American Psychiatric Association Board of Trustees July 11-12, 2015

Materials included in this document

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11.D Report of the Medical Registries

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3. B	Executive Committee Report					
4. A	CEO and MDO Report					
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	11.A - Att. 1	Format for Submissions of Proposed Changes to the DSM				
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BOARD OF TRUSTEES JULY 2015 MEETING

DRAFT ALL ACTIONS BEING PRESENTED FOR CONSIDERATION

Consent Calendar Items Notated by "cc"

- 5. Report of the Secretary Altha J. Stewart, MD
 - A. Minutes of the May 17, 2015 Board of Trustees Meeting
- cc ACTION:

Will the Board of Trustees approve the minutes of its May 17, 2015 Meeting?

- **6.** Report of the Treasurer Frank Brown, MD
 - B. Status of the Board Contingency Fund
- cc ACTION:

Will the Board of Trustees vote to accept the report of the status of the Board Contingency Fund?

- C. Presidents' New Initiative Funds
- cc ACTION:

Will the Board of Trustees vote to accept the report of the status of the Presidents' New Initiative Funds for Dr. Summergrad, Dr. Binder, and Dr. Oquendo?

- D. Assembly New Initiative Fund
- cc ACTION:

Will the Board of Trustees vote to accept the report of the status for the Assembly's New Initiative Fund?

- 8. Reports from Standing Committees and Councils
 - A. Report from the Membership Committee Rahn K. Bailey, MD
- cc ACTION 1:

Will the Board of Trustees approve a recommendation from the Membership Committee to award \$2,678 to each district branch or state association listed in Attachment D as part of the DB/SA Grant process?

ACTION 2:

Will the Board of Trustees approve the recommendation of the Membership Committee to establish a new category of membership, 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.

cc ACTION 3:

Will the Board of Trustees authorize dropping from APA membership the Member listed in Attachment F for failure to meet the requirements of membership?

cc ACTION 4:

Will the Board of Trustees authorize dropping from APA membership the members listed in Attachment G for non-payment of 2015 APA dues if dues are not paid by the deadline?

cc ACTION 5:

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment H, who will be dropped by their district branch if dues are not paid by the deadline?

cc ACTION 6:

Will the Board of Trustees vote to approve the applicants listed in Attachment I for International Membership?

cc ACTION 7:

Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment J?

B. Report from the Finance and Budget Committee – Alan F. Schatzberg, MD

ACTION 1:

Will the APA Board of Trustees approve an increase for CME course registration fees in 2016 as proposed in Attachment A?

ACTION 2:

Will the APA Board of Trustees approve changes to the fees for the 2016 IPS as proposed in Attachment B?

ACTION 3:

Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2016 as proposed in Attachment C?

ACTION 4:

Will the APA Board of Trustees approve in principle that the APA alternates the State Advocacy Conference and the Advocacy Leadership Conference, holding each conference every other year?

ACTION 5:

Will the APA Board of Trustees approve a two year pilot project of discounted group rates for international associations?

ACTION 6:

Will the APA Board of Trustees approve a two year pilot project of discounted group rates for hospital systems or government related agencies?

9. Report of the Speaker – Glenn Martin, MD

A. <u>Executive Summary</u>

cc ACTION 1:

Will the Board of Trustees vote to approve the Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness?

cc ACTION 2:

Will the Board of Trustees vote to approve the Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy)?

cc ACTION 3:

Will the Board of Trustees vote to approve the Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing?

cc ACTION 4:

Will the Board of Trustees vote to approve the Revised Position Statement: Confidentiality of Electronic Health Information?

cc ACTION 5:

Will the Board of Trustees vote to approve the Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection?

cc ACTION 6:

Will the Board of Trustees vote to approve the retirement of the Position Statement: Psychiatric Disability Evaluations by Psychiatrists (2007)?

cc ACTION 7:

Will the Board of Trustees vote to approve the retention of the Position Statement: Consistent Treatment of All Applicants for State Medical Licensure (2008)?

cc ACTION 8:

Will the Board of Trustees vote to approve the retirement of the Retire Position Statement: Employment-Related Psychiatric Examinations (2009)?

cc ACTION 9:

Will the Board of Trustees vote to approve the Revised Position Statement: Publication of Findings from Clinical Trials (2005)?

cc ACTION 10:

Will the Board of Trustees vote to approve the retention of the Position Statement: Use of the Concept of Recovery (2005)?

cc ACTION 11:

Will the Board of Trustees vote to approve the Revised Position Statement: Use of Animals in Research (2009)?

cc ACTION 12:

Will the Board of Trustees vote to approve the retention of the Retain Position Statement: Medication Substitutions (2009)?

cc ACTION 13:

Will the Board of Trustees vote to approve the retention of the Retain Position Statement: Electroconvulsive Therapy (ECT)?

cc ACTION 14:

Will the Board of Trustees vote to approve the Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatry Residency?

cc ACTION 15:

Will the Board of Trustees vote to approve the Proposed Position Statement: Neuroscience Training in Psychiatric Residency Training?

cc ACTION 16:

Will the Board of Trustees vote to approve the Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families?

ACTION 17:

Will the Board of Trustees vote to approve action paper 2015A1 12.A: Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident?

ACTION 18:

Will the Board of Trustees vote to approve action paper 2015A1 12.I: Position Statement on Assisted Outpatient Treatment (AOT)?

ACTION 19:

Will the Board of Trustees vote to approve action paper 2015A1 12.X: Dues Abatement for General Psychiatrists/Members in Puerto Rico?

ACTION 20:

Will the Board of Trustees vote to approve action paper 2015A1 12.CC: Senior Psychiatrists?

11. Work Group and Task Force Reports

A. <u>DSM Steering Committee</u> – Paul Appelbaum, MD

ACTION 1:

Will the Board of Trustees vote to approve the "Format for Submissions of Proposed Changes to the DSM." outlining the information required for proposals for making changes to DSM-5 (Attachment 1)?

ACTION 2:

Will the Board of Trustees vote to approve the creation of 6 DSM Review Committees, as described in the report of the DSM Steering Committee?

ACTION 3:

Will the Board of Trustees vote to approve the changes to DSM criteria listed in Attachment 4, with the understanding that such changes will be reflected in an errata section of the DSM website and incorporated into print versions of the DSM-5 when feasible?

Executive Committee EXPEDITED ACTION BY VOTE June 6, 2015

Executive Committee:

Chair: Renée Binder, MD; Members: Frank Brown, MD; Saul M. Levin, MD, MPA; Glenn Martin, MD; Maria Oquendo, MD; Altha Stewart, MD; Paul Summergrad, MD;

Administration:

Colleen Coyle; Rodger Currie; Yoshie Davison; Margaret Dewar; Kristin Kroeger; Ardell Lockerman; Shaun Snyder; Jason Young;

The Murphy-Johnson Bill

The new bill attracted 18 bipartisan cosponsors on the first day, including 6 House Democrats. See:http://murphy.house.gov/index.cfm?sectionid=250&itemid=2899

In addition, the Senate has begun serious work to advance comprehensive reform and the APA has deeply engaged Senators Christopher Murphy (D-CT) and Bill Cassidy, M.D. (R-LA) who are leading the effort in the upper chamber in coordination with Reps. Murphy and Johnson. See: http://www.murphy.senate.gov/newsroom/in-the-news/murphys-in-house-and-senate-team-to-revive-mental-health-overhaul

As you know, following the June 4 reintroduction of the Murphy-Johnson bill, the APA issued a press release applauding their efforts and praising the new workforce and parity provisions as well as other important APA priorities in the legislation. It is clear that the revised bill is materially improved over the original bill that the Board voted to support in December, and, to an even greater degree, is the most pro-psychiatry legislation in many years. As a result, both Members of Congress have expressed appreciation for APA's "very helpful" press statement and have now requested a formal letter of support with as much detail as possible.

ACTION:

The APA Board Executive Committee voted to authorize the APA to express strong support for the newly reintroduced Murphy-Johnson bill, H.R. 2646, through a support letter to be addressed to the authors.

Report of the
CEO and Medical Director
to the
APA Board of Trustees

July 11-12, 2015

Westin Arlington Gateway
Arlington, VA

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EXECUTIVE SUMMARY

The APA Administration has begun to implement the Board's strategic initiative objectives into their core areas of responsibility and functionality, and is also developing member-focused work products that incorporate one or more of these priorities. These strategic initiative objectives include:

- 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.

To further carry out the strategic initiatives, APA has hired Ashley Mild as Deputy Director, Political Affairs and Grassroots and Director of APAPAC. Ashley started in June and comes to APA with a strong background in fundraising as well as strong grassroots and lobbying experience. Ashley was previously the PAC and Congressional Affairs Manager with the American Academy of Ophthalmology, where she managed the organization's grassroots program and lobbied members of Congress on behalf of the Academy's agenda. Ashley's previous experiences include fundraising for various members of Congress with fundraising firm Erickson and Company and the Democratic Congressional Campaign Committee, and serving as finance director for a number of Congressional, gubernatorial, and state and local political candidates.

Shari Graham, JD, recently started at the APA on June 19 as the Assistant General Counsel. Before joining APA, Shari was an employment attorney and advisor in Bloomfield Hills, Michigan, responsible for counseling clients on labor and employment issues. Prior to her move to Michigan, Shari worked for Skadden, Arps, Slate, Meagher & Flom, LLP in New York as a litigation associate where she practiced in all areas of commercial litigation with a focus on contracts, real estate, and securities law. Shari has a history of public service including having interned or worked for the Equal Employment Opportunity Commission, Partnership for Public Service, the White House, and B'Nai B'Rith Youth Organization.

Stephanie Auditore joined APA at the end of May following the annual meeting as Director of Member Product Development, Engagement, and Portfolio Management in the Membership Department. Prior to joining APA, Stephanie was at the American Medical Association as the Market Segment Development Manager in the Department of Physician Engagement. At AMA, she managed a fast-growing, web-based medical education resource with over 20,000 users. She was also responsible for identifying new resources and products and creating implementation plans to enhance the AMA's portfolio and value proposition.

As the association moves into 3Q 2015, APA will continue to focus on strategic issues, pursue more partnership opportunities, and continue to serve the needs and enhance the experience of APA members.

Advocacy

The Department of Government Relations (DGR) is actively engaging key Members of Congress on comprehensive mental health reform. On June 4, Representatives Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX) introduced the Helping Families in Mental Health Crisis Act (H.R. 2646), which, among other provisions, contains APA-supported language on growing the psychiatric workforce and enforcing the Mental Health Parity and Addiction Equity Act. DGR continues to engage Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA) on the development of a Senate comprehensive mental health reform bill, which is expected to be introduced next month.

DGR is monitoring the Supreme Court closely for the highly-anticipated decision in *King v. Burwell* -- a decision that may have a major impact on the Affordable Care Act. DGR and Healthcare Systems and Financing (HCSF) are assessing the impact of physician payment reforms passed as part of the SGR. We will be educating members on meeting the new merit base incentive payment systems around meaningful use, clinical practice improvement, and quality measurement. The Administration will be attending a meeting with other medical association CEO's and senior policy staff to discuss these new requirements.

Advancing the Integration of Psychiatry

The APA continues to provide guidance to Centers for Medicare and Medicaid Services (CMS) on recently proposed regulations as to how parity applies to Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs). A formal response to the proposed regulations and a summary of our comments were provided for members.

In addition, the APA submitted comments on the Proposed Rule for stage 3 "meaningful use" (MU) of health information technology (HIT). The comments (posted online) expressed concerns for our members to attest to MU stage 3 requirements stating that the impediments to psychiatrists being able to successfully attest to stage 3 are not attributed only to the unique facets related to the way psychiatry is practiced when compared to other medical specialties, but also factors over which they have little control. These include the extent to which:

- 1) interoperability technology has been established by entities with whom psychiatrists need to communicate,
- 2) patients' ability to access highly sensitive clinical information, which may interfere with the psychotherapeutic process,
- 3) pharmacies' varying abilities to accept e-prescriptions, including controlled substances, and

• 4) general dearth of CEHRT vendors that develop EHRs geared toward behavioral health, which results in psychiatrists selecting EHRs that do not allow for them to use the product "meaningfully" within the scope of the goal of the meaningful use program.

The APA Administration in conjunction with the Work Group on Integrated care is working on a draft policy regarding collaborative care in an effort to utilize it for advocacy purposes.

Supporting Research

In 2013, the APA conducted two studies: National Study of Psychiatric Practice under Healthcare Reform and Medicaid Psychiatric Treatment Access Study. The studies provided APA with an understanding of psychiatrists' readiness to adopt to new models of care as well as the treatment gaps and access issues. Findings in these studies will be valuable to our advocacy efforts as well as provide us with a baseline of empirical data to support advocacy efforts for access to clinically indicated medications and psychosocial treatment for Medicaid psychiatric patients.

Education

The Learning Management System (LMS) is on track for its launch later this summer. In addition to migrating the content that is currently on our LMS, we will be adding new content which is intended to help our members understand the changes in healthcare. We are currently collaborating with the AIMS center at the University of Washington to design a number of modules on Integrated Care. We hope that this will be invaluable to members as we try to understand the shifting landscape.

The APA recently launched the registration page for *IPS: The Mental Health Services Conference.* IPS has always been an incredible meeting, particularly for those interested in community psychiatry. In addition to a great program, I can give you a teaser about a new meeting component we are unveiling called the "innovation zone." This will be a place to talk about new tools, models, and technologies for caring for patients in their home and community settings. More information will be forthcoming, but our members are not going to want to miss this meeting in New York City.

Diversity

Mental Health Needs of American Indians Special Event: The Division of Diversity and Health Equity (DDHE) hosted an ON TOUR program on American Indian mental health on April 30, 2015, in Sioux Falls, South Dakota. The day-long event provided 120 local stakeholders (psychiatrists, psychologists, medical students, social workers, therapists, counselors, nurses, and community leaders) a platform for discussion and dialogue about behavioral health inequities in the American Indian community, their root causes, and necessary efforts to address them. A follow-up video conference to continue to discuss next steps for reducing mental health disparities among American Indians is anticipated as well as evaluating outcomes of the ON TOUR program.

During the annual meeting in Toronto, DDHE organized the first, professionally facilitated *Conversation about Diversity and Health Equity* targeting all APA members to convene a dialogue about the what diversity meant for them and their patients. It was also a time for members to collectively brainstorm initiatives that we as APA members would like to see accomplished with regards to diversity. Over 120 members including resident fellow members and early career psychiatrists attended this event. One theme that resonated was the importance of having ongoing forums like this one to give members an opportunity to voice ideas and concerns to each other. Many remarked that it was the first event that EVERY M/UR caucus was represented. Other themes included inviting the leadership to attend at next year's event to hear the collective voice of the membership. Consistent with the mission of the APA, this event highlights the importance of engaging members on what they want and asking APA leadership and the Administration to help members achieve the goals that are important to APA members and their patients.

The information mentioned above gives brief highlights of our ongoing activities. I look forward to our discussions during the July Board of Trustees meeting.

Advocacy

Item: Comprehensive Mental Health Reform

Chief: Rodger Currie, Chief of Government Affairs

A. <u>Division/Department Head</u>: Rodger Currie

- **B.** <u>Division/Offices Involved</u>: Government Affairs, Policy, Planning, and Partnerships, Communications, and Office of the CEO and Medical Director
- C. <u>Background</u>: The Helping Families in Mental Health Crisis Act (H.R. 2646) was reintroduced in the House of Representatives on June 4, 2015. The bipartisan bill, led by Representatives Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX), builds on last year's effort, which was widely considered to be the most pro-psychiatry piece of legislation introduced in many years. The new version of the bill contains very positive language that, among other objectives, strengthens enforcement of the Mental Health Parity and Addiction Equity Act, focuses on building the next generation of psychiatric physicians, and eliminates the lifetime cap for inpatient psychiatric treatment under Medicare. Meanwhile, Senators Christopher Murphy (D-CT) and Bill Cassidy (R-LA) are developing a comprehensive mental health bill in the U.S. Senate. This package is anticipated to be slightly different from, yet compatible with H.R. 2646.
- D. <u>Staff Action/Response</u>: The APA Administration conducted a thorough analysis of H.R. 2646 in the days following introduction. Upon receiving unanimous support from the Executive Committee, Dr. Binder and Dr. Levin sent a letter of support to Representatives Murphy and Johnson on June 10. The APA Administration will remain deeply engaged with Representatives Murphy and Johnson, and Senators Murphy and Cassidy, in the coming months. These offices are committed to advancing their legislation through their respective committee processes and onto their chamber floors. Representative Murphy has indicated a desire to expedite the process as quickly as possible; the House Energy and Commerce Health Subcommittee has quickly scheduled a hearing on the bill for June 16 where Jeffrey Lieberman, MD, was invited to present on behalf of Columbia University.
- **E.** Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Advocacy

Item: King v. Burwell Supreme Court Case

Chief: Rodger Currie, Chief of Government Affairs

A. <u>Division/Department Head</u>: Rodger Currie

- **B.** <u>Division/Offices Involved</u>: Government Affairs, Policy, Planning, and Partnerships, and Communications
- C. <u>Background</u>: The Supreme Court is expected to render a decision in the King v. Burwell case this month. If the court's majority rules in favor of the plaintiffs, then federal subsidies for insurance premiums under the Affordable Care Act (ACA) would become void in the 34 states that currently rely on the federal exchange. This decision would put the entire ACA's viability in serious jeopardy and place enormous political pressure on the Republican Congress to develop a new alternative for millions of Americans. Further details will be shared as developments warrant.
- **D.** <u>Staff Action/Response</u>: The APA Administration is monitoring the Court closely, as well as reviewing potential proposals being made by Members of Congress as alternatives to the existing ACA mechanisms -- should the Court rule in favor of the plaintiffs.
- **E.** Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Advocacy and Advancing the Integration of Psychiatry

Item: Mental Health Parity Regulations for Coverage Offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs)

Chief: Kristin Kroeger, Chief of Policy, Programs, and Partnerships

A. Division/Department Head: Sam Muszynski, Director

B. <u>Division/Offices Involved</u>: Health Care Systems Financing

- C. <u>Background</u>: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. It applied to only the group commercial insurance market and Medicaid Managed Care Organizations upon its passage. In April 2015, CMS issued these separate proposed rules implementing parity and how parity would apply to MCOs, CHIP, and ABPs. CMS based the substance of the Proposed Rule on what it deemed the differences between the commercial market and Medicaid that necessitate a modified approach
- **D.** <u>Staff Action/Response:</u> The APA developed specific comments to CMS on clarifications and concerns needed within the rule and provided members and DB execs with easy to read takeaways from our comments for their advocacy purposes.

Overall, the Proposed Rule retains the essential requirements of the Final Rule for the commercial structure APA's main concern is that Medicaid beneficiaries should receive the same rights and benefits as those in the private insurance market. The Proposed Rule requires proactive analysis by states, or MCOs in certain circumstances, to determine if their overall delivery system complies with the provisions of the Proposed Rule. APA urged CMS to ensure that the rules require full transparency and public disclosure from states and insurers regarding plan design and the compliance process. APA strongly urged CMS to shorten the compliance time for the states from 18 months to 12 months, providing the argument that states have been aware of the MHPAEA final rules for some time, and they received notice that they must comply with the statute even in the absence of regulatory guidance. APA disagreed with CMS's proposal to exclude all long-term care services from the definition of medical-surgical and MH/SUD services in the Medicaid and CHIP context since there is no analog in the commercial insurance market and recommended that CMS provide a definition of long-term care services that delineates those types of long-term care services that are subject to the parity rule. While the Proposed Rule requires a great deal of transparency and disclosure, APA recommended that CMS clarify many details such as ensuring that enrollees have appropriate access to medical necessity criteria and other plan information. APA also urged CMS to reemphasize that network adequacy is regarded as a non-quantitative treatment limitation under the parity rules and that states be required to provide appropriate documentation of compliance lest beneficiary access be just a promise.

E. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Supporting Advocacy, Advancing the Integration of Psychiatry, Research, and Diversity

Item: Annual Meeting 2015

Chief: Shaun Snyder, Chief Operating Officer

A. <u>Division/Department Head</u>: Cathy Nash, Director

B. <u>Division/Offices Involved</u>: Meetings and Conventions

C. <u>Background</u>: The Annual Meeting was held May 16-20, 2015, in Toronto, Canada. By all accounts, the meeting was very successful. All of the comments heard throughout the week were very favorable. The city was affordable, walkable, and easy to navigate, with all of APA committee meetings held in one hotel only about two blocks from the Convention Center.

The preliminary attendance figures are: professional attendance was just over 9,000 and total attendance (with exhibitors, staff, and press) was approximately 10,800. Comparatively, attendance figures in 2014 (New York) was 14,718/16,517 respectively; 2013 (San Francisco) was 12,241/13,793; and 2012 (Philadelphia) was 9,542/11,114. This year, professional attendance includes approximately 5,100 members and 4,000 nonmembers; of which approximately 1,400 were international members and 2,300 international nonmembers.

The "APA Gives Back," was continued this year in support of the Covenant House Toronto. The program serves as a crisis intervention center and provides residential, non-residential and community support services, pastoral ministry, meals, counseling, health care, and a host of other services. A family practice doctor and a psychiatrist are onsite. Through the generosity of the APA members and other attendees at the Annual Meeting, their donations received amounted to \$17,085.00. The APA matches these donations on a dollar-for-dollar basis, bringing the donation to \$34,170.00, the highest amount donated to date.

There were 94 allied association meetings (82 in 2014), 39 allied pharmaceutical meetings (28 in 2014), 129 component meetings (116 in 2014) and 63 governance meetings (63 in 2014) for a total of 325 ancillary meetings (289 in 2014).

The Opening Session was held on Sunday, May 17, and was attended by approximately 2,000 people. For the fourth year, following the Opening

Session, a special session was held entitled, "Special Conversation with Paul Summergrad, M.D., Helen S. Mayberg, M.D., and The Honorable Patrick Kennedy on Science, Advocacy, and Talking About Mental Health."

The APA was honored to have Nora D. Volkow, M.D., Director of NIDA, deliver the William C. Menninger Memorial Convocation Lecture to an audience of over 2,000. During the 59th Convocation of Distinguished Fellows, awards were presented and over 500 new distinguished fellows were inducted.

- **D.** <u>Staff Action/Response</u>: The Meetings and Conventions Department is in the process of reviewing feedback from the Annual Meeting. The lessons learned from the 2015 meeting will be discussed and applied in 2016.
- **E.** Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Membership

Item: Membership Update

Chief: Jon Fanning, Chief Membership and RFM-ECP Officer

A. <u>Division/Department Head</u>: Susan Kuper, Director of Membership

B. <u>Division/Offices Involved</u>: All departments are involved.

C. <u>Front-Burner Issue Background</u>: Total membership was 36,374 as of January 2015. Since Dr. Levin became Medical Director and CEO, there has been growth in every segment of membership, including a:

- 4.4% increase in total members
- 3.1% increase in dues paying members
- 4.6% increase in RFMs
- 2.3% increase in ECPs
- 26.6% increase in Internationals
- 37.1% Increase in Medical Students

Regarding dues paying members, the percentage increase becomes more important when considering that 179 members became dues exempt in the past 18 months. So the APA (both leaders and the administration) had to recruit 179 new, dues paying members just to get back to o. The APA was able to add substantial more but this highlights a topic of discussion. Excluding medical students, there are now over 6,400 members (18%) that are in dues exempt categories and this number is growing each year.

Regarding international members, membership staff members are paying close attention to the appreciation of the US dollar against other currencies. Over the past year, the US dollar is up roughly 27% against major currencies, which makes joining the APA 27% more expensive for members outside the U.S. This is starting to impact recruitment efforts internationally and we are discussing strategies to mitigate this impact.

D. Staff Action/Response

Recent Initiatives

 A new Find a Psychiatrist was created as: 1) a centralized place for patients to find psychiatrists; 2) an APA member benefit for psychiatrists who are accepting patients, especially ECPs; and 3) to provide a more efficient and timely referral mechanism for individuals seeking psychiatric services. This initiative was mainly driven by an APA Assembly action paper and District Branches who wanted the APA to develop this service. This product was launched April 2, 2015, and currently has 600 subscribers as of June 9, 2015. The District Branches and APA are still working to build participation before it is launched publicly. You can opt-into the database or go to www.finder.psychiatry.org to see the functionality.

- The Administration created an electronic staff directory at the request of Board members and the Assembly. It was added to the "Contact Us" page in May. This page is accessible at the top right on every page of APA's website. We will continue to encourage people to contact the APA Call Center first since it is trained to handle calls and direct members to the correct person.
- The APA again teamed with the Hospital Corporation of America to sponsor two educational sessions at the annual meeting titled "Navigating Contracts: The Business Side of Medicine." The first session, with a capacity of 100, filled in five hours. Therefore, a second event was opened for another 100 residents and quickly filled. This is the second year we have done these sessions and they have been incredibly well received by residents preparing to transition into practice.
- Membership is working cross-functionally with departments throughout the Association to build member value, package that value, and raise awareness among our members while recruiting non-members. This will accelerate with the launch of the new website and LMS in the third quarter of 2015.
- F. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Draft

MINUTES OF A MEETING OF THE APA BOARD OF TRUSTEES

May 17, 2015

Draft Minutes of May 17, 2015 Board Meeting Page 2

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Minutes of a Meeting

APA Board of Trustees

May 17, 2015

Toronto, Ontario, Canada

SECTION 1. CALL TO ORDER

Dr. Paul Summergrad, APA President, called the May meeting of the Board of Trustees to order at 2:00 p.m., Sunday, May 17, 2015, at the Toronto Convention Centre. Dr. Summergrad welcomed Board members, guests, and staff to the meeting.

A. <u>Introductions and Verbal Conflict of Interest Disclosures</u>

Board of Trustees

Dr. Summergrad asked each voting member of the Board to state his or her name and then disclose their source(s) of income as well as any potential conflicts of interest.

- Paul Summergrad, MD, President receives income from Tufts University School of Medicine through Tufts Medical Center Physicians Organization; Past President of the American Association of Chairs of Departments of Psychiatry; receives modest stipend for forensic work; receives an APA stipend as President.
- Renée Binder, MD, President-Elect receives income from the University of California; Professor of Psychiatry at the University of California San Francisco; receives an APA stipend as President-Elect.
- Frank Brown, MD, Treasurer receives income from the Emory Clinic in Atlanta, Georgia; serves as Vice President of the American College of Psychiatrists.
- Maria A. Oquendo, MD, Secretary receives income from New York State Psychiatric Institute and Columbia University; receives income from private practice; receives royalties for a suicide rating scale; receives unrestricted educational grants for training; husband is an employee of Bristol-Myers-Squibb.
- Jenny L. Boyer, MD, PhD, JD, Speaker receives income from the Veterans Administration; receives income from two pensions, one from the State of Oklahoma and one from the Federal government; receives an APA stipend as Speaker.
- Glenn Martin, MD, Speaker-Elect receives income from the Icahn School of Medicine at Mt. Sinai; receives income from private practice; receives an APA stipend as Speaker-Elect; Medical Director of Information Exchange in Queens.
- Dilip Jeste, MD, Trustee– receives income as full time faculty at University of California San Diego; receives honorarium as Editor of *American Journal of Geriatric Psychiatry*; Board of Regents of the American College of Psychiatrists.
- John M. Oldham, MD, Trustee– receives income from Baylor College of Medicine; Chiefof-Staff of Menninger Clinic; receives small editorial fees as Editor of the *Journal* of *Psychiatric Practice*; President of the American College of Psychiatrists (uncompensated).
- Vivian B. Pender, MD, Area 2 Trustee receives income from private practice; consulting for the United Nations; on the voluntary faculty at Cornell.
- Brian Crowley, MD, Area 3 Trustee receives income from private practice.
- Judith F. Kashtan, MD, Area 4 Trustee receives income from private practice; on the clinical faculty of the University of Minnesota.
- R. Scott Benson, MD, Area 5 Trustee receives income from private practice in child and adolescent psychiatry; forensic psychiatry in Pensacola, Florida.
- Melinda Young, MD, Area 6 Trustee receives income from private practice.

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- Molly K. McVoy, MD, ECP Trustee-at-Large receives income from Case Western and University Hospitals of Cleveland: royalties from book sales with APA Publishing: serves on APP Editorial Board.
- Gail E. Robinson, MD, M/UR Trustee receives income from the University of Toronto, Professor of Psychiatry, single payer health system, and some expert witness
- Lara J. Cox, MD, Resident-Fellow Member Trustee receives income from NYU; receives income from moonlighting through NYU Gracie Square Hospital and Lennox Hill Hospital.
- Ravi N. Shah, MD, MBA, Resident-Fellow Member Trustee-Elect receives income from New York Presbyterian Columbia, New York State Psychiatric Institute.

Administration:

Saul Levin, MD, MPA, APA CEO and Medical Director - receives income from the APA Tristan Gorrindo, MD, Director of Education- receives income from the APA; no conflicts. Ranna Parekh, MD, MPH, Director of Diversity and Health Equity - receives income from the APA; no conflicts.

Board Guests:

Altha J. Stewart, MD, Secretary (2015-2016) Daniel Anzia, MD, Speaker-Elect (2015-2016) Lama Bazzi, MD, ECP Trustee-at-Large (2015-2016) Ronald M. Burd, MD, Area 4 Trustee (2015-2016) Stella Cai, MD, Resident-Fellow Member Trustee-Elect (2015-2016) Raj Loungani, MD, APA Public Psychiatry Fellow (2015-2016) Uchenna Achebe, MD, APA/SAMHSA/Diversity Leadership Fellow (2015-2016) Misty C. Richards, MD. APA/Leadership Fellow (2015-2016) Marcia Goin, MD, APA Past President Richard Harding, MD, APA Past President John McIntvre, MD, APA Past President Rodrigo Munoz, MD, APA Past President Carol Nadelson, MD, APA Past President Herbert Pardes, MD, APA Past President Michelle Riba, MD, APA Past President Carolyn Robinowitz, MD, APA Past President Pedro Ruiz, MD, APA Past President Steven Sharfstein, MD, APA Past President Allan Talbott, MD, APA Past President

B. Welcome David O. Barbe, MD, MHA, Past Chair, AMA Board of Trustees

Dr. Barbe stated that it was a great opportunity to address the Assembly and the Board of Trustees at the Annual Meeting and given that opportunity, it is extremely valuable in continuing to strengthen the connection between the APA and AMA. He indicated that APA and AMA may not always agree on every issue, but it is important that both agree on larger issues that affect the profession and speak with one voice when advocating to congress. As an example, he noted the close collaboration of APA and AMA on an important issue - bringing an end to the flawed Medicare Sustainable Growth Rate (SGR) formula with the passage of H.R.2, the Medicare Access and CHIP Reauthorization Act. He said this only happened with the strong unified voice of the House of Medicine.

SECTION 2. CONSENT CALENDAR

A. Requests to Remove Items from the Consent Calendar

No items were removed from the Consent Calendar.

B. Approval of Items on the Consent Calendar

Dr. Summergrad presented the Consent Calendar to the Board.

The Board of Trustees voted to approve the Consent Calendar.

SECTION 3. REPORT OF THE PRESIDENT

Paul Summergrad, M.D.

A. Sunsetting of Completed Ad Hoc Work Groups

The following action was approved on the Consent Calendar.

The Board of Trustees voted to sunset, with appreciation, the following Board Ad Hoc Work Groups which have completed their charge:

- Board Ad Hoc Work Group on APA Referendum Voting Procedures
- Board Ad Hoc Committee on APA Research Review
- Board Ad Hoc Work Group on ECP Membership
- Board Ad Hoc Work Group on Education and Training
- Board Ad Hoc Work Group on International Psychiatrists
- Board Ad Hoc Work Group on Liability
- Board Ad Hoc Work Group on Strategic Planning

B. Continued Ad Hoc Work Groups

The following action was approved on the Consent Calendar.

The Board of Trustee voted to continue the following Board Ad Hoc Work Groups until they have completed their charge:

- Board Ad Hoc Work Group on Revise the Ethics Annotations
- Board Ad Hoc Work Group on Health Care Reform (report by October 2015 BOT Meeting)
- Board Ad Hoc Committee on Real Estate (report by July 2015 BOT Meeting)
- Board Ad Hoc Work Group on Telepsychiatry

C. <u>Executive Committee Report</u>

This report was presented for review and appropriate action.

The Executive Committee held two votes by expedited actions since the March 14-15, 2015 Board of Trustees meeting.

The Executive Committee approved the following action on April 27:

The APA Board Executive Committee voted to approve the request to change the American Psychiatric Foundation name to the American Psychiatric Association Foundation, and approved asking the APAF to amend its bylaws accordingly.

The Executive Committee approved the following action on April 7:

The Board of Trustees Executive Committee voted to approve a motion to submit the APA resource document, *Ketamine and Other NMDA Antagonists for the Treatment of Depression: Systematic Review and Meta-Analysis*, to the *American Journal of Psychiatry* for possible publication, subject to the normal peer review processes of that journal.

The Board of Trustees held a conference call on March 22, 2015 and approved the following action:

The Board of Trustees voted to approve the recommendations of the Ad Hoc Work Group on Real Estate that the APA proceed with the purchase of 800 Maine Avenue, SW, Washington, DC ("The Wharf") upon terms substantially similar to those in the letter of intent if due diligence does not unveil any significant problems with leave for the APA Administration to work with the real estate consultants and legal counsel to finalize the details of this purchase and financing and for the Board of Trustees to approve final purchase documents.

SECTION 4. REPORT OF THE CEO and MEDICAL DIRECTOR

Saul Levin, M.D., MPA

Dr. Levin thanked the Board for their guidance this past year, allowing him to seek their counsel and continuing a frank and open dialog with him. He also thanked his administration for their hard work throughout this past year and introduced some of the new administration to the Board. He told the Board that, after a thorough internal organizational analysis, he has completed the internal administrative reorganization of APA. He then outlined the Administration's actions, activities, and accomplishments.

SECTION 5. REPORT OF THE SECRETARY

Maria A. Oquendo, M.D.

A. Minutes of the March 14-15, 2015 Board of Trustees Meeting

The minutes of the March 2015 Board Meeting were approved on the Consent Calendar.

The Board of Trustees voted to approve the minutes of its March 14-15, 2015 meeting.

B. <u>Secretary's Report</u>

Dr. Oquendo provided her written report to the Board, noting that she had already shared it with the Assembly and members at the Annual Business Meeting.

SECTION 6. REPORT OF THE TREASURER

Frank Brown, M.D.

A. <u>Treasurer's Report</u>

Dr. Brown provided his written report to the Board.

B. Status of the Board of Trustees Contingency Fund

A written status report of the Board Contingency Fund was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Board of Trustees Contingency Fund.

C. Status of the Presidential New Initiative Funds

A written status report of the Presidential New Initiative Funds was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Presidential New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder.

D. Status of the Assembly New Initiative Fund

A written status report of the Assembly New Initiative Fund was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Assembly New Initiative Fund.

SECTION 7. REPORT OF THE SPEAKER

Jenny Boyer, MD, PhD, JD

A. Annual Report of the Speaker

Dr. Boyer provided a written report to the Board, noting that she had already shared it with the Assembly and members at the Annual Business Meeting.

SECTION 8. INFORMATIONAL ITEMS

A. Component Appointment Tenure Waivers for the 2015-2016 Appointment Year

Dr. Renée Binder, APA President-Elect, informed the Board of Trustees of the appointment waivers for the 2015-2016 appointment year.

- Council on Psychiatry and Law
 - Paul Appelbaum, MD was reappointed as a corresponding member of the Council on Psychiatry and Law for an additional one year term bringing Dr. Appelbaum's total tenure as a corresponding member on the Council on Psychiatry and Law to five years. (2011-2016)
- Committee on Judicial Action
 - Alan Stone, MD was reappointed as a consultant of the Committee on Judicial Action for an additional one year term bringing Dr. Stone's total tenure as a consultant on the Committee on Judicial Action to five years. (2011-2016)
- Membership Committee
 - Kenneth Busch, MD was reappointed as a corresponding member of the Membership Committee for an additional one year term bringing Dr. Busch's total tenure as a corresponding member on the Committee to seven years. (2009-2016)

Administrative Waivers – To maintain staggered tenures

- Committee on Psychiatric Dimensions of Disasters
 - Robert Ursano, MD was reappointed as a member of the Committee on Psychiatric Dimensions of Disasters for an additional three year term bringing Dr. Ursano's total tenure as a member to eight years (2010-2018). This is two years longer than the usual terms. Doing so maintains the staggered tenures on the committee.
- Blanche F Ittleson Research Award Committee
 - Daniel Pine, MD was reappointed as a member of the Blanche F Ittelson Research Award Committee for an additional three year term bringing Dr. Pine's total tenure as a member to eight years (2010-2018). This is two years longer than usual. Doing so, maintains the staggered tenures on the committee

SECTION 9. UNFINISHED BUSINESS

No unfinished business was introduced to the Board.

SECTION 10. NEW BUSINESS

No new business was introduced to the Board.

SECTION 11. CEREMONIAL PROCEEDINGS

- Dr. Summergrad recognized and thanked those members of the Board who were leaving office. Dr. Summergrad also thanked the Board of Trustees and the APA Administration for their
- excellent work throughout the year.
- Dr. Herbert Pardes presented the Past President's Badge to Dr. Summergrad. He commended Dr. Summergrad for his remarkable job as President of the APA.
- Dr. Summergrad presented the Presidential Medallion, President's Gavel and letters of recognition from Members of Congress to Dr. Renée Binder, incoming President. Dr. Summergrad wished Dr. Binder well during her presidential year. In turn, Dr. Binder thanked Dr. Summergrad for his dedication to APA. She then welcomed the 2015-2016 Board of Trustees members and stated that she is looking forward to serving her term as President.

SECTION 12. ADJOURNMENT

Dr. Summergrad adjourned the meeting of the Board of Trustees at 3:00 pm, Sunday, May 17, 2015. The next meeting of the Board will be July 11-12, 2015 at the Westin Arlington Gateway in Arlington, VA.

AMERICAN PSYCHIATRIC ASSOCIATION BOARD OF TRUSTEES

SUMMARY OF ACTIONS Draft

Toronto Convention Centre May 17, 2015

Agenda Item #	<u>Title/Action</u>	Office/Component Responsible for Follow-up
2.A	Requests to Remove Items from the Consent Calendar No items 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
3.B	 Report of the President The Board of Trustee voted to sunset, with appreciation, the following Board Ad Hoc Work Groups which have completed their charge: [cc] Board Ad Hoc Work Group on APA Referendum Voting Procedures Board Ad Hoc Committee on APA Research Review Board Ad Hoc Work Group on ECP Membership Board Ad Hoc Work Group on Education and Training Board Ad Hoc Work Group on International Psychiatrists Board Ad Hoc Work Group on Liability Board Ad Hoc Work Group on Strategic Planning 	Chief Operating Officer • Association Governance

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Page 10		
Agenda Item #	<u>Title/Action</u>	Office/Component Responsible for Follow-up
3.C	Report of the President	Chief Operating Officer
	The Board of Trustee voted to continue the following Board Ad Hoc Work Groups until they have completed their charge: [cc]	Association Governance
	 Board Ad Hoc Work Group on Revise the Ethics Annotations Board Ad Hoc Work Group on Health Care Reform (report by October 2015 BOT Meeting) Board Ad Hoc Committee on Real Estate (report by July 2015 BOT Meeting) 	
	Board Ad Hoc Work Group on Telepsychiatry	
5.A	Minutes of the March 14-15, 2015 Board of Trustees	Chief Operating Officer
J.A	Meeting	Association Governance
	The Board of Trustees voted to approve the minutes of its March 14-15, 2015 meeting. [cc]	
6.B	Status of the Board Contingency Fund	Chief Financial Officer and
		 Finance & Business
	The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. [cc]	Operations
		Chief Operating Officer
		Association Governance
6.C	Presidential New Initiative Fund	Chief Financial Officer and
	The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr.	• Finance & Business Operations
	Lieberman, Dr. Summergrad, and Dr. Binder. [cc]	Chief Operating Officer
	Bicociman, Br. Summergrad, and Br. Binder. [cc]	Association Governance
6.D	Assembly New Initiative Fund	Chief Financial Officer and
	The Board of Trustees voted to accept the report of the status of the Assembly's New Initiative Fund. [cc]	• Finance & Business Operations
		Chief Operating Officer
		Association Governance

American Psychiatric Association

Treasurer's Report

For the Five Months Ended

May 31, 2015

The financial summary that follows is for the five months ended May 31, 2015. After 5 months net income is \$13.8 million compared to an annual budget of negative \$3.2 million. At the same time last year the net income was \$18.1 million. We have completed 42% of the year. However, unlike many organizations, our income and expense streams are not straight line so each category was not expected to be at 42%.

Membership revenue is \$10 million, 83% of budget compared to \$9.6 million in 2014.

Non DSM publishing is right on target at \$6.7 million. DSM revenue is 25% of the annual budget and less than half of the amount for 2014 at the same time.

CME, while less than last year, is at 83% of budget.

Total revenue is at 57% of budget and \$7 million less than the amount at the same time last year.

Program expenses are all below budget with DSM at 18% of budget while at 25% of revenue.

Most operations expenses are below budget.

The balance sheet remains strong with the only material change the increase in net assets because of the increase in net income.

American Psychiatric Association Statement of Activities For the Five Months Ended May 31, 2015

14	in	th	~	ısa	no	le l

(\$	s in thousands)			
	May 2014 YTD Actual	May 2015 YTD Actual	2015 Annual Budget	42% % of Budget YTD Actual
UNRESTRICTED REVENUE:				
Membership				
Membership Dues	\$8,090	\$8,041	\$9,765	82%
Insurance Program	1,125	1,545	1,500	103%
Membership Affinity Programs APA Job Bank	51 224	49 364	95 700	52% 52%
APA Store	6	00.	-	n/a
List Sales	41	51	60	85%
Board Funds	110	40.050	-	<u>n/a</u>
Membership Subtotal	9,647	10,050	12,120	83%
Advocacy Subtotal	22	4	24	17%
Communications Subtotal Publishing Subtotal	7,229	6,743	15,691	n/a 43%
DSM	7,229	0,743	13,091	4370
DSM IV	62	52	-	n/a
DSM 5	7,333	3,010	11,900	<u>25</u> %
DSM Subtotal	7,395	3,062	11,900	26%
Continuing Medical Education	10.005	7,854	7 005	98%
Annual Meeting CME Products and Accreditation	10,095 313	108	7,995 415	26%
Institute on Psychiatric Services	-	-	482	0%
Focus Journal	490	487	1,336	36%
Continuing Medical Education Subtotal	10,898	8,449	10,228	83%
Research Subtotal	40	35	107	33%
Other Income Subtotal	1	7	5	140%
Total Unrestricted Revenue	35,247	28,354	50,075	57%
UNRESTRICTED EXPENSES:				
Membership Direct Expenses Subtotal	1,055	1,110	2,902	38%
Advocacy Subtotal Communications Subtotal	817 526	999 699	3,273 1,940	31% 36%
Publishing Subtotal	2,525	2,464	6,826	36%
Publishing Overhead Subtotal	2,094	1,934	5,409	36%
DSM Subtotal	2,111	868	4,706	18%
Continuing Medical Education Subtotal Policy, Programs, and Partnerships Subtotal	1,869 1,723	1,313 1,568	5,422 5,964	24% 26%
Operations				
Division of Operations	220	158	487	32%
APA Answer Center Human Resources	58 412	48 545	151 645	32% 84%
Information Technology	1,039	1,245	3,655	34%
Association Mgmt System	94	9	253	4%
Association Governance Office	324	323	851	38%
Operations Subtotal	2,147	2,328	6,042	39%
Foundation Subtotal Administration Subtotal	181 3,157	175 3,012	419 8,305	42% 36%
	3,137	3,012	0,303	30 /6
Organization-Wide Expenses		505	710	740/
General APA Overhead	262 (734)	505 (610)	710 (1,543)	71% 40%
Recovered OH Costs	(10)	-	(17)	0%
Organization-Wide Expenses Subtotal	(482)	(105)	(850)	12%
Governance & Components Expenses Subtotal	784	565	2,858	20%
Total Unrestricted Expenses	18,507	16,930	53,216	32%
Unrestricted Operating Net Income/(Loss)	16,740	11,424	(3,141)	-364%
Total Temp Restricted Revenue Total Temp Restricted Expenses	42 49	57 19	150 215	38% 9%
Temp Restricted Net Income/(Loss)	(7)	38	(65)	-58%
NON-OPERATING ACTIVITY:				
Investment Income - LT	1,382	2,455	85	
Investment Income - ST Less: Portfolio Management Fees	2 (14)	2 (26)	(85)	n/a 31%
Non-Operating Income/(Loss)	1,370	2,431	- (65)	n/a
Income Statement Summary				
Unrestricted Operating Net Income/(Loss)	16,740	11,424	(3,141)	
Temp Restricted Net Income/(Loss)	(7)	38	(65)	
Non-Operating Income/(Loss)	1,370	2,431		
Total Net Income (Loss)	18,103	13,893	(3,206)	
rotal fret modifie (LUSS)	10,103	10,033	(3,200)	

Status of the Board Contingency Fund

ACTION:

Will the Board of Trustees vote to accept the report of the status for the Board Contingency Fund?

Status of Board of Trustee's Contingency Fund as of May 31, 2015

2015 Approved Budget \$ 25,000.00

Less: Expenses paid as of May 31, 2015 1,490.89

Unspent Budget as of May 31, 2015 \$ 23,509.11

Item BOT 6.B Board of Trustees July 11 - 12, 2015

Status of the President's New Initiative Funds

A President's New Initiative Fund is established for each President-Elect in the amount of \$25,000. This amount is available for a three year period starting with the term as President-Elect and ending with the completion of the term as Immediate Past President. Any spending requires the approval of the Executive Committee of the Board.

ACTION:

Will the Board of Trustees vote to accept the report of the status for the President's New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder?

Status of the President's New Initiative for Dr. Lieberman's Fund as of May 31, 2015

Approved Budget	\$ 25,000.00
Less: Expenses paid as of May 31, 2015	25,000.00
Unspent Budget as of May 31, 2015	\$
Status of the President's New Initiative for Dr. Summergrad's Fund as of May 31, 2015	
Approved Budget	\$ 25,000.00
Less: Expenses paid as of May 31, 2015	-
Unspent Budget as of May 31, 2015	\$ 25,000.00
Status of the President's New Initiative for Dr. Binder's Fund as of May 31, 2015	
Approved Budget	\$ 25,000.00
Less: Expenses paid as of May 31, 2015	-
Unspent Budget as of May 31, 2015	\$ 25,000.00

Status of the Assembly's New Initiative Fund

The Assembly's New Initiative Fund is established with no carry over of unspent amounts. Any spending requires the approval of the Assembly.

ACTION:

Will the Board of Trustees vote to accept the report of the status for the Assembly's New Initiative Fund?

Status of the Assembly's New Initiative Fund as of May 31, 2015

2015 Approved Budget \$ 25,000.00

Less: Expenses paid as of May 31, 2015

Unspent Budget as of May 31, 2015 \$ 25,000.00

Report of the Membership Committee to the APA Board of Trustees

Membership Committee Meeting May 18, 2014 Toronto, Ontario, Canada

PRESENT: Members: Drs. Rahn K. Bailey, Chairperson, William Arroyo, Vice-Chairperson, Carol A. Bernstein, Ana E. Campo, Kimberly Gordon, Elizabeth Morrison, Emily S. Stein, Megan Testa; Corresponding Member: Dr. Kenneth Busch; Consultants: Ms. Teri Harnisch, Ms. Robin Huffman, Dr. David Safani; Guests: Drs. Frank Clark, Annette Matthews and Ms. Sara Stramel-Brewer; Staff: Susan Kuper, Trang Smith, Jon Fanning

Unable to Attend: Drs. Jonathan Amiel, Nioaka N. Campbell, Karon Dawkins, Joseph Rubin, Vihang Vahia

Opening Remarks

Dr. Bailey opened the meeting by thanking the committee members for their continued work on committee activities during conference calls and email discussions throughout the year. He also acknowledged the contributions of those committee members whose tenure expired at the end of the Annual Meeting and thanked them for their contributions (Drs. Nioaka Campbell, Ana Campo, Vihang Vahia, and Ms. Robin Huffman).

The Membership Committee reviewed and discussed the information provided in the report below and makes several recommendations to the Board of Trustees.

Membership Activity in 2015

There has been growth in all major membership areas since January 1, 2015, as noted below:

	Jan 2015	May 2015	Change Since Jan
Mbrs Dues-Paying Categories	27,869	28 , 807	3.4%
Mbrs Non-Dues Categories	8,505	8,931	5.0%
Total Members	36,374	37,738	3.7%
RFMs	4,546	4 , 873	7.2%
ECPs	4,142	4,315	4.2%
Internationals	2,045	2,251	10.1%
Medical Students	1, 997	2,498	25.1%

There has also been growth in most member segments when comparing the May 2015 membership counts with May 2014, as noted below:

	May 2014	May 2015	Annual Change
Mbrs Dues-Paying Categories	28 , 650	28,807	0.5%
Mbrs Non-Dues Categories	8,252	8,931	8.2%
Total Members	36,902	37,738	2.3%
RFMs	4,830	4,873	0.9%
ECPs	4,426	4,315	-2.5%
Internationals	2,150	2,251	4.7%
Medical Students	2,026	2,498	23.3%

Attachment A shows an annual comparison of dues-paying and dues-exempt membership categories from January 2004 through January 2015, as well as monthly comparisons in 2015 through May. Attachment B shows gains and losses by membership class for all membership transactions in the month of May 2015, as well as year-to-date totals. This includes new members, reinstatements, drops, resignations, deceased members, as well as changes from one membership category to another (i.e., Resident-Fellow Member to General Member advancements or Life Member to Inactive Member status).

2015 Dues Drop Retention Efforts

Retention efforts started in March with the 4th email reminder and print invoice mailing since October 2014) reminding members of the June 30 payment deadline. Members must *either* pay dues in full *or* enroll in the Scheduled Payment Plan by June 30 to avoid being dropped. Members who pay dues with employer funds from a budget year that begins July 1 or later must notify the Membership office to avoid a lapse in membership.

In mid-April, the annual DB/SA Member Retention campaign kits were sent to all district branches, along with a request to engage local leadership in an effort to contact all members who have not yet paid dues and are at risk of being dropped. The campaign kit included:

- Pending Drop Roster separate attachment with a list of names, contact information, and amount owed for members in arrears for their 2015 membership dues. The names are also listed under the APA and DB Drops section of the Membership Activity Reports which are updated and sent biweekly.
- Membership Department timeline for retention efforts
- Suggestions for organizing a district branch/state society calling campaign
- Speaking points, steps, and a script for members calling members
- Overview of APA Membership Benefits
- Frequently Asked Questions about the dues and APA
- Dues Payment Options form
- Response Tracking Form
- Form to document DB retention efforts

Attachment C shows the Counts of Pending Drops by Area and District Branch through June 3, 2015. The average percentage of district branch members still owing dues is 16.6%. Some district branches have a percentage as low as 8-12%, whereas others are averaging 20% or more.

Throughout the dues cycle which begins in October, three months before the start of the dues year, members receive numerous dues statements and reminders to pay dues. By April, members have been sent at least three print notices and at least three email reminders. The 5th reminder email blast and print invoice mailing were sent in May. A special message highlighting the June 30 deadline was imprinted on the outer envelope of the invoice mailings sent in May. A national calling program began on June 10 with Inalink, the vendor that's been used for the past two years and a company that has extensive experience calling members in medical societies about membership renewal. Membership Department employees wrote the script and provided information about the unpaid members. A full report will be provided at the conclusion of the national calling program.

The June issue of AJP included a cover tip highlighting "This is Your Last Issue" for members that had not paid dues by mid-May when the mailing lists were provided to the printer. A new web banner was created for the website highlighting the June 30 payment deadline and notices have also been running in the weekly member PN e-newsletter. Two emails will be sent in June, including a "last chance" email on June 29 and payments will continue to be processed through July 8 when the drop action will be finalized.

The total number of members still owing dues is approximately 8.5% higher than last year at this time (4,674 in 2015 compared to 4,311 in 2014).

Dues Owed	2015 Dues	2014 Dues	Change 2014-2015
	6/12/2015	6/9/2014	
APA & DB/SA	3,980	3,844	+136
Non-Centralized Billing DB Only	142	188	-46
International	552	279	+273
Total	4,674	4,311	+363

Retention efforts will continue beyond the June 30 payment deadline; the administrative reinstatement period extends until the end of the year. A list of 4,532 members who have not paid dues as of June 12, 2015, is presented in Attachment G for drop action in the Membership Processing action items section below. A list of 142 members who have not paid local dues as of June 12 (to district branches that bill and collect dues separately from APA), is presented in Attachment H for drop action.

District Branch/State Association Grants Expedited Grants

The committee agreed to use \$150K of the \$180K approved for the District Branch/State Association Grant process for "expedited" grant requests. The committee also agreed to award these funds for initiatives involving membership recruitment, ECP or other member segment retention, health care

reform, integrated care, or other educational activities conducted before July 31, 2016. All DBs will be awarded the same amount.

Attachment D is a list of all district branches and state associations that requested a DB Grant with the project type and use of funds noted. There are a total of 56 requests as follows:

- 7 Early Career Psychiatrist (ECP) Retention Initiative
- 7 Other Membership Retention Initiative
- 11 Membership Recruitment Initiative
- 1 Health Care Reform/Affordable Care Act Educational Activity
- 30 Miscellaneous Education Activity
- 56 Total Requests

With 56 total requests, the Membership Committee recommends that each DB/SA be awarded \$2,678 (total \$149,968).

Will the Board of Trustees approve a recommendation from the Membership Committee to award \$2,678 to each district branch or state association listed in Attachment D as part of the DB/SA Grant process?

Innovative Grants

The announcement for the DB/SA Innovative Grants was made in mid-June. There is \$30,000 budgeted for innovative grant requests with the maximum allowable funding amount set at \$10,000. The grant requests are due August 1 and will be reviewed and evaluated by the committee prior to the fall meeting. Recommendations from the committee will be made to the Board of Trustees in December.

DB/SA Membership Chairs

The Membership Committee sponsored a special meeting for district branch membership chairs during the Annual Meeting for the fourth consecutive year. The meeting was facilitated by Elizabeth Morrison, M.D., a member of the committee. There were representatives from 32 DB/SAs, including 25 staff and 16 members. Daniel Yohanna, M.D., Chair, Illinois Psychiatric Society Retention and Recruitment Committee, gave an informative presentation about a creative way to attract residents and early career psychiatrists to a mentoring event by offering a "speed mentoring" opportunity. The district branch invited up to 16 RFMs and ECPs (mentees) on a first-come first served basis to meet with 8 mentors one on one during an evening program. One of the mentees and one of the mentors participated via Skype. During the time when the mentees were not meeting with mentors, there was an informal session with a consultant who discussed effective communication techniques and tips for interviewing with prospective employers; food was also provided. Through survey results the event was deemed a success and the DB has ideas about how the event can be improved for next time. The DB Membership Chairs and DB staff expressed a lot of interest in this program and several people noted that it was something they may try in their own DB. APA Membership staff provided information on upcoming membership promotions and how the DB/SAs can get involved. Most of the meeting was an open forum for attendees to discuss and share ideas about membership recruitment and retention. A summary of the meeting will be posted on the DB Membership Chairs listserv.

Group Membership Discounts

Jon Fanning, Chief of Membership & RFM-ECP Officer, presented a proposal about group memberships for the committee's consideration. The proposal stems from interest that has been expressed by international associations to achieve a discount to offer to their members to incentivize them to become members of the APA. Moreover, health care systems in the US, including Pine Rest and HCA, have expressed an interest in funding their employed physicians to become members of the APA if they could obtain a group discount.

The Membership Committee discussed the pros and cons of offering group discounts. The cons included concerns about HCA's business practice, whether the psychiatrists would continue membership on their own if they leave the group, if APA has a lot of employed psychiatrists as members, will they have more influence over APA policy, and the potential alienation of private practitioners. The pros noted were that employed psychiatrists tend not to belong to APA, so there's a potential to increase membership numbers and dues revenue by offering group discounts to employers. Ultimately, the committee agreed to support the proposal, though they recommended getting the input of other groups and expressing some of the concerns outlined above to the Board of Trustees.

International Psychiatry Society Group Membership Discounts

The committee reviewed a proposal to offer a membership dues discount to members of the South African Society of Psychiatrists (SASOP) and other associations who may express an interest. APA currently has 11 of the 550 members of the SASOP. In addition to the discount, SASOP is also considering subsidizing a percentage of the individual members' annual APA dues. The Membership Committee was supportive of the proposal and approved a recommendation that the Chief of Membership & RFM-ECP Officer move forward with finalizing an agreement with SASOP (and several other international societies that have expressed an interest) as a two year pilot project with the understanding that the discounted scale in the proposal is to be used as a guide and a ceiling. At the end of the pilot period, the outcomes must be evaluated and recommendations made as to whether to continue or discontinue with the program. The committee was supportive of this effort with the understanding that the Board will need to approve.

International RFM Category

The committee discussed the concerns noted by the Board of Trustees at its December 2014 meeting when the recommendation to create a new membership category for international psychiatry residents was introduced. The primary issue raised by the Board is that some countries do not have an accrediting organization for residency training programs that is similar to the ACGME and as a result the quality of training varies throughout the world. One Board member questioned why ten years was given as the length of time one could remain in the category. The Membership Committee noted that the length of time required to train varies and at least two medical societies allow international residents to be in the category for up to ten years. The committee agreed that an international resident should be permitted to remain in the category for the number of years required to complete training. This would be determined individually for each applicant based on the training information provided at the time of application. The committee also agreed that a letter from the residency training program verifying that the resident is in training and confirming the dates of training should be required when submitting the membership application. Dr. Busch, a member of the Council on International Psychiatry, noted that creating a membership category for international psychiatry residents is a high priority for the Council. At the Annual Meeting in New York, there were nearly 500 international psychiatry residents in

attendance (figures not yet available for the Toronto meeting), so there is a lot of potential to grow membership in this area.

Will the Board of Trustees approve the recommendation of the Membership Committee to establish a new category of membership, 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.

Remarks from Dr. Levin

Dr. Saul Levin, CEO & Medical Director, met briefly with the Membership Committee to thank them for their ongoing work on behalf of the organization. He specifically acknowledged improvements to the APA dues payment policies as well as their support for more recent ideas, such as how to work with various groups (e.g., employers, international societies) in ways that will be mutually beneficial to all parties. There was a brief question and answer session followed by the committee expressing appreciation for Dr. Levin's visit.

Distinguished Fellowship Guidelines

The Distinguished Fellowship Guidelines Work Group, chaired by David Safani, M.D., met twice by conference call during the spring. The primary objectives are to: 1) provide a clear explanation of what the committee is looking for in each of the ten categories to ensure the applicant has a good understanding of how to document his/her activities and accomplishments, and 2) standardize the scoring for reviewers. The work group clarified wording in most of the categories and detailed examples of activities for each category that should be provided to the applicant. They also discussed ways to improve the actual form itself to make it easier for the applicant to document their work. The work group will continue its discussions over the summer and will bring drafts of revised guidelines, listing of examples for each category, and a revised nomination form for the committee to review at its fall meeting.

Reduced Dues for Part-time Practitioners and Retirees

The committee reviewed the report of the BOT and ASM Ad Hoc Work Group on Minority and Underrepresented Groups' Issues to the Board of Trustees. One of the recommendations was a request for the APA Membership Committee to consider establishment of a membership option for part-time psychiatrists. Many questions and concerns were raised during the discussion, including whether such an option should be time limited, how would it be monitored, what about the DB/SA dues, whether members with several part-time jobs-would be eligible, some psychiatrists working part-time in private practice may earn more than full-time salaried psychiatrists, etc. The committee also received a request from a district branch to clarify policies and procedures regarding eligibility for Permanent Inactive status (no age requirement) and the dues discount for retired members (must be 70 years old).

The committee recommended that the work group be charged with looking into dues options for part-time psychiatrists, Permanent Inactive status and dues relief options related to other issues, i.e., re-visit the current dues relief criteria. The work group members are: Elizabeth Morrison, M.D. (Chair), Frank Clark, M.D., Kimberly Gordon, M.D., Teri Harnisch, and Annette Matthews, M.D. They will meet during the summer and bring feedback and possible recommendations to the fall meeting.

MPS Ethics Committee Request

The Maryland Psychiatric Society Ethics Committee sent a letter to the Chairs of the APA Membership Committee and Ethics Committee requesting the APA to clarify procedures for district branches to use in reaching a decision on whether to admit members who note prior ethics issues on their membership applications. MPS recently had two applicants who answered yes to at least one of the three ethics questions on the application form. Both had fulfilled their obligations to the state medical boards and each had a current valid medical license. As noted in the APA Operations Manual, in chapter 5D under the section for election to membership, "The criteria used to determine ethical and professional suitability for election to membership, promotion to more advanced membership class, or transfer to another district branch, shall be defined as: 1) an applicant's professional activities meet the standards of responsible psychiatric practice as defined by the local district branch; 2) any physical or emotional impairment an applicant has does not significantly affect his/her ability to fulfill professional responsibilities, as determined by the local district branch." The committee agreed that APA Operations Manual clearly outlines the requirements for membership and that this is an issue for the district branch to resolve since the DB defines its own standards of responsible psychiatric practice.

ECP Retention

The committee reviewed a request from an ECP member to develop an educational and mentoring program for ECPs and RFMs to teach them how to avoid burnout and improve job satisfaction. The member recommended specifically appointing a DB Executive on the Membership Committee to be the point person to develop and promote the program. The committee liked the concept behind the proposal and agrees that such a program could offer value to our most vulnerable member segments, RFMs and ECPs. However, they recommended that this proposal be forwarded to Mr. Fanning for further review and consideration as this idea is not something a committee member could implement on his or her own.

2015 Membership Recruitment and Retention Activities

Medical Students

A recruitment mailing was sent in January to 5,904 American Medical Student Association (AMSA) members who are in their last two years of medical school. The mailing was a self-mailer of the APA medical student membership brochure, which includes the membership application as a postage paid return postcard. Since January, 648 Medical Students have joined the APA. A second outreach is planned for June to 8,200 medical students on the AMSA list.

An email campaign to medical student members was sent on March 4 to promote medical student grant and scholarship opportunities at the APA.

Resident-Fellow Members 100% Club

In December and January, membership staff worked directly with the 71 department of psychiatry residency training programs that qualified for the 100% Club for 2014-2015 and sent all qualified programs their confirmations, certificates or plaques, and special gifts for each resident for those programs that qualified for Platinum and Gold Level status. Three new programs have achieved 100% since the 2013-2014 year: Kaiser Permanente-Fontana, Lincoln Hospital, and NSLIJHS- Hofstra North Shore- LIJ School of Medicine at the Zucker Hillside Hospital. The June print edition of *Psychiatric News*

will feature photos of the six training programs that are at Platinum level as well as a full listing of all the 100% Club members.

There are 45 Residency Training Directors who are not members of the APA. In March, a special mailing was sent to them to encourage them to join the APA and set an example for their residents. We also encouraged them to promote APA membership to their residents and fellows.

In April, membership staff began direct outreach to residency training coordinators to inform and encourage their program to participate in 100% club for the upcoming training year. Through this outreach, membership attained rosters from programs previously not participating in 100% club and newly accredited programs. Membership sent recruitment packets to training programs including RFM applications, 100% club flyer and APA merchandise. Ongoing efforts by membership staff to obtain resident rosters from training programs will continue throughout the year to identify new resident-fellow member prospects.

2014-2015 Stats:	# of Programs	# of Residents
Platinum level (100% for 5 consecutive yrs)	6	121
Gold level (100%)	47	1,117
Silver level (90-99%)	8	213
Bronze level (8o-89%)	11	308
TOTAL	71 (39%)	1,759

Annual Meeting Rebate Program

This year the Annual Meeting Rebate Program included RFMs. Nonmember residents who registered at the full program rate were eligible to join the APA under the rebate program onsite and take advantage of the first year waived national dues as well as receive a \$65 rebate (difference between member and nonmember registration rates). A postcard campaign to 108 nonmember US and Canada advanced full-program registrants was mailed mid-April and an email campaign was sent one week prior to the Annual Meeting to promote the rebate program. A total of 21 residents applied on-site thru the Rebate Program, but only 16 were eligible for the rebate (based on how they registered for the meeting).

Early Career Psychiatrists ABPN Congratulations Campaign

There were 1,888 ABPN diplomates who were newly certified in September 2014 (997 members and 897 nonmembers). We conducted two campaigns to each group: (1) email in March (2) direct mail in April. For both campaigns, APA members were encouraged them to apply for Fellowship status and included the newly designed flyer and application. Nonmembers were invited to join the APA and received a copy of the general membership brochure and application.

