FINAL

MINUTES OF A MEETING
OF THE
APA BOARD OF TRUSTEES

JULY 20-21, 2013

Minutes of a Meeting

APA Board of Trustees

July 20-21, 2013

Arlington, VA

SECTION 1. CALL TO ORDER

Dr. Jeffrey A. Lieberman, APA President, called the July meeting of the Board of Trustees to order at 9:00 a.m., Saturday, July 20, 2013, at the Westin Arlington Gateway Hotel in Arlington, VA. Dr. Lieberman welcomed Board members, guests, and staff to the meeting.

A. Introductions and Verbal Conflict of Interest Disclosures

Board of Trustees

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

Jeffrey A. Lieberman, MD, President– receives income from Columbia University and New York State Psychiatric Institute; receives royalties from various publishing companies for academic publications including APPI; receives an APA stipend as President; member of American College of Neuropsychopharmacology, Biological Psychiatry, and Institute of Medicine.

Paul Summergrad, MD, President-Elect– receives income from Tufts University School of Medicine through Tufts Medical Center Physicians Organization; President of the American Association of Chairs of Departments of Psychiatry; receives an APA stipend as President-Elect.

Frank Brown, MD, Parliamentarian – receives income from the Emory Clinic in Atlanta, Georgia.

Maria A. Oquendo, MD, Secretary – receives income from New York State Psychiatric Institute and Columbia University; receives income from private practice; receive

royalties for a suicide ratings scale; receive unrestricted educational grants for training; husband is an employee of Bristol-Myers-Squibb.

David Fassler, MD, Treasurer – receives income from Private practice and forensic work; Clinical faculty at the University of Vermont; Treasurer-Elect of the American Academy of Child and Adolescent Psychiatry.

Melinda Young, MD, Speaker – receives income from private practice; receives an APA stipend as Speaker.

Jenny L. Boyer, MD, Speaker-Elect– receives income from the Veterans Administration; receives income from a federal pension from the state of Oklahoma; receives an APA stipend as Speaker-Elect.

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; Chief-of-Staff of Menninger Clinic; receives small editorial fees as Editor of the *Journal of Psychiatric Practice*; President of the American College of Psychiatrists (uncompensated).

Carol A. Bernstein, MD, Trustee– receives income as Associate Dean for Graduate Medical Education at NYU School of Medicine and Vice-Chair of Education, Department of Psychiatry; Board of Regents of the American College of Psychiatrists (uncompensated).

Jeffrey Geller, MD, Area 1 Trustee – receives income from University of Massachusetts Medical School and Carson Community Mental Health Center.

James E. Nininger, MD, Area 2 Trustee – receives income from private practice; voluntary faculty at Cornell Weill Medical College, New York Presbyterian Hospital; American Psychiatric Foundation Board, the PAC Board, and vice-chair of the Steering Committee of Practice Guidelines.

Brian Crowley, MD, Area 3 Trustee – receives income from Private practice; income from the Department of Defense, Henry M. Jackson Foundation for the Advancement of Military Medicine; on the voluntary faculty of Uniform Services University of the Health Sciences.

Judith F. Kashtan, MD, Area 4 Trustee – receives income from private practice; on the clinical faculty of the University of Minnesota.

James A. Greene, MD, Area 5 Trustee – receives income from University of Tennessee, Department of Psychiatry.

Marc D. Graff, MD, Area 6 Trustee – receives income from L.A. County, Department of Mental Health.

Jeffrey Akaka, MD, Area 7 Trustee – receives 80% of income from Diamond Head Community Mental Health Center in Hawaii; 20% of income from disability reviews from Social Security; serves on APAPAC Board.

Anita Everett, MD, Trustee-at-Large – receives income from Johns Hopkins Hospital; President of the American Association of Community Psychiatrists.

Molly K. McVoy, MD, ECP Trustee-at-Large – receives income from Case Western and University Hospitals; *Psychiatric News* Editorial Board and receives some royalties from APPI.

Erik R. Vanderlip, MD, MIT Trustee –receives income from University of Washington; moonlighting through King County Public Health.

Lara J. Cox, MD, MIT Trustee-Elect – receives income from York City's Health and Hospitals Corporation; moonlighting through NYU and Lennox Hill Hospital.

Phillip M. Murray, MD, APA/SAMHSA Fellow – receives income from the Cambridge Public Health Commission.

Christina J. Arrendondo, MD, APA Public Psychiatry Fellow – receives income from

Yale and Connecticut Mental Health Center.

Uyen-Khanh Quang-Dang, MD, APA/Leadership Fellow – receives income from University of California, San Francisco.

Staff & Guests:

James H. Scully, Jr., MD, APA Medical Director and CEO – receives income from APA; U.S. Military pension; President-elect of the American College of Psychiatrists (uncompensated); Professor of Neuropsychiatry, University of South Carolina (uncompensated).

Saul Levin, MD, APA Medical Director and CEO Designate – receives income from the APA.

B. Fiduciary Responsibility of the Board

Colleen Coyle, General Counsel

Ms. Coyle informed the Board that Washington, DC law now expressly sets out Trustee responsibilities in a new statute governing non-profit corporations. As Trustees of the Board, Board members were legally responsible for keeping APA true to its mission, safeguarding APA assets, and operating at all times in the best interest of APA.

SECTION 2. CONSENT CALENDAR

A. Requests to Remove Items from the Consent Calendar

Items 9.6 and 9.9 were removed from the Consent Calendar.

B. Approval of Items on the Consent Calendar

Dr. Lieberman presented the Consent Calendar to the Board.

The Board of Trustees voted to approve the Consent Calendar as amended.

SECTION 3. REPORT OF THE PRESIDENT

Jeffrey A. Lieberman, MD

A. Brief Update

Dr. Lieberman briefly discussed the Royal College of Psychiatry Meeting in Edinburgh where he had an opportunity to meet collectively with their President and the President of the World Psychiatric Association. He said both Presidents were very interested in establishing an international coalition on issues affecting mental illness, mental healthcare, and psychiatry in particular.

B. Public Perception/Media Communications/Anti-Stigma

Sharon Reis, Partner, GYMR Public Relations

Ms. Reis discussed the *DSM-5* communications approach with the Board. She stated that, in May, there were 150 media inquiries about the *DSM-5* and 325 story placements within the two weeks surrounding the launch of the *DSM-5*. Fifteen *DSM-5* articles

appeared in the *New York Times*, including an editorial board placement referring to it as the "best tool to guide clinicians on how to diagnose disorders and treat patients."

C. Strategic Planning Discussions

Paul Summergrad, MD

Dr. Summergrad discussed the importance of the Board of Trustees being in complete agreement about the strategic goals and priorities of the organization, an area which falls under the rubric of strategic planning. He noted that APA has several important new initiatives underway including communications, advocacy (on behalf of our membership and patients) and healthcare reform. Dr. Summergrad stated that plans are underway to launch a formal strategic planning process in early 2014.

D. Executive Committee Report

This report was presented for Board review and appropriate action.

Executive Committee
Conference Call Report
June 25, 2013

Executive Committee: Jeffrey Lieberman, MD; Paul Summergrad, MD; David Fassler, MD; Dilip Jeste, MD; James H. Scully, Jr., MD
Excused: Maria Oquendo, MD; Melinda Young, MD
Guest: Saul Levin, MD
Staff: Margaret Dewar; Ardell Lockerman; Colleen Coyle, JD; Terri Swetnam, PhD.; Rebecca Rinehart

Executive Committee Actions:

External Communications
Action: The Executive Committee voted to approve continuing to contract for services from GYMR from now until the end of 2013 with a budget not to exceed $200-300K.

Request to Increase Structural Budget:
This request is for the addition of FTEs (Full Time Employees) with one beginning mid-August 2013, one beginning mid-October 2013, and one beginning mid-November 2013. The focus of the positions will be on the development and implementation of (1) Association Strategy, (2) Programs for MIT/ECPs and (3) Collaboration with Allied Health Organizations to include psychiatric subspecialties. A final budget for each position will be included in the 2014 budget request, pursuant to a market-based review. Preliminarily, it is estimated they will increase the structural budget by up to $845K (annualized amount, which includes benefits). The amount required for 2013 (estimated at $209K, staged as noted) can be covered by salary savings from other vacant positions.

Action: The Executive Committee voted to approve the addition of 3 FTEs at an annualized cost of $845K beginning mid-August 2013.

Staff support for the APA President:

Action: The Executive Committee voted to approve the establishment of a work group of former APA Presidents to clarify the level of staff support to be provided to the APA President and President-Elect and make their recommendations to the Executive Committee by August 13th .

E. Executive Session Actions

1. **Update on the litigation in CT against Anthem and WellPoint**

The APA Board of Trustees reaffirmed its intention to continue the fight to implement parity laws and to improve access to care. Staff informed the board that they had received hundreds of complaints from members regarding implementation of CPT codes in a manner that potentially violates parity. APA is addressing each complaint with the payers, some of which immediately changed their ways. Others have been more difficult.

The APA Board of Trustees instructed staff to continue their efforts and do what is necessary to ensure implementation of the MHPAEA.

The APA encourages anyone who is having difficulty with CPT code implementation, who has not already reported the problem to report the problem to www.psychiatry.org/cptparityabuses. (You will be prompted for your Member login.)

2. ***Psychiatric News* Appointment**

The Board of Trustees voted to approve the appointment of John Luo, M.D., for a three-year term (2013–2016) to the *Psychiatric News* Editorial Advisory Board.

3. ***Psychiatric News* Appointment**

The Board of Trustees voted to approve the appointment of Claudia Reardon, M.D., for a three-year (2013–2016) term to the *Psychiatric News* Editorial Advisory Board.

SECTION 4. REPORT OF THE MEDICAL DIRECTOR/CEO

James H. Scully, Jr., MD

A. Presentation by the Medical Director/CEO

Dr. Scully told the Board that APA just had the most successful Annual Meeting with a total of 13,793 registrants. He said although international members were no longer funded by pharmaceutical companies to attend the Annual Meeting, over 4,000 international members had registered for this meeting.

Dr. Scully reported that APA had eight months of membership growth with an increase in all categories including general members, fellows, and distinguished fellows. Additionally, he said the members-in-training category increased, and the Lifers continue to remain a high retention group.

Dr. Annelle Primm, Director of the APA Office of Minority, National, and International Affairs informed the Board of their current programs. One of the programs mentioned was the OMNA-on-Tour, which essentially is a traveling mental health disparity awareness program across the country. Dr. Primm said the goal of each OMNA on Tour is to foster

knowledge-sharing and collaboration to end disparities and to improve mental health care across diverse population groups.

Rebecca Rinehart, APA Publisher, provided the Board with an update on the sale of *DSM-5*. She said the *DSM-5* was available for advance sale January 18th, however, in May, the American Psychiatric Publishing exclusively launched the sale of the *DSM-5* at the APA Annual Meeting, which concluded with sales totaling $800,000. Currently, she said, sales of the *DSM-5* have totaled about $23 million.

SECTION 5. REPORT OF THE SECRETARY

Maria A. Oquendo, MD

A. Minutes of the May 19, 2013 Board of Trustees Meeting

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve the minutes of its May 19, 2013 meeting.

SECTION 6. REPORT OF THE TREASURER

David Fassler, MD

A. Treasurer's Report

Dr. Fassler provided the Treasurer's Report to the Board of Trustees.

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. Dilip Jeste, Dr. Jeffrey Lieberman, and Dr. Paul Summergrad.

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's New Initiative Fund.

SECTION 7. REPORT OF THE JOINT REFERENCE COMMITTEE (JRC)

Paul Summergrad, MD, Chair

Dr. Summergrad provided the Joint Reference Committee Report to the Board of Trustees along with the following actions:

A. Joint Reference Committee Recommendations

1. Health Level 7

The Board of Trustees voted to approve the APA becoming an Organizational Member of Health Level 7 (HL7) and to review this membership after no longer than three years.

2. APA Mentors of the Year Award

The following action was approved on the Consent Calendar.

The Board of Trustees approved the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the budget of the Council on Medical Education and Lifelong Learning).

SECTION 8. REPORTS FROM STANDING COMMITTEES AND COUNCILS

A. Report from the Membership Committee

Jonathan Amiel, MD, Chair

Dr. Amiel provided the Membership Committee Report to the Board of Trustees along with the following actions:

1. District Branch Grant

The Board of Trustees voted to approve a recommendation from the Membership Committee to award $2,500 to each district branch or state association listed in Attachment E as part of the District Branch Grant process.

2. Membership Drops

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve dropping from APA membership the Member listed in Attachment G for failure to meet the requirements of membership.

3. Dues Drops

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve dropping from APA membership the members listed in Attachment H for non-payment of 2013 APA dues if dues are not paid by the deadline.

4. District Branch Drops

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve dropping from APA membership the Members listed in Attachment I, who will be dropped by their district branch if dues are not paid by the deadline.

5. International Membership

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve the applicants listed in Attachment J for International Membership.

6. Dues Relief

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment K.

B. Report from the Finance and Budget Committee

Alan F. Schatzberg, MD

Dr. Schatzberg provided the Finance and Budget Committee Report to the Board of Trustees along with the following actions:

1. CME Registration

The APA Board of Trustees voted to approve an increase for CME course registration fees in 2014 as proposed.

2. Annual Meeting Registration Fees

a) **The APA Board of Trustees voted to approve that there be no increase to member Annual Meeting registration fees for 2014 and that the registration fees for nonmembers increase as proposed in Attachment A.**
b) **The APA Board of Trustees voted to approve that the significant other/spouse rate be offered to one significant other/spouse of a full dues paying APA member paying a full time registration fee.**

3. IPS Registration Fees

The APA Board of Trustees voted to approve that there be no increase to member registration fees for the 2014 IPS and that the registration fees for nonmembers increase as proposed in Attachment B.

4. Membership Dues Increase for 2014

Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C?

The APA Board of Trustees did not approve increasing the membership dues for 2014. With the sale of the *DSM-5*, the Board deemed it unnecessary to increase the dues for 2014.

5. Procurement Policy

The APA Board of Trustees voted to approve the adoption of clarifying language to the procurement policy, as amended.

Statement of Competition
APA/APF policy and federal regulations require that vendors/contractors be selected on the basis of competition to the maximum extent possible to ensure that the procurement is made in the best interests of the APA/APF and the government, consistent with the circumstances, price and other factors relevant to the particular action. These provisions apply to goods and services provided by all compensated vendors whether payment is made directly, or indirectly on a commission basis.

C. Report from the APA/AMA Delegation

Carolyn B. Robinowitz, MD

Dr. Robinowitz presented a written update on the activities of the APA AMA Delegation/AMA Section Council on Psychiatry.

D. Report from the Audit Committee

David Fassler, MD

The APA Board of Trustees accepted the 2012 Audited Financial Statements as presented.

E. Report from the Investment Oversight Committee

A written report about the investment performance summary was presented to the Board of Trustees for information only.

F. Report from the Election Committee

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on the use of APA, Area Council/State Association and District Branch resources.

SECTION 9. REPORT OF THE SPEAKER

Melinda Young, MD

Dr. Young presented a written report and the following actions to the Board.

A. Assembly Executive Summary Actions

1. Retired Position Statement: Day Care for Preschool Children

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the retirement of the 1991 Position Statement: *Day Care for Preschool Children*.

2. Retention of Position Statement: Therapies Focused on Memories of Childhood Physical and Sexual Abuse

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the retention of the 2000 Position Statement: *Therapies Focused on Memories of Childhood Physical and Sexual Abuse*.

3. Proposed Position Statement: Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the Proposed Position Statement: *Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients*.

4. Retired Position Statement: Delineation of Transcultural Psychiatry as a Specialized Field of Study

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the retirement of the Position Statement: *Delineation of Transcultural Psychiatry as a Specialized Field of Study*.

5. Retired Position Statement: Training of Minority Psychiatrists

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the retirement of the Position Statement: *Training of Minority Psychiatrists*.

6. Retired Position Statement: 1995 Medical Psychotherapy

Will the APA Board of Trustees vote to approve the retirement of the Position Statement: *1995 Medical Psychotherapy*?

The APA Board of Trustees did not approve this action. (N.B.: The Assembly's intention was to retain this position statement rather then retire it.)

7. **Retired Position Statement: 1968 Generic versus Proprietary Drugs**

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the retirement of the Position Statement: *1968 Generic versus Proprietary Drugs*.

8. **Revised Position Statement: Generic versus Proprietary Drugs**

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the Revised Position Statement: *Generic versus Proprietary Drugs.*

9. **Proposed Position Statement: Legal Proceedings and Access to Care for Juvenile Offenders**

The APA Board of Trustees voted to approve with minor revisions the Position Statement: *Legal Proceedings and Access to Care for Juvenile Offenders* (For minor revisions to the paper see summary of actions 9.A.9).

10. **Proposed Position Statement: Use of Medical Marijuana for PTSD**

The following action was approved on the Consent Calendar.

The APA Board of Trustees voted to approve the Proposed Position Statement: *Use of Medical Marijuana for PTSD*.

11. **Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services**

The APA Board of Trustees voted to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services* with amendments to the paper (For amendments to the paper see summary of actions 9.A.11).

SECTION 10. APA c/3 SUBSIDIARY

A. **Report of the American Psychiatric Foundation**

James H. Scully, Jr., MD, Chair and Paul Burke, Executive Director

Paul Burke confirmed that the Foundation is in good operational shape at mid-year and will be expanding its programs and initiatives. The Foundation will be expanding its "Typical or Troubled" program since the demand for this program has surged in the last year, with the Foundation receiving more applications and interest than ever before. This school mental health program trains teachers and parents how to recognize the difference between typical teen behavior and possible mental illness. He told the Board that talks were currently underway about developing a version of this program for use by the military.

SECTION 11. WORK GROUP AND TASK FORCE REPORTS

A. Report of the ECP/MIT Work Group

Carolyn Rodriguez, MD and Jonathan Amiel, MD

As co-chairs, Drs. Rodriguez and Amiel made a joint presentation on the work of the ECP/MIT Work Group.

Dr. Rodriguez told the Board that one disturbing trend they identified is the high attrition in the transition from members in training to early career psychiatrists with a 30 percent membership loss after graduation and a 20 percent membership loss per year for six years post-graduation.

Dr. Amiel said the workgroup reviewed membership trends, past surveys and programs for recruitment and retention of MIT and ECP members, and concluded that many promising initiatives were implemented, but their effectiveness was limited by APA's difficulties in maintaining and evaluating them. He said the workgroup focused on infrastructures and identified four of the following priority areas: mentoring, electronic outreach, leadership opportunities, and peer to peer recruiting. The following are recommendations they presented to the Board.

1. **The APA Board of Trustees voted to ask the Medical Director/CEO to prioritize staff to manage ECP membership marketing, recruitment and retention programs. The budget for the position will be developed during the budget process.**

2. **The APA Board of Trustees voted to approve a placeholder budget of $25K for pilot initiatives for ECP recruitment and retention.**

3. **The APA Board of Trustees voted to ask the President, in consultation with the MIT/ECP Workgroup, to assemble an ECP advisory panel. The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director/CEO annually. [Representatives from the Board, Assembly, and Fellows]**

4. **The APA Board of Trustees voted to charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention.**

B. Report of the Role of Psychiatry in Healthcare Reform Work Group

Paul Summergrad, MD

Dr. Summergrad briefly mentioned the prior report from the work group he chaired on Healthcare Reform. He said the report contained a lot of interesting information and members should have more direct access to it. He told the Board that they should consider using the prior report as part of their communications strategy.

C. Report of the Healthcare Reform Strategic Action Work Group

Howard Goldman, MD

Dr. Goldman restated the composition of the work group, which includes representatives from key APA components as well as external consultants. He said the work group initially met by telephone, where members were asked to develop a single policy item that was important in their focused area. These items were discussed and prioritized at their last meeting, and after reviewing priority statements, the work group decided it would be more productive to divide themselves into the following four subgroups: implementing integrated care, the public sector and the role of psychiatry, measurement strategies, and health insurance exchanges.

D. Report of the DSM Planning Work Group

Steve Hyman, MD (speakerphone)

Dr. Hyman told the Board that their Work Group received a proposal from the *DSM-5* Psychiatry-General Medical Interface Study Group for the development of a primary care version of *DSM-5*. After careful consideration, they recommended this proposal not move forward, but that an electronic app designed to meet the needs of this group be developed. He presented the following recommendations to the Board.

1. **The APA Board of Trustees voted to disapprove the proposal for the development of a *DSM-5* Primary Care version as proposed going forward by the Psychiatry-General Medical Interface Study Group.**

2. **The APA Board of Trustees voted to approve American Psychiatric Publishing (APP) continuing work on the development of an electronic resource (app) based on DSM, with links to treatment information, to meet needs of diverse practitioners, including primary care physicians.**

3. **The APA Board of Trustees voted to approve an advisory board being appointed to support APP's development of the electronic resource, including representatives of primary care specialties, as well as psychiatric experts and reporting back to the DSM Planning Work Group.**

4. Will the Board of Trustees vote to approve a moratorium on any APA-initiated proposals for new ICD-10-CM codes?

   The APA Board of Trustees voted to refer this action back to the DSM Planning Work Group for additional discussion, with input from Dr. Darrel Regier.

SECTION 12. INFORMATIONAL ITEMS

There were no informational items.

SECTION 13. OLD AND UNFINISHED BUSINESS

A. Membership Benefit: Free DSM-5

Melinda Young, MD

Dr. Young summarized for the Board the progression of action paper 12.N Membership Benefit: Free *DSM-5*. She said the action paper was approved at the May Assembly as a member benefit offering free electronic *DSM-5* to all members. It was then presented to the May Board for approval at which time it was deferred to the July Board of Trustees meeting.

Will the Board of Trustees approve item 12.N Membership Benefit: Free DSM-5?

The APA Board of Trustees voted to refer this action to the Membership Committee to work collaboratively with staff to examine what benefits related to *DSM-5* could be provided to members, inclusive of the costs of each item and bring recommendations back to the Board of Trustees.

SECTION 14. NEW BUSINESS

A. Institute of Medicine Study
Jeffrey A. Lieberman, MD

Dr. Lieberman told the Board that during the National Institute of Mental Health Meeting, which he and other members of stakeholder organizations attended, an initiative was presented to support an Institute of Medicine Study to develop standards to evaluate the effectiveness of psychotherapy.

The APA Board of Trustees voted to refer a motion to the American Psychiatric Foundation concerning a request to fund an IOM study to develop standards to evaluate the effectiveness of Psychotherapy. The Board of Trustees suggested a possible funding level of $50,000.

SECTION 15. ADJOURNMENT

Dr. Lieberman thanked the Board and Association Governance staff for their excellent work. Dr. Lieberman adjourned the meeting of the Board of Trustees at 1:00 pm, Sunday, July 21, 2013. The next Board of Trustees meeting will be October 13-14, 2013 at the Philadelphia Marriott Downtown, Philadelphia, Pennsylvania.

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

SUMMARY OF ACTIONS
FINAL

Westin Arlington Gateway Hotel
Arlington, VA

July 20-21, 2013

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
2.A	**Requests to Remove Items from the Consent Calendar** Items 9.6 and 9.9 were removed from the Consent Calendar.	Medical Director's Office • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar as amended.	Medical Director's Office • Association Governance
5.A	**Minutes of the May 19, 2013 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its May 19, 2013 meeting. **[cc]**	Medical Director's Office • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Dilip Jeste, Dr. Jeffrey Lieberman, and Dr. Paul Summergrad. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the report of the status of the Assembly's New Initiative Fund. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
7.A.1	**Joint Reference Committee** The Board of Trustees voted to approve the APA becoming an Organizational Member of Health Level 7 (HL7) and to review this membership after no longer than three years.	Medical Director's Office • Finance & Business Operations
7.A.2	**Joint Reference Committee** The Board of Trustees approved the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the Council's budget). **[cc]**	Medical Director's Office • Finance & Business Operations • Education Council on Medical Education and Lifelong Learning
8.A.1	**Membership Committee Report** The Board of Trustees voted to approve a recommendation from the Membership Committee to award $2,500 to each district branch or state association listed in Attachment E as part of the District Branch Grant process.	Medical Director's Office • Finance & Business Operations o Membership
8.A.2	**Membership Committee Report** The Board of Trustees voted to approve dropping from APA membership the Member listed in Attachment G for failure to meet the requirements of membership. **[cc]**	Medical Director's Office • Finance & Business Operations o Membership
8.A.3	**Membership Committee Report** The Board of Trustees voted to approve dropping from APA membership the members listed in Attachment H for non-payment of 2013 APA dues if dues are not paid by the deadline. **[cc]**	Medical Director's Office • Finance & Business Operations o Membership
8.A.4	**Membership Committee Report** The Board of Trustees voted to approve dropping from APA membership the Members listed in Attachment I, who will be dropped by their district branch if dues are not paid by the deadline. **[cc]**	Medical Director's Office • Finance & Business Operations o Membership

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
8.A.5	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment J for International Membership. **[cc]**	Medical Director's Office • Finance & Business Operations o Membership
8.A.6	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment K. **[cc]**	Medical Director's Office • Finance & Business Operations o Membership
8.B.1	**Finance & Budget Committee Report** The APA Board of Trustees voted to approve an increase for CME course registration fees in 2014 as proposed.	Medical Director's Office • Finance & Business Operations o Annual Meetings
8.B.2a	**Finance & Budget Committee Report** The APA Board of Trustees voted to approve that there be no increase to member Annual Meeting registration fees for 2014 and that the registration fees for nonmembers increase as proposed in Attachment A.	Medical Director's Office • Finance & Business Operations o Annual Meetings
8.B.2b	**Finance & Budget Committee Report** The APA Board of Trustees voted to approve that the significant other/spouse rate be offered to one significant other/spouse of a full dues paying APA member paying a full time registration fee.	Medical Director's Office • Finance & Business Operations o Annual Meetings
8.B.3	**Finance & Budget Committee Report** The APA Board of Trustees voted to approve that there be no increase to member registration fees for the 2014 IPS and that the registration fees for nonmembers increase as proposed in Attachment B.	Medical Director's Office • Finance & Business Operations o Annual Meetings

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
8.B.4	**Finance & Budget Committee Report** Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C? **This action failed.**	Medical Director's Office • Finance & Business Operations o Membership
8.B.5	**Finance & Budget Committee Report** The APA Board of Trustees voted to approve the adoption of clarifying language to the procurement policy as amended. **Statement of Competition** APA/APF policy and federal regulations require that vendors/contractors be selected on the basis of competition to the maximum extent possible to ensure that the procurement is made in the best interests of the APA/APF and the government, consistent with the circumstances, price and other factors relevant to the particular action. These provisions apply to goods and services provided by all compensated vendors whether payment is made directly, or indirectly on a commission basis.	Medical Director's Office • Finance & Business Operations
8.D	**Audit Committee Report** The APA Board of Trustees accepted the 2012 Audited Financial Statements as presented.	Medical Director's Office • Finance & Business Operations
8.F	**Election Committee Report** The APA Board of Trustees voted to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on the use of APA, Area Council/State Association and District Branch resources. **[cc]**	Medical Director's Office • Association Governance
9.A.1	**Speaker's Report** The APA Board of Trustees voted to approve the retirement of the 1991 Position Statement: *Day Care for Preschool Children*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
9.A.2	**Speaker's Report** The APA Board of Trustees voted to approve the retention of the 2000 Position Statement: *Therapies Focused on Memories of Childhood Physical and Sexual Abuse*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.3	**Speaker's Report** The APA Board of Trustees voted to approve the Proposed Position Statement: *Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.4	**Speaker's Report** The APA Board of Trustees voted to approve the retirement of the Position Statement: *Delineation of Transcultural Psychiatry as a Specialized Field of Study*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.5	**Speaker's Report** The APA Board of Trustees voted to approve the retirement of the Position Statement: *Training of Minority Psychiatrists*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.6	**Speaker's Report** Will the APA Board of Trustees vote to approve the retirement of the Position Statement: *1995 Medical Psychotherapy*? **This action failed.** **(N.B.**: The Assembly's intention was to retain this position statement rather then retire it.)	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.7	**Speaker's Report** The APA Board of Trustees voted to approve the retirement of the Position Statement: *1968 Generic versus Proprietary Drugs*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.8	**Speaker's Report** The APA Board of Trustees voted to approve the Revised Position Statement: *Generic versus Proprietary Drugs*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
9.A.9	**Speaker's Report** The APA Board of Trustees voted to approve with minor revisions the Position Statement: *Legal Proceedings and Access to Care for Juvenile Offenders*. Mental illness and neurodevelopmental disorders can have a significant influence on criminal behavior in children and adolescents, and judicial responses to juvenile offenders may have an important impact on their access to treatment for such conditions. The American Psychiatric Association (APA) supports the principle that juveniles with mental illness and neurodevelopmental disorders should have the opportunity to obtain appropriate psychiatric assessment and treatment. Therefore, the APA supports procedures for responding to juvenile offenders that include explicit consideration of the level of development, the nature and impact of mental disorder, and the impact of legal decisions on the offender's access to appropriate care. The APA opposes statutes which permit or require juvenile suspects to be transferred or waived into adult court without judicial review.	Medical Director's Office • Association Governance • Education o Library & Archives
9.A.10	**Speaker's Report** The APA Board of Trustees voted to approve the Proposed Position Statement: *Use of Medical Marijuana for PTSD*. **[cc]**	Medical Director's Office • Association Governance • Education o Library & Archives

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
9.A.11	**Speaker's Report** The APA Board of Trustees voted to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services* with the following amendments to the paper. **Background and Support:** Although concern is understandably heightened when mass tragedies occur, the daily occurrence of murders and suicide due to the use of guns accounts for a ~~vast~~ far greater proportion of gun deaths. ~~Although people with mental disorders are at somewhat increased risk of committing violence towards others, only a minority of people with mental disorders are violent. Indeed, they are far more likely to be the victims than the perpetrators of acts of violence (7).~~ Although people with mental disorders, when treated, are not at increased risk of committing violence towards others, only a small minority of people with mental disorders, even without treatment, are violent.	Medical Director's Office • Association Governance • Education o Library & Archives
11.A.1	**ECP/MIT Work Group Report** The APA Board of Trustees voted to ask the Medical Director/CEO to prioritize staff to manage ECP membership marketing, recruitment and retention programs. Budget for the position to be developed during the budget process.	Medical Director's Office • Education • Finance & Business Operations o Membership
11.A.2	**ECP/MIT Work Group Report** The APA Board of Trustees voted to approve a placeholder budget of $25K for pilot initiatives for ECP recruitment and retention.	Medical Director's Office • Education • Finance & Business Operations o Membership

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
11.A.3	**ECP/MIT Work Group Report** The APA Board of Trustees voted to ask the President, in consultation with the MIT/ECP Workgroup, to assemble an ECP advisory panel. The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director/CEO annually. [Representatives from the Board, Assembly, and Fellows]	Medical Director's Office • Education • Finance & Business Operations o Membership
11.A.4	**ECP/MIT Work Group Report** The APA Board of Trustees voted to charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention.	Medical Director's Office • Education • Finance & Business Operations o Membership Membership Committee
11.C.1	**DSM Planning Work Group Report** The APA Board of Trustees voted to disapprove the proposal for the development of a *DSM-5* Primary Care version as proposed going forward by the Psychiatry-General Medical Interface Study Group.	Medical Director's Office • Office of Publisher • Finance & Business Operations
11.C.2	**DSM Planning Work Group Report** The APA Board of Trustees voted to approve American Psychiatric Publishing (APP) continuing work on the development of an electronic resource (app) based on DSM, with links to treatment information, to meet needs of diverse practitioners, including primary care physicians.	Medical Director's Office • Office of Publisher • Finance & Business Operations
11.C.3	**DSM Planning Work Group Report** The APA Board of Trustees voted to approve an advisory board being appointed to support APP's development of the electronic resource, including representatives of primary care specialties, as well as psychiatric experts and reporting back to the DSM Planning Work Group.	Medical Director's Office • Office of Publisher • Finance & Business Operations

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
11.C.4	**DSM Planning Work Group Report** Will the Board of Trustees vote to approve a moratorium on any APA-initiated proposals for new ICD-10-CM codes? The APA Board of Trustees voted to refer this action back to the DSM Planning Work Group for additional discussion, with input from Dr. Darrel Regier.	Medical Director's Office • Research Division • Office of Publisher • Finance & Business Operations
13.A	**Old and Unfinished Business** Will the Board of Trustees approve item 12.N Membership Benefit: Free DSM-5? The APA Board of Trustees voted to refer this action to the Membership Committee to work collaboratively with staff to examine what benefits related to *DSM-5* could be provided to members, inclusive of the costs of each item and bring recommendations back to the Board of Trustees.	Medical Director's Office • Office of Publisher • Finance & Business Operations o Membership Membership Committee
14.A	**New Business** The APA Board of Trustees voted to refer a motion to the American Psychiatric Foundation concerning a request to fund an IOM study to develop standards to evaluate the effectiveness of Psychotherapy. The Board of Trustees suggested a possible funding level of $50,000.	Medical Director's Office • American Psychiatric Foundation (July 2013 Board Meeting)

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
	Update on the litigation in CT against Anthem and WellPoint The APA Board of Trustees reaffirmed its intention to continue the fight to implement parity laws and to improve access to care. Staff informed the board that they had received hundreds of complaints from members regarding implementation of CPT codes in a manner that potentially violates parity. APA is addressing each complaint with the payers, some of which immediately changed their ways. Others have been more difficult. The APA Board of Trustees instructed staff to continue their efforts and do what is necessary to ensure implementation of the MHPAEA. The APA encourages anyone who is having difficulty with CPT code implementation, who has not already reported the problem to report the problem to www.psychiatry.org/cptparityabuses. (You will be prompted for your Member login.)	Medical Director's Office • Office of the General Counsel
EX.2.1	The Board of Trustees voted to approve the appointment of John Luo, M.D., for a three-year term (**2013–2016**) to the *Psychiatric News* Editorial Advisory Board.	Medical Director's Office • Office of Publisher o Psychiatric News
EX.2.2	The Board of Trustees voted to approve the appointment of Claudia Reardon, M.D., for a three-year (**2013–2016**) term to the *Psychiatric News* Editorial Advisory Board.	Medical Director's Office • Office of Publisher o Psychiatric News

American Psychiatric Association
Board of Trustees
Westin Arlington Gateway Hotel
Arlington, VA

July 20-21, 2013

FINAL AGENDA

SATURDAY, JULY 20TH

8:00 AM – 9:00 AM – Board of Trustees BREAKFAST (*F. Scott Fitzgerald D)*

9:00 AM–5:00 PM, Board of Trustees Meeting (*F. Scott Fitzgerald A/B)*

9:00 am **1. Call to Order –** Jeffrey A. Lieberman, MD

A. Introductions and Verbal Conflict of Interest Disclosures and Affiliations

9:10am **B. Fiduciary Responsibility of Board Members**
Colleen Coyle, General Counsel

2. Consent Calendar – Jeffrey A. Lieberman, MD

A. Requests to Remove Items from the Consent Calendar

B. Approval of Items on the Consent Calendar

ACTION:
Will the Board of Trustees vote to approve the Consent Calendar?

9:30 am **3. Report of the President** – Jeffrey A. Lieberman, MD

A. Brief Update
Jeffrey A. Lieberman, MD

9:50 am **B. Public Perception/Media Communications/Anti-Stigma**
Sharon Reis, Partner, GYMR Public Relations

10:10 am **C. Strategic Planning Discussions**
Paul Summergrad, MD

D. Executive Committee Report (*For Review and Appropriate Action*)

10:30 am **4. Report of the Medical Director/CEO** – James H. Scully, Jr., MD

A. MDO/CEO Presentation

5. Report of the Secretary – Maria A. Oquendo, MD

A. Minutes of the May 19, 2013 Board of Trustees Meeting

cc **ACTION:**
Will the Board of Trustees vote to approve the minutes of its May 19, 2013 meeting?

6. Report of the Treasurer – David Fassler, MD

11:30 am **A. Treasurer's Report**

B. Status of the Board Contingency Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report on the status of the Board of Trustees Contingency Fund? (Please see item BOT 6.B.)

C. Presidents' New Initiative Funds

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the President's New Initiative Funds for Dr. Jeste, Dr. Lieberman, and Dr. Summergrad? (Please see item BOT 6.C.)

D. Assembly New Initiative Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the Assembly's New Initiative Fund? (Please see item BOT 6.C.)

12:00 Noon – 1:00 PM LUNCH (*F. Scott Fitzgerald D)*

8. Reports from Standing Committees and Councils

1:00 pm **B. Finance and Budget Committee Report**
Alan F. Schatzberg, MD

ACTION 1:
Will the APA Board of Trustees approve an increase for CME course registration fees in 2014 as proposed?

ACTION 2:
Annual Meeting Registration:
a) Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2014 as proposed in Attachment A?

b) Will the APA Board of Trustees approve that the guest/significant other rate be offered to members only, and that nonmembers' guest/significant others pay at the regular registration rates?

ACTION 3:
Will the APA Board of Trustees approve changes to the fees for the 2014 IPS as proposed in Attachment B?

ACTION 4:
Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C?

ACTION 5:
Will the APA Board of Trustees approve the adoption of clarifying language to the procurement policy?

1:40 pm **A.** **Report from the Membership Committee**
Jonathan Amiel, MD

ACTION 1:
Will the Board of Trustees approve a recommendation from the Membership Committee to award $2,500 to each District Branch or State Association listed in Attachment E as part of the DB Grant process?

cc **ACTION 2:**
Will the Board of Trustees authorize dropping from APA membership the Member listed in Attachment G for failure to meet the requirements of membership?

cc **ACTION 3:**
Will the Board of Trustees authorize dropping from APA membership the members listed in Attachment H for non-payment of 2013 APA dues if dues are not paid by the deadline?

cc **ACTION 4:**
Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment I, who will be dropped by their district branch if dues are not paid by the deadline?

cc **ACTION 5:**
Will the Board of Trustees vote to approve the applicants listed in Attachment J for International Membership?

cc **ACTION 6:**
Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment K?

11. Work Group and Task Force Reports

2:10 pm **A.** **ECP/MIT Work Group**
Carolyn Rodriguez, MD and Jonathan Amiel, MD

ACTION 1:
Will the Board ask the Medical Director/CEO to dedicate staff to manage ECP membership marketing, recruitment and retention programs? (Budget for the position to be developed during the budget process)

ACTION 2:
Will the Board approve a placeholder budget of $25K for pilot initiatives for ECP recruitment and retention?

ACTION 3:
Will the Board ask the President, in consultation with the MIT/ECP Work Group, to assemble an ECP advisory panel? The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director/CEO annually.

ACTION 4:
Will the Board charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention?

2:50 pm **B.** **Role of Psychiatry in Healthcare Reform Work Group**
Paul Summergrad, MD, Chair

3:05 pm **D.** **Health Care Reform Strategic Action Work Group**
Howard Goldman, MD, Chair

3:30 pm **C.** **DSM Planning Work Group**
Steve Hyman, MD (speakerphone)

ACTION 1:
Will the Board of Trustees vote to approve the proposal for the development of a *DSM-5* Primary Care version not go forward as proposed by the Psychiatry-General Medical Interface Study Group?

ACTION 2:
Will the Board of Trustees vote to approve American Psychiatric Publishing (APP) continue work on the development of an electronic resource (app) based on DSM, with links to treatment information, to meet needs of diverse practitioners, including primary care physicians?

ACTION 3:
Will the Board of Trustees vote to approve appointment of an advisory board to support APP's development of their electronic resource (to include representatives of primary care specialties, as well as psychiatric experts) reporting back to the DSM Planning Work Group?

ACTION 4:
Will the Board of Trustees vote to approve a moratorium on any APA-initiated proposals for new ICD-10-CM codes?

4:00 pm **EXECUTIVE SESSION**

5:00 pm **ADJOURNMENT FOR THE DAY** (Must end at 5 pm, due to another event in the room.)

BOARD DINNER—Willow Restaurant
(Meet in the lobby at 6:45 pm to walk to restaurant. Dinner at 7:00 pm)

SUNDAY, JULY 21

7:00 AM – 8:00 AM – Board of Trustees BREAKFAST (*F. Scott Fitzgerald D*)

8:00 AM–2:00 PM – Board of Trustees Meeting (*F. Scott Fitzgerald A/B*)

8:00 am **EXECUTIVE SESSION** *(if necessary)*

8. Reports from Standing Committees and Councils Continued

8:40 am **C. Report from the APA/AMA Delegation** – Carolyn Robinowitz, MD

9:00 am **D. Audit Committee Report** – David Fassler, MD
Terri McKnight, CPA, Gelman, Rosenberg & Freedman

ACTION:
Will the Board of Trustees accept the 2012 Audited Financial Statements as presented?

E. Investment Oversight Committee Report (*For Information Only*)

F. Election Committee Report

cc **ACTION:**
Will the Board vote to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on use of APA, Area Council/State Association, and District Branch resources?

7. Report of the Joint Reference Committee – Paul Summergrad, MD

9:40 am **A. Joint Reference Committee Recommendations**

ACTION 1:
Will the Board of Trustees approve the APA becoming an Organizational Member of Health Level 7 (HL7)?

cc **ACTION 2:**
Will the Board of Trustees approve the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the Council's budget)?

10:00 am **9. Report of the Speaker** – Melinda Young, MD

A. Executive Summary

cc **ACTION 1:**
Will the Board of Trustees approve the retirement of the 1991 Position Statement: *Day Care for Preschool Children*?

cc **ACTION 2:**
Will the Board of Trustees approve the retention of the 2000 Position Statement: *Therapies Focused on Memories of Childhood Physical and Sexual Abuse*?

cc **ACTION 3:**
Will the Board of Trustees vote to approve the Proposed Position Statement: *Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients*?

cc **ACTION 4:**
Will the Board of Trustees vote to retire the Position Statement: *Delineation of Transcultural Psychiatry as a Specialized Field of Study*?

cc **ACTION 5:**
Will the Board of Trustees approve the retirement of the Position Statement: *Training of Minority Psychiatrists*?

cc **ACTION 6:**
Will the Board of Trustees approve the retirement of the Position Statement: *1995 Medical Psychotherapy*?

cc **ACTION 7:**
Will the Board of Trustees vote to approve the retirement of the Position Statement: *1968 Generic versus Proprietary Drugs*?

cc **ACTION 8:**
Will the Board of Trustees vote to approve the Revised Position Statement: *Generic versus Proprietary Drugs*?

cc **ACTION 9:**
Will the Board of Trustees vote to approve the Revised Position Statement*: Legal Proceedings and Access to Care for Juvenile Offenders*?

cc **ACTION 10:**
Will the Board of Trustees vote to approve the Proposed Position Statement: *Use of Medical Marijuana for PTSD*?

ACTION 11:
Will the Board of Trustees vote to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*?

11:00 am **10.** **Report of the American Psychiatric Foundation** – James H. Scully, Jr., MD Chairperson and Paul Burke, Executive Director

A. **Report from American Psychiatric Foundation**

12. Informational Items

13. Old and Unfinished Business

A. **Membership Benefit: Free DSM-5**
Melinda Young, MD

ACTION:
Will the Board of Trustees approve item 12.N Membership Benefit: Free DSM-5?

14. New Business

12:00 PM – 1:00 PM LUNCH (*F. Scott Fitzgerald D*)

15. Adjournment
Note: Dr. Lieberman plans to conclude the meeting by 2:00 pm.

Future Meetings

2013

October 13-14, 2013, Board of Trustees Meeting, (with Institute on Psychiatric Services), Philadelphia, PA
December 7-8, 2013, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA

2014

March 8-9, 2014, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
May 4, 2014, Board of Trustees Meeting, Marriott Marquis, New York, NY
July 12-13, 2014, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
(Note: New Date) ***September 9-10, 2014****, Board of Trustees Meeting, Hilton Crystal City, Arlington, VA*
December 13-14, 2014, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA

2015
March 14-15, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
May 17, 2015, Board of Trustees Meeting, Convention Center, Toronto, Canada
July 11-12, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
October 10-11, 2015, Board of Trustees Meeting, (w/Institute on Psychiatric Services), New York, NY
December 12-13, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA

BOARD OF TRUSTEES
JULY 2013 MEETING

ALL ACTIONS BEING PRESENTED FOR CONSIDERATION
(As of July 19, 2013)

Consent Calendar Items Notated by "cc"

5. Report of the Secretary – Roger Peele, MD

A. Minutes of the May 19, 2013 Board of Trustees Meeting

cc **Action:** Will the Board of Trustees approve the minutes of its May 19, 2013 Meeting?

6. Report of the Treasurer – David Fassler, 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. Jeste, Dr. Lieberman, and Dr. Summergrad?

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?

7. Report of the Joint Reference Committee – Paul Summergrad, MD

Action 1: Will the Board of Trustees approve the APA becoming an Organizational Member of Health Level 7 (HL7)?

cc **Action 2:** Will the Board of Trustees approve the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the Council's budget)?

8. Reports from Standing Committees and Councils

A. Report from the Membership Committee

Action 1: Will the Board of Trustees approve a recommendation from the Membership Committee to award $2,500 to each district branch or state association listed in Attachment E as part of the District Branch Grant process?

cc **Action 2:** Will the Board of Trustees authorize dropping from APA membership the Member listed in Attachment G for failure to meet the requirements of membership?

cc **Action 3:** Will the Board of Trustees authorize dropping from APA membership the members listed in Attachment H for non-payment of 2013 APA dues if dues are not paid by the deadline?

cc **Action 4:** Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment I, who will be dropped by their district branch if dues are not paid by the deadline?

cc **Action 5:** Will the Board of Trustees vote to approve the applicants listed in Attachment J for International Membership?

cc **Action 6:** Will the Board of Trustees vote to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment K?

B. **Report of the Finance and Budget Committee**

Action 1: Will the APA Board of Trustees approve an increase for CME course registration fees in 2014 as proposed?

Action 2: **Annual Meeting Registration:**

a) Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2014 as proposed in Attachment A?

b) Will the APA Board of Trustees approve that the guest/significant other rate be offered to members only, and that nonmembers' guest/significant others pay at the regular registration rates?

Action 3: Will the APA Board of Trustees approve changes to the fees for the 2014 IPS as proposed in Attachment B?

Action 4: Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C?

Action 5: Will the APA Board of Trustees approve the adoption of clarifying language to the procurement policy?

Action 6: Will the APA Board of Trustees approve up to $200K in 2013 for consulting services to enhance our communications strategies? It is expected that the American Psychiatric Foundation (APF) will fund an additional $70K for these services related to public education.

Action 7: Will the APA Board of Trustees approve the establishment of a Research Advisory Board for APA and APF?

D. Audit Committee Report

Action: Will the Board of Trustees accept the 2012 Audited Financial Statements as presented?

F. Report from the Election Committee

cc **Action:** Will the Board vote to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on the use of APA, Area Council/State Association and District Branch resources?

9. Report of the Speaker

cc **Action 1:** Will the Board of Trustees approve the retirement of the 1991 Position Statement: *Day Care for Preschool Children*?

cc **Action 2:** Will the Board of Trustees approve the retention of the 2000 Position Statement: *Therapies Focused on Memories of Childhood Physical and Sexual Abuse*?

cc **Action 3:** Will the Board of Trustees vote to approve the Proposed Position Statement: *Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients*?

cc **Action 4:** Will the Board of Trustees vote to retire the Position Statement: *Delineation of Transcultural Psychiatry as a Specialized Field of Study*?

cc **Action 5:** Will the Board of Trustees approve the retirement of the Position Statement: *Training of Minority Psychiatrists*?

cc **Action 6:** Will the Board of Trustees approve the retirement of the Position Statement: *1995 Medical Psychotherapy*?

cc **Action 7:** Will the Board of Trustees vote to approve the retirement of the Position Statement: *1968 Generic versus Proprietary Drugs*?

cc **Action 8:** Will the Board of Trustees vote to approve the Revised Position Statement: *Generic versus Proprietary Drugs*?

cc **Action 9:** Will the Board of Trustees vote to approve the Revised Position Statement: *Legal Proceedings and Access to Care for Juvenile Offenders*?

cc **Action 10:** Will the Board of Trustees vote to approve the Proposed Position Statement: *Use of Medical Marijuana for PTSD*?

Action 11: Will the Board of Trustees vote to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*?

11. Work Group and Task Force Reports

A. Report from the ECP/MIT Work Group

Action 1: Will the Board ask the Medical Director/CEO to dedicate staff to manage ECP membership marketing, recruitment and retention programs? Budget for the position to be developed during the budget process.

Action 2: Will the Board approve a placeholder budget of $25K for pilot initiatives for ECP recruitment and retention?

Action 3: Will the Board ask the President, in consultation with the MIT/ECP Workgroup, to assemble an ECP advisory panel? The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director/CEO annually.

Action 4: Will the Board charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention?

C. Report from DSM Planning Work Group

Action 1: Will the Board of Trustees vote to approve the proposal for the development of a *DSM-5* Primary Care version not go forward as proposed by the Psychiatry-General Medical Interface Study Group?

Action 2: Will the Board of Trustees vote to approve American Psychiatric Publishing (APP) continuing work on the development of an electronic resource (app) based on DSM, with links to treatment information, to meet needs of diverse practitioners, including primary care physicians?

Action 3: Will the Board of Trustees vote to approve an advisory board be appointed to support APPI's development of the electronic resource, including representatives of primary care specialties, as well as psychiatric experts, reporting back to the DSM workgroup?

Action 4: Will the Board of Trustees vote to approve a moratorium on any APA-initiated proposals for new ICD-10-CM codes?

13. Old and Unfinished Business

A. Membership Benefit: Free DSM-5

Action: Will the Board of Trustees approve item 12.N Membership Benefit: Free DSM-5?

Executive Committee
Conference Call Report
June 25, 2013

Executive Committee: Jeffrey Lieberman, MD; Paul Summergrad, MD; David Fassler, MD; Dilip Jeste, MD; James H. Scully, Jr., MD

Excused: Maria Oquendo, MD; Melinda Young, MD

Guest: Saul Levin, MD
Staff: Margaret Dewar; Ardell Lockerman; Colleen Coyle, JD; Terri Swetnam, PhD.; Rebecca Rinehart

Executive Committee Actions:

External Communications

Action: The Executive Committee voted to approve continuing to contract for services from GYMR from now until the end of 2013 with a budget not to exceed $200-300K.

Request to Increase Structural Budget:
This request is for the addition of FTEs (Full Time Employees) with one beginning mid-August 2013, one beginning mid-October 2013, and one beginning mid-November 2013. The focus of the positions will be on the development and implementation of (1) Association Strategy, (2) Programs for MIT/ECPs and (3) Collaboration with Allied Health Organizations to include psychiatric subspecialties. A final budget for each position will be included in the 2014 budget request, pursuant to a market-based review. Preliminarily, it is estimated they will increase the structural budget by up to $845K (annualized amount, which includes benefits). The amount required for 2013 (estimated at $209K, staged as noted) can be covered by salary savings from other vacant positions.

Action: The Executive Committee voted to approve the addition of 3 FTEs at an annualized cost of $845K beginning mid-August 2013.

Staff support for the APA President:

Action: The Executive Committee voted to approve the establishment of a work group of former APA Presidents to clarify the level of staff support to be provided to the APA President and President-Elect and make their recommendations to the Executive Committee by August 13th .

Item BOT # 4.A.
Board of Trustees
July 20-21, 2013

REPORT OF THE MEDICAL DIRECTOR/CEO

TO THE

BOARD OF TRUSTEES

AMERICAN PSYCHIATRIC ASSOCIATION

July 20-21, 2013

Respectfully Submitted By:

James H. Scully, Jr., M.D.
Medical Director/CEO

TABLE OF CONTENTS

EXECUTIVE SUMMARY

I am pleased to report to the Board of Trustees on highlighted activities in recent months.

The 2013 Annual Meeting program was a great success. There were over 400 sessions and 58 Courses presented. Revenue for the courses exceeded our expectations by earning $912,910.00 ($69,220 over budget). Much of the revenue increase had to do with the DSM-5 Master Course which had 500 attendees, and sold out prior to the meeting.

The total registration was 13,793 (compared to 11,114 in 2012). This total includes 6,255 members; 5,986 nonmembers. This total also includes 4,202 international registrants, of which 1,172 were members and 3,030 nonmembers. Major promotional efforts were put forth this year to try to increase attendance, such as targeted emails to special populations. We are currently conducting a survey of the attendees and will report results in the next report.

This year, member attendance again was greater than nonmember attendance International attendance increased by 61% from 2011. Approximately seventy-five percent of registrations were completed online.

In the area of **Advocacy,** the never-supposed-to-happen draconian cuts aka "sequester" to the federal budget went into effect on March 28. Under current law, the sequester will be in effect for nine years, unless Congress and the White House are able to reach a significant deficit reduction agreement that replaces it. Preliminary agreement discussions are being held between the Senate and White House. However, the likelihood of a swift resolution is small. Given the federal debt limit ceiling has been pushed to October and the Medicare Trust Fund will be solvent for two more years than previously calculated, hopes are dimming for a repeal of the sequester cuts in FY14.

Beginning at midnight on March 28, 3 to 5 percent reductions in FY13 spending were taken from non-defense discretionary programs (NDD). However, these 3 to 5 percent reductions are being squeezed into six months, meaning the actual drops in funding for the second half of FY13 are in the 6 to 10 percent range.

As previously reported, all Medicare services provided by physicians was subject to a 2

percent payment cut under the budget sequestration on April 1. The 2 percent cut will be imposed on the underlying charge that a participating physician receives from Medicare; coinsurance is not affected.

National Institute of Health has announced its sequester plan. The NIH did so in the Fall of 2012 by stating that they were funding awarded grants and activities at 90 percent. NIH Director Francis Collins, M.D., was adamant that inconsistent funding of scientific inquiry hurts biomedical research and was determined to minimize interruptions in funding. To that end, those affected knew to expect the reduction and to plan for the reduction. NIH does not anticipate furloughs at this time.

National Conference on Mental Health and APA Press Conference

On June 3, the White House hosted a meeting intended to kick off a national dialogue on mental health aimed at addressing stigma. APA, partnered with AMA, in providing information about pending joint efforts to disseminate information—such as APA's Typical or Troubled? Program, the "Let's Talk Facts" brochures—to interested state medical societies and medical specialty organizations.

APA was represented by President Jeffrey Lieberman, M.D., and Jeffrey Borenstein, M.D., Editor-In-Chief of Psychiatric News and president and CEO of the Brain and Behavoir Research Foundation. Paul Summergrad, M.D., APA President-elect attended on behalf of the AHA. Both President Obama and Vice President Biden gave keynote remarks.

Following the National Conference on Mental Health, APA hosted a press conference at the National Press Club to discuss some of the pressing issues in mental health care. Participating in the press conference were Drs. Lieberman, Summergrad, Borenstein; former Member of Congress Patrick Kennedy, a senior strategic advisor for APA and James H. Scully Jr., M.D., APA Medical Director also participated.

Coalition on Mental Health and Violence Issues

On Monday, April 29, the American Psychiatric Association (APA) convened the first meeting of the Coalition on Mental Health and Violence Issues. Participants in the meeting included the American Medical Association, the American Association for Geriatric Psychiatry, the American Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry and the Law, the American Academy of Addiction Psychiatry, the American Association of

Community Psychiatrists, the Academy of Psychosomatic Medicine and the American Association for Emergency Psychiatry. The group, which included AMA president Jeremy Lazarus, M.D., agreed that the problem of violence is complex in American society, but that steps can be taken to lessen its occurrence. Those steps entail the cooperation of mental health organizations, federal, state and local government agencies, the legislative and judicial branches of government and the public at large to identify potentially dangerous individuals and intervene before major violent acts have been committed.

Insurance Coverage and Managed Care Issues

Insurance coverage and managed care issues will remain front and center for the foreseeable future. The key categories of OHSF activities in this are relate to: Medicare and its administrative contractors; commercial payers, including MBHOs; Medicaid, including traditional state programs, managed care arrangements, and the new expansion plans established under the ACA; and required Health Exchange Plans under the ACA.

OHSF and DGR have conducted webinars and posted content on the APA's website regarding health exchanges. OHSF is working with the Assembly executive committee to establish a more formal educational outreach effort for APA members on health reform topics. Primary foci of these efforts will be: 1) basic information about the plans that are part of the exchanges; 2) practical contracting and payment issues for physicians providing services with these plans; 3) models of integrated care and educational training materials regarding these; and 4) other pertinent payer initiatives spawned by health reform. Independent the member education effort, there are a series of policy, legal issues regarding compliance with the Parity Act and key nondiscrimination provisions of the ACA.

OHSF, in conjunction with APA's General Counsel, is involved in a wide variety of compliance and enforcement activities regarding the Parity Act. It is anticipated that the details regarding this activity will be reported in executive session.

OHSF continues to maintain its ongoing, collaborative relationship with CMS staff to ensure that psychiatrists treating Medicare patients will be able to prescribe appropriate medications without an undue administrative burden. Staff continues to assist members with problems they encounter with Part D prescribing, and it should be noted that policy changes were made as a result of these problems having been brought to the attention of CMS staff.

DSM-5

Ahead of the release of the DSM-5, OCPA prepared a comprehensive media audit of all APA and DSM-5 coverage from October 2012- April 2013. The full report is available in PowerPoint format and details what types of outlets are covering the APA and DSM-5 and how frequently. This report provides a strong foundation to construct future earned media strategies.

Upon release of the DSM-5 in May, DGR worked with OCPA and GYMR staff to disseminate appropriate materials regarding the manual's components and revisions to staff on key Congressional committees, as well to offices friendly to mental health policy. As of the writing of this report, no Member of Congress has expressed any indication to take action with respect to DSM-5, such as holding a hearing.

In the area of Education, **Graduate Medical Education,** The results from this year's National Resident Match Program exhibit the highest position fill rate (99.4 percent) in NRMP history. The 2013 Match offered a total of 29,171 PGY-1 and PGY-2 positions, a combined increase of 15.8 percent over 2009. Compared with 2012, there were 2,399 (or 9.0 percent) more positions in 2013. A key contributor to this change was psychiatry (categorical) with an increase of 242 positions (6.7 percent).

Psychiatric News launched a totally revamped, dynamic, graphic-driven Web site in May. The Web site is built so that *Psychiatric News* is now in an "online-first" publication environment in which news and other timely material of interest to APA members can be posted as developments occur. Articles from the print publication will also be posted on the Web site, but the site will no longer be just a "mirror image" or archive copy of the print version. The site is also optimized for easy mobile and tablet reading and includes video and audio reports. Development of an app for *Psychiatric News* and other PsychiatryOnline products is planned for 2014, which will further streamline multichannel electronic distribution of content. Feedback about the new site has been positive: usage (that is, visitors to the Web site) jumped from 42,500 in March to about to 106,000 in May.

Development of all DSM-5 text was completed in March. All chapter proofs were reviewed by the Task Force Chair, vice-Chair, text editors, research director, Division of Research staff, as well as outside reviewers (e.g., coding consultants). Staff from APP also worked

closely with the Division of Research to reconcile conflicts between DSM-5 text/criteria (e.g., specifiers) and codes/coding notes for ICD-9-CM and the forthcoming ICD-10-CM. With assistance from Division of Research, APP implemented the final stages of typesetting in preparation for indexing and printing. The manuscript was shipped for printing at the end of March and was available for publication on May 18, 2013, at the APA Annual Meeting. Following DSM-5's release, the DSM5.org Web site was redesigned to reflect new post-publication user needs. Division of Research staff will continue to work with DSM-5 stakeholders to enhance dissemination and implementation of DSM-5. Documentation of decision-making for DSM-5 is currently underway to support the compilation of DSM-5 Sourcebooks.

See remainder of report for updates from APA divisions, departments and offices.

A. DIVISION OF ADVOCACY

Eugene D. Cassel, J.D., Special Counsel and Director

A.1 Department of Government Relations
A.2 Office of Healthcare Systems and Financing
A.3 Office of Communications and Public Affairs

The Division report covers the period March through June 2013. Updates on Medicare physician payment and the SGR, 2014 CR, psychiatrist workforce, sequestration, appropriations, White House activities, APA Mental Health and Violence Conference, gun control legislation, regulatory and state initiatives (including scope-of-practice legislation) and APAPAC are contained in the Department of Government Relations report. The Office of Communications and Public Affairs (OCPA) details our myriad communications and press initiatives. The Office of Healthcare Systems and Financing (OHSF) addresses the ongoing work of the BOT Healthcare Reform Strategic Action Work Group, mental health parity implementation issues, Medicare and Medicaid practice matters, CPT educational outreach, new Health Insurance Exchanges amongst other initiatives.

A.1 Department of Government Relations

Nick Meyers, Director

The polarization in Washington continues to hamstring efforts made by both parties to address numerous issues important to APA, such as sequestration and public health funding, possible Sustainable Growth Rate (SGR) reform, and possible mental health legislation. While the White House focuses on a public relations campaign for the Patient Protection and Affordable Care Act, Congress is prioritizing immigration reform, scandals involving the Obama Administration, and the unrest in Syria.

The Department of Government Relations continues to advocate across the spectrum of issues surrounding patient access to treatment, reimbursement of physicians, veterans' medical and mental health care, and the like. Much of the Department's energies are expended on collaborative work with the Office of Healthcare Systems and Financing and the Office of Communications and Public Affairs. The former has been heavily engaged (with DGR) on a nearly endless procession of regulations implementing the health reform law, including health insurance exchanges. OCPA, meanwhile, has been an invaluable ally in publicizing and helping to frame numerous difficult issues facing APA in the Congress and the federal Agencies.

Here is a brief summary of the major issues facing the Department and APA:

Congressional Budget Activity for FY14

The House passed Rep. Paul Ryan's 2014 budget on March 21. The 221-207 vote was mostly party-line. The spending plan aims to bring the federal books into balance in 10 years by repealing President Obama's health care law, overhauling Medicare by switching it to a voucher program, block-granting Medicaid, and reducing education spending. Given the diametric opposition of the House and Senate budget resolutions, for the sixth year in a row, there will be no unified budget plan between the chambers. The Senate's 2014 budget was also passed along party lines. That chamber's budget differs from the House-passed budget by approximately $90 billion. Congress is once again headed for a fiscal show-down in the fall.

President Obama's Proposed FY 14 Federal Budget

The President's proposed $3.77 trillion fiscal 2014 budget would increase spending in 2014 by nearly $160 billion—a product of both canceling the previous sequester and implementing the President's new spending initiatives. Many of the President's plans to cut spending would phase in toward the end of the 10-year budget window, effectively trading the pain of sequestration now for cuts in entitlement spending later.

It should be noted that President Obama's FY14 proposed budget is a position platform and messaging document much in the same way that the House- and Senate-passed FY14 budget plans are not binding. Neither the House nor Senate budget plan is acceptable to the other chamber, and President Obama has stated his proposed budget is an effort to strike the middle ground.

Obama Administration Proposes to Fund Effort to Treat Brain Injuries and Diseases

On April 2, President Obama presented a $100 million effort to map out the human brain with the aim of discovering new ways to treat Alzheimer's, epilepsy and other brain injuries and diseases. The BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative was first mentioned by the President in his State of the Union address in February. It will be a joint effort by the National

Institutes of Health, Defense Advanced Research Projects Agency and the National Science Foundation. The National Institutes of Health will take the lead on the project, which is also seeking private-sector partners. APA President Dilip Jeste, M.D., attended the announcement. Congress must appropriate the funds for the BRAIN Initiative.

APA Member Participates in Mental Health Briefing on Capitol Hill

On April 14, APA Member Teo-Carlo Straun, M.D., gave a presentation on his experience with SAMHSA's Minority Fellowship Training program as part of a briefing on workforce needs to Senate staff members on Tuesday. Dr Straun's development of his "Barbershop Initiative" highlighted innovative methods to reach underserved populations.

Congressional Activities Related to Gun Violence

The Senate debated comprehensive gun control legislation (S. 649) in April. The debate largely stemmed from the political reaction to the tragedy at Sandy Hook Elementary School in Newtown, Connecticut, in December, 2012. Despite overwhelming public support on proposals such as instituting mandatory background checks on all firearms sales, the Senate failed to pass any legislation, and the House refused to bring any gun control measure to the floor.

The Senate bill failed after a bipartisan amendment concerning background checks was not adopted. Sponsored by Senators Joe Manchin (D-WV) and Pat Toomey (R-PA), the amendment expanded background checks to include all commercial and online gun sales. It was viewed as the necessary foundation upon which other ancillary issues, such as the illegal trafficking of firearms and mental health service enhancement, could be added. The amendment required a 60-vote threshold in order to stave off any filibuster attempt. The vote was 54-46. Majority Leader Reid voted "no" as part of a procedural move that allows him to call up the measure again at a later date.

Following the defeat of the Manchin-Toomey amendment, several other amendments were defeated largely along party lines. These included a Grassley (R-IA) substitute amendment, a Leahy (D-VT)/Collins (R-ME) amendment to reduce the illegal trafficking of firearms, a Cornyn (R-TX) amendment to establish reciprocity for state

permits to carry concealed weapons, a Feinstein (D-CA) amendment to prohibit the future manufacture and sales of assault weapons, a Burr (R-NC) amendment to establish a separate appeals process for veterans adjudicated as mentally ill, and a Lautenberg (D-NJ) amendment to prohibit large capacity ammunition clips. With the exception of the Leahy amendment, all of these measures were viewed as Democratic or Republican "poison pill" measures, and were bound to fail regardless of the Manchin-Toomey measure.

Two additional votes were held on April 18: a Barrasso (R-WY) measure that prohibits the reporting of certain gun ownership data and a Harkin (D-IA)/ Alexander (R-TN) measure that reauthorizes and expands several mental health provisions within DOE and SAMHSA. Both were adopted and the Harkin/Alexander measure was nearly adopted unanimously (95-2). However, given that the underlying legislation lacks a bipartisan compromise on an issue central to the gun control debate, these adopted amendments were set aside.

APA's priorities in this bill centered on two issues: mental health early identification training, and NICS reporting of mental health records.

Mental Health Early Identification Training: DGR successfully worked with Harkin and Alexander staff on language that would make APF's Typical or Troubled? program eligible for assistance under both SAMHSA and DOE. These provisions were included in the bipartisan mental health amendment that the Senate overwhelmingly adopted 95-2 on April 18. Despite the failure of the underlying gun bill, the affirmative vote was good to have in the record books. Both Harkin and Alexander have indicated to DGR staff that they intend to work to pass the provision as a standalone bill (S. 689). While the Senate has coalesced around a bipartisan mental health package, the House majority is taking a more uncertain route pending the conclusion of House Energy & Commerce Oversight Subcommittee Chairman Tim Murphy's (R-PA) study of the country's mental health system. Lawmakers in the House majority remain reticent to tackle the most pressing federal funding concerns of APA and the mental health community.

NICS Reporting of Mental Health Records: DGR was actively engaged with staff to Senators Graham (R-SC) and Begich (D-AK) on attempts to clarify reporting

requirements for individuals adjudicated as mentally incompetent. APA aligned itself with concerns raised by Paul Appelbaum, M.D., and other experts in mental health law concerning serious loopholes in proposed Graham-Begich language (S. 480). Ultimately, Senators Graham and Begich never filed their bill as an amendment to the gun control legislation; however, both Graham and Begich staff listened to the concerns raised by both Dr. Appelbaum, as well as additional concerns identified by DGR staff, and indicated a desire to modify the bill accordingly. DGR will continue engaging these offices beyond the life of the current gun control bill.

Moving Forward: The defeat of S. 649 constituted a major defeat for the Obama Administration and a major victory for gun advocates, such as the National Rifle Association. At this juncture, it is impossible to predict when, or if, the Senate will return to gun control legislation. Meanwhile, the House has no plans to take up gun control. House interest was tepid at best even when the bill's Senate prospects were brightest.

DGR will remain engaged on the priorities outlined above. APA may also want to consider strategies, such as a Hill briefing, to educate Congress more fully about the relationship between mental health and violence. Debates on the gun control bill featured many speeches that intentionally or unintentionally criminalized mental illness, especially surrounding NICS reporting requirements.

Medicare Sustainable Growth Rate

Repealing the SGR remains the APA and physician community's highest priority. In late December Congress extended the one-year SGR patch until December 31, 2013, thus staving off an imminent threat of significant cuts to Medicare physician reimbursement. The extension was done with the expectation that Congress would proactively work this year to repeal the SGR and replace it with reimbursement formulae that favor both integrated care approaches and quality measures.

Recent news and activity has indicated positive signs for the movement towards permanent SGR repeal and replacement. The Congressional Budget Office (CBO) said in February it would cost $138 billion to repeal the flawed Medicare Sustainable Growth Rate (SGR) formula, a more than $100 billion drop from previous estimates due to the formula's treatment of reduced spending on physician services in recent

years. In related news, work continues in the House Ways and Means and House Energy and Commerce committees to draft legislation for consideration before the August recess addressing the future of Medicare physician reimbursement. The committees envision a framework that creates a period of payment stability followed by the introduction of payments based on provider performance in clinical quality measures and other 'quality improvement activities', with required collaboration between medical societies and the Secretary of Health and Human Services. Many details are still unknown and APA is in close communication with committee members and staff to advocate for psychiatric access in the Medicare program. Several rounds of draft frameworks and solicitation for feedback from the physician community have been released, and our responses can be viewed on the DGR website. Bipartisan legislation has also been introduced by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV) to address the SGR.

Meanwhile, Senate Finance Committee Chairman Max Baucus (D-MT) and Ranking Member Orrin Hatch (R-UT) are considering payment models currently being tested at the Center for Medicare and Medicaid Innovation (CMMI) as potential replacements to the SGR.

Medicaid at Medicare reimbursement rates

Currently, Medicaid reimbursement rates for psychiatry are not adequate to support access to services for millions of Americans, especially in community based settings. Finding office based outpatient psychiatrists that accept Medicaid is difficult in many states, and psychiatrists in larger programs including CMHCs are often salaried to cover the gap in reimbursement rates. Legislation has been introduced in both chambers of Congress (H.R.1838/S.755) to add psychiatrists, neurologists, and OB/GYNs to a provision that brought parity between Medicaid and Medicare reimbursement rates for evaluation & management services. APA has been and will continue actively lobbying on this priority issue.

IPAB Repeal

In January Representative Phil Roe, M.D. (R-TN) reintroduced the Protecting Seniors' Access to Medicare Act, H.R 351, legislation that would repeal the controversial Independent Payment Advisory Board (IPAB). IPAB is a provision passed in the Affordable Care Act that sets up a 15 member panel that has the power to

recommend cuts to the Medicare program and enact them without proper and usual Congressional oversight and approval. Representative Roe is joined by lead co-sponsor Rep. Allyson Schwartz (D-PA) and 82 original co-sponsors. Representative Roe remarked upon introduction: "I am proud to reintroduce this important legislation. As a physician with more than 30 years of experience, I find the ability of this board to intervene in the patient-doctor relationship particularly troubling. I believe my bill is a testament to the fact that members of Congress can put party politics aside, come together and do what's right for our seniors." APA supports the repeal of IPAB and will keep you updated as this effort moves forward.

House Approves Abortion Ban

On June 18, the House of Representatives approved legislation to ban abortions starting at 20-weeks of pregnancy. The measure includes exceptions if a woman is raped and reports it within 48 hours, or if a minor is a victim of incest. The bill passed 228–196, largely along strict party lines. Due to strong opposition in the Senate, it is very unlikely that the legislation will become law; even if the bill were to pass the Senate, President Obama has pledged to veto it.

Physician Payment Sunshine Act Implementation

In late January, HHS released the Final Rule to implement the Physician Payment Sunshine Act. The APA designed a brochure to explain this pharmaceutical and medical device manufacturer reporting law which requires applicable pharmaceutical and device manufacturers to begin collecting data on "reportable" payments and transfers of value it makes to physicians beginning August 1. As part of the APA's Annual Meeting, a workshop with Dr. Scully on the Sunshine Act was convened. Additionally, the APA distributed its Sunshine Act brochure to physicians throughout the duration of the conference. The APA plans to sponsor a webinar on the Sunshine Act later this summer, in advance of August 1. The APA's Sunshine Act brochure directs APA members to the Sunshine Act webpage the APA established at www.psychiatry.org, which features its analysis of the Sunshine Act as well as links a Sunshine Act webpage set up by the American Medical Association. The brochure also directs members to an Open Payments website CMS has designed to explain the Sunshine Act to physicians as well as allow them to register so they may receive applicable manufacturers' reports to CMS once submitted. The APA continues to participate in Sunshine Act working groups comprised of regulatory affairs personnel

and general counsel from the AMA and physician specialty societies in an effort to organize Sunshine Act education for physicians across the country.

The APA has put together a summary which addresses numerous provisions of the Final Rule to the Physician Payments Sunshine Act. We strongly urge APA members to view this document via the APA's website at http://www.psychiatry.org/advocacy--newsroom/advocacy/apa-analysis-on-final-physician-payment-act-rule. Sunshine education materials can be accessed at www.psychiatry.org/sunshineact.

Psychologists as "Physicians" Under Medicare

APA continues to actively oppose legislation introduced by Senator Sherrod Brown (D-OH) and Rep. Jan Schakowsky (D-IL) to include clinical psychologists under Medicare's definition of "physician". DGR has activated our grassroots network and engaged with APA District Branches to discourage support for these bills.

The APA fact sheet opposing H.R. 794/S. 1064 can be found at the following link: http://www.psychiatry.org/advocacy--newsroom/advocacy/non-physician-scope-of-practice

APA Psychiatric Workforce Proposals

NATIVE AMERICANS

On May 16, Kurt Schrader (D-OR) introduced H.R. 2037: the Native American Psychiatric and Mental Health Improvement Act. Developed and spearheaded by APA, this legislation authorizes a five-year demonstration project to identify and disseminate evidence-based best practices on recruiting, training, deploying, and professionally supporting psychiatrists in Indian country. The bill is supported by over 40 tribal nations in the Pacific Northwest, as well as several regional and national tribal organizations. DGR is currently working to secure an endorsement from the Alaska Tribal Health Consortium, which DGR hopes will propel Don Young (R-AK) to join Schrader as an original cosponsor of H.R. 2037, as well as Senator Lisa Murkowski (R-AK) to join Ron Wyden (D-OR) on a Senate companion bill.

VETERANS

DGR has modified the proposed Ensuring Veterans Resiliency Act, which would repurpose up to 50 unfilled GME residencies as psychiatric residency slots afilliated with the VA. Meetings with key committee staff over the past month have been positive, and DGR will continue to work to find a way to advance this proposal forward as Congress continues its long debate on improving veterans healthcare.

From the results found in the report, the psychiatric physician pipeline appears to offer a substantial growth of career interests for residents entering the specialty field. Of the 1,360 positions offered for categorical psychiatry, the fill rate for all applicants increased from 96.6 percent in 2012 to 97.8 percent in 2013. Moreover, the percentage of positions filled by U.S. seniors declined from 55.1 percent to 50.1 percent in 2013, the lowest fill rate by U.S. seniors since 1998. While foreign-trained physicians concentrated in a few specialties, including psychiatry (categorical) accounting for 6.4 percent of the total foreign-trained residents. The NRMP report illustrates an optimistic outlook of the psychiatric physician pipeline.

Regulatory Update

Implementation of health care reform, together with implementation of the mental health parity law, is a major source of activity by both DGR and Healthcare Systems, increasingly in tandem. The rules proposed to operationalize various aspects of the laws have become critically important to our patients and members. Just one initial guideline (i.e. Essential Health Benefits) has posed enormous challenges to the profession and patients; rather than establish a national standard, the Obama Administration has derogated virtually all of the responsibility to the states, thus potentially requiring APA to work in close partnership with our members in all 50 states on extremely complex baselines that vary greatly from state to state, largely as a function of the diverse state-required benefits states have previously enacted which will get rolled into all essential health benefits benchmark plan types which are regulated by state insurance law.

Essential Health Benefits

In a 16 December 2011 Bulletin, the Secretary of HHS assigned the design of states' essential health benefits packages to the states. While the Secretary set limitations on the types of insurance plans states could select as benchmark health care plans to

which to peg their essential health care benefits, the Secretary provided the states with much leeway in the overall composition of their individual essential health benefit packages.

Rules setting forth the minimum standards for the design of essential health benefits came out throughout the summer and fall of 2012. The content of the rules largely paralleled the subregulatory guidance released in 2011. Now, that all states have submitted their benchmark plan selections to HHS, we know that all but five states have selected one of their states' three largest small group employer health plans to be the benchmark plan to which their essential health benefits will be pegged. Consequently, there is no "one size fits all" look for health reform across the United States. The strength of each state's benchmark plan essential health benefits will be a function of what state-required benefits which meet HHS's contracted definition of state-required benefits (have to be about the treatment and care of the insured and cannot be about provider types and provider reimbursement) were on the given state's books before December 31, 2011 and thus were permitted by HHS to be rolled into the given state's benchmark plans at no additional cost to the state.

On February 12, 2013, the APA Division of Advocacy hosted a webinar titled ACA Health Insurance Exchanges: A Primer to educate members on state health exchange types, benchmark plan selection, essential health benefits, and the interaction between the federal parity law and the essential health benefits. Almost 140 members enrolled in the webinar. The APA encourages its members to download this health insurance exchange webinar from its website at http://www.psychiatry.org/advocacy--newsroom/advocacy/apa-holds-webinar-on-health-insurance-exchanges.

Following states' submission of their benchmark plan selections to HHS, the APA has been researching the plans selected to assess to what extent the plans need to be enhanced to comply with the federal mental health parity law, the Mental Health Parity and Addiction Equity Act of 2008. The APA has been thoroughly reviewing certificates of coverage benchmark plan issuers have filed with HHS as well as terms of these issuers' exchange contracts.

The Board has provided the Division of Advocacy with funds to be used to educate members on state health care exchanges. The APA's Division of Advocacy has been researching the statutory provisions, as well as HHS rulemakings, that will impact the benchmark plans to be sold on states' exchanges. The complexity of this project stems from the Administration's decision to assign states the function of developing network adequacy standards and means of assessing plans' compliance with the ACA's numerous provisions. The APA aspires to design Frequently Asked Questions on the topic of state health exchanges, including what contractual provisions to be aware of when scrutinizing a given state's benchmark plan contract and contemplating whether or not to join the plan's network, as well as sponsor additional meetings on health exchanges, which members can access.

The APA has created a resource webpage at http://psychiatry.org/statehealthexchanges intended to assist members and state district branches with their selection of a health exchange essential health benefits benchmark plan. This webpage includes links to guidance issued by HHS in December 2011 on the creation of essential health benefits packages as well as links to white papers on health insurance exchanges, essential health benefits, and mental health parity that have been drafted by top health policy organizations, like the Kaiser Family Foundation and the Alliance for Health Reform, within Washington, DC.

Mental Health Parity

The APA remains committed to ensuring the spirit and letter of the Mental Health Parity and Addictions Equity Act of 2008 law remains part of the implementation process. Following HHS's issuance of an Interim Final Parity Rule in February 2010 that offered little guidance with respect to the scope of services to be covered by MHPAEA, how non-quantitative treatment limitations are to be addressed, and whether or not Medicaid managed care organization carve-outs come under the MHPAEA, the Department of Government Relations, in conjunction with APA's Office of Health Care Systems and Finance, has asked the three federal agencies tasked with implementing MHPAEA for the issuance of a Final Parity Rule to address these more ambiguous issues.

Over the past year, staff from the Office of Healthcare Systems and Finance and the Department of Government Relations have met repeatedly with key regulators from

HHS, Department of Labor, and Treasury, as well as members of Congress, to push for the issuance of final regulatory guidance on MHPAEA. The APA has learned that a Final Rule to operationalize MHPAEA will be released in late 2013, possibly with additional state health exchange regulatory guidance. HHS officials have told the APA a Final Rule will address "scope of services" as well as the "recognized clinically appropriate standard of care" exception all too frequently asserted by insurers when denying payment on a patient's mental health claim. Much to the chagrin of the APA staff, HHS has said the Final Rule will not address the adequacy of provider networks. The APA is hopeful the adequacy of provider networks, which has been identified by HHS in the MHPAEA Interim Final Rule as an example of a non-quantitative treatment limitation, will be addressed in future regulatory guidance implementing essential health benefits.

HIPAA

HHS released a Final HIPAA Omnibus Rule in late January 2013. The APA is pleased with the Final Rule's inclusion of several additional privacy protections for patients, including permitting patients to ask for a copy of their electronic medical record, enabling patients who pay with cash to instruct their health care providers to not make information about their treatment available to insurers, and requiring health care providers who are HIPAA covered entities (CEs) to include within their Notice of Privacy Practices (NPPs) a statement of the right of patients to be notified following a breach of their protected health information.

While the APA advocated for the HIPAA Privacy Rule's permanent protection of decedents' health information, HHS has modified the definition of "protected health information" so that the HIPAA Privacy Rule does not protect the individually identifiable health information of persons who have been deceased for more than 50 years beyond their deaths. HHS emphasizes that this 50-year period of protection for decedent health information does not supersede or interfere with state or other laws that provide greater protection of decedents' individually identifiable health information or the professional responsibilities of mental health or other health care providers. Additionally, HHS would permit CEs to disclose a decedent's information to family members and others who were involved in the care or payment for care of the decedent prior to death," unless disclosure counters the prior expressed preference of the deceased individual as known to the CE.

HHS redefines "breach" and decides against devising a "bright line" rule for breach notification, arguing a bright line standard would be costly and unduly burdensome to implement. To ensure the breach provision is applied uniformly and objectively by CEs and business associates, HHS has removed the harm standard and modified the risk assessment to focus more objectively on the risk that the protected health information has been compromised. Therefore, the Final Rule does not require breach notification if a CE or business associate, as applicable, demonstrates through a risk assessment that there is a low probability that the protected health information has been compromised, rather than demonstrate that there is no significant risk of harm to the individual.

HHS broadens the list of persons who may be liable for HIPAA Privacy Rule violations to include subcontractors employed by a CE's business associates. A four-tier financial penalty structure is set for breaches deemed serious enough to warrant a federal-imposed penalty. Fines range from $100 to $50,000 per violation, with a $1.5 million cap on violations of an identical provision occurring within a calendar year.

The Final Rule additionally allows for subcontractors to a CE's business associates to be directly liable under HIPAA while also requiring CEs to modify their Notices of Privacy Practices (NPP) to include a statement indicating that most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of an individual's protected health information require authorization, as well as a statement that other uses and disclosures not described in the NPP will be made only with authorization from the individual. Additionally, a CE's NPP must advise individuals of their right to restrict disclosures of protected health information to a health plan with respect to health care for which the individual has paid fully out-of-pocket. Members can access the APA's analysis of the Final HIPAA Rule at http://www.psychiatry.org/advocacy--newsroom/advocacy/apa-reviews-final-hipaa-privacy-rule

The APA also recently responded to an Advanced Notice of Proposed Rulemaking issued by the Office of Civil Rights that solicited comments on allowing HIPAA-

covered entities, including physicians and hospitals, to report persons who have been adjudicated as falling within the National Instant Criminal Background Check System (NICS) mental health prohibitor category directly to NICS. The APA stated its preference for courts doing NICS reporting. It provided several reasons for not supporting the enactment of state mandates that would allow physicians or hospitals as HIPAA-covered entities to report to NICS. Chief among these reasons is the importance of the physician-patient privilege to a psychiatric patient's ability to maximize his/her psychiatric treatment. In instances in which a state's infrastructure may not allow all of its courts to report to NICS, the APA expressed its support for allowing state mental health agencies, which are a class of HIPAA-covered entity, to report to NICS, so long as prior to this reporting, the given state has enacted privacy protections and a system for redressing possible grievances that could arise.

Following Newtown, several members of Congress have asked to what extent HIPAA privacy protections may be an impediment to clinicians disclosing whether or not a patient of theirs poses imminent harm to him or herself or a third party. APA has reached out to the Office of Civil Rights at HHS, as well as to colleagues in the American Medical Association, to work on the development of educational materials that may better assist physicians in understanding in what circumstances HIPAA permits them to disclose a patient's protected health information.

State Scope of Practice

AZ-While Arizona introduced SB 1008--legislation that would permit psychologists to practice medicine via rules established by the state's psychology board--it failed to follow the state's "sunrise review" process prior to introduction and, by rule, is not eligible to be considered during the legislature's session.

HI-Hawaii psychologists again sought to secure prescribing authority through the legislature. SB 1219 would grant such authority by establishing a four year pilot program allowing psychologists to prescribe under the supervision of a physician at a federally qualified health center. Qualifying psychologists would have to have obtained a MS in clinical psychopharmacology and have completed "relevant clinical experience sufficient to obtain competency . . . of at least one year, involving four hundred hours treating a diverse population with no fewer than one hundred patients

. . . including at least two hours of weekly supervision." As of mid-February, Hawaii Psychiatric Medical Association reported that their members, working in close concert with long-time HPMA lobbyist Robert Toyofuku, had succeeded in bottling up the bill in Senate committee, apparently killing the bill for the year. The situation in Hawaii is complicated by the establishment of a new MS in Clinical Psychopharmacology program at the University of Hawaii, Hilo. This program was created initially through a 3-year grant to the Tripler Army Medical Center, presumably under the auspices of the late Senator Daniel Inouye. Of concern is the potential for the MSCP to use graduates to generate pressure on the legislature to enable them to prescribe in the state, which they cannot do absent passage of legislation.

IL-In 2013, the Illinois Psychiatric Society has faced a well-financed effort by Illinois psychologists (including 7 lobbyists) to secure prescribing authority through state legislation. Working tirelessly, IPS, ISMS, with strong support from APA and AMA and other key allies, overcame long odds to kill SB 2187 in the House, at least until November if not for the year. The victory represents the extraordinary personal efforts of a core group of IPS leaders who virtually set aside their practices to work around the clock to defeat the bill. SB 2187 was introduced on February 15, and referred to the Senate Committee on Health. As introduced, the bill sought to allow psychologists to apply for and attain a prescribing psychologist certification after obtaining a master's degree in clinical psychopharmacology.

On March 12, the bill was approved by the Senate Committee on Health in an 8-0-1 (present) vote. Six Democrats and two Republicans voted in favor, one Republican voted "present." Senator Harmon subsequently released a "compromise amendment" that changed little of substance.

On April 25, the Illinois Senate approved SB 2187 with the so called "compromise amendment." The vote on passage was 37-10.

In addition to IPS, APA, AMA, the Illinois State Medical Society, the Illinois Association of Family Physicians, Psychologists Opposed to Prescribing Privileges for Psychologists, and NAMI Illinois – to name just a few – have all been very active in opposing SB 2187. As you will recall, in 2012, the Board approved a CALF grant to

support IPS via its engagement of a top-notch public relations firm. DGR has also provided counsel to our colleagues in Illinois, activated other specialties via the AMA's Scope of Practice Partnership, issued multiple Action Alerts on behalf of IPS, and telephoned APA members residing in the home districts of key Illinois Senators to urge them to communicate their opposition. APA's Office of Communications and Public Affairs staff have provided information and suggestions to the PR firm handling the IPS account. To shore up IPS's efforts on the House side, APA and the AMA, through the SOPP, committed additional funds used to hire three additional lobbyists to help defeat the bill.

After landing in the House Healthcare Licensed Activities Committee on April 29, the bill was suddenly re-assigned to the Executive Committee on May 28. After preparing several times for promised hearings on the bill and attendance by the IPS lobbyist and several members to an informal meeting requested by the House sponsor, Representative Bradley, no formal hearings were held. On May 29, SB 2187 was stripped of all substantive legislative language and posted to the House Calendar. On May 31, the stripped bill was re-referred to the Rules Committee. There remains concern that the bill will be resurrected in November during the Illinois veto session. We continue to monitor the situation, extra lobbyists have been retained to continue to work on this issue until the end of the year and are working with IPS regarding PR, grassroots and preparations they can do during the interim to gain the upper-hand on this issue. At the high point of the campaign, DGR staff was in near daily contact with the IPS. Everyone worked very diligently to pull this bill back from the brink of passage. All efforts will continue until this bill is defeated.

IA-As forecasted by the Iowa Psychiatric Society, two bills were introduced this year, IA HSB 149 and SSB 1162. The bills would allow psychologists to acquire a "conditional prescription certificate" wherein they would be allowed to prescribe psychotropic medications provided they have a "collaborative relationship" with licensed physician. After a year and 450 clinical hours, they can then apply for a full "prescription certificate." Iowa Psychiatric Society actively opposed the legislation with the support of APA and several medical specialties, including family physicians, and the state medical society. Both bills died in Committee in early March.

NJ-Two bills (AB 2419 and SB 137) to grant psychologists the authority to prescribe medications remain alive in New Jersey. The bills would permit psychologists to prescribe after completing a "postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution of higher education or has completed equivalent training to the postdoctoral master's degree approved by the board" of psychology. The prescriptive authority would encompass all schedules of drugs.

SB 137 was referred to Senate Commerce Committee where it remains, unchanged.
On December 6, the Assembly companion bill, AB 2419, was voted out of Committee and moved to the full Assembly, where it remained inactive until April 23, when it was scheduled for a vote in the full Assembly for April 29. Working closely with New Jersey Psychiatric Association, their lobbyist, AACAP, and the Medical Society, APA issued a letter on April 26 in opposition of the bill to all NJ Assembly members. The letter echoed concerns outlined in an alert submitted by NJPA the day before.
On April 29, the bill passed the Assembly 41-27 with 8 abstentions (including Speaker Oliver) and 6 not present.

AB 2419/SB 137 both currently reside in the Senate Commerce Committee where SB 137 has been held since introduction and AB 2419 has been for over a month. The bill appears to be dead for the year, although NJPS and APA remain vigilant.

OH-OPPA managed to stop the reintroduction of a bill to allow psychologists to prescribe within the Department of Rehabilitation and Correction as part of a demonstration project. Preparing informative fact sheets on the education and training of prescribing professionals and securing staffing information on the availability of prescribers within the prisons which reflected no shortages, helped to convince the potential Senate sponsors that such a bill and demonstration project were not warranted. Going further, the Senators agreed that the pathways for becoming a prescriber already exists via training as a physician assistant or advance practice nurse and the psychologists should consider that—derailing the psychologists' efforts for this legislative season.

Pay Parity

OR – HB 2902 would require insurers to reimburse physician assistants and nurse practitioners in independent practices at the same rate as physicians for the same services. Since its introduction on February 13, APA has collaborated on efforts to oppose this legislation with OPA and AACAP staff. The legislation passed the House on March 19. OPA and OMA lobbyists were able to secure numerous amendments, including a stipulation that physician payments cannot be lowered to achieve pay parity, for APNs and PAs. HB 2902 was approved by the Senate on June 6 and is expected to be signed by the Governor.

Passage of HB 2902 could presage an escalation of efforts by nurses to significantly expand their scope of practice across the country.

Advocacy Training

On April 12, State Legislative Field Representative, Kate McAllister participated in the Area 1 training hosted by the Massachusetts Psychiatric Society (MPS) in Chatham, MA. Kate illustrated to members the importance of grassroots advocacy and highlighted APA legislative resources. She facilitated a robust discussion on legislation introduced in various states that would allow psychologists to prescribe psychotropic medications. Kate noted that early advocacy efforts are key in a whole host of issues, not the least of which is psychologist prescriptive authority legislation, and emphasized some grassroots "best practices" for District Branches. She stressed that coalition building is of utmost importance in navigating through legislative issues and gave some examples of coalitions and partnerships that have benefited the District Branches and the APA. Kate also presented information on APA's response to gun control legislation on the federal level, and outlined some points that APA looks for in state bills.

Kate was joined in the training by James Tyll, Deputy Director of Communications, who offered information on media training, packaging a message to the media, and APA's social media efforts.

On April 17, Kate worked with Psychiatric News staff to produce a video interview highlighting advocacy training sessions, noting that they are a district branch/state association benefit and are available at district branches, state associations, or

residency training programs at no cost. The video interview was posted in the April 24 edition of the Psychiatric News Weekly Update.

Tracking System

The State Affairs Team has begun interviewing vendors to see if there are better tracking systems available for state legislation and possibly regulation than the current CQ Statetrack. The Team along with Eric Fishman have met with 3 vendors, State Net, Multi-State and StateScape. They have each demonstrated their software programs, discussed our needs and have been sent our top legislative priorities for tracking. We are currently awaiting their estimates on contract costs.

American Psychiatric Association Political Action Committee (APAPAC)

So far in 2013, including the Annual Meeting, the APAPAC has raised over $90,000, including about $10,000 solely at the Annual Meeting. The goal remains $500,000 for the current election cycle. The participation rate of APA members remains low, at about four percent. Having members solicit and inform their peers are the most effective ways to increase participation. With recent discussions concerning the reform of the Sustainable Growth Rate (SGR) and other important issues concerning psychiatry, the 2014 election cycle will be critical for the APAPAC. Moving forward, the PAC will continue to contribute to candidates who demonstrate an understanding of our issues and a commitment to our specialty and our patients. The support of more psychiatrists is vital to the future of psychiatry.

A.2 OFFICE OF HEALTHCARE SYSTEMS AND FINANCING
Irvin "Sam" Muszynski, J.D., Director

Advocating for the Profession

The Office of Healthcare Systems and Financing (OHSF) has four major areas of activities that relate to advocating for the profession. They are:

- Reimbursement and payment issues;
- Direct member services;
- Insurance coverage and managed care issues; and
- Integrated care/delivery system initiatives.

Reimbursement and Payment Issues

OHSF staff is continuing to work with the Committee on RBRVS, Codes, and Reimbursement to do outreach to members and payers who are still having problems with changes to psychiatry procedure coding that went into effect on January 1, 2013. Although members seem to be adjusting to the new coding and general queries have abated, we are now dealing with specific problems related to claims reimbursement. This activity is closely coordinated with the APA's Office of General Counsel to determine where there are clear legal implications that should be pursued. Staff and committee members will be participating in the October AMA RUC meeting, and it is expected that the new codes will receive their final value from CMS as part of the 2014 Medicare Physician Fee Schedule.

OHSF anticipates continuing work with CPT and CMS on the new transitional care codes. The RBRVS committee is also considering the development of a new CPT code for group medication management. There is currently no way to code for this activity.

The April meeting of the AMA's HCPAC yielded a valuation for the psychology prescribing code, 90863, that the APA finds to be totally unacceptable, even though this code is not covered by Medicare, and, hence will not be officially valued by CMS. At a minimum the valuation recommended for this code creates serious rank order issues for the entire family of psychiatry codes. APA is scheduling a meeting with CMS to discuss concerns with the recommended value for this code.

With the 2013 changes to the psychiatry CPT codes, all Medicare Administrative Contractors will have to make changes to the local coverage determinations to accommodate the new codes. Several Medicare contractors have already done so, and it appears that, at least so far, the new LCDs are appropriate. OHSF staff will continue its monitoring of LCD developments with members of the Committee on RBRVS, Codes and Reimbursement, and with the assistance of the DBs and former members of the Medicare Advisory Corresponding Committee to ensure that there is no diminution of coverage for psychiatric diagnoses.

- The work of the APA with the AMA RUC and CPT Panel will remain significant and intensive until at least 2014. We anticipate the exploration of new codes related to integrated care that will be of primary importance

to psychiatry.

- In respect to reimbursement and payment in general, we anticipate a concentrated focus on new and emerging payment methodologies for healthcare and the need for the development and advocacy for appropriate payment strategies for psychiatrists and their patients. This will be occurring for both inpatient and outpatient care and includes payment plans for integrated/collaborative care arrangements, bundled care episodes, and pay for performance. We also anticipate involvement in parity issues in a number of different forums where the parity law can be used to achieve payment equity for psychiatric services.

Direct Member Service

The Practice Management Help Line continues to provide assistance to individual APA members with operations, payment, and documentation issues. Not only does it serve to provide members with a direct, valuable service when they encounter problems with payers or with practice issues, but the calls and emails that come to the Help Line also serve to alert OHSF, and the APA in general, to the real-time issues that are affecting APA members.

Through the relationships staff has established with Medicare and private payers, the Help Line is able to troubleshoot for members, helping them resolve issues (e.g. claim denials, audits, enrollment, etc.)with payers that often seemed insurmountable to them. Again and again, we hear from members that the assistance provided by the Help Line staff is one of the most significant values they've received from their membership in the APA.

Calls about the new CPT coding format for psychiatry have abated somewhat since the beginning of the year. That said, in the first six months of 2013 the Help Line has handled over 1000 calls and emails from members. In all of 2012 the Help Line provided assistance to approximately 1200 calls and e-mails, the vast majority of which occurred in the fall after the new CPT coding was announced. Besides the large number of questions about the new coding, members continue to contact the Help Line about Medicare, contracting with payers, medical record retention, the Medicare e-prescribing rules, and prior authorization. There also continue to be a

number of calls relating to the parity law and how it affects practices, which are coordinated with the Office of the General Counsel.

OHSF is working with a number of managed behavioral health plans through the Association for Behavioral Health and Wellness and with other independent plans on a variety of issues including but not limited to parity, reimbursement, and claims denials.

OHSF has developed a third-party payer outreach effort in collaboration with APIRE to provide teleconferences and webinars on the implementation of the DSM 5. We anticipate these activities will continue to the end of 2013.

OHSF staff continues to lead quarterly phone conferences with senior CMS policy advisors in the Office of the Secretary of HHS. Although originally the phone calls were more frequent and focused entirely on Medicare Part D, they have evolved to provide access to policy makers and information from within all areas of CMS, including the new Medicare and Medicaid Center for Innovation and the division tasked with overseeing care provided to dual eligibles. The next scheduled call will be with a representative from the Center for Consumer Information and Insurance Oversight on the new health exchanges. Other mental health advocacy groups participate in these calls (NAMI, MHA, NCCBH, NASMHPD and other mental health and disability advocates). These regular calls contribute to APA maintaining a close working relationship with CMS that means staff there will help us troubleshoot problems as they arise.

Staff participates in the National Medical Specialty Society Health Insurer Coalition (SSIC). This group is a sub-group of the AMA Federation that meets formally once a year and informally by regular conference call. The SSIC exists to coordinate communications and foster positive working relationships between physicians, physician organizations, employer groups, and the health insurance industry in the interest of identifying divisive problems and concerns, and working together toward their appropriate resolution.

OHSF, in conjunction with the Parity Implementation Coalition, continues to maintain the website that provides information about the Wellstone-Domenici Mental

Health Parity and Addiction Equity Act of 2008, and also serves as a conduit to receive information about how the Parity Act is being administered by insurers. This website, http://www.parityispersonal.org,. The website is continuing to be updated with information respecting parity requirements with new plans established under the Affordable Care Act.

Integrated Care/Delivery System Initiatives

The BOT Work Group on the Role of Psychiatry on Health Care Reform, staffed by OHSF, identified a number of key priorities for the APA to move forward on in the area of integrated care and delivery system initiatives. These include:

- Member education and training on psychiatry in integrated care settings, including CME opportunities;
- Establishment of liaison relationships with key stakeholders in the policy area, including accreditation entities (i.e. URAC,NCQA, Joint Commission); government agencies (i.e., AHRQ, CMS, CMMI); and policy forums (PCPCC) to ensure APA input on both public and private sector developments;
- The continued development of a webpage for members with integrated care resources that was created in 2010 (http://www.psychiatry.org/practice/professional-interests/integrated-care)
- The identification of when appropriate communications strategies are needed; and
- Identification and reporting on necessary APA policy and analysis efforts.

There are a variety of member education and training activities under way, including the courses and other sessions offered at the Annual Meetings and the Intitutes Integration of Primary Care and Behavioral Health. These have included: Practical Skills for the Consultant Psychiatrist, Curricula for Teaching Residents to Work in Integrated Care, Primary Care Skills for Psychiatrists, among others.

OHSF staffs the APA's membership in the Patient Centered Primary Care Collaborative (PCPCC). PCPCC is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). PCPCC is leading the way for employers, commercial and

public payers to collaborate with providers and patients on implementing new treatment and payment models of integrated, accountable and patient centered care. Primary care physicians as an organized body state as a principle that their patients need treatment of BH needs. It is hoped that the APA's leadership in this group will demonstrate the evidence and value of psychiatrists as leaders of the collaborative care team.

Additionally OHSF staff is participating in a number of ongoing accrediting activities through all accrediting agencies, NCQA, URAC, Joint Commision, etc. These agencies have a number of products relevant to psychiatry, for example ACOs, clinically integrated networks (CLINs), medical homes, and specialty medical homes.

OHSF staff is continuing to develop and maintain relationships with Center for Medicare and Medicaid Innovation (CMMI) staff to support the interests of psychiatrists currently active in healthcare reform initiatives and innovations such as integrated care models and new reimbursement models, and to be able to provide support to those members who choose to become involved at a later date. OHSF staff has linked with CMMI's behavioral health program evaluators and has provided assistance and resources related to APA's data on behavioral health quality measures.

With the help of OHSF staff, the Council on Healthcare Systems and Financing (CHSF) continues to monitor and consult on the development and implementation of models of/for integrated treatment and payment. Staff creates and distributes a weekly newsletter on integrated care policy issues, which is currently sent to 350 individuals and which has continued to gain subscribers on a regular basis since its inception in 2010. OHSF is exploring how to expand the content and reach of both the online newsletter and the integrated care webpage.

The council's Work Group on Integrated Care, chaired by Dr. Lori Raney, is directing its attention to creating member resources on the value of psychiatry in the primary care setting and a document on liability issues related to integrated care and continues to provide educational opportunities to members on how to work collaboratively with primary care physicians in both primary care and mental health settings . The work group serves as a key resource for the APA's liaison work with

the key players in integrated care and ACOs (e.g., the Patient Centered Primary Care Collaborative, Centers for Medicare & Medicaid Services (CMS), CMS's new Center for Medicare and Medicaid Innovations, MACPAC, AAFP, the Federally Coordinated Health Care Office, URAC, NCQA, and the Joint Commission.

OHSF staff is maintaining its regular communications with NASMHPD, AACP, HRSA, CIHS (Center for Integrated Health Solutions), and SAMHSA to understand the issues of concern to these groups and coordinate our activities with them. HRSA's current work plan for psychiatry includes training related to integrated care through CIHS.
OHSF staff is participating in the Institute of Medicine's project on Team-Based Care: Principles and Expectations. The goal is to ensure that the interests of psychiatry are included in the IOM discussion.

Advocating for Patients

OHSF staff is working in conjunction with DGR staff on the production of web-based resources for the District Branches on the development of Health Exchanges (http://psychiatry.org/statehealthexchanges) and Medicaid expansion under the ACA. OHSF conducted two webinars to educate members on state exchanges and technical assistance is provided to DBs on request.

