Council also suggested that the statement suggest research on (1) the efficacy and safety of atypical antipsychotics for geriatric bipolar mania, depression, and maintenance therapy; (2) identifying an adequate or minimum effective dose of atypicals for dementia with agitation/psychosis; and (3) how long treatment with antipsychotics should be continued to ensure safe discontinuation when they are used for agitation/psychosis in dementia.

Action Paper: Making Access to Treatment for Erectile Disorder Available Under Medicare

The Council was asked by another Component to weigh in on this action paper and supported it in principle.

Draft Action Paper (not yet submitted): Psychiatrist involvement in medical euthanasia and physician assisted suicide of the non-terminally ill.

The Council provided feedback to the authors in advance of the submission of this draft action paper.

Report of the
Council on Healthcare Systems and Financing
Harsh K. Trivedi, MD, MBA, Chair
Executive Summary

The Council on Healthcare Systems and Financing has focused their efforts on the priority items identified in their work plan (Attachment 1) which includes items referred to the CHSF from the Assembly via the JRC. The work plan is focused on the strategic priorities of the APA Board of Trustees (BOT) (adopted March 2015) and the recommendations of the BOT Workgroup on Health Reform.

The key focus of the Council since the Assembly last met in November has been:

1. Development or revising essential APA position statements of import to APA advocacy efforts. The following three statements will be reviewed by the Assembly at this meeting:
    a. Position Statement on Integrated Care, Drs. Lori Rainey and Eliot Sorel were the primary authors of the proposed position statement with members of the Council on Healthcare Systems and Financing and its Workgroup on Integrated Care and the Council on Psychosomatic Medicine, providing input.
    b. Position Statement on Off-Label Treatments, Drs. Joseph Mawinney and Susan McLeer were the primary authors of the revised position (Position Statement on Patient Access to Treatments Prescribed by Their Physicians) with members of the Councils on Advocacy and Government Relations, Research, and Children, Adolescents and their Families providing input.
    c. The Call to Action: Accountability for Persons with Serious Mental Illness (Adapted from the Position Statement: A Call to Action for the Chronic Mental Patient), Drs. Laurence Miller and Isabel Norian were the primary authors of the revised statement with input from members of the Assembly Committee on Public Psychiatry, Council on Healthcare Systems and Financing, the CHSF Workgroup in Integrated Care, the APA BOT Workgroup on Healthcare Reform, and members of the American Association of Community Psychiatrists.

2. Ongoing analysis of the MACRA legislation and what it means for psychiatrists in terms of options for participation and feasibility of alternative payment methods while awaiting the release of proposed regulations. Psych News will have a series of articles on MACRA and other payment issues. Developing additional resources on MACRA.

3. Collaborating with other medical professional associations on the development and recognition of CPT codes to describe the work of collaborative care as well as ongoing work with Medicare to secure coverage for the interprofessional consultation codes, improvement for coverage of telepsychiatry, and increased recognition of cognitive work essential for appropriate clinical care.
   The AMA CPT Editorial Panel recently approved codes describing the work entailed in providing collaborative care services within a primary care setting. Next steps will be focused on adequately valuing the services.

4. Ongoing outreach regarding parity:
    a. Conducted a "secret shopper" survey of the DC exchange plans which found that nearly 80% of psychiatrists listed in the plans' directory were **NOT** available to see patients. The results were shared with the DC Attorney General, and personnel from his consumer protection unit. We continue to meet with them in hopes of stimulating an investigation of these plans looking at this as a consumer fraud.
    b. Ongoing follow-up meetings with Department of Labor generally regarding complaints about parity and particularly network adequacy.

c. Drafting a model parity bill in conjunction with a coalition of mental health organizations, including the Kennedy Forum, that will be shopped to states interested in passing their own parity legislation.
d. Identification of four states, based on a combination of factors including, politics, media, AG interest in health and consumer fraud, and ground level activism, to begin state level efforts at addressing parity and consumer fraud issues. In particular, the DBs of those states will be asked to conduct their own secret shopper survey (like that conducted in DC), and the results will be shared with enforcement authorities and other interested parties, politicians, media, etc. Also working with a various other states' DBs and members on pending parity issues. Persons interested in more information should contact Maureen Bailey at 703-907-7399.
e. Reviewing CMS's just released rules on parity's application to Medicaid and preparing materials to update members.
f. We are in the process of engaging with the White House's recently announced Mental Health and Substance Use Disorder Parity Task Force to provide expertise and guidance.

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Updated 4/1/2016

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
1.Integrated/ Collaborative care	**a) Development of an APA position statement**	It is a given that integrated care delivery policy initiatives are fundamental to help both public and private payers in pursuing better quality care and desired cost efficiencies. The APA has been in the forefront of placing emphasis on the essential role the treatment of behavioral conditions has in respect to these objectives. However, the APA does not have a current position statement that sets forth the principles it thinks should guide payor initiatives. The Council will undertake a lead role in the development of a position statement to be processed through appropriate APA channels.	1. To immediately begin drafting a position statement that articulates APA principles with input from other key stakeholders within the APA. 2. Secure JRC approval to begin to process this through governance quickly for eventual final approval of an APA Position Statement.	1 to 6 Months (depending on approval process)	Position statement moving forward to the Assembly for consideration in May 2016
	b) Development of specific coding and valuation amounts for the evidence based collaborative care model for persons with behavioral conditions in primary care settings to enable sustainable reimbursement	The problem of access to psychiatric services in primary care settings has been well documented. Care models to improve access in primary care settings have been developed and tested over time. The most prominent evidence-based collaborative care model is the one that the AIMS Center at the University of Washington has stewarded over time. The key barrier to the proliferation of the model has been payment for the essential functions of the model. CMS announced in July 2015 that it intends to move to coverage of, or further demonstration of, this evidence based model, and specifically intends to address how to appropriately reimburse for it. The Council will work to develop and advocate for a specific coding proposal with CMS. This will be done primarily through the Committee on RBRVS, Codes, and Reimbursement.	There are many, many decision points in the following tasks that cannot be specified at this time. 1. Key CPT and RUC representatives will be assessing our options for playing this through given the many stakeholders involved. 2. Designation of a workgroup to begin to draft the required specifications for code development for CPT. 3. Convening a teleconference with APA experts for other medical specialties to explain the model and its requirements. 4. Convening meetings with CMS to provide additional information to the comments APA submitted Sept 2015 on CMS request for information. 5. Developing the content and strategy for when a proposal is submitted to CPT and/or the development of a G code by CMS. This may require two concurrent paths of actions with CPT and CMS. 6. Key tasks that follow from point 5 can only be delineated once we have a more defined pathway which should emerge by December 2015.	The foregoing will occur over the next 18 to 24 months. The timelines that the AMA CPT and RUC work on and that of CMS are complex with respect to completion dates for codes to be considered for Medicare rule-making. However, CMS's announced target for coverage is January 2017. It should be noted that target does not mean that we will not be involved with CPT and RUC after that deadline for refinements in evaluation of the eventual codes.	In February the AMA CPT Editorial Panel approved new CPT codes describing collaborative care services. We will be working with the American Academy of Child and Adolescent Psychiatry, the American College of Physicians (ACP), the American Geriatrics Society (AGS), and the American Academy of Family Physicians to value these services.
	c) Convening an expert workgroup of psychiatrists involved in new care models, e.g. ACOs and health homes	Accountable Care Organizations (ACOs), medical and health homes, and efforts by CMHCs to secure better access for physical health services for the SMI population permeate the landscape. There are stellar examples of achievement--e.g., the Montefiore	1. Develop an outreach plan throughout the existing APA structure, including the Assembly, to identify psychiatrists who are involved in these alternative arrangements. 2. Establish an outreach effort with commercial and public payers to begin	The timeline for assembling the workgroup is late spring 2016.	Staff continues to identify interested participants.

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
	(and working with public and private payers around issues for psychiatry in the new care models)	Pioneer ACO--where the successful integration of treating individuals with behavioral conditions has led to overall success. There are also examples in the health home world where sophisticated approaches to treating behavioral conditions in primary care settings have been successful. There are also a number of CMHC efforts that have been successful. However, the overall penetration of psychiatry in these models has been highly variable as documented in the literature. There is a need to draw on the experience of psychiatrists who have been involved to understand the elements necessary for success and barriers to successful integration. There is also a need to better understand the payer perspective on barriers to the implementation of better care models for behavioral conditions.	discussions. Note that a meeting has already been had with Aetna. 3. Identify existing APA meetings (e.g., area council meetings, the annual meeting and IPS) to convene forums on these issues.		
2) Coding and Payment Issues (separate from those for the CoCM model)	**a)Working to enable payment for the interprofessional consultation codes and/or the possible development of new EM add-on codes for cognitive work, new or revised care coordination codes for all physician specialties and improvement in coverage for telepsychiatry.**	Independent of a specific coding proposal for the CoCM model noted above , there are a number of coding issues that are relevant for all physician specialties in the new healthcare delivery environment. Psychiatry has specific interest in the development of any of these new codes as well as payment for existing codes. We think there are special issues that need to be addressed to expand coverage and payment for telepsychiatry. CHSF, through the Committee on RBRVS, Codes and Reimbursement and with input from the BOT Workgroup on Telepsychiatry, will be actively working on each of these as agenda items.	1. To monitor strategies along with other medical groups to persuade CMS to pay for the existing interprofessional consultation codes. 2. To continue and ensure psychiatry's participation with key coalition groups that have emerged to expand recognition for essential cognitive work and care collaboration and potential new add on codes to the EM CPT codes. 3. Work with the BOT workgroup on telepsychiatry to identify key coverage and payment issues for telepsychiatry and develop an advocacy agenda based on them.	Activities around this have already commenced and given prior experience we expect that they will continue actively throughout the next 12 to 18 months.	APA has been a participant in the Multispecialty Coalition which is made up of medical specialty organizations interested in securing reimbursement for work not currently described within CPT or HCPCs codes. APA will be commenting and working with interested parties on several relevant CPT coding proposals moving forward.
	b) Production of a background paper on the feasibility of alternative payment models for psychiatric/SUD care across all levels of care and payers	Numerous proposals (e.g., value-based payment, bundled payment, episodes of care, and so on) are emerging from both public and private payers as alternatives to fee for service. The feasibility of these alternatives for psychiatric care has not been systematically reviewed. There are many technical issues involved in alternative payment methods (e.g., the cost basis for the unit of payment, however defined; how it is risk adjusted for case mix; how to define the beginning and end points for what triggers an end to an episode and payment for same; and so on). The long-	1. Assemble a group with the requisite expertise to begin to develop the necessary background paper/resource document. 2. Convene the group to begin to identify the essential review and analysis tasks that need to be undertaken to produce a definitive paper/resource document 3. Implement and coordinate the development of the document. 4. Ongoing collaboration with other medical associations regarding Medicare APMs.	We have begun to identify individuals with the appropriate background to serve in this role. Will convene the group in late spring 2016 in preparation for the release of the Federal regulations.	The new Office of Reimbursement will coordinate this effort. We expect Medicare to provide essential clarification on the APM issue through regulation in late spring of 2016.

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
		standing APA experience with prospective payment for inpatient care under Medicare, for instance, bears out that this is an extremely complex task. There are also distinct subset issue with other specialty APMs with respect to how psychiatry should be included for essential consultation functions. Before proceeding to specific proposals the Council thinks it is essential that the APA fully analyze the issues. Even if a way to design an alternative payment model(s) (APM) for psychiatry cannot be found, this effort will assist in defining why these approaches are not appropriate, which may prove to be important in itself in advocating with payers as to how to appropriately deal with psychiatric care. Note that the development of APMs under Medicare is in some respects a special case because of to be stipulated CMS criteria and will be included in the initial work.			
	c) Optimizing payment for psychiatry under the new MIPS formula for Medicare (which cuts across quality, education, and HIT especially) including establishing appropriate exemption thresholds for practicing psychiatrists.	SGR reform (i.e., MACRA) has reconfigured how much physicians will be paid or not paid depending upon how they interact with the various programs and alternative options established under the reform legislation. There are four potential paths that psychiatrists can occupy under MACRA, with each having different physician reporting, risk taking, and bonus/penalty implications. Psychiatrists can choose to: 1. Opt out of Medicare entirely; 2. Participate through the to-be-established MIPS payment formula; 3. Participate and be part of an alternative payment method and potentially be exempt from the MIPS payment formula; or 4. They can participate and be exempt from the MIPS payment formula if they fall under yet-to-be-established low-volume thresholds that exempt physicians from MIPS.	1. Develop materials that fully explain options and implications for APA members; 2. Develop proposals that make it feasible for psychiatrists to meaningfully participate in the MIPS formula (this includes quality measures, meaningful use, and recognized clinical practice improvement activities and appropriate patient attribution methodology) and advocate for same with CMS; 3. Develop a background paper and work with other appropriate medical professional societies to explore the feasibility of an APM for psychiatry consistent with the yet to be developed criteria from CMS; and 4. Develop a specific low-volume threshold exemption for psychiatrist participating in Medicare.	A timeline for this will be more fully mapped out once CMS has provided more clarity about its own timeline for development of essential regulations in this arena.	See above re federal rulemaking. A series of member-education items is being developed. More will follow once regulations are released.
3) Mental health /SUD parity MHPAEA took more	**a) Continuation of current plan of action to secure**	Under MHPAEA network adequacy and reimbursement parity are closely related non-quantitative treatment limitations (NQTLs). It is	1. Building on the current work plan, we need to finalize a letter, which has been prepared, that will go from the New England Business	These efforts have been ongoing and will continue aggressively over the next	Reviewing the recently released Medicaid parity regulations. Results from a

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
than a decade to come to fruition. It is a complex and not well understood statute and regulations. Currently all individual DBs and State Associations are dealing with MHPAEA issues on their own. APA deals with member issues directly with insurance plans and with the federal government and brings in DBs when possible. It is a patchwork approach that is not strategic. To successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before healthcare reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join forces in a coordinated fashion nationwide. Key elements of where we are headed are described below.	**network adequacy and reimbursement equity for psychiatry**	critical for the APA to successfully engage employers as purchaser and regulators as enforcers to move on the issue of network adequacy for psychiatrists, which is a well-documented problem. There have been many ongoing activities by OHSF staff in conjunction with the APA's General Counsel to pursue this, and there are indications that there is a beginning understanding by purchasers and regulators that network inadequacy is a parity violation. Moreover payment equity is fundamental to this. [Mention Parity and Medicaid Managed Care and Exchange Plans]	Group on Health to numerous major insurers requesting specific data and documentation about the status of their psychiatric networks. 2. District Branches need to be educated on the issues and provided with the tools needed to address network adequacy at the state level with legislators and regulators. A series of materials are being finalized to be presented at the state legislative conference in October in Florida. A plan for follow-up with the District Branches will be executed at this meeting. 3. Other outreach efforts on network the adequacy issue as a parity problem need to be made to state insurance commissioners, attorney generals, and others. 4. Develop an appropriate internal and external communications plan around these issues.	twelve months.	secret shopper survey of the DC exchange plans were shared with the DC Attorney General; will be doing something similar in several other states. We continue try to engage patient groups and other mental health groups in an effort to identify problems and co-ordinate efforts. Continue to advise states (CT, PA) on parity legislation and are drafting a model parity bill with a coalition of mental health organizations that will be shopped to states who have not already begun drafting their own parity legislation.
	b) Development of	Many district branches have indicated a desire	1. Work with DBs to identify and define the	These activities have been	Part of the above-mentioned

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
	education/action materials for APA state affiliates to identify and act on parity issues under health plans	to move forward on mental health parity issues, but some do not understand the intricacies of the statutes, the enforcement scheme, or the insurance industry. There is need for a coordinated strategy between the APA and its DBs regarding dealing with all relevant stakeholders around the parity issue. The enforcement authorities and the insurance industry do not distinguish the APA from its district branches and our credibility is tied together.	educational materials most needed to proceed on a local basis regarding parity issues. Some of the needed materials have already been identified, e.g., understanding the enforcement scheme under MHPAEA, and will be disseminated at the October state conference. 2. To prepare other materials needed by the DBs 3. To develop educational opportunities for DBs or other state entities such as in-person meetings or webinar/go-to-meeting events 4. Develop a communications strategy to engage and sustain DB activities on parity with the central office.	ongoing and there will be scheduled events prior to the May 2016 Annual Meeting.	work plan.
	c) Release of resource document on disclosure and transparency re MHPAEA compliance with model recommendations for state advocates	A fundamental issue regarding MHPAEA compliance and enforcement is the virtual total lack of disclosure by health plans and insurers on details that would permit evaluation of compliance with the statute. Disclosure is essential to transparency, and without real transparency there can be no assurances that plans have a legitimate basis for their assertions of parity compliance. An extensive resource document on disclosure under MHPAEA has been prepared and will be reviewed by the Council. A series of recommendations with model disclosure requests will be prepared for advocates at the state or individual level.	1. Review by Counsel and discussion with staff 2. Approval of recommendations and disclosure templates to be distributed 3. Develop and launch an implementation plan to engage APA affiliates on this important issue.	The bulk of the work has already been done and we will target a launch for winter 2016.	The materials are in development and will be integrated with the above noted work plan.
4) Development of communications/marketing materials that illustrate psychiatry's value proposition for healthcare reform care delivery and payment initiatives		APA has asserted that psychiatry has a direct value proposition of health reform and the many health systems and payers involved. For example, it has produced the Milliman report (title) which illustrates the extent of the behavioral health problem, its total impact, and psychiatry's potential contribution to ameliorate it. The relevance of psychiatry's value proposition varies from audience to audience. However, we have not effectively communicated this. CHSF will work with the councils on communications and psychosomatic medicine to develop a set of communications/marketing materials and a dissemination strategy.	1. CHSF and staff will first survey and inventory the research literature relevant to this as well as materials that have already been developed (such as those from the Academy of Psychosomatic Medicine) 2. Convene a conference call with all necessary parties to develop an appropriate message platform and identify materials for internal and external audiences. This would include materials that would be available to members for use on a local basis. 3. Request that the Council on Communications draft and finalize, with review by CHSF, the needed communications materials 4. Request that the Council on Communications develop a distribution plan for the materials and execute it	The target deadline for these materials would be the mid-2016. Consultation with the Division of Communications will commence as soon as practicable and will include specifics of a work plan timeline.	The new Office of Practice Management will coordinate this effort.

Council on Healthcare Systems and Financing (CHSF) Work Plan (2015/2016)

Topic/Issue	Product	Background	Key Tasks	Timeline	Update
5) Pharmacy Benefit Management issues	**a) Execute a survey of APA members on current PBM issues, produce a background document on current issues and options for APA advocacy**	The presence of PBMs is not new but the tremendous increase in micromanagement of pharmacy requests and the associated time burden is. There are many variations in the types of barriers or hurdles PBMs put in place, from securing approval for on or off-label use, to demanding justifications for why step therapy protocols are not in order or why patients who switch plans should be grandfathered on their effective drugs. The volume of complaints coming from members has increased as has the number of action papers from the Assembly on various aspects of this issue. This problem is not limited to psychiatry. We are aware of many other physician specialties that have voiced similar concerns. The council will explore and potentially recommend a plan of action for resolving this managed care problem.	1. Execution of a member survey on a wide variety of PBM issues to enable better definition and identification of what should be considered priority areas. This will also enable better identification of what if any parity issues may be embedded in current practices. 2. Due diligence with other medical associations and the PBM industry to identify potential collaboration and potential points of intervention. 3. The development of a draft action plan for APA for review and consideration by relevant components and governance. 4. Pending consensus on and action plan, implementation of same.	We expect to complete tasks 1 and 2 shortly. The survey instrument has been finalized and mechanisms for distribution have been worked out. Explorations with other medical societies and key players in the PBM world will begin this fall.	The new Office of Practice Management will coordinate this effort. Task 1 has been completed and Task 2 is in process.
6) Continued processing of action items referred to the Council with priority attention given to those which fall within the above mentioned categories		CHSF continually receives requests to act on Action Papers and/or Position Statements and other documents. This is an ongoing process and function of the Council. We would note that material triaged to CHSF and timelines assigned should fully consider where a particular matter fits in terms of the APA's priorities.	The Council reviewed several Action Papers referred to it concerning the development of an Access to Care Toolkit. The Council agreed with these Action Papers that such a toolkit would be useful and will begin to develop the kit. The toolkit will include a compendium of access to care Action Papers and Position Statements as well as an Access to Care Survey, based on one utilized by Area 6, that can be employed by other state associations.		See attachment 2 of this report.

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Updates on JRC/Assembly items from the CHSF are in the last column on the right.