RFM to GM Advancement

In January 2015, an eblast was sent to the remaining 382 RFM to GM advancements whose records show they completed training in 2014. Membership staff actively attempts to verify each member's credentials by checking online licensing websites and contacting residency programs. These efforts

continue for up to a year with emails and letter reminders requesting the necessary information. As of June 2015, only 90 members who completed training in 2014 still need to be verified.

In April 2015, a RFM to GM mailing piece was developed with information about the benefits of membership as an Early Career Psychiatrist and an explanation of the requirements for GM status. RFMs are asked to provide verification of their credentials and to provide additional information if continuing in training. RFMs who do not inform APA that they are continuing training are automatically advanced to General Member. Approximately 1,200 RFMs are contacted at the start of the advancement process and the number decreases through the year as credentials are verified or additional training is reported.

Focus – Complimentary Online Subscription Offer

Email campaign in February and April to promote the complimentary online subscription offer to ECPs. Since April there are 265 ECP Focus subscribers. Two more emails are scheduled this year to coincide with the release of each issue of Focus.

Fellow and International Fellow

A new Fellow and International Fellow flyer and application was developed in March. An email campaign was sent in April to all US and Canada General Members (10,765) and International Members (1,570) inviting members to apply for fellowship. New house ads and web banner ads were also developed and are running in conjunction to maximize exposure of the promotion. Another email campaign is scheduled for July. Coordinated marketing promotions including house ads in journal publications, web banner ad on psychiatry.org, and promotions in *Psych News* and *APA Headlines* emails have been developed and scheduled until the August/September deadlines.

Find a Psychiatrist Opt-In Campaign

Five emails blasts have been scheduled in April and May to US and Canadian members (excluding RFMs, Medical Students, Intl Member, Intl Fellow and Intl Distinguished Fellow). The total count is 22,802 and has been broken out into email groups of 5,000 to alleviate any call volumes to the APA Answer Center. Coordinated communications efforts in *Psychiatric News* and *APA Headlines* have been ongoing.

- Opt-in link is http://apps.psychiatry.org/optinfap/Login.aspx
- Link to see the functionality of the Find a Psychiatrist database http://finder.psychiatry.org/

A postcard handout was also created for distribution at the Annual Meeting. Coordinated marketing promotions including promotions in *Psych News* and *APA Headlines* emails have also been running.

Annual Meeting Rebate Promotion

Annual Meeting rebate promotion was offered to full-program attendees eligible for general membership in the APA. Nonmembers who join the APA onsite during the Annual Meeting will receive a rebate of \$625 to be applied towards their 2015 national and local dues. A postcard mailing to full program advanced registrants to the Annual Meeting was mailed mid-April to the following:

- US Full Program Nonmembers 364
- Canada Full Program Nonmembers 158

A total of 77 General Member applications were submitted on-site as part of the Rebate Program and are in process of verification and approval.

General Promotions

A series of house ads developed last year by the membership department continue to run on a space available basis in *Psychiatric News* educating members and nonmembers alike to the benefits of membership. The ads focus on specific APA resources relating to Annual Meeting member registration discounts, research, practice management, educational and CME opportunities, advocacy, and the availability of the APA Scheduled Payment Plan for members who want to sign up to pay their membership dues in installments. The ads were also turned into a series of rotating banner ads for the APA website and promotional postcards (6 in all), which are being mailed to new members monthly. The postcard series will also be used throughout the year in other member/nonmember promotions, and to other member segments, as an additional outreach opportunity to remind psychiatrists of the benefits of membership.

Exhibits (U.S.)

Membership staff exhibited at the AADPRT Meeting in Orlando, FL on March 5-6, 2014. Upcoming exhibits include: US Psych Congress in San Diego, CA, September 10-13 and American Association of Child and Adolescent Psychiatry in San Antonio, TX, October 26-31.

International Membership Annual Meeting Rebate Program

This year the Annual Meeting Rebate Program was expanded to include International nonmembers. Full-program nonmember registrants to the Annual Meeting were offered the opportunity to join the APA onsite and receive a gift certificate in the amount of their international membership dues to use at the APP bookstore during the exhibit days. They will also receive the member discount of 20% at the bookstore. An email campaign to 617 nonmember international full program advanced registrants. A second email campaign to all nonmember full program registrants was sent out May 11th. A total of 76 International Membership applications were submitted on-site.

Exhibits (International)

Membership staff will be exhibiting at the Royal College of Psychiatrists' (RCP) annual International Congress in Birmingham, UK on June 29 – July 2.

International Ambassador Program

For 2014, five membership ambassadors successfully brought 11 new international members to APA. Of those five, three ambassadors recruited two to four members, earning them each a 15% discount on their 2015 dues and a certificate of appreciation.

For the 2015 International Membership Ambassador Program, 180 International Members and Fellows registered for the Annual Meeting were invited to participate via an email from the APA Membership Committee Chair. Almost 20% responded and asked to meet with APA staff at the Member Center to establish the relationship, learn more about the program, and receive a packet of information to help them speak about the benefits of APA to prospective members in their countries. Ms. Nancy Archey met with the potential ambassadors during four days of face to face meetings and all 33 members from 20 different countries committed to being Membership Ambassadors. Eight of them brought in 17 new

members from home and on-site at the meeting. We are hoping that meeting in person and receiving a sample publication giveaway will help strengthen ambassador commitment to reaching program goals.

New International Member Welcome Reception

For the third year, the Membership Committee hosted a Welcome Reception and Networking Event for new International Members, International Fellows, and International Distinguished Fellows. Approximately 750 honorees and VIPs from 71 countries were invited and 150-175 from nearly 50 countries were in attendance, including several Presidents of International Psychiatry organizations. Drs. Summergrad, Binder, Levin, and Bailey all gave welcoming remarks. The reception was very much appreciated by the new International Members/Fellows/Distinguished Fellows in attendance.

District Branches/State Associations

Ms. Trang Smith, Associate Director of Membership Development, has been contacting DB/SAs individually to introduce herself and set up calls to begin collaborative recruitment campaigns. Ms. Smith is currently working with Illinois DB on a member-get-a-member campaign and nonmember mailing to the former/non-members in the state.

2016 Dues Renewal Cycle

Plans are underway to implement the new dues payment deadline with the 2016 dues renewal cycle. The communications plan will be to communicate a new payment deadline of January 1, 2016. After January 1, 2016, the date of March 31, 2016 will be communicated as the date by which payment must be received before membership is dropped. The communications plan is:

Marketing Channel:	Marketing Vehicle	Date:
Psych News Update - eNewsletter	News blub announcing Membership	Once a month from September
	Dues deadline has changed.	through March
Psychiatric News	Article announcing new membership dues deadline and reinforce the value of membership and importance of maintaining membership	September issue and January issue
Psychiatry.org	Web banner ad — Develop different versions: (1) general announcement of new deadline (2) Payment push for the end of the year (3) Final dues push before deadline and drop status	(1) September – November(2) December(3) January – March
Psychiatry.org	Pop-up window for visitors of the website (much like an advertiser)	Need to investigate possibility with new website
APP Journals and PN	House ads	September – March
APA Customer Service		October/November
District Branch/State Associations		October/November

The revised dues billing schedule will be from September 2015 – March 2016 (7 months):

Marketing Effort		Date	Message
Member Email Renewal #1		September 15	Overall membership
	Member Print Renewal #1	October 1	benefits

Member Email Renewal #2	October 24	List of APA
Member Print Renewal #2	November 17	accomplishments this
Members with NO email addresses		past year
Member Email Renewal #3	November 17	Advocacy focus
Member Print Renewal #3	December 7	Advocacy rocus
AJP Cover Tip In	December Issue	Overall membership benefits
Member Email Renewal #4	December 22	Education
Member Email Renewal #5	January 12	NIinitinti
Member Print Renewal #4	January 19	New initiatives to expect
Telemarketing Campaign – District Branches	January 25	in the coming year
Member Email Renewal #6	February 8	Annual Meeting
Telemarketing Campaign – Inalink	February 15	
Renewal Postcard #5	February 22	We are Stronger
AJP Cover Tip In	March Issue	Overall membership benefits
Member Email Renewal #7 (Final – Last Chance)	March 7	Overall membership
Member Print Renewal #6	March 14	benefits
Member Email Renewal #8 (48 hours before you're dropped)	March 29	Overall membership benefits
Member Drop Letter #7	April	Dropped

Resignations

With the authorization of the Board of Trustees, the Medical Director has regretfully accepted the resignations of 42 members listed in Attachment E (February – May 2015).

Membership Processing Action Items

Dropping of Members – Membership Terminated by APA (off cycle)

Will the Board of Trustees authorize dropping from APA membership the Member listed in Attachment F for failure to meet the requirements of membership?

Dropping of Members - Non-Payment of APA Dues

Will the Board of Trustees authorize dropping from APA membership the members listed in Attachment G for non-payment of 2015 APA dues if dues are not paid by the deadline?

Dropping of Members – Membership Terminated by District Branches

It is a requirement that a member must belong to both the APA and his/her local district branch. The Membership Department has been notified that the 142 members listed in Attachment H have not paid local dues and will be dropped by their branch if payment is not received by the June 30 deadline. These members will no longer eligible for membership in the APA and must be dropped.

BOT Item 8.A Board of Trustees July 11-12, 2015

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment H, who will be dropped by their district branch if dues are not paid by the deadline?

International Membership

Between March and May 2015, 170 applications for International Membership have been reviewed and approved. The applicant names are provided in Attachment I for the Board's approval.

Will the Board of Trustees vote to approve the applicants listed in Attachment I for International Membership?

Dues Relief Requests

The Membership Committee reviewed 57 requests for dues relief (see Attachment J) and recommends that:

- 20 dues waivers be approved
- 21 dues reductions be approved
- 15 transfers to Permanent Inactive Member status be approved
- 1 transfer to Temporary Inactive Member status be approved

Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment J?

Respectfully submitted,

Rahn Kennedy Bailey, M.D., DFAPA Chairperson, APA Membership Committee

Item 8.A Board of Trustees July 11-12, 2015 Attachment A

Comparison of Membership Totals 2004 - Present Dues-Paying and Dues-Exempt Membership Categories

70 00	30 001	20 00	70 00	Н		02 40	п	7.7	CF 40	100 44	lon 4E	Pob 45	Mor 15	AndA	AAON 4E
4	Jan-Up	Jan-00	Jan-07	٦	٥	Jan-10	٦	Jan-12	Jan-13	Jan-14	Jan-15	reo-13	Mar-15	Apr-15 May-15	May-15
4,559	4,129	4,370	4,339	4,357	4,432	4,249	4,187	3,725	3,939	4,396	4,546	4,683	4,740	4,828	4,873
16,069	15,545	15,486	15,433	15,552	15,335	14,947	14,136	13,366	13,116	12,666	12,163	12,259	12,367	12,479	12,571
2,481	2,257	2,072	2,032	1,996	1,910	1,777	1,642	1,552	1,482	1,425	1,365	1,367	1,366	1,367	1,366
6//	886	934	1,045	1,039	1,210	1,406	1,587	2,010	2,177	2,620	3,373	3,373	3,371	3,374	3,374
13	13	11	6	9	9	4	3	3	3	1	0	0	0	0	0
1,790	1,819	1,874	1,908	2,023	2,060	2,133	2,185	2,135	2,167	2,125	2,068	2,067	2,062	2,062	2,063
1,491	1,591	1,636	1,657	1,651	1,656	1,625	1,656	1,638	1,640	1,597	1,549	1,549	1,548	1,548	1,547
43	78	101	155	198	286	355	406	220	609	899	756	758	758	758	758
30	24	21	16	17	12	9	9	5	4	4	4	4	4	4	4
100	1,251	1,213	1,363	1,531	1,582	1,693	1,515	1,388	1,424	1,525	1,553	1,587	1,611	1,658	1,758
62	62	62	63	62	29	53	46			147	427	427	427	427	427
Н								49	64	89	65	64	65	65	99
28,417	27,655	27,780	28,020	28,432	28,548	28,248	27,369	26,421	26,625	27,242	27,869	28,138	28,319	28,319 28,570	28,807

				Num	Number of Memb	mbers in	Dues Ex	empt Mei	ers in Dues Exempt Member Categories	egories						
MS	686	1,344	1,980	2,256	1,910	1,217	1,152	1,017	981	1,111	1,456	1,997	2,067	2,293	2,412	2,498
L₩	1,624	1,658	1,664	1,673	1,693	1,715	1,594	1,651	1,675	1,719	1,801	1,869	1,864	1,845	1,841	1,834
DLF	2,266	2,297	2,267	2,280	2,230	2,227	2,113	2,165	2,186	2,245	2,322	2,398	2,393	2,372	2,368	2,362
LF	2	4	2	4	20	29	39	99	87	132	170	229	229	228	228	227
LA	55	22	22	22	51	54	53	51	49	48	44	42	42	41	41	41
IM/IF	1,951	2,014	2,010	2,096	2,078	2,057	1,986	1,978	1,942	1,937	1,924	1,929	1,925	1,931	1,931	1,928
HF	58	29	28	54	53	52	52	51	46	45	44	41	41	41	41	41
Sub total	6,942	7,431	8,036	8,418	8,035	7,351	6,989	6,969	996'9	7,237	7,761	8,505	8,561	8,751	8,862	8,931
TOTAL	35,359	35,086	35,816	36,438	36,467	35,899	35,237	34,338	33,387	33,862	35,003	36,374	36,699	37,070	37,070 37,432 37,738	37,738

RFM Resident-Fellow Member	۳	Life Fellow
GM General Member	\$	Life Associate
DF Distinguished Fellow	IMBR	International Member
FE Fellow	IFE	International Fellow (re-named IDF and new criteria established for IFE 2013)
AM Associate Member	IDF	Intl Distinguished Fellow (*IFE category name changed to IDF Jan 2012)
LM Life Member	MS	Medical Student
DLF Distinguished Life Fellow	IM/IF	Inactive Member/Inactive Fellow
	生	Honorary Fellow

Item 8.A Board of Trustees July 11-12, 2015 Attachment B

	California de la constanta				STORY OF THE	100 Per		DUES	3-PAY	NG ME	DUES-PAYING MEMBER CATEGORIES	CATE	SORIE	S				700 1000				
					GAINS	NS								TOS	LOSSES							
Modern	Mbr						000	State	40							Class	SS	i d	0 0 0			Member Counts
Class		Z	New	Rei	Reinstate	Cha	Changes In	Ga	Gains	۵	Drop	Res	Resign	Dece	Deceased	Out	t iges	Loss	Loss	Net Ga	Net Gain/Loss Month	Month
		Mo	YTD	Mo	YTD	Θ	YTD	Μo	YTD	Mo	YTD	₽	YTD	Θ	YTD	Mo	YTD	Mo	YTD	Mo	YTD	
RFM	4,828	31	1 296	3 11	100		3 53	45	449		1		3		0		13	0	17	45	432	4,873
GM	12,479	19	9 108	3 78	3 438		1 23	98	569		1	2	16	-	က	3	1,301	9	1,321	92	-752	12,571
DF	1,367		0	(4		105	0	109		0		0	_	2		144	_	146	7	-37	1,366
FE	3,374		0	(7		960	0	967		0		0		4		166	0	170	0	797	3,374
AM	0		0	(0	1	0	0	0		0		0		0		1	0	τ	0	1-	0
ΓM	2,062		0) 2	2 7		1 277	3	284		0	1	3	_	3		234	2	240	1	44	2,063
DLF	1,548		0	(161		162		0		0	T	1		182	1	183	1-	-21	1,547
LF	758		0	(3		163	0	166		0		0		0		29	0	59	0	107	758
Ρ	4		0](0		1	0	1		0		0		0		0	0	0	0	1	4
Intl_Mbr	1,658	71	190) 28	3 52		1 2	100	244		0		13		1	2	287		301	100	-57	1,758
Intl'FE	427		0		1		282	0	283		0		0		1		0		1	0	282	427
Intl DF	65		0		1		1 2	1	3		0		0		1		0	0	1	1	2	99
Subtotal	28,570	121	1 594	119	614		7 2,029	247	3,237	0	2	3	35	4	16	5	2,387	10	2,440	237	797	28,807
Parameter Services	No. of Control of Control				The Strategic			NO	N DUE	S-PA	N DUES-PAYING CATEGORIES	ATEGC	RIES			X1						
MS	2,412	86	3 648	~	0		0	86	648		0		0		0		24	0	24	98	624	2,498
ΓM	1,841		0				146	0	147		1		1	7	46		13	7	61	<i>L</i> -	86	1,834
DLF	2,368		0		0		181	0	181		0		0	9	53		0	9	53	9-	128	2,362
F	228		0		0		63	0	63		1	1	1		0		2	1	4	ļ-	29	227
4	41		0		0		0	0	0		0		0		1		0	0	1	0	-1	41
Inact	1,931		0				12	0	13	,	0		0	3	17		3	က	20	-3	-7	1,928
노			0		0		0	0	0		0		0		0		0	0	0	0	0	41
Subtotal	8,862	98	5 648	0	2		0 402	98	1,052	0	7	1	2	16	117	0	42	17	163	69	889	8,931
TOTAL	37,432	207	7 1,242	119	616		7 2,431	333	4,289	0	4	4	37	20	133	5	5 2,429	27	2,603	306	1,686	37,738

Membership Transactions -- Gains and Losses May 2015

Counts of PENDING Drops (Mbrs Owing Dues) by Area and District Branch -- 2015 Dues Cycle

	Final	Drop % 7/9/15	0.0%	0.0%	0.0%	%0.0	%0.0	0.0%	%0.0	0.0%	0.0%	0.0%	0.0%	0.0%	%0:0	%0.0	%0.0	%0.0	%0.0	0.0%	%0.0	0.0%	%0:0	%0.0	%0.0	%0.0	%0.0	%0:0	%0.0	%0.0	%0.0	%0.0	0.0%	%0.0	%0.0	%0.0	0.0%	0.0%	0.0%	0.0%	%0.0	0.0%	%0.0
ycle	Final	Drops 7/9/15									0														0						0					i							
and District Branch 2015 Dues Cycle	Pending	Drop % 6/15/15	%0.0	0.0%	%0.0	%0.0	0.0%	0.0%	%0.0	0.0%	0.0%	%0.0	0.0%	0.0%	%0.0	%0.0	0.0%	%0:0	%0.0	%0.0	%0.0	%0.0	%0.0	0.0%	%0'0	%0.0	%0.0	%0:0	%0:0	0.0%	0.0%	0.0%	%0.0	%0.0	%0.0	0.0%	%0.0	0.0%	%0.0	%0.0	%0.0	%0.0	%0.0
I 201		Drops 6/15/15									0														0						0												
Ct Diail	Pending	Drop % 6/3/15	19.7%	18.1%	17.0%	11.8%	10.9%	23.4%	11.4%	20.4%	16.5%	29.3%	21.1%	13.9%	13.7%	14.9%	25.5%	20.3%	8.5%	12.1%	22.4%	16.6%	18.7%	17.9%	18.9%	2.9%	9.8%	16.1%	18.1%	19.4%	16.1%	18.0%	13.3%	22.2%	13.9%	15.3%	18.4%	20.0%	13.9%	21.3%	20.3%	2.8%	11.9%
ia Distri		Drops [6/3/15 6	ത	26	224	13	77	88	24	20	582	43	25	15	16	99	14	302	11	4	51	45	23	14	661	2	28	114	233	119	529	147	38	36	22	96	7.1	73	19	10	167	2	38
		Drop % 4/30/15	21.5%	20.1%	19.0%	13.6%	14.6%	24.7%	13.3%	21.4%	18.7%	29.9%	24.1%	15.7%	13.7%	16.4%	27.3%	24.9%	10.1%	24.2%	25.0%	19.2%	19.5%	19.2%	22.0%	7.1%	17.2%	18.9%	22.9%	24.6%	20.9%	20.1%	15.8%	24.1%	17.1%	17.1%	22.0%	21.9%	14.6%	21.3%	23.4%	7.0%	14.1%
n (sand f	5		119	29	250	15	103	96	28	21	629	44	65	17	16	73	15	370	13	8	22	52	24	15	169	9	102	134	294	151	289	164	45	39	27	107	85	80	20	10	192	2	45
will Sowing Dues, by Alea	nes-		553	144	1,316	110	902	380	211	86	3,518	147	270	108	117	444	22	1,486	129	33	228	271	123		3,489	85	592	710	1,285	614	3,286	815	285	162	158	627	386	365	137	47	822	71	319
Counts of Fending Diops (MD		DB# DB NAME		62 Maine Assoc of Psychiatric Physicians	32 Massachusetts Psychiatric Society	68 New Hampshire Psychiatric Society	37 Ontario District Branch	39 Quebec & Eastern Canada District Branch	41 Rhode Island Psychiatric Society	66 Vermont Psychiatric Association	Total Area 1	2	3	56			24							22						48 Washington Psychiatric Society	Total Area 3	13 Illinois Psychiatric Society	14 Indiana Psychiatric Society	16 Iowa Psychiatric Society	17 Kansas Psychiatric Society	21 Michigan Psychiatric Society	22 Minnesota Psychiatric Society	9 Missouri Psychiatric Society	34 Nebraska Psychiatric Society	63 North Dakota Psychiatric Society	35 Ohio Psychiatric Physicians Association	72 South Dakota Psychiatric Association	52 Wisconsin Psychiatric Association
		Area	-	-	-	-	-	1	7	Ψ-		2	2	2	2	2	2	2	2	2	2	2	2	2	2	က	က	3	က	m	23	4	4	4	4	4	4	4	4	4	4	4	4

Counts of Pending Drops	ראבון אין אין אין אין אין אין אין אין אין אי	_		g Dues) by		ind Disti	Area and District Branch	nz u:	Sand cruz	Cycle	
l otal Dues Cat Mbr	l otal Dues Cat Mbr	otal Due: Cat Mbr	-ç	Pending	Pending	Pending	Pending	Pending	Pending	Final	Final
Count Coun	DB NAME	Count 1/2/15		Drops 4/30/15	Drop % 4/30/15	Drops 6/3/15	Drop % 6/3/15	Drops 6/15/15	Drop % 6/15/15	Drops 7/9/15	Drop % 7/9/15
Total Area 4	4	1-4	194	819		-	17.1%				
60 Alabama Psychiatric Physicians Association	30 Alabama Psychiatric Physicians Association		225	44		40	17.8%		0.0%		%0.0
1 Arkansas Psychiatric Society	ety		117	25			17.9%		0.0%		0.0%
	10 Florida Psychiatric Society		911	1	18.8%	136	14.9%		0.0%		0.0%
5 11 Georgia Psychiatric Physicians Association	11 Georgia Psychiatric Physicians Association		538				12.3%		%0.0		0.0%
	18 Kentucky Psychiatric Association		244			38	15.6%		%0.0		%0:0
	9 Louisiana Psychiatric Medical Association		260	68			23.1%		%0.0		%0.0
	3 Mississippi Psychiatric Association, Inc		134	22	16.4%		13.4%		%0.0		%0:0
	9 North Carolina Psychiatric Association		769	161		121	15.7%		%0.0		%0.0
	36 Oklahoma Psychiatric Association		188		19.1%				%0.0		0.0%
70 Puerto Rico Psychiatric Society	70 Puerto Rico Psychiatric Society		118				28.8%		%0.0		0.0%
42	12 South Carolina Psychiatric Association		317	50					%0.0		%0.0
	15 Tennessee Psychiatric Association		269	99	20.8%		18.2%		%0.0		%0.0
46	16 Texas Society of Psychiatric Physicians*		962	137		110	11.4%		%0.0		%0:0
77	77 Society of Uniformed Services Psychiatrists		323	70			19.8%		%0.0		%0.0
47	17 Psychiatric Society of Virginia, Inc		495	66		78	15.8%		%0.0		%0.0
54 West Virginia Psychiatric Association			162	21			11.7%		%0.0		0.0%
Total Area 5	Total Area 5	9	6,032	1,124				0	%0.0	0	
	4 Central California Psychiatric Society		330	78					%0.0		0.0%
	Northern California Psychiatric Society		781	180		156			%0.0		%0.0
76	6 Orange County Psychiatric Society		220	42					%0.0		0.0%
64	34 San Diego Psychiatric Society		271	45					%0.0		0.0%
43	3 Southern California Psychiatric Society*		760	117			13.0%		%0.0		0.0%
	Total Area 6		2,362	462	19.6%			0	%0.0	0	
	1 Alaska District Branch		59	8			10.2%		0.0%		%0.0
2	7 Arizona Psychiatric Society		330	55			13.3%		%0.0		%0:0
2 0	6 Colorado Psychiatric Society		351	62	17.7%		14.2%		0.0%		%0:0
12 Hawali Psychiatric Medical Association	Z Hawaii Psychiatric Medical Association		134	27	20.1%	20	14.9%		%0.0		0.0%
	5 Idaho Psychiatric Association		52	12	23.1%		21.2%		%0.0		%0.0
	3 Montana Psychiatric Association		33	11	28.2%		25.6%		%0.0		0.0%
			132	31	23.5%		19.7%		%0.0		0.0%
29	7 Psychiatric Medical Association of New Mexico		117	21	17.9%		15.4%		0.0%		0.0%
	8 Oregon Psychiatric Association		335	22	17.0%		14.0%		%0.0		0.0%
61 Utah Psychiatric Association	Utah Psychiatric Association		143	34	23.8%	32	22.4%		%0.0		0.0%
	3 Washington State Psychiatric Association		421	69	16.4%	64	15.2%		%0.0		0.0%
	3 Western Canada District Branch		489	86	20.0%		18.4%		%0.0		0.0%
7 75 Wyoming Psychiatric Society	5 Wyoming Psychiatric Society		21	2	9.5%	2	9.5%		%0.0		%00
7 Total Area 7	Total Area 7		2,623	487	18.6%	420	16.0%	0	%0.0	0	0.0%
& Intl)	& Intl)		88	20	22.7%		21.6%		%0.0		%0.0
			25,504	5,007	19.6%	4,2	16.6%	0	%0.0	0	%0.0
Total APA Membership (DB & At-Large Mbrs	Total APA Membership (DB & At-Large Mbrs		25,592	5,027	19.6%	4	16.6%	0	0.0%		%0.0

7

Counts of PENDING Drops (Mbrs Owing Dues) by Area and District Branch -- 2015 Dues Cycle

_	*Non-Centralized Billing DBs Members owi	owing only local dues noted below	I dues note	d below						
			Non-CB		Non-CB		Non-CB			
		Total Dues-DB		Non-CB DB	DB	Non-CB DB DB	DB	Non-CB DB Non-CB	Non-CB	Non-CB
		Cat Mbr	_	Pending	ס		Pending		DB Final	DB Final
		Count		Drop %		۰,				Drop %
_		1/2/15		4/30/15	6/3/15					7/9/15
2 2	25 Greater Long Island Psychiatric Society*	444	20	4.5%	16	3.6%		%0.0		%0.0
3 2	20 Maryland Psychiatric Society, Inc*	592	27	4.6%	7	0.7%		%0.0		0.0%
6 4	43 Southern California Psychiatric Society*	2097	75	%6.6	69	7.8%		%0:0		0.0%
5 4	46 Texas Society of Psychiatric Physicians*	962	66	10.3%	87	%0.6		%0.0		%0.0
	Total owing local dues only to Non-CB DBs		221		166		0		0	
	International Members									
	Lower Income	23	8	34.8%	2	30.4%		%0.0		%0.0
	Lower Middle Income	303	105	34.7%	22	25.4%		%0.0		%0.0
	Upper Middle Income	552	237	42.9%	199	36.1%		%0.0		%0.0
	Upper Income	1,144	309	27.0%	276	24.1%		%0.0		%0.0
	Total International Members/Fellows	2,022	629	32.6%	529	27.6%	0	%0.0	0	%0.0
\downarrow										
	GRAND TOTAL	27,614	2,907		4,972		0		0	

2015 Expedited Grant Applicants

	FUNDING CATEGORY:	ESTIMATED PROJECT
DISTRICT BRANCH	PROPOSED PROJECT	COMPLETION
Alabama Psychiatric Physicians Association	Early Career Psychiatry Retention	SPRING 2016
Alaska Psychiatric Assn	Miscellaneous Educational Activity	FALL 2015
Area 2 — New York State Psychiatric Association	Early Career Psychiatry Retention	Feb-16
Area 6 – California Psychiatric Assn	Miscellaneous Educational Activity	Sept 25-27, 2015
Arizona Psychiatric Soc	Early Career Psychiatry Retention	FALL 2015
Arkansas Psychiatric Soc	Miscellaneous Educational Activity	31-Jul-15
Bronx District Branch	Membership Retention Initiative	FALL 2015
Brooklyn Psychiatric Soc	Membership Retention Initiative	FALL 2015
Central California Psychiatric Society	Early Career Psychiatry Retention	31-May-16
Colorado Psychiatric Soc	Membership Retention Initiative	31-May-16
Connecticut Psychiatric Society	Health Care Reform/ Affordable Care Act Educational Activity	30-May-16
Georgia Psychiatric Physicians Association	Miscellaneous Educational Activity	31-Aug-15
Greater Long Island Psychiatric Society	Miscellaneous Educational Activity	SPRING 2016
Illinois Psychiatric Soc	Miscellaneous Educational Activity	FALL 2015
Indiana Psychiatric Soc	Miscellaneous Educational Activity	Sep-15
Iowa Psychiatric Soc	Miscellaneous Educational Activity	Apr-16
Kansas Psychiatric Soc	Miscellaneous Educational Activity	Jul-15
Kentucky Psychiatric Medical Association	Miscellaneous Educational Activity	12-Mar-16
Louisiana Psychiatric Medical Association	Membership Recruitment Initiative	June 2015-Dec 2016

2015 Expedited Grant Applicants

Maine Association of Psychiatric Physicians	Miscellaneous Educational Activity	23-Oct-15
Maryland Psychiatric Society	Membership Recruitment Initiative	Jun-16
Massachusetts Psychiatric Society	Membership Recruitment Initiative	August 2015-April 2016
Mid-Hudson Psychiatric Society	Membership Recruitment Initiative	Not Specified
Minnesota Psychiatric Society	Miscellaneous Educational Activity	2-May-15
Mississippi Psychiatric Association	Miscellaneous Educational Activity	Feb-16
Missouri Psychiatric Assn	Membership Recruitment Initiative	July 2015-October 2015
Montana Psychiatric Association	Membership Retention Initiative	Not specified
New Jersey Psychiatric Association	Membership Recruitment Initiative	July 2015-December 2015
New York County District Branch	Miscellaneous Educational Activity	27-Mar-16
New York State Capital District Branch	Early Career Psychiatry Retention	FALL 2015 - Spring 2016
North Carolina Psychiatric Association	Miscellaneous Educational Activity	August 2015-October 2015
Northern California Psychiatric Society	Miscellaneous Educational Activity	12-Sep-15
Ohio Psychiatric Physicians Association	Miscellaneous Educational Activity	Fall 2015
Oklahoma Psychiatric Physicians Association	Miscellaneous Educational Activity	Not specified
Orange County Psychiatric Society	Membership Retention Initiative	Fall 2015
Oregon Psychiatric Assn	Membership Recruitment Initiative	Dec-15
Pennsylvania Psychiatric Society	Miscellaneous Educational Activity	Dec-15
Psychiatric Medical Assn of New Mexico	Miscellaneous Educational Activity	Aug-15

2015 Expedited Grant Applicants

De aldred Control of	National Income Programme	
Psychiatric Society of	Miscellaneous Educational	aC Can an
Delaware	Activity	26-Sep-15
Psychiatric Society of	Membership Recruitment	. B.
Virginia	Initiative	31-Dec-15
Psychiatric Society of		
Westchester County	Membership Retention Initiative	30-Apr-16
Quebec & Eastern	Miscellaneous Educational	
Canada District Branch	Activity	16-Oct-15
	,	10 000 15
Queens County	Miscellaneous Educational	
Psychiatric Society	Activity	Oct-15
San Diego Psychiatric	Early Career Psychiatry	
Society	Retention	Monthly - Ending July 2016
Society of Uniformed	Membership Recruitment	
Services Psychiatrists	Initiative	Ending in May 2016
•		Litang iii way 2010
South Carolina	Membership Recruitment	
Psychiatric Association	Initiative	Fall 2015
South Dakota	Miscellaneous Educational	
Psychiatric Association	Activity	May-15
Southern California	Miscellaneous Educational	
Psychiatric Society	Activity	30-Jan-16
		30 Sun 10
Tennessee Psychiatric	Miscellaneous Educational	
Association	Activity	16-Oct-15
Texas Society of		
Psychiatric Physicians	Membership Retention Initiative	20-Nov-15
Washington (DC)	Early Career Psychiatry	
Psychiatric Society	Retention	Concluding April 2016
Washington State	Miscellaneous Educational	Samuel Control of Cont
Psychiatry	Activity	Summer 2015-Spring 2016
West Hudson Psychiatric	Miscellaneous Educational	
Society	Activity	2-Oct-15
West Virginia Psychiatric	Miscellaneous Educational	
Association	Activity	Concluding May 2016
	•	
Western Canada District	Membership Recruitment	News
Branch	Initiative	Nov-15
Wisconsin Psychiatric	Miscellaneous Educational	
Association	Activity	Oct-15

Total: 56 DB SA Expedited grant applicants for 2015.

Member ID Name	Member Category	DB#	DB Name	Reason
32961 Rozana Rab Alam M.D.	Fellow	DB ₂ 6	New Jersey	Not Provided
59008 Wallace Russell Arthur M.D.	General Member	DBo6	Colorado	Not Provided
1005596 Alagappa Arumugam, MD	International Member	APA	Colorado	Not Provided
1005590 Alayappa Alolliogalli, MD	General Member	DB ₇₄	Nevada	Not Provided
89081 Florian Birkmayer, MD	General Member	DB/4 DB67	New Mexico	Not Provided
35470 Michael Charles Carvell M.D.	General Member	DB ₃ 8	Pennsylvania	Not Provided
30783 Sheldon Chase M.D.	Life Member	DB29	North Carolina	Retired
75798 Panupong Chitasombat M.D.	International Member	APA	North Carolina	Not Provided
75/90 i anopolig Chicasombacivi.b.	international Member	ALA		
				Dual Membership
			_	Requirement
1235420 Lawrence Chiu, MD	Resident-Fellow Member	•	Texas	Protest
43411 Stephen Brian Connor, MD	General Member	DB30	Northern California	Not Provided
29429 Paul William De Bell M.D.	General Member	DB27	New York County	Not Provided
87289 Amit Rajendra Desai, MD	General Member	DB10	Florida	Not Provided
1297833 Andrew Samuel Ferber, MD	General Member	DB10	Florida	Retired
1229832 Paulien Gritters, MD	International Member	APA	\ <i>t</i> :	Not Provided
1008200 Jason C Grove, DO	General Member	DB ₄₇	Virginia	Not Provided
70613 Ernest C Hanes M.D.	General Member	DB77	Soc Uniformed Svcs	Not Provided
1231267 Nienke Hipke, MD	International Member	APA	-	Not Provided
1136446 Tomoya Hirota, MD	Resident-Fellow Member	DB ₄₅	Tennessee	Not Provided
79182 Amy E Jones M.D.	General Member	DB42	South Carolina	Not Provided
45259 Susan Phyllis Josephson M.D.	General Member	DB43	Southern California	Not Provided
1090941 Eliza Karwowski, DO, MBA	Resident-Fellow Member	DB10	Florida	Not Provided
42882 Virginia Miller Khoury, MD	General Member	DB ₂ 8	New York State Capital	
1209245 Kathelijne Koorengevel, MD	International Member	APA	-	Not Provided
1090202 Nikolaus Kubista, DO	General Member	DB46	Texas	Not Provided
33118 Philip Eliezer Levine M.D.	Distinguished Life Fellow	DB25	Greater Long Island	Not Provided
1050905 Tara Malekshahi, MD	General Member	DB27	New York County	Not Provided
39647 Ramanujam Mohan, MD	General Member	DB11	Georgia	Not Provided
1240786 Annelies Mulder, MD	International Member	APA		Not Provided
1197928 Graziella Piras, MD	International Member	APA	Western New York	Not Provided Not Provided
72065 Bellamkonda Raghu, MD	General Member General Member	DB51		Not Provided
90853 Denae W Rickenbacker M.D. 63763 Judy Stovall Rivenbark M.D.	Life Member	DB46 DB10	Texas Florida	Retired
14667 Paul E Roberts, MD	Life Member	DB10 DB20	Maryland	Not Provided
	General Member	DB20 DB02	Bronx	Not Provided
78105 Serge Sevy, MD 1000267 Carl Sicard, MD	General Member	DB02 DB20	Maryland	Not Provided
1237532 Ann MJV Vancoppenolle, MD	International Member	APA	iviai yiaiiu	Not Provided
1000896 Laurel A Weaver, MD	General Member	DB ₃ 8	Pennsylvania	Not Provided
1052832 Nicole C Welsh, MD	General Member	DB36	Nebraska	Not Provided
63583 Lynn Elise Wesson M.D.	General Member	DB29	North Carolina	Dues too high
35263 Sam Carroll West, MD	Life Member	DB29	North Carolina	Not Provided
70649 Susan H Wicke M.D.	General Member	DB29	North Carolina	Not Provided
78576 Izzet C Yazgan, MD	General Member	DB30	Northern California	Not Provided
103/0 122ct C 1 azgan, MD	General Member	DD30	Northern Camornia	. voci Tovided

APA Off Cycle Drops Confidential

BOT Item 8.A Board of Trustees July 11-12, 2015 Attachment F

Mbr ID	Name	Member Category	DB#	DB Name	Reason
					No longer enrolled in training
		Resident-Fellow			program (left before
1157353	Nicholas C Ahn, MD	Member	13	Illinois Psych Soc	completed)
28900	Abdel Monem M El-Beshir MD	Life Fellow	48	Washington Psych Soc	No valid license