OHSF Staff and the Council on HSF have been monitoring state Medicaid/State Mental Health Service programs, which have been heavily impacted by state budget shortfalls. An ever increasing number of states are dealing with budget shortages, and the access issues created for essential services are troubling. At the same time, a number of states are integrating behavioral health with somatic medicine (or are considering this integration of care) and OHSF staff is monitoring and advising DBs about these changes. OHSF continues to work closely with DBs and national mental health advocacy groups, assisting with writing letters to legislators and state agency leaders advocating for maintaining access to medically indicated care for their most vulnerable citizens, as well as informing them of the ramifications of losing this care. As issues with commercial Pharmacy Benefit Management (PBM) companies and public access to medications under Medicaid increase, OHSF staff is providing increased assistance to DBs with information on how to work with the companies and how to work with legislatures to facilitate access to medically necessary

psychotropic medications. OHSF's agenda includes a comprehensive review of the PBM issue in conjunction with the Council on Healthcare Systems and Financing.

OHSF staff continues to provide assistance for patients who, with support from their physicians, appeal drug denials under Medicare Part D. Based on experience thus far, appropriately couched appeals have a very high probability of being successful.
OHSF staff has been working with the Michigan, Pennsylvania and Arkansas Psychiatric Societies, the Kentucky Psychiatric Medical Association, and the Mississippi Psychiatric Association, to assist them in their efforts to collaborate with their states on the development of the health exchanges established under the ACA.

Support Education, Training, and Career Development

OHSF staff is working with the Committee on RBRVS, Codes, and Reimbursement to create more educational resources to assist members in understanding the 2013 CPT coding changes and how to use the new coding appropriately. Extensive materials on the new coding are already available on the APA website at http://psychiatry.org/cptcodingchanges. An educational session will be held at the October IPS meeting in Philadelphia.

OHSF's book Practice Management: the Basics (formerly Practice Management for Early Career Psychiatrists) continues to be updated as information changes, and the new information is then posted on the APA website for members to download. Membership distributes a CD-ROM of the book as a new member benefit, and the latest information is always available online.

OHSF is returning to the regular production of a Psychiatric Practice and Managed Care page for Psychiatric News. The focus for the immediate future will be Q&As about the intricacies of the new coding.

OHSF staff and the CPT Coding Network members continue to provide answers to APA members' e-mailed or faxed CPT coding and Medicare questions.

OHSF staff continues to provide support for the creation and publicizing of an "Integrated Care Track" at the APA's Annual Meetings and Institutes for Psychiatric

Services. Staff is also collaborating with the CHSF's integrated care workgroup to identify sessions on collaborative that can be available for CME credit.

A call for nominations for the 2014 Frank J. Menolascino Award for Psychiatric Services for Persons with Intellectual Development Disorders/ Developmental Disabilities will go out in June. Dr. Fred Volkmar will be presented with the 2013 award at the 2013 Institute on Psychiatric Services.

After a one-year hiatus, the Psychiatric Services Achievement Awards, sponsored by the APA, will be presented this year at the 2013 Institute on Psychiatric Services in Philadelphia. Applications were requested this spring from programs that offer services to the mentally ill or disabled, have overcome obstacles and can serve as a model for other programs. In addition to two Gold Awards, programs may be selected for Silver and Bronze Awards. Winning programs will be presented with a grant and a plaque and the programs will be highlighted at a special workshop.

OHSF staff are members of the AMA Federation. This work group meets monthly to develop and communicate practice resources for physicians and in turn psychiatrists.

The BOT Healthcare Reform Strategic Action Workgroup

OHSF will staff the new Board workgroup, which is chaired by Howard Goldman, and which is responsible for review and implementation of the BOT Workgroup on the Role of Psychiatry in Healthcare Reform report as well as well as new policy initiatives and directions.

A.3 Office of Communications and Public Affairs (OCPA)
Eve Herold, Director

OCPA is the primary APA office for developing and disseminating information to the mass media about APA policies, programs, and activities, as well as public information on psychiatry and its benefits to those suffering from mental illnesses. As part of its mission, the OCPA strives to de-stigmatize mental illness and to present psychiatry in a positive light. OCPA provides support to the Board of Trustees, Assembly, Council on Communications, District Branch/State Associations, and APA subsidiaries who request help with media, internal communications, and other key communications issues. OCPA also staffs the Council on Communications.

MEDIA SUMMARY- FEBRUARY 16 TO JUNE 15, 2013

In the month leading up to the APA Annual Meeting and the publication of the DSM-5, OCPA handled upwards of 150 calls and requests from reporters, researchers, and fact checkers. The following is a sample of some of the coverage:

Yahoo News dedicated an entire page to the DSM-5. Key interviews were with g David Kupfer, M.D., Darrel Regier, M.D., Jack Drescher, M.D., Howard Zonana, M.D., Sid Zisook, M.D., and Sanjaya Saxena, M.D.

The Washington Post - "The Bible of the Mind Turns the Page"- Reporter Monica Hesse interviewed APA

Medical Director and CEO James Scully, M.D., and DSM-5 Task Force Vice Chair Darrel Regier, M.D.

NPR- Science Friday- "Bad Diagnosis for New Psychiatry "Bible." APA President Jeffrey Lieberman joined a live panel discussion about the DSM-5.

Clinical Psychiatry News- "The 5 Ways the DSM-5 Could Change your Practice." This piece covers some key issues and features interviews with former APA President Dilip Jeste, M.D., Dan Blazer, M.D., Javier Escobar, M.D., Susan Swedo, M.D., and Joel Dimsdale, M.D.

Slate- "You Do Not Have Asperger's." Takes a look at what the DSM means for people on the autism spectrum. Catherine Lord, Ph.D., and Bryan King, M.D. were interviewed.

Reuters- "Psychiatrists Unveil Their Long-awaited Diagnostic Bible." Sharon Begley featured David Kupfer, M.D., and APA President Jeffrey Lieberman, M.D., for this overview on the release of DSM-5.

Thomson Reuters News and Insights-"Lawyers Worry New Measure of Mental Retardation Could Prompt More Executions." Darrel Regier, M.D., and James Harris, M.D. were interviewed for this piece on Intellectual Developmental Disorder.

Associated Press- "Shrinks, Critics Face Off Over Psychiatric Manual." Dr. Kupfer and Dr. Lieberman spoke about some the controversies and changes in the DSM.

USA Today- "Another Go-round in the Saga of Psychiatry's Bible." A piece about some of the controversial books about the DSM-5 that were just released. Michael First, M.D., answers critics' concerns.

WBUR- Boston "Abandoning The Psychiatry Bible?" APA President-elect, Paul Summergrad, M.D., took on some of the critical comments on the DSM-5 on this live radio broadcast

NPR-Boston "New Edition of DSM Roils Mental Health World." Dr. Lieberman addresses some of the concerns about the new manual.

US News and World Report -"Binge Eating Disorder Will Soon Receive an Official Diagnosis." B. Timothy Walsh, M.D., Chair of the DSM-5 Eating Disorders Work Group, explains binge eating disorder for this article.

JAMA- The journal featured a story about ways to identify and address children who are showing signs of mental illness. The Typical or Troubled?™ program is highlighted in this piece.

Treating More Than One Condition- Many children diagnosed with ADHD may have other conditions like depression and anxiety, and may already be on medications for those conditions. Steven Cuffe, M.D., and Alex Strauss, M.D., offer tips and advice for parents in this situation.

The Windy City Times and the Washington Blade- each featured stories about Dr. Saul Levin, M.D. after the APA Board of Trustees announced his appointment as the APA's next CEO and Medical Director of he APA following the retirement of James Scully, Jr. M.D.

Psychiatric Annals- interviewed Annand Pandya, M.D., Sander Koyfman, M.D., and Craig Katz, M.D. on the devastation caused by the deadly bombings at the Boston Marathon.

ABCNews.com- interviewed Elizabeth Bowman, M.D. about conversion disorder in a follow-up to last year's story about students in one western New York town who came down with the same Tourette's syndrome-like symptoms.

Medscape- New research suggests that Chantix may help in the treatment of alcohol dependence. Frances Levin, M.D., offered comments on a new study.

Medscape- Antonia Baum, M.D., was interviewed about this study that found that many college-level trainers need training to manage athletes with mental health disorders.

OCPA Assisted in setting up interviews for the following stories and videos at the APA Annual Meeting in San Francisco; 77 members of the press from around the world were in attendance.

Medscape Medical News:

- Ketamine May Offer Rapid Relief From OCD Symptoms (Deborah Brauser, June 3, 2013)
- Is Reality TV Making Narcissism the New Normal? (Susan Jeffrey, May 31, 2013)
- Biomarkers May Predict Treatment Response in Depression (Deborah Brauser, May 30, 2013)
- Nasal Spray Shows Promise for Binge Eating Disorder (Caroline Cassels, May 30, 2013)
- Antidepressants in Bipolar Disorder: No Benefit, Possible Harm (Caroline Cassels, May 30, 2013
- CBT Delivered by Email Effective for Anxiety (Deborah Brauser, May 29, 2013)
- TMS for Resistant Depression: Long-term Results Are In (Caroline Cassels, May 24, 2013)
- Smartphone 'Addiction' May Affect Adolescent Development (Deborah Brauser, May 23, 2013)
- UTI Screening, Monitoring May Reduce Psychotic Symptoms (Megan Brooks, May 22, 2013)
- Early Detection, Intervention Prevent Conversion to Psychosis (Megan

Brooks, May 22, 2013)

- High CRP Linked to Late-Onset Schizophrenia (Susan Jeffrey, May 22, 2013)
- ADHD Drug May Decrease Binge Eating Episodes (Deborah Brauser, May 21, 2013)
- Cyberbullying Packs a Potentially Deadly Punch in Teens (Caroline Cassels, May 21, 2013)
- Psychiatrists Not Immune to Mental Health Bias (Susan Jeffrey, May 21, 2013)
- Trigeminal Nerve Stimulation an Option for ADHD? (Susan Jeffrey, May 20, 2013)
- Experimental Antidepressant Moves Closer to US Approval (Deborah Brauser, May 20, 2013)
- DSM-5 Officially Launched, but Controversy Persists (Caroline Cassels, May 18, 2013)
- Eye May Be Key to More Accurate ADHD Diagnosis (Megan Brooks, May 18, 2013)
- DSM-5 Release Likely to Steal the Spotlight at APA Meeting (Deborah Brauser, May 16, 2013)

Clinical Psychiatry News:

Trauma's Physical Effects Persist for Years (Sherry Boschert)

VIDEO: How will the DSM-5 Affect Psychiatrists' Practices? (Gina Henderson)

Healio/Psychiatric Annals:

- DSM-5 anxiety specifier based on link between suicide, severe anxiety (May 29, 2013)
- Trauma survivors experience lasting physical health effects (May 29, 2013)
- Health care providers showed bias against patients with schizophrenia (May 28, 2013)
- Experts warn of coming war over 'food addiction' and public health (May 28, 2013)
- APA President says goal of APA includes pursuit of mental wellness across the lifespan (May 24, 2013)
- Familiarity with DSM-5 'essential' for clinicians and educators (May 24,

2013)

- Lurasidone lowered rates of weight, metabolic changes in bipolar depression (May 23, 2013)
- Comorbid substance use may hold key to understanding neurobiology of mental illness (May 22, 2013)
- Symptomatic improvement found in difficult-to-treat patients with depression using TMS (May 22, 2013)
- APA President-Elect expects increased research to improve diagnostic, treatment measures (May 22, 2013)
- Claiming 'amnesia' may not impact competency to stand trial (May 22, 2013)
- Study: Overuse of smartphones harmful to adolescents (May 22, 2013)
- 'Etiology and syndromes' should be focus of DSM-5 for medical students (May 21, 2013)
- CBT by email appears effective for treating anxiety (May 21, 2013)
- Cyberbullying triples risk for teenage suicide (May 21, 2013)
- Control of polypharmacy, drug interactions key components in treatment of geriatric population (May 21, 2013)
- Depression, sleep symptoms among many additions to PTSD criteria in DSM-5 (May 21, 2013)
- Reduction of stigma key to changes to DSM-5 gender dysphoria diagnosis (May 20, 2013)
- APA sessions highlight psychological wounds of war (May 20, 2013)
- Trainees may not be familiar with DSM changes (May 20, 2013)
- Hopelessness significantly increased risk for suicidality in youth (May 20, 2013)
- Borderline personality may influence course of Axis I disorders (May 19, 2013)
- APA President-Elect: 'Our time is now' (May 19, 2013)
- MD-FM Radio- France: Clementine Wallace (Interview with David Kupfer, M.D., on the DSM-5)

Psychiatric Times:

- Heidi Anne Duerr, Detecting Lithium Toxicity Among Medical Masquerades (May 29, 2013)

- You Are-And Your Mood Is-What You Eat (May 23, 2013)
- Experts Discuss Changes, Updates in DSM-5 (May 22, 2013)
- Will Your Clinical Records Support You in Court? (May 21, 2013

MSNBC interviewed APA President-elect Jeffrey Lieberman, M.D. on the Boston Marathon bombings in the days following the tragic incident.

WJLA-TV in Washington, D.C. spoke with APA Deputy Medical Director, Annelle Primm on the same topic.

NBCnews.com spoke with Elspeth "Cam" Ritchie on the Boston bombings and Harry Croft, M.D. was featured in a story on. OCPA also sent a media toolkit to the District Branch in Massachusetts, to help psychiatrists there prepare for media interviews.

Mental Health Parity was a prominent topic for several news outlets due to the New York Psychiatric Association and two individuals bringing a nationwide class-action suit against Minnesota-based UnitedHealth Group for violating laws requiring parity in mental health coverage. Minnesota Public Radio devoted part of its show, The Daily Circuit to this topic and why gaps still remain in the implementation of the mental health parity law. Paul Summergrad, M.D., was part of a live panel.

Medscape interviewed Henry Harbin, M.D., and APA General Counsel, Colleen Coyle, for a story on the same topic.

Reuters interviewed Steven Daviss, M.D., about a new study that found that it can take up to an hour to get approval from insurance companies to get a psychiatric patient from the emergency room to a hospital bed.

Medscape- Matt Sturm, APA Deputy Director of Government Relations, explained why the Truth in Healthcare Marketing Act of 2013 is so important.

Medscape- Jeremy Musher, M.D., and APA General Counsel Colleen Coyle were both interviewed about the APA's plan for handling CPT code violations.

Autism and the DSM-5 was a prominent topic because April was Autism Awareness Month. Catherine Lord, Ph.D., was very busy doing interviews on this topic. She was interviewed live for the radio program Essential Pittsburgh, NPR Pittsburgh, for a separate piece on the changes for WESA-FM, and for Health Day.com. Walter Kaufmann, M.D., was also interviewed by The Herald News, in Massachusetts.

Explaining the DSM-5 - In April, DSM-5 Task Force Chair, David Kupfer, M.D., did multiple interviews with publications including Nature, The Verge.com and New Zealand Doctor.

The Fix.com spoke with Charles O'Brien, M.D., about addiction and substance disorders.

POLITICO spoke with Elspeth "Cam" Ritchie, M.D., who questioned the value of a new proposal by the Obama Administration to reword the standard mental health question asked of those applying for or renewing a security clearance.

The Sacramento Bee looked into reports that Nevada's primary state psychiatric hospital has been putting hundreds of mentally ill patients on Greyhound buses and sending them to cities and towns across the country. Lorin Scher, M.D., was interviewed. ABC News also teamed up with the Sacramento Bee for a special investigation of this issue.

Medscape explored research suggesting that a panicked reaction to a single inhalation of 35% carbon dioxide (CO2) may predict the risk for anxiety and subsequent posttraumatic stress disorder in military personnel, interviewing Spencer Eth, M.D.

The Aurora Sentinel spoke with Liza Gold, M.D. about James Holmes and a possible insanity defense now that prosecutors are seeking the death penalty for the man accused of deadly theater shootings.

Medscape published a Physician Lifestyle Report that found that one in three psychiatrists say they are burned out, but that makes them one of the more

engaged, satisfied medical specialties. APA President Jeffrey Lieberman, M.D. was interviewed.

ProPublica and Medscape - The investigative journalism website ProPublica recently updated its annual Dollars for Docs database and found that 10 of the 23 highest paid industry speakers were psychiatrists. APA Medical Director and CEO James Scully, M.D., commented on the findings.

Bloomberg TV - Dr. Scully also joined a panel discussion to explain issues related to the DSM. The panel talked about some of the controversies, what it means for patients, and insurance coverage.

ABCNews.com and Medscape spoke with Joel Dimsdale, M.D., Chair of the Somatic Symptoms Disorders Workgroup about Somatic Symptom Disorder and the DSM-5.

ABCNews.com spoke with Charles Zeanah, M.D. about PTSD For Preschoolers and why the DSM-5 now includes guidelines to assist with diagnosing young children with PTSD.

The Wall Street Journal interviewed APA President Jeffrey Lieberman, M.D. on the cost of drug side effects when insurance won't pay for finding the right medication.
USA Today and Stateline/Pew Charitable Trust both interviewed Paul Appelbaum, M.D. about gun ownership and mental illness.

Takepart.com and the Washington Post spoke with Antonia Baum, M.D. about a new report showins that young adults between the ages 18 and 33, are stressed out to almost the breaking point.

AMA News explored the issue of the ACA and gaps in coverage, speaking with Bob Cabaj, M.D., Chair of the APA's Council on Advocacy and Government Relations. Julie Clements, the APA's Deputy Director of Regulatory Affairs, and Barry Perlman, M.D., were both interviewed and commented on the pros and cons of the required ten core essential health benefits.

The Associated Press interviewed Antonia Baum, M.D. about how Houston Rockets player Royce White, who says that when he has been diagnosed with general anxiety and obsessive-compulsive disorder, he asked for special additions to his contract to help him cope with his condition.

DO Magazine interviewed Thomas Wise, M.D. on common ties between D.O.s and M.D.s.

Health Behavior News Service interviewed Iqbal "Ike" Ahmed, M.D. on a study about reducing antipsychotic use in elderly patients with dementia.

Medscape did a story about Illinois and psychologists' right to prescribe, interviewing Kenneth Busch, M.D. and the APA's Department of Government Relations Director, Nick Meyers.

The Fix interviewed Petros Levounis, M.D. about sobriety-friendly ways to deal with panic attacks.

INTERNAL COMMUNICATIONS WORK GROUP MEETING

OCPA continues to lead a monthly communications workgroup meeting held at the APA. Representatives from most departments join in the discussion to share more about their projects and activities. Recent work group meetings focused on annual meeting updates and events, the launch of DSM-5 and how OCPA could help share these projects and activities with members. The meeting enhances the staff's knowledge about what is happening in other departments and supplies OCPA with news about organization-wide activities that can be reported to the District Branches.

PRESIDENTIAL VIDEO ADDRESS

Since the submission of the last MDO report, immediate past President Dilip Jeste, M.D., completed two more video presentations. In March, he provided an overview of APA Annual Meeting highlights. His video address in May offered a summary of his year as president, where he highlighted many of his accomplishments. Both videos can be found at http://www.psychiatry.org/advocacy--newsroom/newsroom/presidents-video-messages.

NEWS FROM THE APA FOR DISTRICT BRANCHES AND STATE ASSOCIATIONS

Each month (February 2013 – June 2013) OCPA sends APA news content to District Branch/State Associations so that they have an opportunity to include APA news in their newsletters and on their websites. Examples of information that has been sent includes: Annual Meeting 2013 general registration information; upcoming award solicitations; Annual Meeting Self-Assessment educational activity; Annual Meeting App launch details; DSM-5 ordering details; and the latest Focus and Mental Health Works publications.

APA DAILY "HEADLINES"

OCPA oversaw the "Headlines" daily e-newsletter briefing and wrote daily news items with links to APA websites and online resources for each issue. OCPA also responded to member feedback, working with the vendor (Bulletin Healthcare) to ensure member satisfaction.

2012 ANNUAL REPORT

OCPA produced the 2012 APA Annual Report to reflect the APA President's theme: Pursuing Wellness Across the Lifespan. OCPA directed a design firm in planning the report's cover and layout. OCPA worked with APF, APP, and each APA division/department to finalize content highlighting significant activities in 2012. OCPA drafted the President's Report and added images, pull quotes, factoids, and hyperlinks to best showcase events, initiatives, and accomplishments of 2012. For the first time, two videos were embedded in online version of the report.

2013 APA TV

OCPA directed APA TV, the Annual Meeting highlights video, which was seen on screens at the Moscone Center on local hotel channels, and on APA's website. For the third year, OCPA worked with WebsEdge to produce a news program each day of the meeting, with interviews that included Baroness Susan Greenfield, former Congressman Patrick Kennedy, NIDA Director Dr. Nora Volkow, AMA President Dr. Jeremy Lazarus, and coverage of the DSM-5 launch and New Research Press Briefing. APA TV was sponsored by 12 academic organizations, and APA received $20,850 in royalties. OCPA coordinated all APA TV interviews and event coverage and publicized APA TV via social media.

PATRICK KENNEDY PSA SERIES

OCPA oversaw production of the first PSA in a series of three with former U.S. Congressman Patrick Kennedy aimed at reducing mental illness stigma and encouraging those suffering from mental illnesses to seek treatment. The PSA aired on APA TV each day as well as 158 times on 15 TV stations in Philadelphia, San Francisco, and Phoenix top markets (1,430,618 audience impressions). OCPA will manage production and distribution of two more PSAs with Patrick Kennedy over the next few months.

WEB SITES/BLOGS

Issues featured on the APA home page during the period included:

- APA President Dilip Jeste's video message about the Annual Meeting
- Several messages about APA actions relating to the changes in CPT codes and monitoring and responding to parity violations
- APA TV video news from the Annual Meeting
- Mental Health Awareness Month
- The Speak Up About Depression education campaign
- The APA press conference on June 3 following the Mental Health conference at the White House. (The full video of the press conference is posted on the Advocacy and Newsroom page.)

A number of website updates were related to the Annual Meeting. APA worked with other departments to provide content for the new Annual Meeting micro site and developed resources specifically for journalists interested in the meeting. APA worked with Webs Edge to post the thought leadership segments and interviews from the meeting. Several key interviews are posted on the "About APA" page.

Featured topics on the Mental Health (public information) section of the website included:

June

PTSD

President Obama's address at June 3 National Conference on Mental Health

"Healthy Minds Minute" PSA with Patrick Kennedy

May

Coping with tragedy
Interview with Patrick Kennedy
New website: MentalHealth.gov
Depression campaigns: - Right Direction for Me (APF and Workplace Mental Health)
- Speak up About Depression (The Joint Commission, APA and others)

April

Autism and Autism Awareness Month
ADHD
Concussions

March

Women's Mental Health
Mental health check-up
African American Mental Health

February

African American Mental Health
Domestic violence
Hoarding

The mental health page also features each new topic addressed in the HealthyMinds blog.

SOCIAL MEDIA OUTREACH

The "Mental Health" section of psychiatry.org and Healthy Minds blog are complemented by Healthy Minds Facebook page and @APAHealthyMinds (Twitter), updated daily by OCPA with new postings to direct members of the public to APA websites and increase mental health awareness. @APAHealthyMinds has 11,077+ followers (2,591 new followers since the last report). Twitter followers send out ("retweet") links to APA sites and resources—reaching new audiences, the media, top mental health organizations, and thought leaders on a daily basis.

APA's main Twitter @APAPsychiatric account has grown to 15,689+ followers (3,804 new followers since the last report). OCPA managed social media for the 2013 Annual Meeting, which included promotion of the Annual Meeting hashtag #APAAM13 so that attendees and press covering the meeting could engage in Annual Meeting conversation via Twitter. Also, those who were unable to attend the Annual Meeting could follow #APAAM13 to see what they were missing. The live Annual Meeting Twitter feed was shown on screens at the Moscone Center and could be accessed via the Annual Meeting mobile app.

OCPA collaborated with Membership to develop the first "Tweet a Testimonial" campaign for the 2013 Annual Meeting. Each day of the meeting, OCPA asked a question via @APAPsychiatric and using #APAAM13 (What do you value most about APA Annual Meeting? Why did you join the APA? Why did you become a psychiatrist?) and received valuable feedback to use in future marketing for membership and the meeting. "Tweet a Testimonial" was publicized in each issue of the Daily Bulletin and promoted every day during APA TV.

OCPA manages APA's official Facebook page and has gained 19,860+ "likes" (an increase of 2,572 since the last report). OCPA posted daily to APA's Facebook page with Annual Meeting highlights, media interviews with APA leadership, and breaking news relevant to psychiatry.

OCPA continues to oversee APA's member-only LinkedIn Group, which now has 2,669 members and its subgroups for APA Residents & Early Career Psychiatrists and eCommunications. APA leadership has joined the APA LinkedIn Group. OCPA monitors discussions to identify any issues that should be directed to APA staff.

Press Releases (February through June)

OCPA produced and distributed the following press releases during this period:

- APA Leaders Join National Dialogue as White House Hosts a Conference on Mental Health
- Multi-Family Group Therapy Shows Promise in Helping Veterans with TBI
- Media Advisory: Press Conference After White House Conversation on Mental Health
- Childhood Neglect Linked to Problems Sustaining Relationships

- Is Reality TV Normalizing Narcissism?
- Studies of Trauma Survivors
- Mental Health Stigma Influences Treatment Decisions of Physicians and Nurses
- Ketamine Shown to Have Significant Antidepressant Effects
- Smartphone Overuse Growing and Harmful to Adolescents
- Cyberbullying Puts Teens at Greater Risk of Suicide
- APA Releases DSM-5
- APA Annual Meeting Features Sessions on Diversity
- APA Annual Meeting: NIDA and APA Host a Special Track on the Science of Addiction
- Coalition on Mental Health and Violence Issues
- Statement from DSM Chair David Kupfer, M.D.
- One Step Forward on Mental Health Parity
- Patients' Self Perceptions Useful in Assessing Risk of Violent Behavior
- New Research in Medicine and Mental Health Press Briefing at APA Annual Meeting
- APA Continues Efforts to Ensure Anthem and Wellpoint Compliance
- APA and AAFP Respond to Mental Health Funding in President's Budget
- APA 2013 Annual Meeting Special Track to Present DSM-5 Changes
- Paul Summergrad, M.D., Elected APA President-elect
- President Obama Announces Investment in Brain Research MARCH
- APA Annual Meeting to Feature Special Track on Military Issues
- APA Commends ValueOptions for Reconsidering its Fee Schedules for Mental Health Benefits
- Infant Growth Unaffected by Prenatal Exposure to Antidepressants or Maternal Depression
- APA Calls for Anthem to Stop Discriminating Against Mental Health Patients
- Collaborative Care for Depression Among Underserved Racial-Ethnic Groups
- APA Annual Meeting in San Francisco, May 18-22

OTHER OCPA ACTIVITIES

- Both the Annual Meeting Daily Bulletin newspaper and the event app were a success this year. In the past Sunovion was the single supporter of the bulletin and the app, but for the first time, the Daily Bulletin and the event app accepted multiple advertisers. The open sales model generated $133,000 in APA revenue. Sunovion sponsored a static publication titled, "Bulletin Extra" which served as a quick reference to session tracks, key locations and Sunovion advertisements. The "Bulletin Extra" was an insert in each issue of the Daily Bulletin.
- OCPA staff is still waiting to receive the Annual Meeting event app usage report, but so far there have been 5,799 total downloads which compares pretty favorably to the 3,986 total from last year.
- Since the last MDO report, OCPA provided media training for Area 1 in coordination with the Department of Government Affairs advocacy training.
- Working with leadership and representative in Area 1, OCPA responded to the Boston Marathon Bombing offering advice and consolation for those affected by the tragedy.
- In an effort to build internal expertise and save money on outsourcing, OCPA sent two staff to be trained on Adobe Premiere video editing software and now produces video content in- house.
- At the APA Annual Meeting, OCPA orchestrated two major press conferences, managed both the APA Press and Briefing room and coordinated dozens of interviews with national press and the APA leadership.
- OCPA Briefed the Council on Communications on a variety of activities, including the design of the APA Annual Stigma Survey.
- OCPA organized a press Conference at the National Press Club after the White House meeting on Mental Health. The Press Conference was hosted by APA President Dr. Jeffrey Lieberman and featured former Congressman Patrick Kennedy.

B. DIVISION OF EDUCATION

Deborah J. Hales, M.D., Director

B.1 Education: Department of CME, Office of Graduate and Undergraduate Education
B.2 Office of Ethics / District Branch & State Association Relations
B.3 Office of Scientific Programs
B.4 Melvin Sabshin Library and Archives

B.1 Education: Department of CME

Kristen Moeller, Director

Maintenance of Certification

The Division of Education continues to offer a number of ABPN-approved products for Maintenance of Certification. FOCUS continues to be the most comprehensive tool available for MOC participants, featuring CME quizzes, a completely new 24 credit Self-Assessment each year approved by ABPN for MOC Part II, and ABPN-approved PIP modules. These clinical modules have continued to be tremendously valuable to FOCUS subscribers, enabling them to fulfill the clinical chart review component of MOC Part IV. APA members can also access these activities at no cost by logging into the Learning Management System at www.apaeducation.org. In addition to existing PIP modules covering Substance Abuse Screening, Assessment, and Treatment, Schizophrenia, and Suicidal Behaviors, a new module on PTSD will be available this summer. These modules are the result of collaboration between the Division of Education and APIRE and reflect an ongoing commitment to keep subscribers up-to-date on changing MOC requirements.

Following the success of the 2011 and 2012 Annual Meeting Self-Assessments, the Division of Education released a 2013 Annual Meeting Self-Assessment designed to help registrants identify areas of strength and weakness and direct an individualized learning program of sessions to attend at the Annual Meeting in San Francisco while earning credit for Part II of MOC. Annual Meeting registrants were enrolled for free, and nearly 900 completed the activity for credit.

APA Online CME

A new and timely offering in APA's online CME program is the new course **"DSM-5: What You Need to Know"**, captured at the Annual Meeting in San Francisco and

now available on www.apaeducation.org. Users can view video of each presentation from the DSM-5 Master Course, with synchronized slides and audio, a CME quiz, and downloadable study materials. This activity is intended to help viewers transition from DSM-IV to DSM-5, understanding what has changed and why. This course offers both CME credit and CE credits for allied mental health professionals.

The **2013 Annual Meeting on Demand** features over 300 hours of lectures, symposia and workshops from the 2013 Annual Meeting, with accompanying quizzes and up to 64 hours of available CME credit. Recorded presentations from the 2013 Annual Meeting are available at www.cmeoncall.com/apa and on a USB flash drive, in partnership with Learner's Digest. Notably, pre-meeting and onsite sales of this product were doubled from 2012 in both units and revenue; this is attributed to both the high quality of this year's content, with strong interest in DSM-5 related sessions, and aggressive marketing, including the Gold Registration package and marketing to non-attendees.

The Learning Management System (LMS), which delivers a variety of CME courses online, has generated $37,500 over the first two quarters of 2012.

FOCUS: The Journal of Lifelong Learning in Psychiatry and the FOCUS Self-Assessment Program

Drs. Dilip Jeste and Helen Lavretsky served as guest editors for the Winter 2013 issue of FOCUS, which addressed Geriatric Psychiatry. An excellent panel of authors covered a wide array of topics in clinical practice: Colin Depp, A'verria Sirkin Martin, and Dilip Jeste wrote about psychiatric implications of successful aging; Taya Varteresian, David Merrill, and Helen Lavretsky discussed the use of natural products in late-life mood and cognitive disorders; Yeates Conwell addressed suicide and suicide prevention in later life; and Corinna Keenmon and David Sultzer covered the role of antipsychotics in treating neuropsychiatric symptoms of dementia.

The Spring 2013 issue on Personality Disorders was published concurrently with the Annual Meeting and featured an exceptionally strong slate of authors and articles. Guest editors John Oldham and Chris Fowler wrote about co-occurring disorders and treatment complexity within personality disorders; John Gunderson, Igor Weinberg, and Lois Choi-Kain reviewed borderline personality disorder; Anthony Bateman, Rory

Bolton, and Peter Fonagy offered a mentalizing framework for antisocial personality disorder; and Andrew Skodol introduced DSM-5 Section III on personality disorders.

Focus Journal continues to enjoy strong sales, with revenue exceeding budget. Focus series workbooks have brought in $45,800 to date in 2013, including the reissued *Focus Psychiatry Review*, *Focus Psychiatry Review Volume 2*, *Patient Management Exercises*, and the *Focus MDD Maintenance of Certification Workbook.* The Annual Meeting was an excellent opportunity to reach new and current subscribers to the journal and accompanying workbooks. Staff at the Focus booth in San Francisco sold over $30,000 in new subscriptions.

Subcommittee on Joint Sponsorship

In the second quarter of 2013, APA sponsored 21 separately planned CME activities with our district branches. Over 150 psychiatrists, representing about 67 district branches, attended the **"Train the Trainers"** session at the Annual Meeting. This month, six district branches have organized DSM-5 related trainings for members during the 2nd Quarter, with over 60 DSM 5 related activities scheduled to take place in the next quarter. All these activities are using materials presented by Drs. Kupfer and Regier at the "Train the Trainers" course.

B.1 Education: Office of Graduate and Undergraduate Education

Nancy Delanoche, Associate Director

The recipients of the first ever Resident Recognition Award were honored this spring. Psychiatry residency directors were encouraged to nominate one resident or fellow from their program who exemplified leadership, compassion, and overall excellence. Winners will be awarded at their graduation, and their names published in Psychiatric News. There are 30 awardees for this year from residency and fellowship programs across the U.S.

This year's Chief Resident Leadership Conference was once again held in conjunction with the APA meeting. One hundred eighteen incoming chiefs from general psychiatry residency and child fellowship programs across the US and Canada

registered to attend. Since we did not receive grant funding from Lilly as we have in the past, we did not provide travel stipends attendees of this program.

The PsychSIGN national medical student meeting was held in conjunction with the APA meeting in San Francisco. The program, organized by the student leaders, attracted more than 80 attendees from over 40 medical schools (allopathic and osteopathic) in the US and Canada. The meeting was supported by the APA.

The Mind Games competition, a highlight of resident activities at the APA meeting, was held on May 21st. More than 400 attendees watched as teams from University of Texas at Houston, Cornell University and UCLA Medical Center competed in the finals. UT Houston won the event, as they did last year.

The Office continues to support the activities of the Committee of MITs, MIT Caucus and the Assembly Committee of Area MITs. The Office connects with residents through e-newsletters, listservs for residents and chief residents and directly through the residency training directors.

The Office also supports and manages the APA Public Psychiatry Fellowship, Vestermark Psychiatry Educator Award, Irma Bland Award for Excellence in Teaching Residents and the Nancy C.A. Roeske, M.D., Certificate of Recognition for Excellence in Medical Student Education. The Office assisted the APA President, Dr. Lieberman, in selecting nominees for positions in the ABPN Board of Directors and the ACGME Psychiatry RRC.

B.2 Office of Ethics / District Branch & State Association Relations

Linda Hughes, Director

Office of Ethics

- This office planned the annual Luncheon for DB Ethics Chairs at the 2013 Annual Meeting. During the luncheon, APA Counsel Colleen Coyle led the DB Ethics Chairs discussion issues related to new state laws around gun laws and the implications on the physician/patient relationship. This venue offers a chance for DB Ethics Chairs to meet directly with members of the APA Ethics Committee to pose questions and discuss ethics issues generally.

- Daily activities of the office include responding to questions from various DBs, APA members and the public regarding the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" and the APA's "Procedures for Handling Complaints of Unethical Conduct."

- The Office assists the APA Ethics Committee to ensure complaints of unethical conduct are processed in accordance with the APA's "Procedures for Handling Complaints of Unethical Conduct."

Office of DB/SA Relations

- The staff planned an Orientation for Incoming DB Presidents and DB Presidents-elect during the 2013 Annual Meeting. We were pleased that S. R. Thorward, MD (past president of a large DB and current president of a small DB) was able to join us and present his unique experiences to his colleagues. The new officers also heard presentations from the APA's General Counsel, the Chief Financial Officer, the, DGR staff, and staff from the Office of Health Care Systems and Financing. The APA M/CEO, APA President, President-elect, Speaker and Speaker-elect also stopped by to give the presidents their greetings.

- The DB/SA Executive Staff met for a one-day meeting during the 2012 Annual Meeting. Their agenda covered topics such DSM-5 regional trainings, and handling disasters that occur in their DB. The staff also met with the staff of the Department of Government Relations, the Office of Healthcare Systems and Financing and Mental Health Works. Dr. Primm met with the staff to discuss the establishment of a diversity month, and also sought information on DB programs on Women in Psychiatry.

- This Office serves as APA liaison to DB/SA staff and responds to inquiries about APA programs or policies.

- This office conducted the outreach and coordination of the "Train-the-Trainer" course held for DB identified members. These members will be authorized to conduct trainings throughout their DB.

- The office has issued a call for grant requests for the 2013 Grant Program for district branches. This year the Membership Committee has allocated $150,000 for Expedited Grants. DBs may receive up to $2500 per DB to fund DSM-5 or CPT training (or other EHR, etc). An additional $30,000 will be awarded for innovative grants. The Membership Committee will review the innovative grants at their October meeting and make recommendations to the BOT.

- Web/Technical Liaison efforts in conjunction with the IT/IS Staff:
  - Worked with IT/IS staff by attending training and testing sessions related to the rollout of the upcoming District Branch Portal.
  - Coordinated a brief introductory demonstration, which was provided by Eric Fishman, for the DB Executive Director's during their Annual Business meeting in May.
  - Coordinated work group participants for the initial testing of the DB Portal by District Branches.
  - Attended training related to the implementation of the email blast service that will serve as the conduit between the APA, the Early Career Psychiatrists and select third parties.

B.3 Office of Scientific Programs (OSP)

Joy Raether, Director

Annual Meeting

The Office of Scientific Programs coordinated regular conference calls with the Scientific Program Committee (SPC) leadership and APA President Dilip V. Jeste, M.D., to plan the 2013 Annual Meeting in San Francisco.

The XML text platform developed through interdepartmental cooperation in 2012 made production of the 2013 annual meeting publications much easier. The OSP staff are currently working with the developers at Attendee Interactive (Ai) to make improvements to the database which will further improve abstract submissions and production of the 2014 annual meeting publications. This will include developing

report queries to make corrections and merge duplicate records in the database routinely once a week.

OSP staff, IT, and Attendee Interactive also worked to provide exports from the online submission system to Tri-Star for their telephone application that was used at the 2013 Annual Meeting. The data export was complicated and worked well. Session information was updated live during the meeting by OSP staff so meeting attendees were kept up-to-date on program changes as they were made.

The Attendee Interactive online submission system was a great success last year. There were only a few persons needing to be "walked through" their submissions in 2013. The report writing tools in Ai made it very easy for staff to create reports to better manage submissions. Attendee Interactive reported that they had very light customer service calls during the first year of operation compared to other medical specialty societies they work with. They were also delighted and pleasantly surprised that they did not need to respond to any "911" calls from OSP staff during the annual meeting. This speaks well to the work of OSP staff and Ai in developing a good first round submission system. The submission system for the 2014 New York AM is slated to open on July 1, 2013.

OSP projects for next quarter include:

- Working with IT and Attendee Interactive to complete upgrades and test the online submission system functionality for the Annual Meeting and IPS.
- Assisting with the IPS meeting and supporting its activities
- Preparing course evaluation materials and reports for the SPC Course Subcommittee meeting in July
- Working with Cameron Carter, M.D., Vice-chair on the Scientific Program Committee to get NIMH staff ready to make their submissions for the 2014 Annual Meeting.

2013 Institute on Psychiatric Services

Planning for the 65th Institute on Psychiatric Services continues. A total of six articles about IPS are scheduled to appear in *Psychiatric News* in July, August, and September. Topics will include meeting highlights, the meeting from a resident's

point of view, recovery, OMNA on Tour and fine dining in Philadelphia. The Scientific Program Committee has invited some notable lecturers to speak at this year's meeting. They include Drs. Raquel Gur, Howard Goldman, Arthur Evans, Lisa Dixon, David Pollack, Ezra Susser, William McFarlane and Mark Ragins. Estelle Richman, Senior Advisor to the Secretary for the U.S. Department of Housing and Urban Development will be giving the Keynote Address at the Opening Session. In order to increase attendance from the Primary Care community, a special non-member reduced registration rate is being offered again to those physicians; the special registration rate is 50% of the daily APA member registration rate. In a continuing effort to reduce meeting expenses, the IPS Preliminary Program will again this year only be available on line.

B.4 Melvin Sabshin Library and Archives

Reference and Research Services

The librarian responded to over 150 reference and research requests during this quarter—55% from APA staff (including District Branches); 17% from members; and 28% from nonmembers (e.g., reporters, attorneys, health care providers, academics, etc.). Extensive research continued for APA President Dilip Jeste as background for his column in *Psychiatric News* and incoming Scientific Program Committee leadership received updated histories of the APA conferences and of awardees to use in their planning.

Document Delivery

Over 100 requests for documents were filled—most for staff (especially APIRE, Division of Education and the Office of Communications and Public Affairs), but also about one-third for members and a dozen or more for nonmembers (e.g., health sciences libraries, academics, government agencies, etc.). Ten (10) interlibrary loan requests were filled for other libraries.

Information Dissemination

Progress continues on building content for the new Library & Archives web site. Several books relevant to the history of the APA and American psychiatry have been scanned and made available online (some with members only access). More positions statements and resource documents have been added and more than a dozen APA Component Directories have been scanned for inclusion on the Members'

Corner. The librarian also continues to prepare final copy of APA documents for posting as data supplements to the *American Journal of Psychiatry* on PsychiatryOnline.org.

DSM Historical Collection

Work continues on processing the DSM-III/III-R and DSM-IV/IV-TR materials for the Archives. The librarian is currently seeking bids to scan these collections as well as pursue options for in-house scanning.

Visiting Scholars

Two visiting scholars visited APA to use APA archival materials: one using the DSM-III & DMS-III-R collection and another using the DSM-IV materials. Another scholar currently in residence is the first to be investigating the DSM-IV planning materials. There are currently over a dozen requests from researches in the queue for research assistance and the librarian actively is working with four individuals to schedule appointments through the rest of summer and into the fall.

Visiting researcher Hannah S. Decker, Ph.D., has sent the library her newest book, *The Making of DSM-III®: A Diagnostic Manual's Conquest of American Psychiatry* (New York: Oxford University Press, 2013), drawing on APA archival materials. It has received very favorable reviews.

Special Projects

Following the success of Deborah Hales, M.D., and Division of Education staff in securing President Bill Clinton as keynote speaker for the Annual Meeting, the librarian continued to respond to Clinton staff and his speaker's bureau representatives' requests for additional information through the APA lead contact, Judith Carrier, Ph.D.

The librarian coordinated two lectures at the 2013 Annual Meeting and assisted with the documentation and approval process for the Adolf Meyer Award:

- The Benjamin Rush Award Lecture - Anne Harrington, Ph.D.
- The Manfred S. Guttmacher Award Lecture - Alec Buchanan, M.D., Ph.D., & Michael Norko, M.D., M.A.R.

Both lectures were well-attended and generated lively discussions with their audiences.

In addition, he provided consultation and technical support for organizing and managing the twelve poster sessions at the Annual Meeting, especially the two sessions for the Resident/Medical Student Poster Competition Session and the International Poster session which required communication with nearly 300 presenters. He also contributed to the production of promotional materials and several conference publications and was a lead contributor in developing and updating content for the Division of Education-initiated Annual Meeting micro site as well as for the IPS web site.

C. DIVISION OF FINANCE AND BUSINESS OPERATIONS

Therese Swetnam, Chief Financial Officer

C.1 Membership Services

C.2 Meetings and Conventions Department

C.1 Membership Services

Susan Kuper, Director

Membership Promotion

Recruitment/Retention Highlights (International Membership)

The International Ambassador Program officially launched in Spring 2013. The development of the International Ambassador Program was originally introduced in the international marketing plan that the APA developed with an outside international marketing consultant in May 2012, whereby APA members who live or travel abroad recruit new International Members to join the APA. The countries participating in the pilot include Australia, Brazil, India, and the Netherlands, where 5-10 members in each country have committed to recruiting colleagues within their countries. These initial countries were selected based on the higher concentration of international members who reside in each country as well as a high rate of attendance by both members and non-members from each country at the APA Annual Meeting. In addition, Japan has been added to the initial launch to take advantage of APA's current collaboration with the Japanese Society of Psychiatry and Neurology in promoting each other's memberships, an initiative that was established during the International BOT Work Group meeting at the World Psychiatric Association Bucharest Congress in April 2013.

Another new international program that APA is currently promoting is the new International Fellow membership category. Ongoing promotional announcements have appeared in APA Headlines and Psychiatric News Alerts and the first of several email blasts regarding the new category was emailed to International Members in May prior to the Annual Meeting. Thirty-eight International Fellow applications were submitted onsite in San Francisco during the Annual Meeting in addition to a substantial number of applications that had been submitted prior. The application deadline for International Fellows is August 1.

Recruitment/Retention Highlights (US & Canada)

- Congratulations letters were mailed to APA members passing the ABPN boards (n=735), and recruitment letters were mailed to non-members (n=554), an ongoing recruitment and retention tool administered by Membership.
- Two email blasts have been sent to Early Career Psychiatrists (ECPs) promoting the new member benefit of free online FOCUS subscriptions for ECP members in 2013, as well as continual ongoing promotion of the benefit in APA's PN Alert and Headlines.
- Promotional banner ads on APA membership are being featured on the American Association for Geriatric Psychiatry's (AAGP) biweekly email news brief to members. The ads, which began in April and will run through July, include messaging to promote benefits to APA members and non-members alike.
- Direct mail postcard was mailed to non-members who pre-registered for the APA Annual Meeting in San Francisco at the full conference non-member rate promoting the APA Annual Meeting Rebate Program (n=375). Ninety-two (92) eligible Rebate applications were received at the Annual Meeting in San Francisco, an all-time high. The Annual Meeting Rebate Program allows non-members who are eligible for General Membership and submit an application onsite at the Annual Meeting to apply the extra money they paid to attend the meeting as a non-member towards APA membership dues.
- The new APA Medical Student benefits brochure and application, now a self-mailer which includes a postage paid return postcard of the membership application, was mailed to first and second year medical students in April (n=5,328).
- A personalized dues renewal postcard was mailed in May to ECPs, General Members, Members-in-Training and Canadian members owing outstanding dues for 2013 with targeted membership benefits specific to their membership category.
- An annual telemarketing campaign to members in the U.S. and Canada who are in danger of having their membership expire on June 30 for non-payment of dues began in early June and will continue through mid-July. A new company is being used this year – Inalink, who came highly recommended by other medical specialty societies who administer similar calling campaigns.

Changes to the 100% Club Beginning in 2013-2014

There will be a new structure to the 100% Club Program beginning in 2013-2014. The APA 100% Club was established to encourage residents throughout the United States and Canada to join the APA with all of the other trainees in their program. Many psychiatric residency programs come close to enrolling all of their residents each year, but fall short because of one or two who do not join. To recognize and honor those programs for their efforts, the 100% Club is being expanded to include three levels of Gold, Silver and Bronze which will recognize programs that have the majority of their residents enrolled. Additionally, there is now a Platinum level, which will recognize programs that have been part of the 100% Club Gold level for the past five consecutive years.

Exhibits at Other Psychiatric Meetings

Membership staff will be exhibiting at these upcoming meetings to promote APA membership:

- Royal College of Psychiatrists (Edinburgh, Scotland, July 2-5, 2013)
- U.S. Psychiatric and Mental Health Congress (Las Vegas, NV, September 30-October 2, 2013)
- American Academy of Child and Adolescent Psychiatry (Orlando, FL, October 22-27, 2013)

New Member Benefit – Healthcare Resources Online (HRO)

This new member benefit, approved by the APA Board of Trustees at the end of 2012, is being formally launched in June under the name Psychiatry Resources Online (PsychPRO) and will be promoted to members via email blast and announcements to members via multiple APA communications channels including a banner ad on the APA homepage, announcements in Psychiatric News and APA Headlines, and in other ongoing promotional efforts throughout the year. PsychPRO provides members with access to a free Surescripts-certified ePrescribing platform and point-of-care resources for patient care available online.

Membership Dues Billing

- The 5th print mailing of the 2013 Membership Dues Invoices was generated on June 17, 2013.
- An email blast to members owing dues was sent on May 7, 2013.
- As of May 31, 2013, 8.1 million (79% of 10.3 million billed to date) in dues revenue has been collected for 2013 dues. This compares to 7.8 million (77% of 10.1 million billed) collected at the same time last year.
- Participation in the Monthly Payment Plan continues to impact revenue collection as participation spreads out dues payments over 12 months.

Dues Year	Members Participating	Amount Billed	Amount Deferred thru year-end
2013	1,859	$945,629	$486,311
2012	1,734	$925,045	
2011	1,489	$786,412	
2010	1,456	$751,862	
2009	1,177	$593,537	

Other Membership Projects and Activities

- 2013 Potential Dues Drops: Members still owing dues have been notified by email at least five times and have received at least five print invoice mailings since last fall. The district branches are being sent updated potential drop rosters on a regular basis and have been asked to contact their members personally to encourage renewal. APA hired a new vendor to call members on behalf of APA and within the first week, they collected approximately $80K.
- Over 900 members who were newly elected to the membership categories of Distinguished Life Fellow, Distinguished Fellow, International Distinguished Fellow and Fellow, as well as Distinguished Fellows reaching Life status and Members with 50-years of membership were invited to participate in the 57th Convocation held at this year's Annual Meeting (San Francisco). The percentage of members who participated was 22%. As a follow-up for those

who could not attend, a mailing of medallions and lapel pins will be coordinated at the end of June.

- Three Membership staff managed the Membership desk and one Membership staff person managed the Membership booth in the Member Center at this year's Annual Meeting. Staff interacted with members and prospective members answering a wide array of questions about membership in the APA (i.e. reinstatement, how to join APA, district branch transfers, fellowship, international fellowship, international ambassador program, etc.). Nearly 240 applications and other documents were received (see below for breakdown) for review and processing.
    - 110 Rebate applications (92 eligible/18 not eligible)
    - 22 Fellow applications
    - 38 International Fellow applications
    - 44 International Membership applications
    - 8 Medical Student applications
    - 1 Member-in-Training application
    - 1 DB Transfer request
    - 1 Retired status
    - 12 Membership update forms

- Also at the Annual Meeting, Membership staff coordinated the New International Member Welcome Reception, the DB Membership Chairs meeting, and the Membership Committee meeting.
- Approximately 1,120 members who completed training in 2013 were contacted requesting that they verify they meet the General Member requirements or provide updated information about continuing training.
- Approximately 120 members who completed training in 2012 still need to verify they meet the General Membership requirements. These members will be dropped in the fall if GM verification is not received.
- Membership staff continues to manage and monitor the APA Linked-In group and field requests from members and non-members requesting to join the group. There are over 2,200 APA members in the APA Linked-in group.
- A new Membership Development Coordinator has been hired and is expected to start employment on June 24, 2013. This position will focus on recruitment and retention of international members as well as members in

mid- and late-career. The other Membership Develop Coordinator position has been re-aligned to focus on recruitment and retention of medical students, residents and early career psychiatrists.

C.2 Meetings and Conventions Department
Cathy Nash, Director

ANNUAL MEETING

- The "APA Gives Back," was continued this year in support of the Mental Health Association of San Francisco. Registrants were encouraged to donate money during the registration process, and $7,526 was raised. The APA matched these donations dollar for dollar and a check in the amount of $15,052 has been sent to the MHASF.
- The total number of commercial and educational exhibiting companies decreased slightly to199 exhibits, from 203 in 2012; but up from 128 in 2011. There were several cancellations prior to the show resulting in the overall count. There was considerable advertising in the exhibit hall and in the lobby areas of the convention center that resulted in increased revenue to the APA, and which allowed us to exceed the exhibit revenue budget this year.
- This was the second year that advanced exhibit booth sales were offered for next year's Annual Meeting. Appointments were made to select space and this year's interest increased from 17 to 24 exhibitors scheduling space, an increase of 71%). The advanced contract requires a minimum payment of 50% of the booth cost paid by June 17. An added incentive to register for 2014 at the 2013 meeting was to pay the 2013 prices since exhibit prices will increase for the 2014 Annual Meeting. Advanced sales will continue with future Annual Meetings.
- To increase traffic in the Exhibit Hall, the following were instituted:
  - ~ New Research Poster Sessions were held within the hall starting on Saturday, May 18 with a new Resident Poster Session and ended on Tuesday, May 21;
  - ~ Food vouchers in the amount of $10 were given to all paid attendees good in all Exhibit Hall Food Courts during exhibit hours only, beginning on Sunday, May 18;

- ~ Two networking lounges, "APA Cafes" were available within the Exhibit Hall to allow attendees to connect with colleagues, while also recharging laptops and cell phones, along with free WIFI, and free coffee/tea services scheduled during the day;
- ~ The Career Fair and International Meeting Pavilion, along with the Publisher's Book Fair and Member Center were open on Saturday, May 18.
- ~ The APP Bookstore and Publishers' Book Fair remained open an additional hour on Saturday May 18 to allow attendees the opportunity to purchase the DSM 5; and
- ~ Product Theaters were held in the exhibit hall again to increase hall traffic Sunday-Tuesday.

- Allied and component meetings were held in conjunction with the Annual Meeting program. There were 86 allied association meetings (97 in 2012, 67 in 2011), 76 allied pharmaceutical meetings (60 in 2012, 45 in 2011), and 124 component meetings (126 in 2012, 130 in 2011,) and 63 governance meetings (62 in 2012, 52 in 2011,) for a total of 349 ancillary meetings (345 in 2012, 294 in 2011).
- The Opening Session was held on Saturday, May 18, due to a scheduling conflict with President Clinton. The Session attracted an audience of approximately 1,800. For the second year, following the Opening Session, a special session was held, entitle "A Special Dialogue Between Drs. Jeste and Elyn Saks." This interview explored various issues relevant to people with serious mental illnesses.
- The 57th Convocation of Fellows took place on Monday evening, May 20, and approximately 2,000 attended. Following the induction of distinguished fellows and the presentation of awards, Baronness Susan Greenfield, C.B.D., D.Phil. delivered an inspiring message.
- At the last minute, President Bill Clinton was feeling under the weather and his doctor instructed him not to fly, so he was unable to attend the APA Annual Meeting as a keynote speaker on Sunday, May 19. However, quick efforts by staff allowed him to speak live via satellite. He was introduced by Dr. Jeste, and after his inspiring speech, Dr. Scully asked questions from APA members which were answered by President Clinton. This was attended by well over 8,000 registrants and comments were very positive. The President

felt bad about not being able to attend and so he waived his entire honorarium.

Institute on Psychiatric Services (IPS)

- The logistical planning is underway for the IPS, which will be held at the Philadelphia Marriott Downtown, Philadelphia, PA, October 10-13, 2013. The theme is, "Pursuing Wellness Through Recovery and Integration." Online registration and housing for the IPS opened June 4.

September Meeting

- The meeting will be held September 18-21, 2013, at the Hilton Crystal City at Washington Reagan National Airport, in Crystal City, VA. This is the first year the meeting will be held at the Hilton as the Sheraton Pentagon City Hotel served as the September Meeting's home for the past three years in Arlington, VA. After feedback from members and staff, an RFP was issued to find a new location that was more centrally located while keeping budget in mind. The Hilton Crystal City offered the best overall package and rates. The Board will not meet in conjunction with the September Meetings, but instead will meet following the IPS meeting in October.

D. DIVISION OF PUBLISHING

Rebecca Rinehart, Publisher

D.1 American Journal of Psychiatry
D.2 Psychiatric News
D.3 Psychiatric Services
D.4 APP Books

D.1 AMERICAN JOURNAL OF PSYCHIATRY

Robert Freedman, M.D., Editor

- At the APA Annual Meeting, AJP hosted a packed research forum on "Treatment of the Pregnant Woman and Her Child." A standing room only crowd in excess of 250 heard the following presentations:
    - Katherine L. Wisner, M.D., M.S., discussed how infants of women who took SSRIs during pregnancy did not differ from infants of unmedicated healthy women in weight, length, or head circumference during the first year of life—information that may help women weigh the risks and benefits of continued antidepressant treatment during pregnancy.
    - Mallay Occhiogrosso, M.D., discussed how newborn pulmonary hypertension, once thought to be an adverse effect of SSRI treatment during pregnancy, is an effect that an extensive epidemiologic investigation has reported is small and as likely to be caused by depression itself as by the medications.
    - Veerle Bergink, M.D., reported on her clinic for pregnant women with a history of bipolar disorder or postpartum psychosis where a prophylactic treatment approach diminishes risk for subsequent illness during or after pregnancy.
    - Randal Ross, M.D., discussed how perinatal supplementation with choline appears to activate neonatal cerebral inhibition—a critical developmental function in the brain related to sensory gating and attention—even in the presence of gene mutations that otherwise delay it, possibly protecting infants from schizophrenia and other severe mental illness in which deficiencies of sensory gating and attention are prominent.
- *Issue Highlights:*

- **March**: featured this "groundbreaking research" by Dr. Ross on choline for prevention of schizophrenia (cited in a great Forbes article "Get Smarter: A Powerful Brain-Boosting Supplement You've Never Heard Of") and a telepsychiatry primer complete with a training video.
- **April**: included a proof-of-concept study showing that immunization with a nicotine vaccine over 20 weeks led to reduction of nicotine binding to receptors, a 23.6% decrease in the amount of nicotine available to enter the brain, and decreases in craving and the number of cigarettes smoked in long-term smokers.
- **May**: featured Dr. Wisner's study on the risks and benefits of continued antidepressant treatment during pregnancy and an editorial and an article on gun violence and public attitudes about individuals with mental illness.
- **June**: featured an article showing that citalopram daily doses above 40 mg are not associated with a higher risk of ventricular arrhythmia or death from either cardiac or noncardiac causes, as had been indicated in a 2011 FDA warning; also highlighted China's new Mental Health Law and the start of a series of commentaries by DSM-5 workgroup chairs discussing what went into decisions about diagnoses and what the future holds.

CME, ELECTRONIC, AND SPECIALTY SOCIETY JOURNALS

Michael D. Roy, Editorial Director

- In February 2013, *Academic Psychiatry* debuted "AP in Advance" and *The Journal of Neuropsychiatry and Clinical Neurosciences* introduced "JNCN in Advance" on their journal websites. These "in Advance" sections are where articles are published online ahead of their appearance in a print issue. Upon online publication the article's metadata is delivered to the National Library of Medicine so that days later, the article is available in MEDLINE and discoverable via PubMed. This means articles now enter the scientific literature in weeks rather than months. Previous efforts to move journals to this new workflow cost many thousands of dollars and took upwards of close to a year. With the help of our vendor partners, the new portion of the site was up and operational in mere weeks.
- FOCUS published its Spring 2013 issue that covered "Personality Disorders", with articles on co-occurring disorders and treatment complexity, borderline

personality disorder, and personality disorders in DSM-5 Section III. Focus also saw its usual nice uptick in subscriptions among attendees at the APA Annual Meeting.

- The Spring 2013 issue of *The Journal of Neuropsychiatry & Clinical Neurosciences* featured an overview of oxytocin's many and varied effects, sites of action in the brain, and stimuli that are implicated in its actions, which include response to infant behavior, such as laughing or crying, "falling in love," and abandonment. Also featured were concepts and strategies for clinical management of blast-induced traumatic brain injury and posttraumatic stress disorder and outcomes of sports-related concussion among college athletes.
- In *Academic Psychiatry*, the March-April discussed improving physician-patient communication through coaching of simulated encounters, the impact of supervision on internal medicine residents' attitudes and management of depression in primary care, and career programs in online and blended-learning environments. The May-June issue featured studies on substance use and attitudes on professional conduct among medical students, attitudes of medical students toward psychiatry and psychiatry as a career, and web-streamed didactic instruction on substance use disorders.
- The AJP Resident's Journal, an e-publication created exclusively for psychiatry residents to share ideas and experiences in training, clinical practice, research, and careers with colleagues, featured articles on published special sections on military psychiatry (April) and DSM-5 (May).

D.2 PSYCHIATRIC NEWS

Jeffrey Borenstein, M.D., Editor in Chief

- *Psychiatric News* concluded its exclusive series of articles on the differences between *DSM-IV* and *DSM-5* in the May 17 issue. (This was also the issue distributed at the annual meeting.) The series, which began in the January 18 issue, covered *DSM-5* on a chapter-by-chapter basis, providing information on new diagnoses and diagnoses for which there have been changes. Articles were accompanied online by fact sheets and video and audio interviews of *DSM-5* experts. These articles have consistently been the most-read articles on the *Psychiatric News* Web site. The articles and related materials can still

be accessed at http://www.psychiatry.org/dsm5. A related series was launched in the March 15 issue, based on a book to be published by American Psychiatric Publishing in August: *DSM-5 Self-Exam Questions: Test Questions for the Diagnostic Criteria.*

- The *Psychiatric News Alert*, *Psychiatric News'* daily news service that is distributed through e-mail and RSS feeds, continues to be a popular communications channel to APA members. Among the posts with the highest open rates within the past 90 days were "Cognitive Remediation, Vocational Rehab Create 'Total Dose Effect' for Schizophrenia" (59.3%); "David Kupfer, M.D., Responds to Criticism of *DSM-5* by NIMH Director" (55.6%); "Zolpidem Use Increasingly Ends in Emergency Room Visits" (55%); "Lieberman, Insel Issue Joint Statement About *DSM-5* and RDoC" (49.1%); "New Intervention for Suicide Attempters Can Facilitate Engagement in Treatment" (46.8%).

- The *Psychiatric News Update*, a weekly e-newsletter also distributed to APA members with an e-mail address on file, continues to enjoy healthy readership among members. Particularly popular in the last quarter were the e-newsletters produced each day of APA's 2013 annual meeting: some open rates exceeded 24% (average open rate of the *Update* is about 20%). The series contained highlights of each day of the meeting as well as video and audio interviews with APA leaders and researchers on a wide variety of topics.

- Psychiatric News won an award for overall design from Association Media & Publishing, a membership organization that serves the needs of association publishers, business operation executives, communications professionals, designers, and other content generators.

D.3 PSYCHIATRIC SERVICES

Howard H. Goldman, M.D., Ph.D., Editor

- **Two new editorial board members:** The BOT approved appointments of two *Psychiatric Services* editorial board members—Regina Bussing, M.D., and T. Scott Stroup, M.D.—for four-year terms beginning in May 2013. Dr. Bussing is a professor in the Department of Psychiatry at the University of Florida. Her research focuses on improving care for children with attention-

deficit hyperactivity disorder and their families. Dr. Stroup is a professor of psychiatry at Columbia University College of Physicians and Surgeons. His research focuses on the effectiveness of interventions and services for people with severe and persistent mental illnesses.

- **Editorial board meeting, May 23:** The *Psychiatric Services* editorial board met via conference call on May 23 (10 of 12 members attended, along with the journal's editor and staff). The board discussed data presented in *Psychiatric Services'* 2012 annual report. Members made several suggestions on a key objective for the coming year: increasing readership among APA Members in Training (MITs), who get free online access to *Psychiatric Services* as a member benefit.

- **March issue:** The lead article examined interventions to better engage patients from underserved racial-ethnic groups in treatment and identified "collaborative care for depression" as the only efficacious approach. An analysis of national data pinpointed factors underlying the marked increase in pediatric use of antipsychotics. Another large study of medication use found no evidence that race-ethnicity plays a role in the effectiveness of clozapine, an underused drug to treat schizophrenia.

- **April issue:** Three articles reported outcomes from a 2007 Washington State initiative that launched a network of recovery-oriented ACT teams. A research group from Massachusetts, which since 2008 has had universal health insurance with an individual mandate, presented data on lessons learned about how to prevent "churn," which occurs when patients are disenrolled from their subsidized health plan, even though they remain eligible, and then must be reenrolled. VA researchers found that African-American veterans who underwent examinations to qualify for PTSD disability benefits gave significantly worse ratings to their examiners (interpersonal qualities and competence) than did white veterans.

- **May issue:** In the lead study, inpatients' ratings of their risk of future violence was a more accurate method of predicting violent behavior after discharge than two widely used violence risk assessment tools. A study in

New York State, which has invested heavily in ACT, found consistent adverse outcomes for clients with recent forensic histories, particularly during their first year of ACT, highlighting the need for enhanced strategies for these high-risk clients. A San Francisco study found that use of pressures such as housing and money to "leverage" treatment had a downside: it increased medication adherence but significantly eroded satisfaction with care.

- **June issue:** As full ACA implementation approaches in 2014, researchers are analyzing past data to reduce uncertainty about anticipated changes, as indicated by two studies. A 1985–2005 data analysis documented substantial shifts in funding for specialty treatment; the authors describe further shifts in the near term resulting from the ACA and parity. Another study, which analyzed data from a recent national population survey, predicted sizable unmet need for substance abuse treatment in newly eligible adults after Medicaid expansion in 2014.

D.4 APP BOOKS

Robert E. Hales, M.D., M.B.A., Editor-in-Chief

- **APA released** 9 new publications through May and on June 11 more than 280 titles were made available as e-books on www.appi.org.

- **DSM-5** and the **DSM-5 Collection** were released for sale on January 18th. DSM-5 was published on May 22, 2013 but was available for purchase at the APA Annual Meeting. DSM-5 online via Psychiatryonline.org became available on June 6.

- **Books** in the DSM-5 Collection include *DSM-5*, *DSM-5 Desk Reference*, *The Pocket Guide to the DSM-5 Diagnostic Exam*, *DSM-5 Guidebook*, *DSM-5 Self-Exam Questions*, *DSM-5 Clinical Cases*, *DSM-5 Handbook of Differential Diagnosis*, and *Study Guide to DSM-5.*

- **APP Book authors** led 25 sessions at the 2013 APA annual meeting in San Francisco: 6 Advances In sessions, 8 Master Courses, 3 invited symposia, and 12 Meet the Author sessions. Staff held 42 author meetings in Authors'

Corner, hosted an Author Reception, held an Editorial Board Meeting, and presented 6 Author Signings in the Annual Meeting Bookstore.

- **Key titles upcoming** on APP's editorial calendar include the following: *APP Textbook of Psychiatry, 6th Edition*, *Gabbard's Treatment of Psychiatric Disorders, 5th Edition*, *Psychodynamic Psychiatry in Clinical Practice, 5th Edition*, *APP Textbook of Personality Disorders, 2nd Edition*, and *APP Textbook of Substance Abuse Treatment, 5th Edition.*

E. Division of Research

Darrel Regier, M.D., M.P.H., Director

E.1. DSM Task Force and Work Group Activities

E.2. DSM-5 Field Trials

E.3. Department of Quality Improvement and Psychiatric Services

E.4. Component and Other Activities

E.1. DSM-5 Task Force and Work Group Activities

DSM-5 Conference Activities

The DSM-5 Track at the 2013 APA Annual Meeting included 21 symposia and workshops. The Division of Research also worked alongside the Division of Education and APP to develop a master course and an invitation-only train-the-trainers course for representatives from APA District Branches and from other mental health professional associations. Both of these educational opportunities complemented marketing strategies and educational/training sessions planned for the meeting, and provided clinicians and researchers with instruction on how to implement DSM-5. Following the annual meeting, the training materials were distributed to the District Branches to facilitate their own local training sessions. The APA continues to provide training and guidance, particularly with regards to insurance implications of revisions in DSM-5, by working with CMS, various insurance agencies, and other healthcare bodies (e.g., the Veteran's Administration) to ensure proper implementation and prevent any disruptions in services provided and reimbursements. Leadership of the Division of Research will also continue providing in-person training presentations at national and international conferences throughout the rest of 2013, as funding permits. For example, the District Branch training session developed for the APA Annual Meeting will be adapted and re-presented as a training course for clinicians at the 2013 IPS gathering (October 10-13).

E. 2. DSM-5 Field Trials

Data analysis and manuscript development to present the results of the DSM-5 field trials in routine clinical care settings, was completed and submitted to *Psychiatric Services*. The manuscript has now been accepted and is anticipated for publication

this fall. Work is continuing on developing a common data set for distribution to the DSM-5 academic field trial sites.

E.3. Department of Quality Improvement and Psychiatric Services (QIPS)

- With guidance from the Committee on Electronic Health Records (EHR), QIPS staff supports an EHR Web page on the APA Web site (www.psychiatry.org/ehr). With staff support, the Committee has completed a listing of functional requirements for EHRs in psychiatric settings, which has been added to the website.
- QIPS, staff from DGR, and the Committee on EHRs monitors federal activities pertaining to health information technology (HIT). Recent effort included drafting comments on a proposed approach to Meaningful Use Stage 3 of the federal EHR incentive program.
- APA is in collaboration with the American College of Physicians and American EHR Partners to field a survey to collect reviews of EHR software from the members of participating associations, including APA. Once they are processed, the over 500 responses received in April-May 2013 will provide actionable information to members about EHR currently in use by psychiatrists, as well as information about desired features that can be communicated to EHR vendors.
- Rob Plovnick, M.D., M.S. represents APA at the PEHRC, and attended its March 13, 2013 meeting. The mission of the PEHRC is to assist physicians, particularly those in small practices, with adoption of health information technology.
- As a partner organization in the Physicians' Clinical Support System-Buprenorphine (PCSS-B), APA has organized and presented monthly webinars on assessing and treating substance use disorders, with particular emphasis on opioid dependence. The sessions were organized by Beatrice Eld and hosted by Dr. John Renner, who serves as APA's Clinical Director for this program. They feature clinical experts, researchers, and government officials. Webinar recordings are available for on-demand viewing at www.psychiatry.org/pcssbwebinars and at www.pcssb.org. Recent topics were: Managing Poly-Substance Abuse: A Case Discussion; Integrating Buprenorphine/Naloxone Into a Methadone Clinic; Pain Management in Patients on Buprenorphine Maintenance; and Management of Buprenorphine Side Effects.
- The PCSS-B program ended on May 31. APA has joined with the American Academy of Addiction Psychiatry, the American Osteopathic Academy of Addiction

Medicine, and the American Society of Addiction Medicine to submit a grant application to continue and expand the program to address all FDA-approved medications for the treatment of opioid dependence. SAMHSA will announce the award decision in the summer.

- APA is also a partner organization in the Prescribers' Clinical Support System for Opioid Therapies. PCSS-O is a federally funded program operated collaboratively by the American Academy of Addiction Psychiatry (lead) and six organizational partners, including APA, AMA, and the American Dental Association. It focuses on (1) the use of opioid therapies for treatment of opioid dependence and (2) the safe use of opioids in treatment of chronic pain including training on how to recognize misuse, abuse, and addiction in those with pain. Recordings of APA's webinars are made available on APA's website for on-demand access (www.psychiatry.org\pcssowebinars). Recent webinar topics were Patters of Opioid Use, Misuse, and Abuse in the Military, the VA, and US Population and The Evidence Behind Alternative/Complementary Chronic Pain Management
- An 8-hour buprenorphine training course was organized and presented at the APA Annual Meeting.
- Beatrice Eld collaborated with the National Institute on Drug Abuse to organize a featured research track at the recent APA Annual Meeting. The series included lectures, symposia, and the Addiction Performance Project, all of which were well attended and positively received.
- A special series of addiction psychiatry sessions were accepted by the IPS Scientific Program Committee.
- Beatrice Eld and John Renner, M.D., represent APA on monthly conference calls convened by SAMHSA's Center for Substance Abuse Treatment. Other participants include representatives of a variety of medical organizations, NIDA, NIAAA, and several additional Federal agencies.
- Frances Levin, M.D., chair of the Council on Addiction Psychiatry, will represent APA at ASAM's *Advancing Access to Addiction Medications Stakeholder Summit*, scheduled for June 20.
- Rob Plovnick has been working with HSF staff to design a new "Health Reform" section of the APA website to educate psychiatrists about various developments and trends in healthcare delivery and payment.
- On May 7, 2013, the Board Executive Committee approved APA's participation in the Choosing Wisely Campaign, in which professional associations target 5 areas

of overuse. Five proposed topics pertaining to the use of atypical antipsychotics (e.g. polypharmacy, monitoring for side effects) were approved.

- Samantha Shugarman participated in the AMA-convened PCPI's (Physician Consortium on Performance Improvement) (an organization of physician specialty societies) stakeholder webinar on the anticipated changes to the PCPI's measure development process. Dr. McIntyre and Lisa Greiner attended the PCPI meeting in Washington, DC on April 4-5, 2013, where PCPI continued to discuss its realignment to a more consultative role.
- On May 14, 2013, Rob Plovnick attended the kickoff meeting of the American Academy of Neurology's effort to develop performance measures on headaches.
- On June 5-6, 2013, John Oldham, MD, Rob Plovnick, and Samantha Shugarman attended the webinar meeting of the NQF panel reviewing behavioral health measures. Two MDD measures developed in association with the PCPI were under review. A measure on evaluation of MDD using DSM criteria and documenting severity was not approved, and a measure on screening for suicide risk at the time of initial diagnosis was approved by the panel.
- Samantha Shugarman continued an in depth review of registry programs that currently exist for medical specialty organizations and how to develop a registry. This review will culminate in a report to inform the organization on the strategic direction it might consider regarding registries.
- An expert work group is developing new practice guidelines on psychiatric evaluation, using a new development process as previously reported. The work group is now determining the strength of recommendation of specific guideline statements, using a modified Delphi process, i.e., through blind iterative voting. The work group's deliberations are informed by results of a systematic review of evidence and results of an expert opinion survey. In accordance with the GRADE Method, each guideline statement will be coded as either a "recommendation" or a "suggestion"; strength of supporting evidence will be coded separately as "high quality," "moderate quality," "low quality," or "insufficient." Draft guidelines will be made available for review by experts, APA members, APA components, and other stakeholders such as patient advocacy organizations. Submission of final guidelines for approval by the APA Assembly and Board of Trustees is planned for May-June 2014.
- A new Guideline Writing Group met in person at the APA Annual Meeting in San Francisco. This group will be asked to write new APA guidelines across topics

using the new development process being piloted for guidelines on psychiatric evaluation, as described above. The first topic will be off-label use of atypical antipsychotics to treat behavioral symptoms of dementia. The Steering Committee on Practice Guidelines chose this topic because of its importance to the field and because of availability of a published 2010 systematic review by the Agency for Healthcare Research and Quality. APA staff and contractors are updating the AHRQ systematic review. A systematic literature search was conducted to identify studies published since 2010. Data from relevant studies has been extracted into evidence tables. The studies will next be graded across multiple quality domains, then an overall rating of strength of evidence will be determined for the body of available evidence.

- The Agency for Healthcare Research and Quality accepts nominations of topics for future development of systematic reviews by AHRQ-sponsored Evidence-Based Practice Centers. Staff worked with the Steering Committee on Practice Guidelines to identify high-priority guideline topics and clinical questions for nomination. In March, questions about the treatment of bipolar disorder were submitted. Systematic reviews are the most expensive component of guideline development; therefore, there is strategic and financial value in having AHRQ select and fund systematic reviews on topics that APA nominates. Other guideline developers including the American Psychological Association have successfully nominated guideline topics to AHRQ for development of a systematic review. Mental health is specifically described by AHRQ as a priority topic area.
- A group of experts has drafted a guideline watch on Alzheimer's disease and other dementias. A guideline watch on obsessive-compulsive disorder was published in May on PsychiatryOnline. Watches are brief reviews of important developments in the scientific literature that could affect the currency of the 14 "old" APA guidelines published on PsychiatryOnline. Watches are being developed informally as APA resources allow to help maintain the relevance of many of these guidelines that were developed under the old development process and have become >5 years old.
- In 2010, the National Library of Medicine awarded a three-year grant to APA's practice guidelines project to apply informatics principles to the development and dissemination of new practice guidelines. Grant-funded activities include the following: a survey to 1,000 psychiatrists with the aim of assessing their clinical information needs was fielded and analyzed; Dr. Fochtmann has designed a

literature search strategy and begun work to develop a computer algorithm to help screen articles for relevance to APA guidelines; staff have designed and piloted a training module for screeners. Without a requested no cost extension, grant funding ends in July 2013.

- As APA representative and Chair of the Professional and Technical Advisory Committee (PTAC) on Behavioral Health, Yad Jabbarpour, M.D. continues to work closely with The Joint Commission on an initiative to establish requirements for a new behavioral health home certification product. APA participated in the field review of these draft requirements and submitted extensive comments. In his capacity as chair, Dr. Yabbarpour attends meetings of TJC's Board of Commissioners.
- APA's representative Dr. Charles Dike, will participate in a June 20 meeting of The Joint Commission's Hospital PTAC.

E.4. Component and Other Activities

Council on Addiction Psychiatry

At its May 20 meeting, the Council approved and forwarded for APA adoption a Position Statement on Marijuana As Medicine. It also met with representatives of Federal organizations, including the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Center for Substance Abuse Treatment, and the Veterans' Health Administration. Topics addressed included: the functional integration of NIDA and NIAAA; the impact of sequestration on each of the Federal organizations; NIDA's commitment to improve residency training on substance use disorders; ongoing efforts to address the abuse of prescription drugs; and the expansion of VA's specialty clinics to include gambling disorders. Additionally, the group met with Dr. Larry Faulkner and discussed a proposal to change residency requirements to allow PG-4 to be a fellowship year, just as it is for child and adolescent psychiatry. It will be discussed at ABPN's formal policy meeting scheduled for this summer.

The Council will collaborate with the leadership of the Council on Psychiatry and Law, NIDA, AACAP, and AAAP, to discuss State initiatives to decriminalize marijuana and consider a possible APA response. A workgroup has been formed and will meet via conference call soon.

Members and staff are currently reviewing SAMHSA's draft Federal Guidelines for Opioid Treatment and will prepare comments on behalf of the Association.

Council on Research and Quality Care

The Council on Research and Quality Care, which informs many of the activities undertaken by QIPS, convened in San Francisco on May 21, 2013. Reporting components of the Council include the Task Force to Revise the Practice of Electroconvulsive Therapy, Steering Committee on Practice Guidelines, Committee on Psychiatric Dimensions of Disasters, Committee on Electronic Health Records, Committee on Research Awards, Workgroup on Gender Dysphoria, Workgroup on Patient Safety, Workgroup on Research Training, Workgroup on Health Services Research, Workgroup on HIV/AIDS, and Workgroup on Standards and Survey Procedures.

Council on Psychosomatic Medicine

The Council focuses on psychiatric care of persons who are medically ill and thus stands at the interface of psychiatry and other medical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being of patients and that full membership in the house of medicine is essential to the well-being of our profession. It accomplishes its goals by initiatives related to research, clinical care, education, and health care policy. Council members have been active throughout the year, and those attending the Annual Meeting met on Monday, May 20. The Council focuses its efforts to the priorities described in the Council Work Plan.

Raising awareness of and recruitment into the subspecialty and remains a top priority. Among other strategies, the Council believes that it is important to build bridges with psychosomatic fellowship directors. At this time, about 70% of directors are APA members.

- In April, Council Chair, Joel Dimsdale, MD sent a letter to the non-APA member fellowship directors highlighting APA efforts on behalf of the subspecialty and encouraging their membership in APA.
- In early May, the Council invited fellowship directors to send information on their programs for display in the Annual Meeting MIT Center. About a dozen programs participated.

- The Council produced a recruitment brochure, *"Why Consider Fellowship Training in Psychosomatic Medicine?"* for distribution at the Annual Meeting. The back of the flyer listed psychosomatic programming at the meeting. Leadership of Academy of Psychosomatic Medicine (APM) was invited to review and comment on the content. About one hundred of the flyers were distributed over the course of the meeting. Plans are to produce additional materials to run in Psychiatric News and other APA media.
- Council members discussed current psychosomatic slots and the potential impact of upcoming participation of the subspecialty in the match.

Raising the visibility of Psychosomatic Medicine within APA

- The Council's popular resident workshop *"Medical mimics of psych illness and psychiatric mimics of medical illness"* was presented at the Annual Meeting. Again, the room was at capacity with both residents and more senior psychiatrists attending.
- Council fellows worked with the Annual Meeting office to request an "MIT Center" at the San Francisco meeting. The room housed resident-targeted workshops and provided a more casual 'meet-up' space. Specialty-specific materials were developed and made available on a literature table.
- Members requested the identification of a "psychosomatic track" through the Scientific Program Committee. The Committee was very receptive to the idea and implemented subspecialty tracks for the 2013 meeting.
- A video segment from the Annual Meeting TV program will be considered for use on the psychosomatic portion of the APA website. One of the segments described the practice of psychosomatic medicine in central Texas. Staff will circulate the clip to members for their review.

Improving affiliation with allied organizations

- Many of the members of the Council are also members of APM allowing for a collaborative relationship among the leadership. Links have been established to APM's website, practice guidelines, and annual meeting information on the psychosomatic section of the APA website. APM drafted a revised description of APM, which also has been posted online.

- Discussion at the May meeting included ideas for disseminating information about APA's efforts on behalf of the subspecialty to the broader APM membership.

Additional discussions at the Council meeting included a review of appointments to the Council, mechanisms to ensure representation of the allied groups on the subspecialty councils, and a discussion of the pros and cons of fellowships beginning in the PGY IV year.

A larger discussion centered around the importance of the production of the DSM-5 PC. Council members had submitted a letter of support for this primary care resource in September and were asked by the Board of Trustees to wait until the DSM Planning Work Group had been appointed. A new letter has been drafted with Lawson Wulsin, MD and has been circulated to the Council on Research and Quality Care and the Council on Healthcare Systems and Finance. Both have endorsed the effort. The Council on Psychosomatic Medicine intends to submit the letter to the Planning Work Group prior to their first meeting. The Council also discussed possible avenues to address the training needs of primary care providers around DSM-5. Discussions will continue throughout the year.

Psychiatric Research Report (PRR)

The PRR is sponsored by the American Psychiatric Institute for Research and Education and APA's Division of Research. It is designed to highlight APIRE's and APA's research and research support activities, as well as to present research related issues of interest to the broader psychiatric community. The Fall 2013 issue is currently in development, with an emphasis on previewing Division of Research and APIRE sessions to be featured at the impending IPS meeting.

F. ASSOCIATION GOVERNANCE

Margaret Cawley Dewar, Director

Board of Trustees

The final meeting of the 2012–2013 Board of Trustees was held on May 19, 2013 at approximately 2:00 p.m., in the Moscone Convention Center, San Francisco, CA. Following this meeting, the organizational meeting of the 2013–2014 Board of Trustees was held. The agenda for these meetings were was largely ceremonial, aside from a thoughtful presentation from the new AMA President, Dr. Jeremy Lazarus.

The May 2013 draft *Summary of Actions of the Board of Trustees* and Board Reports has been made available on the *Network, Board of Trustees* section of the APA website.

The Board of Trustees Executive Committee met on June 7-9, 2013 in New York City. The Executive Committee identified its goals for the meeting. They reviewed high priority ongoing activities of the APA, reviewed APA initiatives for the coming year, including strategic communication, Anti-Stigma efforts and discussion of APA's response to healthcare reform while also beginning the orientation of the next CEO/Medical Director to the APA and other ongoing initiatives.

Assembly

The Assembly met May 17-19, 2013 at the Moscone Convention Center in San Francisco, CA. Twenty-nine action papers were submitted for review by the action paper deadline, twenty-two of which passed. The Assembly will next meet November 8-10, 2013 at the JW Marriott in Washington, DC. The action paper deadline is September 19, 2013.

Assembly Executive Committee

The Assembly Executive Committee (AEC) met May 17 and 20, 2013 in San Francisco, CA. The AEC discussed numerous issues including the Assembly meeting agenda, approved action papers and the Assembly Work Groups on the Legislative/Public Affairs, Access to Care, Membership Engagement/ Mentorship/Leadership, and Long Range Planning. The AEC will next meet July 12-14, 2013 at the Alexis Hotel in Seattle, WA.

Area Councils

All Area Councils met on Friday, May 17 and Saturday, May 18, 2013 in San Francisco, CA.

The Area 7 Fall Council Meeting will be held on Saturday, August 10 and Sunday, August 11, 2013 at Hotel Andra in Seattle, Washington. The Area 1 Council Meeting will be held on Friday, September 6 and Saturday, September 7, 2013, in Montreal, Quebec. The Area 3 Council Meeting will be held on Saturday, September 7, 2013 at Sheppard Pratt in Baltimore, Maryland. The Area 6 Council Meeting will be held Friday, September 27, 2013 at the La Quinta Resort & Spa in La Quinta, California. The Area 2 Council Meeting will be held on Saturday, October 26, 2013 at the LaGuardia Marriott in Queens, New York. Area 5 will meet on Thursday, November 7, 2013 at the J.W. Marriott in Washington, DC. Area 4 will meet during the Assembly meeting on Friday, November 8 and Saturday, November 9, 2013.

Joint Reference Committee

The Joint Reference Committee (JRC), with Dr. Paul Summergrad as the chairperson and Dr. Jenny Boyer as the vice chairperson, met June 2, 2013 in Arlington, VA to review and consider actions from the Assembly, Councils and components. The JRC will forward actions from the Councils to the Board of Trustees for consideration in July. The JRC looks forward to receiving revised position statements from the Councils and working to improve the oversight and evaluation process for the Councils.

The JRC will meet again on October 18, October 2013.

2014 Election

The 2014 National Election will include the following open offices:

- President-Elect
- Treasurer
- Trustee-At-Large
- Area 2 Trustee
- Area 5 Trustee
- Member-in-Training Trustee-Elect (MITTE)

A call for nominations has been sent to listservs for the Assembly, Area Councils, District Branches, and Members-in-Training. The APA website includes information on the national election, including eligibility requirements, a draft nominations schedule, and information on nomination submission requirements. The Nominating Committee will schedule conference calls within the next few weeks to discuss the nomination process.

Committee on Bylaws

Rebecca Brendel, MD, JD has been appointed as the new chairperson of the Committee on Bylaws. The Committee is planning to schedule an in-person meeting during the September Components on September 18-21, to review the proposed amendments by the APA General Counsel, Colleen Coyle, bringing the APA Bylaws in compliance with the Washington, DC non-profit corporations' law. The Committee will continue to develop recommendations for the Board of Trustees for review at the Board meeting in October 2013.

G. OFFICE OF INFORMATION SYSTEMS

Eric Fishman, Senior Director of Information Services and Strategies

Information Services & Strategies

The Office of Information Services & Strategies (ISS) is focused on supporting the APA through a number of current initiatives and the development of technology-based strategies that allow APA to better serve the needs of its members, District Branches and staff.

Infrastructure

Cloud Service Strategies - Further Cloud/SaaS based solutions are currently underway in 2013 with completion of the American Psychiatric Foundation's website redesign and migration to a hosted environment in 2Q13 and the projected completion in mid-2013 of a SaaS based District Branch portal developed on the Salesforce.com platform.

Websites & Mobile Apps

American Psychiatric Foundation Website Redesign

American Psychiatric Foundation Website Redesign – The APF project began in 4Q12 and was successfully deployed in April 2013, timed for "unveiling" at the Annual Meeting. The redesign effort overhauled the American Psychiatric Foundation website with new branding, improved functionality and enhanced content availability. As part of this effort the APF website was migrated from on-premise servers to APA's Cloud website environment at Bridgeline Digital Services.

Mobile Application Development

ISS is focusing efforts on identifying and supporting development of new mobile initiatives which will enable the APA to quickly enter and benefit from the emergence of mobile smartphone and tablet capabilities. These initiatives support the development of mobile applications over the next 12-16 months intended to improve member benefits, add value to existing content and create new utility and value.

Information is provided below for the major mobile app projects currently underway:

- Association Management System (AMS) Mobile App

  Information Services initiated a project in February to develop a mobile app for APA member with general release scheduled for late 3Q13. The objective

of this app is to provide members with mobile access to Member Directory services, dues payment information, member profile updating, as well as APA news feeds and event information. This will be a freely available app for Members.

- DSM-5 Mobile App

  Information Services and American Psychiatric Publishing have teamed with a leading national mobile app development vendor to design a mobile app for the new DSM-5 "Desk Reference to the Diagnostic Criteria." The app will be available on iOS and Android platforms with anticipated rollout in June. A full working version of the DSM-5 Desk Reference app was delivered for public demonstration at the Publishing Bookstore during the Annual Meeting.

Business Systems

Point of Sale System – APP Bookstore

Following a successful pilot test at the 2012 IPS meeting, Information Services and American Psychiatric Publishing completed a full deployment of the new point-of-sales system supporting on-site bookstore sales at APA's 2013 Annual Meeting. The new point-of-sales system performed flawlessly and fully supported record sales activity at the Publishing Bookstore.

District Branch Portal Upgrade

The American Psychiatric Association's current District Branch portal is the organization's primary resource for web-based communication and data sharing between APA and DB offices. The current site was deployed in 2006 and is not widely utilized by District Branch staff due to ongoing problems with the both the existing interface and overall functionality.

A full working version of the District Branch Portal site was demonstrated at the DB/SA Executive Staff Business Meeting in May to an enthusiastic reception. Approximately one dozen District Branches volunteered to help with final testing/review of the system scheduled for early 3Q13. Full rollout to all District Branches will follow the completion of the testing period. The new portal replaces the existing site with a new Cloud-based architecture and will significantly enhance the flexibility, usability and effectiveness of APA's District Branch portal resources as a communication and data sharing vehicle.

Association Management System (Personify)

The first significant version upgrade to APA's association management system in four years was completed in June with the deployment of the new back-office system and eBusiness functionality. The Personify system is used across APA for business critical association and member management activities. The upgrade supports new feature enhancements and technical fixes. These feature enhancements include rollout of new centralized, automated Conflict of Interest / Disclosure Agreement submission and management capabilities. The new Disclosure Agreement system will be phased in to support APA's disclosure agreement activities this summer.

Publication Fulfillment System (Advantage)

Information Services & Strategies and American Psychiatric Publishing successfully completed an upgrade of APA's publication fulfillment management system, Advantage in 1Q13. Advantage is a business critical application which provides functionality to manage all APP publication/journal sales and subscriptions, fulfillment, invoicing and related financial reconciliation activities. The previous version of Advantage was several years old and this project ensures that the latest software fixes and enhancements are available to support APP operations.

H. OFFICE OF MINORITY AND NATIONAL AFFAIRS (OMNA)

Annelle B. Primm, M.D., M.P.H., Director

Advocating for the Profession

- Planning continued for the APA International Medical Graduate (IMG) Summit targeted for the October 2013 IPS meeting. The event will parallel the AMA's 2012 *IMGs at the Crossroads* conference which examined the role of IMGs in American medicine but with focus on IMG psychiatrists.

Advocating for Patients

- OMNA presented four OMNA on Tour programs:
    - *Implementing Solutions to Mental Health Disparities in Rural Communities*. Psychiatrist, Grayson Norquist, M.D., co-facilitated the March 28 event which was attended by 25 mental health, primary care and social service providers and administrators in the Clarksdale, Mississippi Delta area. The event set in motion a movement toward a more integrated system of care that will promote success and sustainability through community partnership to improve the lives of Clarksdale area citizens living with mental illness.
    - Diversity in the workforce was the theme for OMNA on Tour offerings at the May Annual Meeting in San Francisco. *Mental Health Matters: Making Culture Work*, an interactive forum about mental health disparities in the workplace presented by a partnership of the Office of Minority and National Affairs and the American Psychiatric Foundations Partnership for Workplace Mental Health, explored why mental health disparities matter to employers, and what employers can do to address these issues. A variety of employers and health benefit managers from the Bay area were in attendance. The symposium on the APA Annual Meeting scientific program, *Work, Mental Health and Cultural Diversity: A Dynamic Triad* explored how discrimination in the workplace affects one's mental health, its impact in the workplace and the role of employment in recovery. Expert speakers in these sessions included psychiatrists Price Cobbs, MD, renowned San Francisco-based author and corporate adviser, Donald Williams, MD, Professor Emeritus, Michigan State University, Hyong Un, MD, Head of EAP and

Chief Psychiatric Officer at Aetna, Imani Nuru-Jeter, PhD, a social epidemiologist researcher from University of California-Berkeley and Keris Myrick, MBA, a noted mental health advocate and CEO of Project Return in Los Angeles.

- The University of Miami was the backdrop for *Restoring the Haitian Psyche* on June 7 which brought together mental health professionals and community members to explore the state of mental health and family support services for Haitians in Miami and in Haiti since the 2010 earthquake.
- In partnership with the Texas Regional Psychiatry Minority Mentor Network, OMNA presented *What's Age Got To Do With It? Mental Health Equity Across Generations and Cultures* in June at the Ben Taub General Hospital in Houston, TX. This program focused on factors that contribute to disparities in the delivery of mental health services in early and late life, the role of culture and age in family systems, and cultural caregiving challenges.
- Planning is underway for the July 8-9 *Understanding the Dynamics of Military Culture and Mental Health Care* program in Nashville in collaboration with Meharry Medical College Department of Psychiatry and the National Medical Association. The program will demonstrate the importance of military culture, cultural competency, and patient-provider communication when caring for military people with mental illness. The program is geared for executive level leaders responsible for providing healthcare and support services to racially and ethnically diverse military personnel and veterans.

- Dr. Primm presented a lecture on *Public Health, Prevention, Mental Illness, Mental Health and the Affordable Care Act* at a conference called, *The ACA and Behavioral Health: The Shape of Things to Come*, organized by the Center for Public Service Psychiatry of the Western Psychiatric Institute and Clinic and Community Care Behavioral Health Organization in Pittsburgh, PA on June 10, 2013. In addition, Dr. Primm co-led 2 breakout groups with Beth Nolan, PhD, of the University of Pittsburgh School of Public Health focusing on identifying gaps in and barriers to access to community mental health

services and substance use disorder care and developing strategies to rectify such deficits. The breakouts were attended by a wide range of health and mental health professionals, public health educators, family advocates, peer specialists, alcohol and substance use counselors, faith community leaders and human services professionals.

- Dr. Primm represented the APA at the Society for Women's Health Research Annual Gala event and met with Carol Nadelson, M.D., former APA president and member of the board of SWHR, Phyllis Greenberger, SWHR Executive Director and other leaders within government, academic institutions, industry and non-profit organizations focused on women's health.

Training, Education and Career Development

- APA continued work on developing the modules for the Recovery Oriented Care in Psychiatry curriculum as part of the SAMHSA-sponsored Recovery to Practice project. There will be a total of 10 modules which will be delivered both online and in person.

  Draft versions of all 10 modules were completed and posted on the APA website to allow for pilot testing. Several modules were also presented in person as part of the pilot testing process. Presenters at sites included Pablo Sadler, MD in New York City, Rupinder Legha, MD and Christopher Edge, MD, at the University of Colorado in Denver, Co, MD, Annelle Primm, MD, MPH and Jackie Pettis, RN MSN in Washington, DC at Howard University College of Medicine, San Francisco, CA, and Ken Thompson, MD via webinar from Phoenix, AZ. Additional pilot sessions are planned for Houston, TX with trainees and faculty from the Baylor College of Medicine and the University of Texas at Houston.

- Dr. Primm was a plenary presenter at the American College of Psychiatrists 50th Annual Conference. Her presentation focused on the Future of Psychiatry: Special Populations.

- Dr. Primm represented the APA and the Office of Minority and National Affairs at the National Medical Association's Annual Colloquium on African American Health. Her presentation focused on Access to Treatment and Reduction of Mental Health Disparities.

- Dr. Primm represented the APA at the regional World Psychiatric Association Regional Conference in Bucharest, Romania and participated in the educational program in three ways: serving as a panelist on the Belonging symposium focusing on overcoming professional challenges faced by psychiatrists who have diverse identities; serving as chair of the judging panel of the poster session; and serving as a co-presenter on a session focusing on the changes between DSM-IV-TR and DSM 5.
- Dr. Primm provided a presentation on a symposium, *The Psychiatrists Role in Reducing the Number of Persons with Mental Illness in the Criminal Justice System* on the scientific program of the San Francisco Annual Meeting chaired by Marcia Goin, M.D., PhD. Dr. Primm's presentation was on the *Disproportionate Representation of Minorities in the Criminal Justice System.*
- In May, Marilyn King along with five fellows and two medical students from the Minority Fellowship Program (MFP) conducted a Doctors Back to School program visiting the Life Academy High School in Oakland, CA, where they talked and shared their experiences about and why they selected psychiatry as their career path with a select group of 11th and 12th graders.
- A video by MFP fellows was screened during the Annual Meeting to help mark the 40th anniversary of the APA/SAMHSA MFP. The video is designed to pique interest in the fellowship and demonstrate how the program has affected positively MFP fellows and the marginalized minority communities in which they serve. Ms. King is working with the fellows to produce a 40-year anniversary report to accompany the video.
- Dr. Primm and Ms. King attended SAMHSA's 40th MFP anniversary celebration at SAMHSA's headquarters in April in Rockville, MD. The agency has administered the MFP since 1992. Each MFP grantee organization, including APA, had alumni attend the celebration to talk about the benefits of the MFP. Dr. Primm presented an overview of the APA SAMHSA Minority Fellowship Program including a description of the current program, the accomplishments of the fellows and the career achievements of MFP alumni.
- OMNA, in conjunction with the Black Psychiatrists of America, hosted a mentor breakfast in April 2013 at the annual meeting of the Student National Medical Association in Louisville, KY. Medical students joined psychiatrist

mentors and local psychiatry residents to learn about the profession. Ms. Rosa Bracey staffed the breakfast and the exhibit booth.

- OMNA will again sponsor a medical student recruitment luncheon during the Association of American Indian Physicians conference in Santa Clara, CA in August.

Other

- OMNA welcomed Ricardo A. Juarez, formerly the Senior Project Manager in Association Governance, as the new Senior Program Manager for International Affairs. Mr. Juarez is also responsible for the American Psychiatric Leadership and Child and Adolescent fellowship programs.
- In April, Dr. Primm and Louise Martin of the Membership Department attended the World Psychiatric Association Regional Congress in Bucharest, Romania.
- OMNA provided a letter to the US Consulate in Moscow to request expedited visa interviews for three Russian psychiatrists to attend the Annual Meeting. This effort was successful. In addition, OMNA coordinated with the Meetings Department to register three psychiatrists from Burma for the Annual Meeting. In addition, OMNA developed and provided a track of international programs at the Annual Meeting to provide international attendees.
- Dr. Primm participated with Dr. Scully, Paul Burke and American Psychiatric Foundation staff in a visit to the biotechnology company, Genentech, in San Francisco during the time of the Annual Meeting. Dr. Primm provided a presentation in that forum focused on an overview of programs and activities of the Office of Minority and National Affairs.
- OMNA worked with the Committee on Psychiatric Dimensions of Disaster, APA leadership and OCPA to respond to coordinating District Branches with resources in the wake of the Boston Marathon Bombing (April), the West Fertilizer Company explosion in Texas (April), and tornadoes that swept through Oklahoma (May). OMNA is currently managing responses to two requests for the Erich Lindemann District Branch Disaster Grant and planning a review and update of content on the APA website related to disaster psychiatry.

END

DRAFT

MINUTES OF A MEETING
OF THE
APA BOARD OF TRUSTEES

May 19, 2013

Minutes of a Meeting

APA Board of Trustees

May 19, 2013

San Francisco, CA

SECTION 1. CALL TO ORDER

Dr. Dilip V. Jeste, APA President, called the May meeting of the Board of Trustees to order at 2:00 p.m., Sunday, May 19, 2013, at the Moscone Convention Center. Dr. Jeste welcomed Board members, guests, and staff to the meeting.

A. Introductions and Verbal Conflict of Interest Disclosures

Board of Trustees

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

Dilip Jeste, MD, President– 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, receives an APA stipend as President.

Jeffrey A. Lieberman, MD, President-Elect– receives income from Columbia University and New York State Psychiatric Institute; receives royalties from various publishing companies for academic publications including APPI; receives an APA stipend as President-Elect; member of American College of Neuropsychopharmacology, Biological Psychiatry, and Institute of Medicine.

Carolyn B. Robinowitz, MD, Parliamentarian – receives income from private practice; special associate provost for health science, part-time at George Washington University.

Roger Peele, MD, Secretary – receives income from Montgomery County Government; Board member of the American Association for Practicing Psychiatrists; strong interest in the survival of Medicaid.

David Fassler, MD, Treasurer – receives income from Private practice and forensic work; Clinical faculty at the University of Vermont.

R. Scott Benson, MD, Speaker – Private practice in Child and Adolescent and Forensic Psychiatry in Pensacola, Florida; receives an APA stipend as Speaker.

Melinda Young, MD, Speaker-Elect – receives income from Private practice; receives an APA stipend as Speaker-Elect.

John M. Oldham, MD, Trustee– receives income from Baylor College of Medicine; Chief-of-Staff of Menninger Clinic; receives small editorial fees as Editor of the *Journal of Psychiatric Practice*; President of the American College of Psychiatrists (uncompensated).

Carol A. Bernstein, MD, Trustee– receives income as Associate Dean for Graduate Medical Education at NYU School of Medicine and Vice-Chair of Education, Department of Psychiatry.

Alan F. Schatzberg, MD, Trustee – receives income from Stanford University School of Medicine; income from APA and APPI; does a little work for Pharma and start-up companies.

Jeffrey Geller, MD, Area 1 Trustee – receives income from University of Massachusetts Medical School and Carson Community Mental Health Center.

James E. Nininger, MD, Area 2 Trustee – receives income from Private practice; voluntary faculty at Cornell Weill Medical College, New York Presbyterian Hospital; American Psychiatric Foundation Board, the PAC Board, and vice-chair of the Steering Committee of Practice Guidelines.

Brian Crowley, MD, Area 3 Trustee – receives income from Private practice; income from the Department of Defense, Henry M. Jackson Foundation for the Advancement of Military Medicine; on the voluntary faculty of Uniform Services University of the Health Sciences.

Judith F. Kashtan, MD, Area 4 Trustee—receives income from Private practice; on the clinical faculty of the University of Minnesota.

James A. Greene, MD, Area 5 Trustee—receives income from University of Tennessee, Department of Psychiatry.

Marc D. Graff, MD, Area 6 Trustee – receives income from L.A. County, Department of Mental Health.

Jeffrey Akaka, MD, Area 7 Trustee – receives 80% of income from Diamond Head Community Mental Health Center in Hawaii; 20% of income from disability reviews from Social Security; serves on APAPAC Board.

Anita Everett, MD, Trustee-at-Large – receives income from Johns Hopkins Hospital; President of the American Association of Community Psychiatrists

Molly K. McVoy, MD, ECP Trustee-at-Large – receives income from Case Western and University Hospitals; *Psychiatric News* Editorial Board and receives some royalties from APPI.

Alik S. Widge, MD, MIT Trustee – receives income from University of Washington;

Eric R. Vanderlip, MD, MIT Trustee-Elect – receives income from University of Washington; moonlighting through King County Public Health.