Oct Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up/Update
8.B.6	Referral Update Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights (JRCOCT148.G.17) The Council on Advocacy and Government Relations discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." Following the May 2015 meeting, the Council moved to form a work group led by Drs. Bailey and Badaracco (Council on Health Care Systems and Financing). DGR staff worked with other council staff liaisons to gather facts on the use of the current Bill of Rights and made inquiries with APA Administration policy staff to best inform deliberation by the work group. The Council members, being advised of the CHSF initial recommendation to retire the paper and the ongoing deliberation by the joint Council work group, voted the following recommendations, while the work group continues their work: a) Retire the position statement (originated 1996, reaffirmed 2007); b) Notify signatories and other components; c) The joint Council work group will review existing APA policies to see if said policies satisfy the need of members with regards to having an organizational statement of a patient's bill of rights. d) Based on their evaluation, the joint Council work group will determine the potential need, recommending whether or not the drafting of a new bill of rights is essential. Contingent on the results of reviewing APA policies and if determined as necessary, the Council instructed the work group to craft a new APA document which would address the rights of patients, revised to reflect developments in law and policy over the past 15 years. Additional members of the Council volunteered to serve on the work group: Drs. Jenny Boyer, Napoleon Higgins, and Morgan Melock (RFM).	The Joint Reference Committee thanked the Council for the update. While the joint council work group deliberates, the JRC thought it best not to retire the position statement. To kick start the functioning of joint work group, the JRC transferred 'ownership' of the work group from the Council on Advocacy and Government Relations to the Council on Healthcare Systems and Financing. A conference call of the work group was requested within the next month. The JRC would like the position statement revised as it would be useful from both a member and advocacy standpoint.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Joint Reference Committee January 2016 (deadline: 1/6/2016) **CHSF Member point person: Mary Anne Badaracco** **Staff will work with Dr. Badaracco and the existing work group from the Council on Advocacy and Govt Relations on the development of a position statement. The CAGR based work group is in the process of revising the draft document which will be sent to the CHSF for review on a future call. We anticipate forwarding this to the JRC in June pending review and approval by CHSF.**

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Oct Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up/Update
8.G.3	Referral Update Access to Care Related Action Papers Developing an Access to Care Toolkit (ASMMAY1512.C) Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D Access to Care Survey (ASMMAY1512.E) The Council on Healthcare Systems and Financing reviewed the three access to care related items at their September meeting. The Council supported the actions and will incorporate this work into its work plan. It was felt that the survey would provide data that will be necessary to advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will lead the project.	The Joint Reference Committee thanked the Council for the update and noted that the Council on Communications and the Division of Communications should be utilized in the development of a communications plan. The JRC requested that a timeline of the work and communications plans be forwarded to the JRC not later than its January Meeting.	Kristin Kroeger Becky Yowell Jason Young	Joint Reference Committee January 2016 (Deadline: 1/6/2016) **CHSF member point person: Joe Mawhinney** **OHSF staff attended a forum (led by Dr. Mawhinney) held by the Assembly Access to Care Workgroup in November, and Dr. Mawhinney has further defined the scope of work. We have begun to compile the relevant materials. Outreach to the Office of Communications has occurred re the development of a communications plan.** **Timeline: The timeline will be dependent on the scope of work; we anticipate having a web-presence by mid-2016.**
8.G.8	Referral Update Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W) CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar id spent on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.	The Joint Reference Committee thanked the Council for the update and referred the action paper back to the Council for review and feedback. The JRC noted that once approved by the Assembly, the action paper is a product of the Assembly.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing **CHSF member point person: Jim Dilley** **A conference call will be held with Dr. Dilley, APA staff and the action paper author (Jonathan Weker MD) to get a better understanding of the action.**
8.G.9	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by their Physicians (JRCOCT148.G.19) The CHSF was advised of the CAGR recommendation to maintain the existing position statement. A subsequent discussion with CAGR resulted in CAGR endorsing our support for the revised statement. It was reiterated that members of the CHSF thought that the original statement combined too many issues, and lacked clarity for that reason. The Councils on Government Relations and Research support the revised position statement as proposed by the CHSF. The Council on Children has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was needed.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving the proposed position statement on *Patient Access to Treatments Prescribed by their Physicians* once it has been vetted by the Council on Children, Adolescents and Their Families.	Kristin Kroeger Becky Yowell Ranna Parekh, MD, MPH Allison Bondurant	Council on Healthcare Systems and Financing (LEAD) Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 **CHSF member point people: Sue McLeer and Joe Mawhinney** **The JRC approved the position statement in January. It will now go to the Assembly for review.**

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Oct Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up/Update
8.G.10	Referral Update (see also 8.B.5) Multiple Co-payments Charged for Single Prescriptions (ASMMAY1412.A) The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's work plan for the next 12 months.	The Joint Reference Committee thanked the Council for the update and requested a timeline for the dissemination of the survey.	Kristin Kroeger Becky Yowell	Report to JRC on timeline by November 25, 2015 **CHSF member point person: Larry Miller** **In lieu of a survey, APA staff have developed a portal to collect information on pharmacy benefit issues via a form on the APA website:** http://www.psychiatry.org/psychiatrists/practice/practice-management/pharmacy-benefits-complaints **A subsequent work plan will be developed based on the information gathered.**
8.G.11	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers (ASMNOV1412.D) The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers, but also the Indian Health Service, Veterans Administration, and other federal programs. General consensus is that this is an issue in other areas also. CHSF does not think there are any current APA position statements that speak to the issue of compensation. The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back on what kinds of salary income data we are able to discover.	The Joint Reference Committee thanked the Council for the update and requests a progress report and timeline from the Council as part of its report to the JRC in January 2016.	Kristin Kroeger Becky Yowell	Joint Reference Committee January 2016 **CHSF member point person: Harsh Trivedi** **APA staff will work with Dr. Trivedi to review the data and move this forward.**
6.1 (Jan 2016)	Access to Care Provided by the Department of Veterans Affairs (ASMNOV1512.A) Action paper 12.A asks: That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans. That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans. That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA. Will the Joint Reference Committee refer action paper 12.A: Access to Care Provided by the Department of Veterans Affairs to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred action paper 12.A Access to Care Provided by the Department of Veterans Affairs to the Council on Advocacy and Government Relations (LEAD) and the Council on Healthcare Systems and Financing. A report back is requested for the June 2016 JRC.	Jeffrey Regan Deana McRae Kristin Kroeger Becky Yowell	Council on Advocacy and Government Relations (LEAD) Council on Healthcare Systems and Financing Report to the Joint Reference Committee – June 2016 Deadline: May 23, 2016 **Will be discussed at the APA Annual Meeting.**

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Oct Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up/Update
6.4	Payer Coverage for Prescriptions from Nonparticipating Prescribers (ASMNOV1512.F) The action paper 12.F asks: 1) That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and 2) That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and 3) That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and 4) That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists. Will the Joint Reference Committee refer action paper 12.F: Payer Coverage for Prescriptions from Nonparticipating Prescribers to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred action paper 12.F Payer Coverage for Prescriptions from Nonparticipating Prescribers to multiple entities as follows: • Items 1 & 4 to the APA's Policy Department; • Item 2 to the Division of Government Affairs; • Item 3 to the Council on Healthcare Systems and Financing	Kristin Kroeger Jeffrey Regan Becky Yowell	APA Policy Department Division of Government Affairs Council on Healthcare Systems and Financing Report to the Joint Reference Committee – June 2016 Deadline: May 23, 2016
6.6	It is Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fair to Comply with Parity? (ASMNOV1512.H) The action paper asks: That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting. The Ethics Committee review will specifically address at least the following questions: 1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law? 2) If an insurance company policy or the review standards that guide a psychiatrist reviewer's decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer? 3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law? The Assembly voted to refer action paper 12.H to the Council on Healthcare Systems and Financing. Will the Joint Reference Committee refer action paper 12.H: Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity? to the Council on Healthcare Systems and Financing for input or follow-up?		**CommentsRecommendations** The Joint Reference Committee did not approve referring action paper 12.H Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity? to the Council on Healthcare Systems and Financing. The Joint Reference Committee noted that the Assembly did not act to pass or fail the action paper and instead referred it to the Council on Healthcare Systems and Financing. The JRC was unclear as to the purpose of the referral and what would happen to a response from the Council. It was noted that the author requested and received an opinion from the Ethics Committee on this issue.	

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up
6.11	Systems to Coordinate Psychiatric Inpatient Bed Availability (ASMNOV1512.O) Action paper 12.O asks that the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care. **Will the Joint Reference Committee refer action paper 2015A2 12.O: Systems to Coordinate Psychiatric Inpatient Bed Availability to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper 12.O *Systems to Coordinate Psychiatric Inpatient Bed Availability* to the Council on Quality Care (LEAD) and the Council on Healthcare Systems and Financing.	Kristin Kroeger Samantha Shugarman, MS Becky Yowell	Council on Quality Care (LEAD) Council on Healthcare Systems and Financing Report to Joint Reference Committee – June 2016 **Deadline**: May 23, 2016
6.12	Making Access to Treatment for Erectile Disorder Available Under Medicare (ASMNOV1512.P) Action paper 2015A2 12.P asks: That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner. That the Council on Advocacy and Government Relations and the Council on Healthcare Systems and Financing advocate, along with other professional societies and advocacy groups, for legislation to allow access to the full array of medications, mechanical therapies, and other treatments for Erectile Disorder which are currently excluded from coverage under Medicare. **Will the Joint Reference Committee refer action paper 12.P: Making Access to Treatment for Erectile Disorders Available Under Medicare to the appropriate Component(s) for input or follow-up?** The Joint Reference Committee did not refer the action paper 12.P: *Making Access to Treatment for Erectile Disorders Available Under Medicare* to a component(s).			**CommentsRecommendations** The Joint Reference Committee noted that the action paper does not fit within the APA's strategic goals and initiatives and the necessary prioritization of the current work to implement these goals.
8.B.2	Referral Update Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G; JRCJULY156.6) **Will the Joint Reference Committee request from the Assembly (Assembly Executive Committee) clarification of the action paper, including a definition of the problem being addressed?** The Council on Advocacy and Government Relations discussed the JRC referral of Action Paper, "Timely Reimbursement for Psychiatric Treatment" (ASMMAY1512.G). The Council examined the correlation of the timeliness of payment systems and increased participation in plans by psychiatrists, as presented in the Action Paper. Members offered feedback related to reimbursement systems and relative practicality in solo/private practices compared to larger healthcare settings. The Council—agreeing with the comments from the Council on Healthcare Systems and Financing—found the Action Paper does not clearly define its objective or provide a clearly understood outcome for resolution. Through unanimous consent, the Council seconded the recommendation of the Council on Healthcare Systems and Financing and recommended the Action Paper be returned to the authors for further clarification.	Dr. Anzia informed the Joint Reference Committee that the Assembly Executive Committee reviewed the action paper to clarify the paper's intent. They consulted with some of the original authors and Information received from the authors indicated the intent was to ensure that the APA would be involved in efforts to improve physician payment via a card linking the medical record, the cloud and payment systems. Similar systems have been vetted or are already in use in Europe. The Joint Reference Committee thanked Dr. Anzia for the clarification and recommended that the APA Administration reach out to HHS' Office of Coordination to determine what, if anything, the U.S. Government may be doing on this front. It was also recommended that the AMA be approached to ascertain their position and if indicated consider developing a resolution for the AMA House of Delegates.	Saul Levin, MD, CPA Kristin Kroeger	APA Administration CEO/MOD Update to the Joint Reference Committee – June 2016 **Deadline**: May 23, 2016

SUMMARY OF ACTIONS

Council on Healthcare Systems and Financing (updates as of 4/1/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up
8.G.1	Proposed Position Statement: Integrated Care **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Integrated Care, and if approved, forward it to the Board of Trustees for consideration?** Input on this position statement was provided by the Council on Psychosomatic Medicine, the Council on Healthcare Systems and Financing and it's Work Group on Integrated Care.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Integrated Care* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.2	Proposed Position Statement on Off-Label Treatments **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Off-Label Treatments*, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Off-Label Treatments* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.3	If item 8.G.2 is approved, Retire Position Statement: Patient Access to Treatments Prescribed by Their Physicians (2007) **Will the Joint Reference Committee recommend that the Assembly retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians*, and if retired, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that. if the proposed Position Statement: *Off-Label Treatments* is approved by the Assembly, the Assembly should then vote to retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians* and forward to the Board of Trustees for a similar vote on retirement.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 **Deadline**: March 24, 2016
8.G.4	Proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: Call to Action: Accountability for Persons with Serious Mental Illness and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 Deadline: March 24, 2016
8.G.5	If item 8.G.4 is approved: Retire Position Statement: A Call to Action for the Chronic Mental Patient **Will the Joint Reference Committee recommend that the Assembly retire the Position Statement: A Call to Action for the Chronic Mental Patient, and if approved forward it to the Board of Trustees to consideration?**	The Joint Reference Committee recommended that the proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness be referred to the Assembly for review and possible retirement. If the Assembly retires the Position Statement: A Call to Action for the Chronic Mental Patient, it will then be forwarded to the Board of Trustees for retirement.	Shaun Snyder, JD Margaret Dewar Allison Moraske/Laurie McQueen	Assembly – May 2016 Deadline: March 24, 2016

Council on International Psychiatry

The Council is focused on identifying opportunities for the exchange of knowledge and experiences between U.S. and international psychiatrists and psychiatric trainees. This includes engagement on topics of global mental health, refugee mental health, residency training and other issues impacting international medical graduate psychiatrists in the U.S. and international psychiatrists and psychiatric trainees.

Education and Training

A group of Council members are currently engaged in investigating the increase in U.S. teaching hospitals and research universities responding to the mental health needs of low- and middle-income countries and the growing interest by U.S. psychiatric residents and trainees to participate in opportunities to advance global mental health.

A workshop on this topic was accepted for presentation during the 2016 APA Annual Meeting which will feature global mental health clinicians, educators, researchers and trainees discussing lessons drawn from different models for service delivery, research and training in global mental health.

> *Training American Psychiatrists as Global Mental Health Investigators, Implementers, and Partners: What Have We Learned That Can Inform Best Practices?*
> Chairs: Michael D. Morse, M.D., M.P.A., Anne Becker, M.D.
> Monday, May 16, 9:00 am – 10:30 am

A group of Council members have generated an initial list of global mental health residency and post-graduate training and research programs, educational programs and courses, as well as observership opportunities for international psychiatric trainees. This information is the process of refinement in order to share with the public through the APA website.

The Council is also engaged in discussing refugee mental health and Council members are collecting relevant scholarship and various perspectives, including those offered through the recently submitted Assembly Action Papers “Supporting the WACP Position Statement on Migrant Crisis Around the World” and “Disapproval of the Detention of Central American Asylum Seeking Children and Families in Need of International Protection.”

Engagement

The Council is in the process of surveying U.S. based organizations for ethnic groups of psychiatrists to identify opportunities for collaboration. The organizations being contacted include the following:

- American Society of Hispanic Psychiatry
- Arab American Psychiatric Association
- Association of Chinese American Psychiatrists
- Association of Korean American Psychiatrists
- Haitian American Psychiatric Association
- Hellenic American Psychiatric Association
- Indo American Psychiatric Association
- Nigerian American Psychiatrists Association
- Philippine Psychiatrists in America
- Society of Iranian Psychiatrists in North America

- Turkish American Neuropsychiatric Association
- Vietnamese American Psychiatric Association

The Council will review a matrix of responses from each of the organizations covering areas regarding its membership and governance structure as well as their primary objectives and initiatives as an organization of psychiatrists.

The Council is also reviewing the criteria of the Human Rights Award, managed by the Council, to ensure that the award best recognizes the important work of individuals and organizations to address human rights issues. The 2016 Human Rights Award is being awarded to Dr. David Satcher, former U.S. Surgeon General, and will be awarded during a session at the 2016 APA Annual Meeting featuring him as a presenter.

The Surgeon General's Report on Mental Health, Parity and Integrated Care
Chairs: Eliot Sorel, M.D., Constance Dunlap, M.D.
Monday, May 16, 9:00 am – 12:00 pm

The Council also engages with APA members and relevant stakeholders, through liaisons to special groups including the Chair of the APA Caucus on Global Mental Health and Psychiatry, the APA representative to the World Psychiatric Association, and a special advisor to the APA on Unite d Nations' activities related to mental health and psychiatry.

Policy Development

Several groups of Council members are currently engaged in reviewing the following APA position statements to determine if they should be recommended to the JRC to be retained, retired, or revised.

- "Abuse and Misuse of Psychiatry"
- "Identification of Abuse and Misuse of Psychiatry"
- "Denial of Human Rights Abuses"
- "Use of Psychiatric Institutions for the Commitment of Political Dissenters"
- "Resolution Condemning the Role of Psychiatrist Radovan Karadazic in Human Rights Abuses in the Former Yugoslavia"

Additionally, the Council is discussing the issue of international medical graduate psychiatrists spending more time in accredited training program their U.S. medical graduate counterparts prior to obtaining permanent medical licensure. This issue was brought to the attention of the Council by the 2015 Assembly Action Paper "Equality in Permanent Licensure Policy."

ATTACHMENT 1: Council Charge

The charge of the Council on International Psychiatry is as follows:

The purpose of the Council is to facilitate understanding of problems facing international psychiatrists and their patients. It will do so by focusing on international membership in the APA, and through increased membership in the APA, avail all members of the opportunities in education, advocacy, prevention and clinical care that membership in the APA provides.

1. *The Council works in collaboration with the Membership Committee to recruit international members.*
2. *The Council ensures APA policies and positions on international issues are current and appropriate.*
3. *The Council, working in collaboration with the Council on Research, provides recommendations and strategies to enhance the scientific base of international psychiatric care and global mental health.*
4. *The Council identifies opportunities for partnership with other organizations to foster the creation of financially self-sustaining international programs that will benefit all members of the APA and their patients.*
5. *The Council will strive to establish mutually beneficial relationships between the APA and other internationally focused psychiatric organizations. The Council may facilitate collaborative development of clinical, research, training, and forensic guidelines by these various organizations, including the APA, for use by psychiatrists globally, with appropriate modifications for specific countries or regions. The Council may facilitate publication of news about these organizations and their activities in Psychiatric News.*
6. *The Council promotes engagement to enhance shared learning and leadership to achieve participation of all APA members.*

The Council members are experts with experience in global mental health and who are broadly representative (geographically and culturally) of the APA international body. The Council has a standard council composition. APA members who have membership in international organizations may be appointed as corresponding members and serve as liaisons to their international organizations. The Council will utilize freely available electronic communication technology to interact and coordinate with organizations and individuals outside of the United States in lieu of international travel. No APA funds will be budgeted nor used for travel outside the United States by members of this council for the work of this council.

ATTACHMENT 2: 2015-2016 Council Composition

The 2015-2016 composition of the Council on International Psychiatry is as follows:

Chairperson	Michelle Riba, MD, MS	Ann Arbor, MI
Vice Chairperson	Dilip Jeste, MD	La Jolla, CA
Member	David Baron, DO	Altadena, CA
Member	Anne Becker, MD, PhD	Boston, MA
Member (Assembly)	Ken Busch, MD	Chicago, IL
Member	James Griffith, MD	Washington, DC
Member	Nalini Juthani, MD	Scarsdale, NY
Member	Samuel Okpaku, MD, PhD	Nashville, TN
Member	Edmond Pi, MD	La Habra Heights, CA
Member (ECP)	Uyen-Khanh Quang Dang, MD, MS	San Francisco, CA
Member	Pedro Ruiz, MD	Miami, FL
Member	Allan Tasman, MD	Louisville, KY
Corresponding Member	Bibhav Acharya, MD	San Francisco, CA
Corresponding Member	John S. McIntyre, MD	Rochester, NY
Corresponding Member	Solomon Rataemane, MD	Pretoria, South Africa
Corresponding Member	Giuseppe Raviola, MD	Boston, MA
Corresponding Member	Eliot Sorel, MD	Washington, DC
Consultant	Mounir Soliman, MD, MBA	La Jolla, CA
Consultant	Jagannathan Srinivasaraghavan, MD	Marion, IL
Fellow (American Leadership-2nd Year)	Michael Morse, MD	Washington, DC
Fellow (American Leadership-2nd Year)	Rachel Winer, MD	Palo Alto, CA
Fellow (Diversity Leadership-1st Year)	Nakita Natala, MD	Ypsilanti, MI
Fellow (Diversity Leadership-1st Year)	Jennifer Severe, MD	West Springfield, MA
Fellow (Diversity Leadership-2nd Year)	Suni Jani, MD, MPH	Houston, TX
Fellow (Diversity Leadership-2nd Year)	Vera Tate, MD	Atlanta, GA
Fellow (Public Psychiatry-2nd Year)	Christopher White, MD	Moss Beach, CA
Fellow (SAMHSA-1st Year)	Josepha Immanuel, MD	Somerville, MA
Fellow (SAMHSA -1st Year)	Dyani Loo, MD	Albuquerque, NM
Fellow (SAMHSA -1st Year)	Aleema Sabur, MD, MPH	Brentwood, TN

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COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Report to the Assembly

The Council's purview covers issues affecting the continuum of medical education in psychiatry – from undergraduate medical education to lifelong learning and professional development of practicing physicians. The Council is a convening body for the allied educational organizations including AADPRT, ADMSEP, AAP and the ABPN.