n = 2

Member ID	Name	Member Category	DB#	DB Name
000000081192	Joseph R Cassar M.D.	General Member	At-Large	American Psychiatric Association
000000070037	Iqbal Mohammed Ghany M.D.	Life Member	At-Large	American Psychiatric Association
000000076598	Michael N Kabar M.D.	General Member	At-Large	American Psychiatric Association
000000090318	Samuel F Law MD	General Member	At-Large	American Psychiatric Association
000000063558	Mario Valentin Mendoza M.D.	General Member	At-Large	American Psychiatric Association
000000045019	Ossama Tawakol Osman MD	Fellow	At-Large	American Psychiatric Association
000000062555	Leda A Sanchez M.D.	General Member	At-Large	American Psychiatric Association
000000030575	Francisco J Schnaas MD	Distinguished Life Fellow	At-Large	American Psychiatric Association
000000067491	Dan Joseph Stein MD	Fellow	At-Large	American Psychiatric Association
000000061134	Jeffrey Martin Turley M.D.	General Member	At-Large	American Psychiatric Association
000000080065	Alison Monds Ward MD	General Member	At-Large	American Psychiatric Association
000001008094	Ivan O Aldea MD	General Member	1	. Arkansas Psychiatric Society
000001005299	David A Bagley MD	General Member	1	. Arkansas Psychiatric Society
000000312417	Natalie Jill Brush-Strode MD	General Member	1	. Arkansas Psychiatric Society
000000073654	Donald Gene Clay MD	General Member	1	. Arkansas Psychiatric Society
000001083703	Jessica Lynn Coker MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000001098877	Michael Dennis MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000001026022	Romika Dhar MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000001154184	Renea Henderson MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000001016872	Sean Kaley MD	General Member	1	. Arkansas Psychiatric Society
000001119604	William Clint Kindrick MD	General Member	1	. Arkansas Psychiatric Society
000000042490	Irving Kuo MD	Distinguished Fellow	1	. Arkansas Psychiatric Society
000001044740	Jacquelyn Lange MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000001054538	Tiffany N Mattingly MD	Resident-Fellow Member	1	. Arkansas Psychiatric Society
000000087909	Rhonda Matlock Mattox MD	General Member	1	. Arkansas Psychiatric Society
000001114639	Andreya Evette Reed MD	Resident-Fellow Member		. Arkansas Psychiatric Society
000001008077	Cindy E Rossetti MD	General Member		Arkansas Psychiatric Society
000000063928	Jon Carl Rubenow DO	General Member		Arkansas Psychiatric Society
000001161680	Amanda Smith MD	Resident-Fellow Member		Arkansas Psychiatric Society
000001000718	Eloise E Weeks MD	General Member		Arkansas Psychiatric Society
000000091321	Veronica L Williams M.D.	General Member		Arkansas Psychiatric Society
000000311569	Katherine W Yarnell MD	General Member		. Arkansas Psychiatric Society
000001197534	Efrain Acosta-Leon MD	General Member		Bronx District Branch
000001096258	Sanju Adhikari MD	General Member		Bronx District Branch
000000073562	Willy Alexis MD	General Member		Bronx District Branch
000001169059	Christopher S Aloezos MD	Resident-Fellow Member		Bronx District Branch
000000084103	Miguel A Arce MD	General Member		Bronx District Branch
000000032733	Gregory Mark Asnis M.D.	Life Member		Bronx District Branch
000001164676	Ramneesh Baweja MD	Resident-Fellow Member		Bronx District Branch
000000063979	Thomas F Betzler M.D.	General Member		Bronx District Branch
000001117668	Johanna Cabassa MD	General Member		Bronx District Branch
000001204911	Jonathan Carvajal MD	Resident-Fellow Member		Bronx District Branch
000001166235	Connie Wan Yin Chan MD	General Member		Bronx District Branch
000001230194	Lissette Cortazar MD	Resident-Fellow Member		Bronx District Branch
000001230196	Lilia Danilov MD	Resident-Fellow Member		Bronx District Branch
000001091224	Elaina Frances DellaCava MD	Resident-Fellow Member		Bronx District Branch
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000001150382	Niharika Kunapuli MD	Resident-Fellow Member	22 Minnesota Psychiatric Society
000001145868	Jung In In Lee MD	Resident-Fellow Member	22 Minnesota Psychiatric Society
000001185063	Derek Michael LeRoux Smith MD	Resident-Fellow Member	22 Minnesota Psychiatric Society
000001017312	Charles Patman Lewis MD	Resident-Fellow Member	22 Minnesota Psychiatric Society
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000001049593	Hisbay H Ali MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
000000038261	Miguel Angel S Alvarez M.D.	Life Member	25 Greater Long Island Psychiatric Soc
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000001148735	Zubair Khan DO	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
000001187952	Krishna Kishore Kilaru MBBS	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
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000001115462	Madelyn Perez MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
000001155748	Bart Peters MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
000001113997	Fayola Peters MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Soc
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000000043811	Matthew A Menza MD	General Member	26 New Jersey Psychiatric Association
000001017327	Carolina Mercader DO	General Member	26 New Jersey Psychiatric Association
000000026293	Harry Joseph Moffitt M.D.	Life Member	26 New Jersey Psychiatric Association
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000001017249	Prathila Nair MD	General Member	26 New Jersey Psychiatric Association
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000001000523	Nataliya Osmanova MD	General Member	26 New Jersey Psychiatric Association
000001006587	Justin K Paltrowitz MD	General Member	26 New Jersey Psychiatric Association
000001011500	Andrea Papa-Molter DO	General Member	26 New Jersey Psychiatric Association
000001034350	Hyunsoon Edie Park MD	General Member	26 New Jersey Psychiatric Association
000000080942	Jayantilal Ramdas Patel MD	Fellow	26 New Jersey Psychiatric Association
000001005656	Unnati Dharmabhai Patel MD	General Member	26 New Jersey Psychiatric Association
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000000087500	Firoz P Rahman MD	General Member	26 New Jersey Psychiatric Association
000001114248	Rumana Rahmani MD	Resident-Fellow Member	26 New Jersey Psychiatric Association
000001017571	Samina Saadia Raja MD	General Member	26 New Jersey Psychiatric Association
000000102105	Vilayannur R Rao MD	General Member	26 New Jersey Psychiatric Association
000001016406	Shahzad Rashid DO	General Member	26 New Jersey Psychiatric Association
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000000090753	Patrick John Rowan MD	General Member	26 New Jersey Psychiatric Association
000001096394	Susana Sanchez MD	Resident-Fellow Member	26 New Jersey Psychiatric Association
000001090933	Joseph D Scott DO	Resident-Fellow Member	26 New Jersey Psychiatric Association
000001008437	Seena R Sebastian MD	General Member	26 New Jersey Psychiatric Association
000000068456	Sahar Metwaly Shafey M.D.	General Member	26 New Jersey Psychiatric Association
000001016717	Snehal Shah MD	General Member	26 New Jersey Psychiatric Association
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000001123733	Shankar Srinivasan MD	General Member	26 New Jersey Psychiatric Association
000000076107	Michael Stefanovich MD	General Member	26 New Jersey Psychiatric Association
000000089745	Maria-Elissa Torres MD	General Member	26 New Jersey Psychiatric Association
000001017436	Jarrett N Tosk MD	Fellow	26 New Jersey Psychiatric Association
000001036820	Christian J Trentacosta MD	General Member	26 New Jersey Psychiatric Association
000000092473	Sailaja Devi Valiveti MD	General Member	26 New Jersey Psychiatric Association
000000068536	Marilouise Venditti MD	General Member	26 New Jersey Psychiatric Association
000001087208	Mehnaz Waseem MD	Resident-Fellow Member	26 New Jersey Psychiatric Association
000001017729	Matthew F Way MD	General Member	26 New Jersey Psychiatric Association
000000311850	Gony Alexandra Weiss MD	General Member	26 New Jersey Psychiatric Association
000001113738	Swarnalatha Reddy Yerrapu MD	General Member	26 New Jersey Psychiatric Association
000000028343	Perry Howard Zand M.D.	Life Member	26 New Jersey Psychiatric Association
000001112444	Atika Zubera MD	Resident-Fellow Member	26 New Jersey Psychiatric Association
000000066492	Alexander S Zwil M.D.	General Member	26 New Jersey Psychiatric Association
000001008657	Dina Abell MD	General Member	27 New York County Psychiatric Society
000001077824	Joshua R Ackerman MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001143112	Aniefiok Agarin MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001017183	Marieliz V Alonso MD	General Member	27 New York County Psychiatric Society
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000001019702	Deepti Anbarasan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001129502	Azeesat Babajide MD MBA	Resident-Fellow Member	27 New York County Psychiatric Society
000001102135	Meera Balasubramaniam MBBS MPI	l General Member	27 New York County Psychiatric Society
000001096503	Julio Ballestas MD	General Member	27 New York County Psychiatric Society
000001004842	Arkady Barenboim MD	General Member	27 New York County Psychiatric Society
000001013454	Omar Bashayan MD	General Member	27 New York County Psychiatric Society
000001118469	Anahita Bassirnia MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000072642	Juan Jose Baturone M.D.	General Member	27 New York County Psychiatric Society
000000080169	William S Belfar M.D.	General Member	27 New York County Psychiatric Society
000001129941	Erik Bengtsen MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000309114	Joachim A Benitez MD	General Member	27 New York County Psychiatric Society
000001041044	Lori B Bennett-Penn MD PhD	Resident-Fellow Member	27 New York County Psychiatric Society
000001011884	Meredith Paige Bergman MD	General Member	27 New York County Psychiatric Society
000000087006	Joshua A Berman MD PhD	General Member	27 New York County Psychiatric Society
000001190122	Joel A Bernanke MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001203588	Hiren Bhakta MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001137139	D Harshad Bhatt MD PhD	General Member	27 New York County Psychiatric Society
000001006421	Wiktoria B Bielska MD	General Member	27 New York County Psychiatric Society
000001053919	Anne F Bird MD	General Member	27 New York County Psychiatric Society
000000067210	Betsy J Bittman MD	General Member	27 New York County Psychiatric Society
000000311192	Nancy M Bivens MD PhD	General Member	27 New York County Psychiatric Society
000001019701	Thomas M Boes MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000302183	Tyson J Boudreaux MD MPH	General Member	27 New York County Psychiatric Society
000001002676	Kelly Brogan MD	General Member	27 New York County Psychiatric Society
000001144268	Kwame Buabeng MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000310338	Sandip Pradip Buch MD	General Member	27 New York County Psychiatric Society
000001124507	Syed Muhammad Ali Imran Bukhari	Resident-Fellow Member	27 New York County Psychiatric Society
000000091059	Peter Bulow M.D.	General Member	27 New York County Psychiatric Society
000001129869	Sari Jaclyn Burns MD	General Member	27 New York County Psychiatric Society
000000053625	Giovanni Caracci M.D.	Distinguished Fellow	27 New York County Psychiatric Society
000000103284	Sarah A Caraisco MD	General Member	27 New York County Psychiatric Society
000000312211	Conrado A Caraos MD	General Member	27 New York County Psychiatric Society
000000307180	Anthony J Carino M.D.	General Member	27 New York County Psychiatric Society
000001190118	Joanne Chang MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001005940	Wei-Li Chang MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001109496	Colby M Chapman MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001008781	Anthony Charuvastra MD	General Member	27 New York County Psychiatric Society
000000304584	Eran Chemerinski M.D.	General Member	27 New York County Psychiatric Society
000001017438	Noshin Chowdhury MD	General Member	27 New York County Psychiatric Society
000001158396	Priscilla Ngozi Chukwueke MD MPH	l Resident-Fellow Member	27 New York County Psychiatric Society
000001081564	Dorothy Chyung MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000020455	Ruth Paula Cohen MD	Life Member	27 New York County Psychiatric Society
000000305002	Tiziano Colibazzi M.D.	Fellow	27 New York County Psychiatric Society
000000300164	Victoria L Cressman MD PhD	General Member	27 New York County Psychiatric Society
000001002870	Andrya M Crossman MD	General Member	27 New York County Psychiatric Society
000001231127	Christopher Cselenyi MD PhD	Resident-Fellow Member	27 New York County Psychiatric Society
000000307832	Jessica E Daniels MD	General Member	27 New York County Psychiatric Society
000000033633	Edward W Darell MD	Life Member	27 New York County Psychiatric Society
000001235040	Arnab Datta MD	Resident-Fellow Member	27 New York County Psychiatric Society
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000001015687	Adam Ryan Demner MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001220724	Thomas DePrima MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000306704	Eileen DiFrancesco M.D.	General Member	27 New York County Psychiatric Society
000000313215	Narveen Dosanjh MD	General Member	27 New York County Psychiatric Society
000000059716	Stephen Edward Dossick MD	General Member	27 New York County Psychiatric Society
000001188746	Roberta Caetano Dracxler MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000307905	Alejandra Durango MD	General Member	27 New York County Psychiatric Society
000001010093	Christina Dziedzic MD	General Member	27 New York County Psychiatric Society
000001153967	Kenechi G Ejebe MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000305599	Eman M El Gamal MD	General Member	27 New York County Psychiatric Society
000001145739	Rana Emam MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000088469	Dillon Carmickle Euler M.D.	General Member	27 New York County Psychiatric Society
000001144277	Zu Fashan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000065679	Stephen John Ferrando M.D.	General Member	27 New York County Psychiatric Society
000001017876	Francesco Alessandro Ferrari MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001137757	Katherine Fichtel MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001154238	Rachel Fischer MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000062110	Jeffrey Fishberger M.D.	General Member	27 New York County Psychiatric Society
000000312914	Carl Erik Fisher MD	General Member	27 New York County Psychiatric Society
000001078744	Haskel Fleishaker MD	General Member	27 New York County Psychiatric Society
000001059003	Kathryn GC Fort MD	General Member	27 New York County Psychiatric Society
000001116197	Patrice Ananie Fouron DO	Resident-Fellow Member	27 New York County Psychiatric Society
000000066854	Lauralyn Gates Fredrickson M.D.	General Member	27 New York County Psychiatric Society
000000064134	Maxim Frenkel M.D.	General Member	27 New York County Psychiatric Society
000000062126	Richard Alan Friedman MD	Distinguished Fellow	27 New York County Psychiatric Society
000000307883	Katya Frischer MD	General Member	27 New York County Psychiatric Society
000000032975	Abby Joy Fyer MD	Life Member	27 New York County Psychiatric Society
000000311501	Maalobeeka Gangopadhyay MD	General Member	27 New York County Psychiatric Society
000000062138	Dolores Garcia-Moreno M.D.	Fellow	27 New York County Psychiatric Society
000001015620	Christina Dearie Gerdes MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001135641	Dina Ghoneim MD	General Member	27 New York County Psychiatric Society
000001013984	Jennifer Goldman MD	General Member	27 New York County Psychiatric Society
000000081093	Martin A Goldstein MD	Fellow	27 New York County Psychiatric Society
000000307486	Margaret Goni MD	General Member	27 New York County Psychiatric Society
000000304359	Francisco J Gonzalez-Franco M.D.	General Member	27 New York County Psychiatric Society
000001152598	Heather Goodman MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001150729	Margaret Goracy MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000310669	Varendra J Gosein MD	General Member	27 New York County Psychiatric Society
000001200999	Marcel Green MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001220211	Murtuza Zakir Gunja MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001101696	Abha Gupta DO	Resident-Fellow Member	27 New York County Psychiatric Society
000001001288	Joshua M Hain MD	General Member	27 New York County Psychiatric Society
000001215372	Tobias Bernard Halene MD PhD	Resident-Fellow Member	27 New York County Psychiatric Society
000000312946	Helena B Hansen MD PhD	General Member	27 New York County Psychiatric Society
000001144275	Manassa Hany MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001160807	Oliver Louis Harper MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001055062	Abigail Hawkins MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000028538	George Max Hecht M.D.	Life Member	27 New York County Psychiatric Society
000000036438	Carol Hermann M.D.	Life Member	27 New York County Psychiatric Society
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000001016917	Stephanie T Ho MD	General Member	27 New York County Psychiatric Society
000001006834	Gavi E Hollander DO	General Member	27 New York County Psychiatric Society
000000078456	Anna I Holmgren MD	General Member	27 New York County Psychiatric Society
000000307595	Nisba Fatima Husain MD	General Member	27 New York County Psychiatric Society
000000312612	Lucy A. Hutner MD	General Member	27 New York County Psychiatric Society
000001140584	Nkiruka Juliana Iloh MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001130202	Joseph Samuel Insler MD	General Member	27 New York County Psychiatric Society
000000306851	Alla lospa MD	General Member	27 New York County Psychiatric Society
000001270203	Claire Louise Jackson-Rabinowitz D	CGeneral Member	27 New York County Psychiatric Society
000001012777	Reena Jaiswal MD	General Member	27 New York County Psychiatric Society
000000065767	Jonathan Allen Javitch M.D. Ph.D.	General Member	27 New York County Psychiatric Society
000001111629	Megan Jessiman MD PhD	Resident-Fellow Member	27 New York County Psychiatric Society
000001214179	Brandon Johnson MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001150738	Jessy Joseph MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001038636	Judith Fiona Joseph MD	General Member	27 New York County Psychiatric Society
000001119314	Vasanth Kattalai Kailasam MBBS	Resident-Fellow Member	27 New York County Psychiatric Society
000001051235	Adam S Kaufman MD	General Member	27 New York County Psychiatric Society
000001006980	Eileen P Kavanagh MD	General Member	27 New York County Psychiatric Society
000000076298	Melissa T Kaye M.D.	General Member	27 New York County Psychiatric Society
000001114724	Kathryn Anne Keegan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001051233	Mary E Kelleher MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001154116	Rachna Kenia MD	General Member	27 New York County Psychiatric Society
000001078870	Nida Khan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001097530	Ahreum Kim MD MPH	Resident-Fellow Member	27 New York County Psychiatric Society
000001019710	Laura J Kimeldorf MD	General Member	27 New York County Psychiatric Society
000001231153	Benjamin Orlando Klass MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000082878	Zeev Kogen M.D.	General Member	27 New York County Psychiatric Society
000001019712	Cathy A Kondas MD	General Member	27 New York County Psychiatric Society
000000307809	Risa Koren MD	General Member	27 New York County Psychiatric Society
000000085590	Andreas K Kraebber M.D.	General Member	27 New York County Psychiatric Society
000000081851	Markus J Kraebber MD	General Member	27 New York County Psychiatric Society
000000034354	Thomas Kranjac MD	Distinguished Life Fellow	27 New York County Psychiatric Society
000001016597	Simone Lauderdale MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001042278	Samantha Jane Leathers MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001063857	Norman Young Lee MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001005690	Kristin L Leight MD	General Member	27 New York County Psychiatric Society
000001190135	Alison E Lenet MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001071039	Justin Leung MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001103851	Kathleen Bryer Levy DO	Resident-Fellow Member	27 New York County Psychiatric Society
000000042934	Freda Colette Lewis-Hall MD	Distinguished Fellow	27 New York County Psychiatric Society
000000075046	Paulina S Loo M.D.	General Member	27 New York County Psychiatric Society
000000040664	Andrew Clifford Lotterman MD	Life Member	27 New York County Psychiatric Society
000000302380	Christopher Paul Lucas MD MPH	General Member	27 New York County Psychiatric Society
000001063034	Sean X Luo MD PhD	General Member	27 New York County Psychiatric Society
000000305563	Joseph Z Lux MD	Fellow	27 New York County Psychiatric Society
000001051489	Pavan Madan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001077951	Rodwan Mahfouz MD	General Member	27 New York County Psychiatric Society
000001207685	Pradipta Majumder MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001230453	Maria Josefa Malaga Aragon MD	Resident-Fellow Member 54	27 New York County Psychiatric Society
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000001277289	Eleni Maloutas MD	General Member	27 New York County Psychiatric Society
000000028712	Robert Marantz M.D.	Life Member	27 New York County Psychiatric Society
000001015850	Alexandra Roesler Martins MD	General Member	27 New York County Psychiatric Society
000001068216	Cyrus Jonathan Mathew MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001077829	Jaisha Mathew MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001004737	Jose Matias MD	General Member	27 New York County Psychiatric Society
000001230727	Theresa Mauro MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001212639	Stacy McAllister MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000045405	P Anne McBride MD	General Member	27 New York County Psychiatric Society
000001220729	Cheryl McGibbon MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001114301	Daniel Thomas McGovern MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001154327	Kruti Mehta MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001151515	Benjamin Tommaso Merotto MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000309137	Jonathan Merson MD	General Member	27 New York County Psychiatric Society
000001229208	Lesley Michael DO	Resident-Fellow Member	27 New York County Psychiatric Society
000001132800	Eeva Johanna Mikkola MD	General Member	27 New York County Psychiatric Society
000001053887	Jennifer Minami MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000087576	Galina Mindlin MD PhD	General Member	27 New York County Psychiatric Society
000001079897	Liza Mishan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000307987	Lauren B Morris DO	General Member	27 New York County Psychiatric Society
000000313238	Wendy Nash Moyal MD	General Member	27 New York County Psychiatric Society
000001012184	Abby L Mulkeen MD	General Member	27 New York County Psychiatric Society
000001013804	Louise M Mullan MD	General Member	27 New York County Psychiatric Society
000000080143	David M Murdock M.D.	General Member	27 New York County Psychiatric Society
000000064408	Lynn C Nachamie M.D.	General Member	27 New York County Psychiatric Society
000001000974	Niru S Nahar MD	General Member	27 New York County Psychiatric Society
000001081552	Maya Leigh Nair MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000312306	Sara S Nash MD	General Member	27 New York County Psychiatric Society
000000027313	Paul William Nassar M.D.	Distinguished Life Fellow	27 New York County Psychiatric Society
000001015852	Martin D Nau MD	General Member	27 New York County Psychiatric Society
000000031378	James Edward Nininger M.D.	Distinguished Life Fellow	27 New York County Psychiatric Society
000001002170	Ilana R Nossel MD	General Member	27 New York County Psychiatric Society
000000072586	Adriana J Notarfrancesco M.D.	General Member	27 New York County Psychiatric Society
000001054467	Obianuju Jennifer Obi MD MPH	Resident-Fellow Member	27 New York County Psychiatric Society
000001134156	Kelechi Ogbuji MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001001646	Aderonke A Oguntoye MD	General Member	27 New York County Psychiatric Society
000000089155	David D Ott M.D.	General Member	27 New York County Psychiatric Society
000001137758	Larry Ozowara MD	General Member	27 New York County Psychiatric Society
000000102747	Mary Paizis M.D.	General Member	27 New York County Psychiatric Society
000000310435	Khatija N Paperwalla MD	General Member	27 New York County Psychiatric Society
000000312330	Susan S Park MD	General Member	27 New York County Psychiatric Society
000001224366	Birju Patel MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001101818	Milan Manu Patel MD	General Member	27 New York County Psychiatric Society
000000306166	Brian G Pell MD	General Member	27 New York County Psychiatric Society
000001006520	Victoria I Pham DO	General Member	27 New York County Psychiatric Society
000001230015	Nyota Pieh MD MPH	Resident-Fellow Member	27 New York County Psychiatric Society
000001109880	Joseph S Pino MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000037680	Deborah N Plachta M.D.	Life Member	27 New York County Psychiatric Society
000000059343	Dionne R Powell MD	General Member	27 New York County Psychiatric Society
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000001225163	Laura S Powers MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000312118	Raymond Raad MD MPH	Resident-Fellow Member	27 New York County Psychiatric Society
000001011490	Aliza Rabin MD	General Member	27 New York County Psychiatric Society
000000305510	Adam N Raff M.D.	General Member	27 New York County Psychiatric Society
000000082628	Anthony Valentine Raiteri MD	General Member	27 New York County Psychiatric Society
000001141416	Jemila Areke Raji MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000083921	Rachelle H Ramos MD	General Member	27 New York County Psychiatric Society
000001018557	Todd Rankin MD	General Member	27 New York County Psychiatric Society
000001190136	Shervin P Ravan MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000307244	Kathleen L Rein MD	General Member	27 New York County Psychiatric Society
000000087685	Silvana Riggio M.D.	General Member	27 New York County Psychiatric Society
000001107044	Muhammad Furqan Rizvi MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001013644	Xiomara D Rocha-Cadman MD	General Member	27 New York County Psychiatric Society
000001182434	Alicia Alexandra Rojas MD	General Member	27 New York County Psychiatric Society
000001131063	Anna Halperin Rosen MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001223084	Jake Rosenberg MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000305131	Michele J Rosenberg MD	General Member	27 New York County Psychiatric Society
000001160419	Sean M Rumschik MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000037992	Sharon L Sageman M.D.	Distinguished Life Fellow	27 New York County Psychiatric Society
000000066276	John A Sahs M.D.	General Member	27 New York County Psychiatric Society
000001083007	Ferda Sakman MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001096636	Annaheta Salajegheh MD	General Member	27 New York County Psychiatric Society
000000102391	Julia B Samton M.D.	General Member	27 New York County Psychiatric Society
000001037332	Diana Samuel MD	Fellow	27 New York County Psychiatric Society
000001017184	Lorenzo M Santos Gutierrez MD	General Member	27 New York County Psychiatric Society
000000065124	Beth Karen Scharfman M.D.	General Member	27 New York County Psychiatric Society
000000308625	Alan D Schlechter MD	General Member	27 New York County Psychiatric Society
000000080156	Albert J Scublinsky M.D.	General Member	27 New York County Psychiatric Society
000001157124	Ramya P Seeni MBBS	Resident-Fellow Member	27 New York County Psychiatric Society
000000084729	Brealyn M Sellers M.D.	General Member	27 New York County Psychiatric Society
000001163975	Jaqueline Sergie MD	General Member	27 New York County Psychiatric Society
000001019711	Amee K Shah MD	General Member	27 New York County Psychiatric Society
000001013948	Lesha D Shah MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001022226	Nikita Shah MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001109807	Eli Shalenberg MD	General Member	27 New York County Psychiatric Society
000000060332	Zafar A Sharif MD	General Member	27 New York County Psychiatric Society
000001002737	Sonali Sharma MD MSC	General Member	27 New York County Psychiatric Society
000000056780	Alice Jo Siegel M.D.	General Member	27 New York County Psychiatric Society
000001235041	Yona Silverman MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001148743	Jasbir Singh MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001176021	Shailinder Singh MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000044714	Lisa M Sinsheimer M.D.	General Member	27 New York County Psychiatric Society
000001239033	Misha K Sivia MD	General Member	27 New York County Psychiatric Society
000001000347	Jocelyn Soffer MD	General Member	27 New York County Psychiatric Society
000001043428	Laili Soleimani MD	General Member	27 New York County Psychiatric Society
000000306502	Scott M Soloway MD	General Member	27 New York County Psychiatric Society
000000076105	Svetlana Starkman M.D.	General Member	27 New York County Psychiatric Society
000001187425	Louisa Juliane Steinberg MD PhD	Resident-Fellow Member	27 New York County Psychiatric Society
000000304542	Jennifer Cooper Stelwagon MD	General Member	27 New York County Psychiatric Society
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000001040631	Jon D Stiffler MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000042020	Anne Stockton M.D.	General Member	27 New York County Psychiatric Society
000000056987	Ezra S Susser M.D.	General Member	27 New York County Psychiatric Society
000001083714	Amy Swift MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000070271	Fernando T Taveras MD	General Member	27 New York County Psychiatric Society
000000029018	Fatima Taylor MD	Life Member	27 New York County Psychiatric Society
000000026584	Stephen Stuart Teich MD	Life Member	27 New York County Psychiatric Society
000000076476	Eric D Teitel MD	Fellow	27 New York County Psychiatric Society
000001041766	Pilar Trelles MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001229834	Christie Tsimoyianis MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001230737	Allison Ungar MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001128627	Leila Vaez-Azizi MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001008627	Peter J van Roessel MD PhD	General Member	27 New York County Psychiatric Society
000000308285	Jeffrey A Vernon DO	General Member	27 New York County Psychiatric Society
000000091241	Serena Yuan Volpp MD MPH	Fellow	27 New York County Psychiatric Society
000000045546	Steven Gary Wager M.D.	General Member	27 New York County Psychiatric Society
000000311342	Khadijah B Watkins MD MPH	General Member	27 New York County Psychiatric Society
000001217218	Terese Watkins MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000303123	Brendon Omar Watson MD PhD	General Member	27 New York County Psychiatric Society
000001018671	Elhav Weinstein MD	General Member	27 New York County Psychiatric Society
000000303677	Daniel J Weiss M.D.	General Member	27 New York County Psychiatric Society
000000305380	Michael E Weiss MD	General Member	27 New York County Psychiatric Society
000001056071	Alison Welch MD	Resident-Fellow Member	27 New York County Psychiatric Society
000001231120	Fara White MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000044165	David B Wiley M.D.	General Member	27 New York County Psychiatric Society
000000021628	Daniel T Williams MD	Distinguished Life Fellow	27 New York County Psychiatric Society
000001007983	William Ross Winter MD	General Member	27 New York County Psychiatric Society
000000310923	Wendy Elias Wolfson DO	General Member	27 New York County Psychiatric Society
000001003977	Meredith J Wong MD	General Member	27 New York County Psychiatric Society
000000031085	Joseph Kuhn Youngerman MD	Life Member	27 New York County Psychiatric Society
000001006740	Eric Yu MD	General Member	27 New York County Psychiatric Society
000001230730	Rachel Alena Zhuk MD	Resident-Fellow Member	27 New York County Psychiatric Society
000000076115	Sebastian Zimmermann M.D.	General Member	27 New York County Psychiatric Society
000001103647	Rachel Zinns MD	General Member	27 New York County Psychiatric Society
000001009421	Nicole Zuber MD	General Member	27 New York County Psychiatric Society
000000070338	Ilene Sharon Zwirn MD	General Member	27 New York County Psychiatric Society
000000300026	Michelle K Bacares MD	General Member	28 New York State Capital District Branch
000001083022	Sabrina Gratia DO	General Member	28 New York State Capital District Branch
000000032771	Koock Elan Jung MD	Life Member	28 New York State Capital District Branch
000001143784	Nicholas Lawson MD	General Member	28 New York State Capital District Branch
000001053418	Syed A Qamer MD	General Member	28 New York State Capital District Branch
000001053420	Elmer Luis Quintero MD	General Member	28 New York State Capital District Branch
000001008889	Jeffrey Alfred Reynante MD	General Member	28 New York State Capital District Branch
000001013908	Nicole A Tremblay MD	General Member	28 New York State Capital District Branch
000001001420	Fabio L Urresta MD	General Member	28 New York State Capital District Branch
000000057266	Roberta Anne Wagner M.D.	Life Member	28 New York State Capital District Branch
000001053421	Jennifer Yager DO	General Member	28 New York State Capital District Branch
000001004898	Timur C Akinli MD	General Member	29 North Carolina Psychiatric Association
000000073145	Tedra L Anderson-Brown M.D.	General Member	29 North Carolina Psychiatric Association
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000001006809	Dena Carver Armstrong MD	General Member	29 North Carolina Psychiatric Association
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000001086144	Louisa Apongse Ayafor MD	General Member	29 North Carolina Psychiatric Association
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000001069083	Tiffany Bell DO	General Member	35 Ohio Psychiatric Association
000001145698	Suzanne E Bloore MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000000043507	John Franklin Bober MD	General Member	35 Ohio Psychiatric Association
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000001190054	John De Mott DO	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001107223	Thomas Ryan Gspandl DO	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001052161	Sathyan Gurumurthy MD	General Member	35 Ohio Psychiatric Association
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000001176583	Leah P Marron DO	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001109948	Palav M Mehta MD	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001000395	Kevin M Nasky DO	General Member	35 Ohio Psychiatric Association
000001145710	Fabiano G Nery MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000000079008	Julie A Niedermier MD	General Member	35 Ohio Psychiatric Association
000001078204	Nnennaya E Nwokeji MD	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001200648	Vanessa Panizales Penaranda MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000001114899	James G Pennington MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000000074789	Kathleen A Pero M.D.	General Member	35 Ohio Psychiatric Association
000001081477	William F Pierson MD	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001056559	Eric S Rueff DO	Resident-Fellow Member	35 Ohio Psychiatric Association
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000000307729	Jyoti Sachdeva MD	General Member	35 Ohio Psychiatric Association
000001103231	David C Sahadevan MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000001077299	Balaji Saravanan MD	Fellow	35 Ohio Psychiatric Association
000001140322	Therese Scavelli MD	General Member	35 Ohio Psychiatric Association
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000000302106	Isabel N Schuermeyer MD	Fellow	35 Ohio Psychiatric Association
000001149084	Hema A Shah MD	Resident-Fellow Member	35 Ohio Psychiatric Association
000001093802	Neha Shah DO	Resident-Fellow Member	35 Ohio Psychiatric Association
000001093809	Jessica Michaelle Short DO	Resident-Fellow Member	35 Ohio Psychiatric Association
000000090965	Irene Shulga MD	General Member	35 Ohio Psychiatric Association
000001008190	Ali Siavashi MD	General Member	35 Ohio Psychiatric Association
000000058379	Maida Sierra MD	General Member	35 Ohio Psychiatric Association
000001225201	Kathryn L Sigalow MD	Resident-Fellow Member	35 Ohio Psychiatric Association
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000001147000	Mauran Sivananthan DO	General Member	35 Ohio Psychiatric Association
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000001011229	Catharine G Wolfe MD	Resident-Fellow Member	38 Pennsylvania Psychiatric Society
000000312243	Megan C Wynne MD	General Member	38 Pennsylvania Psychiatric Society
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000001221664	Muhammad Khalid Zafar MD	Resident-Fellow Member	38 Pennsylvania Psychiatric Society
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000000067945	Barbara E Ziv M.D.	General Member	38 Pennsylvania Psychiatric Society
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000001058989	Emilie Allaire MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
000001070986	Cedric Andres MD	General Member	39 Quebec & Eastern Canada District Branch
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000001110709	Mylene Arjane M.D.	General Member	39 Quebec & Eastern Canada District Branch
000000310337	Farouk Aumeerally MD	General Member	39 Quebec & Eastern Canada District Branch
000000003542	Elisabeth Banon M.D.	General Member	39 Quebec & Eastern Canada District Branch
000000073530	Guillaume Barbes-Morin M.D.	General Member	39 Quebec & Eastern Canada District Branch
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000000078605	Aileen S Brunet M.D.	General Member	39 Quebec & Eastern Canada District Branch
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000000311044	Jean-Marc Chianetta MD	General Member	39 Quebec & Eastern Canada District Branch
000001060944	Marie-Julie Cimon MD	General Member	39 Quebec & Eastern Canada District Branch
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000001017680	Layla Dabby MD	General Member	39 Quebec & Eastern Canada District Branch
000001014114	Angie Danyluk MD PhD	General Member	39 Quebec & Eastern Canada District Branch
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000001232338	Nazlie Faridi MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
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000001053310	Gabriella Gobbi MD	General Member	39 Quebec & Eastern Canada District Branch
000001002008	Stephane Godin MD	General Member	39 Quebec & Eastern Canada District Branch
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000001052357	Setrak Ishak MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
000001232051	Vhari James MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
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000001124512	Vincent Laliberte MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
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000000071310	Jason Malcolm Morrison MD	General Member	39 Quebec & Eastern Canada District Branch
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000001109688	Katerina Nikolitch MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
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000001202035	Marie Nolin MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
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000001232380	Rimma Orenman MD	General Member	39 Quebec & Eastern Canada District Branch
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000001236353	Cynthia Slade MD	General Member	39 Quebec & Eastern Canada District Branch
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000001122298	Zoe Thomas MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
000001034728	Karen Margaret Thompson MD	General Member	39 Quebec & Eastern Canada District Branch
000000087818	Haji Adam Vayani MD	General Member	39 Quebec & Eastern Canada District Branch
000001214190	Jonathan Wan MD	Resident-Fellow Member	39 Quebec & Eastern Canada District Branch
000000084240	Ashley Wazana MD	General Member	39 Quebec & Eastern Canada District Branch
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000000306027	Pierre L Joseph MD	General Member	40 Queens County Psychiatric Society
000001108418	Sagar Joshi MD	Resident-Fellow Member	40 Queens County Psychiatric Society
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000001277077	Mohammed Mazharuddin MD	Resident-Fellow Member	40 Queens County Psychiatric Society
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000001187953	Lakhvir Singh MD	Resident-Fellow Member	40 Queens County Psychiatric Society
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000001078373	Le-Ben Wan MD PhD	General Member	40 Queens County Psychiatric Society
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000000067100	Deanna Guith Cornelius MD	General Member	42 South Carolina Psychiatric Association
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000001130803	Hosain Manesh MD	Resident-Fellow Member	42 South Carolina Psychiatric Association
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000000304840	Eunice Peterson MD	General Member	42 South Carolina Psychiatric Association
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000000310405	Ralph C Pollock MD	General Member	42 South Carolina Psychiatric Association
000001042864	Benjamin David Potter MD	Resident-Fellow Member	42 South Carolina Psychiatric Association
000000101890	Ervin D Prewette MD	General Member	42 South Carolina Psychiatric Association
000001146008	Ashleigh L Quick MD	Resident-Fellow Member	42 South Carolina Psychiatric Association
000000310406	Jesse A Raley MD	General Member	42 South Carolina Psychiatric Association
000000071031	Melisa D Rowland M.D.	General Member	42 South Carolina Psychiatric Association
000000031077	Philip G Steude M.D.	Life Fellow	42 South Carolina Psychiatric Association
000001160171	Louis David Viamonte MD	Resident-Fellow Member	42 South Carolina Psychiatric Association
000001015679	Olga Grepo Victa MD	General Member	42 South Carolina Psychiatric Association
000001147046	Emily Williams MD	Resident-Fellow Member	42 South Carolina Psychiatric Association
000001060198	Nolan Williams MD	General Member	42 South Carolina Psychiatric Association
000000069689	Lynn Purcell Wright MD	Fellow	42 South Carolina Psychiatric Association
000001052079	Aiying A Xiao MD	General Member	42 South Carolina Psychiatric Association
000001002260	Sheenie Ambardar MD	General Member	43 Southern California Psychiatric Society
000001017621	Marissa Andres MD	General Member	43 Southern California Psychiatric Society
000001152115	Tagbo E Arene MD MPH	Resident-Fellow Member	43 Southern California Psychiatric Society
000000306633	David D Aryanpur M.D.	General Member	43 Southern California Psychiatric Society
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000000043061	Brooke Millon Barton M.D.	General Member	43 Southern California Psychiatric Society
000000043630	Alexander Beebee MD	General Member	43 Southern California Psychiatric Society
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000000310943	, Marcy Forgey Borlik MD MPH	General Member	43 Southern California Psychiatric Society
000000057579	Jerry R Bruns MD	General Member	43 Southern California Psychiatric Society
000001111631	Matthew Chang MD	General Member	43 Southern California Psychiatric Society
000001133653	Monika Chaudhry MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000073649	Scott Cherkasky M.D.	General Member	43 Southern California Psychiatric Society
000001059401	Carlos Alberto Contreras MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000072992	lan A Cook M.D.	Distinguished Fellow	43 Southern California Psychiatric Society
000001119659	Ashley Margo Covington MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001218355	Valerie Ray Davis MD	General Member	43 Southern California Psychiatric Society
000001006049	Priya Sarin Desai MD	General Member	43 Southern California Psychiatric Society
000000022253	Sunil Paul DeSilva MD	Life Member	43 Southern California Psychiatric Society
000001007107	Linda Do DO	Resident-Fellow Member	43 Southern California Psychiatric Society
000001041165	Sarah Domb MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001016057	Ingrid Leah Dombrower MD	General Member	43 Southern California Psychiatric Society
000001160332	Yosra El-Menshawi DO	Resident-Fellow Member	43 Southern California Psychiatric Society
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000001152959	Deborah Fein	General Member	43 Southern California Psychiatric Society
000000054261	Daniel J Fitzgerald III MD	General Member	43 Southern California Psychiatric Society
000000074811	Michael F FitzPatrick MD	General Member	43 Southern California Psychiatric Society
000001131758	Jennifer Ellen Gardner MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000310594	David A Gavel MD	General Member	43 Southern California Psychiatric Society
000001017448	Ariel M Gavino MD MBA	General Member	43 Southern California Psychiatric Society
000000309715	David S Gellman MD	General Member	43 Southern California Psychiatric Society
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000000079697	Victoria Goltsman M.D.	General Member	43 Southern California Psychiatric Society
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000001118022	Qyana Griffith MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001005077	Margaret M Haglund MD	General Member	43 Southern California Psychiatric Society
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000001057754	Marc Aaron Heiser MD Ph D	Resident-Fellow Member	43 Southern California Psychiatric Society
000001196972	Duong Vien Ho DO MED	Resident-Fellow Member	43 Southern California Psychiatric Society
000000089116	Ildiko J Hodde MD	General Member	43 Southern California Psychiatric Society
000000075867	Robert P Holloway M.D.	General Member	43 Southern California Psychiatric Society
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000001069086	John Jimenez MD	General Member	43 Southern California Psychiatric Society
000001000072	Megan Kavanaugh Jones MD	General Member	43 Southern California Psychiatric Society
000001055075	Amandeep Jutla MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000087442	Arif Karim DO	General Member	43 Southern California Psychiatric Society
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000001082322	Eugene Kimn MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001002322	Lauren Kissner MD	General Member	43 Southern California Psychiatric Society
000001010238	Heather M Kurera DO	General Member	43 Southern California Psychiatric Society
000001138635	Serafin Tambaoan Lalas Jr MD	General Member	43 Southern California Psychiatric Society
000001130033	Connie Jean Lane MD	General Member	43 Southern California Psychiatric Society
000001012222	Dung-Nghi Ngo Le MD	General Member	43 Southern California Psychiatric Society
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000001097894	Vania Manipod DO	General Member	43 Southern California Psychiatric Society
000000080730	David L Marcus M.D.	General Member	43 Southern California Psychiatric Society
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000000040708	Sherry Karen Mendelson M.D.	Life Member	43 Southern California Psychiatric Society
000001010668	David A Merrill MD PhD	General Member	43 Southern California Psychiatric Society
000000032503	Thomas Alan Miklusak MD PhD	Life Fellow	43 Southern California Psychiatric Society
000001168793	Desiree Ann Montes DO	General Member	43 Southern California Psychiatric Society
000000309548	Francisco Navarro M.D.	General Member	43 Southern California Psychiatric Society
000001080107	Jared M Nelson DO	General Member	43 Southern California Psychiatric Society
000001014654	Rose Nikravesh MD	General Member	43 Southern California Psychiatric Society
000001161779	Laura Lynn Obit DO	Resident-Fellow Member	43 Southern California Psychiatric Society
000000302987	, Geetha K Paladugu M.D.	Fellow	43 Southern California Psychiatric Society
000000033206	Jerrold J Parrish MD MBA	General Member	43 Southern California Psychiatric Society
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000001004852	Paul R Puri MD	General Member	43 Southern California Psychiatric Society
000000079610	Brenda S K Quon M.D.	General Member	43 Southern California Psychiatric Society
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000001127317	Sean Sassano-Higgins MD	General Member	43 Southern California Psychiatric Society
000001187429	David Sheski MD	Resident-Fellow Member	43 Southern California Psychiatric Society
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000000079235	Jill K Smith M.D.	General Member	43 Southern California Psychiatric Society
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000001013656	Tiffany Y Tsai MD	General Member	43 Southern California Psychiatric Society
000000033130	Walter Burton Van Vort MD	Life Member	43 Southern California Psychiatric Society
000000086425	Judith E Vinocur M.D.	General Member	43 Southern California Psychiatric Society
000001017516	Donnell Wigfall DO	General Member	43 Southern California Psychiatric Society
000000040098	Jeffery Neal Wilkins M.D.	Distinguished Fellow	43 Southern California Psychiatric Society
000000083842	, Mark T Williams M.D.	General Member	43 Southern California Psychiatric Society
000001155926	Michelle Wu MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001107260	Calvin T Yang MD PhD	General Member	43 Southern California Psychiatric Society
000000057473	Lester M Zackler M.D.	Fellow	43 Southern California Psychiatric Society
000001156964	Ahmed M Abdel-Raouf MD	Resident-Fellow Member	45 Tennessee Psychiatric Association
000001202047	Andrei Avenido MD	General Member	45 Tennessee Psychiatric Association
000001164565	Jaymie Uy Avenido MD	Resident-Fellow Member	45 Tennessee Psychiatric Association
000000301090	Michael J Baron MD MPH	General Member	45 Tennessee Psychiatric Association
000000036820	Terry Clayton Borel M.D.	General Member	45 Tennessee Psychiatric Association
000000044933	George Richard Brown M.D.	Distinguished Fellow	45 Tennessee Psychiatric Association
000001066496	Traci Carroll MD	General Member	45 Tennessee Psychiatric Association
000001076401	Shujah S Choudhry DO	Resident-Fellow Member	45 Tennessee Psychiatric Association
000001017030	Ethel Marie Cobbett MD	General Member	45 Tennessee Psychiatric Association
000000301099	Kevin B Collen MD	General Member	45 Tennessee Psychiatric Association
000000311606	Anjani Dhamodharan M.D.	General Member	45 Tennessee Psychiatric Association
000001156682	Anthony Chuka Ekwo MD	Resident-Fellow Member	45 Tennessee Psychiatric Association
000000304537	Don J Elazar M.D.	General Member	45 Tennessee Psychiatric Association
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000001008477	Liusong Fu MD	General Member	45 Tennessee Psychiatric Association
000001131472	Ernest A Gbadebo-Goyea MD	Resident-Fellow Member	45 Tennessee Psychiatric Association
000001013292	Shannon Leigh Hansen MD	General Member	45 Tennessee Psychiatric Association
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000000307122	Frederick Y. Wu MD	General Member	48 Washington Psychiatric Society
000001012062	Jenny Lee Yi MD	Resident-Fellow Member	48 Washington Psychiatric Society
000000309743	Peter D Zemenides MD	General Member	48 Washington Psychiatric Society
000001187707	Xian Zhang MD PhD	Resident-Fellow Member	48 Washington Psychiatric Society
000001224681	Benjamin James Anderson MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000311344	Daniela Balint MD	General Member	49 Psychiatric Soc of Westchester County
000001008139	Josh Arneas Bazell MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000064037	Mary Elizabeth Bongiovi MD PhD	General Member	49 Psychiatric Soc of Westchester County
000001147021	Jorge Ernesto Castillo MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000301647	Joy A Clark MD	General Member	49 Psychiatric Soc of Westchester County
000000307610	Sarah D Cohen MD	General Member	49 Psychiatric Soc of Westchester County
000000042856	Richard Eugene Gallagher M.D.	Life Member	49 Psychiatric Soc of Westchester County
000000311587	Martha C Gamboa MD	General Member	49 Psychiatric Soc of Westchester County
000000087344	Karen G Gennaro M.D.	Distinguished Fellow	49 Psychiatric Soc of Westchester County
000001005325	Michael B Greenspan MD	General Member	49 Psychiatric Soc of Westchester County
000000065803	Myrna Hernandez M.D.	General Member	49 Psychiatric Soc of Westchester County
000000313137	Wilson Nzeadibe Iroham MD	General Member	49 Psychiatric Soc of Westchester County
000000305527	Rhea Johnson MD	General Member	49 Psychiatric Soc of Westchester County
000000033849	Balkrishna Kalayam MD	Life Member	49 Psychiatric Soc of Westchester County
000000080675	Anri A Kissilenko MD	General Member	49 Psychiatric Soc of Westchester County
000000062312	Amy Koppes M.D.	General Member	49 Psychiatric Soc of Westchester County
000000074899	Sheree A Krigsman M.D.	General Member	49 Psychiatric Soc of Westchester County
000001102133	Sara Michelle Lane MD	General Member	49 Psychiatric Soc of Westchester County
000000079994	Marc Laruelle MD	General Member	49 Psychiatric Soc of Westchester County
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000000091172	Fong Liu MD	General Member	49 Psychiatric Soc of Westchester County
000001111499	Ludmilar Mesidor DO	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000071929	Elizabeth M Mirabello MD	General Member	49 Psychiatric Soc of Westchester County
000001001521	Mamta Modhwadia MD	General Member	49 Psychiatric Soc of Westchester County
000000085668	Elizabeth Ortiz-Schwartz M.D.	Distinguished Fellow	49 Psychiatric Soc of Westchester County
000000037676	Daniel Jaime Pilowsky M.D.	Fellow	49 Psychiatric Soc of Westchester County
000001000045	Jonathan E Posner MD	General Member	49 Psychiatric Soc of Westchester County
000001072162	Kandace Reece MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000001144236	Hart Risdell MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000001112116	Aaron J Roberto MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000041793	William Stuart Rosenfeld M.D.	Life Fellow	49 Psychiatric Soc of Westchester County
000000038170	Richard Alan Silverman M.D.	Life Fellow	49 Psychiatric Soc of Westchester County
000001055451	Silky Singh MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000060382	Anthony John Stern M.D.	General Member	49 Psychiatric Soc of Westchester County
000000058415	Robert John Stine MD	General Member	49 Psychiatric Soc of Westchester County
000001144024	Mohammad Tavakkoli MD MPH M	IS Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000001145611	Ana Paula Tovar Hernandez MD	Resident-Fellow Member	49 Psychiatric Soc of Westchester County
000000088178	Richard C Wang MD	General Member	49 Psychiatric Soc of Westchester County
000000074125	Lisa S Weinstock M.D.	General Member	49 Psychiatric Soc of Westchester County
000000063931	Ellen Weissman M.D.	General Member	49 Psychiatric Soc of Westchester County
000000088872	Alexandra Tate Whoriskey MD	General Member	49 Psychiatric Soc of Westchester County
000000311810	Arshad A Zaidi MD	General Member	49 Psychiatric Soc of Westchester County
000000026688	Arthur B Zelman M.D.	Life Member	49 Psychiatric Soc of Westchester County
000001087710	Ramnarine Boodoo MBBS	Resident-Fellow Member	51 Western New York Psychiatric Society
000001001579	Betty J Brown MD	General Member	51 Western New York Psychiatric Society
000001016041	Zhanna Elberg MD	General Member	51 Western New York Psychiatric Society
000001087569	Poonamdeep Gill MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000001146176	Jessica Grudzien MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000001081591	Laura Hanrahan MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000000065108	Junaid Hashim M.D.	General Member	51 Western New York Psychiatric Society
000001086162	Ah Young Kim MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000001010989	Peter S Martin MD MPH	General Member	51 Western New York Psychiatric Society
000001156674	Julia Martisius MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000000045513	Michael Scott Mogerman MD	General Member	51 Western New York Psychiatric Society
000001080098	Aditi Parashar MD	Resident-Fellow Member	51 Western New York Psychiatric Society
000000300942	Rebecca S Phillips MD	General Member	51 Western New York Psychiatric Society
000000045715	Mary Elizabeth Roehmholdt M.D.	Life Associate	51 Western New York Psychiatric Society
000001148074	Adelia A Sazonov MD DO	Resident-Fellow Member	51 Western New York Psychiatric Society
000001013404	Sourav Sengupta MD MPH	General Member	51 Western New York Psychiatric Society
000001012211	Syed Ali Raza Shamsi MD	General Member	51 Western New York Psychiatric Society
000001056715	Joshna Singh MD	General Member	51 Western New York Psychiatric Society
000001010009	Semen Spirin MD	General Member	51 Western New York Psychiatric Society
000000305474	Aimee L Stanislawski MD	General Member	51 Western New York Psychiatric Society
000000079742	Stephen C Williams MD	General Member	51 Western New York Psychiatric Society
000000081705	Carolyn M Young M.D.	General Member	51 Western New York Psychiatric Society
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000001058732	Anna Fay Berg MD	Resident-Fellow Member	52 Wisconsin Psychiatric Association
000001041119	Neil J Brahmbhatt DO	Resident-Fellow Member	52 Wisconsin Psychiatric Association
000000074572	Kenneth C Casimir MD	Fellow	52 Wisconsin Psychiatric Association
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000000307867	James Benjamin Christenson MD	General Member	52 Wisconsin Psychiatric Association
000001040296	Christopher Joseph Christian MD	Fellow	52 Wisconsin Psychiatric Association
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000000305212	Jeffrey S Fait M.D.	General Member	52 Wisconsin Psychiatric Association
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000001040638	Vikram M Gopal MD	Resident-Fellow Member	52 Wisconsin Psychiatric Association
000000045579	Eric Heiligenstein MD	General Member	52 Wisconsin Psychiatric Association
000001000069	Tal Herbsman MD	General Member	52 Wisconsin Psychiatric Association
000000054969	Michael Miller Kaplan MD	Fellow	52 Wisconsin Psychiatric Association
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000001183192	Monika Aneja Khiani MD	General Member	52 Wisconsin Psychiatric Association
000001079286	Annaliese Marie Koller Shumate DO	Resident-Fellow Member	52 Wisconsin Psychiatric Association
000000065981	Rachel Arnold Long M.D.	General Member	52 Wisconsin Psychiatric Association
000000058880	W Bradford Lyles MD	Distinguished Fellow	52 Wisconsin Psychiatric Association
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000000078474	Vani Ray MD	Fellow	52 Wisconsin Psychiatric Association
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000000308397	Steven A Sandstrom MD	General Member	52 Wisconsin Psychiatric Association
000001004043	Sid H Siahpush MD PhD	General Member	52 Wisconsin Psychiatric Association
000000064546	Ather S Siddiqui M.D.	Fellow	52 Wisconsin Psychiatric Association
000000044808	Melvin Jay Soo Hoo M.D.	General Member	52 Wisconsin Psychiatric Association
000000060404	Jeffrey Earle Taxman M.D.	General Member	52 Wisconsin Psychiatric Association
000001023363	Elena Vilija Tuskenis MD	General Member	52 Wisconsin Psychiatric Association
000001017682	Susan C Uyanna MD MPH	General Member	52 Wisconsin Psychiatric Association
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000001106292	Tzeggai Berhe MD	General Member	53 Western Canada District Branch
000000313157	Sara K Binder MD	General Member	53 Western Canada District Branch
000001211642	Simon Bow MD	Resident-Fellow Member	53 Western Canada District Branch
000001112684	Niki Boyko MD	Resident-Fellow Member	53 Western Canada District Branch
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000001068213	Jessica Brown MD	Resident-Fellow Member	53 Western Canada District Branch
000000062749	Kurt Werner Buller M.D.	General Member	53 Western Canada District Branch
000001016023	Liliana Buzatu MD	General Member	53 Western Canada District Branch
000001015810	Kristjana Cameron MD	General Member	53 Western Canada District Branch
000001131843	Stacy Campbell MD	Resident-Fellow Member	53 Western Canada District Branch
000001207602	Magdalena Anna Casagrande MD	Resident-Fellow Member	53 Western Canada District Branch
000001038499	Brian Chaze MD	General Member	53 Western Canada District Branch
000001042183	Joanna Cheek MD	General Member	53 Western Canada District Branch
000001128869	Kaitlin Chivers-Wilson MD	Resident-Fellow Member	53 Western Canada District Branch
000001126355	Sebastien Chow MD	Resident-Fellow Member	53 Western Canada District Branch
000000082790	Mary C Connolly M.D.	General Member	53 Western Canada District Branch
000000078933	Brenda Copen MD	General Member	53 Western Canada District Branch
000000078934	John Copen M.D.	General Member	53 Western Canada District Branch
0000001127116	Stacy Cormack MD	Resident-Fellow Member	53 Western Canada District Branch
00000112/110	Julie Davison MD	Resident-Fellow Member	53 Western Canada District Branch
000001128665	Janet Margaret de Groot M.D.	General Member	53 Western Canada District Branch
30000000025	James margares de Groot M.D.	02	J. Western Canada District Dianell

000000307613	Sandra L Demaries M.D.	General Member	53 Western Canada District Branch
000000078958	Paul Gerard Devlin FRCPC MD	General Member	53 Western Canada District Branch
000001044739	Kuljit Dhaliwal MD	Resident-Fellow Member	53 Western Canada District Branch
000001017071	Omar Din MD	General Member	53 Western Canada District Branch
000001006433	Ryan N Drew-Scott MD	General Member	53 Western Canada District Branch
000001212440	Pu Duan MD	Resident-Fellow Member	53 Western Canada District Branch
000001130542	Maryana Duchcherer MD	General Member	53 Western Canada District Branch
000000305376	Kent Dunn M.D.	General Member	53 Western Canada District Branch
000001130545	Charl Els MD	General Member	53 Western Canada District Branch
000001060235	Nadeesha L Fernando MD	Resident-Fellow Member	53 Western Canada District Branch
000001127938	Brynn Fredricksen MD	Resident-Fellow Member	53 Western Canada District Branch
000001005751	Kathryn C Fung MD	General Member	53 Western Canada District Branch
000001016025	Dr. Shreyasi Gollapudi	General Member	53 Western Canada District Branch
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000001127870	Priyanka Halli MD	Resident-Fellow Member	53 Western Canada District Branch
000000092381	James G Harris M.D.	General Member	53 Western Canada District Branch
000001232818	Roshan Hegde MD	Resident-Fellow Member	53 Western Canada District Branch
000001235803	Nicola P Hodelet MB	General Member	53 Western Canada District Branch
000001225165	Stephanie Hyder MD	Resident-Fellow Member	53 Western Canada District Branch
000001230685	Rajat Jayas MD	Resident-Fellow Member	53 Western Canada District Branch
000001212098	Asia Karakoc MD	Resident-Fellow Member	53 Western Canada District Branch
000001008551	Juliana S Kirova MD	General Member	53 Western Canada District Branch
000001128445	Jasmina Kobiljski MD	Resident-Fellow Member	53 Western Canada District Branch
000001128446	Alexander Leung MD	Resident-Fellow Member	53 Western Canada District Branch
000000080951	Donald W Lint M.D.	Fellow	53 Western Canada District Branch
000001224650	Cindy Liu MD	Resident-Fellow Member	53 Western Canada District Branch
000001002262	Das S Madhavan MBBS	General Member	53 Western Canada District Branch
000001127843	Ai Van Shelly Mark MD	Resident-Fellow Member	53 Western Canada District Branch
000001079262	Jeanine Marshall MD	Resident-Fellow Member	53 Western Canada District Branch
000001224961	Nicole Jacqueline Martin MD	Resident-Fellow Member	53 Western Canada District Branch
000001066500	Joanna McDermid MD	Resident-Fellow Member	53 Western Canada District Branch
000001009723	Mohamed A Megahed Gheis MD	General Member	53 Western Canada District Branch
000001211639	Nicholas Misri MBBS	Resident-Fellow Member	53 Western Canada District Branch
000001067032	Jessica M Moretti MD	Resident-Fellow Member	53 Western Canada District Branch
000001098336	Dina Munim MD	Resident-Fellow Member	53 Western Canada District Branch
000001039928	Rocio Nino-Osorio MD	General Member	53 Western Canada District Branch
000001226013	Graeme D Omelan MD	Resident-Fellow Member	53 Western Canada District Branch
000000302903	Alec O Oskin M.D.	General Member	53 Western Canada District Branch
000001014957	Andriyka Papish MD	General Member	53 Western Canada District Branch
000000067357	Anne Marguerite Parker MD	General Member	53 Western Canada District Branch
000001096107	Eytan Perl MD	Resident-Fellow Member	53 Western Canada District Branch
000001135089	Francois Pretorius MD	General Member	53 Western Canada District Branch
000001137243	Krishnavellie Reddi MD	General Member	53 Western Canada District Branch
000001060876	Karen Alexandra Rivera MD	General Member	53 Western Canada District Branch
000001127952	Dawn Roccamatisi MD	Resident-Fellow Member	53 Western Canada District Branch
000001096582	Suzanne D Ronald MD	Resident-Fellow Member	53 Western Canada District Branch
000001214154	Rachel Allegra Rothbart MB	Resident-Fellow Member	53 Western Canada District Branch
000000068694	Christian Schenk M.D.	General Member	53 Western Canada District Branch
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000000066589	Barry Michael Segal M.D.	General Member	53 Western Canada District Branch
000001127716	Mohit Singh MD	Resident-Fellow Member	53 Western Canada District Branch
000001128418	Rahul Soma MD	Resident-Fellow Member	53 Western Canada District Branch
000001067371	Faiza Somji MD	Resident-Fellow Member	53 Western Canada District Branch
000001056183	Christopher John Staniforth MD	Resident-Fellow Member	53 Western Canada District Branch
000001229835	Petra Stephen MD	Resident-Fellow Member	53 Western Canada District Branch
000000083789	Kevin W Stevenson M.D.	General Member	53 Western Canada District Branch
000001223465	Robert Tanguay MD	Resident-Fellow Member	53 Western Canada District Branch
000001005923	Nadia Nicole Tomy MD	General Member	53 Western Canada District Branch
000001000574	Andrea Tuka MD	General Member	53 Western Canada District Branch
000000086573	William G Warrian M.D.	General Member	53 Western Canada District Branch
000001132633	Russell G Williams MD	General Member	53 Western Canada District Branch
000000080746	Anna B Wisniewska M.D.	General Member	53 Western Canada District Branch
000000084747	Angela S Wong MD	General Member	53 Western Canada District Branch
000001128592	Margaret Wong MD	Resident-Fellow Member	53 Western Canada District Branch
000001209931	Dmitri Zanozin MD	Resident-Fellow Member	53 Western Canada District Branch
000001003969	April M Baisden MD	General Member	54 West Virginia Psychiatric Association
000001068669	Stephen S Brown MD	General Member	54 West Virginia Psychiatric Association
000001018474	Srikanth Challagundla MD	General Member	54 West Virginia Psychiatric Association
000001078197	Vien Dinh MD	Resident-Fellow Member	54 West Virginia Psychiatric Association
000000082281	Stephen D Durrenberger M.D.	General Member	54 West Virginia Psychiatric Association
000001051402	Scott A Gilchrist MD	General Member	54 West Virginia Psychiatric Association
000000304317	Cheryl A Hill M.D.	General Member	54 West Virginia Psychiatric Association
000001111011	Joe H Hime III MD	Resident-Fellow Member	54 West Virginia Psychiatric Association
000000086553	Gianluca La Monaca M.D.	Fellow	54 West Virginia Psychiatric Association
000000084063	Julie E Lewerenz MD	General Member	54 West Virginia Psychiatric Association
000001016927	Melissa A Moody MD	General Member	54 West Virginia Psychiatric Association
000000089317	Christopher J Murphy M.D.	General Member	54 West Virginia Psychiatric Association
000000058944	Victor Ferris Nease M.D.	General Member	54 West Virginia Psychiatric Association
000001017847	Srikanth Nimmagadda MD	General Member	54 West Virginia Psychiatric Association
000000039713	Lawrence D Ostrow M.D.	Life Fellow	54 West Virginia Psychiatric Association
000001111009	Audrey M Schellhaus MD	Resident-Fellow Member	54 West Virginia Psychiatric Association
000000062658	Ted Douglas Thornton M.D.	General Member	54 West Virginia Psychiatric Association
000000067626	Russ Irvin Voltin M.D.	General Member	54 West Virginia Psychiatric Association
000000064678	E Kathryn Worthington MD	General Member	54 West Virginia Psychiatric Association
000001004466	Nikole S Benders-Hadi MD	General Member	55 West Hudson Psychiatric Society
000000078979	Diane DiGiacomo M.D.	General Member	55 West Hudson Psychiatric Society
000000029001	Andrew Hornstein MD	Life Member	55 West Hudson Psychiatric Society
000000083432	Mirlande Jordan M.D.	General Member	55 West Hudson Psychiatric Society
000000032371	Barry Lester Krumper M.D.	Life Member	55 West Hudson Psychiatric Society
000000311067	Iva K Lesniak DO	General Member	55 West Hudson Psychiatric Society
000000042226	Eric Bart London M.D.	General Member	55 West Hudson Psychiatric Society
000000030682	Peter Joseph Panzarino MD	Distinguished Life Fellow	55 West Hudson Psychiatric Society
000000104024	Shelly Pasternak M.D.	General Member	55 West Hudson Psychiatric Society
000001010138	Clovis Raymond MD	General Member	55 West Hudson Psychiatric Society
000001004684	Balveen Singh DO	General Member	55 West Hudson Psychiatric Society
000000027992	Robert Neal Sobel M.D.	Life Member	55 West Hudson Psychiatric Society
000001008111	Suma Srishaila MD MPH	General Member	55 West Hudson Psychiatric Society
000001001269	Sascha Arbouet MD	General Member	56 Central New York District Branch
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000001147027	Joseph J Biedrzycki DO	Resident-Fellow Member	56 Central New York District Branch
000000032748	Shahindokht Buchan MD	Life Member	56 Central New York District Branch
000001004436	Kim Nancy Sison Duque MD	General Member	56 Central New York District Branch
000000021042	Jonathan Ecker MD	Distinguished Life Fellow	56 Central New York District Branch
000001000782	Anwarul Karim MD	General Member	56 Central New York District Branch
000000068286	Helen MacGregor MD	Distinguished Fellow	56 Central New York District Branch
000001157564	Andrew Manoski DO	Resident-Fellow Member	56 Central New York District Branch
000001222714	Mirabelle Mattar MD	Resident-Fellow Member	56 Central New York District Branch
000001163837	Lisa Marie O'Connor MD	General Member	56 Central New York District Branch
000001229006	Curtis Phillips MD	Resident-Fellow Member	56 Central New York District Branch
000001215588	Swati S Shivale MBBS	Resident-Fellow Member	56 Central New York District Branch
000000033953	Jud Adam Staller MD	Life Fellow	56 Central New York District Branch
000001151545	Brandon Yeager MD	General Member	56 Central New York District Branch
000000072274	Safdar Ali M.D.	General Member	57 Arizona Psychiatric Society
000001009326	Mona Amini MD	General Member	57 Arizona Psychiatric Society
000001004133	Margaret E Balfour PhD MD	General Member	57 Arizona Psychiatric Society
000000087204	Winona Z Belmonte M.D.	General Member	57 Arizona Psychiatric Society
000000032714	David Sidney Burgoyne MD	Distinguished Life Fellow	57 Arizona Psychiatric Society
000001013874	Richard Ducusin Camacho MD	General Member	57 Arizona Psychiatric Society
000000104701	Jason Philip Caplan M.D.	Fellow	57 Arizona Psychiatric Society
000001206000	Krystal Fair Chavez DO	Resident-Fellow Member	57 Arizona Psychiatric Society
000001007725	Naveen K Cherukuri MD	General Member	57 Arizona Psychiatric Society
000000104585	Sherry Dianne Dekeyser MD	General Member	57 Arizona Psychiatric Society
000001017632	Matthew Barret DeLiere MD	General Member	57 Arizona Psychiatric Society
000001079652	Michael Paul Downes II MD	Resident-Fellow Member	57 Arizona Psychiatric Society
000000070392	Christine E Edberg M.D.	General Member	57 Arizona Psychiatric Society
000000045098	David Clifford Emelity MD	Fellow	57 Arizona Psychiatric Society
000000089135	Katherine Marie Erdwinn MD	General Member	57 Arizona Psychiatric Society
000001217215	Jeanette E Ferguson MD	Resident-Fellow Member	57 Arizona Psychiatric Society
000000065712	Karl Gathof M.D.	General Member	57 Arizona Psychiatric Society
000000068126	Tariq M Ghafoor M.D.	General Member	57 Arizona Psychiatric Society
000000083596	Shareh Osman Ghani MD	General Member	57 Arizona Psychiatric Society
000001235386	Bahar Golestan MD	Resident-Fellow Member	57 Arizona Psychiatric Society
000001190177	Sasha Hamdani MD	Resident-Fellow Member	57 Arizona Psychiatric Society
000001066099	Sharron Jones-Daggett MD MS	Resident-Fellow Member	57 Arizona Psychiatric Society
000001013705	Amie E Kafer DO	General Member	57 Arizona Psychiatric Society
000000080699	Roya Karbakhsh MD	General Member	57 Arizona Psychiatric Society
000001004478	Courtney Keckich MD	General Member	57 Arizona Psychiatric Society
000000102237	Navaid A Khan MD MPH	Fellow	57 Arizona Psychiatric Society
000000308927	Daniel Kenneth Merrill MD	General Member	57 Arizona Psychiatric Society
000001268693	Supriya Nair DO	General Member	57 Arizona Psychiatric Society
000001112830	Tam N. Redd MD	Resident-Fellow Member	57 Arizona Psychiatric Society
000001109687	Kinjal Patel DO	Resident-Fellow Member	57 Arizona Psychiatric Society
000000306848	Shaili K Patel MD	General Member	57 Arizona Psychiatric Society
000000079251	Christine C Pletkova M.D.	General Member	57 Arizona Psychiatric Society
000000300706	Mohamed I Ramadan MD	Fellow	57 Arizona Psychiatric Society
000001014200	Roopa Sethi MD	General Member	57 Arizona Psychiatric Society
000000038811	Gerald Pawling Shaw M.D.	Life Member	57 Arizona Psychiatric Society
000000085190	Leigh Dudek Sorokin MD	General Member	57 Arizona Psychiatric Society
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000000066538	Michael W Sweeney M.D.	General Member	57 Arizona Psychiatric Society
000001077472	Suzanne Tariot Sheard DO	General Member	57 Arizona Psychiatric Society
000001212195	Misty Tu MD	General Member	57 Arizona Psychiatric Society
000000088045	Christopher B Wiegand M.D.	Fellow	57 Arizona Psychiatric Society
000001017384	Aaron R Wilson MD	General Member	57 Arizona Psychiatric Society
000000067018	Ron Wright MD PhD	General Member	57 Arizona Psychiatric Society
000000069969	Jill Zweig DO	General Member	57 Arizona Psychiatric Society
000001113725	Matthew Todd Boire MD	General Member	58 Oregon Psychiatric Physicians Assn
000001156253	Leigh Anne Bressler DO	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000001073075	Laura Anne Brogoch MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000000033865	Robert Earl Buckler M.D.	Distinguished Life Fellow	58 Oregon Psychiatric Physicians Assn
000000032715	Ronald Edwin Cafferky M.D.	Life Member	58 Oregon Psychiatric Physicians Assn
000000309710	Daniel W Dick MD	General Member	58 Oregon Psychiatric Physicians Assn
000000085351	Todd D Eisenberg M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000001000404	Benjamin R Eliason MD	General Member	58 Oregon Psychiatric Physicians Assn
000001156901	Pari Faraji MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000000091499	Kathryn J Flegel M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000001162930	Brent Frazee MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000001184587	Anne Gross MD	General Member	58 Oregon Psychiatric Physicians Assn
000000067065	Richard Peter Hedlund M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000000030874	Hugh Richard Henderson MD PC	Life Member	58 Oregon Psychiatric Physicians Assn
000000091427	Holly A Hoch M.D.	Fellow	58 Oregon Psychiatric Physicians Assn
000001006370	Jonathan T Horey MD	General Member	58 Oregon Psychiatric Physicians Assn
000001052873	Monique M Jones MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000000070888	Ross David Judice MD MPH	General Member	58 Oregon Psychiatric Physicians Assn
000000080987	Joel C Julian MD	General Member	58 Oregon Psychiatric Physicians Assn
000001158114	Vanessa Ann Katon DO	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000001006840	Melanie Kim MD	General Member	58 Oregon Psychiatric Physicians Assn
000001098326	Sunny Kim MD	General Member	58 Oregon Psychiatric Physicians Assn
000001006441	John R Kratzer MD	General Member	58 Oregon Psychiatric Physicians Assn
000001049796	Mary Kristine Lajoy MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000000305758	Carmel C Lakhani M.D.	Fellow	58 Oregon Psychiatric Physicians Assn
000000311935	Stephanie M Lopez MD	General Member	58 Oregon Psychiatric Physicians Assn
000000311311	Joel D Mack MD	General Member	58 Oregon Psychiatric Physicians Assn
000000071543	Jeffrey D Meyerhoff M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000000073941	Dale N Oller M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000000101861	Kara Laure Pattinson M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000001004796	Carolyn M Phelps MD MSW	General Member	58 Oregon Psychiatric Physicians Assn
000000312855	Asad Mahmood Qalbani MD	General Member	58 Oregon Psychiatric Physicians Assn
000001115704	Veena Raju MD	Resident-Fellow Member	58 Oregon Psychiatric Physicians Assn
000000062508	Jamie Nevelle Read M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000001065114	Shannon Liane Robinson MD	General Member	58 Oregon Psychiatric Physicians Assn
000001015425	Sarah L Roff MD PhD	General Member	58 Oregon Psychiatric Physicians Assn
000001014132	Clara Marina Ruiz MD	General Member	58 Oregon Psychiatric Physicians Assn
000000022370	Lee Wolfe Shershow MD	Life Member	58 Oregon Psychiatric Physicians Assn
000001009345	Michael S Stanley MD	General Member	58 Oregon Psychiatric Physicians Assn
000001196464	Jason Richard Stone MD	General Member	58 Oregon Psychiatric Physicians Assn
000000081049	Lulu Sim Tsai M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000000090361	Rochelle R Tucker M.D. Ph.D.	General Member	58 Oregon Psychiatric Physicians Assn

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000000074096	Lance D Turner M.D.	General Member	58 Oregon Psychiatric Physicians Assn
000000301687	Nedim Hukovic MD	Fellow	59 Northern New York District Branch
000000070186	Arunadevi S. Reddy M.D.	General Member	59 Northern New York District Branch
000000077287	Nalin K Sinha M.D.	General Member	59 Northern New York District Branch
000001007870	Rekha Vijayan MD MBBS	General Member	59 Northern New York District Branch
000001115219	Michael Anderson MD	General Member	60 Alabama Psychiatric Physicians Assn
000000042065	Lee Ian Ascherman M.D.	General Member	6o Alabama Psychiatric Physicians Assn
000000027275	Winkler D Bond MD	Life Member	60 Alabama Psychiatric Physicians Assn
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000001097124	Maria A Hamilton MD	Resident-Fellow Member	6o Alabama Psychiatric Physicians Assn
000001013838	Nathaniel James Hansen MD	General Member	6o Alabama Psychiatric Physicians Assn
000000078358	James B Hassell M.D.	General Member	6o Alabama Psychiatric Physicians Assn
000000060609	Charles Ross Hayden M.D.	General Member	60 Alabama Psychiatric Physicians Assn
000000029050	A Gerry Hodges MD	Life Member	60 Alabama Psychiatric Physicians Assn
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000000303711	Dinesh K Karumanchi M.D.	Fellow	60 Alabama Psychiatric Physicians Assn
000001017462	Nina Vanessa Kraguljac MD	General Member	60 Alabama Psychiatric Physicians Assn
000001017461	Li Li MD PhD	General Member	60 Alabama Psychiatric Physicians Assn
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000001017591	Jayakrishna S Madabushi MD	General Member	60 Alabama Psychiatric Physicians Assn
000001053383	Stephan R Meadors MD	General Member	60 Alabama Psychiatric Physicians Assn
000000043362	Daniel T Meadows MD	Life Member	60 Alabama Psychiatric Physicians Assn
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000001017759	Mary Osborne MD	General Member	60 Alabama Psychiatric Physicians Assn
000000062473	James Edward Parker MD	Fellow	60 Alabama Psychiatric Physicians Assn
000001008432	Stephanie Elaine Parrish MD	General Member	60 Alabama Psychiatric Physicians Assn
000001017458	Rachel L Pope MD	General Member	60 Alabama Psychiatric Physicians Assn
000000071456	Magdy Ayad Ragheb M.D.	General Member	60 Alabama Psychiatric Physicians Assn
000000076885	Saeed A Shah M.D.	Fellow	60 Alabama Psychiatric Physicians Assn
000001086806	George Michael Shehi Jr MD	Resident-Fellow Member	60 Alabama Psychiatric Physicians Assn
000001171445	Richard Sean Sinclair MD	Resident-Fellow Member	60 Alabama Psychiatric Physicians Assn
000001058240	Madhav V Soni MD	General Member	60 Alabama Psychiatric Physicians Assn
000000085381	Mary Avery Strong DO	General Member	60 Alabama Psychiatric Physicians Assn
000001000973	John C Strunk MD	Fellow	60 Alabama Psychiatric Physicians Assn
000001171446	Christina M Talerico MD	Resident-Fellow Member	60 Alabama Psychiatric Physicians Assn
000000028244	Elizabeth O Trawick MD	Life Member	60 Alabama Psychiatric Physicians Assn
000000040071	Charles Mac Van Valkenburg M.D.	General Member	60 Alabama Psychiatric Physicians Assn
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000001124509	Marina Susana Colombo MD	General Member	61 Utah Psychiatric Association
000000038601	Joe Campbell Culbertson MD	Life Member	61 Utah Psychiatric Association
000001113029	Michael David Deveau MD	Resident-Fellow Member	61 Utah Psychiatric Association
000001087720	Meghan Edmundson MD	Resident-Fellow Member	61 Utah Psychiatric Association
000000089432	Lisa Ann Fraleigh DO	General Member	61 Utah Psychiatric Association
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000001112066	Farzad Kamyar MD MBA	Resident-Fellow Member	61 Utah Psychiatric Association
000000090270	James L Kimball MD	General Member	61 Utah Psychiatric Association
000001001012	Travis M Lajoie DO	General Member	61 Utah Psychiatric Association
000001013719	Benjamin R Lewis MD	General Member	61 Utah Psychiatric Association
000001021284	Heidee Lund MD MBA	General Member	61 Utah Psychiatric Association
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000001004530	Travis Scott Mickelson MD	General Member	61 Utah Psychiatric Association
000001107856	Joshua M Mitchell MD MPH	Resident-Fellow Member	61 Utah Psychiatric Association
000001105405	Jay Patrick Nichols MD	Resident-Fellow Member	61 Utah Psychiatric Association
000001009396	Jennifer Grace ODonohoe MD	General Member	61 Utah Psychiatric Association
000000056312	Daniel Rapp MD	General Member	61 Utah Psychiatric Association
000001115043	Sheena Margaret Ray DO	Resident-Fellow Member	61 Utah Psychiatric Association
000001137521	Darrell Allan Roberge DO	Resident-Fellow Member	61 Utah Psychiatric Association
000000303788	Kent D Roundy M.D.	General Member	61 Utah Psychiatric Association
000000072781	Michael S Roundy M.D.	General Member	61 Utah Psychiatric Association
000001017141	Jeffrey Russell Sindt MD	General Member	61 Utah Psychiatric Association
000001115019	Wei Song MD	Resident-Fellow Member	61 Utah Psychiatric Association
000000033422	Richard Beck Spencer M.D.	General Member	61 Utah Psychiatric Association
000001100927	Andre Sullivan MD	General Member	61 Utah Psychiatric Association
000001009359	Kort C Ulicny MD	General Member	61 Utah Psychiatric Association
000001158264	Keerthi Priya Vejerla MD	Resident-Fellow Member	61 Utah Psychiatric Association
000000102282	Susan Marie Wiet M.D.	General Member	61 Utah Psychiatric Association
000001004491	Ryan R Williams MD	Fellow	61 Utah Psychiatric Association
000001117043	Jennifer A Wlodarski MD	Resident-Fellow Member	61 Utah Psychiatric Association
000001158260	Rong Xiao MD PhD	Resident-Fellow Member	61 Utah Psychiatric Association
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000001014284	Dilek Iris Avci MD	General Member	62 Maine Assn of Psychiatric Physicians
000000086420	Rana F Dagher MD	General Member	62 Maine Assn of Psychiatric Physicians
000001016984	Monica L Daigle DO	Resident-Fellow Member	62 Maine Assn of Psychiatric Physicians
000000025063	Neil Bonham Edwards MD	Distinguished Life Fellow	62 Maine Assn of Psychiatric Physicians
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000000305173	Jennifer Lynn Graham M.D.	General Member	62 Maine Assn of Psychiatric Physicians
000000058598	Benjamin Cesare Grasso M.D.	General Member	62 Maine Assn of Psychiatric Physicians
000001109625	Joanna Elizabeth Gratton DO	General Member	62 Maine Assn of Psychiatric Physicians
000001069622	Christine E James DO	Resident-Fellow Member	62 Maine Assn of Psychiatric Physicians
000000091224	Tatyana Karchov M.D.	General Member	62 Maine Assn of Psychiatric Physicians
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000001040988	Theodore P Logan MD	General Member	62 Maine Assn of Psychiatric Physicians
000000311281	Melanie L Morin MD	General Member	62 Maine Assn of Psychiatric Physicians
000000080197	Paul Franklin Perkins MD	General Member	62 Maine Assn of Psychiatric Physicians
000000087664	Michael Price M.D.	Distinguished Fellow	62 Maine Assn of Psychiatric Physicians
000000082993	Timothy F Rockcress M.D.	General Member	62 Maine Assn of Psychiatric Physicians
000000064847	David Eric Schenk MD	Fellow	62 Maine Assn of Psychiatric Physicians
000000079849	Kristin N Smith M.D.	General Member	62 Maine Assn of Psychiatric Physicians
000000045544	William Michael Sullivan M.D.	Life Member	62 Maine Assn of Psychiatric Physicians
000000081009	David E Walter DO	General Member	62 Maine Assn of Psychiatric Physicians
000001190410	Vyoma Acharya MBBS MBA	Resident-Fellow Member	63 North Dakota Psychiatric Society
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000000312235	Michael P Capan MD	Fellow	63 North Dakota Psychiatric Society
000000068876	Thomas James Eick DO	General Member	63 North Dakota Psychiatric Society
000001127091	Sateesh Kumar Gunda MD	Resident-Fellow Member	63 North Dakota Psychiatric Society
000001098332	Nihit Gupta MD	Resident-Fellow Member	63 North Dakota Psychiatric Society
000000075695	Robin M Haaland M.D.	General Member	63 North Dakota Psychiatric Society
000001158848	Amer Ibrahim MD	General Member	63 North Dakota Psychiatric Society
000001128896	Julie O Jarvis DO	General Member	63 North Dakota Psychiatric Society
000001015541	Eric Carl Swensen MD	General Member	63 North Dakota Psychiatric Society
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000001017356	Nevin Arora MD	General Member	64 San Diego Psychiatric Society
000001103026	Jabe M Best MD PhD	Resident-Fellow Member	64 San Diego Psychiatric Society
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000001016228	YuFang Chang MD	General Member	64 San Diego Psychiatric Society
000001160806	Theresa Chen MD MPH	Resident-Fellow Member	64 San Diego Psychiatric Society
000001011519	Maria Carolina Court MD	General Member	64 San Diego Psychiatric Society
000001009048	Natalie Do DO	Resident-Fellow Member	64 San Diego Psychiatric Society
000001002724	Nicole E Esposito MD	General Member	64 San Diego Psychiatric Society
000000079929	Natalia Fudim MD	Fellow	64 San Diego Psychiatric Society
000001042390	Andrea Gallardo MD	Resident-Fellow Member	64 San Diego Psychiatric Society
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000001013428	Steve Hyun Koh MD	Fellow	64 San Diego Psychiatric Society
000001004923	Kristy A Lamb MD	General Member	64 San Diego Psychiatric Society
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000001056717	Ryan A Salahi MD	General Member	64 San Diego Psychiatric Society
000001100513	Christian Robert Small MD	Resident-Fellow Member	64 San Diego Psychiatric Society
000000308389	Ipsit Vihang Vahia MD	General Member	64 San Diego Psychiatric Society
000000305106	Lauretta A Ziajko MD	General Member	64 San Diego Psychiatric Society
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000001159822	Dustin Robert Dippen MD	Resident-Fellow Member	66 Vermont Psychiatric Association
000001083705	Patricia A Fintak MD	Resident-Fellow Member	66 Vermont Psychiatric Association
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000001008800	Edward MacPhee MD	General Member	66 Vermont Psychiatric Association
000001158846	Sanchit Maruti MD	Resident-Fellow Member	66 Vermont Psychiatric Association
000000087620	Maria L Novas-Schmidt MD	General Member	66 Vermont Psychiatric Association
000001011510	Jessica E O'Neil DO	General Member	66 Vermont Psychiatric Association
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000000058099	Paula Jones Lockhart MD	Fellow	67 Psychiatric Medical Assn of New Mexico
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000000089735	Elizabeth Ann Romero MD	General Member	67 Psychiatric Medical Assn of New Mexico
000000077324	John L Schaeffer DO	General Member	67 Psychiatric Medical Assn of New Mexico
000001217664	Pedro Simpson MD	General Member	67 Psychiatric Medical Assn of New Mexico
000000091992	Zinat Sobhani M.D.	General Member	67 Psychiatric Medical Assn of New Mexico
000001130540	Kristina Sowar MD	General Member	67 Psychiatric Medical Assn of New Mexico
000000303903	Reuben Sutter M.D.	General Member	67 Psychiatric Medical Assn of New Mexico
000000092372	Paul Tiger MD	General Member	67 Psychiatric Medical Assn of New Mexico
000000084353	Margaret A Bahder M.D.	General Member	68 New Hampshire Psychiatric Society
000001098459	Danielle Dahle MD	General Member	68 New Hampshire Psychiatric Society
000001169085	Wilder T Doucette MD PhD	General Member	68 New Hampshire Psychiatric Society
000000025970	Ronald Lloyd Green MD	Distinguished Life Fellow	68 New Hampshire Psychiatric Society
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000000031591	C D Hanson M.D.	Life Member	68 New Hampshire Psychiatric Society
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000001002158	Michael D McNamara DO	General Member	68 New Hampshire Psychiatric Society
000001098337	Larry Mitnaul MD MPH	Resident-Fellow Member	68 New Hampshire Psychiatric Society
000001112065	Vijay Phalgoo MD	General Member	68 New Hampshire Psychiatric Society
000000088410	Rekha C Rao MD	General Member	68 New Hampshire Psychiatric Society
000001246091	Magdalena Romanowicz MD	General Member	68 New Hampshire Psychiatric Society
000001017100	Katherine Marie Shea MD	Resident-Fellow Member	68 New Hampshire Psychiatric Society
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000000306893	William Almodovar Sanchez MD	General Member	70 Puerto Rico Psychiatric Society
000001091210	Ana Yolanda Anguita MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001095277	Joalex L Antongiorgi MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001038128	Hector Ruben Caban MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000000040947	Fernando Cabrera-Delgado MD	Distinguished Fellow	70 Puerto Rico Psychiatric Society
000001017758	Viriana Diez Gutierrez MD	General Member	70 Puerto Rico Psychiatric Society
000000086696	Rafael J Echeverria M.D.	General Member	70 Puerto Rico Psychiatric Society
000001083704	Gustavo Enrique Fors MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
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000001158271	Suleika W Galindo Vicens	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001158269	Sharon N Gonzalez MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000000080436	Jorge Gonzalez-Barreto M.D.	General Member	70 Puerto Rico Psychiatric Society
000001052497	Carlos A Hurtado MD	General Member	70 Puerto Rico Psychiatric Society
000001147963	Carissa A Kindy MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001169681	Maritza N Laura MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001171046	Ann M Maldonado-Vazquez MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001055077	Veronica Miranda MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001153975	Delimar Miranda-Viera MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001093829	Ruben Pinero Fuentes MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000000021558	Felix Oswaldo Pitterson M.D.	Distinguished Life Fellow	70 Puerto Rico Psychiatric Society
000001145612	Alex Sandra Porrata Ortiz MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
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000001231882	Myuna Ruiz MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001181274	Luna T Sanchez-Rivera MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000000074524	Lillian Yvonne Segarra MD	General Member	70 Puerto Rico Psychiatric Society
000001103670	German Leroy Serrano-Cruet MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001169823	Ana Suarez MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001113027	Melanie Tapia MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001023469	Caroline Patricia Toro MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001158278	Jonathan Torres Crespo MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
000001044186	Mary Tere Zamora-Lopez MD	Resident-Fellow Member	70 Puerto Rico Psychiatric Society
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000000069088	Charles Frank Burgess M.D.	General Member	71 Alaska District Branch
000001006642	Monique C Dase MD	General Member	71 Alaska District Branch
000000055578	Gregory Alan McCarthy MD	General Member	71 Alaska District Branch
000000066138	David George Ondich M.D.	General Member	71 Alaska District Branch
000001114497	Ann M Bowden MD	General Member	72 South Dakota Psychiatric Association
000001089081	James Chiu MD	General Member	72 South Dakota Psychiatric Association
000000065169	John Talbott Blodgett M.D.	General Member	73 Montana Psychiatric Association
000000070929	Tatjana Caddell DO	General Member	73 Montana Psychiatric Association
000000028453	Richard Reid Felix MD	Distinguished Life Fellow	73 Montana Psychiatric Association
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000000079988	Eleanore R Hobbs M.D.	General Member	73 Montana Psychiatric Association
000000055141	Daniel Allen Korb M.D.	General Member	73 Montana Psychiatric Association
000000088003	Lynn M Mousel MD	General Member	73 Montana Psychiatric Association
000001004937	Andrea L Mow DO	General Member	73 Montana Psychiatric Association
000000080406	Amy E Schuett M.D.	Fellow	73 Montana Psychiatric Association
000000063995	Richard Bralliar DO	General Member	74 Nevada Psychiatric Association
000001017774	Kimberlee Charles MD	General Member	74 Nevada Psychiatric Association
000001076459	Jayleen Chen MD	Resident-Fellow Member	74 Nevada Psychiatric Association
000001110816	Ying-Chia Cheng DO	Resident-Fellow Member	74 Nevada Psychiatric Association
000000071540	Sean Reid Duffy MD	Fellow	74 Nevada Psychiatric Association
000001112551	Jeremy Ernst DO	Resident-Fellow Member	74 Nevada Psychiatric Association
000001147952	Jonathan Ryan Floriani MD	Resident-Fellow Member	74 Nevada Psychiatric Association
000001053408	Deepa Hasija MD	Resident-Fellow Member	74 Nevada Psychiatric Association
000001014096	Priscilla C Hidalgo MD	General Member	74 Nevada Psychiatric Association