Mardoche Sidor, MD, APA/Diversity Leadership Fellow – receives income from Cambridge Health Alliance.

Brian Hurley, MD, APA/Public Psychiatry Fellow – receives income from Partners Health Care in Boston; Board member of the American Society of Addiction Medicine.

Lama Bazzi, MD, APA/Leadership Fellow– receives income from SUNY Downstate Medical Center.

Staff & Guests:

James H. Scully, Jr., MD, APA Medical Director/CEO – receives income from APA; U.S. Military pension; President-elect of the American College of Psychiatrists (uncompensated).

Christina J. Arredondo, MD, 2013-14, APA/Public Psychiatry Fellow

Jenny L. Boyer, MD, 2013-14, Assembly Speaker-Elect

Frank Brown, MD, 2013-14, Board Parliamentarian

Lara J. Cox, MD, 2013-14, Member-in-Training Trustee-Elect

Paul Fink, MD, APA Past President

Marcia K. Goin, MD, APA Past President

Richard K. Harding, APA Past President
Lawrence Hartmann, APA Past President
Jeremy A. Lazarus, MD, [President] Board of Trustees, American Medical Association
John McIntyre, MD, APA Past President
Rodrigo A. Munoz, APA Past President
Phillip M. Murray, MD, 2013-14, APA/Diversity Leadership Fellow
Carol Nadelson, MD, APA Past President and serve on the Board of the American College of Psychoanalysis
Linda B. Nahulu, MD, Board Guest – receives income from University of Hawaii; Chair, Assembly MUR Committee.
Herbert Pardes, MD, APA Past President
Uyen-Khanh Quang-Dang, MD, 2013-14, APA/Leadership Fellow
Michelle Riba, MD, APA Past President and University of Michigan
Gail E. Robinson, MD, 2013-14, M/UR Trustee, University of Toronto
Steven S. Sharfstein, MD, APA Past President
Nada L. Stotland, MD, APA Past President
John A. Talbott, MD, APA Past President
Sandra C. Walker, MD, Board Guest – receives income from Private Practice and part-time community consultation and community psychiatry; Chair of the Council on Minority Mental Health and Health Disparities

B. Welcome Jeremy Lazarus, M.D., AMA President

Dr. Lazarus thank Dr. Jeste for inviting the AMA to be on the APA Coalition on Gun Violence and Mental Health. He said he was very pleased that the AMA is part of a coalition started by the APA on issues related to mental illness, mental health, and gun violence. Dr. Lazarus told the Board he was pleased that the APA has been involved with the AMA Task Force on Sustainable Growth Rate (SGR), which attempted to unite all of organized medicine to be advocate and row in the same direction for repeal of the SGR and its replacement.

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. Jeste presented the Consent Calendar to the Board.

The Board of Trustees voted to approve the Consent Calendar.

SECTION 3. REPORT OF THE PRESIDENT

Dilip V. Jeste, M.D.

A. Executive Committee Report

This report was presented for review and appropriate action.

The Executive Committee held two conference calls since the March 23-24, 2013 Board of Trustees meeting.

The Board of Trustees Executive Committee approved the following actions on a conference call held May 7.

APA and *Choosing Wisely* Campaign

The APA was invited to generate a list of overused psychiatric treatments and procedures to submit to the American Board of Internal Medicine Foundation's *Choosing Wisely* campaign. The goal of the campaign is to improve the quality and safety of medical care by "encouraging physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm."

The Board Executive Committee voted to approve APA participating in the *Choosing Wisely* campaign, and voted to approve the proposed list of "5 things physicians and patients should question".

Grant requests from Vermont Psychiatric Association and Psychiatric Medical Association of New Mexico

The Board Executive Committee voted to approve the CALF grant request for the Vermont Psychiatric Association in the amount of $12,000 as outlined in the accompanying information.

[Recused from the vote: Dr. David Fassler]

The Executive Committee voted to approve the recommendation from the CALF and the CAGR to fund the 2013 PMANM grant request in the amount of $13,359 as outlined in the accompanying information.

Planned Parenthood of the Great Northwest vs. State of Alaska Brief

The Executive Committee voted to approve that CJA should edit the brief in a manner consistent with previous APA legal actions, policies, and position statements, (in particular APA positions on juvenile punishment in criminal cases). The Committee should consult with the Alaska Psychiatric Association before APA signs on to the "*Planned Parenthood of the Great Northwest v. State of Alaska"* brief.

The Board of Trustees Executive Committee approved the following actions on a conference call held April 16.

Anti-Stigma and Public Education Activities
An opportunity to partner with Patrick Kennedy as a Senior Strategic Advisor for the APA. In this role, Mr. Kennedy will provide strategic and political advice to:

- the APA-AMA-Psychiatric Subspecialty Coalition on Mental Health and Violence Issues,
- the APA's Department of Government Relations (DGR) and APA's ongoing efforts to secure House and Senate introduction of legislation to increase opportunities for employment by psychiatrists in the Veterans Administration and the Indian Health Service.
- DGR and OHSF regarding other legislative and regulatory issues of concern to APA members.

We also anticipate that Mr. Kennedy will conduct TV and radio media tours in major media markets, provide blog posts and tweets for the APA's online communications efforts aimed at lessening stigma, and appear as the central spokesperson in a video Public Service Announcements (PSAs). Set forth below is the budget for these efforts:

Consultants – $63K
Patrick Kennedy - $32,000 = estimated level of effort in support of the DGR activities.
Patrick Kennedy - $31,000 = estimated level of effort specifically in support of the OCPA effort.

Costs for three Anti-Stigma videos – including production, digital distribution, publicist, and 50 hard copies for target markets = $50,000 each, total $150,000

The Board Executive Committee voted to approve $63K consulting expense for DGR and OCPA activities.

The Board Executive Committee voted to approve up to $157K for anti-stigma and other public education activities as described, contingent on a discussion with Joe Lockhart endorsing the proposed project.

B. Sunsetting of Completed Ad Hoc Work Groups

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

Ad Hoc Work Group on Role of Psychiatry in Healthcare Reform

Ad Hoc Work Group on APA National Collaboration with State Associations/District Branch

ECP/MIT Ad Hoc Work Group on New Technology

C. Continued Ad Hoc Work Groups

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

ECP/MIT Membership Ad Hoc Work Group (report by September 2014 BOT Meeting)

Ad Hoc Work Group on International Psychiatrists (report by September 2014 BOT Meeting)

SECTION 4. REPORT OF THE MEDICAL DIRECTOR/CEO

James H. Scully, Jr., MD

Dr. Scully provided his written report to the Board, noting that he had already made additional remarks during both the Assembly and the Annual Business Meeting.

SECTION 5. REPORT OF THE SECRETARY

Roger Peele, M.D.

A. Minutes of the March 23-24, 2013 Board of Trustees Meeting

The minutes of the March 2013 Board Meeting were approved on the Consent Calendar.

The Board of Trustees voted to approve the minutes of its March 23-24, 2013 meeting.

B. Secretary's Report

Dr. Peele provided his written report to the Board, noting that he had already shared it with the Assembly and members at the Annual Business Meeting.

SECTION 6. REPORT OF THE TREASURER

David Fassler, M.D.

A. Treasurer's Report

Dr. Fassler provided his written report to the Board, noting that he had already reported to the Assembly and the Annual Business Meeting.

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. John Oldham, Dr. Dilip Jeste, Dr. Jeffrey Lieberman.

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

R. Scott Benson, M.D.

A. Annual Report of the Speaker

Dr. Benson provided a written report, noting that he had already chaired a productive Assembly Meeting and reported to the Annual Business Meeting.

B. Assembly Executive Summary

1. Membership Benefit: Free DSM-5 (ASM Item 2013A1 12.N)

2. Application by the APA to the United Nations to Become Accredited as a Non-Governmental Organization with Consultative Status (ASM Item 2013A1 12.T)

SECTION 8. INFORMATIONAL ITEMS

A. Component Appointment Tenure Waivers for the 2013-2014 Appointment Year

Dr. Jeffrey Lieberman, APA President-Elect, informed the Board of Trustees of the appointment waivers for the 2013-2014 appointment year.

- Finance and Budget Committee
  - Frank Brown, MD was reappointed as a member of the Finance and Budget Committee for an additional one year term bringing Dr. Brown's total tenure as a member of the Finance and Budget Committee to 9 years. (2007-2016)
- Committee on Bylaws
  - Rebecca Brendel, MD was reappointed as a member of the Committee on Bylaws for an additional 3 year term bringing Dr. Brendel's total tenure as a member of the Committee on Bylaws to 9 years. (2007-2016)
- Committee on Reimbursement for Psychiatric Care
  - Bruce Schwartz, MD was reappointed as a member of the Committee on Reimbursement for Psychiatric Care for an additional 3 year term bringing Dr. Schwartz's total tenure to 9 years. (2007-2016)
- Council on Communications
  - Jeffrey Borenstein, MD was reappointed as chairperson of the Council on Communications for an additional 2 year term bringing Dr. Borenstein's total tenure as chairperson to 6 years. (2009-2015)
- Council on Minority Mental Health and Health Disparities
  - Sandra Walker, MD was reappointed as chairperson of Council on Minority Mental Health and Health Disparities for an additional 2 year term bringing Dr. Walker's total tenure as chairperson to 6 years. (2009-2015)

SECTION 9. OLD BUSINESS

No old business was introduced to the Board.

SECTION 10. NEW BUSINESS

No new business was introduced to the Board.

SECTION 11. CEREMONIAL PROCEEDINGS

Dr. Jeste recognized and thanked those members of the Board who were leaving office. Dr. Jeste also thanked the Board of Trustees and Association Governance staff for their excellent work throughout the year.

Dr. Rodrigo A. Munoz presented the Past President's Badge to Dr. Jeste. He commended Dr. Jeste for his remarkable job as President of the APA.

Dr. Jeste presented the Presidential Medallion, President's Gavel and letters of recognition from Members of Congress to Dr. Jeffrey Lieberman, incoming President. Dr. Jeste wished Dr. Lieberman well during his presidential year. In turn, Dr. Lieberman thanked Dr. Jeste for his dedication. He then welcomed the 2013-2014 Board of Trustees members and stated that he is looking forward to serving his term as President.

SECTION 12. ADJOURNMENT

Dr. Jeste adjourned the meeting of the Board of Trustees at 4:00 pm, Sunday, May 19, 2013. The next meeting of the Board will be July 20-21, 2013 at the Westin Arlington Gateway in Arlington, VA.

I have carefully reviewed these minutes, developed by Ardell Lockerman, and I am respectfully submitting them to the Board of Trustees.

Roger Peele, MD
Secretary

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

SUMMARY OF ACTIONS
DRAFT

Moscone Convention Center
San Francisco, CA

May 19, 2013

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
2.A	**Requests to Remove Items from the Consent Calendar** No items were removed.	Medical Director's Office • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar.	Medical Director's Office • 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 Role of Psychiatry in Healthcare Reform • Board-Assembly Ad Hoc Work Group on APA National Collaboration with State Associations/District Branches • ECP/MIT Ad Hoc Work Group on New Technology	Medical Director's Office • Association Governance
3.C	**Report of the President** The Board of Trustee voted to continue the following Board Ad Hoc Work Groups until they have completed their charge: **[cc]** • ECP/MIT Membership Work Group (report by September 2014 BOT Meeting) • Ad Hoc Work Group on International Psychiatrists (report by September 2014 BOT Meeting)	Medical Director's Office • Association Governance • Office of Education • Office of Minority Affairs

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
5.A	**Minutes of the March 23-24, 2013 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its March 23-24, 2013 meeting. **[cc]**	Medical Director's Office • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. John Oldham, Dr. Dilip Jeste, and Dr. Jeffrey Lieberman. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the report of the status of the Assembly's New Initiative Fund. **[cc]**	Medical Director's Office • Association Governance • Finance & Business Operations
7.B.1	**Speaker's Report** Action: Will the Board of Trustees approve item 12.N Membership Benefit: Free DSM-5? The Board of Trustees voted to postpone this action until the July Board of Trustees Meeting.	Medical Director's Office • Association Governance
7.B.2	**Speaker's Report** The Board of Trustees voted to approve item 12.T application by the American Psychiatric Association to the United Nations to become accredited as a Non-Governmental Organization with Consultative Status. **[cc]**	Medical Director's Office • Association Governance

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AMERICAN PSYCHIATRIC ASSOCIATION
REPORT OF THE TREASURER
TO THE
Board of Trustees
David Fassler, MD, Treasurer

The Consolidated Financial Review for May 2013 is attached to this summary as *Appendix 1.* The APA is currently projecting a net surplus of approximately $8.6M which is $2.3M above budget; the Foundation is projecting a net deficit of $3.7M, which is $143K less than budget.

Unrestricted Net Income	May 2012	May 2013	May 2013	YTD Variance	2013 Annual	2013 Annual
APA	Actual YTD	Actual YTD	Budget YTD	Fav (Unfav)	Budget	Projection
Total Unrestricted Revenue	25,609	34,067	29,891	4,176	62,099	62,224
Total Unrestricted Expense	15,839	18,264	20,501	2,236	55,765	53,637
APA Net Income/(Loss)	9,770	15,803	9,390	6,412	6,334	8,587
APF	2012 Actual YTD	2013 Actual YTD	2013 Budget YTD	(Unfavorable)	Budget	Projection
Total Unrestricted Revenue	687	536	763	(227)	1,668	1,798
Total Unrestricted Expense	1,724	1,608	1,829	221	5,482	5,469
APF Net Income/(Loss)	(1,037)	(1,072)	(1,066)	(6)	(3,814)	(3,671)

Unrestricted Revenue for the APA is greater than prior year by $8.5M and above budget by $4.2M due to sales of DSM 5 and Meeting registration. Revenues for the Foundation are running below budget by $227K.

Membership Revenues – Dues receipts are $43K below budget year to date.

Publishing – Non-DSM Publishing revenues are $801K below budget due primarily to lower than expected book sales and display advertising sales for the journals. DSM 5 sales are above budget by $4.5M.

Continuing Medical Education – Annual Meeting revenue is $701K above budget. Registration and courses revenues were higher than anticipated.

Foundation – Revenues for the Research, Public Education, and Fund Raising activities of the Foundation are $227K below budget due to slower receipts of government funding.

Unrestricted Expenses of the APA are greater than prior year by $2.4M, and less than budget by $2.2M. Salary expenses are higher than last year due to the impact of last year's merit increase and

fewer vacant positions. Health insurance costs and consultant fees were higher this year than 2012. In addition, we have begun to amortize DSM 5 development expenses.

Publishing –Year to date non-DSM Publishing expenses are $2.8M, compared to a budget of $4.5M. Under-spending is due to reduced printing and postage costs for the journals, timing of payment of editorial fees, and lower costs related to lower book sales. DSM5 expenses are above budget $899K.

Continuing Medical Education – Actual spending for CME activities is $2.1M, compared to the budget of $2.5M. Expenditures for AV, utilities, and rent are running less than budgeted. These line items are under review; some is due to timing of receipt of invoices.

Administration – Costs for Health insurance are running above budget due primarily to timing.

Foundation – Expenses for the Research, Public Education, and Fund Raising activities of the Foundation are $221K below budget due mostly to slower receipts of government funding.

Nonoperating Activity primarily reflects investment increases or decreases in both the short term and long term portfolio, net of investment fees. As of May, the combined portfolio increased in value by $5.2M due to favorable market activity. The investment fees year to date are $62K.

Statement of Financial Position

Assets increased $12.7M over December 2012 balances, due to increases in Accounts Receivable and the long term investments. The increase in Accounts Receivable is attributable to the DSM sales. The long term investment portfolio is at $85.3M (including $2.5M in Trusts). APA holds $27M, or 33% of the Pooled Fund of $82.8M.

Total liabilities decreased approximately $8.5M, due primarily to the recognition of deferred membership dues and subscription revenue.

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
UNRESTRICTED REVENUE:							
Membership							
Membership Dues	$8,430	$8,085	$8,128	($43)	$9,672	$9,672	
Insurance Program	1,197	1,250	1,125	125	1,500	1,500	
Membership Affinity Programs	54	52	54	(2)	81	81	
APA Job Bank	131	287	245	42	650	650	
APA Store	6	10	4	6	6	10	4
List Sales	42	9	73	(64)	175	175	
Membership Subtotal	***9,860***	***9,693***	***9,629***	***64***	***12,084***	***12,088***	***4***
Advocacy							
PAC	3	2	3	(1)	7	7	
DGR Advocacy Day	17						
OCPA	7	15	12	3	67	67	
Advocacy Subtotal	***27***	***17***	***15***	***2***	***74***	***74***	
Publishing							
American Journal of Psychiatry	1,908	1,740	1,942	(202)	5,188	5,167	(21)
Journal of Psychiatric Services	263	211	386	(175)	927	905	(22)
Psychiatric News	1,689	1,400	1,415	(15)	3,396	3,285	(111)
Books	2,414	1,536	2,221	(685)	5,883	5,600	(283)
Specialty Journals	173	261	234	27	561	585	24
Psychiatry Online	215	246		246			
Electronic Publishing	36	22		22			
Legacy content	21	23	42	(19)	100	75	(25)
Publishing Subtotal	***6,719***	***5,439***	***6,240***	***(801)***	***16,055***	***15,617***	***(438)***

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
DSM							
DSM IV	1,376	395	960	(565)	960	494	(466)
DSM 5		9,008	4,555	4,453	23,103	23,103	
DSM Subtotal	***1,376***	***9,403***	***5,515***	***3,888***	***24,063***	***23,597***	***(466)***
Continuing Medical Education							
Annual Meeting	7,234	8,784	8,083	701	8,435	9,448	1,013
CME Products and Accredition	136	78	35	43	160	160	
Institute on Psychiatric Services					328	328	
Focus Journal	220	494	344	150	825	825	
Continuing Medical Education Subtotal	***7,590***	***9,356***	***8,462***	***894***	***9,748***	***10,761***	***1,013***
Research							
Practice Guidelines	28	24	25	(1)	60	60	
Research Subtotal	***28***	***24***	***25***	***(1)***	***60***	***60***	
Other Income							
Miscellaneous Income	9	135	5	130	15	27	12
Other Income Subtotal	***9***	***135***	***5***	***130***	***15***	***27***	***12***
Total Unrestricted Revenue	***25,609***	***34,067***	***29,891***	***4,176***	***62,099***	***62,224***	***125***

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
UNRESTRICTED EXPENSES:							
Membership Direct Expenses							
Membership Services	1,328	659	729	70	1,788	1,788	
Membership Recruitment	43	72	77	5	230	230	
Membership Affinity Programs	13				14	14	
APA Job Bank (membership)	2		6	6	12	12	
APA Store	2	11	9	(2)	15	15	
Membership Direct Expenses Subtotal	***1,388***	***742***	***821***	***79***	***2,059***	***2,059***	
Advocacy							
APA PAC Operating Expenses	82	63	81	18	143	143	
Division of Advocacy	150	161	186	25	576	576	
Government Relations	823	629	692	63	2,055	2,055	
Communications & Public Affairs	275	317	358	41	1,004	1,004	
Healthcare Systems & Financing	343	326	440	114	1,471	1,471	
CALF		50	104	54	250	250	
Advocacy Subtotal	***1,673***	***1,546***	***1,861***	***315***	***5,499***	***5,499***	
Publishing							
American Journal of Psychiatry	965	969	1,187	218	2,879	2,884	(5)
Journal of Psychiatric Services	296	350	390	40	949	949	
Psych News	1,240	1,184	1,291	107	3,131	3,113	18
Unrelated Business Income Tax	250	208	208		500	500	
Books	1,670	988	1,456	468	4,145	3,895	250
Specialty Journals	127	131	170	39	410	410	
Psychiatry Online	61	29		(29)			
Electronic Publishing	27	31		(31)			
Publishing Subtotal	***4,636***	***3,890***	***4,702***	***812***	***12,014***	***11,751***	***263***

American Psychiatric Association

For the Five Months Ending May 31, 2013

Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
DSM							
DSM IV	293	81	134	53	327	230	97
DSM 5 Publishing Costs		1,526	2,190	663	5,813	4,689	1,123
DSM 5 Communications		220		(220)		348	(348)
DSM 5 Development		2,286	891	(1,395)	6,466	6,701	(234)
DSM Subtotal	***293***	***4,113***	***3,215***	***(899)***	***12,606***	***11,968***	***638***
Publishing Overhead							
Publishing Administration	256	248	265	17	658	658	
Publishing Overhead	(2,430)	(2,966)	(2,966)		(7,117)	(7,117)	
Sales & Marketing	320	328	382	54	926	926	
Customer Service	428	307	881	574	2,032	1,566	466
Advertising Sales	232	228	313	85	750	700	50
Periodical Services	150	10		(10)			
Editorial Development	400	420	560	140	1,367	1,327	40
Editorial Production	342	358	378	20	944	944	
Publishing Overhead Subtotal	***(302)***	***(1,067)***	***(187)***	***880***	***(440)***	***(996)***	***556***
Continuing Medical Education							
Annual Meeting	1,006	1,307	1,674	367	3,235	2,985	250
CME Products & Accreditation	156	194	182	(12)	457	482	(25)
Department of Meetings & Conventions	319	322	294	(28)	733	733	
Office of Scientific Programs	129	132	164	32	410	410	
Institute on Psychiatric Services	27	25	7	(18)	404	404	
Focus Journal	116	128	145	17	352	352	
Continuing Medical Education Subtotal	***1,753***	***2,108***	***2,466***	***358***	***5,591***	***5,366***	***225***
Education							
Division of Education	306	313	440	127	1,083	1,095	(12)
Ethics/DB Relations	96	96	100	4	248	248	
Library & Archives	64	32	62	30	144	144	
Education Subtotal	***466***	***441***	***602***	***161***	***1,475***	***1,487***	***(12)***

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
Minority/National Affairs							
Office of Minority/National Affairs	203	203	261	58	665	665	
Board Funds		1	2	1	2	2	
Minority/National Affairs Subtotal	***203***	***204***	***263***	***59***	***667***	***667***	
Research							
Research - Director's Office	107	196	139	(57)	366	366	
Practice Research Network	1						
Office of QIPS	196	183	262	79	658	664	(6)
Practice Guidelines	90	110	129	19	389	389	
International Programs	6	1	37	36	45	45	
Research Subtotal	***400***	***490***	***567***	***77***	***1,458***	***1,464***	***(6)***
Foundation							
Foundation Operating	152	164	164		392	392	
Foundation Subtotal	***152***	***164***	***164***		***392***	***392***	
Administration							
Medical Director's Office	750	812	895	83	1,630	1,980	(350)
APA Answer Center	73	116	116		277	277	
Division of Business Operations	1,038	1,015	1,134	119	2,763	2,763	
Building Operations	1,112	1,138	1,242	104	2,997	3,016	(19)
Human Resources	161	162	223	61	531	531	
Information Technology	1,203	968	1,163	195	3,154	3,154	
Association Mgmt System	84	91	93	2	395	395	
Association Governance Office	306	309	314	5	800	800	
Employee Benefits	2,033	2,382	2,121	(261)	5,135	5,135	
Fringe Benefits Allocation	(2,118)	(2,008)	(2,322)	(314)	(5,782)	(5,863)	81
Legal Office	157	146	228	82	641	1,841	(1,200)
Budget Reallocation					95	(1,613)	1,708

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
Administration Subtotal	***4,799***	***5,131***	***5,207***	***76***	***12,636***	***12,416***	***220***
Organization-Wide Expenses							
General	408	425	513	88	629	668	(39)
APA Overhead	(724)	(622)	(622)		(1,492)	(1,812)	320
Recovered OH Costs	(30)	(15)	(23)	(8)	(54)	(52)	(2)
Organization-Wide Expenses Subtotal	***(346)***	***(212)***	***(132)***	***80***	***(917)***	***(1,196)***	***279***
Governance & Components Expenses							
Assembly	278	238	278	40	873	883	(10)
Board, Operating	272	360	395	35	726	726	
Standing Committees	71	49	104	55	343	343	
Direct DB Support							
DB Leadership	32	14	87	73	298	298	
BD DB Infrastructure Grants	17	18	36	18	85	85	
Components	53	15	52	37	400	400	
Board Funds	1	20		(20)		25	(25)
Governance & Components Expenses Subtotal	***724***	***714***	***952***	***238***	***2,725***	***2,760***	***(35)***
Total Unrestricted Expenses	***15,839***	***18,264***	***20,501***	***2,236***	***55,765***	***53,637***	***2,128***
Unrestricted Operating Net Income/(Loss)	***9,770***	***15,803***	***9,390***	***6,413***	***6,334***	***8,587***	***2,253***

American Psychiatric Association
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
TEMPORARILY RESTRICTED ACTIVITY:							
Temp Restricted Revenue	***436***	***43***	***133***	***(90)***	***175***	***157***	***(18)***
Temp Restricted Expenses	***220***	***87***	***145***	***58***	***263***	***237***	***26***
Temp Restricted Net Income/(Loss)	***216***	***(44)***	***(12)***	***32***	***(88)***	***(80)***	***(8)***
NON-OPERATING ACTIVITY:							
Investment Income - LT	1,477	1,718	35	1,683	85	1,595	1,510
Investment Income - ST	4	2		2		4	4
Less: Portfolio Management Fees	(16)	(20)	(35)	15	(85)	(85)	
C6 Administration/Reorg			(262)	262	(630)		630
Non-Operating Income/(Loss)	***1,465***	***1,700***	***(262)***	***1,962***	***(630)***	***1,514***	***2,144***

American Psychiatric Foundation
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
UNRESTRICTED REVENUE:							
OMNA Federal Awards	$262	$133	$323	($190)	$775	$775	
Research Federal Awards	233	152	276	(124)	609	609	
General Unrestricted	192	251	164	87	284	414	130
Total Unrestricted Revenue	***687***	***536***	***763***	***(227)***	***1,668***	***1,798***	***130***
UNRESTRICTED EXPENSES:							
OMNA Federal Awards	262	149	316	167	775	775	
Research Federal Awards	233	168	272	104	609	609	
Office of Minority/National Affairs	88	103	107	4	308	372	(64)
Institute on Research & Educ	130	99	148	49	349	349	
Practice Research Network	103	243	276	33	691	691	
Office of AIDS/HIV	50	45	65	20	170	170	
Programs	1	1		(1)	3	146	(143)
National Partnership	73	61	78	17	180	180	
Division of Education			3	3	3	3	
Library & Archives	15	37	33	(4)	92	92	
Board Funds	12	2	2	0	352	171	181
Subtotal, Programs	967	908	1,300	392	3,532	3,558	(26)
Foundation Grants		50	10	(40)	85	219	(134)
New Initiatives Fund					497	(85)	582
Subtotal, Foundation Grants & Other	0	50	10	(40)	582	134	448
Foundation Operating	94	79	126	47	410	421	(11)
Fund Raising	11	126	38	(88)	81	161	(80)
Old C3 Administration	41						
Subsidiary Boards	32	24	16	(8)	65	65	
Subtotal, Administration	178	229	180	(49)	556	647	(91)

American Psychiatric Foundation
For the Five Months Ending May 31, 2013
Statement of Activities

	May 2012 Actual YTD	May 2013 Actual YTD	May 2013 Budget YTD	YTD Variance Fav (Unfav)	2013 Annual Budget	2013 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)
APA Overhead	724	622	622		1,492	1,812	(320)
Recovered OH Costs	(145)	(201)	(283)	(82)	(680)	(682)	2
Subtotal, Overhead	579	421	339	(82)	812	1,130	(318)
Total Unrestricted Expenses	***1,724***	***1,608***	***1,829***	***221***	***5,482***	***5,469***	***13***
Unrestricted Operating Net Income/(Loss)	***(1,037)***	***(1,072)***	***(1,066)***	***(6)***	***(3,814)***	***(3,671)***	***143***
TEMPORARILY RESTRICTED ACTIVITY:							
Temp Restricted Revenue	***233***	***434***	***118***	***316***	***999***	***1,024***	***25***
Temp Restricted Expenses	***625***	***1,095***	***876***	***(219)***	***2,193***	***2,218***	***(25)***
Temp Restricted Net Income/(Loss)	***(392)***	***(661)***	***(758)***	***(97)***	***(1,194)***	***(1,194)***	
NON-OPERATING ACTIVITY:							
Investment Income - LT	3,710	3,462		3,462		3,660	3,660
Less: Portfolio Management Fees	(41)	(43)	(8)	(35)	(20)	(45)	(25)
Non-Operating Income/(Loss)	***3,669***	***3,419***	***(8)***	***3,427***	***(20)***	***3,615***	***3,635***

American Psychiatric Association

Statements of Financial Position

	05/31/12	12/31/12	05/31/13
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$13,819	$11,517	$8,304
Accounts Receivable, Net	3,043	2,887	8,372
Pledges Receivable	90	644	145
Grant Receivable, Net	254	209	220
Publications Inventory, Net	1,062	882	758
Prepaid Expenses and Other Current Assets	1,024	859	1,412
Total Current Assets	*19,292*	*16,998*	*19,211*
Investments in Marketable Securities	76,853	74,671	85,250
Property and Equipment, Net	2,512	2,309	2,188
Intangible	6,590	5,983	5,885
Development Costs	19,415	21,666	21,811
TOTAL ASSETS	***124,662***	***121,627***	***134,345***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	8,496	10,016	9,000
Dues Payable (DB & Other)	635	1,124	396
Deferred Revenue:			
Membership Dues	14	4,684	81
Grants and Contracts			
Other	6,173	7,137	5,087
Total Current Liabilities	*15,318*	*22,961*	*14,564*
Deferred Rent Liability	1,570	1,510	1,442
TOTAL LIABILITIES	***16,888***	***24,471***	***16,006***
NET ASSETS			
Beginning Balance			
Unrestricted	102,092	90,623	112,511
Temporarily Restricted	4,789	5,639	4,902
Permanently Restricted	893	894	926
ENDING BALANCE, NET ASSETS	***107,774***	***97,156***	***118,339***
TOTAL LIABILITIES AND EQUITY	***124,662***	***121,627***	***134,345***

INVESTMENTS

APA and Subsidiaries
Corporate Portfolio
Investment Balances as of April, 2013 for use in the May 2013 Report
(Dollars are in Thousands)

CASH & CASH EQUIVALENTS

	Held by	COST	VALUE
CASH & CASH EQUIVALENTS at May 31, 2013			
Cash and Cash Equivalents	B of A, SunTrust LI	$8,124	$ 8,124
APA c6 ST Invest Account	SunTrust	180	180
TOTAL CASH & CASH EQUIVALENTS		**$ 8,304**	**$ 8,304**

INVESTMENTS IN MARKETABLE SECURITIES

		COST	Market VALUE	APA YTD Mar 2013 Returns *	YTD Mar 2013 Returns	Index Name	Current Portfolio Allocation	Target Allocation +/- 10%
EQUITIES								
Large Cap Equities - Growth	Calamos	3,640	4,318	8.4%	11.5%	Russell Mid-Growth	5.2%	
All Cap Equities - Value	Snow					Russell 3000 Val	0.0%	
All Cap Equities - Core	Vanguard Total St	20,452	25,568	11.0%	11.1%	Dow Jones	30.9%	
Int'l All-Cap Core	Vanguard Intl Stoc	5,664	6,195	3.0%	3.3%	MSCI ACWI ex US	7.5%	
Small Cap Equities	Eagle	3,612	4,168	12.4%	12.4%	Russell 2000 Value	5.0%	
Int'l Equity Mutual Fund	Dodge & Cox	5,110	6,136	3.6%	3.3%	MSCI ACWI ex US	7.4%	
SUBTOTAL EQUITIES		**$ 38,478**	**$ 46,385**				56.0%	70%
MUTUAL & FIXED INCOME FUNDS								
Intermediate Term Bond	Baird FDS Inc	10,437	10,516	0.5%	-0.1%	Barclay's Aggregate	12.7%	
High Yield Bonds	Delaware Pooled	2,644	2,878	3.6%	2.9%	Barclay's High Yield	3.5%	
Floating Rt CL I Mutual Fund	Eaton Vance	2,357	2,812	2.0%	2.4%	CSFB Leverated	3.4%	
Bond Index Mutual Fund	Vanguard	5,912	6,213	-0.1%	-0.1%	Barclay's Aggregate	7.5%	
SUBTOTAL MUTUAL FUNDS		**21,350**	**22,419**				27.1%	30%
Liquidity								
SunTrust Money Market	SunTrust Liquidity	1,288	1,288				1.6%	
SUBTOTAL CASH		**$ 1,288**	**$ 1,288**				1.6%	0%
TOTAL PORTFOLIO IN SUNTRUST CUSTODY		**$ 61,116**	**$ 70,092**				84.7%	
HEDGE & Real Estate Funds								
Common Sense Long		2,542	2,848	5.2%	5.1%	HFRX Equity Hedge Ind	3.4%	
Pinehurst		3,500	4,115	3.6%	3.1%	HFRX Global Hedge Ind	5.0%	
Prime Property LT Real Estate		5,341	5,724	2.5%	2.5%	NFI	6.9%	
SUBTOTAL HEDGE & RE FUNDS		**11,383**	**12,687**				15.3%	
LONG TERM POOLED APA, APF Total		**$ 72,499**	**$ 82,779**	5.6%	5.4%	Composite Benchmark	100.0%	
OTHER LT INVESTMENT ACCOUNTS								
Hostetter Trust	Morgan Stanley	107	117					
Rabbi Trust/Def. Exec. Comp. Accts	NY Life/State Stree	1,829	1,829					
Insurance Trust	Wilmington Trust	524	524					
TOTAL INVESTMENTS IN MARKETABLE SECURITIES		**$ 74,959**	**$ 85,249**					
TOTAL CASH AND INVESTMENTS		**$ 83,263**	**$ 93,553**					

* NOTE: returns are shown net of fees
Cash balances are as of April 30, 2013, Investment Balances are as of March 31, 2013

GLOSSARY

Statement

Advocacy - reflects costs associated with the Departments of Government Relations, the APA PAC, the Fund to Defeat Psychologist Prescribing, the CALF, and the Office of Communications & Public Affairs. In addition, the division expenses include the costs for the activities of Healthcare Systems and Financing, Managed Care Newsletter, and the Business & Industry Initiative.

Education - includes revenues and costs associated with the Division of Education, the Departments of Graduate and Undergraduate Education, Women's Programs, Continuing Medical Education, Ethics, the publication of PSA-R prior to 2003, and the Focus Journal beginning in 2003.

Minority/National Affairs - includes the Office of Minority/National Affairs as well as the costs associated with the newly created Spurlock Office.

Practice Guidelines - revenue is from sales of Practice Guidelines.

Private Awards - includes Revenues and Expenses related to temporarily restricted contributions. Please note that the transfer to/(from) reserves on the Income Statement does not include the Indirect Cost Recovery.

Research - includes Expenses associated with APIRE and PRN, QIPS, Children's Programs, Practice Guidelines, and HIV/AIDS. Research Revenues include temporarily restricted contributions from Private Awards and sales of Practice Guidelines.

Business Operations - includes expenses associated with sales of membership lists and labels. In addition, it includes costs associated with Accounting & Finance, Human Resources, Information Systems, Membership Services, and Governance Support.

Other Income - represents income that is received throughout the year but is not identified to a specific project or activity by year-end.

Organization-wide Expenses - include costs for the Medical Director's office, employee benefits, facilities, legal, insurance program, general insurance, costs for the bad debt expense, portfolio management fees, interest expense for the line of credit, special needs fund, and credit card sales fees. We are exploring the feasibility of being reimbursed out of the Insurance Program for the legal costs associated with Legion.

Governance - represents costs associated with the Board of Trustees, Assembly, Constitutional Committees and component related activities.

Operating Income/Loss - reflects the amount of surplus or (deficit) from operating activities.

4/26/2010

Balance Sheet

Assets

Cash and Cash Equivalents - includes the cash accounts held at Bank of America, M&T Bank and SunTrust Bank.

Accounts Receivable - represents amounts billed to customers of APA publications (e.g. books and advertising sales).

Pledges Receivable - represents the unconditional promises to give and are recorded on a monthly basis.

Grants Receivable – reflects actual activity that has been billed but the funds have not yet been received.

Advances to Affiliates - reflects intercompany activity.

Publications Inventory - the cost of the APA/APPI book inventory, including DSM. It will be expensed when the inventory is sold.

Prepaid Expenses and Other Current Assets - reflects deposits paid in advance for meetings (hotels, air fare, exhibit space). This amount is expensed when the activity is held.

Investment in Marketable Securities - includes the investment accounts held by State Street, Sanford Bernstein, Morgan Stanley, and Private Capital.

Property and Equipment - the cost of APA assets such as computers, software, and furniture, less depreciation to date.

Deferred Expenses – represents costs for DSM-V, that will be expensed at the time of sales, and software development costs which will be depreciated when the software is put into use.

Investment in Medem - Represents the long-term investment in Medem.

Liabilities

Accounts Payable – represents unpaid vendor payments, accrued salaries, accrued vacation and pension benefits.

Dues Payable – represents the dues which APA has collected on behalf of affiliated organizations but have not yet paid the affiliate organization. Payments are made in the month following APA collecting the dues.

Assets Held for Other Organizations - represents monies received by the Insurance Trust in an insurance settlement that are due to other parties to the insurance claim.

Deferred Revenues – Membership Dues – reflects the lump sum dues program from members and dues payments received in the year prior to the dues year. APA accounts for the receipts from members in the fourth quarter of each year as deferred membership revenue and recognizes them as revenue in January of subsequent year.

Deferred Revenues – Other – represents payments received for journal subscriptions and funds received in advance for meetings, such as meeting exhibit spaces. APA accounts for the receipts from Annual Meeting in the fourth quarter of each year as deferred revenue and recognizes them as revenue in January of subsequent year.

Advances from Affiliates – reflects intercompany activity

Deferred Rent Liability – represents the difference between cash rent paid and the accrued rent expense. This line amount will increase until approximately half way through the lease agreement at which point it will begin to decrease.

Capital Lease Obligation – APA purchased furniture for the space in Rosslyn under a capital lease. At the time that the furniture was accepted by APA, the furniture asset was recorded as was the corresponding liability equal to the lease obligation as of the end of the year.

Net Assets

Net Assets are made up of the Unrestricted, Board designated, and Externally restricted funds.

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, 2013

2013 Approved Budget	$ 25,000.00
Less: Expenses paid as of May 31, 2013	-
Unspent Budget as of May 31, 2013	$ 25,000.00

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. Jeste, Dr. Lieberman, and Dr. Summergrad?

Status of the President's New Initiative for Dr. Jeste's Fund
as of May 31, 2013

Approved Budget	$	25,000.00
Less: Expenses paid as of May 31, 2013		25,000.00
Unspent Budget as of May 31, 2013	$	-

Status of the President's New Initiative for Dr. Lieberman's Fund
as of May 31, 2013

Approved Budget	$	25,000.00
Less: Expenses paid as of May 31, 2013		-
Unspent Budget as of May 31, 2013	$	25,000.00

Status of the President's New Initiative for Dr. Summergrad's Fund
as of May 31, 2013

Approved Budget	$	25,000.00
Less: Expenses paid as of May 31, 2013		-
Unspent Budget as of May 31, 2013	$	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, 2013

2013 Approved Budget	$	25,000.00
Less: Expenses paid as of May 31, 2013		-
Unspent Budget as of May 31, 2013	$	25,000.00

Report of the Joint Reference Committee to the Board of Trustees

The Joint Reference Committee (JRC) forwards the following actions to the Board of Trustees for consideration. The draft summary of actions from the JRC meeting held June 2, 2013 may be found as attachment #4, separate from this document. The full reports from the Councils to the Joint Reference Committee may be found on the APA website in the Association Governance section under Joint Reference Committee: http://apps.psychiatry.org/staticfiles/governance/jrc/JRCPortfolio-Jun2013.pdf

ACTION ITEMS

Action Item 7.A.1 (JRCJUN136.14) APA Representation in the HL7 Standards Organization (ASMMAY1312.P) (Please see ATTACHMENT #1)

Will the Board of Trustees approve the APA becoming an Organizational Member of HL7?

Action paper 2013A1 12.P asks that the APA become an Organizational Member of HL7; that the Medical Director/CEO appoint a minimum of three members to participate in HL7 for the purpose of advancing the specialty's interests in the development of health information technologies; that the appointed HL7 participants report to the Committee on Electronic Health Records; that the APA reimburse the appointed HL7 participants for meeting fees, travel and hotel costs with a minimum commitment of sending three participants to each of three work group meetings annually. The estimated cost per year is $36,766.

Action Item 7.A.2 (JRCJUN138.G.2) APA Mentors of the Year Award (Please see ATTACHMENT #2)

Will the Board of Trustees approve the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the Council's budget)?

In recognition of the value the APA places on mentorship, the Council recommends the creation of the new APA Mentors of Year Award to reward outstanding mentors in the psychiatric community. Superb mentors from any of the subspecialty branches of psychiatry and various work/specialized settings are eligible for this award. It is anticipated that awardees will have had a sustained career commitment to mentoring, a significant positive impact on their mentees' careers, fostered the careers of students and colleagues and through their mentees have advanced research and patient care in the field of psychiatry.
One "Mentor of the Year" winner will be selected in each of these mentorship categories:

- Academic Educator
- Administration and Leadership
- Clinical Practice

This award is based on the quality of the nomination letters from mentees including residents and early career psychiatrists, not the mentor's personal career achievements. For the purpose of this award, mentoring is defined as the process of guiding, supporting, and promoting the training and career development of others. The winners will be invited to present a symposium at the Annual Meeting on mentorship along with the Research Mentorship Awardee (award given jointly by the AACDP and the APA Council on Research.)

INFORMATION ITEM

7.B.1 Potential Endorsement of Child Mind Institute's Speak Up for Kids Campaign

The Joint Reference Committee discussed the potential endorsement of the Child Mind Institute's Speak Up for Kids Campaign, working to identify the advantages and potential disadvantages of such endorsement. At this time the Joint Reference Committee recommended that the APA not take any action on support or non-support of the endorsement of Child Mind Institute's Speak Up For Kids Campaign.

7.B.2 Feedback on ACGME Psychiatry RRC Milestones (Please see ATTACHMENT #3)

The Joint Reference Committee forwarded the Council's input to the ACGME Psychiatry RRC Milestones document to the Council on Medical Education and Lifelong Learning and, as an informational item, to the Board of Trustees for consideration toward the APA input to the ACGME before August 2013.

ACTION PAPER
FINAL

TITLE: APA Representation in the HL7 Standards Organization

WHEREAS:
HL7 (Health Level 7) is an international standards development organization that establishes health information technology (HIT) standards that govern how HIT products and services (like electronic health records and health information exchanges) communicate with each other. The standards, developed via consensus by a large group of clinicians and IT expert volunteers, fuel the language of HIT, in the same way that HTML is the language of the internet;

There are over 50 work groups within HL7 (http://www.hl7.org/special/committees/) that together develop the standards using a transparent balloting process where organizational members vote on the proposed standards, and where all objections must be resolved using a consensus-based process that gives voice to minority opinions;

There are several work groups that develop standards that are directly impact psychiatrists and patient care who use or are affected by HIT applications; these work groups include Security, Community Based Collaborative Care, Child Health, Clinical Decision Support, Clinical Quality Information, Electronic Health Records, Emergency Care, Patient Care, Patient Safety, Mobile Health, Orders and Observations, Public Health & Emergency Response, and Structured Documents;

Participation in these work groups requires a high learning curve, as well as dedication, as many of the groups meet biweekly by phone and by three face-to-face meetings annually;

While there are a significant number of physicians involved in these HL7 work groups, there is almost no one representing the needs of mental health groups, including psychiatry and the APA;

If psychiatrists and other mental health specialists are not at these tables where decisions are made about such things as privacy, security, data sharing, sensitive health information, and data segmentation, then our unique needs are unlikely to be adequately addressed within the standards;

The APA supports some members who represent the APA at important meetings where collaborative work is accomplished, in the form of partial reimbursement for meeting attendance expenses;

The APA should have significant involvement in some of the most impactful HL7 work groups;

BE IT RESOLVED:
That the APA will become an Organizational Member of HL7;

That the Medical Director will appoint a minimum of three members to participate in HL7 for the purpose of advancing the specialty's interests in the development of health information technologies;

That the appointed HL7 participants will report to the Committee on Electronic Health Records;

That the APA will reimburse the appointed HL7 participants for meeting fees, travel and hotel costs with a minimum commitment of sending three participants to each of three work group meetings annually.

AUTHORS:
Steven R. Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society
Robert Roca, M.D., MPH, DFAPA, Representative, Maryland Psychiatric Society

ESTIMATED COST:
Author: $23,550 annually
APA: $36,766

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 3 Council

KEY WORDS: Health information technology, standards,

APA STRATEGIC GOAL: Advocating for our profession, Advocating for our patients

REVIEWED BY RELEVANT APA COMPONENT: Committee on Electronic Health Records: "Participation by Psychiatry in health IT standards development organizations at the level where options are discussed and decisions are made is critical to ensuring that the needs of physicians and people with mental illnesses are considered. This is a small investment with a large potential return."

AMERICAN PSYCHIATRIC ASSOCIATION
AWARD REVIEW FORM

Please complete this form in its entirety and forward the form to the Council to which the award committee/board reports along with the nomination of the award recipient. The Council will then forward this documentation on to the Joint Reference Committee.

AWARD NAME: APA Mentors of the Year Award

NAME OF COMMITTEE/ AWARD COMMITTEE/ AWARD BOARD:
Mentor Awards Sub Committee within the Council on Medical Education and Lifelong Learning

CHAIRPERSON: Richard Summers, MD
STAFF LIAISON: Nancy Delanoche

Background:

Mentorship is one of the most important determinants of a successful career in medicine. In recognition of the value the APA places on mentorship, the **APA Mentors of Year Award** will be created to reward outstanding mentors in the psychiatric community. Superb mentors from any of the subspecialty branches of psychiatry and various work/specialized settings are eligible for this award. It is anticipated that awardees will have had a sustained career commitment to mentoring, a significant positive impact on their mentees' careers, fostered the careers of students and colleagues and through their mentees have advanced research and patient care in the field of psychiatry.

This award is based on the quality of the nomination letters from mentees including residents and early career psychiatrists, not the mentor's personal career achievements. For the purpose of this award, mentoring is defined as the process of guiding, supporting, and promoting the training and career development of others. The key roles of a mentor include, but are not limited to providing:

- Intellectual growth and development
- Career development
- Professional guidance
- Advocacy
- Positive role modeling

One "Mentor of the Year" winner will be selected in each of these mentorship categories:

- **Academic Educator**
- **Administration and Leadership**
- **Clinical Practice**

The winners will be invited to present a symposium at the Annual Meeting on mentorship.

The AACDP and the APA Council on Research give a Mentorship Award presented annually during the Research Colloquium Breakfast at the Annual Meeting. The winner of this award will be included as a symposium presenter along with the other "Mentor of the Year" winners.

The generalities of this award have been presented to the AADPRT Executive Council in March 2013.

Description of Eligibility for Award:

- Nominees must APA members
- Nominators must be a current or former mentees of the nominee, and/or colleagues who have personal knowledge of the nominee's mentoring efforts.
- At least one letter from a direct mentee whose has directly benefitted from the nominee's mentoring
- Mentors should be actively involved in research, teaching, mentoring, or other leadership activities.
- Mentors should have devoted significant time to multiple mentees over time

Description of Selection Criteria for Award:

Commitment and extraordinary effort to mentorship may be demonstrated by:

- the number and diversity of students/residents/early career psychiatrist mentored;
- assisting students/residents/early career psychiatrist to present and publish their work, to find financial aid, and to provide career guidance;
- providing psychological support, encouragement, and essential strategies for life in the scholarly community;
- continued interest in the individual's professional advancement;
- offer sound counsel and valuable information to their mentees in order to advance and develop the mentee's own path to academic and professional success;
- generously share their valuable time and expertise in critiquing the mentee's work;
- help to create a vital and engaged academic community in their university;
- involve peers and students in publications, grants and conferences, as well as readily sharing knowledge of such opportunities;
- make others aware of the contributions and value of their mentees;
- serve as role models for their colleagues by maintaining high standards for excellence within their own discipline and at the level.

Nomination packets should include:

- Nomination letter/s (6 is the maximum). Nominations should describe the nominee's mentoring process as well as the impact of the mentor's influence on the careers of residents and/or colleagues. At least one of the mentees who submit a letter of support must be an APA member.
- CV of the nominee
- Residents and early career psychiatrists are eligible to nominate any mentor on any of the above categories.

Award Funding Information:

Cost for Plaques: $600
Source of Funds: Council on Medical Education and Lifelong Learning

Description of the Committee's Selection Process:

Each spring, a call for nominations would be sent to all departments of psychiatry. Any resident or early career psychiatrist can nominate a mentor. These would be sent to the Office of Graduate and Undergraduate Education at the APA for processing.

By summer, the winners will be selected and approved by the Board of Trustees and the winners will be officially notified.

These winners will be invited to present a symposium at next year's Annual Meeting. Presentation of the award certificates would be beginning of the symposium (APA meeting in May of that academic year.)

To: JRC
From: Council on Minority Mental Health and Health Disparities
Date: May 24, 2013
Re: Input to the ACGME Psychiatry RRC Milestones document

Will the Joint Reference Committee forward the Council's input to the ACGME Psychiatry RRC Milestones document to the Council on Medical Education and Lifelong Learning and to the Board for consideration toward the APA input to the ACGME?

Here are detailed suggested edits, comments, and questions relating to integrating more content relating to **culture and family systems issues** into the draft Milestones document.

PC 1 Psychiatric Evaluation
1.2 Obtains relevant collateral information from secondary sources, including contextual family and cultural factors
3.4 Uses biopsychosocial hypothesis driven information gathering techniques
3.5 Evaluates family and social factors supporting recovery

PC 2 Psychiatric Formulation and Differential Diagnosis
2.1 Identifies patterns and recognizes phenomenology from the patient's presentation to generate diagnostic and biopsychosocial/family systems hypotheses
2.4 Elicits from patients a cultural and family definition of the problem; cultural and family perceptions of cause, context, and support; cultural and family factors affecting coping, both past and current
3.4 Incorporates impact of family and other factors such as employment into case formulation
4.2 Incorporates subtle, unusual or conflicting findings into alternative biopsychosocial hypotheses and formulations
4.3 Utilizes the cultural formulation interview to inform assessment and treatment planning with patients from diverse backgrounds
4.3 Assesses patient's position / role in family and incorporate family strengths and weaknesses into case formulation
5.3 Utilizes the cultural formulation interview to inform assessment and treatment planning with populations who have specific needs such as children and adolescents, elderly patients, and immigrants and refugees

PC 3 Treatment Planning and Management
1.4 Recognizes need to maximize family collaboration with the treatment plan
2.1 Sets treatment goals in concert with the patient and, when appropriate, with family or other caregivers
3.4 Applies understanding of psychiatric, neurological, family systems and medical comorbidities to treatment selection
4.3 Includes evidence-based family interventions
5.2 Integrates multiple modalities and providers in comprehensive approach in various service delivery systems (add new footnote – see below)
5.3 Integrates emerging neurobiological, genetic, and ethnopsychopharmacologic knowledge treatment plans

New Footnote – Service delivery systems may include inpatient and ambulatory mental health settings, general hospitals, primary care and specialty clinics, medical homes, person-centered health homes, accountable care organizations, etc.

PC 4 Psychotherapy

Introductory note - Refers to 1) the practice and delivery of psychotherapy, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies, provided in a developmentally, culturally, and linguistically appropriate manner; 2) provision of patient and family psychoeducation and participation in couples, family, and group therapies, and 3) integrating of psychotherapy with psychopharmacology

1.2 Demonstrates interest and curiosity in patient's story, including family system, socio-cultural, and community context

5.4 Ability to provide patient and family psychoeducation

PC 5 Somatic Therapies

Introductory note – Somatic Therapies including, but not limited to psychopharmacology, ECT, and emerging somatic therapies such as TMS and VNS with attention to age-, gender-, race-, and ethnic-related variations.

MK 1 Development through the life cycle

Introductory note – Consideration of the life cycle with reference to both individual patients and their families.

1.2 Describes life cycle stages of individuals

1.3 Describes life cycle stages of families

4.2 Explains influence of psychosocial (such as gender, ethnic, cultural, family, economic), and other community and environmental influences on development

4.3 Explains how family life cycle stages influence individual development

5.2 Integrates knowledge of individual developmental concerns with family life cycle concerns

MK 2 Psychopathology

Introductory note – Includes knowledge of diagnostic criteria, epidemiology, mental/behavioral health disparities, pathophysiology, course of illness, comorbidities, and differential diagnosis of psychiatric disorders, including substance use disorders; presentation of psychiatric disorders across the life cycle, in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.), in various service delivery settings and geographic areas.

3.1 Demonstrates sufficient knowledge to identify and treat most psychiatric conditions through the life cycle, in diverse families and populations, and in a variety of settings.

4.1 Consider adding medical homes, person-centered health homes, accountable care organizations, and integrated delivery systems.

Footnote 1: This level includes identification and treatment of a wider array of conditions across the life cycle (i.e., including childhood, adolescent, adult, and geriatric conditions), in diverse families (e.g., nuclear, single parent, multi-generational, step- and blended) and populations (e.g., racial, ethnic, socio-cultural, religious, immigrant/refugee, disabilities, LGBT, military, incarcerated), and in a variety of settings (e.g., hospital, outpatient, consultation-liaison, subspecialty settings, medical homes, person-centered health homes, accountable care organizations, and integrated delivery systems).

MK 3 Clinical Neuroscience
Introductory note – Includes knowledge of neurology, neuropsychiatry, neurodiagnostic testing, cultural neuroscience, and relevant neuroscience.
[See also:
http://en.wikipedia.org/wiki/Cultural_neuroscience
http://www.thedailybeast.com/newsweek/2010/02/17/west-brain-east-brain.html
http://culturalneuroscience.isr.umich.edu/home.htm
http://culturalneuroscience.wordpress.com/

MK 4 Psychotherapy
Introductory note: Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies, provided in a developmentally, culturally, and linguistically appropriate manner;
1.2 Understand evidence-based patient and family psychoeducational interventions for major mental illnesses
2.5 Assess indications and contraindications for patient and family psychoeducation

MK 5 Somatic Therapies
Introductory note – Somatic Therapies including, but not limited to psychopharmacology, ECT, and emerging somatic therapies such as TMS and VNS with attention to age-, gender-, race-, and ethnic-related variations.

MK 6 Practice of Psychiatry
[Consider adding an introductory note, footnote, or annotation about the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, the Office for Civil Rights Limited English Proficiency Guidance, Joint Commission, and National Quality Forum requirements.]
[Can a milestone be created to indicate provision of culturally and linguistically appropriate psychiatric/behavioral health services to patients from diverse backgrounds in various clinical care settings?]

PROF 1 Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles
[Consider adding an introductory note, milestones, footnote, or annotation relating to dealing with uncertainty and ambiguity, developing an awareness of the impact of stereotyping, bias, prejudice, and the "isms," cultivating cultural humility, and addressing these issues during encounters]
5.4 Systematically analyzes and manages ethical issues in complicated and challenging clinical situations and cross-cultural encounters
Footnote 1 - Diversity refers to unique aspects of each individual patient including, but not limited to gender, age, socioeconomic status, culture, race, ethnicity, language, religion, disabilities, sexual orientation, and migration.

PROF 2 Accountability to self, patients, colleagues, and the profession
[Consider adding material about seeking help as needed with enculturation and acculturation challenges relating to becoming a member of the psychiatric profession and in the geographic area in which one works and lives]

[Consider adding material relating to seeking help when there may be clinical or interpersonal challenges relating to one's own language, accent, and communication skills or other cultural factors]

ICS 1 Relationship development and conflict management with patients, families, colleagues, and members of the healthcare team (GK, GM)
Introductory note (or in Annotation) - includes developing trusting and therapeutic relationships with patients, families, colleagues, and members of the healthcare team from diverse backgrounds, an awareness of the impact of stereotyping, bias, prejudice, and the "isms," and an ability to address these issues during clinical and other encounters.

ICS 2 Information sharing and record keeping
Introductory note (or in Annotation) – includes communicating effectively with patients who have limited English proficiency; low health literacy; and various physical, sensory, intellectual, and developmental disabilities.
1.3 Assesses for level of health and mental health literacy and engages in active listening, "teach back" and other strategies to ensure patient understanding.

PBLI1 Critical evaluation of research and clinical evidence
[For Footnote 1: Examples include randomized controlled trails and meta-analyses vs. retrospective designs vs. case series.
Consider adding translational, community-based participatory, implementation, and dissemination research]

PBLI2 Development and execution of life-long learning through constant self-evaluation
[Consider adding an introductory note, milestones, or footnote relating to recognizing blind spots, dealing with clinical uncertainty and ambiguity, cultivating cultural humility, and addressing these challenges through life-long learning and constant self-evaluation].

PBLI3 Formal practice-based quality improvement based on established and accepted methodologies. Many of these requirements would be satisfied by completed of a mentored QI project within residency.
[Consider including an Introductory note, footnote, or annotation about using quality improvement to reduce/eliminate disparities in mental/behavioral health care and/or providing culturally and linguistically appropriate care. A Footnote could also be added relating to the National Quality Forum report which focuses on health disparities and cultural competency measures]

PBLI4 Teaching
[This section is vague and provides very little detail in terms of specific teaching milestones (knowledge/skills) that residents will master (e.g., precepting, grand rounds, lectures, seminars, webinars, curriculum design, use of teaching technologies, educational evaluation, others) nor the quality or effectiveness of their teaching. How will these milestones be quantitatively and qualitative measured and documented?]

SBP1 Patient Safety and the Healthcare Team

[Consider including an Introductory note, footnote, or annotation about addressing patient safety issues and preventing/reducing medical errors relating to the care of patients who have limited English proficiency; low health literacy; and various physical, sensory, intellectual, and developmental disabilities]

SBP2 Resource Management

[This section is vague and provides very little detail in terms of specific resource management and advocacy milestones (knowledge/skills) that residents will master nor the quality or effectiveness of their resource management. How will these milestones be quantitatively and qualitative measured and documented?]

5.2 –Advocates for improved systems of care including those that reduce disparities in health and behavioral health care at individual and community levels.

SBP3 Community Based Care

2.3 Describes individual, family, and population risk factors for mental illness

[Consider adding material about working and collaborating effectively with other health care professionals in medical homes, person-centered health homes, and integrated delivery systems]

SBP4 Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic, home health, nursing homes)

4.3 Provides integrated care for psychiatric patients through collaboration with other physicians and health care professionals (e.g., nurse practitioners, physician assistants, pharmacists, dentists, physical/occupational therapists, podiatrists, others)

Annotations – proposed additions relating to milestone set, level, footnote (see above comments - there may be other annotations to include)

What is meant by the term "psychiatric formulation?

Along with individual factors, does this formulation also include any family and community factors? Other factors

What is meant by "models of formulation?"

"Models of formulation include those based on either major theoretical systems of the etiology of mental disorders such as behavioral, biological, cognitive, cultural, psychological, psychoanalytic, family systems, sociological, or traumatic …."

What is the Cultural Formulation Interview (CFI)?

"The Cultural Formulation Interview (CFI) in the DSM 5 is a set of sixteen questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of a person's clinical presentation and care. The CFI emphasizes four domains of assessment: Cultural Definition of the Problem; Cultural Perceptions of Cause, Context, and Support; Cultural Factors Affecting Self-Coping and Past Help-Seeking; and Cultural Factors Affecting Current Help Seeking. Supplementary modules also may be used for populations with specific needs such as children and adolescents, elderly patients, and immigrants and refugees (DSM-5 manual – Section 3).

What are Mental/Behavioral Health Disparities?

Mental/Behavioral Health Disparities – is a definition needed?

What is Cultural and Linguistic Competence?

Should a definition of cultural and linguistic competence be provided along with reference to the Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and other relevant requirements (e.g., Joint Commission, NCQA, NQF). Best practices in working with medical interpreters?

What is Limited Health Literacy?

Should a definition of low health literacy be provided along with a discussion of best practices in clear communication (e.g., Health Literacy Screening/Universal Precautions; Avoiding of medical/psychiatric jargon, Teach-Back)

Draft Psychiatric Milestones Document - Selected Supporting Citations

Cultural Psychiatry

DSM-5. Section III. Cultural Formulation Interview and Cultural Concepts of Distress (see PDF)
Mental Health: Culture, Race, Ethnicity Supplement to Mental Health: Report of the Surgeon General, 2001.
http://www.mentalhealth.org/cre/default.asp
Achieving the Promise: Transforming Mental Health Care in America. Report of the President's New Freedom Commission on Mental Health, 2003.
http://www.mentalhealthcommission.gov

Disparities in Mental Health and Mental Health Care

Ruiz, P, Primm A, eds. Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives. Philadelphia, PA: Lippincott Williams & Wilkins, 2009.
Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press, 2003.
http://www.nap.edu/openbook.php?isbn=030908265X.
HHS Action Plan to Reduce Racial and Ethnic Health Disparities, April 2011
http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285

Ethno-Psychopharmacology

Ng CH, Lin K-M,Ssingh BS, Chiu EYK. Ethno-Psychopharmacology: Advances in Current Practice. New York: Cambridge University Press, 2008.

Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

Joint Commission Accreditation Requirements

Hospitals, Language, and Culture: A Snapshot of the Nation, March 2007.
http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations, April 2008.
http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf
"What Did the Doctor Say?" Improving Health Literacy to Protect Patient Safety, February 2007
http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals, August 2010.
http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

National Quality Forum

A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report, 2009
http://www.calendow.org/Collection_Publications.aspx?coll_id=46&ItemID=322
NQF Endorses Healthcare Disparities and Cultural Competency Measures
http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Healthcare_Disparities_and_Cultural_Competency_Measures.aspx

Joint Reference Committee
June 2, 2013
Arlington, VA

DRAFT SUMMARY OF ACTIONS
As of June 20, 2013

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

JRC Members Present:

Paul Summergrad, MD: JRC Chairperson; APA President-Elect (stipend); Chairperson of the Department of Psychiatry at Tufts and Tufts Medical Center; Forensic consulting and some non-promotional speaking; President of AACDP.

Jenny Boyer, MD: JRC Vice Chairperson, Speaker-Elect; Full Time employee – Veteran's Administration; Pension from Deceased Husband; President of the Oklahoma Psychiatric Association; Private Practice; Federal and State pension; Alternate Delegate to the Oklahoma State Medical Society's Delegation to the AMA, Participate in Patients First, Legislative Council for the State of Oklahoma small private practice

Jeffrey Akaka, MD: Area 7 Trustee; Income – Diamond Head Community Mental Health Center Director; Consultant for Social Security Disability, Board member of The Reverend Abraham Akaka Ministries Foundation, Works with the Hawaii Convention Center (no remuneration); serves on APAPAC Board

R Scott Benson, MD: Assembly Immediate Past Speaker; Private practice in Child and Adolescent and Forensic Psychiatry in Pensacola, Florida

James H Scully Jr, MD: Medical Director & CEO; Chair of the CEO's council for the special societies; Second Vice-President of the American College of Psychiatrists; pension from Navy and Federal Service

Glenn A. Martin, MD: Excused
Dilip V. Jeste, MD: Excused

Staff:
Margaret Cawley Dewar: Director of Association Governance
Laurie McQueen: Associate Director, Association Governance

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
2	Review and Approval of Summary of Actions from the January 2013 Joint Reference Committee Meeting Will the Joint Reference Committee approve the draft summary of actions from the January 2013 meeting?	The Joint Reference Committee approved the draft summary of actions from the January 2013 meeting.	Association Governance
6	**Assembly Report**		

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.1	Proposed Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist (JRCOCT128.A.1/ASM Item #2013A1 4.B.1) [attachment 1] The Assembly voted to refer the Proposed Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist back to the Council on Addiction Psychiatry for additional revisions. Will the Joint Reference Committee refer the Proposed Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the proposed position statement back to the Council on Addiction Psychiatry for integration of the Assembly's comments into a revision of the proposed position statement.	Council on Addiction Psychiatry Report to the JRC – October 2013
6.2	Revised Position Statement: Day Care for Preschool Children (JRCOCT128.C.3/ASM Item #2013A1 4.B.2) [attachment 2] The Assembly voted to refer the Revised Position Statement: Day Care for Preschool Children to the Council on Children, Adolescents and their Families for additional revisions. Will the Joint Reference Committee refer the Revised Position Statement: Day Care for Preschool Children to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the revised position statement to the Council on Children, Adolescents and Their Families for consideration of the Assembly's comments.	Council on Children, Adolescents and Their Families Report to JRC – October 2013
6.3	Retain Position Statement: 1991 Child Abuse and Neglect by Adults (JRCOCT128.C.5/ASM Item #2013A1 4.B.4) [attachment 3] The Assembly voted to refer the 1991 Position Statement: Child Abuse and Neglect by Adults to the Council on Children, Adolescents and their Families for revision. Will the Joint Reference Committee refer the 1991 Position Statement: Child Abuse and Neglect by Adults to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the position statement to the Council on Children, Adolescents and Their Families and requested revision of the position statement.	Council on Children, Adolescents and Their Families Report to JRC – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.4	Revised Position Statement: Medical Psychotherapy (JRCOCT128.K.2/ASM Item #2013A1 4.B.11) [attachment 4] The Assembly voted to refer the Revised Position Statement: Medical Psychotherapy to the Council on Healthcare Systems and Financing for revision. Will the Joint Reference Committee refer the Revised Position Statement: Medical Psychotherapy to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the revised position statement back to the Council on Healthcare Systems and Financing for consideration and potential integration of the Assembly's comments. The JRC also referred the position statement to the Assembly Work Group on Psychotherapy and to the Council on Medical Education and Lifelong Learning requesting that they provide feedback on the revised position statement to the Council on Healthcare Systems and Financing.	Council on Healthcare Systems and Financing (LEAD) Assembly Work Group on Psychotherapy Council on Medical Education and Lifelong Learning Report to JRC – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.5	<u>APA Membership Central Billing Allowing for Voluntary Contributions by Members (ASM Item #2013A1 12.E) [attachment 5]</u> Action paper 2013A1 12.E asks that: 1. The American Psychiatric Association Board of Trustees shall forthwith direct the Membership Department staff of the American Psychiatric Association to adopt a membership dues statement, both on paper and electronically, only upon request from the Council(s) of the involved entities, for which the total bill includes billing for a DB/SA PAC contribution, 2. That the TOTAL statement to APA members shall consist of the sum of the APA national membership dues plus the DB/SA membership dues, plus the DB/SA PAC contribution, and 3. That the contributions to the PAC and Advocacy Plans shall represent a voluntary contribution from the individual member, and 4. That there will be a check box appearing before each listing of the DB/SA PAC contribution which, if checked, will indicate that the APA member chooses NOT to make the featured contribution, and that member will deduct the amount checked from the TOTAL amount and instead submit that reduced payment, and 5. That there will be a clear notification to members of the option to check and subtract the voluntary contributions should they wish to do so, and 6. That the billing and negative check-off features made available on electronic billing features used by the APA will be obvious and easy to navigate, and will explicitly state that the contribution is voluntary, and 7. That the APA will refund the full amount of the charges of the negative check off amounts upon request from any member who claims to have paid them erroneously within one year from making such payment, and 8. That the council of the individual DB/SA will set the amounts to be charged for PAC contributions on the statement. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.E to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Membership Committee for their opinion on the content of the paper and the potential impact on dues billing. The JRC also referred the action paper to the APA*PAC* for information on the potential positive and negative effects implementation of this initiative may have on the APA*PAC*.	Membership Committee APAPAC Report to JRC – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.6	<u>APA to Liaison with ABPN Regarding MOC Exam Timing (ASM Item #2013A1 12.F) [attachment 6]</u> Action paper 2013A1 12.F asks that the APA liaison to the ABPN to advocate for members, specifically requesting that if a diplomate takes the re-certification exam prior to the expiration year of his/her certification, that the new 10-year certification period would begin at the expiration of the prior certification period, instead of beginning on the date the exam was taken. And, that the results of this discussion be communicated back to the Assembly at or before the May 2014 Assembly Meeting. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.F to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred this action paper to the Medical Director's Office for referral to the Division of Medical Education and Lifelong Learning. The Division of Education will communicate this issue to the ABPN.	Medical Director's Office Report to JRC – October 2013
6.7	<u>Polypharmacy (ASM Item #2013A1 12.G) [attachment 7]</u> Action paper 2013A1 12.G asks: 1. That the APA have the Steering Committee on Practice Guidelines explore whether a general guide on the use of more than one psychotropic medication in the treatment of psychiatric disorders can be developed based on a consensus. 2. The Steering Committee on Practice Guidelines report back their preliminary findings to the November 2013 Assembly. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.G to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee refers this action paper to the Steering Committee on Practice Guidelines for review and report back to the Assembly November 2013 with a copy to the JRC.	Steering Committee on Practice Guidelines Report to Assembly – November 2013 FYI – JRC October 2013
6.8	<u>APA MIT 100% Club Benefits (ASM Item # 2013A1 12.H) [attachment 8]</u> Action paper 2013A1 12.H asks that Residents of programs that achieve Bronze Club status or higher would have access to Psychiatry Online at a 50% discount off the current MIT price for that membership year. It also requests that the impact of the program be evaluated by the Membership Committee. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.H to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred this action paper to the Membership Committee for evaluation and report back to the Joint Reference Committee October 2013.	Membership Committee Report Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.9	Revitalizing the Public Perception of the APA and the Psychiatric Profession (ASM Item # 2013A1 12.I) [attachment 9] Action paper 2013A1 12.I asks that the APA Board of Trustees reorganize and increase funding to the Council on Communications such that it directs an energized communications and public relations campaign directed towards the public at large, through the lay and social media, utilizing such measures as broad-based advertising, public service announcements, press conferences and other effective public relations measures, seeking advice from public relations professionals; that this effort include messages about how parity violations have and do affect access to care and that the APA Board of Trustees direct the Medical Director to expand APA communications mission. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.I to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the American Psychiatric Foundation and the Council on Communication for review, comment and formation of a proposal for a public relations campaign against stigma and in support of parity.	American Psychiatric Foundation Council on Communications Report to Joint Reference Committee – October 2013
6.10	Poster Awards Pilot Project by Area 5 (ASM Item # 2013A1 12.J) [attachment 10] Action paper 2013A1 12.J asks that: 1. The APA Scientific Program Committee will provide Area V with the approved abstracts with contact information for the posters accepted at the annual meeting beginning in 2014. 2. The APA will print a photograph of the winners in an APA publication such as Psychiatric News. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.J to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee noted that this action paper is being implemented.	
6.11	Inquiry Regarding American Board of Psychiatry and Neurology (ABPN) Data Collection and Data Management Practices (ASM Item # 2013A1 12.K) [attachment 11] Action paper 2013A1 12.K asks that the APA Council on Medical Education Lifelong Learning be charged with the responsibility to inquire of the ABPN what applicant data are collected, how they are utilized, and what privacy protections are in place and what privacy protections will remain in place. And, that the Council on Medical Education and Lifelong Learning generate a report for the Assembly at the May 2014 Assembly Meeting. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.K to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Medical Director's Office with a request to respond to the action paper. FYI – Council on Medical Education and Lifelong Learning	Medical Director's Office Report to Assembly – November 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.12	ECP Oriented Annual Meeting Program (ASM Item # 2013A1 12.L) [attachment 12] Action paper 2013A1 12.L asks that the APA explore the option to create an Early Career Psychiatrist track that would run in parallel and/or in conjunction with MIT and PsychSIGN tracks; That the ECP track will be held over the course of half to full day; That the ECP track will focus on broad areas of interest to ECPs as defined by ASM ECP Committee (including APA ECP BOT, APA AMA Representative, etc) to include but not limited to: early career private practice issues, emerging diagnostic and treatments, negotiations, practice models, emerging public health and policy issues, etc.; That the ECP track be assigned an APA staff to help coordinate the events; That the ECP track be coordinated with relevant parts of the MIT and PsychSIGN tracks; That the ECP track's chair position be determined by ASM ECP Committee members as defined above; That that APA's consideration of this ECP track be reported to the ASM by November of 2013. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.L to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Scientific Program Committee for comment and guidance regarding how creating and ECP track does or doesn't fit in the Annual Meeting program.	Scientific Program Committee Report to Joint Reference Committee – October 2013
6.13	Comprehensive Training for Psychiatric Residents on Violence Management and Self-Protection (ASM Item # 2013A1 12.O) [attachment 13] Action paper 2013A1 12.O asks: 1. That the Council on Medical Education and Lifelong Learning explore whether it would be valuable and feasible for Residency Review Committee of the Council of Graduate Medical Education (ACGME) to make comprehensive training as itemized in Resolve #2, training a requirement of residency training. 2. The ACGME requirement for this comprehensive training shall include the following key three elements: • Prevention • De-escalation • Self Protection And the training shall be done by a qualified trainer. 3. That the Council on Medical Education and Lifelong Learning report their findings to the November, 2013, Assembly. Will the Joint Reference Committee the Assembly passed action paper 2013A1 12.O to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred this action paper to the Council on Medical Education and Lifelong Learning to explore the feasibility of comprehensive training for psychiatric residents on violence management and self-protection.	Council on Medical Education and Lifelong Learning Report to Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.14	<u>APA Representation in the HL7 Standards Organization (ASM Item # 2013A1 12.P) [attachment 14]</u> Action paper 2013A1 12.P asks that the APA will become an Organizational Member of HL7; that the Medical Director/CEO will appoint a minimum of three members to participate in HL7 for the purpose of advancing the specialty's interests in the development of health information technologies; that the appointed HL7 participants will report to the Committee on Electronic Health Records; that the APA will reimburse the appointed HL7 participants for meeting fees, travel and hotel costs with a minimum commitment of sending three participants to each of three work group meetings annually. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.P to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Board of Trustees for consideration.	Board of Trustees – July 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.15	The Development of a Resource Document on Human Trafficking (ASM Item # 2013A1 12.Q) [attachment 15] Action paper 2011A2 12.Q asks that: 1. Working with appropriate APA staff and Components, the Assembly requests that the Women's Caucus of the APA and/or the Council on Research and Quality Care or other appropriate APA or non-APA resources develop an evidence-based resource document covering the psychological, social, and physical repercussions/trauma and sequellae of being a victim of human trafficking as well as the appropriate treatment and care for the victims including social and legal resources that may be available. 2. The resource document be disseminated to the National Officers, and the Officers of the District Branches. 3. The resource document be made easily available to members on the APA Web Site such that it be easily available for members at all times so that, for example resident members could access the resource document at any time. 4. The District Branches be encouraged to disseminate the resource document to their Officers as well as the general membership including Officers of any Chapters in the case that Chapters are part of the District Branch structure. 5. District Branches encourage their membership to gather local information for distribution to their membership concerning available resources for victims of human trafficking. 6. The Resource Document be reviewed and up-dated at least every two years or as indicated by the Council on Research and Quality Care. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.Q to the appropriate Component(s) and/or other entities for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Minority Mental Health and Health Disparities (LEAD) and to the Council on Psychiatry and Law.	Council on Minority Mental Health and Health Disparities (LEAD) Council on Psychiatry and Law Report to the Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.16	<u>APA Should Sign the AllTrials Campaign Petition (ASM Item # 2013A1 12.R) [attachment 16]</u> Action paper 2013A1 12.R asks that: 1. That the American Psychiatric Association should join dozens of other national and international scientific societies in signing the AllTrials.org petition bolded language above. 2. That the Joint Reference Committee, if it feels more background is needed, is asked to refer to the appropriate Council(s) for evaluation and recommendation to the Board of Trustees. 3. The Recorder shall report back to the Assembly at the November 2013 Assembly meeting if the APA has signed the petition, and if not, why not? Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.R to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Research for evaluation and recommendation.	Council on Research Report to the Joint Reference Committee – October 2013
6.17	<u>Use of New CPT Codes in Health Insurance Exchanges (ASM Item # 2013A1 12.S) [attachment 17]</u> Action paper 2013A1 12.S asks: 1. That the APA Division of Government Relations and the APA Division of Healthcare Systems and Financing shall jointly advocate that the Exchanges must cover all CPT® codes and coding conventions (including the new combination codes for psychotherapy services) and must use the Medicare RVU values as the basis for reimbursement for physician services in any fee-for-service plan; and 2. That the APA Division of Healthcare Systems and Financing shall prepare draft language and additional supporting material for use by district branches and state associations in advocating at the state level for both use of CPT® codes and coding conventions and for use of the Medicare RVUs in Exchanges established by states. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.S to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred this action paper to the Medical Director's Office to determine what elements of this action paper are already implemented by the Division of Healthcare Systems and Financing.	Medical Director's Office Report to the Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.18	Committee on Mental Health Information Technology (ASM Item # 2013A1 12.U) [attachment 18] Action paper 2013A1 12.U asks that the Committee on Electronic Health Records is renamed the Committee on Mental Health Information Technology; and the Committee's charter be revised to include addressing of health information technologies, including electronic health records, personal health records, health information exchange, mobile health technologies, psychiatric informatics, secure messaging for communicating health information, and addressing of relevant health care policies, including state and federal regulations and statutes, on issues relating to mental health information technology, such as privacy, security, patient access, granular consent, data segmentation, usability, clinical decision support, meaningful use, and functionality. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.U to the appropriate Component(s) and/or other entities for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Quality Care for review and approval of the revisions to the charge to the Committee on Electronic Health Records.	Council on Quality Care Report to the Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.19	Use of District Branch/State Association/Area Council Electronic Communications by APA Election Candidates (ASM Item # 2013A1 12.V) [attachment 19] Action paper 2013A1 12.V asks: 1. That if a District Branch/State Association/Area Council (DB/SA/AC) chooses to do so, it may permit the use of their electronic communications services (such as email, listservs, bulletin boards, and group messaging) for campaigning by APA election candidates as long as they permit all relevant candidates to have open access to such communication service by temporarily accepting said candidates to a special DB/SA/AC member status that permits them access to the communication service; 2. That the appropriate period for District Branches/State Associations/Area Councils to allow access by candidates to their electronic communications services be from 30 days prior to the beginning of an election through the last day of the election; and 3. That each District Branch/State Association/Area Council has sole governance over the content of its electronic communications and may specify rules of engagement for the candidates to abide by. 4. That the Joint Reference Committee refer this paper to the Elections Committee for consideration of revisions to the elections guidelines to implement the above items. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.V to the appropriate Component(s) and/or other entities for input or follow-up?	The Joint Reference Committee referred the action paper to the Elections Committee for consideration of the issues contained within the action paper and requested a report to the Joint Reference Committee for October 2013	Elections Committee Report to the Joint Reference Committee – October 2013
6.20	APA Referendum Voting Procedure (ASM Item # 2013A1 12.Y) [attachment 20] Action paper 2013A1 12.Y asks that the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.Y to the appropriate Component(s) and/or other entities for input or follow-up?	The Joint Reference Committee held a detailed, lengthy, and thoughtful discussion of this action paper. A motion was made to refer the action paper to the Board of Trustees and failed. The action paper was referred to the Assembly Executive Committee for discussion.	Assembly Executive Committee – July 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.21	Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System (ASM Item # 2013A1 12.Z) [attachment 21] Action paper 2013A1 12.Z asks that the Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will seek to provide deliverables such as a Third Edition of the Guidelines, a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, nationally and nationally to organizations such as NAMI, The National Association of State Mental Health Program Directors and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council and which would report to the Council on Psychiatry and the Law and which would provisionally have the following charge: 1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the criminal justice system, including jails, prisons, law enforcement, or the courts. 2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system. 3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment. 4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons; 5. Revise and update the Position Statement of 1988. 6. Develop the 3rd edition of the APA Guidelines on Psychiatric Services in Jails and Prisons. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.Z to the appropriate Component(s) and/or other entities for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law for their review and feedback on the reinstatement on the Committee on Persons with Mental Illness in the Criminal Justice System.	Council on Psychiatry and Law Report to the Joint Reference Committee – October 2013
8	**COUNCIL REPORTS**		
8.A	**Council on Addiction Psychiatry**	The Joint Reference Committee thanked Dr. Renner for presenting the report of Council on Addiction Psychiatry, providing commentary on the actions below and an update on the Council's activities	

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.A.1	Revised Position Statement on Marijuana as Medicine Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement on Marijuana as Medicine, and if approved, forward it to the Board of Trustees for consideration? (Please see attachment #1)	The Joint Reference Committee referred the revised position statement to the Assembly for consideration. N.B. See minor revision made by the Joint Reference Committee.	Assembly – November 2013
8.A.2	Retire 2009 Position Statement on Marijuana as Medicine Will the Joint Reference Committee recommend that the Assembly retire the 2009 Position Statement on Marijuana as Medicine, and if retired, forward it to the Board of Trustees for consideration? (Please see attachment #2)	The Joint Reference Committee referred the retirement of Position Statement on Marijuana as Medicine to the Assembly in November 2013 for consideration.	Assembly – November 2013
8.B	**Council on Advocacy and Government Relations**	The Joint Reference Committee thanked Dr. Cabaj for presenting the report of Council on Advocacy and Government Relations, providing commentary on the actions below and an update on the Council's activities.	
8.B.1	Action Paper: "Shortage of Beds" (ASMMAY0712.C; JRCFEB12.8.B.1;JRCJUNE126.1; ASMNOV124.B.1; JRCJAN136.20) Will the Joint Reference Committee recommend that the Board of Trustees approve the Council's recommendation of the withdrawal of the action paper, "Shortage of Beds"? (See Minutes pages 4–5 for the Council's rationale)	The Joint Reference Committee accepted the report of the Council on Advocacy and Government Relations to withdraw the action paper and encourages the authors of the original action paper and the Assembly to review the issue in light of the time passed since the writing of the original paper and the changes taking place with healthcare reform.	FYI – Assembly – November 2013
8.C	**Council on Children, Adolescents and Their Families**	The Joint Reference Committee thanked Dr. Kraus for presenting the report of Council on Children, Adolescents and Their Families, providing commentary on the actions below and an update on the Council's activities.	
8.C.1	Revised Position Statement on Newborn Adoptions Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement on Newborn Adoptions, and if approved, forward it to the Board of Trustees for consideration? (Please see attachment A)	The Joint Reference Committee referred the revised position statement back to the Council on Children, Adolescents and Their Families. Members of the JRC had some suggestions for potential revisions which will be forwarded to the Council for consideration.	Council on Children Adolescents and Their Families Report to the Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.C.2	Potential Endorsement of Child Mind Institute's Speak Up for Kids Campaign Will the Joint Reference Committee recommend that the Board of Trustees identify the advantages and potential disadvantages of APA endorsing the Child Mind Institute's Speak Up For Kids Campaign? (Please see page 2 of the Council's report)	At this time the Joint Reference Committee recommended that the APA not take any action on support or non-support of the endorsement of Child Mind Institute's Speak Up For Kids Campaign.	FYI – Board of Trustees – July 2013
8.D	**Council on Communications**	The Joint Reference Committee thanked Dr. Borenstein for presenting the report of Council on Communications, providing commentary on the actions below and an update on the Council's activities.	
8.E	**Council on Geriatric Psychiatry – no report**	The Joint Reference Committee thanked Dr. Roca for presenting an update on the Council's activities.	
8.F	**Council on Healthcare Systems and Financing**		
8.F.1	Resource Allocation for Integrated Care and Collaborative Care Will the Joint Reference Committee recommend that the Board of Trustees allocate the necessary human and financial resources to update and maintain the APA website page dedicated to information on integrated care and collaborative care? (Please see p 4 of the Council's report) Integrated care/collaborative care are areas of medicine that have seen tremendous activity over the past several years. The Council believes that APA needs to designate additional resources to collecting and disseminating relevant information including training opportunities and new developments in the field.	The Joint Reference Committee noted that the work requested in this action is currently underway in APP, Inc.	FYI – Council on Healthcare Systems and Financing
8.F.2	Adequacy of Health Insurance Provider Networks Will the Joint Reference Committee endorse the Council on Healthcare Systems & Financing's plan of action outlined below to collect more detailed information on the adequacy of health insurance provider networks? (Please see p 9-10 of the Council's report) The Council had a thorough discussion with Drs. Steve Daviss and Bob Roca about the issue of network adequacy. Together the Council and authors of an Assembly action paper on this issue developed a plan of action to better understand the issue.	The Joint Reference Committee referred the action to the Medical Director's Office for the development of a cost estimate for the action plan.	Medical Director's Office Report to the Joint Reference Committee – October 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.F.3	<u>Proposed Position Statement Improving Patient Access to Psychiatric Services Through MCO Povider Panels</u> Will the Joint Reference Committee recommend that the Assembly approve the position statement "Improving Patient Access to Psychiatric Services through MCO Provider Panels" as revised by the CHSF at the request of the Assembly, and if approved, forward it to the Board of Trustees for consideration? (Please see p 10 of the Council's report) The Council submitted this position statement for review by the JRC in 2012; the JRC approved the statement, forwarding it to the Assembly for review. The Assembly requested a wording change and referred it back to the CHSF. This newly revised draft position statement addresses the issues raised during the Assembly discussion.	The Joint Reference Committee referred the position statement to the Assembly for consideration.	Assembly – November 2013
8.G	**Council on Medical Education and Lifelong Learning**		

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.G.1	Referral Update: Surveying Recently Graduated Psychiatrists & their Residency Training Programs to Assess Preparedness in the Workforce, & Identify Potential Areas for Improvement in Training (JRCJAN136.10; ASMNOV1212.N) The Action paper asks that the APA undertake a survey of recent psychiatry training program graduates, as well as a representative sample of general APA membership, to help to determine the work roles occupied by psychiatrists, the degree to which training programs prepared them for these roles and areas of strength and areas of potential improvement in current training curricula. The APA Assembly further requests ask the Council on Medical Education to oversee the survey work, review findings, compare findings with existing work and current ACGME standards, and present recommendations at the Fall Assembly. Recommendations should include areas identified as potentially being addressed by training programs, as well as areas that might be an APA membership benefit. The Council noted that psychiatry, from residency training to clinical practice, is in a process of change at this point brought upon by the residency Milestones and to a greater degree, the changes in health care system. It is difficult to know what the practice will be like in 3-5 years and what skills and training are required. The Council supports that spirit of this paper but suggests that the action of surveying graduates and preparing the findings be deferred for approximately 5 years until after we know for certain what the practice landscape will look like. Further, the Council would like to emphasize the realignment of education (from undergraduate to graduate to MOC) in light of the changes in healthcare systems and integrative care system.	The Joint Reference Committee referred the action to the Medical Director's Office and requested that this work be included in the work force survey being done within the Office of Research.	Medical Director's Office

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.G.2	<u>APA Mentors of the Year Award</u> Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the creation of the APA Mentors of the Year Award (at an estimated cost of $600 to come from the Council's budget)? In recognition of the value the APA places on mentorship, the Council recommends the creation of the new APA Mentors of Year Award to reward outstanding mentors in the psychiatric community. Superb mentors from any of the subspecialty branches of psychiatry and various work/specialized settings are eligible for this award. It is anticipated that awardees will have had a sustained career commitment to mentoring, a significant positive impact on their mentees' careers, fostered the careers of students and colleagues and through their mentees have advanced research and patient care in the field of psychiatry. One "Mentor of the Year" winner will be selected in each of these mentorship categories: • Academic Educator • Administration and Leadership • Clinical Practice This award is based on the quality of the nomination letters from mentees including residents and early career psychiatrists, not the mentor's personal career achievements. For the purpose of this award, mentoring is defined as the process of guiding, supporting, and promoting the training and career development of others. The winners will be invited to present a symposium at the Annual Meeting on mentorship along with the Research Mentorship Awardee (award given jointly by the AACDP and the APA Council on Research.)	The Joint Reference Committee recommended that the Board of Trustees vote to approve the creation of the APA Mentors of the Year Award at an estimated cost of $600 per year.	Board of Trustees – July 2013
8.H	**Council on Minority Mental Health and Health Disparities**		
8.H.1	<u>Proposed Position Statement on Issues Related to Homosexuality</u> Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on Issues Related to Homosexuality and if approved, forward to the Board of Trustees for consideration? (Please see Attachment A of the Council's report)	The Joint Reference Committee referred the proposed position statement to the Assembly for Consideration.	Assembly – November 2013
8.H.2	<u>DSM 5 and Cultural Training</u> Will the Joint Reference Committee recommend that the Board of Trustees authorize that 1) DSM 5 training efforts include instruction in the DSM 5 Cultural Formulation Interview (CFI), 2) a training manual and DVD on the CFI as well as a cultural case book be developed and 3) DSM 5 trainers in the district branches be alerted to the importance of the use of the CFI. (Please see page 2 of the Council's report).	The Joint Reference Committee recommended that this action be referred to the DSM Planning Committee.	DSM Planning Committee Request that the DSM Planning Committee report to the BOT by December 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.H.3	Feedback on ACGME Psychiatry RRC Milestones Will the Joint Reference Committee forward the Council's input to the ACGME Psychiatry RRC Milestones document to the Council on Medical Education and Lifelong Learning and to the Board of Trustees for consideration toward the APA input to the ACGME? (Please see Attachment B of the Council's report)	The Joint Reference Committee referred the document to the Council on Medical Education and Lifelong Learning for their consideration in responding to the ACGME Psychiatry RRC Milestone's document before August 2013.	Council on Medical Education and Lifelong Learning Report to Joint Reference Committee – October 2013 FYI – Board of Trustees – July 2013
8.I	**Council on Psychiatry and Law**	The Joint Reference Committee thanked Dr. Hoge for presenting the report of Council on Psychiatry and Law, providing commentary on the actions below and an update on the Council's activities.	
8.J	**Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry)**	The Joint Reference Committee thanked Dr. Dimsdale for presenting the report of Council on Psychosomatic Medicine and providing an update on the Council's activities.	
8.K	**Council on Research and Quality Care**		
8.K.1	Proposed Position Statement on Need to Train Psychiatrists in Provision of Care to Individuals with Disorders of Sex Development and Their Families Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement Need to Train Psychiatrists in Provision of Care to Individuals with Disorders of Sex Development and Their Families, and if approved, forward it to the Board of Trustees for consideration? (Please see attachment #2)	The Joint Reference Committee referred the proposed position statement to the Council on Minority Mental Health and Health Disparities, the Council on Children, Adolescents and Their Families, the Work Group on Gender Issues and the Caucus on JRC Refer for review by the Council on Minority Mental Health and MUR Committee: LGBT Psychiatrists.	Report to the Joint Reference Committee – October 2013
8.K.2	Revised Position Statement on Somatic Cell Nuclear Transfer (SCNT) Research Will the Joint Reference Committee recommend that the Assembly approve the new position statement on Somatic Cell Nuclear Transfer (SCNT) Research, and if approved, forward it to the Board of Trustees for consideration? (Please see attachment #3)	The Joint Reference Committee referred the revised position statement to the Assembly for consideration.	Assembly – November 2013
8.K.3	Criteria Revision for APA Award for Research Will the Joint Reference Committee recommended that the Board of Trustees approve the revised criteria for the APA Award for Research as defined in the APA Operations Manual? (Please see attachment #4)	The Joint Reference Committee approved the criteria revision to the APA Award for Research and directed the Department of Association Governance to the editorial revision in the Operations Manual.	Council on Research – FYI Association Governance

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.K.4	Reassignment of Action Paper ASMNOVE1212.U – The Development of a Resource Document on Rape) Will the Joint Reference Committee reassign action paper ASMNOV1212.U (The Development of a Resource Document on Rape) to a more suitable component?	The Joint Reference Committee combined this action item with the referral update from the Medical Director's Office and reassigned the action paper to the Council on Minority Mental Health and Health Disparities for development of a resource document on rape.	Council on Minority Mental Health and Health Disparities Report to the Joint Reference Committee – October 2013
8.K.5	Will the Joint Reference Committee reassign action paper ASM NOV1212.EE (Managed Care Misuse of FDA Labeling) to a more suitable component? The Council felt the Councils on Advocacy and Government Relations and Council on Healthcare Systems and Financing would be best positioned to advise on how to advocate on the activities of health insurance entities, and recommended that this action paper be referred to those Councils as the action paper authors suggested.	The Joint Reference Committee reassigned the action paper to the Council on Healthcare Systems and Financing.	Council on Healthcare Systems and Financing Report to the Joint Reference Committee - October 2013
9.A	Ethics Committee Assembly Item 2012A2 12.X: The Principles of Medical Ethics with Annotations Applicable to Psychiatry, Social Media and Implications for Criminal Defendants Will the Joint Reference Committee request the Assembly to submit their issues from Action Paper 2012A2 12X in the form of a question to the Ethics Committee so an opinion may be issued and subsequently included in the "Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry?"	The Joint Reference Committee referred the action paper to the Assembly Executive Committee and requested that they submit the issues to the Ethics Committee in question format.	Assembly Executive Committee – July 2013

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
9.B	Medical Director's Office Report Updates on Referrals <u>MOC Certification Language</u> (ASMNOV1212.M) (JRCJAN136.9) Action paper ASMNOV1212.M asks that 1. The APA lobby the ABPN to use a system that does not stigmatize members with lifetime certification who do not choose to pursue MOC requirements. 2. The APA lobby the ABPN to designate lifetime diplomates as "Lifetime Certified; not participating in MOC and not required to do so". The Joint Reference Committee referred this item to the Medical Director's Office and requested that this be brought to the attention of the ABPN. APA leadership will be meeting with the ABPN on February 8th, 2013. <u>APA Providing Accreditation for CMEs for District Branches at No Cost</u> (ASMNOV1212.O) (JRCJAN136.11) Action paper ASMNOV1212.O asks that the APA continue CME administrative support at the current level at no charge for the District Branches. This would add value to District Branches and members. The Joint Reference Committee referred the action paper to the Medical Director's Office for referral to the Division of Education. The Joint Reference Committee wishes to know the APA's lost revenue and expenses associated with providing CME to the District Branches, including how much the APA receives annually by providing CME to the DBs. A report to the Joint Reference Committee is expected in June 2013. The Development of a Resource Document on Rape (ASMNOV1212.U) (JRCJAN136.15) Action paper 2012A2 12.U asks that: 1. Working with appropriate APA staff and Components, the Assembly requests that the Women's Caucus of the APA develop an evidenced based resource document covering the psychological and physical repercussions/trauma and sequellae of rape as well as the treatment thereof. 2. The resource document be disseminated to the National Officers, and the Officers of the District Branches. 3. The District Branches be encouraged to disseminate the resource document to their Officers as well as the general membership including Officers of any Chapters in the case that Chapters are part of the District Branch structure. 4. District Branches encourage their membership to gather local information for distribution to their membership concerning available resources for rape victims. The Joint Reference Committee referred the action paper to the Council on Research and Quality Care for referral to the Steering Committee on Practice Guidelines for development of a resource document. A report to the Joint Reference Committee is expected in June 2013. The Joint Reference Committee suggested that APP, Inc be queried to determine if there currently exists a book or other resource on this topic.	The Joint Reference Committee reviewed the referral updates. <u>MOC Certification Language</u> The Medical Director reported that the APA leadership meets regularly with the ABPN leaders to discuss MOC issues. <u>APA Providing Accreditation for CMEs for District Branches at No Cost</u> The Joint Reference Committee referred the action paper to the Assembly Executive Committee and requested that an open and transparent dialogue on the business relationship between the APA and the District Branches with regard to CME be conducted and the information be reviewed and inform any potential implementation of the action paper. <u>The Development of a Resource Document on Rape</u> The Joint Reference Committee reassigned the action paper to the Council on Minority Mental Health and Health Disparities and requested a report to in January 2014.	

**Report of the Membership Committee
to the APA Board of Trustees**

**Membership Committee Meeting
May 20, 2013
San Francisco, California**

PRESENT: Members: Drs. Joseph E.V. Rubin, Chair, Gabrielle F. Beaubrun, Ana E. Campo, Rao Gogineni, Judith Kashtan, Chetana A. Kulkarni, Lawrence M. Martin, Louis A. Moench, Emily S. Stein; Corresponding Members: Drs. Kenneth G. Busch, Elizabeth Morrison, Nyapati R. Rao, Vihang Vahia; Consultants: Ms. Beverly Dupuis, Ms. Robin Huffman, Dr. David Safani; Guests: Drs. Carol Bernstein, Peter Buckley, Francis Lu; Staff: Susan Kuper, Louise Martin, Therese Swetnam

Unable to Attend: Drs. Nioaka N. Campbell, Alan Schlechter, Mark H. Townsend

Opening Remarks

Dr. Rubin 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. Kulkarni, Martin, Schlechter, Rao, Townsend, and Vahia).

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

Membership Transaction Activity in 2013

- New Medical Student Members total 388 through May 2013, as compared to 278 through May 2012.
- New and reinstating Members-in-Training total 590 through May 2013, as compared to 571 through May 2012.
- New and reinstating General Members total 690 through May 2013, as compared to 505 through May 2012.
- New and reinstating International Members total 260 through May 2013, as compared to 188 through May 2012.
- Members-in-Training advancing to General Member status total 76* through May 2013, as compared to 265 through May 2012.
- District Branch transfers total 308 through May 2013, as compared to 259 through May 2012.

*MITs finishing training during the summer will be automatically advanced to General Member status in August 2013.The 76 MITs who have been advanced through May have contacted APA to verify they meet the GM requirements. The 265 MIT-GM advancements through May 2012 were mostly 2011 graduates automatically advanced to GM status in January 2012 after the BOT approved the new procedures in December 2011.

Attachment A shows an annual comparison of dues-paying and dues-exempt membership categories from January 2001 through January 2013, as well as monthly comparisons in 2013 through May. Attachment B shows gains and losses by membership class for all membership transactions in the month

of May 2013, 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., Member-in-Training to General Member advancements or Life Member to Inactive Member status). The committee also reviewed data comparing APA membership demographics with the AMA master data file. Although the AMA master data file is not perfectly accurate in identifying all psychiatrists who are eligible for APA membership (e.g., self-reported data), it is still the best source available for identifying the "universe" of psychiatrists within the U.S. See attachment C for details.

2013 Dues Drop Retention Efforts

Retention efforts started in late March with an email blast (4th email reminder since October 2012) 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.

On May 1, the annual "DB Member Retention" campaign kit was sent to all district branches, which included 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 2013 membership dues. The names are also listed under the APA and DB Drops section of the Membership Activity Reports which are updated and sent bi-weekly.
- 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 (photocopy and provide to callers)
- Form to document DB retention efforts

Attachment D shows the Counts of Pending Drops by Area and District Branch through June 15, 2013. The average percentage of district branch members still owing dues is 10%. Some district branches have a percentage as low as 5-6%, whereas others are in the range of 13-19%.

Throughout the dues cycle which initially 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. A special message highlighting the June 30 deadline was imprinted on the outer envelope of the invoice mailings sent in April and June. In May, personalized postcards were sent to targeted member segments (MITs, ECPs, Canadians, Other members) listing the benefits of membership that are relevant to their member segment. A national calling program began on June 3 with a new company that has extensive experience calling members in medical societies about membership renewal. Membership staff wrote the script and provided information about the unpaid members. As of June 17, the company collected nearly $150K in dues. A full report will be provided at the conclusion of the national calling program.

With the July issue of AJP, there will be a cover tip highlighting "This is Your Last Issue" for members that had not paid dues by mid-June when the mailing lists were provided to the printer. Notices have also been running in the weekly member e-newsletter and a message is posted on the APA website. A "last chance" email will be sent at the end of June and payments will continue to be processed until the middle of July.

There are nearly 1,300 fewer members on the pending drop list compared to last year at the same time:

Dues Owed	2013 Dues	2012 Dues	Difference
	6/18/2013	6/13/2012	
APA & DB/SA	3,152	4,670	-1,518
Non-Central Billing DB	422	159	263
International	267	311	-44
Total	3,841	5,140	-1,299

Retention efforts will continue beyond the June 30 payment deadline; the administrative reinstatement period extends until the end of the year. A list of 3,122 members who have not paid dues as of June 26, 2013, is presented in Attachment H for drop action in the Membership Processing action items section below. A list of 151 members who have not paid local dues as of June 26 (to district branches that bill and collect dues separately from APA), is presented in Attachment I for drop action. Please note members of Northern California Psychiatric Society have been given an extension to pay until August 31, 2013 and are not included on this list.

Recruitment and Retention Highlights (International Membership)

International Ambassador Program

The International Ambassador Program officially launched in Spring 2013. APA members who live or travel abroad are invited to recruit new International Members to join the APA. The countries participating in the pilot include Australia, Brazil, India, Japan, and the Netherlands. Membership staff has confirmed participation from 5-10 members in each country to recruit colleagues to join APA. These countries were selected based on the higher concentration of international members from these countries, as well as a high rate of attendance by both members and non-members at the APA Annual Meeting. Japan was added to the initial launch to take advantage of APA's current collaboration with the Japanese Society of Psychiatry and Neurology in promoting each other's memberships. This is an initiative that was established during the International BOT Work Group meeting at the World Psychiatric Association Bucharest Congress in April 2013.

International Fellow Category

Membership staff is actively promoting the new *International Fellow* membership category. Ongoing promotional announcements have appeared in *APA Headlines* and *Psychiatric News Alerts* and the first of several email blasts regarding the new category was emailed to International Members in May prior to the Annual Meeting. Almost 100 International Fellow applications have been received through mid-June. The application deadline for International Fellows is August 1.

New International Member Welcome Reception

The Membership Committee and BOT WG on International Psychiatrists co-hosted a New International Member Welcome Reception on Monday morning during the Annual Meeting. There were

approximately 75 people from 26 countries in attendance, including Presidents of International Psychiatry organizations. Drs. Jeste, Scully, Levin, Rubin and Riba all gave welcoming remarks. Dr. Riba also presented certificates of appreciation to the International Presidents. The reception seemed to be very appreciated by those in attendance.

Exhibits at International Psychiatric Meetings

Membership staff has/will be exhibiting at the following meetings to promote APA membership:

- World Psychiatric Association Regional Meeting (Bucharest, Romania, April 9-13, 2013)
- Royal College of Psychiatrists (Edinburgh, Scotland, July 2-5, 2013)

Recruitment and Retention Highlights (US & Canada)

- Congratulations letters were mailed to APA members passing the ABPN board exam (n=735), and recruitment letters were mailed to non-members (n=554); these are ongoing recruitment and retention efforts.
- Two email blasts have been sent to Early Career Psychiatrists (ECPs) promoting the new member benefit of free online FOCUS subscriptions for ECP members in 2013, as well as continual ongoing promotion of the benefit in APA's *PN Alert* and *Headlines*.
- Promotional banner ads on APA membership are being featured on the *American Association for Geriatric Psychiatry's (AAGP)* biweekly email news brief to members. The ads, which began in April and will run through July, include messaging to promote benefits to APA members and non-members alike.
- Postcards were mailed to non-members who pre-registered for the APA Annual Meeting in San Francisco at the full conference non-member rate promoting the APA Annual Meeting Rebate Program (n=375). Ninety-two (92) eligible Rebate applications were received at the Annual Meeting in San Francisco, an all-time high. The Annual Meeting Rebate Program allows non-members who are eligible for General Membership and submit an application onsite at the Annual Meeting to apply the extra money they paid to attend the meeting as a non-member towards APA membership dues.
- The new APA Medical Student benefits brochure and application, now a self-mailer which includes a postage paid return postcard of the membership application, was mailed to a select number of first and second year medical students in April (n=5,328).