- The Council provided input to ACGME on resident "duty hours." In preparation for a complete review of its accreditation requirements the ACGME sought comments on the impact of the ACGME's current duty hour policy on education and clinical care; on implementation/reporting burden; recommendations regarding standards governing key aspects of the learning and working environment; and identification of specific concerns of our field which may be different from other specialties. In January 2016, the APA submitted a letter to Dr. Nasca at the ACGME in response to his request for comments. The APA affirmed its commitment to working with the ACGME, but stressed the importance of developing an evidence base that can inform future ACGME policy. The APA expressed concern that the current duty hour policies have not improved patient safety or quality of care and may also be eroding the educational experience within residency. The APA also advocated for standardization of requirements for residents in all years of training.

- At the request of the Board of Trustees, the Council provided significant input in regards to the Division of Education's creation of a pilot program which would increase APA's educational offerings by partnering with non-ACCME accredited district branches and affiliates to develop live and enduring education through Joint Sponsorship of CME credit. The program will be expanded to include provision of credit to live meetings of allied organizations and online education of district branches and allied psychiatric groups. The Joint Sponsorship program expansion will provide added value to education initiatives impacting psychiatry and enhance professional reputations of district branches and APA affiliates.

- The Council provides general oversight of the APA CME program. In August 2015, the APA launched the APA Learning Center. The website (http://education.psychiatry.org) is the integrated home for all online educational activities. It currently hosts 230 courses, including on-demand webinars, interactive online courses, journal CME and self-assessment activities. As part of the new Learning Center, the APA has created the SET for Success program, which provides resident and fellow members with free access to more than 60 activities on the new Learning Center platform. Activities include both clinical and business of medicine topics such as risk management and negotiating for your first job. A Self-Assessment activity (MOC Part 2) is available in the Learning Center for registrants of the Annual Meeting.

- The Council endorsed APAs large scale initiative to train 3,500 psychiatrists in the clinical and leadership skills needed to support collaborative care. The training is part of the Center for Medicare and Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI). Online and live training opportunities are currently available to all psychiatrists and trainees.

- With the financial support of the National Institute on Drug Abuse, the Council on Addiction Psychiatry and Council on Medical Education will identify, evaluate, and make widely available curricula on substance use disorders that can be used to guide and augment the didactic curricula of general psychiatry residency training programs in accordance with ACGME program requirements. A workgroup of key medical education influencers will be established, comprised of representatives of APA's Council on Addiction Psychiatry, Council on Medical Education and Life Long Learning, Resident Fellow Members of the APA, American Association of Directors of Psychiatry Residency Training, Accreditation Council for Graduate Medical Education (ACGME) members of the Residency Review Committee and others, and the American Academy of Addiction Psychiatry. This group of experts in substance use disorders and medical education will identify and assess the scope and quality of existing open-source SUD curricula, design and implement mechanisms to make the curricula available to all residency training programs, execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors, identify gaps in the existing curricula, with the goal of developing curricula to address these gaps in a future initiative, and develop and implement mechanisms to evaluate the project.

- The Council on Medical Education and Lifelong Learning is working with The Division of Diversity and Health Equity to revamp the APA's fellowships program. Changes will include centralized logistical support, enhancing application systems through an improved user-experience interface, and creating an environment where fellows are empowered to share experiences across fellowships which will promote peer-to-peer networking.

- The Council approved the selection of APA's education awards. The 2016 *Vestermark Psychiatry Educator Award recognizes excellence, leadership, and creativity in the field of psychiatric education. The* winners are John Howard Coverdale, M.D. and Robert E. Hales, M.D., M.B.A. The Council approved nominations for the *Irma Bland Award for Excellence in Teaching Residents* and *The Nancy C.A. Roeske, M.D., Certificate—to individuals who have made outstanding and sustaining contributions to medical student education*.

- The Council is planning several educational activities for the Annual Meeting, including a panel discussion on issues related to faculty development and a workshop, Residents Teaching about Racism: A Novel Educational Approach to Combating Racial Discrimination in Mental Health Care.

- A sub-committee of CMELL fellows who would like to be more involved in medical student recruitment was formed. They are working with PsychSIGN and the Council on Communications to develop social media items which highlight the diversity of work that psychiatrists engage in and that will provide resources to a range of activities in medical schools including community service projects around mental health and illness.

- The Council supported the recent APA testimony to the Department of Veterans Affairs Commission on Care regarding the shortage of psychiatrists and the need to strengthen recruitment and training efforts.

Council on Minority Mental Health and Health Disparities
Report to the Assembly

The Council wishes to report that:

- Council continues its review of diversity-related position statements to ensure timeliness and relevance. These include position statements on diversity, affirmative action, and M/URs in leadership positions.

- Council working to establish liaisons with the caucuses, and continued work with the Division of Diversity & Health Equity on how to recruit and retain M/URs within the APA and how to provide professional opportunities to those populations.

- Work groups formed during the September Components Meetings 2015 are continuing work responding to JRC referrals on:
    - Removing barriers to providing compassionate care to victims of sexual assault
    - Creation of a position statement on the impact of global climate change on mental health
    - How to train psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities

- Additional work groups were formed on:
    - At-risk children and adolescents (a collaboration with the Council on Children, Adolescents and Their Families)
    - Recruitment and retention of psychiatrists from minority and underrepresented groups
    - Revision of position statements on diversity and affirmative action

Council on Psychiatry and Law
Steven Kenny Hoge, M.D., Chairperson

The Council on Psychiatry and Law has continued its work evaluating legal developments of national significance, proposed legislation, regulations, and other government interventions that affect the practice of psychiatry, including the subspecialty of forensic psychiatry.

The Council on Psychiatry and Law has been busy working on an array of subject matters. Here are a few highlights:

Use of Firearms in Hospitals
The Council on Psychiatry and Law formed a workgroup to work on the development of a position statement and/or resource document to address the use of weapons in hospital settings, which was prompted by increasing prevalence of armed police and security in hospitals and emergency rooms.

State of Louisiana v. Doyle
The Council on Psychiatry and Law and the Committee on Judicial Action reviewed and considered a capital case before the Louisiana Supreme Court in *State of Louisiana v. Doyle*. The groups had reservations about participating in the case. The defendant had asked the APA to consider filing an amicus brief to support the defendant's argument that the Eighth Amendment to the Constitution prohibits the execution of a person with a severe mental illness affecting his responsibility for the offense.

Restrictive Housing Standards
At the request of APA President Renée Binder, the Council on Psychiatry and Law reviewed and submitted comment on proposed American Correctional Association restrictive housing standards. For the first time the proposed standards addressed exclusion from isolation for serious mental illness.

In addition, the Council on Psychiatry and Law has several workgroups working on JRC referrals and numerous topics. Here is a sample of some items expected on the Council's agenda in Atlanta: civil commitment hearings, physician assistance with suicide, physician health programs, and mental illness and criminal justice.

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Report to the Assembly
Council on Quality Care: Grayson Norquist, MD, Chair
April 4, 2016

Practice Guidelines: With the approval of the "Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia," by the Board of Trustees on 12/13/15, and a publication date set for May 1, 2016, the Committee continues to discuss the guideline topics that will be undertaken in 2016. Although two additional positions were tentatively included in the 2016 budget as reported to the Council on Quality Care in September 2015, no additional staff support will be added in the coming year (although the Research Department has committed to providing assistance from one of its writers as needed). Given these limitations, the Committee is in the initial planning stages for two new topics. Topics in the development pipeline include:

- Use of Pharmacotherapy for Adults with Alcohol –Use Disorders
- Bipolar Disorder
- Eating Disorders
- Schizophrenia

Committee on Mental Health Information Technology:

- Recent activity of the the Committee include:
- Dr. Daviss represented CMHIT at the Work Group on Telepsychiatry meeting at IPS. The Work Group recorded many short, informational videos on telepsychiatry and also met to discuss the scope and sequence of next steps for the Group.
- Dr. Chan presented on mobile health technology at IPS, which was related to the work he is doing on the Apps Task Force in CMHIT.
- Dr. Chan and Dr. Torous have written a piece on the Software Applicationss Task Force which will appear in Psych News.
- Dr. Daviss has been representing CMHIT on the Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Making Tool
-

Committee on Performance Measurement

During the inaugural year of this committee, goals and current work include:

- The creation of a position/policy statement on APA's role in the quality measurement field based on this groups' decision of where APA can be most effective in the performance measurement space. Discussion and decisions will maintain a degree of flexibility based on the Board of Trustee's vote on the APA developing an association-led mental health registry.
- This group will also act as consultants in the measure selection process in the development of the registry.
- The group discussed further refinement of the notion of acting as subject matter experts and consultants in the outside development of measures. The group still has many unanswered questions, but believes the development of a position statement will help identify goals, opinions, and beliefs of where the Association should stand on measurement development and utilization.
- A subcommittee will identify the gap areas in care as they exist in current reporting programs and existing practice guidelines. Members will review practice guidelines to see where there may be an opportunity for measures. Subcommittee members will consult with the Practice Guideline

Committee in their efforts. Additionally, in recent comments to CMS, the APA volunteered collaboration in their work as it relates to a systematic review of care gaps.

The Council on Research
Dwight Evans, M.D., Chairperson

Referral Updates
The Council on Research (COR) was asked to provide an update on the following Joint Reference Committee (JRC) referral:

> Referral Item Number: JRCJAN168.M.1
> Title: Revised Position Statement: Atypical Antipsychotic Medication
> Action: The JRC referred the revised position statement back to the COR for additional revision. The JRC noted that antipsychotics should not be used as sleep aides or be prescribed for anxiety. The statement should include language regarding the use of antipsychotics for the FDA approved indications. It also was requested that the statement be circulated to the Council on Geriatric Psychiatry for their review.
> Response: The position statement has been revised as suggested and has been reviewed by the Council on Geriatric Psychiatry. All of the Council's suggestions were incorporated into the latest version. The position statement will be resubmitted to the JRC at their next meeting June 18, 2016.

Informational Updates
The Council brings the following Information Items:

1. A group of ECT experts, led by William McDonald, MD, held numerous conference calls to draft a response to the FDA proposal on ECT reclassification. This culminated in a letter, which was sent by the APA to the FDA providing a thorough response to each aspect of the proposal.
2. The National Network of Depression Centers rTMS Task Force, in collaboration with the Council of Research Task Force on Novel Biomarkers and Treatments, has created consensus recommendations to guide clinical practitioners in the safe and effective application of this promising treatment, entitled Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) for the Treatment of Depression. This has been approved by the JRC and has been sent to AJP for publication.
3. The COR work group on Complementary and Alternative Medicine will be submitting the manuscript S-Adenosylmethionine (SAMe) for Neuropsychiatric Disorders: A Clinician-Oriented Review of Research to the JRC for their approval at their June 2016 meeting.
4. The Committee on Psychiatric Dimensions of Disaster is in the process of drafting a Position Statement on the Psychiatric Impacts of Climate Change with input from relevant stakeholders, including APA members and components with expertise on the issue. This action stems from an Assembly Action Paper passed at the May 2015 Assembly.
5. In March 2016, the APA Bruno Lima Award in Disaster Psychiatry was awarded to Dr. Katherine Clegg by the Ohio Psychiatric Physicians Association for her work, in the U.S. and other countries, on disaster preparedness, response, and mental health education and training to psychiatrists, medical students, and other health providers.

Action Items
There are currently no action items for the Assembly's consideration.

To: APA Assembly

From: Carolyn B. Robinowitz, MD, Sr. Delegate, APA AMA Delegation, and Chair, AMA Section Council on Psychiatry

Re: Update on the Activities of the APA AMA Delegation/AMA Section Council on Psychiatry

The APA AMA Delegation has not met formally since the November 2015 Interim Meeting of the House of Delegates (HOD) (see Attachment 1 for our December report to the BOT summarizing that meeting). While most of the attention of the APA Delegation to AMA issues is focused on preparation for and follow up to the HOD meetings with attendant peaks and valleys of intensity, communication and interactions with AMA leaders and staff is on-going, especially in areas such as advocacy and government relations, CPT, and aspects of clinical care.

Psychiatry was well represented by our CEO and Medical Director, Saul Levin, M.D., M.P.A., APA Delegates Kenneth Certa, M.D., Jerry Halverson, M.D. and Jack McIntyre, M.D., and AACAP Delegate Louis Kraus, M.D. at AMA's annual National Advocacy Conference, a three-day meeting held in late winter which brings together leaders from state medical societies as well as specialty organizations to discuss and advocate for important issues affecting the entire field of medicine, and to meet with elected leaders (and their staff) primarily in the Legislative Branch to discuss and promote policies that affect our profession and our patients.

Andy Slavitt, Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) highlighted several recently released (e.g., quality measures) and pending (e.g., MACRA) regulations as well as touted HHS' investment of $840 million dollars over the next four years as part of the Transforming Clinical Practice Initiative (TCPI). APA received a Support and Alignment Network (SAN) grant as part of this initiative. The presentation emphasized CMS' increased commitment to solicit and consider physician input when designing/redesigning programs, including the implementation of MACRA.

Former APA Board of Trustees (BOT) member and current Chair-Elect of the AMA BOT, Patrice Harris, M.D., spoke to the NAC participants about AMA's efforts to combat the opioid epidemic. In particular, she described the five goals of the AMA Task Force to Reduce Prescription Opioid Abuse, which include enhancing physicians' education on effective, evidence-based prescribing. Dr. Harris also welcomed Michael Botticelli, Director of the White House Office of National Drug Control Policy, who applauded AMA's leadership on this issue and spoke about the Administration's efforts to reduce prescription drug abuse and misuse.

As you are likely aware, in late March the Obama Administration announced several initiatives aimed at curbing America's opioid addiction epidemic including the expansion of treatment options for those individuals addicted to opioids while also changing the narrative of the addiction crisis as on that impacts members of every race and socioeconomic status. The president's remarks were made at the National Rx Drug and Heroin Abuse Summit in Atlanta which also included a presentation by Dr. Harris.

We are honored to have Stephen R. Permut, M.D., J.D., Chair of the AMA Board of Trustees (Attachment 2), as the AMA representative who will be speaking to members of the Assembly on the final day of their May meeting. Dr. Permut has been a strong supporter of policies and actions that benefit our patients and profession, as well as a mentor and friend to many of us in our delegation. Additionally, Patrice Harris,

MD, will participate in a scientific session on opioid addiction and how this epidemic affects patients and physicians.

Our major planning activities are now focused on the HOD Annual Meeting held in early June; in addition to reviewing reports and resolutions, our major focus will be Jack McIntyre's campaign for election to the Board of Trustees. This will be a highly competitive race with six candidates running for two seats, and we will be calling on APA members who belong to AMA and their local/state medical societies to help us inform colleagues about Jack's outstanding attributes and qualifications for the Board of Trustees. We will be providing more specific requests in the next few weeks.

We value the impact of our presence and participation with our medical colleagues at the AMA and appreciate the support of our Board of Trustees and Assembly in this important activity.

November 16, 2015

To: APA Board of Trustees

From: Carolyn B. Robinowitz, MD, Sr. Delegate, APA AMA Delegation, and Chair, AMA Section Council on Psychiatry

Re: Update on the Activities of the APA AMA Delegation/AMA Section Council on Psychiatry

Thank you for the opportunity to update you on the activities of the APA AMA Delegation and the Section Council on Psychiatry. The 2015 Interim Meeting of the AMA House of Delegates, held November 14 through 17, is coming to a close as this report is being written. The focus of the Interim Meeting is on advocacy both for the profession and for patients, as demonstrated by considerable emphasis on the impact of consolidation of insurance companies, increased costs of prescription drugs including generic medications, and consideration of various payment systems for medical services. Smaller in scope than the AMA Annual Meeting held each June, the Interim meeting also affords a greater opportunity to implement our strategic goal to increase our successful interactions with other delegations.

Our focus at this meeting was preparing for the future. Not only did we welcome and orient the six new members of the Section Council, but we also engaged in a number of efforts in support of potential candidates for elected or appointed positions. We also focused on leadership development of the younger members of the Section Council—the residents/fellows and the young physicians. To that end, we expanded our interactions with current young leaders in the House including hosting a dinner of the young leaders of the Section Council on Psychiatry and the young leaders of both the Young Physician Section and Resident and Fellow Section. This effort set the stage for greater collaboration with a broad range of future leaders, as well as enhanced collaboration on substantive issues.

The Psychiatric Caucus, a meeting of all psychiatrists attending the AMA HOD meeting representing specialty societies, state medical associations, and AMA sections, continues to provide an opportunity to identify and collaborate on issues of interest. Over 60 psychiatrists attended the Caucus meeting in Atlanta this past week; many of whom are leaders within their own delegations. AMA Past President Jeremy Lazarus, and AMA Board of Trustees Chair Elect Patrice Harris were among the attendees, and members appreciated their input and leadership.

We welcomed several new members to the AMA Section Council on Psychiatry at this meeting including new alternate delegates to the APA and AAPL delegations, and new Young Physician Delegates to AACAP and AAPL. The following delegates and alternate delegates attended the November Interim meeting on behalf of the APA: Delegates Carolyn Robinowitz, MD (senior delegate and chair of the Section Council on Psychiatry), Jeffrey Akaka, MD, Kenneth Certa, MD, Jerry Halverson, MD, Jack McIntyre, MD, Paul Wick, MD; alternate delegates Donald Brada, MD, Frank Brown, MD, Barbara Schneidman, MD, Rebecca Brendel, MD; Young Physician Delegate Paul O'Leary, MD; Resident and Fellow Delegates Alicia Barnes, MD, Simon Faynboym, MD, and Sean Moran, MD. Ray Hsiao, APA YPS Delegate and current President of the Washington State Medical Society, attended this meeting on behalf of Washington State. The American Academy of Child and Adolescent Psychiatry (AACAP) was represented by Louis Kraus, MD, David Fassler, MD, Sharon Hirsch, MD, and George (Bud) Vanna, MD. The American Academy of Psychiatry and the Law (AAPL) was represented by Barry Wall, MD, Linda Gruenberg, MD, Jennifer Piel,

MD, and Tobias Wasser, MD. The American Academy of Geriatric Psychiatry (AAGP) was represented by Allan Anderson, MD. The Gay and Lesbian Medical Association (GLMA) was represented by Brian Hurley, MD. The Section Council on Psychiatry was assisted in its efforts by staff including Amanda Davis, Tristan Gorrindo, MD, Deana McRae, Mark Moran, Kristin Kroeger Ptakowski, Caroline Simms and Becky Yowell (APA staff), Ronald Szabat (AACAP staff), and Jacquelyn Coleman (AAPL staff).

Simon Faynboym, MD, and Sean Moran, MD, were successfully re-elected to RFS Sectional Delegate and Alternate Sectional Delegate seats respectively at this meeting. Jack McIntyre, MD and Jeff Akaka, MD, were also successful in their request for endorsement of their candidacy for the AMA BOT and the AMA Council on Legislation respectively, by the Specialty and Service Society caucus--a caucus whose membership totals approximately 230 voting delegates representing all specialty societies. Dr. McIntyre also received endorsement by the Neuroscience Caucus which will further bolster his nomination for a seat on the AMA BOT, and his campaign will be a major focus of our Spring 2016 efforts.

