Assembly
October 30-November 1, 2015
Meeting Materials

PLEASE CLICK ON THE ITEM NUMBER TO VIEW ITEM

Final Agenda

1. Remarks of the Board of Trustees
   - 1.C Treasurer's Report

2. Report of the CEO and Medical Director

3. Report of the Speaker
   - 3.B Reports of the Meetings of the Board of Trustees
     - 3.B.1 Final Summary of Actions, May 2015
     - 3.B.2 Final Summary of Actions, July 2015
     - 3.B.3 Draft Summary of Actions, October 2015

4. Report of the Speaker-Elect
   - 4.A General Report
   - 4.B Report of the Joint Reference Committee
     - 4.B.1 Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV *(approved at the Fall 2015 Assembly)*
     - 4.B.2 Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly *(approved at the Fall 2015 Assembly)*
     - 4.B.3 Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities *(withdrawn)*
     - 4.B.4 Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution- Joint Statement of the APA/AAAP *(approved at the Fall 2015 Assembly)*
     - 4.B.5 Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices *(referred to the JRC)*
     - 4.B.6 Proposed Position Statement: Substance Use Disorders in Older Adults *(approved at the Fall 2015 Assembly)*
     - 4.B.7 Revised Position Statement: Bias-Related Incidents *(approved at the Fall 2015 Assembly)*
     - 4.B.8 Retire 2007 Position Statement: The Right to Privacy *(approved at the Fall 2015 Assembly)*
     - 4.B.9 Retire 2007 Position Statement: Sexual Harassment *(Assembly voted to retain)*
     - 4.B.10 Retire 2009 Position Statement: Inference with Scientific Research and Medical Care *(approved at the Fall 2015 Assembly)*
     - 4.B.11 Revised Position Statement: Hypnosis *(approved at the Fall 2015 Assembly)*

4.B.12 Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury *(approved at the Fall 2015 Assembly)*

4.B.13 Retain 2010 Position Statement on High Volume of Psychiatric Practice and Quality of Patient Care *(approved at the Fall 2015 Assembly)*

4.B.14 Proposed Position Statement on Tobacco Use Disorder *(approved at the Fall 2015 Assembly)*

4.B.15 Retain 2014 Position Statement: Psychotherapy as an Essential Skill of Psychiatrists *(approved at the Fall 2015 Assembly)*

4.B.16 Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment *(approved at the Fall 2015 Assembly)*

5. Report of the Recorder
   - 5.A Minutes of the May 15-17, 2015 Assembly Meeting *(approved at the Fall 2015 Assembly)*
     - 5.A.1 Summary of Assembly Actions, May, 2015 *(approved at the Fall 2015 Assembly)*
   - 5.B List of Members and Invited Guests
   - 5.C Voting
     - 5.C.1 Voting Strength 2015-2016
     - 5.C.2 Audience Response System (ARS) Voting Instructions
     - 5.C.3 Voting and Ballot Process PowerPoint Presentation
   - 5.D Report of the Assembly Executive Committee (AEC) meetings
     - 5.D.1 Report of the AEC meetings, May 2015
     - 5.D.2 Report of the AEC meeting, July, 2015 *(approved at the Fall 2015 AEC meeting)*

6. Report of the Rules Committee
   - 6.A Action Assignments and Reference Committee Rosters
   - 6.B Consent Calendar *(approved at the Fall 2015 Assembly)*
   - 6.C Special Rules of the Assembly *(approved at the Fall 2015 Assembly)*

7. Reports From Assembly Committees –*Assembly Committees may submit reports onsite which would be included in onsite distributions*
   - 7.A Nominating Committee *(no report submitted)*
   - 7.B Committee on Procedures
   - 7.C Committee on Public & Community *(no report submitted)*
   - 7.D Committee of Minority and Underrepresented Groups (*M/URs*) *(no report submitted)*
   - 7.E Committee of Early Career Psychiatrists (*ECPs*) *(no report submitted)*
   - 7.F Committee of Resident-Fellow Members (*RFMs*)
   - 7.G Committee of Representatives of Subspecialties and Sections (*ACROSS*) *(no report submitted)*

8. Reports from APA Councils
    - 8.A Council on Addiction Psychiatry
    - 8.B Council on Advocacy and Government Relations
    - 8.C Council on Children, Adolescents and Their Families
    - 8.D Council on Communications
    - 8.E Council on Geriatric Psychiatry
    - 8.F Council on Healthcare Systems and Financing
    - 8.G Council on International Psychiatry
    - 8.H Council on Medical Education and Lifelong Learning
    - 8.I Council on Minority Mental Health and Health Disparities
    - 8.J Council on Psychiatry and Law
    - 8.K Council on Psychosomatic Medicine
    - 8.L Council on Quality Care
      Memo RE: Approval of New APA Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia
      (The Assembly voted to approve the New Practice Guideline.)
    - 8.M Council on Research

9. Standing Committees *(no reports submitted)*

10. Reports from Special Components
    - 10.A AMA APA Delegation
    - 10.B Work Group on Access to Care
    - 10.C Work Group on Maintenance of Certification

11. Reports from Area Councils
    - 11.A Area 1 Council
    - 11.B Area 2 Council *(no report submitted)*
    - 11.C Area 3 Council
    - 11.D Area 4 Council *(no report submitted)*
    - 11.E Area 5 Council *(no report submitted)*
    - 11.F Area 6 Council
    - 11.G Area 7 Council

12. Action Papers

APPROVED

12.A Access to Care Provided by the Department of Veterans Affairs

12.B Directions to the Area Nominating Committees

12.D Prior Authorization

12.E Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product

12.F Payer Coverage for Prescriptions from Nonparticipating Prescribers

12.G APA Support for NIMH Funding of Clinical Research

12.I Strengthening the Role of Residency Training to Improve Access to Buprenorphine

12.K Equality in Permanent Licensure Policy

12.L Partial Hospital Training in Psychiatry Residency

12.N Advocating for Medicaid Expansion

12.O Systems to Coordinate Psychiatric Inpatient Bed Availability

12.P Making Access to Treatment for Erectile Disorder Available Under Medicare

12.T Election of Assembly Officers

FAILED

12.C New Names for Psychiatric Conditions

WITHDRAWN BY THE AUTHOR

12.J Need to Gather Information on Physician Health Program (PHP) Performance

12.M Addressing the Shortage of Psychiatrists

12.S Need for Position-Specific Email Addresses for Leadership Roles in the APA

REFERRED

12.H Is It Ethical For A Psychiatrist to Serve as a Utilization Management Reviewer When Review Standards Fail to Comply With Parity?

12.R Senior Life Psychiatrist Seat on the Board of Trustees (BOT)

NOT MOVED BY THE AUTHOR

12.Q Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations

13. Old/Unfinished Business

14. New Business
14.A: Revised Position Statement on Telemedicine in Psychiatry
(approved at the Fall 2015 Assembly)

15. Other

American Psychiatric Association

Assembly

Regency Ballroom, Lower Level, West
Omni Shoreham, Washington, D.C.
October 30-November 1, 2015

FINAL AGENDA

1st PLENARY— FRIDAY, October 30, 2015, 2:00 PM- 3:00 PM

2:00 p.m. **Call to Order- 83rd Meeting of the APA Assembly** — Glenn Martin, MD, Speaker

2:05 p.m. **Speaker's Welcome and Report** — Glenn Martin, MD, Speaker

Introduction of New Assembly Members
Glenn Martin, MD, Daniel Anzia, MD, and Theresa Miskimen, MD

2:25 p.m. **5. Report of the Recorder** — Theresa Miskimen, MD

Quorum Declaration

A. Minutes of the previous Assembly meeting
Action: Will the Assembly vote to approve the minutes of its May 15-17, 2015 meeting?

B. List of Members and Invited Guests (*see written report for information*)

C. Voting Strength (*see written report for information*)
1. **Voting strength for November 2015 and May 2016**
2. **Electronic Voting**

D. Reports of the Assembly Executive Committee (*see written reports for information*)
1. **AEC meeting notes, May 15 and May 18, 2015**
2. **AEC meeting notes, July 24-26, 2015**

cc Indicates item is on the Draft Consent Calendar

1st PLENARY — FRIDAY, October 30, 2015, 2:00 PM- 3:00 PM- CONTINUED

2:45 p.m. **6. Report of the Rules Committee** — Jenny L. Boyer, MD, JD, PhD, Chair

A. Action Assignments & Reference Committee Rosters (*see written report for information*)

B. Consent Calendar

1. Request to remove items from and add items to the Consent Calendar
   Action: Will the Assembly vote to approve the Consent Calendar?

C. Special Rules of the Assembly

Action: Will the Assembly vote to approve the Special Rules of the Assembly?

3:00 p.m. **Recess**

3:00 p.m.- 6:00 p.m. **Reference Committee Meetings**

1: Advancing Psychiatry — Congressional Room A, Lobby Level, West

2: Supporting Research — Congressional Room B, Lobby Level, West

3: Education & Lifelong Learning — Council Room, Lobby Level, West

4: Diversity & Health Disparities — Senate Room, Lobby Level, West

5: Membership & Organization — Forum Room, Lobby Level, West

cc Indicates item is on the Draft Consent Calendar

2nd PLENARY — SATURDAY, October 31, 2015, 10:30 AM- 12:00 noon

10:30 a.m. **Report of the APA President-Elect** — Maria Oquendo, MD

10:40 a.m. **4.** **Report of the Speaker-Elect** — Daniel Anzia, MD

B. Reports of the Meetings of the Joint Reference Committee
(*see written reports for information*)

1. **Joint Reference Committee, Summary of Actions, July 2015**
2. **Joint Reference Committee, Draft Summary of Actions, October 2015**

10:45 a.m. **2.** **Report from the APA CEO and Medical Director** — Saul Levin, MD, MPA

12. Action Papers/Items

11:05 a.m. **Reference Committee 1** — Robert Roca, MD, MPH, Chair

Advancing Psychiatry

cc	2015A2 4.B.16	Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment
	2015A2 12.A	Access to Care Provided by the Veterans Administration
	2015A2 12.B	Directions to the Area Nominating Committees
	2015A2 12.C	New Names for Psychiatric Conditions
cc	2015A2 12.D	Prior Authorization

11:25 a.m. **Reference Committee 2** — Mary Ann Schaepper, MD, Chair

Supporting Research

cc	2015A2 4.B.4	Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP
	2015A2 12.E	Ad Hoc Work Group to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product
	2015A2 12.F	Payer Coverage for Prescriptions from Nonparticipating Prescribers
	2015A2 12.G	APA Support for NIMH Funding of Clinical Research
	2015A2 12.H	Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?

11:45 a.m. **1.C** **Report on APA Finances**
1.C. Treasurer — Frank Brown, MD, Treasurer

12:00 pm — 12:55 pm Assembly Luncheon — Ambassador Ballroom, Lower Level, West

cc Indicates item is on the Draft Consent Calendar

3rd PLENARY — SATURDAY, October 31, 2015, 1:00 PM- 3:00 PM

1:00 p.m. **7. Report from Assembly Committees**

A. Nominating Committee — Jenny L. Boyer, MD, JD, PhD, Chair

Opportunity to nominate "from the floor"

1:10 p.m. **Out of Sight, Out of Mind: The Mass Incarceration of American Mental Illness** — Paul Burton, MD, Chief Psychiatrist, San Quentin State Prison

1:45 p.m. **Report of the APA President** — Renée Binder, MD

12. Action Papers/Items — continued

2:00 p.m. **Reference Committee 3** — Jacob Behrens, MD, Chair

Education & Lifelong Learning

cc	2015A2 4.B.3	Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities
	2015A2 12.I	Strengthening the Role of Residency Training to Improve Access to Buprenorphine
	2015A2 12.J	Need to Gather Information on Physician Health Program (PHP) Performance
	2015A2 12.K	Parity in Permanent Licensure Policy
	2015A2 12.L	Partial Hospital Training in Psychiatry Residency

2:20 p.m. **Reference Committee 4** — Kenneth Certa, MD, Chair

Diversity & Health Disparities

cc	2015A2 4.B.6	Proposed Position Statement: Substance Use Disorders in Older Adults
	2015A2 12.M	Addressing the Shortage of Psychiatrists
cc	2015A2 12.N	Advocating for Medicaid Expansion
	2015A2 12.O	Systems to Coordinate and Optimize Psychiatric Inpatient Bed Availability for Referral of Psychiatric Emergencies
	2015A2 12.P	Making Access to Treatment for Erectile Disorder Available under Medicare

2:40 p.m. **Reference Committee 5** — Melvin P. Melnick, MD, Chair

Membership & Organization

cc	2015A2 4.B.14	Proposed Position Statement on Tobacco Use Disorder
	2015A2 12.Q	Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations
	2015A2 12.R	Senior Psychiatrist Seat on the Board of Trustees (BOT)
cc	2015A2 12.S	Need for Position-Specific Email Addresses for Leadership Roles in the APA
	2015A2 12.T	Election of Assembly Officers

cc Indicates item is on the Draft Consent Calendar

3rd PLENARY — SATURDAY, October 31, 2015, 1:00 PM- 3:00 PM - CONTINUED

3:00 p.m. **Recess of Plenary**

3:15 p.m. - 4:15 p.m. **Assembly Work Group and Committee Meetings**
Assembly Work Group on Access to Care: Congressional Room A, Lobby Level West
Assembly Work Group on Metrics: Congressional Room B, Lobby Level, West
Assembly Work Group on Maintenance of Certification: Empire Room, Lower Level, West
Assembly Work Group on ASM/Foundation Initiatives: Executive Room, Lobby Level, West
Assembly Committee on Public & Community Psychiatry: Cabinet Room, Lobby Level, West

4:30 p.m. - 6:00 p.m. **Area Council Meetings**
Area 1: Congressional Room A, Lobby Level, West
Area 2: Congressional Room B, Lobby Level, West
Area 3: Cabinet Room, Lobby Level, West
Area 4: Palladian Room, Lobby Level, West
Area 5: Empire Room, Lower Level, West
Area 6: Senate Room, Lobby Level, West
Area 7: Executive Room, Lobby Level, West

6:00 p.m. - 7:30 p.m. **Assembly Reception** — Ambassador Ballroom, Lower Level, West

cc Indicates item is on the Draft Consent Calendar

4th Plenary — SUNDAY, November 1, 2015, 8:00 AM- 11:00 AM

8:00 a.m. **Profile of Courage Presentation** — Melinda Young, MD, Chair, Assembly Awards Committee

8:30 a.m. **2016 APA Annual Meeting Atlanta, Georgia**
Steve Koh, MD, Chair, APA Scientific Program Committee
Heather Turner, National Sales Manager, Atlanta Conventions & Visitors Bureau

8:45 a.m. **12. Action Papers/Items — continued**

Area Council and Assembly Group Action Assignments

	2015A2 8.L.1	APA Practice Guideline: Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia All Areas/Groups: Primary – Area 4, Secondary – RFMs
cc	2015A2 4.B.1	Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV All Areas/Groups: Primary – Area 1, Secondary – Area 3
cc	2015A2 4.B.2	Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly All Areas/Groups: Primary – ACROSS, Secondary – Area 4
cc	2015A2 4.B.5	Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices All Areas/Groups: Primary – Area 5, Secondary – Area 7
cc	2015A2 4.B.7	Revised Position Statement: Bias-Related Incidents All Areas/Groups: Primary – ECPs, Secondary – Area 2
cc	2015A2 4.B.8	Retire 2007 Position Statement: The Right to Privacy All Areas/Groups: Primary – RFMs, Secondary – Area 6
cc	2015A2 4.B.9	Retire 2007 Position Statement: Sexual Harassment All Areas/Groups: Primary – Area 7, Secondary – M/URs
cc	2015A2 4.B.10	Retire 2009 Position Statement: Interference with Scientific Research and Medical Care All Areas/Groups: Primary – Area 6, Secondary – Area 1
cc	2015A2 4.B.11	Revised Position Statement: Hypnosis All Areas/Groups: Primary – Area 2, Secondary – RFMs
cc	2015A2 4.B.12	Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury All Areas/Groups: Primary – Area 5, Secondary – ECPs
cc	2015A2 4.B.13	Retain 2010 Position Statement on High Volume Psychiatric Practice and Quality of Patient Care All Areas/Groups: Primary – Area 3, Secondary – ACROSS
cc	2015A2 4.B.15	Retain Position Statement: Psychotherapy as an Essential Skill of Psychiatrists All Areas/Groups: Primary – M/URs, Secondary – Area 5

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4th Plenary — SUNDAY, November 1, 2015, 8:00 AM- 11:00 AM- CONTINUED

9:05 a.m. **7.** **Report from Assembly Committees**

A. Assembly Committee on Procedures — A. David Axelrad, MD, Chair

9:25 a.m. **Report from the APA Political Action Committee (APA*PAC*)** — Charles Price, MD, Chair

9:40 a.m. **Next Steps from the Assembly Work Groups/Committees**

10:00 a.m. **10.** **Report of Special Components**

A. AMA APA Delegation — Carolyn Robinowitz, MD, Senior Delegate

10:10 a.m. **Report from the American Psychiatric Association Foundation** — Saul Levin, MD, MPA, Chairperson/Chief Executive Officer and Medical Director & Paul Burke, Executive Director

10:20 a.m. **Summary and Next Steps** — Glenn Martin, MD, Speaker

10:40 a.m. **Unfinished Business** (if not addressed earlier on the Assembly floor)

10:45 a.m. **New Business**

2015A2 14.A Revised Position Statement: Telemedicine in Psychiatry
All Areas/Groups: Primary – Area 5, Secondary – Area 7

11:00 a.m. **Adjournment**

******ACTION PAPER DEADLINE FOR MAY ASSEMBLY: March 24, 2016**

Future Meeting:
May Assembly
May 13-15, 2016, Atlanta, Georgia

cc Indicates item is on the Draft Consent Calendar

Item 1.C
Assembly
October 30 -November 1, 2015

American Psychiatric Association

Treasurer's Report

For the Eight Months Ended

August 31, 2015

The financial summary that follows is for the eight months ended August 31, 2015. After eight months, net income is $8.3 million, compared to an annual budget of negative $3.2 million. At the same time last year, the net income was $14.4 million. The decline in net income is attributable to the expected declines in DSM sales and lower attendance at the Annual Meeting, both of which were anticipated in the 2015 budget.

We have completed 67% of the year; however, with the exception of salaries and rent, most our income and expense streams are not straight line so each category was not expected to be at 67%. Total unrestricted operating revenue is at 76% of budget, or $37.9 million.

Membership revenue is at 95% of budget, or $11.4 million, a slight increase over the $11.3 million at this point in 2014. Continuing Medical Education revenue is at 92% of budget, or $9.4 million, a decline of $2.5 million over this point in 2014. The decline is attributable to reduced attendance at the Annual Meeting, which was anticipated in the 2015 budget. Non-DSM publishing is right on target at $10.6 million, or 67% of budget, while DSM revenue is 51% of the annual budget and is projected to end the year at $1.9 million less than budgeted.

Total operating (unrestricted) expenses are at 60% of budget, or $32.0 million, a decrease of $1.9 million from this time last year. The decline is attributable in large part to lower costs associated with lower DSM sales and lower attendance at the Annual Meeting. The majority of expense lines are below budget, in large part due to vacant positions throughout the year (See attached Income Statement).

Current projections indicate that APA will end the year $.5 million ahead of budget.

The balance sheet remains strong with net assets of $87.4 million, cash of $10.3 million and investments of $75.2 million (See attached Balance Sheet).

American Psychiatric Association

Statement of Activities

For the Eight Months Ending August 31, 2015

($ in thousands)

	August 2014 YTD Actual	August 2015 YTD Actual	Year-to Year Change	2015 Annual Budget	Variance to Annual Budget
UNRESTRICTED REVENUE:					
Membership					
Membership Dues	$9,211	$9,112	($99)	$9,765	($653)
Insurance Program	1,323	1,740	417	1,595	145
APA Job Bank	612	550	(62)	700	(150)
APA Store	6	0	(6)		0
List Sales	49	58	9	60	(2)
Board Funds	110	0	(110)		0
Membership Subtotal	**11,311**	**11,460**	**149**	**12,120**	**(660)**
Advocacy					
PAC	4	8	4	8	0
Advocacy Leadership Conference	10	7	(3)	16	(9)
Healthcare Systems & Financing					
Advocacy Subtotal	**14**	**15**	**1**	**24**	**(9)**
Communications					
Let's Talk Facts	21	4	(17)	0	4
Communications Subtotal	**22**	**4**	**(17)**	**0**	**4**
Publishing					
American Journal of Psychiatry	3,505	3,324	(181)	5,140	(1,816)
Journal of Psychiatric Services	653	530	(123)	920	(390)
Psychiatric News	2,839	2,561	(278)	3,643	(1,082)
Books	3,716	2,951	(765)	5,637	(2,686)
Specialty Journals	198	183	(15)	326	(143)
Psychiatry Online	349	900	551		900
Electronic Publishing	42	55	13		55
Legacy content	139	70	(69)	25	45
Publishing Subtotal	**11,441**	**10,574**	**(867)**	**15,691**	**(5,117)**
DSM					
DSM IV	125	59	(66)		59
DSM 5	10,600	6,064	(4,536)	11,900	(5,836)
DSM Subtotal	**10,725**	**6,123**	**(4,602)**	**11,900**	**(5,777)**
Continuing Medical Education					
Annual Meeting	10,762	8,066	(2,696)	7,995	71
CME Products and Accreditation	150	279	129	415	(136)
Institute on Psychiatric Services	188	248	60	482	(234)
Focus Journal	815	784	(31)	1,336	(552)
Continuing Medical Education Subtotal	**11,915**	**9,377**	**(2,538)**	**10,228**	**(851)**
Research					
Practice Guidelines	67	86	19	107	(21)
Research Subtotal	**67**	**86**	**19**	**107**	**(21)**
Other Income					
Miscellaneous Income	4	252	248	5	247
Other Income Subtotal	**4**	**252**	**248**	**5**	**247**
Total Unrestricted Revenue	**45,499**	**37,891**	**(7,607)**	**50,075**	**(12,184)**
UNRESTRICTED EXPENSES:					
Membership Direct Expenses Subtotal	1,791	1,794	3	2,902	(1,108)
Advocacy Subtotal	1,279	1,733	454	3,273	(1,540)
Communications Subtotal	915	1,031	116	1,940	(909)
Publishing Subtotal	4,378	4,401	23	6,826	(2,425)
Publishing Overhead Subtotal	3,699	3,379	(320)	5,409	(2,030)
DSM Subtotal	3,110	2,627	(483)	4,706	(2,079)
Continuing Medical Education Subtotal	5,463	4,169	(1,294)	5,422	(1,253)
Policy, Programs, and Partnerships Subtotal	2,830	2,614	(216)	5,964	(3,350)
Operations					

Division of Operations	218	268	50	487	(219)
APA Answer Center	89	78	(11)	151	(73)
Human Resources	597	703	106	645	58
Information Technology	1,780	2,238	458	3,655	(1,417)
Association Mgmt System	273	152	(121)	253	(101)
Association Governance Office	511	523	12	851	(328)
Operations Subtotal	**3,468**	**3,962**	**494**	**6,042**	**(2,080)**
Foundation Subtotal	290	290	0	419	(129)
Administration Subtotal	5,584	4,825	(759)	8,305	(3,480)
Organization-Wide Expenses Subtotal	(651)	(343)	308	(850)	507
Governance & Components Expenses Subtotal	1,650	1,468	(182)	2,858	(1,390)
Total Unrestricted Expenses	**33,806**	**31,950**	**(1,856)**	**53,216**	**(21,266)**
Unrestricted Operating Net Income/(Loss)	**11,693**	**5,941**	**(5,751)**	**(3,141)**	**9,082**
Total Temp Restricted Revenue	43	58	15	150	(92)
Total Temp Restricted Expenses	142	96	(46)	215	(119)
Temp Restricted Net Income/(Loss)	**(99)**	**(38)**	**61**	**(65)**	**27**
NON-OPERATING ACTIVITY:					
Investment Income - LT	2,814	2,445	(369)	85	2,360
Investment Income - ST	3	3	0		3
Less: Portfolio Management Fees	(38)	(50)	(12)	(85)	35
Non-Operating Income/(Loss)	**2,779**	**2,398**	**(381)**	**0**	**2,398**
Income Statement Summary					
Unrestricted Operating Net Income/(Loss)	**11,693**	**5,941**	**(5,751)**	**(3,141)**	**9,082**
Temp Restricted Net Income/(Loss)	**(99)**	**(38)**	**61**	**(65)**	**27**
Non-Operating Income/(Loss)	**2,779**	**2,398**	**(381)**	**0**	**2,398**
Total Net Income (Loss)	**14,373**	**8,301**	**(6,071)**	**(3,206)**	**11,507**
Reconciliation of Net Income to Budget					
Net Income per Financial Statements	**14,373**	**8,301**	(6,072)	**(3,206)**	**11,507**
Less Investment Earnings	**(2,779)**	**(2,398)**	381	**0**	**(2,398)**
Add Contribution from Reserve Fund	**0**	**2,800**	2,800	**2,800**	**0**
Add Board-Authorized Transfers					
Government Relations	**0**	**238**	238	**300**	**(62)**
Other					
Net Budget Performance	**11,594**	**8,941**	**(2,653)**	**(106)**	**9,047**

ANNUAL MEETING - INCLUDED IN DETAIL ABOVE					
Annual Meeting Revenue	*10,762*	*8,202*	*(2,560)*	*8,165*	37
Annual Meeting Direct Expense	*4,799*	*3,322*	*(1,477)*	*4,011*	(689)
Net Annual Meeting Profit	**5,963**	**4,880**	**(1,083)**	**4,154**	**726**

American Psychiatric Association

Statements of Financial Position

For the Period Ending Augsut 31,

($ in thousands)

	August 2014 Actual	December 2014 Actual	August 2015 Actual
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$2,078	$6,598	$10,344
Accounts Receivable, Net	6,593	6,016	2,712
Advances to Affiliates	1,068	1,637	735
Publications Inventory, Net	1,263	1,661	1,374
Prepaid Expenses and Other Current Assets	1,682	847	1,057
Total Current Assets	*12,684*	*16,759*	*16,222*
Investments in Marketable Securities	71,284	72,942	75,160
Property and Equipment, Net	2,128	2,209	2,085
Intangible	3,744	2,600	2,463
Development Costs	9,724	9,206	8,102
TOTAL ASSETS	***99,564***	***103,716***	***104,032***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	5,751	10,074	8,526
Dues Payable (DB & Other)	238	1,183	258
Deferred Revenue:			
Membership Dues	76	4,777	87
Grants and Contracts	0	0	0
Other	4,696	7,358	6,760
Total Current Liabilities	*10,761*	*23,392*	*15,631*
Deferred Rent Liability	1,272	1,174	976
TOTAL LIABILITIES	*12,033*	*24,566*	*16,607*
NET ASSETS			
Unrestricted, Undesignated	37,595	24,856	33,194
Unrestricted, Designated	49,184	53,525	53,500
Temporarily Restricted	752	769	731
TOTAL NET ASSETS	*87,531*	*79,150*	*87,425*
TOTAL LIABILITIES AND NET ASSETS	***99,564***	***103,716***	***104,032***

Report of the

CEO and Medical Director

to the

APA Assembly

October 29- November 1, 2015

Omni Woodley Park
Washington, DC

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EXECUTIVE SUMMARY

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

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

APA has filled a number of key positions that are critical to advancing the strategic initiatives.

Dave Keen joined APA as Chief Financial Officer on August 24. Dave came to the APA from the National Association of Counties and Affiliates (NACo) – a $24M multi-entity organization that includes a 501(c)(6) Association, (c)(3) Foundation, and a for-profit subsidiary. Dave's 20+ years experience in the tax-exempt sector has placed him in many roles – as auditor, tax preparer, advisor, Finance Officer, and Board member – with responsibilities for many areas beyond finance, including strategy and planning, technology, human resources, and more recently business development.

Karen Kanefield started on July 27 as APA's Practice Guidelines Program Director. Karen has over 15 years of experience in mental health professional education. Prior to her appointment at the APA, Karen served as the Director of Training and Accreditation at the American Association of Suicidology (AAS). In that role, she was responsible for all of the association's professional training programs as well as all DoD and VA training contracts. Prior to AAS, Karen was the Director of Training and Professional Development for the American Association for Geriatric Psychiatry, and was also with the American Psychological Association for over 11 years as the Director of the continuing education provider approval program.

Brian Smith is APA's new director of State Government Affairs and started on August 3. Brian came to APA from Hospira, Inc., the world's leading provider of injectable drugs, infusion medical device technologies, and medication management systems. In representing the $15 billion public company before state legislative bodies, Brian's duties included identification and cultivation of allies, public affairs coordination, and legislative strategy – including leadership of a sophisticated campaign to pass model biosimilar legislation in 23 states. He has more than two decades of experience in government affairs, public affairs campaigns, and grassroots strategy. He previously served as Deputy Vice President of Public Affairs & Alliance Development at the Pharmaceutical Research and Manufacturers of America (PhRMA) for more than 7 years. There he managed the organization's regional directors, outreach budgets totaling over $6M, and consulting teams for 50 states.

As the association moves into 4Q 2015, APA will continue to focus on strategic issues, pursue more partnership opportunities, and continue to serve the needs and enhance the experience of APA members.