Changes to the 100% Club Beginning in 2013-2014

There will be a new structure to the 100% Club Program beginning in 2013-2014 and in addition to promoting the program, the Membership Department will now be administering the benefits as well. The APA 100% Club was established to encourage residents throughout the United States and Canada to join the APA with all of the other trainees in their program. Many psychiatry residency programs come close to enrolling all of their residents each year, but fall short if one or two residents do not join. To recognize and honor those programs for their efforts, the 100% Club is being expanded to include three levels of participation (Gold-100%, Silver-90-99% and Bronze- 80-89%). Additionally, there is now a Platinum level, which will recognize programs that have been part of the 100% Club Gold level for the past five consecutive years.

Exhibits at Other Psychiatric Meetings

Membership staff has/will be exhibiting at the following meetings to promote APA membership:

- Nevada Psychopharmacology Update (Las Vegas, NV, February 13-15, 2013)

- U.S. Psychiatric and Mental Health Congress (Las Vegas, NV, September 30-October 2, 2013)
- American Academy of Child and Adolescent Psychiatry (Orlando, FL, October 22-27, 2013)

New Member Benefit – Healthcare Resources Online (HRO)
This new member benefit, approved by the APA Board of Trustees in December 2012, is being formally launched in June under the name Psychiatry Resources Online (PsychPRO). It will be promoted to members via email blast and announcements to members via multiple APA communications channels including a banner ad on the APA homepage, announcements in *Psychiatric News* and *APA Headlines*, and in other ongoing promotional efforts throughout the year. PsychPRO provides members with access to a free Surescripts-certified ePrescribing platform and point-of-care resources for patient care available online.

DB/SA Competitive Grants
The committee agreed to use $150K of the $180K approved for the District Branch Grant process for "expedited" grant requests. The committee also agreed to award these funds for specific educational projects: DSM-5, CPT Coding, or other miscellaneous educational activities (suggested topics were MOC, EHRs, or something applicable to the DB). The projects must be completed in 2013. The amount awarded was advertised as between $2,000-$2,500 to be determined by the total number of DBs requesting funding. All DBs will be awarded the same amount.

Attachment E is a list of all district branches and state associations that requested a DB Grant with the project type and use of funds noted. The breakdown is:

43	DSM-5
1	CPT Coding
4	Other Miscellaneous education activities
48	Total Requests

With 48 total requests, each DB/SA may be awarded $2,500 (total $120K). The remaining $30K may be added to the existing $30K for the competitive grant process (grants to be reviewed at the fall meeting).

> **Will the Board of Trustees approve a recommendation from the Membership Committee to award $2,500 to each district branch or state association listed in Attachment E as part of the DB Grant process?**

DB/SA Membership Chairs Meeting
For the second year, the Membership Committee sponsored a special meeting for district branch membership chairs during the Annual Meeting in San Francisco. Representatives from 34 DB/SAs attended, including 24 staff and 11 members. There were presentations about local recruitment and retention initiatives by Linda Vukelich (Minnesota) and Frank Sommers, M.D. (Ontario), both generating good discussion amongst the group. Bev Dupuis (Massachusetts) presented a draft document of responsibilities for local district branch membership committees and requested feedback from the group. Louise Martin and Susan Kuper presented information on upcoming membership promotions and how the DB/SAs can get involved. A summary of the meeting will be posted on the DB Membership Chairs listserv.

Member Survey

The Member Survey work group, chaired by Dr. Safani, reviewed the results of the 2012 member survey that was conducted in-house with a small group of members. MITs, ECPs, and Internationals were not included in the survey because plans were to survey them separately at a later date. Overall, the greatest value was in supporting their field, opportunities for professional growth, and access to educational meetings at discounted rates. The work group identified some limitations of the survey, for example, the questions were unipolar rather than bipolar (i.e., questions asked how satisfied someone was with a benefit or service rather than if they were satisfied or dissatisfied). The survey also did not directly compare overall importance/satisfaction of the various categories of benefits, but rather only compared the various benefits within their separate categories.

The work group had several recommendations for future surveys (currently budgeted for in 2013), such as to consider fewer option choices overall, provide a comparison of various benefits generally before going into specifics, offer an odd number of choices in response, and include a choice for "aware of benefit but never used." Free response or multiple choice questions for why a benefit was never used could be very informative to find the road blocks to its use. The work group also recommends using focus groups. Staff plans to work with MIT and ECP leadership when moving forward with surveys to these member segments this summer.

Membership Dues Rates for 2014

The Finance and Budget Committee requested input from the Membership Committee about a possible dues increase in 2014. The Membership Committee discussed this issue at the May meeting. Proposed rates with a 2.0% inflationary increase for 2014 were provided for review. After some discussion, the committee recommended no increase for 2014. Since dues were increased in 2013 for the first time since 2010, the committee suggests that the rates remain the same for at least another year. They were also concerned about the potential negative perception of increasing dues immediately following the release of DSM-5 due to the increased revenue generated from the sales. This recommendation was provided to the Finance and Budget Committee before its June meeting.

International Dues-Related Issues

A work group was formed to discuss several dues-related issues for internationals, such as options for retired members, lump sum dues, and creating a new category for international trainees. Members of the work group are Drs. Beaubrun, Buckley, Morrison and Rubin. Drs. Rao and Vahia also agreed to participate if re-appointed to the committee.

Affiliate Member Category

The Membership Committee has discussed membership categories for non-psychiatrists at various times over the past several years. In 2011, a work group of the committee, discussed ideas about expanding membership to other mental health professionals (e.g., nurse practitioners, physician assistants) and physicians who are not psychiatrists. It was noted at the time that some medical societies have membership categories for allied health professionals. There was no consensus among the district branch/state societies on the topic and the committee decided not to pursue. Membership continues to receive periodic inquiries from nurse practitioners, physician assistant, and others about joining APA. The Membership Committee agreed to form a work group to re-visit the issue. Work group members are Drs. Morrison (chair), Gogineni, Moench, Ms. Dupuis, Ms. Huffman, and Dr. Martin (consultant).

MUR Membership Data
Dr. Francis Lu met with the committee to discuss recruitment and retention of minority members. Last fall Dr. Lu conducted an analysis of membership data provided by Membership staff. He presented this to the Council on Minority Mental Health and Mental Disparities and the council made a series of recommendations for the committee to consider. The committee agreed to look further at those recommendations. They also agreed to his suggestion asking if he could be an informal liaison for recruitment and retention of minority members.

Resignations
With the authorization of the Board of Trustees, the Medical Director has regretfully accepted the resignations of 47 members listed in Attachment F (March 2013 – May 2013).

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 G 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 H for non-payment of 2013 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 151 members listed in Attachment I 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.

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

International Membership

Between March and May 2013, 134 applications for International Membership have been reviewed and approved. The applicant names are provided in Attachment J for the Board's approval.

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

Dues Relief Requests

The Membership Committee reviewed 69 requests for dues relief (see Attachment K) and recommends that:

24 dues waivers be approved
22 dues reductions be approved
4 transfer to Temporary Inactive Member status be approved
19 transfers to Permanent 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 K?

Respectfully submitted,

Jonathan M. Amiel, M.D.
Co-Chair, Membership Committee

Joseph E. V. Rubin, M.D.
Co-Chair, Membership Committee

Comparison of Membership Totals 2003 - Present
Dues-Paying and Dues-Exempt Membership Categories

Number of Members in Dues-Paying Member Categories

Mbr Class	Jan-03	Jan-04	Jan-05	Jan-06	Jan-07	Jan-08	Jan-09	Jan-10	Jan-11	Jan-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
MIT	4,848	4,559	4,129	4,370	4,339	4,357	4,432	4,249	4,187	3,725	3,939	4,018	4,146	4,235	4,297
GM	15,695	16,069	15,545	15,486	15,433	15,552	15,335	14,947	14,136	13,366	13,116	13,092	13,213	13,415	13,498
DF	2,576	2,481	2,257	2,072	2,032	1,996	1,910	1,777	1,642	1,552	1,482	1,485	1,489	1,491	1,492
FE	618	779	886	934	1,045	1,039	1,210	1,406	1,587	2,010	2,177	2,172	2,172	2,175	2,180
AM	14	13	13	11	9	6	6	4	3	3	3	3	3	3	3
LM	1,690	1,790	1,819	1,874	1,908	2,023	2,060	2,133	2,185	2,135	2,167	2,134	2,132	2,124	2,123
DLF	1,471	1,491	1,591	1,636	1,657	1,651	1,656	1,625	1,656	1,638	1,640	1,607	1,607	1,608	1,607
LF	18	43	78	101	155	198	286	355	406	550	609	600	602	599	599
LA	46	30	24	21	16	17	12	6	6	5	4	4	4	4	4
Intl	1,014	1,162	1,313	1,275	1,426	1,593	1,641	1,746	1,561	1,437	1,488	1,521	1,580	1,624	1,708
Sub total	27,990	28,417	27,655	27,780	28,020	28,432	28,548	28,248	27,369	26,421	26,625	26,636	26,948	27,278	27,511

Number of Members in Dues Exempt Member Categories

MS	930	989	1,344	1,980	2,256	1,910	1,217	1,152	1,017	981	1,111	1,171	1,237	1,352	1,432
LM	1,580	1,624	1,658	1,664	1,673	1,693	1,715	1,594	1,651	1,675	1,719	1,717	1,707	1,700	1,698
DLF	2,264	2,266	2,297	2,267	2,280	2,230	2,227	2,113	2,165	2,186	2,245	2,242	2,236	2,225	2,223
LF	0	2	4	2	4	20	29	39	56	87	132	137	137	136	136
LA	42	52	55	55	55	51	54	53	51	49	48	46	46	46	46
IM/IF	1,940	1,951	2,014	2,010	2,096	2,078	2,057	1,986	1,978	1,942	1,937	1,926	1,915	1,931	1,930
HF	61	58	59	58	54	53	52	52	51	46	45	45	44	44	44
Sub total	6,817	6,942	7,431	8,036	8,418	8,035	7,351	6,989	6,969	6,966	7,237	7,284	7,322	7,434	7,509
TOTAL	**34,807**	**35,359**	**35,086**	**35,816**	**36,438**	**36,467**	**35,899**	**35,237**	**34,338**	**33,387**	**33,862**	**33,920**	**34,270**	**34,712**	**35,020**

Member Class Key

MIT	Member-in-Training	LF	Life Fellow
GM	General Member	LA	Life Associate
DF	Distinguished Fellow	Intl*	International Member/Distinguished Fellow (*IF category name changed to IDF Jan 2012)
FE	Fellow	MS	Medical Student
AM	Associate Member	IM/IF	Inactive Member/Inactive Fellow
LM	Life Member	HF	Honorary Fellow
DLF	Distinguished Life Fellow		

I:\Membership Statistics\duespay nonduespay comparison 2003-present

Membership Transactions -- Gains and Losses
May 2013

DUES-PAYING MEMBER CATEGORIES																							
		GAINS								LOSSES													
Member Class	Mbr Counts 4/30/13	New		Reinstate		Class Changes In		Subtotal Gains		Drop		Resign		Deceased		Class Changes Out		Subtotal Loss		Net Gain/Loss		Member Counts End of Month
		Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	
MIT	4,235	49	480	12	110	6	37	67	627	2	16	2	3		1	1	76	5	96	62	531	4,297
GM	13,415	14	138	80	552	1	90	95	780		111	4	31	2	5	6	678	12	825	83	-45	13,498
DF	1,491		0	1	9		83	1	92		0		2		0		145	0	147	1	-55	1,492
FE	2,175		0	5	14		316	5	330		6		0		1		115	0	122	5	208	2,180
AM	3		0		0		0	0	0		0		0		0		0	0	0	0	0	3
LM	2,124		0		3		270	0	273		1		14	1	3		194	1	212	-1	61	2,123
DLF	1,608		0		3		161	0	164		0	1	2		17		152	1	171	-1	-7	1,607
LF	599		0		2		104	0	106		3		1		1		44	0	49	0	57	599
LA	4		0		0		0	0	0		0		0		1		0	0	1	0	-1	4
Intl	1,624	56	201	28	59		14	84	274		0		4		1		0	0	5	84	269	1,708
Subtotal	**27,278**	**119**	**819**	**126**	**752**	**7**	**1,075**	**252**	**2,646**	**2**	**137**	**7**	**57**	**3**	**30**	**7**	**1,404**	**19**	**1,628**	**233**	**1,018**	**27,511**
NON DUES-PAYING CATEGORIES																						
MS	1,352	80	388		0		0	80	388		0		0		0		4	0	4	80	384	1,432
LM	1,700		0		0		134	0	134		0		3	2	35		23	2	61	-2	73	1,698
DLF	2,225		0	2	2		151	2	153		0		5	4	39		0	4	44	-2	109	2,223
LF	136		0		0		52	0	52		0		1		0		1	0	2	0	50	136
LA	46		0		0		1	0	1		0		0		2		0	0	2	0	-1	46
Inact	1,931		0		1		25	0	26		0		0	1	30		6	1	36	-1	-10	1,930
HF	44		0		0		0	0	0		0		0		1		0	0	1	0	-1	44
Subtotal	**7,434**	**80**	**388**	**2**	**3**	**0**	**363**	**82**	**754**	**0**	**0**	**0**	**9**	**7**	**107**	**0**	**34**	**7**	**150**	**75**	**604**	**7,509**
TOTAL	**34,712**	**199**	**1,207**	**128**	**755**	**7**	**1,438**	**334**	**3,400**	**2**	**137**	**7**	**66**	**10**	**137**	**7**	**1,438**	**26**	**1,778**	**308**	**1,622**	**35,020**

APA Members by State
Compared to the AMA Masterfile

State	APA Member Count*	% of AMA Count	AMA Masterfile Count
AE	18	30.5%	59
AK	61	56.5%	108
AL	236	55.8%	423
AP	12	60.0%	20
AR	118	41.1%	287
AZ	322	41.6%	774
CA	2,708	40.2%	6,730
CO	426	53.2%	801
CT	676	62.4%	1,084
DC	235	62.5%	376
DE	81	67.5%	120
FL	956	45.2%	2,117
GA	595	54.8%	1,086
GU	4	50.0%	8
HI	156	50.5%	309
IA	187	63.6%	294
ID	45	41.3%	109
IL	923	53.0%	1,743
IN	300	55.7%	539
KS	198	53.8%	368
KY	276	57.1%	483
LA	288	55.8%	516
MA	1,441	59.4%	2,427
MD	1,019	64.7%	1,575
ME	154	53.7%	287
MI	627	49.1%	1,278
MN	381	56.5%	674
MO	383	53.3%	719
MS	140	59.8%	234
MT	47	43.5%	108
NC	781	57.3%	1,363
ND	49	50.0%	98
NE	136	75.6%	180
NH	117	50.9%	230
NJ	878	55.3%	1,588
NM	135	41.3%	327
NV	119	52.0%	229
NY	3,777	64.8%	5,827
OH	875	60.8%	1,440
OK	201	55.1%	365
OR	352	57.8%	609
PA	1,446	62.0%	2,333
PR	88	18.7%	471
RI	211	71.8%	294

*APA member count excludes inactive members/fellows and retired members.

APA Members by State
Compared to the AMA Masterfile

State	APA Member Count*	% of AMA Count	AMA Masterfile Count
SC	335	56.8%	590
SD	66	75.0%	88
TN	314	47.1%	666
TX	1,077	42.9%	2,510
UT	151	56.3%	268
VA	807	66.5%	1,214
VI	2	40.0%	5
VT	120	63.5%	189
WA	476	52.9%	900
WI	343	48.5%	707
WV	146	74.9%	195
WY	23	45.1%	51
Other	91		13
Total	26,129	54.0%	48,406

*APA member count excludes inactive members/fellows and retired members.

APA Members by Gender, Age, and Medical School Compared to the AMA Masterfile

Gender

Gender	APA Member Count*	% of AMA Count	AMA Masterfile Count
Female	10,138	53.3%	19,021
Male	15,797	53.8%	29,360
Unreported	194		25
Total	26,129	54.0%	48,406

Age

Age	APA Member Count*	% of AMA Count	AMA Masterfile Count
30 and Younger	1,826	470.6%	388
31 to 35	2,938	89.1%	3,297
36 to 40	2,503	56.9%	4,401
41 to 45	2,223	46.7%	4,760
46 to 50	2,347	42.3%	5,550
51 to 55	2,763	42.0%	6,582
56 to 60	2,993	42.1%	7,115
61 to 65	2,790	43.2%	6,463
66 to 70	2,157	44.7%	4,826
71 to 75	1,405	55.4%	2,534
76 to 80	968	65.1%	1,486
81 to 85	599	90.1%	665
86 and Older	531	156.6%	339
Unreported	86		
Total	26,129	54.0%	48,406

Medical School

Med School	APA Member Count*	% of AMA Count	AMA Masterfile Count
IMG	6,527	47.3%	13,805
Non_IMG	19,001	57.1%	33,260
Unknown	601	44.8%	1,341
Total	26,129	54.0%	48,406

*APA member counts exclude inactive members/fellows and retired members.

Counts of Pending Drops (Mbrs Owing Dues) by Area and District Branch -- 2013 Dues Cycle

Area	DB#	DB NAME	Total Mbr Count 4/30/13	Pending Drops 4/30/13	Pending Drop % 4/30/13	Pending Drops 5/31/13	Pending Drop % 5/31/13	Pending Drops 6/15/13	Pending Drop % 6/15/13	Final Drops 7/15/13	Final Drop % 7/15/13
1	7	Connecticut Psychiatric Society	745	127	17.0%	109	14.6%	87	11.7%		0.0%
1	62	Maine Assoc of Psychiatric Physicians	180	23	12.8%	20	11.1%	15	8.3%		0.0%
1	32	Massachusetts Psychiatric Society	1,586	252	15.9%	222	14.0%	175	11.0%		0.0%
1	68	New Hampshire Psychiatric Society	142	17	12.0%	10	7.0%	10	7.0%		0.0%
1	37	Ontario District Branch	746	106	14.2%	91	12.2%	72	9.7%		0.0%
1	39	Quebec & Eastern Canada District Branch	397	54	13.6%	46	11.6%	42	10.6%		0.0%
1	41	Rhode Island Psychiatric Society	244	27	11.1%	23	9.4%	16	6.6%		0.0%
1	66	Vermont Psychiatric Association	137	21	15.3%	18	13.1%	17	12.4%		0.0%
1		**Total Area 1**	**4,177**	**627**	**15.0%**	**539**	**12.9%**	**434**	**10.4%**		**0.0%**
2	2	Bronx District Branch	150	27	18.0%	18	12.0%	17	11.3%		0.0%
2	3	Brooklyn Psychiatric Society, Inc	310	73	23.5%	66	21.3%	59	19.0%		0.0%
2	56	Central New York District Branch	135	23	17.0%	20	14.8%	15	11.1%		0.0%
2	5	Genesee Valley Psychiatric Association	156	19	12.2%	16	10.3%	11	7.1%		0.0%
2	25	Greater Long Island Psychiatric Society*	574	74	12.9%	59	10.3%	52	9.1%		0.0%
2	24	Mid-Hudson Psychiatric Society	75	14	18.7%	12	16.0%	11	14.7%		0.0%
2	27	New York County District Branch	1,790	277	15.5%	234	13.1%	191	10.7%		0.0%
2	28	New York State Capital District Branch	153	14	9.2%	10	6.5%	7	4.6%		0.0%
2	59	Northern New York District Branch	39	6	15.4%	5	12.8%	4	10.3%		0.0%
2	40	Queens County District Branch	226	40	17.7%	36	15.9%	29	12.8%		0.0%
2	49	Psychiatric Society of Westchester County, Inc	447	51	11.4%	42	9.4%	33	7.4%		0.0%
2	51	Western New York Psychiatric Society	152	24	15.8%	22	14.5%	19	12.5%		0.0%
2	55	West Hudson Psychiatric Society	108	19	17.6%	17	15.7%	15	13.9%		0.0%
2		**Total Area 2**	**4,315**	**661**	**15.3%**	**557**	**12.9%**	**463**	**10.7%**		**0.0%**
3	8	Psychiatric Society of Delaware	105	15	14.3%	13	12.4%	12	11.4%		0.0%
3	20	Maryland Psychiatric Society, Inc*	696	88	12.6%	60	8.6%	48	6.9%		0.0%
3	26	New Jersey Psychiatric Association	870	134	15.4%	118	13.6%	103	11.8%		0.0%
3	38	Pennsylvania Psychiatric Society	1,623	285	17.6%	239	14.7%	186	11.5%		0.0%
3	48	Washington Psychiatric Society	915	135	14.8%	106	11.6%	84	9.2%		0.0%
3		**Total Area 3**	**4,209**	**657**	**15.6%**	**536**	**12.7%**	**433**	**10.3%**		**0.0%**
4	13	Illinois Psychiatric Society	1,071	136	12.7%	114	10.6%	97	9.1%		0.0%
4	14	Indiana Psychiatric Society	338	42	12.4%	30	8.9%	19	5.6%		0.0%
4	16	Iowa Psychiatric Society	218	39	17.9%	31	14.2%	28	12.8%		0.0%
4	17	Kansas Psychiatric Society	223	32	14.3%	31	13.9%	29	13.0%		0.0%
4	21	Michigan Psychiatric Society	750	105	14.0%	89	11.9%	75	10.0%		0.0%
4	22	Minnesota Psychiatric Society	432	75	17.4%	57	13.2%	50	11.6%		0.0%
4	9	Eastern Missouri Psychiatric Society	446	64	14.3%	55	12.3%	49	11.0%		0.0%
4	34	Nebraska Psychiatric Society	153	22	14.4%	18	11.8%	16	10.5%		0.0%
4	63	North Dakota Psychiatric Society	58	9	15.5%	9	15.5%	8	13.8%		0.0%
4	35	Ohio Psychiatric Physicians Association	992	198	20.0%	165	16.6%	146	14.7%		0.0%
4	72	South Dakota Psychiatric Association	69	14	20.3%	11	15.9%	10	14.5%		0.0%
4	52	Wisconsin Psychiatric Association	407	68	16.7%	56	13.8%	46	11.3%		0.0%

Counts of Pending Drops (Mbrs Owing Dues) by Area and District Branch -- 2013 Dues Cycle

Area	DB#	DB NAME	Total Mbr Count 4/30/13	Pending Drops 4/30/13	Pending Drop % 4/30/13	Pending Drops 5/31/13	Pending Drop % 5/31/13	Pending Drops 6/15/13	Pending Drop % 6/15/13	Final Drops 7/15/13	Final Drop % 7/15/13
4		**Total Area 4**	**5,157**	**804**	**15.6%**	**666**	**12.9%**	**573**	**11.1%**		**0.0%**
5	60	Alabama Psychiatric Society	264	53	20.1%	46	17.4%	42	15.9%		0.0%
5	1	Arkansas Psychiatric Society	134	20	14.9%	14	10.4%	12	9.0%		0.0%
5	10	Florida Psychiatric Society	1,065	149	14.0%	120	11.3%	101	9.5%		0.0%
5	11	Georgia Psychiatric Physicians Association	664	114	17.2%	99	14.9%	80	12.0%		0.0%
5	18	Kentucky Psychiatric Association	318	57	17.9%	49	15.4%	42	13.2%		0.0%
5	19	Louisiana Psychiatric Medical Association	330	54	16.4%	48	14.5%	44	13.3%		0.0%
5	23	Mississippi Psychiatric Association, Inc	163	22	13.5%	16	9.8%	14	8.6%		0.0%
5	29	North Carolina Psychiatric Association	872	126	14.4%	90	10.3%	79	9.1%		0.0%
5	36	Oklahoma Psychiatric Association	222	35	15.8%	29	13.1%	25	11.3%		0.0%
5	70	Puerto Rico Psychiatric Society	107	21	19.6%	15	14.0%	14	13.1%		0.0%
5	42	South Carolina Psychiatric Association	359	70	19.5%	61	17.0%	51	14.2%		0.0%
5	45	Tennessee Psychiatric Association	346	59	17.1%	52	15.0%	48	13.9%		0.0%
5	46	Texas Society of Psychiatric Physicians*	1,210	138	11.4%	111	9.2%	96	7.9%		0.0%
5	77	Society of Uniformed Services Psychiatrists	295	55	18.6%	32	10.8%	31	10.5%		0.0%
5	47	Psychiatric Society of Virginia, Inc	649	91	14.0%	79	12.2%	66	10.2%		0.0%
5	54	West Virginia Psychiatric Association	169	28	16.6%	25	14.8%	18	10.7%		0.0%
5		**Total Area 5**	**7,167**	**1,092**	**15.2%**	**886**	**12.4%**	**763**	**10.6%**		**0.0%**
6	4	Central California Psychiatric Society	370	48	13.0%	35	9.5%	32	8.6%		0.0%
6	30	Northern California Psychiatric Society*	1,107	92	8.3%	70	6.3%	63	5.7%		0.0%
6	76	Orange County Psychiatric Society	260	40	15.4%	31	11.9%	24	9.2%		0.0%
6	64	San Diego Psychiatric Society	346	49	14.2%	42	12.1%	35	10.1%		0.0%
6	43	Southern California Psychiatric Society*	1,069	89	8.3%	77	7.2%	62	5.8%		0.0%
6		**Total Area 6**	**3,152**	**318**	**10.1%**	**255**	**8.1%**	**216**	**6.9%**		**0.0%**
7	71	Alaska District Branch	68	6	8.8%	6	8.8%	5	7.4%		0.0%
7	57	Arizona Psychiatric Society	381	48	12.6%	39	10.2%	36	9.4%		0.0%
7	6	Colorado Psychiatric Society	482	64	13.3%	51	10.6%	37	7.7%		0.0%
7	12	Hawaii Psychiatric Medical Association	173	26	15.0%	19	11.0%	15	8.7%		0.0%
7	15	Idaho Psychiatric Association	50	5	10.0%	4	8.0%	2	4.0%		0.0%
7	73	Montana Psychiatric Association	58	12	20.7%	7	12.1%	5	8.6%		0.0%
7	74	Nevada Psychiatric Association	129	18	14.0%	16	12.4%	12	9.3%		0.0%
7	67	Psychiatric Medical Association of New Mexico	162	29	17.9%	23	14.2%	21	13.0%		0.0%
7	58	Oregon Psychiatric Association*	415	58	14.0%	49	11.8%	43	10.4%		0.0%
7	61	Utah Psychiatric Association	165	25	15.2%	21	12.7%	19	11.5%		0.0%
7	33	Washington State Psychiatric Association	555	88	15.9%	77	13.9%	62	11.2%		0.0%
7	53	Western Canada District Branch	503	62	12.3%	50	9.9%	38	7.6%		0.0%
7	75	Wyoming Psychiatric Society	25	0	0.0%	0	0.0%	0	0.0%		0.0%
7		**Total Area 7**	**3,166**	**441**	**13.9%**	**362**	**11.4%**	**295**	**9.3%**		**0.0%**
		At-Large Members (excluding MS & Intl)	393	27	6.9%	23	5.9%	21	5.3%		0.0%
		Total District Branch Membership	31,343	4,600	14.7%	3,801	12.1%	3,177	10.1%		0.0%
		Total APA Membership (DB & At-Large Mbrs	**31,736**	**4,627**	**14.6%**	**3,824**	**12.0%**	**3,198**	10.1%		**0.0%**

Counts of Pending Drops (Mbrs Owing Dues) by Area and District Branch -- 2013 Dues Cycle

		*Non-Centralized Billing DBs -- Members owing only local dues noted below									
			Total Mbr Count 4/30/13	Non-CB DB Pending Drops 4/30/13	Non-CB DB Pending Drop % 4/30/13	Non-CB DB Pending Drops 5/31/13	Non-CB DB Pending Drop % 5/31/13	Non-CB DB Pending Drops 6/15/13	Non-CB DB Pending Drop % 6/15/13	Non-CB DB Final Drops 7/15/13	Non-CB DB Final Drop % 7/15/13
2	25	Greater Long Island Psychiatric Society*	574	21	3.7%	16	2.8%	13	2.3%		0.0%
3	20	Maryland Psychiatric Society, Inc*	696	25	3.6%	30	4.3%	4	0.6%		0.0%
6	30	Northern California Psychiatric Society*	1,107	317	28.6%	293	26.5%	243	22.0%		0.0%
7	58	Oregon Psychiatric Association*	415	38	9.2%	40	9.6%	36	8.7%		0.0%
6	43	Southern California Psychiatric Society*	1,069	74	6.9%	57	5.3%	49	4.6%		0.0%
5	46	Texas Society of Psychiatric Physicians*	1,209	100	8.3%	109	9.0%	81	6.7%		0.0%
		Total owing local dues only to Non-CB DBs		**575**		**545**		**426**		**0**	
		International Members									
		Lower Income	12	1	8.3%	1	8.3%	1	8.3%		0.0%
		Lower Middle Income	250	80	32.0%	53	21.2%	50	20.0%		0.0%
		Upper Middle Income	867	156	18.0%	113	13.0%	103	11.9%		0.0%
		Upper Income	495	154	31.1%	123	24.8%	113	22.8%		0.0%
		Total International Members/Fellows	**1,624**	**391**	**24.1%**	**290**	**17.9%**	**267**	**16.4%**	**0**	0.0%
		GRAND TOTAL	**33,360**	**5,593**		**4,659**		**3,891**		**0**	

DB/SA Grant Requests (Expedited - $2,500 per DB/SA)

DISTRICT BRANCH	CONTACT NAME	PROJECT TYPE	USE OF FUNDS
ALABAMA PSYCHIATRIC PHYSICIANS ASSOCIATION	JENNIFER HANCOCK	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
ARIZONA PSYCHIATRIC SOCIETY	TERI HARNISCH	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
ARKANSAS PSYCHIATRIC SOCIETY	BONNIE COOK	DSM-5	VENUE; A/V
COLORADO PSYCHIATRIC SOCIETY	LAURA MICHAELS	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
CONNECTICUT PSYCHIATRIC SOCIETY	JACKIE COLEMAN	DISASTER PSYCHIATRY TRAINING	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
FLORIDA PSYCHIATRIC SOCIETY	MARGO ADAMS/BONNIE TOOLE	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
GEORGIA PSYCHIATRIC PHYSICIANS ASSOCIATION	ANITA AMIN	DSM-5	A/V; PRINTING; TRAVEL/HONORARIA
HAWAII PSYCHIATRIC MEDICAL ASSOCIATION	REBEECCA CHAN	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
IDAHO PSYCHIATRIC ASSOCIATION	SHERI SASS	DSM-5	VENUE; PRINTING; TRAVEL/HONORARIA
INDIANA PSYCHIATRIC SOCIETY	SARA STRAMEL	DSM-5	PRINTING; TRAVEL/HONORARIA
KANSAS PSYCHIATRIC SOCIETY	STEVE KEARNEY	DSM-5	VENUE; PRINTING; TRAVEL/HONORARIA
KENTUCKY PSYCHIATRIC MEDICAL ASSOCIATION	BONNIE COOK	DSM-5	TRAVEL/HONORARIA
LOUISIANA PSYCHIATRIC MEDICAL ASSOCIATION	CATHY THOMPSON	DSM-5	VENUE
MARYLAND PSYCHIATRIC SOCIETY	MEAGAN FLOYD	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
MASSACHUSETTS PSYCIATRIC SOCIETY	BEV DUPUIS	DSM-5	A/V; PRINTING
MICHIGAN PSYCHIATRIC SOCIETY	KATHLEEN GROSS	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
MINNESOTA PSYCHIATRIC SOCIETY	LINDA VUKELICH	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
MISSISSIPPI PSYCHIATRIC ASSOCIATION	ANGELA LADNER	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
MISSOURI PSYCHIATRIC	JAMES FLEMING,	DSM-5	VENUE; A/V

DB/SA Grant Requests (Expedited - $2,500 per DB/SA)

ASSOCIATION	MD/SANDRA BOECKMAN		
NEW HAMPSHIRE PSYCHIATRIC SOCIETY	JEFFREY FETTER, MD/ JOY POTTER	CPT CODING	VENUE; PRINTING; TRAVEL/HONORARIA
NEW JERSEY PSYCHIATRIC ASSOCIATION	DEB WILSON	DSM-5	VENUE; PRINTING; TRAVEL/HONORARIA
NEW MEXICO, PSYCHIATRIC MEDICAL ASSOCIATION OF	GLORIA CHAVEZ	DSM-5	VENUE; A/V; PRINTING
OHIO PSYCHIATRIC PHYSICIANS ASSOCIATION	JANET SHAW	DSM-5	VENUE; PRINTING; TRAVEL/HONORARIA
OKLAHOMA PSYCHIATRIC PHYSICIANS ASSOCIATION	RENEE DAVENPORT MIXON	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
OREGON PSYCHIATRIC ASSOCIATION	AMY GOODALL	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
SOUTH CAROLINA PSYCHIATRIC ASSOCIATION	PAMELA TRAPP	DSM-5	VENUE; A/V; PRINTING
TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS	DEBBIE SUNDBERG	MOC	A/V; PRINTING; TRAVEL/HONORARIA
UNFORMED SERVICES, SOCIETY OF	WENDI WAITS, DO/DEB GREIGER	MISCEDUCATIONAL ACTIVITY-MILITARY REFERENCE BOOKLET	PRINTING
VERMONT PSYCHIATRIC ASSOCIATION	VALERIE LEWIS	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
VIRGINIA, PSYCHIATRIC SOCIETY OF	ANDREW MANN	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
WASHINGTON (DC) PSYCHIATRIC SOCIETY	PAT TROY	DSM-5	VENUE; A/V; PRINTING
WASHINGTON STATE PSYCHIATRIC ASSOCIATION	REBEECCA CHAN	DSM-5	VENUE; A/V
WEST VIRGINIA PSYCHIATRIC ASSOCIATION	BARBARA SAMPLES	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
WESTERN CANADA DISTRICT BRANCH	GABRIELLE LYNCH-STAUNTON	DSM-5	TRAVEL/HONORARIA
WISCONSIN PSYCHIATRIC SOCIETY	ERIC OSTERMANN	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
WYOMING ASSN OF PSYCH PHYSICIANS	SHEILA BUSH	DSM-5	VENUE; A/V; PRINTING

DB/SA Grant Requests (Expedited - $2,500 per DB/SA)

NEW YORK -AREA 2			
NEW YORK STATE PSYCHIATRIC ASSOCIATION	DONNA GAJDA	MISC. EDUCATIONAL ACTIVITY - I-STOP TRAININGS	PRINTING
BRONX DISTRICT BRANCH	YENER BALAN, MD	DSM-5	VENUE; PRINTING
BROOKLYN PSYCHIATRIC SOCIETY	LINDA M. MAJOWKA	DSM-5	VENUE; A/V; PRINTING
GREATER LONG ISLAND PSYCHIATRIC SOCIETY	JACKIE CAST	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
NY COUNTY DISTRICT BRANCH	PAULINA GOLDMAN/MEAGAN O'TOOLE	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
NYS CAPITAL DB	NANCY SYKES	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
QUEENS COUNTY PSYCHIATRIC SOCIETY	DANIEL CHEN/DEBBIE WESSELY	DSM-5	VENUE; A/V; PRINTING; TRAVEL/HONORARIA
WEST HUDSON PSYCHIATRIC SOCIETY	LIZ BURNICH	DSM-5	VENUE; A/V; PRINTING
WESTCHESTER COUNTY, PSYCHIATRIC SOCIETY OF	MEGAN ROGERS	DSM-5	VENUE; A/V
CALIFORNIA - AREA 6			
ORANGE COUNTY PSYCHIATRIC SOCIETY	JEFFREY C. GLASS, MD/HOLLY APPELBAUM	DSM-5	VENUE; A/V; PRINTING; REFRESHMENTS
SAN DIEGO PSYCHIATRIC SOCIETY	STEVE KOH, MD/ JANELLE KISTLER	DSM-5	TRAVEL/HONORARIA
SOUTHERN CALIFORNIA PSYCHIATRIC SOCIETY	MINDI THELEN	DSM-5	VENUE; A/V

Total 48 Requests at $2,500 per DB/SA = $120K

Resignations
March 1, 2013 - May 31, 2013

Member #	Name	Member Class	DB # and Name	Reason
33763	Abichandani, Chandrap	Life Member	DB40 Queens County	Not Provided
81240	Ahmed, Nadeem	General Member	DB38 Pennsylvania	Not Provided
57708	Baker, Robert	Distinguished Fellow	DB14 Indiana	Not Provided
60536	Burk, Judy	Distinguished Fellow	DB62 Maine	Economic reasons
1004140	Chargualaf, Jullyn	General Member	DB43 Southern California	Not Provided
35101	Chelf, John	General Member	DB36 Oklahoma	Not Provided
30926	Chun, Yang	Life Member	DB13 Illinois	Not Provided
20456	Collins, Allen	Distinguished Life Fellow	DB27 New York County	Not Provided
34581	Daugherty, David	Life Member	DB22 Minnesota	Not Provided
1004049	Dedesma, Ronit	General Member	DB32 Massachusetts	Not Provided
80611	Dogot, Marianna	General Member	DB25 Greater Long Island	Not Provided
34252	Ersay, Ronald	Life Member	DB10 Florida	Retired
1016100	Eshraghi, Saeed	Member-in-Training	DB43 Southern California	Not Provided
29483	Freedenburg, Daniel	Life Member	DB20 Maryland	Not Provided
15230	Gardner, Russell	Distinguished Life Fellow	DB52 Wisconsin	Not Provided
32495	Geoghegan, Robert	Life Member	DB43 Southern California	Not Provided
102092	Gill, Harwant	General Member	DB48 Washington	Philosophical
33640	Griffin, Adrian	Life Member	DB29 North Carolina	Retired
310225	Kay, Abigail	General Member	DB38 Pennsylvania	Not Provided
1099380	Klaassen, Joyce	International Member	International	Not Provided
44173	Kotha, Aranjyothi	Life Member	DB59 Northern New York	Not Provided
1005081	Krasnova, Margarita	General Member	DB43 Southern California	Not Provided
8744	Lancaster, Howard	Life Member	DB46 Texas	Other
301690	Lavrentiadis, Grigoris	International Member	International	Not Provided
61579	Lim, Sook	General Member	DB40 Queens County	Not Provided
33735	Little, Michael	General Member	DB04 Central California	Retired
90109	Marcin, Michael	General Member	DB30 Northern California	Not Provided
19149	Massie, Henry	Life Member	DB30 Northern California	Retired
63851	Meier, Helen	General Member	DB37 Ontario	Economic reasons
1001374	Patel, Surendra	General Member	DB37 Ontario	Not Provided
10311	Pope, David	Life Fellow	DB48 Washington	Not Provided
83254	Prokhorova, Maria	General Member	DB58 Oregon	Not Provided
12442	Rablen, Elizabeth	Life Member	DB07 Connecticut	Retired
90322	Satpathy, Satyajit	General Member	DB46 Texas	Not Provided
1095925	Schmitz-Kooij, Saskia	International Member	International	Other
1002096	Schols, Diederik	International Member	International	Other
29028	Schwab, Donald	Life Fellow	DB24 Mid-Hudson	Not Provided
8284	Selzer, Melvin	Distinguished Life Fellow	DB64 San Diego	Retired
31984	Simes, E	Life Member	DB73 Montana	Not Provided
44920	Soheil, Harriet	Life Member	DB48 Washington	Not Provided
1000670	Stein, Emily	General Member	DB43 Southern California	Dues too high
305368	Trachtenberg, Susanne	General Member	Member-at-Large	Not Provided

Resignations
March 1, 2013 - May 31, 2013

43158	Walker, Edwin	General Member	DB35 Ohio	Not Provided
307148	Wallman, Kimberly	General Member	DB21 Michigan	Not Provided
72894	Williams, Sarah	General Member	DB27 New York County	Not Provided
28838	Yeu, Hokun	Life Member	DB49 Westchester County	Not Provided
41205	Zetley, Linda	General Member	DB52 Wisconsin	Not Provided

n= 47

Dropping Members
Membership Terminated by APA (Off Cycle)

Member #	Name	Member Class	DB # and Name	Reason
1007517	Gladden, Jamie Lynne	General Member	DB35 Ohio	No current valid license

n = 1

Mbr Id	Name	Member Category	DB #	DB Name
000001082394	Lyndsey Burnett MD	Member-in-Training	1	Arkansas Psychiatric Society
000000073654	Donald Gene Clay MD	General Member	1	Arkansas Psychiatric Society
000000080713	Ali M Hashmi M.D.	Fellow	1	Arkansas Psychiatric Society
000001054538	Tiffany N Mattingly MD	Member-in-Training	1	Arkansas Psychiatric Society
000001006719	Dorothee S Mecum MD	Member-in-Training	1	Arkansas Psychiatric Society
000001002580	James R Parks MD	General Member	1	Arkansas Psychiatric Society
000000063928	Jon Carl Rubenow DO	General Member	1	Arkansas Psychiatric Society
000001005300	Shane E Sparks MD	General Member	1	Arkansas Psychiatric Society
000001000056	Jeremy R Thompson MD	General Member	1	Arkansas Psychiatric Society
000001087202	Lindsey A Wilbanks MD	Member-in-Training	1	Arkansas Psychiatric Society
000000311569	Katherine W Yarnell MD	General Member	1	Arkansas Psychiatric Society
000001051647	Michael Kofi Adusei MD	Member-in-Training	2	Bronx District Branch
000001061559	Carmen E Casasnovas MD	Member-in-Training	2	Bronx District Branch
000001102310	Jaimini Chauhan-James MD	Member-in-Training	2	Bronx District Branch
000001000992	Helen Y Choi MD	General Member	2	Bronx District Branch
000001071577	Felicia DeJesus MD	Member-in-Training	2	Bronx District Branch
000000305890	Mohamed H Eldefrawi MD	General Member	2	Bronx District Branch
000000028370	Howard David Isaacs M.D.	Life Member	2	Bronx District Branch
000000063076	Anthony Thomas Lanotte MD	General Member	2	Bronx District Branch
000001061560	Aracelis J Lu MD	Member-in-Training	2	Bronx District Branch
000001102714	Hilda Mascaro MD	General Member	2	Bronx District Branch
000001004287	Ingrid L Montgomery MD	Member-in-Training	2	Bronx District Branch
000001113943	Mariel Paralitici Morales MD	General Member	2	Bronx District Branch
000000072056	Thomas S Portzline MD	General Member	2	Bronx District Branch
000001051926	Miri Rosen MD	Member-in-Training	2	Bronx District Branch
000001110404	Samuel Shapiro MD	General Member	2	Bronx District Branch
000000044735	Jonathan I Zach MD PhD	General Member	2	Bronx District Branch
000001098849	Rashi Agarwal MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000000073562	Willy Alexis MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000305517	Katherine M Bradshaw M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000000041243	Joe Cephus Brewster MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000043658	Georges Jean Casimir M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000000079447	Kina C Cliette M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000000053878	Edmund V Cyvas M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000000071805	Joseph W Decatus M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000001102403	Selma Demir MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001000887	Janine E Eisman MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001007322	Markos D Emmanouel MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001081061	Suzanne K Eschenbach MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001017628	Hassan Fathy MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000000057868	Sidney Fein M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000001037320	Zorica Filipovic-Jewell MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000033773	William Anthony Florio MD	Life Member	3	Brooklyn Psychiatric Society, Inc
000000306517	Elchin Gajiev DO	General Member	3	Brooklyn Psychiatric Society, Inc
000001040338	Alexandru Gaman MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001087248	Rishi Gautam MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001015998	Sandeep K Gude MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001017404	Swapnil Gupta MBBS MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000000045835	Pierre A Jean-Noel M.D.	Fellow	3	Brooklyn Psychiatric Society, Inc

000001036570	Rushaniya Albertovna Khairova MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001110626	Irina Kiblitsky MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000305053	Sander Koyfman M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000001000611	Ritesha S Krishnappa MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001010167	Myo W Kyaw MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000073847	Maren L Langer M.D.	General Member	3	Brooklyn Psychiatric Society, Inc
000001053651	Tamar Debora Lavy MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000000086419	Charles C Lee MD	General Member	3	Brooklyn Psychiatric Society, Inc
000000060034	Samuel Harold Lustgarten MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001081011	Anup Mani DO	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001005230	Sukriti Mittal MBBS MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001109690	Neel Nene MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000000305452	Carolina D. Nisenoff MD	General Member	3	Brooklyn Psychiatric Society, Inc
000001012825	Rachel Harden Noone MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
000001053413	Kelechi O Ogbonna MD	Member-in-Training	3	Brooklyn Psychiatric Society, Inc
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000001009398	Erin Zerbo MD	General Member	26	New Jersey Psychiatric Association
000001021171	Aphrodite Marta Zimmerman MD	General Member	26	New Jersey Psychiatric Association

000000066492	Alexander S Zwil M.D.	General Member	26	New Jersey Psychiatric Association
000001017359	Nancy Ramzy Abdelmalak MD	Member-in-Training	27	New York County District Branch
000001077824	Joshua R Ackerman MD	Member-in-Training	27	New York County District Branch
000001077826	Oyedolapo O Adeaga MD	Member-in-Training	27	New York County District Branch
000000089812	Asher D Aladjem M.D.	General Member	27	New York County District Branch
000001094683	Maria Alikakos DO	Member-in-Training	27	New York County District Branch
000001005992	Mark R Allen MD	Member-in-Training	27	New York County District Branch
000001079855	Yadira Alonso MD	Member-in-Training	27	New York County District Branch
000001091185	Ashish Anand MD	General Member	27	New York County District Branch
000001107365	Cara Angelotta MD	Member-in-Training	27	New York County District Branch
000000037232	Ricardo E Arango M.D.	Fellow	27	New York County District Branch
000001043577	Nauman Ashraf MD	Member-in-Training	27	New York County District Branch
000001080787	Yasemin Baldik MD	Member-in-Training	27	New York County District Branch
000001096503	Julio Ballestas MD	Member-in-Training	27	New York County District Branch
000001004842	Arkady Barenboim MD	General Member	27	New York County District Branch
000000072642	Juan Jose Baturone M.D.	General Member	27	New York County District Branch
000000302388	Rachel N Becker M.D.	Fellow	27	New York County District Branch
000000072623	Bruce F Beeferman M.D.	General Member	27	New York County District Branch
000000032654	Antonio U Beltramini M.D.	Life Member	27	New York County District Branch
000001004466	Nikole S Benders-Hadi MD	General Member	27	New York County District Branch
000000020948	Dirk Marc Berger MD	Life Fellow	27	New York County District Branch
000000087006	Joshua A Berman MD PhD	General Member	27	New York County District Branch
000001017688	Silvia Bernardi MD	Member-in-Training	27	New York County District Branch
000001051236	Will C Berry MD	Member-in-Training	27	New York County District Branch
000000043642	Linda Margret Bierer MD	General Member	27	New York County District Branch
000001006148	Caroline A Blackman MD	General Member	27	New York County District Branch
000000092082	Mark V Bradley M.D.	General Member	27	New York County District Branch
000000311296	Yanina Brayman MD	General Member	27	New York County District Branch
000001078875	Richard A Callahan II MD	Member-in-Training	27	New York County District Branch
000000103284	Sarah A Caraisco MD	General Member	27	New York County District Branch
000000034342	Christina Brock Casals-Ariet MD	Life Member	27	New York County District Branch
000001099122	Jang Eun Cho MD	Member-in-Training	27	New York County District Branch
000001078872	Vicky Chodha MD	Member-in-Training	27	New York County District Branch
000000306728	Natasha H Chriss MD	General Member	27	New York County District Branch
000001016066	Daniel R Cohen MD	Member-in-Training	27	New York County District Branch
000000034633	Sandra Kopit Cohen M.D.	General Member	27	New York County District Branch
000000305002	Tiziano Colibazzi M.D.	General Member	27	New York County District Branch
000001089091	Erika Concepcion MD	Member-in-Training	27	New York County District Branch
000000310375	Christopher A Conti MD	General Member	27	New York County District Branch
000000053846	Cheryl Henrietta Cottrol M.D.	General Member	27	New York County District Branch
000000069212	Laura Jane Dalheim MD	General Member	27	New York County District Branch
000000306704	Eileen DiFrancesco M.D.	General Member	27	New York County District Branch
000001002685	Victoria Catherine Dinsell MD	General Member	27	New York County District Branch
000000313215	Narveen Dosanjh MD	General Member	27	New York County District Branch
000000086856	Trecia M Doyle M.D.	General Member	27	New York County District Branch
000001043518	David B Edgcomb MD	General Member	27	New York County District Branch
000001097531	Sean Escola MD	Member-in-Training	27	New York County District Branch
000001102809	Elizabeth Evans MD	Member-in-Training	27	New York County District Branch
000001018230	Mia S Everett MD	Member-in-Training	27	New York County District Branch
000000073726	Elizabeth E Feigelson M.D.	General Member	27	New York County District Branch

000000312489	Veronica H Fellman DO	Member-in-Training	27	New York County District Branch
000000032975	Abby Joy Fyer MD	Life Member	27	New York County District Branch
000001015851	Christopher K Gaffney MD	Member-in-Training	27	New York County District Branch
000001008483	Lison Gagne MD	General Member	27	New York County District Branch
000001000348	Sarah E Gleacher MD	General Member	27	New York County District Branch
000000044253	Khema Goldburt MD	Life Member	27	New York County District Branch
000000311904	Ellen Goldstein MD	General Member	27	New York County District Branch
000000024785	Alan Lee Gordon M.D.	Life Member	27	New York County District Branch
000000090748	Joshua A Gordon MD PhD	General Member	27	New York County District Branch
000000086766	Luz Amelia Green MD	General Member	27	New York County District Branch
000000021740	Peter H Gruen M.D.	Distinguished Life Fellow	27	New York County District Branch
000001101696	Abha Gupta MD	Member-in-Training	27	New York County District Branch
000000078082	Elizabeth Haase M.D.	Fellow	27	New York County District Branch
000000310341	Sally M Habib MD	General Member	27	New York County District Branch
000001005296	Sidney H Hankerson MD MBA	General Member	27	New York County District Branch
000000306277	Abigail J Herron DO	General Member	27	New York County District Branch
000000033310	Isaac Steven Herschkopf M.D.	Life Member	27	New York County District Branch
000001000872	Christopher C Holden MD	General Member	27	New York County District Branch
000001016325	Patrick C Hou MD MPH	Member-in-Training	27	New York County District Branch
000000312612	Lucy A. Hutner MD	General Member	27	New York County District Branch
000001012812	Toai T Huynh MD	Member-in-Training	27	New York County District Branch
000001016017	Olivia Joly MD	General Member	27	New York County District Branch
000001077823	Jenny Joseph MD	Member-in-Training	27	New York County District Branch
000001038636	Judith Fiona Joseph MD	Member-in-Training	27	New York County District Branch
000001077828	Peter P Kakatsos MD	Member-in-Training	27	New York County District Branch
000000039466	Vladimir Kasnar M.D.	General Member	27	New York County District Branch
000001004647	Gabriel G Katz MD	General Member	27	New York County District Branch
000001006371	Laura K Kent MD	General Member	27	New York County District Branch
000001042627	Michael A Ketteringham MD MPH	General Member	27	New York County District Branch
000001078870	Nida Khan MD	Member-in-Training	27	New York County District Branch
000001100770	Aruna Khilanani MD	Member-in-Training	27	New York County District Branch
000001019709	Esther Kim MD	Member-in-Training	27	New York County District Branch
000000306985	Patti S Klein DO	General Member	27	New York County District Branch
000001015089	Noam Yeshaya Koenigsberg MD	Member-in-Training	27	New York County District Branch
000000035237	Jeffrey Michael Koffler M.D.	Life Fellow	27	New York County District Branch
000000082878	Zeev Kogen M.D.	General Member	27	New York County District Branch
000001017866	Andrew Michael Kopelman MD	General Member	27	New York County District Branch
000001001538	Jennifer L Kraker MD	General Member	27	New York County District Branch
000001102133	Sara Michelle Lane MD	Member-in-Training	27	New York County District Branch
000001012880	Kyle A. Blumberg Lapidus MD PhD	Member-in-Training	27	New York County District Branch
000001013882	Sonya Lazarevic MD	Member-in-Training	27	New York County District Branch
000001077827	Margara A Lecca MD	Member-in-Training	27	New York County District Branch
000001098611	Eric Jaewon Lee MD	Member-in-Training	27	New York County District Branch
000000305858	Amir Levine M.D.	General Member	27	New York County District Branch
000000021163	David H Lifschutz M.D.	Life Member	27	New York County District Branch
000001039815	Conor Liston MD PhD	General Member	27	New York County District Branch
000001011261	Vicente J Liz Defillo II MD	General Member	27	New York County District Branch
000000075046	Paulina S Loo M.D.	General Member	27	New York County District Branch
000001055078	Sara Lozyniak MD	Member-in-Training	27	New York County District Branch
000000301774	Kishor Malavade MD	General Member	27	New York County District Branch

000001017437	Rehan A Malik MD	Member-in-Training	27	New York County District Branch
000000055493	Manuel G Marinas M.D.	General Member	27	New York County District Branch
000001000126	Omanamhe E Masagbor MD	General Member	27	New York County District Branch
000001077829	Jaisha Mathew MD	Member-in-Training	27	New York County District Branch
000000078091	Laurel Mayer M.D.	General Member	27	New York County District Branch
000001006172	Littal Melnik MD	General Member	27	New York County District Branch
000000311030	Maria Cristina N Mendoza MD	General Member	27	New York County District Branch
000000312844	Michael L Mentari M.D.	General Member	27	New York County District Branch
000001064718	Marissa Fishbeck Miyazak MD	Member-in-Training	27	New York County District Branch
000001015977	Joshua Morris MD	General Member	27	New York County District Branch
000000307987	Lauren B Morris DO	General Member	27	New York County District Branch
000000312690	Lindsay J Moskowitz MD	General Member	27	New York County District Branch
000001013804	Louise M Mullan MD	General Member	27	New York County District Branch
000001017441	Jyotsna Muttineni MD MS	Member-in-Training	27	New York County District Branch
000001000974	Niru S Nahar MD	General Member	27	New York County District Branch
000001078883	John J Naliyath MD	Member-in-Training	27	New York County District Branch
000001078871	Sreenath Nekkalapu MD	Member-in-Training	27	New York County District Branch
000001004554	Shawna Newman MD	General Member	27	New York County District Branch
000000072586	Adriana J Notarfrancesco M.D.	General Member	27	New York County District Branch
000001004117	Melissa Ozga DO	General Member	27	New York County District Branch
000001068915	Vishal Patel MD	General Member	27	New York County District Branch
000000027068	Sherman S Pazner M.D.	Life Member	27	New York County District Branch
000000072048	David Perez-Martinez M.D.	General Member	27	New York County District Branch
000001054374	Angeliki Pesiridou MD	Member-in-Training	27	New York County District Branch
000001051225	Sara E Popkin MD	Member-in-Training	27	New York County District Branch
000001008212	Lukshmi K Puttanniah MD	General Member	27	New York County District Branch
000000311182	Akm Quyyum MD	General Member	27	New York County District Branch
000000045527	Dov Rapoport M.D.	General Member	27	New York County District Branch
000001016701	Erica Kirsten Rapp MD	Member-in-Training	27	New York County District Branch
000001008889	Jeffrey A Reynante MD	General Member	27	New York County District Branch
000000067898	Juan L Riestra-Cortes M.D.	General Member	27	New York County District Branch
000001003976	Luis H Ripoll MD	General Member	27	New York County District Branch
000001011515	Lee A Robinson MD	Member-in-Training	27	New York County District Branch
000000078149	Victor B Rodack M.D.	General Member	27	New York County District Branch
000000058319	Kenneth Rosenberg MD	Distinguished Fellow	27	New York County District Branch
000001004168	Mark Rybakov DO	General Member	27	New York County District Branch
000001096636	Annaheta Salajegheh MD	Member-in-Training	27	New York County District Branch
000000085798	A Alberto Sanchez MD	General Member	27	New York County District Branch
000000310122	Pablo Sanchez-Barranco MD	General Member	27	New York County District Branch
000000038927	Rodolfo Santos Sandin M.D.	Life Member	27	New York County District Branch
000000067181	Mary Spelman Sciutto M.D.	General Member	27	New York County District Branch
000001079569	Olusola T Segun MD	Member-in-Training	27	New York County District Branch
000001016795	Amy Shehata MD	Member-in-Training	27	New York County District Branch
000000090504	David M Sherman M.D.	General Member	27	New York County District Branch
000000056780	Alice Jo Siegel M.D.	General Member	27	New York County District Branch
000000088856	Healy G Smith MD	General Member	27	New York County District Branch
000000306502	Scott M Soloway MD	General Member	27	New York County District Branch
000000062624	Sheri Ellen Spirt M.D.	General Member	27	New York County District Branch
000001004156	Cora Johnson Stabile MD	General Member	27	New York County District Branch
000000076105	Svetlana Starkman M.D.	General Member	27	New York County District Branch

000000071117	Alan I Stearns MD	General Member	27	New York County District Branch
000001002315	Emily N Steinberg MD	General Member	27	New York County District Branch
000000304542	Jennifer Cooper Stelwagon MD	General Member	27	New York County District Branch
000000042020	Anne Stockton M.D.	General Member	27	New York County District Branch
000001014475	Nicholas Taintor MD	General Member	27	New York County District Branch
000001053316	Jamuna Theventhiran MD	General Member	27	New York County District Branch
000000058439	Valery Tolchinsky MD	Life Member	27	New York County District Branch
000000069336	William Craig Tomlinson M.D.	General Member	27	New York County District Branch
000000057130	Manuel Trujillo M.D.	Life Member	27	New York County District Branch
000000310414	Pauline Tsai MD	General Member	27	New York County District Branch
000001006829	May Tsui MD	General Member	27	New York County District Branch
000001050542	Ramakrishna R Veluri MD	Member-in-Training	27	New York County District Branch
000001007763	Matias A Verna MD	General Member	27	New York County District Branch
000001078884	James Wallace MD	Member-in-Training	27	New York County District Branch
000000072222	Adella T Wasserstein M.D.	General Member	27	New York County District Branch
000000311342	Khadijah B Watkins MD	General Member	27	New York County District Branch
000000066461	Ilona Wiener M.D.	General Member	27	New York County District Branch
000001007983	William Ross Winter MD	General Member	27	New York County District Branch
000000305720	Kathleen Marie Young MD	General Member	27	New York County District Branch
000000311574	Anna Yusim MD	General Member	27	New York County District Branch
000000312501	Benjamin D Zebley MD	Member-in-Training	27	New York County District Branch
000001000331	Matthew David Zimmerman MD	General Member	27	New York County District Branch
000001078873	Aleksandr Zverinskiy MD	Member-in-Training	27	New York County District Branch
000001013743	Aparna Rama Iyer MD	General Member	28	New York State Capital District Branch
000000032771	Koock Elan Jung MD	Life Member	28	New York State Capital District Branch
000000079463	Laurie M Nadal MD	General Member	28	New York State Capital District Branch
000000058281	Steven Rappaport M.D.	General Member	28	New York State Capital District Branch
000000085531	Craig S Walike M.D.	General Member	28	New York State Capital District Branch
000000303315	Julie Lynn Adams MD	General Member	29	North Carolina Psychiatric Association
000001006804	Danielle F Adegoroye MD	General Member	29	North Carolina Psychiatric Association
000000040938	Edward Stanley Benfield MD	General Member	29	North Carolina Psychiatric Association
000000312769	Kimberly W Bennett MD MPH	General Member	29	North Carolina Psychiatric Association
000000057725	Birger Steven Bentsen M.D.	Distinguished Fellow	29	North Carolina Psychiatric Association
000000302831	Charles T Browning M.D.	General Member	29	North Carolina Psychiatric Association
000000065497	Julia Wilkerson Burns MD	General Member	29	North Carolina Psychiatric Association
000001007997	Nadia E Charguia MD	General Member	29	North Carolina Psychiatric Association
000000310984	Craig TM Chepke MD	General Member	29	North Carolina Psychiatric Association
000000085114	Eric J Christopher MD	Fellow	29	North Carolina Psychiatric Association
000001013474	Craig A Cook MD	General Member	29	North Carolina Psychiatric Association
000000072978	Richard E D'Alli MD	Distinguished Fellow	29	North Carolina Psychiatric Association
000001098858	Saramma Eappen MD	Member-in-Training	29	North Carolina Psychiatric Association
000000303520	Joumana H El Safy MD	General Member	29	North Carolina Psychiatric Association
000001101817	Sherita Faulcon MD	General Member	29	North Carolina Psychiatric Association
000000064114	Richard Allen Fellman M.D.	General Member	29	North Carolina Psychiatric Association
000000036157	A Kwasi Foluke M.D.	General Member	29	North Carolina Psychiatric Association
000000066599	Bradley Neil Gaynes MD	Distinguished Fellow	29	North Carolina Psychiatric Association
000000307635	Edith M Gettes M.D.	General Member	29	North Carolina Psychiatric Association
000000311091	Predrag V Gligorovic M.D.	General Member	29	North Carolina Psychiatric Association
000000301916	Charin L Hanlon M.D.	General Member	29	North Carolina Psychiatric Association
000000045301	Anne Lowrey Hendricks M.D.	General Member	29	North Carolina Psychiatric Association

000000063740	Joseph Patrick Horrigan M.D.	Fellow	29	North Carolina Psychiatric Association
000000071136	Kenneth Glenn Kallenbach MD	General Member	29	North Carolina Psychiatric Association
000000311285	Micah H Krempasky MD	General Member	29	North Carolina Psychiatric Association
000000087468	Archana Kumar M.D.	General Member	29	North Carolina Psychiatric Association
000000300807	Alyson R Kuroski-Mazzei DO	General Member	29	North Carolina Psychiatric Association
000001013790	Kevin Michael Lamm MD	General Member	29	North Carolina Psychiatric Association
000000089065	Eric J Lespes MD	General Member	29	North Carolina Psychiatric Association
000001008065	Dayna Terese Lobraico MD	General Member	29	North Carolina Psychiatric Association
000000060817	Brian Kenneth Long M.D.	General Member	29	North Carolina Psychiatric Association
000000042458	Martha Anne Mc Knight M.D.	General Member	29	North Carolina Psychiatric Association
000001115712	Monica Anne McGill MD	General Member	29	North Carolina Psychiatric Association
000000304028	David E Miller M.D. Ph.D.	General Member	29	North Carolina Psychiatric Association
000001006746	Ethan J Musgrave MD	General Member	29	North Carolina Psychiatric Association
000001053311	Herman Aronov Naftel MD	Member-in-Training	29	North Carolina Psychiatric Association
000001016792	Elizabeth Smith Nicholson MD	Member-in-Training	29	North Carolina Psychiatric Association
000001004897	Eliza M Park MD	General Member	29	North Carolina Psychiatric Association
000001059621	Jay Patel MD	Member-in-Training	29	North Carolina Psychiatric Association
000000304690	Jirpesh R Patel M.D.	General Member	29	North Carolina Psychiatric Association
000000044286	Roger S Perilstein M.D.	Distinguished Fellow	29	North Carolina Psychiatric Association
000000028328	Ernest A Raba MD	Life Member	29	North Carolina Psychiatric Association
000000090223	Mizanur Rahman M.D.	Fellow	29	North Carolina Psychiatric Association
000000077079	Lawrence M Raines III MD	General Member	29	North Carolina Psychiatric Association
000000077093	Gardy J Rigaud M.D.	General Member	29	North Carolina Psychiatric Association
000000305737	Brian V Robbins M.D.	General Member	29	North Carolina Psychiatric Association
000001023468	Brittany P Rodgers MD	Member-in-Training	29	North Carolina Psychiatric Association
000001019000	Catherine Koontz Rogers MD	Member-in-Training	29	North Carolina Psychiatric Association
000001098981	Reshmi Saranga MD	General Member	29	North Carolina Psychiatric Association
000001000255	Vinay P Saranga MD	General Member	29	North Carolina Psychiatric Association
000000305811	Binoy J Shah M.D.	General Member	29	North Carolina Psychiatric Association
000000066314	Brian Barry Sheitman M.D.	General Member	29	North Carolina Psychiatric Association
000000045539	Thomas Edwin Sibert MD	General Member	29	North Carolina Psychiatric Association
000000304350	Ana Carla P Smith M.D.	General Member	29	North Carolina Psychiatric Association
000000074334	Shelley M Sneed M.D.	General Member	29	North Carolina Psychiatric Association
000001013522	Alexandra Lynn Spessot MD	General Member	29	North Carolina Psychiatric Association
000000033658	Marshall Jay Stein M.D.	Life Member	29	North Carolina Psychiatric Association
000000064743	Rebecca Suzanne Valla M.D.	General Member	29	North Carolina Psychiatric Association
000000070873	Susan Van Meter MD	General Member	29	North Carolina Psychiatric Association
000000042463	Ronald Lloyd Vereen M.D.	General Member	29	North Carolina Psychiatric Association
000001017514	Gerhardt Stefan Wagner MD PhD	General Member	29	North Carolina Psychiatric Association
000000068549	Douglas Alan Waldrep M.D.	Fellow	29	North Carolina Psychiatric Association
000000086835	Barry C Weed M.D.	General Member	29	North Carolina Psychiatric Association
000001013486	Gregory M Weiss MD	General Member	29	North Carolina Psychiatric Association
000000070322	James S Williford M.D.	General Member	29	North Carolina Psychiatric Association
000000087839	Joanna Wolicki-Shannon M.D.	General Member	29	North Carolina Psychiatric Association
000000307732	Nagy A Youssef MD	General Member	29	North Carolina Psychiatric Association
000000301144	Alexandr Zouev MD	General Member	29	North Carolina Psychiatric Association
000001086709	Svetlana Zoueva MD	General Member	29	North Carolina Psychiatric Association
000000301415	Kimberly Kai Arden MD	General Member	30	Northern California Psychiatric Society
000001013555	Usa Aroonlap MD	General Member	30	Northern California Psychiatric Society
000001001119	Jason C Bermak MD PhD	General Member	30	Northern California Psychiatric Society

000000088754	Shree L Bhaskar M.D.	General Member	30	Northern California Psychiatric Society
000000311192	Nancy M Bivens MD PhD	General Member	30	Northern California Psychiatric Society
000001077947	Matthew James Brockwell MD	Member-in-Training	30	Northern California Psychiatric Society
000000305233	Jason T Bromley M.D.	General Member	30	Northern California Psychiatric Society
000000087237	Thu A Bui MD	General Member	30	Northern California Psychiatric Society
000000303966	Sarah E Carey MD	General Member	30	Northern California Psychiatric Society
000000311476	Monica Tierney Caselli MD	General Member	30	Northern California Psychiatric Society
000001098610	Mekhala Chandra MD	Member-in-Training	30	Northern California Psychiatric Society
000001007042	Jasen Andrew Christensen	General Member	30	Northern California Psychiatric Society
000000036098	Joan Elizabeth Cloutier M.D.	Life Member	30	Northern California Psychiatric Society
000000308238	Christopher T Daley MD	General Member	30	Northern California Psychiatric Society
000000083539	Martin M Deasy M.D.	General Member	30	Northern California Psychiatric Society
000000057852	Wendy Ann Eberhardt M.D.	General Member	30	Northern California Psychiatric Society
000001104900	Hetty Beth Eisenberg MD MPH	Member-in-Training	30	Northern California Psychiatric Society
000000071823	Suzhanna M Elam MD	General Member	30	Northern California Psychiatric Society
000000312708	Cindy Elliott MD	General Member	30	Northern California Psychiatric Society
000000312707	Joshua G Elliott MD	General Member	30	Northern California Psychiatric Society
000001059408	Nima Fayazmanesh MD	Member-in-Training	30	Northern California Psychiatric Society
000001001732	Krista T Fielding MD	General Member	30	Northern California Psychiatric Society
000001006307	Elizabeth Gebis MD	General Member	30	Northern California Psychiatric Society
000000036015	Michael German M.D.	Life Member	30	Northern California Psychiatric Society
000000085109	Sukhmani K Gill M.D.	Fellow	30	Northern California Psychiatric Society
000000306206	Suma F Gona M.D.	General Member	30	Northern California Psychiatric Society
000001042138	Abilash Ananth Gopal MD	Member-in-Training	30	Northern California Psychiatric Society
000000083634	Jeffrey L Gould M.D.	General Member	30	Northern California Psychiatric Society
000000084091	Alexander Grinberg M.D.	General Member	30	Northern California Psychiatric Society
000000084094	Jennifer C Hoblyn MD MPH	General Member	30	Northern California Psychiatric Society
000001134554	Josephine Howard MD	General Member	30	Northern California Psychiatric Society
000001096398	Brandon Shigeru Ito MD	Member-in-Training	30	Northern California Psychiatric Society
000000305197	Uma Lerner MD	General Member	30	Northern California Psychiatric Society
000001001518	Naomi E Leslie MD	General Member	30	Northern California Psychiatric Society
000000089446	Edward Mina Lim MD	General Member	30	Northern California Psychiatric Society
000000311390	Gerardo B Manansala M.D.	General Member	30	Northern California Psychiatric Society
000001008617	Karen Theresia Marcus MD	General Member	30	Northern California Psychiatric Society
000001080096	Jennifer M McQuade MD	Member-in-Training	30	Northern California Psychiatric Society
000001099596	Erica Louise Mitchell MD	Member-in-Training	30	Northern California Psychiatric Society
000001008555	Anna Victoria Rotberg Molofsky MD PhD	Member-in-Training	30	Northern California Psychiatric Society
000000057535	Diane Mosbacher MD PhD	General Member	30	Northern California Psychiatric Society
000000028182	Dennis M O'Connor MD	Life Member	30	Northern California Psychiatric Society
000000088338	Lena Osher M.D.	General Member	30	Northern California Psychiatric Society
000000066169	David Roger Pating M.D.	General Member	30	Northern California Psychiatric Society
000000027979	Ruth Rosenblum M.D.	Life Member	30	Northern California Psychiatric Society
000000018672	Franklin A Rumore MD	Life Member	30	Northern California Psychiatric Society
000001002062	Sarah C Ryan MD MS	General Member	30	Northern California Psychiatric Society
000001004981	Erik B Sandegard MD	General Member	30	Northern California Psychiatric Society
000000066710	Hebe E. Schultz MD	General Member	30	Northern California Psychiatric Society
000001005871	James R Shackelford MD	General Member	30	Northern California Psychiatric Society
000001071913	Sweta Shah MD	General Member	30	Northern California Psychiatric Society
000000060946	Nathan H Thuma M.D.	General Member	30	Northern California Psychiatric Society
000000068784	Diane Rose Tomar MD	General Member	30	Northern California Psychiatric Society

000000044086	Barbara Ann Vignola MD	General Member	30	Northern California Psychiatric Society
000001011600	Jeremy M Wilkinson MD	General Member	30	Northern California Psychiatric Society
000000020312	Hugh R Winig M.D.	Distinguished Life Fellow	30	Northern California Psychiatric Society
000000074141	Roger M Y Wu M.D.	General Member	30	Northern California Psychiatric Society
000000104484	Sarah Yasmin MD	General Member	30	Northern California Psychiatric Society
000000026676	Robert Louis Yoerg M.D.	Life Member	30	Northern California Psychiatric Society
000001079587	Oluranti Adepoju MD	General Member	32	Massachusetts Psychiatric Society
000000308395	Hans R Agrawal M.D.	General Member	32	Massachusetts Psychiatric Society
000000311438	Bibi Alamiri MD	General Member	32	Massachusetts Psychiatric Society
000000067160	Mark Joseph Albanese M.D.	Fellow	32	Massachusetts Psychiatric Society
000001017850	Carlos M Alverio-Pares MD	General Member	32	Massachusetts Psychiatric Society
000001080421	Jacqueline R Arenz MD	Member-in-Training	32	Massachusetts Psychiatric Society
000001092354	Husnain Ashraf MD	Member-in-Training	32	Massachusetts Psychiatric Society
000001083006	Amal Asiri MD	Member-in-Training	32	Massachusetts Psychiatric Society
000000058331	Phyllis Sage Atwell MD	General Member	32	Massachusetts Psychiatric Society
000000310409	Lauren M Avery MD	General Member	32	Massachusetts Psychiatric Society
000001062240	Leah K Bauer MD	Member-in-Training	32	Massachusetts Psychiatric Society
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000001008867	Eduardo Jesus Caussade-Rodriguez MD	Member-in-Training	32	Massachusetts Psychiatric Society
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000000102286	Christopher C Bundy MD MPH	General Member	33	Washington State Psychiatric Association
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000000040951	Seeley Dole Chandler M.D.	Life Member	33	Washington State Psychiatric Association
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000001013172	Jonathan Deam MD	General Member	33	Washington State Psychiatric Association
000000054014	Douglas Clark Dicharry M.D.	General Member	33	Washington State Psychiatric Association
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000001016409	Leah Edlund MD	General Member	33	Washington State Psychiatric Association
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000000307060	Yuko Fukuda M.D.	General Member	33	Washington State Psychiatric Association
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000001001953	Hisam S Goueli MD	General Member	33	Washington State Psychiatric Association
000000035184	Brian Lowell Grant MD	Distinguished Fellow	33	Washington State Psychiatric Association
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000000069671	James R Hopfenbeck M.D.	General Member	33	Washington State Psychiatric Association
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000000075424	Linda L Miller DO	General Member	33	Washington State Psychiatric Association
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000001070568	Enrique C Villacres MD	General Member	33	Washington State Psychiatric Association
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000001012915	Samuel B Clinch MD	Member-in-Training	34	Nebraska Psychiatric Society
000001017590	Umer Farooq MD	Member-in-Training	34	Nebraska Psychiatric Society
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000001008502	Thomas Joseph MD	General Member	34	Nebraska Psychiatric Society
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000001090348	Lucas Barton MD	Member-in-Training	35	Ohio Psychiatric Association
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000001060029	Pu Cheng MD	Member-in-Training	35	Ohio Psychiatric Association
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000001019122	Heather Ann Lewis MD	Member-in-Training	35	Ohio Psychiatric Association
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000000063923	Michael Raymond Mizenko DO	General Member	35	Ohio Psychiatric Association
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000000028671	Antonio B Montinola M.D.	Life Member	35	Ohio Psychiatric Association
000001053060	Sonal Moratschek MD	Member-in-Training	35	Ohio Psychiatric Association
000000303600	Quinton E Moss MD	General Member	35	Ohio Psychiatric Association
000000063152	Mary Ann Murphy M.D.	General Member	35	Ohio Psychiatric Association
000001080111	Richard Murphy DO	Member-in-Training	35	Ohio Psychiatric Association
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000001019089	Christopher Michael Nadorff MD	Member-in-Training	35	Ohio Psychiatric Association
000001006790	Sarah M Nagle-Yang MD	General Member	35	Ohio Psychiatric Association
000001078376	Chiranjir Narine MD	Member-in-Training	35	Ohio Psychiatric Association
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000000033092	Michael A Newton M.D.	Life Member	35	Ohio Psychiatric Association
000000079008	Julie A Niedermier MD	General Member	35	Ohio Psychiatric Association
000001049797	Chinyere I Ogbonna MD MPH	Member-in-Training	35	Ohio Psychiatric Association
000000030386	Stuart Oppenheimer M.D.	Life Member	35	Ohio Psychiatric Association
000000309294	Michael J Oros MD MBA	General Member	35	Ohio Psychiatric Association
000000305579	Latifat O Osinowo M.D.	General Member	35	Ohio Psychiatric Association
000001008164	Kristine Marie Packo MD	General Member	35	Ohio Psychiatric Association
000000080102	Debbie J Panke DO	General Member	35	Ohio Psychiatric Association
000000032189	Stephen F Pariser M.D.	Distinguished Life Fellow	35	Ohio Psychiatric Association
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000001044065	Andrew Latus MD	General Member	39	Quebec & Eastern Canada District Branch

000000311694	Maude Lemieux M.D.	General Member	39	Quebec & Eastern Canada District Branch
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000000086499	Jean-Pierre Mottard M.D.	General Member	39	Quebec & Eastern Canada District Branch
000001012951	Pierre Racicot MD	General Member	39	Quebec & Eastern Canada District Branch
000001058677	Daniel Rasic MD	Member-in-Training	39	Quebec & Eastern Canada District Branch
000001037312	Soham Rej MD	Member-in-Training	39	Quebec & Eastern Canada District Branch
000001010885	Anne-Marie Roberge MD	General Member	39	Quebec & Eastern Canada District Branch
000000076451	Pierre Savard M.D. Ph.D.	General Member	39	Quebec & Eastern Canada District Branch
000000312212	Nida Sieu M.D.	General Member	39	Quebec & Eastern Canada District Branch
000000042111	Daniel Solonyna MD	General Member	39	Quebec & Eastern Canada District Branch
000001016892	Jade Theriault MD	General Member	39	Quebec & Eastern Canada District Branch
000000087818	Haji Adam Vayani MD	General Member	39	Quebec & Eastern Canada District Branch
000001002511	Coleen P Walsh MD	General Member	39	Quebec & Eastern Canada District Branch
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000001109181	Kshamta Bhatt MD	Member-in-Training	40	Queens County Psychiatric Society
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000000042032	Edgar Gerstein M.D.	Life Member	40	Queens County Psychiatric Society
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000001017446	Rafael Bienvenido Mustafa Michel MD	General Member	40	Queens County Psychiatric Society
000001017171	Eisaku Oyama MD	General Member	40	Queens County Psychiatric Society
000000306445	Luminita L Perceli-Harghel M.D.	General Member	40	Queens County Psychiatric Society
000001005403	Satpal S Rathour MD	General Member	40	Queens County Psychiatric Society
000000082711	Teresita D Ruiz MD	General Member	40	Queens County Psychiatric Society
000001052207	Stanley Samuel MD	Member-in-Training	40	Queens County Psychiatric Society
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000001011344	Khemdat Umadat MD	General Member	40	Queens County Psychiatric Society
000000087813	Antoinette Valbrune M.D.	General Member	40	Queens County Psychiatric Society
000001019340	Snehamala Veeravalli MD	Member-in-Training	40	Queens County Psychiatric Society
000001017214	Dan Zamfir MD	General Member	40	Queens County Psychiatric Society
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000001004011	Erin A Gates MD	General Member	41	Rhode Island Psychiatric Society
000000081029	Ali Kazim MD	General Member	41	Rhode Island Psychiatric Society
000000037394	Renu Omprakash Kothari M.D.	Fellow	41	Rhode Island Psychiatric Society
000000067445	Brandon Harris Krupp M.D.	Distinguished Fellow	41	Rhode Island Psychiatric Society
000000073879	Louis J Marino MD	Distinguished Fellow	41	Rhode Island Psychiatric Society
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000001001885	Doriana F Morar MD	General Member	41	Rhode Island Psychiatric Society

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000000062633	Ruth Stemp M.D.	General Member	41	Rhode Island Psychiatric Society
000000304290	Tahir Tellioglu M.D.	General Member	41	Rhode Island Psychiatric Society
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000001005284	Maureen Alice Burbage MD	General Member	42	South Carolina Psychiatric Association
000001004798	Bryant Gaddy Byrne MD	General Member	42	South Carolina Psychiatric Association
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000000073149	Victor Shaw Evans MD	General Member	42	South Carolina Psychiatric Association
000000082206	Warachal E Faison M.D.	General Member	42	South Carolina Psychiatric Association
000001008283	Stephen A Fleming MD	General Member	42	South Carolina Psychiatric Association
000000306911	Richard C Ford MD	Fellow	42	South Carolina Psychiatric Association
000001073431	Brian A Frankel MD	Member-in-Training	42	South Carolina Psychiatric Association
000001044026	Jason Gandy MD	Member-in-Training	42	South Carolina Psychiatric Association
000001107407	Anuj Goel MD	Member-in-Training	42	South Carolina Psychiatric Association
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000001002500	Melissa H Kannaday MD	General Member	42	South Carolina Psychiatric Association
000000087519	Steven G Lopez M.D.	General Member	42	South Carolina Psychiatric Association
000001017416	Lissette Madrigal MD	Member-in-Training	42	South Carolina Psychiatric Association
000000086283	Ishmeal Major M.D.	General Member	42	South Carolina Psychiatric Association
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000000308197	Karen L Melendez MD	General Member	42	South Carolina Psychiatric Association
000001008768	Jaya B Merugu MD	General Member	42	South Carolina Psychiatric Association
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000000030565	Katharyn J Ouzts M.D.	Distinguished Life Fellow	42	South Carolina Psychiatric Association
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000000308401	Jennifer D Pender M.D.	General Member	42	South Carolina Psychiatric Association
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000000032836	Alberto Benito Santos MD	Distinguished Fellow	42	South Carolina Psychiatric Association
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000000058706	David Andrew Steiner M.D.	General Member	42	South Carolina Psychiatric Association
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000001008993	LaKeisha Watson MD	Member-in-Training	42	South Carolina Psychiatric Association
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000000043464	Russell Bryan Wolfe MD	Fellow	42	South Carolina Psychiatric Association
000000032696	Harry H Wright MD	Distinguished Life Fellow	42	South Carolina Psychiatric Association

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000001069322	Zoe Sarnat Aron MD	General Member	43	Southern California Psychiatric Society
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000001003995	Maged W Botros MD	General Member	43	Southern California Psychiatric Society
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000000069300	Tracy Marie Chaffee M.D.	General Member	43	Southern California Psychiatric Society
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000001009324	Katrina DeBonis MD	General Member	43	Southern California Psychiatric Society
000001015223	Neevon Carl Esmaili MD	Member-in-Training	43	Southern California Psychiatric Society
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000000311803	Sigrid Marie B Formantes MD	General Member	43	Southern California Psychiatric Society
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000000079707	Lev G Gertsik M.D.	General Member	43	Southern California Psychiatric Society
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000001014417	Maryam Hashemi MD	General Member	43	Southern California Psychiatric Society
000001097893	Micah Hoffman MD	Member-in-Training	43	Southern California Psychiatric Society
000001076458	Stephane Johnson MD MSc	General Member	43	Southern California Psychiatric Society
000001102134	Ian Matthew Jones MD	Member-in-Training	43	Southern California Psychiatric Society
000000087442	Arif Karim DO	General Member	43	Southern California Psychiatric Society
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000000030044	Julia Kit L Lam M.D.	Life Member	43	Southern California Psychiatric Society
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000001070669	Cyrus Nasserian MD	Member-in-Training	43	Southern California Psychiatric Society
000001080107	Jared M Nelson DO	Member-in-Training	43	Southern California Psychiatric Society
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000000033793	Neena Sachinvala MD	Distinguished Life Fellow	43	Southern California Psychiatric Society
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000001039264	David Robert Seigler MD	Member-in-Training	43	Southern California Psychiatric Society
000000061382	Gurmit Singh Sekhon M.D.	General Member	43	Southern California Psychiatric Society
000001107032	Ariel Seroussi MD	Member-in-Training	43	Southern California Psychiatric Society
000001010994	Mohammad F Siddiqui MD	General Member	43	Southern California Psychiatric Society
000000043105	Emil Soorani M.D.	General Member	43	Southern California Psychiatric Society
000000079735	Rosanne C State MD	General Member	43	Southern California Psychiatric Society
000001080108	Chin Tang MD	Member-in-Training	43	Southern California Psychiatric Society
000000064841	Maureen Cathy Terrazano M.D.	General Member	43	Southern California Psychiatric Society

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000000074416	David Seth Turken MD	General Member	43	Southern California Psychiatric Society
000000033130	Walter Burton Van Vort MD	Life Member	43	Southern California Psychiatric Society
000001106386	Sambin Wang DO	Member-in-Training	43	Southern California Psychiatric Society
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000000066452	Lawrence M Weinstein MD	General Member	43	Southern California Psychiatric Society
000000073943	Naomi Wolman MD PhD	General Member	43	Southern California Psychiatric Society
000000057473	Lester M Zackler M.D.	Fellow	43	Southern California Psychiatric Society
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000000302162	Adrian C Buckner MD	General Member	45	Tennessee Psychiatric Association
000000306239	Natalie M Campo MD	General Member	45	Tennessee Psychiatric Association
000000304439	Christine A Carrejo MD	Member-in-Training	45	Tennessee Psychiatric Association
000001066496	Traci Carroll MD	Member-in-Training	45	Tennessee Psychiatric Association
000001000698	Kirk A Carruthers MD	General Member	45	Tennessee Psychiatric Association
000001047567	Melisa Clark MD	Member-in-Training	45	Tennessee Psychiatric Association
000000311215	Cheryl A Cobb MD	General Member	45	Tennessee Psychiatric Association
000001040780	Aimee Rox Coleman MD	General Member	45	Tennessee Psychiatric Association
000001095127	Danica Denton DO	Member-in-Training	45	Tennessee Psychiatric Association
000000311606	Anjani Dhamodharan M.D.	General Member	45	Tennessee Psychiatric Association
000001107825	Lindsay Evans MD JD	Member-in-Training	45	Tennessee Psychiatric Association
000000024073	Otilia Miga Faget M.D.	Life Associate	45	Tennessee Psychiatric Association
000001008477	Liusong Fu MD	General Member	45	Tennessee Psychiatric Association
000001081612	Nara Granja Ingram MD PhD	Member-in-Training	45	Tennessee Psychiatric Association
000000064193	Robert Glenn Harned M.D.	General Member	45	Tennessee Psychiatric Association
000001001718	William L Johnson MD	General Member	45	Tennessee Psychiatric Association
000000044330	Paul Reed Kelley M.D.	Life Member	45	Tennessee Psychiatric Association
000000080247	Prasad V Kondapavuluru M.D.	Fellow	45	Tennessee Psychiatric Association
000000305758	Carmel C Lakhani M.D.	General Member	45	Tennessee Psychiatric Association
000000045591	Richard F Mauroner M.D.	General Member	45	Tennessee Psychiatric Association
000001015175	Mahshid Moradiseresht MD	General Member	45	Tennessee Psychiatric Association
000000062853	Sidney Moragne M.D.	General Member	45	Tennessee Psychiatric Association
000000303690	Stephen E Nicolson M.D.	General Member	45	Tennessee Psychiatric Association
000001009486	Emeke Benedict Nwabuzor MD	General Member	45	Tennessee Psychiatric Association
000001094227	Pragnesh P Patel MD	Member-in-Training	45	Tennessee Psychiatric Association
000001092667	Brittany Ray Peters MD	Member-in-Training	45	Tennessee Psychiatric Association
000000033744	Glenn Richard Peterson M.D.	Life Member	45	Tennessee Psychiatric Association
000000308028	Kenneth G Pittman MD	General Member	45	Tennessee Psychiatric Association
000000021562	Anilkumar S Potdar M.D.	Life Fellow	45	Tennessee Psychiatric Association
000001014472	Albena Radoslavova MD	General Member	45	Tennessee Psychiatric Association
000000074934	Cynthia K Rector MD	General Member	45	Tennessee Psychiatric Association
000001016116	John Stephen Rich Jr MD	Member-in-Training	45	Tennessee Psychiatric Association
000000066234	William Donald Richie M.D.	Distinguished Fellow	45	Tennessee Psychiatric Association
000000060262	Richard Earle Rochester M.D.	General Member	45	Tennessee Psychiatric Association
000001014675	Michael Todd Rutherford MD	Member-in-Training	45	Tennessee Psychiatric Association
000001035959	Shane Savage MD	General Member	45	Tennessee Psychiatric Association
000000300485	Cassandra Goins Simms MD	General Member	45	Tennessee Psychiatric Association
000001007006	Zhiqiang Sun MD PhD	General Member	45	Tennessee Psychiatric Association
000001005166	Kenny Terry MD	General Member	45	Tennessee Psychiatric Association
000001086571	Seth Clayton Thompson MD	Member-in-Training	45	Tennessee Psychiatric Association
000001004641	Danielle M Todd MD	General Member	45	Tennessee Psychiatric Association

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000001099219	Jo Ellen Wilson MD	Member-in-Training	45	Tennessee Psychiatric Association
000000043504	Glenn Russell Yank M.D.	General Member	45	Tennessee Psychiatric Association
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000001005998	Luis M Baez Cabrera MD	General Member	46	Texas Society of Psychiatric Physicians
000000073213	Brigitte Y Bailey MD	General Member	46	Texas Society of Psychiatric Physicians
000001004133	Margaret E Balfour PhD MD	General Member	46	Texas Society of Psychiatric Physicians
000001001704	Ivana Balic MD	General Member	46	Texas Society of Psychiatric Physicians
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000001079975	Roberto Gonzalez MD	General Member	46	Texas Society of Psychiatric Physicians
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000000303687	Stephanie Suzanne Hinds MD	General Member	46	Texas Society of Psychiatric Physicians
000001008478	Kenyatta M Jones MD	General Member	46	Texas Society of Psychiatric Physicians
000001008419	Ramprasad R Kalavapalli MD	General Member	46	Texas Society of Psychiatric Physicians
000001036400	Sawsan Yamin Ali Khan MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
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000000306511	Stacia W Lusby MD	General Member	46	Texas Society of Psychiatric Physicians

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000000088030	Thomas L Matthews M.D.	Fellow	46	Texas Society of Psychiatric Physicians
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000001015561	Maria Luisa Obregon MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001013500	Holly Hollon Olivier DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001008302	Amber E Pastusek MD	General Member	46	Texas Society of Psychiatric Physicians
000000037719	Manjeshwar R Prabhu M.D.	General Member	46	Texas Society of Psychiatric Physicians
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000001042859	Carolyn Marie Rekerdres MD	General Member	46	Texas Society of Psychiatric Physicians
000001095126	Qingmin Ruan MD PhD	Member-in-Training	46	Texas Society of Psychiatric Physicians
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000000309089	Duke J Ruktanonchai MD	General Member	46	Texas Society of Psychiatric Physicians
000001004546	Paul Anthony Schneider DO	General Member	46	Texas Society of Psychiatric Physicians
000001000854	Seema Shah MD	General Member	46	Texas Society of Psychiatric Physicians
000001082117	Mahwish Munir Shakir MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001014202	Afroz Shamim MD	General Member	46	Texas Society of Psychiatric Physicians
000000301480	Monika D Singhal M.D.	General Member	46	Texas Society of Psychiatric Physicians
000000085560	Robert H Stowe M.D.	General Member	46	Texas Society of Psychiatric Physicians
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000000305874	Anil K Swarup MD	General Member	46	Texas Society of Psychiatric Physicians
000000088034	Maria S Sweeney M.D.	General Member	46	Texas Society of Psychiatric Physicians
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000001004355	Josh Warren MD	General Member	46	Texas Society of Psychiatric Physicians
000001007600	Matthew Wesley Warren MD PhD	General Member	46	Texas Society of Psychiatric Physicians
000000311837	Howard L Wong MD	General Member	46	Texas Society of Psychiatric Physicians
000001010998	Jennifer L Yen MD	General Member	46	Texas Society of Psychiatric Physicians
000001014476	Tracey Yost MD	General Member	46	Texas Society of Psychiatric Physicians
000001014093	Connie L Zajicek MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001016454	Ethel Zapata-Bluhm MD	General Member	46	Texas Society of Psychiatric Physicians
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000000104500	Syed M Ahmed MD	General Member	47	Psychiatric Society of Virginia, Inc
000001013031	Saira Arif MD	General Member	47	Psychiatric Society of Virginia, Inc
000000080895	Julia Preston Bond M.D.	General Member	47	Psychiatric Society of Virginia, Inc
000001008539	David Albert Byrnes MD	General Member	47	Psychiatric Society of Virginia, Inc
000000084809	Rosemary G Carr-Malone MD	General Member	47	Psychiatric Society of Virginia, Inc

000001016038	Mohammad Chowdhury MD	General Member	47	Psychiatric Society of Virginia, Inc
000001036727	Julie A Cohn MD	General Member	47	Psychiatric Society of Virginia, Inc
000000078394	Salim A Dahlvani MD	General Member	47	Psychiatric Society of Virginia, Inc
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000001000668	Laura Goldhar Denunzio MD	General Member	47	Psychiatric Society of Virginia, Inc
000001079848	Shivan Desai MD	Member-in-Training	47	Psychiatric Society of Virginia, Inc
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000001041119	Neil J Brahmbhatt DO	Member-in-Training	52	Wisconsin Psychiatric Association
000001039490	Jason R Burns MD	Member-in-Training	52	Wisconsin Psychiatric Association
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000000071230	Richard E Magee MD	General Member	53	Western Canada District Branch
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000001096107	Eytan Perl MD	Member-in-Training	53	Western Canada District Branch
000001014083	Lara Postl MD	Member-in-Training	53	Western Canada District Branch
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000000077105	Kevin R Smith MD	General Member	53	Western Canada District Branch

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000001004684	Balveen Singh DO	General Member	55	West Hudson Psychiatric Society
000000062607	Charles J Smith MD	General Member	55	West Hudson Psychiatric Society
000000307053	Alfred Sorrentino MD	General Member	55	West Hudson Psychiatric Society
000000053786	Gloria C Stone M.D.	General Member	55	West Hudson Psychiatric Society
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000000086180	Marideli Lopez M.D.	General Member	56	Central New York District Branch
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000001017152	Seethalakshmi Ramanathan MD	Member-in-Training	56	Central New York District Branch
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000001103879	Jennifer Selvarajah MD	Member-in-Training	56	Central New York District Branch
000001099051	Diane St. Fleur MD	Member-in-Training	56	Central New York District Branch
000000042134	Anthony J Vinciquerra MD	Distinguished Fellow	56	Central New York District Branch
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000000310518	Heather K Boyle M.D.	General Member	57	Arizona Psychiatric Society
000001002422	Michael A Brooks DO	Member-in-Training	57	Arizona Psychiatric Society

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000000304967	Raymond W Bunch MD	General Member	57	Arizona Psychiatric Society
000001098461	Sutapa Dube MD	Member-in-Training	57	Arizona Psychiatric Society
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000001001350	Holly M Hendin MD	General Member	57	Arizona Psychiatric Society
000000063068	Donald Joe Holland M.D.	General Member	57	Arizona Psychiatric Society
000000077264	Urszula H Kotlow M.D.	General Member	57	Arizona Psychiatric Society
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000000306493	Erica C Montgomery MD	General Member	57	Arizona Psychiatric Society
000001016490	Diane Park MD	General Member	57	Arizona Psychiatric Society
000001017188	Ximena A Prieto Hicks MD	Member-in-Training	57	Arizona Psychiatric Society
000000041189	Eric Michael Reiman MD	General Member	57	Arizona Psychiatric Society
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000000089619	Shane B Russell-Jenkins MD	General Member	57	Arizona Psychiatric Society
000000084385	Alpa Sanghvi MD	General Member	57	Arizona Psychiatric Society
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000000102164	Sirpa A Tavakoli M.D.	General Member	57	Arizona Psychiatric Society
000001004081	Paul Raymund Valbuena MD	General Member	57	Arizona Psychiatric Society
000001052302	Cassandra Villatoro-Bank DO	Member-in-Training	57	Arizona Psychiatric Society
000001007579	Adeel Zafar MD	General Member	57	Arizona Psychiatric Society
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000001010763	Kate H Blumner MD	General Member	58	Oregon Psychiatric Association
000001054009	Daniel Bristow MD	Member-in-Training	58	Oregon Psychiatric Association
000001081052	Megan Brown MD	Member-in-Training	58	Oregon Psychiatric Association
000000304327	Melissa B Buboltz M.D.	General Member	58	Oregon Psychiatric Association
000000309042	James A Conour M.D.	General Member	58	Oregon Psychiatric Association
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000000067778	Henry I Elder M.D.	General Member	58	Oregon Psychiatric Association
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000001056059	Naomi Bickford Fishman MD	Member-in-Training	58	Oregon Psychiatric Association
000001013756	Scott A Friedman MD	General Member	58	Oregon Psychiatric Association
000001009335	Jill C Glazewski MD MPH	General Member	58	Oregon Psychiatric Association
000000033505	Cheryn Lee Grant DO	Life Member	58	Oregon Psychiatric Association
000001099118	Timothy Sean Hofeldt MD	General Member	58	Oregon Psychiatric Association
000000080987	Joel C Julian MD	General Member	58	Oregon Psychiatric Association
000000042600	Paul Kahing Leung MD	Fellow	58	Oregon Psychiatric Association
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000000311311	Joel D Mack MD	General Member	58	Oregon Psychiatric Association
000001006442	Larry W Mak MD	General Member	58	Oregon Psychiatric Association
000001030231	Rebecca D Marshall MD MPH	Member-in-Training	58	Oregon Psychiatric Association
000001014349	Eileen K McCarty MD	General Member	58	Oregon Psychiatric Association
000001080514	Erin Elizabeth Miller MD	Member-in-Training	58	Oregon Psychiatric Association

000001080511	Auvid Momen MD	Member-in-Training	58	Oregon Psychiatric Association
000001098049	Kenneth Alan Monte MD	Member-in-Training	58	Oregon Psychiatric Association
000001018960	Alisha R Moreland MD	Member-in-Training	58	Oregon Psychiatric Association
000001017402	Sudhir Nagaraja DO	General Member	58	Oregon Psychiatric Association
000001001534	Tan D Ngo MD	Member-in-Training	58	Oregon Psychiatric Association
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000000304882	William Ronnie Nunley Jr MD	General Member	58	Oregon Psychiatric Association
000001004796	Carolyn M Phelps MD MSW	General Member	58	Oregon Psychiatric Association
000001014132	Clara M Ruiz MD	Member-in-Training	58	Oregon Psychiatric Association
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000000022370	Lee Wolfe Shershow MD	Life Member	58	Oregon Psychiatric Association
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000000070081	Jorge Walter Castro M.D.	General Member	60	Alabama Psychiatric Society
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000000066605	Calvin Jerome Harris M.D.	General Member	60	Alabama Psychiatric Society
000000305633	Heather K Henig MD	General Member	60	Alabama Psychiatric Society
000000029050	A Gerry Hodges MD	Life Member	60	Alabama Psychiatric Society
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000000308235	Mary K Burris MD	General Member	61	Utah Psychiatric Association
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000000030366	Richard C Ferre MD	Distinguished Life Fellow	61	Utah Psychiatric Association
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000000060695	Morris Alan Hund MD	General Member	63	North Dakota Psychiatric Society
000000306347	Naciye Kalafat MD	General Member	63	North Dakota Psychiatric Society
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000001008642	Ronny Paul Meunier MD	General Member	63	North Dakota Psychiatric Society
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000000038824	Namir Faisal Damluji M.D.	Distinguished Fellow	64	San Diego Psychiatric Society

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000000079718	Michael S Krelstein MD	General Member	64	San Diego Psychiatric Society
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000000304014	Kaimana S MacDonald M.D.	Fellow	64	San Diego Psychiatric Society
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000000307051	Keith A Montgomery MD	General Member	64	San Diego Psychiatric Society
000000300707	Lisa R Ponfick M.D.	General Member	64	San Diego Psychiatric Society
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000000072473	David Joel Printz M.D.	General Member	64	San Diego Psychiatric Society
000000062540	Jeffrey K Rowe M.D.	General Member	64	San Diego Psychiatric Society
000000027851	Stephen Roy Shuchter MD	Distinguished Life Fellow	64	San Diego Psychiatric Society
000000066376	Neal R Swerdlow MD PhD	General Member	64	San Diego Psychiatric Society
000001101181	Ralph Edwin Tuttle MD	Member-in-Training	64	San Diego Psychiatric Society
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000001101467	Chai H Wu MD	General Member	64	San Diego Psychiatric Society
000000311245	Todd B Young MD	General Member	64	San Diego Psychiatric Society
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000001056481	David DeVellis MD	Member-in-Training	66	Vermont Psychiatric Association
000001015972	Rebecca L Dolgin MD	General Member	66	Vermont Psychiatric Association
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000000308595	Erin K Hall MD	General Member	66	Vermont Psychiatric Association
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000000305539	Joseph A Lasek M.D.	General Member	66	Vermont Psychiatric Association
000000312414	Mark R. J. McGee MD	General Member	66	Vermont Psychiatric Association
000001011510	Jessica E O'Neil DO	Member-in-Training	66	Vermont Psychiatric Association
000001005414	Lizabeth J Pontzer MD	General Member	66	Vermont Psychiatric Association
000001063081	Anne Rich MD	General Member	66	Vermont Psychiatric Association
000000021623	Arthur Mark Warwick M.D.	Distinguished Life Fellow	66	Vermont Psychiatric Association
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000000066111	Edward J Neidhardt MD	General Member	67	Psychiatric Medical Association of New Mexico
000001082040	Nathaniel Sharon MD	General Member	67	Psychiatric Medical Association of New Mexico
000000034871	Richard Brian Smith M.D.	General Member	67	Psychiatric Medical Association of New Mexico
000000074974	Lisa Moran Walker MD	General Member	67	Psychiatric Medical Association of New Mexico
000000103269	Heather A Wood M.D.	General Member	67	Psychiatric Medical Association of New Mexico
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000001010500	Brigitte M Hristea MD	General Member	68	New Hampshire Psychiatric Society
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000000067287	Marianne Marsh M.D.	General Member	68	New Hampshire Psychiatric Society
000001079850	Helen Nunberg MD MPH	Member-in-Training	68	New Hampshire Psychiatric Society
000001096667	Dave P Ravi MD	Member-in-Training	68	New Hampshire Psychiatric Society
000001099372	Frances Shin MD	Member-in-Training	68	New Hampshire Psychiatric Society
000000310749	Stacy A Taylor M.D.	General Member	68	New Hampshire Psychiatric Society
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000000302824	Vivian R Pastrana MD	General Member	70	Puerto Rico Psychiatric Society
000000021558	Felix Oswaldo Pitterson M.D.	Distinguished Life Fellow	70	Puerto Rico Psychiatric Society
000001019398	Janice A Rios MD	Member-in-Training	70	Puerto Rico Psychiatric Society
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000000091048	Marco Rodriguez M.D.	General Member	70	Puerto Rico Psychiatric Society
000000304887	Yamilka M Rolon MD	General Member	70	Puerto Rico Psychiatric Society
000001087711	Cristina Ivette Sanchez MD	Member-in-Training	70	Puerto Rico Psychiatric Society
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000000309933	Wioleta E Mazurczak MD	General Member	72	South Dakota Psychiatric Association
000001082655	Steve John Meek MD	Member-in-Training	72	South Dakota Psychiatric Association
000000073312	Matthew B Stanley DO	Fellow	72	South Dakota Psychiatric Association
000001016878	David Whaley MD	General Member	72	South Dakota Psychiatric Association
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000000080406	Amy E Schuett M.D.	Fellow	73	Montana Psychiatric Association
000000301600	Elizabeth A Walter M.D.	General Member	73	Montana Psychiatric Association
000001015772	Share P Angel MD	General Member	74	Nevada Psychiatric Association
000001040986	Dennis Ta-Jen Chang MD	Member-in-Training	74	Nevada Psychiatric Association
000000073664	Becky Jo Conley MD	General Member	74	Nevada Psychiatric Association
000000088549	Olayinka R Harding MD MPH	General Member	74	Nevada Psychiatric Association
000001105962	Hooman Hormozian MD	Member-in-Training	74	Nevada Psychiatric Association
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000001001888	Shaily Jain MD	General Member	74	Nevada Psychiatric Association
000000019554	Gerardo A Juan M.D.	Distinguished Life Fellow	74	Nevada Psychiatric Association
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000000102447	Randall John Burke M.D.	General Member	76	Orange County Psychiatric Society
000001013645	Sara Chiu MD	General Member	76	Orange County Psychiatric Society
000000075357	Lester V Cook MD	General Member	76	Orange County Psychiatric Society
000000079705	Pete Farrell M.D.	General Member	76	Orange County Psychiatric Society
000000102074	Richard Granese M.D.	General Member	76	Orange County Psychiatric Society
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000000029616	Peter Robin Kimmel M.D.	Life Member	76	Orange County Psychiatric Society
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000000040298	Bum Soo Lee M.D.	General Member	76	Orange County Psychiatric Society
000001102922	Stephanie Lei MD	Member-in-Training	76	Orange County Psychiatric Society
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000000075323	Rubina T Najeeb M.D.	General Member	76	Orange County Psychiatric Society
000001088453	Jerry Ngo MD	Member-in-Training	76	Orange County Psychiatric Society
000000087610	Mai H Nguyen M.D.	General Member	76	Orange County Psychiatric Society
000001000071	Toni L Pusateri MD	General Member	76	Orange County Psychiatric Society
000001102925	Natalie L Robinson MD	Member-in-Training	76	Orange County Psychiatric Society
000000306496	Thuy D Rotunda MD	General Member	76	Orange County Psychiatric Society
000001004498	Angela Sagar MD	General Member	76	Orange County Psychiatric Society
000001008436	Clint Harold Salo DO	General Member	76	Orange County Psychiatric Society
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000000082804	Mark C Brown MD	General Member	77	Society of Uniformed Services Psychiatrists
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000000310783	Melinda Gloria Fierros MD	General Member	77	Society of Uniformed Services Psychiatrists
000000305743	Jeremy C Francis MD	General Member	77	Society of Uniformed Services Psychiatrists
000000306934	Herbert J Harman M.D.	General Member	77	Society of Uniformed Services Psychiatrists
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000000308628	Jared Lenz DO	General Member	77	Society of Uniformed Services Psychiatrists
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000000311281	Melanie L Morin MD	General Member	77	Society of Uniformed Services Psychiatrists
000000310266	Aniceto J Navarro M.D.	General Member	77	Society of Uniformed Services Psychiatrists