Attachment 1 lists just some of the actions taken by members of the House of Delegates at this meeting. For additional highlights of the meeting go to the AMA Interim Meeting site

CMTE*	ITEM	TITLE	AMA HOUSE OF DELEGATES ACTIONS – PARTIAL LIST OF ACTIONS
*	CEJA 3	Modernized *Code of Medical Ethics*	**REFERRED**
.Con	BOT 11	Specialty Society Representation in the House of Delegates – Five-Year Review	**ADOPTED** The Board of Trustees recommends that the American Psychiatric Association (and eight other listed societies and associations) retain representation in the AMA House of Delegates and the remainder of this report be filed. (Directive to Take Action)
B	RES 213	Opioid Abuse Deterrent Prescription Drugs	**ADOPTED AS AMENDED** RESOLVED, That our American Medical Association support the Food and Drug Administration's ongoing efforts to evaluate the efficacy, safety, and labeling of abuse-deterrent technology. RESOLVED, That our AMA oppose barriers to appropriate access to and coverage of prescription drugs. **ADOPTED with TITLE CHANGE** ABUSE-DETERRENT PRESCRIPTION DRUGS
B	RES 202 RES 217	Maintaining Freedom of Choice with Insurance Products Health Insurance Company Consolidation	**ADOPTED Substitute Resolution 202 in lieu of Resolution 217** RESOLVED, That our AMA oppose consolidation in the health insurance industry that may result in anticompetitive markets.
B	RES 222	Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing	**REFERRED**
J	CMS 02 RES 806	Pharmaceutical Costs Abuse of Free Market Pharma	**ADOPTED AS AMENDED** (Reaffirm HOD Policy): First five recommendations

CMTE*	ITEM	TITLE	AMA HOUSE OF DELEGATES ACTIONS – PARTIAL LIST OF ACTIONS
	RES 814 RES 817	Addressing the Rising Price of Prescription Drugs High and Escalating Prescription Drug Prices	(Directive to Take Action and New HOD Policy): 6. That our AMA encourage Federal Trade Commission actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. (Directive to Take Action) 7. That our AMA encourage Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. (Directive to Take Action) 8. That our AMA monitor the impact of mergers and acquisitions in the pharmaceutical industry. (Directive to Take Action) 9. That our AMA continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. (New HOD Policy) 10. That our AMA encourage prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. (New HOD Policy) 11. That our AMA support legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (Directive to Take Action) 12. That our AMA support legislation to shorten the exclusivity period for biologics. (Directive to Take Action) 13. That our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. (Directive to Take Action) 14. That our AMA generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting (Directive to Take Action)
J	RES 801	Health Care While Incarcerated	**ADOPTED AS AMENDED** *AACAP submitted language*

CMTE*	ITEM	TITLE	AMA HOUSE OF DELEGATES ACTIONS – PARTIAL LIST OF ACTIONS
			RESOLVED, That our American Medical Association study mental health and health care for incarcerated juvenile and adult individuals and identify the best mental health and health care models for local, state and federal facilities. (Directive to Take Action)
K	RES 901 RES 913	Access to Mental Health Care for Medical Trainees Mental Health Services for Medical Staff	**REFERRED**
J	RES 909	Study OTC Availability of Naloxone	**ADOPTED AS AMENDED** RESOLVED, That our American Medical Association encourage manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration. (New HOD Policy) RESOLVED, That our American Medical Association study and report back at A-16 on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths. (Directive to Take Action)
K	RES 923	Mental Health Crisis Interventions	**ADOPTED AS AMENDED** RESOLVED, That our AMA support federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. (Directive to Take Action)
K	RES 927	Should Drug Ads be Banned?	**ADOPTED First Resolve of Substitute Resolution 927 AS AMENDED** Ban Direct-to-Consumer Advertisement of Prescription Drugs and Implantable Medical Devices RESOLVE, That our American Medical Association support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices. **REFERRED FOR DECISION Second Resolve of Substitute Resolution** RESOLVED, that Policy H-105.988 be rescinded

Stephen R. Permut, MD, JD

Chair, Board of Trustees
American Medical Association

Stephen R. Permut, MD, JD, a family physician from Wilmington, Del., was elected to the American Medical Association Board of Trustees (BOT) in June 2010. Dr. Permut was a member of the AMA House of Delegates for 16 years and served as chair of Delaware's delegation.

He served on the AMA Council on Legislation for eight years, including serving as chair during his final year. While on the council, Dr. Permut served on the AMA-BOT Task Force on Patient Safety, Quality and Information Technology, and as vice chair of the AMA's Evaluation and Management Coding Guidelines Task Force. Dr. Permut now serves as a member of the AMA Foundation board of directors.

Dr. Permut served on the board of trustees of the New Castle County (Delaware) Medical Society and was the founding chair of its Community Relations Committee. He served on the board of trustees of the Medical Society of Delaware (MSD) and was founding chair of its Legislative Action Committee and president from 1992 to 1993. During his term as president, in collaboration with the state's hospital association, MSD formulated a state-wide health system reform plan. MSD has awarded Dr. Permut both the Distinguished Service Award and the President's Award. Dr. Permut currently serves as a member of the Board of Directors of the Philadelphia County Medical Society and on the board of commissioners for The Joint Commission. He is a member of the board of trustees of the College of Physicians of Philadelphia.

Dr. Permut received his bachelor's degree in biology from the University of Pennsylvania, Philadelphia. He began medical school at the Universidad Autónoma de Guadalajara, Mexico, and completed his MD degree at Temple University School of Medicine, Philadelphia. Dr. Permut completed his internship and residency in internal medicine at Indiana University Medical Center, Indianapolis. Later, while in practice, Dr. Permut received a JD from Widener University School of Law in Wilmington, Del.

Board-certified in internal medicine, family medicine and legal medicine, Dr. Permut has been awarded fellowships by the American College of Physicians (ACP), the American Academy of Family Physicians, the American College of Legal Medicine, and the College of Physicians of Philadelphia. He is a recipient of the Laureate Award from the Delaware chapter of the ACP.

Dr. Permut has practiced in a variety of settings—solo, private practice; small single-specialty, group practice; and multi-specialty academic, group practice—and always in underserved inner-city communities. He has also served in a variety of administrative positions, including: (founding) director, family medicine residency program; medical director, managed care organization; and vice president, medical affairs for a community hospital. Dr. Permut is currently a tenured professor and chair of the Department of Family and Community Medicine at Temple University School of Medicine.

Dr. Permut and his wife, Marylene, have two daughters and four grandchildren.

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AMA
AMERICAN MEDICAL ASSOCIATION

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Assembly Work Group on Maintenance of Certification

Report to the May 2016 Assembly Meeting

On behalf of the Assembly Work Group on MOC, I am pleased to report to the Assembly that the APA has continued to have a dialogue with the ABPN to express member concerns. There have been two meetings involving APA Assembly members with ABPN in 2016. There have also been some changes in MOC requirements towards making them more flexible. The most notable change is that the Part 4 Performance in Practice (PIP) program now allows a choice between either doing a feedback module, which could be from patients or peers, or doing a chart review against set standards. This increase in flexibility makes it easier to complete the PIP though with each change, confusion also increases among members.

The two meetings between APA and ABPN were in Chicago and the first of those was in January. That meeting was an annual one involving both Assembly and BOT leadership to provide the ABPN with feedback on certification and MOC. The second meeting was a Crucial Issues Forum with a focus on needed changes in MOC. Participants in both those meetings included myself and Renee Binder our APA President. Carver Nebbe Assembly Rep from Iowa was chosen to accompany the group at the January meeting. Valerie Arnold, Assembly Rep from Tennessee, and L. Russell Pet, Assembly Rep from Rhode Island were chosen to attend the Crucial Issues Forum. Lama Bazzi attended the forum as well representing the board. APA staff also attended both sessions.

Here are some key issues that the Assembly might wish to know:

1. ABPN is in the process of reviewing options for MOC and is reviewing all elements of the process including the examination, Self Assessment CME and PIP.
2. There are opportunities for psychiatrists to influence the process by providing suggestions and novel approaches for MOC that would be less onerous and still useful in advancing practice.
3. Other boards are using pilot projects such as peer reviewed articles with questions that ultimately could supplant the need for the exam.

Please continue to communicate with your Area MOC Work Group Rep about your thoughts and ideas or contact me directly.

Respectfully submitted,

James R. (Bob) Batterson, MD
MOC Work Group Chair and Area 4 Rep

Item 2016A1 10.E
Assembly
May 13-15, 2016

Assembly Metrics Work Group Report
American Psychiatric Association

The Metrics Work Group last met April 4th, 2016 via conference call to discuss the work of the work group and prepare this report.

The objective of the metrics work group is to develop some measureable outcomes and metrics for Assembly leadership. The work group met at the Assembly in the Fall and developed two primary issues of focus for the group:

1: Identify the extent to which the Assembly work impacts the APA by reviewing APA actions. Specifically trustee policy was reviewed from the last five years to determine which items were generated by the Assembly.

2: That the Assembly helps the APA identify APA leadership.

The initial exploration of measurable outcomes is included below. The work group visualizes this as an ongoing process in which it continues to define and streamline measures to ascertain the efficiency and work of the Assembly. There have been a number of suggestions of areas to pursue and we focused on those topics below as the starting point.

A. Membership Attendance:

As a first step, we polled the Areas to see how many members continued to be in attendance at the Sunday morning Assembly meeting last November. Six Areas reported with 9 members not in attendance Sunday who were present at the Assembly prior to Sunday.

B. Action Papers that became Board of Trustee's Policy:

March, 2012

Action: Will the Board of Trustees vote to approve the request in Assembly action paper 12.Q, Reinstating the APA State Legislative Institutes and request the Finance and Budget Committee to identify appropriate funding in the 2013 budget after working with the Medical Director/CEO and appropriate Advocacy staff to implement the request in the most effective manner?

The Board of Trustees voted to approve the request in ASM action paper 12.Q, Reinstating the APA State Legislative Institutes and request the Finance and Budget Committee to identify appropriate funding in the 2013 budget after working with the Medical Director/CEO and appropriate Advocacy staff to implement the request in the most effective manner.

[State Legislative Leadership Conference was held October 23-25, 2015 in Hollywood, Florida]

May, 2013

Action: Will the Board of Trustees approve item 12.T: *Application by the APA to the United Nations to Become Accredited as a Non-Governmental Organization with Consultative Status*?

The Board of Trustees voted to approve item 12.T application by the American Psychiatric Association to the United Nations to become accredited as a Non-Governmental Organization with Consultative Status.

July, 2013

Action: Will the Board of Trustees vote to approve the *Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*?

The APA Board of Trustees voted to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services* with the following amendments to the paper.

Background and Support:

Although concern is understandably heightened when mass tragedies occur, the daily occurrence of murders and suicide due to the use of guns accounts for a ~~vast~~ far greater proportion of gun deaths.

~~Although people with mental disorders are at somewhat increased risk of committing violence towards others, only a minority of people with mental disorders are violent. Indeed, they are far more likely to be the victims than the perpetrators of acts of violence (7).~~

Although people with mental disorders, when treated, are not at increased risk of committing violence towards others, only a small minority of people with mental disorders, even without treatment, are violent.

December, 2013

Action: Will the Board of Trustees approve item 12.S, *Change from Member-in-Training (MIT) to Resident-Fellow Member (RFM)?*

The Board of Trustees approved item 12.S, Change from Member-in-Training (MIT) to Resident-Fellow Member (RFM) which asks that the current name for residents and fellows be changed from Member-in-Training to Resident Fellow Member.

This action item has been completed.

March, 2015

The APA Board of Trustees, acting on the recommendation of the Assembly Executive Committee, and representing over 36,000 psychiatrists, supports the elimination of part IV of MOC. Therefore, the Board of Trustees recommends to the ABPN that they lobby and advocate the ABMS to eliminate part IV of the MOC, that the APA reaffirms its commitment to lifelong learning and quality improvement and support for the highest scientific and ethical standards of medical practice and that the APA will establish a joint Board and Assembly Work Group with the charge to evaluate the broad issue of maintenance of certification for psychiatry and its

relationship to maintenance of state licensure and other accrediting bodies. The goal of the work group is to return timely reports to the Board and Assembly including recommendations, if appropriate, for any positions the APA should take regarding any and all parts of Maintenance of Certification.

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There were also action papers that led to other Board actions, such as changing MIT to RFM and giving FOCUS Journal to ECPs as a member benefit.

C. Other Work Products of the Assembly:

POSITION STATEMENTS:

Position Statement on Abortion (1977)
Position Statement on Active Treatment [revised by an Assembly Task Force] (1978)
Position Statement on US Military Policy of "Don't Ask, Don't Tell" (2009)
Policy on Conflicts of Interest Principles and Guidelines: with Special Interest for Clinical Practice & Research [developed by Assembly Conflicts of Interest Work Group] (2010)
Position Statement on Psychiatry and Primary Care Integration across the Lifespan (2010)
Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services (2014)
Position Statement on Prior Authorization for Psychotropic Medications (2014)

Review and Approval of the DSM 5

D. Assembly as an Incubator for APA Leadership:

On the current Board of Trustees, Drs. Binder, Robinson, Geller, Young, Benson, Burd, and Akaka are or were members of the Assembly.

E. Annual Meeting Survey:

At the 2016 Annual Meeting, we hope to survey the District Branch Executive Directors to identify how many DB Reps submitted reports to their DB and if it was to the DB Executive Committee, through a newsletter, etc.

Conclusion: This concludes the report of the Metrics Work Group. Any input is welcome. We would particularly like to thank Allison Moraske for her wonderful assistance with gathering much of the information.

Sincerely,

Stephen Brown, M.D., Chair & Representative, Area 7
John de Figueiredo, M.D., Representative, Area 1
Robert Roca, M.D., Representative, Area 3
Eileen McGee, M.D., Representative, Area 4
Molly Garthright, M.D., Representative, Area 5
Peter Forster, M.D., Representative, Area 6
Rajeev Sharma, M.D., Representative, ECPs
David Tompkins, M.D., Representative, M/URs
Jeremy Kidd, M.D., Representative, RFMs
John Wernert, M.D., Parliamentarian (Consultant)
Theresa Miskimen, M.D., Recorder
Allison Moraske, APA Staff

DRAFT

Area 4 Council Meeting Minutes

Omni Shoreham Hotel, Washington, D.C.

October 30 and 31, 2015

Attendance

Area 4 Rep: Dr. Bob Batterson

Area 4 Dep Rep: Dr. Bhasker Dave

Area 4 Trustee: Dr. Ronald Burd

Illinois Reps: Dr. Lisa Rone, Dr. Shastri "Swami" Swaminathan, Dr. Linda Gruenberg

Indiana Reps: Dr. Heather Fretwell, Dr. Brian S. Hart

Iowa Reps: Dr. Robert Smith, Dr. Carver Nebbe

Kansas Reps: Dr. Donald Brada, Dr. Nolan Williams [Acting Rep]

Michigan Reps: Dr. William Sanders, Dr. Lisa MacLean, Dr. Denise Gribbin

Minnesota Reps: Dr. Dionne Hart, Dr. Maria Lapid

Missouri Reps: Dr. James Fleming, Dr. Sherifa Iqbal

Nebraska Reps: Dr. Soniya Marwaha [Acting Rep], Dr. Venkata Kolli [Acting Rep]

North Dakota Rep: Dr. Ronald Burd

Ohio Reps: Dr. Jonathan Dunn, Dr. Eileen McGee, Dr. Karen Jacobs, Dr. Brien Dyer

South Dakota Rep: Dr. William Fuller

Wisconsin Rep: Dr. Clarence Chou

RFM: Dr. Sarit Hovav [Area 4 RFM Rep], Dr. Matthew Kruse [Area 4 RFM Dep Rep]

ECP: Dr. Jacob Behrens [Area 4 ECP Rep], Dr. John Korpics [Area 4 ECP Dep Rep]

MUR: Dr. Francis Sanchez [Rep, Asian-American Psychiatrists]
Dr. Judith Kashtan [Dep Rep, Women Psychiatrists]

Attendance (Continued)

AAOL: Dr. Cheryl Wills [American Academy of Psychiatry and the Law]
Dr. Prudence Gourguechon [American Psychoanalytic Association]
Dr. Beverly Fauman, [American Association for Social Psychiatry]
Dr. David Lott [American Academy of Addiction Psychiatry]

APA Staff: Mr. Jeffrey Regan [Deputy Director, Government Affairs]
Ms. Kristin Kroeger, [Chief of Policy, Programs and Partnerships]
Dr. Ranna Parekh, [Director, Division of Diversity and Health Equity]
Mr. Jon Fanning, [Chief of Membership]
Ms. Stephanie Auditore

Guests: Dr. Renee Binder [APA President]
Dr. Maria Oquendo [APA President-Elect]
Dr. Daniel Anzia [Speaker-Elect]
Dr. Jenny Boyer [Immediate Past Speaker]
Dr. John Wernert [Parliamentarian]
Ms. Sara Stramel-Brewer [Executive Director, Indiana Psychiatric Society]
Ms. Carol Wang [Executive Director, Nebraska Psychiatric Society]
Dr. Jon Berlin [American Association of Emergency Psychiatrists]
Dr. Laura Fochtmann [Vice-Chair, Guideline Writing Group]
Ms. Karen Kanefield [Practice Guidelines Program Director]

Friday, October 30, 2015

1. Call to Order and Introductions

Dr. Batterson called the meeting to order at 12:30 p.m. Introductions were made of those attending the meeting, with each attendee reporting any pertinent conflicts.

The agenda was reviewed and accepted as distributed. Mentors were assigned for the new members attending this Assembly Meeting.

2. Representative's Report

Dr. Batterson made preliminary remarks about the Action items coming up at the Assembly. He strongly encouraged all Council members to attend the Reference Committee Meetings scheduled for later this afternoon. Dr. Batterson made assignments for Council members who will be represented on each of the five Reference Committees.

Dr. Batterson also announced to the new members of the Area 4 Council that he will meet with them from 8 a.m. to 8:15 a.m. on October 31, 2015, to provide an overview of the functioning of the Area Council and the Assembly.

3. Reference Committee Assignments

Dr. Batterson then asked the Area 4 Council to break up into five groups with each group representing one of the five Reference Committees. Each group was chaired by an Area 4 Council member on the Reference Committee. The groups reviewed and discussed the Position Statements and Action Papers assigned to the five Reference Committees.

The Area 4 Council recessed at 2 p.m. on Friday, October 30, 2015.

The Area Council resumed at 8:30 a.m. on Saturday, October 31, 2015.

4. Call to Order

Dr. Batterson called the Meeting to order at 8:30 a.m. Introductions were made of those members who were not able to attend the Council Meeting on October 30, 2015, with these additional attendees reporting any pertinent conflicts.

5. Reports from Area 4 Representatives on Reference Committees.

Dr. Batterson invited reports on the deliberations of the five Reference Committees.

- **Reference Committee 1 – Advancing Psychiatry**

  Dr. Gourguechon participated in the Reference Committee on October 30, 2015. Dr. Gourguechon reported on the Reference Committee Actions as follows:

  - **cc 2015A2 4.B.16** Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment
    RC did not discuss as it remained on the consent calendar.

  - **2015A2 12.A** Access to Care Provided by the Veteran's Administration
    RC supported with changes as noted in Packet #3, Distribution #9.

  - **2015A2 12.B** Directions to the Area Nominating Committees
    RC supported with changes as noted in Packet #3, Distribution #10.

  - **2015A2 12.C** New Names for Psychiatric Conditions
    RC did not support this Action Paper.

- **cc 2015A2 12.D** Prior Authorization
  RC did not discuss as it remained on the consent calendar.

- **Reference Committee 2 – Supporting Research**

  Dr. Rone participated in the Reference Committee on October 30, 2015. Dr. Rone reported on the Reference Committee Actions as follows:

  - **cc 2015A2 4.B.4** Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP
    RC supported this Action Paper as written.

  - **2015A2 12.E** Ad Hoc Work Group to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product
    RC supported with changes as noted in Packet #3, Distribution #10.

  - **2015A2 12.F** Payer Coverage for Prescriptions from Nonparticipating Prescribers
    RC supported with changes as noted in Packet #3, Distribution #12.

  - **2015A2 12.G** APA Support for NIMH Funding of Clinical Research
    RC supported with changes as noted in Packet #3, Distribution #13.

  - **2015A2 12.H** Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?
    RC supported with changes as noted in Packet #3, Distribution #14.

- **Reference Committee 3 – Education & Lifelong Learning**

  Dr. Fleming participated in the Reference Committee on October 30, 2015. Dr. Fleming reported on the Reference Committee Actions as follows:

  - **cc 2015A2 4.B.3** Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities
    RC did not support this proposed Position Statement.

  - **2015A2 12.I** Strengthening the Role of Residency Training to Improve Access to Buprenorphine
    RC supported with changes as noted in Packet #3, Distribution #15.

  - **2015A2 12.J** Need to Gather Information on Physician Health Program (PHP) Performance
    RC did not support this Action Paper.

  - **2015A2 12.K** Parity in Permanent Licensure Policy
    RC supported with changes as noted in Packet #3, Distribution #16.

  - **2015A2 12.L** Partial Hospital Training in Psychiatric Residency
    RC supported this Action Paper as written.

- **Reference Committee 4 – Diversity & Health Disparities**

  Dr. Dionne Hart participated in the Reference Committee on October 30, 2015. Dr. Dionne Hart reported on the Reference Committee Actions as follows:

- **cc 2015A2 4.B.6** Proposed Position Statement: Substance Abuse Disorders in Older Adults
  RC did not discuss this proposed Position Statement as it remained on the consent calendar.

- **2015A2 12.M** Addressing the Shortage of Psychiatrists
  RC did not support this Action Paper.