Advancing the Integration of Psychiatry

APA Comments to Centers for Medicare and Medicaid Services (CMS) on Long-Term Care: CMS recently released a comprehensive overhaul of long-term care facility requirements. This is the first amendment of its scale and scope in nearly 20 years, and the proposed regulations outline a slew of new quality and ethics rules for facilities that participate in the Medicare and Medicaid programs. Among many other provisions, the proposed rule touches on staffing adequacy and training, psychotropic medication administration and oversight, the discharge process, and a variety of lifestyle issues. The APA filed comments on September 14 that address areas of interest including behavioral health care service requirements, pharmacy services, administration and oversight of psychotropic medication provisions (including the expansion of requirements related to antipsychotic administration to all psychotropic medications), transitions of care, resident assessments, and comprehensive person-centered care planning. The comments can be read here.

Advocacy

***Insurance Industry Consolidations*:** With the flurry of announced mergers in the health insurance industry this year, the APA Administration has focused its attention on how these proposed consolidations would impact physician practices and access to care for our patients. Concerns that are under discussion include the likely influence that a highly concentrated insurance industry could wield, including implications for network adequacy, pricing power, parity compliance, and criteria for treatment coverage. The proposed major mergers have generated an APA assessment of consolidation implications for psychiatry and our patients. APA is working closely with our house of medicine colleagues to advocate for appropriate access to treatment and promote nondiscriminatory coverage of psychiatric disorders. On September 9, the APA transmitted a letter to the Department of Justice Antitrust Division which outlined these concerns. In response, the Department of Justice has asked to meet with members of the APA Administration to further discuss these issues.

Comprehensive Mental Health Reform: Momentum continues to build for congressional action on comprehensive mental health reform (CMHR). On June 4, Representative Tim Murphy (R-PA), chairman of the powerful House Energy and Commerce Subcommittee on Oversight and Investigations, and Representative Eddie Bernice Johnson (D-TX) introduced a refined version of their CMHR legislation, "The Helping Families in Mental Health Crisis Act of 2015" (H.R. 2646). The bill quickly gathered 105 co-sponsors, including 29 Democrats, prior to the August Congressional recess.

On August 5, Senators Bill Cassidy, M.D. (R-LA) and Christopher Murphy (D-CT) introduced a strikingly similar comprehensive reform bill, "the Mental Health Reform Act of 2015." Although Congress left town the next day, Senators Susan Collins (R-ME), David Vitter (R-LA), Debbie Stabenow (D-MI), and Al Franken (D-MN) immediately signed on as cosponsors. Both bills are now under consideration by the leadership of the key House and Senate committees, with particularly active negotiations underway in

the House Energy and Commerce Committee – and with the APA Administration deeply involved as appropriate. Despite these advances, we do not expect formal House committee consideration to occur until the key Democratic ranking members are satisfied that their concerns with several aspects have been addressed, including their objections to the creation of an Assistant Secretary for Mental Health, modifying HIPAA, and several other provisions. Similarly, the leadership of the Senate committee intends to move a smaller package of reauthorizations for existing federal mental health programs before beginning CMHR negotiations. The APA Administration continues to prioritize our workforce, parity, clinical leadership, research funding, and other goals for any resulting legislation. We are actively engaged in both grassroots advocacy in support of CMHR and partnering with APA's District Branches/State Associations (DB/SAs) to encourage cosponsorship of these bills and the advancement of CMHR through Congress.

Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation and Enforcement: The APA's divisions of Government Relations and Healthcare Systems Financing continue to promote the need to fulfill the promise of parity through our work with the relevant Executive Branch agencies in addition to promoting parity enforcement on the Hill. As you know, CMHR efforts in both chambers contain strong parity enforcement provisions. The Murphy-Johnson bill contains provisions that would require de-identified parity compliance reporting from the relevant Departments as well as a mandated report from the Government Accountability Office concerning federal efforts to implement the law. The Cassidy-Murphy Senate-side bill contains these provisions, as well as additional parity enforcement language that would give relevant Departments randomized audit authority to ensure compliance of MHPAEA by the plans. Further, the advocacy team is working with Rep. Joe Kennedy (D-MA), who sits on the Energy and Commerce Subcommittee on Health, to advance his plan to introduce robust parity enforcement legislation in September. The APA will continue to devote significant lobbying resources to pushing the organization's parity priorities.

State Advocacy Leadership Conference: After a 15-year hiatus, the APA is bringing back the State Advocacy Leadership Conference this October. There will be 45 DBs/SAs participating at the conference. The goal of the Florida event is to mobilize state psychiatric leadership in order to address top legislative and regulatory priorities related to mental health and psychiatric practice. APA members in attendance will have the opportunity to share best practices regarding our scope of practice and parity implementation priorities – and will be provided training and guidance on effective legislative lobbying strategies, winning communication plans, and successful ways to navigate regulatory obstacles.

Diversity

All Fellows Orientation: On September 10, for the first time, the Division of Diversity and Health Equity (DDHE) held an all-day meeting with all APA fellows from the seven APA fellowships – Minority Fellowship Program (Diversity Leadership and SAMHSA funded), Public Psychiatry, American Psychiatric Leadership, Child/Adolescent, Research scholars and fellows, and Jeanne Spurlock Congressional Fellowship. This was put together after significant feedback from alumni, membership, current fellows. A core committee, under Ranna Parekh, MD, MPH, was created in the summer soon

after the decision to consolidate all fellowships under DDHE. This committee included, among others, UK Quang-Dang, MD, MS; Erik Vanderlip, MD, MPH; Vanessa Torres, MD; Auralyd Padilla, MD; and Francis Lu, MD. Throughout the day, over 110 fellows heard from APA leadership on the importance of mentorship, how to take advantage of opportunities throughout your career, and the importance all the residents have in being a part of the APA fellowship program. They learned about the governance of APA, the importance of advocacy through grassroots involvement, communication, and partnerships as well as how research principles can help throughout their career.

APA/White House Diversity Conference Planning: APA is planning and co-sponsoring a conference with the White House Office of Science and Technology, General Motors, and the University of Ohio on best practices in cultural competency/sensitivity training. The program will include representatives from the business industry, health, and technology. The conference is expected to take place the first week of December.

Education

***NIDA Contract to Develop a Model Curriculum Toolkit*:** The Division of Education has received $40,000 from NIDA to fund a toolkit development project focusing on substance abuse education. NIDA has funded several online education initiatives with limited uptake by the medical education community. The APA will create an ad hoc editorial board to review these outside programs and to assemble them into a toolkit which educators can pick and choose from in deciding how to best apply the various components in their work with residents or medical students. The editorial board will consist of members from CMELL, the Council on Addictions, and outside experts. The group will look to disseminate the findings of this project at the APA Annual Meeting and other educator conferences.

IPS: The Mental Health Services Conference: IPS registration is now exceeding the level from last year. As of September 21, two weeks before IPS, there are 1,158 professional registrations (does not include exhibitors, press, or staff) for 2015 (NYC), as compared to 2014 when there were 989 for the San Francisco meeting, and 2013 when there were 848 registrations for the Philadelphia meeting. In 2012, IPS in New York had a final registration report of 1,597. We expect registration numbers will continue to increase as we get closer to the meeting and with onsite registration.

Transition to ICD-10: As of October 1, all HIPAA-covered entities must transition from using ICD-9 codes to using ICD-10 codes. The APA Administration began a robust communications campaign to educate our members and allied behavioral health and primary care providers on these changes. We have developed a question and answer guide on how to use the DSM-5 when transitioning to ICD-10, as well as a 5-minute video that clarifies how the ICD-10 codes are included in the DSM-5. We have also communicated with members over the web, email, social media, Psychiatric News and a mini advertising campaign. Click here to access the video on our website. DSM-5 uses ICD-10 codes and not any other DSM coding system.

Launch of #IAmPsychiatry YouTube contest: In July, APA with the American Association of Directors of Psychiatric Residency Training (AADPRT), Association of Directors of Medical Student Education in

Psychiatry (ADMSEP), and PsychSIGN launched a contest on YouTube. This initiative is a pilot project that came from the Board of Trustees' Healthcare Reform Report. The main audience is medical students and the goal of this project is to inspire and express pride in being a psychiatrist, celebrate a diverse picture of who goes into psychiatry, why they chose this career, and what they find the most fulfilling and energizing about their role – in a creative and engaging way. Winning videos will be featured on the APA, AADPRT, and ADMSEP websites. We received 6 submissions and the winning video will also be played at IPS: The Mental Health Services Conference in New York City. In addition, two $250 gift cards to the APA Publishing Bookstore will be awarded to the entries deemed "most creative" and "most inspiring."

Supporting Research

Federal Support for Psychiatric Research: APA continues to lobby for enhanced federal funding for psychiatric research activities within the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). As you will recall, one of the key APA priorities in our CMHR lobbying is the proposed $40M annual authorized funding increase for NIMH for the purposes of research on the determinants of self and other-directed violence as well as for the NIMH Brain Initiative. The APA also continues to promote funding for these institutes through the Congressional appropriations process. While Hill appropriators remain limited by the "Budget Control Act of 2011" spending caps and sequestration, both House and Senate appropriations bills include significant increases for NIH's budget. Separately, the House "21st Century Cures" initiative would establish a new mandatory $1.75 billion per year NIH funding increase in addition to proposed FDA reforms, although the proposed funding mechanism remains quite controversial. The APA will continue to push for enhanced federal support of vital psychiatric research activities.

Search for APA Publishing, Books Editor-in-Chief: The Search Committee has met and reviewed potential candidates for recruitment. The application deadline is October 31. Candidates will be evaluated online and selected for interview prior to making a final recommendation. The Search Committee includes the following members: John Oldham, MD, Chair; Stuart Yudofsky, MD; Alan Schatzberg, MD; Glen Gabbard, MD; and Ruth Shim, MD.

Search for* Psychiatric Services *Editor: The Search Committee has reviewed and evaluated applicants and interviews with finalists are being scheduled. A recommendation will be presented to the Board of Trustees in March 2016. The Search Committee includes the following members: Grayson Norquist, MD, Chair; Sheryl Kataoka, MD; Amy Bauer, MD; Marcela Horvitz-Lennon, MD; Robert Freedman, MD; and Mary F. Brunette, MD.

Other Updates: *Helping Kids in Crisis*, edited by Fadi Haddad, MD, and Ruth Gerson, MD, has received the British Medical Association's Medical Book Award for the best book of the year in psychiatry. Published by APA Publishing, the book provides expert guidance to practitioners responding to high-risk situations, such as children considering or attempting suicide, cutting or injuring themselves

purposely, and becoming aggressive or violently destructive. The competition for the award included well-known works from large world-class publishers.

I hope the information above provides you with helpful updates of APA's ongoing programs and activities. I look forward to our continued discussions during the October Assembly meeting.

Item: **Physician Fee Schedule**

Chief: **Kristin Kroeger, Chief of Policy, Programs, and Partnerships and Rodger Currie, JD, Chief of Government Affairs**

Division/Department Head: Sam Muszynski, JD, and Matt Sturm

Division/Offices Involved: Healthcare Systems and Financing, Quality Improvement, and Government Affairs

Front-Burner Background:

Physician Fee Schedule: APA submitted comments for the Centers for Medicare and Medicaid Services' (CMS) *Proposed Rule for Medicare Program, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016.* We focused our comments on:

- Collaborative Care Models;
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) implementation;
- Payment Accuracy for Primary Care and Care Management Services;
- Chronic Care Management (CCM) and Transitional Care Management (TCM) Services;
- PQRS reporting; and
- EHR incentives program.

We were most pleased that this year they singled out the evidence-based Collaborative Care Model (CoCM) for special consideration in its discussion about establishing separate payment for collaborative care and most of our comments focused on this. Feedback on these comments was solicited from and vetted through the appropriate councils.

Staff Action/Response: We stressed that the coverage for the CoCM has positive implications for ongoing CMS care-delivery and payment initiatives, emphasized the robust evidence-base for the model. Our comments outlined the three basic elements of the model: 1) care coordination and care management; 2) regular, proactive outcome monitoring and treatment to target using validated clinical rating scales; and 3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement and recommended that CMS adopt a payment methodology as expeditiously as possible that enables covering its approach on a national basis. We recommended new codes be developed to properly value the services provided within the model. Our comments also discussed the applicability of this to all treatment modalities as well as recommending the general consent to confer with relevant specialists including a psychiatric consultant should be obtained prior to enrolling patients into primary care treatment, and not to require special informed

consent for participating in the CoCM in primary care as it would single out patients treated for a behavioral health problem and, given the stigma associated with behavioral health problems, might reduce access to this essential and effective service.

Payment Accuracy for Primary Care and Care Management Services: We recommended that CMS consider payment for existing E/M codes, such as the interprofessional telephone/Internet consultation service codes (99446-99449) and the codes describing prolonged services without direct patient contact (99358-99359), that enable more effective treatment but are not currently reimbursed.

Chronic Care Management (CCM) and Transitional Care Management (TCM) Services: CMS has solicited comments on ways to further improve beneficiary access to transitional care management and chronic care management services while balancing practitioner burdens associated with providing these services and we noted that considerations need to be given to the beneficiary cost-sharing obligation for these services, as this could they present a barrier to beneficiary consent, which is required for the services.

PQRS Reporting: We were pleased to see that CMS has not reduced the measures available for claims-based reporting for this reporting period and we strongly urged CMS to retain claims-based reporting for at least some measures going forward or to develop a small or solo practice exemption. Also due to the timing of the Measure-Applicability Validation (MAV) process, we recommended CMS establish timely feedback for clinicians so they may attempt to report on all available measures by the end of the relevant reporting period. Regarding specific measures we 1) support the integration of the Multiple Chronic Conditions Measures Group, but maintain concerns about the measure group criteria; and 2) we urged CMS to finalize the move to group measures by specialty and include NQF #2152 (Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) in the PQRS program in the future.

Electronic Health Record (EHR) Incentives Program: CMS is seeking comments on whether they should substitute or add another measure that would focus specifically on the use of health information technology, rather than meeting overall Meaningful Use requirements (e.g., the transitions of care measure required for the EHR Incentives Program). We have recommended that the measure be a substitution rather than an addition to the measures in the reporting programs and would support that change.

Please click here to access our full comments.

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

Item 2015A2 3.B.1
Assembly
October 30-November 1, 2015

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

SUMMARY OF ACTIONS
Final

Toronto Convention Centre
May 17, 2015

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

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
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]** • Board Ad Hoc Work Group on Revise the Ethics Annotations • Board Ad Hoc Work Group on Health Care Reform (report by October 2015 BOT Meeting) • Board Ad Hoc Committee on Real Estate (report by July 2015 BOT Meeting) • Board Ad Hoc Work Group on Telepsychiatry	Chief Operating Officer • Association Governance
5.A	**Minutes of the March 14-15, 2015 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its March 14-15, 2015 meeting. **[cc]**	Chief Operating Officer • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder. **[cc]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance
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]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance

Item 2015A2 3.B.2
Assembly
October 30-November 1, 2015

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

FINAL

SUMMARY OF ACTIONS
July 11-12, 2015

Agenda Item #	**Title/Action** **Consent Calendar Items Notated by [CC]**	**Responsible Office/Component**
2.A	**Requests to Remove Items from the Consent Calendar** Items 9.A.1 and 9.A.14 were removed from the Consent Calendar	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar as amended.	Chief Operating Officer • Association Governance
3.C	**Real Estate – Building** The Board of Trustees voted to authorize the CEO to execute the Lease for 800 Maine Avenue, SW, and in so doing approve the terms of the Purchase Option, including the Purchase and Sale Agreement that will govern the purchase of the Property in 2020 if APA elects to exercise the Purchase Option in 2019/2020.	CEO and Medical Director Chief Operating Officer • Association Governance General Counsel
5.A	**Minutes of the May 17, 2015 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its May 17, 2015 Meeting. **[CC]**	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Summergrad, Dr. Binder, and Dr. Oquendo. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
7.A.1	**Joint Reference Committee Report** The Board of Trustees voted to approve the creation of the Committee on Performance Measures reporting to the Council on Quality Care at an estimated yearly cost of $615. NB: The Committee will be a standard committee with 6 members, one of who will serve as chairperson. The committee will conduct all of its work by email and conference call and may meet in-person at the APA Annual Meeting as noted in the APA Operations Manual. A standard committee budget will be provided to the committee from the APA Operating Budget. Appointments to the committee will be made by the APA President and initial terms will be staggered.	Chief Operating Officer • Association Governance Council on Quality Care

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.A.1	**Membership Committee Report** The Board of Trustees approved a recommendation from the Membership Committee to award $2,678 to each district branch or state association listed in Attachment D as part of the DB/SA Grant process. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.A.2	**Membership Committee Report** The Board of Trustees voted to approve the recommendation of the Membership Committee to establish a new category of membership, as follows: *International Resident-Fellow Member:* Physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, verified with a letter from the training program. **[Abstention: Dr. Pender]**	Chief of Membership & RFM-ECP Officer • Membership
8.A.3	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Member listed in Attachment F for failure to meet the requirements of membership. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.A.4	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members listed in Attachment G for non-payment of 2015 APA dues if dues are not paid by the deadline. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.A.5	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Members listed in Attachment H, who will be dropped by their district branch if dues are not paid by the deadline. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.A.6	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment I for International Membership. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.A.7	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment J. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.B.1	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve an increase for CME course registration fees in 2016 as proposed in Attachment A.	Chief Financial Officer • Budget & Financial Analysis Chief of Policy, Programs & Partnerships • Education Chief Operating Officer • Meetings and Conventions

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.B.2	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve changes to the fees for the 2016 IPS as proposed in Attachment B, with nonmember residents, should they sign up for APA membership, be given the member rate.	Chief Financial Officer • Budget & Financial Analysis Chief Operating Officer • Meetings and Conventions
8.B.3	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve the rate adjustments for Annual Meeting registration fees for 2016 as proposed in Attachment C.	Chief Financial Officer • Budget & Financial Analysis Chief Operating Officer • Meetings and Conventions
8.B.4	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve in principle that the APA alternates the State Advocacy Conference and the Advocacy Leadership Conference, holding each conference every other year.	Chief Financial Officer • Budget & Financial Analysis Chief of Government Affairs • Federal Advocacy • State Advocacy Chief Operating Officer
8.B.5	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve a two year pilot project of discounted group rates for international associations.	Chief Financial Officer • Budget & Financial Analysis Chief Membership & RFM-ECP Officer

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.B.6	**Finance and Budget Committee Report** The APA Board of Trustees voted to approve a two-year pilot project of discounted group rates for hospital systems, academic institutions, government related agencies, group practices and those in solo practice.	Chief Financial Officer • Budget & Financial Analysis Chief Membership & RFM-ECP Officer
8.D	**Report from the APA/AMA Delegation** The Board of Trustees agreed to contribute to the American Academy of Child and Adolescent Psychiatry in support of Dr. Louis Kraus' campaign for election to the AMA Board of Trustees in 2017 in dollar for dollar matching funds not to exceed $10,000. **[Abstention: Drs. Martin, Oquendo, and Shah]**	Chief of Government Affairs • APA/AMA Delegation Chief of Policy, Programs & Partnerships
9.A.1	**Report of the Speaker** The Board of Trustees voted to approve the Joint Proposed Position Statement: *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness*.	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Diversity & Health Equity Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.2	**Report of the Speaker** The Board of Trustees voted to approve the Revised Position Statement: *Medical Necessity Definition* (Endorsed AMA Policy). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Healthcare Systems & Financing Chief Operating Officer • Association Governance
9.A.3	**Report of the Speaker** The Board of Trustees voted to approve the Proposed Position Statement: *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing*. **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance
9.A.4	**Report of the Speaker** The Board of Trustees voted to approve the Revised Position Statement: *Confidentiality of Electronic Health Information*. **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Healthcare Systems & Financing Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.5	**Report of the Speaker** The Board of Trustees voted to approve the Revised Position Statement: *Psychiatric Implications of HIV/HCV Co-Infection*. **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education Chief Operating Officer • Association Governance
9.A.6	**Report of the Speaker** The Board of Trustees voted to approve the retirement of the Position Statement: *Psychiatric Disability Evaluations by Psychiatrists* (2007). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance
9.A.7	**Report of the Speaker** The Board of Trustees voted to approve the retention of the Position Statement: *Consistent Treatment of All Applicants for State Medical Licensure* (2008). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.8	**Report of the Speaker** The Board of Trustees voted to approve retirement of the Position Statement: *Employment-Related Psychiatric Examinations* (2009). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education Chief Operating Officer • Association Governance
9.A.9	**Report of the Speaker** The Board of Trustees voted to approve the Revised Position Statement: *Publication of Findings from Clinical Trials* (2005). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance
9.A.10	**Report of the Speaker** The Board of Trustees voted to approve the retention of the Position Statement: *Use of the Concept of Recovery* (2005). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.11	**Report of the Speaker** The Board of Trustees voted to approve the Revised Position Statement: *Use of Animals in Research* (2009). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Research Chief Operating Officer • Association Governance
9.A.12	**Report of the Speaker** The Board of Trustees voted to approve retention of the Position Statement: *Medication Substitutions* (2009). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance
9.A.13	**Report of the Speaker** The Board of Trustees voted to approve retention of the Position Statement: *Electroconvulsive Therapy* (*ECT*). **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education • Healthcare Systems & Financing Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.14	**Report of the Speaker** The Board of Trustees did not approve the proposed Position Statement: *Support for Four Years of Generalist Training in Adult Psychiatry Residency*. The Board of Trustees voted to approve a motion to refer the proposed Position Statement: *Support for Four Years of Generalist Training in Adult Psychiatry Residency* to the Joint Reference Committee.for additional review.	Chief Operating Officer • Association Governance Chief of Policy, Programs, and Partnerships • Education
9.A.15	**Report of the Speaker** The Board of Trustees voted to approve the Proposed Position Statement: *Neuroscience Training in Psychiatric Residency Training*. **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education Chief Operating Officer • Association Governance
9.A.16	**Report of the Speaker** The Board of Trustees voted to approve the Proposed Position Statement: *Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families*. **[CC]**	Chief Membership & RFM-ECP Officer • Library & Archives Chief of Policy, Programs, and Partnerships • Education Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.17	**Report of the Speaker** Will the Board of Trustees vote to approve action paper 2015A1 12.A: *Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident*? The Board of Trustees did not approve action paper 2015A1 12.A: *Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident*. **[Abstentions: Drs. Anzia and Crowley]**	Chief Operating Officer • Association Governance
9.A.18	**Report of the Speaker** Will the Board of Trustees vote to approve action paper 2015A1 12.I: *Position Statement on Assisted Outpatient Treatment (AOT)*? The Board of Trustees voted to refer the action paper 2015A1 12.I: *Position Statement on Assisted Outpatient Treatment (AOT)* to the Council on Psychiatry and Law for incorporation into the proposed position statement currently in development by the Council, with appropriate consultation with the Ethics Committee. **[Abstention: Drs. Anzia]**	Chief of Government Affairs Chief of Policy, Programs, and Partnerships • Healthcare Systems & Financing Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
9.A.19	**Report of the Speaker** Will the Board of Trustees vote to approve action paper 2015A1 12.X: *Dues Abatement for General Psychiatrists/Members in Puerto Rico*? The Board of Trustees voted to refer the action paper 2015A1 12.X: *Dues Abatement for General Psychiatrists/Members in Puerto Rico* to the Membership Committee and the Finance & Budget Committee.	Chief Membership & RFM-ECP Officer • Library & Archives • Membership Chief Operating Officer • Budget & Financial Analysis Membership Committee Finance and Budget Committee
9.A.20	**Report of the Speaker** Will the Board of Trustees vote to approve action paper 2015A1 12.CC: *Senior Psychiatrists*? The Board of Trustees voted to refer the action paper 2015A1 12.CC: *Senior Psychiatrists* to the Joint Reference Committee for further action.	Chief Operating Officer • Association Governance
11.A.1	**DSM Steering Committee Report** The Board of Trustees voted to approve the "Format for Submissions of Proposed Changes to the DSM." outlining the information required for proposals for making changes to *DSM-5* (Attachment 1).	Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships • Research
11.A.2	**DSM Steering Committee Report** The Board of Trustees voted to approve the creation of 6 DSM Review Committees, as described in the report of the DSM Steering Committee.	Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships • Research

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
11.A.3	**DSM Steering Committee Report** The Board of Trustees voted to approve the changes to DSM criteria listed in Attachment 3, with the understanding that such changes will be reflected in an errata section of the DSM website and incorporated into print versions of the DSM-5 when feasible.	Chief Operating Officer • Association Governance Chief of Policy, Programs and Partnerships • Research
11.D	**Medical Registry – Business Plan** The Board of Trustees voted to request that the CEO and Medical Director and his Administration produce a detailed business plan for development of a Medical Registry.	CEO and Medical Director Chief Operating Officer Chief of Policy, Programs & Partnerships
EX.1.1	**Psychiatric News Editorial Advisory Board Appointments** The Board voted to approve the reappointment of Paramjit T. Joshi, M.D., to the *Psychiatric News* Editorial Advisory Board for a three-year term to begin May 2015 and expire May 2018.	Chief Communications Officer • Member Communication & *Psychiatric News* Chief Operating Officer • Association Governance
EX.1.2	**Psychiatric News Editorial Advisory Board Appointments** The Board voted to approve the reappointment of Molly McVoy, M.D., to the *Psychiatric News* Editorial Advisory Board for a three-year term to begin May 2015 and expire May 2018.	Chief Communications Officer • Member Communication & *Psychiatric News* Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
EX.1.3	**Psychiatric News Editorial Advisory Board Appointments** Will the Board vote to approve the reappointment of Ann Marie T. Sullivan, M.D., to the *Psychiatric News* Editorial Advisory Board for a three-year term to begin May 2015 and expire May 2018?	Chief Communications Officer • Member Communication & *Psychiatric News* Chief Operating Officer • Association Governance
EX.2	**Support for Maryland Psychiatric Society Amicus Brief** The Board of Trustees voted to approve the recommendation of the Committee on Judicial Action with support from the Council on Psychiatry and Law for support of the Maryland Psychiatric Society's brief in *Allmond v. DHMH* in the amount of $7,500.	Chief of Government Affairs Council on Psychiatry & Law Committee on Judicial Action

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AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

DRAFT SUMMARY OF ACTIONS
October 11-12, 2015

Agenda Item #	**Title/Action** **Consent Calendar Items Notated by [CC]**	**Responsible Office/Component**
2.A	**Requests to Remove Items from the Consent Calendar (item 7.A.1 was removed)**	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar.	Chief Operating Officer • Association Governance
5.A	**Minutes of the July 11-12, 2015 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its July 11-12, 2015 Meeting. **[CC]**	Chief Operating Officer • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Summergrad, Dr. Binder, and Dr. Oquendo. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[CC]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
7.A.1	**Joint Reference Committee Report** The Board of Trustees voted to retain the position statement *Active Treatment*, and refer it to the Council on Healthcare Systems and Financing for appropriate review.	Council on Healthcare Systems and Financing Chief of Policy, Programs and Partnerships • Healthcare Systems & Financing Chief Operating Officer • Association Governance • Joint Reference Committee (For Information)
8.B	**Bylaws Committee Report** The Board of Trustees voted to approve the proposed language to incorporate the International Resident-Fellow Member category as approved by the Board of Trustees at their July 2015 meeting.	Chief Membership & RFM-ECP Officer • Membership Chief Operating Officer • Association Governance
8.C.1	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Members listed in Attachment D for failure to meet the requirements of membership. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.C.2	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment E for International Membership. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership
8.C.3	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment F. **[CC]**	Chief of Membership & RFM-ECP Officer • Membership

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.E	**MOC Discussion- Request from ABPN** The Board of Trustees voted to approve relaying the following feedback to the ABPN: 1. The APA does not agree that there should be an exam every ten years for MOC. 2. Certification of lifelong learning should be an integrated ongoing process relevant to actual practice. 3. APA will work with ABPN to improve the certification of lifelong learning process—APA will recommend members for a committee to do this. 4. Should there be an exam at any point; most questions should be related to the psychiatrist's subspecialty with inclusion of some relevant general psychiatry questions. 5. No psychiatrist should be forced to maintain her/his underlying general and subspecialty certification through more than one certification process. [**unanimous vote**]	Chief Executive Officer Chief of Policy, Programs & Partnerships • Director of Education
8.F.1	**Ethics Committee Report** The Board of Trustees voted to approve the broadening of the Carol Davis Ethics Award criteria to include any APA member who has authored an outstanding publication on ethics in psychiatry.	General Counsel Chief Operating Officer • Association Governance
8.F.2	**Ethics Committee Report** The Board of Trustees voted to approve changing the Carol Davis Ethics Award frequency from annually to aperiodic (given at the discretion of the Ethics Committee, but no more than once a year).	General Counsel Chief Operating Officer • Association Governance

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
8.F.3	**Ethics Committee Report** The Board of Trustees voted to approve revision of the Carol Davis Ethics Award description in the APA Operations Manual to reflect the aforementioned proposed changes. (attachment 1)	General Counsel Chief Operating Officer • Association Governance
8.F.4	**Ethics Committee Report** The Board of Trustees voted to approve the revision of the Carol Davis Ethics Award description on the APA public website to reflect the aforementioned proposed changes. (attachment 2 and action 8.F.1 and 8.F.2)	General Counsel Chief Operating Officer • Association Governance
11.A	**Ad Hoc Work Group on Involvement with 'Social' Issues** The Board of Trustees voted to approve the four criteria proposed by the Ad Hoc Work Group on Social Issues. • The APA should have substantial expertise or perspective to offer • Positions should be relevant to access of care or the prevention, diagnosis, or treatment of psychiatric disorders. • The issue being considered should be significant for psychiatrists and their patients. • The APA should develop positions on issues where the APA may have a meaningful impact and positively shape public opinion.	CEO and Medical Director Chief Communications Officer Joint Reference Committee (for information to all councils)

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
11.C	**Ad Hoc Work Group on Healthcare Reform** The Board of Trustees voted to request that the Ad Hoc Work Group on Health Care Reform provide a progress report back to the Board of Trustees at its March, 2016 meeting.	Chief of Policy, Programs & Partnerships • Healthcare Systems & Financing Ad Hoc Work Group on Health Care Reform – Progress Report- March 2016 BOT
11.D	**Ad Hoc Work Group on Telepsychiatry Report** The Board of Trustees voted to refer the proposed policy from the Ad Hoc Work Group on Telepsychiatry to the Joint Reference Committee.	Joint Reference Committee Chief of Policy Programs & Partnerships • Quality Improvement
13.A	**Proposed Position Statement: Support For Generalist Training in Adult Psychiatry Residency** The Board of Trustees did not approve the Proposed Position Statement: Support for Generalist Training in Adult Psychiatry Residency.	Chief of Policy, Programs & Partnerships • Education (for information)
14.A.1	**New Business:** The Board of Trustees voted to approve the appointment of Paul Summergrad, M.D., to the DSM Steering Committee. **[CC]**	Chief of Policy, Programs & Partnerships • Research
14.A.2	**New Business:** The Board of Trustees voted to approve the appointment of Sarah Morris, M.D., to the DSM Steering Committee. **[CC]**	Chief of Policy Programs & Partnerships • Research DSM Steering Committee
EX.1.1	***The American Journal of Psychiatry* Editorial Board Appointments** The Board voted to approve the appointment of Felton Earls, MD, to *The American Journal of Psychiatry* Editorial Board to a four-year term to begin January 1, 2016, and expire December 31, 2019.	Chief Operating Officer • Association Governance • Publishing ○ APP Journals

Agenda Item #	Title/Action Consent Calendar Items Notated by [CC]	Responsible Office/Component
EX.1.2	***The American Journal of Psychiatry* Editorial Board Appointments** The Board voted to approve the appointment of Roy Perlis, MD, to *The American Journal of Psychiatry* Editorial Board to a four-year term to begin January 1, 2016, and expire December 31, 2019.	Chief Operating Officer • Association Governance • Publishing ○ APP Journals
EX.2	**Request to sign Maryland Psychiatric Society Amicus Brief** The Board of Trustees voted to approve signing the amicus brief of the Maryland Psychiatric Society in *Allmond v. Department of Health and Mental Hygiene*.	Chief of Government Affairs Council on Psychiatry & Law Committee on Judicial Action
EX.3	**Request to sign Washington State Psychiatric Association's Amicus Brief** The Board of Trustees voted to approve signing the amicus brief of the Washington State Psychiatric Association in *Volks v. DeMeerleer*	Chief of Government Affairs Council on Psychiatry & Law Committee on Judicial Action

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Assembly
October 30-November 1, 2015

Report of the Speaker-Elect

I thank the Assembly for the opportunity and privilege of serving as Speaker-Elect. It has been a pleasure to begin and continue work with Drs. Martin and Miskimen, with the Past Speakers Drs. Boyer and Young, and with the Assembly Executive Committee. I have approached and experienced the work of this first half of the year with excitement and optimism, and I hope I convey this to the Assembly in person and in this report.