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000000074268	John J Stasinos M.D.	General Member	77	Society of Uniformed Services Psychiatrists
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000001016913	Raquel T Williams MD	General Member	77	Society of Uniformed Services Psychiatrists
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000000078350	Robin Dossmann MD	General Member		American Psychiatric Association
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000000074675	Siu Wa Tang MD PhD	Fellow		American Psychiatric Association

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000000090035	Javier A Didia Attas M.D.	International Member		Argentina
000000089860	Miguel Juan Ekizian M.D.	International Member		Argentina
000000091708	Carlos A Finkelsztein M.D.	International Member		Argentina
000000087054	Maria Lilia Gonzalez M.D.	International Member		Argentina
000001087043	Maria Elina Grecco MD	International Member		Argentina
000001045071	Rosa Maria Gricar MD	International Member		Argentina
000000091707	Sergio Halsband M.D.	International Member		Argentina
000000089896	Luis G Herbst M.D.	International Member		Argentina
000000091687	Carlos A Lamela M.D.	International Member		Argentina
000000090048	Hugo O Lande M.D.	International Member		Argentina
000000103701	Mario O Levin M.D.	International Member		Argentina
000000091966	Andrea Marquez M.D.	International Member		Argentina
000001001069	Pedro Miranda MD	International Member		Argentina
000000031275	Jorge Enrique Richardson MD PC	International Member		Argentina
000001104675	Carlos Rocca MD	International Member		Argentina
000000089971	Pablo R Rozic M.D.	International Member		Argentina
000001002355	Eric H Wainwright MD	International Member		Argentina
000000077548	Rebecca E Adams M.D.	International Member		Australia
000001089266	Andrew Carroll MD	International Member		Australia
000001105087	Anthony A Dinesh MD	International Member		Australia
000001095926	Samuel Lim MD	International Member		Australia
000001072817	Carlson K Loke MD	International Member		Australia
000001004913	Peter D McCarthy MD	International Member		Australia
000001072860	Helen A Schultz MD	International Member		Australia
000000304192	Ah M Firoz M.D.	International Member		Bangladesh
000001008127	Brian S Maclachlan MD	International Member		Barbados
000000087051	Michel Floris M.D.	International Member		Belgium

000000103300	Loes Gabriels MD PhD MScEng	International Member		Belgium
000001026275	Peter Martens MD	International Member		Belgium
000001101392	An Verbrugghe MD	International Member		Belgium
000001012285	Marianna G Andrade MD	International Member		Brazil
000001005906	Sueli Castro Bernardes MD	International Member		Brazil
000001014818	Rodrigo Noguiera Borghi MD	International Member		Brazil
000001072818	Marilene M Costa MD	International Member		Brazil
000001104290	Milena Ferreira Franca MD	International Member		Brazil
000001052305	Rafael Ferreira Garcia MD	International Member		Brazil
000000308637	Gabriel Chittó Gauer MD PhD	International Member		Brazil
000000091565	Luiz A Godoy M.D.	International Member		Brazil
000000310501	Leo De Souza Machado M.D.	International Member		Brazil
000000089033	Jair De Jesus Mari MD	International Member		Brazil
000000091549	Richado A Moreno M.D.	International Member		Brazil
000000310200	Ivan Sérgio Nirenberg MD	International Member		Brazil
000001100367	Marcelo Papelbaum MD	International Member		Brazil
000000092239	Rubens Pitliuk M.D.	International Member		Brazil
000001083332	Nadia Posklinski MD	International Member		Brazil
000001007393	Joel Renno Jr MD PhD	International Member		Brazil
000000312726	Pablo Miguel Roig M.D.	International Member		Brazil
000001040841	Luciana Maria Sarin MD	International Member		Brazil
000000102522	Valeria Barreto Novais Souza M.D.	International Member		Brazil
000001044715	Jose Geraldo Vernet Taborda MD	International Member		Brazil
000001042002	Vera Lucia Carvalho Tess MD	International Member		Brazil
000000300606	Nora Jane Thormann M.D.	International Member		Brazil
000001104644	Evelyn Vinocur MD	International Member		Brazil
000000091150	Jorge Cabrera MD	International Member		Chile
000001017007	Zeping Xiao MD PhD	International Member		China
000001098835	Claudia Isabel Cala Carrisoza MD	International Member		Colombia
000001011908	Rodrigo Cordoba MD	International Member		Colombia
000001016960	Carlos Julio Corredor Villalba MD	International Member		Colombia
000001100364	Mauro Alberto Egas Realpe MD	International Member		Colombia
000001099152	Amaury Rafael Garcia Blanco MD	International Member		Colombia
000000013568	Roberto Garcia M.D.	International Member		Colombia
000001100002	Guillermo Esteban Giraldo Cuentas MD	International Member		Colombia
000000306780	Cesar Gonzalez MD	International Member		Colombia
000000080771	Javier F Leon-Silva MD	International Member		Colombia
000001016055	Heidi Celina Oviedo MD	International Member		Colombia
000000089947	Alberto Perez-Medina M.D.	International Member		Colombia
000001098936	Alicia Lucia Sanchez Quintana MD	International Member		Colombia
000001098214	Luis Arturo Serrano MD	International Member		Colombia
000001006767	Hugo Soto Cabrera MD	International Member		Colombia
000001011910	Martin Suarez-Jimenez MD	International Member		Colombia
000001098838	Adrian Antonio Villanueva Vera MD	International Member		Colombia
000001029866	Milana Zivkov-Starcevic MD	International Member		Croatia (Hrvatska)
000000093076	Henrik Lublin MD DMSc	International Member		Denmark
000001041114	Axinia Karina Martinez Pichardo MD	International Member		Dominican Republic
000000085045	Cesar Mella Mejias M.D.	International Member		Dominican Republic
000000313182	Rose E Nina M.D.	International Member		Dominican Republic
000000313006	Juan Aguilera M.D.	International Member		Ecuador

000001007468	Edisson Almeida MD	International Member		Ecuador
000001104659	Rommel Artieda MD	International Member		Ecuador
000001016948	Patricio Benavides MD	International Member		Ecuador
000000310542	Consuelo Camacho M.D.	International Member		Ecuador
000001071917	Marcia Elisabeth Chumy Teran MD	International Member		Ecuador
000001104645	Miguel Gonzalez Sarmiento MD	International Member		Ecuador
000001045159	Diego Mera Orces MD	International Member		Ecuador
000001044100	Luis Moya MD	International Member		Ecuador
000000041973	Pedro M Perez M.D.	International Member		Ecuador
000001045075	Nelly Tobar Toro MD	International Member		Ecuador
000001042612	Carlos Verdesoto MD	International Member		Ecuador
000000089863	Mohamed R Elfiky MD	International Distinguished Fellow		Egypt
000001107826	Mohamed Fouad Abdel-Tawab MD	International Member		Egypt
000001107037	Shokry Abo Elenain Ali MD	International Member		Egypt
000001015613	Hafez Amin MD	International Member		Egypt
000001096913	Amany Ahmad Baalash MD	International Member		Egypt
000001041381	Nahed Khairy MD	International Member		Egypt
000001005544	Nahla El-Sayed Nagy MD	International Member		Egypt
000001059749	Ashraf Salama MD	International Member		Egypt
000001001492	Pauli Tapani Karvonen MD	International Member		Finland
000000306572	Kristian Wahlbeck MD	International Member		Finland
000001064329	Josephine Caubel MD	International Member		France
000001017017	Philippe Nubukpo MD PhD	International Member		France
000001111927	Chloe M Rackow MBBS	International Member		France
000001001030	Andreas Sobottka MD	International Member		Germany
000000302345	Gunter Wagner MD	International Member		Germany
000000302340	Helen Bahtalia M.D.	International Member		Greece
000000074996	Roubini Kambolis M.D.	International Member		Greece
000001097896	Stylianos P Kympouropoulos MD	International Member		Greece
000000303994	Ilias Manavis M.D.	International Member		Greece
000000091557	Grigoris Vaslamatzis M.D.	International Member		Greece
000000071518	Helga Hannesdottir M.D.	International Member		Iceland
000001006458	Kedar Ranjan Banerjee MBBS	International Member		India
000001006489	Dipesh Bhagabati MBBS	International Member		India
000001096234	Peter John Castelino MD	International Member		India
000001001974	Ashok Dagaria MD	International Member		India
000001094788	Avinash A De Sousa MD	International Member		India
000001006453	Sandeep Dattatraya Jadhav MD	International Member		India
000001016477	Philip John MD	International Member		India
000001094497	Kunal Kala MD	International Member		India
000001002518	Parmanand Kulhara MD	International Member		India
000001016428	Parmod Kumar MD	International Member		India
000001007185	Vinay Kumar MBBS	International Member		India
000001002538	Vidya Dhar Meel MD	International Member		India
000001020686	Choudhary Laxmi Narayan MD	International Member		India
000001016733	Jagdish Raj MD	International Member		India
000000069995	P. C. Shastri MD	International Member		India
000001006451	Om Prakash Singh MBBS	International Member		India
000001012174	Pramod Kumar Singh MBBS	International Member		India
000001006443	Rajkumar Lenin Singh MBBS	International Member		India

000001016890	Ranbir Singh MD	International Member		India
000001045059	Shakil Singh MBBS	International Member		India
000001008744	Sushil Kumar Sompur Vasanthkumar MD	International Member		India
000001006486	Prabhat Sood	International Member		India
000001042168	Paresh C Trivedi MD	International Member		India
000001001488	Radhika Reddy Vemireddy MD	International Member		India
000001006076	Sethumadhavan Venkatraman MD	International Member		India
000001014275	Rawisht Rasheed Sabri MD	International Member		Iraq
000000086697	Joanne Fenton MD	International Member		Ireland
000001090211	Raphael Ese Mayone MD	International Member		Ireland
000001103820	Adewale Raji MBBS	International Member		Ireland
000000061101	Deborah Rachel Duitch MD	International Member		Israel
000000305930	Jennie Goldstein MD	International Member		Israel
000000076088	Haim Knobler M.D.	International Member		Israel
000000089108	Pier Maria Furlan M.D.	International Distinguished Fellow		Italy
000001007512	Guido Di Sciascio MD	International Member		Italy
000000306569	Michele Raja M.D.	International Member		Italy
000000031540	Edward A Allen MD	International Member		Jamaica
000000092238	Yuji Okazaki M.D.	International Member		Japan
000000090151	Almotasem Alomari MD FRCPI FACP FAPA	International Distinguished Fellow		Jordan
000001104918	Samir Samawi MD	International Member		Jordan
000000086120	Ik-Keun Hwang MD	International Member		Korea, Republic of
000000033403	Elie George Karam MD	International Member		Lebanon
000001007415	Manuel Aguilar Saens MD	International Member		Mexico
000001012589	Maria del Pilar Alonso MD	International Member		Mexico
000001012635	Hilda Cervera MD	International Member		Mexico
000000104340	Benjamin Dultzin MD	International Member		Mexico
000000092397	Alberto Ladron de Guevara M.D.	International Member		Mexico
000001038613	Ofelia Guadalupe Medrano MD	International Member		Mexico
000000311919	Jose Novoa MD	International Member		Mexico
000000104260	Jose Romero-Quezada MD	International Member		Mexico
000000302543	Antonio Torres-Ruiz MD	International Member		Mexico
000001006430	Dieneke Bloemkolk MD	International Member		Netherlands
000001016557	Ad Blom MD	International Member		Netherlands
000001068494	Boris Drozdek MD	International Member		Netherlands
000001101822	Jacobus Maria Duindam MD	International Member		Netherlands
000000310550	Cecilia Gijsbers Van Wijk MD	International Member		Netherlands
000000092228	J.J. Sandra Kooij M.D.	International Member		Netherlands
000001016491	Wim Kramer MD	International Member		Netherlands
000000309608	Renske Lonhard M.D.	International Member		Netherlands
000001104529	Ella Mutter MD	International Member		Netherlands
000001001683	Paul Naarding MD	International Member		Netherlands
000001012107	Herman Rooze MD	International Member		Netherlands
000000306522	Ton Roulanx M.D.	International Member		Netherlands
000001005865	Anna Maria Schaap MD	International Member		Netherlands
000000306525	G Fred Schreuder M.D.	International Member		Netherlands
000001006115	Ivo Stessel MD	International Member		Netherlands
000001072786	Saskia Annemikt Van Der Laan MD	International Member		Netherlands
000001007416	Hendrika Van de Schepop MD	International Member		Netherlands
000000312294	Lourens Van Krimpen M.D.	International Member		Netherlands

000001002619	Patricia Van Wijngaarden-Cremers MD	International Member		Netherlands
000001016944	Antonius Vergouwen MD	International Member		Netherlands
000001006743	Bastiaan Verwey MD	International Member		Netherlands
000000303932	Karel Wieme M.D.	International Member		Netherlands
000000309233	Arie C Wijma M.D.	International Member		Netherlands
000000302661	Tjeerd A Wouters M.D.	International Member		Netherlands
000001099688	Glenn E Matroos MD	International Member		Netherlands Antilles
000000075576	Shivananda Jena MD	International Member		New Zealand
000001002604	Maymunah Kadiri MD	International Member		Nigeria
000001093067	Martins Oche MD	International Member		Nigeria
000001010278	Brit Haver MD	International Member		Norway
000000091830	Christen Salvesen M.D.	International Member		Norway
000001069085	Shajaat Ali Khan MBBS	International Member		Pakistan
000001035069	Mukesh K Ambwani MD	International Member		Pakistan
000000312491	Dr.Abdul Hamid Choudhry MD	International Member		Pakistan
000000313004	Nasar Sayeed Khan MD	International Member		Pakistan
000001102410	Abdul Malik MD	International Member		Pakistan
000001020009	Ghulam Rasool MD	International Member		Pakistan
000000313172	Muhammad Ishaq Sarhandi MD	International Member		Pakistan
000001104657	Kishore Sindhi MD	International Member		Pakistan
000001105318	Jose Alberto Calderon Artieda MD	International Member		Panama
000001016939	Nerytza Grimaldo MD	International Member		Panama
000000086133	Isabel C Riano Quijano MD	International Member		Panama
000001002145	Carlos Alberto Sayavedra MD	International Member		Panama
000001072820	Myrna B Astillero MD	International Member		Philippines
000000306950	Michelene E Buot M.D.	International Member		Philippines
000000102360	Maria Lourdes Evangelista MD	International Member		Philippines
000001004700	Elaine Leynes MD	International Member		Philippines
000001044004	Gregorio Santos Tan MD FPPA	International Member		Philippines
000001105315	Guruswamy Ramachandrappa MD	International Member		Saint Lucia
000001104638	Alshomrani Abdulaziz MD	International Member		Saudi Arabia
000001104641	Samirah Alghamdi MD	International Member		Saudi Arabia
000001038621	Zuhair Izzat Dabbagh MD	International Member		Saudi Arabia
000000103400	El-Sheikh R Ibrahim MD PhD	International Member		Saudi Arabia
000001002664	Sherif Osman MD	International Member		Saudi Arabia
000000310556	Lee-Peng Kok MD	International Member		Singapore
000001005851	Zukiswa Zingela MD	International Member		South Africa
000000071514	Manuel Bousono-Garcia M.D.	International Member		Spain
000000103464	Fernando Canas de Paz MD	International Member		Spain
000000101967	Maria Begona Salcedo M.D.	International Member		Spain
000000089868	Werner J Fuchs M.D.	International Member		Switzerland
000001016502	Michael Hsin-Te Huang MD	International Member		Taiwan
000001016321	Duangta Graipaspong MD	International Member		Thailand
000000015530	Helene Marceau-Crooks M.D.	International Member		Trinidad And Tobago
000001002352	Hazel A Othello MD	International Member		Trinidad And Tobago
000001002234	Vashtee Ramoutar MD	International Member		Trinidad And Tobago
000000313174	Z Bengi Semerci MD	International Member		Turkey
000001104768	Mustafa Ulusoy MD	International Member		Turkey
000000076783	Yousef Abou-Allaban M.D.	International Member		United Arab Emirates
000000071516	Naresh K Dhar MBBS	International Member		United Arab Emirates

000001016980	Mohammad Wafeek A Eid MD	International Member		United Arab Emirates
000001080252	Haytham Saeed Shabayek MD	International Member		United Arab Emirates
000001089362	Oghenevwoke Eguono Akpubi MD	International Member		United Kingdom
000000306288	Oyedeji A Ayonrinde M.D.	International Member		United Kingdom
000001043810	Amir Bashir MD	International Member		United Kingdom
000001096148	Alan Currie MD	International Member		United Kingdom
000001092173	Kalpana Elizabeth Dein MD	International Member		United Kingdom
000000311744	Celine A Hamilton MD	International Member		United Kingdom
000001001241	Philips Idahosa MD	International Member		United Kingdom
000001067232	Babalola Olufemi MD	International Member		United Kingdom
000001011584	Hiranmayi Pantula MD	International Member		United Kingdom
000001102156	Rajiv Parinja MD	International Member		United Kingdom
000000302662	Patrick F Purcell M.D.	International Member		United Kingdom
000001101823	Alan Jeffrey Thomas MD	International Member		United Kingdom
000000042827	Daisy M Acosta Valerio MD	International Member		United States
000001002537	Joon Ho Ahn MD	International Member		United States
000001040989	Ram Jeevan Bishnoi MD	International Member		United States
000000092481	Francesca Foghini-Fiumi M.D.	International Member		United States
000000071186	Douglas A Ghrist M.D.	International Member		United States
000001089062	Mona A Mahar MBBS	International Member		United States
000001009293	Ignacio N Te Lano	International Member		United States
000000074126	Edward N Weissberg M.D.	International Member		United States
000001104798	Petra Aponte Martinez MD	International Member		Venezuela
000000103763	Carmen Juarez MD	International Member		Venezuela
000000020723	Jorge Posadas PhD	International Member		Venezuela
000000312703	Libertad C Velazquez De Suarez M.D.	International Member		Venezuela
000000091571	June M Samuel M.D.	International Member		Virgin Islands (British)

n=255 International Members/Distinguished Fellows still owe dues

n=2,867 APA/DB Members still owe dues

Total = 3,122 Members at risk if dues are not paid by 6/30/13

Membership Terminated by District Branches*
for Non-Payment of Local Dues (as of 6/26/13) - Confidential

Mbr Id	Name	Member Category	DB #	DB Name
000000071690	Curtis N Adams MD	General Member	20	Maryland Psychiatric Society, Inc
000000304999	Aimee Y Alinsonorin M.D.	General Member	20	Maryland Psychiatric Society, Inc
000000073542	Brian J Grady M.D.	General Member	20	Maryland Psychiatric Society, Inc
000000313237	Cessar L Scott III MD	General Member	20	Maryland Psychiatric Society, Inc
000001042139	Zainab Al-Dhaher MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001015978	Suparna Basu MD	General Member	25	Greater Long Island Psychiatric Society
000000033200	George Gage Fairey M.D.	Life Member	25	Greater Long Island Psychiatric Society
000001008685	Karine A Grigoryants MD	General Member	25	Greater Long Island Psychiatric Society
000001054840	Nishanie Gunawardane DO	Member-in-Training	25	Greater Long Island Psychiatric Society
000001049600	Navneet Iqbal MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001020083	Sameer Khan MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001056046	Priya Krishnasamy MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001078752	Pamela C Montano MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001000713	Indroneil Mukerji MD	General Member	25	Greater Long Island Psychiatric Society
000001052871	Rachit H Patel MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001053883	Shannon Terkell MD	Member-in-Training	25	Greater Long Island Psychiatric Society
000001071572	Jose Luis Aguilar Jr MD	Member-in-Training	43	Southern California Psychiatric Society
000001110193	Steven Andrew Allen MD	Member-in-Training	43	Southern California Psychiatric Society
000000307997	Arastou Aminzadeh M.D.	General Member	43	Southern California Psychiatric Society
000001112083	Cristina Barolet-Garcia MD	Member-in-Training	43	Southern California Psychiatric Society
000001112073	Danit Bar Ziv MD	Member-in-Training	43	Southern California Psychiatric Society
000000300889	Eraka P Bath MD	General Member	43	Southern California Psychiatric Society
000000043630	Alexander Beebee MD	General Member	43	Southern California Psychiatric Society
000001107824	Sharilee Bryant MD	Member-in-Training	43	Southern California Psychiatric Society
000001063690	Roger Cabansag MD	General Member	43	Southern California Psychiatric Society
000001100016	Andrea Carter MD	Member-in-Training	43	Southern California Psychiatric Society
000001112082	Stephanie H Chan MD	Member-in-Training	43	Southern California Psychiatric Society
000000074590	Esther L Chodakiewitz M.D.	General Member	43	Southern California Psychiatric Society
000001111117	Kiyomi Cohn DO	Member-in-Training	43	Southern California Psychiatric Society
000001004047	Emily B Defraites MD MPH	General Member	43	Southern California Psychiatric Society
000001081582	Tammy Duong MD	Member-in-Training	43	Southern California Psychiatric Society
000000305962	Frederick Falvo Jr MD	General Member	43	Southern California Psychiatric Society
000000020044	Richard N Feldman M.D.	Life Fellow	43	Southern California Psychiatric Society
000001014046	Timothy J Garvey MD	General Member	43	Southern California Psychiatric Society
000001011727	Joseph L Gulino MD	General Member	43	Southern California Psychiatric Society
000001112079	Talene Keshishian MD	Member-in-Training	43	Southern California Psychiatric Society
000001004940	Alisha Desai Kohm MD	General Member	43	Southern California Psychiatric Society
000001096150	Jamie Lim Lacsina DO	Member-in-Training	43	Southern California Psychiatric Society
000000085656	Jeffrey N Mar MD	General Member	43	Southern California Psychiatric Society
000000075861	Magdi S Mikhael M.D.	Distinguished Fellow	43	Southern California Psychiatric Society
000001013138	Sarah Nena Mourra MD	Member-in-Training	43	Southern California Psychiatric Society
000000079950	Douglas P Murphy M.D.	General Member	43	Southern California Psychiatric Society
000001017687	Jennifer ODay MD	General Member	43	Southern California Psychiatric Society
000000088473	Sharat G Parameswaran MD	Member-in-Training	43	Southern California Psychiatric Society
000001005541	Shawn S Sidhu MD	Member-in-Training	43	Southern California Psychiatric Society
000000045062	Kathy J Tobias M.D.	General Member	43	Southern California Psychiatric Society
000001112080	Peter J Ureste MD	Member-in-Training	43	Southern California Psychiatric Society
000000302989	Cynthia J Washington M.D.	General Member	43	Southern California Psychiatric Society
000000078112	Aleksandra Wirga M.D.	General Member	43	Southern California Psychiatric Society
000001002483	Felicia Wong MD	General Member	43	Southern California Psychiatric Society
000001064582	Pauline Wu DO	General Member	43	Southern California Psychiatric Society
000001043728	Elizabeth C Zaleski MD	Member-in-Training	43	Southern California Psychiatric Society
000000074803	Shanawar Alam M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001014255	Straight Line Arla MD	General Member	46	Texas Society of Psychiatric Physicians

Membership Terminated by District Branches*
for Non-Payment of Local Dues (as of 6/26/13) - Confidential

000001008945	David Louis Atkinson MD	General Member	46	Texas Society of Psychiatric Physicians
000001110780	Andres Arturo Avellaneda Ojeda MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000306281	Daniel S Baer M.D.	General Member	46	Texas Society of Psychiatric Physicians
000000020941	Richard M Barrett M.D.	Life Member	46	Texas Society of Psychiatric Physicians
000001131795	Anna K Beasley MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000059233	David Henry Beyer Jr MD	Fellow	46	Texas Society of Psychiatric Physicians
000001110782	Dana Christian Billups MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000069430	Greg D Blaisdell M.D.	General Member	46	Texas Society of Psychiatric Physicians
000000310145	Kalonda K Bradshaw MD	General Member	46	Texas Society of Psychiatric Physicians
000001110386	Nicholas James Bryant MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000305531	Robert J Buchanan MD	General Member	46	Texas Society of Psychiatric Physicians
000000085571	John W Burruss M.D.	Fellow	46	Texas Society of Psychiatric Physicians
000000065502	Arthur Lee Buswell MD	General Member	46	Texas Society of Psychiatric Physicians
000001008717	Elizabeth Alexandra Carroll MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001013536	Joven V Cavazos MD	General Member	46	Texas Society of Psychiatric Physicians
000001012185	Nora Choubkha MD	General Member	46	Texas Society of Psychiatric Physicians
000001079666	Faria Tariq Chudhri DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001014868	Letitia Danielle Chukwumah MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001116587	Nicole Cyr MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001001839	Bachir Debba MD	General Member	46	Texas Society of Psychiatric Physicians
000001103821	Deepti Dongargaonkar MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001117075	Lauren Douglas MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001117333	John Wylder DuBose MD MS	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001007267	Lindsay N French-Rosas MD	General Member	46	Texas Society of Psychiatric Physicians
000001016793	Brandy Michelle Gallien MD	General Member	46	Texas Society of Psychiatric Physicians
000001096515	Elena I Gherman MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000081139	Christina Z M Golden MD	General Member	46	Texas Society of Psychiatric Physicians
000000305711	Muhammad R Haqqani M.D.	Fellow	46	Texas Society of Psychiatric Physicians
000001008491	Sarah Hardy DO	General Member	46	Texas Society of Psychiatric Physicians
000000071937	Toi B Harris MD	Fellow	46	Texas Society of Psychiatric Physicians
000001110158	Stephanie Hernandez DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000091270	Marguerite I Hogan MD	General Member	46	Texas Society of Psychiatric Physicians
000000064223	Paul Tamer Homsy M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001017540	Hussam Aldeen Jefee Bahloul MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001103193	Li Jin DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001071027	Anne Elizabeth Johnson MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000305447	Neysa L Johnson M.D.	General Member	46	Texas Society of Psychiatric Physicians
000000065260	Dominic M Joseph MD	General Member	46	Texas Society of Psychiatric Physicians
000001016754	Arjun Karkhanis MD MPH	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001014135	Aarti Kaul MD	General Member	46	Texas Society of Psychiatric Physicians
000001087256	Alisha King MD	General Member	46	Texas Society of Psychiatric Physicians
000001013494	Pilar Laborde Lahoz MD	General Member	46	Texas Society of Psychiatric Physicians
000001017868	Mechibelle Mabanta Lynch MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001079672	Azalia Veronica Martinez II MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000308480	Olajide H Masha MD	General Member	46	Texas Society of Psychiatric Physicians
000000022327	Kenneth Lee Matthews MD	Distinguished Life Fellow	46	Texas Society of Psychiatric Physicians
000000311325	Chanda L Mayers-Elder MD	General Member	46	Texas Society of Psychiatric Physicians
000001005416	Carrie J McAdams MD	General Member	46	Texas Society of Psychiatric Physicians
000000085974	Ruben V Mendoza M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001009389	Ana E Monterrosa MD	General Member	46	Texas Society of Psychiatric Physicians
000001078200	Amy L Motamed DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001000693	Hannah Giese Moussa MD	General Member	46	Texas Society of Psychiatric Physicians
000001110790	Claude Silvanus Murugen MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000042779	Ruth Evans Netscher MD	Fellow	46	Texas Society of Psychiatric Physicians
000001055061	Lynn Nguyen MD	Member-in-Training	46	Texas Society of Psychiatric Physicians

Membership Terminated by District Branches*
for Non-Payment of Local Dues (as of 6/26/13) - Confidential

000001110787	Lauren Pace DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001103822	Rashmi P Parmar MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001000878	Divyansu D Patel MD	General Member	46	Texas Society of Psychiatric Physicians
000001000985	Rupa Peddireddy MD	General Member	46	Texas Society of Psychiatric Physicians
000000060223	Michael R Pittman M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001128733	India Richards MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000060278	Pradeep K Roy M.D.	Fellow	46	Texas Society of Psychiatric Physicians
000001004918	Michael F Salib MD	General Member	46	Texas Society of Psychiatric Physicians
000001001659	Jason Sapp DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001100317	Hina Sarwar MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001006315	Khurram Rafi Shaikh MD	General Member	46	Texas Society of Psychiatric Physicians
000000303706	Michael A Shiekh M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001001894	Gwen Shipe MD	General Member	46	Texas Society of Psychiatric Physicians
000001110169	Christina Smith MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001130736	Elizabeth Stevens DO	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000070280	Fernando G Torres M.D.	General Member	46	Texas Society of Psychiatric Physicians
000001008903	Tho Van Tran MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001116196	Jia Wang MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000001016458	Jennifer Ward MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000074744	Robert G Wilkerson M.D.	General Member	46	Texas Society of Psychiatric Physicians
000000312335	Claire Alease Williams MD	Member-in-Training	46	Texas Society of Psychiatric Physicians
000000082756	Ella M Williams MD	General Member	46	Texas Society of Psychiatric Physicians
000000304030	Marketa M Wills MD	General Member	46	Texas Society of Psychiatric Physicians
000001056018	Andrea Jennifer Wright MD	General Member	46	Texas Society of Psychiatric Physicians
000001006438	Stephanie A Axman MD	General Member	58	Oregon Psychiatric Association
000000042834	Catherine C Barlow MD	General Member	58	Oregon Psychiatric Association
000000070093	John Kelly Bischof M.D.	General Member	58	Oregon Psychiatric Association
000000075485	Neff R Breen MD	General Member	58	Oregon Psychiatric Association
000000052998	Jackson Tyler Dempsey M.D.	General Member	58	Oregon Psychiatric Association
000000312153	Diana S Domnitei MD	General Member	58	Oregon Psychiatric Association
000000311074	Brian Esparza M.D.	General Member	58	Oregon Psychiatric Association
000000088866	Caroline E Fisher MD PhD	General Member	58	Oregon Psychiatric Association
000001004209	Stacey Gramann DO MPH	General Member	58	Oregon Psychiatric Association
000000054742	William Franklin Hoffman MD PhD	General Member	58	Oregon Psychiatric Association
000000311877	Sandra Jane Krussel DO	General Member	58	Oregon Psychiatric Association
000001006018	Toresa Martell DO	General Member	58	Oregon Psychiatric Association
000001002334	Daniel B McCabe MD	General Member	58	Oregon Psychiatric Association
000000076742	Darian V Minkunas M.D.	General Member	58	Oregon Psychiatric Association
000000062767	Michael S Rappaport MD PhD	General Member	58	Oregon Psychiatric Association
000001096573	Liban Abdi Rodol MD	General Member	58	Oregon Psychiatric Association
000001004523	Marie V Soller MD	General Member	58	Oregon Psychiatric Association
000000078431	Anna M Williams M.D.	General Member	58	Oregon Psychiatric Association

n=151

*Excludes approximately 250 members from Northern California Psychiatric Society who have an extension until August 31, 2013 to pay NCPS dues.

New International Membership Applications

Member #	Name	Country	Country Income Category
1133636	Ahmad, Bashir	Pakistan	Lower Middle Income
1138783	Ahmed, Magdi	Sudan	Lower Middle Income
45361	Amin, Smarhar	India	Lower Middle Income
1131678	Ansari, Moin	Pakistan	Lower Middle Income
1138824	Arcena, Maria Bernadette	Philippines	Lower Middle Income
1138721	Bautista, Maria Annette	Philippines	Lower Middle Income
81671	Brahma, Suchandra	India	Lower Middle Income
1130566	Daplas, June Anne	Philippines	Lower Middle Income
1136820	Gnanasekharan, Meena	India	Lower Middle Income
1028097	Gupta, Neeraj	Australia	Lower Middle Income
1138383	Kalita, Pranab	India	Lower Middle Income
1138337	Morsy, Ola	Egypt	Lower Middle Income
1108669	Ojo, Osamuede	Nigeria	Lower Middle Income
1132210	Orellana Folgar, Mauricio	Honduras	Lower Middle Income
1137987	Pande, Neha	India	Lower Middle Income
1138516	Raddaoui, Kamal	Morocco	Lower Middle Income
1132840	Saldanha, Daniel	India	Lower Middle Income
1138801	Singh, Ajai	India	Lower Middle Income
1138706	Tarigan, Jendariah	Indonesia	Lower Middle Income
63461	Thomas, Kuruvilla	India	Lower Middle Income
1135100	Torales, Julio	Paraguay	Lower Middle Income
1132801	Warraich, Ijaz	Pakistan	Lower Middle Income

n= 22

1138675	Altamimi, Falah	Jordan	Upper Middle Income
1138685	Barra Ahumada, Luis	Chile	Upper Middle Income
1135644	Barros, Isabele	Brazil	Upper Middle Income
1136693	Bustamante, Moacyr	Brazil	Upper Middle Income
1134503	Capece, Jose	Argentina	Upper Middle Income
1135823	Carvalho, Murilo Abel	Brazil	Upper Middle Income
1130661	Chalela Mantilla, Pablo Alberto	Colombia	Upper Middle Income
1047280	Copetti, Jordano	Brazil	Upper Middle Income
1138578	Corpus, Felipe	Mexico	Upper Middle Income
1137534	Cunha, Paul	Brazil	Upper Middle Income
1134357	Cury, Camilo	Brazil	Upper Middle Income
1138577	De Paiva Pinheiro, Luiz Carlos	Brazil	Upper Middle Income
1133463	Derenusson, Guilherme	Brazil	Upper Middle Income
1138518	Dillon, Maria	Ecuador	Upper Middle Income
1138723	dos Santos, Daniel	Brazil	Upper Middle Income
1138512	Duailibi, Kalil	Brazil	Upper Middle Income
1033384	Florio, Ligia	Brazil	Upper Middle Income

New International Membership Applications

1136000	Garcia, Celso	Brazil	Upper Middle Income
1138543	Gonzalez Garcia, Julio	Venezuela	Upper Middle Income
89558	Jeeva, Shabeer	South Africa	Upper Middle Income
1129090	Kendall, Rommy	Peru	Upper Middle Income
1138514	Kussunoki, Debora	Brazil	Upper Middle Income
1025710	Ladeira, Rodolfo	Brazil	Upper Middle Income
1135090	Lobao, Bruno	Brazil	Upper Middle Income
1133247	Martinho, Eduardo	Brazil	Upper Middle Income
1128633	Matta, Oswaldo	Colombia	Upper Middle Income
1138349	Mendizabal, Jose Arturo	Mexico	Upper Middle Income
1137759	Molina, Carlos	Colombia	Upper Middle Income
1138508	Ordonez Mancheno, Jose	Ecuador	Upper Middle Income
1135494	Paniza, Frederico	Brazil	Upper Middle Income
1131283	Pereira, Alexandre	Brazil	Upper Middle Income
1137345	Piedra Oyenard, Maria	Uruguay	Upper Middle Income
1138686	Risco, Luis	Chile	Upper Middle Income
1137483	Sharma, Davendranand	Dominica	Upper Middle Income
1133379	Shu, Weijie	China	Upper Middle Income
1138521	Tafet, Gustavo	Argentina	Upper Middle Income

n = 36

1029864	Absalan, Farideh	Australia	Upper Income
1130561	Adsersen, Mik	Denmark	Upper Income
1138526	Al-Zaben, Faten	Saudi Arabia	Upper Income
1138649	Alponsu, Rajapaksha	Australia	Upper Income
1131640	Andrae, Eva	Germany	Upper Income
1131284	Andrew, Martin	United Kingdom	Upper Income
1132839	Aquilina, Carmelo	Australia	Upper Income
1132212	Aten, Jan-Jaap	Netherlands	Upper Income
1132943	Bakija, Ivana	Croatia (Hrvatska)	Upper Income
1127862	Beatrice, Salimbeni	France	Upper Income
1133916	Bosmans, Aad	Belgium	Upper Income
308936	Brockway, Stephen	Australia	Upper Income
1131356	Chan, Pamela	Singapore	Upper Income
1132639	Chaudhary, Juthika	Australia	Upper Income
1127325	Chichakly, Rashad	Switzerland	Upper Income
1132211	Danilewicz, Maciej	United Kingdom	Upper Income
1138542	De Jager, Bert	Netherlands	Upper Income
1132797	Degmecic, Dunja	Croatia (Hrvatska)	Upper Income
1134976	Dierckx, Bram	Netherlands	Upper Income
1134385	Gielen, Konstant	Netherlands	Upper Income
1131086	Guddat, Oliver	Netherlands	Upper Income

New International Membership Applications

1138589	Gudelj, Lea	Croatia (Hrvatska)	Upper Income
1132867	Herceg, Miroslav	Croatia (Hrvatska)	Upper Income
1131641	Hofecker Fallahpour, Maria	Switzerland	Upper Income
1132796	Holwerda, Tjalling	Netherlands	Upper Income
1138527	Hood, Sean	Australia	Upper Income
1134760	Huizenga, Sonja	Netherlands	Upper Income
1133246	Joshi, Uday	United Kingdom	Upper Income
1132865	Karlovic, Dalibor	Croatia (Hrvatska)	Upper Income
1132500	Khoo, Mee-Ling	Australia	Upper Income
1132942	Kovac, Ruzica	Croatia (Hrvatska)	Upper Income
1135744	Kuijpers, Daphne	Netherlands	Upper Income
1047351	Lacy, Benjamin	New Zealand	Upper Income
1133915	Laidli, Chahinez	France	Upper Income
1132866	Lasic, Davor	Croatia (Hrvatska)	Upper Income
1132981	Lee, Eun	Korea, Republic of	Upper Income
1130564	Lemke, Matthias	Germany	Upper Income
59129	Macfadden, Wayne	Switzerland	Upper Income
1138342	Mahendran, Rathi	Singapore	Upper Income
1132868	Markovic, Hrvoje	Croatia (Hrvatska)	Upper Income
1138590	Maron, Michel	France	Upper Income
1134358	Meier-Allmendinger, Diana	Switzerland	Upper Income
1030397	Melidonis, Nicole	Australia	Upper Income
1096575	Messer, Thomas	Germany	Upper Income
1132795	Mikulan, Mario	Croatia (Hrvatska)	Upper Income
1132983	Milosevic, Gorana	Australia	Upper Income
1133432	Mueller, Helge	Germany	Upper Income
1133086	Munro, Janet	France	Upper Income
1138591	Nielsen, Svend-Ole	Norway	Upper Income
1131948	OBrien, Angela	New Zealand	Upper Income
1132241	Oladele, Taiwo	United Kingdom	Upper Income
1135643	Omara, Anne	United Arab Emirates	Upper Income
1132835	Padovani, Romain	France	Upper Income
304189	Pal, Sanu	New Zealand	Upper Income
1135495	Perusic, Darko	Croatia (Hrvatska)	Upper Income
1133087	Portier, Constance	Netherlands	Upper Income
1132275	Quaak, Johannis	Netherlands	Upper Income
1133914	Ramzan, Asif	United Kingdom	Upper Income
1131850	Reddy, Dhammadam	Bahamas	Upper Income
1130359	Remane, Annette	Germany	Upper Income
1130363	Salmenkylae, Katariina	Finland	Upper Income
1132949	Samuel, Mathew	Australia	Upper Income
1131993	Shanurkeyl, Shamsulhag	Netherlands	Upper Income
1138511	Shwe, Myat Kaung	United Kingdom	Upper Income

New International Membership Applications

1132794	Silic, Ante	Croatia (Hrvatska)	Upper Income
1128457	Sondergaard, Mia Hee	Denmark	Upper Income
1138803	Strack Van Schijndel-Garofoli, Barbara	Netherlands	Upper Income
1138519	Suokas, Jaana	Finland	Upper Income
1124515	Takahashi, Hidetoshi	Japan	Upper Income
305690	Talih, Farid	Lebanon	Upper Income
1135824	Todd, Fraser	New Zealand	Upper Income
1137973	Van Haaren, Mirjam	Netherlands	Upper Income
1138517	Varma, Shashjit	Australia	Upper Income
1133527	Vos, Alexandra	Netherlands	Upper Income
1132982	Yasuhiro, Matsuda	Japan	Upper Income
1098050	Yeung, Ming	Hong Kong	Upper Income

n = 76

Dues Relief Requests - Confidential

Dues Waivers - Approved

Member #	Name	Member Class	District Branch
78390	Arudra Bodepudi M.D.	General Member	Central California Psychiatric Society
41706	Alta Lois Brubaker M.D.	General Member	Psychiatric Society of Virginia Inc
89276	Tara Lynn Buhl, MD	General Member	Minnesota Psychiatric Society
58745	Cherye Celeste Callegan, MD	General Member	Texas Society of Psychiatric Physicians
1008682	Janel Casey, MD, FRCPC	General Member	Western Canada District Branch
42749	Miguel Antonio Castro M.D.	General Member	Florida Psychiatric Society
59714	Katherine Donovan-Sherpa, MD	General Member	South Carolina Psychiatric Association
31041	John Ray Edwards M.D.	Life Member	Vermont Psychiatric Association
28454	Mark B Fishtein, DO	General Member	Pennsylvania Psychiatric Society
69598	Ruth S Garfield M.D.	General Member	Pennsylvania Psychiatric Society
306692	Jinous Hamidi M.D.	General Member	Ontario District Branch
66681	Caroline D Kirshner M.D.	General Member	Ontario District Branch
1016428	Parmod Kumar, MD	International Member	
58880	W Bradford Lyles, MD	Distinguished Fellow	Wisconsin Psychiatric Association
43540	Howard Samuel Mahler, MD	General Member	Greater Long Island Psychiatric Society
80193	Claudia T Miles, DO	Fellow	South Carolina Psychiatric Association
41738	Melodie Morgan-Minott, MD	Distinguished Life Fellow	Ohio Psychiatric Physicians Association
87860	Karen Melissa Moyer, DO	General Member	New Hampshire Psychiatric Society
70538	Ellen Perricci M.D.	General Member	Pennsylvania Psychiatric Society
309748	Sarah Polfliet, MD	General Member	Northern California Psychiatric Society
306590	Sara Vieweg Rosen, MD	General Member	Maryland Psychiatric Society Inc
62555	Leda Sanchez, MD	At Large	
43300	Fryderyka R Shabry, MD	Distinguished Life Fellow	Brooklyn Psychiatric Society Inc
300680	Tara Y Yuan M.D.	General Member	Orange County Psychiatric Society
	n=24		

Dues Reductions - Approved

Member #		Member Class	District Branch Name
45938	Deborah Ann Brogan M.D.	General Member	Arizona Psychiatric Society
70767	Marc Cantillon M.D.	General Member	New Jersey Psychiatric Association
307180	Anthony J Carino M.D.	General Member	New York County District Branch
63544	Lucile Dennison Clotfelter M.D.	General Member	North Carolina Psychiatric Association
31583	Surinder K Dargan, MD	Life Fellow	Orange County Psychiatric Society
103287	Navdeep Dhaliwal	General Member	Psychiatric Socieity of Virginia
31052	William M Glazer, MD	Distinguished Life Fellow	Massachusetts Psychiatric Society
65041	Haven Howell, MD	General Member	Colorado Psychiatric Society
305678	Fahmy B Ibrahim MD	General Member	Orange County Psychiatric Society
74437	Claudia W Joyner, MD	General Member	Illinois Psychiatric Society
71326	Marie T Kelly, MD	General Member	Texas Society of Psychiatric Physicians
20647	Dyana Lowndes-Rosen M.D.	General Member	South Carolina Psychiatric Association
86958	Thomas W Meeks, MD	General Member	San Diego Psychiatric Society
17446	K C R Nair, MD, MBA	Distinguished Fellow	Michigan Psychiatric Society
31520	Glenn David Prentice M.D.	General Member	Maine Association of Psychiatric Physicians
41793	William Stuart Rosenfeld M.D.	Life Fellow	Psychiatric Society of Westchester County Inc
42633	Ronald Bruce Schwartz M.D.	General Member	New York County District Branch
305933	Olga Segal, MD	General Member	Northern California Psychiatric Society
56725	Vinod Sharma, MD	Life Member	Ohio Psychiatric Physicians Association
29167	Lee Jules Shonfield M.D.	Life Fellow	Ohio Psychiatric Physicians Association
91435	Amy L Sproch M.D.	General Member	Pennsylvania Psychiatric Society
306814	Melanie H. De Luna Vlahos, MD	General Member	Northern California Psychiatric Society
	n=22		

Dues Relief Requests - Confidential

Permanent Inactive - Approved

Member #	Name	Member Class	District Branch Name
39017	Julius Fletcher Amaker M.D.	General Member	South Carolina Psychiatric Association
34912	Robert Michael Beckhardt M.D.	Life Member	Massachusetts Psychiatric Society
34350	Gail Brenner M.D.	Life Fellow	Northern California Psychiatric Society
35311	Randall Mark Christenson M.D.	Distinguishef Fellow	Michigan Psychiatric Society
304566	Bertrand J Duval-Arnould M.D.	General Member	Connecticut Psychiatric Society
70454	Nancy G Dvorak M.D.	General Member	New York State Capital District Branch
25940	Frank L Giordano, MD	Life Fellow	Texas Society of Psychiatric Physicians
300082	Thomas Gosciniak M.D.	International Member	At Large Members
29560	Carol Ann Hauk M.D.	Life Member	Colorado Psychiatric Society
39398	Reginald A Hoffler M.D.	General Member	Connecticut Psychiatric Society
54799	Bruce P Hurter M.D.	General Member	Massachusetts Psychiatric Society
35164	Richard David Kadison M.D.	Life Member	Massachusetts Psychiatric Society
28707	Samuel John Keith, MD	Life Member	Psychiatric Medical Association of New Mexico
33561	James Richard Lehman, MD	International Member	At Large Members
21176	Eugene D Maloney M.D.	Life Member	North Carolina Psychiatric Association
43147	James Gwyn Peden, Jr, MD	Distinguishef Fellow	North Carolina Psychiatric Association
21864	Timothy S Schuster M.D.	Distinguishef Life Fellow	Psychiatric Medical Association of New Mexico
31726	Kaushal Kumar Sharma M.D.	Distinguished Life Fellow	Orange County Psychiatric Society
72186	Gary L Stern, DO	General Member	Arizona Psychiatric Society
	n-=19		

Temporary Inactive Status - Approved

Member #	Name		District Branch Name
305678	Fahmy B Ibrahim MD	General Member	Orange County Psychiatric Society
86958	Thomas W Meeks, MD	General Member	San Diego Psychiatric Society
76099	Zeba Saeed Nizam M.D.	General Member	New Jersey Psychiatric Association
312821	Jessica L Wood MD, PhD	General Member	Iowa Psychiatric Society
	n=4		

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

PROPOSED ACTIONS

1. **CME Paid Course Fees:**

   Will the APA Board of Trustees approve an increase for CME course registration fees in 2014 as proposed?

2. **Annual Meeting Registration:**

   A. Will the APA Board of Trustees approve the rate adjustments for Annual Meeting registration fees for 2014 as proposed in Attachment A?

   B. Will the APA Board of Trustees approve that the guest/significant other rate be offered to members only, and that nonmembers' guest/significant others pay at the regular registration rates?

3. **IPS Registration:**

   Will the APA Board of Trustees approve changes to the fees for the 2014 IPS as proposed in Attachment B?

4. **Membership Dues:**

   Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C?

5. **Procurement Policy Clarification:**

   Will the APA Board of Trustees approve the adoption of clarifying language to the procurement policy?

6. **Communications & New Media Strategy:**

   Will the APA Board of Trustees approve up to $200K in 2013 for consulting services to enhance our communications strategies? It is expected that the APF will fund an additional $70K for these services related to public education.

7. **Future of Research**

   Will the APA Board of Trustees approve the establishment of a Research Advisory Board for APA and APF?

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

The Finance and Budget Committee held its last meeting on June 1 – 2, 2013. The following actions are presented to the APA Board of Trustees.

CME Paid Course Registration Fees

The Finance and Budget Committee conducted the annual review of CME paid course fees and recommends the Board approves the rates proposed by the Education Division for course fees in 2014. The average increase is 8% for master courses given that registration for these courses comes with a book, and the average increase for all other courses is 3% subject to rounding as detailed below.

Course Enrollment Fees

		Early Bird	Advance	Onsite
2013	Half day (4 hrs.)	145	165	190
	Full day (6 hrs.)	210	240	275
	Full day (8 hrs.)	250	300	340
	Master Courses	325	350	380
2014	Proposed			
	Half day (4 hrs.)	150	170	195
	Full day (6 hrs.)	215	245	280
	Full day (8 hrs.)	255	305	345
	Master Courses	350	380	410

The Committee suggests that the Education Division develop a proposal for restructuring the course fees to offer a member and non-member fee for courses in 2015, reinforcing to the extent possible the advantage to being a member. If the number of registrants remains constant at the 2013 level, approval of the new rates could result in $40K additional revenue. Course revenue as of May, 2013 was $941K exceeding budgeted revenue by $141K.

Course Enrollment Revenue ($ thousands)

Actual 2010	Actual 2011	Actual 2012	Actual (May) 2013	Budget 2013
536	541	627	941	800

ACTION #1: Will the APA Board of Trustees approve an increase for CME course registration fees in 2014 as proposed?

Annual Meeting Registration

The Finance and Budget Committee conducted the annual review of Annual Meeting registration and recommends fee adjustments as proposed in Attachment A, as proposed by the Education Division and Meetings and Conventions Department. The proposed rate adjustment is an average increase of 5%. Some fee increases are higher in order to maintain consistency in the historical differential between categories.

The proposal also includes a daily presenter fee. It is hoped that a daily presenter fee will encourage presenters who are only presenting one day to register. This is consistent with the IPS.

Nurses and social workers have been included under the rate for residents/chaplains/advocacy groups and non-medical students. They have been registering at this rate in the past.

The proposal includes waiving the fee for medical students and undergraduate students. There were 10 undergraduate students registered this year. It is thought that this might encourage them to consider a career in psychiatry.

There is also a two-day fee to encourage more weekend attendance.

The Committee recommends that guest/significant other rate be offered to members only; and that non-members' guest and significant others pay at the regular registration rates.

If registration remains constant at the 2013 level, approval of the new rates could result in $284K additional revenue.

ACTION# 2A: Will the APA Board of Trustees approve the rate adjustments for Annual meeting registration fees for 2014 as proposed in Attachment A?

ACTION # 2B: Will the APA Board of Trustees approve that the guest/significant other rate be offered to members only, and that nonmembers' guest/significant others pay at the regular registration rates?

The Committee suggests that staff review other organizations and present a recommendation to simplify the fee structure for Courses and Registration for 2015.

Rate Increase for IPS Registration – 2014

The Finance and Budget Committee conducted the annual review of IPS registration fees. The proposed IPS registration fees for 2014 (Attachment B) are recommended by the Division of Education and the Meetings and Conventions Department. The fees have been adjusted in order

to maintain the differential between members and non-members. Approval of the new rates could result in 2%, or $9K, additional revenue based upon the 2012 registration level.

ACTION# 3: Will the APA Board of Trustees approve changes to the fees for the 2014 IPS as proposed in Attachment B?

Rate Increase for Member Dues

The Finance and Budget Committee conducted the annual review of member dues and agreed to recommend to the APA Board of Trustees, an inflationary increase of 2% for 2014 (subject to rounding). The Membership Committee does **not** support an increase for 2014 since dues were increased in 2013 for the first time since 2010. That Committee suggests that the current rate remain for at least another year. There was concern about the potential negative perception of increasing dues immediately following the release of DSM -5 due to the increased revenue generated from sales.

Both Committees support the recommendation set forth in Assembly Action Paper ASNOV1212.Q regarding the ECP member dues structure and how the rates for the first six years of general membership should be allocated. (The Board approved the following percentages of the full rate for GM dues: Yr.1-25%, Yr.2-35%, Yr.3-45%, Yr.4-60%, Yr.5-75%, Yr.6-90%). This was taken into consideration in the development of the rates. The inflationary increase proposed for 2014 is included at Attachment C. If membership remains constant at the 2012 level, approval of the new rates could result in $185K additional revenue.

ACTION #4: Will the APA Board of Trustees approve an increase in membership dues for 2014 as proposed in Attachment C?

Procurement Policy Clarification

Background: APA/APF has a procurement policy that is designed to ensure

- expedient procurement of quality goods and services
- free and open competition
- best price and delivery terms for goods and services
- compliance with external regulations
- purchases and/or commitments are within budget and properly authorized
- maximum flexibility while protecting APA business risk

An important tenet of the policy is that the process of competition provides information critical to the decision-making process. We have identified an area where the policy has not been as

clear as it could be and, therefore, staff have been confused as to whether services provided by vendors who are not paid directly, but receive their fees from commissions paid by third parties with whom we do business, should be competed. This is most commonly seen in the insurance arena - corporate and health insurance brokers may be compensated via commissions paid by the insurance providers - but also for investment advisors and firms that handle sales of products for APP.

The Finance & Budget Committee recommends to the APA Board of Trustees the adoption of the following clarifying language (highlighted below):

STATEMENT ON COMPETITION

APA/APF policy and federal regulations require that vendors/contractors be selected on the basis of competition to the maximum extent possible to ensure that the procurement is made in the best interests of the APA/APF and the government, consistent with the circumstances, price and other factors relevant to the particular action.

Competition vs. Sole source

Competition:

- Competitive procurement generally lowers the price, produces information regarding current market technology and trends, reinforces the need for timely receipt of goods and services, stimulates creativity in products, solutions, or system design concepts.
- For all procurement actions exceeding $2,500, three price quotations/proposal submissions are required.
- The degree of formality of the competition depends on the dollar level, complexity and type of transaction. The Director of Procurement and Contracts will determine most appropriate method. (See also Price Analysis.)
- Award selection does not necessarily need to be based on lowest cost; "best value" is often the most appropriate criterion.
- Services with an annual cost of over $25,000 must go through the competitive process every 3-6 years with a formal Request for Proposal. Services with an annual cost of under $25,000 will be reviewed on an individual basis by the Contracts Office regarding the timeframe for re-competing the service.
- Competition is required for services provided by all compensated vendors – whether payment is made directly, or indirectly on a commission basis.

ACTION #5: Will the APA Board of Trustees approve the adoption of clarifying language to the procurement policy?

Communications and New Media Strategy

The goal of this project is to enhance overall APA/APF communications capability, strengthen APA media surveillance and rapid response, expand social media tools and create a strategy to implement a campaign to change public perception of psychiatry and to reduce the stigma associated with mental illness. The objective is to formulate a long term plan. Initial activities include the identification of eternal experts to build a more comprehensive set of media communications in the long run including the recruitment of an expert public relations advisor/media consultant to conduct an assessment of current communications activities, advise on media surveillance and response tactics and recommend an enhanced communications strategy and plan of action. The initial cost of this project is estimated at $270K, subject to the outcome of an RFP process. Staff will provide a detailed budget request when the plans are finalized.

ACTION #6: Will the APA Board of Trustees approve up to $200K in 2013 for consulting services to enhance the Association's communications strategy? It is expected that the APF will fund an additional $70K for these services related to public education.

Future of Research

The Committee discussed the direction and focus of the APA research activities, including DSM-5, the development of DSM-related instruments for clinicians and researchers and the "living document" approach. The Finance and Budget Committee recommends that the APA Board of Trustees establish a Research Advisory Board to develop a recommended strategy and direction for research in APA and APF. It is recommended that the Advisory Board include an equal number of representatives from both organizations. Using the standard component structure, a 6 member workgroup with one face to face meeting would cost approximately $7K; two in-person meetings would be approximately $13K.

ACTION #7: Will the APA Board of Trustees approve the establishment of a Research Advisory Board for APA and APF?

Presidential Support

The Committee discussed the need to clarify the level of staff support for the President and President-Elect to assist in the coordination of teleconferences, planning of agendas, responding to numerous questions and requests from APA staff and members, the medical community, media and the public. The Committee discussed the level of support that that would enable the APA President and President-Elect to optimally fulfill the role and responsibilities of the position. After much discussion the Committee suggested a sub-group of recent past presidents

be established to clarify the kind and level of staff support that would be provided to the President and President-Elect.

PROPOSED ACTION: Will the APA Board of Trustees approve the establishment of a sub-group of past APA Presidents to clarify the level of staff support to be provided to the APA President and President-Elect?

UPDATE: On June 25, 2013, the Executive Committee approved the recommended action.

2014 PROPOSED ANNUAL MEETING REGISTRATION FEES **Attachment A**

CATEGORIES	2012	2013	2014 Proposed Fees	Change	Comment
MEMBERS - FULL TIME REGISTRATION					
Early Bird	$360	$365	$370	$5	
Advance	$405	$415	$420	$5	Maintains $50 differential
On Site	$445	$455	$470	$15	Recommending a a higher, $100 differential between early and onsite
Medical Students, Undergraduate Students & APA Honorary Fellows	$0	$0	$0		
Members in Training					
Early Bird	$100	$100	$100		
Advance	$135	$140	$140		
On Site	$160	$165	$165		
PROGRAM PRESENTERS - MEMBERS AND NON-PSYCHIATRISTS					
Early Bird		$275	$280	$5	Needs to be $90 less than member category
Advance		$275	$280	$5	Needs to be same as early fee
On Site		$299	$315	$16	Recommending a higher $35 differential
MEMBERS - DAILY REGISTRATION					
Early Bird	$190	$195	$200	$5	Needs to be 54% of of full-time member rate
Advance	$210	$215	$230	$15	Recommending a higher $30 differential

CATEGORIES	2012	2013	2014 Proposed Fees	Change	Comment
On Site	$230	$235	$250	$15	Recommending a higher, $50 differential between early and onsite
MEMBERS - TWO-DAY REGISTRATION					
North American Members					
Early Bird			$320		Recommend a New Two-Day Fee to Encourage More Weekend Attendance for those who can't take time during the week
Advance			$370		$50 differential between early and advance
On Site			$420		$100 differential between early and and onsite
NON-MEMBERS - FULL-TIME REGISTRATOIN					
Early Bird	$935	$960	$975	$15	
Advance	$980	$1,000	$1,015	$15	Recommending a a higher, $50 differential between early and advance
On Site	$1,025	$1,100	$1,075	-$25	Recommending lower so that we keep the $100 differential the same as it is for members between early and onsite.
Residents/Chaplains/Advocacy Groups/Non-Medical Students/Nurses and Social Workers					
Early Bird	$150	$155	$160	$5	
Advance	$155	$160	$200	$40	Recommending increasing the differential so it's the same $40 as it is for MITs
On Site	$165	$170	$225	$55	Recommending increasing the differential so it's the same $65 as it is for MITs between early and onsite
DAILY - NON-MEMBER CATEGORIES					
Early Bird	$495	$510	$525	$15	54% of nonmember full-time

CATEGORIES	2012	2013	2014 Proposed Fees	Change	Comment
Advance	$525	$535	$555	$20	Recommending increasing the differential so it's the same $30 as it is for member daily between early and advance
On Site	$555	$570	$575	$5	Recommend adjusting so the differential is the same $50 as it is for member daily between early and onsite
NON-MEMBERS - TWO-DAY REGISTRATION					Recommend a New Two-Day Fee to Encourage More Weekend Attendance for those who can't take time during the week
Early Bird			$925		
Advance			$975		$50 differential between early and advance
On Site			$1,025		$100 differential between early and onsite
GUEST					
Early Bird	$200	$205	$210	$5	
Advance	$225	$230	$255	$25	Recommending increasing the differential so it's the same $40 as it is for nonmember residents
On Site	$250	$255	$275	$20	Recommending increasing the differential so it's the same $65 as it is for nonmember residents between early and onsite
PROGRAM PRESENTERS - NONMEMBER PSYCHIATRISTS					
Early Bird		$660	$675	$15	$300 less than nonmember full-time (more than the daily rate, but less than two-day rate)
Advance		$660	$675	$15	Must be same as early fee
On Site		$725	$740	$15	Increased to maintain $65 differential

Attachment B

2014 PROPOSED IPS REGISTRATION FEES

	Members			Non-Members		
	2013	**2014**	**Change**	**2013**	**2014**	**Change**
Full Time						
Early Bird	265	270	5	435	445	10
Advance	320	325	5	490	500	10
Onsite	390	395	5	560	570	10
Member in Training						
Early Bird	75	75	-	0	0	
Advance	90	90	-	0	0	
Onsite	105	105	-	0	0	
Primary Care Physicians Full Time						
Early Bird	0	0	-	105	105	-
Advance	0	0	-	135	135	-
Onsite	0	0	-	165	165	-
Non-member: Residents, Students, Mental Health Chaplains, Advocacy Group Members			-			
Early Bird	0	0	-	105	105	-
Advance	0	0	-	135	135	-
Onsite	0	0	-	165	165	-
Daily Registrants						
Early Bird	160	160	-	260	265	5
Advance	190	195	5	295	300	5
Onsite	235	235	-	335	340	5

Attachment B

2014 PROPOSED IPS REGISTRATION FEES

	Members				Non-Members		
	2013	**2014**	**Change**		**2013**	**2014**	**Change**
Daily Registrants - Sunday only							
Early Bird	80	80	-		130	130	-
Advance	95	95	-		150	150	-
Onsite	120	120	-		170	170	-
			-				
Program Presenter Full Time							
Early Bird	200	200	-		200	200	-
Advance	200	200	-		200	200	-
Onsite	270	270	-		270	270	-
Program Presenter Daily							
Early Bird	100	100	-		100	100	-
Advance	100	100	-		100	100	-
Onsite	135	135	-		135	135	-
Program Presenter - Sunday only							
Early Bird	50	50	-		50	50	-
Advance	50	50	-		50	50	-
Onsite	70	70	-		70	70	-
			-				
Medical Students			-				
Early Bird	0	0	-		0	0	-
Advance	0	0	-		0	0	-
Onsite	0	0	-		0	0	-
Honorary Fellow							
Early Bird	0	0	-		0	0	-

Attachment B

2014 PROPOSED IPS REGISTRATION FEES

	Members				Non-Members		
	2013	**2014**	**Change**		**2013**	**2014**	**Change**
Advance	0	0	-		0	0	-
Onsite	0	0	-		0	0	-
			-				
Full Day Course on Treating the Homeless Mentally Ill Session			-				
Early Bird	0	0	-		0	0	-
Advance	0	0	-		0	0	-
Onsite	0	0	-		0	0	-
Full Day Course on Buprenorphone Training							
Early Bird	0	0	-		0	0	-
Advance	0	0	-		0	0	-
Onsite	0	0	-		0	0	-
Spouse/ Significant Other							
Early Bird	0	0	-		260	265	5
Advance	0	0	-		295	300	5
Onsite	0	0	-		335	340	5

Attachment C

2014 PROPOSED MEMBER DUES RATES

	2009	2010	2011	2012	2013	**2014 PROPOSED RATES (using inflation 2.0% +/-)**
Member in Training - US	80	105	105	105	105	**107**
Member in Training - Canadian	50	65	65	65	65	**66**
General Member (1 yr) - US	180	205	205	205	105	**145**
General Member (2 yr) - US					205	**205**
General Member (3 yr) - US					260	**265**
General Member (4 yr) - US					345	**350**
General Member (5 yr) - US					430	**440**
General Member (6 yr) - US	360	395	395	395	520	**525**
General Member (7+ yrs) - US	540	565	565	565	575	**585**
General Member (1 yr) - Canadian	110	125	125	125	65	**90**
General Member (2 yr) - Canadian					125	**125**
General Member (3 yr) - Canadian					160	**160**
General Member (4 yr) - Canadian					210	**215**
General Member (5 yr) - Canadian					265	**270**
General Member (6 yr) - Canadian	220	240	240	240	315	**325**
General Member (7+ yrs) - Canadian	330	345	345	345	350	**360**
Fellow, Distinguished Fellow, & Associate Member - US	540	565	565	565	575	**585**
Fellow, Distinguished Fellow, & Assoc Mbr - Canadian	330	345	345	345	350	**360**

Attachment C

2014 PROPOSED MEMBER DUES RATES

	2009	2010	2011	2012	2013	**2014 PROPOSED RATES (using inflation 2.0% +/-)**
Fellow, Distinguished Fellow, General Member, Associate Member w/ at Least 15 TYM & 70 years of age	360	375	375	375	380	**390**
Life Status:				-		
Distinguished Life Fellow, Life Member, Life Fellow, & Life Associate (1-5 Years) - US	360	375	375	375	380	**390**
Distinguished Life Fellow, Life Member, Life Fellow, & Life Associate (1-5 Years) - Canadian	220	230	230	230	235	**240**
Distinguished Life Fellow, Life Member, Life Fellow, & Life Associate (6-10 Years) - US	180	190	190	190	195	**200**
Distinguished Life Fellow, Life Member, Life Fellow, & Life Associate (6-10 Years) - Canadian	110	115	115	115	120	**120**
International - Low Income	50	50	50	50	50	**50**
International - Low/Middle Income	100	125	125	125	130	**135**
International - Upper Middle Income	150	175	175	175	180	**185**
International - Upper Income	180	205	205	205	210	**215**

June 25, 2013

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 since our last written report in March.

The following delegates, alternate delegates and society leadership attended the AMA Annual Meeting June 14-20, 2013, on behalf of the APA: Carolyn Robinowitz, MD (senior delegate and chair of the Section Council on Psychiatry), Jeffrey Akaka, MD, Kenneth Certa, MD, Joseph English, MD, Saul Levin, MD, Jack McIntyre, MD, Paul Wick, MD, Jenny Boyer, MD (Speaker-Elect), Donald Brada, MD, Tiffany Farchione, MD, Jerry Halverson, MD, Paul Summergrad MD (President-Elect), Harsh Trivedi, MD, John Wernert, MD, Barbara Schneidman, MD, Ray Hsiao, MD, Paul O'Leary, MD, Jacob Behrens, MD, and APA Medical Director and CEO James H. Scully, MD. The American Academy of Child and Adolescent Psychiatry (AACAP) was represented by Louis Kraus, MD, David Fassler, MD, Kayla Pope, MD, Sharon Hirsch, MD, Anita Chu, MD and AACAP President, Martin Drell, MD. The American Academy of Psychiatry and the Law (AAPL) was represented by Robert Phillips, MD, Barry Wall, MD, Ryan Hall, MD, and AAPL Medical Director Howard Zonana, MD. The American Association for Geriatric Psychiatry was represented by Allan Anderson, MD. The Section Council on Psychiatry was assisted in its efforts by staff including Eugene Cassel, JD, Becky Yowell, Scott Barnes, Erin Connors, Mark Moran, Chathan Smoot, (APA staff), Kristin Kroger Ptakowski (AACAP staff), and Jacquelyn Coleman (AAPL staff).

The Section Council welcomed Allan Anderson, MD, a geriatric psychiatrist practicing in Easton, Maryland as a member of the Section. Dr. Anderson is representing the American Association for Geriatric Psychiatry which has been accepted as a member by the AMA's Specialty and Service Society caucus (SSS). AAGP will have a seat and vote at the SSS and an opportunity to apply for membership and a vote in the AMA HOD if sufficient AAGP members are also members of the AMA. Other Section Council on Psychiatry member organizations will work collaboratively with AAGP to try to achieve that goal. This was the final meeting for APA's two Resident and Fellow members who completed their residencies. Drs. Behrens and Kraguljac will be leaving the APA Delegation at the end of the end of June. We are in the process of reviewing the materials of those residents/fellows who have applied.

The Section Council on Psychiatry met multiple times throughout the course of the meeting to discuss items of business moving forward at the HOD. We met as part of the Neuroscience Caucus which is composed of neurologists, neurosurgeons, and psychiatrists who attend the House, and currently serve as chair. We also held a caucus of all psychiatrists in the HOD who are delegates from their state medical societies and other organizations not officially a part of the Section Council on Psychiatry to discuss issues of mutual interest. There are an increasing number of young psychiatrist residents and fellows who are involved in the AMA through their state medical societies which bodes well for psychiatry's future leaders in the HOD.

Several members of the AMA Section Council on Psychiatry met for an informal dinner with representatives from the American Academy of Neurology at the Academy's invitation. The AAN had

noted the success of our Section Council in addressing important issues as well as getting individuals elected or appointed to AMA positions and were interested in learning more about our function.

Many psychiatrists continue to participate (elected/appointed) in the various sections of the AMA (i.e., Senior Physicians, Organized Medical Staff, Minority Affairs, IMG) as well as the state delegations, and hold leadership roles in AMA Councils, Sections and other activities of the House of Delegates. Among them: James Sabin, MD on the Council on Ethical and Judicial Affairs; Louis Kraus, MD and Stuart Gitlow, MD on the Council on Science and Public Health; Clifford Moy, MD, Al Herzog, MD and newly appointed Alik Widge, MD on the Council on Long Range Planning and Development; Jack McIntyre, MD on the Council on Medical Service; Dionne Hart, MD, chair of the Section on Minority Affairs; Claudia Reardon, MD, immediate past-chair of the Women Physicians' Congress; Vijayalakshmi Appareddy, MD immediate past chair of the Section on International Medical Graduates; Clarence Chou, MD President of the AMA Foundation Board of Directors and Patrice Harris, MD, AMA BOT representative to the AMA Foundation Board; Paul Wick, MD chair-elect on the Governing Council of the Senior Physicians' Group**;** Brian Hurley, MD, psychiatrist and representative from the Gay and Lesbian Medical Association on the AMA Advisory Committee on GLBT Issues. In addition; Jerry Halverson, MD and Art Traugott, MD chaired two of the AMA eight Reference Committees.

Psychiatrists also played a role in several AMA educational activities. Drs. Lazarus and Scully provided presentations on best practices on finding the "Road to Leadership" at the Basharat Ahmad, MD, Leadership Development Program. Others including Drs. Wick and Schneidman facilitated a general educational session, "The Aging Physician: Opportunities and Challenges," which was co-sponsored by the Senior Physicians Section, the IMG Section and several others.

Our successes also bring challenges. APA members are not very aware of the value of our involvement in AMA and the importance of being involved with other medical colleagues and leaders at the state level. The size of our delegation is determined essentially by the numbers of APA members who are psychiatrists. Additionally, several of our members holding appointed/elected positions will be "terming out" in the next few years. Planning for their successors requires a more long term strategy, as the time lines for such decisions at AMA are much longer than those at APA, and it takes time to become known, respected and trusted in the HOD. Jeremy was a highly respected as well as articulate and effective leader; we are working to ensure the re-election of Patrice Harris to the Board of Trustees to ensure that visible and effective leadership continues. We also must continue our interactions with representatives of other specialty organizations as well as state medical societies to address important substantive issues particularly as the shape of medical practice evolves under the ACA. We will be holding a mini retreat in November at the end of the HOD meeting, to address strategies and needed resources and will report back to you in December.

In his final address as AMA President, Jeremy Lazarus, MD, psychiatrist and APA member spoke about how events of the year shaped his work. He spoke of the shootings, both in Colorado and Connecticut, stating "first there was shock. And then, dozens of physicians, physician organizations and other health care professionals mobilized within days – even hours [following Sandy Hook] -- to again denounce the plague of gun violence. It also brought to the forefront problems with our mental health system -- and our capacity to prevent at least some of these tragic events. And as a psychiatrist myself, I was at the same time all too aware of the potential backlash against mental health patients. Some may paint them all with the same broad brush of potential violence – but we know that the vast amount of violence – whether guns are involved or not – has no relation to mental illness." He went on to address AMA's involvement in initiatives to remove the stigma against those with mental illness and to offer better treatment options for those affected--work that has been done alongside the APA including meetings with Obama Administration officials. Discussions included developing strategies to address gun regulation, mental

illness and public education. He noted AMA's ongoing commitment to seeing meaningful gun legislation is passed, and he praised the decision to support epidemiological research by the CDC on gun violence which will better inform the ongoing debate.

He touched on other activities within the AMA including a shout-out to the new Integrated Physician Practice Section saying "it's now crystal-clear to me that the future of medical care depends much on how well physician-led integrated practices work to keep patients healthy, and how well they function for their physician members." He also mentioned the overwhelming response by medical personnel and every day citizens following the bombings during the Boston Marathon. "This level of bravery and presence of mind, saved many lives. It reminded me that as Americans -- this is who we are as a people. And I have rarely been more proud to be a physician." As a marathoner famous for his running analogies, he ended by saying "now it's up to you to keep on running. Our profession is worth it. This country needs us to be our very best, and together, this generation and all that follow, will cross every finish line together!"

Dr. James Madara, MD, CEO and EVP of the AMA followed with a speech which focused on three AMA strategic initiatives: improving health outcomes, accelerating change in medical education, and the shaping of the healthcare delivery and payment models. With the Improving Health Outcomes initiative, AMA has selected cardiovascular disease and type 2 diabetes as the initial focus. The Section Council on Psychiatry will encourage AMA to also focus on depression, one of the most costly co-morbid conditions. The AMA's Accelerating Change in Medical Education initiative provided grants of one million dollars each to 11 medical schools to implement projects to transform medical education. Results of those efforts will be shared with other schools in an effort to effect a broad-based positive change. And the third initiative is AMA's work to shape care delivery and payment models. Dr. Madara touted this as one of the most critical pieces of AMA's work. It is "our ambitious plan to create a better health care system for the country … and to do so with the underlying assumption that a better health care system will only emerge if the critical providers—the physicians—have a more satisfying and sustainable practice environment….In short, we will do everything in our power to restore joy in medicine," he said, "to ensure that physicians in every practice environment can thrive in our evolving health care system."

In her inaugural address, incoming President, Ardis D. Hoven, MD, an internist and infectious disease specialist spoke of her work in the AIDS epidemic and called on physicians to face today's challenges head on. She encouraged physicians to work together to leverage the power of organized medicine. She noted that such an effort would lead to gains in areas such as fighting the national epidemic of chronic diseases, fostering innovation in medical education, creating a practice environment in which physicians can thrive, achieving meaningful medical liability reform, and eliminating Medicare's sustainable growth rate formula. "Today we stand at a crossroads in the history of health care in this great nation," she said. "Let's never forget the future of American health care is in our hands."

Social media was used to highlight activities of interest as they were occurring during the meeting. See **Attachment 1** for more details.

Actions of the HOD

BOT Elections

The AMA HOD elected Robert Wah, MD, Immediate Past-Chair of the AMA Board of Trustees as President Elect. Dr. Wah, is a reproductive endocrinologist and ob-gyn in the Washington, D.C. area and a retired Navy Captain. http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-18-robert-wah-elected-ama-president.page

David O. Barbe, MD, a family physician in Mountain Grove, Mo was re-elected to the BOT and Gerald E. Harmon, MD, a family physician in Pawleys Island, SC, was elected to the AMA BOT for his first term. Maya Babu, MD, a neurosurgery resident in Rochester, MN joined the BOT as the RFS member and Ryan Ribeira, will serve as the medical student member.

The following are just a few of the actions taken by the HOD at the 2013 Annual meeting:

Committee on Amendments to Constitution and Bylaws

CEJA Report 2, Gifts to Physicians from Industry, which updates ethics policy on gifts to physicians from industry, was referred following mixed testimony.

The HOD heard testimony on two resolutions (*Resolution 004 and 005*, both of which were titled *Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients*) that dealt with supporting the ability of transgender patients to change the gender designation on their birth certificate following completion of gender transition. The HOD adopted Resolution 004 which simply asked the AMA to support the change on the certificate. Resolution 005, which was broader in scope than Resolution 004, was referred to allow for additional study.

CEJA 3, Confidential Care for Minors, was adopted. This report recommends that Opinion E-5.055, "Confidential Care for Minors", be amended to clarify that minors' ability to consent to treatment for a sexually transmitted disease (current policy) also includes the ability to consent to measures to prevent sexually transmitted diseases.

Reference Committee A

Members of the HOD voted to adopt the recommendations of *CMS Report 5, Delivery of Care and Financing Reform for 25 Medicare and Medicaid Dually Eligible Beneficiaries*. The recommendations consist of a series of principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible beneficiaries. The recommendations include: a. Various approaches to integrated delivery of care should be promoted under demonstrations such as primary care medical homes with adequate payment to physicians, provision of care management and mental health resources; b. Customized benefits and services from health plans are necessary according to each beneficiary's specific medical needs; c. Care coordination demonstrations should not interfere with the established patient-physician relationships in this vulnerable population; d. Delivery and payment reform for dually eligible beneficiaries should involve actively practicing physicians and take into consideration the diverse patient population and local area resource; e. States with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; f. Conflicting payment rules between the Medicare and Medicaid programs should be eliminated; g. Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated and h. Care plans for beneficiaries should be streamlined among all clinical providers and social service agencies.

Members of the HOD voted to approve *substitute Resolution 116, Extending Medicaid Payment Increases to Primary Care Physicians to Include Obstetricians/Gynecologists* which asks the AMA to advocate for the expansion of the Medicaid payment increases to primary care physicians. Primary care physicians include all physicians (including psychiatrists) who furnish a substantial portion (60%) of their Medicare or Medicaid billings for designated primary care services. Note: Psychiatry is not currently defined by CMS as a "primary care" specialty however if CMS adopts the above criteria, any psychiatrist who meets the definition would be eligible for the bump in payment. APA and others have also had legislation

introduced on the Hill supporting a move to designate psychiatrists, neurologists and ob-gyns as primary care providers (and thus eligible for the Medicaid bump in payment).

Reference Committee B

Resolution 203, Needle Exchange program, was approved by members of the HOD. This amended resolution supports the referral of patients to established programs and asks that AMA advocate that employees of the needle exchange program be protected from prosecution.

The AMA adopted policy that recognizes the crisis of inadequate public health funding and encourages all medical societies to work together to restore resources at the state and local level. *(Resolution 206, Preservation of public health infrastructure)*

Resolutions 221, Gun Control and Mental Illness, and *222, National Violent Death Reporting System Gun* were discussed as one. The HOD voted to adopt substitute resolution 221 which asks AMA to support research on firearm related injuries and deaths, increase funding for firearms injury registries, encourage patient education on firearm safety, enhance access to mental and cognitive health care with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders and work with state and specialty medical societies to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Members of the HOD voted to approve *Resolution 228, The Safe Act,* which asks that AMA immediately seek an opinion and guidance from HHS Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the NY state SAFE Act and federal HIPAA Regulations. This action was brought forward by the MSSNY in conjunction with NYSPA.

Resolution 231, Redefining the AMA's Position on ACA and Healthcare Reform was adopted as amended. This resolution asks that AMA refine its position on the ACA and develop policy statements on specific aspects of the legislation. This includes opposition to all P4P or VBP that fail to comply with AMA's Principles and Guidelines; continuing advocacy for the repeal of the SGR and Independent Payment Advisory Board (IPAB) and the adoption of a payment mechanism that supports AMA Principles; support for medical savings accounts, flexible spending accounts and the Medicare Patient Empowerment Act (private contracting); support for steps that will reduce healthcare spending, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage and protect Medicare; and repeal of the no-physician provider non-discrimination provisions of the ACA. The AMA was also directed to designate resources for a multipronged approach to accomplishing these goals.

Reference Committee C

CME Report 4, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, members of the HOD voted to adopt the recommendations in this report. The recommendations are to: reaffirm AMA policy (H-275.923, Maintenance of Certification/Maintenance of Licensure), to reinforce that our AMA encourages rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time; and 2. To reaffirm AMA policy (H-275.924, Maintenance of Certification), to reinforce that any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones); and to 3. continue to monitor and be actively involved in the evolution of these certification programs and report back to the HOD.

The HOD approved an amended *Resolution 307, Support for Residents and Fellows During Family and Medical Leave Time*, which asks that specialty boards and RRC's study alternative pathways for completion of coursework to provide those taking family or medical leave have an opportunity to graduate as closely as they can to their original date.

Reference Committee D

CSAPH 3, Is Obesity a Disease? was adopted by the HOD. The CSAPH report examines the definitions of obesity and disease, the limitations of those definitions, and arguments both for and against the classification of obesity as a disease. The possible implications for provider reimbursement, public policy, and patient stigma were also considered as well as the potential impact of classifying obesity as a disease on improving patient care and health outcomes. The report did not, however, recommend that obesity be classified as a disease but *Resolution 420, Recognition of Obesity as a Disease,* was adopted. There was mixed testimony on the issue. The delegates voted to support the adoption of Resolution 420 which recognizes obesity as a disease. Patrice Harris, MD, has been a spokesperson for the BOT on this issue following the adoption of the resolution.

The HOD voted to approve *Resolution 410, Physicians and the Public Health Issue of Gun Safety*, which asks AMA to ask the US Surgeon General to produce a report and educational campaign aimed at reducing the number of firearm related injuries and deaths.

Reference Committee E

CSAPH 7, Genetic Discrimination and Genetic Information Nondiscrimination Act, was adopted by the HOD. This report examines genetic discrimination and the Genetic Information Nondiscrimination Act (GINA), and identifies gaps in protections and the necessary steps toward filling those gaps and strengthening protections.

Delegates voted to approve *CSAPH 8, National Drug Shortages: Update.* Testimony expressed strong support for the Council report and the ongoing work of the Council in helping to monitor the issue of drug shortages and keeping the HOD informed.

Resolution 512, Cannabis Decriminalization, Regulation and Taxation was referred; the CSAPH is currently working on a report on federal drug policies.

Substitute Resolution 518, FDA Recommendation on Scheduling of Hydrocodone Combination Products was adopted which asks AMA to issue a public statement to the Commissioner of the FDA, urging her to issue a scientifically-based recommendation for changing hydrocodone combination products from Schedule III to Schedule II of the Controlled Substances Act.

Reference Committee F

BOT 11, Designation of Specialty Societies for Representation of the House of Delegates, was referred. This report recommended the discontinuation of the specialty balloting process which impacts the delegate count. While members of the HOD supported the discontinuation of that process, there was insufficient information in the report to clearly understand the impact on specialty delegation size. The HOD voted to refer the report, requesting additional information.

Members of the HOD voted down *BOT 30, Future of the Interim Meeting of the House of Delegates,* which recommended discontinuation of the AMA Interim meeting. There was mixed testimony on the issue and as a result it lacked a sufficient number of votes for adoption.

Council on Constitution and Bylaws / Council on Long Range Planning and Development 27 Report 1 – AMA Policy Directives which are Obsolete, Duplicative or Accomplished. This report was amended following testimony on the floor by the Section Council on Psychiatry to retain of Policy D-49 180.998, "Insurance Parity for Mental Health and Psychiatry," because the intent of the directive has not yet been accomplished despite the passage of mental health parity.

Reference Committee G

BOT 26, Security of Telemedicine Communication, which recommends that AMA collaborate with the American Telemedicine Association to develop physician and patient specific content on the use of telemedicine services was approved.

Resolution708, Mental Health Services for School-Aged Children (co-sponsored by AACAP), was referred. The HOD voted to refer this issue to gather more information and to ensure that AMA remains engaged in the discussions about this issue.

Resolution 710, Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy, asks AMA to oppose restrictions that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder. The HOD approved this resolution in spite of concerns that were raised that to do so may impact the work currently occurring to re-evaluate the methods for treating chronic pain and addiction, balancing patient safety and patient access. As stated in their report "Your Reference Committee appreciates this concern, but concurs with testimony that preserving the patient-physician relationship and eliminating unwarranted interference by third parties is critically important. Issues related to the risks associated with the use and abuse of controlled substances need to be addressed in ways that do not interfere with a physician's ability to exercise professional judgment."

The HOD passed amended *Resolution 712, Patient Access to Independent Appeal and Grievance Procedures,* which asks AMA to establish an External Grievance procedure for all health plans including those under the Patient Protection and Affordable Care Act (PPACA).

Resolution716, Criminalization of Good Faith Errors, which asks that AMA oppose the criminalization of good faith errors in medical judgment and medical record keeping, and adopt a policy that in the absence of fraud, errors in the preparation of medical records should not be criminalized, was adopted by the House.

Members of the HOD approved *Resolution 719, Prescription Management – Changing the Renewal Length to Improve Practice Efficiency and Quality of Care,* which asks that AMA work with the State Boards of Pharmacy and the state legislatures to extend the validity of state non-controlled substance prescription renewal length to 13 months.

For more information on the AMA Annual Meeting go to:

http://www.ama-assn.org/ams/pub/meeting/index.shtml

Social Media and Interview Activities at the AMA HOD Meeting, June 14-18

Social media activities were in full swing at the AMA House of Delegates Meeting.

Twitter
Tweets were sent out real time during House of Delegates meetings, Psychiatric Caucus Meetings, Council on Psychiatry meetings, and social events. Tweets ranged from resolutions up for discussion before the HOD, features on Reference Committee Chairs, real time photos of the election of the new President-elect, and pictures of Section Council on Psychiatry members in action at the meeting. Twenty -five tweets were sent out over the course of the meeting, with 120 new followers gained, and 107 re-tweets, including a re-tweet for the very first time from the AMA (on the Medical Student Showcase), and one from AACAP (on the topic of obesity).

Facebook
For Facebook, 32 new postings were added over the course of the meeting included 21 pictures and interviews with APA CEO and Medical Director, James Scully, MD, CEO-Designee, Saul Levin, MD, Reference Committee Chair, Jerry Halverson, MD, 2 interviews with Anita Chu, M.D., Anna Piotrowski, MD, Ray Hsiao, MD, APA President-elect Paul Summergrad, MD, and AMA Delegate Patrice Harris, MD

Results
Comments and likes were posted on just about every picture and video we posted. Members of the AMA Section Council on Psychiatry delegation and other members of the APA were also involved and following along with our social media activities all week long.

25 followers shared our pictures and video with others and we gained hundreds of new "likes" for our postings.

Here is an example of the reach we saw:

- The pictures of APA Young Psychiatrists talking with medical students were viewed 4,132 times
- The posting about Obesity being recognized as a disease was viewed 5,796 times
- The photo of the Section Council on Psychiatry showing Dr. Lazarus their appreciation by giving him a gift was viewed 3,230 times.

Formal interviews were also conducted for the Website with Jeremy Lazarus, M.D., Patrice Harris, MD, and Saul Levin, MD. The interview with Dr. Lazarus is up on the main page of our website.

http://www.psychiatry.org/advocacy--newsroom/newsroom/video-news

AMERICAN PSYCHIATRIC ASSOCIATION
Audit Committee
Report to the Board of Trustees

David Fassler, MD, Chair

Action:

Will the Board of Trustees accept the 2012 Audited Financial Statements as presented?

AMERICAN PSYCHIATRIC ASSOCIATION
Audit Committee
Report to the Board of Trustees

David Fassler, MD, Chair

The Audit Committee met on June 1, 2013. The Committee was joined by Terri McKnight of Gelman, Rosenberg, and Freedman.

The audited financial statements were presented by APA's auditors. The audit was conducted according to the approved audit plan, and included an audit of the consolidated financial statements, as well as looking at the individual entities – APA and APF.

Ms. McKnight presented the 2012 audited financial statements, A-133, and required correspondence to the audit committee. The opinion rendered by Gelman is a "clean" opinion which is the desired result. There were no material weaknesses; therefore, no management letter was required.

Action:

Will the Board of Trustees accept the 2012 Audited Financial Statements as presented?

DATE

To the Board of Trustees
American Psychiatric Association and Affiliates
Arlington, Virginia

We have audited the consolidated financial statements of the American Psychiatric Association and Affiliates (the Association) for the year ended December 31, 2012, and have issued our report thereon dated DATE. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated February 6, 2013. Professional standards also require that we communicate to you the following information related to our audit.

- **Qualitative Aspects of Accounting Practices**

  Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Association are described in Note 1 to the consolidated financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended December 31, 2012. We noted no transactions entered into by the Association during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the consolidated financial statements in the proper period.

  Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

The most sensitive estimates affecting the consolidated financial statements were:

- Valuation and collectability of receivables
- Allocation of expenses between APA and its affiliates
- The capitalized costs associated with DSM V
- Fair value of investments and liabilities

We evaluated the key factors and assumptions used to develop these estimates in determining that they are reasonable in relation to the consolidated financial statements taken as a whole.

The disclosures in the consolidated financial statements are neutral, consistent and clear. Certain consolidated financial statement disclosures are particularly sensitive because of their significance to financial statement users.

- **Difficulties Encountered in Performing the Audit**

  We encountered no significant difficulties in dealing with management in performing and completing our audit.

- **Corrected and Uncorrected Misstatements**

  Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements.

  As a result of audit procedures, we recorded three (3) adjusting journal entries to the American Psychiatric Foundation that, in the aggregate, increased the net assets by approximately $59,900. Additionally, we recorded three (3) adjusting journal entries to the American Psychiatric Association that, in the aggregate, increased the net assets by approximately $485,000. The most significant entries were to adjust beginning balance net assets to actual and adjust prepaid tax expense balance.

  In the aggregate, after recording eliminating inter-company transactions, the net effect on the consolidated net assets of the Association was an increase of approximately $932,000.

- **Disagreements with Management**

  For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the consolidated financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

- **Management Representations**

  We have requested certain representations from management that are included in the management representation letter dated DATE.

- **Management Consultations with Other Independent Accountants**

  In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Association's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

- **Other Audit Findings or Issues**

  We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Association's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

With respect to the supplementary information accompanying the consolidated financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with U.S. generally accepted accounting principles, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the consolidated financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the consolidated financial statements or to the consolidated financial statements themselves.

This information is intended solely for the use of the Audit Committee, Board of Trustees and management of the American Psychiatric Association and Affiliates and is not intended to be, and should not be, used by anyone other than these specified parties.

Bethesda, Maryland
DATE

To the Board of Trustees
American Psychiatric Association and Affiliates
Arlington, Virginia

In planning and performing our audit of the consolidated financial statements of the American Psychiatric Association and Affiliates (the Association) as of and for the year ended December 31, 2012, in accordance with auditing standards generally accepted in the United States of America, we considered the Association's internal control over financial reporting (internal control) as a basis for designing our auditing procedures, for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Association's internal control. Accordingly, we do not express an opinion on the effectiveness of the Association's internal control.

Our consideration of the Association's internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in the Association's internal control that might be significant deficiencies or material weaknesses; therefore, there can be no assurance that all such deficiencies have been identified. However, as discussed below, we identified certain deficiencies in the Association's internal control, in prior years, that we considered to be significant deficiencies.

A deficiency in the Association's internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency or combination of deficiencies in the Association's internal control, such that there is a reasonable possibility that a material misstatement of the Association's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. We did not identify any deficiencies in the Association's internal control that we consider to be material weaknesses.

PRIOR YEAR COMMENTS WITH CURRENT YEAR STATUS

Key Personnel

APF A-133 Finding 2011-1: Under 45 CFR, Part 74.25(c)1 Recipients shall obtain prior approvals from the awarding agency for changes in the project director or principal investigator or other key persons specified in the award document. Cumulatively, the grants name seven (7) employees as key personnel and assign a level of effort percentage to each position. During our review of these seven (7) key personnel, we were informed that two (2) of the employees named in the grant, terminated with APF in 2010. Furthermore, two (2) additional employees did not charge any time to the respective grants during the fourteen month period ended December 31, 2011, indicating no level of effort spent on the programs. A failure to notify the awarding agency of changes in key personnel is a violation of the grant terms and conditions. We recommend that APF take the appropriate action to notify the awarding agency of the changes in key personnel and level of efforts. Furthermore, any future changes should have prior documented approval from the awarding agency.

Current Year Status: During the year under audit, APF appropriately notified the granting agency of changes in key personnel and level of efforts.

Allowable Costs

APF A-133 Finding 2011-2: In January, 2012, APF received notification from the NYU School of Medicine (NYUSOM) to report that they would reimburse APF $320,627 for unsupported expenditures and $12,649 for costs that should not have been charged to the grant between 2002 and 2010. We recommend that APF promptly repay the federal government upon receipt of funds from NYUSOM.

Current Year Status: The funds were returned to the government in May of 2012. APF has not been notified of any additional unsupported costs for the year under audit.

This communication is intended solely for the information and use of the Audit Committee, management, the Board of Trustees and others within the American Psychiatric Association and Affiliates and is not intended to be, and should not be, used by anyone other than these specified parties.

Bethesda, Maryland
DATE

CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONTENTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees
American Psychiatric Association and Affiliates
Arlington, Virginia

We have audited the accompanying consolidated financial statements of the American Psychiatric Association and Affiliates (the Association) (a non-profit organization), which comprise the consolidated statements of financial position as of December 31, 2012 and 2011, and the related consolidated statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Association as of December 31, 2012 and 2011, and the consolidated changes in its net assets and its consolidated cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental schedules on pages 29 - 37 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Bethesda, Maryland

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2012 AND 2011
(DOLLARS IN THOUSANDS)

ASSETS

	2012	2011
CURRENT ASSETS		
Cash and cash equivalents	$ 11,591	$ 16,007
Receivables:		
Accounts receivable, net	2,886	4,293
Grants and contracts receivable, net	209	439
Contributions receivable	644	101
Income taxes receivable	832	870
Publications inventory, net	882	1,177
Prepaid expenses	623	658
Total current assets	17,667	23,545
FIXED ASSETS		
Furniture and equipment	1,374	1,630
Software	3,534	4,661
Leasehold improvements	838	829
Website development	38	-
	5,784	7,120
Less: Accumulated depreciation and amortization	(3,436)	(4,349)
Net fixed assets	2,348	2,771
OTHER ASSETS		
Investments (Notes 2, 7 and 11)	74,559	68,810
DSM 5 development costs	21,628	18,234
Assets held under unitrust agreement (Notes 3 and 11)	112	115
Deposits	162	162
Total other assets	96,461	87,321
TOTAL ASSETS	**$ 116,476**	**$ 113,637**

See accompanying notes to consolidated financial statements.

LIABILITIES AND NET ASSETS

	2012	2011
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	$ 4,923	$ 6,108
Deferred revenue:		
Membership	4,684	4,533
Subscriptions	3,636	3,624
Meetings	1,031	806
Other deferred revenue, current portion	1,043	1,007
Current portion of deferred rent abatement (Note 8)	165	102
Liability under unitrust agreement, current portion (Note 3)	8	8
Refundable advance	-	317
Total current liabilities	15,490	16,505
LONG-TERM LIABILITIES		
Accrued pension liability (Notes 7 and 11)	5,632	4,681
Other deferred revenue, net of current portion	1,420	2,420
Deferred rent abatement, net of current portion (Note 8)	1,345	1,500
Deferred compensation plan (Notes 2 and 7)	1,359	1,007
Liability under unitrust agreement, net of current portion (Note 3)	58	64
Total long-term liabilities	9,814	9,672
Total liabilities	25,304	26,177
NET ASSETS		
Unrestricted (Note 4)	85,014	81,895
Temporarily restricted (Note 5)	5,656	5,064
Permanently restricted (Notes 2 and 6)	502	501
Total net assets	91,172	87,460
TOTAL LIABILITIES AND NET ASSETS	**$ 116,476**	**$ 113,637**

See accompanying notes to consolidated financial statements.

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATED STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(DOLLARS IN THOUSANDS)

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE				
Publications	$ 19,702	$ -	$ -	$ 19,702
Annual meeting	8,194	-	-	8,194
Membership dues	9,663	-	-	9,663
Contributions	649	2,286	1	2,936
Government grants and contracts	1,277	-	-	1,277
Label sales	83	-	-	83
Royalties	-	-	-	-
Other revenue	481	-	-	481
Change in value of unitrust agreement (Note 3)	-	(2)	-	(2)
Net assets released from donor restrictions (Note 5)	1,996	(1,996)	-	-
Total revenue	42,045	288	1	42,334
EXPENSES				
Program Services:				
Publications	12,503	-	-	12,503
CME and life long learning	6,543	-	-	6,543
External affairs	4,617	-	-	4,617
Research and OMNA	4,698	-	-	4,698
Member relations	1,778	-	-	1,778
Public education	1,468	-	-	1,468
Total program services	31,607	-	-	31,607
Supporting Services:				
General and administrative	11,003	-	-	11,003
Governance	2,798	-	-	2,798
Total supporting services	13,801	-	-	13,801
Total expenses	45,408	-	-	45,408
Changes in net assets before other items	(3,363)	288	1	(3,074)
OTHER ITEMS				
Investment income (loss) (Note 2)	7,826	304	-	8,130
Cancellation - grant expense	-	-	-	-
Minimum pension liability adjustment (Note 7)	(1,276)	-	-	(1,276)
Income tax expense	(68)	-	-	(68)
Total other items	6,482	304	-	6,786
Changes in net assets	3,119	592	1	3,712
Net assets at beginning of year	81,895	5,064	501	87,460
NET ASSETS AT END OF YEAR	**$ 85,014**	**$ 5,656**	**$ 502**	**$ 91,172**

See accompanying notes to consolidated financial statements.

2011			
Unrestricted	Temporarily Restricted	Permanently Restricted	Total
$ 22,167	$ -	$ -	$ 22,167
8,242	-	-	8,242
9,721	-	-	9,721
611	1,753	-	2,364
1,245	-	-	1,245
113	-	-	113
1,500	-	-	1,500
678	-	-	678
-	(4)	-	(4)
2,254	(2,254)	-	-
46,531	(505)	-	46,026
12,790	-	-	12,790
6,352	-	-	6,352
4,085	-	-	4,085
4,682	-	-	4,682
1,766	-	-	1,766
1,706	-	-	1,706
31,381	-	-	31,381
10,598	-	-	10,598
2,712	-	-	2,712
13,310	-	-	13,310
44,691	-	-	44,691
1,840	(505)	-	1,335
(2,080)	(128)	-	(2,208)
(478)	-	-	(478)
(1,142)	-	-	(1,142)
(83)	-	-	(83)
(3,783)	(128)	-	(3,911)
(1,943)	(633)	-	(2,576)
83,838	5,697	501	90,036
$ 81,895	**$ 5,064**	**$ 501**	**$ 87,460**

See accompanying notes to consolidated financial statements.

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(DOLLARS IN THOUSANDS)

	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	$ 3,712	$ (2,576)
Adjustments to reconcile changes in net assets to net cash used by operating activities:		
Depreciation and amortization	783	794
Unrealized (gain) loss	(6,375)	6,127
Realized loss (gain)	376	(2,241)
Permanently restricted contributions	(1)	-
Change in value of liability under unitrust agreement	2	4
Direct write-off of contributions receivable	5	(487)
Change in allowance and direct write-offs for obsolete inventory	22	(131)
Loss on disposal of fixed assets	6	172
(Increase) decrease in:		
Accounts receivable	1,407	2
Grants and contracts receivable, net	230	576
Contributions receivable	(548)	335
Income taxes receivable	38	971
Publications inventory	273	230
Prepaid expenses	35	(293)
DSM 5 development costs	(3,394)	(5,028)
Increase (decrease) in:		
Accounts payable and accrued liabilities	(1,185)	672
Deferred revenue	(576)	(1,539)
Deferred rent abatement	(92)	(39)
Refundable advance	(317)	317
Accrued pension liability	951	956
Deferred compensation plan	352	234
Net cash used by operating activities	(4,296)	(944)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of fixed assets	(366)	(787)
Purchase of investments	(5,507)	(19,751)
Sale of investments	5,760	10,768
Net cash used by investing activities	(113)	(9,770)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payment to beneficiary under unitrust agreement	(8)	(9)
Permanently restricted contributions	1	-
Net cash used by financing activities	(7)	(9)

See accompanying notes to consolidated financial statements.

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011
(DOLLARS IN THOUSANDS)

	2012	2011
Net decrease in cash and cash equivalents	$ (4,416)	$ (10,723)
Cash and cash equivalents at beginning of year	16,007	26,730
CASH AND CASH EQUIVALENTS AT END OF YEAR	**$ 11,591**	**$ 16,007**
SUPPLEMENTAL INFORMATION:		
Taxes Paid	**$ 31**	**$ -**

See accompanying notes to consolidated financial statements.