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000000300183	Leslie Jeanne Howell DO	General Member	74 Nevada Psychiatric Association
000000308056	Yvette R Kaunismaki M.D.	General Member	74 Nevada Psychiatric Association
000001013807	Ritesh Kool MD	General Member	74 Nevada Psychiatric Association
000001152073	Matthew Ford Larsen DO	Resident-Fellow Member	74 Nevada Psychiatric Association
000001001064	Ryan Ley MD	General Member	74 Nevada Psychiatric Association
000001110817	Kathryn A Lowery DO	Resident-Fellow Member	74 Nevada Psychiatric Association
000000102130	Jerome N Nwokike M.D.	General Member	74 Nevada Psychiatric Association
000001017077	Daniel Park DO	General Member	74 Nevada Psychiatric Association
000001110815	Brian M Pierson MD	Resident-Fellow Member	74 Nevada Psychiatric Association
000001016512	Tracy Regina Protell MD	General Member	74 Nevada Psychiatric Association
000001055910	Mustafa M Rawaf DO	General Member	74 Nevada Psychiatric Association
000001134424	Erika Ryst MD	General Member	74 Nevada Psychiatric Association
000001008573	Faisal A Suba MD	General Member	74 Nevada Psychiatric Association
000001151217	John Tan MD	Resident-Fellow Member	74 Nevada Psychiatric Association
000000065136	Eva King Wang M.D.	Life Member	74 Nevada Psychiatric Association
000000070909	Linda J White MD	General Member	74 Nevada Psychiatric Association
000000086694	David Morgan Martorano MD	General Member	75 Wyoming Assn of Psychiatric Physicians
000001000531	Joseph G Schaaf MD	General Member	75 Wyoming Assn of Psychiatric Physicians
000001193419	Edwin Romel Soriano de Leon MD	General Member	76 Orange County Psychiatric Society
000000038112	Michael David Doucette M.D.	Life Fellow	76 Orange County Psychiatric Society
000001000491	Brenda L Garro MD	General Member	76 Orange County Psychiatric Society
000000311871	Khoiviet Hathuc DO	General Member	76 Orange County Psychiatric Society
000000043719	Kathleen Ann Herron MD	Fellow	76 Orange County Psychiatric Society
000001144834	Varsha Iyer MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000044654	Robert Royce Johnson DO	Fellow	76 Orange County Psychiatric Society
000000310601	Mona Karimpour DO	General Member	76 Orange County Psychiatric Society
000000084886	Jason P Kellogg MD	General Member	76 Orange County Psychiatric Society
000001170822	Anna Khijniak MD	General Member	76 Orange County Psychiatric Society
000000042766	James R Kuechler M.D.	General Member	76 Orange County Psychiatric Society
000001055056	Esther Lee MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000082084	Piper C Lillehoff MD	General Member	76 Orange County Psychiatric Society
000001095154	Ella Miropolskiy MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000311144	Andrew D Morrow MD	General Member	76 Orange County Psychiatric Society
000000309180	Shari S Muir MD	General Member	76 Orange County Psychiatric Society
000001088453	Jerry Ngo MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000028675	Nicole Poliquin MD	Distinguished Life Fellow	76 Orange County Psychiatric Society
000001000958	Rodney J Reid MD PhD	General Member	76 Orange County Psychiatric Society
000001102925	Natalie Lauren Robinson MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000001021955	Sina M Safahieh MD	General Member	76 Orange County Psychiatric Society
000001000314	Rita C Silva-Leu DO	General Member	76 Orange County Psychiatric Society
000001017528	Serena R Srikureja MD	General Member	76 Orange County Psychiatric Society
000001041994	Kavitha Tadikonda MD	General Member	76 Orange County Psychiatric Society
000001144836	Thien-Huong Vu MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000065773	Clifford Brian Widmark M.D.	Fellow	76 Orange County Psychiatric Society
000001113072	Maurice A Wiggins MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000000028837	Stephen Marc Wyman M.D.	Distinguished Life Fellow	76 Orange County Psychiatric Society
000001144843	Tianyuan Yin MD	Resident-Fellow Member	76 Orange County Psychiatric Society
000001202383	Aaron K Andersen DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001170649	David Wade Atwood MD	General Member	77 Soc of Uniformed Services Psychiatrists
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000000084567	Charles Benson MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001145745	Andrew Christian Buchholz DO MF	PFResident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001215589	John Burger MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000080493	Janis R Carlton MD PhD	Fellow	77 Soc of Uniformed Services Psychiatrists
000001170508	Kristi L Cassleman DO	General Member	77 Soc of Uniformed Services Psychiatrists
000000307714	Paulette T Cazares MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001006831	Jonathan C Chang MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000085996	Jennifer C Chow MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000310268	Percival Lino Cueto MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001161103	John Daula MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001207497	Daniel De Cecchis MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001154257	Christopher DeLange MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000076695	Gerald F Donovan M.D.	General Member	77 Soc of Uniformed Services Psychiatrists
000001111909	Kenneth Faubel DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001042662	Francisco Javier Fletes MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000091933	Julianne Flynn M.D.	General Member	77 Soc of Uniformed Services Psychiatrists
000000075557	Fredrick L Fox M.D.	General Member	77 Soc of Uniformed Services Psychiatrists
000001047783	Ryan Matthew Fugate MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000310445	Sawsan Ghurani M.D.	Fellow	77 Soc of Uniformed Services Psychiatrists
000000037384	Agustin Alejo Gomez MD	Life Member	77 Soc of Uniformed Services Psychiatrists
000001109028	Phillip Daniel Guajardo MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001171443	Jared Hagan DO	General Member	77 Soc of Uniformed Services Psychiatrists
000000083784	David Barlow Hammer MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001141300	Edward Hearn DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000303574	Christopher G Ivany M.D.	General Member	77 Soc of Uniformed Services Psychiatrists
000001170506	Ehab A Komsan DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001014040	Louis J Land MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000302312	Duane M Lawrence MD	Fellow	77 Soc of Uniformed Services Psychiatrists
000001037319	Melanie Nicole Leadley DO	General Member	77 Soc of Uniformed Services Psychiatrists
000001008065	Dayna Terese Lobraico MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001070227	George Loeffler MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001098827	Lance Anthony Lopez MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001192837	Starla N Lyles DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001095966	Meghan Magley Steinhour MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001000192	Christopher T Manetta DO	General Member	77 Soc of Uniformed Services Psychiatrists
000000072655	Gail H Manos MD	Distinguished Fellow	77 Soc of Uniformed Services Psychiatrists
000001156720	Rogelio Martinez II MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000086701	Margaret A Mc Keathern M.D.	General Member	77 Soc of Uniformed Services Psychiatrists
000001107194	Peter C McGowan MD	Fellow	77 Soc of Uniformed Services Psychiatrists
000001167672	Brian Eugene McKinney MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001040356	Michelle Monro DO	General Member	77 Soc of Uniformed Services Psychiatrists
000001221908	James Q Nguyen MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000001115042	Samuel Alvin Nicolas IV MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000033934	Marvin Alan Oleshansky M.D.	Distinguished Life Fellow	77 Soc of Uniformed Services Psychiatrists
000001171039	Ngac N Phan MD	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000104121	Ben Kirk Phillips MD	General Member	77 Soc of Uniformed Services Psychiatrists
000000075154	James J Reeves MD	Fellow	77 Soc of Uniformed Services Psychiatrists
000001089277	Mary Maynadier Rhodes MD	General Member	77 Soc of Uniformed Services Psychiatrists
000001066494	Christina B Rumayor MD	Fellow	77 Soc of Uniformed Services Psychiatrists
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BOT Item 8.A Board of Trustees July 11-12, 2015 Attachment G

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000001170505	Brady L Yates DO	Resident-Fellow Member	77 Soc of Uniformed Services Psychiatrists
000000310441	Darrell Zaugg DO	General Member	77 Soc of Uniformed Services Psychiatrists

Total = 3980 APA/DB Member Drops

Mbr Id	Name	Member Category	Country
000001228826	Estela R Abraham MD	International Member	Argentina
000001087045	Maria Victoria Barel MD	International Member	Argentina
000000089828	Gabriel O Brarda M.D.	International Member	Argentina
000001134503	Jose Capece MD	International Fellow	Argentina
000001012618	Marta Marcela Carmona MD	International Member	Argentina
000001228166	Ana Maria Cativa MD	International Member	Argentina
000000310486	Marcelo G Cetkovich MD	International Member	Argentina
000001231423	Carol Dillon MD PhD	International Member	Argentina
000001240562	Claudio C Finkelsztein MD	International Member	Argentina
000001235048	Mariana Fontao MD	International Member	Argentina
000000008599	Mario Enrique Forteza M.D.	International Member	Argentina
000000090041	Gerardo M Garcia-Bonetto MD	International Fellow	Argentina
000001045053	Dario H Gigena-Parker MD	International Member	Argentina
000001228151	Miguel M Goñi MD	International Member	Argentina
000000302754	Fernando Luis Gonzalez M.D.	International Member	Argentina
000001022563	Rafael Groisman MD	International Member	Argentina
000000082763	Salvador M Guinjoan MD PhD	International Member	Argentina
000001015744	Enzo Eduardo Guzzo MD	International Member	Argentina
000001240967	Ricardo E Heffel MD	International Member	Argentina
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000000312646	Alicia G Lischinsky MD	International Member	Argentina
000001228158	Florencia C Lopez MD	International Member	Argentina
000000300086	Christian Maria Rosa Lupo MD	International Member	Argentina
000001012109	Maria Cristina Romina Magistrelli Qu	International Member	Argentina
000001001069	Pedro Miranda MD	International Member	Argentina
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000001228154	Alexis A Mussa MD	International Member	Argentina
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000000091978	Jaime José Pahissa MD	International Fellow	Argentina
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000000302740	Sergio Leonardo Rojtenberg MD	International Member	Argentina
000000089971	Pablo R Rozic M.D.	International Member	Argentina

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000001012083	Norberto S Saidman MD	International Member		Argentina
000001228157	Ronald David Schimpf MD	International Member		Argentina
000000091832	Gustavo H Vazquez MD PhD	International Member		Argentina
000000090021	Rodolfo M Zaratiegui MD	International Member		Argentina
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000001231115	Basem Dall MD	International Member		Australia
000001105087	Anthony A Dinesh MD	International Member		Australia
000001046442	Spencer Duke MD	International Fellow		Australia
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000001206426	Geoffrey Philip Fosbrooke MD	International Member		Australia
000001231116	Karen Narcelle Gaunson MD	International Member		Australia
000001119543	Thomas George MD	International Member		Australia
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000001214056	Sharon L Harding MBBS	International Member		Australia
000001224646	Jacob S Holmes MBBS	International Member		Australia
000001204936	David Kurt Huppert MD	International Member		Australia
000001190036	Aleksandra Isailovic MD	International Member		Australia
000001227311	Rowan Keighran MBBS	International Member		Australia
000000310555	Brian Kelly MD	International Member		Australia
000001190900	Giorgina Kimber MBBS	International Member		Australia
000001237648	Virendra C Kothari MD	International Member		Australia
000001223393	Varun Kumar MD	International Member		Australia
000001212524	Christina Elizabeth Lawry MD	International Member		Australia
000001229205	Carolynne Joy Marks MBBS	International Member		Australia
000001004913	Peter D McCarthy MD	International Member		Australia
000001072931	Josephine F McKeown MD	International Member		Australia
000000070000	William R McLeod M.D.	International Distinguished F	ellow	Australia
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000001006803	Shavtay Misrachi MD	International Member		Australia
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000001099123	James Frederick Macleod Oldham M	International Member		Australia
000001217810	Matt Paradise MD	International Member		Australia
000001233357	Augustus E Pusic MBBS	International Member		Australia
000001207503	Joy Yee Quek MD	International Member		Australia
000001035758	Anila Rao MBBS	International Member		Australia
000001239202	Neeraj Sareen MBBS	International Member		Australia
000001203582	Lavinia Schmidtman MD	International Member		Australia
000001034987	Carol L Silberberg MBBS	International Fellow		Australia
000001029626	Carolyn Simms MB	International Member		Australia
000001241212	Gordon A Sloss MD	International Member		Australia
000001035066	Jasna M Stepanovic MD	International Member		Australia
000001207724	Nicola Gay Stephens MD	International Member		Australia
000001240793	Ashish Takyar MBBS	International Member		Australia
000001206363	Sarah Kate Talbot MBBS	International Member		Australia
000000028269	Eng-Seong Tan M.D.	International Distinguished F	ellow	Australia
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000001213916	Adrienne Elise Taylor MD	International Member	Australia
000001154995	Tiago Zuanazzi Tomazzoni MD	International Member	Australia
000001160336	Sally Louise Tregenza MBBS	International Member	Australia
000001006729	Rigo C Van Meer MD	International Member	Australia
000001212934	Carlene M Ward MD	International Member	Australia
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000001240759	Detlev O Nutzinger MD	International Member	Austria
000001002626	Anton Tolk MD	International Member	Austria
000001131850	Dhammadam Rajasekhara Reddy M	International Member	Bahamas
000001228773	Md Shah Alam MBBS	International Member	Bangladesh
000001240908	Md. Salemir Hossain Chowdhury MB	International Member	Bangladesh
000001229062	MD Abdul Hamid MBBS	International Member	Bangladesh
000001011618	Mahmood Hasan MBBS	International Member	Bangladesh
000001221415	Ahm Mustafizur Rahman MD	International Member	Bangladesh
000001008127	Brian S Maclachlan MD	International Member	Barbados
000001221427	Sara J.E. Adriaenssens MD	International Member	Belgium
000000057551	Marc Ansseau MD	International Member	Belgium
000001034464	Ann Irene Lia Berens MD	International Member	Belgium
000001228150	Kathleen Dewandeleer MD	International Member	Belgium
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000001211837	Denis Hers MD	International Member	Belgium
000001016439	Sylvia Hoste MD	International Member	Belgium
000001026275	Peter Martens MD	International Member	Belgium
000001220214	Frank Van Dael MD	International Member	Belgium
000001101392	An Verbrugghe MD	International Member	Belgium
000001087047	Theresa Livramento Sisnando Almeio	International Member	Brazil
000001152854	Simone Barazzetti Olsson MD	International Member	Brazil
000001014818	Rodrigo Noguiera Borghi MD	International Member	Brazil
000001017013	Maria De Lurdes Braun MD	International Member	Brazil
000000303990	Milton A Cots Filho MD	International Fellow	Brazil
000001137534	Paulo Michelucci Cunha MD	International Member	Brazil
000001134357	Camilo Ramos Cury MD	International Member	Brazil
000001235748	Marcelo Daudt Von Der Heyde MD	International Member	Brazil
000001138577	Luiz Carlos De Paiva Pinheiro MD	International Member	Brazil
000000093072	Helio Elkis M.D.	International Member	Brazil
000001131282	Fabiana Nery Fernandes MD	International Member	Brazil
000001041828	Ivete Contieri Ferraz MD	International Member	Brazil
000001002201	Antonio Raimundo Gomes Frota Net	International Member	Brazil
000001230160	Ilana Frydman MD	International Member	Brazil
000000312785	Cintia S Fuzikawa MD	International Member	Brazil
000001123904	Pedro Caldana Gordon MD	International Member	Brazil
000001207514	Luiza Schmidt Heberle MD	International Member	Brazil
000001104129	Renata Krelling MD	International Member	Brazil
000001138514	Debora K. Kussunoki MD	International Member	Brazil
000001135090	Bruno Figueiredo Lobao MD	International Member	Brazil
000001133247	Eduardo Martinho Jr MD	International Member	Brazil
000001206427	Tais Michele Minatogawa-Chang MI	International Member	Brazil
000001012082	Paula Villela Nunes MD	International Member	Brazil
000001236637	Eduardo Lopes Paulucio MD	International Member	Brazil
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000001280556Andre G.J. Pellizzari MDInternational MemberBrazil000000300603Walmor J Piccinini M.D.International FellowBrazil000001213904Camilla Moreira De Sousa Pinna MD International FellowBrazil00000092239Rubens Pitliuk M.D.International MemberBrazil000001238101Leticia Cristine Ribas MDInternational MemberBrazil00000067618Saulo C Ribeiro M.D.International MemberBrazil	
000001213904Camilla Moreira De Sousa Pinna MDInternational FellowBrazil000000092239Rubens Pitliuk M.D.International MemberBrazil000001238101Leticia Cristine Ribas MDInternational MemberBrazil00000067618Saulo C Ribeiro M.D.International MemberBrazil	
000000092239 Rubens Pitliuk M.D. International Member Brazil 000001238101 Leticia Cristine Ribas MD International Member Brazil 000000067618 Saulo C Ribeiro M.D. International Member Brazil	
000001238101 Leticia Cristine Ribas MD International Member Brazil 000000067618 Saulo C Ribeiro M.D. International Member Brazil	
000000067618 Saulo C Ribeiro M.D. International Member Brazil	
000001140599 Flavia Campos Romualdo MD International Member Brazil	
000001228753 Ana Leticia Santos Nunes MD International Member Brazil	
000001223182 Luiz Carlos Scocca Jr MD International Member Brazil	
000001104646 Adriano Segal MD International Member Brazil	
000001238780 Julieta F.R. Silva MD PhD International Member Brazil	
000001238782 Paula F.R. Silva MD International Member Brazil	
000000313187 Maria de Fatima Viana Vasconcellos International Member Brazil	
000001043512 Maria Auxiliadora Viana MD International Member Brazil	
000001026411 Luiz Henrique Viegas Costa MD International Member Brazil	
000001140589 Ulisses De Miranda Vieira MD International Member Brazil	
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000000090924 Veronica Larach MD International Member Chile	
000000063458 Sofia Salamovich M.D. International Member Chile	
000000307750 Marcelo Sanhueza MD International Member Chile	
000001034038 Jaime Solis MD International Member Chile	
000001217217 Juan E Bitar MD International Member Colombia	
000001215587 Manella S Garcia Vasquez MD International Member Colombia	
000001011911 Juan Carlos Molano MD International Member Colombia	
000001137759 Carlos Ivan Molina MD International Member Colombia	
000001016055 Heidi Celina Oviedo MD International Member Colombia	
000001016074 Alexander Pinzon MD International Fellow Colombia	
000001240556 Marlen Eliana Reina Jimenez MD International Member Colombia	
000001098214 Luis Arturo Serrano MD International Member Colombia	
000001006767 Hugo Soto Cabrera MD International Member Colombia	
000001045073 Elvia Ines Velasquez MD International Member Colombia	
000001098838 Adrian Antonio Villanueva Vera MD International Member Colombia	
000001011463 Arturo Lizano-Vincent MD International Member Costa Rica	
000000305508 Luis A Meza M.D. International Fellow Costa Rica	
000000092037 Jose L Salas-Jerez M.D. International Member Costa Rica	
000001132943 Ivana Bakija MD International Member Croatia (Hrvatska)	
000001222983 Astrid Periskic Markovic MD International Member Croatia (Hrvatska)	
000001197228 Ivan Pozgain MD PhD International Member Croatia (Hrvatska)	
000001196308 Esta Susic MD International Member Croatia (Hrvatska)	
000001235749 Marija Zuljan Cvitanovic MD International Member Croatia (Hrvatska)	
000001212547 Marcela Antoncikova MD International Member Czech Republic	
000001212559 Jiri Bohac MD International Member Czech Republic	
000001212572 Pavel Cech MD International Member Czech Republic	
000001212614 Josef Kotranyi MD International Member Czech Republic	
000001213216 Petr Martinek MD International Member Czech Republic	
000001213252 Pavla Novotna MD International Member Czech Republic	
000001213263 Eva Pasekova MD International Member Czech Republic	
000001213272 Ivo Pavlicek MD International Member Czech Republic	
000001229807 Slavomir Pietrucha MD International Member Czech Republic	

				Attachine
000001213277	Danuše Roubcova MD	International Member		Czech Republic
000001213290	Ingrid V Vurmova MD	International Member		Czech Republic
000001213302	Markéta Zemanová MD	International Member		Czech Republic
000001206660	Kathrine Dahler-Eriksen MD	International Member		Denmark
000001223665	Annamaria Giovanna Elena Giraldi N	International Member		Denmark
000001240535	Birgitte Kirk MD	International Member		Denmark
000001223666	Ellids Mellerup Kristensen MD	International Member		Denmark
000001017106	Povl Munk-Jorgensen MD	International Member		Denmark
000001232736	Griffin Carty Benjamin MD	International Member		Dominica
000000312494	Rafael O Johnson MD	International Member		Dominican Republic
000001007414	Nelson Tabar Garcia MD	International Fellow		Dominican Republic
000000313006	Juan Aguilera M.D.	International Member		Ecuador
000000310497	Jose F Cruz M.D.	International Member		Ecuador
000001240918	Jose Dimas Maldonado Chala MD	International Member		Ecuador
000001240935	Anibal J Riofrio Rivera MD	International Member		Ecuador
000001012651	John K Robalino Rodriguez MD	International Member		Ecuador
000000090007	Victoria Valdez M.D.	International Member		Ecuador
000001197672	Abeir Abdel Aal Elmeleigi MD	International Member		Egypt
000001183726	Alaa Salah Elnajjar MD	International Member		Egypt
000001138337	Ola Mostafa Morsy MD	International Member		Egypt
000001005544	Nahla El-Sayed Nagy MD	International Member		Egypt
000001104639	Khadiga Mohamed Ragheb MD	International Member		Egypt
000001230434	Michael Victor Samy MD	International Member		Egypt
000000087058	Ulf Larsson Hagert M.D.	International Member		Finland
000001217833	Jarno Ilmari Heino MD	International Member		Finland
000000091810	Anna Savela M.D.	International Member		Finland
000001217201	Tommi Tapani Vayrynen MD	International Member		Finland
000001231752	Dominique Bouchard MD	International Member		France
000000087042	Daniel J Delcroix MD	International Fellow		France
000001077814	Guillemain P Geraud MD	International Member		France
000001133915	Chahinez Djamila Laidli MD	International Member		France
000001228754	Marina Litinetskaia MD	International Member		France
000000092232	Eric J Marcel M.D.	International Member		France
000000310504	Markus Pawelzik M.D.	International Member		Germany
000001001030	Andreas Sobottka MD	International Member		Germany
000001212963	Denis H Chino MD	International Member		Guadeloupe
000000073409	Julio R Barrios-Flores M.D.	International Member		Guatemala
000001045136	Walter William Rinze Turton MD	International Member		Guatemala
000000070038	Marco Cyrano Ruiz-Herrarte MD	International Member		Guatemala
000001221956	Wing Ho William Chui MBBS	International Member		Hong Kong
000001219371	Chit Tat Lee MD	International Member		Hong Kong
000001211998	Sing Heung Lui MD	International Member		Hong Kong
000001240785	Ying-King Miao MBBS	International Member		Hong Kong
000001237082	Viktor Voros MD PhD	International Member		Hungary
000000063463	Tomas Zoega M.D.	International Member		Iceland
000000045361	Smarhar Mahendraprasad Amin MD	International Fellow		India
000001151638	Thirupapuliyur Venugopalan Asokan	International Fellow		India
000000021933	Kamala Ranjan Banerjee MD	International Distinguished Fe	ellow	India
000001202793	Ruma Bhattacharya MBBS	International Member		India

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000000073398	Rakesh Kumar Chadda MD	International Distinguished Fe	ellow	India
000001191021	Biswadip Chatterjee MBBS	International Member		India
000001017035	Joginder Singh Dhillon MBBS	International Member		India
000001044789	Ajay Dattatrey Dikshit MD	International Member		India
000001238968	Kaushik Ramakant Gupte MBBS	International Member		India
000001148760	Dilip Kumar Jayaraman MBBS	International Member		India
000001012550	Roy Abraham Kallivayalil MD	International Distinguished Fe	ellow	India
000001129675	Yogesh Avinash Kulkarni MBBS	International Member		India
000001016926	Channaveerachari Naveen Kumar MI	International Member		India
000001007419	Harish Matai MD	International Member		India
000001195772	Sai Kumar Reddy Mavuluru MD	International Member		India
000001006435	Sunil Mittal MBBS	International Member		India
000001005836	Amitabha Mukerji MD	International Member		India
000001115214	Amit Ramesh Nagarkar MD DNB	International Member		India
000001267584	Ajay Kumar Nihalani MD	International Member		India
000001234100	Ismail Yusuf Pala MD	International Member		India
000001217191	Dilipkumar N Pandav MBBS	International Member		India
000001202073	·	International Member		India
000001212042	Karthik Rao MBBS	International Member		India
000001002504	Debashis Ray MD	International Member		India
000000092214	Prakash N Shukla M.D.	International Member		India
000000313007	Roop Chand Sidana M.D.	International Fellow		India
000001276826	Malaya Kant Singh MD	International Member		India
000001006451	Om Prakash Singh MBBS	International Member		India
000001012174	Pramod Kumar Singh MBBS	International Member		India
000001016890	Ranbir Singh MD	International Member		India
000001008744	Sushil Kumar Sompur Vasanthkumar	International Member		India
000001225544	Jonas Suganthan Sundarakumar MB	International Member		India
000001042168	Paresh C Trivedi MD	International Member		India
000001006502	Mrugesh Vaishnav MBBS	International Fellow		India
000001065545	Sandeep Verma MD	International Fellow		India
000001201019	George Reddy Vimantala MBBS	International Member		India
000001090601	Cian Denihan MD	International Member		Ireland
000001223243	Elaine Rosemary Greene MB	International Member		Ireland
000001231130	Cecelia Aoibhinn Lynch MB	International Member		Ireland
000000091173	Donal T O'Hanlon MD	International Member		Ireland
000001136287	Bolanle Oluwatoyin Omoniyi MBBS	International Member		Ireland
000001229203	Vivienne Mary Whelan MB	International Member		Ireland
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000001240172	Shai Greenshtain MD	International Member		Israel
000001130562	Lorenzo Gasperi MD	International Member		Italy
000000300652	Ugo Lancia M.D.	International Fellow		Italy
000001236350	Giovanni Martinotti MD	International Member		Italy
000000075587	Leonardo Tondo M.D.	International Member		Italy
000000031540	Edward A Allen MD	International Member		Jamaica
000000060525	Janet La Grenade M.D.	International Member		Jamaica
000001207972	Shinsuke Koike MD	International Member		Japan
000000061284	Morihiro Sekiyama MD	International Distinguished Fe	ellow	Japan
000000086138	Shigeto Yamawaki MD	International Member		Japan

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000000312490	Nasri E Jacir M.D.	International Member		Jordan
000001104918	Samir Samawi MD	International Member		Jordan
000001235050	Muthoni Anna Mathai MB	International Member		Kenya
000000085039	Jin-Hee Han MD	International Member		Korea, Republic of
000001228750	Sang Bae Hyun MBBS	International Member		Korea, Republic of
000001195786	Young-Chul Jung MD	International Member		Korea, Republic of
000001132981	Eun Lee MD	International Member		Korea, Republic of
000001104630	Min-Soo Lee MD PhD	International Distinguished Fell	low	Korea, Republic of
000000087113	Se-Joong Oh MD	International Fellow		Korea, Republic of
000001189394	Changho Sohn MD	International Member		Korea, Republic of
000001094489	Virginija Adomaitiene MD	International Member		Lithuania
000001227687	Chandra Mohan Panchadcharam MI	International Fellow		Malaysia
000001080704	Mohd Razali Salleh MD	International Member		Malaysia
000000312643	Anton Grech MD PhD	International Member		Malta
000001029201	Hemlata Charitar MD	International Member		Mauritius
000001007415	Manuel Aguilar Saens MD	International Member		Mexico
000000019925	Victor A Albores M.D.	International Member		Mexico
000000300654	Pablo A Cuevas M.D.	International Member		Mexico
000000302542	Arturo De-La-Vega M.D.	International Member		Mexico
000001017005	Gilberto Esquivel MD	International Member		Mexico
000001045185	Claudio Garcia-Barriga MD	International Member		Mexico
000000065353	Gerhard Heinze M.D.	International Member		Mexico
000001012481	Antonio Hinojosa Flores MD	International Member		Mexico
000000306784	Jorge G Martinez-Garcia M.D.	International Member		Mexico
000001012573	Sergio Munoz Fernandez MD	International Member		Mexico
000000091685	Addy L Palma M.D.	International Member		Mexico
000001002567	Claudia Rico MD	International Fellow		Mexico
000001104784	Rosario Rivera MD	International Member		Mexico
000001139713	Andrea Sada MD	International Fellow		Mexico
000001012530	Jorge Saucedo Perez MD	International Member		Mexico
000000305489	Alejandro Torre-Sarlat MD	International Fellow		Mexico
000001002026	Alisina Allahbakhshi MD	International Member		Netherlands
000001229902	Ljiljana Bamburac MD	International Member		Netherlands
000001007412	Jane Beck-Lie A Fat MD	International Member		Netherlands
000001220731	Rogier Bemmelen MD	International Member		Netherlands
000001124514	Hendrikus Johannes Blom MD	International Member		Netherlands
000001189354	Lianne Boersma MD	International Member		Netherlands
000001192997	Tineke Bronzwaer MD	International Member		Netherlands
000001231117	Catharina De Groot MD	International Member		Netherlands
000001216297	Foka Eekhof MD	International Member		Netherlands
000001219064	Elsbeth Eerden MD	International Member		Netherlands
000001211986	Martijn Figee MD	International Member		Netherlands
000001016189	Orland Joachim Gerard MD	International Member		Netherlands
000001220734	Lisette Giesberts MD	International Member		Netherlands
000001016203	Ronald Graveland MD	International Member		Netherlands
000001212593	Jochem Gerard Gregoor MD	International Member		Netherlands
000001097677	Hendrica Hagestein-De Bruijn MD Pl	International Member		Netherlands
000000310554	Cornelis Helms MD	International Member		Netherlands
000001207504	Cees Hoek MD	International Member		Netherlands

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000000302180	Bart B Jacobs M.D.	International Member	Netherlands
000001023755	Arnoud Jansen MD	International Member	Netherlands
000001214962	Rozemarijn Jansen MD	International Member	Netherlands
000001067859	Nikola Kmetic MD	International Member	Netherlands
000000087069	Herro Foeke Kraan MD	International Member	Netherlands
000001016964	Colleen Kroeze MD	International Member	Netherlands
000001210514	Nathalie Kuijpers MD	International Member	Netherlands
000000307757	Ann-Louise Lasschuit MD	International Member	Netherlands
000001215016	Esther Lauwen MD	International Member	Netherlands
000000309247	Erik Lemmen MD	International Member	Netherlands
000001206043	Joost Marx MD	International Member	Netherlands
000001128472	Paul D Meesters MD	International Member	Netherlands
000001240536	Reinier Mensink MD	International Member	Netherlands
000001127098	Erik Morsch MD	International Member	Netherlands
000001001683	Paul Naarding MD	International Member	Netherlands
000001002049	Dirk Ploem MD	International Member	Netherlands
000001002241	Ruth Van Der Pol MD	International Member	Netherlands
000001133087	Constance Barbara Portier MD	International Member	Netherlands
000000309647	Esmeralde Maria Raven MD	International Member	Netherlands
000001230684	Johan Remmerie MD	International Member	Netherlands
000001016865	Alex de Ridder MD	International Member	Netherlands
000000312639	Anja Rietman MD	International Member	Netherlands
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000001011289	Helga V Saez Scheihing MD	International Member	Netherlands
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000001006115	Ivo Stessel MD	International Member	Netherlands
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000001230492	Babette Van Beusekom MD	International Member	Netherlands
000001001861	Theodoor Michiel van den Boogaard	International Member	Netherlands
000001130662	Gerbrand Hendrik Van Den Bosch M		Netherlands
000001231753	Suzanne Christine Van Der Padt MD		Netherlands
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000001210585		International Member	Netherlands
000001045545	Masab Al-Alami MD	International Member	New Zealand

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000001100442 Syed Salahuddin Babur MD International Member Pakistan
000000312491 Dr. Abdul Hamid Choudhry MD International Member Pakistan
000001230448 Syed Liaqat Hussain MBBS International Member Pakistan
000001099055 Akhtar Javaid MD International Member Pakistan
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000000072012 Ayesha Muquim M.D. International Member Pakistan
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000001006477 Rizwan Taj MBBS International Distinguished Fellow Pakistan
000001100798 Jasmine Garcia Vergara MD International Member Palau
000001016481 Patricia Arroyo MD International Fellow Panama
000001016939 Nerytza Grimaldo MD International Member Panama
000001235045 Giselle Karin Guevara Murillo MD International Member Panama
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000000092209 Rafael Navarro M.D. International Member Peru
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000001002441 Ramon S Javier MD International Member Philippines
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000001004700 Elaine Angela Leynes M.D. International Fellow Philippines
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000000306952 Jacqueline Te Sy MD International Fellow Philippines
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000001238351 Abdullah Genc MD International Member Turkey	
000001212863 Kasim Goktas MD International Member Turkey	
000001213092 Suleyman Gunduz MD International Member Turkey	
000001212894 Savas Karatayli MD International Member Turkey	
000001230502 Cengiz Kilic MD PhD International Member Turkey	
000001213099 Ozcan Kilic O Kafali MD International Member Turkey	
000000304980 Ismet Kirpinar MD International Fellow Turkey	
000000313011 Ertugrul H Koroglu MD International Fellow Turkey	
000001006966 Ayse Fulya Maner MD International Member Turkey	
000001212901 Helmet Ozbek MD International Member Turkey	
000001225574 Urun Ozer Ceri MD International Member Turkey	
000001212864 Nermin Ozkan MD International Member Turkey	
000001212979 Mustafa Reyhancan MD International Member Turkey	
000001213109 Hasan Sahin MD International Member Turkey	
000001213085 Ozlem Saran MD International Member Turkey	
000001212860 Selsuk Simsek MD International Member Turkey	
000001213135 Burcu Sirlier Emir MD International Member Turkey	
000001011822 Ahmet Tiryaki MD International Member Turkey	
000001212903 Memhet Serif Top MD International Member Turkey	
000001212884 Mehtap Topuz MD International Member Turkey	
000001213127 Ramazan Murat Ucak MD International Member Turkey	
000001043415 Zeynep Isil Ugurad MD International Member Turkey	
000001219052 Gonca Ayse Unal MD International Member Turkey	
000001212859 Secil Setinkaya Uysal MD International Member Turkey	
000001006942Duygu Yigitturk MDInternational MemberTurkey	
000001219054 Bayram Yildiz MD International Member Turkey	
000001274676 Andrii Gorbunov MD International Member Ukraine	
000000076783 Yousef Abou-Allaban M.D. International Fellow United Arab Emirates	
000001007482 Ali Vahdani MD International Member United Arab Emirates	
000001096140 Osaretin Anthony Akenzua MD International Member United Kingdom	
000001149115 Christina Joy Browne MBBS International Member United Kingdom	
000001224368 Samuele Cortese MD PhD International Member United Kingdom	
000001212000 Darlington Daniel MD International Member United Kingdom	
000001132211 Maciej Jozef Danilewicz MD International Member United Kingdom	
000001230436 Subodh P Dave MD International Member United Kingdom	
000001229204 Katrin Edelman MBBS International Member United Kingdom	
000001181846 Martin Anthony Fahy MD International Member United Kingdom	
000001090600 Alexandra Garcia Rosales MD International Member United Kingdom	
000001098612 Carol Henshaw MD FRCpsych International Member United Kingdom	
000000044329 Peter L G Jenkins MD International Member United Kingdom	
000000312640 Ashok Kumar Krishnamoorthy MD International Fellow United Kingdom	
000001223250 Sandeep Kumar MBBS International Member United Kingdom	
000001187467 Azlan Luk MD International Member United Kingdom	
000001149107 Parimala Moodley MD International Member United Kingdom	
000001232777 Nuala N Mullan MBBS International Member United Kingdom	
000001011583 Dennis Okolo MD International Member United Kingdom	

BOT Item 8.A Board of Trustees July 11-12, 2015 Attachment G

000001132241	Taiwo T Oladele MBBS	International Member	United Kingdom
000001133914	Asif Yusif Ramzan MB CHB	International Member	United Kingdom
000001212003	Giles Richards MD	International Member	United Kingdom
000001149105	Leela Sivaprasad MBBS	International Member	United Kingdom
000001098335	Andre Strydom MD	International Member	United Kingdom
000001094787	Yvonne Treffurth MD	International Member	United Kingdom
000001111931	Chinedu Umeadi MBBS	International Member	United Kingdom
000000309656	Stephen V Vethanayagam MBBS	International Member	United Kingdom
000001240522	Catherine M Walsh MB BCh BAO FR	International Member	United Kingdom
000001012128	Mariana de Lima Cots MD	International Member	United States
000000018514	Manuel Isaias Lopez Gomez MD PhD	International Member	United States
000001007234	Xiaohong Lu M.D. Ph.D.	International Member	United States
000001012532	Luis Madrid Peroza MD	International Member	United States
000001052306	Francisco J Mata Pitti MD	International Member	United States
000001241160	Pir Mohammad MD	International Member	United States
000001009293	Ignacio N Te Lano	International Member	United States
000000074126	Edward N Weissberg M.D.	International Member	United States
000001027857	Alvaro Enrique D'Ottone MD	International Member	Uruguay
000001129890	Adolfo Alejandro Lea Plaza MD	International Member	Uruguay
000001012535	Minerva Calderon Flores MD	International Member	Venezuela
000001012529	Franca Caterina Pisichio MD	International Member	Venezuela
000001138543	Julio Gonzalez Garcia MD	International Member	Venezuela
000000103763	Carmen Juarez MD	International Member	Venezuela
000000092208	Danilo Martinez M.D.	International Fellow	Venezuela
000001229005	Gioconda Edith Medrano MD	International Member	Venezuela
000000087117	Pastor A Oropeza M.D.	International Member	Venezuela
000000091788	Manuel Ortega Sanchez M.D.	International Member	Venezuela
000000091571	June M Samuel M.D.	International Member	Virgin Islands (British)
000001000909	Boshra Abdulrahman Almoayed MD	International Member	Yemen

Total = 552 Drops for International Members/Fellows/Distinguished Fellows Dues
Total = 3,980 Drops for APA/DB Dues

Total = 4,532

Member ID	Name	Member Category	DB# DB Name
000001080288	Laura Eskander MD	Resident-Fellow Member	20 Maryland Psychiatric Society, Inc
000001044127	Carolina Vidal MD	General Member	20 Maryland Psychiatric Society, Inc
000001078743	Padam Bhatia MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001101243	Lauren N Buchheim MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001155521	Tiffany Cao MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001155644	Christine Charles MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001127084	Benjamin Delucia MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001011228	Andrea L DeStories MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001230192	Marian Droz MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001114249	Rahul Kodali MD MPH	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001078752	Pamela Carolina Montano MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001155747	Shamik Mukherji MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000000055943	Lola Occhiogrosso M.D.	Life Member	25 Greater Long Island Psychiatric Society
000000061124	Deborah Lynn Pfeffer MD	General Member	25 Greater Long Island Psychiatric Society
000000305147	Sobia Rizvi M.D.	General Member	25 Greater Long Island Psychiatric Society
000001131377	Nilofar Sarvaiya MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001111637	Matisyahu Shulman MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000000057053	Rajani Thangavelu MD	Fellow	25 Greater Long Island Psychiatric Society
000001155923	Thomas C Yang MD	Resident-Fellow Member	25 Greater Long Island Psychiatric Society
000001071572	Jose Luis Aguilar Jr MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001000566	Bushra Ali Akber MD	General Member	43 Southern California Psychiatric Society
000001014478	Binyamin Amrami MD	Fellow	43 Southern California Psychiatric Society
000000312099	Clarissa Andic M.D.	General Member	43 Southern California Psychiatric Society
000001017812	Mirza S Baig MD	General Member	43 Southern California Psychiatric Society
000001090190	Nadia Barati MD	General Member	43 Southern California Psychiatric Society
000001107824	Sharilee Bryant MD	General Member	43 Southern California Psychiatric Society
000000081430	Andrea L Caldwell M.D.	General Member	43 Southern California Psychiatric Society
000001235171	Eric Chaghouri MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000079057	Valery Chamberlin M.D.	General Member	43 Southern California Psychiatric Society
000001234506	Paul S Chung MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000080329	Flocerfida De Jesus M.D.	General Member	43 Southern California Psychiatric Society
000000065627	Pamela Diefenbach M.D.	Fellow	43 Southern California Psychiatric Society
000001090203	Tatyana Ellison MD	General Member	43 Southern California Psychiatric Society
000000307827	Kaney J Fedovskiy MD MPH	General Member	43 Southern California Psychiatric Society
000000042855	Ihor A M Galarnyk M.D.	Fellow	43 Southern California Psychiatric Society
000001129411	Renee Michelle Garcia MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000068859	Nick Martin Gutierrez MD	General Member	43 Southern California Psychiatric Society
000001112831	Peter Hung MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000087408	Laja I Ibraheem MD	General Member	43 Southern California Psychiatric Society
000001014022	Felipe A Jain MD	General Member	43 Southern California Psychiatric Society
000001234117	Jason Jalil MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001054947	Ippolytos Andreas Kalofonos MD		43 Southern California Psychiatric Society
000000076040	Zoheir Mohammad Kassem MD	General Member	43 Southern California Psychiatric Society

000001016835	John Charles Kelleher III MD	General Member	43 Southern California Psychiatric Society
000000065927	Stephen Mark Kramer M.D.	General Member	43 Southern California Psychiatric Society
000001281746	Han Luong DO	Resident-Fellow Member	43 Southern California Psychiatric Society
000000062380	Paul Jay Markovitz M.D. Ph.D.	General Member	43 Southern California Psychiatric Society
000001234507	Cole J Marta MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000041177	James Thomas Mc Cracken MD	Distinguished Fellow	43 Southern California Psychiatric Society
000001043728	Elizabeth C McGuire MD	General Member	43 Southern California Psychiatric Society
000001014344	Esther Oh MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001087860	Uchenna Barbara Okoye MD MPI	Resident-Fellow Member	43 Southern California Psychiatric Society
000000307462	Mailan D Pham MD	General Member	43 Southern California Psychiatric Society
000001005101	Patrick Nicholas Pompl MD MS	General Member	43 Southern California Psychiatric Society
000000090663	Ricardo Restrepo MD MPH	General Member	43 Southern California Psychiatric Society
000000304886	Janine Roach MD	General Member	43 Southern California Psychiatric Society
000000035458	Rhonda J Robinson Beale MD	Life Member	43 Southern California Psychiatric Society
000000063666	M Steven Sager MD	General Member	43 Southern California Psychiatric Society
000000306733	Heather S Silverman M.D.	General Member	43 Southern California Psychiatric Society
000000040759	Bruce Richard Steinberg M.D.	Life Member	43 Southern California Psychiatric Society
000001100800	Marcos A Suarez MD	General Member	43 Southern California Psychiatric Society
000001280887	Angela Sureen MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000001234127	Kara Tabor-Furmark MD	Resident-Fellow Member	43 Southern California Psychiatric Society
000000302989	Cynthia J Washington M.D.	General Member	43 Southern California Psychiatric Society
000000304546	Adedapo B Williams M.D.	Fellow	43 Southern California Psychiatric Society
000000079388	Oladele A. Adebogun MD. FAPA.	Fellow	46 Texas Society of Psychiatric Physicians
000001222036	Saima Alam MD	General Member	46 Texas Society of Psychiatric Physicians
000000311458	Virginia L Allen MD	General Member	46 Texas Society of Psychiatric Physicians
000000090352	Norma Jean Anderson DO	Fellow	46 Texas Society of Psychiatric Physicians
000001049638	Aparna Atluru MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001293599	Matthew Ryan Ayers DO	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000059233	David Henry Beyer Jr MD	Life Fellow	46 Texas Society of Psychiatric Physicians
000000307308	Jason M Boley M.D.	General Member	46 Texas Society of Psychiatric Physicians
000001273692	Neha Chaudhary MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001017241	Samuel James Collier MD	General Member	46 Texas Society of Psychiatric Physicians
000001321740	Leigh Erin Cunningham MD	General Member	
000001273302	3	deficial Method	46 Texas Society of Psychiatric Physicians
	Venkata Vijaya Kumar Dalai MD 1		46 Texas Society of Psychiatric Physicians46 Texas Society of Psychiatric Physicians
000001001839	= =		
000001001839 000001277418	Venkata Vijaya Kumar Dalai MD I	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
-	Venkata Vijaya Kumar Dalai MD I Bachir Debba MD	Resident-Fellow Member General Member	46 Texas Society of Psychiatric Physicians46 Texas Society of Psychiatric Physicians
000001277418	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD	Resident-Fellow Member General Member Resident-Fellow Member	46 Texas Society of Psychiatric Physicians46 Texas Society of Psychiatric Physicians46 Texas Society of Psychiatric Physicians
000001277418	Venkata Vijaya Kumar Dalai MD I Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D.	Resident-Fellow Member General Member Resident-Fellow Member Fellow	 46 Texas Society of Psychiatric Physicians
000001277418 000000092261 000001193232	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D. Joseph Charles Drumm DO	Resident-Fellow Member General Member Resident-Fellow Member Fellow Resident-Fellow Member	 46 Texas Society of Psychiatric Physicians
000001277418 000000092261 000001193232 000001042031	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D. Joseph Charles Drumm DO Ye Beverly Du MD	Resident-Fellow Member General Member Resident-Fellow Member Fellow Resident-Fellow Member General Member	 46 Texas Society of Psychiatric Physicians
000001277418 00000092261 000001193232 000001042031 000001001164	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D. Joseph Charles Drumm DO Ye Beverly Du MD John V Fermo MD	Resident-Fellow Member General Member Resident-Fellow Member Fellow Resident-Fellow Member General Member General Member	 46 Texas Society of Psychiatric Physicians
000001277418 00000092261 000001193232 000001042031 000001001164 000001007267	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D. Joseph Charles Drumm DO Ye Beverly Du MD John V Fermo MD Lindsay Nicole French-Rosas MD	Resident-Fellow Member General Member Resident-Fellow Member Fellow Resident-Fellow Member General Member General Member General Member	 46 Texas Society of Psychiatric Physicians
000001277418 00000092261 000001193232 000001042031 000001001164 000001007267 000000089225	Venkata Vijaya Kumar Dalai MD N Bachir Debba MD Huiqiong Deng MD PhD Emily J Doyle M.D. Joseph Charles Drumm DO Ye Beverly Du MD John V Fermo MD Lindsay Nicole French-Rosas MD Prashant Gajwani MD	Resident-Fellow Member General Member Resident-Fellow Member Fellow Resident-Fellow Member General Member General Member General Member General Member	 46 Texas Society of Psychiatric Physicians

000001139896	James Arthur Halgrimson DO	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001008491	Sarah L Hardy DO	General Member	46 Texas Society of Psychiatric Physicians
000000071937	Toi B Harris MD	Fellow	46 Texas Society of Psychiatric Physicians
000001017595	Jared C Heathman MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001235476	Umair M Hemani DO MS	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001110158	Stephanie Hernandez DO	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001254835	Brent Jakubec MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001111624	Jason James MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001013810	Trenton L James MD	General Member	46 Texas Society of Psychiatric Physicians
000001288219	Nathan Scott Johnston DO MS	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001014135	Aarti Kaul MD	General Member	46 Texas Society of Psychiatric Physicians
000001053591	Tina Kaviani MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001148745	Darrow Khosh-Chashm MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000026944	Ted William Krell M.D.	Distinguished Life Fellow	46 Texas Society of Psychiatric Physicians
000001077423	Whitney Landa MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000065314	Jane Ann Leeves M.D.	General Member	46 Texas Society of Psychiatric Physicians
000000030671	Anthony T Machi M.D.	Life Fellow	46 Texas Society of Psychiatric Physicians
000001008520	Lisa L Madsen MD	General Member	46 Texas Society of Psychiatric Physicians
000000305561	Michelle Magid M.D.	General Member	46 Texas Society of Psychiatric Physicians
000001303528	Amber Mansoor MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000303791	Melissa Martinez M.D.	General Member	46 Texas Society of Psychiatric Physicians
000001012243	Jacob Stephens Mays DO	General Member	46 Texas Society of Psychiatric Physicians
000001212097	Shane McKay MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000309527	Roger L McRoberts III MD	General Member	46 Texas Society of Psychiatric Physicians
000000302143	Zahur Mohiuddin M.D.	General Member	46 Texas Society of Psychiatric Physicians
000001235483	Jessica Renee Moore MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001103823	Saira Mushtaq MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000306996	Jelil O Onanuga MD	Fellow	46 Texas Society of Psychiatric Physicians
000001017649	Pavan Kumar R Pamadurthi MD	General Member	46 Texas Society of Psychiatric Physicians
000001011981	Sandhya Prashad MD	General Member	46 Texas Society of Psychiatric Physicians
000001006631	Neil V Puri MD	General Member	46 Texas Society of Psychiatric Physicians
000000073033	Lucy J Puryear M.D.	General Member	46 Texas Society of Psychiatric Physicians
000000311085	Salah Qureshi MD	General Member	46 Texas Society of Psychiatric Physicians
000000081167	Mercedes Ellis Ramirez MD	General Member	46 Texas Society of Psychiatric Physicians
000001058814	Michael Joseph Regal MD	General Member	46 Texas Society of Psychiatric Physicians
000001041007	Racquel E Reid MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000310429	Walter W Root MD	General Member	46 Texas Society of Psychiatric Physicians
000000060278	Pradeep K Roy M.D.	Fellow	46 Texas Society of Psychiatric Physicians
000001071056	Writtika Roy MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001001425	Shree Om Shrestha MD	Fellow	46 Texas Society of Psychiatric Physicians
000001080997	Walter Shuham MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000073194	Annapurni B Teague M.D.	General Member	46 Texas Society of Psychiatric Physicians
000000310733	Cuong C Tieu MD	General Member	46 Texas Society of Psychiatric Physicians
000000304334	Lawrence V Tucker M.D.	General Member	46 Texas Society of Psychiatric Physicians

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000000305771	M. Renee Valdez MD PhD	General Member	46 Texas Society of Psychiatric Physicians
000001008301	Elizabeth Varghese MD	General Member	46 Texas Society of Psychiatric Physicians
000001001062	Angela M Velez MD	General Member	46 Texas Society of Psychiatric Physicians
000001255138	Ksenia Voronina MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000308498	Amy E Walton MD	General Member	46 Texas Society of Psychiatric Physicians
000001135488	Rebecca Anne Wehrly MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000000074744	Robert G Wilkerson M.D.	General Member	46 Texas Society of Psychiatric Physicians
000000082756	Ella M Williams MD	General Member	46 Texas Society of Psychiatric Physicians
000001056018	Andrea Jennifer Wright MD	General Member	46 Texas Society of Psychiatric Physicians
000001272335	Hanjing Wu MD PhD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians
000001268635	Bradley A Zicherman MD	Resident-Fellow Member	46 Texas Society of Psychiatric Physicians

Total = 142

Member ID Label Name

1344803 David K Basangwa, MD

Country

Uganda

Item 8.A **Board of Trustees** July 11-12, 2015 Attachment I

Country Income Cat

Lower Income

1344003 David K Dasarigwa, MD	Oganda	Lower income
1344829 Avra Das Bhowmik, MD	Bangladesh	Lower Income
1344824 Niaz Mohammad Khan, MD	Bangladesh	Lower Income
1344827 MD. Abdul Mohit, PhD, MD	Bangladesh	Lower Income
1320364 Monica Eva Mucheru, MBBS	Kenya	Lower Income
1344828 M M Jalal Uddin, MD	Bangladesh	Lower Income
n = 6		
1344782 Muhammad A Afridi, MBBS	Pakistan	Lower Middle Income
		Lower Middle Income
1329700 Tusharkumar Iswerlal Agravat, Mi	Pakistan	Lower Middle Income
1330854 Sohail Ahmed, MBBS		
1341481 Bassem Hamed Badr, MD	Egypt	Lower Middle Income
1344403 Arvind Barad, MBBS	India -	Lower Middle Income
1344785 Doaa Barakat, MD	Egypt	Lower Middle Income
1344774 Jeremias G Bautista, MD	Philippines	Lower Middle Income
1321370 Vanessa Kathleen Bautista Caingl		Lower Middle Income
1016281 Bhaskar Chandrasekaran, MBBS	India	Lower Middle Income
1344765 Daisy L Chu-Daquilanea, MD	Philippines	Lower Middle Income
1344680 Monina G Cruz, MD	Philippines	Lower Middle Income
1341252 Carmelita Indefenso Custodio, MI	D Philippines	Lower Middle Income
73675 Gerald Etiemowei Dariah, MD	Nigeria	Lower Middle Income
1338933 Belen Mojares Dimatatac, MD	Philippines	Lower Middle Income
1344776 Mohamed Adel Elhadidi, PhD, MD	D Egypt	Lower Middle Income
1344763 Nourelhuda Elhag, MD	Sudan	Lower Middle Income
1344780 Mohamed Ahmed Elwasify Bily, P	PhD, MD Egypt	Lower Middle Income
1344781 Atef Ali Fayed, MD	Egypt	Lower Middle Income
1344982 Shah B Gautam, MBBS, DPM, MD) India	Lower Middle Income
1345326 Mina Reffat Gobran, MBBS	Egypt	Lower Middle Income
1344844 Azhar Hussain, MBBS, DPM	Pakistan	Lower Middle Income
1335889 Hala F Ibrahim, MD	Canada	Lower Middle Income
1318580 Nikhil Jain, MD	India	Lower Middle Income
1344822 Vikas Jain, MD	India	Lower Middle Income
1344845 Anisuzzaman Khan, MBBS, DPM	Pakistan	Lower Middle Income
1344984 Amgad Khairy Khela, MD, MS	Egypt	Lower Middle Income
1336512 Sathishka Wajantha Kotalawala, I	3 7.	Lower Middle Income
1308175 Rajesh Kumar, MD	India	Lower Middle Income
1344937 Marife Perez Mararang, MD	Philippines	Lower Middle Income
1334029 Boshra Nasseef Matta Mekhaiel, I	• •	Lower Middle Income
1344764 Emma Concepcion Mendoza, MD		Lower Middle Income
1344823 Sameer Moideen, MD	India	Lower Middle Income
1344787 Maria Cecilia M Ocampo, MD	Philippines	Lower Middle Income
1344/0/ Iviana Cecilia ivi Ocampo, Ivid	rillippliles	Lower Middle income

Item 8.A Board of Trustees July 11-12, 2015 Attachment I

1321625 Anne Marie Rios Pineda, MD	Philippines	Lower Middle Income
1344767 Dulce Teresa Platon, MD	Philippines	Lower Middle Income
1315585 Shazad Rauf, MBBS	Pakistan	Lower Middle Income
1344821 Byron Orlando Recinos, MD, PhD	Guatemala	Lower Middle Income
1014146 Maria R Santa Cruz, MD	Paraguay	Lower Middle Income
1343416 Muhammad Naim Siddiqi, MRC	Pakistan	Lower Middle Income
1337516 Ahmed Shoaib Tabassum, MBBS	Pakistan	Lower Middle Income
1312786 Mohammad Tariq, MBBS	Pakistan	Lower Middle Income
1316948 Anatolii Tsarkov, MD	Zambia	Lower Middle Income

n = 42

1332400 Ramon Emilio Acevedo, MD	Colombia	Upper Middle Income
1344831 Pedro Luis Alipazaga Perez, MD	Peru	Upper Middle Income
1314237 Rocio Barrios, MD	Colombia	Upper Middle Income
1334027 Lucina Gabriela Buffa, MD	Argentina	Upper Middle Income
1333819 Jorge Guillermo Caffarello, MD	Argentina	Upper Middle Income
1339580 Maria Eugenia Carrozzino, MD	Argentina	Upper Middle Income
1324204 Natchanan Charatcharungkiat, MD	Thailand	Upper Middle Income
1332937 Yuliya Chebanova, MD	Argentina	Upper Middle Income
1344681 Marco A Cigognini, MD	Brazil	Upper Middle Income
1344832 Serhat Citak, PhD, MD	Turkey	Upper Middle Income
1334136 Alejandro Maximo Conte, MD	Argentina	Upper Middle Income
1336223 Monica Fabiana Cornejo, MD	Argentina	Upper Middle Income
1320198 Alejandro Corte Perez, MD	Mexico	Upper Middle Income
1315856 Fernanda Benquerer Costa, MD	Brazil	Upper Middle Income
1344762 Maria Valeria Dabate, MD	Argentina	Upper Middle Income
1344769 Wasim Darawish, MD	Jordan	Upper Middle Income
1339581 Carina Marcela De Cesare, MD	Argentina	Upper Middle Income
1027305 Mauricio De La Espriella, MD	Colombia	Upper Middle Income
1344783 Maria Di Camillo, MD	Argentina	Upper Middle Income
1342608 Claudia Marcela Di Pietro, MD	Argentina	Upper Middle Income
1332934 Juan Pablo Diaz, MD	Argentina	Upper Middle Income
1344665 Jose Augusto Dos Santos, MD	Brazil	Upper Middle Income
1345006 German Duarte, MD	Colombia	Upper Middle Income
1337796 Elizabeth Monica Fariña, MD	Argentina	Upper Middle Income
1345015 Alberto Genaro Fernandez-Arana, MD	Peru	Upper Middle Income
1335507 Paola P Florez, MD	Colombia	Upper Middle Income
1345110 Jose Gallucci-Neto, MD, MSc	Brazil	Upper Middle Income
1316144 Lucas Gandarela, MD	Brazil	Upper Middle Income
1344784 Selvia Garritano, MD	Argentina	Upper Middle Income
1333817 Maria Veronica Gleria, MD	Argentina	Upper Middle Income
91959 Sergio Griselli, MD	Argentina	Upper Middle Income

Item 8.A Board of Trustees July 11-12, 2015 Attachment I

1329640 Ricardo Alfonso Haydar Ghisays, MD	Colombia	Upper Middle Income
1343137 Cielo Huertas, MD	Colombia	Upper Middle Income
1034956 Jorge Luis Irigoin, MD	Argentina	Upper Middle Income
1332936 Ricardo Alberto Klein, MD	Argentina	Upper Middle Income
1042688 Caleb K Korngold, MD	China	Upper Middle Income
1334590 Andrea Horvath Marques, MD	Brazil	Upper Middle Income
1332935 Maria Del Rosario Martina, MD	Argentina	Upper Middle Income
1314241 Silvia Martinez, MD	Colombia	Upper Middle Income
1321535 Marco Andre Urbach Mezzasalma, MD	Brazil	Upper Middle Income
1335515 Ana Gilma Millan, MD	Colombia	Upper Middle Income
1344976 Mariana C Moncaut, MD	Argentina	Upper Middle Income
1345251 Juliana B Moraes, MD	Brazil	Upper Middle Income
1335552 Jose Moura Neves Filho, MD	Brazil	Upper Middle Income
1334028 Juan Pablo Oszurkiewicz, MD	Argentina	Upper Middle Income
1335496 Andrea Otero Ospina, MD	Colombia	Upper Middle Income
1306904 Braz Torrezan Poliana, MD	Brazil	Upper Middle Income
1335501 Juan C Ramos, MD	Colombia	Upper Middle Income
1335498 Regulo A Ramos, MD	Colombia	Upper Middle Income
1312241 Marcela Romo Guardado, MD	Mexico	Upper Middle Income
1344766 Octavio M Saliba, MD	Brazil	Upper Middle Income
1338628 Gabriela Silvina San Roman, MD	Argentina	Upper Middle Income
1339485 Andrey Sindeev, MD	Peru	Upper Middle Income
1337456 Carina E Spano, MD	Argentina	Upper Middle Income
1336224 Carina Nelli Spelta, MD	Argentina	Upper Middle Income
1344819 Felipe De Medeiros Tavares, MD	Brazil	Upper Middle Income
1335495 Homero P F Vallada, MD, PhD	Brazil	Upper Middle Income
1333818 Juan Humberto Vallejos, MD	Argentina	Upper Middle Income
1002622 Jaime R Vengoechea, MD	Colombia	Upper Middle Income
1345019 Enrique O Villavicencio, MD	Peru	Upper Middle Income
1344834 Jairo Werner, MD	Brazil	Upper Middle Income

n = 61

1297848 Usama Abdul Kader Abdoul Khafez, MD	Saudi Arabia	Upper Income
1335883 Tarik Abou Amarah, MD	Saudi Arabia	Upper Income
1318582 Fatema Al Mansouri, MBBS	United Arab Emirates	Upper Income
1098839 Bandar Salman AlAdwani, MBBS	Saudi Arabia	Upper Income
1038611 Meshal Khaled Alaqeel, MD	Saudi Arabia	Upper Income
1344779 Sharifa Saad Aldakheel, MBBS	Saudi Arabia	Upper Income
1310572 Fahad Abdullah Almatham, MD	Saudi Arabia	Upper Income
1343062 Abdullah Bakhit Alzahrani, MD	Saudi Arabia	Upper Income
1345279 Per Beaeff, MD	Sweden	Upper Income
1344839 Giles S Berrisford, MD	United Kingdom	Upper Income

1314226	Bas Bouten, MD	Netherlands	Upper Income
	Peter Bowie, MD	United Kingdom	Upper Income
	Sally Ann Braithwaite, MSc, MB	United Kingdom	Upper Income
	Andrew David Brittlebank, MBBS	United Kingdom	Upper Income
	Sean Cross, MD	United Kingdom	Upper Income
	Aisling Denihan, MD	Ireland	Upper Income
_	Tatjana Dobrostane, MD	Sweden	Upper Income
	Peter E Evers, MD	Netherlands	Upper Income
	Mohamed H Fayek, MD	United Arab Emirates	Upper Income
	Igor Filipcic, MD, PhD	Croatia (Hrvatska)	Upper Income
	Naomi Fineberg, MBBS	United Kingdom	Upper Income
	Anders Forsell, MD	Sweden	Upper Income
	Ann Franberg, MD	Sweden	Upper Income
1335094	Lev A Fridgant, MBBS	Australia	Upper Income
1338627	Anders Hansen, MD	Sweden	Upper Income
1344981	Nicolas Hoertel, MD, MPH	France	Upper Income
309234	Zainab S Jabur, MD, MPH	United Kingdom	Upper Income
1320131	Anke De Jong, MD	Netherlands	Upper Income
1335885	Basanth Kumar Kenchaiah, MBBS	Australia	Upper Income
1344830	Sarwar Khan, MBBS, MSc	United Kingdom	Upper Income
1315399	Elvira Koic, MD	Croatia (Hrvatska)	Upper Income
1320205	Merit Kudeviita, MD	Estonia	Upper Income
1318577	Aparna Laddipeerla, MBBS, DPM	Australia	Upper Income
1301028	Kyungjin Lee, MD	Korea, Republic of	Upper Income
1345192	Juwamer Mavlud, MD	Norway	Upper Income
1315379	Alma Mihaljevic Peles, MD, PhD	Croatia (Hrvatska)	Upper Income
1344768	Alan Nasier Nadery, MD	Netherlands	Upper Income
1344778	Farooq Naeem, MBBS	United Kingdom	Upper Income
1332944	Atsuo Nakagawa, MD	Japan	Upper Income
1302735	Olutade Adekunle Olajitan, MD	United Kingdom	Upper Income
1344188	Henk Parmentier, MD	United Kingdom	Upper Income
1337493	Lisi Aiafi Petaia, MBBS	New Zealand	Upper Income
1312797	Daniela Petric, MD, PhD	Croatia (Hrvatska)	Upper Income
1344775	Biju Rajan, MBBS	Australia	Upper Income
1001152	Annalease S Richards, MD	Bahamas	Upper Income
	Marina Sagud, MD, PhD	Croatia (Hrvatska)	Upper Income
	Hawraa Sajwani, MD	United Arab Emirates	Upper Income
	John J Schmidt, MD	Denmark	Upper Income
	Martin Mathias Schmidt, MD	United Kingdom	Upper Income
	Pritpal Singh, MBBS	United Kingdom	Upper Income
	Maureen Maria Smeets-Janssen, MD	Netherlands	Upper Income
	Nick James Stafford, MBBS	United Kingdom	Upper Income
1320204	Deividas Sumskas, MD	Sweden	Upper Income

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1318607 Jeffrey O Swift, MBBS	Australia	Upper Income
1309783 Wai Kwong Tang, MD	Hong Kong	Upper Income
1333465 Willem Frederik Van Der Bend, MD	Netherlands	Upper Income
1318579 Tineke Van Veen, MD	Netherlands	Upper Income
1329698 Pascal Verjans, MD	Netherlands	Upper Income
1344934 Nalin C Wijesinghe, MBBS	Australia	Upper Income
312115 Jean-Claude Yazbek M.D.	Lebanon	Upper Income
1316145 Maja Zivkovic, MD, PhD	Croatia (Hrvatska)	Upper Income

n = 61

Total = 170

Dues Relief Requests - Confidential

Dues Waivers - Approved Member # Name

30079 Howard S Brode MD PC 1000931 Angela M Camacho-Duran, MD 1103217 Robin Lee Casey, MD 304073 Evelyn R Driscoll M.D. 28454 Mark B Fishtein, DO 57568 Mindy Jennifer Fullilove, MD 54772 Beth Ann Howell, MD 102922 Renee C Koronkowski M.D. 1005283 Joanna K Mansfield, MD 301727 Christine E Negendank, MD 66744 Vernon Michael Neppe M.D., Ph.D Distinguished Fellow 66665 Lisa Norelli, MD, MPH 40276 Larry Joseph Siever M.D. 82721 Sarah C Smith M.D. 33678 Ana Maria Soto M.D. 1017065 Emily Toch, MD, MS 91993 Joycelyn H Vanterpool M.D.

Member Class Life Member General Member Resident-Fellow Member General Member Life Member General Member General Member General Member General Member General Member Distinguished Fellow Distinguished Life Fellow General Member Distinguished Life Fellow

Michigan Psychiatric Society Ontario District Branch North Carolina Psychiatric Assn Arizona Psychiatric Society Pennsylvania Psychiatric Society NY County Psychiatric Society Oregon Psychiatric Physicians Assr Minnesota Psychiatric Society Ontario District Branch Michigan Psychiatric Society Washington State Psychiatric Assn New York State Capital New York County Psychiatric Society Western Canada Missouri Psychiatric Assn Northern California Psychiatric Society Florida Psychiatric Society Orange County Psychiatric Society Tennessee Psychiatric Assn Colorado Psychiatric Society

District Branch

Dues Reductions - Approved Member # Name

n=20

44139 Carey M Vigor M.D.

86068 Laura Wuarin M.D.

72217 Meredith Walgren, MD, PhD

31933 Lloyd Allan Wells, MD 1009682 Daniel J Abrams, MD 310697 Katherine K Babington M.D. 20405 Robert Henry Belmaker, MD 306578 Robin L Bitner, MD 63994 Jo Ellen Brainin-Rodriguez M.D. 64021 Araceli Gonzalez Casso M.D. 29220 Peggy Anne Finston M.D. 303060 Margo Fugate 34411 Don Lewis Houts M.D. 89903 Nikola N Ilankovic M.D. 303313 Samar Aisha Jasser, MD 74472 Kimberly Toland Jones M.D. 81456 Judythe S McKay, MD 80193 Claudia T Miles, DO 1049333 Justin Michael Mortimer, MD 1006884 Kerry E Opdyke, MD 1004117 Melissa Ozga, DO 70398 Kimberly A Pesaniello M.D.