I expect that we will all notice and appreciate the new energy and diversity of the Assembly that results from the reorganization we approved in May, along with the usual turnover of Assembly representatives. This also means, though, that we have many new members who will be dealing with the complexity and pace of the Assembly for the first time. I trust that we'll extend the commitment we've made to mentorship for all our new members, to help them be active and effective contributors in the Assembly from the outset. We will also be adjusting to the new venue for the November Assembly, the Omni Shoreham. I hope that most will appreciate the ambience and the utility of the layout and meeting spaces, but also that everyone will give us the opportunity to work out the inevitable kinks over the next year or two.

From my perspective now in my second year on the Joint Reference Committee and my first year on the Board of Trustees, I want to emphasize a few observations:

- There is a clear shared commitment to the working together of the Assembly, Board, and APA Administration toward the strategic goals, for the benefit of our members, our patients, and our society.
- The large majority of the initiatives of the Assembly are being carried through to clear outcomes in the form of work products or ongoing processes with defined accountable individuals or groups. Our new metrics efforts should track and demonstrate this on an ongoing basis.
- The policies of the Association, as articulated in our Position Statements, are a shared responsibility of the Assembly and the Board of Trustees, with the expert input of the APA's component Councils and Committees. The Joint Reference Committee is providing focused oversight of the processes and interactions among our governance components and the administration so that we are working together effectively year-round, not just in periodic spurts.
- The APA Administration is very responsive to the Assembly, especially as we represent the voice of the APA membership!

In an internal matter for the Assembly, Dr. Miskimen and I have agreed that potential candidates for Assembly office, and especially those elected, could benefit from a brief compilation of the scheduled meeting and travel commitments (fixed and variable) of the Assembly officers, and of the processes in place affecting their work. We are working on pulling these together and will work with the APA

Governance staff and the Speaker and Past Speakers to make them available, hopefully for the candidates who will be nominated at this meeting and next year's new officers.

I look forward to bigger and better things ahead for the Assembly and the APA!

Item 2015A2 4.B
Assembly
October 30-November 1, 2015

Joint Reference Committee
Report to Assembly
Fall 2015

The Joint Reference Committee (JRC) refers the following actions to the Assembly for consideration.

Item 4.B.1 Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV (JRCOCT148.A.1)

Will the Assembly retain the Position Statement*: Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Addiction Psychiatry states that the statement is current, relevant and should be retained.

Item 4.B.2 Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly (JRCOCT148.E.3)

Will the Assembly retain the Position Statement*: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services of the Elderly* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.

Item 4.B.3 Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities (JRCOCT148.J.3)

Will the Assembly approve the proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities* and if approved, forward it to the Board of Trustees for consideration?

Developed by the Council on Psychiatry and Law

Item 4.B.4 Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution – Joint Statement of the APA/AAAP (JRCJUL158.A.3)

Will the Assembly approve the proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution – Joint Statement of the APA/AAAP* and if approved, forward it to the Board of Trustees for consideration?

Developed by the Council on Addiction Psychiatry and the AAAP

Item 4.B.5 Reaffirm APA's Adoption of the AMA's 2010 Position Statement Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices (JRCJUL158.B.1)

Will the Assembly retain the 2010 Position Statement: *Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices* and if retained, forward it to the Board of Trustees for consideration? (N.B. the APA is adopting the AMA's position statement)

Rationale: The Council on Advocacy and Government Relations discussed the JRC referral of Action Paper, "Direct to Consumer Advertising" [ASMNOV1412.A; JRCJAN156.1] to determine political aspects of the Action Paper. The Council addressed APA's previous adoption of AMA's Direct-to-Consumer position in 2010. The Council believes the AMA position supports FDA accountability and physician responsibility. Through unanimous consent, the Council recommends the Action Paper not move forward and to reaffirm current APA policy. The Council has shared their recommendations with the Council on Quality of Care (LEAD).

Item 4.B.6 Proposed Position Statement: Substance Use Disorders in Older Adults (JRCJUL158.E.1)

Will the Assembly approve the proposed Position Statement: *Substance Use Disorders in Older Adults* and if approved, forward it to the Board of Trustees for consideration?

Developed by the Council on Geriatric Psychiatry and the Council on Addiction Psychiatry

Item 4.B.7 Revised Position Statement: Bias-Related Incidents (JRCJUL158.I.1)

Will the Assembly approve the revised Position Statement: *Bias-Related Incidents* and if approved, forward it to the Board of Trustees for consideration?

Please note *that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired.*

Rationale: The revision updates key concepts based on the references above. Specifically, the following changes were made:
1. The new position statement includes a more comprehensive list of cultural identity variables in the first sentence consistent with current understanding of cultural identity in DSM-5 (See the DSM-5 revised Outline for Cultural Formulation section "Cultural Identity" p. 749-750).

2. The new position statement expands the description of bias as "both intentional/explicit/conscious and unintentional/ implicit/unconscious" in the second sentence consistent with current understanding of bias. (Blair IV, Steiner JF, Havranek EP. Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here? *The Permanente Journal*. 2011;15(2):71-78. Accessed 6/15/15 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/)

3. The new position statement expands the description of bias-related incidents to include "intimidation" and "micro-aggressions" in addition to "violence" and "harassment" in the third sentence consistent with current understanding of bias-related incidents. (Derald Wing Sue (2010). *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. Wiley. And Sue, Derard Wing (2010). *Microaggressions and Marginality: Manifestation, Dynamics, and Impact*. Wiley.)

Item 4.B.8 Retire 2007 Position Statement: The Right to Privacy (JRCJUL158.J.1)

Will the Assembly retire the Position Statement: *The Right to Privacy* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The original position statement was driven by concern about the privacy of people to engage in consensual sexual acts with members of the same sex. This is no longer a concern. In addition, there is a separate position paper on abortion rights. From these two examples, the Council on Psychiatry and Law felt that there is no need for a general statement on right to privacy as there is little value without specifying a given situation.

Item 4.B.9 Retire 2007 Position Statement: Sexual Harassment (JRCJUL158.J.2)

Will the Assembly retire the Position Statement: *Sexual Harassment* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law reviewed the 2007 Position Paper on Sexual Harassment. After much discussion, the Council felt the paper should be retired as sexual harassment is illegal and there is no need for the paper.

Item 4.B.10 Retire 2009 Position Statement: Interference with Scientific Research and Medical Care (JRCJUL158.M.1)

Will the Assembly retire the Position Statement: *Interference with Scientific Research and Medical Care* and if retired, forward it to the Board of Trustees for consideration?

Please note *that if the revision to the Position Statement is approved, the 2005 version of the statement will automatically be retired.*

Rationale: The Council on Research recommends that the statement be retired as it seems to function as an overly generic statement about de-stigmatization rather than provide a specific perspective on psychiatric practice or research designed to enhance and support the profession. Further, given recent advances in the legislature on mental health parity, the statement is less relevant today than when it was developed.

Item 4.B.11 Revised Position Statement: Hypnosis (JRCJUL158.M.2)

Will the Assembly approve the revised Position Statement: *Hypnosis* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The position statement is still relevant, but the Council on Research recommends that the statement be revised for language and clarity. As per the Joint Reference Committee's request, it also has been reformatted so that it conforms to the latest APA position statement formatting guidelines.

Please note *that if the revision to the Position Statement is approved, the 2009 version of the statement will automatically be retired.*

Item 4.B.12 Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury (JRCJUL158.M.3)

Will the Assembly retain the Position Statement: *Posttraumatic Stress Disorder and Traumatic Brain Injury* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The revisions are only for adherence to the latest APA position statement formatting guidelines. The statement is still relevant and useful. No content revisions are warranted at this time.

Item 4.B.13 Retain 2010 Position Statement on High Volume of Psychiatric Practice and Quality of Patient Care (JRCJUL158.L.2)

Will the Assembly retain the Position Statement: *High Volume of Psychiatric Practice and Quality of Patient Care* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Quality Care recommends retaining the position statement as it is still relevant.

Item 4.B.14 Proposed Position Statement on Tobacco Use Disorder (JRCJUL158.A.1)

Will the Assembly approve the proposed Position Statement: *Tobacco Use Disorder* and if retained, forward it to the Board of Trustees for consideration?

The position statement was developed by the Council on Addiction Psychiatry.

Item 4.B.15 Retain 2014 Position Statement: Psychotherapy as an Essential Skill of Psychiatrists (JRCJUL158.L.3)

Will the Assembly retain the Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Quality Care recommends retaining the position statement as it is still relevant.

Item 4.B.16 Proposed Position Statement: Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment (JRCJUL158.J.4)

Will the Assembly approve the proposed Position Statement: *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*, and if retained, forward it to the Board of Trustees for consideration?

The position statement was developed by the Council on Psychiatry and Law and reviewed by the Ethics Committee.

APA Official Actions

Position Statement on Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV

Approved by the Board of Trustees, July 2012
Approved by the Assembly, May 2012

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

Issue

There is a high prevalence of substance abuse and psychiatric disorders among HIV-infected individuals. Importantly, drug and alcohol-use disorders are frequently co-morbid with depression, anxiety and severe mental illness. Not only do these disorders increase the risk of contracting HIV, they have also been associated with decreased highly active antiretroviral therapy (HAART) utilisation, adherence and virological suppression.

Position Statement

Recommendations:

1. Psychiatrists should attend to the HIV-related prevention and psychiatric and substance use treatment needs of their patients (see position statements for specific settings and patient groups). Psychiatrists treating patients with substance use disorders are encouraged to stay abreast of psychosocial and somatic interventions with proven efficacy for these problems and their negative consequences (e.g., antabuse, naltrexone, buprenorphine, motivational enhancement therapy, cognitive behavioral therapy, needle exchange programs, and methadone maintenance).
2. Psychiatrists are encouraged to collaborate with their medical colleagues (physicians and others) to provide comprehensive and integrated care for HIV-infected patients. This can include collaboration with the treatment of substance use disorders and other mental illnesses, pain, sleep, and sexual disorders. Coordination is essential to maximize adherence and minimize drug-drug interactions and overlapping medication toxicities. Such coordination may also need to take into account the treatment of medical disorders commonly association with HIV, such as Hep C, Hep B, and TB. For psychiatrists who regularly evaluate and treat HIV-positive patients, staying knowledgeable about current HIV-related medical care will enhance their abilities to meaningfully engage in these collaborations.
3. When a psychiatrist evaluates a change of mental status in an HIV-infected patient, consideration should always be given to disorders due to general medical conditions and substance-induced disorders as possible underlying causes.

Prepared by the Steering Committee on HIV Psychiatry.

APA Official Actions

Position Statement on Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly

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

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

The American Psychiatric Association stands as an advocate for access to and delivery of quality psychiatric care for aging populations. Psychiatric treatments have been shown to be effective in the management of the emotional and mental disorders of late life. While older Americans benefit from access to psychiatric treatment, they still do not have adequate access to these services.

The American Psychiatric Association endorses the following fundamental principles regarding the treatment of older Americans with psychiatric illnesses:

1. All older Americans should have access to timely psychiatric consultation and treatment.
2. Treatment of older adults with psychiatric illness must be provided with respect and compassion.
3. Psychiatric physicians caring for older adults must adhere to the ethical standards of the American Psychiatric Association and provide treatments that are appropriate and effective.
4. Psychiatric physicians have unique skills in the provision of psychotherapeutic, psychopharmacologic, social and family interventions. Elderly patients benefit when a psychiatric physician participates in a multidisciplinary treatment team for evaluation and for delivery of treatment services.
5. Additional research (basic and clinical) is necessary to develop new treatments for the elderly that are safe and effective.

Revision of the 1997 position statement by the Council on Aging.

Item 2015A2 4.B.3
Assembly
October 30-November 1, 2015

PROPOSED POSITION STATEMENT

Position Statement on Segregation of Juveniles with Serious Mental Illness in Correctional Facilities

Juvenile detention and rehabilitation facilities sometimes use segregation for disciplinary or administrative reasons. The term "segregation" refers to conditions of confinement characterized by an incarcerated juvenile generally being locked in a cell for 23 hours or more per day without access to facility programming such as attending school or the opportunity to interact with others.

Segregation of detained juveniles with a serious mental illness should be avoided, with rare exceptions, due to potential emotional and developmental harm to the juvenile, including an increased risk of suicide in isolation. Efforts to avoid segregation, including behavioral treatment, psychotherapy, pharmacotherapy, and other developmentally appropriate interventions and efforts to identify and address precipitants to segregation should be proactively implemented.

Background

Approximately 100,000 juveniles are in custody on any given day (Sickmund 2005). Nearly 70% of female detainees and 60% of male detainees have a psychiatric disorder other than conduct disorder (Teplin et al. 2002). Approximately 3% of juveniles in detention have a psychotic illness and nearly 11% of boys and 29% of girls suffer from major depressive disorder (Fazel 2008). Incarcerated male juveniles have higher rates of self-harm behavior than the general adolescent community population (Chowanee et al. 1991) and approximately 50% of all juvenile suicides in confinement occur in some type of room confinement (e.g., time-out, isolation, or segregation) (Hayes 2009).

There are serious concerns regarding the potential impact of segregation on the mental health of detained youth. The rationale for segregation includes disciplinary placement and isolation from other inmates for administrative or protective reasons (Metzner et al. 2007). Placement of a juvenile with a serious mental illness in segregation can be contraindicated because of the potential for the juvenile to clinically deteriorate or not improve. Juveniles who are at high suicide risk or demonstrating active psychotic symptoms should not be placed in segregation and instead should be transferred to an acute psychiatric setting for stabilization. If there is a concern that segregation is a result of a serious mental illness, transfer to a mental health facility is strongly recommended.

The following principles should be observed when a juvenile with a serious mental illness is to be placed in segregation: 1. The juvenile should not be placed in segregation solely because the juvenile exhibits symptoms of a serious mental illness; 2. The juvenile who is placed in segregation must have access to psychiatric and medical services that meet the juvenile's medical and psychiatric needs; 3. The juvenile who is suffering from a psychiatric crisis, including psychosis, severe mood disturbance, or suicidality, should be removed from segregation and will likely need transfer to a mental health facility. 4. The juvenile should be assessed on a regular basis by qualified mental health practitioners to identify and respond to emerging crises at the earliest possible moment. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming, including recreational and physical activities for these juveniles.

For the purposes of this position statement, the definition of serious mental illness (SMI) below closely parallels the definition of SMI included in the American Psychiatric Association's document titled "Psychiatric Services in Correctional Facilities" (American Psychiatric Association, Psychiatric Services in Correctional Facilities, in preparation) with the addition of disorders particularly relevant for detained children and adolescents.

In particular, psychiatric disorders that include psychotic symptoms, at least on an intermittent basis, are uniformly considered to meet criteria for SMI. Schizophrenia, schizoaffective disorder, and delusional disorder are examples of such serious mental illnesses. Other mental disorders, such as major depression, bipolar disorder, autistic spectrum disorder, and posttraumatic stress disorder, that result in serious distress or serious functional impairment, whether acute or chronic, almost always meet criteria for SMI. Some juveniles with cognitive disorders or adjustment disorders may meet criteria for SMI, either acutely or chronically, depending on the level of resulting functional impairment.

Clinical judgment must always be employed in determining the appropriate care for a juvenile whether or not they meet SMI criteria. In addition, a juvenile's development and maturity level should be considered in any decision that involves placement in segregation. Input from family members, when reasonably available, may provide an important source of information about potential behavioral intervention strategies that can serve as a successful alternative to administrative segregation.

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Item 2015A2 4.B.4
Assembly
October 30-November 1, 2015

Proposed
Joint Position Statement of
American Psychiatric Association and
American Academy of Addiction Psychiatry

TITLE: Opioid Overdose Education and Naloxone Distribution

ISSUE:

There has been a significant increase in mortality from prescription drug overdoses over the past 20 years in the U.S. (1). Overdose deaths now exceed automobile accidents as the leading preventable cause of death in the U.S., posing a significant public health crisis (2). Rates of opioid overdose have surged throughout the world, including in Canada, Europe, Asia, and Australia (3-7). In addition to the traditional risks associated with heroin use, increasing use of opioid analgesics (especially long-acting formulations at high doses) has been a major contributor to increased overdose mortality (8-10).

Position Statement

The American Psychiatric Association and the American Academy of Addiction Psychiatry endorse expanded access to naloxone, along with appropriate training and education, for bystanders, family members, and other individuals who may be in a position to initiate early response to opioid overdose, including EMTs, paramedics, corrections officers, and law enforcement. Naloxone kits should be distributed to individuals at high risk of witnessing or experiencing an opioid overdose, including users of heroin or other opioid drugs. Additionally, naloxone should be prescribed to groups at heightened risk for opioid-induced respiratory depression including individuals: 1) on high-dose full-agonist opioid pharmacotherapy (i.e. greater than 100 mg of morphine equivalence per day), 2) prescribed opioids in combination with benzodiazepines, and/or 3) suspected or known nonmedical opioid use (15).

Individuals authorized to dispense naloxone overdose kits should be required to undergo training and education in the recognition of signs and symptoms of overdose, techniques for administration of naloxone, and referral to emergency medical services. Supervision and training of these individuals should be maintained on an ongoing basis.

Additionally, states should actively protect the efforts of providers and civilians through Good Samaritan laws, amnesty protections for certified providers, and the allowance of third-party prescriptions (i.e. for the family member of the index patient). States with limitations on access to naloxone should be encouraged by their state health officials and medical societies to broaden distribution of naloxone and support legislation to remove barriers to naloxone access.

Background:

Naloxone is an opioid antagonist that is used to rapidly reverse respiratory depression and other effects of opioids in cases of suspected overdose. It is approved for use by IM, SC, or IV routes of administration; an intranasal (IN) spray is also available for off-label use. Adverse effects other than

precipitation of opioid withdrawal are rare. Recently, the FDA approved a hand-held autoinjector, similar to an "epi pen" that may be used by untrained persons outside of healthcare settings.

Reversal of opioid overdose is a time-sensitive medical emergency, and individuals at the scene of an overdose may be reluctant to call for emergency services for fear of legal consequences or arrest. Opioid Overdose Education and Naloxone Distribution (OOEND) initiatives involving laypeople who may be first responders at the time of overdose have been associated with reduced mortality from opioid overdose in multiple studies (11-15). Findings have demonstrated that bystanders may safely administer naloxone via intramuscular injection or IN insufflation in cases of suspected overdose. Distribution of naloxone kits should be accompanied by brief training that incorporates education about opioid overdose recognition and response and calling for emergency services. Although a randomized controlled trial has not been conducted due to logistical and ethical barriers, mounting empirical evidence supports this public health intervention. The substantial evidence for effectiveness of naloxone, as well as the low risk and low cost of the intervention, strongly support its use, particularly when considering the lethal potential of opioid overdose.

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APA Official Actions

Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988

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

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

H-105.988
Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

It is the policy of our AMA:

1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines:

a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for nonprescription products.
d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.
i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.

3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTC.

Item 2015A2 4.B.6
Assembly
October 30-November 1, 2015

Position Statement: Substance Use Disorders in Older Adults

Issue: Substance use disorders are a growing trend among older adults and aging Baby Boomers (born in 1946-1964) and are currently underdiagnosed and undertreated. Substance use disorders in older adults can lead to significant problems for individuals, families and communities, and present major challenges to primary care and substance use disorder treatment providers due to increased comorbidity with medical, mental and cognitive disorders in later life, and increased rates of suicide. It is currently estimated that 8.2% of older adults misuse alcohol and medications and although the majority (87%) of older adults see a physician regularly about 40% of those who are at risk do not self-identify or seek services for substance-related problems and are unlikely to be identified by their physicians (7).

Position: It is the position of the American Psychiatric Association that:

1. The diagnosis and treatment of substance use disorders should be recognized as an essential part of medical and psychiatric care of older adults. Patients with identified substance use disorders should be educated about the condition and offered or referred for appropriate treatment;
2. Psychiatrists and other involved healthcare providers should promote screening for co-occurring mental and substance use disorders by primary health care, mental health, and substance abuse treatment providers and encourage the development of integrated treatment strategies;
3. Careful attention is needed in evaluating psychosocial stressors that may contribute to increased risk of substance use disorder (e.g., retirement, financial stressors, loneliness, medical problems, etc).
4. Psychiatrists must remember that older adults, and particularly older women, may be more sensitive to the toxic effects of substances due to physiological changes with aging, including reduction in lean body mass, comorbid medical, cerebrovascular and neurodegenerative processes that reduce brain resilience to the effects of substances and prescription pain- and sedative medications. Assessment of these risk factors should be considered routinely in management of older adults, particularly when considering prescribing controlled substances or when managing substance use disorders.
5. Older adult mental health services, including substance use prevention and treatment services, should be integrated into primary health care, long-term care and community-based service systems;
6. Older adults should have full access to an affordable and comprehensive range of mental health services, including substance use disorder services; these should include acute treatment and prevention of substance use disorders and should include home-based care and community–based care, as well as outreach to long-term care facilities;
7. Training at the level of medical school, residency and fellowship should help develop competence in the diagnosis, treatment, and prevention of substance use disorders in older adults;
8. More research is needed on the effects of medicinal and recreational cannabis use in older adults and interaction with comorbid medical and cognitive disorders and other prescription medication;
9. Development of public policy should help modify public and private health and long-term care insurance plans to:
    - eliminate exclusions based on pre-existing conditions;

- guarantee parity in coverage and reimbursement for physical health and mental health, including substance use disorders;
- ensure that older persons who are eligible for Medicare have access to a full range of treatment options for substance use disorders;
- improve and effectively coordinate benefits, at all government levels, for those individuals who are dually eligible for Medicare and Medicaid coverage;
- promote the development and implementation of home and community-based care for substance use disorders as an alternative to institutionalization through a variety of public and private funding mechanisms;
- promote older adult mental health and substance use disorder treatment research, and coordinate and finance the movement of evidence-based and emerging best practices between research and service delivery;
- increase collaboration among aging, health, mental health, and substance use disorder consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant government agencies to promote more effective use of resources and to reduce fragmentation of services.

Background document:

The twentieth century witnessed the doubling of life expectancy in the western hemisphere and a three-fold increase in the number of individuals aged 65 years and older (1). Aging is often associated with an increase in psychosocial stressors and health problems. These are recognized risk factors for substance use disorders, and in the elderly, can lead to further health complications as well as social withdrawal and isolation (1).

Substance use disorders (SUD) have traditionally been thought of as disorders disproportionally affecting younger populations. Indeed, many epidemiological studies have shown that the rates of maladaptive substance use decrease with age (2, 3). In fact, it has been shown that a decline in rates of substance use is noted for individuals in their 30's and older and is associated with a substantial shift in accountabilities such as the need to maintain a stable job, steady relationships and parenthood (4, 5). In addition, higher mortality rates have been reported in substance users, contributing to this decline in prevalence of SUD in older adults. (6).

Currently, it is estimated that 8.2% of Americans older than 65 years binge drink alcohol, 2.2% meet diagnostic criteria for alcohol use disorders, 10.3% use tobacco regularly and 1.0% use illicit drugs (7). Some have suggested that the breadth of addictions among the elderly might be even more significant than these numbers seem to report, as in many such cases substance use disorders are ignored or misdiagnosed. To that end, in the context of the relatively lower prevalence of SUD among the elderly, providers often misdiagnose them with a mood or anxiety disorder or dementia (8).

Over the next decade, it is estimated that these numbers will increase dramatically because of the aging baby boomers. A prospective study estimated that by 2020, 4.4 million Americans aged 50 or older will be requiring treatment for SUD. That is triple what these figures were in 2000 and 2001 (9). These noticeable numbers will transform the way healthcare professionals and governmental organizations tackle substance use among the elderly.

Substance Use Disorders are particularly concerning problems among those individuals ages 65 and older because of their effects on associated co-morbid medical and psychiatric conditions such as mood or psychotic disorders, diabetes and cardiovascular disease. Older adults, and particularly older women, may be more sensitive to the toxic effects of substances due to physiological brain changes with aging, and with comorbid medical, cerebrovascular and neurodegenerative processes that reduce brain resilience to the effects of substances and prescription pain and sedative medications (10, 11).Factors that have been found to be associated with SUD's in the elderly include a past history of substance use disorders, social isolation, as well as being a female (12-14). The latter factor is moderated by women being diagnosed with a SUD less frequently and the fact that manifest symptoms occur at an older age in women compared to men (15). While depressive and anxiety disorders can lead many aged 65 and older to "self-medicate", it has been found that older men are more likely to abuse alcohol while older women are more likely to abuse prescription drugs (8). In fact, benzodiazepines and narcotic pain medication are frequently prescribed to the elderly resulting in physical dependence, while withdrawal symptoms or tolerance are infrequently reported (12 – 14).

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Item 2015A2 4.B.7
Assembly
October 30-November 1, 2015

Proposed revision to
Position Statement on Bias-Related Incidents
May 2015

This statement is based on the 1992 position statement that was reaffirmed in 2007.

Issue: Bias-related incidents arise from discrimination and intolerance based on race/ethnicity, color, gender, age, religion/spirituality, places of birth and growing up, migrant status, socioeconomic status, sexual orientation, gender identity, physical and mental illness or disabilities, and veteran status among other characteristics. Biases, both intentional/explicit/conscious and unintentional/ implicit/unconscious, underlie these incidents that are widespread in society and continue to be a source of social disruption, individual suffering, trauma, and health and mental health inequities. These bias-related incidents, occurring in both urban and rural areas, consist of acts of violence, harassment, intimidation, and microaggressions based on stereotypes that devalue the human dignity of stigmatized individuals, families, and communities. These bias-related incidents result in despair and hopelessness that undermine the mental health and well-being of affected individuals and ultimately affects the whole nation.

APA Position: The American Psychiatric Association (APA) opposes bias-related incidents. We recognize that these incidents occur in our nation's communities, institutions, organizations and throughout all levels of society. The APA encourages its members to take appropriate actions to prevent such incidents as well as actively respond when such bias-related incidents occur.