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION

Organizations -

American Psychiatric Association -

The American Psychiatric Association (APA) was incorporated in 2000 as a 501(c)(6) trade association. Its 35,000 U.S. and international physician members specialize in the diagnosis and treatment of mental and emotional disorders and substance abuse disorders. APA's goals and activities include advocating for patients; advocating for the profession; supporting education, training and career development; and defining and supporting professional values. These activities are funded primarily through membership dues, annual meeting fees, and publications sales and advertising.

American Psychiatric Foundation -

The American Psychiatric Foundation (APF) was incorporated in December 1981 under the District of Columbia Non-Profit Corporation Act. The mission of APF is to engage in public education, research and fundraising activities of APA affiliated organizations through private and governmental contracts and grants.

The Board of Trustees of APF consists of thirteen (13) voting members. Nine (9) of the members are appointed by the Board of Trustees of APA. The sole corporate member of APF is APA.

American Psychiatric Insurance Trust -

The American Psychiatric Insurance Trust (APIT) is a grantor trust established by APA in 1984, under the laws of the state of Delaware.

American Psychiatric Association Political Action Committee -

The American Psychiatric Association Political Action Committee (APAPAC), an unincorporated separate fund of APA, was established in 2001 and is registered under the Federal Election Campaign Act of 1971 (as amended). APAPAC is controlled by a Board of Trustees appointed by APA.

APAPAC seeks to promote good citizenship through personal and financial participation in the elective process by providing interested eligible persons an opportunity to contribute to the support of worthy candidates for federal office who believe and have demonstrated their beliefs in the principles to which APA is dedicated, including the advancement of psychiatry and excellence in the care and delivery of psychiatric services.

Basis of presentation -

The accompanying consolidated financial statements reflect the activities of the above-mentioned organizations for the years ended December 31, 2012 and 2011.

The financial statements of APA and its affiliates (collectively, the Association) have been consolidated because they are under common control. All intercompany transactions have been eliminated in consolidation.

The accompanying consolidated financial statements are presented on the accrual basis of accounting, and in accordance with FASB ASC 958-810, *Not-for-Profit Entities*, *Consolidation*.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Cash and cash equivalents -

The Association considers all cash and other highly liquid investments with initial maturities of three months or less to be cash equivalents. All other highly liquid instruments, which are to be used for long-term purposes of the Association, are classified as investments.

Through December 31, 2012, the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank Act") provided temporary unlimited deposit insurance coverage for non-interest bearing transaction accounts at all Federal Deposit Insurance Corporation (FDIC) insured depository institutions (the "Dodd-Frank Deposit Insurance Provision"). The Association maintained a portion of its cash balance at a financial institution in a non-interest bearing account; thereby, all of this cash balance was protected by the FDIC under this Act. Beginning January 1, 2013, funds deposited in non-interest bearing accounts will no longer receive unlimited deposit insurance coverage. Bank deposit accounts at one institution will be insured by the FDIC up to a limit of $250,000. Management believes the risk in these situations to be minimal.

At times during the year, the Association maintains cash balances in interest bearing accounts at financial institutions in excess of the Federal Deposit Insurance Corporation (FDIC) limits. As of December 31, 2012 and 2011, the amount of uninsured cash was approximately $717,000 and $6,055,000, respectively.

Investments -

Investments are recorded at their readily determinable fair value. Realized and unrealized gains and losses are included in investment income (loss) in the Consolidated Statements of Activities and Changes in Net Assets.

Accounts receivable -

Accounts receivable approximate fair value. Accounts receivable consists of amounts due to the Association from the sale of its books and other publications, and advertising. The allowance for doubtful accounts is determined based upon an annual review of account balances, including the age of the balance, subsequent collections, historical experience with the customer and an assessment of the general financial conditions affecting the customer base. As of December 31, 2012 and 2011, the Association has established an allowance of approximately $497,000.

Grants and contracts receivable -

Grants and contracts receivable approximate fair value. The allowance for doubtful accounts is determined based upon an annual review of account balances, including the age of the balance, subsequent collections and historical experience with the grantor.

During the year ended December 31, 2011, management deemed that approximately $478,000 of the grants and contracts receivable balance was uncollectible and, accordingly, established an allowance for doubtful accounts in that amount. As of December 31, 2012, the allowance and the related uncollectible grants and contract receivable balances remain unchanged.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Contributions receivable -

Contributions receivable approximate fair value. Management considers all amounts to be fully collectible within one year. Accordingly, neither an allowance for doubtful accounts nor a discount has been established.

Publications inventory -

Publications inventory consists of books and other written materials and is stated at the lower of cost or net realizable value using the weighted average cost method. The Association establishes a reserve for obsolete publications inventory based upon historical sales trends to reflect estimated net realizable value. For the years ended December 31, 2012 and 2011, the Association established a reserve of approximately $807,000 and $796,000, respectively.

Prepaid expenses -

Prepaid expenses include advance royalties paid on unpublished manuscripts. These costs are charged to expense over three years beginning when the manuscripts are published or immediately expensed if determined to be abandoned.

Fixed assets -

Fixed assets in excess of $5,000 are capitalized and stated at cost. Furniture, equipment and software are depreciated on a straight-line basis over the estimated useful lives of the related assets, generally three to five years. Leasehold improvements are depreciated over the lesser of the remaining life of the lease or estimated useful life of the improvements. The cost of maintenance and repairs is recorded as expenses are incurred.

Certain costs of internally developed software and website development are capitalized. These costs are being amortized over the estimated useful lives of the software and website which is estimated to be three to five years.

Rare book collections -

The Association does not capitalize its collections, which consist principally of rare books and early writings associated with the care and treatment of the mentally ill, as their relative financial significance is generally not objectively determinable.

The Association maintains these historical writings using techniques to preserve their integrity for future generations. There were no sales or disposals for the years ended December 31, 2012 and 2011.

DSM 5 development costs -

All costs, including materials and direct labor, associated with the production of the fifth edition of the publication *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) are capitalized as incurred. DSM 5 is expected to be published in May 2013, at which time, these costs will be included in inventory and expensed through cost of goods sold as DSM 5 is sold. As of December 31, 2012 and 2011, total capitalized DSM 5 development costs were approximately $21,628,000 and $18,234,000, respectively.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Intangible assets -

Intangible assets consist of the following items that resulted from the 2010 sale of APF publishing business to APA:

- DSM IV Publications rights. To be amortized over two years starting in 2011.
- DSM 5 Publication rights. To be amortized over seventeen years starting in 2013.
- Non-DSM Publication rights including various copyrights, trademarks and goodwill. To be evaluated annually for impairment.

The Association periodically reviews the carrying value of its publications and trademarks to determine whether an impairment exists. During the year ended December 31, 2012 it was determined that the Non-DSM Publication rights were impaired and, accordingly, written down by the $211,000 loss in value. There were no determined impairments for the year ended December 31, 2011. Intangible assets were eliminated in consolidation.

Deferred revenue -

Deferred membership dues and subscription payments received in advance are recognized over the membership and subscription period. Meeting registration fees received in advance are recognized when the meeting is held. Other deferred revenue is recognized when earned.

Net asset classification -

The net assets are reported in three self-balancing groups as follows:

- **Unrestricted net assets** include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of the Association and include both internally designated and undesignated resources.
- **Temporarily restricted net assets** include revenue and contributions subject to donor-imposed stipulations that will be met by the actions of the Association and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the Consolidated Statements of Activities and Changes in Net Assets as net assets released from restrictions.
- **Permanently restricted net assets** represent funds restricted by the donor to be maintained in-perpetuity by the Association. There are restrictions placed on the use of investment earnings from these endowment funds.

Contributions, grants and contracts -

Unrestricted and temporarily restricted contributions and grants are recorded as revenue in the year notification is received from the donor. Temporarily restricted contributions and grants are recognized as unrestricted support only to the extent of actual expenses incurred in compliance with the donor-imposed restrictions and satisfaction of time restrictions.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Contributions, grants and contracts (continued) -

Temporarily restricted contributions and grants received in excess of expenses incurred are shown as temporarily restricted net assets in the accompanying consolidated financial statements. Conditional promises to give are not included as support until the conditions are met.

The Association receives funding under grants and contracts from the U.S. Government for direct and indirect program costs. This funding is subject to contractual restrictions, which must be met through incurring qualifying expenses for particular programs. Accordingly, such grants are considered exchange transactions and are recorded as unrestricted income to the extent that related expenses are incurred in compliance with the criteria stipulated in the grant agreements.

Grants and contracts receivable represents amounts due from funding organizations for reimbursable expenses incurred in accordance with the grant agreements. Grant and contract funding received in advance of incurring the related expenses is included in other deferred revenue in the Consolidated Statements of Financial Position.

Publications revenue -

Publications revenue is recorded when the related publication is shipped and is reported in the accompanying Consolidated Statements of Activities and Changes in Net Assets, net of any returns and discounts. Cost of goods sold of approximately $613,000 and $817,000 is included in publications expense for the years ended December 31, 2012 and 2011, respectively.

Income taxes -

APA is exempt from the payment of Federal and state taxes on income, other than net unrelated business income, under Section 501(c)(6) of the Internal Revenue Code. APA receives unrelated business income from advertising and psychiatry placement services.

During the years ended December 31, 2012 and 2011, APA generated approximately $4,470,000 and $5,941,000, respectively, in gross taxable unrelated business income. APA has recorded a Federal and state tax receivable of approximately $832,000 and $870,000 as of December 31, 2012 and 2011, respectively. The tax expense associated with the unrelated business income totaled approximately $68,000 and $83,000 for the years ended December 31, 2012 and 2011, respectively.

APF is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying consolidated financial statements as this organization had no taxable unrelated business income. APF is not a private foundation.

APIT is exempt from the payment of Federal and state income taxes as it is a grantor trust and all income and expenses pass through to APA.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Income taxes (continued) -

APAPAC is exempt from Federal income taxes under Section 527 of the Internal Revenue Code. This section does not exempt taxation of investment income. No income taxes were payable at December 31, 2012 and 2011, respectively.

Uncertain tax positions -

In June 2006, the Financial Accounting Standards Board (FASB) released FASB ASC 740-10, *Income Taxes*, that provides guidance for reporting uncertainty in income taxes. For the years ended December 31, 2012 and 2011, the Association has documented its consideration of FASB ASC 740-10 and determined that no material uncertain tax positions qualify for either recognition or disclosure in the consolidated financial statements. The Federal Form 990, *Return of Organization Exempt from Income Tax*, is subject to examination by the Internal Revenue Service, generally for three years after it is filed.

Use of estimates -

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

Functional allocation of expenses -

The costs of providing the various programs and other activities have been summarized on a functional basis in the Consolidated Statements of Activities and Changes in Net Assets. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

Risks and uncertainties -

The Association invests in various investment securities. Investment securities are exposed to various risks such as interest rates, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying consolidated financial statements.

Fair value measurement -

The Association adopted the provisions of FASB ASC 820, *Fair Value Measurement*. FASB ASC 820 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the quality of inputs (assumptions that market participants would use in pricing assets and liabilities, including assumptions about risk) used to measure fair value, and enhances disclosure requirements for fair value measurement. The Association accounts for a significant portion of its financial instruments at fair value or considers fair value in their measurement.

2. INVESTMENTS

Investments consisted of the following at December 31, 2012 and 2011:

(In Thousands)

	2012	2011
	Fair Value	
Money market funds	$ 2,296	$ 2,270
Equities	7,733	9,974
Alternative investments	12,826	11,210
Mutual funds:		
Artio International Equity Fund	-	4,357
Baird Aggregate Bond Fund	8,099	-
Delaware Pooled High-Yield Bond Fund	2,730	-
Dodge and Cox International Stock Fund	5,209	-
Eaton Vance Floating Rate Fund	2,740	2,531
Fidelity Floating Rate High Income Fund	-	2,511
Vanguard Total Bond Market Index Fund	6,532	15,393
Vanguard Total International Stock Index Fund	5,569	4,708
Vanguard Total Stock Market Index Fund	20,825	15,856
TOTAL INVESTMENTS	**$ 74,559**	**$ 68,810**

Included in investments as of December 31, 2012 and 2011 is approximately $502,000 and $501,000, respectively, representing the Association's permanently restricted endowment funds (see Note 6).

Also included in investments as of December 31, 2012 and 2011 is approximately $1,371,000 and $1,022,000, respectively, of assets held for the deferred compensation plan (see Note 7).

Alternative investments, and the respective terms of the agreements, are comprised of the following at December 31, 2012 and 2011:

(In Thousands)

Investment Type	2012	2011	Liquidity
Pinehurst Institutional Ltd. with Citigroup	$ 3,966	$ 3,642	Hedge fund of a fund. Quarterly liquidity with 90 days notice; no initial lockup period.
Common Sense Long-Biased Offshore Ltd.	3,643	3,568	Hedge fund of a fund. Quarterly liquidity with 100 days notice; one (1) year lockup period. Lockup amount of $1,000,000 expired in May 2012.
Morgan Stanley Prime Property Fund	5,217	4,000	Real estate fund. Quarterly liquidity; no initial lockup period.
ALTERNATIVE INVESTMENTS	**$ 12,826**	**$ 11,210**	

2. INVESTMENTS (Continued)

Included in investment income (loss) are the following at December 31, 2012 and 2011:

	(In Thousands)	
	2012	**2011**
Interest and dividends	$ 2,131	$ 1,678
Unrealized gain (loss)	6,375	(6,127)
Realized (loss) gain	(376)	2,241
TOTAL INVESTMENT INCOME (LOSS)	**$ 8,130**	**$ (2,208)**

Interest income includes interest earned on operating cash and cash equivalents.

3. CHARITABLE REMAINDER UNITRUST

APF is the Trustee of a charitable remainder unitrust. The beneficiary of the trust is to receive payments equal to 7% of the fair value of the trust assets annually. Upon the death of the beneficiary, the trust assets, including accumulated investment earnings, pass to APF for its unrestricted use.

In accordance with accounting principles generally accepted in the United States of America, the assets held in trust under the agreement and the estimated liability have been recorded at fair value in the Consolidated Statements of Financial Position. On an annual basis, the Association revalues the estimated liability based on applicable mortality tables and discount rates. The difference between the change in the fair value of the assets received and the liability to the beneficiary is recognized as temporarily restricted revenue. As of December 31, 2012 and 2011, the assets held for the unitrust agreements were approximately $112,000 and $115,000, respectively.

The estimated liability at December 31, 2012 and 2011 was calculated using the following assumptions:

	2012	**2011**
Long-term rate of return on assets	8.00%	8.00%
Discount rate on future payments to beneficiary	2.54%	2.57%
Estimated period of distributions to beneficiary	9 years	10 years

	(In Thousands)	
	2012	**2011**
Liability under unitrust agreement	$ 82	$ 91
Less: Discount to present value	(16)	(19)
Net liability under unitrust agreement	66	72
Less: Current portion	(8)	(8)
LIABILITY UNDER UNITRUST AGREEMENT, NET OF CURRENT PORTION	**$ 58**	**$ 64**

4. BOARD DESIGNATED NET ASSETS

As of December 31, 2012 and 2011, net assets have been designated by the Board of Trustees for the following purposes:

	(In Thousands)	
	2012	**2011**
American Psychiatric Association (APA):		
Reserve Replenishment Fund	$ 23,134	$ 20,910
Lump Sum Dues	94	85
Special Projects	331	312
Total APA Board Designated Net Assets	23,559	21,307
American Psychiatric Foundation (APF):		
K Street Proceeds	12,325	10,220
APF Legacy Fund	12,059	-
APF Reserve Replenishment Fund	6,656	5,520
Special Projects	146	123
Total APF Board Designated Net Assets	31,186	15,863
Total Board designated net assets	54,745	37,170
Undesignated net assets	30,269	44,725
TOTAL UNRESTRICTED NET ASSETS	**$ 85,014**	**$ 81,895**

5. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consisted of the following at December 31, 2012 and 2011:

	(In Thousands)	
	2012	**2011**
Restricted research and awards	$ 2,301	$ 1,596
Grants and contracts	3,355	3,468
TOTAL TEMPORARILY RESTRICTED NET ASSETS	**$ 5,656**	**$ 5,064**

The following temporarily restricted net assets were released from donor restrictions, at December 31, 2012 and 2011, by incurring expenses (or through the passage of time), which satisfied the restricted purposes specified by the donors:

	(In Thousands)	
	2012	**2011**
Restricted research and awards	$ 397	$ 649
Grants and contracts	1,599	1,605
TOTAL NET ASSETS RELEASED FROM DONOR RESTRICTIONS	**$ 1,996**	**$ 2,254**

6. ENDOWMENT

The Association's endowment consists of donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. The Board of Trustees has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Association classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, the Association considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- The duration and preservation of the fund;
- The purpose of the organization and the donor-restricted endowment fund;
- General economic conditions and the possible effect of inflation and deflation;
- The expected total return from income and the appreciation of investments; and
- Investment policies of the organization.

Endowment net asset were restricted for the following as of December 31, 2012 and 2011:

	(In Thousands)	
	2012	**2011**
Gralnick Award	$ 100	$ 100
Ozarin Fund	50	50
APIRE Endowment	41	40
Schizophrenia Research Awards	311	311
TOTAL FUNDS	**$ 502**	**$ 501**

The principal for all funds are required to be invested in-perpetuity. The income may be expended as follows:

- *Gralnick Award* - to support awards to individuals doing research in the area of Schizophrenia.
- *Ozarin Award* - to support the Benjamin Rush Award lecture at the APA Annual Meeting as well as other relevant projects concerning the APA library and archives.
- *APIRE Endowment* - to support awards to individuals doing research in the area of psychiatry.
- *Schizophrenia Research Awards* - to support awards to individuals doing research in the area of schizophrenia.

6. ENDOWMENT (Continued)

Changes in endowment net assets for the years ended December 31, 2012 and 2011:

(In Thousands)

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, January 1, 2011	$ (1)	$ 47	$ 501	$ 547
Investment return:				
Investment income	-	29	-	29
Net depreciation (realized and unrealized)	-	(77)	-	(77)
Total investment return	-	(48)	-	(48)
Other changes:				
Transfer for deficiency of endowment funds	(35)	35	-	-
ENDOWMENT NET ASSETS, DECEMBER 31, 2011	**(36)**	**34**	**501**	**499**
Investment return:				
Investment income	-	25	-	25
Net appreciation (realized and unrealized)	-	78	-	78
Total investment return	-	103	-	103
Contributions	-	-	1	1
Appropriation of endowment assets for expenditure	-	(22)	-	(22)
Other changes:				
Recovery of transfers for deficiencies of funds	36	(36)	-	-
ENDOWMENT NET ASSETS, DECEMBER 31, 2012	**$ -**	**$ 79**	**$ 502**	**$ 581**

6. ENDOWMENT (Continued)

Funds with Deficiencies -

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the Association to retain as funds of perpetual duration. In accordance with GAAP, deficiencies of this nature that are reported in unrestricted net assets were approximately $36,000 as of December 31, 2011. These deficiencies resulted from unfavorable market fluctuations which occurred after the investment of permanently restricted contributions and continued appropriations for certain programs that were deemed prudent by the Board of Trustees. There were no remaining fund deficiencies as of December 31, 2012.

Return Objectives and Risk Parameters -

The Association has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment, while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Association must hold in-perpetuity. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of the S&P 500 index while assuming a moderate level of investment risk.

The Association expects its endowment funds, over time, to provide an average rate of return of approximately 8.6 percent annually. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives -

To satisfy its long-term rate-of-return objectives, the Association relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Association targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy -

The Association allocates the investment income generated by the endowment each year based on the purpose of the endowment as described in the donor’s request. If the donor does not specify a purpose for the income generated from their permanently restricted endowment, the income is used for general support.

7. PENSION PLANS

Defined Contribution Plans -

The Association sponsors a 401(k) employee savings plan (the Plan). Participants of the Plan are allowed to contribute a portion of their annual compensation. The Plan requires the Association to make a matching contribution equal to 100% of a participant's contribution to a maximum of 4% of the participant's compensation. Additionally, the Association contributes 3% of the salary of eligible employees. For the years ended December 31, 2012 and 2011, the Association made contributions to the Plan on behalf of its employees of approximately $1,032,000 and $930,000, respectively.

7. PENSION PLANS (Continued)

Deferred Compensation Plan -

The Board of Trustees authorized a deferred compensation plan for a select group of management. The Association contributed approximately $298,000 and $244,000 during the years ended December 31, 2012 and 2011, respectively. The corresponding asset is included in Investments and separately shown as a liability in the accompanying consolidated financial statements.

Defined Benefit Plan -

The Association's defined benefit pension plan (the Plan) no longer accepts new participants.

The Plan provides benefits based on the employees' final monthly average compensation for the last five years of employment and total years of service. The following is a summary of the funded status of the Plan as of December 31, 2012 and 2011; the key assumptions used by the Plan's actuary; and the cost to the Association of providing retirement benefits.

Change in Projected Benefit Obligation

(In Thousands)

	2012	2011
Projected benefit obligation, beginning of year	$ (11,458)	$ (10,043)
Service cost	(293)	(270)
Interest cost	(568)	(549)
Actuarial loss	(1,724)	(875)
Actual distributions	312	279
PROJECTED BENEFIT OBLIGATION, END OF YEAR	**$ (13,731)**	**$ (11,458)**

Accrued pension cost recognized in the Consolidated Statements of Financial Position as the accrued pension liability amounted to approximately $5,632,000 and $4,681,000, as of December 31, 2012 and 2011, respectively.

(In Thousands)

	2012	2011
Projected benefit obligation	$ (13,731)	$ (11,458)
Fair value of plan assets	8,099	6,777
FUNDED STATUS - UNDER FUNDED	**$ (5,632)**	**$ (4,681)**

Items not yet recognized as a component of net periodic pension cost:

(In Thousands)

	2012	2011
Actuarial Gain	**$ 4,757**	**$ 3,481**

7. PENSION PLANS (Continued)

Components of net periodic pension cost recognized as expenses in the accompanying Consolidated Statements of Activities and Changes in Net Assets:

	(In Thousands)	
	2012	**2011**
Service cost	$ 293	$ 270
Interest cost	568	549
Actual return on assets	(729)	(60)
Net amortization payments	214	126
Deferred gain (loss) on assets	234	(394)
NET PERIODIC BENEFIT COST	**$ 580**	**$ 491**

Amounts of net gain and net prior service cost recognized in the accompanying Consolidated Statements of Activities and Changes in Net Assets apart from expenses:

	(In Thousands)	
	2012	**2011**
Amounts Arising During the Period	**$ 1,276**	**$ 1,142**

Estimated amounts to be recognized during the following year:

	(In Thousands)	
	2013	**2012**
Actuarial Gain	**$ 299**	**$ 204**

Weighted average assumptions used to determine the benefit obligation and net periodic benefit cost are as follows:

	2012	**2011**
Benefit Obligation:		
Discount rate	4.50 %	5.00 %
Expected return on plan assets	7.00 %	7.00 %
Rate of compensation increase	3.50 %	3.50 %
Net Periodic Benefit Cost:		
Discount rate	4.50 %	5.00 %
Expected return on plan assets	7.00 %	7.00 %
Rate of compensation increase	3.50 %	3.50 %

The expected long-term rate of return on assets was developed based on historical returns. In general, it was based on returns for the Plan and the Plan's target asset allocation.

7. PENSION PLANS (Continued)

The components of the Plan assets are as follows at December 31, 2012 and 2011:

(In Thousands)

	2012	2011
Cash and cash equivalents	$ 242	$ 2,709
Fixed income mutual funds	3,159	2,768
Equity mutual funds	4,698	1,300
TOTAL	**$ 8,099**	**$ 6,777**

All Plan investments are valued at quoted prices in an active market for identical assets (Level 1).

The Plan's weighted asset allocations, by asset category, are as follows at December 31, 2012 and 2011:

(In Thousands)

	2012	2011
Cash and cash equivalents	3 %	40 %
Equity mutual funds	58 %	19 %
Fixed income mutual funds	39 %	41 %
TOTAL	**100 %**	**100 %**

The Association utilizes a target allocation of approximately 40% fixed income and 60% equities. Barring any unforeseen market changes, the target allocation will not change significantly in the future. As of December 31, 2011 the Association was not in compliance with their target allocations due to the liquidation of assets to transfer plan investments to a new custodian. The transfer of plan assets was effective January 1, 2012.

Contributions

The Association made contributions to the pension plan of approximately $905,000 and $676,000 during the years ended December 31, 2012 and 2011, respectively.

The Association expects to make a contribution of approximately $545,000 to the pension plan in fiscal year 2013.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year Ending December 31,	*(In Thousands)*
2013	$ 463
2014	507
2015	519
2016	550
2017	554
2018 to 2022	3,516
	$ 6,109

8. LEASE COMMITMENTS

The Association leases office space under a fifteen-year agreement, which expires on December 31, 2017. Base rent is approximately $1,740,000 per year, increasing by a factor of 2.75% per year, plus a proportionate share of real estate taxes and operating expenses.

Accounting principles generally accepted in the United States of America require that the total rent commitment should be recognized on a straight-line basis over the term of the lease. Accordingly, the difference between the actual monthly payments and the rent expense being recognized for financial statement purposes is recorded as a deferred rent liability on the Consolidated Statements of Financial Position.

The following is a schedule of the future minimum lease payments:

Year Ending December 31,	*(In Thousands)*
2013	$ 2,380
2014	2,445
2015	2,512
2016	2,581
2017	2,652
	$ 12,570

Rent expense, including taxes and operating expenses, for the years ended December 31, 2012 and 2011, totaled approximately $2,426,000 and $2,399,000, respectively. The deferred rent liability totaled approximately $1,510,000 and $1,602,000, respectively.

9. CONTINGENCY

APF receives grants from various agencies of the United States Government. Such grants are subject to audit under the provisions of OMB Circular A-133. The ultimate determination of amounts received under the United States Government grants is based upon the allowance of costs reported to and accepted by the United States Government as a result of the audits. Audits in accordance with the provisions of OMB Circular A-133 have been completed for all required fiscal years through 2012. Until such audits have been accepted by the United States Government, there exists a contingency to refund any amount received in excess of allowable costs. Management is of the opinion that no material liability will result from such audits.

10. COMMITMENTS

The Association is committed under agreements for conference space through the year 2022. The total commitments under the agreements are not determinable as it depends upon attendance and other unknown factors. There are cancellation penalties that would be due if the agreements were cancelled prior to the event date. The amount of the cancellation penalties increase through the date of the event.

11. FAIR VALUE MEASUREMENT

In accordance with FASB ASC 820, *Fair Value Measurement*, the Association has categorized its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument.

Investments recorded in the Consolidated Statements of Financial Position are categorized based on the inputs to valuation techniques as follows:

Level 1. These are financial instruments where values are based on unadjusted quoted prices for identical assets in an active market Association has the ability to access.

Level 2. These are investments where values are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, or model-based valuation techniques that utilize inputs that are observable either directly or indirectly for substantially the full-term of the investments.

Level 3. Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation methodology used for assets and liabilities measured at fair value. There have been no changes in the methodologies used at December 31, 2012 and 2011.

- *Money market funds* - Fair value is equal to the reported net asset value of the fund.
- *Mutual funds* - The fair value is equal to the reported net asset value of the fund, which is the price at which additional shares can be obtained.
- *Equities* - Valued at the closing price reported on the active market in which the individual securities are traded.
- *Assets held under unitrust agreement* - Fair value is derived from quotes from a dealer or broker, where available for the underlying assets held in the charitable remainder unitrust.
- *Alternative investments* - consists of investments in hedge funds. Management has used the practical expedient for these investments which permits the use of net asset value without adjustment. These hedge funds have various redemption frequency and redemption notice periods.
- *Accrued Pension Liability* - The fair value of liability is determined by the actuarial cost method. This method matches a pro-rata portion of the actual pension benefits expenses to be paid in the future to the period of service over which it was accrued. The actuarial present value of accumulated plan benefits is determined by an actuary and is that amount that results from applying actuarial assumptions to adjust the accumulated plan benefits to reflect the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as for death, withdrawal or retirement) between the valuation date and the expected date of payment.
- *Charitable Remainder Unitrust Liability*—The Association revalues the liability, annually, based on applicable mortality tables and discount rates.

11. FAIR VALUE MEASUREMENT (Continued)

The table below summarizes, by level within the fair value hierarchy, the Association's investments and other financial instruments as of December 31, 2012:

(In Thousands)

	Level 1	Level 2	Level 3	Total December 31, 2012
Asset Class:				
Money market funds	$ 2,296	$ -	$ -	$ 2,296
Equities	7,733	-	-	7,733
Alternative investments	-	-	12,826	12,826
Mutual funds:				
Baird Aggregate Bond Fund	8,099	-	-	8,099
Delaware Pooled High-Yield Bond Fund	2,730	-	-	2,730
Dodge and Cox International Stock Fund	5,209	-	-	5,209
Eaton Vance Floating Rate Fund	2,740	-	-	2,740
Vanguard Total Bond Market Index Fund	6,532	-	-	6,532
Vanguard Total International Stock Index Fund	5,569	-	-	5,569
Vanguard Total Stock Market Index Fund	20,825	-	-	20,825
Total investments	61,733	-	12,826	74,559
Assets held under unitrust agreement	-	112	-	112
TOTAL ASSETS	**$ 61,733**	**$ 112**	**$ 12,826**	**$ 74,671**
Liability Category:				
Accrued Pension Liability	-	-	5,632	5,632
Charitable Remainder Unitrust Liability	-	-	66	66
TOTAL LIABILITIES	**$ -**	**$ -**	**$ 5,698**	**$ 5,698**

The table below summarizes, by level within the fair value hierarchy, the Association's investments and other financial instruments as of December 31, 2011:

(In Thousands)

	Level 1	Level 2	Level 3	Total December 31, 2011
Asset Class:				
Money market funds	$ 2,270	$ -	$ -	$ 2,270
Equities	9,974	-	-	9,974
Alternative investments	-	-	11,210	11,210
Mutual funds:				
Artio International Equity Fund	4,357	-	-	4,357
Eaton Vance Floating Rate Fund	2,531	-	-	2,531
Fidelity Floating Rate High Income Fund	2,511	-	-	2,511
Vanguard Total Bond Market Index Fund	15,393	-	-	15,393
Vanguard Total International Stock Index Fund	4,708	-	-	4,708
Vanguard Total Stock Market Index Fund	15,856	-	-	15,856
Total investments	57,600	-	11,210	68,810
Assets held under unitrust agreement	-	115	-	115
TOTAL ASSETS	**$ 57,600**	**$ 115**	**$ 11,210**	**$ 68,925**
Liability Category:				
Accrued pension liability	-	-	4,681	4,681
Charitable Remainder Unitrust Liability	-	-	72	72
TOTAL LIABILITIES	**$ -**	**$ -**	**$ 4,753**	**$ 4,753**

11. FAIR VALUE MEASUREMENT (Continued)

Level 3 Financial Assets

The following table provides a summary of changes in fair value of the Association's financial assets for the years ended December 31, 2011 and 2012:

	(In Thousands) Investments
Beginning balance as of January 1, 2011	$ 5,152
Purchases	6,000
Unrealized gains	58
BALANCE AS OF DECEMBER 31, 2011	**11,210**
Purchases	923
Unrealized gains	693
BALANCE AS OF DECEMBER 31, 2012	**$ 12,826**

The amounts of total gains for the years ended December 31, 2012 and 2011 included in net unrestricted net assets attributable to the change in unrealized gains for Level 3 financial assets still held at the reporting date were $693,000 and $58,000, respectively.

12. SUBSEQUENT EVENTS

In preparing these consolidated financial statements, the Association has evaluated events and transactions for potential recognition or disclosure through , the date the consolidated financial statements were issued.

SUPPLEMENTAL INFORMATION

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATING SCHEDULE OF FINANCIAL POSITION
AS OF DECEMBER 31, 2012
(DOLLARS IN THOUSANDS)

ASSETS

	APA	APF	PAC	APIT	Eliminations	Total
CURRENT ASSETS						
Cash and cash equivalents	$ 3,640	$ 7,921	$ 30	$ -	$ -	$ 11,591
Receivables:						
Accounts receivable, net	2,882	4	-	-	-	2,886
Grants and contracts receivable, net	-	209	-	-	-	209
Contributions receivable	-	644	-	-	-	644
Income taxes receivable	832	-	-	-	-	832
Due from affiliates	409	-	-	-	(409)	-
Publications inventory, net	882	-	-	-	-	882
Prepaid expenses	617	6	-	-	-	623
Total current assets	9,262	8,784	30	-	(409)	17,667
FIXED ASSETS						
Furniture and equipment	1,374	-	-	-	-	1,374
Software	3,455	79	-	-	-	3,534
Leasehold improvements	838	-	-	-	-	838
Website development	-	38	-	-	-	38
	5,667	117	-	-	-	5,784
Less: Accumulated depreciation and amortization	(3,380)	(56)	-	-	-	(3,436)
Net fixed assets	2,287	61	-	-	-	2,348
OTHER ASSETS						
Investments	26,632	47,400	-	527	-	74,559
DSM 5 development costs	21,628	-	-	-	-	21,628
Assets held under unitrust agreement	-	112	-	-	-	112
Deposits	162	-	-	-	-	162
Intangible assets	5,983	-	-	-	(5,983)	-
Total other assets	54,405	47,512	-	527	(5,983)	96,461
TOTAL ASSETS	**$ 65,954**	**$ 56,357**	**$ 30**	**$ 527**	**$ (6,392)**	**$ 116,476**

LIABILITIES AND NET ASSETS

	APA	APF	PAC	APIT	Eliminations	Total
CURRENT LIABILITIES						
Accounts payable and accrued liabilities	$ 4,498	$ 421	$ 4	$ -	$ -	$ 4,923
Due to affiliates	-	390	19	-	(409)	-
Deferred revenue:						
Membership	4,684	-	-	-	-	4,684
Subscriptions	3,636	-	-	-	-	3,636
Meetings	1,031	-	-	-	-	1,031
Other deferred revenue, current portion	1,043	-	-	-	-	1,043
Current portion of deferred rent abatement	165	-	-	-	-	165
Liability under unitrust agreement, current portion	-	8	-	-	-	8
Total current liabilities	15,057	819	23	-	(409)	15,490
LONG-TERM LIABILITIES						
Accrued pension liability	5,632	-	-	-	-	5,632
Other deferred revenue, net of current portion	1,420	-	-	-	-	1,420
Deferred rent abatement, net of current portion	1,345	-	-	-	-	1,345
Deferred compensation plan	1,359	-	-	-	-	1,359
Liability under unitrust agreement, net of current portion	-	58	-	-	-	58
Total long-term liabilities	9,756	58	-	-	-	9,814
Total liabilities	24,813	877	23	-	(409)	25,304
NET ASSETS						
Unrestricted	40,117	50,346	7	527	(5,983)	85,014
Temporarily restricted	1,024	4,632	-	-	-	5,656
Permanently restricted	-	502	-	-	-	502
Total net assets	41,141	55,480	7	527	(5,983)	91,172
TOTAL LIABILITIES AND NET ASSETS	**$ 65,954**	**$ 56,357**	**$ 30**	**$ 527**	**$ (6,392)**	**$ 116,476**

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATING SCHEDULE OF ACTIVITIES
FOR THE YEAR ENDED DECEMBER 31, 2012
(DOLLARS IN THOUSANDS)

	APA	APF	PAC	APIT	Eliminations	Total
UNRESTRICTED REVENUE						
Publications	$ 19,702	$ -	$ -	$ -	$ -	$ 19,702
Annual meeting	8,194	-	-	-	-	8,194
Membership dues	9,663	-	-	-	-	9,663
Contributions	6	448	195	-	-	649
Government grants and contracts	-	1,277	-	-	-	1,277
Label sales	83	-	-	-	-	83
Other revenue	472	9	-	-	-	481
Net assets released from donor restrictions	496	1,500	-	-	-	1,996
Total unrestricted revenue	38,616	3,234	195	-	-	42,045
EXPENSES						
Program services:						
Publications	12,714	-	-	-	(211)	12,503
CME and life long learning	6,543	-	-	-	-	6,543
External affairs	4,378	-	239	-	-	4,617
Research and OMNA	1,834	2,864	-	-	-	4,698
Member relations	1,778	-	-	-	-	1,778
Public education	-	1,468	-	-	-	1,468
Total program services	27,247	4,332	239	-	(211)	31,607
Supporting services:						
General and administrative	9,876	1,521	-	2	(396)	11,003
Governance	2,798	-	-	-	-	2,798
Total supporting services	12,674	1,521	-	2	(396)	13,801
Total expenses	39,921	5,853	239	2	(607)	45,408
Change in unrestricted net assets before other items	(1,305)	(2,619)	(44)	(2)	607	(3,363)
OTHER ITEMS						
Investment income	2,355	5,471	-	-	-	7,826
Minimum pension liability adjustment	(1,276)	-	-	-	-	(1,276)
Income tax expense	(68)	-	-	-	-	(68)
Change in unrestricted net assets	(294)	2,852	(44)	(2)	607	3,119
TEMPORARILY RESTRICTED REVENUE						
Contributions	479	1,807	-	-	-	2,286
Change in value of unitrust agreement	-	(2)	-	-	-	(2)
Net assets released from donor restrictions	(496)	(1,500)	-	-	-	(1,996)
Investment income	3	301	-	-	-	304
CHANGE IN TEMPORARILY RESTRICTED NET ASSETS	**$ (14)**	**$ 606**	**$ -**	**$ -**	**$ -**	**$ 592**

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATING SCHEDULE OF ACTIVITIES
FOR THE YEAR ENDED DECEMBER 31, 2012
(DOLLARS IN THOUSANDS)

	APA	APF	PAC	APIT	Eliminations	Total
PERMANENTLY RESTRICTED REVENUE						
Contributions	$ -	$ 1	$ -	$ -	$ -	$ 1
CHANGE IN PERMANENTLY RESTRICTED NET ASSETS	**$ -**	**$ 1**	**$ -**	**$ -**	**$ -**	**$ 1**

AMERICAN PSYCHIATRIC ASSOCIATION AND AFFILIATES

CONSOLIDATING SCHEDULE OF CHANGE IN NET ASSETS
FOR THE YEAR ENDED DECEMBER 31, 2012
(DOLLARS IN THOUSANDS)

	APA	APF	PAC	APIT	Eliminations	Total
UNRESTRICTED NET ASSETS						
Net assets at beginning of year	$ 40,411	$ 47,494	$ 51	$ 529	$ (6,590)	$ 81,895
Change in unrestricted net assets	(294)	2,852	(44)	(2)	607	3,119
NET ASSETS AT END OF YEAR	**$ 40,117**	**$ 50,346**	**$ 7**	**$ 527**	**$ (5,983)**	**$ 85,014**
TEMPORARILY RESTRICTED NET ASSETS						
Net assets at beginning of year	$ 1,038	$ 4,026	$ -	$ -	$ -	$ 5,064
Change in temporarily restricted net assets	(14)	606	-	-	-	592
NET ASSETS AT END OF YEAR	**$ 1,024**	**$ 4,632**	**$ -**	**$ -**	**$ -**	**$ 5,656**
PERMANENTLY RESTRICTED NET ASSETS						
Net assets at beginning of year	$ -	$ 501	$ -	$ -	$ -	$ 501
Change in permanently restricted net assets	-	1	-	-	-	1
NET ASSETS AT END OF YEAR	**$ -**	**$ 502**	**$ -**	**$ -**	**$ -**	**$ 502**

AMERICAN PSYCHIATRIC ASSOCIATION

UNCONSOLIDATED SCHEDULES OF FINANCIAL POSITION
AS OF DECEMBER 31, 2012 AND 2011

ASSETS

	2012	2011
CURRENT ASSETS		
Cash and cash equivalents	$ 3,640,111	$ 6,963,692
Accounts receivable, net	2,881,913	3,880,225
Contributions receivable	-	25,000
Due from affiliates	408,535	3,493,799
Publications inventory, net	882,293	1,177,178
Prepaid expenses	616,736	646,045
Taxes receivable	832,197	869,629
Total current assets	9,261,785	17,055,568
FIXED ASSETS		
Furniture and equipment	1,374,404	1,629,664
Software	3,454,578	4,613,844
Leasehold improvements	837,584	828,664
	5,666,566	7,072,172
Less: Accumulated depreciation and amortization	(3,380,100)	(4,322,301)
Net fixed assets	2,286,466	2,749,871
OTHER ASSETS		
Investments	26,632,338	21,918,114
DSM 5 development costs	21,628,188	18,234,060
Deposits	162,079	162,079
Intangible assets	5,983,000	6,589,500
Total other assets	54,405,605	46,903,753
TOTAL ASSETS	**$ 65,953,856**	**$ 66,709,192**

LIABILITIES AND NET ASSETS

	2012	2011
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	$ 4,496,855	$ 5,557,733
Due to affiliates	-	23,781
Deferred revenue:		
Membership	4,683,926	4,532,623
Subscriptions	3,636,283	3,624,489
Meetings	1,031,106	805,679
Other deferred revenue, current portion	1,042,819	1,006,507
Current portion of deferred rent abatement	165,427	101,744
Total current liabilities	15,056,416	15,652,556
LONG-TERM LIABILITIES		
Accrued pension liability	5,631,520	4,681,252
Other deferred revenue, net of current portion	1,420,000	2,420,000
Deferred rent abatement, net of current portion	1,344,632	1,499,736
Deferred compensation plan	1,359,411	1,006,821
Total long-term liabilities	9,755,563	9,607,809
Total liabilities	24,811,979	25,260,365
NET ASSETS		
Unrestricted	40,117,657	40,410,524
Temporarily restricted	1,024,220	1,038,303
Total net assets	41,141,877	41,448,827
TOTAL LIABILITIES AND NET ASSETS	**$ 65,953,856**	**$ 66,709,192**

AMERICAN PSYCHIATRIC ASSOCIATION

UNCONSOLIDATED SCHEDULES OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE				
Publications	$ 19,702,361	$ -	$ -	$ 19,702,361
Annual meeting	8,193,692	-	-	8,193,692
Membership dues	9,663,279	-	-	9,663,279
Contributions	6,360	478,621	-	484,981
Label sales	83,185	-	-	83,185
Royalties	-	-	-	-
Other revenue	472,430	-	-	472,430
Net assets released from donor restrictions	495,950	(495,950)	-	-
Total revenue	38,617,257	(17,329)	-	38,599,928
EXPENSES				
Program Services:				
Publications	12,714,297	-	-	12,714,297
CME and life long learning	6,542,819	-	-	6,542,819
External affairs	4,377,582	-	-	4,377,582
Research and OMNA	1,834,073	-	-	1,834,073
Member relations	1,777,642	-	-	1,777,642
Total program services	27,246,413	-	-	27,246,413
Supporting Services:				
General and administrative	9,876,274	-	-	9,876,274
Governance	2,797,668	-	-	2,797,668
Total supporting services	12,673,942	-	-	12,673,942
Total expenses	39,920,355	-	-	39,920,355
Changes in net assets before other items	(1,303,098)	(17,329)	-	(1,320,427)
OTHER ITEMS				
Investment income (loss)	2,355,119	3,246	-	2,358,365
Minimum pension liability adjustment	(1,276,420)	-	-	(1,276,420)
Income tax expense	(68,468)	-	-	(68,468)
Total other items	1,010,231	3,246	-	1,013,477
Changes in net assets	(292,867)	(14,083)	-	(306,950)
Net assets at beginning of year	40,410,524	1,038,303	-	41,448,827
NET ASSETS AT END OF YEAR	**$ 40,117,657**	**$ 1,024,220**	**$ -**	**$ 41,141,877**

2011			
Unrestricted	Temporarily Restricted	Permanently Restricted	Total
$ 22,167,349	$ -	$ -	$ 22,167,349
8,241,836	-	-	8,241,836
9,720,960	-	-	9,720,960
7,299	617,230	-	624,529
112,946	-	-	112,946
1,500,000	-	-	1,500,000
668,113	-	-	668,113
582,021	(582,021)	-	-
43,000,524	35,209	-	43,035,733
12,790,523	-	-	12,790,523
6,351,825	-	-	6,351,825
3,890,018	-	-	3,890,018
1,773,671	-	-	1,773,671
1,766,350	-	-	1,766,350
26,572,387	-	-	26,572,387
9,390,385	-	-	9,390,385
2,711,959	-	-	2,711,959
12,102,344	-	-	12,102,344
38,674,731	-	-	38,674,731
4,325,793	35,209	-	4,361,002
(660,673)	-	-	(660,673)
(1,141,633)	-	-	(1,141,633)
(83,494)	-	-	(83,494)
(1,885,800)	-	-	(1,885,800)
2,439,993	35,209	-	2,475,202
37,970,531	1,003,094	-	38,973,625
$ 40,410,524	**$ 1,038,303**	**$ -**	**$ 41,448,827**

DATE

To the Board of Trustees
American Psychiatric Foundation
Arlington, Virginia

We have audited the financial statements of the American Psychiatric Foundation (APF) for the year ended December 31, 2012, and have issued our report thereon dated DATE. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards* and OMB Circular A-133, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated February 6, 2013. Professional standards also require that we communicate to you the following information related to our audit.

- **Qualitative Aspects of Accounting Practices**

  Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by APF are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended December 31, 2012. We noted no transactions entered into by APF during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

  Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

The most sensitive estimates affecting the financial statements were:

- Valuation and collectability of receivables
- Allocation of expenses between APF programs and affiliates
- Fair value of alternative investments

We evaluated the key factors and assumptions used to develop these estimates in determining that they are reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear.

- **Difficulties Encountered in Performing the Audit**

  We encountered no significant difficulties in dealing with management in performing and completing our audit.

- **Corrected and Uncorrected Misstatements**

  Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

  We proposed three adjusting journal entries that increased the net assets by $59,867. The most significant of these was to adjust net assets to actual.

- **Disagreements with Management**

  For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

- **Management Representations**

  We have requested certain representations from management that are included in the management representation letter dated DATE.

- **Management Consultations with Other Independent Accountants**

  In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to APF's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

- **Other Audit Findings or Issues**

  We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as APF's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

With respect to the supplementary information accompanying the financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with U.S. generally accepted accounting principles, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

This information is intended solely for the use of the Audit Committee, Board of Trustees and management of the American Psychiatric Foundation and is not intended to be, and should not be, used by anyone other than these specified parties.

Bethesda, Maryland
DATE

AUDIT REPORT

FINANCIAL AND FEDERAL AWARD COMPLIANCE EXAMINATION

FOR THE YEAR ENDED DECEMBER 31, 2012

AMERICAN PSYCHIATRIC FOUNDATION

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FINANCIAL STATEMENTS

American Psychiatric Foundation
Advancing public understanding of mental illnesses

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

AMERICAN PSYCHIATRIC FOUNDATION

CONTENTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees
American Psychiatric Foundation
Arlington, Virginia

Report on the Financial Statements

We have audited the accompanying financial statements of the American Psychiatric Foundation (APF) (a non-profit organization), which comprise the statements of financial position as of December 31, 2012 and 2011, and the related statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of APF as of December 31, 2012 and 2011, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The Schedule of Expenditures of Federal Awards on page I-21, as required by Office of Management and Budget Circular A-133, A*udits of States, Local Governments, and Non-Profit Organizations*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated on our consideration of APF's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering APF's internal control over financial reporting and compliance.

Bethesda, Maryland

AMERICAN PSYCHIATRIC FOUNDATION

STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2012 AND 2011

ASSETS

	2012	2011
CURRENT ASSETS		
Cash and cash equivalents	$ 7,920,583	$ 9,010,990
Accounts receivable	4,123	412,546
Grants receivable, net of allowance for doubtful accounts of $478,376 in 2012 and 2011	209,292	439,420
Contributions receivable	643,547	75,830
Prepaid expenses	6,435	11,510
Total current assets	8,783,980	9,950,296
FIXED ASSETS		
Software	78,551	47,037
Website development	37,504	-
	116,055	47,037
Less: Accumulated amortization	(55,799)	(26,720)
Net fixed assets	60,256	20,317
OTHER ASSETS		
Investments (Notes 2 and 9)	47,400,292	46,362,881
Assets held under unitrust agreement (Notes 3 and 9)	112,079	115,041
Total other assets	47,512,371	46,477,922
TOTAL ASSETS	**$ 56,356,607**	**$ 56,448,535**

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES		
Accounts payable and accrued liabilities	$ 420,904	$ 543,861
Liability under unitrust agreement, current portion (Note 3)	7,846	8,062
Due to affiliates (Note 4)	389,496	3,493,799
Refundable advance	-	317,364
Total current liabilities	818,246	4,363,086
LONG-TERM LIABILITIES		
Liability under unitrust agreement, net of current portion (Note 3)	57,792	63,505
Total liabilities	876,038	4,426,591
NET ASSETS		
Unrestricted (Note 5)	50,345,865	47,493,942
Temporarily restricted (Note 6)	4,632,163	4,026,561
Permanently restricted (Note 7)	502,541	501,441
Total net assets	55,480,569	52,021,944
TOTAL LIABILITIES AND NET ASSETS	**$ 56,356,607**	**$ 56,448,535**

See accompanying notes to financial statements.

AMERICAN PSYCHIATRIC FOUNDATION

STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUE				
Contributions	$ 447,677	$ 1,806,885	$ 1,100	$ 2,255,662
Government grants and contracts	1,277,280	-	-	1,277,280
Other revenue	8,790	-	-	8,790
Change in value of unitrust agreement (Note 3)	-	(2,124)	-	(2,124)
Net assets released from donor restrictions (Note 6)	1,499,720	(1,499,720)	-	-
Total revenue	3,233,467	305,041	1,100	3,539,608
EXPENSES				
Program Services:				
Research Programs	2,863,669	-	-	2,863,669
Public Education	1,468,126	-	-	1,468,126
Total program services	4,331,795	-	-	4,331,795
Supporting Services:				
General and Administrative	1,521,114	-	-	1,521,114
Total expenses	5,852,909	-	-	5,852,909
Changes in net assets before other items	(2,619,442)	305,041	1,100	(2,313,301)
OTHER ITEMS				
Investment income (loss) (Note 2)	5,471,365	300,561	-	5,771,926
Cancellation - grant expense	-	-	-	-
Changes in net assets	2,851,923	605,602	1,100	3,458,625
Net assets at beginning of year	47,493,942	4,026,561	501,441	52,021,944
NET ASSETS AT END OF YEAR	**$ 50,345,865**	**$ 4,632,163**	**$ 502,541**	**$ 55,480,569**

See accompanying notes to financial statements.

2011			
Unrestricted	Temporarily Restricted	Permanently Restricted	Total
$ 437,077	$ 1,136,385	$ 125	$ 1,573,587
1,244,671	-	-	1,244,671
7,074	-	-	7,074
-	(3,598)	-	(3,598)
1,672,288	(1,672,288)	-	-
3,361,110	(539,501)	125	2,821,734
2,907,792	-	-	2,907,792
1,706,279	-	-	1,706,279
4,614,071	-	-	4,614,071
1,599,812	-	-	1,599,812
6,213,883	-	-	6,213,883
(2,852,773)	(539,501)	125	(3,392,149)
(1,418,923)	(128,263)	-	(1,547,186)
(478,376)	-	-	(478,376)
(4,750,072)	(667,764)	125	(5,417,711)
52,244,014	4,694,325	501,316	57,439,655
$ 47,493,942	**$ 4,026,561**	**$ 501,441**	**$ 52,021,944**

See accompanying notes to financial statements.

AMERICAN PSYCHIATRIC FOUNDATION

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	$ 3,458,625	$ (5,417,711)
Adjustments to reconcile changes in net assets to net cash used by operating activities:		
Amortization	15,710	9,407
Unrealized (gain) loss	(4,533,674)	4,361,772
Realized loss (gain)	284,186	(1,695,211)
Permanently restricted contributions	(1,100)	(125)
Change in value of unitrust agreement	2,124	3,598
Change in allowance for doubtful accounts	-	255,906
Direct write-off to bad debt expense	4,572	-
(Increase) decrease in:		
Accounts receivable	403,851	1,243,676
Grants receivable	230,128	(380,773)
Contributions receivable	(567,717)	282,065
Prepaid expenses	5,075	20,667
Increase (decrease) in:		
Accounts payable and accrued liabilities	(122,957)	212,272
Due to affiliates	(3,104,303)	(1,170,483)
Refundable advance	(317,364)	317,364
Net cash used by operating activities	(4,242,844)	(1,957,576)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of fixed assets	(55,649)	-
Purchase of investments	(4,411,379)	(6,066,778)
Proceeds from sale of investments	7,626,418	7,007,429
Net cash provided by investing activities	3,159,390	940,651
CASH FLOWS FROM FINANCING ACTIVITIES		
Permanently restricted contributions	1,100	125
Payment to beneficiary under unitrust agreement	(8,053)	(8,624)
Net cash used by financing activities	(6,953)	(8,499)
Net decrease in cash and cash equivalents	(1,090,407)	(1,025,424)
Cash and cash equivalents at beginning of year	9,010,990	10,036,414
CASH AND CASH EQUIVALENTS AT END OF YEAR	**$ 7,920,583**	**$ 9,010,990**

See accompanying notes to financial statements.

AMERICAN PSYCHIATRIC FOUNDATION

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION

Organization -

The American Psychiatric Foundation (APF), an affiliate controlled by the American Psychiatric Association (APA), was incorporated in December 1981 under the District of Columbia Non-Profit Corporation Act. The mission of APF is to engage in public education, research and fundraising activities in the field of psychiatry. APF carries out some of the scientific and educational activities of APA affiliated organizations through private and government contracts and grants.

The Board of Trustees under APF consists of thirteen (13) voting members. Nine (9) of the members are appointed by the Board of Trustees of APA. The sole corporate member of APF is APA.

Basis of presentation -

The accompanying financial statements are presented on the accrual basis of accounting, and in accordance with FASB ASC 958, *Not-for-Profit Entities*.

The accompanying financial statements represent the activity of APF only. For the years ended December 31, 2012 and 2011, the financial statements of APF have been consolidated with APA and its affiliates in accordance with FASB ASC 958-810, *Not-for-Profit Entities, Consolidation*. The consolidated financial statements are available at APA's headquarters.

Cash and cash equivalents -

APF considers all cash and other highly liquid investments with initial maturities of three months or less to be cash equivalents. All other highly liquid instruments, which are to be used for long-term purposes of APF, are classified as investments.

Through December 31, 2012, the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank Act") provided temporary unlimited deposit insurance coverage for non-interest bearing transaction accounts at all Federal Deposit Insurance Corporation (FDIC) insured depository institutions (the "Dodd-Frank Deposit Insurance Provision"). APF maintained a portion of its cash balance at a financial institution in a non-interest bearing account; thereby, all of this cash balance was protected by the FDIC under this Act. Beginning January 1, 2013, funds deposited in non-interest bearing accounts will no longer receive unlimited deposit insurance coverage. Bank deposit accounts at one institution will be insured by the FDIC up to a limit of $250,000. Management believes the risk in these situations to be minimal.

Investments -

Investments are recorded at their readily determinable fair value. Realized and unrealized gains and losses are included in investment income in the Statements of Activities and Changes in Net Assets.

Accounts receivable -

Accounts receivable are stated at net realizable value, which approximates fair value. Management considers all amounts to be fully collectible. Accordingly, an allowance for doubtful accounts has not been established.

AMERICAN PSYCHIATRIC FOUNDATION

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Grants and contributions receivable -

Grants and contributions receivable approximate fair value. Management considers all amounts to be collectible within one year. The allowance for doubtful accounts is determined based upon an annual review of account balances, including the age of the balance, subsequent collections and historical experience with the customer.

Fixed assets -

Fixed assets in excess of $5,000 are capitalized and stated at cost. Fixed assets currently consists of software and internally developed software in progress. These costs, once implemented, are amortized on a straight-line basis over the estimated useful lives of the software, generally five years. The cost of maintenance and repairs is recorded as expenses are incurred.

Prepaid expenses -

Prepaid expenses represent deposits for future meetings.

Net asset classification -

The net assets are reported in three self-balancing groups as follows:

- **Unrestricted net assets** include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of APF and include both internally designated and undesignated resources.

- **Temporarily restricted net assets** include revenue and contributions subject to donor-imposed stipulations that will be met by the actions of APF and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the Statements of Activities and Changes in Net Assets as net assets released from restrictions.

- **Permanently restricted net assets** represent funds restricted by the donor to be maintained in-perpetuity by APF. There are restrictions placed on the use of investment earnings from these endowment funds.

Contributions and grants -

Unrestricted and temporarily restricted contributions and grants are recorded as revenue in the year notification is received from the donor. Temporarily restricted contributions and grants are recognized as unrestricted support only to the extent of actual expenses incurred in compliance with the donor-imposed restrictions and satisfaction of time restrictions.

Temporarily restricted contributions and grants received in excess of expenses incurred are shown as temporarily restricted net assets in the accompanying financial statements. Conditional promises to give are not included as support until the conditions are met.

AMERICAN PSYCHIATRIC FOUNDATION

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Contributions and grants (continued) -

APF receives funding under grants from the U.S. Government and other grantors for direct and indirect program costs. This funding is subject to contractual restrictions, which must be met through incurring qualifying expenses for particular programs. Accordingly, such grants are considered exchange transactions and are recorded as unrestricted income to the extent that related expenses are incurred in compliance with the criteria stipulated in the grant agreements.

APF also receives funding under contracts from the U.S. Government, which are considered to be available for unrestricted use, unless specifically restricted by the funder. Revenue from such contracts is recognized based on the work performed in correlation to the deliverables of the contract.

Grants receivable represents amounts due from funding organizations for reimbursable expenses incurred in accordance with the grant agreements. Grant funding received in advance of incurring the related expenses is recorded as a refundable advance.

Income taxes -

APF is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements. APF is not a private foundation.

Uncertain tax positions -

In June 2006, the Financial Accounting Standards Board (FASB) released FASB ASC 740-10, *Income Taxes*, that provides guidance for reporting uncertainty in income taxes. For the years ended December 31, 2012 and 2011, APF has documented its consideration of FASB ASC 740-10 and determined that no material uncertain tax positions qualify for either recognition or disclosure in the financial statements.

The Federal Form 990, *Return of Organization Exempt from Income Tax*, is subject to examination by the Internal Revenue Service, generally for three years after it is filed.

Use of estimates -

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

Functional allocation of expenses -

The costs of providing the various programs and other activities have been summarized on a functional basis in the Statements of Activities and Changes in Net Assets. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

AMERICAN PSYCHIATRIC FOUNDATION

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GENERAL INFORMATION (Continued)

Functional allocation of expenses (continued) -

Fundraising expenses are immaterial and these expenses are included in general and administrative expense in the accompanying Statements of Activities and Changes in Net Assets.

Risks and uncertainties -

APF invests in various investment securities. Investment securities are exposed to various risks such as interest rates, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying financial statements.

Fair value measurement -

APF adopted the provisions of FASB ASC 820, *Fair Value Measurement*. FASB ASC 820 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the quality of inputs (assumptions that market participants would use in pricing assets and liabilities, including assumptions about risk) used to measure fair value, and enhances disclosure requirements for fair value measurements. APF accounts for a significant portion of its financial instruments at fair value or considers fair value in their measurement.

2. INVESTMENTS

APF owns shares in a pooled investment account with its affiliate. APF's allocated share of investments consisted of the following at December 31, 2012 and 2011:

	Fair Value	
	2012	2011
Money market funds	$ 266,273	$ 512,741
Equities	5,160,900	7,112,657
Alternative investments	7,465,140	6,391,598
Mutual funds:		
Artio International Equity Fund	-	3,107,311
Baird Aggregate Bond Fund	5,405,500	-
Delaware Pooled High-Yield Bond Fund	1,822,096	-
Dodge and Cox International Stock Fund	3,476,850	-
Eaton Vance Floating Rate Fund	1,828,865	1,804,862
Fidelity Floating Rate High Income Fund	-	1,790,465
Vanguard Total Bond Market Index Fund	4,359,229	10,977,674
Vanguard Total International Stock Index Fund	3,716,778	3,357,629
Vanguard Total Stock Market Index Fund	13,898,661	11,307,944
TOTAL INVESTMENTS	**$ 47,400,292**	**$ 46,362,881**

2. INVESTMENTS (Continued)

Alternative investments, and the respective terms of the agreements, are comprised of the following at December 31, 2012 and 2011:

Investment Type	2012	2011	Liquidity
Pinehurst Institutional Ltd with Citigroup	$1,928,375	$ 1,773,610	Hedge fund of a fund. Quarterly liquidity with 90 days notice; no initial lockup period.
Common Sense Long-Biased Offshore Ltd.	1,752,370	1,716,473	Hedge fund of a fund. Quarterly liquidity with 100 days notice; 1 year lockup period; Lockup amount of $1,000,000 expired in May 2012.
Morgan Stanley Prime Property Fund	3,784,395	2,901,515	Real estate fund. Quarterly liquidity; no initial lockup period.
ALTERNATIVE INVESTMENTS	**$7,465,140**	**$ 6,391,598**	

Included in investment income (loss) are the following:

	2012	2011
Interest and dividends	$ 1,522,438	$ 1,119,375
Unrealized gain (loss)	4,533,674	(4,361,772)
Realized (loss) gain	(284,186)	1,695,211
TOTAL INVESTMENT INCOME (LOSS)	**$ 5,771,926**	**$ (1,547,186)**

3. CHARITABLE REMAINDER UNITRUST

APF is the trustee of a Charitable Remainder Unitrust. The beneficiary of the trust is to receive payments equal to 7% of the fair value of the trust assets annually. Upon the death of the beneficiary, the trust assets, including accumulated investment earnings, pass to APF for its unrestricted use. In accordance with accounting principles generally accepted in the United States of America, the assets held in trust under the agreement and the estimated liability have been recorded at fair value in the Statements of Financial Position.

On an annual basis, APF revalues the liability based on applicable mortality tables and discount rates. The difference between the change in the fair value of the assets received and the liability to the beneficiary is recognized as temporarily restricted revenue. As of December 31, 2012 and 2011, the assets held by APF for the unitrust agreements were $112,079 and $115,041, respectively.

3. CHARITABLE REMAINDER UNITRUST (Continued)

The estimated liability at December 31, 2012 and 2011 was calculated using the following assumptions:

	2012	2011
Long-term rate of return on assets	8.00%	8.00%
Discount rate on future payments to beneficiary	2.54%	2.57%
Estimated period of distributions to beneficiary	9 years	10 years
Liability under unitrust agreement	$ 82,236	$ 90,870
Less: Discount to present value	(16,598)	(19,303)
Net liability under unitrust agreement	65,638	71,567
Less: Current portion	(7,846)	(8,062)
LIABILITY UNDER UNITRUST AGREEMENT, NET OF CURRENT PORTION	**$ 57,792**	**$ 63,505**

4. AFFILIATES TRANSACTIONS

APF regularly carries on transactions with its related organizations. APF was formed for the purpose of supporting the mission and purposes of the American Psychiatric Association (APA).

American Psychiatric Association (APA)

APA has the authority to appoint nine (9) members of APF Board of Trustees and provides shared employees, administrative services, and facilities to APF. APA charged APF $3,955,731 and $4,595,998 related to these shared costs during the years ended December 31, 2012 and 2011, respectively.

As of December 31, 2012 and 2011, APF owed APA $389,496 and $3,493,799, respectively.

5. BOARD DESIGNATED NET ASSETS

As of December 31, 2012 and 2011, net assets have been designated by the Board of Trustees for the following purposes:

	2012	2011
K Street Proceeds	$ 12,324,774	$ 10,220,315
Legacy Fund	12,059,094	-
Reserve Replenishment Fund	6,656,374	5,519,796
Special Projects	146,221	123,472
Total Board designated net assets	31,186,463	15,863,583
Undesignated net assets	19,159,402	31,630,359
TOTAL UNRESTRICTED NET ASSETS	**$ 50,345,865**	**$ 47,493,942**

6. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consisted of the following at December 31, 2012 and 2011:

	2012	2011
Judges Leadership Initiative	$ 511,946	$ 297,569
APF Schizophrenia Research Fellowship	464,655	-
Typical or Troubled	454,345	517,950
Kempf Fund	329,675	288,843
National Partnership for Workplace Mental Health	289,114	525,457
Marmor Award	172,897	146,598
Research Scholars	170,361	71,894
Community Connection	167,745	167,745
Psychiatric Research Fellowship	148,463	102,042
Kun-Po Soo Award	147,336	122,425
Helping Hands Otsuka	124,484	95,643
Research Grant	118,269	98,075
APF Partnership Program	112,658	126,643
APF Minority Mental Health Awards	101,923	44,879
Other Programs	1,318,292	1,420,798
TOTAL TEMPORARILY RESTRICTED NET ASSETS	**$ 4,632,163**	**$ 4,026,561**

The following temporarily restricted net assets were released from donor restrictions by incurring expenses (or through the passage of time), which satisfied the restricted purposes specified by the donors:

	2012	2011
National Partnership for Workplace Mental Health	$ 539,392	$ 267,631
Psychiatric Research Fellowship	198,579	206,895
Typical or Troubled	257,395	205,740
Judges Leadership Initiative	85,624	197,207
AstraZeneca Minority Fellowship	90,333	176,257
Young Academician Award-Merck	52,269	49,560
APF Partnership Program - Give and Hour	48,184	27,842
APF Minority Mental Health Awards	33,259	22,036
Prescriber's Clinical Support	32,655	17,092
Other Programs	162,030	502,028
	$ 1,499,720	**$ 1,672,288**

7. ENDOWMENT

APF's endowment consists of donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. The Board of Trustees has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary.

AMERICAN PSYCHIATRIC FOUNDATION

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2012 AND 2011

7. ENDOWMENT (Continued)

As a result of this interpretation, APF classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, APF considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- The duration and preservation of the fund;
- The purpose of the organization and the donor-restricted endowment fund;
- General economic conditions and the possible effect of inflation and deflation;
- The expected total return from income and the appreciation of investments; and
- Investment policies of the organization.

Endowment net assets were restricted for the following as of December 31, 2012 and 2011:

	2012	2011
Schizophrenia Research	$ 311,603	$ 311,603
Gralnick Award	100,000	100,000
Ozarin Fund	50,000	50,000
APIRE Endowment	40,938	39,838
TOTAL FUNDS	**$ 502,541**	**$ 501,441**

Change in endowment net assets for the years ended December 31, 2011:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, January 1, 2011	**$ (991)**	**$ 47,031**	**$ 501,316**	**$ 547,356**
Investment return:				
Investment income	-	29,384	-	29,384
Net appreciation (realized and unrealized)	-	(77,080)	-	(77,080)
Total investment return	-	(47,696)	-	(47,696)
Contributions	-	-	125	125
Other changes:				
Transfer for deficiency of endowment funds	(35,115)	35,115	-	-
ENDOWMENT NET ASSETS, DECEMBER 31, 2011	**$ (36,106)**	**$ 34,450**	**$ 501,441**	**$ 499,785**

7. ENDOWMENT (Continued)

Change in endowment net assets for the year ended December 31, 2012:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, December 31, 2011	**$ (36,106)**	**$ 34,450**	**$ 501,441**	**$ 499,785**
Investment return:				
Investment income	-	25,201	-	25,201
Net appreciation (realized and unrealized)	-	78,277	-	78,277
Total investment return	-	103,478	-	103,478
Contributions	-	-	1,100	1,100
Appropriation of endowment assets for expenditure	-	(21,803)	-	(21,803)
Other changes:				
Recovery of transfers for deficiencies of funds	36,106	(36,106)	-	-
ENDOWMENT NET ASSETS, DECEMBER 31, 2012	**$ -**	**$ 80,019**	**$ 502,541**	**$ 582,560**

Funds with Deficiencies -

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the organization to retain as funds of perpetual duration. In accordance with GAAP, deficiencies of this nature that are reported in unrestricted net assets were $36,106 as of December 31, 2011. These deficiencies resulted from unfavorable market fluctuations which occurred after the investment of permanently restricted contributions and continued appropriations for certain programs that were deemed prudent by the Board of Trustees. There were no remaining fund deficiencies as of December 31, 2012.

Return Objectives and Risk Parameters -

APF has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment, while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that APF must hold in-perpetuity. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of the S&P 500 index while assuming a moderate level of investment risk. APF expects its endowment funds, over time, to provide an average rate of return of approximately 8.6 percent annually. Actual returns in any given year may vary from this amount.

7. ENDOWMENT (Continued)

Strategies Employed for Achieving Objectives -

To satisfy its long-term rate-of-return objectives, APF relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). APF targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy -

APF allocates the investment income generated by the endowment each year based on the purpose of the endowment and the donor's request. If the donor does not specify a purpose of the income generated from their permanently restricted endowment, the income is used for general support.

8. CONTINGENCY

APF receives grants from various agencies of the United States Government. Such grants are subject to audit under the provisions of OMB Circular A-133.

The ultimate determination of amounts received under the United States Government grants is based upon the allowance of costs reported to and accepted by the United States Government as a result of the audits. Audits in accordance with the provisions of OMB Circular A-133 have been completed for all required fiscal years through 2012. Until such audits have been accepted by the United States Government, there exists a contingency to refund any amount received in excess of allowable costs. Management is of the opinion that no material liability will result from such audits.

9. FAIR VALUE MEASUREMENT

In accordance with FASB ASC 820, *Fair Value Measurement*, APF has categorized its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument. Investments recorded in the Statements of Financial Position are categorized based on the inputs to valuation techniques as follows:

Level 1. These are investments where values are based on unadjusted quoted prices for identical assets in an active market APF has the ability to access.

Level 2. These are investments where values are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, or model-based valuation techniques that utilize inputs that are observable either directly or indirectly for substantially the full-term of the investments.

9. FAIR VALUE MEASUREMENT (Continued)

Level 3. Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation methodology used for investments measured at fair value. There have been no changes in the methodologies used at December 31, 2012 and 2011.

- *Money market funds* - Fair value is equal to the reported net asset value of the fund.
- *Mutual funds* - The fair value is equal to the reported net asset value of the fund, which is the price at which additional shares can be obtained.
- *Equities* - Valued at the closing price reported on the active market in which the individual securities are traded.
- *Alternative investments* - consists of investments in hedge funds. Management has used the practical expedient for these investments which permits the use of net asset value without adjustment. These hedge funds have various redemption frequency and redemption notice periods.

The table below summarizes, by level within the fair value hierarchy, APF's investments as of December 31, 2012:

	2012			
	Level 1	Level 2	Level 3	Total
Asset Class:				
Money market funds	$ 266,273	$ -	$ -	$ 266,273
Equities	5,160,900	-	-	5,160,900
Alternative investments	-	-	7,465,140	7,465,140
Mutual funds:				
Baird Aggregate Bond Fund	5,405,500	-	-	5,405,500
Delaware Pooled High-Yield Bond Fund	1,822,096	-	-	1,822,096
Dodge and Cox International Stock Fund	3,476,850	-	-	3,476,850
Eaton Vance Floating Rate Fund	1,828,865	-	-	1,828,865
Vanguard Total Bond Market Index Fund	4,359,229	-	-	4,359,229
Vanguard Total International Stock Index Fund	3,716,778	-	-	3,716,778
Vanguard Total Stock Market Index Fund	13,898,661	-	-	13,898,661
Total investments	39,935,152	-	7,465,140	47,400,292
Assets held under unitrust agreement	-	112,079	-	112,079
TOTAL	**$ 39,935,152**	**$112,079**	**$ 7,465,140**	**$ 47,512,371**

9. FAIR VALUE MEASUREMENT (Continued)

The table below summarizes, by level within the fair value hierarchy, APF's investments as of December 31, 2011:

	2011			
	Level 1	Level 2	Level 3	Total
Asset Class:				
Money market funds	$ 512,741	$ -	$ -	$ 512,741
Equities	7,112,657	-	-	7,112,657
Alternative investments	-	-	6,391,598	6,391,598
Mutual funds:				
Artio International Equity Fund	3,107,311	-	-	3,107,311
Eaton Vance Floating Rate Fund	1,804,862	-	-	1,804,862
Fidelity Floating Rate High Income Fund	1,790,465	-	-	1,790,465
Vanguard Total Bond Market Index Fund	10,977,674	-	-	10,977,674
Vanguard Total International Stock Index Fund	3,357,629	-	-	3,357,629
Vanguard Total Stock Market Index Fund	11,307,944	-	-	11,307,944
Total investments	39,971,283	-	6,391,598	46,362,881
Assets held under unitrust agreement	-	115,041	-	115,041
TOTAL	**$ 39,971,283**	**$115,041**	**$ 6,391,598**	**$ 46,477,922**

Level 3 Financial Assets

The following table provides a summary of changes in fair value of APF's financial assets for the years ended December 31, 2012 and 2011:

	Investments
Balance as of January 1, 2011	$ 3,443,247
Purchases	2,901,516
Unrealized gains	46,835
Balance as of December 31, 2011	6,391,598
Purchases	669,751
Unrealized gains	403,791
BALANCE AS OF DECEMBER 31, 2012	**$ 7,465,140**

10. SUBSEQUENT EVENTS

In preparing these financial statements, APF has evaluated events and transactions for potential recognition or disclosure through , the date the financial statements were issued.

SUPPLEMENTAL INFORMATION

AMERICAN PSYCHIATRIC FOUNDATION

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED DECEMBER 31, 2012

Federal Granting Agency and Program Title	Pass-Through Entity	CFDA or Grant Number	Expenditures
Department of Health and Human Services:			
Substance Abuse and Mental Health Services-Projects of Regional and National Significance	N/A	93.243	$ 958,264
Mental Health Research Grants	N/A	93.242	1
HIV Care Formula Grants	Research Foundation for Mental Hygiene, Inc.	93.917	11,780
Mental Health Research Grants	N/A	93.307	49,158
Using Medical Information Principles	N/A	93.879	101,993
TOTAL EXPENDITURES OF FEDERAL AWARDS			**$ 1,121,196**

Note 1. Basis of Presentation

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) includes the Federal grant activity of APF under programs of the Federal government for the year ended December 31, 2012. The information in the Schedule is presented in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Because the Schedule presents only a selected portion of the operations of APF, it is not intended to and does not present the financial position, changes in net assets or cash flows of APF.

Note 2. Summary of Significant Accounting Policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in OMB Circular A-122, *Cost Principles for Non-Profit Organizations*, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Pass-through entity identifying numbers are presented where available.

Note 3. Reconciliation to Revenue

Included in Government grants and contracts revenue on the accompanying Statement of Activities and Changes in Net Assets are the following:

Federal Cost-reimbursable government grants	$ 1,121,196
Federal fixed price government contracts	156,084
TOTAL GRANTS AND CONTRACTS REVENUE	**$ 1,277,280**

In accordance with the OMB A-133 Section 205(a), federal fixed price government contracts have been excluded from the above Schedule of Expenditures of Federal Awards.

AMERICAN PSYCHIATRIC FOUNDATION

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED DECEMBER 31, 2012

Section I - Summary of Auditor's Results

Financial Statements

1). Type of auditor's report issued: **Unmodified**

2). Internal control over financial reporting:

- Material weakness(es) identified? ☐ **Yes** ☒ **No**
- Significant deficiency(ies) identified that are not considered to be material weakness(es)? ☐ **Yes** ☒ **None Reported**

3). Noncompliance material to financial statements noted? ☐ **Yes** ☒ **No**

Federal Awards

4). Internal control over major programs:

- Material weakness(es) identified? ☐ **Yes** ☒ **No**
- Significant deficiency(ies) identified that are not considered to be material weakness(es)? ☐ **Yes** ☒ **None Reported**

5). Type of auditor's report issued on compliance for major programs: **Unmodified**

6). Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of Circular A-133? ☐ **Yes** ☒ **No**

7). Identification of major programs:

Federal Program Title	Pass-Through Entity	CFDA or Award Number	Expenditures
Substance Abuse and Mental Health Services-Projects of Regional and National Significance	N/A	93.243	$ 958,264

8). Dollar threshold used to distinguish between Type A and Type B programs: **$300,000**

9). Auditee qualified as a low-risk auditee? ☒ **Yes** ☐ **No**

AMERICAN PSYCHIATRIC FOUNDATION

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED DECEMBER 31, 2012

Section II - Financial Statement Findings

There were no reportable findings.

Section III - Federal Award Findings and Questioned Costs (Circular A-133, Section .510)

There were no reportable findings.

Section IV - Prior Year Findings

Finding 2011-1: Key Personnel

Federal Programs: CFDA #93.243 **-** Substance Abuse and Mental Health Services-Projects of Regional and National Significance**.**

Criteria: Under 45 CFR, Part 74.25(c)1 Recipients shall obtain prior approvals from the awarding agency for changes in the project director or principal investigator or other key persons specified in the award document**.**

Condition: APF failed to notify the awarding agency of changes in key personnel. APF did not adequately document the level of effort provided by key personnel.

Questioned Cost: None

Context, Effect and Cause: Cumulatively, the grants name six (6) employees as key personnel and assign a level of effort percentage to each position. During our review of these six (6) key personnel, we were informed that two (2) of the employees named in the grant were terminated with APF in 2010. The granting officer was notified of one of these departures via email. Furthermore, two (2) additional employees did not charge any time to the respective grants during the year ended December 31, 2011, indicating no level of effort spent on the programs. Discussions with management indicated that their time was donated to the program and charged to an administrative cost code; however, their timesheets do not provide an adequate record that the required level of effort had been met. A failure to notify the awarding agency of changes in key personnel is a violation of the grant terms and conditions.

Recommendation: We recommend APF take the appropriate action to notify the awarding agency of the changes in key personnel and their level of effort. Any future changes should have prior documented approval from the awarding agency. We further recommend that for wages not directly charged to the program, the level of effort be clearly documented on the employees' timesheet.

Current Year Status: During the year under audit, APF appropriately notified the granting agency of changes in key personnel and level of efforts.

AMERICAN PSYCHIATRIC FOUNDATION

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED DECEMBER 31, 2012

Section IV - Prior Year Findings (Continued)

Finding 2011-2: Allowable Costs

Federal Programs: CFDA #93.243 **-** Substance Abuse and Mental Health Services-Projects of Regional and National Significance

Criteria: 2 CFR Part 230, Attachment A, part A2g states that to be allowable to a Federal award, costs must be adequately documented.

Condition: In January, 2012, APF received notification from the NYU School of Medicine (NYUSOM) to report that they would reimburse APF $320,627 for unsupported expenditures and $12,649 for costs that should not have been charged to the grant between 2002 and 2010.

Questioned Cost: None

Context, Effect and Cause: The letter from NYUSOM identified poor financial accounting and record keeping practices as the cause of the unsupported expenditures.

Recommendation: We recommend APF promptly repay the Federal Government upon receipt of funds from NYUSOM.

Current Year Status: The funds were returned to the government in May of 2012. APF has not been notified of any additional unsupported costs for the year under audit.

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

Independent Auditor's Report

To the Board of Trustees
American Psychiatric Foundation
Arlington, Virginia

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the American Psychiatric Foundation (APF) as of and for the year ended December 31, 2012, and the related notes to the financial statements, which collectively comprise APF's basic financial statements, and have issued our report thereon dated .

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered APF's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances, for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of APF's internal control. Accordingly, we do not express an opinion on the effectiveness of APF's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of APF's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit, we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether APF's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Bethesda, Maryland

REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE

Independent Auditor's Report

To the Board of Trustees
American Psychiatric Foundation
Arlington, Virginia

Report on Compliance for Each Major Federal Program

We have audited the American Psychiatric Foundation's (APF) compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of APF's major federal programs for the year ended December 31, 2012. APF's major federal programs are identified in the summary of auditor's results section of the accompanying Schedule of Findings and Questioned Costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of APF's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about APF's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of APF's compliance.

Opinion on Each Major Federal Program

In our opinion, APF complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2012.

Report on Internal Control Over Compliance

Management of APF is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered APF's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of APF's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

Bethesda, Maryland

Item # 8E
Board of Trustees
July 20-21, 2013

Investment Oversight Committee

Report to the Board of Trustees
Larry Faulkner, M.D., Chair

INTRODUCTION

The Investment Oversight Committee held its last meeting on June 2, 2013. The Committee's responsibility is to assist the Secretary-Treasurer and the Boards of the Association with fulfilling their fiduciary responsibilities for the corporate and staff investment portfolios, and to provide general direction in fulfilling the duties of managing the investment portfolios. The following is an update about the investment performance and current Committee issues.

Long-Term Pooled Investment Performance Summary

As of March 31, 2013: The market value of the long term pooled investment portfolio was $81.8 M including $22.2M fixed income, $33.7M US equity, $11.8M international equity, $6.9M hedge fund of funds, $5.7M real estate core and $1.3M cash equivalents. (Cash includes Common Sense redemption of $958K that was received on April 29th.) The asset allocations are

Asset Class	Allocation	Target
Fixed Income	27.1%	27.5%
U.S. Equity	41.2%	40.0%
Non-U.S. Equity	14.5%	15.0%
Hedge Fund of Funds	8.5%	10.0%
Real Estate Core	7.0%	7.5%
Cash Equivalents	1.7%	0.0%

Investment Activity: Overall investment activity resulted in net non-operating income of $4M in the quarter. The portfolio earned $304K in interest and dividends. There was $338K in realized gains, with unrealized gains of $3.1M, and $388K of unreal gains for hedge fund and real estate funds. The fund's net return as of March 31, 2013 is 5.6%.[1]

[1] Over the investment horizon established in the policy, it is the goal of the Fund to exceed an absolute real rate of return of 5%, which is in excess of current inflation, or a total rate of return of 5% plus the Consumer Price Index ("CPI"), which is the measure of inflation, net of all fees (fees include management advisory fees and custody charges).

The composite benchmark as of March 31, 2013 (net of fees) is 5.4%.[2]

The estimated annual investment management fee based on the market value at the end of the quarter is $301K, thirty-seven basis points (0.37%), which is below industry standards of fifty-nine basis points or 0.59%) for a fund with this target asset allocation.

After all fees were paid, APA's share of the portfolio is $26.6M (33%); and APF's share is $55.1M (67%).

The annual investment advisory fee for all the Association's portfolios is $80K.

Rebalancing the Portfolio

The APA and APF Boards approved a change in the structure of the 20% allocation of alternative investments to allow for more flexibility and to eliminate the specific allocation limits to the underlying alternative investments within the current 20% allocation of alternative investments. The investment advisor recommended an increase of 2.5% to the real estate allocation bringing the allocation to 10% of the portfolio and reducing core fixed income allocation by 2.5%. The allocations to alternatives will remain within the 20% limit.

In this regard, the Committee agreed to an increase in the real estate allocation, committing an additional 2% of the portfolio ($1,750,000) to the core real estate allocation with the Morgan Stanley Prime Property Fund. This amount will come from core fixed income.

Manager Change

The investment advisor recommended the termination of Calamos from managing the mid-cap growth portfolio. Calamos currently has a 5% target allocation with the long term reserves. This allocation will be moved from mid-cap growth to the all-cap core allocation managed by the Vanguard Total Stock Index Fund. There will be no future target to mid-cap growth. The future target to all-cap core will be 35%.

Pension Plan

The market value of the Pension Fund as of March 31, 2013 was $8.4M including $3.1M fixed income, $4.3M U.S equity, $845K non-US equity, and $238K cash equivalents.

[2] Each type of investment is assigned a comparable index, e.g. we use a blend of Russell MidCap Growth, Russell 2000, Dow Jones, MSCI ACWI ex USA Gross, Barclay's Aggregate, Barclay's High Yield, CSFB Leveraged Loan, HFRX Global Hedge Fund Index, HFRX Equity Hedge Fund Index, and NFI for Real Estate. These indices are then weighted to develop a composite index for the total portfolio.

The allocations are

Asset Class	Allocation	Target
Fixed Income	37.0%	40.0%
U.S. Equity	50.2%	50.0%
Non-U.S. Equity	10.0%	10.0%
Cash Equivalents	2.8%	0.0%

The fee for management of the portfolio was $14K, seventeen basis points (0.17%) against an industry average of twenty-eight basis points (0.28%).

*Funding Commitment***:** The Plan is currently funded to the extent required. Funding is less than the estimated accumulated benefit obligation by $5.6M due in part to changing market conditions.

Retirement Savings Plan

The market value of the Retirement Savings Plan as of March 31, 2013 was $34.5M including $11.6M fixed Income, $15.1M U.S. equity, $3M non-U.S. equity, $3.7M lifestyle funds, loans $453K, and self-directed brokerage $490K.

The breakdown of current utilization is fixed income 33.6%, U.S. equity 44.0%, international 8.9%, lifestyle funds 10.8%, loans 1.3%, and the portion of the portfolio allocated to self-directed brokerage is 1.4%. There are 205 participants.

The estimated annual fee is 71 basis points (0.71%) or $243K, against an industry average of 66 basis points (0.66%). Revenue sharing is 25 basis points (0.25%).

Our investment advisor worked with New York Life and the Human Resources Department to restructure the line-up of funds in the portfolio and new funds have been implemented giving participants a good variety of investment options to choose from. The Human Resources Department is providing regular notifications by email and employee education sessions.

Investments 101

Mike Piotrowski, the APA investment advisor will present to the APA Board at its July meeting and the APF Board, background information on fiduciary responsibility, asset allocation, and alternative investments.

Next Meeting

The next meeting of the Investment Oversight Committee will take place at a time and date to be decided, to coincide with the next meeting of the Finance and Budget Committee in the fall, 2013.

Item 8.F
Board of Trustees
July 20-21, 2013

ACTION: Will the Board vote to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on use of APA, Area Council/State Association, and District Branch resources?

RATIONAL FOR CHANGE PROPOSED BY THE ELECTIONS COMMITTEE

Chairperson: Barry K. Herman, M.D.; Members: Steven Epstein, M.D., Robert Kelly, M.D., Michelle Riba, M.D.; Staff: Margaret Dewar, Chiharu Tobita

The proposed change is in response to concerns expressed by DB members that the Election Guidelines are not clear in describing the scope of prohibitions on use of APA, Area Council/State Association, and District Branch resources. This lack of clarity has led to difficulties in planning DB activities in events where all candidates for a given post are invited to attend and/or present their views. DB members pointed out that the Election Guidelines state that DB funds may be "used to support the expenses of candidates invited to the branch/area meeting for election purposes"; but the Election Guidelines appear to prohibit DB funds from being used to support electronic presentations, even though such presentations are allowed and would likely save time and money compared with in-person presentations.

The problem stems from one sentence in the Election Guidelines that reads "Use of APA, Area Council/State Association, or District Branch resources or personnel is prohibited." This categorical statement contradicts other statements in the Election Guidelines that enumerate various exceptions, allowing 1) DB funds to be used to support the expenses of candidates invited to branch/area meetings for election purposes; 2) the APA M2M listserver to be used for campaign purposes; 3) the APA website to be used for dissemination of information about candidates; and 4) DB newsletters to be used for dissemination of information about candidates. The statement also contradicts current and past practices of the APA, Area Council/State Associations, and District Branches, such as the practices of 1) allowing candidates to present their campaign ideas at the Annual Assembly Meeting; 2) allowing special interest groups within the APA to use the APA website as a conduit to communicate campaign-related statements to their members; 3) allowing campaign statements to appear in *Psychiatric News*; and 4) allowing APA election operations to be run by APA staff with APA resources.

The Elections Committee has addressed these contradictions in past years by interpreting the problematic sentence as if it read

> "Use of APA, Area Council/State Association, or District Branch resources or personnel is **generally** prohibited, **except to support the election process, including communication of candidate statements to members**."

To avoid confusion among our members it would be helpful if the Election Guidelines were modified to reflect this interpretation, adding the words shown above in boldface. This change in wording would not change the way the Election Guidelines are implemented, because the sentence after these words adds "APA, Area Council/State Association, or District Branch funds, services, stationery, or staff may not be used to endorse, support or promote any candidate; however, Area Council/State Association or District Branch funds – not APA funds - may be used to support the expenses of candidates invited to the branch/area meeting for election purposes."

ACTION: Will the Board vote to approve a minor addition to the Resources section of the Election Guidelines, to clarify the scope of prohibitions on use of APA, Area Council/State Association, and District Branch resources?

EXECUTIVE SUMMARY

Assembly

The Assembly met in San Francisco, CA, May 17-19, 2013, 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 12.

The Assembly brings the following action items:

1. Retire Position Statement: 1991 Position Statement: Day Care for Preschool Children

The Assembly voted to approve the retirement of the 1991 Position Statement: Day Care for Preschool Children (Attachment 1)

> **Action: Will the Board of Trustees approve the retirement of the 1991 Position Statement: Day Care for Preschool Children?**

2. Retain Position Statement: 2000 Therapies Focused on Memories of Childhood Physical and Sexual Abuse

The Assembly voted to approve the retention of the 2000 Position Statement: Therapies Focused on Memories of Childhood Physical and Sexual Abuse (Attachment 2)

> **Action: Will the Board of Trustees approve the retention of the 2000 Position Statement: Therapies Focused on Memories of Childhood Physical and Sexual Abuse?**

3. Proposed Position Statement: Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

The Assembly voted to approve the Proposed Position Statement: Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients (Attachment 3)

> **Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients?**

4. Retirement of Position Statement: Delineation of Transcultural Psychiatry as a Specialized Field of Study (1969)

The Assembly voted to retire the Position Statement: Delineation of Transcultural Psychiatry as a Specialized Field of Study (1969) (Attachment 4)

Action: Will the Board of Trustees vote to retire the Position Statement: Delineation of Transcultural Psychiatry as a Specialized Field of Study?

5. Retirement of Position Statement: Training of Minority Psychiatrists (1975)

The Assembly voted to retire the Position Statement: Training of Minority Psychiatrists (1975) (Attachment 5)

Action: Will the Board of Trustees approve the retirement of the Position Statement: Training of Minority Psychiatrists?

6. Retain Position Statement: 1995 Medical Psychotherapy

The Assembly voted to retain the 1995 Position Statement: Medical Psychotherapy (Attachment 6)

Action: Will the Board of Trustees approve the retirement of the Position Statement: 1995 Medical Psychotherapy?

7. Retire Position Statement: 1968 Generic versus Proprietary Drugs

The Assembly voted to approve the retirement of the 1968 Position Statement: Generic versus Proprietary Drugs (Attachment 7)

Action: Will the Board of Trustees vote to approve the retirement of the Position Statement: 1968 Generic versus Proprietary Drugs?

8. Revised Position Statement: Generic versus Proprietary Drugs

The Assembly voted to approve the Revised Position Statement: Generic versus Proprietary Drugs (Attachment 8)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Generic versus Proprietary Drugs?

9. Revised Position Statement: Legal Proceedings and Access to Psychiatric Care for Juvenile Offenders

The Assembly voted to approve the Revised Position Statement: Legal Proceedings and Access to Psychiatric Care for Juvenile Offenders (Attachment 9)

Action: Will the Board of Trustees vote to approve the Revised Position Statement: Legal Proceedings and Access to Care for Juvenile Offenders?

10. Proposed Position Statement: Use of Medical Marijuana for PTSD

The Assembly voted to approve the Proposed Position Statement: Use of Medical Marijuana for PTSD (Attachment 10)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Use of Medical Marijuana for PTSD?

11. Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

The Assembly voted unanimously to approve the Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services (Attachment 11)

Action: Will the Board of Trustees vote to approve the Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services?

The 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 2013 to May 2014:

   Speaker-Elect: Jenny L. Boyer, M.D.

   Recorder: Glenn Martin, M.D.

APA Official Actions

Position Statement on Day Care for Preschool Children

This statement was prepared by the Task Force on Day Care for Early Pre-School Children[1] of the APA Council on Children, Adolescents, and Their Families. It was approved by the Assembly of District Branches in November 1991 and by the Board of Trustees in December 1991.

The American Psychiatric Association recognizes that the early development of children has a profound impact on later psychological development and the potential of individuals. Practicing psychiatrists are confronted directly and indirectly with questions related to child care through their involvement with families. The psychiatrist, as physician, is able to integrate the knowledge and skills needed in understanding the biopsychosocial dimensions that arise for all concerned with child day care. The Task Force on Day Care for Early Pre-School Children is cognizant of the debate on the merits of day care, the controversy about its impact on development, and the absence of comprehensive criteria to assess day care quality.

Research indicates that the infant-parent relationship is a fundamental cornerstone of infant development: a secure attachment to ongoing caregivers (most often parents) has been identified as a necessity for psychological and emotional development. Infants who are securely attached to their caregivers are more socially competent than infants who have not developed secure attachments.

Other research indicates that when parents can take advantage of leave from work, infant-parent attachment is enhanced. Demonstration of those findings required a minimum of 4 months of leave, but further research may be able to better pinpoint the crucial developmental times when such added parental presence is particularly helpful. Clearly, whether parents are in professional or occupational training or in the general work force, special considerations are vital to support parenting functions.

There is evidence that good-quality day care for preschool children in vulnerable populations has a *positive* developmental outcome. Additional research has documented that poor-quality care has detrimental developmental consequences for infants and young children. Better working conditions for child care providers correlates with stability of staff and continuity of day care offered to the children, both important variables in quality care.

Often child care by persons other than parents is not a matter of choice. Thus, both government and the private sector must respond to this reality. To assure the well-being of children and the facilitation of the family, the developing body of information about the influences on health development must be considered. Whether traditional family care or child day care, it is the quality of care that is crucial.

Primary developmental issues are significant throughout the preschool years, and they increasingly involve not only the parents but also other caregivers and peers. At the same time that interpersonal relationships increase in complexity, maturing youngsters also solidify their intrapsychic development. Day care provides a special opportunity for enhancement of or interference with development. Good preschool day care incorporates attention to all health care issues, alertness to hazards of traumatic experience (including abuse), and special attention to individual needs related to physical illness, handicaps, and cultural and ethnic uniquenesses. As psychiatrists, we are particularly aware that the absence of attention to these important factors in child development can lead to psychopathology, both in childhood and in adult life. Therefore, the American Psychiatric Association adopts the following policies:

1. The American Psychiatric Association, with other national organizations, shall advocate for the right of children to have developmentally appropriate care in a safe and caring environment.
2. The American Psychiatric Association believes that the assurance of quality care through a variety of means is essential for the healthy development of children. The adoption of developmentally appropriate day care standards is integral to the achievement of quality care.
3. The American Psychiatric Association will work with other professional organizations and consumer groups to help inform parents and other utilizers of child care about the issues of quality day care.
4. The American Psychiatric Association and its district branches, with other appropriate groups, will work to recognize the professional role of child care workers and the importance of appropriate compensation and provision of career incentives. The continuing development of training curricula for child care workers, with sensitivity to cultural diversities, is essential.
5. The American Psychiatric Association recognizes that certain populations may require special consideration in the development of day care standards. Additional educational and supportive services may be desirable to provide adequately for the care of, for example, children of single parents or two-job employees or children who are mentally or physically disadvantaged.
6. The American Psychiatric Association urges the adoption of policies, by all appropriate parties, that will allow the type of parental leave options, including part-time training and employment, that will enhance mother-infant bonding and the facilitation of the family. The absence of appropriate parental leave policies places children and families at risk for adverse psychological development.
7. The American Psychiatric Association urges increased research on the impact of day care on preschool children. Research is needed within the ecology of day care, not only focusing on the child per se but also extending to the potential consequences for the family system and for our society.

[1] The task force members are Myron L. Belfer, M.D. (chairperson), Shahla Chehrazi, M.D., Shaila Misri, M.D., Aubrey W. Metcalf, M.D., Nancy W. Stone, M.D., Moira V. Kennedy, M.D. (Member-in-Training), and Thomas G. Webster, M.D. (consultant).

APA Official Actions

Position Statement on Therapies Focused on Memories of Childhood Physical and Sexual Abuse

Approved by the Board of Trustees, March 2000
Approved by the Assembly, May 1999

"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.*

This position statement addresses the use of specific techniques whose central focus and intent is to elicit memories of childhood abuse. The Statement does not concern reports of individuals who seek therapy with already existing memories of childhood abuse or where the authenticity of memories has been corroborated by reliable outside sources.

Childhood physical and sexual abuse is associated with an increased risk of serious psychiatric and social difficulties in adult life. Child abuse is a public health problem that must be addressed compassionately and responsibly. Public confusion over this issue and the possibility of false accusations must not discredit the reports of patients who have indeed been traumatized by actual abuse.

Some therapeutic approaches attempt specifically to elicit memories of childhood abuse as the central technique for relieving emotional distress. The validity of such therapies has been challenged. Some patients receiving this treatment have later recanted their claims of recovered memories of abuse and accused their therapists of leading or pressuring them into such ideas.

Research has shown that memory does not always record events accurately. In the presence of severe or prolonged stress, people may suffer significant impairment of the retention, recall and accuracy of memories. Memories can also be altered as a result of suggestions particularly by a trusted person or authority figure. No specific unique symptom profile has been identified that necessarily correlates with abuse experiences. In general, psychotherapy focuses on the patient's perceived experience, and does not customarily search for proof of veracity of memories. Psychotherapy works with memories, dreams, altered states of consciousness and related material within the larger context of understanding the patient's current difficulties, accompanied by cautions against premature action by the patient. It is well documented that both dismissing true accounts, and accepting false accounts, can harm patients and possibly others.

Recommendations:

1. Regardless of issues of childhood abuse, all patients should receive a complete psychiatric evaluation. Psychiatrists should maintain an empathic, nonjudgmental, neutral stance towards reported memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient's difficulties, or the veracity of the patient's reports. A strong prior belief that physical or sexual abuse, or other factors are or are not the cause of the patient's problems is likely to interfere with appropriate assessment and treatment.
2. When no corroborating evidence is available to confirm or refute reports of new memories of childhood abuse, treatment may focus on assisting patients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help patients to understand the impact of the memories/abuse experiences on their lives, and to reduce the impact of these experiences and the detrimental consequences in the present and future.
3. When asked to provide expert opinion involving memories of abuse, psychiatrists should refrain from making public statements about the historical accuracy of uncorroborated individual patient reports of new memories based on observations made in psychotherapy.
4. Further research and education regarding memory and childhood abuse are required in order to enhance psychiatrists' ability, on the basis of empirical evidence, to assist patients struggling with these profoundly difficult issues.

Attachment #3
Item 2013A1 4.B.7
Assembly
May 17-19, 2013

FINAL

PROPOSED POSITION STATEMENT

Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

This statement updates and revises the 1969 position statement The Delineation of Transcultural Psychiatry as a Specialized Field of Study- APA Document Reference No. 196902 and the 1975 Training of Minority Psychiatrists- APA Document Reference No. 197506.

Position Statement:

The American Psychiatric Association supports Cultural Psychiatry as a specific field of study relevant to the assessment and care of all patients. It seeks to understand both the preferences and values of patients, which is important in the implementation of evidence – based medicine and patient-centered care, and the unconscious assumptions and biases of clinicians which leads to mental health disparities. It has three elements: research in cultural psychiatry, cultural competence training, and culturally appropriate services.

Background Information:

This is located below the Recommendations section due to its length.

Recommendations:

1. The American Psychiatric Association (APA) supports research in cultural psychiatry involving these issues: research questions that involve culturally diverse populations (especially the underserved) and as well as how cultural psychiatry addresses the needs of all patients since every patient has a culture that influences patient preferences and values, which are important in the implementation of evidence – based medicine and patient-centered care; research with the aim of reducing mental health disparities and/or improving the quality of mental health care with culturally diverse populations (especially the underserved) as well as for all patients; research methodology that involves community engagement; and data analysis that incorporates cultural factors when appropriate.

2. The APA supports cultural competence training in medical student education and postgraduate medical education in psychiatry consistent with both LCME and ACGME accreditation standards involving the development of knowledge, attitudes, and skills to achieve core competencies involving sociocultural issues relevant to all patients. The APA reaffirms its support for the Minority Fellowship Program, which

has provided critically important support for cultural psychiatry training since 1975 in psychiatry residency programs through both the development of faculty and curricula.

3. The APA supports culturally appropriate services for all segments of the patient population consistent with the HHS Office of Minority Health CLAS standards, the DSM-IV Outline for Cultural Formulation, and the DSM-V Cultural Formulation Interview.

Background Information

Background and History of Cultural Psychiatry

The comparative study of mental health and mental illness among diverse societies, nations, and cultures and the multiple interrelationships of mental disorders with cultural environments have occupied the interest of individual psychiatrists and psychiatric organizations in the U.S. and abroad for many years. The growth of international collaboration in psychiatry since World War II, the many advances in clinical methods and research, particularly in the last several decades, have greatly enhanced interest in the field, as has the rapprochement of psychiatry with cultural anthropology, sociology, and behavioral sciences. The phenomena of globalization, the impact of migration, the progress in technology and its communication products, the ease of modern international travel, and a variety of other factors has quickened the pace of development.

H.B.M. Murphy of McGill University founded the World Psychiatric Association (WPA) Section on Transcultural Psychiatry in 1970 and the Society for the Study of Psychiatry and Culture in 1980. Wen-Shing Tseng from the University of Hawaii founded the World Association of Cultural Psychiatry (WACP) in 2005. An impressive body of literature has evolved including the foundation of four journals. In 1956, the *Transcultural Psychiatric Research Review (*now *Transcultural Psychiatry)*, edited by Dr. Eric Wittkower, began publication as the first specialized journal demarcating the field and is the official journal of the WPA Section on Transcultural Psychiatry. Arthur Kleinman, one of the pioneers in cultural psychiatry established *Culture, Medicine and Psychiatry*, a cross-cultural peer-reviewed medical journal, in 1976. The *World Cultural Psychiatry Research Review* in 2006 emerged as the official journal of the WACP and the *International Journal of Culture and Mental Health* began publication in 2007. In addition, many journals of general psychiatry and other sub-specialties have printed articles dealing with clinical-cultural psychiatry issues. For instance, *World Psychiatry*, the official journal of the WPA, has devoted space to articles on diagnostic, educational, and clinical aspects of cultural psychiatry.

The DSM-IV-TR contains an Outline for Cultural Formulation and a glossary of Culture Bound Syndromes as well as an Age, Gender, and Culture section in the narrative section for 79 of the diagnostic categories. DSM-V will include a sixteen question Cultural Formulation Interview (CFI) with 12 supplementary modules including the Explanatory Model, Level of Functioning, Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, School-Age Children and Adolescents, Coping and Help-Seeking and the Patient–Clinician Relationship. Since 1975, the U.S. government has supported the APA Minority Fellowship Program, which strengthens a resident's cultural psychiatry training by providing support through grants from NIMH, CMHS and SAMHSA for cultural competence training, research in cultural psychiatry, and the development of new services. The field of cultural psychiatry is aligned with the following three Goals of the APA (Operations Manual, 2012): 1) To improve access to and quality of psychiatric services, 2) To improve research into all aspects of mental illness, including causes, prevention, and treatment of psychiatric disorders, 3) To improve psychiatric education and training.