- **cc 2015A2 12.N** Advocating for Medicaid Expansion
  RC did not discuss this Action Paper as it remained on the consent calendar.

- **2015A2 12.O** Systems to Coordinate and Optimize Psychiatric Inpatient Bed Availability for Referral of Psychiatric Emergencies
  RC supported with changes as noted in Packet #3, Distribution #18.

- **2015A2 12.P** Making Access to Treatment for Erectile Disorder Available under Medicare
  RC supported this Action Paper as written.

- **Reference Committee 5 – Membership & Organization**

  Dr. Brian Hart participated in the Reference Committee on October 30, 2015. Dr. Brian Hart reported on the Reference Committee Actions as follows:

  - **cc 2015A2 4.B.14** Proposed Position Statement: on Tobacco Use Disorder
    RC did not discuss this proposed Position Statement as it remained on the consent calendar.

  - **2015A2 12.Q** Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations
    RC supported with changes as noted in Packet #3, Distribution #19.

  - **2015A2 12.R** Senior Psychiatrist Seat on the Board of Trustees (BOT)
    RC supported with changes as noted in Packet #3, Distribution #20.

  - **cc 2015A2 12.S** Need for Position-Specific Email Addresses for Leadership Roles in the APA
    RC did not support this Action Paper.

  - **2015A2 12.T** Election of Assembly Officers
    RC supported with changes as noted in Packet #3, Distribution #21.

6. Visit by APA President

Dr. Renee Binder visited the Area Council during this session. Dr. Binder addressed the Council briefly. She indicated that she is looking forward to an active and productive Assembly Meeting. She voiced her support for the work done by the Assembly. Dr. Binder then reported the following items:

- Her focus during her year as the President is to highlight the plight of the seriously mentally ill in the nation's jails and prisons, and to advocate for and seek solutions.
- The APA Board of Trustees toured the San Quentin State Prison in California in June 2016.
- APA has established new APEX (American Psychiatric Excellence) Awards. These awards are to recognize deserving recipients who use a public forum, such

as entertainment, sports, media, etc. to address important psychiatric issues. The first APEX Awards will be given on April 18, 2016.

7. Review of new APA Practice Guidelines, assigned to Area 4.

- Assembly Item 8.L.1

  The Council reviewed the "Practice Guideline: Use of Antipsychotics to Treat Psychosis and Agitation in Patients with Dementia." Area 4 was assigned as the primary reviewer for this new Practice Guideline. The Assembly Committee of RFMs was the secondary reviewer.

  In preparation for discussion on this Practice Guideline, Dr. Dave distributed a four-page handout that included 15 "Guideline Statements" included in the Practice Guidelines.

  Dr. Dave shared information regarding his participation in a conference call of the Assembly Liaisons to the Steering Committee on Practice Guidelines. He reviewed information shared by Dr. Fochtmann during the conference call regarding the development and approval process for the Guidelines. This information was also included on page 2 of his handout.

The Area Council briefly discussed the Guidelines as well as the material distributed by Dr. Dave in his handout.

A motion was made and seconded that Area 4 Council recommend passage of this Practice Guideline by the Assembly. This motion passed.

The Area Council Meeting recessed at 10:25 a.m. on October 31, 2015.

The Area Council Meeting resumed at 4:30 p.m. on Saturday, October 31, 2015.

8. Call to Order

Dr. Batterson called the meeting to order at 4:30 p.m.

9. Minutes of the Previous Meeting

Dr. Dave distributed the 11-page minutes he had prepared of the Area 4 Council Meeting on May 15 and 16, 2015, at the Metro Toronto Convention Centre, Toronto, Canada. The minutes were reviewed.

A motion was made and seconded to accept the minutes as distributed. The motion passed.

10. Guest Presentations

- Dr. Anita Everett and Dr. Frank Brown, candidates for the office of the President-Elect of APA, visited the Area 4 Council during this session and made brief presentations regarding their background/experience, issues they were interested in and their goals if elected.

- Dr. Wernert, Parliamentarian, spoke about the importance of APA PAC and urged all Council members to contribute to it.

11. Budget and Audit Committee Report

Dr. Dave presented the report of the Budget and Audit Committee. He distributed a handout which included a report on the current status of the Area 4 Block Grant.

The written report compared the revenue and expenditures year-to-date with the budget as approved in November 2014.

Dr. Dave raised a concern regarding minimal funds remaining in the Block Grant at this time, despite not holding the summer Area 4 Council Meeting in 2015. He noted that the Block Grant amount was increased from $21,943 in 2014 to $34,650 in 2015. However, the Area Council began the year with a total negative balance in the Block Grant of $18,996.14 from excess expenditure in 2014 (when the Area Council held two meetings, one in Chicago and one in Indianapolis). Thus, the Council only had $15,653.86 available in the Block Grant for Calendar Year 2015.

Dr. Dave reported that following his inquiry regarding the charge of $9,086.72 to the Area 4 Block Grant by Marriott Business Services on December 23, 2014, it has been learned that this charge was in error and the entire amount has been refunded to the Area 4 Block Grant.

Despite this amount being refunded, we currently have a negative balance of $2,440.33 in the Block Grant account.

Dr. Dave informed the Council that each Area 4 Council meeting held separately from the Assembly meeting costs us approximately $20,000. He cautioned that the Block Grant amount for 2016, even with the addition of our own dues receipts from DBs, will not fully cover two Area 4 Council meetings during 2016.

Dr. Dave presented a draft Area 4 Budget for 2016, which included two options: one with the summer meeting and one without the summer meeting. There was a discussion regarding both options.

A motion was made and seconded to approve the draft Budget including a summer meeting during 2016. The motion passed.

A motion was made and seconded to approve the consolidated Treasurer's Report and the Budget and Audit Committee Report, as presented. The motion passed.

12. Central Office Report

Mr. Jeffrey P. Regan, M.A., Deputy Director, Department of Government Affairs, APA, distributed a written report by e-mail to Council members. Excerpts from his report are reproduced below:

- Comprehensive Mental Health Reform:
  APA continues to push comprehensive mental health reform in both Congressional chambers. On the House side, the bipartisan Helping Families in Mental Health Crisis Act (H.R. 2646) has 147 cosponsors. Representative Tim Murphy (R-PA) continues to promote his legislation in speeches around the nation… Meanwhile, on the Senate side, the bipartisan Mental Health Reform Act of 2015 (S. 1945) has 10 cosponsors… Given the continued national dialogue on mental health reform, opioid addiction, and parity enforcement, APA is reasonably confident that both chambers will move to advance reform measures in the coming couple of months.

- Insurance Mergers:
  APA has joined the American Medical Association and other physician organizations expressing concern about the proposed mergers of four insurance companies: Anthem-Cigna and Aetna-Humana. While sharing the concerns about limiting access to care and price increases, APA also expressed concern that these mergers could make it easier for insurance companies to limit psychiatric care in violation of the Mental Health Parity and Addiction Equity Act (MHPAEA). APA has asked the Department of Justice to take the central tenets of MHPAEA into consideration when reviewing the proposed mergers.

- Scope of Practice:
  APA continues to work in opposition to legislation introduced last Congress that defines clinical psychologists as physicians under Medicare. To date, the bill has not been reintroduced in the 114th Congress. APA continues to work in states where psychologists are looking to expand prescribing privileges, including Hawaii and Idaho.

- Parity Poster Legislation:
  APA is actively engaged with Senator Richard Blumenthal on a legislative proposal that would mandate the posting of beneficiary "rights" under the Mental Health Parity and Addiction Equity Act. This proposal comports with the "parity poster" initiative being advanced with success by the Division of Communications. APA anticipates legislation will be introduced before the end

of year.

- State Advocacy Conference
  Between October 23 and 25, 2015, APA hosted a state advocacy conference in Hollywood, FL, which brought together over 100 DB Executives, DB Leaders, and state lobbyists to discuss strategies and topics centered on winning state advocacy. Presentations were given by APA Administration staff on topics salient to state advocacy, including mental health parity enforcement and scope of practice. Other presentations were given on developing partnerships with allied stakeholders and enhancing communications capabilities.

- Briefing on the Decriminalization of Persons with Mental Illness:
  On Thursday, October 29, APA hosted a Capitol Hill briefing entitled, "Moving Mental Health Care from the Jails to the Community: Decriminalizing People with Mental Illness." The briefing featured perspectives on mental health and the criminal justice system from clinicians, county leaders, law enforcement, and patients. Dr. Renee Binder was a key presenter and joined by presenters affiliated with NAMI, the National Association of Counties, and the Major Sheriffs Association. Two presenters came from states in Area 4: County Commissioner Mary Ann Borgeson of Douglas County, NE, and Sheriff Rich Stanek of Hennepin County, MN.

13. ACROSS Reports

I. American Psychoanalytic Association

Dr. Gourguechon distributed a written report and discussed a few items from her report:

- American Psychoanalytic Association (APsaA) will consider grants to investigators with psychoanalytic and psychodynamic psychotherapy projects. Grant applicants do not need to be members of APsaA. Information is available on the APsaA website.
- Psychiatrists and Residents may join as Associates.
  - Psychotherapist Associates
  - Student/Resident Associates

  All Associate members get reduced registration fees at APsaA meetings, a free subscription to the quarterly magazine, the American Psychoanalyst, and reduced subscription rate to the Journal of the American Psychoanalytic Association.
- Residents and ECPs can also apply to APsaA's fellowship program. All qualified applicants receive a psychoanalyst mentor. Applications for 2016-2017 fellowship program are due by February 8, 2016.

- There is a "Teachers' Academy" aimed at facilitating interest in psychoanalysis and psychodynamic therapy in clinical teachers of psychiatric residents and medical students.

II. American Association for Social Psychiatry

Dr. Fauman reported the following:

- The American Association for Social Psychiatry (AASP) has proposed several workshops and symposia for the 2016 APA Annual Meeting, including:
  - Diversity Experience in Residency Training – Drs. Fauman, Sperber, Aida
  - Social Trauma – Drs. Judge, Yehuda, Pumariega
  - Child Poverty – Dr. Thompson, and others
- AASP will present a Halpern award and associated symposium. The awardee next year is Dr. Nada Stotland, who will speak on abortion rights, along with a distinguished panel on various components of those rights.
- AASP plans to sponsor a luncheon again for residents attending the 2016 APA annual meeting who have an interest in Social Psychiatry. AASP has hosted this luncheon for many years, generally welcoming 20-30 residents each time to a collegial lunch and discussion.

III. American Academy of Addiction Psychiatry

Dr. Lott informed the Council that the American Academy of Addiction Psychiatry will be holding its annual meeting from December 3-6, 2015 in Huntington Beach, California. A scientific program titled "Addictions and Their Treatment Course" will be held in conjunction with the meeting

14. MUR Report

Dr. Sanchez presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of his report.

- The MUR group has been very pleased with the increased emphasis on "diversity" as outlined in the goals of the APA. In line with this, there is a call to have a push to have diversity in all district branch activities, representation and leadership.
- The seven different caucuses have an active and involved membership but continue to need participation by constituents.
- MUR caucuses have different activities at the annual meeting. There are also opportunities for leadership positions through the caucuses. RFM and ECP participation has significantly increased.
- The APA's DDHE, through the leadership of Dr. Parekh, now has incorporated cultural competency as part of APA fellowships.

15. ECP Report

Dr. Behrens presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of his report.

- ECPs continue to work with ABPN to optimize the physician folio portion of their website for tracking and streamlining the MOC tracking process.
- ECPs are having monthly meetings to review action papers and assignments while also fostering ongoing connections with the ECP trustee, AMA delegation reps, and the RFM mentor.
- ECPs are planning combined social events with RFMs to foster mentorship.

16. RFM Report

Dr. Hovav presented an oral report. She referenced her ACORF report that was distributed as Item 7.F in the Assembly packet. Highlights from her report:

- ACORF has been holding monthly conference calls. These conference calls facilitate communication amongst the group members.
- Dr. Hovav has created an e-mail account specific for the ACORF chair and will be passed on from one chair to the next each year.
- ACORF members have been active in writing Action Papers. Four Action Papers were submitted by ACORF members for the Fall Assembly.
- To facilitate communication amongst ACORF members who sit in various locations, with their respective Areas, Dr. Hovav created a WhatsApp group (a free app on iTunes and Google Play) where a member can text the entire group. This will allow for improved communication during the plenary sessions.

Dr. Batterson reported that Dr. Hovav was the recipient of the 2015 William Sorum Award for an RFM from Area 4. He presented her with the Award certificate.

17. District Branch Reports

I. Wisconsin

Dr. Chou presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of his report.

- The Wisconsin legislators have been working on parts of the Physicians' Drug Monitoring Program with a lot of input from Wisconsin Psychiatric Association (WPA) and the state medical society.
- Wisconsin has passed legislation regarding the multi-state compact for medical licensure.
- WPA had a well attended educational program on the issue of Opioid Abuse/Dependence, with presentations from researchers, clinicians, legislators, and representatives of the justice system.
- The next WPA meeting will be in Madison in April 2016.

II. South Dakota

Dr. Fuller distributed a written report by e-mail to Council members. He discussed key items from his report:

- South Dakota Psychiatric Society (SDPS) held a successful Fall meeting at the Custer State Game Lodge. Topics at the meeting included:
    - Medical Uses of Marijuana.
    - Predicting Dangerousness – Clinical and Forensic.
- The SDPS Winter meeting in February will be on the topic of Integrated Care Addressing Rural and Underserved Areas.
- No "scope of practice" bills pertaining to psychiatry were submitted this year.
- The membership is increasing, with active involvement of young psychiatrists and psychiatry residents.
- A program titled "Addressing Disparities in American Indian Mental Health" was organized by the APA "On Tour Program" in Sioux Falls on April 30, 2015. Among the presenters were Saul Levin, M.D., MPA, APA Medical Director and Ranna Parekh, M.D., MPH, Director, APA's Division of Diversity and Health Equity. The program was aimed at improving access and equality of treatment for Native Americans in South Dakota.

III. Ohio

Dr. McGee distributed a written report and discussed key items from her report:

- Ohio Psychiatric Physicians' Association (OPPA) is providing input to a House Study group about:
    - Mental health parity laws
    - Reimbursement for telepsychiatry services
    - Integrated/collaborative care
- Psychologists are again seeking sponsorship for legislation seeking prescriptive privileges.
- There is a bill in the House to allow APRNs to practice independently.
- A bill was passed allowing Pharmacists to dispense Naloxone without a prescription under an authorization from a physician in accordance with a protocol developed by the State Board of Pharmacy.
- A bill was passed to require Ohio's higher education institutions to establish suicide prevention and education programs.
- OPPA's Annual Psychiatric Conference will take place in Columbus on March 13, 2016 and is titled "Innovations and Controversies."

IV. Nebraska:

Dr. Hovav distributed a written report by e-mail to Council members. Key items from the report include:

- Nebraska Psychiatric Society (NPS) has been working with a lobbyist and meeting with state lawmakers to prevent psychologists from introducing a bill seeking prescriptive privileges.
- A new law will allow Nurse Practitioners to practice independent of physician collaborative agreements.
- The Nebraska legislature approved a 2.25% rate increase for behavioral healthcare providers.
- NPS is connecting with psychiatrists in private practice groups, as part of recruitment efforts.
- NPS is making efforts to serve as a resource for rural based primary care practices across the state.

V. Missouri

Dr. Iqbal distributed a written report by e-mail to Council members. She reviewed several items from her report:

- The Missouri Psychiatric Association (MPA) hosted a Fall educational program titled "Addressing the Psychiatric Impact of Economic Disparity, Societal Stress and Racial Profiling."
- Bills of interest from the legislative session:
    - A Tort Reform bill passed.
    - A bill was passed requiring health benefit plans to cover the diagnosis and treatment of eating disorders.
    - A bill that recommended screening for depression in medical students did not pass.
    - No "scope of practice" bills seeking psychologist prescribing privileges were introduced this year.
- MPA is advocating for approval of a prescription monitoring program.

Dr. Fleming informed the group about the next MPA meeting, which will be in conjunction with the Missouri State Medical Association in St Louis on Saturday March 19. Agenda items include an update from APA staff members on current APA advocacy efforts and an update on two state commissions attempting to deal with the aftermath of the 2014 unrest in Ferguson, MO.

VI. Minnesota

Dr. Dionne Hart distributed a written report. She reviewed pertinent items:

- Dr. Hart and two other psychiatrists from the Minnesota Psychiatric Society (MPS) attended the APA's State Advocacy Conference in October 2015, in

Hollywood, Florida. These participants are now brainstorming creative ways to engage their local and state legislators.

- The State mental health system continues to have long waiting lists for inpatient beds. There are reports of numerous assaults on patients and staff. MPS has invited one of the state hospital system's Medical Directors to their next Council Meeting on November 14, 2015.
- A federal judge has ruled that the Minnesota Sex Offender Program (that currently has about 700 offenders in the program) violates the U.S. Constitution. The judge has ordered a risk assessment of all offenders in this program to determine which of them can be put on a pathway for release. Lawyers for the state have filed an appeal with the Eighth U.S. Circuit Court of Appeals.
- Minnesota legislature increased funding this year for community crisis teams.

VII. Michigan:

Dr. Sanders presented a written report and discussed key items from his report:

- Collaborative efforts among several constituents including the Michigan Psychiatric Society (MPS) and the Michigan State Medical Society have been successful in blocking any scope of practice issues this year.
- MPS is working with the APA in supporting parity for mental health care in Michigan.
- Modifications are being considered by the legislature in the state's assisted outpatient treatment law to make it less cumbersome and easier to use. MPS is supporting the proposed modifications.
- The Lieutenant Governor has recently convened an opioid and prescription drug abuse task force to help address this serious issue. The MPS has made its resources available to the task force.

VIII. Iowa

Dr. Smith distributed a written report and discussed key items from his report:

- Iowa has several ongoing projects currently at both the University and private hospital settings that hopefully will serve as the stimuli to bring Integrated/Collaborative Care to wide spread adoption in Iowa.
- Iowa continues to have a shortage of psychiatrists. On a positive note, more residents completing training at University of Iowa are staying in the state.
- For the first time in decades, the IPS membership has dropped below 170.
- The state of Iowa will privatize the Iowa Medicaid program beginning January 1, 2016. Contracts have been signed by four companies – Amerigroup, AmeriHealth, UnitedHealthCare and Wellcare. The state estimates that this will save $51 million in the first six months. Medicaid covers 560,000 low income/disabled Iowans.

IX. Indiana

Dr. Brian Hart distributed a written report by e-mail to Council members. He reviewed key items from his report:

- Indiana Psychiatric Society (IPS) hosted its Fall Symposium in Indianapolis in September. The topic was suicide, with particular focus on physician suicide. The Symposium was timed to allow attendees to participate in the "Out of the Darkness" suicide prevention walk.
- In January 2016, IPS will host a DSM-5/ICD-10 retraining/training event. The program will review diagnostic changes from DSM-IV to DSM-5, with emphasis on understanding the appropriate use of ICD-10 codes.
- "Regional Integrated Mental Health Conference" is scheduled for April 22-24, 2016 at the West Baden Springs Hotel, West Baden Springs, Indiana. Presenters include Glenn Martin, M.D., Speaker of the Assembly, and Ranna Parekh, M.D., MPH, Director, APA's Division of Diversity and Health Equity.
- Plans are progressing on building a new state psychiatric hospital in Indianapolis.

X. Illinois

Dr. Rone presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of her report.

- Illinois psychology prescribing bill is in the Rules committee and already the psychologists are trying to expand the original bill. Illinois Psychiatric Society (IPS) is working with the state medical society to prevent it from being altered and have a psychiatrist on the regulatory board that will oversee this licensing.
- With the state's troubled budget, cuts continue to be made for funding of mental health programs. IPS is continuing to work with various policy makers to help them understand the impact on community mental health centers.

18. Future Meetings

- Area Council Meeting at Loews Chicago O'Hare Hotel in Chicago on February 27 and 28, 2016.
- The APA Annual Meeting in Atlanta, Georgia with the Assembly Meeting from May 13-15, 2016.
- Fall Assembly Meeting at OMNI Shoreham in Washington D.C. from November 4-November 6, 2016.

The Area Council Meeting adjourned at 6:00 p.m.