Background Information:

A recent publication has summarized the importance of discrimination as a social determinant of mental health. Michael Compton et al. in the book "The Social Determinants of Mental Health" (APPI, 2015) has one chapter on discrimination. Summarizing the chapter in a section entitled "Key Points," it is stated that:
"1. The linked concepts of chronic stress and discrimination represent a useful conceptual lens to understand one potential etiology of poor physical and mental health.
2. Clinical programs and clinicians must be sensitive to the nuances of race, color, ethnicity, and nativity, as well as other aspects of individual differences that engender discrimination, in treating behavioral disorders, especially mood and anxiety disorders.
3. Cultural competency and cultural humility training are important vehicles for developing knowledge of different cultural practices, awareness of one's own cultural worldview, attitudes towards differences, and the cross-cultural skills that are needed to understand, be respectful of, and be responsive to the needs of diverse patients.
4. Communities affected by discrimination have to assume greater responsibility in educating and developing effective antiracism and antidiscrimination movements through collaborations with private and government institutions and majority and minority racial communities. Vigorously working to eliminate discrimination is the responsibility of not only those who are discriminated against but also those who might discriminate, either through their own actions or through their interactions that contribute to maintaining forms of institutional discrimination." (p. 40-41)

Secondly, in the DSM-5 revised Outline for Cultural Formulation in the section "Cultural features of the relationship between the individual and the clinician," it is stated: "Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance." (p. 750)

Thirdly, the DSM-5 Cultural Formulation Interview "Guide to the Interviewer" for Question 16 on the "Clinician-Patient Relationship" states: "Elicit possible concerns about the clinic or the clinician-patient relationship including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery." (p. 754)

Recommendations:

1. The APA, throughout all parts of the organization, must actively affirm that a basic principle of our organization is the importance of valuing human dignity as the basis for optimal mental health and well-being. The APA, throughout all parts of the organization, must actively demonstrate consistent modeling of respect for others and willingness to remain open and curious when assessing for and addressing individual and institutional/organizational biases.

2. APA members must educate themselves about biases, both intentional/explicit/conscious and unintentional/implicit/unconscious, and promote this skill as relevant to all members of society as necessary for optimum mental health and human dignity. This should include specific training on cultural competency and cultural humility in the following levels of training: 1) Medical students consistent with LCME accreditation standards and 2) Psychiatry residents consistent with ACGME core competencies and milestones assessment. Finally, both APA educational meetings such as the Annual Meeting and the Institute on Psychiatric Services and APPI publications should offer sessions and resource materials respectively on these topics.

3. APA leadership and members must develop valuing messages and images to challenge stereotypes and broaden our viewpoints to be inclusive of diverse individuals, families, and communities.

4. APA leadership and members must understand that dissemination of evidence-based research that demonstrates effective paths to decrease or eliminate bias-related incidents is critical to addressing these issues in society, our organization and in our work with patients.

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Item 2015A2 4.B.8
Assembly
October 30-November 1, 2015

APA Document Reference No. 910007

The Right to Privacy
POSITION STATEMENT

Approved by the Assembly, November 1991
Approved by the Board of Trustees, December 1991
REAFFIRMED 2007

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

The American Psychiatric Association supports the right to privacy in matters such as birth control, reproductive choice, and adult consensual sexual relations conducted in private, and it supports legislative, judicial, and regulatory efforts to protect and guarantee this right.

This statement was proposed by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs.

[1]The members of the Committee on Gay, Lesbian, and Bisexual Issues are Richard A. Isay, M.D. (chairperson), Margery Sved, M.D., Rochelle L. Klinger, M.D., Robert M. Kertzner, M.D., Debbie Rene Carter, M.D., Kenneth Ashley, M.D. (APA/NIMH Fellow), and Robert P. Cabaj, M.D. (Assembly liaison and corresponding member).

Item 2015A2 4.B.9
Assembly
October 30-November 1, 2015

Position Statement on Sexual Harassment

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

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

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

Position Statement on Interference with Scientific Research and Medical Care

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

The American Psychiatric Association deplores any and all acts of intimidation, physical interference, terrorism, and violence that impede the progress of scientific research or the provision of legal medical care.

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.

The position statement originally was approved by the Assembly in May 1995 and by the Board of Trustees in March 1995.This position statement was proposed by the Council on National Affairs. The members of the council are Terry Stein, M.D. (chairperson), Nada L. Stotland, M.D. (vice chairperson and Assembly liaison), Leah J. Dickstein, M.D., Clifford K. Moy, M.D., Lourdes M Dominguez, M.D., Fred Gottlieb, M.D. (Board liaison), Mary Kay Smith, M.D. (Board liaison), Billy Jones, M.D. (observer-consultant), and Andrew J. Elliott, M.D. (APA/BurroughsWellcome Fellow).

Item 2015A2 4.B.11
Assembly
October 30-November 1, 2015

Title: Position Statement on Hypnosis

Background:

Hypnosis is a state of aroused, attentive, focal concentration accompanied by a relative reduction in peripheral awareness (dissociation), and heightened response to social cues (suggestibility). It can be utilized to facilitate a variety of psychotherapeutic interventions, including psychodynamic, cognitive-behavioral, and exposure-based treatments. ~~Hypnosis is a specialized psychiatric procedure and as such is an aspect of the doctor-patient relationship. Hypnosis is not in itself a therapy, but rather is a state of aroused, attentive, focal concentration with a relative reduction in peripheral awareness that can be utilized to facilitate a variety of psychotherapeutic interventions.~~ The capacity to experience hypnosis can be spontaneous or it can be activated by a formal induction procedure which taps the inherent ~~neural~~ hypnotic capacity of the individual. This capacity varies widely but is a stable trait that can be reliably measured in clinical and research settings. Hypnosis provides an adjunct to research, to diagnosis, and to treatment in psychiatric and other medical practice. ~~Because of its intensity and adaptability to training patients in the use of self-hypnosis for symptom management, it often shortens the clinical time required for a psychotherapeutic effect.~~

Randomized clinical trials have shown that interventions employing hypnosis are effective in the treatment of pain, anxiety, stress, ~~cancer surgery,~~ phobias, psychosomatic disorders, nausea and vomiting, irritable bowel syndrome, and habit control problems, such as smoking and weight control. It is also helpful in the management of patients with dissociative and posttraumatic stress disorders. Also, hypnosis may enhance the effectiveness of analgesia and anxiolysis in the context of medical procedures. ~~Clinical trials have demonstrated comparable outcomes to exposure-based and psychodynamic treatment for PTSD, smoking cessation rates that compare favorably with pharmacological approaches, and superior analgesia and anti-anxiety effects to standard medication during medical procedures.~~

Issue:

Hypnosis is being delivered by a wide variety of professional and non-professional clinicians who vary in their training to deliver hypnosis and who vary in the way that they delivery hypnosis therapy.

APA Position:

1. ~~Since h~~Hypnosis ~~is a psychotherapeutic facilitator of a primary treatment strategy, it~~ should be employed by psychiatrists~~, other physicians, psychologists,~~ or other health care professionals with appropriate licensure and training, and it should be implemented within the scope of their professional expertise.
2. ~~2.~~ Hypnosis should be implemented in the context of a thorough medical and psychiatric evaluation, and its delivery should be consistent with the treatment plan for that patient. ~~or hypnotic treatment, as in any other psychiatric medical procedure, calls for all examinations necessary to a properly diagnose diagnosis and to the formulation of adequately formulate the immediate therapeutic needs of the patient. The technique of induction and termination of the trance state should be clearly structured and usually can be brief. Long induction ceremonies using a sleep paradigm are misleading.~~
3. The induction and termination of the trance state should be clearly structured and consistent with evidence-based hypnosis practice.

4. Hypnosis training should be delivered by professionally credentialed institutions and, optimally, includes both didactic education and supervised clinical contact.

~~Because of the heightened responsiveness to suggestion in hypnosis, it is especially important that therapeutic strategies and language be formulated carefully. Although similar dangers attend the improper or inept use of all other aspects of the doctor-patient relationship, the nature of hypnosis renders its inappropriate use particularly hazardous. For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is essential.~~

~~Since hypnosis has definite application in the various fields of medicine and allied health care disciplines, appropriate training is important. Courses conducted, physicians have recently shown increasing interest in hypnosis and have turned to psychiatrists for training in hypnosis.~~

~~To be adequate for medical purposes, all courses in hypnosis should be given in conjunction with recognized medical teaching institutions or teaching hospitals, or appropriate professional organizations in medicine, psychology, and related disciplines provide a basis for practice. under the auspices of the department of psychiatry and in collaboration with those other departments which are similarly interested. Although lectures, demonstrations, seminars, conferences and discussions are helpful, the basic learning experience must should also derive from closely supervised clinical contact with patients. Since such psychiatrically centered courses are virtually non-existent, many physicians have enrolled in the inadequate brief courses available, which are taught often by individuals without medical or psychiatric training. These courses have concentrated on prolonged redundant induction ceremonies and have neglected or covered psychodynamics and psychopathology in a superficial or stereotyped fashion.~~

Originally developed by the APA Committee on Therapy and adopted by the APA Council in 1961. This revision was prepared by David Spiegel, M.D., Michael First, M.D., and John Krystal, M.D. ~~and Herbert Spiegel, M.D.~~

(Clean Version, For Readability)

Title: Position Statement on Hypnosis

Background:
Hypnosis is a state of aroused, attentive, focal concentration accompanied by a relative reduction in peripheral awareness (dissociation), and heightened response to social cues (suggestibility). It can be utilized to facilitate a variety of psychotherapeutic interventions, including psychodynamic, cognitive-behavioral, and exposure-based treatments. The capacity to experience hypnosis can be spontaneous or it can be activated by a formal induction procedure, which taps the inherent hypnotic capacity of the individual. This capacity varies widely but is a stable trait that can be reliably measured in clinical and research settings. Hypnosis provides an adjunct to research, to diagnosis, and to treatment in psychiatric and other medical practice.

Randomized clinical trials have shown that interventions employing hypnosis are effective in the treatment of pain, anxiety, stress, phobias, psychosomatic disorders, nausea and vomiting, irritable

bowel syndrome, and habit control problems, such as smoking and weight control. It is also helpful in the management of patients with dissociative and posttraumatic stress disorders. Also, hypnosis may enhance the effectiveness of analgesia and anxiolysis in the context of medical procedures.

Issue:
Hypnosis is being delivered by a wide variety of professional and non-professional clinicians who vary in their training to deliver hypnosis and who vary in the way that they deliver hypnosis therapy.

APA Position:

1. **Hypnosis should be employed by psychiatrists or other health care professionals with appropriate licensure and training, and it should be implemented within the scope of their professional expertise.**
2. **Hypnosis should be implemented in the context of a thorough medical and psychiatric evaluation, and its delivery should be consistent with the treatment plan for that patient.**
3. **The induction and termination of the trance state should be clearly structured and consistent with evidence-based hypnosis practice.**
4. **Hypnosis training should be delivered by professionally credentialed individuals and, optimally, includes both didactic education and supervised clinical contact.**

Dates and Authorship:
Originally developed by the APA Committee on Therapy and adopted by the APA Council in 1961. This revision was prepared by David Spiegel, M.D., Michael First, M.D., and John Krystal, M.D., in 2015.

Item 2015A2 4.B.12
Assembly
October 30-November 1, 2015

Title: Posttraumatic Stress Disorder and Traumatic Brain Injury

Issue:
As the nation cares for those returning from war as well as those who are victims of violence in our own country, the importance of sustaining research and education to better care for those with both psychiatric and neurologic injury such as Posttraumatic Stress Disorder and Traumatic Brain Injury is prominent.

Position Statement:

The APA strongly encourages the support and development of neuropsychiatry research, education and training for care to meet the needs of those with combined psychiatric and neurologic disorders particularly Posttraumatic Stress Disorder and Traumatic Brain Injury.

Adoption Date and Authors:
Approved by the Board of Trustees, May 2010
Approved by the Assembly, November 2009
Developed by the Council on Research and Quality Care and revised by the Joint Reference Committee.

Background:
Posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) are complex conditions that can co-occur, particularly in combat veterans. The prevalence of PTSD and TBI has increased over the past several decades due to persisting engagement of the U.S. in combat, the increased survival rate of individuals with life-threatening physical injuries, and the increased awareness and screening for each disorder (See NCPTSD Research Quarterly 2010;21(1); available at: http://www.ptsd.va.gov/PTSD/professional/newsletters/research-quarterly/v21n1.pdf). In particular, comprehensive screening initiatives in the Department of Defense and Department of Veterans affairs have increased the diagnosis of PTSD and mild-to-moderate TBI. PTSD is among the most common psychiatric disorders in military populations (male and female), and among military personnel, presence of TBI has been found to increase the likelihood of PTSD by 3-fold (Carlson et al. 2010).

PTSD involves the presence of intrusive memories, persistent avoidance of stimuli that are reminders of the trauma, negative alterations in cognition or mood, and alterations in arousal and reactivity. It also carries a significant risk of suicidal ideation and attempts (Panagioti et al. 2012, Panagioti et al, 2009) and is commonly comorbid with substance use disorders, depression, and anxiety disorders (Kessler et al., 1995; Ginzberg et al. 2010).

Symptoms of TBI can vary depending on severity of injury and time elapsed since injury. Changes in memory, headache, and confusion or alteration in mental status all can occur even with mild TBI. At more severe levels, loss of consciousness or death can occur. Physical and neurocognitive symptoms can remain for weeks to months post-injury. TBI is a strong predictor of subsequent PTSD (Yurgil et al., 2014). In addition to PTSD, TBI may be associated with chronic pain (Cifu et al., 2013), mood and anxiety symptoms (Kim et al., 2007; Jorge et al., 2004), and suicidal behavior (Silver et al., 2002). The presence of PTSD may mediate the relationship between mild-to-moderate TBI and behavioral, mood, and anxiety symptoms. Thus, when these symptoms are present in the context of TBI, PTSD treatment may be indicated (Zatzick et al., 2010).

Co-occurrence of PTSD and TBI is associated with significant psychosocial and functional impairments as well as decrements in quality of life. The overlap of symptoms associated with each individual syndrome may make complicate the diagnosis of their co-occurrence. There is some evidence that presence of TBI can influence symptoms of PTSD (Simonovic et al. 2011), but findings are not consistent.

There are no controlled studies of the treatment of PTSD comorbid with TBI; thus, no firm conclusions can be drawn about the optimal treatment of this comorbidity. Cognitive behavioral therapy is a validated treatment for PTSD that has been applied to the comorbid group of patients (McMillan et al., 2003).

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Other Relevant Resources:

Comorbidity of PTSD and TBI: http://www.ptsd.va.gov/professional/co-occurring/traumatic-brain-injury-ptsd.asp

Item 2015A2 4.B.13
Assembly
October 30-November 1, 2015

Position Statement on High Volume Psychiatric Practice and Quality of Patient Care

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

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Psychiatrists must practice in ways that maintain the quality of the treatment provided and the safety of their patients. Financial, organizational or other administrative pressures imposed by psychiatric or non-psychiatric administrators should not compromise the quality or safety of the care psychiatrists provide, such as when these non-clinical pressures may impinge on the time allocated to conduct evaluation and treatment in conformance with standard of practice.

Developed by the former Council on Quality Care.

Item 2015A2 4.B.14
Assembly
October 30-November 1, 2015

POSITION STATEMENT

TITLE: Tobacco Use Disorder

ISSUE: As one of the most addictive substances, tobacco has the highest prevalence of all psychiatric and substance-related disorders in the United States; tobacco is also the most common preventable cause of mortality in the United States, causing 480,000 premature deaths, 200,000 of which are among persons with mental illnesses and substance use disorders. Approximately 18% of the U.S. population are cigarette smokers; while smoking rates have declined steadily overall in the US since 1965, prevalence remains high among adults with mental health and substance use disorders, with recent estimates ranging from 50% to 85%. People with mental illness consume about half of all cigarettes sold in the US and carry a disproportionate share of the medical burden, including cardiovascular and pulmonary diseases and cancer associated with smoking. Accruing evidence indicates that tobacco use worsens the course of psychiatric disorders and that quitting tobacco decreases anxiety and improves mood. National practice guidelines recommend providing evidence-based tobacco cessation treatment to all smokers, and given the high prevalence, morbidity and mortality in psychiatric and behavioral health settings, treatment is even more essential.

APA Position:
APA advocates and supports the development of policies and programs that promote prevention, treatment, and research activities in the area of tobacco use disorder. It urges:

1. All mental health providers to ask, advise, assess, assist and arrange follow up on tobacco use disorder at initial intake and as clinically indicated thereafter;
2. Appropriate diagnosis and treatment of tobacco use disorder as a comorbid condition with other psychiatric disorders while recognizing the possible role of tobacco and underlying neurochemical mechanisms in the understanding, diagnosis, and treatment of other psychiatric disorders, including comorbid substance use;
3. Psychiatrists to address the prevention of tobacco use, as patients with other mental disorders are especially vulnerable to developing tobacco use disorder; and
4. Psychiatrists to be active in research, prevention, and advocacy related to reducing tobacco use; and
5. Expanded teaching about the nature of tobacco use disorder and its treatment in medical schools, psychiatry residency training programs, addiction fellowship training programs, and continuing professional education programs to a level comparable to levels for other substance-related disorders.

Additionally the APA supports and advocates for:
1. Policies that aid in the prevention and reduction of tobacco use;
2. Development of tobacco-free policies in all health care facilities and in society at large, and the development provision of treatments for tobacco use disorder for institutionalized patients.
3. Adequate health insurance coverage of both pharmacological and behavioral treatments of tobacco use disorder by qualified health professionals, especially via third party payers or government supported insurance who can provide reimbursement; and
4. Public education to reduce and prevent tobacco use.

Authors: APA Workgroup on Tobacco Use Disorder, Council on Addiction Psychiatry

Background: Tobacco Use Disorder

Tobacco use is the largest and most preventable cause of mortality in the United States. According to the U.S. Office on Smoking and Health, smoking causes more than more than 480,000 premature deaths annually among U.S. smokers alone, with minority and low-income populations at special risk. Almost half of those deaths that occur each year from smoking are among people with mental illness and/or substance use disorders. There is also evidence for an independent association between suicide in males and current smoking and longer lifetime smoking duration.

Tobacco use disorder and withdrawal can influence the diagnosis and treatment of psychiatric disorders. For example, symptoms of nicotine withdrawal (e.g., dysphoria, irritability, restlessness and insomnia) can be confused with some psychiatric disorders and conditions (e.g., akathisia, depression, and alcohol withdrawal). Smoking, via action of inhaled aromatic hydrocarbons (not nicotine) decreases blood levels of several medications (through induction of the hepatic CYP 1A2 system) which may require higher doses of medications among smokers and necessitate dose adjustments for certain psychotropic drugs if patients quit or reduce smoking. In some cases (e.g. recurrent depression), smoking cessation may appear to temporarily worsen symptoms or produce an exacerbation of illness symptoms, but this is generally due to withdrawal (smoking is not a method of self-medication for psychiatric disorders). On the other hand, treatment of tobacco use disorder is associated with a decreased likelihood of rehospitalization, reduction in psychiatric symptoms, and an increased likelihood of sobriety among smokers in treatment for addictive disorders. There is increasing evidence that treating tobacco use disorder has a synergistic effect in the long term in mental health and substance use recovery.

Tobacco use disorder can be treated by using pharmacological, behavioral, or psychosocial treatments or a combination. Tobacco use disorder should be integrated into every patient's assessment and plan at every visit. The 7 FDA approved pharmacological treatments include nicotine replacement therapies (e.g. patch, gum, lozenge, inhaler and nasal spray), sustained-release bupropion and the nicotinic partial agonist varenicline. Treatment of tobacco use disorders can reduce the deleterious health consequences of smoking that disproportionately affect those with mental illness. Psychiatrists are uniquely positioned to provide an impactful treatment given their knowledge and skills in psychotherapy (ie cognitive behavioral relapse prevention or mindfulness models) and pharmacological therapies. Psychosocial treatments include groups, quit lines and integrated care models.

Psychiatrists must take an active role in research into the causes, prevention and treatment of tobacco use disorders. In a recent survey by the American Association of Medical Colleges, it was found that nearly a quarter of psychiatrists felt that smoking cessation leads to worsening of other symptoms and almost half of psychiatrists felt that there are too many more immediate problems to address. There is extensive research that treating tobacco use disorder does not worsen other psychiatric outcomes and likely improves the course of these disorders. Although tobacco use is recognized as the most preventable cause of early of early death and disability in the Western world, only a small portion of the overall federal budget for medical research supports research on behavioral and psychiatric aspects of tobacco use disorder. Areas of particular relevance to psychiatry include the comorbidity of tobacco use disorder with other mental disorders, the potential role of nicotine in biochemical systems involved in cognition, substance use disorders and motivation in general. The effects of tobacco-free inpatient

units on the psychiatric treatment of patients, methods and timing of tobacco cessation treatment for patients with substance use disorders, the potential beneficial effects of nicotine and nicotinic agents on clinical and cognitive aspects of psychiatric conditions, risks/risk reduction potential of newer electronic delivery systems and the effect of tobacco use on efficacy of interventions for other psychiatric disorders are all deemed to be crucial areas for future research.

Strategies that promote prevention, treatment, and research activities in the area of tobacco use disorder include, but are not limited to, the following:

Primary Focus	**Recommendations**
Individual Providers	• All mental health providers implement the 5 A's: ask, advise, assess, assist and arrange follow up on tobacco use disorder in routine clinical encounters. • Appropriate diagnosis and treatment of tobacco use disorder as a comorbid condition with other psychiatric disorders. • Activity in research, prevention, and advocacy related to reducing tobacco use.
Education	• Expand teaching about the nature of tobacco use disorder and its treatment in medical schools, psychiatry residency training programs, psychiatry fellowship training programs and continuing professional education programs to a level comparable to levels for other substance-related disorders. • Specialized training and education for psychiatrists and trainees about the unique assessment and treatment issues for tobacco use and related nicotine products amongst their patients with mental illness and / or substance use disorders, including impact on medication blood levels, severity of tobacco use, and social support for quitting.
Systems	• Development of tobacco-free policies in all health care facilities, and in society at large, and the development of treatments for tobacco use disorder for institutionalized patients. • Policies that aid in the prevention and reduction of smoking. These may include the following: 1. Prohibiting advertising and sports-activity sponsorship that promote smoking; 2. Controlling the availability of tobacco products to young persons through the establishment of a national minimum age of 21 years for purchase of tobacco products and improving the enforcement of existing laws regulating the sale of tobacco products; 3. Banning advertisements in print and other media and abolishing the use of entertainers or sports activities to promote tobacco; 4. Eliminating subsidies and all other forms of government assistance that encourage the production or exportation of tobacco and tobacco products and, concomitant with this, encouraging funding of transition programs for those with tobacco-related jobs; 5. Increasing the state and federal taxes on tobacco products and applying the proceeds of such taxes to the prevention, treatment, and research on tobacco use disorder; and 6. Changing the warning labels on tobacco products to include the high likelihood of developing tobacco use disorder and the significant effects on morbidity/mortality. • Expand public education in ways such as the following: 1. Promote early teaching in schools to inform young people about the high risk of developing tobacco use disorder after experimentation with tobacco and about the health hazards consequent to it; and 2. Promote counter marketing measures, including public service announcements and anti-tobacco marketing programs, to counter the seduction of tobacco advertising imagery and to educate the public about the hazards of smoking, to discourage experimentation with smoking, and to promote tobacco cessation. • Advocate adequate health insurance coverage of both pharmacological and behavioral treatments of tobacco use disorder by qualified health professionals, especially via third

	party payers or government supported insurance who can provide reimbursement.

In summary, tobacco use disorder takes an enormous toll on the physical and mental health of our nation and the rest of the world, disproportionately affecting people with psychiatric and substance use disorders. APA urges all of its members to work toward the goals outlined in this statement.

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Item 2015A2 4.B.15
Assembly
October 30-November 1, 2015

Position Statement on Psychotherapy as an Essential Skill of Psychiatrists

Approved by the Board of Trustees, July 2014
Approved by the Assembly, May 2014

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Issue

Psychiatrists are uniquely positioned to provide comprehensive, integrated treatment either by providing medication alone, psychotherapy alone, or combined treatment. Importantly, psychotherapy and prescribing medication flourish on the same foundation—confidentiality, trust, and active patient participation—which readily allows psychiatrists to change or add treatment modalities e.g., switch from psychotherapy to medications or add medication to psychotherapy, while keeping a clear focus on the complex interplay of patient, practitioner, pharmacotherapy, and psychotherapy. Even when a psychiatrist provides "only" medication, psychotherapeutic elements in the therapeutic alliance enhance the effectiveness of any medication. Indeed, although cost per session is higher for psychiatrists, integrated psychiatric care (as compared to split treatment by a psychiatrist and non-MD therapist) may lead to lower total costs and decreased patient suffering.

Position Statement

The APA advocates for psychotherapy to remain a central treatment option for all patients and for psychotherapy (alone or as part of combined treatment) by psychiatrists to be reimbursed by payers in a manner that integrates care and does not provide financial incentives for isolating biological treatments from psychosocial interventions, e.g., isolated use of medication management without consideration of psychosocial issues requiring essential psychotherapy. The APA supports the Accreditation Council for Graduate Medical Education (ACGME)/ Residency Review Committee (RRC) in their continued accreditation requirement that psychiatry resident training programs provide comprehensive training in evidence-based psychotherapies, as well as in collaborative treatment models. It collaborates with AADPRT and AACDP to address the increasing difficulty programs face in supporting the time and money required for teaching and supervising psychotherapy.

Authors: Mantosh Dewan, M.D., Michele T. Pato, M.D., Nicole Del Castillo, M.D. (Council on Research and Quality Care)

POSITION STATEMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT [1]

Prepared by the Council on Psychiatry and Law

Approved by the Board of Trustees, TBD

Approved by the Assembly, TBD

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

The American Psychiatric Association recognizes that there is a substantial population of persons with severe mental illness whose complex treatment and human service needs go unmet by community mental health programs. For many persons so affected, their course is frequently complicated by non-adherence with treatment and as a result, they frequently relapse, are hospitalized or incarcerated. They also interact with a variety of human service agencies— substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and patient outcomes, has led policymakers to consider court-ordered treatment as a way to improve treatment adherence. In this document the term 'involuntary outpatient commitment' is used to refer to outpatient treatment mandated under state involuntary commitment statutes.

Involuntary outpatient commitment is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It can be used on release from involuntary hospitalization, an alternative to involuntary hospitalization or as a preventive treatment for those who do not currently meet criteria for involuntary hospitalization. It should be used in each of these instances for patients who need treatment to prevent relapse or behaviors that are dangerous to self or others.

Involuntary outpatient commitment programs have demonstrated their effectiveness when *systematically implemented*, *linked to intensive outpatient services* and *prescribed for extended periods of time*. Based on empirical findings and on accumulating clinical experience, involuntary outpatient commitment can be a useful tool in the effort to treat patients with severe mental illness with clinical histories of relapse and re-hospitalization. It is important to emphasize, however, that all programs of involuntary outpatient commitment must include these elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective. There is also clear evidence that involuntary outpatient commitment programs help focus the attention and effort of the providers on the treatment needs of the patients subject to

[1] Outpatient court-ordered treatment may be referred to as 'assisted outpatient treatment', 'involuntary outpatient commitment', 'mandated community treatment', or 'community treatment orders'. Some regard the term 'assisted outpatient treatment' as a euphemistic term for treatment under coercion. In this document the term 'involuntary outpatient commitment' is used to refer to these programs.

involuntary outpatient commitment.

Involuntary outpatient treatment raises an ethical tension between the principles of autonomy and beneficence. Therefore states should make every effort to dedicate resources to voluntary outpatient treatment and only if such treatment fails resort to involuntary treatment. Psychiatrists must be aware of the conflict between the patient's interest in self-determination and promotion of the patient's medical best interest. In any system of treatment, including involuntary outpatient treatment, principles of non-maleficence—doing no harm—and justice must be considered. Involuntary treatment, like any intervention, must not be discriminatory, and must be fairly applied and respectful of all persons.

The APA supports the following positions and principles regarding involuntary outpatient commitment.

1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness.

2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

3. Involuntary outpatient commitment should be available in a preventive form and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization. The preventive form should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness.

4. Assessment of the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on a clearly delineated clinical history of such episodes in the past several years based on available clinical information.

5. Involuntary outpatient commitment should be available to assist patients who, as a result of their mental illness, are unlikely to seek or voluntarily adhere to needed treatment.

6. Studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

7. States authorizing involuntary outpatient commitment should provide due process protections equivalent to those afforded patients subject to involuntary hospitalization.

8. Data have shown that involuntary outpatient commitment is likely to be most successful when it is provided for a sustained period of time. Statutes authorizing involuntary outpatient commitment should consider authorizing initial commitment periods of 180 days, permitting extensions of the commitment period based on specified criteria to be demonstrated at regularly scheduled hearings. Based on clinical judgement, such orders may be terminated prior to the end of a commitment period as deemed appropriate.

9. A thorough psychiatric and physical examination should be a required component of involuntary outpatient

commitment, because many patients needing mandated psychiatric treatment also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery. Clinical judgment should be employed in determining when, where and how these examinations are carried out.

10. Clinicians who are expected to provide the court-ordered treatment must be involved in decision-making processes to assure that they are able and willing to execute the proposed treatment plan. Before treatment is ordered, the court should be satisfied that the recommended course of treatment is available through the proposed providers.

11. Efforts to engage patients and, where appropriate, their families in treatment should be a cornerstone of treatment, even though court-ordered. Patients and their families should be consulted about their treatment preferences and should be provided with a copy of the involuntary outpatient commitment plan, so that they will be aware of the conditions to which the patient will be expected to adhere.

12. Involuntary outpatient commitment statutes should contain specific procedures to be followed in the event of patient non-adherence and should ensure maximum efforts to engage patients in adhering to treatment plans. In the event of treatment non-adherence, provisions to assist with adherence may include empowering law enforcement officers to assume custody of non-adherent patients to bring them to the treatment facility for evaluation. In all cases there should be specific provisions for a court hearing when providers recommend involuntary hospitalization or a substantial change in the court order.

13. Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan when medication is indicated. However, involuntary administration of medication should not be authorized as part of the involuntary commitment order without separate review and approval consistent with the state's process for authorizing involuntary administration of medication on an outpatient basis.

14. Implementation of a program of involuntary outpatient commitment requires critical clinical and administrative resources and accountability. These include administrative oversight of and accountability for involuntary outpatient commitment program operations, the ability to monitor patient and provider adherence with treatment plans, the ability to track involuntary outpatient commitment orders and to report program outcomes.

15. There is limited research to evaluate the possible disproportionate use of involuntary outpatient commitment among minority and disenfranchised groups. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.

Item 2015A2 5.A
Assembly
October 30-November 1, 2015

Minutes of a Meeting of the Assembly of the American Psychiatric Association Metro Toronto Convention Centre – Toronto, Ontario, CANADA May 15-17, 2015

Welcome and Introductions

Dr. Jenny L. Boyer, Speaker of the Assembly, called the 82nd meeting of the Assembly of the American Psychiatric Association (APA) to order on May 15th, 2014, at the Metro Toronto Convention Centre in Toronto, Canada. Dr. Boyer recognized Dr. Padraic Carr, President of the Canadian Psychiatric Association (CPA) who welcomed the Assembly to Canada. Dr. Carr emphasized the common goals of CPA and the APA in supporting psychiatrists in practice, education and advocating for patient care.

The Assembly had moments of silence for Prakash Desai, M.D., Past Speaker of the Assembly, Herbert Peyser, M.D., Representative, New York State Psychiatric Association, and for Yusor Mohammad Abu-Salha, Razan Mohammad Abu-Salha, and Deah Shaddy Barakat, the daughters and son-in-law of APA member Mohammed Abu-Salha, M.D.

1. Remarks of the Board of Trustees

Report of the APA President

Dr. Paul Summergrad, APA President addressed the APA Assembly. Dr. Summergrad highlighted some of the work the Assembly and Board of Trustees have done together including the request to the ABPN that it lobby the American Board of Medical Specialties (ABMS) to make Part 4 of the MOC optional. This was an issue that was brought forward by the Assembly Executive Committee and subsequently passed unanimously by the Board of Trustees. Dr. Summergrad also highlighted the joint efforts of both the Assembly and Board of Trustees on the development of the APA's new strategic priorities, which were approved by the Board of Trustees in March, 2015.

The strategic priorities of the APA are:

1. Advancing the integration of psychiatry in the evolving health care delivery system by
    a. Advocating for the central role of psychiatry in all care settings and working to ensure full implementation and robust enforcement of mental health parity
    b. Meeting the educational needs of members throughout their careers and providing assistance to them in the changing practice environment and as new technologies emerge
    c. Building the psychiatric workforce, developing and advocating for equitable reimbursement models, and safeguarding the practice of psychiatric medicine.

2. Supporting research to advance treatment and the best possible clinical care, as well as to inform credible quality standards; advocating for increased research funding. APA will enhance clinical care and reduce the burden of mental illness for our patients and society by
    a. Leading the development, refinement, and evaluation of appropriate quality measures
    b. Conducting, supporting, and encouraging research, including data analysis and registries to inform APA, its members, and society about current and future best practices of mental health delivery and clinical care

c. Leading advocacy to increase funding from public and private sources to advance the understanding, prevention, treatment, and ultimate cure of mental illness.

3. Educating patients, families, the public, and other practitioners about mental disorders and evidence-based treatment options.

4. Supporting and increasing diversity within APA; serving the needs of evolving, diverse, underrepresented, and underserved patient populations; and working to end disparities in mental health care.

Dr. Summergrad concluded his remarks by stressing the need for the organization to work together to accomplish its goals.

Report of the President-Elect

Dr. Renée Binder, APA President-Elect addressed the Assembly. Dr. Binder reminded members that most of the action items of the Assembly are sent to the Joint Reference Committee (JRC), a committee chaired by the President-Elect. The JRC reviews and assigns the action papers to various APA Councils or other referrals, as appropriate.

Dr. Binder announced some initiatives she plans to focus on during her presidential year. One is that "There is no health care without mental health care". Dr. Binder has already formed a Board Ad Hoc Work Group on Telepsychiatry which will be presenting at the IPS meeting in New York City as well as at next year's APA Annual Meeting in Atlanta. Another initiative will focus on the criminalization of people with mental illness which has become a critical issue in the United States due to the closure of many state hospitals and the defunding of mental health services. Dr. Binder is planning a marquee event, cosponsored by the APA and the American Psychiatric Foundation. A third area of focus during her presidency has to do with ethics. Dr. Binder noted that the APA, under the leadership of Dr. Steven Sharfstein, took a very strong stance that psychiatrists should not participate in torture. This is an example of how ethics are not static. Dr. Binder has appointed a Board Ad Hoc Work Group to Revise the Ethics Annotations with the groups asked to review the current APA Code of Ethics.

C. Treasurer

Dr. Frank Brown, Treasurer, presented his report to the Assembly. APA's unrestricted revenue is $5.170M over budget due to significant contributions from DSM ($1.655) publishing in general ($1.949) CME ($1.099) and Membership ($469k). Unrestricted expenses are $258K under budget. Investment income was $4.3M compared to $5.6M in 2013. Reserves for the American Psychiatric Foundation are at approximately $62 million and the APA has approximately $82 million in its reserves.

2. Report of the CEO and Medical Director

Dr. Saul Levin, MPA, CEO and Medical Director addressed the Assembly. He noted that it has been wonderful working with Drs. Boyer, Martin, and Anzia as well as the rest of the Assembly Executive Committee. He thanked the Assembly for its hard work as well.

Dr. Levin introduced Dr. Ranna Parekh, the Director of the APA's Division of Diversity and Health Equity, Dr. Tristan Gorrindo, the Director of Education, and Nicole Lewis, Special Assistant to the CEO and Medical Director. Dr. Levin also thanked Margaret Dewar and the staff of Association Governance for its hard work on behalf of the Assembly.

Dr. Levin announced that the new APA brand will be revealed at the Opening Session. He thanked Jason Young, Chief Communications Officer, who headed the APA's new branding initiative. He stressed that the Benjamin Rush seal will continue to be the official seal of the APA.

Dr. Levin highlighted the work the APA continues to do for mental health parity including meeting with the Department of Labor (DOL), who has indicated a willingness to investigate any insurance plans that do not include mental health parity. The APA developed a questionnaire for APA members, data from which the APA will use to help the Department of Labor identify insurance companies who are not parity compliant.

On May 1, Understanding Mental Disorders: Your Guide to DSM-5 was released. The consumer guide is to help educate people with mental illnesses and their families. It included collaboration with many mental health organizations including NAMI, Mental Health America, and SAMHSA. American Psychiatric Association Publishing has updated its website (http://www.appi.org) to make it more user friendly.

In terms of membership, the APA continues into its second year of growth. The APA has had a 4.4% increase in membership for 2014, a 3.1% increase in dues paying members, 4.6% increase in RFMs, 2.3% increase in ECPs, 26.6% increase in international psychiatrist members, and a 37.1% increase in medical students joining the APA.

Dr. Levin noted that the APA re-endorsed American Professional Agency, Inc., (http://www.americanprofessional.com/) as its liability insurance provider. The focus of the endorsement was making a program that is a true member benefit in which members are more financially protected than before with industry leading terms. He also highlighted the creation of the Find a Psychiatrist feature on the APA website which is an APA benefit for psychiatrists who are accepting patients. Members can opt-in to the database and see its functionality at: http://finder.psychiatry.org/.

Dr. Levin concluded his remarks by emphasizing the importance of donating to the American Psychiatric Association Political Action Committee (APA*PAC*), and answering some questions from the Assembly members.

5. Report of the Recorder

Dr. Daniel Anzia, Recorder, referred members to his report contained within Section 5 of the backup materials. He asked that the Assembly approve the minutes of the November 7-9, 2014 meeting (5.A).

> **Action: Will the Assembly vote to approve the minutes of its November 7-9, 2014 Meeting? The Assembly voted to approve the November 2014 Assembly Minutes**.

Dr. Anzia sought to determine if a quorum was present by asking if representatives from the following District Branches were in attendance: *Ontario District Branch, Quebec and Eastern Canada District Branch, Rhode Island Psychiatric Society, Indiana Psychiatric Society, Iowa Psychiatric Society, Michigan Psychiatric Society, Minnesota Psychiatric Society, Nebraska Psychiatric Society, North Dakota Psychiatric Society, South Dakota Psychiatric Association, Arkansas Psychiatric Society, Mississippi Psychiatric Association, North Carolina Psychiatric Association, Puerto Rico Psychiatric Society, Tennessee Psychiatric Association, Alaska District Branch, Idaho Psychiatric Association, Montana Psychiatric Association, Nevada Psychiatric Association, and the Psychiatric Medical Association of New Mexico.* Of the District Branches called, the following had representation at the meeting: *Ontario District Branch, Rhode Island Psychiatric Society, Indiana Psychiatric Society, Iowa Psychiatric Society, Michigan Psychiatric Society, Minnesota Psychiatric Society, North Dakota Psychiatric Society, South Dakota Psychiatric Association, Arkansas Psychiatric Society, Mississippi Psychiatric Association, North Carolina Psychiatric Association, Puerto Rico Psychiatric Society, Idaho Psychiatric Association, Montana Psychiatric Association, Nevada Psychiatric Association, and the Psychiatric Medical Association of New Mexico.*

Dr. Anzia declared a quorum of the Assembly.

6. Report of the Rules Committee

Dr. Melinda Young, Chair of the Rules Committee, referred the Assembly to the Rules Committee report. Item 6.A included the action assignments to reference committees and other Assembly groups. Dr. Young presented Item 6.B, the consent calendar, and asked if any member of the Assembly wished to add or remove any item. Items 4.B.4, and 4.B.17 were removed from the consent calendar.

Action: Will the Assembly vote to approve the Consent Calendar with the exception of 4.B.4, and 4.B.17 removed?
The Assembly voted to approve the Consent Calendar as amended.

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

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

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

7. Reports of Assembly Committees

A. Nominating Committee

Dr. Melinda Young, Chair of the Assembly Nominating Committee reminded the Assembly of the procedures for Assembly election voting and reviewed the roster of Assembly candidates for 2015-2016. For Speaker-Elect: Dr. Daniel Anzia (Area 4) and Dr. Robert Roca (Area 3). For Recorder: Dr. Ludmila De Faria (Area 5), and Dr. Theresa Miskimen (Area 3). Later in the meeting Dr. Young announced the voting results.

Dr. Daniel Anzia was elected as Speaker-Elect
Dr. Theresa Miskimen was elected as Recorder

B. Committee on Procedures

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

ACTION: Will the Assembly vote to approve the proposed language in the *Procedural Code* to reflect the Assembly Reorganization and the new voting strength formula?

The Assembly voted to approve the proposed language in the *Procedural Code* to reflect the Assembly Reorganization and the new voting strength formula.

ACTION: Will the Assembly vote to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant?

The Assembly voted to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant.

ACTION: Will the Assembly vote to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "*Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)*"?

The Assembly voted to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)".

ACTION: Will the Assembly vote to approve the recommended amendments to the Criteria to become an Allied Organization in Article V- Allied Organizations of the *Procedural Code* to offer inclusiveness to the Assembly Allied Organizations?

The Assembly voted to approve the recommended amendments to the Criteria to become an Allied Organization in Article V- Allied Organizations of the *Procedural Code* to offer inclusiveness in the Assembly Allied Organizations.

ACTION: Will the Assembly vote to approve the language for the *Procedural Code* under Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs?

The Assembly voted to approve the language for the *Procedural Code* under Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs.

ACTION: Will the Assembly vote to approve the recommended language to the *Procedural Code* in Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs, to reflect the APA Bylaws?

The Assembly voted to approve the recommended language to the *Procedural Code* in Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs, to reflect the APA Bylaws.

ACTION: Will the Assembly vote to approve the recommended language to the *Procedural Code* in Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures, that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis?

The Assembly voted to approve the recommended language to the *Procedural Code* in Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures, that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis.

8. Reports of Councils and Components

Written Council Reports may be found in the backup materials.

10. Reports from Special Components

A. APA AMA Delegation Report & Remarks from David Barbe, M.D., Immediate Past Chair, AMA Board of Trustees

Dr. David Barbe, Immediate Past Chair of the AMA Board of Trustees reported to the Assembly on the recent activities of the AMA. He noted that the AMA House of Delegates is made up of 186 state and specialty societies. The AMA is governed by a House of Delegates, the policy setting body of the AMA.

The APA has seven delegates and six alternate delegates. There are also many other psychiatrists involved in the AMA and psychiatrists are well represented on the AMA councils.

Dr. Barbe explained that the AMA has been working hard on the issue of SGR and that the repeal of SGR has been an excellent move forward towards bettering Medicare and the health care system. In addition to SGR, the AMA has been working on other issues such as the ICD-10 and electronic health records. The AMA has been working with other groups, such as the APA, on recommended changes to EHR so that it can become a useful tool. The AMA and APA have also been working on CPT and the RUC. CMS has now adopted some new definitions of values of mental health codes which will shift some Medicare money into mental health diagnoses and codes.

In the area of improving health outcomes, the AMA has partnered with Johns Hopkins on blood pressure programs and the YMCA on pre-diabetes education. The AMA is also looking at physician satisfaction and practice sustainability. Dr. Barbe completed his report by stressing the importance of the AMA/APA relationship.

Presentation of Assembly Awards:

District Branch Best Practice Award

Dr. R. Scott Benson presented the District Branch Best Practice Award to the North Carolina Psychiatric Association. An honorable mention for the award also went to the New York County District Branch.

Ronald Shellow Award

The Ronald Shellow Award was presented posthumously to Dr., Herbert Peyser, Representative, New York State Psychiatric Association. The award will be presented to his family in New York at a later date.

Remarks from Lois Margaret Nora, MD, JD, MBA, President and Chief Executive Officer, American Board of Medical Specialties (ABMS)

Dr. Nora, President and Chief Executive Officer of the American Board of Medical Specialties addressed the Assembly. Dr. Nora stated that the mission of the American Board of Medical Specialties is to serve the public and serve the profession by improving the quality of health care. She spoke about board certification and how it's a key outcome measure for graduate medical education. She explained that maintenance of certification (MOC) was developed in 2006 and is grounded in assessment, educational, and quality science research. ABMS did a review of MOC in 2012-2013 and the feedback received from this review led to significant changes in the MOC standards, including ongoing review of the MOC process. Dr. Nora emphasized that Part 4 of MOC is a way for physicians to be engaged in quality improvement of his/her practice and that the process needs be trusted by the public and believed in by the profession.

Dr. Nora concluded her presentation by responding to questions submitted in writing by the Assembly.

11. Area Council Reports

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

12. Action Papers

Please refer to the Summary of Assembly actions.

13. Old Business

Please refer to the Summary of Assembly actions.

14. New Business

Farewell to Speaker and Welcome to New Speaker

Dr. Martin congratulated Dr. Boyer for her outstanding service as Speaker of the APA Assembly from May 2014 to May 2015. He also presented her with a plaque to commemorate her year as Speaker.

Dr. Boyer welcomed Dr. Martin as Speaker of the Assembly and passed on the Assembly gavel.

13. Adjournment

Respectfully submitted,
Daniel Anzia, M.D.
Assembly Recorder

Assembly
May 15-17, 2015
Toronto, CANADA

SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.1	Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness	The Assembly voted to approve the Proposed Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.2	Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy)	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Medical Necessity Definition (Endorsed AMA Policy).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.3	Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.4	Proposed Position Statement: Patient Access to Electronic Mental Health Records	The Assembly did not approve the Proposed Position Statement: Patient Access to Electronic Mental Health Records as it was felt the position needed additional review.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.5	Revised Position Statement: Confidentiality of Electronic Health Information	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Confidentiality of Electronic Health Information.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.6	Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.7	Retire Position Statement: Active Treatment	The Assembly did not approve the retirement of the Position Statement: Active Treatment as it was felt this position statement is still current.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.8	Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability	The Assembly did not approve the Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability and referred it back to the Council on Geriatric Psychiatry as well as the Council on Psychiatry and Law.	Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.9	Retire Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007)	The Assembly voted, on its Consent Calendar, to retire the Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.10	Retain Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008)	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.11	Retire Position Statement: Employment-Related Psychiatric Examinations	The Assembly voted, on its Consent Calendar, to retire the Position Statement: Employment-Related Psychiatric Examinations.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.12	Revised Position Statement: Publications of Findings from Clinical Trials (2005)	The Assembly voted to approve the Revised Position Statement: Publications of Findings from Clinical Trials (2005).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.13	Retain Position Statement: Use of the Concept of Recovery (2005)	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Use of the Concept of Recovery (2005).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.14	Revised Position Statement: Use of Animals in Research (2009)	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: Use of Animals in Research (2009).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.15	Retain Position Statement: Medication Substitutions (2009)	The Assembly voted, on its Consent Calendar to retain the Position Statement: Medication Substitutions (2009).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.16	Retain Position Statement: Electroconvulsive Therapy (ECT).	The Assembly voted, on its Consent Calendar, to retain the Position Statement: Electroconvulsive Therapy (ECT).	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 4.B.17	Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatric Residency	The Assembly voted to approve the Proposed Position Statement: Support for Four Years of Generalist Training in Adult Psychiatric Residency.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.18	Proposed Position Statement: Neuroscience Training in Psychiatry Residency Training	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: Neuroscience Training in Psychiatry Residency Training.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 4.B.19	Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families	The Assembly voted to approve the Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families.	Board of Trustees, July 2015 FYI- Joint Reference Committee, July 2015 FYI – Melvin Sabshin Library and Archives
2015 A1 5.A	Will the Assembly vote to approve the minutes of the November 7-9, 2014 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 7-9, 2014 meeting.	Chief Operating Officer • Association Governance
2015 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2015A1 4.B.4 and 4.B.17 were removed from the Consent Calendar. The Assembly approved the Consent Calendar as amended.	Chief Operating Officer • Association Governance
2015 A1 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2015 A1 7.A	2015-2016 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2015 to May 2016: Speaker-Elect: Daniel Anzia, M.D., Area 4 Recorder: Theresa Miskimen, M.D., Area 3	Chief Operating Officer • Association Governance
2015 A1 7.B.1	Will the Assembly vote to approve the proposed language in the *Procedural Code* to reflect the Assembly Reorganization and the new voting strength formula?	The Assembly voted to approve the proposed language in the Procedural Code to reflect the Assembly Reorganization and the new voting strength formula.	Chief Operating Officer • Association Governance FYI Office of Ethics and District Branch/State Association Relations
2015 A1 7.B.2	Will the Assembly vote to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant?	The Assembly voted to approve the proposed recommendation that the District Branch appoints a Representative, if the position of the Representative to the Assembly becomes vacant.	Chief Operating Officer • Association Governance FYI Office of Ethics and District Branch/State Association Relations

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 7.B.3	Will the Assembly vote to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)"?	The Assembly voted to approve the recommended amendments to the Procedural Code incorporating the approved Action Paper 12.S "Assembly Allied Organization and Liaisons (AAOSL) Committee Name Change to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS)".	Chief Operating Officer • Association Governance
2015 A1 7.B.4	Will the Assembly vote to approve the recommended amendments to the Criteria to become an Allied Organization in Article V- Allied Organizations of the *Procedural Code* to offer inclusiveness to the Assembly Allied Organizations?	The Assembly voted to approve the recommended amendments to the Criteria to become an Allied Organization in Article V- Allied Organizations of the *Procedural Code* to offer inclusiveness in the Assembly Allied Organizations.	Chief Operating Officer • Association Governance
2015 A1 7.B.5	Will the Assembly vote to approve the language for the *Procedural Code* under Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs?	The Assembly voted to approve the language for the *Procedural Code* under Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs.	Chief Operating Officer • Association Governance
2015 A1 7.B.6	Will the Assembly vote to approve the recommended language to the *Procedural Code* in Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs, to reflect the APA Bylaws?	The Assembly voted to approve the recommended language to the *Procedural Code* in Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs, to reflect the APA Bylaws.	Chief Operating Officer • Association Governance
2015 A1 7.B.7	Will the Assembly vote to approve the recommended language to the *Procedural Code* in Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures, that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis?	The Assembly voted to approve the recommended language to the *Procedural Code* in Article I: The Assembly, 9. Committees and Task Forces, c. Committee on Procedures, that the Committee on Procedures reviews DB bylaws on a rotating 5 year, instead of 3-year basis.	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.A	Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident	The Assembly voted to approve action paper 2015A1 12.A which asks: 1. The American Psychiatric Association supports comprehensive mental health benefits for the survivors and their significant others (i.e. spouses or life partners and children) as well as the significant others (i.e. spouses or life partners and children) of those who were killed in the Fort Hood incident. 2. The American Psychiatric Association will lobby through its Office of Advocacy and Government Relations for legislation to be passed by Congress making such eligibility possible. 3. That the Speaker of the Assembly brings this action paper to the next Board of Trustees as time is of essence if the Assembly is to have a meaningful role in this matter.	Board of Trustees, July 2015
2015 A1 12.B	New Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Disorders and Mental Health Services	The Assembly voted to refer action paper 2015A1 12.B to the Council on Psychiatry and Law. *[The JRC oversees APA councils so the item will be sent to the JRC, noting the requested referral to the Council on Psychiatry and Law]*	Joint Reference Committee, July 2015
2015 A1 12.C	Developing an Access to Care Toolkit	The Assembly voted to approve action paper 2015A1 12.C which asks: 1. That an Access to Care Tool Kit be developed and maintained by the Council on Healthcare Systems and Financing to include relevant Action Papers, Position Statements, Guidelines, model or sample state legislation, survey instruments and a repository of related legal actions from states. The Tool Kit should include links to the Parity Tool Kit and other related resources and to be easily downloadable to members. 2. The availability of the Tool Kit and its components should be publicized in APA News, and to District Branches and State Organizations through the Federal Legislative Representative Network and the Office of Ethics and District Branch/State Association Relations.	Joint Reference Committee, July 2015
2015 A1 12.D	Compendium of Access to Care Action Papers and Position Statements	The Assembly voted to approve action paper 2015A1 12.D which asks that a compendium of Action Papers and Position Statements relating to access to care be included in an easily downloadable Access to Care Tool Kit to be developed and maintained by the Office of Health Care Systems and Financing.	Joint Reference Committee, July 2015
2015 A1 12.E	Access to Care Survey	The Assembly voted to approve action paper 2015A1 12.E which asks that one or more patient centered Access to Care Surveys, such as the Area 6 Access to Care Survey, be included in an Access to Care Toolkit, to be developed and maintained by the Council on Health Care Systems and Financing.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.F	Level of Service Intensity Instrument	The Assembly voted to approve action paper 2015A1 12.F which asks: 1. Within six months the APA Administration will research what level of care/intensity of service tools are available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. 2. This data will be presented to the Councils on Quality Care and Healthcare Systems and Financing to determine whether APA should: a. Endorse a specific tool or set of criteria, or; b. Propose development of such a tool by APA 3. That the Councils will report their recommendations to the Joint Reference Committee the following year.	Joint Reference Committee, July 2015
2015 A1 12.G	Timely Reimbursement for Psychiatric Treatment	The Assembly voted to approve action paper 2015A1 12.G which asks that the APA Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance-paneled psychiatrists (and patients of psychiatrists who have opted out of third party payors excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.	Joint Reference Committee, July 2015
2015 A1 12.H	Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault	The Assembly voted to approve action paper 2015A1 12.H which asks: 1. The APA develop a Position Statement and a Resource Document regarding the psychiatric morbidity associated with sexual assault, including the psychological difficulties attendant to sexual assault evidence procurement and the failure of acting upon such evidence; 2. The relevant component of the APA work with the American Association for Emergency Psychiatry to ascertain that the emergency treatment of sexual assault victims, including that the administration of sexual assault evidence assessment kits, be coupled with provision of information about access to mental health treatment resources; 3. The relevant component of the APA liaise with the entities responsible for analyzing sexual assault victim evidence kits and acting upon their results in order to educate those entities to the psychiatric morbidity of their failing to do so, and to be available to assist those entities in their efforts to obtain adequate funding by providing them with information about the psychiatric morbidity associated with sexual assault; 4. The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.I	Position Statement on Assisted Outpatient Treatment (AOT)	The Assembly voted to approve action paper 2015A1 12.I which asks: 1. That the new Position Statement be passed by the Assembly at this Assembly meeting. 2. That the Speaker of the Assembly brings this Action paper to the Board of Trustees (BOT) for passage by the Board of Trustees at the next Board of Trustees meeting as time is of the essence if the Assembly is to have a meaningful role in this matter.	Board of Trustees, July 2015
2015 A1 12.J	Fostering the Next Generation of Leaders within the APA	The Assembly voted to approve action paper 2015A1 12.J which asks: That the APA develop a comprehensive and coordinated set of leadership, team building and enrichment activities aimed at fostering leadership and promoting positive relationships between the young leaders* of the APA and established APA leadership. That the APA look to consolidate and coordinate current offerings to prevent duplication of efforts and to ensure the best use of resources That these activities occur at the APA Annual Meeting in May. That these activities be coordinated by the Chief RFM-ECP Officer, the Director of the Division Diversity and Health Equity, and the Director of Education. *Possible groups include: 1. ACORF 2. ECP 3. RFM Trustee and Trustee elect 4. APA representative to the AMA resident & fellow section 5. Chief residents 6. RFM Caucus 7. APA fellowships a. Leadership b. Minority c. Child and adolescent d. Public psychiatry fellowship e. Spurlock fellowship f. Research fellowship	Joint Reference Committee, July 2015
2015 A1 12. K	Parity in Pay, National Guard	The action paper was withdrawn by the author.	N/A
2015 A1 12.L	The Impact of Global Climate Change on Mental Health	The Assembly voted to approve action paper 2015A1 12.L which asks: 1. That the Assembly recommends the American Psychiatric Association adopt a Position Statement addressing the mental health impact of extreme weather events and natural disasters resulting from global climate change. 2. Should the Assembly approve this action paper, it will be referred to the Committee on Psychiatric Dimensions of Disasters to study and produce a position statement.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.M	Promoting Military Cultural Knowledge among Psychiatrists	The Assembly voted to approve action paper 2015A1 12.M which asks: 1. That the APA supports as a core professional practice that psychiatrists consider asking the question: "Have you or someone close to you served in the military?" as part of the clinical evaluation. 2. That the APA supports psychiatrists' attaining a basic level of military cultural knowledge through the completion of Module I of the free, accredited, online DoD/VA course at http://deploymentpsych.org/military-culture 3. Through the APA Department of Education's website and educational activities, the APA promote the availability of resources for attaining military cultural knowledge. 4. That the APA, through its educational liaisons to other medical education organizations, promotes education about military cultural knowledge among clinicians. 5. That the APA consider drafting a position paper on the importance of promoting military cultural knowledge among psychiatrists.	Joint Reference Committee, July 2015
2015 A1 12.N	Changing ECP Status to 8 Years Following Completion of Training	The Assembly voted to approve action paper 2015A1 12.N which asks that the APA adopt a similar position to the AMA in defining the ECP period as eight years following the completion of residency/fellowship training.	Joint Reference Committee, July 2015
2015 A1 12.O	Improving APA Support of the Mental Health of African American Males	The Assembly voted to approve action paper 2015A1 12.O which asks that the Council on Medical Education and Lifelong Learning and the Office of Education investigate, in collaboration with experts, how to provide training opportunities for psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities.	Joint Reference Committee, July 2015
2015 A1 12.P	Removing Unnecessary Arbitrariness from Future DSMs	The Assembly did not approve action paper 2015A1 12.P.	N/A
2015 A1 12.Q	Removing Clinician's Subjective Impression from the Definition of Mental Disorders	The Assembly did not approve action paper 2015A1 12.Q.	N/A
2015 A1 12.R	Replacing "Personality Disorder" with "Syndrome"	The Assembly did not approve action paper 2015A1 12.R.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.S	Emergency Department Boarding of Individuals with Psychiatric Disorders	The Assembly voted to approve action paper 2015A1 12.S which asks: That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding.	Joint Reference Committee, July 2015
2015 A1 12.T	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior	The Assembly voted to approve action paper 2015A1 12.T which asks: That the APA will establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins to advise the Division of Education. That the Assembly of the APA requests that the APA Division of Education develop an educational plan aimed at educating the general membership of the APA on the scientific, clinical and regulatory aspects of the neuro-developmental and behavioral effects of environmental toxins.	Joint Reference Committee, July 2015
2015 A1 12.U	Parity in Payment, Parity in Policy Implementation	The Assembly voted to approve action paper 2015A1 12.U which asks: That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act. That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments, That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services. That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.V	Location of Civil Commitment Hearings	The Assembly voted, on its Consent Calendar, to approve action paper 2015A1 12.V which asks: 1. The Council on Psychiatry and Law will develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings. 2. In developing the position statement the Council on Psychiatry and Law shall consider the following proposed principles: a. Holding civil commitment hearings at hospitals where psychiatric inpatients are detained should be regarded as a best practice for courts; b. Courts hearing civil commitment cases should exhaust all reasonable alternatives, including working with hospitals to develop appropriate on-site courtroom facilities or telecourt, before transporting detained inpatients to court; c. APA recognizes that exceptional circumstances may sometimes necessitate transporting inpatients to a courthouse for civil commitment hearings; d. Patient preference for a courtroom hearing, when a courtroom hearing is available, constitutes such an exceptional circumstance; e. Convenience of the court and counsel does not constitute an exceptional circumstance; f. When transportation to a courthouse is necessary because of an exceptional circumstance, courts should conduct an individual assessment of each detainee's violence and elopement risks before ordering the use of physical restraints.	Joint Reference Committee, July 2015
2015 A1 12.W	Reconfiguring the Health Care Percentage of the GDP	The Assembly voted to approve action paper 2015A1 12.W which asks that the APA delegation to the AMA House of Delegates present a motion in that body that calls on the AMA to establish a process for providing the public with separate percentages of the GDP corresponding to actual health care provision and to ancillary, administrative-management-type economic activities that have been linked to health care.	Joint Reference Committee, July 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.X	Dues Abatement for General Psychiatrists/Members in Puerto Rico	The Assembly voted to approve action paper 2015A1 12.X which asks: That the dues for APA members practicing in Puerto Rico be set at the same amount as APA members not practicing in the fifty United States. That the APA request the BOT in conjunction with the Finance Committee review the economic impact on the APA's budget of implementing this dues reduction, and request the Council on Advocacy and Government Relations to explore any potential unintended consequences. Precluding any problems, that the dues reduction be implemented applying only to those general member psychiatrists who are members of the DB of the PR chapter of the APA. At present the annual dues are at $575. The dues reduction proposed is to lower it using the same annual dues scale as used by Canada, which is scaled up to a maximum of $350 per general member per year. That this be referred directly to the Board of Trustees.	Board of Trustees, July 2015
2015 A1 12.Y	Mental Health Leave in Colleges	The Assembly voted to approve action paper 2015A1 12.Y which asks: That the APA help to develop mental health guidelines for colleges so that they feel adequately equipped to deal with the challenges of mental health crisis. That the APA produce a position statement in collaboration with the Caucus on College Mental Health, Council on Minority Mental Health and Health Disparities and the Council on Children, Adolescents and Their Families supporting the idea that student mental health should follow guidance from mental health providers who treat these students and that colleges need to invest in more on-campus mental health services in order to be prepared and equipped to better address such problems in a way that protects the future of their students. This should also include a statement that psychiatric problems which arise while students are enrolled are treated on campus adequately and at parity with any other health problems. That the APA affirms its position by advocating that requiring students with mental health problems to take a year off away from campus can further adversely affect students' mental health and self-esteem, and recommends that students' safety prior to returning to college must be determined in collaboration with by a mental health care provider on a case-by-case basis.	Joint Reference Committee, July 2015
2015 A1 12.Z	Providing APA and APA/SAMHSA Fellowship Awardees the Opportunity to Get Involved with the APA Assembly	The Assembly voted to approve action paper 2015A1 12.Z which asks that the APA establish a formal mentorship program within the Assembly for interested APA/SAMHSA Fellowship Awardees.	Assembly Executive Committee, July 2015
2015 A1 12.AA	Social Media at the APA Assembly	The Assembly voted to approve action paper 2015A1 12.AA which asks that the Office of Communications report and update, as part of the APA communication strategy, the progress of exploration and implementation of live social media of Assembly proceedings at the November 2015 Assembly.	Office of the CEO and Medical Director • Chief Communications Officer