In 1964, the APA Board of Trustees established a Committee on Transcultural Psychiatry, which was replaced by the Council of Minority and National Affairs, and in 2002 renamed the Council of Minority Mental Health and Health Disparities (CMMHHD). The Council, and OMNA (Office of Minority and National Affairs) has supported minority and under-represented groups interests through position statements, action papers, presentations at national meetings, awards, fellowships, and publications.

In a 1969 Position Statement, the APA recognized transcultural, or cross-cultural, psychiatry (also known as Cultural Psychiatry) (1). The Position Statement succinctly delineated psychiatry's role in transcultural studies, clarified the terminology of the field, described its interdisciplinary nature, and outlined its major objectives, problems, and areas of application. Since then, theoretical principles of cultural psychiatry have expanded due to definitive advances in clinical recognition of cultural components in the patient's history and their impact on diagnostic and therapeutic approaches, plus solid accomplishment in research (including studies on bio-cultural connections). Further, Cross et al.'s (2) seminal work helped define cultural competence as a continuum between cultural destructiveness and advanced cultural assessments. Establishing this definition was a key step in operationalizing cultural competence conceptually and systemically the overall field of cultural psychiatry.

Important regulatory milestones in the development of the field include the Title VI Civil Rights Act of 1964 (3), which forbade discrimination on the basis of sex and race in hiring, promoting, and firing. The Americans with Disabilities Act (ADA) was passed in 1990 (4) and prohibits private employers, state and local governments, employment agencies, and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. In 1993, the State of California became the first state in the country to mandate that each of its 58 counties create a Cultural Competence Plan, to assess the race/ethnicity, gender, and languages of their mental health patients and providers. The Plan required that they provide services and brochures in any language spoken by 3,000 non-English-speaking Medi-Cal members or 5% of the Medi-Cal population (5). In 1997, New York initiated similar requirements by publishing the New York State Cultural and Linguistic Competency Standards (6).

Professional organizations such as the American Counseling Association (7), the American Psychological Association (8), and the National Association of Social Workers (9) issued their own guidelines on how to implement cultural competence standards. The APA published in 1994 the DSM-IV, which included a groundbreaking Outline for Cultural Formulation, and in 2003 the Practice Guideline on the Psychiatric Evaluation of Adults (2nd edition), included it in the text (10). The APA's Council on Aging produced a Curriculum Resource Guide for Cultural Competence in 1997 (11) that was revised in 2006. Following a pair of conferences sponsored by the Center for Mental Health Services (CMHS), the Accreditation Council of Graduate Medical Education (ACGME) Residency Review Committee (RRC) incorporated cultural competence requirements into its Guidelines for Psychiatry Residencies (12).

Other national agencies supported cultural competence, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Minority Health (OMH), and the Office of Civil Rights (OCR). In 1997, the Western Interstate Commission for Higher Education (WICHE) developed a SAMSHA-funded report entitled "*Cultural Competence Standards in Managed Mental Health Care for Four Underserved/ Underrepresented Racial/Ethnic Groups*" (13) that outlined core cultural standards for mental health treatment and objectives for training in serving Latinos, African Americans, Native American/Alaskan Natives, and Asian/Pacific Islander Americans. This work involved four national panels (representing each racial/ethnic group) that met together in Washington, D.C., to reach consensus standards for all four racial/ethnic groups.

These standards present demographic and health profiles for the four major racial/ethnic groups. They also identify 16 "Guiding Principles" (i.e., consumer-driven and community-based systems of care and natural support). Specific standards of quality care are identified along with associated implementation guidelines. Appropriate performance indicators and recommended outcomes also are delineated.

The OMH produced the *National Standards on Culturally and Linguistically Appropriate Services* (CLAS) (14), which described 14 standards for health care organizations when providing health care (including mental health care) to ethnic minorities. Finally, the OCR, empowered by an executive order from the White House, required that all federal agencies formally address how they would provide access to their services to clients with Limited English Proficiency (LEP) (15).

Four other documents were important to raising the mental health community's awareness of the disparities that ethnic minorities experience. In September 2001, the Surgeon General David Satcher, MD, published "*Mental Health: Culture, Race, and Ethnicity,"* the supplement to the Surgeon General's report on Mental Health, which for the first time highlighted that "the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity." The supplement (16) established that ethnic minorities do not use services as much as the majority population even though "culture counts."

In response to the report, APA President Richard K. Harding, M.D., convened an APA Steering Committee to Reduce Disparities in Access to Psychiatric Care. After careful deliberation, the Committee developed a "Plan of Action" approved by the Board of Trustees in 2005 consistent with APA's mission and goals. This plan made four broad-based recommendations. *First*, expand the science base by gathering and disseminating new knowledge with specific recommendations like continued study and publishing findings on racial and ethnic disparities in mental health. *Second,* support education, training and career development by fostering "capacity development" to reduce mental health disparities while noting, "Minorities are underrepresented as providers, researchers, and as administrators and policymakers and consumer and family organizations. Furthermore, many providers and researchers of all backgrounds are not fully aware of the impact of culture on mental health, mental illness, and mental health services." *Third,* enhance access and reduce barriers to mental health services for racial and ethnic minorities. *Fourth,* promote advocacy and collaboration to reduce racial and ethnic mental health disparities by forging coalitions with other allied health organizations and with consumer and family advocacy organizations such as the National Alliance of the Mentally Ill (NAMI) and the National Mental Health Association (NMHA).

The President's New Freedom Commission Report on Mental Health (17) highlighted the need for serving ethnic minorities and rural populations with culturally-competent services, to improve access and decrease disparities. In March 2002, the Institute of Medicine issued *Unequal Treatment; Confronting Racial and Ethnic Disparities in Healthcare*, (18) which documented disparities in access and quality of care for racial and ethnic minorities for many medical conditions. The report pointed out that the minorities are disproportionately more likely to be uninsured and overrepresented in publicly-funded health systems. Moreover, even among racial and ethnic minorities with similar health insurance statuses as whites, these health care disparities persisted. The IOM report stated that physicians' stereotypes and biases about race and ethnicity affected their judgment of the severity of the patient's illness and their interpretation of their presentations during clinical encounters due to race and ethnicity could potentially contribute to healthcare disparities. The report cited research studies that demonstrated disparities in care based on racial and ethnic differences during a clinical encounter. In addition, the report cited the characteristics of health systems that contribute to healthcare disparities. The document offered suggestions to eliminate racial and ethnic disparities in healthcare by educating both the patients and

providers using culturally-appropriate programs to improve their knowledge of accessing care and their ability to participate in clinical-decision-making, raising public and health care professionals' awareness of the problem, intervening at the health system level through targeted resource allocation, policy decisions in terms of payments to providers at a level paid by private insurers, and regulations to monitor the care delivered.

In 2006, the Agency for Healthcare Research and Quality (AHRQ) (19) began to publish the annual National Health Care Disparities Report, which confirmed that disparities based on race, ethnicity, and socioeconomic status continued to exist and have a devastating personal and societal cost. The report emphasized the need for reduction of barriers to care, preventive care, and further research in health disparities. The 2009 Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives edited by Pedro Ruiz and Annelle Primm also expanded the understanding of mental healthcare disparities related to race/ethnicity, gender, socioeconomic status, geographic location, among many factors (20). Finally, the APA Position Statement on Diversity supports the development of cultural diversity among its membership, trainees, faculty, research and administration to prepare psychiatrists to better serve a diverse U.S. population (21). The focus is on the recruitment of a diverse workforce that can support the development of "knowledge of cultural factors in the delivery of mental health care and in patient health-related behavior in graduate and under-graduate education, in faculty development, and in clinical practice.

Psychiatrists and Cultural Psychiatry

The 1969 Position Statement on Transcultural Psychiatry stated that psychiatrists have as a principal concern "the study of how human beings think, feel, and act with reference to the sociocultural contexts in which they are reared or live as adults." The authors go on to state that

"psychiatrists are active investigators in this area by virtue of their concern, as physicians, with matters of health and disease, and because their clinical training uniquely equips them to study human behavior. They are familiar with mental functioning, in its covert as well as overt aspects…. All of these factors especially fit psychiatrists to engage in studies of the relationship between culturally institutionalized practices, motivational factors, character traits, individual and group behavior, and potential mental health or disorders." (1).

Help-seeking behaviors and diagnostic, therapeutic, and preventive activities should be added to this list.

Interdisciplinary Considerations and Labeling

Transcultural psychiatry is derived from social and biological sciences, clinical medicine and psychiatry, epidemiology, experimental and clinical psychology, and psychoanalysis (22). Thus, psychiatrists are most qualified to investigate the relationship 'between individual behavior and sociocultural systems and subsystems.'(1) Transcultural psychiatry or cultural psychiatry, is also known as

"*cross-cultural psychiatry* (23*); crossnational, transnational, or international psychiatry; intercultural psychiatry; ethnopsychiatry* (24); *comparative psychiatry*; and *social psychiatry*. This last label is often used to include the others. Some labels used more often by nonpsychiatrists are: *psychiatric sociology*,

sociology of mental disease (25), *comparative social research*, *comparative behavior studies*, [medical anthropology], and *culture and personality studies*. Much research so labeled may be regarded as within the proper domain of cultural anthropology, sociology, social psychology, or even history, but these do not always include adequate definition of the personal human variable in health and illness. Other work falls within the field of epidemiology, defined as the study of the form, incidence, and distribution of disorders in relation to demographic, social, and physical environmental factors. Still other research may be recognized as an aspect of human ecology." (1)

Also important is a proper understanding of the concept of cultural competence, as described by Cross (2), who provided a philosophical framework and practical ideas for improving service delivery to children who are severely emotionally disturbed in four socio-cultural groups: African Americans, Asian Americans, Hispanic Americans, and Native Americans. The cultural competence model is defined as a set of congruent behaviors, attitudes, and policies that enables an agency (or an individual professional) to work effectively in cross-cultural situations. Cultural competence may be viewed as a goal and a developmental process. Agencies, or individuals, can be in at least six stages along a continuum: Cultural Destructiveness; Cultural Incapacity; Cultural Blindness; Cultural Pre-Competence; Cultural Competence; and Cultural Proficiency.

Research in Cultural Psychiatry

Research has covered such themes as:

1) similarities and differences in the form, course, or manifestation of mental illness in different societies and cultures;

2) the occurrence, incidence, and distribution of mental illness or behavioral characteristics in relation to sociocultural factors;

3) sociocultural factors predisposing to mental health or to optimal function or to increasing vulnerability to or perpetuating or inhibiting recovery from mental illness or impaired function;

4) the forms of treatment or methods of dealing with people defined as deviant or physically or mentally ill that are practiced or preferred in various sociocultural settings; 5) the influence of sociocultural factors on the assessment of clinical psychiatric issues (such as therapeutic approaches, progress, and diagnosis) and the adaptation of established psychiatric principles to varying sociocultural contexts;

6) the relationship between culture and personality through studies of the character traits shared by members of the same society derived from exposure to similar patterns of child rearing and to positive and negative social sanctions;

7) the understanding of conflict in persons experiencing rapid social and cultural change; 8) attitudes and beliefs regarding behavioral deviance and the mentally ill, including the labeling of behavior;

9) the psychological and social adaptation of migrants, voluntary or involuntary, within or across national boundaries or those of the receiving society;

10) psychiatric or behavioral aspects of communication between individuals and groups from differing cultural or national regions;

11) response to varying culturally-based stressful situations; and

12) cultural determinants of transnational interaction and public policy decisions within nations…

Other projects may be aimed at the definition of particular behavioral states, relationships or processes unique to a socioculture. These may include studies of culture-bound reactions, syndromes, treatment methods, perceptual styles, and reactions to stress. Or they may be concerned with mass behavior such as group loyalties, the formation of stereotypes or misperceptions. All of these studies deal in one way or another with: 1) the relationships between the functions of whole sociocultural systems and those individual humans and groups who compose them (26), and 2) comparative aspects of sociocultural systems and their components." (1)

To this list, we would add the nature and magnitude of stigma, stereotypes, prejudices and discrimination. Stress syndromes were added to the DSM-IV in 2000.

Training in Cultural Psychiatry

Cross-cultural curricula have taken various forms, such as fellowships as seen at UCLA (27) and Harvard, where 39 fellows have trained since 1984, supported by grants from the National Institute of Mental Health (NIMH) to establish a program of research training in 'clinically relevant medical anthropology' in the field of culture and mental health services at the Department of Global Health and Social Medicine (28). Others are imbedded within the General Psychiatry programs, such as UC Davis School of Medicine (29), Oregon Health Sciences Center (30), the University of Toronto (31), and the Cambridge Health System (32) while others are offered as special institutes, such as the program of transcultural psychiatry offered by McGill University in Montreal (33).

Academic Psychiatry has published cross-cultural curricula for psychiatry training programs originating from several Committees that reported to the Council of Minority and National Affairs/Minority Mental Health and Health Disparities on Gay Lesbian, and Bisexuals (34), Women (35), Native Americans (36), Hispanics (37), Asian Americans (38), and African Americans (39). The curricula for psychiatry training programs on religious and spiritual issues was published by the National Institute for Healthcare Research in 1997 (40). The APA's Council on Aging produced the APA Ethnic Minority Elderly Curriculum in 2006 (41). The Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC) requires graduate medical education programs in general psychiatry to provide training in sociocultural issues for 5 of the 6 core competencies, which are related to cultural psychiatry, in 2007. The WPA presented their template for undergraduate and graduate psychiatric education, which includes a section vi entitled the centrality of cultural competencies in the teaching of medical students and residents, and describes knowledge, attitudes, and skills that should be learned by medical students and residents, including assessments and treatment planning (42).

Articles describing a comprehensive overview of strategies that stimulate a culture where diversity is an integral part of the educational environment to descriptions of various psychiatric residency curriculums at the Oregon Health Sciences University, the University of Toronto, and McGill University in Montreal, which described an approach to supporting research through the use of training at McGill University. Further resources for developing cultural curriculum can be found in Tseng's *Handbook of Cultural Psychiatry* (43), and in the American Psychiatric Publishing's catalog, such as Lim's *Clinical Manual of Cultural Psychiatry* (44), the Group for the Advancement of Psychiatry's *Cultural Assessment in*

Clinical Psychiatry (45), and Tseng and Streltzer's *Culture and Psychotherapy* (46). Lu's *Annotated Bibliography on Cultural Psychiatry and Related Topics* (47) is available online. The American Association of Directors of Psychiatry Residency Training (AADPRT) has chosen and published on its website two model curricula on cultural psychiatry: one from New York University and the other from the University of California, Davis (48, 49).

Culturally Appropriate Services

According to Cross (2), five essential elements contribute to an agency's ability to become more culturally competent. The culturally competent system: 1) values diversity; 2) has the capacity for cultural self-assessment; 3) is conscious of the dynamics inherent when cultures interact; 4) has institutionalized cultural knowledge; and 5) has developed adaptations to diversity. Each of these five elements must function at every level of the agency. Attitudes, policies, and practices must be congruent within all levels of the agency.

Culturally-competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the client population. Four service models frequently appear: 1) mainstream agencies providing outreach services to minorities; 2) mainstream agencies supporting services by minorities within minority communities; 3) agencies providing bilingual/bicultural services; and 4) minority agencies providing services to minorities.

In designing services, the following should be considered: the concept of least restrictive alternatives; community-based approaches with strong outreach components; strong interagency collaboration, including natural helpers and community systems; early intervention and prevention; intake and client identification to reduce differential treatment of minority youth; assessment and treatment processes that define "normal" in the context of the client's culture; developing adequate cross-cultural communication skills; the case management approach as a primary service modality; and the use of home-based services.

Planning for cultural competence involves assessment, support building, facilitating leadership, including the minority family and community, developing resources, training and technical assistance, setting goals, and outlining action steps. Not all agencies will approach the issue in the same way, and each will have a different timeline for development. Through this or similar planning approaches, organizations can avoid the perception that the task is unmanageable.

The National Standards for Culturally and Linguistically-Appropriate Services in Health Care (CLAS)-Final Report from the U.S. Department of Health and Human Services Office of Minority Health (March 2001) (15) responds to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner and gives guidance on how to do so.

These standards for culturally and linguistically appropriate services (CLAS) were proposed to correct inequities in the provision of health services and to make these services more responsive to the individual needs of all patients. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence

(Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS *mandates* are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7). CLAS *guidelines* are activities recommended for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13). CLAS *recommendations* are suggested for voluntary adoption by health care organizations (Standard 14).

The four standards organized around the theme Language Access Services are classified as *mandates*. They are consistent with the OCR's interpretation of Limited English Proficiency, and the APA supports their implementation. The standards state that Health care organizations must offer and provide language assistance services without additional cost, in both verbal and written forms. Interpreters need to be linguistically competent—the use of family members and friends should be avoided, and signage should be provided in common languages encountered in the clinical setting.

Finally, there are examples of services that are provided in culturally competent settings, and consultation services that provide the cultural context necessary to develop a culturally appropriate treatment plan. The Transcultural Wellness Center is an example of Ethnic Specific Services, where the staff is chosen to represent and serve the cultures that are seen in the community (50). In the inpatient setting, San Francisco General Hospital has an Asian Focus Unit, which provides both interpretation and cultural brokerage (51, 52), and Bellevue Hospital in New York also has an Asian Unit (53). McGill has a cultural consultation service for three hospitals (54), which inspired Sacramento County to start a Cultural Consultation Service (55). Finally, Chen and others in New York City (56) reported on collaboration between the primary care clinic and the mental health clinic in the Charles B. Wang Community Health Center in which primary care doctors referred patients with mental illnesses to the mental health clinic in the same building and noticed an increase in utilization of the mental health clinic. The collaboration was known as the Bridge project and has proven to be replicable at other sites (57). These initiatives illustrate how services can be adapted or supplemented to provide culturally competent care.

The following named members participated in the drafting of the original 1969 statement: Drs. Eugene B. Brody, then chairman, Horacio Fabrega, Ari Kiev, Joseph Lubart, Perry Ottenberg, Jean Fortin, Augustin Palacios, and Alfred Wiener, Drs. Eric Wittkower, chairman, H. B. M. Murphy, Ronald Wintrob, Jean Fortin, C. P. Hellon, Edward Margetts, and Robert Weil. Participating in the revision were Russell F. Lim, Francis G. Lu, Helena Hansen, Renato Alarcon, Kenneth Sakuye, and Dinesh Mittal.

Position Statement on the Delineation of Transcultural Psychiatry as a Specialized Field of Study

This statement was approved by the Board of Trustees of the American Psychiatric Association in May 1969 upon recommendation of the Association's Committee on Transcultural Psychiatry. The statement had been prepared jointly by this committee and the Committee on Transcultural Psychiatry of the Canadian Psychiatric Association; it was approved by the Board of Directors of the Canadian Psychiatric Association in February 1969.

The comparative study of mental health and mental illness among different societies, nations, and cultures and the interrelationships of mental disorders with cultural environments has for many years occupied the interest of individual psychiatrists here and abroad. The growth of international collaboration in psychiatry since World War II, and particularly in the past decade, has greatly enhanced interest in the field, as has the rapprochement of psychiatry with cultural anthropology, sociology, and behavioral science generally. The ease of modern international travel and communications has also quickened the pace of development. An impressive body of literature has evolved. The *Transcultural Psychiatric Research Review*, edited by Dr. Eric Wittkower, was established in 1956 as a specialized journal demarcating the field. Increasingly large segments of our own annual meeting programs and of international meetings in which the Association participates are devoted to transcultural psychiatry. Several university graduate education programs in psychiatry now offer training in this special field.

The Board of Trustees has witnessed the growth of transcultural psychiatry with gratification and considers that it offers great promise of eliciting new insights into the nature of the mental disorders that will advance the objectives of the Association.

In 1964 the Board of Trustees (then the Council) established a Committee on Transcultural Psychiatry.[1] In 1967 the Canadian Psychiatric Association did likewise.[2] These two committees have collaborated in formulating the following statement, which succinctly delineates psychiatry's role in transcultural studies, clarifies the terminology of the field, describes its interdisciplinary nature, and outlines its major objectives, problems, and areas of application.

The Board of Trustees is pleased to lend its endorsement to the statement following and hopes that it will further active research in transcultural psychiatry and understanding of the relevance of its concepts and data to clinical and organizational practice.

Psychiatrists and Transcultural Research

The study of how human beings think, feel, and act with reference to the sociocultural contexts in which they are reared or live as adults is a principal concern of psychiatrists. This applies to subjectively experienced states and objectively observable behavior, whether defined as "normal," "sick," or "deviant." It also applies to the attempt to recognize those aspects of behavior that are independent of or transcend particular sociocultural contexts(2).

Psychiatrists are active investigators in this area by virtue of their concern, as physicians, with matters of health and disease, and because their clinical training uniquely equips them to study human behavior. They are familiar with mental functioning, in its covert as well as overt aspects, in a wide variety of settings including the catastrophic and encompassing the range of psychophysiologic and organic variations. Their recognized helping status gives them access to and enables them to participate in ordinarily inaccessible life experiences. All of these factors especially fit psychiatrists to engage in studies of the relationship between culturally institutionalized practices, motivational factors, character traits, individual and group behavior, and potentials for mental health or disorder.

[1]The following named members participated in the drafting of this statement: Drs. Eugene B. Brody, then chairman, Horacio Fabrega, Ari Kiev, Joseph Lubart, Perry Ottenberg, Jean Fortin, Augustin Palacios, and Alfred Wiener. (The last three, as well as Dr. Brody, are no longer on the committee.)

[2]Drs. Eric Wittkower, chairman, H. B. M. Murphy, Ronald Wintrob, Jean Fortin, C. P. Hellon, Edward Margetts, and Robert Weil.

Position Statement on the Training of Minority Psychiatrists

This statement, a revision of a previously approved statement (published in the August 1971 issue), was approved by the Assembly of District Branches at its November 4–5, 1975, meeting and by the Board of Trustees at its December 5–6, 1975, meeting. The revision was recommended by the Council on National Affairs.[1] The original statement was recommended by the Committee on Medical Education.[2]

ALL RESIDENCIES must provide treatment facilities; in these facilities the proportion of minority patients should reflect that of the surrounding community and/or represent its ethnic, socioeconomic, and cultural balance.

The future of stipends for psychiatric residents is uncertain, but if they are to be continued, minority residents should be favored. If there are to be loans for psychiatric residents, the lowest possible interest rate should be granted to minority residents, and the interest rate should be lower for those with greater need.

The Assembly of District Branches should study the situation in the district branches to see what effort they are making to deal with minority problems. The Assembly of District Branches may recommend that a specific committee on minority problems be set up within each district branch.

An annotated bibliography of the literature on the treatment of minorities, including papers by both minority and other psychiatrists, should be developed by APA, and the Association should determine how such a bibliography might best be distributed to its membership.

APA must powerfully encourage and support systematic research into such issues as the treatment, demography, sociology, etc., of minorities. These are the same questions that have been studied extensively in whites. The Council on Research and Development should determine if private or public funds are available for such research, because the problem of funding both minority and other research workers is crucial for the future of the Association. While most minority psychiatrists are currently on the "firing line," a few must be protected so that they can do research. This might be done by the National Institute of Mental Health and/or foundations developing career research and teacher funds for minority psychiatrists.

The American Board of Psychiatry and Neurology should investigate residency training programs to see if they are deficient in training minorities. If deficiencies are found, the Residency Review Committee should recommend specific changes, with further certification of the programs dependent upon the implementation of the changes.

The written examination of the Board should include a significant number of questions regarding minority psychiatry, and all oral examiners for the Board should include such questions in their examinations.

An effective residency training program should have an ethnically balanced faculty. Certification should be dependent upon proof of an ethnic balance or upon the presentation of a schedule for the program's achieving such a balance.

It is essential that APA express its sense of urgency in this matter. No unnecessary bureaucratic machinery should slow the process of implementing the recommendations as they are accepted.

[1]The Council on National Affairs included Harold M. Visotsky, M.D., chairperson, James M. Bell, M.D., vice-chairperson, Hiawatha Harris, M.D., Jean Shioda Bolen, M.D., Frank M. Ochberg, M.D., Hector Jaso, M.D., Assembly of District Branches liaison, Esther P. Roberts, M.D., observer-consultant, and Marshall Belaga, M.D., Ezra Griffith, M.D., and Russell Phillips, M.D., Falk Fellows.

[2]The Committee on Medical Education then included Robert J. Stoller, M.D., chairperson, Jeanne Spurlock, M.D., James I. Mathis, M.D., S. Mouchly Small, M.D., Henry Coppolillo, M.D., Manuel Pearson, M.D., and Robin C.A. Hunter, M.D.

APA Official Actions

Position Statement on Medical Psychotherapy

This position statement was written by Norman Clemens, M.D., in consultation with the Committee on the Practice of Psychotherapy.[1] *It was approved by the Assembly in May 1995 and by the Board of Trustees in July 1995.*

Medical psychotherapy is fundamental to American psychiatry and essential to the skills of the psychiatrist. Medical psychotherapy relies on the unique relationship between psychiatrist and patient. It employs verbal communication to treat a broad spectrum of mental disorders, dysfunction, and distress. The psychiatrist brings to this work specialized knowledge and experience, grounded in the physician's expertise and professional standards. Most forms of medical psychotherapy are derived from one of two theoretical models: psychoanalytic theory and learning theory. Often the two approaches are integrated to meet the needs of particular patients. Various adaptations, taking biological and social factors into account, are frequently used for children and youth, the elderly, people with dual diagnoses of addictive and mental disorders, and people with severe nonpsychiatric illness. Medical psychotherapy takes place through individual, family, and group modalities, depending on medical necessity.

The special education, training, and medical experience of a psychiatric physician provide the differentiating variables that define medical psychotherapy. As physicians, psychiatrists add unique and vital dimensions to psychotherapy that limited licensed practitioners do not have: medical standards of ethics and professional responsibility for life-and-death decisions, comprehensive grounding in medical diagnosis and treatment, the capacity to integrate complex psychopharmacology with psychotherapy and social rehabilitation, and in-depth knowledge of human biology, general medical conditions, and their interaction with psychiatric illness and mental phenomena. Psychiatrists are thoroughly grounded in human emotional development and the life cycle. Provision of both psychotherapy and medication management by the same treating psychiatrist provides high-quality, comprehensive, and accountable care. However, psychiatrists are also in an optimal position to prescribe and perform psychotherapy as the sole treatment modality. Psychiatrists in organized systems must be free to conduct psychotherapy with their patients without financial or other disincentives.

Psychiatrists have extensive training in the conduct of medical psychotherapy. Because of the expanded role of neurobiology in psychiatry and marked constriction of services allowed in managed systems, academic departments must struggle to preserve the quality of medical psychotherapy training in psychiatric residencies. These training experiences must be maintained for psychiatrists to retain expertise in the full range of core skills needed to treat the psychiatrically ill.

Conditions necessary for effective medical psychotherapy are 1) a setting of confidentiality and privacy, 2) active participation by the patient in treatment decisions, and 3) continuity of therapist so that a doctor-patient working alliance can develop and work begun can be properly concluded.

The aforementioned conditions necessary for effective medical psychotherapy must be maintained in any system of health care delivery. Intrusive micromanagement and central data-collecting systems create special challenges to these conditions that call for active negotiation by APA. Psychiatrists should vigorously expose inadequacies in managed health care systems that restrict or deny medically necessary treatment, including medical psychotherapy, and endeavor to rectify such inadequacies. Superficial advice or referral to self-help groups, as often advocated in managed behavioral health care organizations, does not substitute for needed specific treatments, including medical psychotherapy.

Affordable point-of-service options or other similar measures must be available to allow patients the choice of continuing with essential doctor-patient relationships when health plan contracts or conditions are changed and to seek consultation or treatment from psychiatrists with special qualifications for their treatment needs. Psychiatrists and patients must be free to contract privately and independently for services if they so choose, with no third-party interference or requirements for reporting to external entities. These concerns apply to all patients but are especially compelling for those in medical psychotherapy.

There is abundant scientific evidence that medical psychotherapy is effective for a wide variety of psychiatric illnesses and that it reduces utilization of more expensive medical services and improves compliance with treatment regimens. Data on pervasive mind-body interactions are rapidly accumulating, requiring psychiatrists familiar with both brain and mind. The cost of medical psychotherapy is a modest and predictable segment of overall medical expenditures in a large-scale system, and utilization is self-limiting even when benefits are generous.

Many patients' psychiatric disorders respond to short-term psychotherapeutic treatments. Some patients gain much more from intensive and/or long-term medical psychotherapy and should have access to it; such patients commonly have longstanding conditions that cause significant dysfunction and distress in their family, work, and social relationships. Development of evidence-based practice guidelines has reinforced the critical role of medical psychotherapy in the treatment of patients with mental disorders.

Patients in need of medical psychotherapy should have the same respect and access to care as any other persons needing medical treatment. APA strongly objects to stereotyping or caricaturing patients who utilize medical psychotherapy, especially in ways that minimize the seriousness of their illness.

[1]The members of the Committee on the Practice of Psychotherapy are William Sledge, M.D. (chairperson), Glen Gabbard, M.D., Jerome Gans, M.D., David Goldberg, M.D., Richard Munich, M.D., Marcia Goin, M.D., Ph.D. (consultant), Jerald Kay, M.D. (consultant), Bernard Foster, M.D. (Assembly liaison), Irma Bland, M.D. (corresponding member), David Fassler, M.D. (corresponding member), Mardi Horowitz, M.D. (corresponding member), Katherine Kennedy, M.D. (corresponding member), Paulina Kernberg, M.D. (corresponding member), Howard Kibel, M.D. (corresponding member), Robert Ursano, M.D. (corresponding member), and Todd Ivan, M.D. (APA/Burroughs Wellcome Fellow).

OFFICIAL ACTIONS

Position Statement on Generic Versus Proprietary Drugs

This statement was approved by the Council of the American Psychiatric Association on February 24, 1968.

The profession of psychiatry at this time is less directly concerned with the problems of generic versus proprietary drugs than are other branches of medicine. Within the next few years, however, when patents for many of the major drugs used by psychiatrists expire, they will be as much concerned as other physicians. In any case the social implications of the problem make it appropriate now for the American Psychiatric Association to present a considered view of the matter.

The objective of proposed legislation governing generic versus proprietary drugs is to offer the consumer an adequate product without excessive cost. It has been charged that manufacturers of proprietary drugs sometimes acquire what appear to be unreasonable profits from high charges for the drugs they market.

The proposed legislative remedy, however, providing for sudden transition from proprietary to generic products, oversimplifies a problem which is in fact complex.

To begin with, the same chemicals compounded in different vehicles may differ significantly in therapeutic potency. If generic drugs were to be substituted for proprietary drugs, it would first be necessary to ensure that the generic products of different manufacturers were uniform and equal in therapeutic potency to proprietary products. To achieve this, the enabling legislation would need to establish procedures designed to assess the therapeutic potency of the finished products and to guarantee that both proprietary and generic drugs met prescribed standards before being administered to a patient. Similarly, how to ensure quality control based on intermittent sampling of all dosage forms, criteria for shelf-life stability, penalties for failure to maintain controls, and related considerations would have to be spelled out. The establishment of such safeguards might prove extremely difficult to legislate and also extremely expensive—so expensive, in fact, that it could eliminate some small drug manufacturers who could not compete with larger ones in underwriting the cost.

In sum, the American Psychiatric Association believes that the problem does not lend itself to solution by a simple and arbitrary transition from proprietary to generic drugs.

FINAL
REVISED POSITION STATEMENT
TITLE: GENERICS VERSUS PROPRIETARY DRUGS

STATEMENT OF ISSUE:

Generic drugs are a growing and well-established therapeutic component of standard psychiatric practice. Prescribing psychiatrists – and physicians in the other branches of medicine– currently view generic psychotropic drugs as efficacious, safe, and cost-effective alternatives to proprietary medications. In light of these developments the APA has reviewed this topic and revised its position statement regarding generic versus proprietary medications.

Many factors favor the prudent use of generic prescription drugs when clinically indicated. A generic drug is required to demonstrate bioequivalence to the brand-name drug. Generics are similar to brand-name drugs in terms of their intended therapeutic indication or use, active ingredients, dosage form and strength, route of administration, safety, quality, performance, purity, and stability. The U.S. Food and Drug Administration (FDA) maintain quality-control guidelines to ensure the bioequivalence of the proprietary and generic drugs. Generic drugs may differ in shape, scoring configuration, release mechanisms, packaging, colors, flavors, preservatives, and product expiration. Proposed legislation currently before Congress will create the infrastructure for enhanced FDA vigilance and strict oversight of the production of international generic prescription medications. This landmark agreement will broaden the availability of safe and efficacious generic drugs in a health care marketplace that increasingly demands cost effective treatments. The APA supports the FDA's enhanced oversight of domestic and international generic drug production. Containing costs by judicious use of generic prescription medications should reduce health care costs for the government, private insurers, and individuals.

The main difference between generic and brand-name drugs is the amount and type of evidence supporting the market application of the respective drug. A brand-name drug is required to demonstrate substantial preclinical and clinical evidence showing safety and efficacy in a patient population. A generic drug does not have to demonstrate this safety or efficacy, as it is assumed the bioequivalent generic drug will act in a similar manner. Therefore, issues remain regarding the use of generic psychotropic medications:

1. *Bioequivalence vs. therapeutic equivalence.* Interchanging bioequivalent generic versus proprietary preparations (i.e. from a proprietary to generic, from generic to proprietary, or from generic to bioequivalent generic drug) raises pharmacokinetic, tolerability, and clinical equivalence concerns that should be addressed by a physician on an individual and disease-specific basis. When such switches are undertaken closer clinical monitoring for efficacy and side effects until response or clinical stability is determined.

2. *Verbal informed consent regarding substitution of generic medications is urged.* Patients' expectations regarding generic medications and their concerns about perceived differences between preparations (such as variations in typography, color, shape, size, markings, and flavor) can cause patient confusion and need to be addressed to ensure patient adherence and safety. Communication between physicians and patients about the risks versus benefits of generics is essential – as is a full discussion of treatment planning that includes the rationale for choosinga generic versus proprietary product. The goal is to arrive at informed consent with written documentation of this discussion.

3. *Substitution or restriction of a psychotropic formulation must be approved by the treating physician.* The APA acknowledges the current fragmentation and divergence of policies among statewide agencies, managed care providers, and pharmacists' mandates regarding dispensation of prescription generics versus proprietary medications. Limitations of proprietary medications in favor of generic medications currently exist beyond the treating physician's authority (such as prior approvals, increased co-pays, restricted formularies). The APA has no formal position with regard to these divergent policies. In 2009, the APA reaffirmed its position regarding opposition to medication substitution, including generic to brand-name interchangeability, without expressed consent of the psychiatrist (APA Position Statement #19951; "Medication Substitution"; reaffirmed Sept 2009). More specifically, restriction of access to an intended formulation or alteration of a physician-approved regimen due to cost factors alone is not optimal.

POSITION:
The American Psychiatric Association believes that generic prescription psychotropic medication can be a safe, efficacious, and economical alternative to costlier proprietary drugs, when clinically indicated, appropriately monitored and approved by a physician.

AUTHORS (CRQC):
Jeffrey Lieberman, MD, Matthew Erlich, MD and Gregory Dalack, MD

REVISED Position Statement on Legal Proceedings and Access to Psychiatric Care for Juvenile Offenders

FINAL

~~Approved by the Board of Trustees, December 1996~~
~~Approved by the Assembly, November 1996~~
REVISED October, 2012

Juvenile adjudication involves a balance between protecting society and rehabilitating young offenders. State statutes vary substantially in procedures and criteria for determining whether juvenile offenders are tried in juvenile court or in adult court and in the disposition process for some serious juvenile offenders after adjudication.

Some state statutes provide that transfer and sentencing decisions be made entirely on the basis of the seriousness of the offense involved. In contrast, other statutes confer discretion on judges, prosecutors, and other officials to make determinations about what legal responses may be appropriate in particular cases. Such discretionary decisions usually include consideration of the nature of the offense in question, but may also include consideration of other issues, such as the degree and type of risk that the offender may present to the public and the offender's likelihood of responding to rehabilitative services.

Mental illness and neurodevelopmental disorders can have a significant influence on criminal behavior in children and adolescents, and judicial responses to juvenile offenders may have an important impact on their access to treatment for such conditions. The American Psychiatric Association (APA) supports the principle that juveniles with mental illness and neurodevelopmental disorders should have the opportunity to obtain appropriate psychiatric assessment and treatment. Therefore, the APA supports procedures for responding to juvenile offenders that include explicit consideration of the level of development, the nature and impact of mental disorder, and the impact of legal decisions on the offender's access to appropriate care.

Juvenile offenders are at much higher risk for mental disorders than the general population. When it appears that a juvenile offender may suffer from mental or neurodevelopmental disorder, the results of a competent psychiatric assessment should be considered in making discretionary decisions regarding such issues as placement, supervision, transfer to criminal adult court, and disposition. The APA recommends that that such assessments be performed by psychiatrists or other mental health experts who have special training and/or experience in the diagnosis and treatment of children, adolescents and their families and who are familiar with the range of behavioral, emotional, developmental, psychological, and social problems experienced by juvenile offenders, as well as with the interventions available to the court for responding to these problems.

A competent assessment includes a thorough diagnostic evaluation of the juvenile, including the juvenile’s educational history and mental health history, as well as an evaluation of the juvenile’s family and others who may be instrumental in providing supports and fostering treatment adherence, thereby increasing the likelihood that the youth will benefit from the intervention. To the extent possible, it should specify the types and length of interventions that will be required if treatment is to be successful and address the availability of the necessary treatment within the justice system. While avoiding explicit predictions about an offender's future behavior, the assessment should identify factors bearing on the risk of future offending.

Attachment #10
Item 2013A1 4.B.15
Assembly
May 17-19, 2013

Proposed Position Statement
Use of Medical Marijuana for PTSD

FINAL

Because of the lack of any credible studies demonstrating clinical effectiveness, the APA cannot endorse the use of medical marijuana for the treatment of post-traumatic stress disorder (PTSD). The Council on Research and Quality Care reviewed available evidence regarding the use of marijuana in the treatment of PTSD (1-6) and concluded that no published evidence of sufficient quality exists in the medical literature to support the practice.

1. Campos-Outcall D et al. Medical Marijuana for the treatment of post traumatic stress disorder: An evidence review. Mel and Enid Zuckerman College of Public Health, University of Arizona, 2012. (literature reviewed through June 2012)
2. Mashiah M. Medical Cannabis as treatment for chronic combat PTSD: Promising results in an open pilot study. Presented at "Patients out of Time" conference, Tucson, Az 2012. A double blind study is planned but has not yet been conducted.
3. Grant I et al. Report to the Legislature and Governor of the State of California presenting findings pursuant to SB847 which created the CMCR and provided state funding. Center for Medicinal Cannabis Research. UC San Diego, Prepared February 11, 2010.
4. Bostwick JM. Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana. Mayo Clin Proc. 2012;87(2):172-186.
5. American Psychiatric Association: Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry 2004; 161(Nov suppl).
6. PubMed search using terms "marijuana," "PTSD," and "treatment," conducted December 1, 2012

Attachment #11
Item 2013A1 14.A
Assembly
May 17-19, 2013

FINAL

Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

5/17/2013

Position Statement

The American Psychiatric Association recognizes the critical public health need for action to promote safe communities and reduce mortality due to firearm-related violence. As such, the APA supports the following actions:

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory action. These actions should include:

   a. Limiting access to guns by persons who are identified as dangerous, whether or not they have been diagnosed with a mental disorder;

   b. Requiring more extensive background checks and waiting periods on all gun sales or transactions;

   c. Requiring safe storage of all firearms in the home, office or other places of daily assembly; and

   d. Limiting access to semi-automatic firearms, high capacity magazines and high velocity ammunition to reduce risk of critical injuries and death from firearms;

2. Research and training on the causes of violence and its effective control should be a national priority.

   a. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of high-risk individuals.

   b. Funding for such research should be supported broadly, drawing on a range of resources such as the Centers for Disease Control, the National Institutes of Health, the National Science Foundation, academic institutions, and community foundations. Administrative, regulatory or legislative barriers to federal support for violence research, including research on firearms violence, should be removed.

   c. Psychiatrists, as well as other physicians and health professionals, must continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal and state resources should be

allocated for training of these professionals. (see APA Position Statement on Firearms Access: Inquiries in Clinical Settings)

d. Resources should be increased for safety education programs related to responsible use and storage of firearms.

3. Recent attention to the mental health system has highlighted the need for improved services and access to care.

a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in a national and local agenda to augment prevention strategies, reduce the stigma of treatment, and diminish the consequences of untreated mental disorders.

b. For those people with mental illness who ultimately pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be removed. Access to care and associated resources to enhance community follow up should be maximized to ensure that patients obtain treatment and are not lost to care.

c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws mandating psychiatrists and other mental health professionals to report to law enforcement officials everyone who appears to be a danger to themselves or others are likely to be counterproductive and should not be adopted.

d. The President of the United States should consolidate and coordinate current interests in improving mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

Background and Support:

Gun violence is a major public health issue in our country. The most recent data indicate that 19,392 people used a gun to kill themselves in 2010, and 11,078 killed someone else with a firearm.(1) The United States has a homicide rate seven times more than the average of other high income countries (2). The Harvard Injury Control Research Center has shown that “more guns” means “more death” and there is no evidence that having more guns reduces crime (3). African Americans, particularly in the younger age groups, bear a disproportionately higher burden of the national homicide rate (4). Although concern is understandably heightened when mass tragedies occur, the daily occurrence of murders and suicide due to the use of guns accounts for the vast proportion of gun deaths.

The role of mental disorders in violence is often misunderstood. Mental disorders are much more closely linked to suicide than to homicide. Diagnosable mental disorders are present in an overwhelming proportion of people who commit suicide. However, the best available data suggest that only 3-5% of acts of violence towards others in our communities are attributable to people with diagnosed mental disorders(5), and only a tiny percentage of such acts (2-3% in a major study) involve guns(6).

Although people with mental disorders are at somewhat increased risk of committing violence towards others, only a minority of people with mental disorders are violent. Indeed, they are far more likely to be the victims than the perpetrators of acts of violence (7).

Gun violence may be committed during periods of great personal stress and emotional turmoil, often heightened by substance misuse, or in a myriad of other circumstances, by people who have ready access to guns and may act either impulsively or with impaired judgment.

Acts of murder-suicide, of which mass violence is an example, are devastating to the communities in which they occur. Mass violence by firearms or other means can be perpetrated for many reasons, and by persons with a variety of motivations and personal issues. Although mental disturbances may be present in those rare perpetrators of mass violence by firearms followed by suicide, when mental illness is present it is often undiagnosed, as the perpetrator may not have come to the attention of mental health professionals. In those circumstances, missed opportunities for needed treatment could be avoided by enhancing broader access to care and minimizing barriers to access.

References:

1. Centers for Disease Control, 2010 Mortality Multiple Cause Micro-Data Files. Table 10. Number of deaths from 113 selected causes. Enterocolitis due to Clostridium difficile, drug-induced causes, alcohol-induced causes, and injury by firearms, by age. Unites States, 2010. Accessed at http://www.cdc.gov/nchs/data_access/vitalstatsonline.htm

2. Richardson EG, Hemenway D. Homicide, suicide, and unintentional firearm mortality: comparing the United States with other high-income countries, 2003. Journal of Trauma 2011; 70:238-243.

3. Hemenway D: Private Guns, Public Health. University of Michigan Press, 2004.

4. Cole D: Who pays for the right to bear arms? New York Times, January 2, 2013.

5. Swanson JW. Mental disorder, substance abuse, and community violence: an epidemiology approach. In Monahan J, Steadman HJ (eds), Violence and Mental Disorder. Chicago: University of Chicago Press, 1994, pp. 101-136.

6. Monahan J, Steadman H, Silver E, Appelbaum PS, Robbins PC, Mulvey EP, Roth LH, Grisso T, Banks S. Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, 2001.

7. Teplin LA, McClelland GM, Abram KM, Weiner DA. Crime victimization in adults with severe mental illness: comparison with the national crime victimization survey. Arch Gen Psychiatry 2005; 62:911-921.

Attachment #12

Assembly
May 17-19, 2013
San Francisco, California

DRAFT II SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 4.B.1	Proposed Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist	The Assembly voted to refer the Proposed Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist* to the Council on Addiction Psychiatry. The Assembly felt that the background materials and its relationship to the position statement were not clear.	Joint Reference Committee, June 2013
2013 A1 4.B.2	Revised Position Statement: Day Care for Preschool Children	The Assembly voted to refer the Revised Position Statement: *Day Care for Preschool Children* to the Council on Children, Adolescents and their Families. The Assembly felt that the position statement did not take into sufficient account new information specifically on the data of adverse childhood experiences that would illustrate that there are other kinds of adverse health effects besides psychological effects associated with poor treatment in children.	Joint Reference Committee, June 2013
2013 A1 4.B.3	Retire Position Statement: 1991 Position Statement: Day Care for Preschool Children	The Assembly voted, on its consent calendar, to retire the Position Statement: *Day Care for Preschool Children*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.4	Retain Position Statement: 1991 Child Abuse and Neglect by Adults	The Assembly voted to refer the 1991 Position Statement: *Child Abuse and Neglect by Adults* to the Council on Children, Adolescents and their Families. The Assembly felt that the position statement did not take into sufficient account new information specifically on the data of adverse childhood experiences that would illustrate that there are other kinds of adverse health effects besides psychological effects associated with poor treatment in children.	Joint Reference Committee, June 2013
2013 A1 4.B.5	Retain 2000 Position Statement: Therapies Focused on Memories of Childhood Physical and Sexual Abuse	The Assembly voted, on its consent calendar, to retain the 2000 Position Statement: *Therapies Focused on Memories of Childhood Physical and Sexual Abuse*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.6	Proposed Position Statement: Detained Immigrants with Mental Illness	The Assembly voted to approve the Proposed Position Statement: *Detained Immigrants with Mental Illness*. **N.B.:** After the Assembly approved the Proposed Position Statement, necessary edits were made to the document by the Council on Psychiatry and Law and the Council on Minority Mental Health and Health Disparities. As a result of the extensive changes, the Proposed Position Statement was referred back to the Assembly for consideration at its November, 2013 meeting.	Assembly, November 2013 FYI- Joint Reference Committee, October 2013
2013 A1 4.B.7	Proposed Position Statement: Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients	The Assembly voted to approve the Proposed Position Statement: *Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 4.B.8	Retirement of Position Statement: Delineation of Transcultural Psychiatry as a Specialized Field of Study (1969)	The Assembly voted, on its consent calendar, to retire the Position Statement: *Delineation of Transcultural Psychiatry as a Specialized Field of Study* (1969).	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.9	Retirement of Position Statement: Training of Minority Psychiatrists (1975)	The Assembly voted, on its consent calendar, to retire the Position Statement: *Training of Minority Psychiatrists* (1975).	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.10	Retire Position Statement: 1995 Medical Psychotherapy	The Assembly voted to retain the 1995 Position Statement: Medical Psychotherapy. The Assembly voted to retain the original Position Statement as they voted to refer the Revised Position Statement: Medical Psychotherapy to the Council on Healthcare Systems and Financing.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.11	Revised Position Statement: Medical Psychotherapy	The Assembly voted to refer the Revised Position Statement: *Medical Psychotherapy* to the Council on Healthcare Systems and Financing. The Assembly felt that that the position statement does not include many of the critical points which demonstrate the value of psychotherapy delivered by a psychiatrist.	Joint Reference Committee, June 2013 Assembly Executive Committee, July 2013
2013 A1 4.B.12	Retire Position Statement: 1968 Generic versus Proprietary Drugs	The Assembly voted, on its consent calendar, to retire the 1968 Position Statement: *Generic versus Proprietary Drugs*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.13	Revised Position Statement: Generic versus Proprietary Drugs	The Assembly voted, on its consent calendar, to approve the Revised Position Statement: *Generic versus Proprietary Drugs*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.14	Revised Position Statement: Legal Proceedings and Access to Psychiatric Care for Juvenile Offenders	The Assembly voted, on its consent calendar, to approve the Revised Position Statement: *Legal Proceedings and Access to Psychiatric Care for Juvenile Offenders*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 4.B.15	Proposed Position Statement: Use of Medical Marijuana for PTSD	The Assembly voted to approve the Proposed Position Statement: *Use of Medical Marijuana for PTSD*.	Board of Trustees, July 2013 FYI- Joint Reference Committee, June 2013 Melvin Sabshin Library and Archives
2013 A1 5.A	Will the Assembly vote to approve the minutes of the November 9-11, 2012 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 9-11, 2012 meeting.	Medical Director's Office • Association Governance
2013 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2013A1 4.B.2, 4.B.4, 4.B.10, 4.B.11 and 12.T were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Medical Director's Office • Association Governance
2013 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.	Medical Director's Office • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 7.A	2013-2014 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2013 to May 2014: Speaker-Elect: Jenny L. Boyer, M.D. Recorder: Glenn Martin, M.D.	Medical Director's Office • Association Governance
2013 A1 7.B.1	Will the Assembly vote to approve the recommended amendments to the Procedural Code incorporating Action Paper 2012A1 *12.EE Voice of the Assembly: Directing the Speaker to Move a Passed Action Paper Directly at the Board of Trustees Meeting*?	The Assembly voted to approve the recommended amendments to the Procedural Code incorporating Action Paper 2012A1 *12.EE Voice of the Assembly: Directing the Speaker to Move a Passed Action Paper Directly at the Board of Trustees Meeting*.	Medical Director's Office • Association Governance
2013 A1 7.B.2	Will the Assembly vote to approve the "Senior Psychiatrists" to become an Assembly Allied Organization?	The Assembly voted to approve the "Senior Psychiatrists" become an Assembly Allied Organization.	Medical Director's Office • Association Governance
2013 A1 12.A	Assembly Reaction to Unsubstantiated and Discriminatory Statements Linking Violence and Mental Disorders	The Assembly voted, on its consent calendar, to approve 2013A1 12.A which asks that the Assembly of the American Psychiatric Association supports the letter written by Dilip Jeste, MD, President of the APA, dated December 20, 2012, to the leadership of U.S. Congress, following the shooting incident at Sandy Hook Elementary School in Newtown, CT, rejecting statements suggesting that all those who commit heinous gun crimes are mentally ill and re-stating the evidence that most acts of violence are not committed by individuals with mental disorders.	Assembly Executive Committee, July 2013
2013A1 12.B	Improving the Mental Health Services System in the United States	The Assembly voted, on its consent calendar to approve 2013A1 12.B which asks that the Assembly of the American Psychiatric Association supports the statement made by Paul Appelbaum MD to the Vice President Joseph Biden's Gun Violence Task Force proposing the appointment of a Presidential Commission to develop a vision for a system of mental health care; the creation of a mechanism for facilitating response to key mental health issues; the improvement of an early identification of young people with mental health problems; and sensible, non-discriminatory approaches to keeping firearms out of the hands of dangerous people.	Assembly Executive Committee, July 2013
2013 A1 12.C	Supporting the Role of the CDC in the Prevention of Firearm Related Violence	Item 2013A1 12.C was consolidated into item 2013A1 14.A*: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*.	N/A
2013 A1 12.D	Board of Trustees-Assembly Ad-Hoc Work Group on Gun Violence	Item 2013A1 12.C was consolidated into item 2013A1 14.A: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.E	APA Membership Central Billing Allowing for Voluntary Contributions by Members	The Assembly voted to approve 2013A1 12.E which asks that: 1. The American Psychiatric Association Board of Trustees shall forthwith direct the Membership Department staff of the American Psychiatric Association to adopt a membership dues statement, both on paper and electronically, only upon request from the Council(s) of the involved entities, for which the total bill includes billing for a DB/SA PAC contribution, 2. That the TOTAL statement to APA members shall consist of the sum of the APA national membership dues plus the DB/SA membership dues, plus the DB/SA PAC contribution, and 3. That the contributions to the PAC and Advocacy Plans shall represent a voluntary contribution from the individual member, and 4. That there will be a check box appearing before each listing of the DB/SA PAC contribution which, if checked, will indicate that the APA member chooses NOT to make the featured contribution, and that member will deduct the amount checked from the TOTAL amount and instead submit that reduced payment, and 5. That there will be a clear notification to members of the option to check and subtract the voluntary contributions should they wish to do so, and 6. That the billing and negative check-off features made available on electronic billing features used by the APA will be obvious and easy to navigate, and will explicitly state that the contribution is voluntary, and 7. That the APA will refund the full amount of the charges of the negative check off amounts upon request from any member who claims to have paid them erroneously within one year from making such payment, and 8. That the council of the individual DB/SA will set the amounts to be charged for PAC contributions on the statement.	Joint Reference Committee, June 2013
2013 A1 12.F	APA to Liaison with ABPN Regarding MOC Exam Timing	The Assembly voted to approve item 2013A1 12.F which asks that the APA liaison to the ABPN to advocate for members, specifically requesting that if a diplomate takes the re-certification exam prior to the expiration year of his/her certification, that the new 10-year certification period would begin at the expiration of the prior certification period, instead of beginning on the date the exam was taken; That the results of this discussion be communicated back to the Assembly at or before the May 2014 Assembly Meeting; That the APA liaison to the ABPN advocate greater flexibility, including but not limited to, a wider window for scheduling and taking the exam as well as allowance for extenuating circumstances.	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.G	Polypharmacy	The Assembly voted to approve item 2013A1 12.G which asks: 1. That the APA have the Steering Committee on Practice Guidelines explore whether a general guide on the use of more than one psychotropic medication in the treatment of psychiatric disorders can be developed base on a consensus. 2. The Steering Committee on Practice Guidelines report back their preliminary findings to the November 2013 Assembly.	Joint Reference Committee, June 2013
2013 A1 12.H	APA MIT 100% Club Benefits	The Assembly voted to approve item 2013A1 12.H which asks that Residents of programs that achieve Bronze Club status or higher would have access to Psychiatry Online at a 50% discount off the current MIT price for that membership year. And, an impact of the program will be evaluated by the Membership Committee.	Joint Reference Committee, June 2013
2013 A1 12.I	Revitalizing the Public Perception of the APA and the Psychiatric Profession	The Assembly voted to approve item 2013A1 12.I which asks that the APA Board of Trustees will reorganize and increase funding to the Council on Communications such that it directs an energized communications and public relations campaign directed towards the public at large, through the lay and social media, utilizing such measures as broad-based advertising, public service announcements, press conferences and other effective public relations measures, seeking advice from public relations professionals; that this effort include messages about how parity violations have and do affect access to care and that the APA Board of Trustees direct the Medical Director to expand APA communications mission.	Joint Reference Committee, June 2013
2013 A1 12.J	Poster Awards Pilot Project by Area 5	The Assembly voted, on its consent calendar, to approve item 2013A1 12.J which asks that: 1. The APA Scientific Program Committee will provide Area V with the approved abstracts with contact information for the posters accepted at the annual meeting beginning in 2014. 2. The APA will print a photograph of the winners in an APA publication such as *Psychiatric News*.	Joint Reference Committee, June 2013
2013 A1 12. K	Inquiry Regarding American Board of Psychiatry and Neurology (ABPN) Data Collection and Data Management Practices	The Assembly voted to approve item 2013A1 12.K which asks that the APA Council on Medical Education Lifelong Learning be charged with the responsibility to inquire of the ABPN what applicant data are collected, how they are utilized, and what privacy protections are in place and what privacy protections will remain in place. And, that the Council on Medical Education and Lifelong Learning generate a report for the Assembly at the May 2014 Assembly Meeting.	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.L	ECP Oriented Annual Meeting Program	The Assembly voted, on its consent calendar, to approve item 2013A1 12.L which asks that the APA explore the option to create an Early Career Psychiatrist track that would run in parallel and/or in conjunction with MIT and PsychSIGN tracks; That the ECP track will be held over the course of half to full day; That the ECP track will focus on broad areas of interest to ECPs as defined by ASM ECP Committee (including APA ECP BOT, APA AMA Representative, etc) to include but not limited to: early career private practice issues, emerging diagnostic and treatments, negotiations, practice models, emerging public health and policy issues, etc.; That the ECP track be assigned an APA staff to help coordinate the events; That the ECP track be coordinated with relevant parts of the MIT and PsychSIGN tracks; That the ECP track's chair position be determined by ASM ECP Committee members as defined above; That that APA's consideration of this ECP track be reported to the ASM by November of 2013.	Joint Reference Committee, June 2013
2013 A1 12.M	Providing DSM-5 Teaching Material to APA District Branches	The action paper was withdrawn by the author.	N/A
2013 A1 12.N	Membership Benefit: Free DSM-5	The Assembly voted to approve item 2013A1 12.N which asks: 1) That the electronic version of the full text of DSM-5 be given quid pro quo as a member benefit to all APA Members. 2) That the Speaker move this Action Paper at the May, 2013, Broad of Trustees meeting. **N.B:** The Board of Trustees voted to defer discussion of this action paper until its July, 2013 meeting.	Board of Trustees, May 2013
2013 A1 12.O	Comprehensive Training for Psychiatric Residents on Violence Management and Self-Protection	The Assembly voted to approve item 2013A1 12.O which asks: 1. That the Council on Medical Education and Lifelong Learning explore whether it would be valuable and feasible for Residency Review Committee of the Council of Graduate Medical Education (ACGME) to make comprehensive training as itemized in Resolve #2, training a requirement of residency training. 2. The ACGME requirement for this comprehensive training shall include the following key three elements: Prevention De-escalation Self Protection And the training shall be done by a qualified trainer. 3. That the Council on Medical Education and Lifelong Learning report their findings to the November, 2013, Assembly.	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.P	APA Representation in the HL7 Standards Organization	The Assembly voted to approve item 2013A1 12.P which asks that the APA will become an Organizational Member of HL7; that the Medical Director will appoint a minimum of three members to participate in HL7 for the purpose of advancing the specialty's interests in the development of health information technologies; that the appointed HL7 participants will report to the Committee on Electronic Health Records; that the APA will reimburse the appointed HL7 participants for meeting fees, travel and hotel costs with a minimum commitment of sending three participants to each of three work group meetings annually.	Joint Reference Committee, June 2013
2013 A1 12.Q	The Development of a Resource Document on Human Trafficking	The Assembly voted to approve item 2013A1 12.Q which asks that: 1. Working with appropriate APA staff and Components, the Assembly requests that the Women's Caucus of the APA and/or the Council on Research and Quality Care or other appropriate APA or non APA resource develop an evidenced based resource document covering the psychological, social, and physical repercussions/trauma and sequellae of being a victim of human trafficking as well as the appropriate treatment and care for the victims including social and legal resources that may be available. 2. The resource document be disseminated to the National Officers, and the Officers of the District Branches. 3. The resource document be made easily available to members on the APA Web Site such that it be easily available for members at all times so that, for example resident members could access the resource document at any time. 4. The District Branches be encouraged to disseminate the resource document to their Officers as well as the general membership including Officers of any Chapters in the case that Chapters are part of the District Branch structure. 5. District Branches encourage their membership to gather local information for distribution to their membership concerning available resources for victims of human trafficking. 6. The Resource Document be reviewed and up-dated at least every two years or as indicated by the Council on Research and Quality Care.	Joint Reference Committee, June 2013
2013 A1 12.R	APA Should Sign the AllTrials Campaign Petition	The Assembly voted to approve item 2013A1 12.R which asks: 1. That the American Psychiatric Association should join dozens of other national and international scientific societies in signing the AllTrials.org petition bolded language above. 2. That the Joint Reference Committee, if it feels more background is needed, is asked to refer to the appropriate Council(s) for evaluation and recommendation to the Board of Trustees. 3. The Recorder shall report back to the Assembly at the November 2013 Assembly meeting if the APA has signed the petition, and if not, why not?	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.S	Use of New CPT Codes in Health Insurance Exchanges	The Assembly voted, on its consent calendar, to approve item 2013A1 12.S which asks: 1. That the APA Division of Government Relations and the APA Division of Healthcare Systems and Financing shall jointly advocate that the Exchanges must cover all CPT® codes and coding conventions (including the new combination codes for psychotherapy services) and must use the Medicare RVU values as the basis for reimbursement for physician services in any fee-for-service plan; and 2. That the APA Division of Healthcare Systems and Financing shall prepare draft language and additional supporting material for use by district branches and state associations in advocating at the state level for both use of CPT® codes and coding conventions and for use of the Medicare RVUs in Exchanges established by states.	Joint Reference Committee, June 2013
2013 A1 12.T	Application by the American Psychiatric Association to the United Nations to Become Accredited as a Non-Governmental Organization with Consultative Status	The Assembly voted to approve item 2013A1 12.T which asks that: 1. The Assembly requests that the Speaker bring this to the May 2013 Board of Trustees meeting so that the APA apply for consultative status with the UN if possible by May 31, 2013. 2. That APA designate staff to assist with the process. 3. That an update report be given to the Assembly in November 2013. 4. If appropriate, UN staff be invited to address the Assembly at the May 2014 APA Annual Meeting in New York. **N.B.:** The Board of Trustees voted to approve item 2013A1 12.T	Board of Trustees, May 2013
2013 A1 12.U	Committee on Mental Health Information Technology	The Assembly voted, on its consent calendar, to approve item 2013A1 12.U which asks that the Committee on Electronic Health Records is renamed the Committee on Mental Health Information Technology; and the Committee's charter be revised to include addressing of health information technologies, including electronic health records, personal health records, health information exchange, mobile health technologies, psychiatric informatics, secure messaging for communicating health information, and addressing of relevant health care policies, including state and federal regulations and statutes, on issues relating to mental health information technology, such as privacy, security, patient access, granular consent, data segmentation, usability, clinical decision support, meaningful use, and functionality.	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.V	Use of District Branch/State Association/Area Council Electronic Communications by APA Election Candidates	The Assembly voted to approve item 2013A1 12.V which asks: 1. That if a District Branch/State Association/Area Council (DB/SA/AC) chooses to do so, it may permit the use of their electronic communications services (such as email, listservs, bulletin boards, and group messaging) for campaigning by APA election candidates as long as they permit all relevant candidates to have open access to such communication service by temporarily accepting said candidates to a special DB/SA/AC member status that permits them access to the communication service; 2. That the appropriate period for District Branches/State Associations/Area Councils to allow access by candidates to their electronic communications services be from 30 days prior to the beginning of an election through the last day of the election; and 3. That each District Branch/State Association/Area Council has sole governance over the content of its electronic communications and may specify rules of engagement for the candidates to abide by. 4. That the Joint Reference Committee refer this paper to the Elections Committee for consideration of revisions to the elections guidelines to implement the above items.	Joint Reference Committee, June 2013
2013 A1 12.W	Assembly Reimbursement for Liaisons to the Assembly from Allied Organizations	The Assembly voted to approve item 2013A1 12.W which asks that the travel and lodging expenses of one Assembly Allied Organization Liaison representative per Allied Organization be funded by the APA to attend the Fall Assembly meeting and twice yearly meetings of the Area Councils in which the AAOLs are seated at which other members are funded; That the funding for the Area Council Meeting shall come out of the Assembly Budget and not from the Area Council Block Grant.	Assembly Executive Committee, July 2013
2013 A1 12.X	MIT and ECP Vote by Strength in APA Assembly	The action paper was withdrawn by the author.	N/A
2013 A1 12.Y	APA Referendum Voting Procedure	The Assembly voted to approve item 2013A1 12.Y which asks that the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing.	Joint Reference Committee, June 2013

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2013 A1 12.Z	Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System	The Assembly voted to approve item 2013A1 12. Z which asks that the Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will seek to provide deliverables such as a Third Edition of the Guidelines, a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, nationally and nationally to organizations such as NAMI, The National Association of State Mental Health Program Directors and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council and which would report to the Council on Psychiatry and the Law and which would provisionally have the following charge: 1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the criminal justice system, including jails, prisons, law enforcement, or the courts. 2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system. 3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment. 4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons; 5. Revise and update the Position Statement of 1988. 6. Develop the 3rd edition of the APA Guidelines on Psychiatric Services in Jails and Prisons.	Joint Reference Committee, June 2013
2013 A1 12.AA	Opposing Laws Limiting Ability of Physicians to Discuss with their Patients Issues Related to Firearms Possession and Use	Item 2013A1 12.C was consolidated into item 2013A1 14.A: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	N/A
2013 A1 12.BB	Opposing Laws Mandating Psychiatrists to Report to Law Enforcement Officials Anyone who Appears to be a Danger to Himself, Herself or Others	Item 2013A1 12.C was consolidated into item 2013A1 14.A: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	N/A
2013 A1 12.CC	Supporting Rational Firearm Control Policy	Item 2013A1 12.C was consolidated into item 2013A1 14.A: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	N/A
2013 A1 14.A	*Proposed Position Statement: Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	The Assembly voted unanimously to approve the Proposed Position Statement: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	Board of Trustees, July 2013

REPORT OF THE AMERICAN PSYCHIATRIC FOUNDATION

2nd QUARTER 2013

JULY 20-21, 2013

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EXECUTIVE SUMMARY

July 10, 2013

APA Board of Directors,

I am pleased to present this report on the activities of the American Psychiatric Foundation.

The American Psychiatric Foundation continues to represent a tremendous opportunity to leverage the combined expertise of the two former subsidiaries, APF and APIRE, into a single robust, effective and efficient entity. We look forward to continuing the development of the vision, mission and branding of the new APF.

2012 was a successful year for the American Psychiatric Foundation as APF Board members, staff and consultants worked together to:

- Finalize our organization's name and mission statement;
- Design and approve new branding;
- Raised fund to support our public education and research initiatives, as well as, support key APA activities;
- Endorse a strategic plan for future organizational priorities and activities;
- Translate Typical or Troubled? ™ into Spanish, expanding its value to communities;
- Continue the Research Training Program to invest in promising new psychiatric investigators.

At mid-year, 2013 APF activities suggest that the months ahead will be just as exciting. We'll be expanding APF programs and initiatives, monitoring and adjusting APF's new website, and disbursing the Legacy Fund and New Initiative Fund monies to support very valuable fellowships, and new ideas! After highly focused meetings with external supporters at the APA Annual meeting in San Francisco, APF is anticipating a successful Corporate Advisory Council meeting on July 18th at APA headquarters.

The Board of Directors of the APF will meet again on July 25th, to continue the process of developing an agreed upon and endorsed strategic plan for the new APF and the establishment of key organizational objectives for the next three years. We anticipate the continue ability to advance our public education, research and industry liaison mission in 2013 and beyond.

The Board of Directors consists of 13 voting directors. The APA Medical Director and CEO serves as the Chairperson of the APF Board of Directors.

The members of the new APF Board, as selected by the APA Board of Trustees are: Dr. James H. Scully, Jr. [*Chairperson*]; Drs. Richard Harding, James Nininger, Judge Steven Leifman, Laura Roberts, Amy Ursano, Donna Norris, Jack Barchas, Stuart Yudofsky and Grayson Norquist. Drs. Dilip Jeste, David Fassler and Paul Summergrad serve as voting directors, in an ex-officio capacity.

The following report includes a summary of current APF activities, as of July 15th, 2013.

REPORT OF THE EXECUTIVE DIRECTOR

A. AMERICAN PSYCHIATRIC FOUNDATION

Paul T. Burke, Executive Director

Typical or Troubled?™ **School Mental Health Education Grant Program**

Miami Dade County Technical Assistance program

The Miami Dade County School system has partnered with the Foundation to provide planning and training for in the implementation of *Typical or Troubled?*™ to the more than 400 middle and high schools within their school system. The Foundation is in process of planning with the school system to provide two train the trainer workshops in Miami in March and July of this year.

These master trainers will provide training to all middle and high school teachers and school staff over the next year.

2013-14 School-year Planning

Twenty six school groups have been chosen to receive grants from $500 to $2000 for the implantation of the in school training for a total of $30,000 in grants. This will train 18,500 additional teachers and school staff about the warning signs of adolescent mental health and the referral system in their 175 schools. Grantees will receive teleconference training and technical assistance and all the materials to provide the training in their schools, including pretests and evaluations.

A newly designed and branded English brochure and book mark for Typical or Troubled? ™ are now in use for this school year. The Spanish translation of the brochure to be completed by the end of June.

Judges Leadership Initiative and Psychiatrist Resource Group

Two new grants for the JLI program have been approved for a total of $400,000 from Janssen Pharmaceuticals and Eli Lilly and Company. We will continue to partner with the Council on State Governments to provide training to general jurisdiction judges in recognition of mental health issues with arrested individuals and working in their communities to integrate support services for them. The video case studies with discussion questions are in final editing. These case studies will be part of the training for judges and psychiatrists. We will begin the selection

of our first 3 conferences from the states that have requested the training. Upon selection, APF will then work with the state judicial college coordinator to schedule additional trainings.

A meeting of the Judicial Advisory group to review a framework publication, Reducing Recidivism and promoting Recovery: Research to Practice for Judges from the Council of State Government Justice center to be used in the training of judges. The meeting was held in New York on June 12th.

The Psychiatric Leadership Group will meet for similar discussions at APA on August 8th. Both groups will be part of a Judicial Leadership Summit on the decriminalization of Mental Illness at the IPS in October. We continue to work with our partner organization the Council of State Governments on education at the state level for general court judges in recognition of individuals with mental illness who become justice involved and the submission of education programs for psychiatrists to the APA Annual Meeting and IPS.

Partnership for Workplace Mental Health:

Mental Health Works

The Second Quarter 2013 issue of *Mental Health Works*, the Partnership for Workplace Mental Health's quarterly newsletter, was distributed to near 50,000 recipients. The issue's headlines include:

- Pacific Gas and Electric Company: Realizing the Power of Program Integration
- Study Finds Substantial Economic Impact of ADHD in the United States
- Your Mental Health Parity Questions Answered
- Corporate Leaders Discuss Return to Work
- Partnership Congratulates Carruthers on Retirement

Partnership Advisory Council

The Partnership Advisory Council met May 22-23, 2013 in San Francisco, CA coinciding with the APA Annual Meeting. The Council provides strategic guidance to the program and represents a diversity of experience and perspectives, including employers, psychiatrists, and related purchasing stakeholders. A number of guests presented on key topics, including:

- APA member Steve Daviss, MD presented to the Council about network adequacy.
- APA Office of Healthcare System and Financing (OHSF) spoke to the Council about CPT coding changes and their potential impact on employees.
- OHSF director, Sam Muszynski, JD & APA member Henry Harbin, MD discussed parity and the APA response to the next phase of health care reform.

The Council provided feedback on specific projects and activities under development by staff, including a checklist of employer practices for mental health and program evaluation. The Council also discussed integration and collaborative care and heard from its two members actively involved in integrated care projects, Laurel Pickering, MPH and Hyong Un, MD.

The Partnership Advisory Council's next meeting takes place in late October or November in Washington DC. In addition to meeting, the Council also presented an annual meeting symposium titled: Return to Work: the Most Underutilized "Pill" in the Psychiatrist's Formulary (see Annual Meeting activities below).

Employee/Employer Worksite Education

Right Direction

The Partnership is collaborating with Employers Health, Inc., an employer purchasing coalition based in Ohio, on the development and implementation of employee educational materials for delivery at the workplace called Right Direction. The materials focus on depression and include an employee website, and HR toolkit for implementation and educational materials for employees to decrease stigma and increase help-seeking behaviors. Right Direction was launched on May 15 at Employers Health annual employer conference. The Partnership promoted this program at the APA Annual Meeting and has already sent out Right Direction kits to over 40 employers. Several media outlets have covered the initiative, including Forbes.com. Employers Health and the Partnership are convening webinars in June and July to continue to promote this initiative and engage employers to encourage implementation of the program at their companies.

Wellness Works!

The Partnership is included in a $3M contract award from the California Mental Health Services Authority to Mental Health America of California. The Partnership is providing employer outreach expertise to MHA-CA and its collaborative partners in the development and execution of a statewide mental health in the workplace program called *Wellness Works!*. The program is working to foster systems change through the strategic engagement of employers, adaptation and deployment of existing best-practice tools for workplace wellness, and managing symptoms of mental illness while countering the fear, bias, and discrimination that reduces workplace productivity and employee morale. This is accomplished through various education modules for managers.

The partnership participates in monthly leadership calls to provide strategic feedback and suggestions. After the initial in person Advisory Committee meeting for *Wellness Works!* on March

24, the partnership has continued its support on monthly calls to facilitate the program as it moves from a funded to fee-based program.

Associate director, Kate Burke, MA and the partnership's consultant Nancy Spangler, PhD, OTR/L led two engagement training refresher courses on Apr 4 and May 16 adapted from our original training in November 2012 as the program has evolved and new staff was hired in CA.

Give An Hour:

APF is proud to continue its partnership with *Give an Hour* to create a public education campaign to help generate awareness about the mental health issues faced by our veterans and their families. APF was proud to be a sponsor of and a participant in the GAH "Celebration of Service" Military mental health conference in New York City on June 2-3. APF and GAH will also conduct two town hall meetings on military mental health in 3rd and 4th Quarters of 2013.

Give an Hour is a nonprofit organization providing free mental health services to military personnel and their families. To date, over 6,500 providers have contributed their time.

PBS Collaboration:

The American Psychiatric Foundation (APF) continues to support the PBS series *Healthy Minds* produced by WNET & WLIW TV in New York City. The filming of *Healthy Minds'* 2013 series is completed. APF and WNET-WLIW continue to focus on the distribution of the 2013 Healthy Minds series.

This season, three thirty-minute 2013 episodes will focus on military mental health issues. The first episode, titled "Service, Resilience and Dedication to our Warriors," features a compelling dialogue with Admiral Mullen, former Chair of the Joint Chiefs of Staff, and his wife.

The second episode, "The Invisible Injuries of War and Post Traumatic Stress," features interviews with Col. David Sutherland and Give an Hour Founder and CEO, Dr. Barbara Van Dahlen. The third episode is titled "Serving Those Who Serve and Their Families" and features veteran Mark Steppe, his wife Amy, and other families who share their personal experiences with PTSD.

This episode also includes interviews with CBS television Special Correspondent and author Rita Cosby and former APA President Dr. Alan Schatzberg.

We estimate that *Healthy Minds* will be available to over 60% of US TV households in 2013.

Industry Liaison Activities/Corporate Advisory Council

APF continues to manage a proactive industry liaison effort with on-going visits to individual corporate headquarters and continued meetings with industry executives at APA headquarters.

Linda Bueno and Paul Burke also met with 15 CAC member companies at the Annual Meeting. A half day meeting was held at Genentech headquarters in South San Francisco with Exective Team members from both APA and Genentech. Other meetings in the Foundation suite with APA and CAC member representatives came to discuss areas of mutual interest, collaboration and share information. One new company, EnVivo Pharma, attended the meetings and will attend the July CAC meeting.

A meeting of the Corporate Advisory Council will be held on July 18th with a networking reception on the evening before. The council meeting will be at APA headquarters.

APF Support of APA Programs and the Annual Meeting

The Foundation continues to have a major role in supporting the APA, which includes coordinating new Annual Meeting and IPS initiatives and negotiating financial support for APA Programs, Fellowships, and Awards. Planning for support opportunities for the 2013 Annual Meeting is underway to introduce new ideas for support and advertising that would generate additional revenue for the meeting.

Sponsorships for the Annual Meeting brought in over $825,500 in support for the meeting. Sponsorships included 6 product theaters, two therapeutic updates, Daily Bulletin and the mobile application for the program book and days at a glance. It also included the APA Cafes and Connection Café along with the internet access in the public areas of the convention center. New this year were sponsorships for a doctors bag with announcements and invitations to meeting events and exhibits.

APA and APF Awards Grants and Fellowships

A database for all awards, grants and fellowships has been developed with IS. It will be a resource on all awards, grants and fellowships. All of the fields in the database have been completed for the 46 APF awards. A call for the awardees for 2014 is underway from councils and committees by last September to be approved at the APF board meeting before the IPS..

The call for applications for the Gralnick Award for Schizophrenia Research has gone out with the award and lecture to be presented at the IPS in October

REPORT OF THE EXECUTIVE DIRECTOR

Helping Hands Grant Program and Awards for Advancing Minority Mental Health

Awards for Advancing Minority Mental Health

- The four recipients of the 2013 Awards were in San Francisco to receive their awards during the Foundation Benefit on Saturday, May 18th.

Helping Hands Grant Program

Sponsorship of the 2013-2014 grant program has been secured by a grant from Otsuka. Applications were posted early March for students to begin to apply, and applications were due May 31st. The review process has begun, and grantees will be recommended for funding in July.

Development Programs & Outreach

Corporate & Foundation Giving

A central priority is securing new prospects to support research and public education efforts and invitations to submit letters of inquiry and proposals to a wide variety of funding sources, such as:

- Kresge Foundation
- California Wellness Foundation
- Ronald McDonald House Charities
- California Endowment
- The Harry and Jeanette Weinberg Foundation
- Ittleson Foundation
- Langeloth Foundation
- Boehringer Ingelheim Corporate Giving Program
- Commonwealth Fund
- Josiah R. Macy, Jr. Fund
- Wm. T. Grant Foundation

Approximately 25 other potential funders are currently being developed as funding sources, including Walmart, Aetna, Robert Wood Johnson Foundation, MacArthur Foundation, and other corporate and foundation grant makers. It is also worth noting that many other foundation and corporate funders have been approached on behalf of APF. These include organizations such as the Alfred P. Sloan Foundation, David and Lucile Packard, Atlantic Philanthropies, and others, who value APF's work but are unable to support the organization at this time.

REPORT OF THE EXECUTIVE DIRECTOR

Case for Support

A case for support was finalized, designed and ready for use at the Annual Meeting in San Francisco.

Fund Raising Communications

A template has been designed for a new e-newsletter that will be a part of a larger fund raising communication strategy currently under development. The e-newsletter is going to donors and prospects and will highlight the role of philanthropy at the Foundation. A new presentation for APF, using the software program "Prezi", was also completed in time for the Annual Meeting.

APF launched its first brand messaging campaign at the Annual Meeting. The campaign, entitled "Mobilize your money to overcome mental illness," was highlighted prominently and promoted heavily throughout the entire meeting through a wide variety of marketing efforts, including print, broadcast and electronic media in collaboration with the APA messaging throughout the Moscone Center and on APA TV News. This effort helped to build the Foundation's presence among the APA membership as a charitable organization that requires philanthropic support to carry out its mission.

Individual Giving

Activities to date result from an analysis of the DonorTrends reports, which we shared with the APF Board at the February 28, 2013 Board Meeting. Action plans for each unique group, including major donor prospects, are based on giving potential and relationship to APF.

- Annual Appeal In late-March, we sent a spring appeal letter to members of the APA and active APF donors. We segmented this group based on their giving potential and relationship to APF. We used specific messaging and dollar amounts targeted to each specific group. We asked existing donors to consider modest upgrades, and asked non-donors to consider modest first time donations of $50. As June 1, 2013, the appeal has generated $15,850.00, which surpasses the amount raised from the last spring-summer appeal, which was sent in 2011. Those who have not responded to this appeal will receive a follow-up email reminding them of the letter that was sent to them, and the urgent need for their support. As a way of saying "thank you" to donors to this appeal, we are enclosing DVDs from our "Conversations" series with the acknowledgement letters.

- Major Gifts Invitations and follow-up emails and calls were sent and/or made to all major donor prospects and active donors to attend a small reception at the Annual Meeting to introduce and update on the work of the Foundation. This effort represented the first step in an overall cultivation strategy to engage with this group. Additionally, development staff spent time with the "Senior Psychiatrists" at the APA Annual Meeting in San Francisco to introduce them to the philanthropic and giving opportunities of the APF.

B. AMERICAN PSYCHIATRIC INSTITUTE FOR RESEARCH AND EDUCATION

Darrel Regier, M.D., M.P.H.

B.1. Practice Research Network

National Study of Psychiatry under Health Care Reform and Budget Austerity

APIRE is collaborating with the APA Divisions of Healthcare Systems and Financing, Advocacy and Government Relations on a study that will provide important data to help the APA assess work force readiness before the implementation of the 2014 provisions of the Patient Protection and Affordable Care Act (ACA). Given the complexities and scale of the health reforms currently being implemented in the US during a period of fiscal austerity, there may be unintended effects for psychiatrists and their patients. This study will provide psychiatrist, practice, and caseload-level data on current payment options, workforce, and health care reform issues. It will also provide APA with important information on treatment gaps and access issues facing psychiatrists and their patients, and on the status and readiness of psychiatrists as health services move into new models of care.

The APF Board has provided New Initiative funds to implement this study. The data collection instrument has been developed and is being reviewed by internal and external experts in preparation for field work in the fall of 2013.

Performance in Practice Self-Assessment Tools

APIRE staff are collaborating with the Division of Education and the QIPS Department to develop Performance-in-Practice (PIP) practice self-assessment tools for selected disorders to speed the

adoption of evidence-based care into clinical practice. The most recently completed PIP tool on assessment and treatment of schizophrenia was published in the spring, 2012 issue of APA's *Focus*. We are currently in the process of updating existing PIP tools to include the DSM-5 diagnostic criteria. An abridged revision of the PTSD PIP Tool is scheduled for publication in the summer of 2013. Additional PIP tools are being considered on suicide risk among children and adolescents, patient safety, and opiate prescribing behaviors. All PIP tools are available free of charge to APA members.

Using Medical Informatics Principles to Enhance Development and Dissemination of Clinical Practice Guidelines on Major Depressive Disorder

APIRE and QIPS staff are collaborating on a study supported by the National Library of Medicine aimed at harnessing new technologies to enhance the development and dissemination of clinical practice guidelines. An APIRE-developed survey to gather data on psychiatrists' current practices, sources of clinical information, and clinical information needs was completed in 2012, and study findings were presented during a workshop at APA's 2013 Annual Meeting. Workshop attendees were invited to provide additional feedback on their clinical information needs to inform practice guideline development. Analyses for publication of findings are under way.

E-mail and Web-Based Physician Education Program on the Dissemination of Off-Label Use of Atypical Antipsychotics

APIRE staff collaborated with the Division of Education to develop and submit a successful application to the Agency for Healthcare Research and Quality (AHRQ) for a demonstration research grant. The purpose of the study is to develop a novel application of interactive learning modules delivered via e-mail to help educate physicians on the risks, benefits, and costs of off-label use of atypical antipsychotics, in order to provide the safest and most effective patient care. This grant has now been awarded and work has begun on developing CME modules; under the direction of Dr. Deborah Hales, is the Principal Investigator.

National Depression Management Leadership Initiative (NDMLI)-Shared Care Initiative

The Depression Shared Care Initiative extends the work of the National Depression Management Leadership Initiative, a collaborative effort of the American Psychiatric Association, the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP), supported by the American Psychiatric Foundation. The purpose of the Shared Care project is to examine how systematic use of the 9-Item Patient Health Questionnaire (PHQ-9) and other self-rated assessments may improve communication between primary care practitioners, psychiatrists, and other mental health providers, with the goal of achieving better outcomes for patients with depression and anxiety disorders. The first phase of the project defined opportunities for collaboration between psychiatric and primary care settings and convened a steering committee of collaborators and stakeholders to facilitate planning and development of proposals.

Research and survey consultation and coordination

As APA's chief resource for high level statistical expertise on sampling and implementing surveys, PRN provides key research and survey consultation and coordination to APA leadership, divisions, and components to minimize survey response burden on APA members and increase the quality of member surveys and usefulness of survey data to the APA, its members, and the profession of psychiatry. Staff are currently working with Healthcare Systems and Finance, and QIPS, and the Membership department. PRN staff are also working with APA's Division of Education on analyses of data on recruitment of medical students into psychiatry training programs.

Walter Reed Army Institute for Research (WRAIR) Army Mental Health Care Study

As part of this ongoing collaboration with the Walter Reed Army Institute for Research (WRAIR), APIRE staff have developed two manuscripts, "Mental Health Treatment Access and Quality in the Army: The Perspective of Behavioral Health Clinicians" and "Quality of Assessment and Treatment for Alcohol Use Disorder in Army Behavioral Health Treatment Facilities." A workshop entitled "Using Empirical Clinical Practice Data to Inform Policy and Improve Care for Service Members" was presented as part of the Military Mental Health track at the 2013 Annual Meeting, and will be repeated at the 2013 Institute on Psychiatric Services. Staff have also

completed analyses for a new paper focused on the diagnostic and clinical complexity of service members receiving specialty mental health treatment.

National Intrepid Center of Excellence Tri-Service Workflow Project Management Plan

APIRE staff are providing consultation to the US Air Force Tri-Service Workflow Team and EHR Total Solutions on the design of a clinical workflow system for use by the National Intrepid Center of Excellence (NICoE), located on the grounds of the Walter Reed National Military Medical Center in Bethesda. The overall goal of this activity, using principles of measurement-based care, is to support quality assessment and care for service members with combat and mission-related traumatic brain injury and behavioral health needs. As tens of thousands service and National Guard members are deactivated and return to their communities, some with continuing need for high quality care, successful completion of this project has the potential to translate to other psychiatric and other medical care settings outside of the military health care system.

B.2. Research Training Programs

This year, APA, through the APIRE, will administer a diverse array of research training-related activities, ranging from intensive, year-long mentored fellowships, to participation in research grantsmanship colloquia, to brief research exposure experiences. Applications were accepted from October through January for various programs as potential applicants responded to announcements about these opportunities. It is anticipated that in 2013, medical students, psychiatric residents, and young psychiatry faculty members will be introduced to the possibilities of careers in psychiatric research or will acquire specific research career-facilitating skills.

The APA Work Group on Research Training, along with APIRE staff presented the 18th Annual Research Colloquium for Junior Investigators on May 19, 2013, in San Francisco as part of the 2013 APA Annual Meeting. APIRE received funding from the National Institute of Mental Health (NIMH) to support the 2013 Research Colloquium. Although the original goal was to invite a

total of 30 persons to attend the Research Colloquium, it was necessary to invite only 24 because of a reduction in funding by NIMH. The participants were able to spend the day meeting in small breakout groups consisting of four mentees and two mentors, where trainees presented their research projects and received feedback from mentors. The APA Work Group on Research Training recommended offering the same topics from last year's workshop that include Molecular, Translational, and Neuroscience Research; Clinical Psychobiology; and Treatment from Psychopharmacology and Psychotherapy to Neural Strategies.

Applications were accepted for the industry-supported awards and fellowships and the award winners were recognized during the APA annual meeting in San Francisco. These included the Lilly, Pfizer, and Merck awards and fellowships, along with the foundation-supported Kempf Fund Award. In addition, a new fellowship program and an early academic career award that were supported by Genentech honored the winners of those awards. The Resident Psychiatric Research Scholars program that had been supported by Janssen from 1999 through 2010 was reinstituted and award recipients that included psychiatry residents were invited to attend the annual meeting. APIRE also supported the winners of the APA/Lilly Resident Research Award which honors five residents who submit an original unpublished scientific paper.

Descriptions of the various APA-sponsored activities and funding mechanisms follow:

- *Research Colloquium for Junior Investigators* – One-day workshop for senior residents, research fellows, and junior faculty will be provided at the 2013 APA Annual Meeting in San Francisco; a total of 24 participants for 2013 were invited.

- *Lilly Research Fellowship* – One year of support of $45,000. Two participants were awarded in 2013.

- *APA/Pfizer M.D., Ph.D. Research Fellowship* – One year of support of $45,000. One participant was awarded in 2013.

- *APA/Genentech Schizophrenia Research Fellowship* - One year of support of $45,000. Three participants were awarded in 2013.

- *APA/Merck Early Academic Career Award* – One year of support of $45,000. One participant was awarded in 2013.

- *APA/Genentech Early Academic Career Award on Schizophrenia Research.* One year of support of $45,000. Three participants were awarded in 2013.

- *Kempf Fund Award for Research Development in Psychobiological Psychiatry* – Provides one year of support for the mentee at $20,000 and $1,500 for the mentor. The mentee can be at the research fellowship or junior faculty level.

- *APA/Lilly Resident Research Award* – Five residents who submit the best original, unpublished scientific papers each received a $1,500 honorarium and their respective residency programs also received a prize of $1,000.

- *APA/Janssen Resident Psychiatric Research Scholars* – one-year support for residents at first through third year of training (PGY-1 - PGY-3) to attend APA annual meeting and $2,500 to pay for a small research project under the guidance of a mentor. Total participants for 2013 were 20.

Web-Based Training for Post Resident Psychiatrists

APIRE had received funding in the past from NIMH to develop a shared, online-accessible, Web-based interactive training structure for former psychiatric research trainees. A panel "Developing and Sustaining Research Careers: Psychiatrists from Underrepresented Groups Share Their Experiences" moderated by Annelle Primm, M.D., has been videotaped, edited and is now available. This video will be placed on the APA Website and is designed to support young psychiatrists from minority populations across the trajectory of their research careers. This will

allow minority psychiatrists supported to attend the 2014 Research Colloquium that will be funded by NIMHD to view this site.

B.3. Office of HIV Psychiatry

Local and Regional Trainings

- **Johns Hopkins Children Center.** *HIV/AIDS in Children and Adolescence.* Dr. Suad Kapetanovic presented a 1-hour lecture outlining the key psychiatric aspects of HIV/AIDS in youth born and living with HIV. Dr. Kapetanovic also met with residents to discuss clinical cases and lead a roundtable discussion.
- **Prince William Behavioral Medicine.** *HIV Psychotropic Medication Interactions and Toxicity***.** Dr. Kelly Cozza provided a 2-hour overview on the use of psychotropic medications in patients with HIV infection.
- **California Pacific Medical Center.** *Neuropsychiatric Overview*. Dr. Larry McGlynn presented a 1½-hour lecture followed by a 1-hour case discussion with residents.
- **Inova Juniper.** *Psychotropic Medication Review and Managing Difficult Patients.* Dr. Marshall Forstein presented a 2-hour overview on the use of psychotropic medications in patients with HIV infection and issues corresponding to dealing with difficult patients.
- **Einstein Medical Center**. *Neuropsychiatric Overview*. Dr. Donna Sudak provided a 1½-hour grand round followed by a 1-hour case discussion with residents.
- **St. Elizabeth Hospital**. *Triple Diagnosis*. Dr. William Lawson presented a 1½-hour overview on HIV neuropsychiatry, substance abuse and mental health.
- **Albany Medical Center**. *Neuropsychiatric Overview*. Dr. Mary Alice O'Dowd provided a 1½-hour grand round followed by a 1 hour case discussion with residents.
- **University of Medicine and Dentistry of NJ.** *Triple Diagnosis*. Dr. William Lawson presented a 1½-hour overview on HIV neuropsychiatry, substance abuse and mental health.

- **Boston Medical Center.** *Triple Diagnosis.* Dr. Marshall Forstein presented a 1½- hour grand rounds on HIV's impact on the CNS, specifically mood and cognitive disorders. Data was presented to convey the epidemiological evidence for HIV in the central nervous system and the current research on the neuropathology of HIV in the brain.
- **The Cleveland Clinic.** *HIV Related Neuropsychiatric Complications*. Dr. Francisco Fernandez presented a 1-hour grand rounds, providing an up-to-date medical review, discussion of the assessment and diagnosis of neuropsychiatric disorders, and review of the most current and effective psychopharmacologic treatment options.
- **Dept. of Mental health (Comprehensive Psychiatric Emergency Program),** *Triple Diagnosis*. Dr. Yavar Moghimi presented a 1½-hour overview on HIV neuropsychiatry, substance abuse and mental health.
- **Annual Meeting**

  *HIV Update***.** Drs. Francine Cournos, Moupail Da, Suad Kapetanovic, Jodi Blanch, Phil Bialer presented a 3-hour symposium on the general medical aspects of HIV/AIDS, which included an update on the latest advances in diagnosis and treatment and a discussion of disease management across the lifespan. Additional presentations addressed the psychiatric aspects of HIV/AIDS, such as the co-occurrence of substance use disorders, and the necessary skills for helping patients improve outcomes (e.g., mortality and morbidity) and increase their quality of life.

  *The 6th Vital Sign***.** Drs. Marshall Forstein, Larry McGlynn, Karl Goodkin, Suad Kapetanovic presented a 3-hour residents-only symposium that included a clinical case discussion to help prepare trainees to recognize and treat HIV-associated neurocognitive disorders. Roundtable discussions gave attendees the opportunity for further discussion with clinical experts.

  *HIV, STDs, and Related Medical Comorbidities***.** Drs**.** Marshall Forstein Karl Goodkin, Marc Safran, Antoine Douaihy presented a 3-hour symposium providing an overview of common comorbid conditions, including endocrine abnormalities, cardiovascular dysfunction, hepatitis C, and sexually transmitted diseases.

HIV-Related Neurocognitive Disorders. Drs. Karl Goodkin, Larry McGlynn, Steve Ferrando, Peter Hunt presented a 3-hour symposium that included presentations on the manifestation, diagnosis, and treatment of neuropsychiatric disorders; disease course and impact of antiretroviral treatment; general psychopharmacology for neurocognitive decline; and specific discussion of when to initiate antiretrovirals.

Upcoming Trainings

Staff is working to coordinate upcoming trainings at the following sites: Meharry Medical College, University of Illinois College of Medicine, Louisiana State University Health Science Center, Texas Tech University Health Sciences, University of Kentucky, University of Missouri Medical Center, Loyola Medical Center, University of Colorado, University of Tennessee Health Science Center, and the APA Institute on Psychiatric Services.

Medical Student Elective

Seven students were selected from an applicant pool of twenty-two rising 4th year medical students for this month-long elective. Now in its ninth year, clinical programs are offered at: New York's Beth Israel Medical Center, Columbia University, Harvard's Zinberg Clinic, Howard University, University of Pittsburgh, and Stanford. Students travel to Arlington, VA for a 2-day didactic program and then travel to their clinical sites. This year one of our 2004 alums will serve as one of the mentors at the Columbia site.

Steering Committee on HIV Psychiatry

Members of the Committee met briefly during the Annual Meeting in San Francisco. The agenda included discussion of module updates, the CMHS preauthorization policy, liaison appointments, major developments in the field, and policy revisions to APA's statements on *Psychiatric Implications of HIV/HCV Co-Infections* and *HIV Antibody Testing.* (The statement on HIV/HVC has been forwarded to the Council on Research for their review and approval.) The Committee also addressed the current funding stream for the APA AIDS Education Project which will end in September 2014. Members outlined ideas for enduring materials and education should continuing funding not be secured.

B.4. Minority Fellowship Programs

- The Minority Fellowship Program Selection Committee reviewed fifty-seven applications for the 2013-2014 academic years. Twenty-two SAMHSA fellows were selected; 1 of which is for the substance abuse fellowship; ten Diversity Leadership fellows were selected. The committee also selected 4 alternates to be awarded if funding permits or if one of the winners declines. Seventeen current SAMHSA fellows were selected to continue as trainee-consultants. The total number of residents who will be participating in the minority fellowships is forth-nine.

- Thirteen minority medical students received the travel scholarship to attend the APA Annual Meeting in May in San Francisco. The students participated in special activities and were matched with a resident mentor and met with senior psychiatrists. Four of the eligible students will begin psychiatry training in July. Nine additional students were selected to participate in one of the two summer student programs. Twenty-two students applied for the student fellowship in HIV psychiatry; seven were selected to participate. The students will start their didactic training in August then continue to their clinical rotation in September.

- The SAMHSA and Diversity Leadership fellows participated in special activities during the May 2013 Annual Meeting in San Francisco. They met with mentors during the mentor breakfast, presented posters and workshops, and networked with alumni at their annual reception where the Jeanne Spurlock Minority Fellowship Achievement Award was presented to Dr. Cheryl Al-Mateen. The 2014 award nominee was selected by the selection committee. The fellows presented two workshops during the annual meeting: "Positive Psychiatry: Strength Based Recovery Model Focused on Under Represented Minorities in Medical School and Residency," and "E-Psychiatry: How Innovative Websites Reach Diverse Populations."

- Some fellows and medical students participated in our "Doctors back to School" program where we visited a local High School in Oakland, CA. Ms. King along with five fellows and two medical students paid a visit to Life Academy High School where they talked and shared their experiences and why they selected psychiatry as their career path with a select group of 11th and 12th graders.

- The fellows presented their MFP video during the annual meeting to help mark the 40th anniversary of the APA/SAMHSA Minority Fellowship Program. The video is designed to pique interest in the fellowship and demonstrate how the program affects often marginalized minority communities. Ms. King is working with the fellows to produce a 40-year anniversary report to accompany the video.

- Dr. Primm and Ms. King attended SAMHSA's 40th year anniversary celebration at SAMHSA' s headquarters in April. The celebration was held at the Rockville, Md., offices of the Substance Abuse and Mental Health Services Administration (SAMHSA); the agency has administered the program since 1992. Administrator Pamela Hyde, J.D., kicked off the celebration with a keynote address. Each grantee, including psychiatry had alumni attend the celebration to talk about the benefits of the fellowship.

- The Office of Minority and National Affairs in conjunction with the Black Psychiatrists of America's annual sprint conference hosted a mentor breakfast in April 2013 at the annual meeting of the Student National Medical Association (SNMA), in Louisville, KY. Students joined mentors and local residents to learn about psychiatry. Ms. Rosa Bracey staffed the breakfast and the exhibit booth.

- The Office of Minority and National Affairs/MFP will again sponsor a medical student recruitment luncheon during the Association of American Indian Physicians conference in Santa Clara, CA in August.

B.5. Melvin Sabshin Library & Archives

Reference and Research Services

The librarian responded to over 150 requests for information—55% from APA staff (including District Branches); 17% from members; and 28% from nonmembers (e.g., reporters, attorneys, health care providers, academics, etc.).

Document Delivery

Over 100 requests for documents were filled—most for staff (especially APIRE, Division of Education and *the* Office of Communications and Public Affairs), but also about one-third for members and a dozen or more for nonmembers (e.g., health sciences libraries, academics, government agencies, etc.). Ten (10) interlibrary loan requests were filled for other libraries.

Information Dissemination

Progress continues on building content into the new Library & Archives web site. More resource documents have been added and more than a dozen *APA Component Directories* have been scanned for inclusion on the Members' Corner.

Visiting Scholars

Two visiting scholars visited APA to use APA archival materials: one using the *DSM-III & DMS-III-R* collection and another using the *DSM-IV* materials. Another scholar currently in residence is the first to be investigating the *DSM-IV* planning materials. There are currently over a dozen requests from researches in the queue for research assistance and the librarian actively is working with four individuals to schedule appointments through the rest of summer and into the fall.

Annual Meeting / Awards, etc.

The librarian coordinated two lectures at the 2013 Annual Meeting:

- The Benjamin Rush Award Lecture - Anne Harrington, Ph.D.
- The Manfred S. Guttmacher Award Lecture - Alec Buchanan, M.D., Ph.D., & Michael Norko, M.D., M.A.R.

Both lectures were well-attended and generated lively discussions with their audiences.

The librarian provided consultation and technical support in organizing and managing the twelve poster sessions at the Annual Meeting, especially the two sessions for the Resident/Medical Student Poster Competition Session which alone required communication with nearly 200 presenters.

The librarian also contributed to the production of several conference publications and was a lead contributor in developing and updating content for the Annual Meeting web site.

Item BOT #11.A
Board of Trustees
July 20-21, 2013

Executive Summary of the Ad Hoc Workgroup on Members-in-Training (MIT) and Early Career Psychiatrists (ECP) to the Board of Trustees of the American Psychiatric Association

1. **ACTION: Will the Board ask the Medical Director to dedicate staff to manage ECP membership marketing, recruitment and retention programs? Budget for the position to be developed during the budget process.**

2. **ACTION: Will the Board approve a placeholder budget of $25k for pilot initiatives for ECP recruitment and retention?**

3. **ACTION: Will the Board ask the President, in consultation with the MIT/ECP Workgroup, to assemble an ECP advisory panel? The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director annually.**

4. **ACTION: Will the Board charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention?**

Report of the Ad Hoc Workgroup on Members-in-Training (MIT) and Early Career Psychiatrists (ECP) to the Board of Trustees of the American Psychiatric Association

July 2013

Background

Part of the mission of the American Psychiatric Association (APA) is to advance and represent the profession of psychiatry and to serve the professional needs of its members. To do this, the APA must recruit and retain psychiatrists. Understanding the value of the APA membership, especially in the early career stages and in the transition from Member-in-raining (MIT) to Early Career Psychiatrist (ECP), is crucial. This workgroup has worked to determine how the APA can provide value through membership and reduce attrition during the transition from MIT and ECP.

Workgroup Charge

Dr. Jeffrey Lieberman charged the workgroup to:

(i) Determine the value of membership in the APA for MITs and ECPs,

(ii) Identify barriers to continued membership of ECPs in the APA

(iii) Provide recommendations to increase the actual and perceived value of APA membership for MITs and ECPs to enhance their recruitment and retention in the transition from MIT to ECP status.

Workgroup Members

Thirteen MITs and ECPs were invited to join the workgroup, representing a diversity of geographic locations, institutions, genders and ethnicities. The workgroup was co-chaired by Drs. Jonathan Amiel and Carolyn Rodriguez and included Drs. Jake Behrens, Andrea Brandon, Chetana Kulkarni, Beverly Du, Brian Hurley, Laura Kent, Christina Mangurian, Molly McVoy, Erik Vanderlip, Jose Vito and Alik Widge.

Consultants

The workgroup was advised by APA past-president Dr. Carol Bernstein, APA Education Division Chief Dr. Deborah Hales, MIT Trustee Lara Cox, Assembly ECP Committee Chair Dr. Steve Koh and APA senior staff Nancy Delanoche. We thank Terri Swetnam for her thoughtful input.

Process

The workgroup met in person on January 11, 2013 in New York to receive its charge from Dr. Jeffrey Lieberman and to kick off its work. We then met via teleconference on February 5, 2013 and March 5, 2013 to review membership and recruitment data and to formulate our initial recommendations. We met again in person on April 4, 2013 in New York to discuss the initial recommendations in depth and to identify priority areas for the Board of Trustees. We met twice more via teleconference on May 6, 2013 and June 17, 2013 to prepare the final recommendations for the July Board of Trustees meeting.

Value of Membership for MITs and ECPs

The workgroup reviewed data collected by the APA in 1998, 2003 and 2007:

- In its report of July 1998, the Task Force on Strategic Planning recommended enhancing member recruitment and retention by aligning the work of the national APA and the district branches, reducing dues by 20% over five years, continuing existing recruitment and retention programs and launching a major marketing campaign.

- In a commissioned report presented in 2003, Public Opinion Strategies surveyed 2,775 APA members and found that members' impression of the APA was more warm and favorable than not (mean score of 65 on a scale of 0 being cold and unfavorable and 100 being warm and favorable), that 60% of members agreed that their dues represented good value for the money, that 84% of members were at least somewhat familiar with the services offered by the APA to its members and that members were essentially neutral regarding the effectiveness of their individual district branches.