Respectfully submitted,

Bhasker J. Dave, M.D., D.L.F.A.P.A.
Area 4 Deputy Representative

Item 2016A1 11.F
Assembly
May 13-15, 2016

Area 6 Report

Area 6 held its most recent meeting in Sacramento on April 3rd. We had our council meeting that Sunday, and many of our council members stayed overnight in Sacramento for advocacy training and visits to our state legislators on Monday. Catherine Moore, our current treasurer, opened the meeting as both our president and president-elect were on flights that were delayed! We enjoyed hearing from the candidates for APA Assembly offices. Federal updates, APA action papers, and other APA business were extensively discussed but the focus of this report will be to provide an update on issues that are active within our area. The Council did unanimously endorse the Assembly Action Papers on Human Trafficking as a Psychiatric Issue and Eliminating Out of Pocket Cost Barriers to Care for Patients with Serious Mental Illness and Recurrent Disabling Mental Disorders, as well as a Position Statement titled "The Call to Action: Accountability for Persons with Serious Mental Illness".

Our president noted that the transition in staffing has gone well – we now have improved office quarters at a reduced cost, our annual meeting has had improved attendance and income, and increased corporate support has helped us financially. We had our first Psychiatry for Primary Care Conference which was highly successful in Northern California and will be repeated in Southern California this summer. Our president summarized that we are working well with the Department of Managed Health Care and active in our legislature as well as continuing to advocate in the judicial arena. He would like to see us focus on increasing membership, as well as work on issues of mental illness in the incarcerated and homeless populations.

Our annual meeting will have a preconference this year for the first time – on psychopharmacology, and perhaps a free post-conference on collaborative care. We will also be increasing our funding to help residents, medical students and ECPs attend advocacy day and this meeting.

Our incoming president elect will be Robert McCarron, and Mary Ann Schaepper will be our incoming Treasurer. William Arroyo was elected to join Tim Murphy and fill the California Medical Association delegation position vacated by Barbara Weissman when she was elected to the Board of Trustees for the CMA.

CPA took positions on several ballot initiatives, including support for the Tobacco Tax Initiative that would increase the tax on cigarettes by $2 a pack with substantial money going to health care including raising Medicaid reimbursement rates for physicians. We will be supporting the Children's Education and Health Care Initiative which extends a tax on income of over $250k to support education and health care. We opposed a ballot measure involving parental notification for reproductive services for women under age 16, as well as supported an initiative designed to keep more juveniles in juvenile court as opposed to moving them to the criminal justice system. Finally, after extensive discussion about an initiative that would legalize recreational marijuana use that has been supported by our state medical society, the decision was to stay neutral and neither support nor oppose the initiative.

We updated our platform plank on firearm violence, which is compatible with APA's current policy, and also added a plank on education to our policies. We are sponsoring a bill for a pilot project on Early Psychosis Intervention (AB1576) as well as one to develop a Psychiatric Bed Registry (AB2743) and a bill allowing Emergency Room doctors to drop involuntary holds in Emergency Departments (AB1300) when appropriate. We have legislation involving our Laura's Law (involuntary outpatient commitment), about minimum level of training for evaluations of state hospital patients, and other scope of practice issues such as chiropractors wishing to do health exams in schools. We are hoping to exclude therapists from a bill that allowing a petition of the court for orders to take guns away from patients and are supporting a bill about a firearms research center. We are also opposing a bill that asks for various state departments to review any physician prescribing two antipsychotics to youth in a 90-day period and generate a report to the medical board. Although there are no current bills, we are aware of ongoing efforts by the psychological association to allow psychologists to practice medicine including the prescribing of psychiatric medications.

Our committees remain quite active. The Managed Care Committee is interested in the secret shopper information out of Washington about provider availability. The PAC made a pitch to council members. The Child and Adolescent Committee has been very involved with bills in the legislature – including managing a bill remodeling the foster care system in California that passed last year and follow-up legislation on it this year. The legislature is still focused on the prescribing of psychotropics to this population, including the bill mentioned above involving reports to and by the Medical Board on prescribing. The Integrated Care Committee reported on the highly successful Primary Care Conference, and a survey of residency training directors as well as a survey of primary care doctors about psychiatric issues. The Public Psychiatry Committee is involved with issues around involuntary holds and assisted outpatient treatment, issues of hospital beds and shortages, integrating substance abuse into mental health treatment including getting vivitrol as a pharmacy benefit, and the interest in prescribing in youth. The State Facilities Committee continues to work against pressure for uniformed bylaws in all of their facilities bypassing the autonomy of medical institutions. The Judicial Action Committee is monitoring several cases including case potentially broadening Tarasoff duty to warn requirements.

Respectfully submitted
Barbara Weissman, MD and Joe Mawhinney, MD

American Psychiatric Association
Area VII Meeting
Scottsdale, Arizona
March 5-6-16

Attending
Glenn Martin, MD Speaker
Daniel Anzia, MD Speaker-Elect
Theresa Miskimen Recorder
Matthew Sturm, APA Staff
Tim Miller, APA Staff
Craig Zarling, MD Area VII Rep
Charles Price, MD Area VII Dep Rep
Jeff Akaka, MD Area VII Trustee

Alaska
Alexander vonHofften, MD Rep
John Pappenheim, MD Rep

Arizona
Gurjot Reena Marwah, MD Rep
Payam Sadr, MD Rep

Colorado
Alexis Giese, MD Rep
L. Charolette (Charlie) Lippolis, DO Rep

Hawaii
Leslie Gise, MD Rep
Iqbal (Ike) Ahmed, MD Rep

Idaho
Zach Morairty, MD Rep
James Saccomando, MD Rep

Montana
Joan Green, MD Rep

Nevada
Dodge Slagle, MD Rep
Phil Malinas, MD Rep

New Mexico
Brooke Parish, MD Rep

Oregon
Annette Matthews, MD Rep
Amela Blekic, MD Rep

Utah
Jason Huntziker, MD Rep
Dentino Stamatios, MD Rep

Washington
Matthew Layton, MD Rep
Brian Waiblinger, MD Rep

Western Canada
Adeyinka (Yinka) Marcus, MD Rep
Ian Forbes, MD Rep
Colleen Northcott, MD Alternate Rep
Wyoming
Stephen Brown, MD Rep
O'Ann Fredstrom, MD Rep
ECP
Joshua Sonkiss. MD Rep
Jason Collison, MD Rep
RFM
Kelly Jones, MD Rep
Robert Mendenhall, MD Dep Rep
MUR
Linda Nahulu, MD Rep
Mary Roessel, MD Dep Rep

Guests:
John M. de Figueiredo, MD candidate for Speaker-Elect
Robert (Bob) Batterson, MD candidate for Recorder
David Scasta, MD candidate for Recorder
Teri Harnisch Arizona Ex. Dir.
Charles Min APA photographer

Not able to attend
Krista David, MD Rep Montana
Ruben Sutter, MD Rep New Mexico
James Ethier, MD Rep Washington
Adel Gabriel, MD Rep Western Canada
Kimberly Nordstrom, MD Rep ACROSS

Dr. Zarling opened the Council with a discussion of the APA Strategic Priorities: Advancing Psychiatry, Supporting Research, Education, Diversity after the minutes of the last Area Council meeting were approved.

He then gave an overview of the meeting followed by these leadership reports:
Dr. Zarling reported on the AEC meeting from January 22-24 in Charleston, SC. This report included discussion of the APA Disorder Registry, Ethics Principles document is on the website, APA headquarters completion date in 2018 is ahead of schedule, an Action Paper on vote for Assembly Leadership, and 15 position statements for the Assembly to review. He discussed an educational grant for training in collaborative care, the focus on Parity Violations as an area of interest, federal leadership positions, candidate videos, new awards to include District Branches with the highest percentage of members voting, Woman's Caucus Award, and metrics.

Dr. Martin, Speaker of the Assembly, then spoke on registries for parity violations, Action Papers being followed up on, language to change the Procedural Code to one person – one vote, Nominating Committee on the issue of greater than two candidates for Area Trustee, Trustees may serve as alternate DB Reps, Area Rep and Dep Rep cannot represent a District Branch. Dr.

Martin discussed block grants – most Areas felt they could use an increase in their grants of about 5,000 with Area 7 requesting more. District Branch Presidents, Executive Directors and Legislative Reps could be helpful.

Dr. Anzia, Speaker-Elect of the Assembly, discussed the close attention being paid to fiscal issues, metrics being worked on by Steve Brown and John Wernert. APA is incorporated in DC and thus is governed by DC law. All MUR caucuses are different which may be an issue in this regard and are working to fix the problem. He recognized Craig Zarling regarding Fellowship integration in the Assembly. He gave a detailed discussion of developing a registry that is in a very early stage of formulation.

Matt Sturm gave a report from Government Affairs. There is a lot of discussion on collaborative care, integrated care training.

Tim Miller State Advocacy Regional Field Director for Areas 6 & 7 was introduced and mentioned he has attended several state meetings including Nevada, Colorado and Oregon among others.

Committee Reports:
Procedures – Dr. Hunziker discussed the revisions to the Area Bylaws. He will take back the comments suggested to modify the Bylaws and send a copy incorporating these suggestions back to the Area Council for further discussion.
Elections – Dr. Gise reported on the nominations for RFM and ECP Dep. Reps. Following our usual process RFM Dep. Rep. elected was Kimberly Yeager from New Mexico, and ECP Dep. Rep elected was Jacqueline Calderone from Colorado. As the Assembly Operations Manual states that odd numbered Areas will elect officers in odd numbered years, the Area Rep. and Dep. Rep. elections will be next year. Area Trustee is not up for election this year.
Rules – Drs. Brown and Blekic had nothing to report
Awards – Drs. Layton and Nahulu had no report

New Action Papers
Dr.Matthews presented an AP on facebook and other social media issues outlining liability.
Dr. Sonkiss led the discussion of the APs on Mandatory Competency for Senior Physicians, Length of residency, and a position Statement on Direct to Consumer Advertising.
Dr. De Figueriredo presented an AP on refugees
The AP Competency to Practice Psychiatry due to Mental Ability was discussed

Dr. Batterson, candidate for Recorder, and Dr. De Figueriredo, candidate for Speaker-Elect were introduced and gave a brief statement and answered questions.

District Branch Reports. DB reports and ensuing discussion are consistently rated as the most valuable part of being members of the Area 7 Council. Therefore the entire DB reports are attached to the minutes.

Report of the Wyoming Association of Psychiatric Physicians
Area 7 March, 2016

Our District Branch is experiencing slow and gradual changes that could reach a crisis in the next year or two. We currently have 23 members (down from 24), many of whom are retired or inactive from practice. We have a small handful of members who are active in the DB.

There are near equal numbers of actively practicing psychiatrist who are members as those who are not members of the APA. This reflects a membership crisis. We have a constant flux of psychiatrists who leave the state, come to the state or are retiring. It is difficult to retain psychiatrists in our state, despite having a lack of managed care barriers.

We continue to hold monthly conference call meetings to address DB issues and legislative activity. Our finances are on a stable track with the help of the Infrastructure Grants from the APA.

Our Legislature is currently wrapping up the Budget Session and the time of this meeting they will have voted (passed) SF 0058 which addresses our involuntary commitment process. This bill is significant for the inclusion of an Outpatient Commitment option and complicated by the inclusion of amendments concerning "examiner" and "gatekeeper" positions to oversee the individual cases. Twenty three counties have 23 different circumstances of managing this process with 23 variations of facilities and personnel. The State is moving to take over the process but likely at the expense of the outpatient treatment needs of our underfunded population and Community Counseling Centers. This is happening in light of the Legislative vote to turn down Medicaid Expansion for the third year in a row and this time with Gov. Matt Mead's plea FOR the expansion. Our state (and DB) is very concerned and watchful about the decreasing revenues from oil, gas, and coal.

It is difficult to attract AND retain psychiatrists in the State of Wyoming.

Respectfully Submitted,
O'Ann Fredstrom, Rep
Stephen Brown, Rep

Western Canada District Branch Report

APA Area 7
Phoenix, March 5-6, 2016

Membership

Total of 519 with new applications coming inThere are 120 members eligible for Distinguished Fellow status.

Medical students and residents

Medical students number of14 also up slightly. The Movie night last October was successful again as means informing them about APA and psychiatry in general. Plan is for a Resident Research Night in April.

Finances

Stable with general increase in membership. No major financial commitments recently

Other WCDB Activities

APA has been helping to design a branch logo. Will put out proposed designs to the membership for voting.

The WCDB will have their AGM in conjunction with the APA Annual Meeting as has been the tradition. The Canadian district branch cocktail gathering is scheduled for May 16 from 7:00-9:00 PM, likely at the OMNI. Everyone welcome!

Legislation and Mental Health Issues

Physician-Assisted Dying (PAD)

In February 2015, the Supreme Court of Canada ruled as unconstitutional the criminal prohibition against physician-assisted dying, striking it down and suspending it. The federal government was given one year to amend the Criminal Code of Canada to address the concerns; later were granted an extension until June, 2016. In the meantime the CMA and CPA proposed interim guidelines for clinicians, based on extensive member feedback on this timely issue. Guidelines attempt to address many of the nuances of the complex ethics involved, including physician "conscientious objection" and underscoring the importance of providing quality palliative care for those suffering. Some effort has been focused on the assessment of "capability" and the consent process, but the details remain unclear, with psychiatry's role not the only option available to those requesting PAD. Indeed, in this four month interim period, and in response to patients' and families' demands for PAD, BC and Ontario Colleges of Physicians & Surgeons have "interim guidelines", Alberta has "advice", Saskatchewan has "policy" and Manitoba and Nova Scotia have "standards of care". All require at least two physician assessments, and person must be adult and capable of consent. For example, a fourteen day window of desire for PAD in BC is considered "a reasonable length of time that wish is expressed", and psychiatric disorders are not excluded. Locally, the BCPA/ local WCDB members mobilized feedback to the committee and to speak to Psychiatry Residents about the implications of the pending legislation. Many, including the public, have expressed concern regarding the tight time line. "If we do this, we should do it right".

A report by a Special Joint Committee of the House and Senate, on Physician Assisted Dying was just released on Feb. 25th. The report is to provide the federal government advice on crafting new legislation on medical assistance in dying (MAID). Recommendations pertaining to mental illness are:

- that individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition
- that physical or psychological suffering that is enduring or intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access MAID
- permission to use advance requests for MAID be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable.

  The committee recognized the unique challenges to mental illness but, providing competency and other issues were looked at, the Charter rights should apply. With respect to minors more time should be taken, but no more than three years.

New Federal Government

Liberals under Honorable Justin Trudeau swept to power October 2015, with new Health Mandates and charges to address challenges in the following: First Nations health and suicide rates, immigration and refugees, homeless and incarcerated persons, veterans and those in armed forces, child & youth mental health, medical marijuana, PAD, and establishment of a pan-Canadian Expert Advisory Council on mental health. The BCPA has just completed a survey of mental health provision as part of the Child & Youth Mental Health and Substance Use Collaborative. The CPA under President Dr. Sonu Gaind has offered ongoing support to Federal Ministers in all of these issues, and our DB members can contribute as well to these initiatives through these allied organizations.

BC

New fees for physicians include one for corresponding with patients via email. Increased fees for group medical visits. rTMS pending

Ministry funding to support MDs who want to work at QI, other committees, hospital redevelopment and so forth. Longer term plans for increased funding to support mental health as part of primary care. Increased resources for community enhancement- ACT, AHBT, AOT- where police are involved.

MHES and the Vancouver police were full partners in award winning initiative developed for the Assertive Outreach Team (AOT) in Vancouver. The Webber Seavey award is presented to an organization that has raised the standard of quality in law enforcement and focuses on continual improvement of services to local communities. The AOT was considered an innovative and breakthrough program to provide outreach support to people with addictions and mental health issues who are routine offenders. Early numbers suggest about a 40% reduction in negative police involvement and a 56% reduction in violent offences for these individuals. .

Insite (Safe injection site)- likely this program will be expanded under the new federal government. Harm reduction program has been strongly promoted by the public health agencies and they have research to support the program has been effective reducing accidental overdose, other health concerns.

Cannabis

BC College- Marijuana for Medical Purposes (Professional Standards and Guidelines). VCH guidelines.

A Federal Court judge has struck down federal regulations restricting the rights of medical marijuana patients to grow their own cannabis and given the Liberal government six months to come up with new rules. Feb 24, 2016.

City deciding who can obtain a license to sell cannabis products- location etc.

Alberta

Provincial legislation Bill C10 again regarding PAD, and to go in effect June, 2016.

Gender based issues legislation- students in school are to be addressed by any means they choose including 'ze', for example, in addition to the more usual 'he' or 'she'. No designated restrooms or change rooms in sports.

Electronic medical reports- implementation continues at steady rate, although psychiatrists in hospitals are still allowed to write on the chart.

Respectively submitted,

Ian Forbes MD
Colleen Northcott MD
Yinka Marcus MD
Western Canada District Branch representatives

Dr.Miskimen, candidate for Speaker-Elect was introduced and gave a brief statement and answered questions.

Arizona DB reported and were thanked for being the host for this meeting in Scottsdale AZ

Arizona Psychiatric Society (APS) Report for Area Council, March 2016 Legislative issues:

1. Scope of Practice – An Advance Practice Registered Nurse's scope of practice that expanded nurse's ability to work without physician collaboration or oversight and to prescribe independently and administer anesthesia without supervision narrowly made it out of the Sunrise process. Physican groups, led by ArMA and AOMA, with APS participating actively, have engaged on a multi-faceted front, using social media and more active grass roots and public relations efforts than in the past. As a result of their efforts, the first version of the bill, introduced in the Senate by Senator Barto, did not have enough votes to pass and was not presented for a final vote. It did not drop as a bill on the House side (most likely because the House Health Committee, which would be the COR, did not have the votes to support it), but there is still a possibility that the bill could appear as a strike-everything amendment from an off-topic COR. ArMA sought additional financial support from the AMA and hired additional lobbyists staff, public policy staff, and a public relations firm for this campaign. The Anesthesiology Society has contributed to this effort financially as well.
2. Psychologists did not file for prescribing authority in the Sunrise process for 2015-2016. Despite concerns for the Sunrise process in Arizona, the leadership of the Arizona Psychological Association have reported to the APS Lobbyist that they will honor the process and any future filings will continue to honor the Sunrise process. The Society has been engaged positively with the Psychologists on an Interprofessional Committee with all behavioral health counseling/therapy providers, and have worked in common on other mental health legislation we can all support.
3. Budget – Governor Ducey continues his efforts to streamline and find maximum economies of efficiency in the Arizona budget. It is believed there will be a push to settle the Budget early and end sine die before the end of April, especially with some state legislators announcing campaigns for national offices and an eye to devote more time to their campaign efforts.
4. Lobbyist- A full time lobbyist, Joe Abate Esq; is funded by APS membership dues and represents the APS.

5. State DB PAC- There is no DB PAC

District Branch Activities: The Society had an ECP-led planning committee plan what type of event to bring to the membership with the support of the APA expedited grant. A Picnic with Psychiatry was just held on Saturday, February 27, 2016, at The Farm at South Mountain. Attended by more than 40, including members and family, the event was a success in accomplishing what it intended. All who came out enjoyed a wonderful day, did not have to leave their families home, were in a setting where social conversations could be held. The day included some get-to-know-you activities, a hosted lunch, with no alcoholic beverages, games, bubbles, activities—something for everyone. Feedback from all who attended is that they would like to see the event continued. Thanks to the APA Membership Department for their support, a member and non-member mailing on the strengths of the APA and the APS was sent out, including a flyer about the Picnic. The Society's Annual Meeting will be Saturday, April 30, 2016, at Phoenix Tempe Marriott at The Buttes on Innovations in Psychiatry. The event will incorporate a poster breakfast session, inviting members, attendings, residents, and medical students to poster present.
A Friday evening social will be hosted by American Professional Agency, Inc. relating to the Annual Meeting (on April 29, 2016).

Membership Status: Membership holds steady. Arizona had a residency program repeat in the 100% Club this y ear (MIHS with 84%, bronze level), and our RFM members on the Council have been very activity in growing the RFM membership in the Society. With the earlier drop date, the Membership Committee will be working hard on staying ahead of the drop numbers for 2016.
Financial status: The DB remains in stable condition financially. Members event expenses and higher than budgeted expenses for the 2015 Annual Meeting resulted in an overall loss for the fiscal year. The Society has financial reserves to absorb that loss with future affect on the 2016 Budget.
Management and work structure: Part-time Executive Director is employed through ArMA, the state medical association.
Physician Leadership: The Executive Officers of the Society move up the ladder from Secretary to President and then serve three more terms as Past President. Officers will be elected at the Spring Annual Meeting. Treasurer Dr. Taylor-Desir is moving to be CMO of a sovereign indian community in ND, so the current Secretary will move up two slots, and a long-time Legislative Committee and Council member, Dr. Fowls, will step into the Treasurer slot, with new officers being Dr. Jasleen Chhatwal (from UofA Tucson) as Secretary, and Drs. Wanda Shao (Banner-UMC Phx) and Brandon Yates (UofA). Dr. Gurjot Marwah will move up to President after the APA Annual Meeting, and Dr. Aaron Wilson will move up to President-Elect and serve as the second APA Assembly Representative pursuant to Arizona Bylaws. Dr. Payam Sadr will serve as first APA Assembly Representative through 2017.
Rebranding. After reviewing the presentation materials from the APA, the Arizona Executive Council voted to retain its brand but to pursue some updates to make it more cohesive in appearance with the APA brand in terms of type font, appearance, and color. We have had a pending question in to the APA on font, colors, and cohesive styling and await their response in order to move forward.
State News: As a streamlining measure, legislation was enacted that transfers the roles and responsibilities of the Division of Behavioral Health over to AHCCCS. This is part of the administrative simplification plan proposed by the Governor. The switch becomes effective July

1, 2016.
As the reality of the UofA/Banner merger works itself out, efforts are being made to make the distinction between the University and its medical education programs and Banner, which are intended to operate as separate entities.
Mercy Maricopa continues to develop its integrated medicine approach to care. In Southern Arizona, the UofA has the Center for Integrative Medicine.
Our DB will be participating in the SAN outreach to Arizona stakeholder groups.