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A1 12.BB	APA General Elections	The Assembly did not approve action paper 2015A1 12.BB.	N/A
2015 A1 12.CC	Senior Psychiatrists	The Assembly voted to approve action paper 2015A1 12.CC which asks that the Board of Trustees appoints a work group comprised of members from the Board and Assembly to include senior psychiatrists. The Task Force will be charged to explore mechanisms to best meet the needs of this group of members and bring its recommendations to the Assembly and to the Board within 1 year for implementation.	Board of Trustees, July 2015
2015 A1 12.DD	Elimination of Votes by Strength	The action paper was withdrawn by the author.	N/A

MEMBERS AND INVITED GUESTS
ASSEMBLY
October 30-November 1, 2015
As of 10-15

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Area 3 Deputy Representative	William Greenberg, M.D.
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ECP Representative	Mark Haygood, D.O.
ACROSS Representative	David Scasta, M.D.
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James Maier, M.D., Representative

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Shery Zener, M.D., Representative
TBD, Representative

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L. Russell Pet, M.D., Representative

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

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Deborah Weisbrot, M.D., Representative

Mid-Hudson Psychiatric Society
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Felix Torres, M.D., Representative
Henry Weinstein, M.D., Representative

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Russell Denea, M.D., Representative

Northern New York District Branch
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West Hudson Psychiatric Society
Nigel Bark, M.D., Representative

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

Western New York Psychiatric Society
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Ranga Ram, M.D., Representative

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Robert Roca, M.D., MPH, Representative

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Charles Blackinton, M.D., Representative
Charles Ciolino, M.D., Representative

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Jyoti Shah, M.D., Representative

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Eliot Sorel, M.D., Representative

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Brian Hart, M.D., Representative

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Carver Nebbe, M.D., Representative
Robert Smith, M.D., Representative

Kansas Psychiatric Society
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Nolan Williams, M.D., for Matthew Macaluso, D.O., Representative

Area 4 (*continued*)

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Lisa MacLean, M.D., Representative
William Sanders, D.O., Representative

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

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

Nebraska Psychiatric Society
Soniya Marwaha, M.D., for Jennifer McWilliams, M.D., Representative
Venkata Kolli, M.D., for Syed Qadri, M.D., Representative

North Dakota Psychiatric Society
Ronald Burd, M.D., Representative
Kevin Dahmen, M.D., Representative

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

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

Wisconsin Psychiatric Association
Clarence Chou, M.D., Representative
John Schenider, M.D., Representative

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Paul O'Leary, M.D., Representative

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Eugene Lee, M.D., Representative

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

Georgia Psychiatric Physicians Association, Inc
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Sultan Simms, M.D., Representative

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Mark Wright, M.D., Representative

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

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

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

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

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

Area 5 (continued)

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J. Clay Sawyer, M.D., Representative

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James West, M.D., Representative

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Adam Kaul, M.D., Representative
John Shemo, M.D., Representative

West Virginia Psychiatric Association
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Daniel Elswick, M.D., Representative

AREA 6

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

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

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

Area 6 (continued)

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

Area 7

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

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

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

Hawaii Psychiatric Medical Association
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Idaho Psychiatric Association
Zachary Morairty, M.D., Representative
James G. Saccomando, Jr., M.D., for Nicole Thurston, M.D., Representative

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

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

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

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

Area 7 (continued)

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

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

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

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

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Simha Ravven, M.D., Deputy Representative

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

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

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

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

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

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

* Also listed with the Assembly Executive Committee

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

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

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

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

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

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

* Also listed with the Assembly Executive Committee

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Rebecca Allen, M.D., MPH, Deputy Representative

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

Area 3
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Area 4
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Area 5
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Hannah Scott, M.D., Deputy Representative

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

Area 7
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Robert Mendenhall, D.O, Deputy Representative

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

* Also listed with the Assembly Executive Committee

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Academy of Psychosomatic Medicine
David Gitlin, M.D.

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

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

American Academy of Psychoanalysis
Eric Plakun, M.D.

Area 2

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

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

Association of Family Psychiatrists
Gregory Miller, M.D.

Area 3

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

American Society for Adolescent Psychiatry
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Association of Gay and Lesbian Psychiatrists
David Scasta, M.D.*

Southern Psychiatric Association
Mark Komrad, M.D.

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American Academy Addiction Psychiatry
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American Acadmy of Clinical Psychiatrists
Donald Black, M.D.

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

American Psychoanalytic Association
Prudence Gourguechon, M.D.

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

Area 5

Senior Psychiatrists, Inc
Jack Bonner, M.D.

Area 6

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

* Also listed with the Assembly Executive Committee

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

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

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

FELLOWS

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

DISTRICT BRANCH PRESIDENTS, PRESIDENTS-ELECT & EXECUTIVES

standing invitation

* Also listed with Assembly Executive Committee

PAST SPEAKERS OF THE ASSEMBLY

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

* Also listed with Assembly Executive Committee

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

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

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

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

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

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

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

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Alabama Psychiatric Physicians Association	251	2
Alaska Psychiatric Association	64	2
Arizona Psychiatric Society	389	2
Arkansas Psychiatric Society	133	2
Bronx District Branch	160	1
Brooklyn Psychiatric Society, Inc.	306	1
Central California Psychiatric Society	374	1
Central New York District Branch	134	1
Colorado Psychiatric Society	425	2
Connecticut Psychiatric Society	686	3
Delaware, Psychiatric Society of	99	2
Florida Psychiatric Society	1084	4
Genesee Valley Psychiatric Association	149	1
Georgia Psychiatric Physicians Association, Inc	609	3
Greater Long Island Psychiatric Society	530	3
Hawaii Psychiatric Medical Association	172	2
Idaho Psychiatric Association	56	2
Illinois Psychiatric Society	985	4
Indiana Psychiatric Society	321	2
Iowa Psychiatric Society	190	2

District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Kansas Psychiatric Society	197	2
Kentucky Psychiatric Medical Association	271	2
Louisiana Psychiatric Medical Association	304	2
Maine Association of Psychiatric Physicians	171	2
Maryland Psychiatric Society, Inc	683	3
Massachusetts Psychiatric Society	1566	5
Michigan Psychiatric Society	739	3
Mid-Hudson Psychiatric Society	66	1
Minnesota Psychiatric Society	424	2
Mississippi Psychiatric Association, Inc	149	2
Missouri Psychiatric Association	436	2
Montana Psychiatric Association	50	2
Nebraska Psychiatric Society	149	2
Nevada Psychiatric Association	147	2
New Hampshire Psychiatric Society	129	2
New Jersey Psychiatric Association	844	3
New Mexico, Psychiatric Medical Association of	141	2
New York County Psychiatric Society	1859	6
New York State Capital District Branch	153	1
North Carolina Psychiatric Association	855	3
North Dakota Psychiatric Society	49	2
Northern California Psychiatric Society	1005	4
Northern New York District Branch	39	1
Ohio Psychiatric Physicians Association	925	4
Oklahoma Psychiatric Physicians Association	208	2
Ontario District Branch	753	3
Orange County Psychiatric Society	246	1
Oregon Psychiatric Physicians Association	388	2
Pennsylvania Psychiatric Society	1498	5
Puerto Rico Psychiatric Society	139	2
Quebec & Eastern Canada District Branch	405	2
Queens County Psychiatric Society	251	1
Rhode Island Psychiatric Society	237	2
San Diego Psychiatric Society	323	1
South Carolina Psychiatric Association	356	2
South Dakota Psychiatric Association	77	2
Southern California Psychiatric Society	1009	4
Tennessee Psychiatric Association	306	2
Texas Society of Psychiatric Physicians	1128	4
Uniformed Services Psychiatrists, Society of	337	2
Utah Psychiatric Association	161	2
Vermont Psychiatric Association	112	2
Virginia, Psychiatric Society of	570	3
Washington Psychiatric Society	852	3
Washington State Psychiatric Association	492	3
West Hudson Psychiatric Society	102	1
West Virginia Psychiatric Association	174	2
Westchester County, Psychiatric Society of	399	1
Western Canada District Branch	503	3
Western New York Psychiatric Society	148	1
Wisconsin Psychiatric Association	374	2

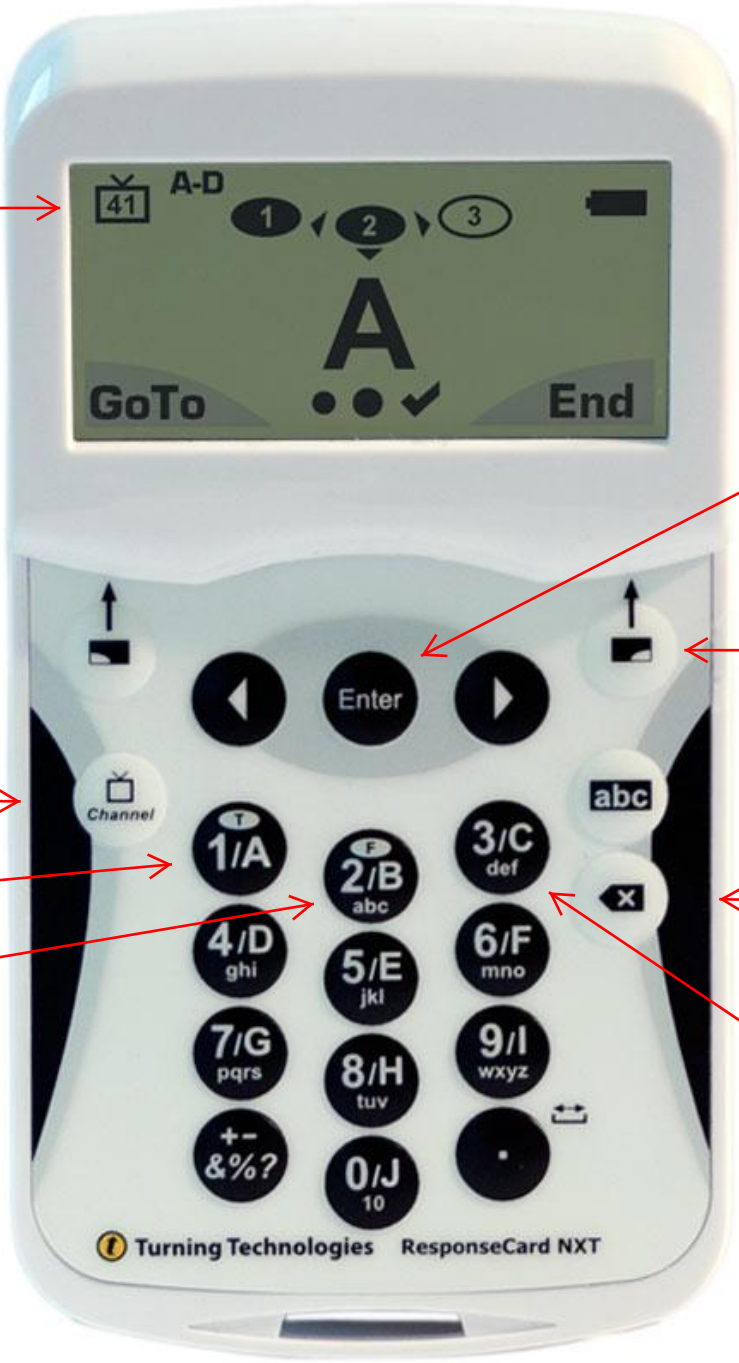
District Branch/State Association (alphabetical order)	Voting Strength	# Reps
Wyoming Association of Psychiatric Physicians	24	2

Voter Instructions for "Standing Vote" with ARS devices

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

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

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



To submit your vote:

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

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

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body.

VOTES BY STRENGTH

Paper Ballot Instructions

Tellers and Ballot counting process

Author: Theresa Miskimen, MD (Recorder) | October 30. 2015

VOTING STRENGTH BY DB/SA –YELLOW SHEET –

Voting Strength by State for the
October/November 2015 and May 2016
Assembly Meeting

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

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Western Canada District Branch	503	3
Western New York Psychiatric Society	148	1
Wisconsin Psychiatric Association	374	2
Wyoming Association of Psychiatric Physicians	24	2

VOTES BY STRENGTH

AMERICAN PSYCHIATRIC ASSOCIATION

- Used when the issue seems in doubt, and the other methods of voting appear not to reflect the will of the membership
- Voting Strength information by DB/SA is distributed prior to the Assembly Meeting
- When you attend the meeting you review this information in order to enter the information correctly when you fill out the ballot
- Every group can be fully represented so long as any one Representative or voting Deputy Representative is present at the Assembly

VOTES BY STRENGTH (CONT'D)

AMERICAN PSYCHIATRIC ASSOCIATION

- Votes by strength shall be initiated if called for by at least 6 voting members from at least 2 Areas of the Assembly representing State Associations, or the District Branches of the Unites States, Western Canada, Ontario, Quebec & Eastern Canada, Puerto Rico, the Washington Psychiatric Society and the Society of Uniformed Services
- All District Branch or other group representatives or voting Deputy Representatives are authorized to apportion the votes they cast (among Yes, No, or Abstain) according to instructions from the group or their assessment of the prevailing opinion in their group

VOTES BY STRENGTH (CONT'D)

- The total number of votes of a District Branch may be divided by agreement among the DB's Representatives; the total of all their votes should equal the DB's voting strength

  For example, in a DB with 1000 members and 4 Reps, they may divide the votes to cast 250 each

- When in doubt discuss with your Area Representative or Group Chairperson (RFM, ECP, MUR, and ACROSS)

SAMPLE BALLOT (NJ) - BEFORE

AMERICAN PSYCHIATRIC ASSOCIATION

Assembly Ballot for Vote by Strength

Action Item #:	
District Branch/Component/Position:	New Jersey Psychiatric Association
Area:	Area 3
Total Number of Votes (Voting Strength):	844
Voter's Name (please print):	
Voter's Position (please print) :	

*Please indicate the **number** of votes below (if dividing votes, sum of votes must equal **Voting Strength** indicated above)*

"YES": _____	**"NO":** _____	**"ABSTAIN":** _____

SAMPLE BALLOT (NJ) - AFTER

AMERICAN PSYCHIATRIC ASSOCIATION

Sample

Assembly Ballot for Vote by Strength

Action Item #: 15.A.

District Branch/Component/Position: New Jersey Psychiatric Association

Area: Area 3

Total Number of Votes (Voting Strength): 844

Voter's Name (please print): Benjamine Rush, M.D.

Voter's Position (please print) : Representative

*Please indicate the **number** of votes below (if dividing votes, sum of votes must equal **Voting Strength** indicated above)*

"YES": 404	"NO": 240	"ABSTAIN": 200

BALLOT COUNTING PROCESS

- Ballots are collected
- Each assigned tellers (3-4) record votes into paper tally sheet
- Unclear/questionable ballots are put aside
- Administrative member is assigned to enter tally results electronically into a final or "master" tally sheet
- Tellers confer to interpret any unclear/questionable ballots
- The master file is printed out for tellers to certify/sign
- The final results are delivered to the Speaker
- Results are announced

QUESTIONS?

Please feel free to contact me or the Governance staff if you have questions or concerns about the vote-by-strength process:

- Theresa Miskimen, MD , Assembly Recorder
  - miskimtm@ubhc.rutgers.edu
- Margaret Dewar: Director of Association Governance
  - mdewar@psych.org
- Chiharu Tobita: Senior Projects Manager
  - ctobita@psych.org

Assembly
Assembly Executive Committee
Report
Friday, May 15, & Monday, May 18, 2015
Metro Toronto Convention Centre & Fairmont Royal York
Toronto, Ontario, CANADA

Jenny L. Boyer, M.D.,JD, PhD, Speaker
Glenn Martin, M.D., Speaker-Elect
Daniel Anzia, M.D., Recorder
Gary Weinstein, M.D., Parliamentarian
Brian Benton, M.D., Area 1 Rep (*Friday*)
A. Evan Eyler, M.D., Area 1 Dep Rep
Seeth Vivek, M.D., Area 2 Rep
Jeffrey Borenstein, M.D., Area 2 Dep Rep (*Friday*)
Harry Brandt, M.D., Area 3 Rep (*Friday*)
Joseph Napoli, M.D., Area 3 Dep Rep
James R. Batterson, M.D., Area 4 Rep
Bhasker Dave, M.D., Area 4 Dep Rep
Laurence Miller, M.D., Area 5 Rep
Philip Scurria, M.D., Area 5 Dep Rep
Joseph Mawhinney, M.D., Area 6 Rep
Barbara Weissman, M.D., Area 6 Dep Rep
Craig Zarling, M.D., Area 7 Rep
Charles Price, M.D., Area 7 Dep Rep
Ludmila De Faria, M.D.,M/UR Rep
Edward Thomas Lewis, III, M.D., RFM Rep
Steve Koh, M.D., ECP Rep (*Friday*)
David Scasta, M.D., AAOL Rep
Melinda Young, M.D., Immediate Past Speaker
R. Scott Benson, M.D., Past Speaker
Saul Levin, M.D., MPA, CEO and Medical Director

Guests (Friday):
A. David Axelrad, M.D., Chair, Assembly Committee on Procedures
Lawrence Gross, M.D., Chair, Reference Committee #1
Robert Roca, M.D., Chair, Reference Committee #2
Leslie Gise, M.D., Chair, Reference Committee #3
Melvin Melnick, M.D., Chair, Reference Committee #5

Guests (Monday)
William Greenberg, M.D., Incoming Area 3 Dep Rep
Sarit Hovav, M.D., Incoming RFM Rep
Manuel Pacheco, M.D., Incoming Area 1 Dep Rep
Anil Thomas, M.D., for Mark Haygood, D.O., Incoming ECP Rep

Administration:
Margaret C. Dewar, Director of Association Governance
Allison Moraske, Senior Governance Specialist, Assembly
Shaun Snyder, Esq., Chief Operating Officer
Rodger Currie, Chief of Government Affairs
Colleen Coyle, JD, APA General Counsel (*Friday*)
Yoshie Davison, Chief of Staff (*Friday*)
Jon Fanning, Chief of Membership & RFM/ECP Officer (*Friday*)
Tristan Gorrindo, M.D., Director, Division of Education (*Friday*)
Kristin Kroeger, Chief of Policy, Programs & Partnerships (*Friday*)
Nicole Lewis, Special Assistant to the CEO & Medical Director (*Friday*)
Ranna Parekh, M.D., MPH, Director, Division of Diversity and Health Equity (*Friday*)

Friday, May 15, 2015 (Metro Toronto Convention Centre)

1. **Call to Order and Opening Remarks** — *Dr. Boyer*

2. **Approval of Report of the AEC meeting January 2015**

MOTION APPROVED: The AEC voted to approve the report of the Assembly Executive Committee Meeting from January 2015.

3. **Remarks from Speaker-Elect** — *Dr. Martin*
Dr. Martin briefly addressed the AEC. He noted his expectation for a highly successful Assembly meeting.

4. **Remarks from the CEO and Medical Director** — *Dr. Levin*
Dr. Levin began by thanking Dr. Boyer for her hard work and acknowledging the hard work of the AEC and the Assembly. He also thanked the Chiefs and Executive Administration in attendance as well as Margaret Dewar and Association Governance for their work. Dr. Levin noted that the APA has been working on several issues, including member services and programming, parity enforcement, and APA branding. He announced that the APA has a new logo which will be revealed at the opening session. The APA has developed a new benefit for both members and individuals seeking mental health services called "Find a Psychiatrist", a searchable database that APA members can opt into (http://apps.psychiatry.org/optinfap/Default.aspx). The functionality of the new database can viewed at: http://finder.psychiatry.org/. Dr. Levin concluded his remarks by introducing new APA Administration in attendance: Dr. Tristan Gorrindo, Director of the Division of Education, and Nicole Lewis, Special Assistant to the CEO and Medical Director.

5. **Review of Assembly Agenda** — *Dr. Boyer*
The Assembly Executive Committee reviewed the Assembly agenda. Dr. Boyer announced that there were two guest speakers scheduled for Sunday: Dr. Lois Margaret Nora, President and Chief Executive Officer of the American Board of Medical Specialties and Dr. David Barbe, Immediate Past Chair of the AMA Board of Trustees. She noted that Dr. Nora will be speaking about Part IV of the MOC and will respond to questions submitted in writing by the members in attendance.

Drs. Boyer and Martin also explained that the vote on the Assembly reorganization will be held Saturday afternoon and that the relevant changes to the *Procedural Code of the Assembly* will be included.

6. **Reports of Assembly Component Chairs**

A. Rules Committee — *Dr. Young*
Dr. Young remarked that there are 30 action papers and 19 JRC items on the agenda. There was a request to move item 4.B.19, "Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and their Families" to Saturday afternoon. Dr. Boyer approved this request.

B. Awards Committee — *Dr. Benson*
Dr. Benson announced that the DB Best Practice Award is being awarded to the North Carolina Psychiatric Association and that the New York County Psychiatric Society is receiving an Honorable Mention. The Ronald Shellow Award will be presented posthumously to Dr. Herbert Peyser, Representative from the New York State Psychiatric Association and that this presentation will occur during the first plenary.

C. Committee on Procedures — *Dr. Axelrad*
Dr. Axelrad reiterated that Dr. Martin will present the motion on the Assembly reorganization and that the relevant changes to the *Procedural Code of the Assembly* will be presented after the vote. The remaining actions and report of the Committee on Procedures will occur Sunday during the fourth plenary.

D. Assembly Nominating Committee — *Dr. Young*
Dr. Young reviewed the candidates for the upcoming Assembly election:

Candidates for Recorder:
Ludmila De Faria, M.D.
Theresa Miskimen, M.D. [*Elected Recorder 2015-2016*]

Candidate for Speaker-Elect:
Daniel Anzia, M.D. [*Elected Speaker-Elect 2015-2016*]

Robert Roca, M.D.

Monday, May 18, 2015 (Fairmont Royal York)

7. Introduction of New Assembly Executive Committee Members

Dr. John Wernert, Parliamentarian (*not present*)
Dr. Manuel Pacheco, Deputy Representative, Area 1
Dr. William Greenberg, Deputy Representative, Area 3
(Name Pending Confirmation from DDHE), M/UR Chair (*not present*)
Dr. Sarit Hovav, RFM Chair
Dr. Mark Haygood, ECP Chair (*not present*)

8. Follow-up on Passed Assembly Actions — Dr. Boyer

The AEC reviewed the passed Assembly actions.

JRC items 4.B.4: *Proposed Position Statement: Patient Access to Electronic Mental Health Records*, 4.B.7: *Retire Position Statement: Active Treatment*, and 4.B.8: *Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability (2007)* were not approved by the Assembly and will be sent back the JRC for review and possible referral to the appropriate APA component.

The AEC reviewed the approved action papers and referred the following to go directly to the Board of Trustees in July:
12.A: Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident
12.I: Position Statement on Assisted Outpatient Treatment (AOT)
12.X: Dues Abatement for General Psychiatrists/Members in Puerto Rico
[12.CC: Senior Psychiatrists was referred to the Board of Trustees following the AEC meeting.]

The AEC then prioritized the top six action papers of those referred to the Joint Reference Committee.
12.C: Developing an Access to Care Toolkit **[5]**
12.H: Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault **[3]**
12.J: Fostering the Next Generation of Leaders within the APA **[2]**
12.N: Changing ECP Status to 8 Years Following Completion of Training **[6]**
12.O: Improving APA Support of Mental Health of African American Males **[4]**
12.S: Emergency Department Boarding of Individuals with Psychiatric Disorders **[1]**

10. Planning for AEC Summer Meeting — Dr. Martin

The AEC will be meeting July 24-26 at the Omni Mont-Royal in Montreal, Canada. Dr. Martin noted that two subjects he plans to discuss at the AEC meeting are the role of other members of the Assembly (aside from DB Representatives) and the Areas. He remarked that the Areas are a useful component however their structure needs to be evaluated. Dr. Martin would also like to evaluate the need for better integration of the Assembly with the APA components, the Reference Committee structure, member seating at the plenary sessions (specifically dais seating), the Special Rules of the Assembly (procedures for handling floor discussions), visibility of microphones, and reviewing District Branches who fund their Assembly Representatives to attend the May Assembly meeting.

11. Assembly Work Groups

DSM: The charge will be developed by Drs. Anzia and Eyler for review by the AEC meeting in July.

Steering Committee on Practice Guidelines: Dr. John Shemo will be Chair of the Assembly Liaisons to the Steering Committee on Practice Guidelines. Dr. Dave will be the Area 4 Liaison.

Access to Care: Dr. Mawhinney reported the group had a lively discussion on Saturday. However, the group felt the meeting time was too limited.

ASM/Foundation Initiative: Dr. Borenstein noted that the purpose of the work group is to create a link between the Assembly and the American Psychiatric Foundation. The group is looking for members who are interested in the Foundation and learning more about its projects. He requested some time on the Assembly agenda in the fall to highlights some products of the Foundation.

Maintenance of Certification: Dr. Batterson stated that the work group believes that MOC will continue to be a major issue, given the anger and irritation level of members across the country. Dr. Batterson discussed the ABPN meeting in January and the suggestion that Part IV should be optional. He would like feedback from members of the AEC noting the response from each Areas' members on this issue.

12. Area Council Meetings

Area 1: September 18, Toronto, CANADA
Area 2: October 10
Area 3: September 19
Area 4: *no meeting*
Area 5: October 29, Washington, DC
Area 6: July 11
Area 7: August 8-9, Portland, Oregon

13. New/Unfinished Business [awards]

Action paper *2014A1 12.U: Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting* was referred to the AEC by the JRC with a request that they consider having this become an Assembly Award to be given to one District Branch and one Area each year. At its July, 2014 meeting, the AEC referred the paper to the Assembly Award Committee. The Awards Committee subsequently reviewed the outcome of the APA national election for 2012, 2013, 2014, and 2015 and noted that a pattern emerged where the voting of the winning DB and the winning Area were likely influenced by the geographic distribution of candidates. Based on these results, the Awards Committee proposed modifying the award to the following:

The voter turnout by Area and by District Branch would be made available to these organizations. If the organization would like to compete they are encouraged to design a "Get out the vote plan" and submit that plan before the slate of national officers is announced. The group with the most successful plan as measured by an increase in voter turnout would be recognized and the details of their effective campaign would be distributed to other DBs and Areas for consideration in their own GOTV planning.

After some discussion, Dr. Martin requested that item be discussed further at the AEC meeting in July.