29167 Lee Jules Shonfield M.D.

n=21

Member Class

General Member

General Member

General Member

General Member

Fellow

Distinguished Fellow General Member General Member Intl Distinguished Fellow General Member General Member General Member Life Member Distinguished Life Fellow Intl Distinguished Fellow General Member Distinguished Fellow General Member Fellow Resident-Fellow Member General Member Fellow General Member Life Member 58691 Mahmoud Mohamed Wahba, MD Distinguished Fellow

District Branch Name

Minnesota Psychiatric Society Colorado Psychiatric Society Washington State Psychiatric Assn At Large Members Northern California Psychiatric Society Northern California Psychiatric Society Texas Society of Psychiatric Physicians Arizona Psychiatric Society Psychiatric Society of Westchester Cty Inc San Diego Psychiatric Society At Large Members Pennsylvania Psychiatric Society Pennsylvania Psychiatric Society North Carolina Psychiatric Association South Carolina Psychiatric Association Connecticut Psychiatric Society Oregon Psychiatric Physicians Assn New York County Psychiatric Society Maryland Psychiatric Society Inc Ohio Psychiatric Physicians Assn Missouri Psychiatric Association

BOT Item Board of Trustees July 11-12,2015 Attachment J

Permanent Inactive Status - Approved Member # Name

69708 J.P. Cooper M.D. 44119 Mary Patrice Gillespie M.D. 36874 Scott Duane Gleditsch M.D. 29560 Carol Ann Hauk M.D. 30879 Peter C Joosse M.D. 34646 Jane Elizabeth Marke M.D. 32631 Ruth Swimmer Martin M.D. 35115 James Walter Millward M.D. 56255 Alan Quenton Radke MD MPH 64740 Julia Kruger Reschke M.D. 79684 Said A Shefayee, MD 56856 Barbara H Sohmer, M.D. 66353 Barbara Ann Stein M.D. 38854 Michael L Zarr M.D. 32519 Jerry Martin Zober M.D. n=15

F L L . L PH (F F

Member Class Fellow Life Member Life Member Life Member Life Member General Member Life Member Life Member General Member General Member General Member Fellow Fellow Distinguished Life Fellow Life Fellow

District Branch Name Ontario District Branch Pennsylvania Psychiatric Society North Carolina Psychiatric Assn Colorado Psychiatric Society Wisconsin Psychiatric Assn New York County Psychiatric Society Ohio Psychiatric Physicians Assn Pennsylvania Psychiatric Society Hawaii Psychiatric Medical Assn Wisconsin Psychiatric Assn Northern California Psychiatric Society Pennsylvania Psychiatric Society Florida Psychiatric Society Michigan Psychiatric Society Ohio Psychiatric Physicians Assn

Temporary Inactive Status - Approved Member # Name

1090976 Faith Nerine Contell, MD n=1

Member Class Intl Fellow

FINANCE AND BUDGET COMMITTEE REPORT TO THE APA BOARD OF TRUSTEES Alan Schatzberg, MD, Chair

SUMMARY OF PROPOSED ACTIONS

1. CME Paid Course Fees:

Will the APA Board of Trustees approve an increase for CME course registration fees in 2016 as proposed in Attachment A?

2. IPS: The Mental Health Services Conference Registration:

Will the APA Board of Trustees approve changes to the fees for the 2016 IPS as proposed in Attachment B?

3. Annual Meeting Registration:

Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2016 as proposed in Attachment C?

4. Recommendation regarding the planning of the State Advocacy Conference and Advocacy Leadership Conference:

Will the APA Board of Trustees approve in principle that the APA alternates the State Advocacy Conference and the Advocacy Leadership Conference, holding each conference every other year?

5. Membership Proposal Regarding International and Domestic Membership:

- (a) Will the APA Board of Trustees approve a two year pilot project of discounted group rates for international associations?
- (b) Will the APA Board of Trustees approve a two year pilot project of discounted group rates for hospital systems or government related agencies?

The Finance and Budget Committee met on June 3 - 4, 2015. The following actions are being referred to the APA Board of Trustees for approval:

CME Paid Course Registration Fees - 2016

The Finance and Budget Committee conducted the annual review of CME paid course fees and agreed to recommend slight increases in the rates for course fees in 2016 as presented in Attachment A. Since 2009, the APA Board of Trustees has approved annual CME course fee increases. The proposed rates for 2016 include an increase of \$10 across all categories.

Action: Will the APA Board of Trustees approve an increase for CME course registration fees for 2016 as proposed in Attachment A?

Rate Increase for IPS: The Mental Health Services Conference Registration – 2016

The Finance and Budget Committee conducted the annual review of IPS registration fees and agreed to recommend to the APA Board of Trustees for approval, changes to the fees as proposed for 2016 (Attachment B). The Board approved an increase in registration fees for non-members in 2014 but did not approve an increase to member registration rates. In 2015 an inflationary increase in some categories was approved and adjustments were made in order to maintain the differential between members and non-members.

Action: Will the APA Board of Trustees approve changes to the fees for the 2016 IPS as proposed in Attachment B?

Annual Meeting Registration – 2016

The proposed rates for 2016 reflecting adjustments as detailed below for the meeting to be held in Atlanta and are presented in Attachment C. In 2015, the Board approved an inflationary rate increase.

Action: Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2016 as proposed in Attachment C?

State Advocacy Conference and Advocacy Leadership Conference

In light of budget considerations, the Finance and Budget Committee is forwarding to the APA Board of Trustees for consideration and approval in principle, the Board's preference for regularity in holding the State Advocacy Conference and the Advocacy

Leadership Conference. The Committee is requesting the Board's recommendation as to whether the Board has a preference for holding these conferences annually - alternating these conferences every other year.

Action: Will the APA Board of Trustees approve in principle that the APA alternates the State Advocacy Conference and the Advocacy Leadership Conference, holding each conference every other year?

Membership Proposal Regarding International and Domestic Membership

The Finance and Budget Committee reviewed a proposal from the Membership Committee that focuses on building international and domestic membership and voted to recommend to the APA Board of Trustees a two year group discount pilot project as detailed in Attachment D.

Action:

- (a) Will the APA Board of Trustees approve a two year pilot project of discounted group rates for international associations?
- (b) Will the APA Board of Trustees approve a two year pilot project of discounted group rates for hospital systems or government related agencies?

Executive Committee Budget Approvals

The Finance and Budget Committee noted the additional funding approved by the Executive Committee of the Board for projects relating to Government Affairs and Foundation development. This funding was approved after the 2015 budget had been approved. It was suggested that the Finance and Budget Committee be notified of funding approved by the Executive Committee during the year after the annual budget has been approved.

Attachment A

COURSE FEES

2015		Early Bird	Advance	Onsite
MEMBER	Half day (4 hrs.)	155	175	200
	Full day (6 hrs.)	215	250	285
	Full day (8 hrs.)	260	310	330
	Master Courses	355	385	415
NONMEMBER				
	Half day (4 hrs.)	180	200	225
	Full day (6 hrs.)	265	300	350
	Full day (8 hrs.)	360	410	430
	Master Courses	455	485	515
PROPOSAL FOR 2016		Early Bird	Advance	Onsite
MEMBER	Half day (4 hrs.)	165	185	210
	Full day (6 hrs.)	225	260	295
	Full day (8 hrs.)	270	320	340
	Master Courses	365	395	425
NONMEMBER				
	Half day (4 hrs.)	190	210	235
	Full day (6 hrs.)	275	310	360
	Full day (8 hrs.)	370	420	440
	Master Courses	465	495	525

Attachment B

2016 Proposed Registration Fee – IPS

		N	/lembers	rs Nonmembers		ers	
		2015	2016	Change	2015	2016	Change
Full-Time							
	Early Bird	270	275	5	460	465	5
	Advance	325	330	5	515	520	5
	Onsite	395	400	5	585	590	5
Resident Fellow							
	Early Bird	80	80	0	110	140	30
	Advance	95	95	0	140	170	30
	Onsite	110	110	0	170	200	30
Primary Care Physic	cians Full Time						
	Early Bird		N/A		110	115	5
	Advance		N/A		140	145	5
	Onsite		N/A		170	175	5
Nonmember: Resid Group Members, N	lents, Students, Menta on-physicians	al Health Cha	aplains, A	dvocacy			
	Early Bird		N/A		110	115	5
	Advance		N/A		140	145	5
	Onsite		N/A		170	175	5
Daily Registrants							
	Early Bird	165	165	0	270	275	5
	Advance	195	195	0	305	310	5
	Onsite	240	240	0	345	350	5
Daily Registrants - S	Sunday only						
	Early Bird	85	85	0	135	140	5
	Advance	100	100	0	155	155	0
	Onsite	125	120	-5	175	175	0

2016 Proposed Registration Fee - IPS

2010 Froposed Registration Fee 113								
		Members				Nonmembers		
		2015	2016	Change	2015	2016	Change	
Program Presenter	Full Time							
	Early Bird	205	205	0	205	205	0	
	Advance	205	205	0	205	205	0	
	Onsite	275	275	0	275	275	0	
Program Presenter	Daily							
_	Early Bird	105	105	0	105	105	0	
	Advance	105	105	0	105	105	0	
	Onsite	140	140	0	140	140	0	
Program Presenter	- Sunday only							
	Early Bird	50	50	0	50	50	0	
	Advance	50	50	0	50	50	0	
	Onsite	70	70	0	70	70	0	
Medical Students								
	Early Bird	Fee	Exempt		ı	Fee Exem	ot	
	Advance		Exempt			Fee Exem _l		
	Onsite	Fee	Exempt		1	Fee Exem	ot	
Honorary Fellow								
,	Early Bird	Fee	Exempt			N/A		
	Advance		Exempt			N/A		
	Onsite	Fee	Exempt			N/A		
*Spouse/ Significan	t Other							
- p / O	Early Bird		N/A		280	285	5	
	Advance		N/A		315	320	5	
	Onsite		N/A		355	360	5	

^{*}A member benefit- only APA members can register a nonmember spouse/guest at this discounted rate, others must register as full-time nonmember

Attachment C

2016 PROPOSED ANNUAL MEETING REGISTRATION FEES

MEMBER		2015	2016	CHANGE
Full Time	- 1 - 1		0=0	
	Early Bird	370	370	0
	Advance	420	420	0
	On Site	465	470	5
Resident Fellow Full Time				
	Early Bird	105	105	0
	Advance	145	145	0
	On Site	170	170	0
Doilu				
Daily	Early Bird	200	200	0
	Advance	230	230	0
	On Site	250	250	0
	On Site	230	230	U
Two Day				
North American Members Only				
	Early Bird	325	325	0
	Advance	375	375	0
	On Site	425	425	0
Medical Students, Undergraduate Students & APA Honorary Fellows			Fee Exempt	
Program Presenter Full Time				
3	Early Bird	280	280	0
	Advance	280	280	0
	On Site	315	315	0
Program Presenter Daily NEW CATEGORY				
	Early Bird	0	100	100
	Advance	0	100	100
	On Site	0	135	135

		2015	2016	CHANGE
NONMEMBER				
Full Time				
ruii Time	Early Bird	990	1010	20
	Advance	1040	1060	20
	On Site	1090	1110	20
	011 0110	1030	1110	20
Residents/Chaplains/Advocacy				
Groups/Non-Medical				
Students/Nurses and Social Workers				
	Early Bird	170	175	5
	Advance	210	215	5
	On Site	235	240	5
Daily				
	Early Bird	535	545	10
	Advance	565	575	10
	On Site	585	595	10
Two Day				
Two Day	Early Bird	940	960	20
	Advance	990	1010	20
	On Site	1040	1010	20
	On Site	1040	1000	20
*Spouse/Significant Other				
	Early Bird	215	215	0
	Advance	255	255	0
	7.07000			0
	On Site	280	280	
Program Presenter - Nonmember Psych	niatrist - Full Ti	me		
	- 1 - 1			•
	Early Bird	690	710	20
	Advance	690	710	20
	On Site	755	775	20

Program Presenter - Nonmember Psychiatrist Daily NEW CATEGORY

Early Bird	0	460	460
Advance	0	460	460
On Site	0	525	525

Program Presenter - Nonpsychiatrist Full Time

Early Bird	fee exempt
Advance	fee exempt
On Site	fee exempt

^{*}As a member benefit, only an APA member can register their spouse/significant other at this discounted rate. Nonmembers must register at the full nonmember rate.

Attachment D

Two Year Group Discount Pilot Project

The Finance and Budget Committee, Membership Committee, and Council on International Psychiatry voted to bring this proposal to the Board.

The APA has been working on building membership value both domestically and internationally. It has also been communicating the value being developed to both large systems domestically and international medical associations. During those communications, the APA was asked if it would consider a discounted dues structure depending on the number of <u>new members</u> obtained through group billing.

For simplicity, the proposal highlights the international opportunity and then the domestic opportunity.

International Membership

The South African Society of Psychiatrists (SASOP) has proposed offering APA membership to all of its members at a discounted price. Currently, the APA has 11 members in South Africa and SASOP has 550 paid members. The current cost of APA member for Psychiatrists in South Africa is \$180. All benefits are delivered electronically to international members so there is little hard cost to adding additional international members. The proposal is that the APA would only offer discounted dues for new members who come through SASOP. However, an alternative is to give all members of SASOP the discounted rate given that we only have 11 members. If 100 of the 550 members were added, this would increase membership revenue by \$18,000 per year in addition to broadening the APA's reach.

We have recently had expressions of interest from a few other international associations, including those in Saudi Arabia, Israel and India. This increased interest is because the APA is developing a new learning management system to deliver valuable content to our members. Since many of these Associations don't have the expertise or resources to create similar content and deliver it electronically, they are interested in exploring closer relationships with the APA.

The APA has two choices to reach the international community, both of which have hard costs. The highest cost of recruiting new members is identifying who they are, finding ways to contact them, and actually making the contact. This is especially costly internationally since this requires the purchase of mailing lists, mailing material, advertising in publications and attending international conferences. E-mails are almost impossible to obtain until they are provided by the individual when they join. The second option is incentivizing international associations with large memberships to help the APA grow its membership. The way to incentivize international associations is to 1) develop something unique that international associations don't have the expertise and/or resources to create and 2) make the international association feel like its

achieving something for its membership by getting a financial incentive that they can pass on to their members.

The second choice seems to be the best and most cost-effective option. We have been talking with international associations about the creation of a new learning management system (LMS) and the content that will be delivered through that system. This is something that many don't have the time, expertise, or financial resources to create. Therefore, they see an opportunity to deliver this to their members. They have also asked for a group discount, which is value that they can highlight as an association that an individual could not achieve. We are proposing the following scale.

10-50 <u>new members</u> 10%
 50-150 <u>new members</u> 15%
 150+ new members 20%

We are proposing that these tiers be considered guidelines that cannot be exceeded. For example, if the Administration could negotiate a 10% discount for bringing on 150+ members instead of a 20% discount, then it would. However, it wouldn't be able to offer a 30% discount because that exceeds the established scale. Consequently, the Administration would like some flexibility in its approach to obtain the best possible financial and membership results based on the unique circumstances. However, if more palatable, the proposed scale above could be strictly applied so every international association was offered the same group discount based on the number of new members that were obtained.

In relation to applying the group discount, the proposal is that the discount will be applied to the non-members. Therefore, if SASOP brought on 100 new members, in addition to the 11 that APA already has, the 10% discount would be applied to the 100, not the 11, and SASOP would be group billed. Given that the APA only has about 1% of the international psychiatrist outside of the US and Canada, there is a lot of growth potential.

Domestic Membership

We have been in communication with two large health systems over the past two years stressing the current and future value that the APA can provide to their employed psychiatrists. Pine Rest in Grand Rapids Michigan is a cutting-edge system that we have been talking with, which has about 70 psychiatrists, 31 of which are non-members. Moreover, we didn't even know some of these psychiatrists existed until we starting talking with the system about membership. Currently, all of the residents of Pine Rest are members, in addition to the program director who is active in the APA Assembly. We have spoken to the COO and president of the system on multiple occasions. They have stated that they are almost certain to pay for all their employed psychiatrists to be members if they could obtain a group discount. This would result in \$12,546 in revenue

per year for the APA, including the 10% discount applied to the non-members, and \$9,870 for the Michigan District Branch, not including the discount.

The Hospital Corporation on American (HCA) has also expressed an interest in the group discount. It has 99 employed psychiatrists, 64 of which are non-members. HCA is also planning to add over 100 new psychiatrists in the coming years and two residency training programs. The 64 new members would add \$40,800 in APA revenue per year, including the discount applied to non-members, and about \$35,000 to DB revenue.

The administration has weighed the possible pros and cons of a group discount. First, the trend is that a larger percentage of our younger members are choosing to become employed than in the past. This is a trend that we need to adjust for to keep the organization growing. Second, it takes less time administratively to identify, recruit and bill large groups of psychiatrists. Moreover, it provides the APA with institutional eyes and ears on the ground. A possible con includes a scenario in which a system starts paying the membership dues for all its employed physicians, the economy goes in to a major recession, the system wants to eliminate the program, and these members have to start paying their own dues. With this said, the benefits seem to outweigh the potential costs. First, the APA has to have the member to lose the member. Without moving forward, the opportunity is lost to bring non-members into the APA family and showcase our increasing value and relevance to them.

Similar to the International, we are proposing the following scale.

10-50 <u>new</u> members 10%
 50-150 <u>new</u> members 15%
 150+ <u>new</u> members 20%

Similar to the international proposal, the Administration would like some flexibility in its approach to obtain the best possible financial and membership results based on the unique circumstances. However, if more palatable, the proposed scale above could be strictly applied. This same approach could be applied to the VA or other government related agencies. The DB portion is not being discounted since their willingness to do so is uncertain.

Conclusion

The APA Administration will closely track the performance of this proposal and report back to the Board in the CEO's report at least once per year. If the pilot fails to deliver large groups of members either domestically or internationally within two years, it will be retired.

Proposed Action 1: Will the Board approve a two year pilot project of discounted group rates for international associations?

Proposed Action 2: Will the Board approve a two year pilot project of discounted group rates for hospital systems or government related agencies?

Investment Oversight Committee Report to the APA Board of Trustees David Fassler, MD., Chair

The following is an update for the APA Board of Trustees about the 1st quarter investment performance for 2015. There are no actions being put forward for consideration at this time.

Long-Term Consolidated Investment Performance Summary

As of March 31, 2015: The market value of the consolidated investment portfolio was approximately \$131.4M. The portfolio is well diversified with allocations including \$33.3M fixed income, \$49.5M US equity, \$24.7M non-US equity, \$11.1M hedge fund of funds, \$12.0M real estate and \$711K cash equivalents. The portfolio increased by \$8.0M over the quarter resulting from investment earnings of \$3.0M and net contributions of \$5.0M. Over the trailing twelve months the portfolio increased by \$14.9M with investment earnings of \$9.0M and net contributions of \$5.9M.

The table below shows the asset allocation as of March 31, 2015:

		Policy Asset Allocation Guidelines		
	% of			
Asset Class	Portfolio	Minimum	Target	Maximum
Fixed Income	25.3%	20.0%	25.0%	30.0%
U.S. Equity	37.7%	32.5%	37.5%	42.5%
Non-U.S. Equity	18.8%	12.5.0%	17.5%	22.5%
Hedge Fund of Funds	8.9%	3.0%	8.0%	13.0%
Real Estate	9.1%	7.0%	12.0%	17.0%
Cash Equivalents	0.5%	0.0%	0.0%	5.0%

Fees: The annual fee for the overall investment management of the entire fund is approximately \$471K, 39 basis points (0.39%), which is below industry standards of 50 basis points (0.50%) for a fund with this target asset allocation. This represents a fee savings of over \$140K annually. After all fees were paid, the approximate allocation of the portfolio is as follows: APA's share is \$72.6M (55%); and APF's share is \$58.7M (45%).

Pension Fund

The market value of the Pension Fund as of March 31, 2015 was \$10.6M including \$3.9M fixed income, \$4.8M U.S equity, \$1.4M non-US equity, and \$379K cash equivalents.

Fees: The annual fee for investment management of the portfolio is seventeen basis points (0.17%). This is significantly below the industry standard of approximately twenty-eight basis

points (0.28%) for a portfolio of this size and with this target allocation. This represents a fee savings of approximately \$11K annually.

Retirement Savings Plan

The market value of the Retirement Savings Plan as of March 31, 2015 was \$34.7M including \$10.3M fixed income, \$16.5M U.S. equity, \$3.0M non-U.S. equity, \$4.1M lifestyle funds, \$395K in loans and \$305K in self-directed brokerage.

The current utilization is fixed income 29.9%, U.S. equity 47.6%, international 8.7%, lifestyle funds 11.8%, loans 1.1%, and self-directed brokerage 0.9%.

Fees: The fee for the investment management of the plan is approximately 66 basis points (0.66%) annually. This is significantly below the industry standard of 89 basis points (0.89%) for a portfolio of this size and target allocation.

Manager Reviews and Asset Reallocation

The Committee agreed to terminate the Eaton Vance Fund due to underperformance and to hire the Nuveen Symphony Fund as its replacement.

The Committee also agreed to conduct a review the services of SunTrust, the current custodian.

At its meeting of December 7-9, 2013 the APA Board of Trustees approved increasing the real estate target allocation from 7.5% to 12%. The investment advisors recommended adding an investment in UBS Trumbull Property Growth and Income Fund (UBS-TPG) with a commitment of \$3M pending capital call. In June 2015, the first notice of capital call has just been received in the amount of \$1.5M. Funds will be reallocated within the portfolio for this investment. The portfolio remains within the ranges set forth for the asset allocations.

Building Fund

If the APA proceeds with plans to purchase real estate requiring a down payment of approximately \$15M - \$20M, the Committee recommends that funds be set aside within the pooled investment portfolio and managed with specific reference to this intended use and the anticipated timeframe. The Committee encourages the APA Board of Trustees and the APA Foundation Board of Directors to discuss this issue in the coming months, with appropriate feedback and direction so we can plan and proceed accordingly.

Next Meeting

The next meeting will be planned to coincide with the date and time of the Finance and Budget Committee.

6/12/15

June 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 following is a brief summary of the significant activities of the delegation since our last report to the Board of Trustees.

APA Annual Meeting, May 16-20, 2015

Members of the AMA Section Council on Psychiatry attending the APA Annual Meeting in Toronto met informally on Monday, May 18. The agenda included a review of the schedule and various activities occurring during the June House of Delegates meeting in Chicago, including a brief discussion on reports and resolutions to be acted upon in June, and of the campaign activities of Patrice Harris, MD in her bid for re-election to the AMA Board of Trustees (AMA BOT) as well as the future campaign of Jack McIntyre, MD for the AMA BOT in 2016.

Dr. David Barbe, immediate past chair of the AMA BOT spoke to members of the APA Assembly at their May meeting in Toronto, updating them on AMA's recent successes and ongoing initiatives including:

- Medicare Access and CHIP Reauthorization Act (MACRA): The AMA mobilized its Physicians'
 Grassroots Network to advocate successfully for the passage of legislation that repealed the
 SGR formula and streamlined what AMA termed the "regulatory tsunami" of payment reforms.
 This achievement was in large part due to a sustained advocacy effort with a ground-swell of
 support from physicians from all states and specialties.
- ICD -10: AMA was successful in its efforts to delay implementation of ICD-10. Current advocacy efforts are focused on identifying and resolving potential claims-processing issues to ensure that the conversion does not disrupt claims payment.
- Electronic Health Record (EHR): AMA is working to improve EHR usability.
- Mental Health Policy: AMA has long-supported mental health parity and has current policy on ensuring adequate services and numbers of psychiatrists and other mental health professionals; and policy supporting physician-led teams in emerging models of care. A three-year effort to re-define and re-value psychiatric services between AMA, CPT, RUC, APA, and CMS resulted in \$150 million dollar/6% yearly increase in Medicare payments to psychiatrists.
- Maintenance of Certification (MOC): AMA continues to try to address widespread concerns about the MOC process.

Dr. Barbe mentioned with appreciation the contributions of members of the Section Council on Psychiatry to the AMA and concluded his presentation by noting the work AMA has accomplished as part of its three-part strategic plan to accelerate change in medical education, improve health outcomes for patients and improve physician satisfaction and sustainability.

AMA House of Delegates Meeting, June 6 -11, 2015

The major focus for which we worked and celebrated was the re-election of Patrice Harris, MD to a

second four-year term on the AMA Board of Trustees (Attachment 1). Not only did Dr. Harris receive the largest number of votes of any candidate in this highly contested election, but she then was unanimously elected by her colleagues on the Board to the position of Chair-Elect of the AMA BOT. This second and remarkable victory reflected the Board members' respect of and admiration for her leadership. It also documented our successful implementation of a long term strategic plan begun in December 2000 under the wise direction of Dr. Joseph T. English. The goals of the plan included: greater recognition of and respect for psychiatrists and psychiatric issues; the election and appointment of psychiatrists to AMA leadership positions (e.g., councils and committees), and the support of the AMA for public policy and other issues related to clinical care such as parity, workforce, access, stigma and discrimination. For psychiatrists to achieve these goals required a longer range plan—keeping our eyes on the prize—while recognizing that AMA's operations and time table differ from those of APA, and learning to work well in AMA's organizational culture.

The Section Council's successes lead to future challenges. Not only must we mount a strong and successful campaign for Dr. Jack McIntyre in his quest for a seat on the AMA Board of Trustees in 2016, but we also must engage in activities that promote our next decade of success—identifying, mentoring, and promoting the next generation of psychiatrist leaders. Work is already under way to expand our interactions with young physician leaders in the House—leaders representing state societies as well as the broad range of specialties, in addition to continued work to strengthen the positive relationships with other specialty and state medical societies that have developed over the past four years. More information about these directions will be available in our next report.

The following delegates and alternate delegates attended the June, 2015 Annual Meeting of the AMA House of Delegates 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, Saul Levin, MD, MPA (CEO & APA Medical Director), John Wernert, MD, Paul Wick, MD; alternate delegates Daniel Anzia, MD (Speaker-Elect), Donald Brada, MD, Barbara Schneidman, MD, Harsh Trivedi, MD; Young Physician Delegates Ray Hsiao, MD and Paul O'Leary, MD; Resident and Fellow Delegates Alicia Barnes, MD, Simon Faynboym, MD, and Sean Moran, MD. Jacob Behrens, MD joined us at this meeting as a member of the Section Council. The American Academy of Child and Adolescent Psychiatry (AACAP) was represented by Louis Kraus, MD, David Fassler, MD, Sharon Hirsch, MD, Bud Vanna, MD, AACAP President Paramjit Joshi, MD, and AACAP President-Elect Gregory Fritz, MD. The American Academy of Psychiatry and the Law (AAPL) was represented by Barry Wall, MD, Ryan Hall, MD, and Jennifer Piel, MD. The American Academy of Geriatric Psychiatry (AAGP) was formally admitted into the House of Delegates June 8, and was represented by Allan Anderson, MD and Sandra Swantek, 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 Erin Connors, Rodger Currie, Tristin Gorrindo, MD, Deana McRae, Mark Moran, Ranna Parekh, MD, Kristin Kroeger Ptakowski, Caroline Williams and Becky Yowell (APA staff), Heidi Fordi, and Ronald Szabat (AACAP staff), and Jacquelyn Coleman (AAPL staff).

In addition to the routine monitoring of reports and resolutions moving forward at the AMA House of Delegates meetings, APA, AACAP, AAPL, GLMA along with the American Academy of Neurology and the Massachusetts Medical Society, co-sponsored a resolution on Military Medical Policies Affecting Transgender Individuals. Additionally, prior to the meeting APA provided input to AMA staff on CMS Report 6 Integrating Physical and Behavioral Health Care. The resolution regarding the military policies was adopted as submitted. An additional recommendation was added to CMS report 6 following testimony by the APA. That recommendation asks that the AMA promote the development of sustainable payment models that would be used to fund the necessary services inherent in integrating

behavioral health care services into primary care settings.

Attachment 2 provides more information about these reports as well as a list of reports and resolutions of more general interest. For the full listing of the preliminary actions go to http://www.ama-assn.org/sub/meeting/reportsresolutions.html (login required) and review the reference committee reports.

Members of the Section were also quite active in the Senior Physicians Section (SPS), of which Paul Wick, serves as Chair. Glen Gabbard, MD, Clinical Professor of Psychiatry at Baylor College of Medicine, was the featured speaker at an educational session sponsored by the Section entitled "The Aging Physician: Possibilities and Perils." Section Council on Psychiatry members participating in the session included SPS Governing Council member Barbara Schneidman, MD, MPH, as the moderator and Louis Kraus, MD as a panelist. Dr. Gabbard's well-received presentation addressed the perils of perfectionism, for both physicians and patients.

Presentation

James Madara, MD, CEO and Executive Vice President of the American Medical Association highlighted the progress made in implementing three parts of the AMA strategic plan:

Accelerating Change in Medical Education: AMA awarded five-year grants to 11 medical schools to develop models for transforming medical education. The initial plan is to promote communication and collaboration among the grantees, as well as develop ways to incorporate feedback from medical schools beyond the original group. Over the next four years, the AMA will work with these schools on prototyping and disseminating their innovative programs and ideas within the 11-school consortium and beyond.

Improving Health Outcomes for Patients: AMA has been working collaboratively with a number of organizations including the YMCA, Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center to Eliminate Cardiovascular Health Disparities, the U.S. Department of Health and Human Services' "Million Hearts®" initiative, as well as the Centers for Disease Control and Prevention's National Diabetes Prevention Program, to prevent the progression of pre-diabetes to diabetes and to achieve better control of high blood pressure. The long-term goal is to identify patients at risk earlier before they develop diabetes and/or hypertension.

Improving Physician Satisfaction and Practice Sustainability: A recent AMA study on physician satisfaction found that most physicians find the ability to provide high-quality health care to be the primary driver of job satisfaction, and obstacles to quality patient care a source of stress. The study also found that physicians are dissatisfied by the "treadmill" like workload with limited time for each patient, and the burdensome impact of a growing number of rules and regulations. Factors influencing those physicians reporting greater satisfaction were a sense of collegiality, fairness and respect. In response, AMA developed STEPS Forward (https://www.stepsforward.org/), a series of educational modules designed to help physicians and their staff revitalize their practice while improving patient care. Topics range from improving medication adherence to creating strong team culture and preventing physician burnout, and are designed to help physicians and their staff revitalize their practice while improving patient care.

For more information on all of these initiatives go to: http://www.ama-assn.org/sub/at-a-glance/

Communications Report for AMA HOD

Once again this year we were very active on Facebook and Twitter at the AMA HOD in Chicago. Posts

Item 8.D Board of Trustees July 11-12, 2015

featured APA members at work in the House of Delegates, in reference committee hearings, and during section council meetings. Communications staff also assisted with preparing Patrice Harris, MD for her presentation for re-election to the Board of Trustees and with preparing campaign support letters to voting members of the house. Tweets from the APA Twitter account were re-tweeted by actress Patty Duke (on transgender in the military) and AMA President Dr. Robert Wah (congratulations to AAGP).

Formal interviews for the APA Website were conducted with Drs. Levin and Harris.

NEWS RELEASE



For Information Contact:

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APA Member Patrice Harris, M.D., Voted in as Chair-Elect of AMA Board of Trustees



CHICAGO, June 10, 2015 — Patrice Harris, M.D., a psychiatrist and past member of the American Psychiatric Association (APA) Board of Trustees, was voted into office as Chair-Elect of the American Medical Association (AMA) Board of Trustees earlier today.

The Board of Trustees is an elected body of 21 physicians who guide the AMA as it sets standards and policy for the medical profession. "I am thrilled that Dr. Harris will serve as Chair-Elect on the AMA Board," said APA President Renee Binder, M.D.

"The APA Board of Trustees is looking forward to working with her as both groups strive to improve and advance the practice of medicine."

Harris' election to Chair-Elect comes in the wake of her re-election yesterday to a second term on the AMA Board of Trustees. She was first elected to the board in 2011. APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted: "It's an honor to have one of our former Board of Trustees members re-elected to the AMA Board of Trustees and become Chair-Elect of the board. Dr. Harris will continue to carry the integration of psychiatry and mental health within the house of medicine."

Harris has taken on several leadership roles at the AMA, including a term as chair of the AMA Council on Legislation. "It's a great honor to be elected Chair-Elect to our AMA Board of Trustees," Harris said. "I am proud to be in this role and to have a strong voice for the patients we serve. My success in the AMA is in no small part due to the hard work of the members of the Section Council on Psychiatry."

Harris is the Director of Fulton County (Ga.) Health Services and the head of the Fulton County Department of Behavioral Health and Developmental Disabilities. As director of health services for Fulton County, which includes Atlanta, Harris directs all county health services, including health partnerships that deliver a wide range of treatment and prevention services. She is a past president of the Georgia Psychiatric Physicians Association and served as a member of the AMA Women Physicians Congress. Harris also maintains a private psychiatric practice.

The American Psychiatric Association is a national medical specialty society whose physician members specialize in the diagnosis, treatment, prevention, and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org.

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action				
.Con	BOT 02	New Specialty Organizations Representation in the House of Delegates	ADOPTED The Board of Trustees recommends that the American Association for Geriatric Psychiatry and the American Society of Breast Surgeons be granted representation in the AMA House of Delegates and the remainder of this report be filed. (Directive to Take Action)				
.Con	CEJA 01	Ethical Practice in Telemedicine	REFERRED				
.Con	CEJA 03	Modernized <i>Code of Medical Ethics</i>	REFERRED The full text of the modernized Code of Medical Ethics is posted online at www.ama-assn.org/go/cejaforum				
.Con	Res 011	Military Medical Policies Affecting Transgender Individuals	PA endorsed resolution ESOLVED, That our American Medical Association affirm that there is no medically valid reason to exclude transgender individuals from service in the US military (New HOD Policy); and be it further (SOLVED, That our AMA affirm transgender service members be provided care as determined by patient and physician according to the same edical standards that apply to non-transgender personnel. (New HOD Policy)				
A	CMS 06	Integrating Physical and Behavioral Health Care	ADOPTED AS AMENDED The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-345.983, which endorses access to and payment for integrated physical and behavioral health care, and supports standards that encourage medically appropriate treatment. (Reaffirm HOD Policy) 2. That our AMA encourage private health insurers to recognize CPT® codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day. (New HOD Policy) 3. That our AMA encourage all state Medicaid programs to pay for physical and behavioral health care services provided on the same day. (New HOD Policy) 4. That our AMA encourage state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings. (New HOD Policy) 5. That our AMA encourage practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care. (New HOD Policy) 6. That our AMA rescind Policy D-345.987. (Rescind HOD Policy) 7. That our AMA promote the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.				
A	RES 111	Evaluate Vouchers Program for Veterans to Purchase to Purchase Private Health	ADOPTION of Substitute Resolution 111 in lieu of Resolutions 112, 114 and 130 ACCESS TO HEALTH CARE FOR VETERANS				

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
	RES 112 RES 114 RES 130	Insurance Improving Timely Access to Quality Healthcare for America's Veterans An HSA Card will Give Veterans Better, Faster Health Care Ensuring Enhanced Delivery of Health Care to our Nation's Veterans	RESOLVED, That our AMA continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system. (New HOD Policy); and be it further RESOLVED, That our AMA monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system. (New HOD Policy); and be it further RESOLVED, That our AMA call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans. (New HOD Policy); and be it further RESOLVED, That our AMA advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. (New HOD Policy); and be it further RESOLVED, That our AMA advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans. (New HOD Policy); and be it further RESOLVED, That our AMA support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans. (New HOD Policy)
A	RES 116	Study the Impact of the ACA Medicaid Expansion	ADOPTED AS AMENDED RESOLVED, That our American Medical Association use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low- income adults as specified by the Affordable Care Act to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population as opposed to those who are otherwise insured, (b) the quality of health care services provided to those who are part of the Medicaid expansion population as opposed to those who are otherwise insured, (c) the adequacy of provider payments for the services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use (Directive to Take Action); and be it further RESOLVED, That our AMA provide this report to the HOD at the 2016 Annual Meeting. (Directive to Take Action)
A	RES 106 RES 117 RES 124 RES 125 RES 127	Controlling the Skyrocketing Costs of Generic Prescription Drugs Pricing of Generic Drugs Reducing Prescription Drug Prices Rising Generic Drug Prices Controlling Rapidly Escalating Generic Medication Prices	ADOPTION of Substitute Resolution 106 in lieu of Resolutions 117, 124, 125 and 127 RESOLVED, That our American Medical Association work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs (New HOD Policy); and be it further RESOLVED, That our AMA advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients (New HOD Policy); and be it further RESOLVED, That our AMA encourage the development of methods that increase choice and competition in the development and pricing of generic prescription drugs (New HOD Policy); and be it further RESOLVED, That our AMA support measures that increase price transparency for generic prescription drugs. (New HOD Policy)

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action			
В	BOT 07	Reducing Gun Violence	Substitute Recommendation REFERRED That our AMA strongly support requiring criminal background checks for all firearm purchases, including, but not limited to, sales by gun dealers, sales at gun shows, and private sales between individuals.			
В	BOT 12	Development and Promotion of Single National Prescription Drug Monitoring Program	ADOPTED AS AMENDED The Board recommends that the following be adopted in lieu of Resolution 230-A-14, and that the remainder of the report be filed. 1. That our AMA reaffirm Policy H-95.945, "Prescription Drug Diversion, Misuse and Addiction," Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality," Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances," and Policy H-95.990, "Drug Abuse Related to Prescribing Practices." (Reaffirm HOD Policy) 2. That our AMA support the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (New HOD Policy) 3. That our AMA encourage states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (New HOD Policy) 4. That our AMA support the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (New HOD Policy) 5. That our AMA encourage states to foster increased PDMP use through a seamless registration process; (New HOD Policy) and 6. That our AMA encourage all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management. (New HOD Policy) 7. That our AMA encourage states to share access to PDMP data across state lines, within the safeguards applicable to protected health information. (Directive to Take Action) 8. That our AMA encourage state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines. (Directive to Take Action)			
В	RES 230	Opposing Linking ABMS Certification to Interstate	Resolution 235 ADOPTED in lieu of Resolutions 230 and 231			
В	RES 231	Licensure and Telemedicine Opposing the Federation of State Medical Boards Interstate Medical Licensure Compact	RESOLVED, That our American Medical Association, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact. (Directive to Take Action)			
В	RES 235	MOC Provisions of Interstate Medical Licensure Compact				
С	CME 05	Competency and the Aging Physician	ADOPTED AS AMENDED with change in title ASSURING SAFE AND EFFECTIVE CARE FOR PATIENTS BY SENIOR/LATE CAREER PHYSICIANS			

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action	
			The Council on Medical Education recommends that the following recommendations be adopted, and that the remainder of the report be filed. 1.That our American Medical Association (AMA) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior aging/late career physicians remain able to provide safe and effective care for patients. (Directive to Take Action) 2. That our AMA convene encourage organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior aging/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (Directive to Take Action) 3. That our AMA rescind Policy D-275.959, Competency and the Aging Physician, since this directive has been accomplished through this report. (Rescind HOD Policy)	
С	CME 10	Aligning the Evaluation of Physicians Across the Medical Education Continuum	The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be fi 1. That our American Medical Association (AMA) support the concept that evaluation of physicians as they progress along the medical educontinuum should include the following: a. Assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and b. Use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the education continuum. (New HOD Policy) 2. That our AMA encourage study of competency-based progression within and between medical school and residency. a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression medical school. b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Accreditation System support competency-based progression in residency. (Directive to Take Action) 3. That our AMA encourage research on innovative methods of assessment related to the six competency domains of the ACGME/Americ of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum. (Directive to Take Action) 4. That our AMA encourage ongoing research to identify best practices for workplace-based assessment that allow performance data relate each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice. (Directive to Take Action)	
С	RES 301	Alerting Physicians to Deadlines for Maintenance of Certification	RESOLVED, That our American Medical Association continue to work with the American Board of Medical Specialties (ABMS) to ensure that physicians are clearly informed of the maintenance of certification requirements for their specific board and the timelines for accomplishing those requirements (Directive to Take Action); and RESOLVED, That our AMA encourage the ABMS and its member boards to develop a system to actively alert physicians to the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification. (Directive to Take Action)	
С	RES 302	Re-Evaluating Knowledge Assessment in Maintenance of Certification	ADOPTED RESOLVED, That our American Medical Association work with the American Board of Medical Specialties to streamline and improve the Cognitive	

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action					
			Expertise (Part III) component of Maintenance of Certification, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination. (Directive to Take Action)					
С	RES 304	Addressing the Increasing Number of Unmatched Medical Students	RESOLVED, That our American Medical Association study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match (Directive to Take Action); and be it further RESOLVED, that our AMA discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions. (Directive to Take Action)					
С	RES 309	Maintenance of Certification	REFERRED RESOLVED, That our American Medical Association advocate for a moratorium on the maintenance of certification requirements of all medical and					
D	CSAPH 03	Concussion and Youth Sports	RESOLVED, That our American Medical Association advocate for a moratorium on the maintenance of certification requirements of all medical and surgical specialties until it has been reliably shown that these programs significantly improve patient care. (Directive to Take Action) ADOPTED AS AMENDED The Council on Science and Public Health recommends that the following recommendations be adopted in lieu of Resolutions 401, 410, and 412-41 and the remainder of the report be filed. 1. That Policies H-470.959 "Return to Play after Suspected Concussion" and H-470.966 "Harmful Practices for Child Athletes" be amended by substitution to read as follows: REDUCING THE RISK OF CONCUSSION AND OTHER INJURIES IN YOUTH SPORTS (1) Our AMA promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other					

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			adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; and (c) promote educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers. (Modify Current HOD Policy
			That Policies H-10.965 "Mild Traumatic Brain Injury Awareness," H-470.957 "Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention," and D-470.997 "Sports Injury Reduction" be amended by substitution to read as follows:
			REDUCTION OF SPORTS-RELATED INJURY AND CONCUSSION Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports- related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
			Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related
			injuries. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients. (Modify Current HOD Policy)
			3. That the following policies be reaffirmed: H-10.982 Injury Prevention; H-470.956 Injuries in Cheerleading; H-470.958 Head Injury Prevention in Hockey; H-470.960 Soccer Injuries; H- 470.963 Boxing Safety; H-470.967 Safety in Youth Baseball and Softball; H-470.971 Athletic Pre-participation Examinations for Adolescents; H- 470.974 Athletic Helmets; H-470.984 Brain Injury in Boxing; H-470.995 Athletic (Sports) Medicine (Reaffirm HOD Policy)
D	RES 412	Regulation of Electronic Cigarettes	ADOPTED AMENDED Policies H-495.987 and H-495.972 in lieu of Resolutions 412 and 419; REAFFIRMED Policy H-495.973
D	RES 419	Taxation of Tobacco Products	H-495.987 Taxation of All Tobacco Taxes Products and Electronic Nicotine Delivery Systems (ENDS) (1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to pass increased federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage tobacco use; (2) An increase in federal, state, and local excise taxes for tobacco such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating the tobacco such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.

		1	Attaciment 2				
Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action				
			H-495.972 Electronic Cigarettes, Vaping, and Health: 2014 Update 1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes.				
D	RES 421	Raising the Minimum Legal Age to Purchase Tobacco Products to 21	DOPTED AMENDED Policy H-495.986 in lieu Resolutions 421 and 424; REAFFIRMED Policies H-495.973, H-490.909 and H-495.972 .495.986 Tobacco Product Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes				
D	RES 424	Child-Proof Packages for E- Cigarette Liquid Refills	Our AMA (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, ncluding electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors.				
D	RES 425	Ban on Powdered Alcohol Distribution and Sale	REFERRED RESOLVED, That our American Medical Association adopt policy urging the ban of the distribution and sale of powdered alcohol (New HOD Policy); and be it further				
			RESOLVED, That our AMA lobby Congress and the Administration to ban by law or regulation the distribution and sale of powdered alcohol in the U.S. (Directive to Take Action)				
E	BOT 14	Risk Evaluation and Mitigation Strategies for Methadone	ADOPTED The Board of Trustees recommends that the following statement be adopted and the remainder of the report be filed: That Policy D-120.985, "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone," be reaffirmed in lieu of Resolution 512-A-14. (Reaffirm HOD Policy)				
Е	Joint CMS- CSAPH	Coverage for Chronic Pain Management	ADOPTED AS AMENDED The Councils recommend that the following recommendations be adopted in lieu of Resolution 112-A-14, and that the remainder of the report be filed 1. That our American Medical Association advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. (New HOD Policy). 2. That our AMA support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. (New HOD Policy) 3. That our AMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain				

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action				
			management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process. (New HOD Policy)				
E	RES 517	Recreational Use and Abuse of Prescription Drugs	ADDRESSING RECREATIONAL MISUSE AND DIVERSION OF CONTROLLED SUBSTANCES RESOLVED, That our American Medical Association, in conjunction with other Federation members, and key public and private stakeholders, and pharmaceutical manufacturers, pursue and intensify collaborative efforts involving a public health approach in order to: 1) reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; 2) increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and 3) reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.				
Е	Res 518	Increasing Access to Care for Patients with Opioid Use Disorders	Existing AMA policy was REAFFIRMED in lieu Resolution 518 (via reaffirmation consent calendar) H-95.979 Curtailing Prescription Drug Abuse While Preserving Therapeutic Use -Recommendations for Drug Control Policy H-120.960 Protection for Physicians Who Prescribe Pain Medication H-95.990 Drug Abuse Related to Prescribing Practices H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs D-180.998 Insurance Parity for Mental Health and Psychiatry D-120.953 Treatment of Opioid Dependence				
F	Res 607	Preventing Violent Acts Against Health Care Providers	ADOPTED AS AMENDED RESOLVED, that our American Medical Association work with other appropriate organizations, as appropriate, to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, and that our AMA widely disseminate the results of this study.				

AMA HOD June 2015 Communication Report

Facebook Report (June 5-9, 2015)

23 Pictures and 5 videos were posted on the APA Facebook page. The videos featured AMA Section Council on Psychiatry Chair, Dr. Carolyn Robinowitz, and Dr. Jeffrey Akaka, Dr. Barbara Schneidman, and Dr. Simon Faynboym. The videos were viewed 1,096 times (as of 6/10) and "liked" 33 times. The pictures received 91 "likes."

Twitter Report (June 5-9, 2015)

Tweets	Tweet Impressions	Retweets	Favorites	Engagement Rate (Average)	Link Clicks
44	76.5K	144	168	2.1%	137

Top Tweets

Highest number of engagements:

200, 7.1% engagement rate



Highest impressions & retweets:

4,057 impressions, 11 retweets



Positive testimony on APA res. on transgender indivd in military- no medical reason transgender individ can't serve and serve well! #AMAmtg

12:36 PM - 7 Jun 2015

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Highest engagement percentage:

10.9%



EXECUTIVE SUMMARY

Assembly

[To view items within the report, simply click on the highlighted item.]

The Assembly met in Toronto, CANADA, May 15-17, 2015, and refers the following action to the Board of Trustees (BOT), below. The draft summary of actions from the Assembly meeting is provided as Attachment 21.

The Assembly brings the following action items:

1. Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness (JRCOCT148.G.1; ASMMAY154.B.1)

The Assembly voted to approve the Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness (Attachment 1)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness?

2. Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy) (JRCOCT148.G.10; ASMMAY154.B.2)

The Assembly voted to approve the Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy) (Attachment 2)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy)?

3. Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (JRCOCT148.J.1; ASMMAY154.B.3)

The Assembly voted to approve the Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (Attachment 3)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing?

4. Revised Position Statement: Confidentiality of Electronic Health Information (JRCOCT148.L.3; ASMNOV1312.D; ASMMAY154.B.5)

The Assembly voted to approve the Revised Position Statement: Confidentiality of Electronic Health Information (Attachment 4)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Confidentiality of Electronic Health Information?

5. Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection (JRCOCT148.M.2; ASMMAY154.B.6)

The Assembly voted to approve the Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection (Attachment 5)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection?

6. Retire Position Statement: Psychiatric Disability Evaluations by Psychiatrists (2007) (JRCOCT148.G.3; ASMMAY154.B.9)

The Assembly voted to approve the retirement of the Position Statement: Psychiatric Disability Evaluations by Psychiatrists (2007) (Attachment 6)

Action: Will the Board of Trustees vote to approve the retirement of the Position Statement: Psychiatric Disability Evaluations by Psychiatrists (2007)?

7. Retain Position Statement: Consistent Treatment of All Applicants for State Medical Licensure (2008) (JRCJAN158.H.1; ASMMAY154.B.10)

The Assembly voted to approve the retention of the Position Statement: Consistent Treatment of All Applicants for State Medical Licensure (2008) (Attachment 7)

Action: Will the Board of Trustees vote to approve the retention of the Position Statement: Consistent Treatment of All Applicants for State Medical Licensure (2008)?

8. Retire Position Statement: Employment-Related Psychiatric Examinations (2009) (JRCOCT148.G.8; ASMMAY154.B.11)

The Assembly voted to approve the retirement of the Position Statement: Employment-Related Psychiatric Examinations (2009) (Attachment 8)

Action: Will the Board of Trustees vote to approve the retirement of the Retire Position Statement: Employment-Related Psychiatric Examinations (2009)?

9. Revised Position Statement: Publication of Findings from Clinical Trials (2005) (JRCJAN158.M.2; ASMMAY154.B.12)

The Assembly voted to approve the Revised Position Statement: Publication of Findings from Clinical Trials (2005) (Attachment 9)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Publication of Findings from Clinical Trials (2005)?

10. Retain Position Statement: Use of the Concept of Recovery (2005) (JRCJAN158.M.4; ASMMAY154.B.13)

The Assembly voted to approve the retention of the Position Statement: Use of the Concept of Recovery (2005) (Attachment 10)

Action: Will the Board of Trustees vote to approve the retention of the Position Statement: Use of the Concept of Recovery (2005)?

11. Revised Position Statement: Use of Animals in Research (2009) (JRCJAN158.M.5; ASMMAY154.B.14)

The Assembly voted to approve the Revised Position Statement: Use of Animals in Research (2009) (Attachment 11)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Use of Animals in Research (2009)?

12. Retain Position Statement: Medication Substitutions (2009) (JRCJAN158.M.7; ASMMAY154.B.15)

The Assembly voted to approve the retention of the Position Statement: Medication Substitutions (2009) (Attachment 12)

Action: Will the Board of Trustees vote to approve the retention of the Retain Position Statement: Medication Substitutions (2009)?

13. Retain Position Statement: Electroconvulsive Therapy (ECT) (JRCJAN158.M.8; ASMMAY154.B.16)

The Assembly voted to approve the retention of the Position Statement: Electroconvulsive Therapy (ECT) (Attachment 13)

Action: Will the Board of Trustees vote to approve the retention of the Retain Position Statement: Electroconvulsive Therapy (ECT)?

14. Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatry Residency (JRCMAR158.H.1; ASMMAY154.B.17)

The Assembly voted to approve the Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatry Residency (Attachment 14)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatry Residency?

15. Proposed Position Statement: Neuroscience Training in Psychiatric Residency Training (JRCMAR158.H.2; ASMMAY154.B.18)

The Assembly voted to approve the Proposed Position Statement: Neuroscience Training in Psychiatric Residency Training (Attachment 15)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Neuroscience Training in Psychiatric Residency Training?

16. Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families (JRCOCT148.L.1; ASMMAY154.B.19)

The Assembly voted to approve the Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families (Attachment 16)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families?

17. Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident (ASMMAY12.A)

The Assembly voted to approve action paper 2015A1 12.A which asks:

- 1. The American Psychiatric Association supports comprehensive mental health benefits for the survivors and their significant others (i.e. spouses or life partners and children) as well as the significant others (i.e. spouses or life partners and children) of those who were killed in the Fort Hood incident.
- 2. The American Psychiatric Association will lobby through its Office of Advocacy and Government Relations for legislation to be passed by Congress making such eligibility possible.
- 3. That the Speaker of the Assembly brings this action paper to the next Board of Trustees as time is of essence if the Assembly is to have a meaningful role in this matter. (Attachment 17)

Action: Will the Board of Trustees vote to approve action paper 2015A1 12.A: Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident?

18. Position Statement on Assisted Outpatient Treatment (AOT) (ASMMAY12.I)

The Assembly voted to approve action paper 2015A1 12.I which asks:

- 1. That the new Position Statement be passed by the Assembly at this Assembly meeting.
- 2. That the Speaker of the Assembly brings this Action paper to the Board of Trustees (BOT) for passage by the Board of Trustees at the next Board of Trustees meeting as time is of the essence if the Assembly is to have a meaningful role in this matter. (Attachment 18)

Action: Will the Board of Trustees vote to approve action paper 2015A1 12.1: Position Statement on Assisted Outpatient Treatment (AOT)?

19. Dues Abatement for General Psychiatrists/Members in Puerto Rico (ASMMAY12.X)

The Assembly voted to approve action paper 2015A1 12.X which asks:

That the dues for APA members practicing in Puerto Rico be set at the same amount as APA members not practicing in the fifty United States.

That the APA request the BOT in conjunction with the Finance Committee review the economic impact on the APA's budget of implementing this dues reduction, and request the Council on Advocacy and Government Relations to explore any potential unintended consequences.

Precluding any problems, that the dues reduction be implemented applying only to those general member psychiatrists who are members of the DB of the PR chapter of the APA. At present the annual dues are at \$575. The dues reduction proposed is to lower it using the same annual dues scale as used by Canada, which is scaled up to a maximum of \$350 per general member per year.

That this be referred directly to the Board of Trustees. (Attachment 19)

Action: Will the Board of Trustees vote to approve action paper 2015A1 12.X: Dues Abatement for General Psychiatrists/Members in Puerto Rico?

20. Senior Psychiatrists (ASMMAY12.CC)

The Assembly voted to approve action paper 2015A1 12.CC which asks that the Board of Trustees appoints a work group comprised of members from the Board and Assembly to include senior psychiatrists. The Task Force will be charged to explore mechanisms to best meet the needs of this group of members and bring its recommendations to the Assembly and to the Board within 1 year for implementation. (Attachment 20)

Action: Will the Board of Trustees vote to approve action paper 2015A1 12.CC: Senior Psychiatrists?

The Assembly brings the following informational items:

1. Assembly Nominating Committee Report

The Assembly voted to elect the following candidates as officers of the Assembly from May 2015 to May 2016:

Speaker-Elect: Daniel Anzia, M.D., Area 4

Recorder: Theresa Miskimen, M.D., Area 3

Attachment #1 Item 2015A1 4.B.1 Assembly May 15-17, 2015

Joint Reference Committee October 2014 Item 8.G

Title: Joint* Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness

*The following organizations have approved this statement as written: Association of Medicine and Psychiatry (AMP), American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM)

Issue: Patients with mental illness, including those with serious mental illnesses, experience disproportionately high rates of medical disorders such as tobacco-related pathology, obesity, hypertension, hyperlipidemia and diabetes. Some psychotropic medications contribute to this excess morbidity in addition to the challenges of poverty, social exclusion, sedentary lifestyles, poor dietary choices and other unhealthy behaviors. Additionally, there is a lack of access to high quality primary, secondary and tertiary medical care including preventive health and screening for common medical conditions. As a result, premature mortality in those with mental illness is significantly increased relative to the general population, contributing to a widening gap in life expectancy.

Psychiatrists have medical training as physicians that distinguish them from other mental health disciplines. As such, they play a particularly important role on the behavioral health treatment team regarding clinical care (assessment, diagnosis and treatment), advocacy and teaching related to improving the health status and medical care of their patients. As part of the broader medical neighborhood of primary care and specialist providers, psychiatrists have a role in the care management and care coordination of a subset of their patients because of the chronicity and severity of their patients' illnesses and their barriers in accessing traditional primary and preventive healthcare. For patients in specialty psychiatric services, psychiatrists are often the only physicians they routinely see. In this vein, psychiatrists are similar to other medical specialists charged with coordinating and sometimes providing chronic care to individuals with specialty-specific illnesses (e.g. nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer).

In addition, as health care reform moves traditional behavioral health treatment settings towards Behavioral Health Homes and Certified Behavioral Health Centers, psychiatrists must be prepared to serve as medical leaders of these systems designed to improve not only the mental health but also the physical health of patients.

Position:

It is the joint position of the American Psychiatric Association (APA) the Association of Medicine and Psychiatry (AMP), the American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM) that:

- Screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, limiting harm that can come from use of psychotropic medications (including use of existing APA/ADA guidelines1), and monitoring the medical care being delivered by other medical providers are essential components of psychiatric practice.
- 2. Psychiatrists should identify patients receiving no or suboptimal primary care and may intervene when most appropriate based on their identified competencies, local resources and patient preferences for care. Co-management of common medical conditions when clinically necessary should be recognized as a potential component of the overall care of patients with mental illnesses (when this occurs appropriate reimbursement should also be made).
- 3. Appropriate primary care training in the treatment of common medical conditions, including the leading determinants of mortality in populations with serious mental illnesses, should be made available to psychiatrists seeking to better manage physical health conditions in patients with mental illnesses. Furthermore, the APA and partner organizations such as the AMP should increase efforts to provide adequate training and clinical experience throughout the spectrum of medical education from residency and fellowship levels to Continuing Medical Education (CME) for the current psychiatric workforce.
- 4. The scope of this endeavor should include development of measurable competencies in the screening for common medical disorders, knowledge of age and culturally appropriate disease prevention concepts, and current approaches to the treatment of common medical conditions.
- The APA and AMP support the development of partnerships between primary care
 providers and psychiatrists to provide consultation and oversight in the management of
 chronic medical conditions in a variety of settings.
- The APA and AMP support the development of guidelines that clarify the clinical circumstances in which psychiatrists may become involved in the management of common medical disorders for a subset of their patients.
- 7. The APA and AMP advocate for appropriate funding for training psychiatrists in primary care skills to work confidently and competently in a variety of settings, both traditional and nontraditional, such as in public mental health clinics and outreach services to immigrant and homeless populations.

8. The APA and AMP should continue to support the research, development, and wider implementation of integrated models of health care including outcome studies for psychiatrists treating the conditions contributing to increased mortality.

Authors: Lori Raney, MD, Erik Vanderlip MD, Jeffrey Rado, MD, Robert McCarron, MD, the APA Workgroup on Integrated Care, APA Council on Healthcare Systems and Financing, Association of Medicine and Psychiatry (AMP).

Supporting Organizations:

Association of Medicine and Psychiatry (AMP)
American Academy of Community Psychiatry (AACP)
Academy of Psychosomatic Medicine (APM

This Position Statement was reviewed and approved by the Council on Geriatric Psychiatry, the Council on Psychosomatic Medicine, and the Council on Medical Education and Lifelong Learning.

1 Consensus development conference on antipsychotic drugs and obesity and diabetes. (2004). Diabetes Care, 27(2), 596–601.

Attachment #2 Item 2015A1 4.B.2 Assembly May 15-17, 2015

Position Statement on Medical Necessity Definition

Approved by the Board of Trustees, October 2000 Reaffirmed, 2008

The American Psychiatric Association endorses the statement from the American Medical Association which defines "medical necessity" as:

"... <u>Health care</u> services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with the generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the <u>economic benefit</u> <u>convenience of the health plans and purchasers or for the convenience</u> of the patient, <u>treating</u> physician, or other health care provider."

H-320.953 Definitions of "Screening" and "Medical Necessity"

- (1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
- (2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."
- (3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- (4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
- (5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
- (6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
- (7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
- (8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06)

Proposed Position Statement:

Title: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing

Issue: The APA recognizes the important role served by licensing boards, institutional privileging committees, insurance credentialing panels, and other entities charged with protecting the public from impaired physicians, attorneys, and other licensees. In discharging their responsibilities, these entities legitimately may inquire about current functional impairment in professional conduct and, when relevant, current general medical or mental disorders that may be associated with such impairment. However, the APA believes that prior diagnosis and treatment of a mental disorder are, *per se*, not relevant to the question of current impairment and that oversight entities should not include questions about past diagnosis and treatment of a mental disorder as a component of a general screening inquiry.

Position Statement:

The APA recommends the following principles to guide licensing boards and other regulatory agencies, and training programs.

- 1. General screening inquiries about past diagnosis and treatment of mental disorders are overbroad and discriminatory and should be avoided altogether. A past history of work impairment, but not a report of past treatment or leaves of absence, may be requested.
- 2. The salient concern for licensing entities is always the professional's current capacity to function and/or current functional impairment. Questions on application forms should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee, and that are relevant to present practice. As examples of questions that might be asked, the following are suggested:
 - Question: Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner would be impaired? (Yes/No)
 - Question: Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner? (Yes/No)
- 3. If a relevant impairment of functioning has been acknowledged by the applicant or documented by other sources, inquiries about mental health treatment may be appropriate for the sole purpose of understanding current functioning and future performance.
- 4. If conduct that would otherwise provide grounds for denial or revocation of a professional license or privileges has been documented or acknowledged by the applicant, it would also be appropriate to ask the applicant whether a disorder or condition was raised to explain that conduct.
- 5. Applicants must be informed of the potential for public disclosure of any information they provide on applications.

Authors: Council on Psychiatry and the Law.

Written by Richard Bonnie, Paul Appelbaum, and Patricia Recupero.

Background

Professional licensing agencies have traditionally made wide-ranging inquiries into applicants' past psychiatric histories. Although the passage of the Americans with Disabilities Act in 1990 raised serious doubts about the legality of these inquiries, licensing agencies have been reluctant to abandon them, notwithstanding official statements disapproving them by the American Bar Association in 1994¹ and the American Psychiatric Association in 1997. The issue has recently received renewed attention in the press, in the legal literature and in the courts. Against this backdrop, the Department of Justice's Civil Rights Division launched a formal investigation of Louisiana's attorney licensure system in 2011, culminating in a settlement agreement in August, 2014.² The provisions of this agreement significantly clarify the position of the Justice Department regarding the scope and type of questions about mental health histories and current condition that may be used in professional licensing inquiries. In light of these developments, it is likely that responsible licensing and privileging agencies will be reconsidering their current practices. This Position Statement is designed to summarize the key principles that ought to guide these agencies as they review their questionnaires and protocols.

The APA's Position Statement is congruent, in principle, with the 1994 Resolution adopted on this subject by the American Bar Association, which states:

BE IT RESOLVED, That the American Bar Association recommends that when making character and fitness determinations for the purpose of bar admission, state and territorial bar examiners, in carrying out their responsibilities to the public to admit only qualified applicants worthy of the public trust, should consider the privacy concerns of bar admission applicants, tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so.

BE IT FURTHER RESOLVED, That fitness determinations may include specific, targeted questions about an applicant's behavior, conduct or any current impairment of the applicant's ability to practice law.

The prefatory paragraph of the APA's Position Statement briefly reaffirms the basic anti-discrimination principle that lies at the heart of the ADA. Overly broad inquiries about past behavioral health treatment discriminate against applicants by: making overbroad and unwarranted inquiries regarding applicants' behavioral health diagnoses and treatment; subjecting applicants to burdensome supplemental investigations triggered by their behavioral health status or treatment; making unwarranted licensure or admissions recommendations based on stereotypes of persons with disabilities; imposing additional financial burdens on people with disabilities; failing to provide adequate confidentiality protections during the licensing or admissions process; and implementing burdensome, intrusive, and unnecessary conditions on licensure or admissions that are improperly based on individuals' behavioral health diagnoses or treatment.

The APA's Position Statement enunciates 5 principles:

- The first principle declares that open-ended inquiries about past mental health diagnosis and treatment, or proxy questions pertaining to leaves of absence, are unacceptable. The DOJ-Louisiana Settlement Agreement acknowledges this principle.
- The second principle declares that inquiries about the person's current mental and physical
 condition are acceptable if and only if they relate to the person's current capacity to carry out
 professional functions. The illustrative questions are similar to the questions used by the
 National Conference of Bar Examiners and were specifically endorsed in the DOJ-Louisiana

Settlement Agreement. The meaning of "current" condition is not defined in the Settlement Agreement or the APA Position Statement.