- In a commissioned report presented in 2007, McKinley Marketing surveyed 3,628 APA members and past members and found that MIT respondents were generally satisfied with their memberships and planned to maintain them into general membership though nearly half of members perceived that the cost of their membership exceeded its value.

In light of these findings, which seem consistent over time but have not led to actions that could stem the tide of member loss in the early career phase, the workgroup consensus was that MITs

and ECPs perceive significant value in their affiliation with APA. Specifically, there is significant value in the access to life-long learning resources, including study materials for the board examinations and educational resources for maintenance of certification, networking with other members and opportunities for career advancement. However, the workgroup agreed that the APA should communicate its offerings to ECPs in a more consistent and integrated way to further enhance members' engagement in the association and their perception of the value of membership.

Barriers to Retention of MITs and ECPs

There is a gap of data pertaining to the reasons that ECPs stop their memberships or let them lapse. The 2007 McKinley survey showed lower satisfaction with the APA's educational resources but did not cite their levels of satisfaction with other services or the intangible aspects of membership including affiliation and networking opportunities.

The workgroup discussed our own experiences with the APA's recruiting and retention efforts at length as a proxy for the general ECP membership, recognizing that the group is not representational of the ECP membership at large but is biased toward academically affiliated psychiatrists with high levels of involvement in the APA. With that disclaimer, the workgroup found several domains to improve the process by which APA engages its ECP members. Specifically, though our perception of the significant value of the services offered by the APA is consistent with prior surveys, we have found that these valuable resources are difficult to access because through the current infrastructure:

- Educational resources are not centrally aggregated for easy access
- Outreach from the APA appears sporadic and is not tailored to individual member interests
- There are few structured mentoring opportunities

Efforts to Enhance MIT/ECP Recruitment and Retention to Date

As we have described, the APA has undertaken multiple efforts to improve recruitment and retention of its MIT and ECP members. The workgroup identified four priority areas for such programs and analyzed the effectiveness of programs in these areas.

Mentoring: Prior efforts have included the development of member-led online discussion groups (Facebook, LinkedIn), professional development fellowships, MIT and ECP events at the Annual Meeting and District Branch activities. Many of these efforts have generated significant interest from MITs and ECPs, but retention of member interest and engagement in these efforts has been temporary. After a burst of activity, interest has waned, particularly as member leaders have moved on in their careers. We have also found that alumni of programs such as the fellowships are interested in maintaining their engagement but find limited opportunities to serve as near-peer mentors.

Electronic Outreach: Prior efforts have included a Constant Contact email listserv for MITs/ECPs. The "open rate" for the APA's emails to MITs and ECPs is high (>50%), demonstrating that members are interested in receiving information from the APA, but again interest and follow-through from MIT and ECP members wanes. The workgroup concluded here that MIT and ECP Members want online communication, but that targeted messaging is crucial and the ability to customize online preferences for communication is needed. An important aspect of these programs is a coherent vision for the goal that each serves and how it fits in to the APA's mission. Follow-up to these electronic outreach efforts is also crucial. APA staff are currently engaged in developing systems of electronic outreach, organized into "communities", that could aid in this process. APA IT staff need to be provided with member-led direction and support in implementing these resources.

Leadership: Prior efforts in this area have included the APA fellowships and appointed positions on Councils and Committees. The workgroup concluded that these opportunities are sought-after and popular with MIT and ECP members, but that they engage limited numbers of MITs who are awarded the fellowship and ECPs who know the APA well enough to be appointed to its councils and committees. The workgroup did not think that the APA should expand its pool of leadership opportunities for MITs and ECPs, but did conclude that the programs should be more visible and the selection process should be transparent to communicate to potentially interested members (and non-members) that their involvement is welcomed and appreciated.

Peer-to-Peer Recruiting: This is a priority area in which there have been limited efforts in the past.

Recommendations to Improve MIT/ECP Recruitment Going Forward

In reviewing membership trends, past surveys and programs for recruitment and retention of MIT and ECP members, the workgroup concluded that many promising initiatives have been identified, designed and implemented, but that their effectiveness has been limited by APA's difficulties in maintaining and evaluating them. To that end, we propose a focus on infrastructure to facilitate effective programming:

- Designate national staff dedicated to ECP recruitment and retention. This person will work with the psychiatry residency training programs, district branches and state associations on various efforts and initiatives for membership issues. (0.5 FTE and $25k funding for pilot initiatives)

  ACTION: Will the Board ask the Medical Director to dedicate staff to manage ECP membership marketing, recruitment and retention programs? Budget for the position to be developed during the budget process.

  ACTION: Will the Board approve a placeholder budget of $25k for pilot initiatives for ECP recruitment and retention?

- Convene Advisory Panel for new initiatives involving ECPs that reports directly to the Board of Trustees. This panel would include twelve members (representative of Assembly ECPs, current fellows, fellowship alums, and senior MIT leaders). The panel would meet by teleconference four times yearly and advise staff on the development and evaluation of pilot initiatives.

  ACTION: Will the Board ask the President, in consultation with the MIT/ECP Workgroup, to assemble an ECP advisory panel? The panel will meet virtually at a budget of less than $1,000 and will report to the Board and the Medical Director annually.

- Use clear metrics to track impact of new initiatives on the value of membership, recruitment, retention

  ACTION: Will the Board vote to charge the Membership Committee to prospectively designate outcome measures to evaluate new initiatives in ECP recruitment and retention?

With the infrastructure described above in place, we recommend staff and the Advisory Panel consider the following in the four priority areas:

<u>Mentoring</u>

- Maintain selected current initiatives: MIT Center at annual meeting, MIT Facebook Page, Sunny Side Up Breakfast, Common ECP/MIT recommended hotel at APA
- Consider new initiatives: Extend MIT initiatives to ECPs, Facilitate online networks (Facebook, LinkedIn), Implement "ask a mentor"

<u>Electronic Outreach</u>

- Develop flexible and extensible technology platform that allows members to customize how they receive information, network with others, and provide input to APA.
- During membership renewal, elicit data to identify the needs and interests of the individual member and use this to facilitate targeted communications and messaging
- Create and maintain an ECP email listserv for at least three years, then evaluate whether ECPs are using this communications medium.

<u>Leadership Opportunities</u>

- Maintain fellowships and opportunities for involvement on councils and committees
- Prioritize workforce gaps and seek to link existing resident/fellow opportunities to those areas, or create new opportunities that address these gaps
- Develop and distribute descriptions of councils and committees to inform potential members

Peer-to-Peer Recruiting

- Foster word-of-mouth recruitment by highlighting positive experiences with APA (ie, fellowships, online resources, etc.)
- Sponsor local community-building activities (ie, MOC informational forums)

Item 11.B

Report of the

Work Group on the Role of Psychiatry in Healthcare Reform

Executive Summary to the APA Board of Trustees

March 23-24, 2013

The Work Group on the Role of Psychiatry in Healthcare Reform

Paul Summergrad, M.D., Chair
Dr. Frances S. Arkin Professor and Chairman
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Work Group on the Role of Psychiatry in Healthcare Reform

Executive Summary to the APA Board of Trustees

Introduction

Health reform, broadly stated, is a combination of market forces, health policy changes, and statutory/regulatory initiatives shaping health insurance markets, coverage, and the organization, delivery, and payment for healthcare services. Healthcare reform is not simply about what is codified in the Affordable Care Act (ACA). There are market forces and government budget forces -- at both state and federal levels -- that predate the ACA, and will persist going forward. The underlying reality is that healthcare costs are continuing to grow at an unsustainable pace and the fiscal pool that underwrites these expenditures is shrinking. How to reshape the trajectory of the healthcare costs has become the policy imperative for government, employers, and all payers. Untreated psychiatric and substance use disorders have a significant impact total healthcare costs. The implications of health reform for psychiatric practice are quite broad, although they will differentially impact APA members depending on their primary practice settings and choices regarding participation in emerging models of care and payment.

While the changes wrought by health reform are not fully predictable, they will, because of the underlying fiscal realities, be widespread and ongoing. It is likely that some aspects of psychiatric practice will remain relatively unchanged, even as reform initiatives change other aspects of practice significantly. We have approached our work focused on what changes in our current care systems are most likely to improve the quality of care and costs for patients with psychiatric, substance use, and medical illnesses. The work group believes that it is imperative for us to remain focused on what is best for patients and their families. We are confident that this focus will provide an important guide both for our overall healthcare system and for the support of psychiatric practice.

There are a myriad of factors that shape the context in which psychiatry and its patients find themselves.

Psychiatric Practice and the Field: Psychiatry brings many formidable legacy issues into the emerging healthcare environment and the challenges it poses. Greater understanding of the impact of psychiatric illnesses and substance use disorders on total healthcare costs by the government, employers, and the public will be needed. Recognition that the key policy objectives and the initiatives of reform afford major opportunities for improved patient care and new options for practice is also essential. However, many psychiatrists operating in solo or small group private practices may be ill prepared for these transitions. It is critical that the APA act to ensure recognition of the significance of mental health and substance use disorder conditions and contribute to the leadership of health reform initiatives in these areas. It is also vital that we prepare the field internally for changes that are likely to occur.

The Triple Aim--Accountability for Patient Care and Cost: The key organizing principles underlying most current healthcare initiatives are embodied in the so-called Triple Aim of health reform: 1) patient-centeredness, i.e., better, evidence-based care for individuals; 2) cost effectiveness; and 3) improved population health. At its core, this embodies accountability for patient outcomes, efficient use of treatment resources, and the well-being of the community.

At the Policy Level: Key components of the policy calculus to achieve the Triple Aim include: 1) coverage expansion and insurance market redesign; 2) development and implementation of integrated care models; 3) adoption of patient care performance metrics (e.g., quality indicators, evidence-based clinical guidelines, etc.); and 4) development and adoption of payment methods that create provider incentives to achieve the patient care and cost objectives. There are a large number of commercial, federal, and state government-driven initiatives underway.

At the Patient Level: We cannot know how the foregoing will affect practice and patient care at this point in time nor will these be the only factors affecting psychiatric care. Advances in science, new understandings of psychiatric illness, more effective treatment, and controlled trials of delivery reforms will all affect practice. Appropriate access to treatment for psychiatric and substance use disorders remains a formidable challenge and a healthcare-system-wide problem. Health reform advocates must cope with the reality that these conditions are highly prevalent and usually associated

with high total healthcare costs. The intersection of health reform objectives, clinical practice, and patient care must be negotiated properly and become a primary focus while not losing support for existing evidence-based care models or the role of research in improving care and changing our fundamental understanding of these disorders.

At the System Level: The fragmentation, disarray, and defunding of the behavioral health delivery system continues. This reality has been well documented by two Presidential Commissions, the IOM, and other research entities. Attempts to address the serious challenges of access, integration of services, and quality have repeatedly failed to solve these problems. Although health reform was not designed specifically to change the behavioral health system, it offers significant new opportunities to transform care and treatment, i.e., through insuring many more individuals, including those with high rates of illness; paying for previously unreimbursed services; integrating care using new information technology; advancing and adopting underused evidence-based interventions. The Mental Health Parity and Addiction Equity Act (MHPAEA) provides significant potential leverage to enable transformation on an equitable basis for the populations with mental health and substance use disorders.

The potential afforded by these opportunities will not occur without leadership and sustained effort. Psychiatry has to assume a leadership role in these transformations. To date the APA has not fully embraced that role.

Key Findings and Recommendations

Health reform is occurring now and will move forward rapidly with or without deliberate actions by organized psychiatry. There are definable opportunities and choices that will allow the APA to help shape the outcome. The Work Group believes there are significant actions that the APA should undertake.

The Work Group intends that the recommendations set forth here and in the reference document and the accompanying analysis by Milliman should be a starting point for discussion and action within the APA. It is our intention to highlight implications for the allocation and organization of resources within the APA.

This executive summary provides recommendations for key areas affected by health reform that the Work Group explored and on which it deliberated.

Each section of the summary provides a brief background discussion and findings respecting the topic and then sets forth the recommendations.

- Contemporary Health Reform Efforts
- Integrated Care (IC): A Healthcare Reform Imperative
- The Financing of Psychiatric Care: Structure, Payment, and Administration
- Quality and Performance Measurement
- Health Information Technology (HIT)
- Workforce, Work Environment, and Medical Education and Training
- Research and the Mental Health Evidence Base
- APA as an Organization in a Health Reform Environment

In July 2011, the Board of Trustees voted to establish a Work Group on the Role of Psychiatry in Healthcare Reform. Paul Summergrad, M.D., was named chair by then APA president John Oldham, M.D. The Work Group was charged to address a number of questions and issues in, including:

1. What is the role of a psychiatrist in a primary-care led practice?
2. Who will care for the seriously mentally ill population?
3. Identify models (What is role of psychiatrists in integrated care system?)
4. What is the political strategy allowing APA to be a "player" in development of policy"?
5. What is the best way to effectively educate members about new models of care?

The Work Group convened numerous times over the course of the last 18 months, and regular presentations and/or meetings were held with the Board of Trustees, the Assembly, and relevant councils and components for discussion -- and input. Extensive background reviews of key topic areas were undertaken and meetings and interviews were held with various experts.

Contemporary Health Reform Efforts

<u>Background</u>

As stated in the introduction, health reform is a combination of market forces and statutory/regulatory initiatives shaping health insurance markets and coverage for the organization and delivery of and payment for healthcare services. Healthcare reform is not simply what is codified in the Affordable Care Act (ACA). There are market forces and government budget forces in motion that predate the ACA, and will persist going forward. One must not forget that state deficits are heavily driven by medical spending.

The changes in the healthcare system have numerous implications and likely consequences for psychiatric care, ranging from performance metrics for patient care to alternative payment methodologies.

The primary underlying market reality is that healthcare costs continue to grow at an unsustainable pace and the fiscal pool, particularly at the state and federal levels that underwrites much of healthcare expenditures, is shrinking. How to reshape the trajectory of the healthcare costs has become the policy imperative for both commercial and public sector payers. Psychiatric and substance use conditions and their related medical co-morbidities are acknowledged to be significant cost drivers.

The initiatives to achieve this policy objective derive from a "consensus" assessment of the core problems with the current system:

- Present care delivery is uncoordinated
- Current payment methodologies are inefficient
- There is a lack of practitioner accountability
- There is an insufficient focus on the patient

Hence, the key principles guiding health reform efforts can be characterized by the Triple Aim:

- Better care for individuals – patient centeredness;
- Cost effectiveness; and
- Improved population health.

Key components of the policy calculus to achieve the Triple Aim include:

- Insurance coverage expansion and market redesign;
- Development of integrated care models; and
- Adoption of performance metrics and payment methods to align stakeholder incentives.

These developments, as reviewed below, are unfolding at federal and state levels and within the commercial sector.

The Affordable Care Act (ACA): The ACA represents the most significant regulatory reform of the United States healthcare system since the enactment of Medicare and Medicaid in 1965. The ACA's provisions further and/or codify reform initiatives to facilitate better patient access and clinical and cost outcomes through:

1. Coverage expansion;
2. Insurance market redesign; and
3. Delivery system and payment reform.

These provisions and their implications for individuals suffering from mental health and substance use disorders are described in more detail below.

Coverage Expansion

The ACA's key reforms include a mandate for individuals to purchase health insurance and an expansion of Medicaid, aiming to increase access to health insurance coverage for Americans who were previously uninsured. The ACA incorporates coverage – by mandate -- of mental health and substance use disorder services and extends the Mental Health Parity and Addiction Equity Act (MHPAEA) to new plans.

Insurance Market Redesign

The Individual Mandate: Beginning January 1, 2014, the ACA aims to improve access to health insurance coverage by requiring individuals and their dependents who are not covered by Medicare, Medicaid, an employer-sponsored health plan, or other private insurance to maintain a minimum level of health insurance coverage.

Insurance Exchanges, Medicaid, and Essential Health Benefits: To meet the individual mandate, the ACA requires the creation of an exchange program (American Health Benefit Exchanges) in each state to serve as a marketplace where individuals and small businesses can purchase health insurance. These exchanges are meant to decrease the cost of health insurance coverage through risk pooling and to make private health insurance more affordable. States have the choice to elect to create their

own exchange (called a State Exchange) or allow the Department of Health and Human Services to establish a "federally-facilitated exchange" for them.

The ACA provides that health exchange plans (along with small group plans that are not self-insured and individual products offered outside of exchanges and Medicaid expansion plans described below) must offer an essential health benefits (EHB) package that includes mental health and substance use services.

The scope of EHB under the health plans is to be substantially equal to the scope of the benefits offered by a benchmark plan selected by the state.

Coverage for mental health and substance use disorders under health plans offered through Exchanges and Medicaid benchmark and benchmark equivalent plans and plan terms and conditions must comply with the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA).

Medicaid Expansion: Also, beginning January 1, 2014, the ACA aims to further improve access to health insurance coverage by expanding Medicaid eligibility to all individuals and families with incomes under 133 percent of the federal poverty level.

The Supreme Court held that states could not be forced to expand Medicaid to the newly eligible, therefore making such expansion optional for states. As of this writing, 24 states have elected to participate.

Issues with Expansion Provisions: Despite these key provisions, which expand insurance coverage in populations with high mental health needs and extend mental health parity requirements for individuals suffering from mental health and substance use disorders, there are a number of issues raised by these provisions that we should be concerned about.

There will still be coverage gaps: Despite the ACA's Medicaid expansion provisions, there will still be individuals who will remain uninsured after January 1, 2014.

In addition, other individuals will make a personal decision to remain uninsured and opt for the penalty for failing to elect coverage.

There will be numerous EHBs and state laws to track and analyze: States play a critical role as decision makers under the ACA's healthcare exchanges for qualified plans and under Medicaid expansion. Decisions as to how

healthcare reform will be operationalized will occur at both the state and federal levels. This will present special challenges because of the need to effectively interact with a potential of 50 different reform plans, and will have implications for the APA's role with state associations.

There is no defined scope of services requirement: The actual state mental health and substance use disorder services provided will be defined by what is in the benchmark plan selected by the state.

While MHPAEA applies to Medicaid non-managed care plans, it is not clear how MHPAEA's Interim Final Rule applies to Medicaid benefit and benefit equivalent plans.

The problems with compliance and enforcement issues regarding MHPAEA will still exist under coverage expansion plans unless more guidance is issued and states are made to enforce MHPAEA.

Delivery System and Payment Reform

Insurance Market Redesign: In addition to coverage expansion, the ACA requires comprehensive reforms to the private health insurance market that are aimed at improving access to coverage, protecting consumers from abusive insurance company practices, and improving the quality of care for health plans sold through and outside state exchanges.

Physician payment reform: It seems certain that any repeal of the Medicare Sustainable Growth Rate (SGR) will be tied to dramatic changes to Medicare physician payment that heavily emphasize quality improvements.

New Models of Care: The Centers for Medicare and Medicaid Services (CMS) and its Center for Medicare and Medicaid Innovation (CMMI) are tasked with implementing and/or exploring a vast range of care models and payment initiatives for the Medicare and Medicaid programs.

Purchasers, employers, and commercial payers: Market forces driven by current and anticipated resource constraints are driving purchasers/employers and payers to restructure the delivery of and payment for care independent of federal/state statutory/regulatory initiatives.

*Managed behavioral health organizations (MBHOs): A*fter a long period of consolidation, MBHOs are focusing their efforts on expanding services. In

tune with market forces and healthcare reform, MBHOs are engaged in developing wellness programs, identifying at-risk patients, and expanding the use of health information technology and integrated care.

Common denominators: The common health reform themes going forward in both the public and private sectors are:

1. New models of care delivery (with varying degrees of evidence to support them) are under development and/or being deployed.
2. The measuring and monitoring of care (quality and performance measures) will be increasingly codified.
3. Alternative payment methodologies will be developed and deployed.
4. Patient-centered principles of care.

Health Reform Implications for Persons with Psychiatric Illnesses/Substance Use Disorders (SUD)

The policy objectives of health reform are highly significant for all patients with psychiatric illnesses. For the purpose of this discussion, patients with primary medical conditions and comorbid psychiatric/SUD conditions and patients with primary psychiatric/SUD diagnoses and comorbid medical conditions represent two overlapping populations/categories and the principal treatment settings in which they are seen may differ as well. However, whether their disorder is primarily psychiatric or they have a psychiatric comorbidity to a primary medical condition, their care is fragmented and uncoordinated and they are generally high cost patients. Populations newly eligible for insurance coverage are known to have a high prevalence of mental health and substance use conditions. Mental health conditions are a significant public health problem whether seen in the primary care or psychiatric sector. Multiple studies have shown patients with major depression, anxiety disorders, and substance use disorders have 50 to 100 percent higher total medical costs over a one-year period even after controlling for socio-demographic factors and chronic medical illnesses. In 2008, a study from the actuarial firm Milliman found that untreated mental disorders in patients with chronic medical conditions cost commercial insurers and Medicare between $130 billion and $350 billion annually in additional health related expenses.

What is significant is that both of these populations, with respect to their comorbid conditions, are in large measure undertreated or not treated at all. This under-/non-treatment of comorbidities, medical or psychiatric, has significant consequences for both clinical outcomes and the utilization of healthcare resources.

The serious and persistent mental illness (SPMI) population (including duals): Approximately 40 percent of the dual eligible population has both physical and mental conditions (as opposed to less than 20 percent of other Medicaid beneficiaries), and the vast majority of individuals with SPMI are part of the dual ranks. Approximately half of the dual eligible population aged 18-64 has at least one mental health or cognitive condition and these individuals have a much higher incidence of serious mental disorders than the general Medicare population. Treating these patients for their comorbid medical conditions is an especially daunting task in a fragmented system. Dual eligible demonstration projects are being launched or considered in many states. These state-level pilots vary significantly and will have a major impact on reshaping the care and practice environment.

Psychiatrists have a number of unique essential medical/clinical skills that are vital to meeting the clinical challenges in treating these multiply co-morbid populations whatever the setting, and treatment by psychiatrists has been demonstrated in research trials to positively contribute to better patient outcomes and improved healthcare resource utilization.

Health reform implications for psychiatrists and their patients: Psychiatry has a central role and demonstrated effectiveness in the new patient care delivery and payment models. Psychiatry will, however, need to define new basic units of clinical care and/or management for reimbursement and better performance measures will be required to enable proper payment. Psychiatrists, working with other healthcare providers, will need to be ready to assume risk, enter into integrated gain-sharing arrangements, and work in and oversee primary care and other integrated settings for care. This will be particularly important in public settings that are further removed from many mainstream healthcare reform settings. Further elaboration of these multiple psychiatric roles will evolve parallel to the many demonstration projects, research efforts, and delivery reforms currently underway.

Integrated Care (IC): A Healthcare Reform Imperative

Background

Many view integration of medical and psychiatric care as a significant part of the solution to the challenges of rising healthcare costs, the lack of population and quality focus, and the excess morbidity and mortality among patients with psychiatric/SUD illness. Both the public and private sectors are actively involved in exploring various integrated care models. *Integrated care models* refers to various emerging models ranging from collaborative care to patient-centered medical homes to co-located care and accountable care organizations (ACOs). Even if none of the integrated models currently being discussed prevails, the volume and variety of the pilots underway in the public and private sectors suggests that elements of these models will play out in some way in the future. Whether today or tomorrow, the principles underlying integrated care will have an impact on the way psychiatry is practiced. Hence, this report's central emphasis on these evolving models of integrated care.

The Work Group recommends that psychiatrists must play a major role in formulating the integrated care solution. Psychiatrists' unique training with the most critically ill psychiatric and medical patients and their general medical, psychopharmacologic, and psychotherapeutic expertise have the potential to bring significant value to the healthcare reform imperative. Leadership and active participation by psychiatric physicians in integrating behavioral health and medical care, formally studying its effects, and overseeing key elements of care will be essential if these efforts to integrate services are to be effective and the best possible patient care is to be provided.

The Work Group's survey and review of the field yielded numerous primary findings that it believes should drive essential considerations for the APA. These findings form the basis for the Work Group's recommendations to the Board**.**

Findings

Lack of common language for integrated care, but core principles emerge. Integrated care has been defined differently in different studies, by different groups, and in different settings. The Agency for Healthcare Research and Quality (AHRQ) has begun the task of developing a lexicon for the field. In general, integrated care uses behavioral or general medical care managers

to track the wellbeing and care of a population and uses psychiatrists to provide consultation to care managers and PCPs and, in some settings, direct consultative care to patients. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington has advanced the following "core principles of effective integrated behavioral healthcare":

- *Patient-centered care*. Primary care and behavioral health providers collaborate effectively using shared care plans.
- *Population-based care*. A care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving, and mental health specialists provide caseload-focused consultation, not just ad hoc advice.
- *Measurement-based treatment to target*. Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.
- *Evidence-based care*. Patients are offered treatments that research has shown to be effective in treating their target conditions.
- *Accountable care*. Providers are accountable and reimbursed for quality care and outcomes.

Based on the core principles and a survey of the field, five models of integrated care emerged. The impetus of healthcare reform, and the Affordable Care Act (ACA) specifically, played a role in the selection of the five models discussed below, as well as in the various models' potential impact in the public and private sectors.

1. Collaborative Care
2. Care Management
3. Co-location (e.g., patient-centered primary care based homes with psychiatric or other mental health provider presence) and reverse co-location (e.g., community mental health centers with psychiatric leadership and primary medical care services) or as more recently identified, bi-directional models
4. Medical Homes: patient-centered medical homes (PCMHs) and patient-centered behavioral health homes (PCBHHs) with a broad range of medical and psychiatric/behavioral care
5. Accountable Care Organizations (ACOs)

The evidence base is robust for some collaborative care models. Collaborative care models have been studied most extensively and rigorously (randomized controlled trials) for patients with comorbid [?]depression, although models are now being extended to patients with other co-morbidities including anxiety, substance use, and multiple medical co-morbidities. A meta-analysis of 37 trials showed that collaborative care compared with usual primary care was associated with a two-fold increase in antidepressant adherence, improvements in outcomes for depression that lasted up to two to five years, and increased patient satisfaction with depression care and primary care. [Thota AB, et al.]

Care/case/disease management models yield positive results. One study assessed the two-year outcomes, costs, and financial sustainability of a medical care management intervention for a CMHC and found that sustained improvements were obtained in the intervention group in the quality of primary care preventive services, the quality of cardio-metabolic care, and the mental health related quality of life. However, the program was not financially sustainable after the grant funding ended. [Druss] Data was collected on the Missouri Medicaid program participants in CMHCs and, overall, case management services were effective in reducing total healthcare costs for seriously mentally ill people with moderate to severe illness. These positive results did not apply to the most severely ill. [Parks et al.] Another approach to integrated case management augments traditional care coordination by allowing trained medical or mental health managers to help complex patients. This has the potential to maximize clinical and functional value while reducing total health-related costs. [Kathol] The *New England Journal of Medicine* reported that disease management models achieved modest improvements in quality of care measures but that the interventions were costing more than the diseases.

- *Reverse co-location; bringing primary care into CMHCs.* There are also a number of pilots integrating primary care into specialty public sector settings. Druss et al. tested a population-based medical care management intervention designed to improve primary medical care in CMHCs. At a 12-month follow-up, the intervention group received an average of 59 percent of recommended preventive services compared with a rate of 22 percent in the usual care group. Overall, medical care

management was associated with significant improvements in the quality and outcomes of primary care. [Druss et al.: *Am J Psychiatry*, Feb. 2010] The state of Missouri has initiated several programs to improve the health of people with serious mental illness. One involved providing primary care nurse liaisons on site at all CMHCs. Preliminary results found that the program almost broke even after 18 months. A follow-up analysis showed a cost savings of 17 percent off expended trends. [Miller JE and Prewitt E: *Reclaiming Lost Decades*, National Association of State Mental Health Program Directors, May 2012]

Data for medical homes and ACOs is pending. The Patient Centered Primary Care Collaborative (PCPCC) is tracking 54 pilot projects from around the country that cover nearly 5 million patients. In these pilots, primary care physicians are creating a patient-centered medical home (PCMH) for their patients that provides some level of care coordination. Data collected thus far, as reported on the PCPCC website, show that medical homes in primary care have decreased emergency room visits, decreased hospitalizations, and decreased the number of outpatient visits per person. However, Mathematica Policy Research reviewed 498 studies published from January 2000 through September 2010 on PCMHs and found only 12 study settings met its criteria as a PCMH and that more evaluation is needed of PCMHs. Less than half of the evaluations assessed all triple aim outcomes.

Healthcare legislation is funding many integrated care demonstration projects, results pending. The Center for Medicare & Medicaid Innovation (CMMI) housed in the Centers for Medicare and Medicaid Services is playing a significant role in the testing of new care models. The ACA specifically charged CMMI with exploring 20 new models of care. Of the 106 projects CMMI has funded, 15 are directed at testing integrated care arrangements for behavioral health care. Several are collaborative care models. The ACA gave the Secretary of Health and Human Services Secretary, who administers CMS, the flexibility to change Medicare and Medicaid programs nationwide based on the outcomes of these care models, making the CMMI pilot projects highly significant for psychiatry.

Sustainability for developed and emerging integrated models is a major issue. Developing integrated care models that can be sustained into the future will require financial changes, as well as operational changes, to the current system of delivery healthcare. Traditional reimbursement models

will not work. Operationally, sophisticated health-records-keeping methods must be in place; performance metrics must be incorporated into everyday practice; healthcare providers must be trained in team-based care; and roles must be clearly defined. The financial obstacles will, however, present the greatest challenges. See the Druss et al. study noted above.

Advancing understanding of the financial and quality consequences of integrated care. Given the prevalence of psychiatric and substance use disorders in primary care and specialty settings and their high total healthcare cost , improving the quality of care to patients with multiple co-morbidities is essential. However, the prevalence and cost of these conditions in financial and quality terms is not widely understood by key purchaser and payer audiences.

Substance use disorders will have to be addressed. There will be increasing attention to substance use disorders by payers, whether as a primary or secondary condition and regardless of whether individuals present in primary care or specialty settings. The role of psychiatry vis-à-vis substance use disorders needs to be better defined and articulated, and more research on effective care models in integrated settings is required.

Mental health disparities and younger populations. The role of collaborative care in addressing issues respecting mental health disparities and children and adolescents has not been well studied and needs investigation.

- *APA leadership is needed to ensure success of integrated care.*

Despite the healthcare imperative for integrated care, there is no central or organized leadership within the APA to highlight this agenda. The APA does not have a designated effort at this time to systematically address integrated care and its essential building blocks of advocacy, accountability, health information technology, and education of members.

- *APA needs increased presence with the stakeholders.* Many stakeholders have vested interests in shaping, promoting, and implementing various integrated care models integrated care. The Work Group is concerned that these groups will affect government, regulatory, and payer policies and that the APA must expand and enhance its presence and focus on some or all of these groups:

- The Federal Government, e.g., the Center for Medicare & Medicaid Innovation (CMMI), the Centers for Medicare & Medicaid Services, the Veterans Administration, the Agency for Healthcare Research and Quality (AHRQ).
- Accreditation entities, e.g., URAC, an independent, nonprofit organization that accredits, educates, and measures healthcare programs; National Committee for Quality Assurance (NCQA); the National Quality Forum (NQF)
- Collaborative organizations, which include employers, e.g., the Patient Centered Primary Care Collaborative (PCPCC).
- Medical associations, e.g., the American Academy of Family Physicians, the American College of Physicians, the American Medical Association
- Patient groups, e.g., National Alliance on Mental Illness (NAMI), Mental Health Association (MHA)
- Non-physician healthcare professionals, such as the Case Management Society of America, the American Nurses Association, physician assistants, etc.
- Proprietary groups that will vend collaborative care services to payers, e.g., Tanber.

Standards, quality measures, performance metrics, and payment methods for these core models are still in development and/or evolving: For example, URAC's Standards for Clinically Integrated Networks I & II, the Joint Commission standards for specialty care health homes, and CMMI pilots are all important. These will establish accountability standards that will shape patient care and psychiatric practice. Coordinated psychiatric input has been sparse.

Psychiatrists require core competencies to participate in integrated care models: Integrated care models, especially those incorporating all the core principles noted above, require psychiatrists to perform different clinical and management functions than are otherwise required in clinical practice. Psychiatrists must have a number of areas of expertise in medical care and ongoing population management to effectively perform these functions. Appropriate training and

education respecting these issues for the current and future psychiatric work force are essential.

Data on current psychiatric practice is lacking: The number of psychiatrists currently involved with alternate care arrangements is not known. Nor do we have information regarding the training and education and/or technical assistance needs of psychiatry for participating in these new arrangements (e.g., how to contract). Given the cottage industry nature of psychiatric practice and the low adoption of health information technology and electronic medical record keeping (some estimate as few as five percent of psychiatrists use HIT), the Work Group is concerned that psychiatrists will not be ready to operate effectively under new payment or integration models. Psychiatrists may need considerable technical assistance with these issues or in forming larger groups or joining multispecialty groups.

The role of the psychiatrist in team-based healthcare settings must be defined: The responsibilities and risks of all healthcare providers must be clearly defined in a team-based, integrated setting. When partnering with others, psychiatrists will have to determine 1) the amounts and types of services to be exchanged; 2) the ability of both the medical and behavioral staff involved to work effectively together; 3) how clinical information will be documented and shared; 4) how to protect one's self from clinical risks and legal liabilities; and 5) perhaps most important, what the lines of authority are.

<u>Recommendations [N.B. need to make reference to Sorel document]</u>

The Work Group thinks there are a number of essential considerations for the APA as it promotes and/or advocates for integrated care solutions. Clearly, the patient's best interests are primary. Although there are various approaches or models to achieve integrated care, it is axiomatic that successful care models incorporate 1) quality/performance metrics; 2) alternative reimbursement schemes; 3) electronic medical records (EMRs) and registries; and 4) team-based approaches to care under physician oversight. The best outcomes in integrated care have thus far been shown to occur in models that include either a psychiatrist providing caseload supervision and decision support to case managers or ongoing evaluation and follow-up visits with a psychiatrist. Currently, no one approach to

integrated care seems to resolve the needs of all populations in all settings. However, some of the models have considerable data to support their efficacy in meeting the Triple Aim while others, such as the ACOs, are just beginning to collect data.

As noted, the research evidence base suggests that certain integrated care models have more efficacy than others. For example, various studies show screening and referrals to behavioral health specialists alone are not sufficient to improve outcomes for adults with commonly occurring disorders. Other studies show that the establishment of collaborative care as a standard of mental health care in primary care settings is associated with a wide range of improved clinical, economic, patient, and provider satisfaction outcomes. For some of the new integrated care approaches, e.g., ACOs, medical homes (primary care or specialty based), the evidence base is less well-established and really only beginning to emerge. It seems reasonable, therefore, to concentrate APA's attention and support at this time on those models with the most evidence for improving patient care quality and satisfaction, improving the health of populations, and reducing costs. While it is critical that proven models of integrated care be given priority attention, it is also vital that emerging models be appropriately evaluated as to their efficacy since there will likely be a range of models deployed.

APA must actively lead the development of integrated models on several levels: with government and private agencies, academia, and researchers; at the implementation level where federal and private groups are piloting new systems; and at the advocacy and communication level to inform psychiatrists, other mental health professionals, the public, the media, and legislators about the changes at hand. To sit on the sidelines as healthcare reform evolves is not a viable option.

APA should support the value of integrated medical and psychiatric care for patients with psychiatric illness in all treatment settings: This support should be based on best evidence regarding optimal care for all patients and care that is patient-centered and consistent with goals of the Triple Aim. *Particular attention should be paid to the distinct needs of patients of varying ages, in different care settings and, in particular, in the public sector:*

- There is clear evidence from a large body of well-designed studies that psychiatrists have vital roles to play in integrated care models in a variety of settings.
- These roles include oversight of population-based psychiatric care in integrated medical psychiatric settings, including the public sector, and an important consultative role with other primary-care based specialists and other mental health caregivers.

APA needs to produce a clear, simple set of statements for psychiatrists and their patients regarding integrated care; define the role of psychiatrists as team leaders and/or team partners and/or consultants; state how psychiatry's role in integrated care will benefit patients; and clarify this role vis-à-vis other physicians, allied health practitioners, and other mental health clinicians.

APA should consider developing a formal vision statement to address these recommendations.

The APA should develop a specific internal program function to monitor and insure that it has input on policies and standards that will impact the practice of psychiatry as part of integrated care models. In addition, monitoring policy efforts at the state level in coordination with state associations and providing targeted expertise when requested will be essential.

A number of key public and private entities are shaping standards, policy, and reimbursement for development of alternative delivery systems, which include various integrated care models. These include, but are not limited to, CMS, the Agency for Healthcare Research and Quality (AHRQ), the Center for Integrated Health Solutions (CIHS), the Medicare Payment Advisory Commission (MEDPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association of Medicaid Directors (NAMD), the Institute of Medicine (IOM), commercial payers, managed behavioral healthcare organizations (MBHOs), the Patient Centered Primary Care Collaborative (PCPCC), accrediting bodies, and so on. Currently, the APA does not have a deliberate, coordinated effort to monitor and advocate

for issues of import to psychiatry concerning integrated care model development.

APA should maintain particularly close working relationships with the AMA, major primary care medical associations, and specialty collaboratives.

APA should take a lead role with CMS and other federal agencies in developing any quality metrics for integrated care and the patient registries needed to implement these. This should include a priority focus on monitoring projects funded by CMMI.

The APA should establish an ongoing inventory of current models of integrated care for all populations and promulgate that information to psychiatrists, other physicians, healthcare leaders, and policy makers. This should include data on best evidence for integrated care and its implementation. The APA should work closely with psychiatric and medical specialty organizations in this effort. The APA should pay particular attention to models that achieve the Triple Aim, are well-designed, incorporate evidence-based care for psychiatric and medical-psychiatric care, and feature psychiatrists in leadership roles. The APA should establish an interdepartmental capacity to inform members and state associations/district branches about:

- New models of care;
- Results of current research;
- Implications for their practices, including barriers to adoption; and
- Ways to participate or at least influence the future practice of psychiatry given these reform initiatives.

Guidance on related aspects of healthcare system change, including practice organization, contracting payer issues, coding, and related matters should be included to the extent legally permissible.

Psychiatrists will need assistance in forming new practice relationships if healthcare reform shows evidence of significantly affecting the flow of and payment for clinical care. Although the Work Group does not believe that self-pay private practices or even insurance-based solo or small group

practices will disappear, it is likely that control over payments and practices may shift to larger health system entities. Other specific recommendations related to assessing the exact nature of current psychiatric practice, EHR adoption, and financing are addressed elsewhere in this report.

Given the unique nature of psychiatric practice, including its direct access and public sector roles, a robust communications strategy will need to be a goal of these efforts. The APA should develop specific communications strategies to promote the value of integrated care and psychiatric physician leadership with key stakeholder audiences.

The Financing of Psychiatric Care: Structure, Payment, and Administration

Background

The financing of and payment for psychiatric care is a complex topic, and no discussion of it in the context of health reform is complete without due consideration of its sources, structure, and management, and the inequities relative to general healthcare. While the ACA offers the potential to expand coverage and access and enable new care delivery models, this will be unrealized if fundamental payment issues are not addressed.

The behavioral health system in the United States is financed through multiple revenue sources. These include state and county governmental units, the Medicare program, Medicaid, private commercial health insurers, patient out-of-pocket expenditures, and various smaller public and private programs.

Combined, these funding sources comprise a complex patchwork of payer programs, each with its own benefit packages, eligibility, and coverage rules.

The structure and management of payment for psychiatric care, regardless of funding source, is also a confounding issue that requires due consideration, especially as it relates to integrated care models. Behavioral healthcare is generally separated from other healthcare in a way that fails to account for their interdependence. The prevalence of carved-out arrangements for management and payment of psychiatric care, so-called MBHOs, presents a special set of issues for consideration. At the level of

essential clinical transactions, there is a large deficit in the understanding of what is needed respecting payment for essential psychiatric services and functions even within integrated care delivery models that recognize the inextricable interdependence of general medical and psychiatric care. Essential clinical and psychiatric management functions must be defined and recognized and payment mechanisms developed to compensate for them.

Moreover, the prevailing fee-for-service reimbursement methodology for healthcare is undergoing revision in many significant ways. Pay for performance is an overarching policy direction and how this is best operationalized for psychiatry within integrated systems or separately is a matter that has not been fully studied. The implications for psychiatric patients and practices where payers are moving toward alternative payment models are significant. In the healthcare payment environment that is emerging, it is doubtful that payment improvements (let alone maintaining current levels) can occur without performance metrics.

Finally, there are ongoing inequities in psychiatric reimbursement by third-party payers relative to other physicians' reimbursement that require redress. These payment disparities will not automatically disappear in a global payment environment. The principles and regulations embedded in MHPAEA provide potential for appropriate remedies regarding many of the issues noted above.

Key Findings

Milliman report: The Work Group commissioned a report by Milliman to estimate the economic impact of integrated medical-behavioral healthcare for commercially insured, Medicare, and Medicaid populations.

Key findings of the study include:

- Persons with a treated psychiatric and or substance use disorder typically cost 2-3 times more on average when accounting for their total medical costs than those without a behavioral condition in all market segments.
- Persons with a treated psychiatric and/or substance use disorder constituted only 14 percent of the total insured studied, but accounted for over 30 percent of total health spending.
- Persons with a treated psychiatric and or substance use disorder had a higher proportion of their total medical non-prescription

dollars spent on facility-based services than on professional services.

Total health costs for persons with chronic medical conditions and a psychiatric and/or substance use disorder were compared to those with a chronic medical condition but no behavioral comorbidity. Costs for those with a psychiatric and/or substance use disorder always exceeded the costs for those without. Milliman defined the difference between the two as the "value opportunity," i.e., what could theoretically be saved through an integrated care approach.

A total value opportunity was calculated for each group and yielded the following:

Total value opportunity of $162 billion in the commercial market

- Total value opportunity of $30.8 billion for Medicare
- Total value opportunity of $100.4 billion for Medicaid
- Total Value Opportunity $293.2 billion

Based on its review of various integrated care studies, Milliman rendered conservative estimates of the cost impact (projected savings) of integration for persons with a treated psychiatric and or substance use disorder:

Commercial	$16-32 billion
Medicare	3- 7 billion
Medicaid	7-10 billion
Total Projected Savings	$26-49 billion

Milliman estimated total annual psychiatric wages to be $7.3 billion. Given the projected savings estimate of $26-48 billion:

- The potential impact of integrated care programs can be 3.5 to 6.6 times annual psychiatrist earnings.
- It is approximately equal to total all physician expenditures as estimated by SAMHSA to be $35 billion by 2014.

Milliman also states this alternatively: [to be revised per revisions to Milliman]

- A theoretically modest ten percent gain-sharing arrangement for psychiatry would increase aggregate annual psychiatrist earnings by 50 percent; and the other

- 90 percent of savings through collaborative care could be used to lower premiums, reinvest in services and/or share with other practitioners who are part of the collaborative care arrangement.

- It estimated total payer expenditures for MH/SU services are approximately $95 billion per year, and the value opportunity as approximately $293 billion per year. If all state and local payments for MH/SU services are added to the private and public payer total, SAMHSA estimated this would be $239 billion per year, still less than the Milliman value opportunity of $293 billion.

Medicaid is the largest payer. For mental health services in the United States, Medicaid is the largest payer. It comprises 27 percent of all expenditures for mental health services (60 percent in the public sector). As a result, Medicaid coverage policy can have a significant impact on the health of this population as well as on the quality and costs of both health and behavioral health services. Individuals with mental health disorders comprise almost 11 percent of those enrolled in Medicaid and represent almost 30 percent of all Medicaid medical and behavioral health expenditures.

Medicaid reimbursement policy. Medicaid payment policy is complex and is becoming increasingly decentralized with respect to decision-making regarding coverage and payment policy through the "waiver" process and multiple state demonstration projects.

ACA gives new authority for dual initiatives. The ACA launched new authority for Medicare/Medicaid initiatives for dual eligibles that will reshape Medicare payments for the SPMI population.

Current fee for service (FFS) payment methodologies are projected to shift toward global payment and value purchasing. It is unclear how these alternative payment methodologies compensate for disparities in payment, lack of infrastructure supports, or payment for consultation and care management functions in integrated care settings. In addition, there is likely to be substantial conflict between and among primary care physicians and specialists and cognitive and procedurally based physicians given the

need for interim payment and accounting methods within risk-based or other contracts that will likely rely on modified current FFS-based models, at least for the present. The Medicare Fee Schedule, especially relative work value units, will likely retain significance. Medicare SGR reform is a critical matter and will become a benchmark for public and commercial payers.

Fee for Service (FFS) still has a future. Most proposed payment approaches, such as medical homes and shared savings for accountable care organizations, do maintain fee-for-service components. Fee schedule codes and prices are the building blocks for other proposed approaches. Bundled payments for episodes of care and global payments also depend on FFS pricing (e.g., per member per month payments are calculated on the basis of service volume and intensity multiplied by their respective FFS rates), as do other actuarial functions such as premium calculations. Any distortions in the Medicare Fee Schedule are carried over to these payment methods. Moreover, hospitals, healthcare systems, and medical groups utilize FFS-based relative value units to assess physician productivity.

Pay for performance will be more and more prevalent. It is highly likely that payment levels/fee schedules for all physicians will be, in part, dependent on performance metrics. The development and adoption across all payers of appropriate metrics for psychiatry are a critical matter. There is very limited experience with pay for performance incentives in behavioral healthcare and little is known about these incentives in the context of population-focused primary care based collaborative care programs.

Financial sustainability for integrated care initiatives is essential. The ability to provide appropriate MH/SUD services in primary care settings (and vice-versa) is impeded by a number of reimbursement barriers. The sustainability of desired integrated care initiatives is dependent on permanent solutions including payment for infrastructure, care management, and currently non-reimbursed consultative services.

We have not endeavored to catalog the entire landscape of alternative payment schemes that have emerged. Regardless, it can be unequivocally stated at this juncture that the appropriateness of these methods for psychiatric practice and the implications for patient care require focused study and analysis.

Payment inequities for psychiatry. Payment to psychiatrists for work valued similarly for other physicians is generally not at par when measured on an RVU basis. This pattern has persisted despite enactment of the parity law.

Structure and management of payment: carved out v. integrated. The advent and evolution of managed behavioral healthcare in the early 1980s fundamentally altered the structure and administration of MH/SUD care delivery and payment. Estimates are that specialty behavioral health organizations (MBHOs) with carved-out arrangements manage treatment for some 171 million individuals under commercial and public sector payers, including coverage of dual eligible individuals. The specialty managed care industry for MH/SUD has always been surrounded by controversy. The increasing focus on the integration of mental health, substance use disorder, and somatic care services is demanding a re-examination of the nature and utility of these carved-out arrangements – and the extent to which they are barriers to optimal integration.

Given the scope of their market penetration as a management option for MH/SUD, it is not clear what the evolution of these models may be in an increasingly integrated environment. There are some advantages (protection of limited MH/SU dollars) and many disadvantages to the carve-out models and the legacy issues they bring that are barriers to the quest for integrated care. These must be resolved if they are to remain a management option, especially for public sector populations.

On the other hand, there are also many issues raised when considering the option of integrating the MH/SUD benefits back into the management and budget for general medical care. This is especially acute in the public sector where integrating MH/SUD budgets is viewed as providing improved care and potential financial incentives to care and, negatively, as putting at risk currently-budgeted MH/SU services.

Regarding integrated care models and accountability (e.g., payment and operations); there are issues that must be resolved because they are vital to successful integration. It is unlikely that without integrated payment the full value of integrated medical and psychiatric/substance use care will be achieved.

Given the primary tenet of patient-centered care, it seems self-evident that regardless of the financing and/or administrative structures, all health plan entities share accountability. Accreditation and related standards for health plans generally, and integrated care specifically, are needed.

FQHC payment advantages. Federally Qualified Health Centers, which are primary care based settings, have distinct and consequential reimbursement advantages over CMHCs.

CPT Coding Changes may be needed. Codes that describe essential services and functions provided by psychiatrists in integrated care systems may be needed.

Recommendations

We strongly support payer and insurance mechanisms that integrate the payment, use of standard CPT codes, and systems of managing psychiatric care with the broader medical healthcare budgets.

- In any system that integrates care, the value of psychiatric care in improving total healthcare quality and reducing costs needs to be accounted for in such a way that the psychiatric care system, our patients, and psychiatrists can benefit from the improvement in cost of total care.

- Appropriate payment arrangements that recognize necessary psychiatric clinical and case management functions as well as other infrastructure costs for care in integrated care models are essential. This is an absolute prerequisite for the sustainability and participation of psychiatry.

- The APA should support payment streams for psychiatric care that are not carved out of existing medical budgets or, if carve-out payers continue to operate, the credentialing, CPT codes, and payment for psychiatric physician services must be integrated with the overall medical budget. Accreditation and related standards should be developed.

- The APA should work with other medical societies to support ongoing improvements to evaluation and management (E/M) coding to bring reimbursements for these codes in line with procedural valuations**.**

- Contracts for ongoing carve-out services should be structured in such a fashion as to place performance expectations on the quality and cost of medical as well as psychiatric care.

- Integrated care budgets -- particularly for public sector patients -- must have formal budget and quality mechanisms to protect existing mental health budget resources.

- The APA will need the capacity to track changes to payment systems, the results of demonstration projects, delivery and payment reform, and formal research and the impact on sustainability and various payment sectors. This will include alternative payment methodology developments and their implications for psychiatric care and reimbursement.

- The APA should develop a core program function that specifically monitors and reports on Medicare and Medicaid policy and related program developments regarding state Medicaid plans and program efforts directed at the dual-eligible population in support of federal advocacy and APA's state associations.

- The APA needs a more active and strategic presence in the many nongovernmental groups that will define policy and accreditation standards. This will also require more intensive work with the employer community and a focused public relations strategy.

- The APA should continue strategic efforts to utilize MHPAEA to secure equity for psychiatrists and their patients.

Quality and Performance Measurement

Background

Performance indicators are seen as essential to improving patient care and have been increasingly used for quality improvement initiatives, public accountability, and healthcare reimbursement. Healthcare reform has greatly accelerated the development and use of performance indicators and these will be increasingly applied to psychiatric care and mental health/substance use disorder care.

It is unclear, however, whether psychiatry (and the MH/SUD field generally) is prepared to adequately function in this new environment. Concerns include the status of current measures and practitioner and system readiness to implement them.

The ACA gave even greater importance to quality measurements in 2010, including some that apply specifically to mental health and substance use disorders. As part of the comparative effectiveness research push, ACA established and funded the Patient-Centered Outcomes Research Institute,

In addition, the ACA allocated $10 billion through 2018 to the Center for Medicare & Medicaid Innovation (CMMI*),* which includes performance metrics in pilot models to be studied.

Under the ACA, health insurers and group health plans are to report annually to the HHS Secretary on quality improvement measures.

We need to know what works and what doesn't work—what models of care, which treatments, and which structures are most effective in meeting the Triple Aim.

A loosely coordinated "national quality enterprise" has already emerged through which clinical performance measures are developed, and more than 40 different behavioral health quality measurement initiatives are currently underway in the United States.

There are now multiple entities that promulgate performance measures, including the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), the AMA, the Physician Consortium for Performance Improvement (PCPI), the Joint Commission, the National Committee for Quality Assurance (NCQA), and the National Quality Enterprise (NQE). A description of these organizations is included in the

reference document. The field currently lacks leadership, and that presents an opportunity for psychiatrists. To be a player in the healthcare reform initiatives, psychiatrists will have to be represented at many levels of these organizations.

Findings

Goals: Before performance measures are written, there must be consensus among psychiatrists about what quality domains are most important to measure. Not all measures are equal. Psychiatrists will increasingly be expected to use performance measures as healthcare reform moves forward.

Quality of current performance measures: Few performance measures in behavioral health are fully validated and reliable, nor are they robustly included in existing measure sets. Psychiatry and other mental health groups do not appear adequately engaged in working with the agencies and organizations that are developing performance measures.

Range of quality measures: It is important to develop and measure indicators not only for individual medical and behavioral health conditions but also for the key processes associated with clinical integration

Awareness of APA members: Although psychiatric quality measures are in their infancy, it is not clear that psychiatrists are sufficiently informed or use measures frequently.

Health information technology (HIT): A central feature that is needed to facilitate quality improvement is health information technology, which includes the use of electronic health records (EHRs). The ACA explicitly requires that HIT be part of the PCMH demonstration projects.

Risk adjustment: Many measures do not adequately account for variations in patient panels nor do they necessarily account for more severely psychiatrically ill or patients with multiple comorbidities.

Adoption: Given the greater prevalence of solo or private practice for psychiatry, the adoption of performance measures may be more difficult. It is estimated that less than five percent of psychiatrists are currently using EHRs.

Accreditation and certification: Current programs do not robustly include psychiatric input or adequate mental health substance use measures or measures of coordination with general healthcare and medical comorbidity.

Recommendations

The recommendations that follow are rooted in the foregoing findings and their implications for the future credibility of organization and payment for psychiatric care.

- Clarify and articulate the APA's vision for mental health quality measures. Psychiatric measures must not be separated from the rest of medical care.

- Undertake a systematic review and analysis of quality and performance measures that are used to accredit and/or certify alternative care delivery models and/or for healthcare reimbursement purposes.
- Broaden the range of quality measures to include outcome measures and measures of integrated care for individuals with multiple comorbidities.
- Engage where appropriate in research activity on quality in psychiatric practice.
- The APA should consider a leadership role in the development of EHR and registry quality capacity.
- Disseminate psychiatric outcome measures that are meaningful and actionable.
- Continue/expand educational outreach on performance measurement targeting APA membership.
- Continue/expand participation in national initiatives at all levels (federal, private insurance, local, etc.).
- Continue/expand APA efforts in monitoring and participation in health plan certification/accreditation.
- The APA will need to lead on quality metrics for psychiatric care and their consistent adoption across payers and other regulatory entities. This could be approached by identifying a few priority areas for improvement, and/or by identifying a series of goals covering various areas of practice.

Electronic Health Records (EHR) and Related Technology

Background

Electronic Medical Records are the electronic framework that provides for the comprehensive management and secure exchange of health information among providers, insurers, government, patients, and other entities. EHRs, in particular, have emerged at the center of the national strategy to improve healthcare quality, communication, prevention and wellness, and to reduce unnecessary cost.

EHRs are embedded in a framework of health information technology (HIT) that also includes telemedicine, e-mail, websites, databases, electronic prescribing, and patient-controlled personal health records. HIT is fundamental to the array of emerging alternate care delivery models. Any entity that coordinates care and promotes accountability among a group of providers for a given patient population will require capabilities that will be difficult to achieve without the use of HIT.

Recent legislation has created a series of initiatives designed to increase the acquisition and use of EHRs and other forms of HIT, including financial incentives to clinicians and hospitals through Medicare and Medicaid; the establishment of networks (Health Information Exchanges) to exchange health information within and between communities; and the development of new technical standards to support health information technology infrastructure. Increased attention and resources have been allocated to other types of HIT as well, such as telemedicine.

Findings

While EHRs are fundamental to healthcare transformation – there are specific issues for psychiatry and the mental health/substance use disorders field, including:

- Technology acquisition – Psychiatrists, who are disproportionately solo and small-group practitioners, have lagged behind other specialties in adopting EHR, in part due to cost or adaption of EHR to psychiatric care needs. Support for psychiatric acquisition of EHR technology has been limited to large systems and public payer meaningful use, which may only represent a minority of practicing psychiatrists not in private practice or public sector settings. Failure to alter this pattern of EHR

use will make it difficult to survive and/or be relevant in the emerging environment.

- Federal policy issues – The decision to exclude non-physician behavioral healthcare providers and community mental health centers or free standing psychiatric hospitals from the HITECH Act means that, at present, there is no federal support for this necessary transformation, limiting vendor interest and adoption.

  Notably, non-physician mental health and substance abuse treatment providers (including CMHCs) are not eligible for the Medicare and Medicaid EHR Incentive Program funds. Eligible hospitals under Medicare are subsection (d) hospitals in the 50 states or DC, critical access hospitals, and Medicare advantage hospitals. Under Medicaid, eligible hospitals are acute care hospitals and children's hospitals. Psychiatric hospitals were not included in the legislation.

- Medicaid Record Confidentiality – Psychiatric and substance use disorder medical records present numerous problems in the emerging era of health information exchange, which must be overcome especially with regard to integrated care initiatives. While some aspects of this are distinctive for psychiatrists, the Work Group notes that many patients with MH/SU disorders are seen solely in the general medical sector where this information is embedded in existing electronic records and that other aspects of medical care can be highly sensitive as well.

- Integrated care models – Success under most emerging integrated care models is dependent on deployment of EHR and patient registries. Psychiatry and the MH/SUD fields' success with these ventures will be dependent on access to and adoption of EHR. The current low rate of use is an issue, as is the fact that there are limited vendor products available that incorporate the flexibility needed by psychiatrists.

Demonstration Projects: The ACA explicitly requires that information technology be a part of Title XIX Medicaid medical home demonstration projects. It has been pointed out that the new demonstration projects will

require maintaining an inventory of evidence-based approaches for integrating care and measuring and improving quality improvement, as well as developing and disseminating standardized templates for EHRs, personal health records, and the registry.

Patient Registries: Registries are mentioned repeatedly in all discussion of HIT. A patient registry is a tool that allows for tracking all of the patients seen in a practice with a particular condition(s) or set of characteristics. In essence, it is a database in which key data about a target population is organized in one place. AHRA defines a 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."

Many professional associations, particularly procedural based disciplines, are supporting or plan to support registries. For example, the thoracic surgeons have an outcomes registry, as does cardiology. Registries serve a variety of functions, including reporting clinical performance measures, tracking practices for high risk patients and population management, quality improvement and maintenance of certification, and research. Challenges in establishing a clinically relevant registry in psychiatry include the facts that the model isn't as intuitive with chronic conditions and that outcomes for mental health are difficult to define and capture in a standardized way. Establishing and hosting a registry is a staff and financial-resource intensive endeavor, and some registries will eventually be spinning off from professional associations into standalone companies.

Health information exchanges: The term *health information exchange* (HIE) actually encompasses two related concepts: as a verb, it is the electronic sharing of health-related information among organizations; as a noun, it is the organization that provides services to enable the electronic sharing of health-related information. HIE can provide the connecting point for an organized, standardized process of data exchange across statewide, regional, and local initiatives.

Research: Researchers at the Office of the National Coordinator (ONC) for HIT published a review of studies on the effectiveness of HIT in a 2011 issue

of *Health Affairs*. They found predominantly positive effects on key aspects of care, including quality and efficiency. [Buntin MB et al., The Benefits of Health Information Technology: A Review of the Recent Literature Shows Predominantly Positive Results, *Health Affairs*, March 2011.] On the other hand, *BMC Psychiatry* (November 2011) reported that not a single study has been published supporting any significant benefit to the creation of electronic personal mental health records.

Key organizations: Several organizations are key to funding and setting policy for developing HIT: CMS; the Health Resources and Services Administration (HRSA); the Office of the National Coordinator for HIT (ONC); and the Nationwide Health Information Network Exchange, all of which are described more fully in the reference document.

EHR adoption: It is widely agreed that performance measurement will be most effective when it is minimally intrusive into the clinical workflow. Although EHRs are expected to allow for measurement to be integrated into workflow and therefore lower the administrative burden on practicing clinicians, widespread adoption of EHRs in psychiatry and the technical standards required to uniformly implement measures are still years away. Mental health and substance abuse treatment systems have historically lagged behind other areas of medicine in the development and standardization of information technology tools. Furthermore, legal/regulatory barriers (42CFR Part 2; psychiatric medical record laws) have limited the exchange of information between primary care and mental health and substance abuse treatment settings. Confusion about applicable laws and obligations under multiple federal and state statues is high. Regardless of specialty, solo practitioners are the lowest adopters of EHRs because of challenges they face, such as limited administrative and technical support and the potentially high cost of purchasing and maintaining systems. The percentage of psychiatrists using EHRs is particularly low – estimates range from five percent to eight percent.

Privacy, security, and confidentiality: High profile breaches of health information security have undermined patient confidence that their sensitive information will be protected. Although technology is under development, today's HIT systems have limited capability for selectively protecting sensitive information from inappropriate sharing. There are many issues regarding psychiatric medical record/substance use disorder confidentiality

that need to be vetted and appropriately balanced within integrated EHRs. Currently, there is little if any consensus as to how to do this.

HIE sharing: Due to the complexity and variation in policies and laws, as well as to concerns about the sensitivity of information pertaining to mental health treatment, communities are facing challenges in deciding how information pertaining to mental health information will be shared over health information exchanges. Both of the two most common approaches (sharing mental health information without any additional protection and withholding mental health information from any form of exchange) are problematic for patients with mental illness, especially given high medical comorbidity and the frequency of psychiatric care occurring solely in the general medical sector.

EHR products for behavioral health: The variety of EHR products available is most robust for primary care and smaller for behavioral health settings and clinicians.

- The APA's Committee on Electronic Health Records is developing a list of features that EHRs should include in order to meet the needs of psychiatrists. This list will support many activities, including educating APA members and communicating with software vendors about psychiatrists' needs.

- The APA has partnered with the American College of Physicians and other professional associations to support the American EHR website, which consolidates information about software products submitted by practicing physicians. A survey of APA membership to collect information on EHR systems used by psychiatrists is forthcoming.

- Legislation, which was introduced in the last Congress aimed at correcting current limitations on non-physician mental health providers receiving EHR incentives from Medicare and Medicaid has not been introduced in the current session.

Recommendations

The Work Group believes that the failure to integrate psychiatric and medical records into EHRs subject to the limitations and safeguards noted below will

permanently impair improvements in our patients' health and wellbeing. Recognizing the sensitivity of these issues, communication and education of the membership, patients, policy makers, and the general public is essential. Opt out provisions, limitations on sharing of psychotherapy notes as opposed to general psychiatric records, and ongoing recommendations regarding law and policy will be essential for the APA and its state associations. It is also essential that policymakers understand that more ambulatory psychiatric services are provided by non-psychiatric physicians than by psychiatrists or other mental health providers and that their electronic records already contain both mental health and other sensitive medical information.

- The APA should develop resources that help members select, implement, maintain, and use EHRs and other forms of HIT. Possibilities could include written resources and online instruction videos; software reviews; accounts of members' experiences with HIT; telephonic consulting and technical support services; and in-person support services.

  Standardized templates for electronic medical records and personal health records should include the data elements needed to manage and coordinate general medical care and mental health and substance abuse care. These systems must be carefully designed to ensure that critical information on health status and services can be extracted for measuring service patterns and performance.

- The APA should continue/expand activities pertaining to HIT privacy. Activities include feedback to the federal government through submission of public comments and responses to requests for information; development of educational content on how to maintain HIT privacy and discuss privacy issues with patients; and talking to HIT vendors about privacy functionality.
- The appropriateness and feasibility of APA developing patient registries for psychiatric patients should be explored. This should include due consideration of various structures and uses and recommendations as to options for the APA. The Council on Research and Quality Care will address this at its May 2013 meeting.

- The APA should explore developing an RFR to vendors with specific technical capacities that would be needed for endorsement and should

consider evaluation of its role in the development of EHR products. This activity could be a valuable resource to members, but APA must be aware of the risks involved in dealing with an immature industry.

- The APA should continue/expand quality and performance measurement activities as under the quality performance measurement topic**:** Performance measurement is a key function of HIT and includes a variety of components related to payment, quality, and research through patient registries.

- The APA should assess the adoption of and impact of HIT on quality in psychiatric practice and identify strategies to maximize findings that indicate the positive impact.

- The APA should develop policy and training on EHRs and privacy/confidentiality. The importance of electronic health records going forward is self-evident. There are, however, numerous privacy/confidentiality issues for psychiatric records.

The Work Group believes that psychiatric records should be integrated into medical records provided there is patient consent and this is consistent with statutory requirements. (It must be noted that Medicare/Medicaid patients do not have the option to opt out of EHRs.) Confidentiality is essential to proper psychiatric patient care and psychiatrists will need to differentiate between psychiatric notes that can be included in the medical record and psychotherapy notes that cannot. APA members will need authoritative guidance on content/inclusion in the medical record and the role of state versus federal regulation.

- The APA should make policy development for confidentiality of MH/SUD records and HIT a priority matter**.** Development of training and technical assistance materials for members will be essential.
- The APA should engage with Health Information Exchange (HIE) efforts*.* Currently, HIEs are forming at the local level, and each locale is handling psychiatric health information differently. In order to realize the potential of HIE to facilitate integrated care, APA could participate in oversight bodies at the national level and develop educational material for APA members.

- The APA should continue/expand efforts to develop resources that help members select, implement, maintain, and use Electric Health Records and other forms of HIT. Possibilities include an RFR process as noted above; written resources and online instructional video; software reviews; accounts of member experiences with HIT; telephonic consulting and technical support services; and in-person support services.

- The APA should continue/expand its efforts to advocate for expansion of HIT to all aspects of the mental healthcare system. Non-physician mental health clinicians and many specialty mental health settings are currently excluded from current national initiatives. Specific advocacy efforts are needed to correct federal policy.

- The APA should assess the feasibility of maintaining patient registries. Given CMS's interest, APA should do pilot work to assess these more fully. This assessment has begun through APA's Council on Research and Quality.

Workforce, Work Environment, Medical Education and Training

Background

It is clear that key health reform trends underway have important implications for the demand, types, and provision of psychiatric services. The exact shape of these changes, the skills that will be required, and who in the general medical, psychiatric, and broader mental health communities will provide this care is unknown. The plans to be offered through the new exchanges and Medicaid expansion under the ACA will greatly increase the number of insured people with MH/SUD conditions.

Findings

Provider payment rates under ACA coverage expansion health plans: Expansion schemes may not offer payment rates that make participation attractive.

Supply and distribution of psychiatric workforce: What is relevant is that there are known shortage area designations (distribution issues) for both psychiatric and non-MD behavioral health practitioners. These shortage designations have a high degree of correlation with sites of service delivery that will likely be points of access for many of the newly insured.

Federal health manpower policy: Federal medical workforce policy places premium emphasis on primary care over specialty physicians. There are no foreseeable changes that will radically alter numbers in the near future.

Healthcare reform is predicated on an expanded non-medical workforce. ACA workforce provisions and initiatives for the behavioral health workforce are focused on training and developing non-MD practitioners.

There is a disconnect between the likely need and demand for specialty psychiatric physician services as part of behavioral healthcare delivery and current federal behavioral health manpower development policy.

Coverage expansion, increased demand, the non-medical workforce and scope of practice: The composition (education and training) of the current workforce in most shortage areas/settings and the general non-availability of physicians will likely contribute to increased scope-of-practice debates across all of medicine and on the part of non-medical mental health and substance use disorder practitioners and non-medical primary care practitioners.

Psychiatry's role and responsibility in integrated care models and core competencies required: While integrated care models utilize a wide range of medical and nonmedical practitioners in both primary care and behavioral health care, psychiatry has medical skill sets that are essential to successful IC delivery models. This includes general medical expertise, expertise in the psychiatric presentation of medical illness, deep psychopharmacologic knowledge, and training with the most critically ill psychiatric and substance use patients in settings of considerable independent clinical authority. This skill set is not replicable by other physicians or non-physician personnel.

Current physician training initiatives re integrated healthcare: There are a number of training curriculum/course opportunities for practicing psychiatrists currently available through the APA, the AIMS Academy, and the National Council.

Core competencies: There is a gap between the typical current competencies of psychiatric physicians and those needed to function appropriately in integrated care models, particularly in ongoing medical expertise and maintenance of these skills along with development of ambulatory consultative expertise and expertise in population management. These core competencies are not fully developed in most medical education and training programs.

- A curriculum on integrated care for psychiatric residency training programs is under development by the AIMS Center (Advancing Integrated Mental Health Solutions), University of Washington).

- While the need and demand for psychiatry to be appropriately embedded in IC delivery models is relatively self-evident, it is not clear that there are sufficient numbers of trained individuals within the current manpower supply who can meet the demand, or even that a significant number of currently practicing psychiatrists are interested in these roles.

<u>Recommendations</u>

- Future workforce: The APA should work with the American Association of Directors of Psychiatric Residency Training (AADPRT), the Academy of Psychosomatic Medicine (APM), and the American Academy of Child and Adolescent Psychiatry (AACAP) to facilitate the development and

implementation of a curriculum for residents that includes the core competence/skill sets for integrated care practice, including the maintenance of core medical skills.

- The APA should work with the Accreditation Council for Graduate Medical Education (ACGME) to develop accreditation standards to establish specific milestones for psychiatric residents to achieve proficiency in core competencies for integrated care practice and settings, or highlight existing milestones that are relevant for these efforts.

- Current workforce: Within the healthcare reform movement, many opportunities exist for psychiatrists who have the necessary skills and experience to participate in the new models of integrative care. However, many lack the core competencies respecting a number of necessary skills.

- The APA should develop practice management modules (CME) for its members to enhance their skills in the following areas: reviews of common medical problems in general medical care and public sector populations, leading teams of mental health professionals, setting up and/or participating in integrated care settings, teaching PCPs about identifying and screening for mental health illnesses and substance use disorders, and health information technology.

- Non-psychiatrist physicians and allied practitioners: the APA should explore potential collaboration with primary care personnel (both M.D and non-M.D.) regarding needed education and alliances regarding care delivery development (especially for shortage areas).

Research and the Mental Health Evidence Base

Background

The ACA contemplates a transformation of care delivery and payment reform and has also set into motion a plethora of research and evaluation efforts to inform policy and clinical care. Its repeated emphasis on quality of care

measures and on evidence-based treatment increases the need for proven approaches in mental healthcare delivery.

A variety of entities will be involved in these research and evaluation endeavors from Patient-Centered Outcomes Research Institute (PECORI) to SAMHSA and NIH. There are many questions embedded in all of these initiatives for which the present research base does not have answers. While the array of pilots and demonstrations underway have valuation protocols built into them, there will be issues about the utility of the data they generate. All of these efforts will require appropriate monitoring.

The foregoing will play a role in advancing our understanding of how the organization and financing of care affect cost, quality, and access. The APA has a role, internally and externally, to play with this health reform research agenda.

Clearly there are important research questions across the topical areas discussed in this report. The Work Group has identified many of what it considers important research questions. The Work Group believes this should be regarded as a starting point for further deliberation to identify priority areas and the development of a plan to advance an agenda regarding needed research. It is evident that a variety of entities will perform these needed research projects.

<u>Research Issues Covering Topical Areas Involved in Health Reform</u>

Integrated Care

- Develop standards for classifying models of integrated care and measuring outcomes of such models.
- What is the effectiveness of integrated care in general medical and related psychiatric practice settings?
- What is the effectiveness of integrated care for those with severe mental illness? What models will work best in this population and help with medical disorders found in them?
- What models of integrated care can be used in rural areas with underserved populations?

- What models work best with various age groups (e.g., children and the elderly population)?
- What accounts for the effectiveness of integrated care – clinician integration, introduction of evidence-based practice, care management, system integration, etc.?
- What organizational models of care are best for certain populations and settings? (Note this goes beyond "integrated" care – perhaps there are other ways that work best for certain groups and settings.)
- What models could ensure sustainability?
- What other factors (e.g., clinician/staff beliefs) may impact effectiveness of integrated care models?
- Support increased research into the mechanisms of increased morbidity and mortality with co-occurring medical and psychiatric disorders.
- Support/conduct epidemiologic studies of co-morbidity (medical, mental illness/substance use) including prevalence and impact of care

Financing of Psychiatric Care

- What is the cost-effectiveness of integrated care models in various populations and settings?
- What are the best models for financing integrated care models?
- What reimbursement models lead to the best outcomes for people with mental illness?
- What models of financing will ensure appropriate care under health care reform for those within the current public mental health system?
- What is the contribution of mental illness/substance abuse to overall health care costs and the effect of appropriate behavioral healthcare interventions on those costs? How do these differ by population (e.g., those with dual eligibility, co-morbid conditions)? How do different mental health clinicians affect these costs?
- What models of payment by Medicaid/Medicare are best for those with mental illness?

- What interventions should be covered? Identify those interventions with the highest cost-effectiveness and include not only clinical treatments but others like case management, peer navigators, etc.
- How do various coding schemas affect delivery of care, costs of care and outcomes?
- What mental health and substance abuse interventions should be part of a basic package of insurance coverage (this becomes esp. relevant with health exchanges and expansion of Medicaid)?
- What are the barriers to the adoption of best practices?

Quality and Performance Measurement

- Increase research to build an evidence base for treatment of various illnesses. There is a need to identify gaps in knowledge that should be a priority for clinical research. Which outcome measures most predict improvement, reduced morbidity and mortality from all causes?
- What personalized treatment options are available now or could be developed in the near future?
- Increase the number of quality and performance indicators with a clear link to improved outcomes in those with mental illnesses and substance use disorders.
- Develop pay for performance models in MH/SUD, including integrated models.
- Increase development of patient-centered outcome measures.
- What are the best risk adjustment models? (also relevant to financing)
- What implementation/dissemination models are effective in improving practice?
- What models of person-centered care lead to better outcomes for patients?

Health Information Technology (HIT)

- Develop EHR applications to improve quality of care in various treatment settings. What applications actually improve care and outcomes?
- Develop EHR applications that can monitor individual practice and patient outcomes.
- What EHR data related to those with mental health/substance use disorders are critical for improved treatment outcomes?
- Develop large data network(s) to be used for research on various conditions and to monitor changes in population health.
- Expand practice-based research network for practice research. Incorporation of EHR and other data systems will expand opportunities within this network.
- Expand support for novel and entrepreneurial capacity to assess wellbeing, symptoms, and response to treatment.
- Ethical considerations in health IT.

Workforce, Training, and Education

- What is the projected demand for services given the increase in coverage under the ACA?
- What is the projected available number of psychiatrists and other mental health care professionals?
- What is the projected available number of primary care physicians, non-physician primary medical caregivers, and specialists who will be providing mental health and substance use disorder services?
- What range of disorders will primary care physicians, non-physician primary care medical caregivers, and specialists treat? What are existing and expected skill sets and training they will need?
- What skill sets are needed now for psychiatrists to practice in future models of health care?
- What are unique skill sets for psychiatrists vs. other mental health clinicians vs. other physicians?

- What recruitment and retention models work best to ensure an adequate number of psychiatrists?
- What education models are most effective in training psychiatrists, primary care physicians currently practicing and those in training?

DSM-V

- How does adherence to DSM-V criteria improve practice and outcomes for patients?
- What changes need to be made in DSM criteria? (This would come from longitudinal studies once DSM-V is implemented.)
- What new coding/payment/performance methods are most effective using DSM-V?

Healthcare Reform: Organizational Implications for the APA

Background

The APA, as a specialty medical organization, serves many essential scientific, educational, and advocacy functions for and/or on behalf of psychiatry and its patients. This occurs both nationally and at state levels.

We have entered into a period of dramatic, rapid, and consequential change in the American healthcare system. Health reform presents a number of significant considerations for the functional activities of the APA. The healthcare environment for patients and physicians will not be business as usual whether we are talking about patient care guidelines, measurement of outcomes and quality, or provider performance. The locus of decision making regarding policy, the complexity of the issues, and the compressed timeframes within which we will need to respond will stretch our resources and governance. While there is and should be legitimate skepticism about the efficacy of any particular changes, it is clear there will be ongoing pressure for change.

The trends and changes in motion will affect the APA membership in various ways. Regardless of whether a psychiatrist's current practice configuration involves her in a small or large way, the question of member readiness and

how the APA can best act in all these domains requires due consideration. Whether at the policy or individual psychiatrist level, how does the APA become essential to the deliberations that will occur across many policy settings and serve its members' various needs?

Findings

The APA internal operations responsible for research, quality, education, and advocacy (advocacy for the purposes of this report encompasses the three offices within the Division of Advocacy—Government Relations, Communications, and Healthcare Systems and Financing) have been very active players in the health reform milieu. Core activities range from continued development of quality measures; responses to a myriad of federal regulations, to state society needs for technical assistance, and to member needs for education on integrated care models; and legislative advocacy for psychiatric manpower development. Through these activities, many, but not all, of the moving pieces of the health reform puzzle are being covered. These activities, however, do not yet have a centrally developed and coordinated strategy based on the APA's priorities and targets concerning health reform.

The APA's governance structure, its various councils and components, mirror internal operations. Most of the pressing health reform issues cut across the areas of expertise based in the various parts of this structure.

The pace of change creates additional pressure and challenges. The APA has an increased need to be able to determine which events are critical and which are not. This includes the need to identify and take action with those entities whose decisions may have a major downstream effect or where we need influence and allies. The ability to have a rapid decision making and action capacity that will enable us to act within the decision-making cycle of other groups is critical.

Monitoring and reporting versus advocacy creates very different problems. Because many of these issues will occur at the state level, but also may be centralized in some in overall federal policy or nationwide non-governmental organizations (NGOs), monitoring, reporting, and executing effective advocacy will tax both resources and governance decision making.

Health reform issues are detailed, complex, and labor intensive to resolve. The nature of the issues APA must respond to are increasingly difficult and often require specialized knowledge/expertise that is not currently possessed by staff and/or cannot be marshaled in a timely manner within the current council/component structure.

Effective communications, advocacy, and technical assistance require new capacity and understanding of what state affiliates need.

Current APA communications efforts, while performing a number of essential functions in priority areas for the APA, do not have a centralized directive regarding health reform issues, or well-honed messaging.

Recommendations

- The APA should establish a set of health reform priority activities (developmental and implementing) consistent with the major findings and recommendations of this report and a strategy/plan of action to implement them.

- The APA should establish an ongoing working group within the current governance structure to oversee this plan of action and regularly report on developments and actions. This should include a plan to ensure a rapid response capability.

- The Medical Director/CEO, under the oversight of the board, should assess how current staff can best be configured to ensure that the functions of this work group are appropriately executed. This should include recommendations concerning additional staff and/or consultant expertise that may need to be retained (with the budget implications). There are various recommendations in other sections of this report that concern internal staffing. These should receive due consideration as part of this effort.

- The APA should develop a communications campaign that addresses how to best advance the APA agenda, internally with it members and

externally with key stakeholder audiences. This campaign will likely require external communications expertise. Psychiatry's value proposition for health reform is not self-evident to key policy/payer audiences and members. Moreover, a fully informed and educated membership will be essential to fulfill the demands for psychiatric services that the APA's agenda embodies.

- A centralized strategy for assistance to the APA's state affiliates will have to be developed.

- Governance implications of these efforts, including the rapid response capability, will need to be carefully and directly assessed.

Item 11.C

Action Item from the DSM Planning Work Group

ACTION 1:
Will the Board of Trustees vote to approve the proposal for the development of a *DSM-5* Primary Care version not go forward as proposed by the Psychiatry-General Medical Interface Study Group?

ACTION 2:
Will the Board of Trustees vote to approve APP continue work on the development of an electronic resource (app) based on DSM, with links to treatment information, to meet needs of diverse practitioners, including primary care physicians?

ACTION 3:
Will the Board of Trustees vote to approve an advisory board be appointed to support APPI's development of the electronic resource, including representatives of primary care specialties, as well as psychiatric experts, reporting back to the DSM workgroup?

ACTION 4:
Will the Board of Trustees vote to approve a moratorium on any APA-initiated proposals for new ICD-10-CM codes?

Background: The DSM Planning Work Group received a proposal from the DSM-5 Psychiatry-General Medical Interface Study Group for the development of a primary care version of DSM-5 (see attachments). After careful consideration, the Work Group recommended that this proposal not move forward, but that an electronic app designed to meet the needs of this group be developed. The reasons for this recommendation are:

1) APP's experience with the DSM-IV Primary Care version was discouraging. Few copies were sold and the book lost money. APP's perspective is that primary care physicians are much less likely to buy books than are psychiatrists; they prefer electronic tools that can be carried with them into the examination room;

2) Dr. Kupfer's interactions with primary care groups around DSM suggested similar conclusions. An electronic app would be more likely to be taken up by primary care physicians than a book, especially if linked to a source of information about recommended treatments;

3) Development costs for the proposed DSM-5 Primary Care would approximate $600,000, an amount unlikely to be recouped by sales;

4) APP already has in process an electronic version of a DSM app that would meet these needs; for treatment-related information, diagnostic criteria could be linked to recommendations in the

APP Textbook of Psychiatry. This is likely to appeal to many psychiatrists in addition to primary care physicians, and thus will have a much broader market;

5) Obtaining input from the relevant primary care specialties during the development process is critical, and can be accomplished by appointing an advisory committee from both psychiatry (including Dr. Wulsin from the Psychiatry-General Medical Interface Study Group) and representatives of primary care groups.

To: Paul Applebaum, MD
Steve Hyman, MD

From: Lawson Wulsin, MD
Chair, Psychiatry-General Medical Interface Study Group

Date: 4/24/13

Re: DSM5 PC

We understand from Drs Kupfer and Regier that your work group will soon review the considerations for funding the development and publishing of the proposed DSM5 PC. We would like to facilitate your deliberations by providing you with a brief summary of the status of the DSM5 PC project and the rationale for supporting it. We volunteer this summary in the hopes that it will help you come to a decision as soon as possible, since, according to APPI, the window of opportunity for this product is at most 2 years from the date of the publication of DSM5. To meet that deadline we should begin the next phase of DSM5 PC this summer.

Rationale

Why should the American Psychiatric Association Board of Trustees vote to invest in the production of *DSM5 PC: A Guide for Psychiatric Diagnosis in Primary Care*?

1) **Serving APA's Vision and Mission**. By facilitating the access of large numbers of clinicians and their patients to state-of-the-art diagnosis of psychiatric disorders, DSM5 PC will play a key role in the APA's efforts to contribute to "a society that has available, accessible quality psychiatric diagnosis and treatment."
2) **Setting the Standard.** DSM5 PC should be the first publication to define the DSM5 approach to mental illness for non-mental health specialists, a far larger group both within the US and globally than those who will use DSM5 as specialists.
3) **Delivering the Message.** DSM5 PC will deliver the message to non-psychiatrists that the assessment of mental illness belongs in primary care and throughout medical settings, as well as in specialty mental health settings. One system of diagnosis that works in both specialist and generalist settings facilitates collaboration across disciplines.
4) **Delivering on a Guiding Principle of DSM5.** From the beginning of the DSM5 planning process, the Task Force has embraced as a guiding principle the necessity to

produce a classification system that works for non-psychiatrists as well as psychiatrists. The mandate of our P-GMI Study Group has been to help implement this principle.

5) **Seizing a Revenue Opportunity.** [*Revise by APPI marketing expert:*The market for DSM5 PC is…]

DSM5 PC Status

We have completed a working draft of the DSM5 PC Introduction, Table of Contents, Chapter Outline, and suggested Appendices (draft attached). The text of each individual chapter (33 chapters total) remains to be drafted from the parent chapters of DSM5.

We have completed a proposal for a feasibility and utility study of the DSM5 PC draft

We have collected preliminary selections of screening and severity measures for use in primary care.

Proposal for Completion of DSM5 PC

We propose the following schedule for completion. P-GMI Study Group, with help of the Adult and Pediatric Advisory Committees, will take the lead in developing the proposal and content:

Summer 2013: 30 chapter revisions for primary care clinicians.
Summer-Fall of 2013: development training plan, including content and format for focus groups and webinar modules, website resources, selection of trainers. Approval by DSM5 Research Committee.
Winter 2013-2014: approval of training materials
Winter-Spring 2014: administer pilot studies, then training events and collect data from clinicians at 3 sites or practice networks for feasibility and clinical utility.
Summer 2014: analyze data and revise DSM5 PC
December 2014: Submit manuscripts and electronic formats
May 2015: publish DSM5 PC

Funding

[Estimate to cover APA staff support for P-GMI Study Group, development of training materials, training trainers, costs of training events, data collection and analysis, publishing of DSM5 PC]

Majority of development costs will be covered by APA Development budget from reserves—to be amortized with DSM5 sales.

Outcomes

[Estimated revenue]

Guide to DSM5 for use by non-specialists: print and digital versions.

Template for developing EMR programs for mental health assessment in primary care.

DSM 5 PC

A Guide for Primary Care Assessment of Mental Disorders

Draft 4/24/13

General Medical Interface Study Group
of the
DSM5 Task Force

DSM5 PC Contents

Panic Disorder

Separation Anxiety

Obsessive-Compulsive and Related Disorders

Unspecified Obsessive-Compulsive Disorder

Trauma and Stress-related Disorders

Adjustment Disorder

Acute Stress Disorder

Posttraumatic Stress Disorder

Somatic Symptom and Related Disorders

Somatic Symptom Disorder

Illness Anxiety Disorder

Eating Disorders

Binge Eating Disorder

Anorexia and Bulimia

Sleep Disorders

Insomnia Disorder

Sexual Dysfunctions

Erectile Disorder

Substance/Medication-Induced Sexual Dysfunction

Unspecified Sexual Dysfunction

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder

Substance Use Disorders

Alcohol Use Disorder

Substance Use Disorder

Tobacco Use Disorder

Neurocognitive Disorders

Delirium

Major and Mild Neurocognitive Disorder

Personality Disorders

Personality Disorders, general

Appendix

Screening and severity monitoring measures
Guidelines for screening in primary care
Stepped care approach
Full list of DSM5 diagnoses and codes
Useful DSM5 resources

Introduction

DSM5 PC provides a guide for primary care clinicians to facilitate the assessment of mental disorders. This guide recognizes that primary care clinicians will vary in their choice of the level of specificity of a mental disorder diagnosis required for optimal care, depending on the clinician's expertise, available treatment resources, and patient preferences. With this guide the clinician can proceed as needed from the least to the most specific level of assessment for mental disorders in primary care.

This guide includes disorder descriptions for 33 of the disorders most commonly seen in primary care. The sequence of sections follows the chapter organization of DSM5 but should not obscure the prominence in primary care of four main groups of disorders: mood disorders, anxiety disorders, somatic disorders, and substance misuse disorders. Approaches to disorders not listed here are described in the introductions to each group of disorders and in the differential diagnosis sections of the specific described disorders. The DSM5 PC disorder descriptions include the DSM5 diagnostic criteria and diagnostic codes, but selected parts of the descriptive text have been modified for the needs of primary care clinicians and non-psychiatric specialists. For easy cross-referencing to DSM5, each DSM5 PC disorder description includes the relevant DSM5 chapter and page numbers.

The organization and content of the DSM5 PC reflect the stepped care process by which most primary care clinicians approach the assessment and management of mental disorders. Beginning with the patient's presenting symptoms or problems, the clinician's initial inquiry, exam, or screening identifies the broad category for a working diagnosis. The decision about whether to further evaluate for greater specificity of diagnosis then depends on the clinician's assessment of factors such as time available, need for referral, the clinician's clarity about differential therapeutics for this disorder, interest in initiating treatment, and the availability of treatments. With more complex problems or treatments, greater specificity of diagnosis is often necessary to provide evidence-based care.

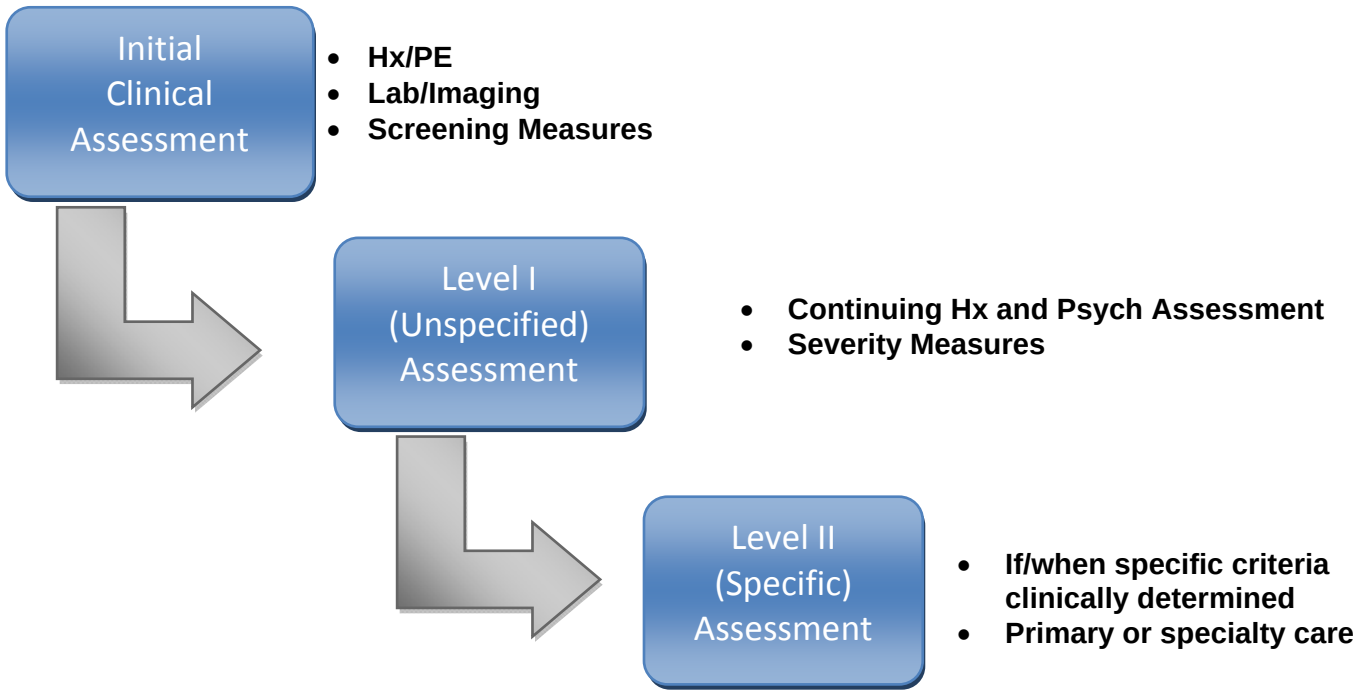
Recommendations in DSM5 PC for screening and severity measures reflect the range of needs in primary care: a) to screen and refer, b) to treat symptoms without specifying the disorder at a five digit level, c) to select a specific treatment for a specific disorder, and d) to monitor the course of a disorder and response to treatment.

The Stepped Care Approach

In contrast to the mental health specialty setting, the primary care setting imposes constraints on time, resources, and competing priorities that demand a stepped care approach for chronic conditions, including mental illness. And primary care clinicians vary widely in their levels of expertise in the management of mental illness. The stepped care approach optimizes the use of scarce resources along a range of expertise levels (See Figure 1).

Given limited resources to address a wide range of clinical conditions, primary care clinicians need to be selective in their choices of assessment interventions. Ready access to brief screening and severity measures is essential to making evidence-based decisions about the need for increasing intensity of treatment. And ready access to appropriate mental health specialists is essential to the process of selecting those who will most benefit from specialty care.

Figure 1 – Stepped Care Overview:



Since primary care clinicians vary in their interest and ability to assess and treat mental illness, the stepped care approach must allow for flexibility in decisions about when to refer to specialty care. For those patients who improve on symptomatic treatment alone, the primary care clinician may choose to continue the initial course, rather than pursuing diagnostic explorations to higher levels specificity. Many patients prefer to begin with symptomatic treatment alone. However, when the follow-up exam and severity measures show the patient is not improving, the clinician then pursues the next steps toward more rigorous diagnostic assessments, modifying treatment plans, and/or consulting a mental health specialist.

The benefits of the effective use of the stepped care approach to the assessment and treatment of mental illness in primary care settings include better clinical outcomes for both the mental illness and the co-morbid medical illnesses, lower total costs, and greater patient and clinician satisfaction. Though the specific steps vary from disorder to disorder, the principles of the stepped care approach apply across all mental disorders and their presenting conditions.

The Assessment Process

In contrast to the approach in mental health specialty settings, the stepped care approach to mental illness in primary care settings encourages clinicians to begin at the non-specific level of presenting symptoms. This level of specificity is best captured in the DSM5 diagnostic terminology by the term “unspecified”. When clinical presentations do not match any diagnosis of higher specificity, the diagnosis should remain at the unspecified level. Consequently, the frequency with which primary care clinicians use unspecified diagnostic codes should greatly exceed the frequency of the use of unspecified codes in specialty settings.

The stepped care approach to clinical diagnosis is broken into three steps (Initial Assessment, Level I Assessment and Level II Assessment) which occur along a continuum. At each step, there are DSM5 PC recommendations for interventions that fit that component of care.

Initial Clinical Interventions

In this phase of assessment, the primary care clinician must quickly gather pertinent information via clinical interview, screening measures, physical exam, mental status assessment and laboratory testing, if indicated. For the pediatric population the objective assessment also may need developmental standardized testing. Based upon these assessments, the clinician can focus initially on ensuring safety, ruling out essential medical comorbidities and treating one or more of the primary chief complaint symptoms (i.e. poor sleep etc). Key tasks at this stage include:

- Attaining a targeted history and physical exam
- Ordering targeted laboratory and imaging studies if indicated
- Performing targeted Screening Measures
- Assessing/ensuring safety
- Assessing environmental stressors including exposure to trauma and loss
- Assessing current functioning including capacity for relationship
- Assessing medical and iatrogenic co-morbidities
- Assigning either a symptom based, Level I or Level II (Specific) DSM5 PC diagnosis

Level I Assessment

In this phase of assessment, the clinician reviews results of data collected during Initial Assessment (i.e. lab data, screening data etc), collects additional clinical information, performs severity measures, and considers results of initial interventions. At this point, if the clinician has insufficient data to make the more specific diagnosis, a general unspecified diagnosis is typically made. Beginning with the patient's presenting symptoms, and incorporating info from the clinician's inquiry, exam and structured screening, the broad unspecified category of diagnosis is most appropriate. Key tasks at this stage include:

- Additional history
- Review laboratory and imaging studies if obtained
- Continuing psychological assessment
- Severity Measures (to support diagnosis and/or monitoring)
- Assigning a Level I DSM5 PC diagnosis

Level II Assessment

Over time, as clinicians continue to collect data and assess responses to treatment, they may choose to make a more specific DSM5 PC diagnosis. This step is usually essential in managing patients who do not respond fully to symptomatic treatment at the Level I specificity.

When symptoms or functioning do not improve or worsen, the clinician should consider diagnosing at a higher level of specificity before modifying the treatment plan. The decision about whether or when to further evaluate to a greater level of diagnostic specificity depends on patient progress, clinic resources, clinician interest or skill set, and patient preferences. Additional factors such as time available, availability of referral, and clarity

about differential therapeutics all contribute to this clinical decision. With more complex problems and treatments, a greater specificity of diagnosis will often be necessary to provide optimal evidence-based care. At this step, decisions about referral to specialty care for additional assessment and treatment interventions often take place. Key tasks at this step include:

- Assess patient progress and treatment preference
- Determine level of comfort with Level I vs Level II DSM5 PC diagnosis
- Determine if specific criteria have been met to make diagnosis of higher specificity
- Assigning a Level II (Specific) DSM5 PC diagnosis if indicated

Development of DSM5 PC

The development of DSM5 PC was guided by several factors. First, the General Medical Interface Study Group of the DSM5 Task Force was assigned the primary responsibility for developing the draft proposal for DSM5 PC. This process, guided primarily by revisions to DSM5 and by the effort to improve on DSM IV PC, aimed to harmonize as much as possible with the parallel efforts of the ICD 11 Primary Care Consulting Group so that DSM5 PC would closely match ICD 11 PC. DSM5 PC contains the relevant ICD 11 codes within each chapter and notes on the remaining salient differences between ICD 11 and DSM5 as they relate to primary care. The Adult Primary Care Advisory Group and the Pediatric Primary Care Advisory Group provided guidance to the General Medical Interface Study Group in the development of the draft proposal for DSM5 PC.

Disorder Descriptions

DISORDER NAME

Short Definition: One line disorder description

Special considerations for primary care and/or medical (non-psychiatric) settings
(previews of what the pc clinician may want to do, including:
steps in moving from low to high specificity of diagnosis
screening vs diagnostic measures
limitations of measures
monitoring considerations
threshold for referring to mental health specialist
resources to consider

Special considerations for low resource settings

Diagnostic Criteria – ICD-10-CM code

Diagnostic Features

Associated Features Supporting Diagnosis

Screening Measures

Severity Measures

Indications and limitations of each recommended measure

Subtypes (common in primary care)

Specifiers (relevant to primary care)

Differential Diagnosis

Prevalence

Development and Course

Risk and Prognostic Factors

Clinical Expression across the Lifespan

Other Age, Gender, and Culture Related Issues

Recording Procedures

Notes on
Related DSM5 codes
Relevant differences from
DSM IV code
ICD 9 code
ICD 11 code

References

Include links to relevant DSM5 chapters

2-3 Refs from parent chapter or elsewhere relevant to this disorder in PC

Item 11.C, Att. 3

Proposal to DSM5 Research Committee

For

Feasibility and Utility Studies of DSM5 PC

(Draft notes from LW 7/19/12; revised 7/20; Motsinger revision 9/25/12; LW revised 10/31/12 and 3/6/13 and 4/24/13)

Problem

There is no data yet on the feasibility and utility of the proposed approach and content of DSM5 PC for use in primary care and specialty medical settings. Prior to the publication of DSM5 PC in 2014 or 2015, it would improve the eventual credibility and acceptance of DSM5 PC to incorporate revisions from systematic field testing with primary care clinicians and selected medical specialists. Feasibility and utility studies ideally should assess both the concept and the product(s).

During several meetings of the Psychiatry-General Medical Interface Study Group in the spring of 2012, the study group selected the following as the most feasible of several options for field testing of the concept:

DSM5 PC Brief Training Module

The essentials of the DSM5 PC guide are presented in a 30 min overview, plus a 30 minute focused Q&A, delivered live or via webinar. Supplemental materials include the DSM5 PC Draft booklet, DSM5 PC website (FAQ's, practice vignettes, blog with experts, etc), copies of screening and severity measures. Qualitative data on feasibility and utility of the DSM5 PC will be collected from participants at the completion of this training.

Proposal

Step 1: Algorithm creation

Simple algorithms for the 2-3 most common primary care diagnoses (depression, anxiety, alcohol misuse) are written for DSM5 PC in formats that can be made into a simple pocket guide, App or integrated into an EMR. These algorithms will include clinical decision support.

This approach would facilitate the concept testing in Step 2 and will allow for practical field-testing of the selected products in Step 3.

Step 2: Concept testing

Through 60-90 minute group sessions with primary care clinicians (focus groups, talks, webinars, CME events, etc) a few aspects of the DSM5 PC concept will be assessed by selected groups of potential users responding to the following questions:

a) **Approach:** How well do the essential elements of the approach as outlined in the Introduction match the practitioner's current or desired approach?

b) Content: Is the list of disorders both short enough and long enough? How well does it cover the common disorders in primary care? Are there any common and important disorders not included?

c) Format: How user-friendly is the organization of the DSM5 PC book, the disorder chapters, the measures, the Appendix?

d) Measures: How useful is the recommended set of Level I and II assessment measures?

While this level of concept testing does not ask the clinician to apply the approach to cases or use it in the clinical setting, it may provide useful revisions before we develop the final form of the products.

Selection of clinicians to participate in concept testing and product testing will be through Practice-based Research Networks (PBRN's). Options include 1) AAFP PBRN, 2) CORNET (Jan Serwint), 3) PROS (Mort Wasserman), 4) DBPNet (Nathan Blum).

Step 3: Product testing

An algorithmic workflow for depression and anxiety will be developed to describe how Level 1 crosscutting measures and level 2 measures could be used to help determine the initial or unspecified diagnosis.

Three products, DSM5 PC booklet (and pocket guide) and a "DSM5 PC app" (an application" for mobile devices and clinical websites), and a possible DSM5 enabled EMR will be used to conduct field-testing of these algorithms. All products may be necessary for eventual wide use of DSM5 PC across the range of clinical settings.

Resources Required

Personnel: project coordinator, trainers (part-time), data manager, AV support as needed, software developer for digital DSM5 PC, data analysis

Funding for

a) personnel

b) incentives for participants (?)

c) travel for trainers

Schedule

Spring-Summer of 2013: initiate 30 chapter adaptations to brief presentation for primary care physicians. Summer-Fall of 2013: begin development of training plan, including content and format for focus groups and webinar modules, website resources, selection of trainers. P-GMI Study Group, with help of Adult and Pediatric Advisory Groups, will take the lead in developing the proposal and content. Approval by DSM5 Research Committee

Winter 2013-2014: approval of training materials

Spring 2014: administer pilot studies, then training events and collect data from clinicians at 3 sites or practice networks for feasibility and clinical utility.

Summer 2014: analyze data and revise DSM5 PC

Submit manuscripts and electronic formats December 2014: publish DSM5 PC, May 2015.

Potential Outcomes

Evidence to support the utility of the final draft of DSM5 PC

Feasibility data on how best to train non-specialists to use DSM5

Item 13.A
Board of Trustees
July 20-21, 2013

Item 2013A1 12.N
Assembly
May 17-19, 2013

ACTION PAPER
FINAL

TITLE: Membership Benefit: Free DSM-5

WHEREAS:
1. Providing each APA Members with a free copy of DSM makes sense, as the APA should conceive of the DSM as a product of all of the Members. Free, not reduced costs, adequately captures the need for all the Members to share in this APA product. AJP is free to Members, and there is no substantial reason to conceptualize DSM as less valuable.

2. We want every APA Member to feel: "I helped develop DSM-5 through being a Member of APA."

3. Providing each Member with a DSM underlies the importance of all psychiatrists having a DSM as a foundation of their practice.

4. In branding "a Member of the American Psychiatric Association," it helps to conceptualize a Member as one who helped develop DSM-5.

5. Providing all Members with a current DSM would be a valuable Member Benefit. In 1997, APA Membership was nearly 44,000. Today, it is less than 34,000. While the 1997 numbers are inflated with trainees who are not Members in 2013, no one questions that there had been a significant decline in APA Membership over the past 15 years. While no single action will reverse this downward spiral, providing a free DSM to all Members should help remind Members of APA's relevance to their practice.

6. Providing a substantial membership benefit can contribute to increased dues income for District Branches.

BE IT RESOLVED:
1] That the electronic version of the full text of DSM-5 be given quid pro quo as a member benefit to all APA Members.

2] That the Speaker move this Action Paper at the May, 2013, Broad of Trustees meeting.

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Catherine May, M.D., DFAPA, APA Member

ESTIMATED COST:
Author: Uncertain
APA: $2,777,175

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: Unknown the degree to which a free DSM-5 will contribute to psychiatrists wanting to be a Member of the APA, which would impact the dues collection of the APA -- and of the DBs – over the years.

ENDORSED BY: Washington Psychiatric Society, Area 3

KEY WORDS: Membership, DSM-5

APA STRATEGIC GOAL: Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT
Has been sent to the APA Membership Committee
Has been sent to the APA Finance and Budget Committee