Psychiatric Training Program: The training programs in the State remain unchanged. The Tucson Psychiatry Residency programs under Dr. Ole Thienhaus leadership have facilitated the increased participation of Tucson members. The MIHS Psychiatry Residency Program under Dr. Carol Olson has the largest membership, having attained Bronze Level, 100% Club Status in 2015 (at 84%).
Specific Member Concerns re: APA: Building and developing the membership of APS, with the support of the APA, continue to be a specific concern and focus.
Respectfully submitted,
Payam M. Sadr, MD, FAPA Gurjot K. Marwah, MD Arizona Assembly Representative President-Elect and Arizona Assembly Representative

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Hawaii DB reported
HPMA Report to AC7 3/5/16 – Leslie Hartley Gise MD, APA Assembly Rep
Mission: Helping Hawai'i's Psychiatrists Provide the Highest Quality Care
Membership: More than other states, 229, up 29% from 6 mo ago, most we ever had since I remember.
We called the folks on the drop list.
Finance: In the black, about the same as 1 year ago.
Monthly Meetings: Attendance 10-15, much improved.
Members reaching out to residents and private practice psychiatrists to attend meetings.
Hot topics: Network Adequacy, Ethics & Professional Boundary Violations, rTMS, The History of HSH, How to Manage A Private Practice, NAMI
A member presented on Network Adequacy in Hawai'i and attached a 50-page paper.
HI has 1 of the highest rates of insurance (93%) because of HI's PrePaid Heath Act of 1974 (employer mandate). But HI has an access problem and its getting worse. Doctors are not available and there are long waits.
There is a legal obligation for Network Adequacy. Inadequate networks help plans increase profits and take money out of the state which strains the state budget and increases the reliance on public programs. The insurance commissioner and state officials are not providing oversight. They propose actions like crash course prescribing for psychologists. HI has a shortage of doctors, need = almost 4000, have <3000, almost 1000 short. This erodes the quality of care. Private managed care of public programs (Medicaid and Medicare) has 5 companies (nonprofit = HMSA (BCBS) and AlohaCare, for-profit = Kaiser, United and Wellcare). HI started using the federal exchange 10/15/15.
It is not clear how to make a complaint. The insurance companies are responsible. The insurance companies that run the health plans have billions of dollars and are the only entities with the authority, expertise and resources to make reforms.
Health plans give the appearance of Network Adequacy by inflating provider directories

and hiding complaints. Health plans don't recruit doctors or do prevention but they should. Health insurance companies are responsible to maintain Network Adequacy. Responsible state officials must audit health plans, monitor them for Network Adequacy and apply penalties for failure to comply with laws.

Legislative: Despite much lobbying, crash course prescribing bill passed Senate Health and Judiciary committees and will be heard by Ways and Means Committee.

HPMA legislative committee mobilized the membership to fight the bill, including working with APA staff & using grants from APA and AMA to educate and mobilize the community of psychiatrists, patients, other healthcare organizations and community members. HPMA joined the Partnership for Access to Safe Care (PASC, http://accesstosafecare.com/contact-us-3/, a group of local community members working on a long term, sustainable approach to improving access to safe health care including opposing the scope bill.

HPMA surveyed the public about safety issues related to the bill and better alternatives to crash course prescribing (eg integrated care models, telepsychiatry). Our lobbyist is actively working with members to educate the legislature. An ongoing public relations effort includes the development of a facebook page & an impressive website for the Partnership.

HPMA created 2000 glossy mental health access flyer cards which were distributed to community organizations including community centers, hospitals, primary care, libraries, YMCAs, health clubs, etc to help the community access psychiatrists.

Psychopharmacology conference Feb 2016 put on by UH Hilo College of Pharmacology & HI Assn of Professional Nurses, 5 out of 10 speakers were MDs.

State Advocacy Conference: 2 members attended in FL 10/2015

DB Innovative Grant: 4 Oahu HPMA members did extremely successful and well received community outreach presentations to 2 libraries on Kauai in January.

APA: APA Staff visited, met with stakeholders, and appreciated dinner at jeff Akaka's home.

Management: Old paper files were converted to digital files (PDFs) on a DVD. Since 2014 files have been digitalized and uploaded into cloud storage. No more paper files.

NAMI: HPMA supported the NAMI Walk and doubled our fundraising goal, almost $2000.

AACP: Community Psychiatry has been looking for an AC7 person to be on Bd of Directors. Maggie Bennington-Davis OR has been doing it for a long time.

Dr. Miskimen gave the Recorder's report and updated us on Action Paper tracking

RFM Report was given by Dr. Kelly Jones

RFM REPORT – Area 7 Spring Council Meeting

- One action paper currently coming out of ACORF with a second possibly in the works
    - Increasing awareness of ACORF and opportunities for RFMs
    - Incentives to take leadership roles in the APA
- Currently brainstorming ways to keep ACORF alumni active as ECPs
- A Resident's Guide for Surviving Psychiatric Training, 3rd Edition is now available under the Resident tab on the APA website
    - http://www.psychiatry.org/residents-medical-students/residents
- The name of the 100% Club is changing to The InCircle
- Annual Meeting activities for RFMs
    - Chief Resident track at the annual meeting will now be open to all residents and will be on leadership topics throughout the week

    - Subspecialty day - all subspecialties meet in “speed dating” style
    - CV workshop - sign up for 15 min slots and get personalized attention
    - RFM leaders to be at poster symposium and mind games
    - BINGO games - get stamps for doing activities and get entered for prize
- Mentor Award deadline was 01 March with nominations from every area, which didn't happen last year.

Washington State DB 33 – Update for Area 7 Meeting – Phoenix, 3/5-6/2016

Washington State Legislature Activity

There are two bills WSPA has committed its efforts to in this session. The bill numbers are HB 2793 and HB 2335. The first aims to incentivize education for pharmacists and gunshot owners on identifying customers at risk for suicide and on how to properly educate them about secure means storage. There was a tax incentive in there to really encourage the firearms dealers to make appropriate storage materials available for low cost, but it was stricken out via an amendment. 2335 aims to regulate and shorten waiting times for providers applying for insurance credentials with payers.

WSPA is looking at investing more in lobbyist and support staff services, as well as looking at various options to partner with other organizations to deliver a more comprehensive and effective messages to representatives, staffers and government officials.

Psychiatric bed shortage

Spokane just received approval from the Washington State Department of Health for our Certificate of Need application to build a 100-bed inpatient psychiatric facility. It will hopefully open in 2017. There will be a considerable need for us to recruit psychiatrists to meet the demand.

The State has been given until May 2016 to comply with federal court orders to meet strict timelines for competency evaluations for incarcerated individuals. The statute says this must take place within 7 days, and many people with severe psychiatric disorders have waited months for their evaluations to occur. State hospital officials say they are making progress in increasing capacity to conduct these evaluations.

Membership

As of January 2016, WSPA had a total of 546 members (Distinguished Fellow 9, Distinguished Life Fellow 62, General Member 271, Inactive Fellow 1, Inactive Member 3, Life Associate 1, Life Fellow 15, Life Member 83, Member-in-Training 1, Resident Fellow Member 43, Fellow 51). This is an increase over the total in January 2015, which was 525.

Psychiatry Graduate Medical Education

Three psychiatry residents are over half-way through their first year in our new 4-year psychiatry residency program in Spokane. There were 700 applications for 3 slots in the upcoming Match.

Finances

WSPA is financially doing very well. We do not expect any particular challenges or shortfalls in the near future.

Strategic Planning

The WSPA Executive Council met in November 2015 for a Strategic Planning session. Areas identified as needing more concentrated efforts included Government Relations and Community/Public Relations. Our goal is to implement agreed-upon strategies over the course of this calendar year.

Respectfully submitted,

Matthew E. Layton, M.D., Ph.D.
layton@wsu.edu
Utah District Branch Report
Utah Psychiatric Association:
Current members: 176
Psychiatrists in Utah: 362 approximately (This includes retired, residents, and practicing)
2016 Rates: $95 – GM 1st, 2nd, 3rd yr. in practice
$190 – GM full member
$190 – Distinguished Fellow
$127 – Life members 1 – 5 yrs. (multiple categories)
$63 – Life members 6 - 10 yrs. (multiple categories)
Treasury: $28K dollars before our spring meeting
Spring Meeting with be a family day at the Bee's minor league baseball game on May 7th.

Utah Health care legislation:
SB 73 Medical Cannabis ACT
passed Senate currently to the House Standing Committee
SB 58 NP Amendments – allows prescribing schedule II without any consultation
Passed Senate, House Standing committee
SB 106 Assault Offense Amendment – increase assault penalty against healthcare professionals/ER staff
Passed senate, House returned to Rules due to fiscal impact
HB 18 Medicaid PDL amendments – amends length that prior auth can go, requires all ACO's to pre-auth not on the list. Requires 40% of the money saved to be deposited in a PDL Restricted Account
House Substituted, Senate put on second read calendar
HB 259 Substance Abuse Fraud House Substituted/Passed, Senate put on second read calendar
HB 264 End of Life Options Act
House Second reading
HB 265 Mental Health Practitioner Amendments
House Substituted, Senate second reading calendar
HB 274 Involuntary Civil Commitment Modifications
House substituted/third reading calendar to Rules
At least 10 different bills that have to do with opiate prescribing, death due to overdose, access to database, rules about prescribing, and others.
University of Utah:

New teen suicide text line started up

New call in center for community referral and resources

New expansion plan for adult residency, child fellowship and triple board program

Working on a medical home model for addiction and geriatrics

Introducing residents into our community clinics to work with the currently imbedded social workers

Growing Gate program (https://www.gateutah.org/)

Department of psychiatry reception at the APA in Atlanta.

ECP report was given by Dr. Josh Sonkiss
No activity in the ECP committee this reporting period so there is nothing to report.
MUR report was given by Dr. Nahulu
There was a robust discussion of problem-solving efforts among the various MUR caucuses with a move toward some consistency and compliance with governing DC law.
Discussion of Area finances was led by Drs. Zarling and von Hafften. Finances continue to be tight. Usual Area meeting attendance has been between 50% and 78% which has allowed us to barely be within budget. At this meeting attendance is 90%. A watchful eye will be kept on Area finances and Dr. von Hafften is leading the way on this. Of note, the Area Reps. asked the Assembly Executive Committee at the January meeting to consider increasing the Area 7 block grant by 17,000 per year as we are trying to get more DB participation in our meetings. It is clear that the most vulnerable DBs need to be strengthened and these are the DBs that tend to not be able to send a full compliment of Reps.
Colorado DB report
Colorado is excited to host the summer Area Council meeting in Denver at the Monaco Hotel August 6 and 7.

Colorado Psychiatric Society
Spring 2016 District Branch Report

Office Staffing
CPS welcomed a new Administrative Assistant to the organization in June. Beth Pippin has a background in management of individual nursing school campuses and operational oversight of college locations as a whole. CPS is very lucky to have Ms. Pippin on board since she is incredibly organized, thoughtful and personable. The CPS staff office also moved to a new location.

Nomination of Area 7 Early Career Psychiatrist Representative
The Colorado Psychiatric Society Executive Council voted to nominate Jacqueline Calderone, MD, for the position of Area 7 Early Career Psychiatrist Representative because Dr. Calderone is an appreciated member of our Executive Council, she never hesitates to ask insightful and probing questions, she has a keen interest in advocacy and leadership and she is a warm, engaging person.

Newsletter
In 2015, the Executive Council approved an overhaul of the CPS newsletter and decided that a magazine style platform with mobile device compatibility was the best option. CPS then applied for funding to cover the newsletter update from the APA's Expedited Grant, listened to feedback from other DBs, contracted with a new graphic designer and got to work. The first issue with the new format, look and platform was Fall 2015 (available here). We wanted to create a fresh, modern experience so members could better enjoy the newsletter, whether it is viewed on a

computer, smartphone or tablet.

Events

2016 Area 7 Meeting in Denver

CPS will be holding a reception for APA Area 7 Representatives and CPS members in a private room at the Wynkoop Brewery, a Denver institution originally co-founded by Colorado Governor John Hickenlooper. The reception will be the evening of Friday, August 5th with heavy appetizers and an open bar sponsored by APA, Inc. The Wyncoop is about .5 miles from the Monaco Hotel and representatives can use the free mall ride and only have to walk 1-2 blocks or take a taxi.

2015 Legislative Training

In November, CPS held a Legislative Training. There was a strong turn-out for the training and we anticipate more involvement from early career psychiatrist members on the committee. CPS expert lobbyist Debbie Wagner started the CPS Legislative briefing with an overview of the Colorado legislative process and how a bill becomes law. She then covered Committees and how to testify before a Legislative Committee, including examples. Finally, we discussed the role of executive branch agencies such as the Governor's Office, the Colorado Department of Human Services, the Department of Corrections and the Department of Health Care Policy and Financing.

2015 Winter Party

In December, CPS members gathered for the 2015 Winter Party, a networking and social event for Colorado psychiatrists. It was great event and we received positive feedback on what is quickly becoming a fun CPS tradition.

2016 Spring Meeting

The CPS Annual Spring dinner meeting will be "Physician-assisted death: A discussion of legal, ethical and care considerations." We will have a well-rounded discussion on end of life options. The meeting will begin with brief talks explaining considerations to take into account in terms of law, ethics and palliative care. There will be an open mic and the remainder of the time will be dedicated to a discussion between audience members. The three speakers are: Richard Martinez, MD, MH is the Robert D. Miller Professor of Forensic Psychiatry and the Director of the Forensic Psychiatry Training Program at the University of Colorado Denver School of Medicine.

Daniel Johnson, MD, FAAHPM is the Physician Lead for Palliative Care, Care Management Institute at Kaiser Permanente and the Medical Director of Supportive Care Solutions at KP-Colorado. Claire Zilber, MD, DFAPA has served on the Colorado Psychiatric Society's Ethics Committee since 1993, and has chaired the committee since 2003. She was a member of the APA's Ethics Committee from 2012-2015. She writes a monthly ethics column for APA's PsychNews, and is a three-time recipient of the APA's Carol Davis Ethics Award.

2016 Fall National Network of Depression Centers Conference

CPS is partnering with the NNDC on their national meeting, which will be held in September Denver. The theme is Behavioral and Physical Integrated Care, Tele-Health Services using Clinical and Research-based talks and CMEs will be awarded.

Mental Health Stories

The Mental Health Stories project is a partnership between the Public Information and

Education Committee of the Colorado Psychiatric Society and the CHARG Resource Center. In 2015, we broadened its impact by inviting Peer Specialists to play an active role in the Mental Health Stories Committee. We received numerous entries and, after much debate, eight honoraria were awarded. These stories, as well as booklets from previous years, can be accessed on the CPS website, http://www.coloradopsychiatric.org/. We encourage everyone to share these stories and hope you learn as much as we have reading them.

Financial
CPS continues to be financially solvent. We are moving to a tiered exhibitor pricing structure for the Spring 2016 meeting.

Legislative
Key bills of interest to CPS before the 2016 Colorado legislature include:

Interstate Medical Licensure Compact - The bill enacts and authorizes the governor to enter into an interstate compact with other states to recognize and allow physicians licensed in a compact member state to obtain an expedited license, enabling them to practice medicine in Colorado or another member state. Thank you to Dr. Lippolis for testifying on behalf of CPS in support of this bill, which passed out of committee unanimously.

End-of-life Options For Terminally Ill Individuals
The bill enacts the Colorado End-of-life Options Act, which authorizes an individual with a terminal illness to request, and the individual's attending physician to prescribe to the individual, medication to hasten the individual's death. The bill was amended by the House Judiciary Committee to include the amendment requested by CPS and CPA to limit the professions who can determine if the requesting individual is capable of making an informed decision to psychiatrists and licensed psychologists rather than all licensed mental health professional as written in the draft.

Videotape Mental Condition Evaluations
The bill requires a court-ordered mental condition examination to be video and audio recorded.

Concerning The Ability Of A Physician Assistant To Perform Functions Authorized By A Physician That Are Within The Physician Assistant's Scope Of Practice – This bill has not been introduced yet. Dr. Lippolis attended an early stake-holder meeting with much concern being voiced by all specialty areas over breadth and scope of the proposed 117 page bill.

Prohibit Conversion Therapy Mental Health Provider – This bill prohibits a licensed psychiatrist or a licensed mental health professional from engaging in conversion therapy with a patient younger than 18 years of age.

Dr. Scasta, candidate for Recorder, was introduced and gave a brief statement and answered questions.

Oregon District Branch Report

Membership
Membership remains around 400, the Membership Committee is working on qualifying members for fellowship and distinguished fellowship status. The committee has been working on residents' engagement and held a gathering "Resident Mixer" in November 2015 with great success, connecting psychiatry residents with practicing psychiatrists in Oregon. The plan is to continue similar gatherings and engagements.

Financial Status
Financial status remains a constant challenge. As of October 2015 the association has had about $25,000 in Legal Fund and $10,500 in Reserve Fund. Currently the association is meeting all of its expenses on time, but our Winter Conference just held in February 2016 did not attract the predicted number of participants, the most current report is pending.

Legislation
Our Legislation Committee continues to work with enthusiasm and engagement. We just recently welcomed the new lobbyist, Katy King.
Ms. King has over 21 years of experience with State government including 14 years as the government relations manager and lobbyist for the Public Health Division in the Oregon Health Authority. Ms. King Katy currently the lobbyist for the Oregon Chapter of the American College of Emergency Physicians and the Children's Health Alliance, an association of over 100 pediatricians in Oregon and in SW Washington.

SB 1503 A
Repeals sunset on requirement that insurers reimburse licensed nurse practitioners and physician assistants (HB 2902, 2013).
SB 1503, which is backed by the Oregon Nurses Association, would repeal the 2018 sunset for pay parity for primary care providers.
Amendments supported by the Oregon Psychiatric Physicians Association and the Oregon Medical
Association would require the Oregon Health Authority to look at the impact of the 2013 law on healthcare workforce development, recruitment and retention. They weren't adopted given the fiscal impact, however, the OHA has committed to working with provider groups over the interim to see what can be accomplished with existing data. This bill passed the House floor with a divided vote of 44-15.

HB 4075
Relating to student safety; replaces School Safety Hotline established by Department of Justice with statewide tip line established by Department of State Police for anonymous reporting of information concerning threats to student safety.
This bill is moving forward with amendments to address a more comprehensive approach. It includes threats such as cyberbullying or suicide. This bill has passed the House and is now in Ways and Means.

HB 4136
Relating to noneconomic damages; would increases $500,000 limit on noneconomic damages recoverable in wrongful death actions and other statutorily created causes of action to $1.5 million.
This bill is dead for this session.

SB 1558

Relating to student health records; prohibits disclosure of records of college or university student health center, mental health center or counseling center, or records of health professional retained by college or university to provide health care, mental health care or counseling services to students, to other individuals, offices or entities within, affiliated with or acting on behalf of college or university.
The bill clarifies that medical records are not student records; thus, they belong to the students and not the institutions they attend. This privacy protection is intended to help students experiencing abuse, trauma or crisis who turn to their campus-based health centers for support. This bill passed the House on February 23 and has gone to leadership and the governor for their signatures.

HB 4147
Relating to firearm transfer criminal background checks. Prohibits transfer of firearm by dealer or private party if Department of State Police is unable to determine whether recipient is qualified to receive a firearm within 10 days. The bill passed the House but is unlikely to clear the Senate given the backlog of bills.

SB 1511 A, HB 4014 A
The Oregon Senate passed SB 1511 A, which directs the Oregon Liquor Control Commission to register marijuana producers and retailers. Another set of amendments (-28) to increase minimum dosage size, failed to advance. A second bill (HB 4014A), makes changes to the law regulating the production, processing, sale and use of cannabis.