- The third and fourth principles are designed to address the limited circumstances under which licensing agencies may inquire about past mental health history and treatment. They may do so only when they are exploring the current and future significance of past impairments of functioning or misconduct documented in the record or acknowledged by the applicant. The kinds of questions that would be compatible with these principles are illustrated in paragraph 14 of the DOJ-Louisiana Settlement Agreement which specifically endorses question 27 on the National Conference of Bar Examiners questionnaire:
 - 27. Within the past five years, have you engaged in any conduct that:
 - (1) resulted in an arrest, discipline, sanction or warning;
 - (2) resulted in termination or suspension from school or employment;
 - (3) resulted in loss or suspension of any license;
 - (4) resulted in any inquiry, any investigation, or any administrative or judicial proceeding by an employer, educational institution, government agency, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure; or
 - (5) endangered the safety of others, breached fiduciary obligations, or constituted a violation of workplace or academic conduct rules?

If so, provide a complete explanation and include all defenses or claims that you offered in mitigation or as an explanation for your conduct.

• The fifth principle is designed to assure that applicants are advised of the circumstances under which information obtained during the agency's inquiry are accessible to the public

¹ ABA Bar Admissions Resolution, 18 Mental and Physical Disability Law Reporter 597 (1994)

²Settlement Agreement Between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Act, August 13, 2014, http://www.ada.gov/louisiana-supreme-court_sa.htm

Attachment #4 Item 2015A1 4.B.5 Assembly May 15-17, 2015

Position Statement on Confidentiality of Computerized Records Electronic Health Information

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.

Issue: Computerization of medical records can bring clear-cut benefits to the delivery and quality of health care, including psychiatric treatment. Electronic health records (EHRs), as well as the sharing of information via health information exchanges (HIEs), can raise significant security challenges and potential threats to patients' confidentiality. Government intelligence agencies, such as the NSA, are reported to be able to access the personal health information of patients by bypassing built-in security and encryption features of EHRs and HIEs. Psychiatrists have an obligation to advocate for HER and HIE policies, features, and implementations that allow the sharing of medically necessary information to enhance care, as well as to support a culture of confidentiality and respect for patients' privacy and their preferences in the electronic storage, access, and sharing of health information.

Patients should be able to benefit from the potential improvements in the delivery and quality of care with electronic health records (EHRs), without being forced to relinquish the privacy and confidentiality of their personal health-related information. Patients should also be able to enjoy the care coordination benefits provided by EHRs and health information exchanges (HIEs) without having to share all or none of their information, i.e., they should be able to identify classes of data for more restricted access. Approaches to accessing electronic health information via HER and HIE record access should consider the diverse settings in which electronic health information records will be used, including their its use in emergency and other acute settings where rapid access to medically necessary information is essential. Such approaches should also consider that patients have a broad range of needs, preferences and abilities to provide informed consent about the implications of electronic record access. At the very least, computerized records should give patients as much control over their information as they have with paperbased records. In addition, computerized records should not force patients to choose between either making all or none of their information available. Electronic health record design and implementation should leverage technology to give more flexible approaches to access for sensitive information. Government organizations or other third parties should not be able to inappropriately access electronic health information by bypassing built-in security and encryption features of EHRs and HIEs. As health information technology continues to advance and evolve, the complexities and potential consequences of computerized records make it

essential for psychiatrists to be aware of the implications for their patients and advocate for a culture of confidentiality and respect for patients' <u>privacy preferences</u>.

This revision of the 1997 position statement was developed by the Council on Research and Quality Care

Attachment #5 Item 2015A1 4.B.6 Assembly May 15-17, 2015

Revised Position Statement Psychiatric Implications of HIV/HCV Co-infection

Title

Psychiatric Implications of HIV/HCV Co-infection

Issue

People with HIV infection are disproportionally affected by viral hepatitis. [i] In addition, about 80% of people with HIV who inject drugs also have hepatitis C virus (HCV). [i] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone.

APA Position

The APA strongly supports the important role psychiatrists should play in the diagnosis and treatment of co-morbid HIV/HCV infection. Psychiatrists are uniquely positioned to contribute to the management of these patients, but to be effective they need to stay abreast of the rapid changes taking place in the treatment of people with comorbid HIV and HCV infection. Both of these infections are over-represented among people with mental illness. Both of these infections, and their treatments, are associated with psychiatric complications. New treatments for HCV infection now produce high rates of cure, potentially extending the lives of these co-infected patients.

The Role of the Psychiatrist

- 1. Psychiatrists should stay current in their medical knowledge of the psychiatric and neuropsychiatric manifestations of HIV and HCV disease and the complications of their treatments.
- 2. Psychiatrists should consider, encourage, facilitate and in certain instances (such as inpatient psychiatric care) provide both HIV and HCV testing.
- 3. Patients should be treated for current mood disorders prior to initiating HCV treatment. When interferon is part of the HCV regimen, patients with a past history of mood or other psychiatric disorders may benefit from prophylaxis with <u>antidepressant</u> medications. It is also desirable to ensure that the patient is as stable as possible with regard to psychiatric symptoms, substance use, psychosocial support and housing, as these factors are associated with adherence to treatment.
- 4. Psychiatrists have a responsibility to advocate for necessary access to HCV treatment for their infected patients. In addition, psychiatrists should be involved in closely monitoring changes in neuropsychiatric functioning, such as mood, behavior and cognition.

- 5. Psychiatrists are encouraged to collaborate with hepatologists, infectious disease physicians and other primary care providers for the HIV/HCV infected.
- 6. Because of the increased hepatotoxicity in the HCV co-infected patient, psychiatrists should collaborate with the HCV treatment team <u>and other clinical specialists</u> to actively monitor the potential for drug-drug interactions and overlapping toxicities of treatments for HCV, HIV and psychiatric disorders. In addition, attention should be paid to the potential for the interaction of substances of abuse with HIV/HCV antiretroviral treatment and psychiatric medications.

<u>Authors</u>

Francine Cournos, M.D.

Antoine Douaihy, M.D.

Marshall Forstein, M.D.

Benjamin Smoak, M.D.

Steering Committee on HIV Psychiatry Council on Research

Resource Document

Approximately one quarter of people with HIV in the U.S. are also infected with Hepatitis C (HCV). In high risk groups the rate of co-infection rises and HCV is found in 50 to 70 percent of HIV-infected intravenous drug users. [ii] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone. Psychiatrists have much to contribute to the management of these patients, but to be effective they need to stay abreast of rapidly changing treatment advances.

Patients at risk for or infected with HIV are also at risk for infection with Hepatitis B, and/or C, and sometimes Hepatitis A depending on high risk behaviors. HIV and HCV co-infection rates are particularly high as the viruses share similar routes of transmission. [iii] Though there are more public awareness campaigns to encourage people to learn about their HCV status, psychiatric patients, in particular, may not have had adequate assessment of their hepatitis exposure status. Studies show that people with severe mental illness have higher rates of Hepatitis C virus (HCV) compared to the general population. [iv]

The most common route of HCV infection is injection drug use. Sexual transmission is less common but also occurs. For unclear reasons the cohort of "baby-boomers" born between 1945 and 1965 has an elevated rate of HCV infection independent of their reporting risk factors. The CDC therefore recommends HCV testing in those with risk factors and at least once for those born between 1945 and 1965 regardless of reported risk factors. CDC guidelines for Hepatitis C testing can be found at www.cdc.gov/hepatitis/hcv/GuidelinesC.htm

Independent of HIV, HCV becomes chronic in 80-85% of infected individuals. Of those, 20-25% will develop serious chronic liver disease. In fact, HCV is the most common reason for liver transplants in the U.S. Most chronically infected people, however, usually remain asymptomatic for many years before being diagnosed with HCV, [v] and the majority of people with HCV infection are unaware of their infection.

HIV complicates the course of HCV by increasing the prevalence and hastening the development of liver disease and failure and increasing the risk of developing hepatocellular carcinoma. There appears to be enhancement of HCV replication in the context of HIV. The effects of HCV co-infection on HIV disease progression are less certain and studies have had conflicting results. Some studies have suggested that HCV infection is associated with more rapid progression to AIDS or death. However, while the subject remains controversial, it is possible that HCV has detrimental effects on the liver's ability to process medications used to treat HIV and its associated medical consequences. Among the problems that follow is the potentially increased toxicity of the antiretroviral medications.

Like HIV, HCV is also a neurotropic virus, which may invade the CNS much as HIV does via infected monocyte/macrophages, a process known as the "Trojan Horse" mechanism. HCV replicates in the brain, its viral load can be measured in the cerebrospinal fluid, and there is cognitive impairment independent of HIV infection. Patients with HCV mono-infection have been shown to have cognitive impairments including difficulties with concentration and working memory. However, unlike HIV, HCV alone does not lead to frank dementia. There is emerging evidence that HCV and HIV co-infected patients demonstrate more cognitive impairment than patients with HIV mono-infection. Thus, there may be an increased likelihood of HIV Associated Neurocognitive Disorders (HAND) in the setting of HCV co-infection (see statement on the Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments). In advanced HCV disease, metabolic complications due to liver failure can lead to CNS impairment, potentially affecting treatment adherence, and making the diagnosis of cognitive impairment due to HIV more problematic.

Unlike HIV treatment, the goal of HCV treatment is eradication of the virus and cure. The criterion for cure is sustained virologic response (SVR) that continues after HCV treatment has been discontinued. Treatment is not recommended, or necessary, for all people with HCV infection. However, all HIV/HCV co-infected patients should undergo readiness evaluation for HCV treatment. When possible, it is often advisable to treat HCV before initiating treatment for HIV to avoid the issues of drug interactions between HCV and HIV medications and to reduce the risk of ARV related hepatotoxicity. In patients with CD4 counts <200 cells/mul and/or plasma HIV RNA counts above 100,000 copies/ml, it may be better to consider anti-HIV treatment before HCV treatment regimens.

Rapid and dramatic changes are occurring in assessing the degree of liver disease present in people with HCV infection and in the treatment of HCV infection. Non-invasive techniques have largely replaced liver biopsy when assessing liver fibrosis. Two new medications, both protease inhibitors, are on the market and many other new HCV medications are in the pipeline. These new medications are anticipated to reduce the toxicity of HCV treatment, allow HCV treatment to be completed in shorter periods of time, and achieve cure rates approaching 100%.

The treatment of HCV infection has also changed dramatically with the introduction of new medications that reduce the toxicity of HCV treatment, allow HCV treatment to be completed in shorter periods of time, and achieve cure rates approaching 100%. There are also some treatment regimens that no longer require the use of interferon. HCV treatment will continue to evolve as new medications in the pipeline become FDA approved. Guidelines for HCV treatment can be found at www.hcvguidelines.org

<u>In regimens for which interferon is still required, it's important to bear in mind that</u> interferon (IFN) has significant neuropsychiatric side effects, most importantly severe depression and suicidal thinking and

behaviors. In addition, fatigue, insomnia, anxiety, and impaired neurocognitive function have also been observed. Essentially any psychiatric symptom has the potential to worsen on IFN treatment. [vi] Ribavirin, another older medication that is still used in many HCV treatment regimens, also has problems associated with toxicity, predominantly anemia (which may also increase fatigue), depression, and cognitive dysfunction. Hepatologists and other medical providers, recognizing these potential effects, may be concerned about initiating treatment for HCV in people with significant histories of depression and other mental illnesses. However, based on clinical experience, and published research, the high incidence of depressive symptoms with IFN treatment suggests prophylaxis with antidepressants may prove to be beneficial in most patients. It is anticipated that as HCV treatment regimens that do not require IFN and/or ribavirin become available, patients will experience less severe toxicities during treatment.

The two currently available HCV protease inhibitors, telapravir and bocepravir, have numerous drugdrug interactions due to metabolism via CYP450 3A4. These medications are both inducers and inhibitors of the enzymes and pose potential interactions with many classes of medications, including antiretrovirals (protease inhibitors, NNRTI's, and tenofovir) and numerous psychotropics (anticonvulsants, antidepressants, sedative hypnotics and antipsychotics). Keeping track of drug-drug interactions is best achieved through the use of online drug interaction websites, keeping in mind that most interactions are listed as between two medications and less is known about drug interactions when multiple medications are prescribed. Two useful drug interaction websites are www.hiv-druginteractions.orghttp://www.hiv-druginteractions.org and www.hcv-druginteractions.org.

Common side effects of telapravir and bocepravir include rash (including potential for Stevens Johnson Syndrome), pruritis, anemia, fatigue, and headache.

Pre-morbid psychiatric disorders, including severe depression, other mood disorders, and substance abuse, are not necessarily reasons to withhold HCV treatment. However, Every effort should be made to stabilize psychiatric issues prior to HCV treatment. Patients who are stable on psychotropics should be maintained on the effective therapy. Psychiatrists can support HCV treatment initiation by enhancing treatment readiness, including obtaining baseline and follow-up depression inventories, and enlisting other supportive resources (e.g., family support, psychotherapy, support groups). Psychiatrists can also participate after treatment initiation in supporting adherence and treatment response monitoring. When INF is part of the regimen, SSRIs remain the most extensively studied medications for both prophylactic treatment in patients with a history of depression, and for the treatment of depression during IFN therapy. Suicidal ideation and behaviors are potential clinical manifestations of interferon treatment and should be assessed at every visit. [viii]

Co-morbid substance use disorders and behaviors that put patients at risk of becoming re-infected with HCV need to be addressed aggressively if treatment rates for HCV are to be improved in the HIV-HCV co-infected populations. Integrated patient-centered care involving an interdisciplinary team of mental health professionals and substance abuse counselors can promote better outcomes.

New HCV medications are very expensive and the team of providers treating the patient may need to assist patients with obtaining insurance coverage and advocate for them. This availability of insurance coverage for new HCV treatments will vary from state to state.

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[i] CDC HIV and Viral Hepatitis [fact sheet] May 2014

[ii] Rockstroh JK, Spengler U: HIV and hepatitis C virus co-infection. Lancet Infect Dis 2004; 4:437-444

[iii] Rotman Y and Liang TJ: Coinfection with Hepatitis C Virus and Human Immunodeficiency
Virus: Virological, Immunological, and Clinical Outcomes. J. Virol August 2009 Vol. 83 no. 15 7366-7374

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[v] Ly, KN, Xing J, et al.: The Increasing Burden of Mortality From Viral Hepatitis in the United States Between 1999 and 2007 Ann Intern Med. 2012; 156(4):271-278.

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Item 8.G Joint Reference Committee January 25-26, 2015

Attachment 1

Attachment #6 Item 2015A1 4.B.9 Assembly May 15-17, 2015

APA Official Actions

Position Statement on Psychiatric Disability Evaluations by Psychiatrists

Approved by the Board of Trustees, July 2007 Approved by the Assembly, November 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.

Psychiatric disorders impair social and occupational functioning. Attention to disabilities must be included in a comprehensive plan of psychiatric care for adults, children and adolescents. When a disability application is completed as part of a disability adplication process, this is often most effectively and efficiently done by a psychiatric physician. Disability evaluations by psychiatrists must be reimbursed at appropriate rates so as not to discriminate or discourage them.

Attachment #7 Item 2015A1 4.B.10 Assembly May 15-17, 2015

Position Statement on Consistent Treatment of All Applicants for State Medical Licensure

Approved by the Board of Trustees, July 2008 Approved by the Assembly, May 2008

"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 fully endorses the need for an equitable, fair and consistent treatment for those applicants who graduated from medical school in the state they are applying, graduated from a school in another state or graduated from a school in another country.

Revision of the 1997 position statement.

APA Official Actions

Position Statement on Employment-Related Psychiatric Examinations

Approved by the Board of Trustees, September 2009 Approved by the Assembly, May 2009

"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.

- Prior to beginning an employment-related psychiatric evaluation the psychiatrist should obtain informed consent from the individual being examined. Such informed consent includes the following:
 - a. The purpose of the required examination, the referral source, and the reason for the referral.
 - b. The nature of the report to be prepared and limitations of confidentiality.
 - c. The party, or parties, to whom the report will be provided and the nature of the evaluee's access to the report in accordance with applicable state and federal law.

2. If, in the judgment of the examining psychiatrist, the individual referred for an employment-related examination is in need of treatment, when possible, the individual should be referred to another psychiatrist for such treatment.

This is a revision of the 1984 position statement.

Developed by the Corresponding Committee on Psychiatry in the Workplace (Andrea G. Stolar, M.D., Chair, Marilyn Price, M.D., CM, Marie Claude Rigaud, M.D., Marcia Scott, M.D., Jeffrey P. Kahn, M.D., and Aron S. Wolf, M.D., members).

Attachment #9 Item 2015A1 4.B.12 Assembly May 15-17, 2015

Revised Position Statement on Publication of Findings from Clinical Trials

This document states the position of the American Psychiatric Association (APA) on the publication rights of researchers participating in clinical trials and on the broader issue of participation in a national, comprehensive, clinical trials registry as a condition for publication in peer-reviewed scientific journals.

The APA believes that all encourages researchers should have the freedom to contribute to the design of clinical trials. Whenever possible, to critically evaluate the design of an established trial when they consider participation, and to publish all findings from the trials in which they participate regardless of outcome. APA thus discourages investigators and their institutions who participatinge in clinical trials research from entering into agreements with trial sponsors that place restrictions of any kind on the right to publish.

Simultaneously, <u>The APA</u> urges Institutional Review Boards (IRBs) and journal editors to require researcher assurances of unfettered access to methodology, findings and results as a condition of approval and of publication, respectively. Public accessibility to all methods and findings related to clinical trials has direct implications for improved patient care and treatment, while the suppression of negative findings has the potential of exposing patients to ineffective and potentially harmful treatments.

With regard to the overarching issue of research integrity in the conduct of clinical trials, APA believes that a comprehensive endorses participation in, and values the function of, clinicaltrials.gov and believes a public registry of all clinical trials initiated in the United States, whether publicly—or privately funded, promotes transparency will go a long way toward alleviating the mistrust and doubt currently surrounding published data on the of information relevant to efficacy and safety of medications treatments for children and for adults diagnosed with mental disorders.

The APA supports and advocates for legislation mandating and funding a national registry initiative to be implemented by the National Institutes of Health in accordance with principles and procedures already established and successfully implemented in other comprehensive national and international databases. As part of the legislation on this subject, the APA strongly encourages inclusion of provisions—directed toward IRBs and scientific journals—that require registration and assignment of unique trial identifiers as conditions of IRB approval and of journal publication.

Additionally, in the interest of improved ethical standards and public safety, the APA encourages legislative provisions that require registration as a necessary condition for clinician referral and for patient participation in clinical trials.

Attachment #10 Item 2015A1 4.B.13 Assembly May 15-17, 2015

Position Statement on Use of the Concept of Recovery Approved by the Board of Trustees, July 2005 Approved by the Assembly, May 2005

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care of chronically and persistently mentally ill adults, including the concept of resilience in seriously emotionally disturbed children. The concept of recovery emphasizes a person's capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of mental health and medical care, and that the best results come when patients feel that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals. It focuses on wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of psychopharmacologic and psychosocial treatments.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation techniques and by encouraging other mental health professionals to adopt the concept of recovery, psychiatrists can enhance the care of all clinical populations served within the community based and other public sector mental health and behavioral health systems.

The concept of recovery values include maximization of 1) each patient's autonomy based on that patient's desires and capabilities, 2) patient's dignity and self-respect, 3) patient's acceptance and integration into full community life, and 4) resumption of normal development. The concept of recovery focuses on increasing the patient's ability to successfully cope with life's challenges, and to successfully manage their symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify a retraction of resources.

The concept of recovery is predicated on a partnership between psychiatrist, other practitioners, and patient in the construction and direction of all services aimed at maximizing hope and quality of life.

Attachment #11 Item 2015A1 4.B.14 Assembly May 15-17, 2015

Revised Position Statement on Use of Animals in Research

In recognition of the need for the appropriate and humane use of animals in research, and in response to the growing pressure from other organizations that would deny Americans the health benefits evolving from research using animals, the APA joins with other scientific and medical organizations in support of the following policy statement:

- 1. Psychiatric medicine is at a crucial point. The past few <u>years decades</u> have seen tremendous advances in neuroscience, in our capacity to diagnose and treat patients effectively. The advances depend in large part on studies of living systems, requiring the use of laboratory animals. Building on these advances also will require animal studies.
- 2. The study of living systems is essential, either directly or indirectly, to virtually all forms of biological, behavioral and medical research. The absence of laboratory animals would paralyze basic research in the life sciences as well as bring an end to the overwhelming majority of research programs aimed at relieving human disease and suffering. Behavior is the cornerstone of psychiatric diagnosis and it cannot be studied in vitro. This necessitates the use of animals or humans to better understand behavior.
- 3. Today, the psychiatric and neuroscience community is on the threshold of even greater progress through expanded research in genetics, neuroimaging, immunology, epidemiology and in understanding the complex functioning of neurotransmitters. Because of the complexity of these interrelated areas, further research cannot depend upon the use of human volunteers, computer models or epidemiological studies. Further advances against mental illnesses must continue to depend on the use of living systems, mandating the careful and humane use of animals, and respect for them as living beings.
- 4. In recognition of this necessity, society at large supports the humane treatment of animals in research. It has conferred upon psychiatric researchers who use animals a high level of responsibility for the health and well-being of these living creatures entrusted to their care. Psychiatric researchers must make every effort to ensure that their research is conducted in a humane manner. They should permit no unnecessary pain or discomfort. They should design experiments using the minimum number of animals necessary to ensure scientific validity.
- 5. All research with animals must be conducted with strict adherence to the standards promulgated by appropriate scientific and professional organizations, as well as in compliance with applicable federal, state or local statutes.

Because the major psychiatric disorders are now known to arise from dysfunction of the brain, it is necessary to better understand brain function in order to understand the pathophysiology of psychiatric disorders.

This revision of the 1989 statement was developed by the Council on Research and Quality Care.

Attachment #12 Item 2015A1 4.B.15 Assembly May 15-17, 2015

Position Statement on Medication Substitutions Approved by the Board of Trustees, December 1995 Reaffirmed, September 2009

The American Psychiatric Association opposes the practice of therapeutic interchange of psychoactive medication, including the interchangeability of generic and brand medications, without the express consent of the prescribing psychiatrist.

The above statement if considered a supplement to the Joint Statement on Anti-substitution Laws and Regulations, which was adopted by the American Psychiatric Association in February 1973, and is endorsed by a number of other medical societies.

Attachment #13 Item 2015A1 4.B.16 Assembly May 15-17, 2015

Position Statement on Electroconvulsive Therapy (ECT) Approved by the Board of Trustees, December 2007 Approved by the Assembly, November 2007

Electroconvulsive Therapy (ECT) is a safe and effective evidence-based medical treatment. ECT is endorsed by the APA when administered by properly qualified psychiatrists for appropriately selected patients.

Attachment #14 Item 2015A1 4.B.17 Assembly May 15-17, 2015

To: APA Assembly

From: Council on Medical Education and Lifelong Learning

RE: Position Statement on Support for Four Years of Generalist Training in Adult

Psychiatry Residency

Date: March 17, 2015

The APA Board of Trustees Ad Hoc Work Group on Education and Training was convened to study the significant changes taking place in funding, educational and competency requirements within residency training, and the projected future roles for psychiatrists in America's healthcare workforce. The Work Group's considerations incorporate an understanding of the APA's role as a leader in psychiatric education, its unique ability to bring together educators across the psychiatric education continuum, its partnership with education organizations in the field, and its recognition that psychiatrists must take a leadership role in shaping the skills of our future workforce.

The deliberations and conclusions reached by this Work Group are based on participation from leaders in psychiatric education, and included representatives from the American Association for Directors of Psychiatric Residency Training (AADPRT), the Association of Directors of Medical Student Education in Psychiatry (ADMSEP), the Association for Academy Psychiatry (AAP), the American Board of Psychiatry and Neurology (ABPN), and the American Association of Chairs of Departments of Psychiatry (AACDP).

While the Work Group is aware of the significant funding pressure to shorten the years of education and training, it views four years of generalist psychiatry training in residency as necessary given the increasing body of knowledge essential for all psychiatrists to master, the need for enhanced experience in psychosomatic medicine, geriatric and addictions psychiatry, the expanding field of neuroscience, and the myriad roles psychiatrists will be asked to assume throughout their careers in the changing healthcare landscape.

The final report of the Ad Hoc Work Group, "Training the Psychiatrist of the Future", was presented to the American Psychiatric Association Board of Trustees on March 14, 2015, and was unanimously accepted in its entirety.

Position Statement

Title: Support for Four Years of Generalist Training in Adult Psychiatry Residency

Issue: An essential element of the mission of the American Psychiatric Association is to promote excellence in psychiatric education and training in order to foster the highest quality of care for individuals with mental disorders, mental retardation and substance—related disorders, and their families. The APA must take a leadership role in advocating for the necessary elements in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans.

APA Position:

Generalist psychiatry training is critical to meet the public health need. General psychiatry training should be of four years duration in order to provide sufficient time for trainees to develop the necessary breadth and depth of experience and expertise. Training in psychosomatic medicine, geriatric, and addictions, as well as integrated care, is essential for graduating psychiatrists. Continued attention to child and adolescent and forensic psychiatry is needed. Child and adolescent psychiatry, as a two-year training experience, should maintain its historic exception to the four-year adult requirement.

Authors:

The Ad Hoc Work Group on Education and Training, 2015:

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Background Information: Please see attached Ad Hoc Workgroup report on Education and Training.

American Psychiatric Association

Training the Psychiatrist of the Future

A Report by the

American Psychiatric Association

Board of Trustees Ad Hoc Work Group on Education and Training

2015

APA Board of Trustees Ad Hoc Work Group on Education and Training

Executive Summary

The Work Group was established to study the significant changes taking place in the funding and requirements for residency training and the projected future need for psychiatrists. The context for the Work Group's activity includes the APA's role as a leader in psychiatric education, its unique ability to convene educators across the psychiatric education continuum, its partnership with the education organizations in the field, and the need for psychiatrists to take leadership in shaping the skills of our future workforce.

The Work Group identified the following four critical educational goals:

- Ensuring a robust pipeline of psychiatrists to meet the public health needs of Americans now and in the future.
- Aligning residency structure with current educational demands.
- Preparing faculty to meet the educational needs of trainees.
- Training residents for effective integration of behavioral health care with primary care.

To accomplish these goals, we make the following recommendations. **Bolded recommendations** are of high priority and should be well underway within six months.

1. Overarching Commitment:

A. The APA should take a leadership role in advocating for the changes in residency education necessary to prepare future psychiatrists to meet the behavioral health needs of Americans. This will be best accomplished by partnering effectively with the education organizations in the field.

2. APA Position Statement:

A. The APA should adopt the following position statements:

i. Generalist psychiatry training is critical to meet the public health need. General psychiatry training should be of four years duration in order to provide sufficient time for trainees to develop the necessary breadth and depth of experience and expertise. Training in psychosomatic medicine, geriatric, and addictions, as well as integrated care, is essential for graduating psychiatrists. Continued attention to child and adolescent and forensic psychiatry is needed. Child and adolescent psychiatry, as a two-

^{*} We use the term behavioral health to encompass mental health, mental illness and substance abuse.

- year training experience, should maintain its historic exception to the fouryear adult requirement.
- ii. A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of training.

3. <u>Programmatic Initiatives for the Department of Education:</u>

- A. The APA should focus the psychiatric educational agenda by convening an annual face-to-face meeting to facilitate communication between the education-related organizations in psychiatry.
- B. The APA should promote the following educational efforts:
 - i. Dissemination of best practices in training for integrated care models.
 - ii. Communication and collaboration among primary care specialty organizations, including inter-specialty collaboration on curriculum development.
 - iii. Communication and collaboration among mental health professional organizations, including inter-professional collaboration on curriculum development.
 - iv. Development of neuroscience curricular materials and pedagogic innovations.
 - v. Collaborations to tackle pressing workforce pipeline issues.
- C. The APA should promote faculty development by:
 - Collaborating with AADPRT and AAP to conduct a needs assessment for faculty development, particularly in the areas of neuroscience, research, and quality improvement.
 - ii. Creating a competitive Visiting Scholar Program focused on faculty development and training.
 - iii. Considering the potential value of an APA Academy of Master Educators in Psychiatry to support faculty development, retention, advancement and recognition at their home institutions.
- D. The APA should consider how current APA educational awards could be better aligned to promote current educational goals.

4. Legislative Advocacy Initiatives:

- A. The APA should vigorously advocate for maintaining and increasing funding for graduate medical education, including funding for training in innovative care delivery systems.
- B. The APA should advocate for the continued designation of Psychiatry as a primary care specialty.

5. <u>Collaboration with Councils:</u>

- A. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing to promote training for integrated behavioral health care.
- B. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Department of Research and the Council for Research, along with partner educational organizations, to:
 - Determine the most effective strategies to enhance research training and encourage the development of physician-scientists in psychiatry.
 - ii. Gather and synthesize data on recruitment into psychiatry and disseminate the findings.
- C. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Steering Committee on Practice Guidelines to:
 - i. Identify priority topics for residency teaching, as well as assist with the development of curricular materials for medical students and residents.
 - ii. Make the Practice Guidelines available online for ready access by all those involved in psychiatric education.

These recommendations should be implemented by the Office of the CEO/Medical Director, Department of Education, Council on Medical Education and Lifelong Learning, and other Councils and Departments as indicated.

APA Board of Trustees Ad Hoc Work Group on Education and Training

Work Group Report

In August 2014, APA President, Paul Summergrad, M.D., appointed members with experience in psychiatric education and representatives from stakeholder education associations to a new Board of Trustees Ad Hoc Work Group on Education and Training.

The **charge** of the Work Group was to make recommendations to the Board of Trustees for changes in psychiatric education and training by reviewing current pressures on residency education and training, including the following areas:

- Graduate Medical Education (GME) funding and other funding sources
- Curriculum changes, especially related to areas such as neuroscience
- Changed models of training for residents that are aligned with changes in health care delivery (i.e., integrated care and payment models)
- Research training

The context for the Work Group includes the recent calls for GME funding reform, the roll out of the Psychiatry Milestones by the Accreditation Council for Graduate Medical Education (ACGME), the Affordable Care Act (ACA) and market forces driving innovation in service delivery, especially integrated behavioral health care, increasing inter-specialty and inter-professional collaboration, departmental budget constraints affecting teaching faculty, new knowledge in neuroscience, and the increasing importance of quality improvement activities.

Work Group Members:

Richard F. Summers, M.D., Chairperson
Sheldon Benjamin, M.D., Member
Tami Benton, M.D., Member
Carol Bernstein, M.D., Member
Lara J.Cox, M.D., M.S. Member
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Vision of the Psychiatrist of the Future

The Work Group developed the following vision of the psychiatrist of the future to guide our study and recommendations:

The aging of the population, large number of individuals with co-morbid medical, psychiatric and substance use disorders, significant incidence of complex behavioral problems that accompany other acute and chronic medical conditions, and the expansion of health care coverage highlight the limitations of the current psychiatric workforce. Given these needs, it is critically important that general psychiatrists have sufficient training to:

- Establish a meaningful doctor-patient relationship with patients from a wide range of cultural, racial, ethnic and gender/sexual backgrounds.
- Diagnose and manage adults, adolescents and children with psychiatric disorders, as well as elderly, addicted, and medically ill patients with psychiatric co-morbidities.
- Apply a comprehensive understanding of emerging neuroscience and its implications to patient care.
- Practice in integrated behavioral health care models.

The Work Group identified 23 potential priorities in residency education and decided after surveying its members and arriving at consensus that the psychiatrist pipeline, residency structure, faculty development, and integrated care were the most salient areas. We defined the following critical educational goals consistent with these four areas:

- Ensuring a robust pipeline of psychiatrists to meet the public health needs now and in the future;
- Aligning residency structure with current educational demands;
- Preparing faculty to meet the educational needs of trainees;
- Training residents for effective integration of behavioral health care with primary care.

Our first recommendation provides an overarching theme and unifies these four areas:

Recommendation 1.A. The APA must take a leadership role in advocating for the necessary changes in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans. This will be best accomplished by partnering effectively with the education organizations in the field.

Our specific recommendations are organized by the four goals we identified and by the type of action we are calling upon the APA to take.

Ensuring the Psychiatrist Pipeline

There is a wide range of estimates of the number of psychiatrists necessary to take care of America's mental health needs. Some reports suggest that significantly more psychiatrists will be needed than the number projected to be available at the current rate of training (Holt, et al, 2014). But, the Institute of Medicine Report on GME Financing (IOM, 2014) concludes that the current number of residents across all fields is appropriate because of anticipated changes in health care delivery systems, such as integrated care, telemedicine, and the anticipated increased use of non-physician health care professionals.

The Work Group concludes that estimates of physician and psychiatric work force needs have been quite unreliable over the past 30 years and thus has some skepticism about our ability to predict this. Thus, we regard it as essential to maintain a pipeline of psychiatrists in training to address access issues and ensure appropriate care for our most vulnerable population of patients. It is important that this is a diverse and inclusive workforce.

An healthy psychiatrist pipeline means sustaining the current GME funding, as well as looking for opportunities to increase training slots through new programs, such as reauthorization of funding for the Teaching Health Center provision under the ACA and consideration of new funding sources for Child and Adolescent Psychiatry programs.

The APA can facilitate the psychiatrist pipeline through the following <u>Programmatic</u> Initiatives for the Department of Education:

The APA is the logical organization to bring together relevant stakeholders to provide a forum for consistent, ongoing communication around education. It has strong ongoing relationships with allied groups and can help to provide "one voice" to Federal entities. The following organizations are important partners in educational leadership: American Board of Psychiatry and Neurology (ABPN), American Association of Medical Colleges (AAMC), American Association of Directors of Psychiatry Residency Training Programs (AADPRT), Association of Directors of Medical Student Education in Psychiatry (ADMSEP), American Association of Chairs of Departments of Psychiatry (AACDP), Association for Academic Psychiatry (AAP), American College of Neuropsychopharmacology (ACNP), ACGME Psychiatry Review Committee for Psychiatry (Psychiatry RC), and the American Academy of Child and Adolescent Psychiatry (AACAP). Although many of these organizations have liaison relationships with the Council on Medical Education and Lifelong Learning, communication between these organizations is sporadic and not well organized. Each organization has specific competencies that contribute to psychiatry education.

<u>Recommendation 3.A.</u> The APA should focus the psychiatric educational agenda by convening an annual face-to-face meeting to facilitate communication between the education-related organizations in psychiatry. This should include:

- Annual face-to-face education summit meetings with partner organizations involved in psychiatric education on topics of timely importance.
- An APA-sponsored listserv, quarterly conference calls or another consistent meeting mechanism should promote on-going communication/discussion
- Planning for jointly-planned workshops and symposia with partner organizations at the Annual Meeting and the Institute for Psychiatric Services.

Although there are a number of organizations with an interest in different aspects of the workforce pipeline, and each works on disseminating best practices, there is no mechanism for effective communication among these groups. Such information is critical if the APA is to take a leadership role with these oversight organizations.

<u>Recommendation 5.B.ii.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Department of Research and the Council for Research, along with partner educational organizations, to gather and synthesize data on recruitment into psychiatry and disseminate the findings. The following are examples of data needed:

- Successful methods for engaging medical students in careers in psychiatry.
- Identification of barriers that may deter medical students from choosing careers in psychiatry.
- Innovative training models.
- Approaches available to enhance funding for training, such as the Veterans Administration, FQHC, and Teaching Health Center models.
- Best practices for fostering a diverse and inclusive workforce.

The following are potential dissemination strategies:

- Presentation of promising practices and innovations at the APA annual meeting and IPS.
- Engagement of the Assembly by organizing presentations to publicize findings and enlistment of Assembly members to advocate for investments in pipeline development in their respective areas.
- Scholarly contributions in journals, including "FOCUS," "Academic Psychiatry" and the "American Journal of Psychiatry."
- Weekly updates focused on innovations in training and pipeline issues similar to communications developed by the AAMC and other organizations.
- Development of social media approaches to enhance the breadth and reach of the dissemination of material.

<u>Recommendation 3.B.v.</u> The APA should promote collaborations to tackle pressing workforce pipeline issues. For example, the APA could:

- Encourage the development of a cohort of future leaders in psychiatry by bringing together education and funding organizations to develop fellowships in a variety of areas including education, neuroscience, leadership, community psychiatry, and integrated care.
- Develop toolkits to:
 - Encourage medical students to pursue careers in psychiatry;
 - Incentivize and reward medical educators;
 - o Facilitate the creation of a culture where medical educators are valued;
 - Impart basic knowledge on the foundations of professionalism including lifelong learning;
 - Coordinate and promote programs that support formal career;
 - Development opportunities for medical educators interested in becoming Department Chairs or holding broader leadership roles in schools of medicine.

The APA can support GME funding and the development of increased workforce through <u>Advocacy Initiatives.</u>

The Work Group made recommendations to the APA Council on Advocacy and Governmental Relations and the Department of Governmental Affairs on the IOM Report on GME Funding. This informed the APA's response to the House of Representatives Committee on Energy and Commerce query on GME funding. The essential elements of this response were requesting that Congress:

- Lift the arbitrary cap on GME funding that was put in place in the 1997 Balanced Budget Act;
- Consider combining the two GME funding streams (direct and Indirect) into one payment to reduce administrative burden and make it easier to fund training in outpatient settings;
- Dissent with the IOM's recommendation to divert existing funding away from training operations toward a new administrative structure for data collection and payment model piloting;
- Support the involvement of other stakeholders in the GME funding stream and the
 consideration by Congress of an all-payer model that is thoroughly tested and built upon
 the foundation of sustained Medicare GME funding.

The APA can build on this advocacy in the following ways:

<u>Recommendation 4.A.</u> The APA should vigorously advocate for maintaining and increasing funding for graduate medical education, including funding for training in innovative care delivery systems. This should include the following specific issues:

- Collaboration with AACAP and the Association of Children's Hospitals to find common ground and pool resources to find funding for innovative programs to address the ongoing shortage of child psychiatrists.
- Partner with other relevant organizations to advocate for the reauthorization of funding for the Teaching Health Center provision under the ACA.

The designation of psychiatry as a primary care specialty is important because federal and state funding for GME will likely increasingly be directed toward specialty-focused priorities and will most likely focus on primary care specialties.

<u>Recommendation 4.B.</u> The APA should advocate for the continued designation of Psychiatry as a Primary Care Specialty.

The Work Group on Education and Training did not specifically focus on training in psychiatric research. It is important to support the development of new knowledge, the alignment of psychiatric clinical care and research, and the mission of academic medical centers. Thus, instead of including the research pipeline agenda within this report, we recommend that another initiative be undertaken to address this need.

<u>Recommendation 5.B.i.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Research to determine the most effective strategies to enhance research training and encourage the development of physician-scientists in psychiatry.

Aligning Residency Structure with Current Educational Demands

The aging of the population, the large number of individuals with co-morbid medical, psychiatric and substance use disorders, the significant incidence of complex behavioral problems that accompany acute and chronic medical conditions, and the expansion of health care coverage will require a well-trained psychiatric workforce. It is critically important that general psychiatrists have sufficient training to diagnose and manage the elderly, addicted, or medically ill. In addition, a comprehensive understanding of emerging neuroscience and its implications for patient care are essential to the education of the 21st century psychiatric graduate.

There is a debate in the field about the importance of the PGY4 year, the need for generalist training, and the balance between specialization and sub-specialization. It is the view of the Work Group that generalist training must be encouraged. Thus, we propose that:

• General psychiatry training programs remain four years in length. This is more than warranted because of the substantial volume of clinical knowledge in the areas of neuroscience, ethnic/social diversity and systems of integrated health care along with

- the necessary continuing attention to the traditional psychiatric skills that are required of a generalist psychiatrist.
- The areas that must be covered during the four years of general psychiatry training
 include psychosomatic medicine, geriatric medicine, child and adolescent psychiatry,
 forensic psychiatry, substance abuse/addiction, and integrated care. Increased clinical
 exposure to these areas during general residency training will be required to ensure that
 generalist practitioners will be able to meet the clinical demands of the future.

The following proposed APA Position Statements support this view:

Recommendation 2.A. The APA should adopt the following position statements:

- i. Generalist psychiatry training is critical to meet the public health need. General psychiatry training should be of four years duration in order to provide sufficient time for trainees to develop the necessary breadth and depth of experience and expertise. Training in psychosomatic medicine, geriatric, and addictions, as well as integrated care, is essential for graduating psychiatrists. Continued attention to child and adolescent and forensic psychiatry is needed. Child and adolescent psychiatry, as a two-year training experience, should maintain its historic exception to the four-year adult requirement.
- ii. A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of training.

The increase in clinically applicable neuroscience knowledge has created a need for residency curricular development. The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (http://www.nncionline.org/). APA can continue this work through the following Programmatic Initiative for the Department of Education:

<u>Recommendation 3.B.iv.</u> The APA should promote the development of neuroscience curricular materials and pedagogic innovations.

<u>Preparing Faculty to Meet the Educational Needs of Trainees</u>

The development and implementation of changes in residency training requires thoughtful and comprehensive faculty development. While this is the responsibility of institutions, departments, and a shared concern with AADPRT and AAP, the APA has a strong record of convening professional groups and developing/disseminating content knowledge. There is a lack of data about faculty development and it would be useful to survey departments of psychiatry to identify perceived faculty development needs and ascertain best practices regarding faculty development. The findings would serve as models for dissemination.

Many programs face challenges in assisting faculty in their educational growth and development. Few departments of psychiatry have formal programs to orient new faculty to their roles, including their responsibilities as educators and supervisors, or assist them in the process of promotion and career planning. It is challenging for departments to identify and incentivize sufficient numbers of senior faculty to appropriately mentor junior faculty using existing strategies. The appointment of mentoring committees often comes too late in a junior faculty's career to make a real difference in career development. There are some exemplary programs of high quality that provide effective faculty development, but there is no systematic description.

It would be very helpful to develop an APA Visiting Scholar Program to identify expert educators in psychiatry who could provide workshops and consultation directly to programs for faculty development projects. After review by an award committee, the selected program(s) would be assigned a visiting scholar to provide one to two day workshops on teaching, supervising and evaluating trainees for faculty. These programs could also offer focused consultation on improving current training and assisting with specific training improvement goals, such as the use of technology in teaching. The program could be modeled after the AADPRT Teichner Award, which has a competitive process in selecting programs to receive specialized support and training in the teaching of psychodynamic psychotherapy principles.

The dramatic developments in basic neuroscience and clinical research in the past decade have had limited impact on training in patient evaluation and treatment. There have been attempts to bridge this gap through efforts such as the annual AADPRT BRAIN Conference, but attendance has been limited to primarily program directors. While most programs include didactics on research findings and methods, there is very little presented on research techniques relevant to clinical care, such as training in Single Case Study Design. The APA could develop such materials and facilitate the creation of model curriculum on these topics.

Many residency programs are operationalizing the ACGME requirement for Patient Safety and Quality Improvement training. Some institutions have centralized this through the use of online training, e.g. Institute for Healthcare Improvement (IHI), or institution-specific training. There is an educational need for the development of QI modules specific to psychiatry to encourage engagement in QI activities among psychiatrists and development of scholarly output from these efforts. The APA Department of Education and Council on Medical Education and Lifelong Learning should engage in partnership with IHI and others to develop modules that demonstrate psychiatry-relevant QI activity.

The development of an APA Academy of Master Teachers in Psychiatry program could provide a multi-level training and recognition process could address some of these concerns. The education of residents relies on contributions from academic and community-based clinician educators. For academic clinician-educators, support for faculty development to enhance teaching skills often varies greatly across institutions. Although existing programs sponsored by ADMSEP, AADPRT, and AAP exist, a broader effort to support the career development of psychiatry faculty is needed. This effort should also reach volunteer and

community-based faculty who are often excluded from institutionally-based faculty development programs.

Online training modules could encourage faculty who are dedicated to education by providing accessible resources, and certification of their completion would provide documentation of their skills and development. These online modules could include teaching skills related to psychiatric supervision, self-assessment, and providing feedback.

The establishment of multi-level recognition provides opportunities for educators to enhance their academic credentials and demonstrate those attributes required for academic advancement. Courses could also be offered at annual meetings, similar to the AAP and ADMSEP models, with advanced modules for Program Directors or educators in subspecialties. In addition to providing CME, these training modules could also provide necessary documentation required for MOC-4 feedback, making them even more desirable for educators and programs.

The following <u>Programmatic Initiatives for the Department of Education</u> would meet these needs:

Recommendation 3.C. The APA should promote faculty development by:

- Collaboration with AADPRT and AAP to conduct a needs assessment for faculty development, particularly in the areas of neuroscience, research, and quality improvement.
- ii. Creating a competitive Visiting Scholar Program focused on faculty development and training.
- iii. Considering the potential value of an APA Academy of Master Educators in Psychiatry to support faculty development, retention, advancement and recognition at their home institutions.

The APA should also extend or reconfigure existing APA Education Awards to support current educational goals. For example, those receiving the awards might serve as members in the proposed Visiting Scholar Program above. It may also be useful for the APA to convene a meeting of the other professional psychiatric societies that give educational awards to see how greater benefit could be derived from these honors.

<u>Recommendation 3.D</u>. The APA should consider how current APA educational awards could be aligned to promote current educational goals.

Collaboration with Councils:

Because the APA Clinical Practice Guidelines are now institutionalized in the Psychiatry Milestones (ACGME, 2013), the APA Department of Education and the Council on Medical Education and Lifelong Learning should provide assistance on identifying priority topics. Currently, the selection of topics for development of Clinical Practice Guidelines is described in the APA New Development Process for Practice Guidelines of the APA (December, 2011).

Suggestions come from the APA Assembly, open nomination by members and identification of areas of need and opportunities by the Steering Committee on Practice Guidelines. The restrictions on funding and time needed for the development and revision of APA Clinical Practice Guidelines increases the importance of selecting the priority of topics in the use of limited resources.

As the APA Clinical Guidelines are central in the training of psychiatrists, it would be important for the APA Council on Education Medical Education and Lifelong Learning to provide information on gaps in current education to the Steering Committee on Practice Guidelines. Finally, to ensure broad dissemination, the APA Clinical Practice Guidelines should be freely available for access and use for all those involved in psychiatric education.

Additionally, while the APA provides CME materials for some of the APA Clinical Practice Guidelines, it would be helpful to have training materials and modules that could be implemented in medical student and resident training. This effort could be undertaken in cooperation with AADPRT, AAP and ADMSEP and should include materials such as vignettes, videos, and other teaching materials as well as links to other resources such as Symptom Media (http://symptommedia.com/).

<u>Recommendation 5.C.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Steering Committee on Practice Guidelines to:

- Identify priority topics for residency teaching, as well as assist with the development of curricular materials for medical students and residents.
- ii. Make the Guidelines available online for ready access by all those involved in psychiatric education.

Integrated Care

The greatly increased focus on integration of behavioral health care with primary care has resulted in the development of new models of service delivery. These ideas have been referenced several times in the preceding discussion and recommendations and the APA Council on Medical Education and Lifelong Learning Report on Education for Integrated Behavioral Health Care is a comprehensive review of these innovative care models as well as educational approaches for medical students, residents and practitioners.

The Work Group strongly supports educating psychiatrists about integrated behavioral health care and responding to the need to train a generation of physicians who can take on clinical and advocacy roles in integrated care. Further, we conclude that all components of the psychiatric education continuum will need to examine their current practices and consider how to incorporate integrated care models and techniques into didactic and clinical training to meet this need. We anticipate building excitement and enthusiasm around these new models and

developing psychiatrists who are both competent and confident in the provision of these new models of care.

Recommendation 3.B. The APA should promote the following educational efforts:

- i. Dissemination of best practices in training for integrated care models.
- ii. Communication and collaboration among primary care specialty organizations, including inter-specialty collaboration on curriculum development.
- iii. Communication and collaboration among mental health professional organizations, including inter-professional collaboration on curriculum development.
- iv. Development of neuroscience curricular materials and pedagogic innovations.

<u>Recommendation 5.A.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing to promote training for integrated behavioral health care.

Conclusion

The increasing awareness of the centrality of behavior health in the health care system, changes in the funding and regulatory environment of residency training, and the development of new knowledge makes this an exciting moment in psychiatric education. The Board of Trustees Ad Hoc Work Group on Education and Training has identified four critical goals we must meet to prepare our trainees to meet the needs of the American public – ensuring a robust pipeline of psychiatrists, aligning the structure of residency with the educational needs, preparing the faculty to teach effectively, and promoting the skills and knowledge necessary to function in integrated care roles.

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Attachment #15 Item 2015A1 4.B.18 Assembly May 15-17, 2015

To: APA Assembly

From: Council on Medical Education and Lifelong Learning

RE: Neuroscience Training in Psychiatric Residency Training

Date: March 17, 2015

The APA Board of Trustees Ad Hoc Work Group on Education and Training was convened to study the significant changes taking place in funding, educational and competency requirements within residency training, and the projected future roles for psychiatrists in America's healthcare workforce. The Work Group's considerations incorporate an understanding of the APA's role as a leader in psychiatric education, its unique ability to bring together educators across the psychiatric education continuum, its partnership with education organizations in the field, and its recognition that psychiatrists must take a leadership role in shaping the skills of our future workforce.

The deliberations and conclusions reached by this Work Group are based on participation from leaders in psychiatric education, and included representatives from the American Association for Directors of Psychiatric Residency Training (AADPRT), the Association of Directors of Medical Student Education in Psychiatry (ADMSEP), the Association for Academy Psychiatry (AAP), the American Board of Psychiatry and Neurology (ABPN), and the American Association of Chairs of Departments of Psychiatry (AACDP).

The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (www.nncionline.org/). The APA must take a leadership role in advocating for the necessary elements in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans.

The final report of the Ad Hoc Work Group, "Training the Psychiatrist of the Future", was presented to the American Psychiatric Association Board of Trustees on March 14, 2015 and was unanimously accepted in its entirety.

Position Statement

Title: Neuroscience Training in Psychiatric Residency Training

Issue: An essential element of the mission of the American Psychiatric Association is to promote excellence in psychiatric education and training in order to foster the highest quality of care for individuals with mental disorders, mental retardation and substance—related disorders, and their families. The increase in clinically applicable neuroscience knowledge has created a need for residency curricular development. The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (www.nncionline.org/). The APA must take a leadership role in advocating for the necessary elements in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans.

APA Position: A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of psychiatric training.

Authors:

The Ad Hoc Work Group on Education and Training, 2015:

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Background Information

The APA Board of Trustees Ad Hoc Work Group on Education and Training was convened to study the significant changes taking place in funding, educational and competency requirements within residency training, and the projected future roles for psychiatrists in America's healthcare workforce. The Work Group's considerations incorporate an understanding of the APA's role as a leader in psychiatric education, its unique ability to bring together educators across the psychiatric education continuum, its partnership with education organizations in the field, and its recognition that psychiatrists must take a leadership role in shaping the skills of our future workforce.

The deliberations and conclusions reached by this Work Group are based on participation from leaders in psychiatric education, and included representatives from the American Association for Directors of Psychiatric Residency Training (AADPRT), the Association of Directors of Medical Student Education in Psychiatry (ADMSEP), the Association for Academy Psychiatry (AAP), the American Board of Psychiatry and Neurology (ABPN), and the American Association of Chairs of Departments of Psychiatry (AACDP).

The final report of the Ad Hoc Work Group, "Training the Psychiatrist of the Future", was presented to the American Psychiatric Association Board of Trustees on March 14, 2015, and was unanimously accepted in its entirety.

The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (www.nncionline.org/).

The workgroup report is attached.

American Psychiatric Association

Training the Psychiatrist of the Future

A Report by the

American Psychiatric Association

Board of Trustees Ad Hoc Work Group on Education and Training

2015

APA Board of Trustees Ad Hoc Work Group on Education and Training

Executive Summary

The Work Group was established to study the significant changes taking place in the funding and requirements for residency training and the projected future need for psychiatrists. The context for the Work Group's activity includes the APA's role as a leader in psychiatric education, its unique ability to convene educators across the psychiatric education continuum, its partnership with the education organizations in the field, and the need for psychiatrists to take leadership in shaping the skills of our future workforce.

The Work Group identified the following four critical educational goals:

- Ensuring a robust pipeline of psychiatrists to meet the public health needs of Americans now and in the future.
- Aligning residency structure with current educational demands.
- Preparing faculty to meet the educational needs of trainees.
- Training residents for effective integration of behavioral health care with primary care.

To accomplish these goals, we make the following recommendations. **Bolded recommendations** are of high priority and should be well underway within six months.

1. Overarching Commitment:

A. The APA should take a leadership role in advocating for the changes in residency education necessary to prepare future psychiatrists to meet the behavioral health needs of Americans. This will be best accomplished by partnering effectively with the education organizations in the field.

2. APA Position Statement:

A. The APA should adopt the following position statements:

i. Generalist psychiatry training is critical to meet the public health need. General psychiatry training should be of four years duration in order to provide sufficient time for trainees to develop the necessary breadth and depth of experience and expertise. Training in psychosomatic medicine, geriatric, and addictions, as well as integrated care, is essential for graduating psychiatrists. Continued attention to child and adolescent and forensic psychiatry is needed. Child and adolescent psychiatry, as a two-

^{*} We use the term behavioral health to encompass mental health, mental illness and substance abuse.

- year training experience, should maintain its historic exception to the fouryear adult requirement.
- ii. A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of training.

3. <u>Programmatic Initiatives for the Department of Education:</u>

- A. The APA should focus the psychiatric educational agenda by convening an annual face-to-face meeting to facilitate communication between the education-related organizations in psychiatry.
- B. The APA should promote the following educational efforts:
 - i. Dissemination of best practices in training for integrated care models.
 - ii. Communication and collaboration among primary care specialty organizations, including inter-specialty collaboration on curriculum development.
 - iii. Communication and collaboration among mental health professional organizations, including inter-professional collaboration on curriculum development.
 - iv. Development of neuroscience curricular materials and pedagogic innovations.
 - v. Collaborations to tackle pressing workforce pipeline issues.
- C. The APA should promote faculty development by:
 - Collaborating with AADPRT and AAP to conduct a needs assessment for faculty development, particularly in the areas of neuroscience, research, and quality improvement.
 - ii. Creating a competitive Visiting Scholar Program focused on faculty development and training.
 - iii. Considering the potential value of an APA Academy of Master Educators in Psychiatry to support faculty development, retention, advancement and recognition at their home institutions.
- D. The APA should consider how current APA educational awards could be better aligned to promote current educational goals.

4. Legislative Advocacy Initiatives:

- A. The APA should vigorously advocate for maintaining and increasing funding for graduate medical education, including funding for training in innovative care delivery systems.
- B. The APA should advocate for the continued designation of Psychiatry as a primary care specialty.

5. <u>Collaboration with Councils:</u>

- A. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing to promote training for integrated behavioral health care.
- B. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Department of Research and the Council for Research, along with partner educational organizations, to:
 - Determine the most effective strategies to enhance research training and encourage the development of physician-scientists in psychiatry.
 - ii. Gather and synthesize data on recruitment into psychiatry and disseminate the findings.
- C. The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Steering Committee on Practice Guidelines to:
 - i. Identify priority topics for residency teaching, as well as assist with the development of curricular materials for medical students and residents.
 - ii. Make the Practice Guidelines available online for ready access by all those involved in psychiatric education.

These recommendations should be implemented by the Office of the CEO/Medical Director, Department of Education, Council on Medical Education and Lifelong Learning, and other Councils and Departments as indicated.

APA Board of Trustees Ad Hoc Work Group on Education and Training

Work Group Report

In August 2014, APA President, Paul Summergrad, M.D., appointed members with experience in psychiatric education and representatives from stakeholder education associations to a new Board of Trustees Ad Hoc Work Group on Education and Training.

The **charge** of the Work Group was to make recommendations to the Board of Trustees for changes in psychiatric education and training by reviewing current pressures on residency education and training, including the following areas:

- Graduate Medical Education (GME) funding and other funding sources
- Curriculum changes, especially related to areas such as neuroscience
- Changed models of training for residents that are aligned with changes in health care delivery (i.e., integrated care and payment models)
- Research training

The context for the Work Group includes the recent calls for GME funding reform, the roll out of the Psychiatry Milestones by the Accreditation Council for Graduate Medical Education (ACGME), the Affordable Care Act (ACA) and market forces driving innovation in service delivery, especially integrated behavioral health care, increasing inter-specialty and inter-professional collaboration, departmental budget constraints affecting teaching faculty, new knowledge in neuroscience, and the increasing importance of quality improvement activities.

Work Group Members:

Richard F. Summers, M.D., Chairperson
Sheldon Benjamin, M.D., Member
Tami Benton, M.D., Member
Carol Bernstein, M.D., Member
Lara J.Cox, M.D., M.S. Member
Jed Magen, D.O., M.S., Member
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Christopher Varley, M.D., AADPRT Representative Annelle Primm, M.D., M.P.H., APA Administration Kristin Kroeger, APA Administration Nancy Delanoche, M.S., APA Administration

Vision of the Psychiatrist of the Future

The Work Group developed the following vision of the psychiatrist of the future to guide our study and recommendations:

The aging of the population, large number of individuals with co-morbid medical, psychiatric and substance use disorders, significant incidence of complex behavioral problems that accompany other acute and chronic medical conditions, and the expansion of health care coverage highlight the limitations of the current psychiatric workforce. Given these needs, it is critically important that general psychiatrists have sufficient training to:

- Establish a meaningful doctor-patient relationship with patients from a wide range of cultural, racial, ethnic and gender/sexual backgrounds.
- Diagnose and manage adults, adolescents and children with psychiatric disorders, as well as elderly, addicted, and medically ill patients with psychiatric co-morbidities.
- Apply a comprehensive understanding of emerging neuroscience and its implications to patient care.
- Practice in integrated behavioral health care models.

The Work Group identified 23 potential priorities in residency education and decided after surveying its members and arriving at consensus that the psychiatrist pipeline, residency structure, faculty development, and integrated care were the most salient areas. We defined the following critical educational goals consistent with these four areas:

- Ensuring a robust pipeline of psychiatrists to meet the public health needs now and in the future;
- Aligning residency structure with current educational demands;
- Preparing faculty to meet the educational needs of trainees;
- Training residents for effective integration of behavioral health care with primary care.

Our first recommendation provides an overarching theme and unifies these four areas:

Recommendation 1.A. The APA must take a leadership role in advocating for the necessary changes in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans. This will be best accomplished by partnering effectively with the education organizations in the field.

Our specific recommendations are organized by the four goals we identified and by the type of action we are calling upon the APA to take.

Ensuring the Psychiatrist Pipeline

There is a wide range of estimates of the number of psychiatrists necessary to take care of America's mental health needs. Some reports suggest that significantly more psychiatrists will be needed than the number projected to be available at the current rate of training (Holt, et al, 2014). But, the Institute of Medicine Report on GME Financing (IOM, 2014) concludes that the current number of residents across all fields is appropriate because of anticipated changes in health care delivery systems, such as integrated care, telemedicine, and the anticipated increased use of non-physician health care professionals.

The Work Group concludes that estimates of physician and psychiatric work force needs have been quite unreliable over the past 30 years and thus has some skepticism about our ability to predict this. Thus, we regard it as essential to maintain a pipeline of psychiatrists in training to address access issues and ensure appropriate care for our most vulnerable population of patients. It is important that this is a diverse and inclusive workforce.

An healthy psychiatrist pipeline means sustaining the current GME funding, as well as looking for opportunities to increase training slots through new programs, such as reauthorization of funding for the Teaching Health Center provision under the ACA and consideration of new funding sources for Child and Adolescent Psychiatry programs.

The APA can facilitate the psychiatrist pipeline through the following <u>Programmatic</u> Initiatives for the Department of Education:

The APA is the logical organization to bring together relevant stakeholders to provide a forum for consistent, ongoing communication around education. It has strong ongoing relationships with allied groups and can help to provide "one voice" to Federal entities. The following organizations are important partners in educational leadership: American Board of Psychiatry and Neurology (ABPN), American Association of Medical Colleges (AAMC), American Association of Directors of Psychiatry Residency Training Programs (AADPRT), Association of Directors of Medical Student Education in Psychiatry (ADMSEP), American Association of Chairs of Departments of Psychiatry (AACDP), Association for Academic Psychiatry (AAP), American College of Neuropsychopharmacology (ACNP), ACGME Psychiatry Review Committee for Psychiatry (Psychiatry RC), and the American Academy of Child and Adolescent Psychiatry (AACAP). Although many of these organizations have liaison relationships with the Council on Medical Education and Lifelong Learning, communication between these organizations is sporadic and not well organized. Each organization has specific competencies that contribute to psychiatry education.

<u>Recommendation 3.A.</u> The APA should focus the psychiatric educational agenda by convening an annual face-to-face meeting to facilitate communication between the education-related organizations in psychiatry. This should include:

- Annual face-to-face education summit meetings with partner organizations involved in psychiatric education on topics of timely importance.
- An APA-sponsored listserv, quarterly conference calls or another consistent meeting mechanism should promote on-going communication/discussion
- Planning for jointly-planned workshops and symposia with partner organizations at the Annual Meeting and the Institute for Psychiatric Services.

Although there are a number of organizations with an interest in different aspects of the workforce pipeline, and each works on disseminating best practices, there is no mechanism for effective communication among these groups. Such information is critical if the APA is to take a leadership role with these oversight organizations.

<u>Recommendation 5.B.ii.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Department of Research and the Council for Research, along with partner educational organizations, to gather and synthesize data on recruitment into psychiatry and disseminate the findings. The following are examples of data needed:

- Successful methods for engaging medical students in careers in psychiatry.
- Identification of barriers that may deter medical students from choosing careers in psychiatry.
- Innovative training models.
- Approaches available to enhance funding for training, such as the Veterans Administration, FQHC, and Teaching Health Center models.
- Best practices for fostering a diverse and inclusive workforce.

The following are potential dissemination strategies:

- Presentation of promising practices and innovations at the APA annual meeting and IPS.
- Engagement of the Assembly by organizing presentations to publicize findings and enlistment of Assembly members to advocate for investments in pipeline development in their respective areas.
- Scholarly contributions in journals, including "FOCUS," "Academic Psychiatry" and the "American Journal of Psychiatry."
- Weekly updates focused on innovations in training and pipeline issues similar to communications developed by the AAMC and other organizations.
- Development of social media approaches to enhance the breadth and reach of the dissemination of material.

<u>Recommendation 3.B.v.</u> The APA should promote collaborations to tackle pressing workforce pipeline issues. For example, the APA could:

- Encourage the development of a cohort of future leaders in psychiatry by bringing together education and funding organizations to develop fellowships in a variety of areas including education, neuroscience, leadership, community psychiatry, and integrated care.
- Develop toolkits to:
 - Encourage medical students to pursue careers in psychiatry;
 - Incentivize and reward medical educators;
 - o Facilitate the creation of a culture where medical educators are valued;
 - Impart basic knowledge on the foundations of professionalism including lifelong learning;
 - Coordinate and promote programs that support formal career;
 - Development opportunities for medical educators interested in becoming Department Chairs or holding broader leadership roles in schools of medicine.

The APA can support GME funding and the development of increased workforce through <u>Advocacy Initiatives.</u>

The Work Group made recommendations to the APA Council on Advocacy and Governmental Relations and the Department of Governmental Affairs on the IOM Report on GME Funding. This informed the APA's response to the House of Representatives Committee on Energy and Commerce query on GME funding. The essential elements of this response were requesting that Congress:

- Lift the arbitrary cap on GME funding that was put in place in the 1997 Balanced Budget Act;
- Consider combining the two GME funding streams (direct and Indirect) into one payment to reduce administrative burden and make it easier to fund training in outpatient settings;
- Dissent with the IOM's recommendation to divert existing funding away from training operations toward a new administrative structure for data collection and payment model piloting;
- Support the involvement of other stakeholders in the GME funding stream and the
 consideration by Congress of an all-payer model that is thoroughly tested and built upon
 the foundation of sustained Medicare GME funding.

The APA can build on this advocacy in the following ways:

<u>Recommendation 4.A.</u> The APA should vigorously advocate for maintaining and increasing funding for graduate medical education, including funding for training in innovative care delivery systems. This should include the following specific issues:

- Collaboration with AACAP and the Association of Children's Hospitals to find common ground and pool resources to find funding for innovative programs to address the ongoing shortage of child psychiatrists.
- Partner with other relevant organizations to advocate for the reauthorization of funding for the Teaching Health Center provision under the ACA.

The designation of psychiatry as a primary care specialty is important because federal and state funding for GME will likely increasingly be directed toward specialty-focused priorities and will most likely focus on primary care specialties.

<u>Recommendation 4.B.</u> The APA should advocate for the continued designation of Psychiatry as a Primary Care Specialty.

The Work Group on Education and Training did not specifically focus on training in psychiatric research. It is important to support the development of new knowledge, the alignment of psychiatric clinical care and research, and the mission of academic medical centers. Thus, instead of including the research pipeline agenda within this report, we recommend that another initiative be undertaken to address this need.

<u>Recommendation 5.B.i.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Research to determine the most effective strategies to enhance research training and encourage the development of physician-scientists in psychiatry.