14. Closing Remarks — Drs. Martin and Boyer

15. Adjournment

UPCOMING AEC MEETINGS

- **July 24-26, 2015, Montreal, QC, CANADA**
- **Friday, October 30, Washington, D.C.**
- **Sunday, November 1, Washington, D.C.**

American Psychiatric Association
Assembly Executive Meeting
Montreal, QC, CANADA
July 24-26, 2015
Report

Assembly Executive Committee Members:

Glenn Martin, MD, Speaker
Daniel Anzia, MD, Speaker-Elect
Theresa Miskimen, MD, Recorder
John Wernert, MD, Parliamentarian
A. Evan Eyler, MD, MPH, Area 1 Rep
Manuel Pacheco, MD, Area 1 Dep Rep
Seeth Vivek, MD, Area 2 Rep **[A]**
Jeffrey Borenstein, MD, Area 2 Dep Rep **[A]**
Joseph Napoli, MD, Area 3 Rep
William Greenberg, MD, Area 3 Dep Rep
James R. Batterson, MD, Area 4 Rep
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Laurence Miller, MD, Area 5 Rep **[A]**
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David Scasta, MD, ACROSS Rep
Jenny L. Boyer, MD, JD, PhD, Immediate Past Speaker
Melinda Young, MD, Past Speaker
Saul Levin, MD, MPA, CEO and Medical Director

APA Administration:
Margaret Cawley Dewar, Director of Association Governance
Colleen Coyle, JD, APA General Counsel (*Via speakerphone Saturday*)
Jon Fanning, Chief Membership, RFM &ECP Officer (*Via speakerphone Saturday*)
Jessica Hopey, Senior Governance Coordinator
Kristin Kroeger, Chief of Policy, Programs, and Partnerships (*Via speakerphone Friday & Saturday*)
Allison Moraske, Senior Governance Specialist, Assembly
Ranna Parekh, MD, MPH, Director of the Division of Diversity and Health Equity
Shaun Snyder, Esq., Chief Operating Officer

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

A. Introductions

Dr. Martin welcomed the AEC to Montreal and had everyone introduce themselves and disclose any potential conflicts of interest. He noted that Drs. Borenstein and Miller were unable to attend due to previous commitments and that Dr. Vivek had a medical emergency that prevented him from traveling to the meeting. The AEC wished him a speedy recovery. Dr. Martin also explained that Dr. Nahulu's very recent appointment as M/UR Chair prevented her attending the AEC meeting but that she would be participating via speakerphone during the update/discussion of the BOT/ASM Ad Hoc Work Group Report on M/UR Issues. Dr. Napoli and the AEC pranked Dr. Martin by adding red clown noses to their faces while

the officers distracted Dr. Martin. He appreciated the moment of levity during a serious discussion and a commemorative photo was taken of the event (*see the end of the report*).

Dr. Martin reviewed the agenda for the meeting. He mentioned the agenda allowed for extended discussion of some of the topics discussed at the AEC meeting in May.

B. Approval of the May, 2015 AEC Report

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

Report from the Speaker – *Glenn Martin, MD*

Dr. Martin reported on the July Board of Trustees meeting. He announced that the Board approved the lease of space within a property known as "The Wharf" on 800 Maine Avenue, SW, in Washington, DC as the new APA headquarters location. The Board also approved a number of actions from the DSM Steering Committee, chaired by Dr. Paul Appelbaum, including the criteria to review proposed changes to the DSM, the creation of 6 DSM Review Committees, and some minor changes to DSM criteria. Additionally, the Board of Trustees voted to request that the CEO and Medical Director and APA Administration produce a detailed business plan for the development of an APA directed Registry. Registries are increasingly part of the practice of medicine and other specialty organizations are hosting them. Dr. Martin noted that he expects that at some point in the development process the Assembly will be involved. In addition to a number of position statements, the Assembly brought four action papers directly to the Board of Trustees. Action paper 12.A: *Compensation, Treatment, and Recognition of Survivors of Fort Hood Shooting Incident* was not approved by the Board as it was felt that the bulk of this issue is already addressed by APA positions and this was not an opportune moment for more specific action by the Board. The Board voted to refer action paper 12.I: *Position Statement on Assisted Outpatient Treatment (AOT)* to the Council on Psychiatry and Law for incorporation into the proposed position statement currently in development by the Council, with appropriate consultation with the Ethics Committee. The Board voted to refer the action paper 12.X: *Dues Abatement for General Psychiatrists/Members in Puerto Rico* to the Membership Committee and the Finance & Budget Committee. Additionally, the Board voted to refer the action paper 12.CC: *Senior Psychiatrists* to the Joint Reference Committee for further action.

Action paper 12.Z: *Providing APA and APA/SAMHSA Fellowship Awardees the Opportunity to Get Involved with the APA Assembly* was referred to the Assembly Executive Committee for review and implementation. Dr. Parekh gave a brief history of the APA Fellowships, noting that there are approximately 50 Fellows. She also stated that there will be an orientation for all Fellows at the September Components Meeting and that the Division of Diversity and Health Equity has started a formalized mentorship process which matches Fellows with a veteran APA member. There was a question as to how many SAMHSA Fellows have expressed interest in the Assembly and concerns about having such a large group join the Assembly and/or ACORF.

MOTION APPROVED: The Assembly Executive Committee voted to establish a small work group to consider all issues related to the inclusion of some/most/all SAMHSA Minority Fellows in the Assembly meetings.

The issues to consider include:

- Source of funding (travel, hotel, stipend, increased meeting costs)
- Organizational impact of a possible increase of up to 50 psychiatrists to the Assembly
- Clarification of their potential role within the Assembly
- Information as to current SAMHSA Minority Fellowship program activities and how this would impact their current APA schedules.

Members of the work group include: Drs. Haygood, Hovav, Young, and Zarling with involvement and consultation by Drs. Ranna Parekh and Elie Aoun (*RFM Mentor*). The work group will report back to the AEC at its meeting in the fall.

Report from the Speaker-Elect – *Daniel Anzia, MD*

Dr. Anzia briefed the AEC on the recent Joint Reference Committee meeting, which took place July 17th. He remarked that the Assembly referred a couple of position statements back the JRC. The JRC had a question as to why the Proposed Position Statement: Patient Access to Electronic Mental Health Records was referred back to the JRC. Area 7 said they would follow up with Dr. Anzia and APA Administration about the concerns raised at its Area Council meeting with regards to this position statement. Dr. Anzia noted that most of the action papers were referred to APA Councils and that the JRC agreed with the Assembly that the position statement on *Active Treatment* should be retained.

Practice Guidelines:

(For this discussion, Kristin Kroeger, Chief of Policy, Programs and Partnerships, participated via teleconference.)

Dr. Anzia reported that the *Draft Guideline on the Use of Antipsychotics to Treat Agitation and Psychosis in Patients with Dementia* will be ready for public comment by the end of July. [**N.B**.: The guideline is available for review online at: http://psychiatry.org/psychiatrists/practice/clinical-practice-guidelines/review-draft-guidelines]. The comment period will be until **September 19th** after which the guideline writing group will review and edit the guideline in time for the fall Assembly. The AEC suggested capturing, if possible, the role of individuals who were commenting (Assembly member, etc.). Ms. Kroeger noted that there is also plans for a conference call to submit comments and that the final product should be available by October 10th. APA Administration confirmed that the final guideline could be distributed prior to the Assembly meeting packet, if needed. Dr. Martin stressed the need for this to be an action item for review on the agendas of all upcoming Area Council meetings before and during the Fall Assembly as there will be an up or down vote at the Fall meeting

Report from the Recorder – *Theresa Miskimen, MD*

Dr. Miskimen reviewed some of the highlights of the May Assembly meeting. In addition to approving the Assembly reorganization, several amendments to the *Procedural Code of the Assembly* were passed including changing the name of the Committee of Assembly Allied Organization (AAOL) to the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS) and aligning the *Procedural Code* with the APA Bylaws with regards to the Area Trustee election process. She also gave brief reports on the presentations by the CEO and Medical Director, the APA President, Dr. Nora, and Dr. Barbe. Dr. Miskimen continued to update the document titled "What Happened to your Action Paper?" which will be distributed prior to the next Assembly meeting.

Dr. Miskimen analyzed the results of the *Survey Monkey* that was distributed to the Assembly shortly after the May meeting. She reported that 76 members responded (approximately 34% of the Assembly members) and that of the responses, she focused her analysis on five topic areas:
a. Area Council and District Branch related questions,
b. Reference Committee related questions,
c. Formal presentations,
d. Meeting materials, and
e. General meeting feedback.
The survey results reflected that the Assembly finds the Area Council meetings useful and well organized, and that while the general consensus was that the Saturday afternoon work group meetings be continued, they should not interfere with the Area Council meetings. Reference Committees were thought to be well run and that a written report from the Reference Committees, distributed Saturday morning to the Area Councils, would be useful. The presentations by Drs. Nora and Barbe were perceived as informative and the meeting materials were distributed in a timely fashion. The general meeting feedback included requests for a more realistic schedule and that the Speaker should encourage not limit debate, strict adherence to parliamentary procedure, increase attendance at the Reference Committees by assigning more members from the Area Councils to attend, standardize the reporting process from the Reference Committees, consider using Google Docs (https://www.google.com/docs/about/) to edit the action papers in real time, send action papers to the Area Councils for input, keep presentations short, and no pharmaceutical support for internet access during meeting.

Action Papers

The AEC reviewed the current action paper process and how it can be improved. It was felt that the Area Councils need to be more involved in vetting action papers instead of adding simple Area Council endorsements. There was robust discussion of the parliamentary precedent that once an action paper is submitted, it belongs to the Assembly and there was a consensus that this should guide the Assembly.The AEC also discussed direct referrals of action papers to the Board of Trustees. While the *Procedural Code of the Assembly* does outline the process for direct referrals of an action to the Board of Trustees, it was felt that most papers should not be sent directly to the Board and that the criteria in the *Procedural Code* should be followed, i.e., that referral should be made because of the time sensitive nature of the action paper. The AEC discussed three options with regards to direct referrals:

1. The AEC reviews the action items at its post Assembly meeting and designates time-sensitive/high priority items that should go directly to the Board of Trustees for consideration. This is allowed under the current code.
2. Addition to Special Rules: The motion for direct referral to the Board of Trustees will be taken up as a separate motion after the action paper vote is taken on the Assembly floor. The Reference Committee's input regarding the direct referral motion will be taken into consideration. Debate on this motion will be limited as to timeliness and thus the appropriateness of a direct referral.
3. Limiting direct referrals to allow for the normal review process to be carried out, as prior experience indicates that direct referrals to the Board can lengthen the approval process, since the Board may still seek out other reviews before deciding on the issue.

MOTION APPROVED: The Assembly Executive Committee voted to develop an educational piece on direct referrals, ask the Reference Committees where relevant to weigh in on the issue of timeliness

during the discussion of the action papers both during the Reference Committee and on the Assembly floor, and create a Special Rule* on referring an action paper directly to the Board of Trustees. (*The Special Rule will be developed as a pilot project for 12-18 months, with formal reassessment after that time.)

The AEC also discussed having a formal report from the Reference Committees, consisting of 1-2 paragraphs on what was discussed during the Reference Committee meetings and that this would be distributed Saturday morning prior to the Area Council meetings.

- **MOTION APPROVED**: The Assembly Executive Committee voted unanimously to support an expanded Reference Committee review process. APA Administration will develop written Reference Committee reports which include a brief (3-5 lines) report on each action paper to include: How the action paper links to the APA's Strategic Initiatives.
- Structured feedback regarding the Reference Committee's view of positive/negative aspects of the action papers.

The reports will be distributed to the Assembly the following morning in time for consideration at the Area Council meetings the following day.

Report from the CEO and Medical Director – *Saul Levin, MD, MPA*

Dr. Levin provided an update to the AEC on a number of issues. He noted that the transition from ICD-9 to ICD-10 will occur on October 1 and that all ICD-10 codes are included in the DSM-5. Education/communication and outreach to members and other behavioral health clinicians on the transition has begun through member emails, social media, *Psych News*, and behavioral health outlets. Dr. Levin suggested that the AEC discuss these changes with their DB staff as well as the membership of their local district branches/state associations.

Dr. Levin gave an update on the Comprehensive Mental Health Reform Legislation (CMHR). In December, 2014, the Board of Trustees voted to voice greater support for CMHR. The bill, HR 2646 "The Helping Families in Mental Health Crisis Act" was reintroduced in June and it contains notable modifications, including those related to workforce, parity, AOT, HIPAA, proposed SAMHSA cuts, and IMD exclusion. (A detailed summary of the bill can be found online at: www.psychiatry.org/CMHR/.)

Dr. Levin announced that the newly formed State Government Affairs infrastructure will include two staff at APA headquarters (a Director and a manager), and 4 field representatives (**Region 1**: Areas 1, 2, 3; **Region 2**: Area 4; **Region 3**: Area 5; **Region 4**: Areas 6 & 7). He mentioned the recently-announced insurance mergers (Humana-Aetna, Health Net-Centene Corporation, Cigna-Anthem) and that the APA is watching them closely. The new APA rebranding initiative launched on May 17 and has almost completed its three month transition period. The new logo is now on the APA letterhead, business cards, journals, websites, and social media. *Psychiatric News* PsychoPharm is devoted exclusively to news and education related to psychopharmacology. It is currently in beta trial period and is available on the first and third Fridays of the month through December as an electronic newsletter.

Membership growth continues in all areas. There was a 4.4% increase in total members, 3.1% increase in members in dues paying categories, 4.6% increase in RFMs, 2.3% increase in ECPs, and a 26.6% increase in international members. Phil Wang, M.D., will become APA's new Director of Research on August 24, 2015. The APA is moving forward with a lease with option to purchase at "The Wharf" on the top three floors (63,000 square feet) of a LEED gold certified building (energy efficient and green) that

is close to hotels, public transportation, and the airport. The Board of Trustees will decide in 2020 whether to purchase the property or continue leasing.

Dr. Levin outlined the new Strategic Priorities of the APA which are: **advancing psychiatry**, **supporting research**, **education**, and **diversity**. He concluded his remarks by thanking the AEC for donating to the APA*PAC* and the American Psychiatric Foundation as well as thanking the staff for their hard work. He then took questions from members of the AEC.

Areas

The AEC reviewed the Area Councils, their functions and their structure. It was felt that the Area Councils are very useful and need to be preserved. However, there are some aspects of Area Councils functionality that could be improved , such as action paper mentoring, and editing, mentoring of new Assembly members, and promoting diversity. These functions are important and need to be tied to measureable outcomes. There was also interest in incorporating legislative functions at the Area Council level. The AEC had adjusted the Area Council block grants funds in January 2015. While that mechanism is not perfect rather than change it immediately it was requested that the Areas provide the AEC with feedback as to whether the new funds are adequate for the Area Council's needs. It was suggested that the Area Councils try to better incorporate information technology, and hold some of its meetings via teleconference. Dr. Martin will be creating a small work group on technology, which will include both members of the AEC and APA Administration, to consult/review options for expanded use of communication technology. The work group will solicit information on the best technology for meetings involving multiple sites, central locations, and dispersed populations. In addition, the AEC will be its own test case use video/audio conferencing for its upcoming conference calls to test its functionality.

Role of Assembly Group Members

(For this discussion, Jon Fanning, Chief Membership & RFM-ECP Officer, participated via teleconference.)

The AEC discussed the expectations and functions of members of the Assembly who are not representing District Branches. (ACROSS, ECPs, M/URs, and RFMs). It was noted that while all Areas give voice and vote to the M/URs who are members of the Area Councils, not all Area Councils do so for the ACROSS members. Dr. Martin pointed out that while currently the M/UR and ACROSS representatives are members of the area they live in, per the *Procedural Code of the Assembly*, "the Speaker may reassign the individual members of MUR and AAOL in order to provide a balance representation." It is also left up to the Area Councils whether the Area Trustee has a vote. In addition, there are a couple of Areas which have Area Trustees who have dual representative roles. The AEC agreed that there should be uniformity among the Areas on Area Council voting and dual roles. Dr. Martin will appoint a tiger team to look at the role of the Area Trustee within the Area Councils which will report back to the AEC for further discussion and possible recommendations to the Assembly Committee on Procedures.

Currently the ECP and RFM Representatives (not Deputy Representatives) are funded to attend two Area Council meetings per year from the Assembly budget, not the Area Council block grant funds. The M/UR Representatives, Deputy Representatives, and ACROSS Representatives are funded to attend the November Assembly but not to attend the Area Council meetings. It was felt that these groups need to be treated separately as the M/URs are elected from within an APA caucus while the ACROSS

Representatives are from subspecialty organizations. The AEC agreed to add a funding request in the 2016 budget for M/UR Representatives and Deputy Representatives to attend two Area Council meetings per year. If approved, new funds would be within the Assembly budget, not the Area Council block grant funds. The AEC determined further discussion/information is needed with regards to funding for the ACROSS Representatives in various aspects of Assembly functioning . The Speaker will examine this issue, with input from the APA Administration. Ms. Kroeger, Chief of Policy, Programs, and Partnerships, will be asked to provide input regarding the allied organization's resources, as well as the level of involvement and interest with the Assembly and the APA.

Review of Assembly Committees and Work Groups

The AEC reviewed the existing Assembly Committees and Work Groups.

Assembly Committees

The Assembly Liaisons to the Steering Committee on Practice Guidelines and the Assembly DSM Component were felt to be similar as they both involve near continuous ongoing review of documents that require approvalby the Assembly. The Assembly Liaisons to the Steering Committee on Practice Guidelines works in conjunction with the Steering Committee on Practice Guidelines and will continue.

The AEC then reviewed the draft charge (*below*) developed by Drs. Anzia, Eyler, and Napoli for the Assembly DSM Component, to be called the Assembly Committee on Psychiatric Diagnosis and the DSM.

Assembly Committee on Psychiatric Diagnosis and the DSM

Composition: The Committee is composed of one member from each Area, and one member each from the Assembly Resident and Fellow Members, the Assembly Early Career Psychiatrists, the Assembly Minority/Underrepresented Members, and the Assembly Committee of Representatives of Subspecialties and Sections. Members shall be elected by the relevant group annually, to serve no more than four consecutive years. The Chair shall be appointed from among this group annually by the Speaker.

Function: The Committee will serve to receive concerns and opinions from the members of the Assembly, and from the Association membership as a whole through the Assembly Representatives, about the American Psychiatric Association's ongoing or actively considered activities regarding psychiatric diagnosis and nomenclature, including but not limited to the Diagnostic and Statistical Manual (DSM). The Committee will deliberate about matters brought to it, and when appropriate, transmit recommendations for actions to the Assembly for approval and referral to the Board of Trustees or its authorized components then operating in these matters. From time to time the Assembly Committee may solicit input or opinion from the Assembly or the Association membership, especially regarding the applications of diagnosis and diagnostic criteria in clinical practice, and the perceptions of clinicians on the need for or advisability of change

MOTION APPROVED: The Assembly Executive Committee voted to approve the proposal to set up an Assembly Committee on the DSM and refer the proposal to the Assembly Committee on Procedures for implementation and integration in to the *Procedural Code of the Assembly*.

Dr. Martin deferred the discussion of the Assembly Committee on Public and Community Psychiatry to the next AEC meeting due to Dr. Miller's absence as Dr. Miller can provide some historical insight on the Committee. Additionally, the Committee is an official committee of the Assembly and cannot be sunset unless there is a change to the Procedural Code which would involve approval of the Assembly.

Assembly Work Groups

The AEC reviewed the current Assembly Work Groups and, based on the discussion, Dr. Martin determined that:

- **RETAINED**: Access to Care, Maintenance of Certification (MOC), and Metrics
- **RETIRED**: Communications*****, Legislative Affairs, Long Range Planning, and Mentorship******
  *****It was suggested that Dr. Jacob Behrens (former Chair of the Work Group on Communications) act as an informal liaison from the Assembly to the CEO and Medical Director and Office of Communications.
  ******Mentoring must occur within the Areas and District Branches and each Area should provide updates to the AEC on their mentoring of new/younger members.
- **PENDING**: Dr. Martin will follow up with Dr. Borenstein on the Work Group on the Assembly/Foundation Initiative to clarify its status and have a formal statement of purpose and expected work product with expectation it will sunset after the May meeting

Update on the BOT/ASM Ad Hoc Work Group Report on M/UR Issues

(For this discussion, Dr. Linda Nahulu, Chair of the M/UR Committee, Colleen Coyle, JD, APA General Counsel, and Kristin Kroeger, Chief of Policy, Programs and Partnerships, participated via teleconference.)

Dr. Parekh gave a brief update as to what has been accomplished to date from the recommendations within the original report. Recommendations for the Assembly included creating a time-limited work group to recommend *Procedural Code* amendments to enhance/clarify the relationship between the Assembly and the M/UR caucuses and increasing the number of meetings of the Assembly M/UR Committee. [**N.B**.: The M/UR Committee is now scheduled to meet twice during the November and May Assembly meetings.]

It was felt that as the M/URs are a body of the Assembly, the Assembly has the responsibility to assure the framework that helps maintain and strengthen democratic and representative M/UR caucuses. Dr. Martin will compile a small group of veteran AEC members, Dr. Nahulu, appropriate APA Administration, and APA General Counsel Colleen Coyle to assist the caucuses by developing a stripped-down version of "model bylaws" to include consistent caucus procedural language for key areas within all caucuses such as:

- Caucus management
- Elections processes for all M/UR caucus officers with standard and equal term limits
- Shared process for review and nomination of the M/UR Trustee candidates to ensure clear procedure and fairness
- Open membership per normal APA caucus procedures with the understanding that a member may only vote in one M/UR caucus.

Assembly Awards

Dr. Young, Chair of the Assembly Awards Committee, noted that there are currently eight Assembly awards, three of which are given by the Assembly: Profile of Courage, District Branch Best Practice,

and the Ronald Shellow Award. The rest of the awards are given by the Area Councils. One award, the Excellence in Service and Advocacy award, which was developed to recognize activities by women that promote mental health and reduce stigma related to psychiatric illness (particularly on behalf of women and members of disadvantaged population groups) has never been given. Dr. Young will be contacting the Women's Caucus, who are assigned to review the nominations, to see if they are interested in keeping this award. Dr. Young is also going to remind the Areas about the Area specific awards as well as the Assembly-related awards. Dr. Martin requested that the Awards Committee, along with Dr. Vivek, develop the criteria for the new Assembly award on the DB/Area with the highest percentage of voting so that it can reviewed at the next AEC meeting

Assembly Reorganization Update

Assembly Reorganization

The AEC discussed the recent Assembly reorganization. Changing Deputy Representatives to Representatives increased representation for some District Branches and provided an opportunity to increase diversity among the member so the Assembly. Areas 1, 4, and 6 highlighted the diversity of the new representatives from the District Branches that gained Representatives. There are some District Branches whose additional Assembly Representative appointments are pending due to ongoing elections or DB bylaw amendments. Dr. Martin requested that the Area Representatives/Deputy Representatives work with the staff of the District Branches that are amending their bylaws due to the Assembly reorganization and to complete the process as quickly as possible,Dr. Hovav noted that the Nebraska Psychiatric Society's bylaws limit changes to DB appointments. Dr. Miskimen and APA Administration will poll the DB/SA Executive Staff to determine if this issue is more widespread and provide necessary feedback and support to resolve any open issues.

Assembly Appointments

Dr. Martin updated the AEC on the Assembly appointment process. He highlighted the selection process outlined the *Procedural Code* for the composition of the Assembly Nominating Committee. It was determined that most Areas do not follow the selection process but simply ask for volunteers among their Area members.

MOTION APPROVED: The Assembly Executive Committee voted that current appointments to the Assembly Nominating Committee will remain in place but that, for subsequent appointments, each area council should follow the *Procedural Code of the Assembly* guidelines for Nominating Committee appointments. The Assembly Executive Committee will revisit any wish to change the *Procedural Code* at a later date.

[From the *Procedural Code of the Assembly*]
1) Composition: The Assembly Nominating Committee shall be selected in the following manner:

(a) The chair shall be appointed annually by the Speaker.
(b) Each of the Area Councils shall elect one Area Selector to this Committee and an Alternate Selector to serve in the Selector's absence. Such election shall occur in the year following the election of the Area Representative. All such Selectors shall serve for a term of two years. In the event neither the Selector nor the Alternate can act, the Area Representative may fill the vacancy by appointment of a

constituent District Branch Representative to serve until the next Annual Meeting when a successor shall be elected in the manner described above.
(c) The Committee of Minority/Underrepresented Groups, the Committee of Area Resident-Fellow Member Representatives, the Committee of Area Early Career Psychiatrist Representatives, and the Assembly Committee of Representatives of Subspecialties and Sections shall each elect a Selector and Alternate Selector to serve on the Assembly Nominating Committee in a manner comparable to the Area Selectors and Alternate Selectors given above in (b).

Assembly Voting

The AEC reviewed the Assembly voting process. Currently, electronic voting is used only "standing" votes and paper ballots are used for votes by strength. Because of the ability per the Procedural Code for representatives to split their votes by strength using the electronic voting system would be a challenge and the AEC felt that at this time, Assembly voting procedures, both for standing votes and votes by strength should essentially continue as is. The Excel spreadsheet currently in use to tally votes by strength will be continued however improvements to the process, such as rewriting the ballots, will be investigated by Dr. Miskimen and APA Administration. In addition, the numbers of tellers will be increased from three to four to ensure that there are a sufficient number of participants. During electronic voting the Assembly will be reminded of the maximum possible total votes. Voting will be time-limited and an indicator e.g. music will be used to notify members when the electronic voting will be closed. Administration will try to arrange for the tally of votes to be displayed by area.

MOTION APPROVED: The Assembly Executive Committee voted to retain the paper votes by strength for this Assembly cycle. [Dr. Eyler abstain]

The AEC also agreed that the total number of clicker votes will be recorded and that votes will be noted as unanimous in the Assembly summary of actions only if a separate motion from the floor is made immediately after the vote and approved .

October/November Assembly 2015

Reference Committees

The Reference Committees will be re-named to align with the new APA strategic priorities:

1. Advancing Psychiatry
2. Supporting Research
3. Education & Lifelong Learning
4. Diversity & Health Disparities
5. The title of the fifth Reference Committee will be determined by Dr. Martin and will encompass sustainability of organization/membership/governance/administration issues.

Dr. Martin requested that the Areas provide nominees for specific Reference Committees, including two sentences on their expertise related to that Reference Committee. In addition, a one-page resource document will be shared with the entire Assembly that will include the new Strategic Priorities and other key information on the meeting using a *Fast Facts* format. It is hoped that this document will also encourage experienced members of the Assembly to attend the orientation.

Assembly Plenary Set-up

The plenary set-up will retain the two-tier dais however the Area Representatives and Deputy Representatives will be seated as close to the location of their Area Council as possible. To accomplish this, Association Governance will experiment with the Assembly seating chart, and have the Area Councils sit in groups or rectangles rather than in long rows. It was suggested that the Areas use the mobile app "Whatsapp" (https://www.whatsapp.com/) to facilitate communication among the Area members during the meeting. The microphones on the sides of the Assembly floor will be removed and replaced with three microphones in the center of the room which will be labeled **Pro**, **Con**, and **Procedural Matters.**

Assembly Schedule

The AEC discussed the following changes to the Assembly schedule:

- Schedule the AEC meeting earlier on Friday, October 30 to give the AEC enough time to review the meeting agenda and meeting-related issues.
- Increase the meeting time of the Saturday morning Area Council meetings to allow for a more thorough review of the action papers.
- Adjust the time of the Assembly New Member Orientation (*if needed*).
- Consider adjusting the Reference Committee meeting end times to allow for development and review of the Reference Committee reports to the Area Councils and additionally, providing light refreshments for the Reference Committee members.

New Business

The Assembly Executive Committee discussed a motion (*see below*) that was approved on a recent conference call of the Council on Advocacy and Government Relations.

Council on Advocacy and Government Relations (CAGR) Motion to the Board of Trustees: "CAGR is concerned by a growing trend of industry consolidation among the large, national health insurers. Consequently, CAGR recommends that the Board of Trustees instruct APA to prioritize an expeditious assessment of the implications these consolidations may have on the practice of psychiatry and psychiatric patients, and in the cases of consolidations with clear negative implications, advocate against them by utilizing internal resources as well as by participating in coalitions with other professional and consumer advocacy groups."

MOTION APPROVED: The Assembly Executive Committee voted unanimously to support the motion from the Council on Advocacy and Government Relations (CAGR) on insurance mergers.

Dr. Price announced that there is 100% participation by the AEC to the APA*PAC*. Dr. Martin noted that he will be stressing the importance of Assembly member participation to the APA*PAC* and he asked that the Area Councils relay this message to their members as well.

Dr. Young requested that the AEC send her emails about what types of information and helpful tools the APA and more specifically the Council on Medical Education and Lifelong Learning can provide for further learning for members.

Adjournment

Dr. Martin concluded the meeting by thanking the AEC for its hard work and wished everyone safe travel.