HB 4194
Improvements to compatibility with PDMP and EDIE; allows pharmacists to dispense naloxone. This bill would streamline the Prescription Drug Monitoring Program for front line health care providers through integrated access with the Emergency Department Information Exchange. It also would allow pharmacists to dispense naloxone over-the-counter. This bill passed the House on an unanimous vote and now heads to the Senate.

District Branch Activities
CME Accreditation
As reported in the past our district branch was placed on probation in February 2015 by the Institutional Accreditation Committee of the Oregon Medical Association. We have been working on correcting the issues, the Oregon Medical Association reviewed and approved two of four criteria that OPPA was under review and the probation status will continue for 6 months to give the additional time to resolve the issues.
CME
43rd Annual Winter Continuing Medical Education Conference
“A Mosaic of Modern Mental Health”

Even though it was an excellent conference it appears that we had less participants than predicted and most likely no revenue, but no final report received.

Public Information & Education Committee
Our new chair for Public information & Education Committee Dr. Daniel Bristow has been very active in media relations and public education. Dr. Bristow and OPPA responded immediately when Roseburg, Oregon was affected by mass shooting.

With the assistance of the APA and leadership of OPPA president Dr. Craig Zarling and Public Information & Education chair, Dr. Dan Bristow, OPPA sent news releases to Oregon media following the shooting, but Dr. Bristow also traveled to Roseburg where he met with media, community leaders and Roseburg citizens. Dr. Bristow said in one of his e-mails to the Executive Council:
"Aaron Levin did a Psychiatric News Alert from our interview Friday morning. He plans to do a lengthier story in the next week or two. We did 2 TV interviews Friday and 2 radio interviews. I also spent a decent amount of time talking with the support workers, Roseburg citizens, police, and ODOT to provide general moral support. These experiences were certainly informative for me, and I plan to write a story about this for local and national press."

Attached are the articles written by Dr. Zarling and Dr. Bristow.
Respectfully submitted,

Amela Blekic, MD
Oregon Representative

A focus on healing instead of speculation in wake of Roseburg shootings

Portland, Oregon -- October 1, 2015
With the tragic shootings today in Roseburg, Oregon on the campus of Umpqua Community College, discussions in the media have already started to focus on common themes in the wake of mass shootings in America: gun control, the motivations of the shooter, whether or not the shooter was suffering from mental illness. Oregon psychiatrist Dr. Dan Bristow says that focusing on healing and supporting those affected should be the primary concern. Bristow is the chairperson for the Public Information and Education Committee for the Oregon Psychiatric Physicians Association.
"The idea that anyone who commits an atrocity has to be mentally ill is simply inaccurate," says Bristow. "The vast majority of any violent crime is criminal behavior where the person who commits the violence understands that the act is wrong and commits the act anyway."
Bristow says that mental illness is rarely the cause of violent crime. "We don't know the motivation of the shooter but to automatically label him as mentally ill can be damaging to anyone dealing with a mental illness." Stigma against those with a mental illness remains a barrier in people seeking treatment who might be helped by it.
Bristow add, "It's unethical to speculate as to the cause of this tragedy when we should be focusing on helping our fellow Oregonians grieve and heal. This is a time to support (and be supported by) the ones we love: friends, family, neighbors, and fellow Oregonians."

For more information, contact:
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Oregon Psychiatric Physicians Association
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Message from President Craig Zarling, MD

With the tragic shootings at Umpqua Community College in Roseburg, Oregonians have once again found themselves in the vortex of an evolving national disaster of violence and mass murder.

As our hearts are with the victims and their families, and our gratitude is extended to the brave officers who's actions certainly saved many lives, it is necessary to look to the future with determination to end this terrible era where children and young adults are gunned down in their prime as they are working to create their future.

Governor Brown was right in her comments that our first priority is to aid the victims and comfort the bereaved families of those killed. I am personally grateful to our members and all the mental health practitioners who traveled to Roseburg to help. You should know that your colleagues were involved. I have heard from Dan Bristow, MD who traveled to Roseburg, that the local resources, including the Community Mental Health Alliance, have received strong support from the Oregon practitioner community. Also, individual companies, such as Umpqua Bank, who have reached out for help, have found a strong response to their requests for counselors for their employees.

After the immediate shock and need of this disaster passes, the OPPA and the APA, as professional organizations and therefore leaders in our society, must step up and address the causes of these recurring mass killings. Untreated mental illness is relevant, guns are relevant, and numerous societal issues pertain. As the echoes of the shots fired in Roseburg become quiet, we must not forget the grief we feel today, but must be motivated by it and find constructive measures to change our troubled reality.

As member organizations, we cannot move as quickly as the individuals who dedicated their efforts to help in Roseburg, but hopefully we can act powerfully and with lasting effect. You should know that currently our APA leaders are working in Washington on bipartisan legislation introduced by Reps. Tim Murphy, R-PA, and Eddie Bernice Johnson, D-TX, that addresses efforts at comprehensive mental health reform. You should be confident that disaster response and legislative advocacy will be prominent on the OPPA agenda, and that it has become a renewed priority for me. Rather than remain locked in a philosophical stalemate, I feel we must take an educational and pluralistic approach to this complex problem. We as psychiatrists will be in familiar territory, given our daily efforts with multi-determined issues about which there are strong and conflicted emotions, and so may be in a position to help others also move past inevitable disagreements. My hope is that as an organization of professionals dedicated to the welfare of individuals, that we can now help society move forward on this serious problem that continues to erode the wellbeing of all of us, and urge you to join me in those efforts.

Craig Zarling, MD
President, Oregon Psychiatric Physicians Association

The Roseburg tragedy
by Dan Bristow, MD

I drove to Roseburg on the Friday night following the tragic shootings. The morning was filled with media requests for someone from OPPA to provide perspective on another senseless mass shooting. Thankfully, the television and radio reporters I spoke with all agreed with taking a healing approach to support the community in the wake of the tragedy, rather than a speculative or inflammatory focus. As I drove down I-5 from Portland, I didn't know what to expect. I knew it was important to be there, but I didn't know how I was going to help. I soon found out that simply being there, meeting people, sharing stories, and finding out how to go forward was the most valuable contribution.

I arrived at Umpqua Community College (UCC) around 9:30 Friday night. The active crime scene was secured, thanks in part to Oregon Department of Transportation (ODOT) workers. There

were a dozen media trucks and vans (both local and national) parked along the road. I parked among them and walked along the sidewalk, chatting with media folks and ODOT workers. The scene was mostly quiet, with cameras and reporters springing to action only at the "top of the hour" when the national news would pick up the satellite feed for the reporters to report on what was known. After the cameras were turned off, the scene was calm again. It was an eye opening experience for me. The real story wasn't happening in front of the cameras. It was happening behind them.

The real story wasn't about the shooter's motives. It was about the carload of Roseburg citizens who drove up and handed ODOT workers trays of cups of coffee, thanking them for their service. The real story wasn't about gun control. It was about the ODOT workers insisting that I have a cup, despite me trying to be there to support them. The story on camera at the top of the hour wasn't the real story.

I walked to the nearby state police office and found two officers closing up for the night. A family with kids in tow was there, delivering boxed meals to the officers. I shook the officers' hands and thanked them. I couldn't image what they must have dealt with that day, yet they wanted to make sure that I had a place to spend the night. That family and those officers showed me more of the real story. The real story is that Roseburg is a strong community that automatically sprang into action supporting friends, family, and fellow citizens in a time where there was no good explanation for the tragedy that occurred. I could tell that is how the people there live—as a real community.

The following day I met many other impressive citizens who further proved Roseburg's strength: the young women working at the coffee shop who were planning to donate their tips to the families of those who lost their lives at UCC, the store clerk who waited in line over six hours at the Red Cross to donate blood, the music store employees who invited folks into their store and witnessed a spontaneous jam session take place between strangers who just needed some music therapy. These people were living the real story.

But the real story also has a negative side—little access to long-term psychiatric care in Oregon (especially rural Oregon). What happens when the camera crews and disaster relief teams leave Roseburg? The disaster response was great with multiple counselors and support staff from the Red Cross and United States Public Health Service traveling to Roseburg from all over the country. When I visited the community mental health clinics to thank the workers, they had the situation well under control. But as I talked with mental health professionals in Roseburg, I soon became frustrated by the lack of access to psychiatric care that many of us in Oregon know too well.

OPPA member and Roseburg psychiatrist Dr. George Middlekauff told me that Roseburg's only inpatient psychiatry unit closed years ago due to lack of profitability. I spoke with a crisis nurse who asked that I ask legislators for more psychiatric beds. As in most other places in Oregon, patients wait in emergency rooms, sometimes for weeks, for inpatient psychiatric care. I met with Janet Holland, Executive Director of Community Health Alliance (Roseburg's community mental health program). We discussed the need for long-term access to care and funding for necessary services, and hoped these needs could be met after the media attention went away. How can we ensure that Roseburg has access to the mental health care it will need in the months and years to come? The people of Roseburg showed me how strongly they react in the face of tragedy. We owe it to them to make sure they have adequate mental health care available when they need it.

For more information, contact:
Dan Bristow, MD, Chair

Public Information and Education
Phone: 503-608-8791

10 tips for helping children cope with traumatic events
Portland, Oregon -- October 1, 2015

Thursday's shootings in Roseburg, Oregon highlight how a community can quickly be traumatized by a tragic event. In the aftermath of such tragedies, survivors are often left with a complex mix of emotions ranging from disbelief to fear. Direct survivors are not the only people affected by these events; those who learn of the violence indirectly through the media can experience a similar mix of complicated emotions. Children can especially be affected, and parents are often confused or unsure on how to talk with their children after these events occur.

The American Psychiatric Association and the Oregon Psychiatric Physicians Association provide some tips for how parents might discuss traumatic events with their kids:
1) Allow children to talk openly about their thoughts on the event. (Children differ in how they express their thoughts and feelings. Some may speak openly and candidly; some may not. Give children time to ask questions, and let them talk about it at their own pace.)
2) Don't force a child to talk about their thoughts if they are not interested or ready to do so.
3) Avoid overexposure to news event on TV though keep informed from credible sources.
4) Understand that fears of danger are natural and often pass with time.
5) Help children stay connected with friends and other family members who might be sharing similar thoughts and feelings about the event.
6) Use simple language kids understand.
7) Be honest but reassuring when answering their questions.
8) Children who have been traumatized in the past are often more sensitive to traumatic events and might need extra support.
9) Remember that children often learn how to respond to tragedy by watching how parents respond.
10) If a child develops ongoing signs of worry, sleep problems, fears about dying, or other symptoms that do not resolve and negatively affect their daily lives, consider seeking an evaluation from a psychiatric physician.
More information can be found on the American Psychiatric Association's website: www.psychiatry.org/mental-health.

Dan Bristow, M.D.
Chairman, Public Information and Education Committee, Oregon Psychiatric Physicians Association

New Mexico DB report
New Mexico, DB 67 - Highlights
Update for Area 7 –March 5, 2016 Meeting

Community Activities & Member Services:

PMANM will sponsor Part B of the Marijuana topic from Septmber's town hall. This will cover the Legalization Decriminalization aspect, which will be scheduled late spring.
PMANM once again promoted The Roadrunner Food Bank and collected food and money donations.

PMANM will be attending a resident's meeting for further bridge building with UNM and the residents.

Organizational changes:

In the past our association was supported by NM medical society and we paid them for our Executive director time. They have decided not support any specialty societies. We will most likely be hiring Gloria Chavez independently.

Financial Status:

The Financial status of the district branch continues to be healthy. Our annual expenditures have been kept low and consistent.

Legislative Update:

This was a short session focused on financial issues. A bill for assisted outpatient treatment was passed and is waiting governor's signature.

Membership Status:

PMANM members - 164 Residents – 34
This remains fairly stable with a slight decrease.

Coalition Building

PMANM continues to collaborate with other NMPA and other professional organization in discussing a plan to help support HSD through on-going planning and problem solving regarding the behavioral health system, and addressing the problems of the Medicaid system. Unfortunately several of the Az companies have moved out. Currently, there remains several legal entanglements.

Physician Leadership – Resident Training "Beyond Residency":

Resident membership continues to grow at a successful rate. PMANM continues to reach out to those residents who are not APA/PMANM members. Applications continue to come in for membership.

Respectfully submitted

Brooke Parish, MD
Area VII Representative
Nevada DB report
Nevada Psychiatric Association

District Branch Report to Area VII Council
Mar 5-6, 2015
Scottsdale, AZ

NPA Management: In addition to our elected officers, we have an Executive Director, Dr. Lesley Dickson. We have a full-time Conference Coordinator. We have part-time lobbyist who is also salaried to establish our social media presence. Our Executive Director Assistant resigned in December. Our Executive Director expects to retire in 2016; we will be looking to hire someone to replace her. We also have a bookkeeper and accountant.

Our Executive Council consists of the President, Immediate Past President, President-Elect, Secretary/Treasurer, President of the Southern Chapter, President of the Northern Chapter, Executive Director, Director of Education, Ethics Chair, Public Affairs Representative, Early Career Psychiatrist, two Assembly Representatives, Resident/Fellow Representative, State Legislative Representative, and National Legislative Representative. All of these positions are filled.

Our current Executive Director is also a Trustee with the Clark County Medical Association.

Our Executive Committee meets formally monthly. In addition, we have a finance committee and conference committee that meet regularly. We are in the process of establishing Membership, Community Outreach and Government Affairs Committees.

Membership Status: Our membership appears to have grown approximately 10%. We are working hard to recruit younger members, as the membership is aging. Our residency program in the north has 100% APA membership.

Financial Status: Our financial status is overall strong. We have a profitable CME meeting every February, and use these profits to fund our activities for the year. We fund our lobbyist, employees, and consultants with these monies in addition to membership dues. We have established an Investment Fund, which will help limit our overall financial exposure from the meeting.

Member Services: We have Northern (primarily Reno) and Southern Branches (Las Vegas), and each meet monthly.

We have no new issues for employed physicians or self-employed physicians. We continue to encourage RFM's and medical students to participate. NPA member students and residents are invited to our Annual Psychopharmacology meeting at no cost.

Southern Nevada is in the process of opening two new medical schools and developing a new psychiatry residency. We are supporting all of these endeavors.

Bylaws: Our Bylaws were revised at our Annual Retreat in July 2015, and we are in the process of finalizing them by vote of the membership.

Community Activities:

Annual Psychopharmacology Conference: Our Annual Psychopharmacology Conference was a successful. We had the most attendees ever. We are able to bring excellent psychiatric educators to Nevada. Our program schedule for 2017 is already set, and we are working on the 2018 schedule.

We sponsored outpatient commitment and suicide prevention seminars during our Annual Meeting.

Legislative and High-Profile Activities: This is an off year for the legislature in Nevada.

Scope of Practice: No new issues in Nevada.
Parity: No new issues in Nevada.

Lobbying: Our part-time lobbyist remains active with our legislature.

Dodge Slagle DO
Nevada Representative

Montana DB report
MPA report:

MPA now is officially chartered with the state again and we are working on our new logo. We have 4 new members. Current budget is $22,977.20, I believe $15000 of that is a calf grant. Only 7 people attended the annual business meeting attached to the Aware Big SKy Conference in January. We hosted a meet and greet after one of the meetings but plan to change the business meeting to before the AACAP dinner next year in the hopes of drawing more members to come.

Legislative issues include: Project ECHO, a hub for PCP's to call into for consultation and IMPACT which is a collaborative care model the state is exploring. MT is number one in the US in terms of suicide rate and there is a coalition that is working on understanding the risk factors so that we may intervene more effectively. Seeking funding for residency training spots in MT.

Concerns still regarding MOC requirements, membership, finances. Dr. Reyes has become a Life Fellow and Dr. Lantz applied for Distinguished Fellow.

Idaho DB report
Idaho District Branch Report – March 2016

Membership Status

- Membership remains stable and outreach to members who will be dropped effective March 31 have begun.

Financial Status

- While the District Branch's financial status has stabilized, it continues to be an ongoing concern that requires diligence going forward.

Education

2016 Annual Conference: The 2016 Annual Conference will be held April 22-23 in Meridian. The topic of the conference is *Evidence-Based Psychiatry.* We have a great line up of topics and speakers:

- *Evidence-Based Psychopharm*, Rex Lott, PharmD, BCPP
- *ECT & TMS: Evidence and Practice*, Zach Morairty, MD
- *Evidence-Based Psychotherapy*, Barbara McCann, PhD

Additional information and registration forms are available on our website: www.idahopsychiatry.org

Legislative Issues: The 2016 Idaho legislative session is well underway and once again the Idaho Psychological Association brought forth a proposal seeking prescribing authority. We were very fortunate to receive a generous CALF grant from APA which allowed us to retain a lobbyist – Ken McClure, who is thought of by many in the state to be the top healthcare issue lobbyist in Boise. Once again, the chairman of the House Health and Welfare Committee, Representative Fred Wood, a retired ER physician did not grant a hearing in his committee. In order to kill the bill, he has directed us to meet with the Idaho Psychological Association in the interim to discuss next steps. We greatly appreciate the resources and support of the APA, including our new district APA representative Tim Miller. We are also grateful for the information shared by other DBs that have faced this issue.

In better legislative news, the very conservative (politically and fiscally) Idaho legislature has approved funding for two additional mental health crisis centers. The two new centers will be located in Twin Falls and Boise and join the two already located in Idaho Falls and Coeur d'Alene with the ultimate goal of seven centers statewide.

Other Updates

The legislative budget writers approved continued funding for Idaho's sole psychiatry residency. Of the 14 residents that have thus far completed the residency, 8 are currently practicing in Idaho.

A member has alerted the branch to a possible mental health parity issue involving preauthorization requirements for psychiatry services provided to Medicaid patients in an inpatient or outpatient hospital. In collaboration with the Idaho Medical Association, the issue has been brought to the attention of the Idaho Department of Health and Welfare.

As you know, our other Area VII representative, Dr. Nicole Thurston has resigned from this position. I would like to close by thanking Nicole for her service and dedication in representing psychiatrists and their patients within our state.

Respectfully submitted

Zachary Morairty, MD, Area VII Representative

Alaska DB report
Area VII Council
American Psychiatric Association
Alaska Psychiatric Association
Report: March 5-6, 2016

I. District Branch Well Being

The APA website lists 70 members. The annual CME meeting is the primary DB activity. The DB finances remain stable and the DB is currently meeting expenses. The DB does not have a lobbyist. DB member participation is limited. DB member participation in the Alaska State Medical Association (ASMA) is limited. Dr. Vanessa Venezia is the President. Kirsten Pickard is the Executive Director. The DB e-mail address is akpsychassoc@gmail.com.

II. Annual CME Meeting

The 23rd annual CME meeting will be at the Hotel Alyeska in Girdwood Alaska April 15-17, 2016. Topics will include the Treatment of Schizophrenia (W. Gordon Frankle, MD, MBA), the Impact of Cannabis on the Brain (W. Gordon Frankle, MD, MBA), the Treatment and Evaluation of Sexual Offenders (Barbara Beadles, MD), the Truth About Cannabis Use Disorder (C.R. Sullivan MD), Medication Assisted Treatment of Opioid Use Disorder (C.R. Sullivan, MD), and a one-day training on Dialectic Behavior Therapy (Marsha Linehan, PhD, ABPP). Information is available at http://www.psychiatryalaska.org.

III. Access to Care

There are major gaps in access to care. Many primary clinics provide versions of integrated care. Most of the integrate care models are not adequately identifying and effectively managing serious psychiatric illness. The Alaska Criminal Justice Commission completed an analysis and set of recommendations ("Justice Reinvestment Report") to reduce the average daily prison population by 20% and reduce the Department of Corrections budget by $424 million over the next decade. The report does not identify how community mental health resources will be increased.

IV. Legislative Affairs

Alaska is implementing Medicaid expansion within a significant state fiscal deficit environment. The following topics are included in current bills: Medicaid expansion, Medicaid audits, the prescription drug monitoring program, telemedicine, voluntary termination of life, interstate medical licensure, background checks of board of

psychology licensees, childhood abuse and neglect, marijuana, contraceptives, abortion, and discrimination based on gender identity. Dr. Paul Topol is the legislative affairs representative.

Respectfully submitted,
Alexander von Hafften, M.D.
Assembly Representative,
Alaska Psychiatric Association

Great appreciation was voiced by all present and a standing ovation given to Reena Marwah for her and her family's incredible hospitality in hosting the Saturday night dinner in magnificent Indian cuisine style.

Dr. Zarling summed up the salient points discussed during the meeting and the meeting was adjourned at 11:00am on Sunday March 6, 2016.

Respectfully submitted,

Charles Price, M.D.
Deputy Rep. Area VII