Aligning Residency Structure with Current Educational Demands

The aging of the population, the large number of individuals with co-morbid medical, psychiatric and substance use disorders, the significant incidence of complex behavioral problems that accompany acute and chronic medical conditions, and the expansion of health care coverage will require a well-trained psychiatric workforce. It is critically important that general psychiatrists have sufficient training to diagnose and manage the elderly, addicted, or medically ill. In addition, a comprehensive understanding of emerging neuroscience and its implications for patient care are essential to the education of the 21st century psychiatric graduate.

There is a debate in the field about the importance of the PGY4 year, the need for generalist training, and the balance between specialization and sub-specialization. It is the view of the Work Group that generalist training must be encouraged. Thus, we propose that:

• General psychiatry training programs remain four years in length. This is more than warranted because of the substantial volume of clinical knowledge in the areas of neuroscience, ethnic/social diversity and systems of integrated health care along with

- the necessary continuing attention to the traditional psychiatric skills that are required of a generalist psychiatrist.
- The areas that must be covered during the four years of general psychiatry training
 include psychosomatic medicine, geriatric medicine, child and adolescent psychiatry,
 forensic psychiatry, substance abuse/addiction, and integrated care. Increased clinical
 exposure to these areas during general residency training will be required to ensure that
 generalist practitioners will be able to meet the clinical demands of the future.

The following proposed APA Position Statements support this view:

Recommendation 2.A. The APA should adopt the following position statements:

- i. Generalist psychiatry training is critical to meet the public health need. General psychiatry training should be of four years duration in order to provide sufficient time for trainees to develop the necessary breadth and depth of experience and expertise. Training in psychosomatic medicine, geriatric, and addictions, as well as integrated care, is essential for graduating psychiatrists. Continued attention to child and adolescent and forensic psychiatry is needed. Child and adolescent psychiatry, as a two-year training experience, should maintain its historic exception to the four-year adult requirement.
- ii. A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of training.

The increase in clinically applicable neuroscience knowledge has created a need for residency curricular development. The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (http://www.nncionline.org/). APA can continue this work through the following Programmatic Initiative for the Department of Education:

<u>Recommendation 3.B.iv.</u> The APA should promote the development of neuroscience curricular materials and pedagogic innovations.

<u>Preparing Faculty to Meet the Educational Needs of Trainees</u>

The development and implementation of changes in residency training requires thoughtful and comprehensive faculty development. While this is the responsibility of institutions, departments, and a shared concern with AADPRT and AAP, the APA has a strong record of convening professional groups and developing/disseminating content knowledge. There is a lack of data about faculty development and it would be useful to survey departments of psychiatry to identify perceived faculty development needs and ascertain best practices regarding faculty development. The findings would serve as models for dissemination.

Many programs face challenges in assisting faculty in their educational growth and development. Few departments of psychiatry have formal programs to orient new faculty to their roles, including their responsibilities as educators and supervisors, or assist them in the process of promotion and career planning. It is challenging for departments to identify and incentivize sufficient numbers of senior faculty to appropriately mentor junior faculty using existing strategies. The appointment of mentoring committees often comes too late in a junior faculty's career to make a real difference in career development. There are some exemplary programs of high quality that provide effective faculty development, but there is no systematic description.

It would be very helpful to develop an APA Visiting Scholar Program to identify expert educators in psychiatry who could provide workshops and consultation directly to programs for faculty development projects. After review by an award committee, the selected program(s) would be assigned a visiting scholar to provide one to two day workshops on teaching, supervising and evaluating trainees for faculty. These programs could also offer focused consultation on improving current training and assisting with specific training improvement goals, such as the use of technology in teaching. The program could be modeled after the AADPRT Teichner Award, which has a competitive process in selecting programs to receive specialized support and training in the teaching of psychodynamic psychotherapy principles.

The dramatic developments in basic neuroscience and clinical research in the past decade have had limited impact on training in patient evaluation and treatment. There have been attempts to bridge this gap through efforts such as the annual AADPRT BRAIN Conference, but attendance has been limited to primarily program directors. While most programs include didactics on research findings and methods, there is very little presented on research techniques relevant to clinical care, such as training in Single Case Study Design. The APA could develop such materials and facilitate the creation of model curriculum on these topics.

Many residency programs are operationalizing the ACGME requirement for Patient Safety and Quality Improvement training. Some institutions have centralized this through the use of online training, e.g. Institute for Healthcare Improvement (IHI), or institution-specific training. There is an educational need for the development of QI modules specific to psychiatry to encourage engagement in QI activities among psychiatrists and development of scholarly output from these efforts. The APA Department of Education and Council on Medical Education and Lifelong Learning should engage in partnership with IHI and others to develop modules that demonstrate psychiatry-relevant QI activity.

The development of an APA Academy of Master Teachers in Psychiatry program could provide a multi-level training and recognition process could address some of these concerns. The education of residents relies on contributions from academic and community-based clinician educators. For academic clinician-educators, support for faculty development to enhance teaching skills often varies greatly across institutions. Although existing programs sponsored by ADMSEP, AADPRT, and AAP exist, a broader effort to support the career development of psychiatry faculty is needed. This effort should also reach volunteer and

community-based faculty who are often excluded from institutionally-based faculty development programs.

Online training modules could encourage faculty who are dedicated to education by providing accessible resources, and certification of their completion would provide documentation of their skills and development. These online modules could include teaching skills related to psychiatric supervision, self-assessment, and providing feedback.

The establishment of multi-level recognition provides opportunities for educators to enhance their academic credentials and demonstrate those attributes required for academic advancement. Courses could also be offered at annual meetings, similar to the AAP and ADMSEP models, with advanced modules for Program Directors or educators in subspecialties. In addition to providing CME, these training modules could also provide necessary documentation required for MOC-4 feedback, making them even more desirable for educators and programs.

The following <u>Programmatic Initiatives for the Department of Education</u> would meet these needs:

Recommendation 3.C. The APA should promote faculty development by:

- Collaboration with AADPRT and AAP to conduct a needs assessment for faculty development, particularly in the areas of neuroscience, research, and quality improvement.
- ii. Creating a competitive Visiting Scholar Program focused on faculty development and training.
- iii. Considering the potential value of an APA Academy of Master Educators in Psychiatry to support faculty development, retention, advancement and recognition at their home institutions.

The APA should also extend or reconfigure existing APA Education Awards to support current educational goals. For example, those receiving the awards might serve as members in the proposed Visiting Scholar Program above. It may also be useful for the APA to convene a meeting of the other professional psychiatric societies that give educational awards to see how greater benefit could be derived from these honors.

<u>Recommendation 3.D</u>. The APA should consider how current APA educational awards could be aligned to promote current educational goals.

Collaboration with Councils:

Because the APA Clinical Practice Guidelines are now institutionalized in the Psychiatry Milestones (ACGME, 2013), the APA Department of Education and the Council on Medical Education and Lifelong Learning should provide assistance on identifying priority topics. Currently, the selection of topics for development of Clinical Practice Guidelines is described in the APA New Development Process for Practice Guidelines of the APA (December, 2011).

Suggestions come from the APA Assembly, open nomination by members and identification of areas of need and opportunities by the Steering Committee on Practice Guidelines. The restrictions on funding and time needed for the development and revision of APA Clinical Practice Guidelines increases the importance of selecting the priority of topics in the use of limited resources.

As the APA Clinical Guidelines are central in the training of psychiatrists, it would be important for the APA Council on Education Medical Education and Lifelong Learning to provide information on gaps in current education to the Steering Committee on Practice Guidelines. Finally, to ensure broad dissemination, the APA Clinical Practice Guidelines should be freely available for access and use for all those involved in psychiatric education.

Additionally, while the APA provides CME materials for some of the APA Clinical Practice Guidelines, it would be helpful to have training materials and modules that could be implemented in medical student and resident training. This effort could be undertaken in cooperation with AADPRT, AAP and ADMSEP and should include materials such as vignettes, videos, and other teaching materials as well as links to other resources such as Symptom Media (http://symptommedia.com/).

<u>Recommendation 5.C.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Steering Committee on Practice Guidelines to:

- Identify priority topics for residency teaching, as well as assist with the development of curricular materials for medical students and residents.
- ii. Make the Guidelines available online for ready access by all those involved in psychiatric education.

Integrated Care

The greatly increased focus on integration of behavioral health care with primary care has resulted in the development of new models of service delivery. These ideas have been referenced several times in the preceding discussion and recommendations and the APA Council on Medical Education and Lifelong Learning Report on Education for Integrated Behavioral Health Care is a comprehensive review of these innovative care models as well as educational approaches for medical students, residents and practitioners.

The Work Group strongly supports educating psychiatrists about integrated behavioral health care and responding to the need to train a generation of physicians who can take on clinical and advocacy roles in integrated care. Further, we conclude that all components of the psychiatric education continuum will need to examine their current practices and consider how to incorporate integrated care models and techniques into didactic and clinical training to meet this need. We anticipate building excitement and enthusiasm around these new models and

developing psychiatrists who are both competent and confident in the provision of these new models of care.

Recommendation 3.B. The APA should promote the following educational efforts:

- i. Dissemination of best practices in training for integrated care models.
- ii. Communication and collaboration among primary care specialty organizations, including inter-specialty collaboration on curriculum development.
- iii. Communication and collaboration among mental health professional organizations, including inter-professional collaboration on curriculum development.
- iv. Development of neuroscience curricular materials and pedagogic innovations.

<u>Recommendation 5.A.</u> The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing to promote training for integrated behavioral health care.

Conclusion

The increasing awareness of the centrality of behavior health in the health care system, changes in the funding and regulatory environment of residency training, and the development of new knowledge makes this an exciting moment in psychiatric education. The Board of Trustees Ad Hoc Work Group on Education and Training has identified four critical goals we must meet to prepare our trainees to meet the needs of the American public – ensuring a robust pipeline of psychiatrists, aligning the structure of residency with the educational needs, preparing the faculty to teach effectively, and promoting the skills and knowledge necessary to function in integrated care roles.

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Attachment #16 Item 2015A1 4.B.19 Assembly May 15-17, 2015

Position Statement

Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families

Issue:

Disorders of sex development (DSDs) are congenital conditions (including but not limited to those formerly referred to as intersex disorders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal and/or genital sex. The gender that should be assigned to infants may not be obvious at birth, and in many cases the process of decision making regarding gender assignment is complex and laden with uncertainties. Individuals with DSDs may experience gender dysphoria in the initially assigned gender and require gender reassignment. Gender reassignment may be rendered more complicated if early genitoplasty was employed to align the appearance of the external genitalia with the initially assigned gender. The proportion of individuals with DSDs who request gender reassignment varies as a function of both the particular DSD syndrome and the initial gender assignment. Besides initial gender assignment, and sometimes reassignment, other complex decisions are often required in areas were consensus for optimal management is lacking, particularly those involving irreversible elective surgical procedures performed on minors who lack capacity to participate in these decisions.

DSDs and the decision making they entail have the potential to cause great distress for both parents who struggle to make the best decisions for their children, and for the affected individuals themselves many of whom report feelings of stigmatization and shame. Accordingly, DSD advocacy groups, several existing treatment guidelines for DSDs, many individuals with DSDs, and the APA Task Force on Treatment of Gender Identity Disorder have called for an increased role of mental-health professionals in the care of individuals with DSDs and their parents or primary caregivers.

APA Position:

- 1) Because of the multiplicity of DSDs, the complex differences among them, and their implications for medical, surgical and mental healthcare, provision of care to individuals with DSDs and their families is best accomplished by integrated interdisciplinary teams; because of the psychological distress associated with such decisions and the complex developmental processes involving body, brain, and mind that must be considered, these teams should include mental-health professionals.
- 2) Because of their medical training, and because of the complex biological and medical considerations that come to play in decision making and psychoeducation regarding DSDs, with limited additional training psychiatrists can become well prepared to participate in these interdisciplinary teams.
- 3) In light of the existing dearth of psychiatrists with the necessary training and expertise to contribute to such interdisciplinary teams, opportunities should be increased in residency and fellowship programs, including child and adolescent psychiatry and consultation-liaison

psychiatry, for psychiatric training in the provision of care to individuals with DSDs and their families.

4) Given the deficiencies in the evidence base upon which many management decisions must currently be made, APA encourages increased support for longitudinal outcome studies in collaboration with other disciplines

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Background

As employed here, the term, *disorders of sex development (DSD)* refers to congenital conditions (formerly called intersex disorders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal and/or genital sex. The gender that should be assigned may not be obvious at birth, and in many cases the process of decision making with respect to gender assignment is complex and fraught with uncertainties. Although gender reassignment can be made without genital surgery, genitoplasty is often employed to bring the appearance of the external genitalia in line with the assigned gender; in most cases, its outcome is essentially irreversible. Additionally, gonadectomy may be considered in a variety of DSD syndromes in which there is an increased risk of gonadal malignancy. Various viewpoints have been expressed on these controversial interdisciplinary issues (1;3;5;6;12-14).

The presence of a genital anomaly complicating gender assignment at birth can engender a sense of "psychosocial emergency" for parents and healthcare providers (3;4;11). Parents sometimes report feeling that their consent for surgical procedures was not fully informed or was given at a time of emotional duress (4). Such situations call for dispelling the sense of urgency, and advising against making irreversible decisions in an atmosphere of crisis. Informed consent requires knowledge of the limitations of the evidence base, even in this emotionally laden area. Various DSD advocates and ethicists have argued for postponing any elective genital surgery until the age of consent of the patient with a DSD. On the other hand, 4 surveys of clinical samples of individuals with DSDs have been conducted, and in these the majority of individuals, but not all, retrospectively endorsed a childhood age for genital surgery rather than adolescence or later (7;9;10;15). This controversy remains unresolved.

Some individuals with DSDs, in a proportion that varies greatly with syndrome and assigned gender, become dysphoric in the initially assigned gender and may choose to live in a different gender

role. They may request or require endocrinological, surgical or mental-health services to facilitate gender transition. The clinical options and decision making processes that bear on gender transition and reassignment in individuals with a DSD overlap with those for transgender patients without a DSD. When a DSD is present, however, there are fewer barriers to legal gender reassignment, and the barriers to hormonal and surgical treatments in conjunction with gender reassignment are lower, particularly in individuals for whom gonadectomy has already been performed or is indicated due to their particular DSD (2;8).

Because of the multiplicity of DSDs, the complex differences among them, and their implications for medical, surgical and mental healthcare, provision of care to individuals with DSDs and their families is best accomplished by integrated interdisciplinary teams. These teams should include mental-health professionals because DSDs and the decision making they entail have the potential to cause great distress for both parents who struggle to make the best decisions for their children, and for the affected individuals, themselves, many of whom report feelings of stigmatization and shame, and some of whom report dissatisfaction with the treatment decisions made on their behalf. The role of mental-health professionals in caring for individuals with DSDs and their families has been detailed elsewhere (2;3;11).

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Attachment #17 Item 2015A1 12.A Assembly May 15-17, 2015

ACTION PAPER FINAL

TITLE: Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident

WHEREAS:

- 1. On November 5, 2009 an American Army psychiatrist, radicalized by extremist beliefs, opened fire on his fellow soldiers in Fort Hood, Texas, killing 14 people, including an unborn child, and wounding 32
- 2. The Government labeled this incident as workplace violence committed by a disgruntled employee and not as an act of terror by an extremist
- 3. Survivors of this incident and their significant others (i.e. spouses or life partners and children) as well as significant others (i.e. spouses or life partners and children) of those who were killed have suffered from severe mental health problems, including posttraumatic stress disorder and demoralization, and at least two survivors committed suicide.

BE IT RESOLVED:

- The American Psychiatric Association supports comprehensive mental health benefits for the survivors and their significant others (i.e. spouses or life partners and children) as well as the significant others (i.e. spouses or life partners and children) of those who were killed in the Fort Hood incident.
- 2. The American Psychiatric Association will lobby through its Office of Advocacy and Government Relations for legislation to be passed by Congress making such eligibility possible.
- 3. That the Speaker of the Assembly brings this action paper to the next Board of Trustees as time is of essence if the Assembly is to have a meaningful role in this matter.

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ESTIMATED COST: Author: \$20,000 APA: \$20,846.92

ESTIMATED SAVINGS: \$0

ESTIMATED REVENUE GENERATED: \$0

ENDORSED BY: Area 2, Women Psychiatrists

KEY WORDS: Fort Hood, Combat injury benefits

APA STRATEGIC GOAL: Advocating for Patients, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

ACTION PAPER FINAL

TITLE: Position Statement on Assisted Outpatient Treatment (AOT)

WHEREAS:

- 1. The APA has no Position Statement on Assisted Outpatient Treatment (AOT).
- AOT is an evidenced based treatment.
- 3. The Board of Trustees at its December 2014 meeting voted "to express clear support for House Energy and Commerce Oversight Subcommittee Chairman Tim Murphy (R-Pa.) and Representative Eddie Bernice Johnson (D-Tex.) in their efforts to achieve bipartisan comprehensive mental health reform in the 114th Congress, and gave guidance to the APA Administration and Department of Government Relations regarding authorized advocacy activities in order to help assure that federal mental health activity is informed by APA's policies and the scientific evidence base."
- 4. As a result, the APA Division of Government Relations has publically lobbied for support of AOT in a document titled: "Assisted Outpatient Treatment: An Effective Tool that Should be Available".
- 5. The above document states as APA's lobbying position: "APA urges you to support the full appropriation of authorized funding for the Assisted Outpatient Treatment for Individuals with Serious Mental Illness program (Public Law 113-93, Section 224). If properly implemented and funded, outpatient commitment can be a useful tool in an overall program of intensive outpatient services aiming to improve compliance, reduce hospitalization readmission rates, and decrease violent behavior among a subset of individuals with severe and chronic mental illness."
- 6. The Assembly has not been heard on the matter of AOT and should be heard, and now.
- 7. A Position Statement, rapidly adopted, is the way for the Assembly to be heard, and heard now.

BE IT RESOLVED:

- 1. That the new Position Statement be passed by the Assembly at this Assembly meeting. (Position statement appears at the end of the Action Paper).
- 2. That the Speaker of the Assembly brings this Action paper to the Board of Trustees (BOT) for passage by the Board of Trustees at the next Board of Trustees meeting as time is of the essence if the Assembly is to have a meaningful role in this matter.

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ESTIMATED COST:

Author: \$0 APA: \$0

ESTIMATED SAVINGS: \$0

ESTIMATED REVENUE GENERATED: \$0

ENDORSED BY: Area 1, Area 3

KEY WORDS: Assisted Outpatient Treatment, Murphy Bill, APA lobbying

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT:

APA POSITION STATEMENT

ISSUE

Ninety percent of the states in the United States and several provinces in Canada have Assisted Outpatient Treatment (AOT) statutes. Of these statutes, the vast majority fail to provide a statutory basis for psychiatrists to use AOT in any meaningful way, and there are states and provinces with no AOT statute at all. AOT, an evidence-based treatment, should be available to psychiatrists as one of many tools in the treatment of individuals who could benefit from this intervention. The APA must take a leadership role in assisting its members to have AOT as an option they can actually employ in their practice.

POSITION

Every state/province in the United States/Canada should have an Assisted Outpatient Treatment (AOT) statute that allows psychiatrists to effectively treat appropriate patients pursuant to that AOT statute.

ACTION PAPER FINAL

TITLE: Dues Abatement for General Psychiatrists/Members in Puerto Rico

WHEREAS:

Whereas, APA members practicing in Puerto Rico do not have access to APA-sponsored malpractice insurance designed specifically for the practice of psychiatry.

Whereas the Commonwealth of Puerto Rico receives no PAC or other legislative support, such as advocacy.

Whereas APA members practicing outside the fifty United States annual dues pay less than APA members practicing within the fifty United States.

BE IT RESOLVED:

That the dues for APA members practicing in Puerto Rico be set at the same amount as APA members not practicing in the fifty United States.

That the APA request the BOT in conjunction with the Finance Committee review the economic impact on the APA's budget of implementing this dues reduction, and request the Council on Advocacy and Government Relations to explore any potential unintended consequences.

Precluding any problems, that the dues reduction be implemented applying only to those general member psychiatrists who are members of the DB of the PR chapter of the APA. At present the annual dues are at \$575. The dues reduction proposed is to lower it using the same annual dues scale as used by Canada, which is scaled up to a maximum of \$350 per general member per year.

That this be referred directly to the Board of Trustees.

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ESTIMATED COST:

Author: \$15,300 in the first year

ESTIMATE OF LOSS: \$575(old fee) - \$350(new fee) = \$225 x 68 full paying members

(general+Fellow+DF) = \$15,300

APA: \$16,850

ESTIMATED SAVINGS: If the loss of 132 general psychiatrists were full paying, this represented a loss of \$75,900 per year. The more we can recruit the more we will be offsetting the loss which can be considered a saving.

ESTIMATED REVENUE GENERATED: None at first but with more joining, there will be more revenue. If we were to get back to 200, which means 132 more general members, in 3 months we would break even and from then on there would be a "profit." More realistically, if only 5 more general members join, break-even on the \$15,300 is in just over 10 years.

ENDORSED BY: Area 5

KEY WORDS: economic burden, membership

APA STRATEGIC GOAL: Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #20 Item 2015A1 12.CC Assembly May 15-17, 2015

ACTION PAPER FINAL

TITLE: Senior Psychiatrists

WHEREAS:

The over 65 population of the United States is expanding.

Life Members/Fellows of the APA constitute a significant portion (about 20%) of APA membership.

Senior psychiatrists face a variety of experiences common to this life/career stage. Retirement, practice closure, ability to continue to practice in the face of age-related impairment, sharing of lifetime experiences and giving back to the profession are among the challenges and opportunities facing this group of members.

The APA has recognized the interests/needs common to certain membership groups by life/career stage including ECPs and RFMs.

BE IT RESOLVED:

The Board of Trustees appoints a work group comprised of members from the Board and Assembly to include senior psychiatrists. The work group will be charged to explore mechanisms to best meet the needs of this group of members and bring its recommendations to the Assembly and to the Board within 1 year for implementation.

AUTHOR:

Jack W. Bonner, III, M.D., Liaison, Senior Psychiatrists jwb2@att.net

ESTIMATED COST: Author: \$1,318.97 APA: \$5,035.90

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Senior, Life Members, Life Fellows

APA STRATEGIC GOAL: Advocating for the Profession, Supporting Education, Training and Career Development, Defining and Supporting Professional Values, Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

Assembly May 15-17, 2015 Toronto, CANADA

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.1	Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness	The Assembly voted to approve the Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.2	Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy)	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.3	Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.4	Proposed Position Statement: Patient Access to Electronic Mental Health Records	The Assembly did not approve the Proposed Position Statement: Patient Access to Electronic Mental Health Records as it was felt the position needed additional review.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.5	Revised Position Statement: Confidentiality of Electronic Health Information	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Confidentiality of Electronic Health Information.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and
2015 A1 4.B.6	Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection.	Archives Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.7	Retire Position Statement: Active Treatment	The Assembly did not approve the retirement of the Position Statement: Active Treatment as it was felt this position statement is still current.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.8	Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability	The Assembly did not approve the Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability and referred it back to the Council on Geriatric Psychiatry as well as the Council on Psychiatry and Law.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.9	Retire Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007)	The Assembly voted, on its Consent Calendar, to retire the Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.10	Retain Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008)	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.11	Retire Position Statement: Employment-Related Psychiatric Examinations	The Assembly voted, on its Consent Calendar, to retire the Position Statement: Employment-Related Psychiatric Examinations.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.12	Revised Position Statement: Publications of Findings from Clinical Trials (2005)	The Assembly voted to approve the Revised Position Statement: Publications of Findings from Clinical Trials (2005).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.13	Retain Position Statement: Use of the Concept of Recovery (2005)	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Use of the Concept of Recovery (2005).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.14	Revised Position Statement: Use of Animals in Research (2009)	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Use of Animals in Research (2009).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.15	Retain Position Statement: Medication Substitutions (2009)	The Assembly voted, on its Consent Calendar to retain the Position Statement: Medication Substitutions (2009).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.16	Retain Position Statement: Electroconvulsive Therapy (ECT).	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Electroconvulsive Therapy (ECT).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.17	Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatric Residency	The Assembly voted to approve the Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatric Residency.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.18	Proposed Position Statement: Neuroscience Training in Psychiatry Residency Training	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: Neuroscience Training in Psychiatry Residency Training.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.19	Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families	The Assembly voted to approve the Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 5.A	Will the Assembly vote to approve the minutes of the November 7-9, 2014 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 7-9, 2014 meeting.	Chief Operating Officer • Association Governance
2015 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2015A1 4.B.4 and 4.B.17 were removed from the Consent Calendar. The Assembly approved the Consent Calendar as amended.	Chief Operating Officer • Association Governance
2015 A1 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 A1 7.A	2015-2016 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2015 to May 2016: Speaker-Elect: Daniel Anzia, M.D., Area 4 Recorder: Theresa Miskimen, M.D., Area 3	Chief Operating Officer • Association Governance
2015 A1 7.B.1	Will the Assembly vote to approve the proposed language in the <i>Procedural Code</i> to reflect the Assembly Reorganization and the new voting strength formula?	The Assembly voted to approve the proposed language in the Procedural Code to reflect the Assembly Reorganization and the new voting strength formula.	Chief Operating Officer
2015 A1 7.B.2	Will the Assembly vote to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant?	The Assembly voted to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant.	Chief Operating Officer
2015 A1 7.B.3	Will the Assembly vote to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)"?	The Assembly voted to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)".	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 7.B.4	Will the Assembly vote to approve the recommended amendments to the Criteria to become an Allied Organization in Article V-Allied Organizations of the Procedural Code to offer inclusiveness to the Assembly Allied Organizations?	The Assembly voted to approve the recommended amendments to the Criteria to become an Allied Organization in Article V- Allied Organizations of the Procedural Code to offer inclusiveness in the Assembly Allied Organizations.	Chief Operating Officer • Association Governance
2015 A1 7.B.5	Will the Assembly vote to approve the language for the <i>Procedural Code</i> under Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs?	The Assembly voted to approve the language for the <i>Procedural Code</i> under <u>Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs.</u>	Chief Operating Officer • Association Governance
2015 A1 7.B.6	Will the Assembly vote to approve the recommended language to the <i>Procedural Code</i> in <u>Article II: Area Councils</u> , 8.d. Appointment of an Area Trustee if an interm vacancy occurs, to reflect the APA Bylaws?	The Assembly voted to approve the recommended language to the <i>Procedural Code</i> in <u>Article II: Area Councils, 8.d. Appointment of an Area Trustee if an interm vacancy occurs,</u> to reflect the APA Bylaws.	Chief Operating Officer • Association Governance
2015 A1 7.B.7	Will the Assembly vote to approve the recommended language to the <i>Procedural Code</i> in <u>Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures, that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis?</u>	The Assembly voted to approve the recommended language to the <i>Procedural Code</i> in <u>Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures,</u> that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis.	Chief Operating Officer • Association Governance
2015 A1 12.A	Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident	The Assembly voted to approve action paper 2015A1 12.A which asks: 1. The American Psychiatric Association supports comprehensive mental health benefits for the survivors and their significant others (i.e. spouses or life partners and children) as well as the significant others (i.e. spouses or life partners and children) of those who were killed in the Fort Hood incident. 2. The American Psychiatric Association will lobby through its Office of Advocacy and Government Relations for legislation to be passed by Congress making such eligibility possible. 3. That the Speaker of the Assembly brings this action paper to the next Board of Trustees as time is of essence if the Assembly is to have a meaningful role in this matter.	Board of Trustees, July 2015
2015 A1 12.B	New Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Disorders and Mental Health Services	The Assembly voted to refer action paper 2015A1 12.B to the Council on Psychiatry and Law. [The JRC oversees APA councils so the item will be sent to the JRC, noting the requested referral to the Council on Psychiatry and Law]	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.C	Developing an Access to Care Toolkit	The Assembly voted to approve action paper 2015A1 12.C which asks: 1. That an Access to Care Tool Kit be developed and maintained by the Council on Healthcare Systems and Financing to include relevant Action Papers, Position Statements, Guidelines, model or sample state legislation, survey instruments and a repository of related legal actions from states. The Tool Kit should include links to the Parity Tool Kit and other related resources and to be easily downloadable to members. 2. The availability of the Tool Kit and its components should be publicized in APA News, and to District Branches and State Organizations through the Federal Legislative Representative Network and the Office of Ethics and District Branch/State Association Relations.	Joint Reference Committee, July 2015
2015 A1 12.D	Compendium of Access to Care Action Papers and Position Statements	The Assembly voted to approve action paper 2015A1 12.D which asks that a compendium of Action Papers and Position Statements relating to access to care be included in an easily downloadable Access to Care Tool Kit to be developed and maintained by the Office of Health Care Systems and Financing.	Joint Reference Committee, July 2015
2015 A1 12.E	Access to Care Survey	The Assembly voted to approve action paper 2015A1 12.E which asks that one or more patient centered Access to Care Surveys, such as the Area 6 Access to Care Survey, be included in an Access to Care Toolkit, to be developed and maintained by the Council on Health Care Systems and Financing.	Joint Reference Committee, July 2015
2015 A1 12.F	Level of Service Intensity Instrument	The Assembly voted to approve action paper 2015A1 12.F which asks: 1. Within six months the APA Administration will research what level of care/intensity of service tools are available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. 2. This data will be presented to the Councils on Quality Care and Healthcare Systems and Financing to determine whether APA should: a. Endorse a specific tool or set of criteria, or; b. Propose development of such a tool by APA 3. That the Councils will report their recommendations to the Joint Reference Committee the following year.	Joint Reference Committee, July 2015
2015 A1 12.G	Timely Reimbursement for Psychiatric Treatment	The Assembly voted to approve action paper 2015A1 12.G which asks that the APA Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance-paneled psychiatrists (and patients of psychiatrists who have opted out of third party payors excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.H	Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault	The Assembly voted to approve action paper 2015A1 12.H which asks: 1. The APA develop a Position Statement and a Resource Document regarding the psychiatric morbidity associated with sexual assault, including the psychological difficulties attendant to sexual assault evidence procurement and the failure of acting upon such evidence;	Joint Reference Committee, June 2015
		2. The relevant component of the APA work with the American Association for Emergency Psychiatry to ascertain that the emergency treatment of sexual assault victims, including that the administration of sexual assault evidence assessment kits, be coupled with provision of information about access to mental health treatment resources;	
		3. The relevant component of the APA liaise with the entities responsible for analyzing sexual assault victim evidence kits and acting upon their results in order to educate those entities to the psychiatric morbidity of their failing to do so, and to be available to assist those entities in their efforts to obtain adequate funding by providing them with information about the psychiatric morbidity associated with sexual assault;	
		4. The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault.	
2015 A1 12.I	Position Statement on Assisted Outpatient Treatment (AOT)	The Assembly voted to approve action paper 2015A1 12.I which asks: 1. That the new Position Statement be passed by the Assembly at this Assembly meeting. 2. That the Speaker of the Assembly brings this Action paper to the Board of Trustees (BOT) for passage by the Board of Trustees at the next Board of Trustees meeting as time is of the essence if the Assembly is to have a meaningful role in this matter.	Board of Trustees, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.J	Fostering the Next Generation of Leaders within the APA	The Assembly voted to approve action paper 2015A1 12.J which asks: That the APA develop a comprehensive and coordinated set of leadership, team building and enrichment activities aimed at fostering leadership and promoting positive relationships between the young leaders* of the APA and established APA leadership. That the APA look to consolidate and coordinate current offerings to prevent duplication of efforts and to ensure the best use of resources That these activities occur at the APA Annual Meeting in May. That these activities be coordinated by the Chief RFM-ECP Officer, the Director of the Division Diversity and Health Equity, and the Director of Education. *Possible groups include: 1. ACORF 2. ECP 3. RFM Trustee and Trustee elect 4. APA representative to the AMA resident & fellow section 5. Chief residents 6. RFM Caucus 7. APA fellowships a. Leadership b. Minority c. Child and adolescent d. Public psychiatry fellowship e. Spurlock fellowship f. Research fellowship	Joint Reference Committee, July 2015
2015 A1 12. K	Parity in Pay, National Guard	The action paper was withdrawn by the author.	N/A
2015 A1 12.L	The Impact of Global Climate Change on Mental Health	The Assembly voted to approve action paper 2015A1 12.L which asks: 1. That the Assembly recommends the American Psychiatric Association adopt a Position Statement addressing the mental health impact of extreme weather events and natural disasters resulting from global climate change. 2. Should the Assembly approve this action paper, it will be referred to the Committee on Psychiatric Dimensions of Disasters to study and produce a position statement.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.M	Promoting Military Cultural Knowledge among Psychiatrists	The Assembly voted to approve action paper 2015A1 12.M which asks: 1. That the APA supports as a core professional practice that psychiatrists consider asking the question: "Have you or someone close to you served in the military?" as part of the clinical evaluation. 2. That the APA supports psychiatrists' attaining a basic level of military cultural knowledge through the completion of Module I of the free, accredited, online DoD/VA course at http://deploymentpsych.org/military-culture 3. Through the APA Department of Education's website and educational activities, the APA promote the availability of resources for attaining military cultural knowledge. 4. That the APA, through its educational liaisons to other medical education organizations, promotes education about military cultural knowledge among clinicians. 5. That the APA consider drafting a position paper on the importance of promoting military cultural knowledge	Joint Reference Committee, July 2015
2015 A1 12.N	Changing ECP Status to 8 Years Following Completion of Training	among psychiatrists. The Assembly voted to approve action paper 2015A1 12.N which asks that the APA adopt a similar position to the AMA in defining the ECP period as eight years following the completion of residency/fellowship training.	Joint Reference Committee, July 2015
2015 A1 12.O	Improving APA Support of the Mental Health of African American Males	The Assembly voted to approve action paper 2015A1 12.O which asks that the Council on Medical Education and Lifelong Learning and the Office of Education investigate, in collaboration with experts, how to provide training opportunities for psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities.	Joint Reference Committee, July 2015
2015 A1 12.P	Removing Unnecessary Arbitrariness from Future DSMs	The Assembly did not approve action paper 2015A1 12.P.	N/A
2015 A1 12.Q	Removing Clinician's Subjective Impression from the Definition of Mental Disorders	The Assembly did not approve action paper 2015A1 12.Q.	N/A
2015 A1 12.R	Replacing "Personality Disorder" with "Syndrome"	The Assembly did not approve action paper 2015A1 12.R.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.S	Emergency Department Boarding of Individuals with Psychiatric Disorders	The Assembly voted to approve action paper 2015A1 12.S which asks: That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding.	Joint Reference Committee, July 2015
2015 A1 12.T	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior	The Assembly voted to approve action paper 2015A1 12.T which asks: That the APA will establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins to advise the Division of Education. That the Assembly of the APA requests that the APA Division of Education develop an educational plan aimed at educating the general membership of the APA on the scientific, clinical and regulatory aspects of the neuro-developmental and behavioral effects of environmental toxins.	Joint Reference Committee, July 2015
2015 A1 12.U	Parity in Payment, Parity in Policy Implementation	The Assembly voted to approve action paper 2015A1 12.U which asks: That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act. That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments, That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services. That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
1tem # 2015 A1 12.V	Location of Civil Commitment Hearings	The Assembly voted, on its Consent Calendar, to approve action paper 2015A1 12.V which asks: 1. The Council on Psychiatry and Law will develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings. 2. In developing the position statement the Council on Psychiatry and Law shall consider the following proposed principles: a. Holding civil commitment hearings at hospitals where psychiatric inpatients are detained should be regarded as a best practice for courts; b. Courts hearing civil commitment cases should exhaust all reasonable alternatives, including working with hospitals to develop appropriate on-site courtroom facilities or telecourt, before transporting detained inpatients to court; c. APA recognizes that exceptional circumstances may sometimes necessitate transporting inpatients to a courthouse for civil commitment hearings; d. Patient preference for a courtroom hearing, when a courtroom hearing is available, constitutes such an exceptional circumstance; e. Convenience of the court and counsel does not constitute an exceptional circumstance; f. When transportation to a courthouse is necessary because of an exceptional circumstance; violence and elopement risks before ordering	Referral/Follow-up Joint Reference Committee, July 2015
		the use of physical restraints.	
2015 A1 12.W	Reconfiguring the Health Care Percentage of the GDP	The Assembly voted to approve action paper 2015A1 12.W which asks that the APA delegation to the AMA House of Delegates present a motion in that body that calls on the AMA to establish a process for providing the public with separate percentages of the GDP corresponding to actual health care provision and to ancillary, administrative-management-type economic activities that have been linked to health care.	Joint Reference Committee, July 2015

Agenda	Action	Comments/Recommendations	Governance
2015 A1	Dues Abatement for	The Assembly voted to approve action paper 2015A1	Referral/Follow-up Board of Trustees, July 2015
12.X	General Psychiatrists/Members in Puerto Rico	12.X which asks: That the dues for APA members practicing in Puerto Rico be set at the same amount as APA members not practicing in the fifty United States. That the APA request the BOT in conjunction with the Finance Committee review the economic impact on the APA's budget of implementing this dues reduction, and request the Council on Advocacy and Government Relations to explore any potential unintended consequences.	Board of Trustees, July 2013
		Precluding any problems, that the dues reduction be implemented applying only to those general member psychiatrists who are members of the DB of the PR chapter of the APA. At present the annual dues are at \$575. The dues reduction proposed is to lower it using the same annual dues scale as used by Canada, which is scaled up to a maximum of \$350 per general member per year. That this be referred directly to the Board of Trustees.	
		That all be referred all early to the Board of Trustees.	
2015 A1 12.Y	Mental Health Leave in Colleges	The Assembly voted to approve action paper 2015A1 12.Y which asks: That the APA help to develop mental health guidelines for colleges so that they feel adequately equipped to deal with the challenges of mental health crisis. That the APA produce a position statement in collaboration with the Caucus on College Mental Health, Council on Minority Mental Health and Health Disparities and the Council on Children, Adolescents and Their Families supporting the idea that student mental health should follow guidance from mental health providers who treat these students and that colleges need to invest in more on-campus mental health services in order to be prepared and equipped to better address such problems in a way that protects the future of their students. This should also include a statement that psychiatric problems which arise while students are enrolled are treated on campus adequately and at parity with any other health problems. That the APA affirms its position by advocating that requiring students with mental health problems to take a year off away from campus can further adversely affect students' mental health and self-esteem, and recommends that students' safety prior to returning to college must be determined in collaboration with by a mental health care provider on a case-by-case basis.	Joint Reference Committee, July 2015
2015 A1 12.Z	Providing APA and APA/SAMHSA Fellowship Awardees the Opportunity to Get Involved with the APA Assembly	The Assembly voted to approve action paper 2015A1 12.Z which asks that the APA establish a formal mentorship program within the Assembly for interested APA/SAMHSA Fellowship Awardees.	Assembly Executive Committee, July 2015
2015 A1 12.AA	Social Media at the APA Assembly	The Assembly voted to approve action paper 2015A1 12.AA which asks that the Office of Communications report and update, as part of the APA communication strategy, the progress of exploration and implementation of live social media of Assembly proceedings at the November 2015 Assembly.	Office of the CEO and Medical Director

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.BB	APA General Elections	The Assembly did not approve action paper 2015A1 12.BB.	N/A
2015 A1 12.CC	Senior Psychiatrists	The Assembly voted to approve action paper 2015A1 12.CC which asks that the Board of Trustees appoints a work group comprised of members from the Board and Assembly to include senior psychiatrists. The Task Force will be charged to explore mechanisms to best meet the needs of this group of members and bring its recommendations to the Assembly and to the Board within 1 year for implementation.	Board of Trustees, July 2015
2015 A1 12.DD	Elimination of Votes by Strength	The action paper was withdrawn by the author.	N/A



REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION

SUBMITTED BY Paul T. Burke, Executive Director

A. AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION (APAF) DEVELOPMENT UPDATE Jane Chittick, CFRE, Director of Development

The APAF development team remains concentrated on increasing contributions to the Annual Fund. In January 2015, we created a 12-month Annual Fund Plan. Since our March 2015 report, we have sent solicitations focused on APAF efforts to support early career psychiatrists and a solicitation focused on the APAF efforts to support minority mental health. Between these solicitations and those we reported on in March, we have gained, or recaptured, more than 100 donors, which represents an increase of nearly \$20,000 compared to the January 1-May 31 time period from the prior year.

Our May 18, 2015, benefit at the CN Tower in Toronto was extremely successful with 450 attendees. In 2014, we hosted 134 people on the Intrepid aircraft carrier in New York City.

In terms of non-Pharma Foundations, we have contacted the Brandon Marshall Foundation and the Hope and Grace Foundation. We have learned that the Kresge Foundation has delayed its review of our grant application until fall 2015. We have identified 11 other foundations that we will be making initial contacts with over the next six to nine months.

Finally, APAF worked for over five-months to have funding in the amount of \$280,000 from the Robert E. Jones Fund and the Alliance (also known as the Auxiliary) transferred to APAF.

Corporate Advisory Council (CAC) Memberships and Meetings

The Foundation, as the APA industry liaison, negotiates sponsorships throughout the year with large companies, both pharmaceutical and non-pharmaceutical. Each year at the Annual Meeting, APAF meets with members of each company to discuss our flagship programs, their concerns and desire to meet with APA leadership, and how we can further develop our working relationship. In Toronto, we met with 11 companies. We have an upcoming CAC meeting on July 16th, for which 25 company representatives have already accepted. Membership renewals for 2015 include 14 pharmaceutical companies to date. Our fundraising staff is revamping the sponsorship packages to be discussed briefly at the summer CAC meeting. In our efforts to expand the CAC to non-pharma corporations, we secured a \$15,000 Genomind sponsorship and also made personal contacts with Pathway Genomics and Assurex Health. Two other companies also are on the horizon.

APAF secured funding for each of its educational programs. Typical or Troubled?® has received cumulatively \$200,000 from Janssen Pharmaceuticals and Shire for the 2015-2016 school year. The

Judicial Leadership Initiative/Psychiatric Leadership group has received \$225,000 for main program support and annual trainings. Janssen is the sole funder to date for the program. For the National Summit also known as the 'Stepping Up Initiative' we've received \$1,006,900 to date. This amount includes pharmaceutical funding from Janssen Pharmaceuticals (\$500,000), Alkermes, Otsuka, and the South Florida Behavioral Health Network. Also, a large contribution of \$235,000 was given by the Elizabeth K. Dollard Charitable Trust to support the work leading up to and at this conference. Additional funding will be sought in fall of 2015 for this 2016 conference.

For the Partnership for Workplace Mental Health, pharmaceutical funding has been secured in the amount of \$165,000 cumulatively from AstraZeneca, Janssen, Otsuka, Forest, Merck, and the Takeda-Lundbeck Alliance These funds are used to support ongoing projects and activities of the program, such as Mental Health Works, e-updates, ICU, conferences, and the Advisory Council. In addition, the Takeda-Lundbeck Alliance has supported Right Direction, the worksite depression awareness initiative with a grant for Right Direction in the amount of \$91,960.

B. APAF PUBLIC EDUCATION PROGRAMS

Typical or Troubled?® School Mental Health Education Program Lindsey Fox, Director of Corporate and Community Relations

This year, the Foundation will fund approximately 26 school systems with grants, materials, and technical assistance training, reaching 102 individual schools. This represents training for over 17,500 teachers and other school staff. Recently, we hosted a Train-the-Trainer session in Orange County, CA, which involved 60 school counselors and mental health professionals. These trainers will be training all Orange County Public School teachers on an In-Service Day in August. The Foundation is also exploring a potential opportunity with American Psychiatric Association Publishing to develop digital toolkits of the program on APA's new Learning Management System. Two schools from Albuquerque, New Mexico have reached out with interest in purchasing the program.

Judicial Leadership Initiative

Lindsey Fox, Director of Corporate and Community Relations

The standard JLI/PLG trainings continue with the most recent training being held in San Destin, FL, on June 12th hosted by Louisiana Judicial College. The JLI/PLG National Summit, also known as the 'Stepping Up Initiative' continues to develop. As stated above, to date this conference has received \$1,006,900 in funding. APAF, in concert with CSG (Council of State Governments) and NACo (National Association of Counties), will be hosting 70 county teams in Washington to participate in a county-level mental health training program in April of 2016. Four 'Call to Action' events took place in early May (DC, Miami-Dade, FL, Johnson County, KS, and Sacramento, CA) igniting the events leading up to this Summit. APA/APAF representatives included Dr. Renee Binder in Sacramento, who at the time was APA's President-Elect, and Judge Steven Leifman in Miami-Dade, FL (APAF Board Member). Grants will be submitted late-summer/early fall for additional Summit and post-Summit activity funding. Webinars are ongoing with participating county leaders through October 2015. Each NACo hosted webinar is led by a member of the PLG and/or nominated representatives by NACo and/or CSG

and is a training session for county leaders on mental health and how to recognize the signs and symptoms of SMIs in their judicial system. The first webinar, held on May 14th, had 400 leaders in attendance. This was one of the largest webinars ever held by NACo. To date we have over 50 counties that have passed a resolution to adopt the 'Stepping Up Initiative'. This is predates our large marketing push planned for the fall.

Mental Health and Faith Community Partnership

Amy Porfiri, MBA, and Ranna Parekh, MD, MPH

The Mental Health and Faith Community Partnership completed an update to the 1999 APA Guide for Faith Leaders. The two-part guide consists of *Mental Health: A Guide for Faith Leaders* and a companion *Quick Reference on Mental Health for Faith Leaders*. Both guides can be downloaded at www.psychiatry.org/faith.

Seven sessions relating to mental health and faith took place at the 2015 APA Annual Meeting in Toronto. All sessions were well-attended, ranging from 30 to 150 participants. Members of the Mental Health and Faith Community Partnership Steering Committee will be submitting sessions for the 2016 APA Annual Meeting.

Partnership for Workplace Mental Health

Clare Miller, Director, Partnership for Workplace Mental Health

The second <u>quarter issue</u> of *Mental Health Works* was published. The issue features how Sprint incorporates mental and behavioral health into its health and wellness initiatives through their total wellbeing approach. The leadership of Collier Case, Sprint's director of health and productivity (and longtime member of the Partnership for Workplace Mental Health's Advisory Council) is highlighted in the article. The open rate for this issue was 19% - well above the education industry average of 8%. The Partnership for Workplace Mental Health's Advisory Council offered a workshop at the APA Annual Meeting titled, "Evaluating Disability in Your Patient: The Long Winding Road Involving Therapeutic Process, Employers, and Employees." The workshop was developed at the request of psychiatrists who expressed concern about the lack of training they receive on how to assess functional limitations that affect job performance and how to navigate the disability management process. <u>APA TV News highlighted this session</u>. The workshop was extremely well-received; approximately 140 attendees participated. Presenters included Paul Pendler, PsyD, ABPP, Vice President for Employee Assistance & WorkLife Program at JPMorgan Chase, and Scott Benson, MD, APA Board of Trustees. Drs. Pendler and Benson are both active members of the Partnership Advisory Council.

Since the last board meeting, Partnership programs and initiatives were presented at several employer conferences and webinars, including the Mid-America Coalition on Health Care, South Carolina Business Group on Health, Northeast Business Group on Health, Midwest Business Group on Health, and Healthcare 21 Business Coalition.

The employer guide to the Mental Health Parity and Addiction Equity Act continues to be warmly received by employers. Sam Muszynski and Clare Miller presented a webinar hosted by the Midwest Business Group on Health on the topic. The webinar was attended by large employers, including Ace Hardware Corporation, Federal Reserve Bank of Chicago, McCain Foods, Wolters Kluwer US, and S & C Electric Company. The guide updates a previous version to reflect the law's final regulations and was covered in several leading employer benefits trade media outlets, including Employee Benefit News and BenefitsLink Health & Welfare Plans.

Staff continues to work with the Northeast Business Group on Health (NEGBH), the New York City Metro chapter of the National Alliance on Mental Illness (NAMI-NYC), and the Kennedy Forum on a CEO initiative to take place October 29, 2015, at the New York Stock Exchange. A framework is being developed by a small group of employers and other workplace mental health leaders over a series of meetings and conference calls. We have developed a pledge that CEOs would sign and a toolkit to implement strategies to improve mental health. Staff also continues to focus on the issue of network adequacy with NEBGH and has a meeting with employers scheduled for June 29, 2015, to develop a strategy for engaging the plans in making changes.

The Partnership actively continues its Right Direction worksite depression awareness program. An advertisement for the initiative ran in a <u>special insert on mental health</u> in the weekend edition of *USA Today*. The three-day print edition ran May 29-31, 2015, in the Los Angeles, Chicago, and New York City markets (circulation 250,000; readership of 750,000). A <u>new case study featuring how OCLC</u> implemented the initiative was published. OCLC is a nonprofit, membership, computer library service and research organization employing approximately 950 employees in the U.S. and 1,300 globally.

New collateral materials have been positively received by employers (three new posters, a business card handout, refreshed web content, a new implementation guide, and planning and evaluation tools for the program). A survey was deployed to employers who have interacted with the program to garner feedback on the program and assist companies needing additional support to implement it. Results indicate that employers find the initiative of great value; the primary barrier to implementation is difficulty getting leadership and management to buy in to the topic. Four business coalitions from around the country received implementation grants to bring Right Direction to their employer communities: the Mid-America Coalition on Health Care, NEBGH, the St. Louis Area Business Health Coalition, and the South Carolina Business Coalition on Health. Staff meets monthly with these coalitions to support roll out efforts to their employer communities.

Active promotion continues on the newly released <u>ICU program</u>. ICU ("I See You") is an awareness campaign designed to decrease the stigma associated with mental health and foster a workplace culture that supports emotional health by teaching people how to recognize and respond to signs of distress among colleagues.

Physical Health	"I See You"	ICU Steps to Improve Emotional Health
Intensive	I	Identify the signs
Care	C	Connect with the person
Unit	U	Understand the way forward together

The award-winning ICU program was originally developed by DuPont and delivered to its 70,000 employees worldwide. It was given to the Partnership to make available to other employers at no cost. Two large employers with more than 30,000 employees are early adopters of the program and are in the process of rolling it out to their respective organizations. The program centers on a 5-minute video on emotional health and how employees can appropriately connect with distressed peers who may need support. In addition to the video, ICU program components include an implementation guide, a leadership presentation, and templates for a flyer and email message. The implementation guide includes information on how employers can measure the program's impact on their company.

C. APAF RESEARCH

Kristin Kroeger, Acting Director

National Study of Psychiatric Practice under HealthCare Reform

The complexities and scale of health care reform underway in the U.S. may have unintended consequences for psychiatrists and their patients. This study will provide the APA with important information on the status and readiness of psychiatrists in adapting to new models of care and on treatment gaps and access issues facing psychiatrists and their patients. Preliminary findings have been presented to the APA CEO and Medical Director and to the APA Board of Trustees Workgroup on Healthcare Reform, and a paper on psychiatrists' reports of treatment access problems for mental health and substance use disorders will be presented at the annual research meeting of "Academy Health". Papers are being drafted for submission to peer-reviewed journals.

Medicaid Psychiatric Treatment Access Study

The Affordable Care Act reflects a major milestone in expanding health and mental health benefits and improving treatment access, but there may be gaps in the ability of the available treatment infrastructure to meet current or increased demand for services. This study gathered detailed data from a large sample of psychiatrists treating Medicaid patients to document patient access to evidence-based psychosocial and pharmacologic treatments. It will provide APA with an important baseline of empirical data to support advocacy efforts for access to clinically indicated medications and psychosocial treatment for Medicaid psychiatric patients. Data analyses are underway.

E-mail and Web-Based Physician Education Program on the Dissemination of Off-Label Use of Atypical Antipsychotics

In collaboration with the APA Division of Education and Office of Quality Improvement and Psychiatric Services, APAF research staff is assessing a novel application of interactive learning modules to help educate physicians on the risks, benefits, and costs of off-label use of atypical antipsychotics. The study is supported by the US DHHS, Agency for Healthcare Research and Quality (AHRQ) through a demonstration research grant, which APAF research staff helped develop. Research staff is leading the evaluation of the program. A self-assessment exercise was released in April 2014, followed by the staged release of 9 clinical vignettes and self-assessments through May 2015. The final vignettes will be released in the summer of 2015. A FOCUS Live session on Off-Label Use and Evidence for Antipsychotics, based on the CME program, was presented at the APA Annual Meeting in May. All components of the course offer *AMA PRA Category 1 Credits* ™ and are available free of charge.

Using Medical Informatics Principles to Enhance Development and Dissemination of Clinical Practice Guidelines on Major Depressive Disorder

Under continued funding by a grant from the National Library of Medicine, APAF and APA researched the application of medical informatics principles to practice guideline development. A global literature search strategy was devised, and draft inclusion criteria were defined for screening abstracts for general relevance to APA guidelines. The draft criteria are currently being tested in a screening of more than 20,000 abstracts. Data preparation and analyses from the survey of psychiatrists' information needs is completed, and a manuscript will be submitted for publication in a peer-reviewed journal. The work on the grant will be completed by July 2015.

Psychiatry Undertaking Freedom from Smoking (PUFFS)

APAF research staff helped Division of Education staff and the APA Workgroup on Tobacco Use Disorder (TUD) write a successful contract proposal to the Smoking Cessation Leadership Center (SCLC) to develop a strategic plan to improve psychiatrists' knowledge and practice of evidence-based approaches for the assessment and treatment of tobacco use disorder. The strategic plan and position statement on TUD have been developed, and a pilot survey instrument was pre-tested at the APA Annual Meeting. The pilot survey to gather information on psychiatrists' treatment approaches to tobacco cessation will be fielded in June-July.

2015 APA Research Colloquium for Junior Investigators

This annual mentoring opportunity was held May 17, 2015, in conjunction with the APA Annual Meeting in Toronto. Twenty-nine successful applicants to the Research Colloquium received a \$1,000 travel stipend and presented their research in a one-day meeting with distinguished senior leaders in psychiatric research. Junior investigators received guidance, mentorship, and information on career development and grantsmanship in small- and large-group sessions. A grant application to support the 2016 Research Colloquium was submitted to the National Institute on Minority Health and Health Disparities in April and is currently under review.

D. OFFICE OF HIV PSYCHIATRY

Ian Hedges, Associate Director

In second quarter 2015, the Office of HIV Psychiatry has continued to develop virtual training tools that will be beneficial to physicians treating HIV-positive patients with mental illness. With the Office's contractual partner, EDC, the Office of HIV Psychiatry is starting a medical update series on HIV and Tobacco Cessation, which includes a video on patient experience and physician consultation, an info graphic, and a written guide for options on how to engage HIV-positive patients in tobacco cessation. Furthermore, the Office of HIV Psychiatry is assisting in the production of a video on HIV-associated neurocognitive disorder. These educational materials will be available to the public through a SAMHSA-sponsored website by the end of third quarter 2015.

The Office of HIV Psychiatry also is preparing for its annual medical student elective. The Office received a record 32 applicants, for which 7 were chosen to participate in an intensive didactic training in Washington, D.C., and receive support for a clinical rotation at 6 different sites around the country. The Office also is piloting many virtual training tools to enhance the students' experiences while they are placed at their rotation sites.

In addition to the Office's educational activities, the Office of HIV Psychiatry has been actively engaged with stakeholders on upcoming revisions to the *National HIV/AIDS Strategy*. The Office of HIV Psychiatry assisted the Steering Committee on HIV and the APA's Council on Psychosomatic Medicine in providing comments to the White House Office of National AIDS Policy about further programmatic inclusions and funding of mental health and substance use treatment with HIV care in the *National HIV/AIDS Strategy*.

E. DIVISION OF DIVERSITY AND HEALTH EQUITY

Ranna Parekh, M.D., M.P.H., Director

Minority Fellowship Program

A new cohort of Minority Fellows will begin in July: 24 SAMHSA Fellows (including 2 Addiction Fellows) and 10 Diversity Leadership Fellows. These fellows will participate, along with their second-year counterparts, in the APA September Components Meeting where they will attend meetings of their assigned councils. Both cohorts also will take part in a day-long, comprehensive orientation session for residents. The orientation is designed to provide fellows with training and professional development advice by leading psychiatrists, including APA leadership, on a myriad of topics useful for career growth.

Eight medical students will participate in the Summer Mentoring Program, and 5 medical students were selected for the Summer Externship in Addictions. For 1 month, these students will shadow a mentor of their choice anywhere in the U.S. Stipend support for living expenses is provided.

This concludes the APAF Report to the APA Board of Trustees.

Report of the DSM Steering Committee

Paul S. Appelbaum, MD, Chair July 12, 2015

This is the first report of the DSM Steering Committee to the APA Board of Trustees. It provides background regarding the establishment of the Steering Committee (SC), outlines its work to date and future foci, and presents three Action Items for the Board's consideration.

Background – Anticipating the need for updating the DSM-5, the Board of Trustees established a Work Group on the Future of the DSM in Spring 2013. The Work Group produced a report, which was presented to and approved by the Board at its March 2014 meeting, and was then sunset. The report presented a model for iterative updating of individual diagnostic categories, as new data become available to support such changes. It offered recommendations for governance of the process, identification of targets for revisions (including changes to existing categories, additions of new categories, and deletions of existing categories), drafting of proposed revisions, and review and approval of proposed revisions.

Based on the recommendations in the Work Group's report, the DSM Steering Committee was appointed in Spring 2014. Members of the SC are: Paul Appelbaum, MD, (Chair); Kenneth Kendler, MD (Vice-chair); Ellen Leibenluft, MD (Vice-chair); Renato Alarcon, MD; Deanna Barch, PhD; Pamela Collins, MD, PhD; Michelle Craske, PhD; Michael First, MD; Steven Hyman, MD; Dilip Jeste, MD; Glenn Martin, MD; Susan Schultz, MD; and Kimberly A. Yonkers, MD. External liaisons are: Wilson Compton, MD (NIDA); Bruce Cuthbert, PhD (NIMH); George Koob, PhD (NIAAA); and Geoffrey Reed, PhD (WHO/ICD). Staff support for the SC comes from Jennifer Shupinka.

Progress Report – The Steering Committee held a face-to-face organizational meeting at APA Headquarters on November 24, 2014, and has had monthly conference calls since. It also met face-to-face on Sunday evening, May 17, 2015 at the APA Annual Meeting in Toronto. Conference calls have been well attended, and usually joined by APA and APP leadership, including Dr. Levin and Ms. Rinehart. SC efforts have been focused on three major areas:

Establishing Criteria and Format for Submission of Proposals – Spearheaded by a subgroup headed by Dr. Kendler, the SC developed a document outlining the information required for proposals for changes to the DSM (i.e., changes to existing criteria sets; addition of new diagnostic categories; deletion of existing categories). The document is titled "Format for Submissions of Proposed Changes to the DSM." (see Attachment 1). The approach outlined in the document, drawn substantially from the Work Group report that was approved by the Board, is based on the principle that future changes to the DSM should be motivated by the availability of data demonstrating the value of the proposed change. Specifically, proposals must demonstrate that the changes improve validity, reliability or clinical utility of the criteria; that proposed new categories are valid, can be assessed reliably, and have clinical utility; or that categories proposed for deletion lack validity or have minimal utility.

Item #: 11A Board of Trustees July 11-12, 2015

The SC intends to turn this document into a web-based format for submissions. The format has not been finalized, pending Board approval of these recommendations, but a draft suggesting how this might be done is in Attachment 2.

Action Item 1 – Will the Board of Trustees vote to approve the "Format for Submissions of Proposed Changes to the DSM." outlining the information required for proposals for making changes to DSM-5 (Attachment 1)?

Developing the Process for Review of Proposed Changes – The Work Group report outlined in general terms a process for review of proposed changes, once they have been screened and found to comply with the submission criteria. Proposals will be reviewed by the SC to determine whether there is sufficient evidence to believe that the proposed revision is likely to meet the criteria for change described above. (The SC will be working during upcoming conference calls to operationalize that standard.) When the SC makes that determination, proposals will be referred to a Review Committee (RC). The RC will examine the submission in detail; if necessary obtain additional information and consult with experts in the area; and if the RC concludes that the proposal is meritorious, draft criteria and text for consideration by the SC.

The Work Group recommended, and the SC agrees, that a small number of standing RCs should be established to address proposals. In contrast to the approach used for previous editions of the DSM, which established work groups for each major area of psychiatric diagnosis, the SC recommends that a smaller number of groups with responsibility for broader areas be created. Virtues of this approach include greater consistency across areas of psychiatry and a reduction in the proliferation of ever-narrower diagnostic categories driven, in part, by the interests of researchers and clinicians who have worked extensively in these areas. Of necessity, given the smaller number of RCs, members will need to take a broader perspective and engage with areas of research and practice with which they have not been directly involved.

The SC recommends the creation of six Review Committees, with responsibility for oversight of proposals in the following areas:

- 1. Intellectual Disability, Learning, Communication, Autism Spectrum, and Motor Disorders
- 2. Schizophrenic Spectrum, Psychotic and Bipolar Disorders
- 3. Depressive, Anxiety, Trauma, Obsessive-Compulsive, Dissociative, and Somatic Symptom Disorders
- 4. Personality, Disruptive, Impulse Control, Substance Use, and Paraphilic Disorders
- 5. Feeding and Eating, Elimination, Sleep-Wake, Sexual Dysfunction, and Gender Dysphoria Disorders
- 6. Neurocognitive Disorders

Note that the SC recognizes that any division of psychiatric diagnosis into 6 categories is necessarily arbitrary; we acknowledge that this is only one possible approach, albeit one that the members of the SC have endorsed. The SC will monitor the RCs to determine whether there is a

serious imbalance in work load or whether an adjustment in the division of responsibilities among the RCs is indicated for other reasons. We envision that each RC will have 6 members, with staggered terms, including a chair appointed for that person's broad perspective of psychiatry. Although RCs might want to meet face-to-face at the Annual Meeting, the majority of their work will be done by conference call and electronically. RC chairs will be invited to join the SC meetings, so that they are aware of broader issues being dealt with and of proposals for changes the DSM in areas outside the scope of their committees. We are aware that concerns have been expressed regarding the cost of establishing and staffing the RCs, but we believe strongly that having them in place will avoid substantial delay in addressing proposals as they begin to arrive. Until the RCs are actually dealing with proposals, there will be minimal burden on staff; only once proposals begin to arrive will both members and support staff begin spending substantial time dealing with them. At that point, overall staffing of the DSM effort may need to be reconsidered.

Action Item 2 – Will the Board of Trustees vote to approve the creation of 6 DSM Review Committees, as described in the report of the DSM Steering Committee?

Correcting Errors in the DSM-5 – A subgroup led by Dr. First has been examining errors in the DSM-5 that have been reported to APA or that have otherwise come to their attention. Many of these errors, whether in text or in criteria, represent failures to catch inconsistencies across diagnostic categories or between criteria and text. Given that the line between an error and a statement that could be more artfully phrased is not always clear, the SC has attempted to limit its recommendations to items that appear to represent clear-cut mistakes or contradictions. Ms. Rinehart has been involved in these discussions on behalf of APP, and the SC has transmitted to her a list of corrections to the text that will be posted on an errata page of the DSM-5 website, and corrected in print editions when feasible. For the information of the Board, those corrections are shown in the first section of Attachment 3. However, for the four corrections to diagnostic criteria shown in the second section of Attachment 3, since the original criteria were approved by the Board, the SC believes that Board review and approval is necessary for these changes to be made. Note that, as indicated in the table, all changes have been discussed with the appropriate DSM-5 Work Group chairs (and in some cases also with other Work Group members who were specifically involved in revising the criteria in question), who have confirmed that they reflect errors in the process.

Action Item 3 – Will the Board of Trustees vote to approve the changes to DSM criteria listed in Attachment 4, with the understanding that such changes will be reflected in an errata section of the DSM website and incorporated into print versions of the DSM-5 when feasible?

Future Work – The next tasks for the SC are to consider the relevant aspects of the process of reviewing proposals for changes, including the standards to be applied for SC review; the procedures for obtaining input from the field and other interested parties; and how to handle non-empirically based requests for changes. In addition, as the process of appointing RCs is completed and the web-based submission format is finalized, the SC will consider how best to roll-out the availability of the process to the field. The SC looks forward to keeping the Board apprised of our work and welcomes input at all points in the process.

Format for Submissions of Proposed Changes to the DSM DSM Steering Committee July 12, 2015

Background

To facilitate the work of the DSM Steering Committee (SC), we require that all proposals for change to DSM-5 be submitted in a standard format (called a "Proposal in Support of Change" or PSC). "Change" is defined as the addition, deletion, or modification of diagnostic categories or criteria.

Three types of proposed changes are anticipated:

Type 1: Changes to an existing diagnostic criteria set.

For Type 1 changes, the PSC would need to provide substantial evidence that the proposed changes would markedly improve at least one of the following:

Type 1a. Validity of an existing diagnostic criteria set.

Type 1b. Reliability of a diagnostic criteria set, without an undue reduction in validity;

Type 1c. Clinical utility of a diagnostic criteria set, without a reduction in validity or reliability

or would substantially reduce:

Type 1d. Deleterious consequences associated with a diagnostic criteria set, without a reduction in validity

Type 2: Addition of a new diagnostic category or specifier

For Type 2 changes involving a new category, the PSC must provide substantial evidence that the proposed category would accomplish <u>all</u> of the following:

- Meet criteria for a mental disorder (see DSM-5, p. 20);
- Have strong evidence of validity (see Part III, below);
- Be capable of being applied reliably (i.e., at least moderate reliability has been demonstrated [see Part IV, below]);
- Manifest substantial clinical value (e.g., identify a group of patients now not receiving appropriate clinical attention; facilitate the appropriate use of available treatment[s]);
- Avoid substantial overlap with existing diagnoses, and not be better conceptualized as a subtype of an existing diagnosis; and
- Have a positive benefit/harm ratio (e.g., acceptable false positive rate; low risk of harm due to social or forensic considerations).

For type 2 changes involving the addition of a new specifier or subtype, the PSC should provide substantial evidence that the new specifier/subtype:

- Has strong evidence of validity (e.g., identifies a subgroup of patients with a common biological marker) or clinical utility (e.g., identifies a subgroup of patients that responds to the same treatment),
- Can be applied reliably and
- Avoids substantial overlap with existing specifiers or subtypes

Type 3: Deletion of an existing diagnostic category or specifier/subtype

For Type 3 changes involving the deletion of an existing category, the PSC must provide substantial evidence that the existing category:

- o Has weak evidence of validity; and
- o Has minimal utility (e.g., is rarely used in clinical practice or research); or
- o Does not meet criteria for a mental disorder or is better conceptualized as a subtype of an existing diagnosis.

For Type 3 changes involving the deletion of an existing specifier or subtype, the PSC should provide substantial evidence that the existing specifier/subtype:

- o Has weak evidence of validity, or
- o Has minimal utility (e.g., is rarely used in clinical practice or research)

A subcommittee of the SC will screen all submitted PSCs. Substantive proposals will be referred to the full SC for further consideration. Proposals that are editorial in nature (e.g., identifying errors in the criteria or text, or proposing reconciliation of inconsistencies in the text) will be forwarded to the standing DSM Editorial Subcommittee.

We first describe the components that should be included in every PSC and then provide specific instructions for proposals according to the type of change proposed (i.e., Types 1 through 3 above).

Part I – Reasons for Change

The PSC should state clearly the proposed change, outlining the justification for the change, and stating which one of the types listed above is its main focus. The introduction should also put the proposal into its historical context.

The PSC should include a discussion of possible negative consequences of the proposed change and a consideration of arguments against the change. Given that it is

desirable that proposed changes to DSM-5 reflect a broad consensus of expert opinion, the proposal should include a brief section outlining any significant controversies or disagreements among researchers and clinicians in the field concerning the proposed change.

Part II - Magnitude of the Change

The proposer should specify the magnitude of the proposed change, i.e., whether it is best considered to be a clarification, a modest change, or a substantial change, using the following guidelines. One important determinant of the magnitude of change is whether it is likely to lead to a change in caseness.

Clarification of criterion/criteria or specifier definition includes: changes aimed at improving the understanding and application of an ambiguous DSM-5 diagnostic criterion or specifier definition. For example, the "With Panic Attacks" specifier in DSM-5 indicates neither the number of panic attacks nor the time frame. A proposal to specify a minimum number of attacks over a specific time (e.g., at least one panic attack in the past month) would fall into this category.

Modest change includes:

- a) Substantial changes to a definition of an existing specifier or subtype that go beyond clarification of an ambiguity of the definition. An example would be changing the number of binges per week that define mild, moderate, severe and extreme binge eating disorder based on new empirical evidence.
- b) Additions to the "examples of presentations" that can be specified using the "other specified" designation.
- c) Changes to diagnostic criteria that are not likely to result in a change in caseness.

Substantial change includes:

- a) Addition of a new diagnosis or specifier or subtype or the deletion of a diagnosis or specifier or subtype
- b) Changes to the DSM-5 criteria that have the potential to result in shifts in caseness from one diagnostic category to another (e.g., a change in the duration of mood symptoms required in the diagnosis of schizoaffective disorder, shifting individuals from Schizoaffective to Schizophrenia)
- c) Addition of a new specifier or subtype to a diagnosis
- d) Changes to the DSM-5 criteria of a well-studied/well-validated diagnosis that could create significant discontinuities in research or clinical care (e.g., elimination of somatic symptoms from criteria for a Major depressive

episode), regardless of the potential for causing shifts in caseness or treatment.

The SC will make an independent determination of the magnitude of the change based on the proposer's presentation in light of the above parameters.

To determine which of the following sections are relevant to a specific PSC, see "Specific Guidance for Each Type of Proposal" below.

Part III – <u>Validators for the Change</u>

This section should contain a thorough review of the relevant literature and results from any secondary data analyses conducted by the proposers. Proposals for change should, in so far as possible, focus on a single question that evaluates two alternative hypotheses. For Type 1a (criteria set changes to improve validity), the question will typically be: is the validity of the proposed set of criteria for disorder X superior to the DSM-5 criteria for disorder X? However, for proposals for new criteria sets (Type 2), two questions will typically need to be addressed: i) does the new disorder have sufficient validity to be included as an official DSM category and ii) is the new disorder sufficiently distinct, in its performance on validators, from other disorders already in the manual to constitute an independent disorder?

For criteria set changes that aim to improve reliability (Type 1b), utility (Type 1c), or reduce deleterious consequences (Type 1d), the question will typically be: *is the validity of the proposed set of criteria for disorder X at least equal to that of the current DSM-5 criteria for disorder X* (which may simply involve a lack of change in caseness between the DSM-5 criteria and the proposed criteria)?

This section should be organized around the following ten classes of validating criteria. Proposers should note that the SC would prefer to see evidence for validity from a diversity of populations, especially for substantial changes. In addition, the SC recognizes that for many PSCs, data may not be available for many of these categories.

I. Antecedent Validators

- A. *Familial aggregation and/or co-aggregation (i.e., family, twin or adoption studies)
- B. Socio-Demographic and Cultural Factors
- C. Environmental Risk Factors
- D. Prior Psychiatric History

II. Concurrent Validators

- A. Cognitive, emotional, temperament, and personality correlates (unrelated to the diagnostic criteria).
- B. *Biological Markers, e.g., molecular genetics, neural substrates
- C. Patterns of Comorbidity
- D. *Degree or nature of functional impairment

III. Predictive Validators

- A. *Diagnostic Stability
- B. *Course of Illness
- C. *Response to Treatment

Asterisks denote high priority validators that will generally be seen as providing stronger evidence than the other validators listed above. The PSC should contain a summary table for each relevant validator class (i.e., each validator for which data exist). In this table, each study would be represented by a row, with columns reflecting the lead author, year of publication, sample size, methods, and a brief summary of the relevant results. Proposers are encouraged to include a qualitative judgment of the overall methodological strength of each study (e.g., on a 1-5 scale) as indicated by, e.g., quality of diagnostic assessments and validating measures, size and representativeness of the sample, and rigor of the statistical analyses.

It is desirable to have a final summary table in which rows represent the relevant validators. The table should summarize the degree to which data from each validator class support the proposed change (again on a 1-5 scale).

Because of the inclusion of these tables, the text can be brief, focusing first on summarizing the overall nature and strength of the data and commenting on controversial issues, contradictory data, and/or the importance of particular studies or methods.

Part IV – Reliability

Information should be summarized in tabular form about the comparative reliability of the proposed criteria and, if relevant, the reliability of the DSM-5 criteria that they seek to replace. We recommend a table with a line for each study that lists the sample size, the reliability (hopefully calculated by the kappa coefficient or one of several related chance-corrected statistics), the type of reliability assessed (e.g., interrater, inter-interviewer, test-retest), the nature of the sample (e.g., clinical versus epidemiological) and prior training of the interviewers. If possible, improved reliability should be shown across different populations. The proposers should present data showing that the proposed criteria improve reliability while identifying largely the same cases as the original DSM-5 criteria, unless an improvement in validity is also being claimed.

Part V – Clinical Utility

Proposers should summarize available information about the clinical utility of their proposed criteria compared to the current DSM-5 criteria. For example, ff the proposal shortens the criteria set, information should be provided here about the degree to which caseness would not be altered by the new, briefer criteria. That is, the argument that shortening a criteria set does not lead to a loss of validity could be

accomplished by showing a very high rate of agreement between case definition by the newer, shorter and the older, longer DSM-5 criteria. Note, to be convincing, this should be shown in several different populations differing by gender, age, ethnicity, etc.

Although the types of empirical studies that would be helpful to establish an improvement in clinical utility are less well established than for validity and reliability, a 2004 paper by First and colleagues (Am J Psychiatry 2004; 161:946–954), developed by an ad hoc subcommittee of the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment, provides some guidance. Parameters of clinical utility that could be measured include whether proposed changes improve user acceptability, clinicians' ability to apply the diagnostic criteria accurately, clinicians' adherence to practice guidelines, and ultimately clinical outcomes.

Proposals that would improve the clinician's ability to select the best treatment or determine prognosis, while certainly improving the clinical utility of the DSM-5, are best considered to be proposals to improve validity and are better included under part III above.

Part VI - Deleterious Consequences

Proposers should summarize available information about the potential deleterious consequences of the current DSM-5 criteria and, if they exist, how the proposed criteria change will reduce or eliminate them. For example, if over-diagnosis is being claimed, empirical evidence will need to be presented demonstrating false positive diagnoses utilizing DSM-5 criteria. The proposers should also present data showing the degree to which their proposed criteria reduce the deleterious consequences of the criteria. Proposals for new diagnostic categories should comment on potential deleterious consequences of their adoption.

Specific Guidance for Each Type of Proposal

Specific types of proposals to change criteria sets are based on the primary area that is expected to be improved by the proposed changes. We recognize that many proposals will be "hybrids," i.e., the proposers will claim positive effects consistent with more than one type of proposal.

<u>Type 1a Proposals (changes to improve validity).</u> Part III will be the major focus of such proposals but parts I and II should be completed carefully. Although such proposals may have limited information on changes in reliability or utility, some comments should be made for parts IV and V. A brief comment should also be made with respect to part VI, i.e., if there are any deleterious consequences of the DSM-5 criteria, whether these would be changed by the revised criteria, and whether the revision raises the possibility of new deleterious consequences.

Since these are likely to be the most common types of proposals, we provide some additional comments here.

- 1. Even requests for modest changes should have at least some support from the validators listed above.
- Substantial changes should generally have broad support from several validator classes and particularly from at least one high priority validator. For most substantial changes, we would expect support from several high priority validators.
- 3. Substantial changes should rarely if ever be based solely on reports from a single researcher or research team.
- 4. Substantial changes should generally have consistent support across validators. In particular, we would not generally expect to recommend adoption of substantial changes if a significant proportion of the literature contained evidence that contradicted the evidence presented in support of the change.

Type 1b Proposals (changes to improve reliability) The major focus of such proposals will be on part IV but all other parts should be completed. Part III will typically be much briefer than for type 1a (validity) proposals. Here the goal is to provide information that the criteria changes that produce better reliability do not result in a decline in validity. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for improved reliability without a change in validity.

Type 1c Proposals (changes to improve utility). Here the major focus will be on part V. Parts III and IV will typically be briefer than those seen in type 1a (validity) and type 1b (reliability) proposals, respectively. Part VI should also be commented upon briefly. The major focus of such proposals will be to demonstrate that the changes in criteria that improve clinical utility do not result in decreased validity and/or reliability. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for improved utility and no change in validity.

Type 1d Proposals (changes to reduce deleterious consequences) During the DSM-5 process, critics raised concerns that several of the changes were likely to lead to individuals without mental disorders being inappropriately labelled as having a disorder. For example, some critics cautioned that formulating somatic symptom disorder (SSD) in terms of somatic complaints combined with excessive thoughts, feelings, or behaviors related to the somatic complaints was likely to label individuals with a medical illness as having a somatic symptom disorder. Any proposal to change somatic symptom disorder on these grounds would require empirical evidence that medically ill but psychiatrically well individuals are in fact receiving the SSD diagnosis and that the proposed change would correct this problem. All other parts need to be commented on. In particular, there needs to be reasonable evidence that these changes will not be accompanied by a reduction in diagnostic validity. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for a reduction in deleterious consequences and no change in reliability.

In the appendix to this document, the SC provides examples of what it considers to be high quality reviews of validators as well as table templates that should be used by proposers to organize the data for their PSC.

Type 2 Proposals (addition of a new category or specifier): Part I (reasons for change) and Parts III (validity), IV (reliability), and V (utility) should be the focus of these proposals. (Part II need not be completed because by definition, Type 2 proposals are considered to be "substantial.") There should be strong evidence of validity, evidence of at least moderate reliability, and there should be some clinical utility related to the addition of the new category (e.g., identifying a group of patients that are likely to respond to a particular intervention). In addition, Part I should include a discussion of why the proposed condition meets the definition of mental disorder and a discussion of the likely benefit/harm ratio.

Type 3 Proposals (deletion of an existing category, subtype or specifier): The major focus of the proposal should be Part I (reasons for change) and Parts III (validity), V (utility), and possibly VI (deleterious consequences). Part III (validity) should focus on evidence regarding lack of validity or that it is better conceptualized as a subtype of an existing diagnosis. Part V should offer evidence of minimal utility. If relevant, part VI would focus on evidence that the current use of the category, subtype or specifier in DSM-5 has deleterious consequences that would be eliminated by its deletion.

PROPOSAL IN SUPPORT OF CHANGE TO DSM-5 DRAFT SUBMISSION TEMPLATE

Thank you for your interest in contributing to the process for making potential changes to the DSM. Below is a template for submission of your proposal. PLEASE BE SURE TO READ THE GUIDELINES ASSOCIATED WITH EACH SECTION OF THIS PROPOSAL IN SUPPORT OF CHANGE VERY CAREFULLY. ONLY PROPOSALS THAT ARE IN STRICT ACCORDANCE WITH THESE GUIDELINES WILL BE REVIEWED. A "Change" to DSM-5 is defined as the addition, deletion, or modification of diagnostic categories or criteria. Due to the potential high volume of proposals we may receive, we may not be able to respond to all proposals, though all that adhere to the guidelines will be reviewed by an expert committee.

Your name(s):
Your degree(s) (MD, PhD, etc.):
Institutional Affiliation(s):
Area(s) of research expertise:
Contact email address:
Contact telephone number:
Diagnostic Category or Name of Disorder for which you are proposing a change, addition, or deletion:

Please indicate the type(s) of changes by checking the below box(es):

Type 1 Proposals: Changes to an existing diagnostic criteria set

☐ **Type 1a:** Change that would markedly improve its **validity**

□ **Type 1b:** Change that would markedly improve reliability without an undue reduction in validity

□ **Type 1c:** Change that would improve **clinical utility** without an undue reduction in validity or reliability

□ **Type 1d:** Change that would substantially **reduce deleterious consequences** associated with a criteria set without a reduction in validity

☐ Type 2 Proposal: Addition of a new diagnostic category or specifier

For Type 2 changes involving a new category, you will need to provide substantial evidence that the proposed category would accomplish <u>all</u> of the following:

- Meet criteria for a mental disorder
- Have strong evidence of validity
- Be capable of being applied reliably
- Manifest substantial clinical value (e.g., identify a group of patients now not receiving appropriate clinical attention; facilitate the appropriate use of available treatment[s]);
- Avoid substantial overlap with existing diagnoses, and not be better conceptualized as a subtype of an existing diagnosis; <u>and</u>
- Have a positive benefit/harm ratio (e.g., acceptable false positive rate; low risk of harm due to social or forensic considerations).

For type 2 changes involving the addition of a new specifier or subtype, you will need to provide substantial evidence that the new specifier/subtype:

- Has strong evidence of validity or clinical utility
- Can be applied reliably and
- Avoids substantial overlap with existing specifiers or subtypes

☐ Type 3 Proposal: Deletion of an existing diagnostic category or specifier/subtype

For Type 3 changes involving the deletion of an existing category, you will need to provide substantial evidence that the existing category:

- o Has weak evidence of validity; and
- o Has minimal utility (e.g., is rarely used in clinical practice or research); or
- o Does not meet criteria for a mental disorder or is better conceptualized as a subtype of an existing diagnosis.

For Type 3 changes involving the deletion of an existing specifier or subtype, you will need to provide substantial evidence that the existing specifier/subtype:

- o Has weak evidence of validity, or
- o Has minimal utility (e.g., is rarely used in clinical practice or research)

For each proposal, please fill in the following seven sections. The information that you provide in the text boxes will be used to summarize your proposal. You will have the opportunity to upload your complete proposal at the bottom of this form.

Part I: Reason for Change

Provide a clear statement of the proposed change, outlining the justification for the change, and state which of the types listed above are the main focus of your proposal. Include the historical context for your proposal. Also include a discussion of possible negative consequences of the proposed change and a consideration of arguments against the change. Given that it is desirable that proposed changes to DSM-5 reflect a broad consensus of expert opinion, include a brief section outlining any significant controversies or disagreements among researchers and clinicians in the field concerning the proposed change. Provide a summary of this information in the text box below.

Reason(s) for Proposed Change:		

Part II: Magnitude of the Change

Specify the magnitude of the proposed change, using the guidelines. One important determinant of the magnitude of change is whether it is likely to lead to a change in caseness. However, the reviewers of this proposal will ultimately make an independent determination of the magnitude of the change.

Check appropriate box indicating the magnitude and provide rationale for that decision below and in your proposal:

□ Clarification of criterion/criteria or specifier definition

Clarification of criterion/criteria or specifier definition includes: changes aimed at improving the understanding and application of an ambiguous DSM-5 diagnostic criterion or specifier definition. For example, the "With Panic Attacks" specifier in DSM-5 indicates neither the number of panic attacks nor the time frame. A proposal to specify a minimum number of attacks over a specific time (e.g., at least one panic attack in the past month) would fall into this category.

□ Modest change

Modest change includes:

- a) Substantial changes to a definition of an existing specifier or subtype that go beyond clarification of an ambiguity of the definition. An example would be changing the number of binges per week that define mild, moderate, severe and extreme binge eating disorder based on new empirical evidence.
- b) Additions to the "examples of presentations" that can be specified using the "other specified" designation.
- c) Changes to diagnostic criteria that are not likely to result in a change in caseness.

□ Substantial change

Substantial change includes:

- a) Addition of a new diagnosis, specifier or subtype or the deletion of an existing diagnosis, specifier or subtype
- b) Changes to the DSM-5 criteria that have the potential to result in shifts in caseness from one diagnostic category to another (e.g., a change in the duration of mood symptoms required in the diagnosis of schizoaffective disorder, shifting individuals from Schizoaffective to Schizophrenia)
- c) Addition of a new specifier or subtype to a diagnosis
- d) Changes to the DSM-5 criteria of a well-studied/well-validated diagnosis that could create significant discontinuities in research or clinical care (e.g., elimination of somatic symptoms from criteria for a Major depressive episode), regardless of the potential for causing shifts in caseness or treatment.

Rationale:			

Part III - Validators for the Change

Include a thorough review of the relevant literature and results from any unpublished secondary data analyses in your proposal, and a brief summary in the text box below. In so far as possible, focus on a single question that evaluates two alternative hypotheses. For Type 1a (criteria set changes to improve validity), the question will typically be: is the validity of the proposed set of criteria for disorder X superior to the DSM-5 criteria for disorder X? However, for proposals for new criteria sets (Type 2), two

questions will typically need to be addressed: i) does the new disorder have sufficient validity to be included as an official DSM category and ii) is the new disorder sufficiently distinct, in its performance on validators, from other disorders already in the manual to constitute an independent disorder?

For criteria set changes that aim to improve reliability (Type 1b), utility (Type 1c), or reduce deleterious consequences (Type 1d), the question will typically be: is the validity of the proposed set of criteria for disorder X at least equal to that of the current DSM-5 criteria for disorder X (which may simply involve a lack of change in caseness between the DSM-5 criteria and the proposed criteria)?

Organize this section around the following ten classes of validating criteria. Note that reviewers would prefer to see evidence for validity from a diversity of populations, especially for substantial changes. (It is recognized that, for many proposals, data may not be available for many of these categories.)

I. Antecedent Validators

- A. *Familial aggregation and/or co-aggregation (i.e., family, twin or adoption studies)
- B. Socio-Demographic and Cultural Factors
- C. Environmental Risk Factors
- D. Prior Psychiatric History

II. Concurrent Validators

- A. Cognitive, emotional, temperament, and personality correlates (unrelated to the diagnostic criteria).
- B. *Biological Markers, e.g., molecular genetics, neural substrates
- C. Patterns of Comorbidity
- D. *Degree or nature of functional impairment

III. Predictive Validators

- A. *Diagnostic Stability
- B. *Course of Illness
- C. *Response to Treatment

Asterisks denote high priority validators that will generally be seen as providing stronger evidence than the other validators listed above. Attach a summary table to your proposal for each relevant validator class (i.e., each validator for which data exist). In this table, each study should be represented by a row, with columns reflecting the lead author, year of publication, sample size, methods, and a brief summary of the relevant results. You are encouraged to include a qualitative judgment of the overall methodological strength of each study (e.g., on a 1-5 scale) as indicated by, e.g., quality of diagnostic assessments and validating measures, size and representativeness of the sample, and rigor of the statistical analyses. A sample of such a table is available here [ADD LINK].

It is desirable to have a final summary table in which rows represent the relevant validators. The table should summarize the degree to which data from each validator class support the proposed change (again on a 1-5 scale).

Because of the inclusion of these tables, the text can be brief, focusing first on summarizing the overall nature and strength of the data and commenting on controversial issues, contradictory data, and/or the importance of particular studies or methods.

Summary explanation of data on validators:
Part IV – Reliability
Information should be summarized in tabular form about the comparative reliability of the proposed criteria and, if relevant, the reliability of the DSM-5 criteria that you seek to replace. A table with a line for each study that lists the sample size, the reliability (hopefully calculated by the kappa coefficient or one of several related chance-corrected statistics), the type of reliability assessed (e.g., inter-rater, inter-interviewer, test-retest), the nature of the sample (e.g., clinical versus epidemiological) and prior training of the interviewers is recommended. If possible, improved reliability should be shown across different populations. Data should be presented showing that the proposed criteria improve reliability while identifying largely the same cases as the original DSM-5 criteria, unless an improvement in validity is also being claimed. Include this information in your proposal and summarize this information below.
Summary explanation of data on reliability:

Part V – Clinical Utility

Summarize available information about the clinical utility of the proposed criteria compared to the current DSM-5 criteria in your proposal and in the text box below. For example, if the proposal shortens the criteria set, information should be provided here about the degree to which caseness would not be altered by the new, briefer criteria. That is, the argument that shortening a criteria set does not lead to a loss of validity could be accomplished by showing a very high rate of agreement between case definition by the newer, shorter and the older, longer DSM-5 criteria. Note, to be convincing, this should be shown in several different populations differing by gender, age, ethnicity, etc.

Although the types of empirical studies that would be helpful to establish an improvement in clinical utility are less well established than for validity and reliability, a 2004 paper by First and colleagues (Am J Psychiatry 2004; 161:946–954), developed by an ad hoc subcommittee of the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment, provides some guidance. Parameters of clinical utility that could be measured include whether proposed changes improve user acceptability, clinicians' ability to apply the diagnostic criteria accurately, clinicians' adherence to practice guidelines, and ultimately clinical outcomes.

Proposals that would improve the clinician's ability to select the best treatment or determine prognosis, while certainly improving the clinical utility of the DSM-5, are best considered to be proposals to improve validity and are better included under part III above.

Summary explanation of data on clinical utility:	

Part VI - Deleterious Consequences

In your proposal and in the text box below, summarize available information about the potential deleterious consequences of the current DSM-5 criteria and, if they exist, how the proposed criteria change will reduce or eliminate them. For example, if over-diagnosis is being claimed, empirical evidence will need to be presented demonstrating false positive diagnoses utilizing DSM-5 criteria. Also include data showing the degree to which the proposed criteria reduce the deleterious consequences of the criteria. Proposals for new diagnostic categories should comment on potential deleterious consequences of their adoption.

Summary of information on deleterious consequences:	

Specific Guidance for Each Type of Proposal

Specific types of proposals to change criteria sets are based on the primary area that is expected to be improved by the proposed changes. It is recognized that many proposals will be "hybrids," i.e., the proposers will claim positive effects consistent with more than one type of proposal.

<u>Type 1a Proposals (changes to improve validity).</u> Part III will be the major focus of such proposals but parts I and II should be completed carefully. Although such proposals may have limited information on changes in reliability or utility, some comments should be made for parts IV and V. A brief comment should also be made with respect to part VI, i.e., if there are any deleterious consequences of the DSM-5 criteria, whether these would be changed by the revised criteria, and whether the revision raises the possibility of new deleterious consequences.

Since these are likely to be the most common types of proposals, some additional comments are provided here.

- 1. Even requests for modest changes should have at least some support from the validators listed above.
- Substantial changes should generally have broad support from several validator classes and particularly from at least one high priority validator.
 For most substantial changes, support from several high priority validators should be provided.
- 3. Substantial changes should rarely if ever be based solely on reports from a single researcher or research team.
- 4. Substantial changes should generally have consistent support across validators. In particular, proposals for substantial changes would not generally be accepted if a significant proportion of the literature contained evidence that contradicted the evidence presented in support of the change.

<u>Type 1b Proposals (changes to improve reliability)</u> The major focus of such proposals will be on part IV but all other parts should be completed. Part III will typically be much briefer than for type 1a (validity) proposals. Here the goal is to provide information that the criteria changes that produce better reliability do not result in a decline in validity. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for improved reliability without a change in validity.

<u>Type 1c Proposals (changes to improve utility)</u>. Here the major focus will be on part V. Parts III and IV will typically be briefer than those seen in type 1a (validity) and type 1b (reliability) proposals, respectively. Part VI should also be commented upon briefly. The major focus of such proposals will be to demonstrate that the changes in criteria that improve clinical utility do not result in decreased validity and/or reliability. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for improved utility and no change in validity.

<u>Type 1d Proposals</u> (changes to reduce deleterious consequences) During the DSM-5 process, critics raised concerns that several of the changes were likely to lead to individuals without mental disorders being inappropriately labeled as having a disorder. For example, some critics cautioned that formulating somatic symptom disorder (SSD) in terms of somatic complaints combined with excessive thoughts, feelings, or behaviors related to the somatic complaints was likely to label individuals with a medical illness as having a somatic symptom disorder. Any proposal to change somatic symptom disorder on

these grounds would require empirical evidence that medically ill but psychiatrically well individuals are in fact receiving the SSD diagnosis and that the proposed change would correct this problem. All other parts need to be commented on. In particular, there needs to be reasonable evidence that these changes will not be accompanied by a reduction in diagnostic validity. The larger the changes to criteria in these proposals, the stronger the evidence will need to be for a reduction in deleterious consequences and no change in reliability.

In the appendix to this document, examples are provided of high quality reviews of validators as well as table templates that should be used to organize the data for your proposal.

Type 2 Proposals (addition of a new category or specifier): Part I (reasons for change) and Parts III (validity), IV (reliability), and V (utility) should be the focus of these proposals. (Part II need not be completed because by definition, Type 2 proposals are considered to be "substantial.") There should be strong evidence of validity, evidence of at least moderate reliability, and there should be some clinical utility related to the addition of the new category (e.g., identifying a group of patients that are likely to respond to a particular intervention). In addition, Part I should include a discussion of why the proposed condition meets the definition of mental disorder and a discussion of the likely benefit/harm ratio.

Type 3 Proposals (deletion of an existing category, subtype or specifier): The major focus of the proposal should be Part I (reasons for change) and Parts III (validity), V (utility), and possibly VI (deleterious consequences). Part III (validity) should focus on evidence regarding lack of validity or that it is better conceptualized as a subtype of an existing diagnosis. Part V should offer evidence of minimal utility. If relevant, part VI would focus on evidence that the current use of the category, subtype or specifier in DSM-5 has deleterious consequences that would be eliminated by its deletion.

DSM-5 Definition of a Mental Disorder

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Attach your proposal and appendices here. In order to be considered, your proposal must adhere to the guidelines described above and contain complete information for Parts I-VI.

Attach full proposal and appendices:		

Thank you for your interest in contributing to the process for making potential future changes to the DSM.

List of DSM-5 Errors To Be Fixed

During the course of the preparation of the DSM-5 revision of the Structured Clinical Interview for DSM (SCID), some errors in the DSM criteria and text have been identified, some of which are potentially substantive. Given the technical complications involved in correcting these errors, especially those involving the criteria sets or specifiers, the following list of proposed error fixes have been culled from the original list of 15 to remove those proposals judged to be less clinically urgent and that could wait to be fixed in the next major revision. Of these nine proposed changes, the first five involve changes limited to the descriptive text with the remaining four involving changes to criteria sets or specifiers. Of the four proposed criteria set changes, the first (in autism spectrum disorder) is aimed at correcting an ambiguity in an important criteria set that may lead to an incorrect application of the diagnostic algorithm. The second (involving adding back the missing melancholic and atypical specifiers in bipolar II Disorder), is clinically important given the high prevalence of atypical and melancholic features in bipolar II disorder. The third (fixing the unusable definition for mild manic episode) is both clinically and administratively important since episode severity impacts the diagnostic coding. The final proposed change (fixing the unusable definition of mixed features specifier in major depressive disorder) involves a clinical important phenomenon newly added to DSM-5.

Page references where the fixes need to be implemented are supplied for both the DSM-5 and corresponding pages in the desk reference. (Missing desk reference pages indicate that there is no corresponding page in the Desk reference, as is the case for changes that are confined to the text). Note that the following convention is used in the sections of this document that provide "the fix:" words that are <u>underlined</u> need to be added and words that are <u>double crossed out</u> need to be deleted.

Proposed Text Changes

Delusional Disorder text Status: Approved by group and Kathy Phillips and by WG chair, Will Carpenter	Psychotic forms of Body Dysmorphic Disorder (BDD) are diagnosed as BDD in DSM-5 and not Delusional Disorder. Text suggested they should still be diagnosed as Delusional Disorder.	Page 92, line 7 in text for delusional disorder Somatic delusions can occur in several forms. Most common is the belief that the individual emits a foul odor; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are misshapen or ugly; or that parts of the body are not functioning.
Disruptive Mood Dysregulation	There is a discrepancy between	Page 157:
Disorder criteria and text	the diagnostic criteria ("not	"Because the symptoms of

Approved by group and Jan Fawcett	before 6 or after 18") and text ("7-18 years") regarding age range at which DMDD can be diagnosed	disruptive mood dysregulation disorder are likely to change as children mature, use of the diagnosis should be restricted to age groups similar to those in which validity has been established (7–6–18 years)."
Persistent Depressive Disorder (PDD) text Status: approved by group, Bill Coryell, and Jan Fawcett	Conflict between the diagnostic criteria and text regarding whether both Major Depressive Disorder and Persistent Depressive Disorder should be diagnosed comorbidly. There is no exclusion criterion in MDD that keeps it from being diagnosed with PDD and in one place text states ""Individuals whose symptoms meet major depressive disorder criteria for 2 years should be given a diagnosis of persistent depressive disorder as well as major depressive disorder as well as major depressive sufficient for a diagnosis of a major depressive episode at any time during this period, then the diagnosis of major depression should be noted, but it is coded not as a separate diagnosis but rather as a specifier with the diagnosis of persistent depressive disorder."	Page 171 (starting at the top): "criteria are sufficient for a diagnosis of a major depressive episode at any time during this period, then the diagnosis of major depression should be noted made, but it is coded not as a separate diagnosis but rather and also noted as a specifier with the diagnosis of persistent depressive disorder.
Generalized Anxiety Disorder text Status: approved by group and by WG chair Kathy Phillips	There is a discrepancy between diagnostic criteria and descriptive text regarding relationship of GAD with MDD, Bipolar and Schizophrenia. Whereas the criterion in GAD excluding cases of GAD that occur at the same time as MDD and Schizophrenia was removed from DSM-5, text continues to state the opposite.	Pages 225-226: "Depressive, bipolar, and psychotic disorders. Although ⊕generalized anxiety/worry is a common associated feature of depressive, bipolar, and psychotic disorders, generalized anxiety disorder may be diagnosed comorbidly if the anxiety/worry is sufficiently severe to warrant clinical attention. and should not be diagnosed separately if the

		excessive worry has occurred only during the course of these conditions"
Status: approved by workgroup chair (Joel Dimsdale and other members of WG, Arthur Barksy and Francis Creed)	Discrepancy between the diagnostic criteria and the statement in differential diagnosis section of the text. Text states "A separate diagnosis of somatic symptom disorder is not made if the somatic symptoms and related thoughts, feelings, or behaviors occur only during major depressive episodes" but criteria does not exclude symptoms during depressive episodes.	Differential Diagnosis If the somatic symptoms are consistent with another mental disorder (e.g., panic disorder), and the diagnostic criteria for that disorder are fulfilled, then that mental disorder should be considered as an alternative or additional diagnosis. A separate diagnosis of somatic symptom disorder is not made if the somatic symptoms and related thoughts, feelings, or behaviors occur only during major depressive episodes. If, as commonly occurs, the criteria for both somatic symptom disorder and another mental disorder diagnosis are fulfilled, then both should be coded, as both may require treatment.

Proposed Criteria Set Changes

Disorder	Description of Error	Proposed Fix
Autism Spectrum Disorder	Unclear whether all three items	(Page 50) (Page 27 in Desk
criteria	in criterion A are required	Reference) in criteria for autism spectrum disorder:
Status: approved by group and		"A. Persistent deficits in social
Sue Swedo, chair of		communication and social
Neurodevelopmental WG		interaction across multiple
		contexts, as manifested by <u>all of</u>
		the following, currently or by
		history (examples are
		illustrative, not exhaustive; see
		text):"
Hypomanic Episode criteria in	The "organic rule-out criterion"	Page 125 in hypomanic episode
Bipolar I and Bipolar II Disorder	(i.e., the episode is not	in bipolar I disorder and page
	attributable to the physiological	133 in bipolar II disorder.
Approved by Trish Suppes and	effects of a substance [e.g., a	"F. The episode is not
Jan Fawcett	drug of abuse, a medication,	attributable to the physiological

	other treatment] is missing the	effects of a substance (e.g., a
	"another medical condition"	drug of abuse, a medication,
	component, that is included in	other treatment) or to another
	the comparable version of this criterion for all of the other mood	medical condition."
	episodes.	
Specifiers in Bipolar II Disorder	Errors in Bipolar II specifiers	Page 135 (page 75 in Desk
	include: 1) the including of the	Reference) in criteria for Bipolar
Status: approved by Trish Suppes	erroneous statement about	II Disorder and to the DSM-5
and WG chair, Jan Fawcett	applicability only to major	Classification, p. xvi; Desk
	depressive episodes in "with seasonal pattern" (which is in	Reference p. xiv]
	conflict with definition of	Specify if:
	seasonal pattern), and 3)	With anxious distress (p. 149)
	erroneous implication that the	With mixed features (pp. 149-
	severity specifiers apply to	150)
	hypomanic episodes as well	With rapid cycling (pp. 150–151)
	(they only apply to major depressive episodes in Bipolar II)	With melancholic features (p. 151)
	depressive episodes in bipolar ii)	With atypical features (pp. 151–
		152)
		With mood-congruent psychotic
		features (p. 152)
		With mood-incongruent
		psychotic features (p. 152)
		With catatonia (p. 152). Coding note: Use additional code 293.89
		(F06.1).
		With peripartum onset (pp.
		152–153)
		With seasonal pattern (pp. 153-
		154): Applies only to the pattern
		of major depressive episodes. Specify course if full criteria for a
		mood episode are not currently
		met:
		In partial remission (p. 154)
		In full remission (p. 154)
		Specify severity if full criteria for
		a mood <u>major depressive</u> episode are currently met:
		Mild (p. 154)
		Moderate (p. 154)
		Severe (p. 154)
		D
		Page xvi in DSM-5 classification under Bipolar II Disorder:
		Specify severity if full criteria for
	<u> </u>	Specify Severity if full criteria for

	episode are currently met:
	Mild, Moderate, Severe
Addition of new severity Definition of "mild" which wa	s Page 154, insert next text
Specifiers for Manic Episode intended to work for both ma	inic starting at line 18 (Page 92, line
episodes and major depressiv	ve 10 in Desk Reference)
Status: discussed with Trish episodes ("few, if any sympto	ms Specify current severity of manic
Suppes and WG chair Jan in excess of those required,	the episode:
Fawcett intensity of the symptoms is	Severity is based on the number
distressing but manageable, a	
the symptoms result in minor	
impairment in social or	the degree of functional
occupational functioning")	disability.
contradicts the requirement in	
Manic Episode Criterion C tha	
"The mood disturbance is	episode.
sufficiently severe to cause	Moderate: Very significant
marked impairment in social of	· · · · · · · · · · · · · · · · · · ·
occupational functioning or to	
necessitate hospitalization to	·
prevent harm to self or others	
or there are psychotic feature	
The solution is to add separat severity specifiers for manic	Specify current severity of major
episode, taken from DSM-IV.	depressive episode:
episode, taken nom bsivi-iv.	Severity is based on the number
	of criterion symptoms, the
	severity of those symptoms,
	and the degree of functional
	disability.
	alsasmey.
	While it might appear that the
	deletion of so much text would
	have an impact on pagination,
	because the text appears at the
	very last page of the chapter on
	Bipolar Disorders, in fact this
	change would not affect
	pagination at all.
Mixed Features Specifier in The wording of criterion A	Page 184 (Page 108 in Desk
Major Depressive Disorder contains logically inconsistent	-
phrases regarding when the	A. At least three of the following
Status: approved by group. symptoms must occur: "prese	_
Discussed with Ellen Frank (of nearly every day" and "for the	present nearly every day during
Mood WG) who concurred and majority of days" making this	the majority of days of a major
Jan Fawcett criterion impossible to appl	depressive episode:

APA Registries Work GroupDraft Report

- 1 Executive Summary:
- 2 The APA Registries Work Group was constituted as an ad hoc component of the Council on Quality
- 3 Care that also receives input from and provides reports to the Council on Research and Council on
- 4 Healthcare Systems and Financing. The work group was charged to perform its work over a 6-month
- 5 period and to provide a report of findings and recommendations to the three councils mentioned above
- 6 and the APA CEO.

The workgroup discussed the various forms of registries across medical specialties and determined that APA's initial effort in establishing a registry should be focused and achievable while working to create a registry platform that could be scaled to incorporate additional aims from a broader group of patients, providers and EMR systems. Based on our discussions regarding: the purpose(s) of a registry; the nature and form of collecting and reporting registry data; involvement of key stakeholders and potential partners; and the funding and sustainability of APA registries, we have reached the general consensus that APA should establish its own registry. More specifically, we make the following recommendations:

 Recommendation 1. Focus on collecting circumscribed, validated patient self-assessment data with patient self-entry into a HIPAA-compliant, web-based platform. The targeted patient population should include adults and youth, ages 12 and higher. Patients should have access to the registry not only for data entry, but also to access certain outcomes and other information in order to support patient engagement and participation in data collection.

Recommendation 2. Engage third party payors in planning discussions in order to be proactive in identifying how registry activities would align with quality initiatives, reimbursement etc.

Recommendation 3. Implement an APA-specific registry while simultaneously engaging other disciplines/specialties around current and future complementary and collaborative efforts. The advantages of a registry managed by entirely by APA (e.g., speed of implementation, alignment with priorities) outweigh the potential advantages of cross-society collaborative efforts at this time.

Recommendation 4. Involve patients and families through advocacy groups (e.g., NAMI, DBSA) in the registry development process to ensure a patient-centered focus.

Recommendation 5. Select and work with an established registry vendor rather than develop the electronic infrastructure in-house. The possibility remains of partnering with the Council of Medical Specialty Societies (CMSS) if there is an acceptable agreement reached by CMSS with a particular vendor, as long as expansion and scalability seem feasible and reasonably priced.

Recommendation 6. Work initially to engage a subset of members (e.g., perhaps through existing networks of academic centers as well as psychiatrists in a wide variety of routine practice settings) to pilot patient enrollment and participation in a registry and determine how to scale up, both in terms of the instruments/data included in a registry and the number of enrollees.

Recommendation 7. Establish a new full-time Patient Registry Specialist at APA. Administration of the Office of Quality Improvement and the Division of Research would need long-term involvement in the

APA Registries Work Group

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- development and maintenance of the patient registry. Additional APA administration areas, such as the 46
- 47 Division of Education and Office of Healthcare Systems and Financing, will also need to provide input.
- A standing member component should be established, formally reporting to the Council on Quality 48
- 49 Care, but with member representatives from to the Council on Research, the Council on Healthcare
- Systems and Financing, and the Committee on Health Information Technology. 50

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Workgroup Members and Report

53 The APA Registries Work Group was constituted as an ad hoc component of the Council on Quality Care that also receives input from and provides reports to the Council on Research and Council on 54 55

Healthcare Systems and Financing. The work group was charged to perform its work over a 6-month

period and to provide a report of findings and recommendations to the three councils mentioned above

and APA CEO. 57

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Workgroup members:

Name	Role on Workgroup
Gregory Dalack, MD	Chair
Steve Daviss, MD	Member
Brent Nelson, MD	Resident/Fellow Member
Joe Parks, MD	Member
James Potash, MD, MPH	Member
Lori Raney, MD	Member
Tom Smith, MD	Member
Mauricio Tohen, MD, DrPH, MBA	Member
Jürgen Unützer, MD, MA, MPH	Member
Alex Young, MD	Member
Bonnie Zima, MD, MPH	Member
Kristin Kroeger	APA Administration
William Narrow, MD, MPH	APA Administration
Samantha Shugarman, MS	APA Administration
Rebecca "Becky" Yowell	APA Administration

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The workgroup met by phone on the following dates: July 8, 21, August 7, 18, September 4, 22, October 9, 23, November 6, 20, December 4, 15, 2014) by conference call. A face to face meeting took place during the APA Components meeting, September 11, 2014.

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This report is keyed to the work group charge elements listed below. The workgroup framed as its goal to help APA plant the initial flag in broader data collection across its membership for the benefit of its individual members and their patients, and ultimately to help improve the provision of care on a population basis. We view this report as a summary of our efforts to generate ideas that will lead to a clear roadmap for the APA. We aspire to a larger vision of what high quality registries can make possible, and anticipate that, done well, registries will help the APA, its individual members and the field to quantify, evaluate and improve patient care. At the same time, we recognize that the initial efforts of this workgroup are just the first important steps in a longer journey. The near term goal is to establish the first credible proof of concept registry for the APA.

73 74 The work group was charged with:

- 1. Establishing a working definition of a registry;
- 2. Laying out the potential nature, scope and purposes of psychiatric registries and key questions that such registries might answer;
- 3. Advising on which types of psychiatric registries might be most suitable and appropriate for APA involvement.
- 4. Identifying key stakeholders for such APA registries;
- 5. Assessing the current environment of medical specialty society's involvements with registries: currently active and developing registries among medical specialty societies and other healthcare organizations, and where registries fit in the current healthcare legal and regulatory environment;
- 6. Determining the different mechanisms through which the APA might become involved in patient registries, which should include direct involvement in the establishment of a new APA-owned registry focused on depression, the possible provision of guidance to existing registries, and local vs. national scope;
- 7. Determining an initial process and timeline for developing a new registry, including key personnel needs, the possibility of a small-scale pilot study, etc.;
- 8. Addressing long-term sustainability, including budgetary considerations for various registry development scenarios and potential funding sources.

1. Establishing a working definition of a registry;

The Agency for Healthcare Research and Quality¹ defines a patient registry as "an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes." AHRQ further states that among many potential purposes, registries can be used "to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health-care products and services, to measure or monitor safety and harm, and/or to measure quality of care."

The workgroup discussed the various forms of registries across medical specialties and determined that APA's initial entry into this area should be focused and achievable while working to create a registry

¹ Gliklich R, Dreyer N, Leavy M, eds. Registries for Evaluating Patient Outcomes: A User's Guide. Third edition. Two volumes. (Prepared by the Outcome DEcIDE Center [Outcome Sciences, Inc., a Quintiles company] under Contract No. 290 2005 00351 TO7.) AHRQ Publication No. 13(14)-EHC111. Rockville, MD: Agency for Healthcare Research and Quality. April 2014. http://www.effectivehealthcare.ahrq.gov/registries-guide-3.cfm.

platform that can be scaled to incorporate additional aims from a broader group of patients, providers and EMR systems. We spent considerable time considering potential purposes of an APA registry. These included:

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a. Monitoring Outcomes of Clinical Care

- i. A registry could be used to document initial clinical status (symptom severity, disabilities, and quality of life), treatments provided, and outcomes of treatment.
- ii. This activity should be measurement-based, with both clinician and patient reports being used.
- iii. Psychiatrists are the natural target audience for an APA-sponsored registry, but opportunities for expansion into other clinical professions should be kept in mind. Primary care specialties may have a particular interest in mental disorder registries focused on psychiatric conditions frequently seen in primary care.

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b. Quality Improvement

- i. Outcomes monitoring can be used for individual provider and/or system-wide performance improvement and other quality reporting needs.
- ii. It is important to keep in mind the ever-increasing reporting demands on clinicians from outside agencies. Maintenance of Certification (MOC), the Physician Quality Reporting System (PQRS), and other reporting requirements can be satisfied through an appropriately designed registry.
- iii. At a system level, registry data could help drive reimbursement-linked outcomes monitoring toward measures included in the registry

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c. Research studies

- Registries generate rich databases that can be used for research purposes. It is important to have the initial research questions developed before the registry is designed.
- ii. APA could position itself to have these large clinical databases available for "big data" research opportunities in partnership with academia and/or industry.
- iii. New research topics from the field or lay public might be addressed using an existing registry's measurement battery, or may be the basis for a new, separate registry.

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- 2. Laying out the potential nature, scope and purposes of psychiatric registries and key questions that such registries might answer; and
- 3. Advising on which types of psychiatric registries might be most suitable and
 appropriate for APA involvement.
- 151 (Registry Content)

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Recommendation 1. The work group recommends that APA focus on collecting circumscribed, validated patient self-assessment data with patient self-entry into a HIPAA-compliant, web-based platform. We have also agreed that the targeted patient population should include youth, ages 12 and higher. Patients should have access to the registry not only for data entry, but also to access certain outcomes and other information supporting patient engagement and participation in data collection.

There were different opinions regarding the initial target patient sample: some members felt that the initial registry efforts should target patients with a depressive disorder, while others felt that the registry should include self-report measures applicable to all patients regardless of diagnosis. The work group ultimately agreed that initial efforts should focus on circumscribed patient enrollment and set of assessment tools and, with the opportunity to expand these as experience with registry work was acquired.

There was a consensus that the long-term goal should be a registry or set of registries that could include all patients presenting for psychiatric care and have flexibility with respect to the assessment tools and scales used. However, in view of the near-term goal of a carefully constructed proof of concept registry for APA, the workgroup agreed that a focus on the most common diagnoses of patients presenting for care, such as Anxiety-Depression spectrum disorders, would be the most prudent initial strategy. This would also allow a shorter menu of validated, standardized tools for initial testing. APA should create a clear and detailed process to determine what tools could be added to the registry in the future.

a. Potential data elements: The work group agreed that measure selection would need to follow specification of the registry aims and the target patient population. In general, however, it was agreed that patient self-report measures should cover common symptoms, functional status, and quality of life. The workgroup underscored the importance of considering any specific measures' sensitivity to change over time, as well as the time frame for meaningful change to occur in a clinical situation. For example, disability status will change more slowly than symptom status.

b. Examples of self-report tools to be considered for an initial registry include:

 i. PHQ-9 for depressive disorder symptom severity (can also be used as a measure for distress or significant depressive symptoms in patients with other disorders)

ii. GAD-7 for generalized anxiety disorders (similar to PHQ-9, can be used for distress or significant anxiety symptoms across all disorders)

iii. Screen for current and past history of manic symptoms for those presenting with depression

iv. WHODAS or other disability measure

 $v. \ \ WHOQOL \ or \ other \ quality \ of \ life \ measure$

 vi. Multidimensional symptom screens, such as the cross-cutting symptom measures included in DSM-5 (Level 1 measures, NIH PROMIS, NIDA-modified ASSIST, etc.)

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It is also important to consider clinician-completed data elements. For example, diagnostic data (psychiatric and general medical), treatments employed over time, problem lists, and assessment of changes in clinical status might be entered by clinicians. Clinician burden is a major concern, however, and the work group recommends that initial registry efforts focus on patient self-report data. Minimizing clinician burden associated with registry participation was seen by the work group as a crucial element to successfully populating any a patient registry.

4. Identifying key stakeholders for an APA registry;

Recommendation 2. Work group members recommend engaging with third party payors in planning discussions in order to be proactive in identifying how registry activities would align with quality initiatives, reimbursement etc.

Recommendation 3. The work group recommends that APA implement its own registry while simultaneously engaging other disciplines around current and future complementary and collaborative efforts. The advantages of a registry managed by entirely by APA (e.g., speed of implementation, alignment with priorities) outweigh the potential advantages of cross-society collaborative efforts at this time.

Recommendation 4. The work group recommends involving patients and families through advocacy groups (e.g., NAMI, DBSA) in the registry development process to ensure a patient-centered focus.

The work group had considerable discussion about ways to engage clinicians practicing across a spectrum of settings that including inpatient, outpatient, and partial hospital programs; private practice (solo and group), academic medical centers, and various public settings. We considered whether and when to reach out to colleagues in psychology (i.e., American Psychological Association), and in primary care (e.g., American Academy of Family Physicians). It should be noted that the American Psychological Association has announced that it has developed a registry focusing on PQRS compliance. Measures for participation include several measures appropriate for physician reporting (e.g. Antidepressant medication during acute phase for patients w/ MDD (Measure #9). The American Psychological Association will market their registry for use to behavioral health clinicians outside their membership (e.g. social workers, psychiatric nurses) as well as psychiatrists.

Members of the workgroup represented research consortia and other entities that have explored or implemented registries (e.g., Advancing Integrated Mental Health Solutions [AIMS Center] at the University of Washington and their Care Management Tracking System [CMTS]) as well as other medical specialty societies and organizations such as American Academy of Neurology, American College of Cardiology, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and the Council of Medical Specialty Societies [CMSS]; see below). We recommend continued engagement with such entities as registry development progresses.

5. Assessing the current environment of medical specialty society's involvements with registries: currently active and developing registries among medical specialty societies and other healthcare

organizations, and where registries fit in the current healthcare legal and regulatory environment;

The workgroup first confirmed that there are no local APA District Branch level registry-like activities. This was in contradistinction to some specialty societies (e.g., some American Academy of Pediatrics registries were initiated and continue to exist at the local chapter level).

APA is a member of the Council of Medical Specialty Societies (CMSS) and participates in its meetings and conference calls related to registries. APA administration attended the first CMSS Registry Summit in May 2014 and distributed to the work group an inventory of registry activities across specialties (Appendix I). There is broad consideration at CMSS about whether to work with one or a few vendors to purchase the registry infrastructure into which specific societies can import their data. These discussions are at an early stage and should be monitored for periodic updates that will have implications for APA registry development. Based on work group members' assessments and discussions with vendors, it does appear that there is a variety of financially solid commercial registry platform developers.

A site-visit was held with the American College of Cardiology to learn about their extensive registry activities and to see some of their registries in action. There were also discussions with counterparts involved in registry work at the American Academy of Neurology and American Academy of Pediatrics. Summary recommendations from these meetings and discussions are included in the Appendix II, but in general each group recommended the APA:

• Begin with the end in mind (e.g. financial yield, quality improvement benefit to members, the Association as owners of large data).

• "Don't make perfect the enemy of the good." Start with a pilot phase and begin each registry with fewer users than the maximum expected capacity.

• Attract users with perks (e.g. getting data for MOC); do not formally "incentivize."

• Recommend starting small with a few commonly encountered conditions

Minimize clinician data entry in favor of patient-reported data when possible. The ability
to download appropriate data from a clinician's EHR into the registry is valuable when
feasible. The option to upload clinical data from the registry to the clinician's EHR
should also be considered.

Beyond the medical specialty societies, there are also institutions and networks that have registry processes underway and in place. Work group members have had direct involvement in the National Network of Depression Centers, the AIMS Center, and the State of Minnesota registries. Considering whether and how to link such efforts to APA registry activities will be an important priority in further planning.

6. Determining the different mechanisms through which the APA might become involved in patient registries, which should include direct involvement in the establishment of a new APA-owned registry focused on depression, the possible provision of guidance to existing registries, and local vs. national scope;

Recommendation 5. It seems most practical to select and work with an established registry vendor rather than develop the electronic infrastructure in-house. The possibility remains of partnering with

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289 CMSS if there is an acceptable agreement reached with a particular vendor, as long as expansion and scalability seem feasible and reasonably priced.

7. Determining an initial process and timeline for developing a new registry, including key personnel needs, the possibility of a small-scale pilot study, etc.:

Recommendation 6. APA should work initially to engage a subset of members (e.g., perhaps through an existing network of academic centers like the National Network of Depression Centers, and the APA Practice Research Network to extend the reach further to psychiatrists in a wide variety of routine practice settings) to pilot enrollment and participation in a registry and determine how to scale up, both in terms of instruments/data included in a registry and number of enrollees.

Recommendation 7. Establish a new full-time Patient Registry Specialist at APA. Administration of the Office of Quality Improvement and the Division of Research would need long-term involvement in the development and maintenance of the patient registry. Additional APA administration areas, such as the Division of Education and Office of Healthcare Systems and Financing, will also need to provide input. A standing member component should be established, formally reporting to the Council on Quality Care, but with member representatives from to the Council on Research, the Council on Healthcare Systems and Financing, and the Committee on Health Information Technology.

8. Addressing long-term sustainability, including budgetary considerations for various registry development scenarios and potential funding sources.

This will entail the development of a clear business plan, the specifics of which will include APA CFO and staff. Based on our discussion with other specialty societies, the funding of their registries depends on the type of registry in question. Registries for specific illnesses, particularly chronic conditions, are often provided as a member benefit. Device/procedure registries are typically funded by fees paid for by the hospitals providing the service, with the return of quality reports to them, the device manufacturers and hospital credentialing agencies.

During the time of our telephone conference with AAN (October 2014), their Board of Trustees were in final deliberations around which IT vendor to choose, while the American College of Cardiology has been managing multiple registries for about 20 years. Given the groups' experience with registries each of these organizations acknowledged a starting budget allotment of \$2 million dollars for the pilot phase.

For some registries, industry pays fees for access to data for research purposes, and these fees help underwrite registry activities. It is important to note that the workgroup discussed the need to develop a business plan for the Board of Trustees to Review, which will outline budget and programmatic implications.

Summary Statement:

The workgroup respectfully submits this summary of its work in the hopes that it provides initial guidance to APA to consider next steps towards the development of business and implementation plans for the near and longer-term development of patient registries. These efforts will constitute some of

APA Registries Work Group Draft Report

January 20, 2015

APA's major contributions to helping members and the association achieve the Triple Aim goals of improving health, improving healthcare and reducing costs.



CMSS Specality Socie es with Ac ve Clinical Data Registries • NUMBER OF REGISTRIES USED

American Academy of Allergy Asthma & Immunology (AAAAI) Launched in 2014 American Academy of Dermatology (AAD) Launched in 2009 American Academy of Neurology (AAN) Expected to launch 2015 American Academy of Ophthalmology (AAO) Launched in 2014 American Academy of Otolaryngology -Head & Neck Surgery (AAO-HNS) First launch 2012 American Associa on of Neurological Surgeons (AANS) Launched in 2012 American College of Cardiology (ACC) First registry launched in 1998 American College of Emergency Physicians (ACEP) American College of Obstetricians and Gynecologists (ACOG) American College of Physicians (ACP) Launched In 2014 American College of Radiology (ACR) First registry launched in 2005 American College of Rheumatology (ACR) American College of Surgeons (ACS) First registry launched 1990 American Gastroenterological Associa on (AGA) Launched in 2013 American Osteopathic Associa on (AOA) Launched in 2008 American Society for Radia on Oncology (ASTRO) Launched In 2011 American Society for Reproduc ve Medicine (ASRM) Launched in 1980 American Society of Anesthesiologists (ASA) First registry, launched in 2010. American Society of Clinical Oncology (ASCO) Launched In 2006 American Society of Plas c Surgeons (ASPS) First registry launched in 2002 American Urological Associa on (AUA) Launched in 2014 North American Spine Society (NASS) Launched in 2014 Society of Cri cal Care Medicine (SCCM) Launched in 2008 Society of Hospital Medicine (SHM) Launched in 2010 Society of Thoracic Surgeons (STS) Launched in 1989 APA Registry Workgroup Telephone Conference October 23, 2014 Summary

Administration Present: Kroeger, Narrow

Workgroup Members Absent: Daviss, Potash, Raney, Smith, Wells, Zima

1) Welcome and Review of COI (please update as needed)

Greg Dalack	Participates in the National Network of Depression Centers (NNDC)
Brent Nelson	Fourth year resident with previous long-term background in software
	development. Schizophrenia/psychosis registry in MN.
Joe Parks	Missouri DMH, now with Medicaid. Familiarity with state level claims
	and clinical care management companies and consultants
Jürgen Unützer	15-20 years of experience with chronic illness registries including
	diabetes, depression. IMPACT trial for depression. Care
	management tracking system licensed in US and Canada.
Alex Young	UCLA, VA of Los Angeles, no COI

2) Follow-up on action items:

Check-in on scenario feed-back/review everyone's findings: Greg updated those on the call that feedback from stakeholders regarding the scenarios had been received from several workgroup members; other feedback was anticipated. The feedback was being compiled into a document that would be shared with workgroup members.

Brent updated the group that he was obtaining input from administrative folks in his area. He also indicated that the Minnesota Dept. of Human Services had recently mandated completion of the WHODAS (thought to be the 12 item patient self-report measure) on all new evaluations. There was concern expressed about the "mandated" aspect of this and the burden this would represent for clinicians and patients without a clear rationale stated for this particular measure or how it would be used going forward. Bill noted that he worked with the Minnesota DB to clarify in a letter to MN DHS the role of the WHODAS in DSM-5. He stated that while the WHODAS has many very attractive properties, its implementation in clinical psychiatric settings is relatively untested. A discussion ensued about the utility of a functional measure like this in our or any registry. One view was that a more specific functional outcome measure (e.g., having the patient set and work to achieve one personal goal with outcome scored on a 1-10 scale) was more meaningful. Others advocated for a standardized measure like the WHODAS as a reasonable first step that could be further refined as psychiatric functional outcome measures evolved.

3) Information from the American Academy of Neurology regarding their efforts to establish

patient registries (Bill Narrow)

Bill, Sam, and Kristin had a telephone conference with a representative from the American Academy of Neurology. The AAN registry workgroup had to get buy in from their board of trustees who had some skepticism about whether members would buy-in, whether the cost would be prohibitive, etc. The workgroup brought in an impressive speaker from Ophthalmology who talked about their member buy-in and the benefit to their members of participating. This was helpful in convincing the AAN board and we may want to consider bringing in a really experienced and credible speaker to help persuade our BOT about the value of registries.

AAN put out an RFP for a registry vendor, received 11 responses, and are now looking at 2.

They estimated the cost at \$2-2.5M for 3 years. They are considering capping membership in the registry at 1000 (clinicians) for the first year, then growing slowly in years 2 and 3. Their plan is to limit the conditions that will be entered into the registry to 1-2 commonly seen conditions and also conditions for which there are existing quality measures that can be used in practice. Among the diseases they are considering are: headache, migraine, Parkinson's disease. In this way, members can benefit from participating by meeting quality reporting requirements through PQRS. This would be a member benefit. This stepped evaluation and growth, with explicit member benefit was key to the acceptance of the initial registry plan by the AAN BOT. The AAN workgroup offered to share their business plan with us and their phased implementation plan as well. At this point, they have individual practitioners interested in participating as well as larger health systems. They are also opening the registry up to international members.

Discussion followed in our workgroup, resonating with the idea that it is better to start with 1-2 measures. Jurgen noted that Primary care only measures 1 thing for DM (HgbA1c) and only about 4-5 items across the conditions they treat. So for us, depression and anxiety would be good to start.

Joe added that whatever measure we decide to use, it will be used at an administrative level for bench-marking, measuring, etc. Hence, we should be careful in what we pick. There was some discussion about whether we should use measures that can aggregate easily (e.g., PHQ-9). The point was made that absolute scores are less important than change scores over time. Jurgen indicated that in his setting there is a 4-fold difference in PHQ scores depending on setting and population so change score is more important.

The discussion returned to functional measures with the suggestion that many stakeholders are more interested in improvement in function than change in symptom scores. There was discussion again about the merits of SF 12, 8, and WHODAS. It was noted that as a rule, less change in disability will occur from visit to visit, compared to change in symptom severity

- 4) Matters Arising: none
- 5) ACTION ITEM: Greg asked members to submit comments from stakeholders to be included in the summary document being prepared with the goal of circulating this for review prior to

the next meeting. Greg will try to send out an outline of the final report for discussion on 11/6/14 as well.

APA Registry Workgroup Telephone Conference December 15, 2014 Summary

Administration Attendance: Kroeger, Narrow, Shugarman, Yowell

1) Welcome and Review of COI (please update as needed)

Ty Welcome and net	y welcome and neview of cor (please update as needed)		
Greg Dalack	Participates in the National Network of Depression Centers (NNDC)		
Steve Daviss	Participates in the HIE Policy Board and the private company M3.		
	This product includes registry functionality.		
Brent Nelson	Fourth year resident with previous long-term background in software		
	development. Schizophrenia/psychosis registry in MN.		
James Potash	Sits on the Executive Committee of the NNDC. Involved with registry		
	development at Johns Hopkins and Iowa		
Lori Raney	As Chair of the Integrated Care Workgroup of the Council on Health		
	Systems and Finance, educates membership on registries. Uses		
	registries in her work in Colorado.		
Tom Smith	Medical Director, Office of Managed Care, New York State Office of		
	Mental Health. Has worked on predictive modeling for high-risk		
	populations using large databases		
Jürgen Unützer	15-20 years of experience with chronic illness registries including		
	diabetes, depression. IMPACT trial for depression. Care		
	management tracking system licensed in US and Canada.		
Ken Wells	Has worked on collaborative care initiatives focused on electronic		
	registries post hurricane Katrina. Has worked with Dr. Unützer on		
	registries.		
Alex Young	UCLA, VA of Los Angeles, no COI		
Bonnie Zima	Child and health services research including integrated care using		
	registries. Experience in large sample analyses, data set merging.		

2) Follow-up on action items:

- Check-in on report feed-back, Updates to the draft will be made based on new recommendations of last draft distributed to the group. Please share your comments, edits in track changes and share with Dr. Dalack and Ms. Shugarman.
- ACC meeting summary, On December 9, 2014, Dr. Daviss, Ms. Kroeger, and Ms.
 Shugarman attended a meeting at the American College of Cardiology. The purpose of the meeting was for the APA to hear from the ACC in their experience starting and managing a registry. ACC has been in the business of registries since 1997. The focus of the discussion was on the ACC's Pinnacle Registry which focuses on outpatient care and integrates various specialties of medicine.

The take home points from the meeting were:

- O When developing the recommendations and business plan, "begin with the end in mind." "Skate to where the puck will be"—look ahead 5/10 years down the road. What do we want out of this registry?
- Not necessary to offer "incentives" for participation, but not a bad idea to inform users of benefits of using the registry (e.g. benchmarking, MOC, PQRS penalty avoidance), partner with a malpractice liability company to allow for discounts if using registry
- Start small in scale of users and conditions
- o Don't limit to a specific disease, consider 4-5
- Paper data collection is not sustainable, and they don't recommend web based collection either (at least completed by the clinician)--
- Ideal collection is done through an already established EHR, or data entered by the patient
- Consider governance: include a research group, a steering committee, and allow the financial benefits to live closer to the BOT
- After initial recommendations and operationalization plan is developed, it must go through an IRB
- ACC manages their own data warehouse, it might be easier for APA to outsource. Will likely need experts to help determine this decision.
- For the purposes of future planning, it is not a bad idea to get an IT architect to help with a relational data structure.

Brief discussion around budgetary advice included ACC allotting 3 million dollars for the first year of their registry, when data was collected in a paper-based format. It was notated that the cost would likely decrease under an electronic/web-based version

• Deadline/Governance Review update, Finalize to share with the CQC, CHSF, and COR, and Dr. Levin. Plan to share an update and report for the JRC in January.