Upcoming Meetings:

*Assembly, October 30-November 1, 2015, **Omni Shoreham**, Washington, DC*
Assembly Executive Committee, January 22-24, 2016, Charleston, South Carolina
Assembly, May 13-15, 2016, Atlanta, Georgia

Rules Committee Report

FINAL Action Assignments

Reference Committee Rosters

Reference Committee 1 — Advancing Psychiatry

Meets: Friday, October 30, 2015, 3:00 PM-6:00 PM, Congressional Room A, Lobby Level, West

Presents: 2nd Plenary, Saturday, October 31, 2015, 10:30 AM- 12:00 PM

Roster:

Robert Roca, M.D., MPH, Area 3, CHAIR
Marshall Forstein, M.D., Area 1
Richard Altesman, M.D., Area 2
Prudence Gourguechon, M.D., Area 4
Mark Wright, M.D., Area 5
Richard Granese, M.D., Area 6
Dodge Slagle, D.O., Area 7
Loreen Pirnie, M.D., RFM
John Korpics, M.D., ECP
Kimberly Yang, M.D., M/UR
Mark Komrad, M.D., ACROSS

Assignments: 4.B.16, 12.A, 12.B, 12.C, 12.D

cc	2015A2 4.B.16	Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment
	2015A2 12.A	Access to Care Provided by the Veterans Administration
	2015A2 12.B	Directions to the Area Nominating Committees
	2015A2 12.C	New Names for Psychiatric Conditions
cc	2015A2 12.D	Prior Authorization

Reference Committee 2 — Supporting Research

Meets: Friday, October 30, 2015, 3:00 PM-6:00 PM, Congressional Room B, Lobby Level, West

Presents: 2nd Plenary, Saturday, October 30, 2015, 10:30 AM- 12:00 PM

Roster:

Mary Ann Schaepper, M.D., Area 6, CHAIR
Lisa Catapano-Friedman, M.D., Area 1
Aaron Satloff, M.D., Area 2
William Greenberg, M.D., Area 3
Lisa Rone, M.D., Area 4
Valerie Arnold, M.D., Area 5
Iqbal Ahmed, M.D., Area 7
Candes Dotson, M.D., RFM
Maria Bodic, M.D., ECP
David Tompkins, MD, M/UR
Jeffrey Geller, M.D., ACROSS

Assignments: 4.B.4, 12.E, 12.F, 12.G, 12.H

cc	2015A2 4.B.4	Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP
	2015A2 12.E	Ad Hoc Work Group to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product
	2015A2 12.F	Payer Coverage for Prescriptions from Nonparticipating Prescribers
	2015A2 12.G	APA Support for NIMH Funding of Clinical Research
	2015A2 12.H	Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?

Reference Committee 3 — Education& Lifelong Learning

Meets: Friday, October 30, 2015, 3:00 PM-6:00 PM, Council Room, Lobby Level, West
Presents: 3rd Plenary, Saturday, October 31, 2015, 1:00 PM- 3:00 PM

Roster:

Jacob Behrens, M.D., ECP, CHAIR
Shery Zener, M.D., Area 1
Henry Weinstein, M.D., Area 2
Sheila Judge, M.D., Area 3
James Fleming, M.D., Area 4
Debra Atkisson, M.D., Area 5
Robert McCarron, MD, Area 6
Matthew Layton, M.D., Area 7
Kelly Jones, M.D., RFM
Ubaldo Leli, M.D., M/UR
Jack Bonner, M.D., ACROSS

Assignments: 4.B.3, 12.I, 12.J, 12.K, 12.L

cc	2015A2 4.B.3	Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities
	2015A2 12.I	Strengthening the Role of Residency Training to Improve Access to Buprenorphine
	2015A2 12.J	Need to Gather Information on Physician Health Program (PHP) Performance
	2015A2 12.K	Parity in Permanent Licensure Policy
	2015A2 12.L	Partial Hospital Training in Psychiatry Residency

Reference Committee 4 — Diversity & Health Disparities

Meets: Friday, October 30, 2015, 3:00 PM-6:00 PM, Senate Room, Lobby Level, West
Presents: 3rd Plenary, Saturday, October 31, 2015, 1:00 PM- 3:00 PM

Roster:

Kenneth Certa, M.D., Area 3, CHAIR
Reena Kapoor, M.D., Area 1
Felix Torres, M.D., Area 2
Dionne Hart, M.D., Area 4
Eugene Lee, M.D., Area 5
Alexis Seegan, M.D., Area 6
Linda Nahulu, M.D., Area 7
Jessica Abellard, M.D., RFM
Jason Collison, M.D., ECP
Maureen Van Niel, M.D., M/UR
Gregory Miller, M.D., ACROSS

Assignments: 4.B.6, 12.M, 12.N, 12.O, 12.P

cc	2015A2 4.B.6	Proposed Position Statement: Substance Use Disorders in Older Adults
	2015A2 12.M	Addressing the Shortage of Psychiatrists
cc	2015A2 12.N	Advocating for Medicaid Expansion
	2015A2 12.O	Systems to Coordinate and Optimize Psychiatric Inpatient Bed Availability for Referral of Psychiatric Emergencies
	2015A2 12.P	Making Access to Treatment for Erectile Disorder Available under Medicare

Reference Committee 5 — Membership & Organization

Meets: Friday, October 30, 2015, 3:00 PM-6:00 PM, Forum Room, Lobby Level, West
Presents: 3rd Plenary, Saturday, October 31, 2015 4, 1:00 PM- 3:00 PM
Roster:

Melvin P. Melnick, M.D., Area 3, CHAIR
Paul Lieberman, M.D., Area 1
Ramaswamy Viswanathan, M.D., Area 2
Brian Hart, M.D., Area 4
John Bailey, M.D., Area 5
Lawrence Gross, M.D., Area 6
Amela Blekic, M.D., Area 7
Matthew Kruse, M.D., RFM
Joshua Sonkiss, M.D., ECP
Rahn Bailey, M.D., M/UR
Richard Ratner, M.D., ACROSS

Assignments: 4.B.14, 12.Q, 12.R, 12.S, 12.T

cc	2015A2 4.B.14	Proposed Position Statement on Tobacco Use Disorder
	2015A2 12.Q	Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations
	2015A2 12.R	Senior Psychiatrist Seat on the Board of Trustees (BOT)
cc	2015A2 12.S	Need for Position-Specific Email Addresses for Leadership Roles in the APA
	2015A2 12.T	Election of Assembly Officers

Area Council and Assembly Group Action Assignments

Presents: 4th Plenary, Sunday, November 1, 2015, 8:00 AM - 11:00 AM

Assignments: **8.L.1, 4.B.1, 4.B.2, 4.B.5, 4.B.7, 4.B.8, 4.B.9, 4.B.10, 4.B.11, 4.B.12, 4.B.13, 4.B.15, 14.A**

	2015A2 8.L.1	APA Practice Guideline: Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia All Areas/Groups: Primary – Area 4, Secondary – RFMs
cc	2015A2 4.B.1	Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV All Areas/Groups: Primary – Area 1, Secondary – Area 3
cc	2015A2 4.B.2	Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly All Areas/Groups: Primary – ACROSS, Secondary – Area 4
cc	2015A2 4.B.5	Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices All Areas/Groups: Primary – Area 5, Secondary – Area 7

cc	2015A2 4.B.7	Revised Position Statement: Bias-Related Incidents All Areas/Groups: Primary – ECPs, Secondary – Area 2
cc	2015A2 4.B.8	Retire 2007 Position Statement: The Right to Privacy All Areas/Groups: Primary – RFMs, Secondary – Area 6
cc	2015A2 4.B.9	Retire 2007 Position Statement: Sexual Harassment All Areas/Groups: Primary – Area 7, Secondary – M/URs
cc	2015A2 4.B.10	Retire 2009 Position Statement: Interference with Scientific Research and Medical Care All Areas/Groups: Primary – Area 6, Secondary – Area 1
cc	2015A2 4.B.11	Revised Position Statement: Hypnosis All Areas/Groups: Primary – Area 2, Secondary – RFMs
cc	2015A2 4.B.12	Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury All Areas/Groups: Primary – Area 5, Secondary – ECPs
cc	2015A2 4.B.13	Retain 2010 Position Statement on High Volume Psychiatric Practice and Quality of Patient Care All Areas/Groups: Primary – Area 3, Secondary – ACROSS
cc	2015A2 4.B.15	Retain Position Statement: Psychotherapy as an Essential Skill of Psychiatrists All Areas/Groups: Primary – M/URs, Secondary – Area 5
	2015A2 14.A	[**New Business**] Revised Position Statement on Telemedicine in Psychiatry All Areas/Groups: Primary – Area 5, Secondary – Area 7

Assembly Rules Committee
FINAL Consent Calendar

To provide time for discussion and debate on many issues on the agenda, the Assembly has approved using a Consent Calendar at its meetings. Placement on the Consent Calendar does not imply that an issue is not of prime interest or importance, but rather that it is perceived to be non-controversial, routine, for information (perhaps to another component), or an administrative matter.

When the Consent Calendar if brought to the floor of the Assembly, any member may request removal of any item for debate, for individual action, or for information. Members may have suggestions for additions to the Consent Calendar when it is presented for a vote.

The remaining items are voted on en bloc. Items removed are then taken up in the order in which they appear on the agenda schedule.

A. Does any member of the Assembly wish to add any item to the Consent Calendar?
B. Does any member of the Assembly wish to remove any item from the Consent Calendar?
C. Will the Assembly vote to approve the remaining items on the Consent Calendar?

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cc #1 **2015A2 4.B.1** Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV
If removed: **All Areas/Groups**: Primary – Area 1, Secondary – Area 3

cc#2 **2015A2 4.B.2** Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly
If removed: **All Areas/Groups**: Primary – ACROSS, Secondary – Area 4

cc#3 **2015A2 4.B.3** Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities
REMOVED FROM THE CONSENT CALENDAR
If removed: **Reference Committee #3**

cc#4 **2015A2 4.B.4** Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution-Joint Position Statement of the APA/AAAP
If removed: **Reference Committee #2**

cc#5 **2015A2 4.B.5** Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices
REMOVED FROM THE CONSENT CALENDAR
If removed: **All Areas/Groups**: Primary – Area 5, Secondary – Area 7

cc#6 **2015A2 4.B.6** Proposed Position Statement: Substance Use Disorders in Older Adults
If removed: **Reference Committee #4**

cc#7 **2015A2 4.B.7** Revised Position Statement: Bias-Related Incidents
If removed: **All Areas/Groups**: Primary – ECPs, Secondary – Area 2

cc#8 **2015A2 4.B.8** Retire 2007 Position Statement: The Right to Privacy
If removed: **All Areas/Groups**: Primary – RFMs, Secondary – Area 6

cc#9 **2015A2 4.B.9** Retire 2007 Position Statement: Sexual Harassment
REMOVED FROM THE CONSENT CALENDAR
If removed: **All Areas/Groups**: Primary – Area 7, Secondary – M/URs

cc#10 **2015A2 4.B.10** Retire 2009 Position Statement: Interference with Scientific Research and Medical Care
If removed: **All Areas/Groups**: Primary – Area 6, Secondary – Area 1

cc#11 **2015A2 4.B.11** Revised Position Statement: Hypnosis
If removed: **All Areas/Groups**: Primary – Area 2, Secondary – RFMs

cc#12 **2015A2 4.B.12** Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury
If removed: **All Areas/Groups**: Primary – Area 5, Secondary – ECPs

cc#13 **2015A2 4.B.13** Retain 2010 Position Statement on High Volume Psychiatric Practice and Quality of Patient Care
If removed: **All Areas/Groups**: Primary – Area 3, Secondary – ACROSS

cc#14 **2015A2 4.B.14** Proposed Position Statement on Tobacco Use Disorder
If removed: **Reference Committee #5**

cc#15 **2015A2 4.B.15** Retain Position Statement: Psychotherapy as an Essential Skill of Psychiatrists
If removed: **All Areas/Groups**: Primary – M/URs, Secondary – Area 5

cc#16 **2015A2 4.B.16** Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment
If removed: **Reference Committee #1**

cc#17 **2015A2 12.D** Action Paper: Prior Authorization
If removed: **Reference Committee #1**

cc#18 **2015A2 12.N** Action Paper: Advocating for Medicaid Expansion
If removed: **Reference Committee #4**

cc#19 **2015A2 12.S** Action Paper: Need for Position-Specific Email Addresses for Leadership Roles in the APA
REMOVED FROM THE CONSENT CALENDAR
If removed: **Reference Committee #5**

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Special Rules of the Assembly

1) There will be a maximum of three minutes for each presentation during debate.

2) The author or presenter has priority in making statements.

3) The Speaker will attempt to solicit a balance of pros and cons.

4) The Speaker will entertain a motion for the question when it is felt that there has been sufficient debate, both positive and negative on the motion.

5) A Reference Committee model is being used as an alternative to Area Council review for some Action Papers. The Rules Committee will select the papers to be processed in this way. The Reference Committee will be selected by the Speaker from nominees submitted by the Area Councils, the ECP Committee, the RFM Committee, the M/UR Committee, and the ACROSS Committee, to equalize participation as much as possible. Council Chairs may be appointed as non-voting participants in the Reference Committees. The Reference Committees may modify or combine Action Papers. Their recommended actions will be distributed in time for discussion in the Area Council meetings before being brought to the floor.

6) Presenters of reports should be limited to spelling out clearly the title and identification of the report, giving a short summary of the salient points if necessary, calling for action if indicated, and being available for questions from the floor.

7) New Business should be kept to a minimum, particularly if the issue is already reflected in another Action Paper on the Agenda that was emailed before the meeting.

8) The author will move his or her paper. The Reference Committee will give a report of recommendations to approve, not approve, amend, or otherwise act on the paper. If the Reference Committee proposes amendments, they will move them en bloc as an amendment by substitution, which does not require a second or acceptance by the author. The discussion will be on the amendment by substitution. Two additional levels of amendment will be permitted to this amendment by the Reference Committee. At the end of the discussion, if the Reference Committee's wording with any passed amendment fails, then discussion will revert to the original paper.

9) The question of direct referral of an Action Paper to the Board of Trustees will be divided and handled as a separate motion following passage of the Action Paper, even if direct referral is included in the Action Paper's "Be it Resolved." The Reference Committee's input regarding the direct referral motion will be taken into consideration. Debate on this motion will be limited as to timeliness and thus the appropriateness of a direct referral.

Assembly Committee on Procedures

Executive Summary

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

Report of the Assembly Committee on Procedures

Chairperson: A David Axelrad, MD (Area 5); Members: David Gitlin, MD (Area 1) , Nigel Martyn Bark, MD (Area 2), Robert, Paul Roca, MD (Area 3), James Robert Batterson, MD (Area 4), Maria L. Tiamson-Kassab, MD (Area 6), Jason W. Hunziker, MD (Area 7), Eric Martin Plakun, MD (AAOL), Simha Esther Ravven, MD (ECP), Subhash Chandra, MD (RFM), Jose E. De La Gandara, MD (M/UR) and John J. Wernert III, MD (Parliamentarian); Administration: Margaret C. Dewar (Director, Association Governance) and Chiharu Tobita (Sr. Projects Manager, Association Governance)

1) **Assembly Committee on Psychiatric Diagnosis and the DSM**
At its' July 2015 meeting, the AEC reviewed the draft charge (below) developed by Drs. Dan Anzia, Evan Eyler, and Joseph Napoli for the Assembly DSM Component, to be called the Assembly Committee on Psychiatric Diagnosis and the DSM. The AEC voted to approve the proposal to set up an Assembly Committee on the DSM and refer the proposal to the Assembly Committee on Procedures for implementation and integration in to the *Procedural Code of the Assembly*.

Assembly Committee on Psychiatric Diagnosis and the DSM
Composition: *The Committee is composed of one member from each Area, and one member each from the Assembly Resident and Fellow Members, the Assembly Early Career Psychiatrists, the Assembly Minority/Underrepresented Members, and the Assembly Committee of Representatives of Subspecialties and Sections. Members shall be elected by the relevant group annually, to serve no more than four consecutive years. The Chair shall be appointed from among this group annually by the Speaker.*

Function: *The Committee will serve to receive concerns and opinions from the members of the Assembly, and from the Association membership as a whole through the Assembly Representatives, about the American Psychiatric Association's ongoing or actively considered activities regarding psychiatric diagnosis and nomenclature, including but not limited to the Diagnostic and Statistical Manual (DSM). The Committee will deliberate about matters brought to it, and when appropriate, transmit recommendations for actions to the Assembly for approval and referral to the Board of Trustees or its authorized components then operating in these matters. From time to time the Assembly Committee may solicit input or opinion from the Assembly or the Association membership, especially regarding the applications of diagnosis and diagnostic criteria in clinical practice, and the perceptions of clinicians on the need for or advisability of change*

The Committee on Procedures reviewed this proposed language to ensure that the content and format is consistent with the *Procedural Code*. The Committee voted to approve the adoption of the AEC-approved amendment to the *Procedural Code*.

ACTION 1: Will the Committee on Procedures vote to approve the recommended AEC-approved amendment to the *Procedural Code* incorporating the Assembly Committee on the DSM composition/ function based on the approved Action Paper 12.M. "Assembly DSM Component"?

2) **Update from the Work Group to review DB bylaws/Area Procedural Code**

Chairperson: Dr. A David Axelrad
Members: Drs. Jason Hunziker, Robert Roca, Eric Plakun, Simha Esther Ravven and John Wernert
Consultant: Ms. Bonnie Cook (Executive Director, Kentucky Psychiatric Medical Association)

a. Review for consistency of Area Procedural Codes

In 2014, a concern was raised about the consistency of APA legal documents. Work Group members were assigned to review the *Area Procedural Codes* for consistency with the *APA Bylaws* and *APA Operations Manual (OPS Manual)*:

REVIEWER	ASSIGNMENT
Eric Plakun, MD	Area 1 Procedural Code
David Axelrad, MD	Area 2 Procedural Code Area 4 Procedural Code
Theresa Miskimen , MD Robert Roca, MD	Area 3 Procedural Code
Gary Weinstein, MD John Wernert, MD	Area 5 Procedural Code
Jose Vito, MD Simha Ravven, MD	Area 6 Procedural Code
Jason Hunziker, MD	Area 7 Procedural Code

The review comments will be distributed to the Area Reps after the October/November 2015 Assembly meeting. The Procedures Committee requests that the Area Councils adopt the suggested changes by March/ April 2016.

b. Upcoming DB Bylaws Review Schedule

There are a total of 31 DB/SA bylaws that are up for review by the end of this year: Massachusetts, Rhode Island, Brooklyn, Genesee Valley, Greater Long Island, New York State, Northern New York, Queens, Missouri, Illinois, Iowa, Kansas, Michigan, Minnesota, North Dakota, Ohio, South Dakota, Arkansas, Louisiana, Mississippi, North Carolina, Virginia, Puerto Rico, Uniformed Services, Tennessee, Texas, Central California, Montana, Nevada, New Mexico and Western Canada.

In 2016, the following 11 DB/SA bylaws will be up for review: Quebec, Maryland, New Jersey, Indiana, Nebraska, Wisconsin, Oklahoma, South Carolina, Southern California, Hawaii and Washington State.

In 2019, the following 29 DB/SA bylaws will be up for review: Connecticut, Maine, New Hampshire, Ontario, Vermont, Bronx, Central New York, Mid-Hudson, New York County, Westchester County, West Hudson, Western New York, Pennsylvania, Delaware, DC, Alabama, Florida, Georgia, Kentucky, West Virginia, Northern California, Orange County, San Diego, Alaska, Arizona, Colorado, Idaho, Oregon, Utah and Wyoming.

The Committee on Procedures will share their review comments before the May 2016 Assembly meeting.

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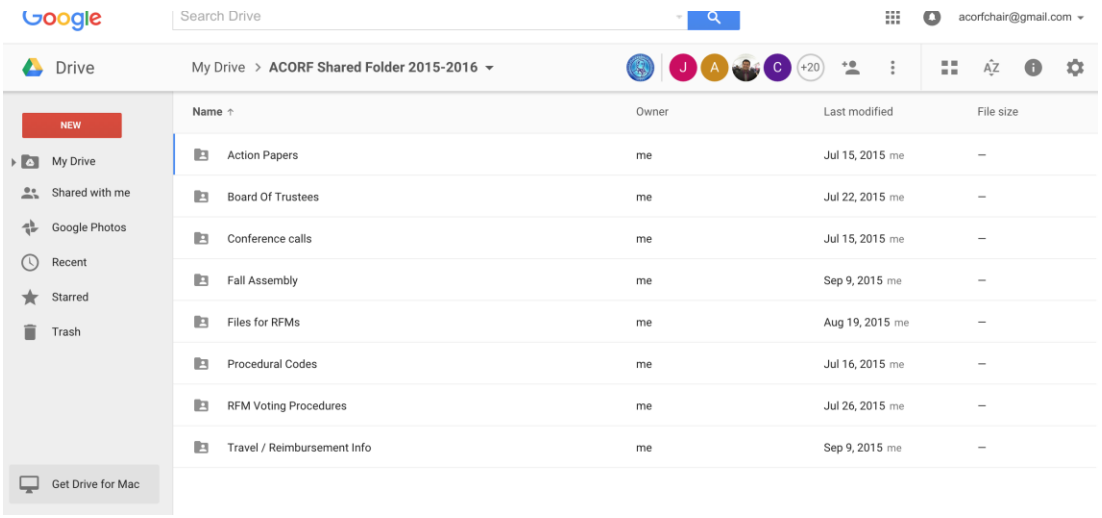
Report of the Assembly Committee of Resident-Fellow Members (RFMs)

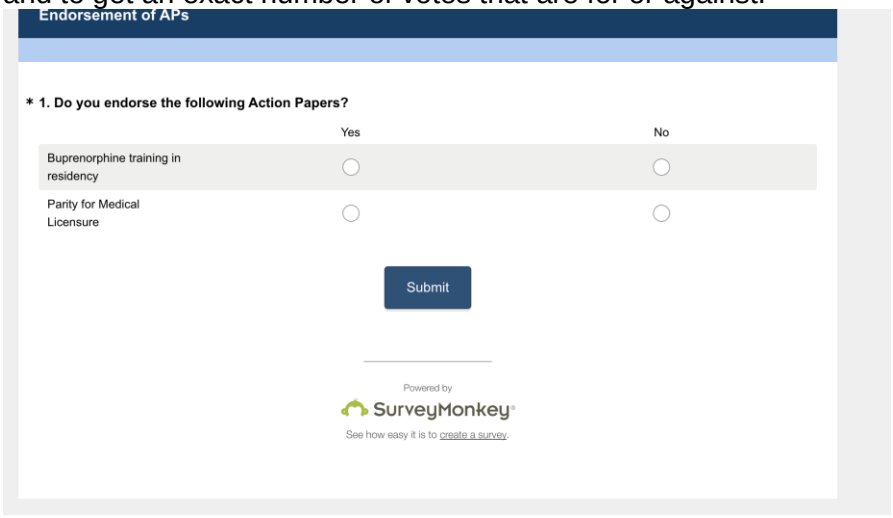
I. Communication

a. Conference Calls:
   i. Take place at 2100 EST on the 3rd Wednesday of each month (with few exceptions) and last no longer than 60 minutes.
   ii. Are attended by each Area RFM Dep Rep and Rep ("ACORFians," as I have chosen to call them), the ACORF Mentor, Jon Fanning, and Stephanie Auditore (if their schedule so allows). The RFMT and RFMTE are also invited, but typically attend only if there is an update from the BoT. The M/UR RFM Rep is also invited, but attends only sporadically.
   iii. The agenda is made available prior to the meeting, and the minutes are posted within 48 hours of the call. See Technology, below, for how we post our agenda and minutes.
   iv. Each call gives time for Officer updates (Chair, APA Staff, ECP liaison/ACORF mentor), discussion of area-specific issues, AP discussion, and whatever other issues are pertinent.
   v. Dates: July 15; August 19; September 9; October 21; November 18; December 16; January 20; February 17; March 16; April 20; June 15. An additional date for election of new Chair will be sometime prior to Spring Assembly.

b. Technology:
   i. Email: I have created an email account acorfchair@gmail.com that will be passed on from one Chair to the next each year. This is to allow for easy communication with new Chair, to keep a list of contacts without the need to transfer this over, and to have the Google Drive associated with the email (see below) passed on from one Chair to another
   ii. Google Drive: The G-Drive has allowed me to share important documents and forms with the "ACORFians" that are easy to see, never "get lost" in the email archives, and can be easily updated live without the need to re-send. These documents include the agenda and minutes of each conference call, action paper templates, RFM guides, the RFM contact list, information on travel/reimbursement, and any information that the RFMT, or staff would like to share with us. If you are interested in seeing how this is organized, please contact me (Acorfchair@gmail.com) and I will send you a link to our shared Drive. Note that the administrator (Chair) has the ability to share with editing or viewing-only privileges.



iii. Survey Monkey: This year, I implemented a way for us to vote to either endorse or not endorse an action paper via electronic voting. In previous years, when asked on the conference call if we endorse, a few voices saying "yes" were heard, but it was not a formal way to know that in fact, it is an endorsement from the entire group. As such, Survey Monkey has allowed me to create a survey, with only 14 voters allowed (2 per area, restricted by IP), and to get an exact number of votes that are for or against.



II. Fall Assembly preparation

a. Action Papers:

i. The mission of ACORF is to provide the Assembly with the trainee's perspective on issues facing the field of psychiatry. With this in mind, we aim to write Action Papers addressing this.

ii. For the Fall Assembly, four APs were written by ACORFians. They all received endorsement by ACORF. As some were written quite late, not all were able to ask for ECP endorsement.

iii. At least two more APs are already in the thought process (or beyond) for the Spring Assembly.

b. Travel and Reimbursement:
    i. 100% of ACORFians will be attending this Assembly (as is known at the time of this writing)
    ii. I have requested that all ACORFians request reimbursement for travel expenses within 2 weeks of returning, and there seems to be a positive response to this.
    iii. There have been quite a few issues for residents trying to make arrangements with ATC online
c. Social Event:
    i. Our meeting time for Friday evening will be held during dinner at a local restaurant, to allow us to socialize and enjoy each other's company while still discussing business.
d. Communication during the Assembly:
    i. RFMs (and ECPs) are unique such that we do not sit together as a group, but rather all with our respective areas. Therefore, communication can be a challenge. This year, I have created the WhatsApp group (a free app on iTunes and Google Play) where we can text the entire group. This will be used during the plenary to communicate ideas, as well as a place to remind the entire group on times and meeting locations. 10 of 14 RFMs have already been added to the group as of this writing, and 100% "attendance" is expected.

III. Thoughts moving forward

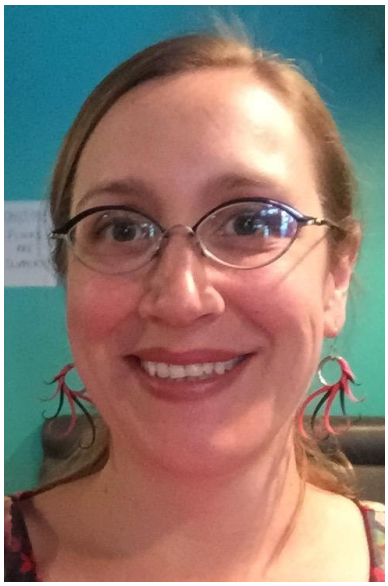
a. Aspirations:
    i. We are planning on creating a major "get the vote out" geared toward RFMs, with a goal of 50% of RFMs to vote this year (last year, only about 10% of RFMs voted).

IV. Meet us!

a. Area 1 Rep: Loreen Pirnie, MD

Loreen is a PGY3 at Brown University/Butler Hospital. Her interests are in resident and medical students as well as in public education. She would like to see more of the smaller residencies in Area I involved in the APA, and to collaborate in writing APs.

b. Area 1 Dep Rep: Rebecca Allen, MD, MPH



Rebecca completed Harvard Longwood Psychiatry Residency and is now a Neuropsychiatry fellow at Brigham and Women's Hospital. She wrote the monthly MPS Healthcare Systems & Financing newsletter column and now writes the RFM Corner monthly column. She looks forward to getting involved in mental health advocacy on a national level.

c. Area 2 Rep: Subhash Chandra, MBBS

Subhash is a PGY4 at SUNY Downstate Medical Center. Beyond the APA, he is also serving on the AMA-IMG Governing Council as the AMA-RFS Representative.

d. Area 2 Dep Rep: Jeremy Kidd, MD

Jeremy is a PGY3 at New York Presbyterian/Columbia University. He is interested in Addiction psychiatry and LGBT (particularly transgender) mental health.

e. Area 3 Rep: Jessica Abellard, MD

Jessica is a PGY3 at Cooper University Hospital. Her interests lie in advocating for our profession, patients, and providing a voice for those who feel unheard. She is humbled by the opportunity of being a RFM Rep and wants to advocate for patients and dispel stigma, especially in underserved and underrepresented populations. As a Haitian American woman, she also finds women's health issues and cultural psychiatry important areas of discussion. She would like to take advantage of networking and mentorship opportunities.

f. Area 3 Dep Rep: Raul Poulson, MD

Raul is a PGY3 at Rutgers-Robert Wood Johnson Medical School. He is interested in Child and Adolescent Psychiatry, Cultural Psychiatry, Advocacy Issues, and the Hispanic Community.

g. Area 4 Rep and ACORF Chair: Sarit Hovav, MD

Sarit is a PGY4 at University of Nebraska/Creighton University. She is originally from Israel, but has lived all over the US and in several countries. She's thrilled to be a part of Area 4. She completed a 3 year Postdoc fellowship at UCLA for Brain Stimulation and Neuroimaging. She is interested in combining her love of Geriatrics and Neuromodulation. She is currently also the RFM on the APAPAC, and is passionate about advocacy.

h. Area 4 Dep Rep: Matt Kruse, MD, MBA

Matt is a PGY4 at the University of Minnesota. He has a special interest in forensics, as well as health policy and healthcare economics. He's always interested in continuing to build connections in both DC and his state legislation.

i. Area 5 Rep: Candes Dotson, DO

Candes is a Child and Adolescent Fellow at Johns Hopkins. She is looking forward to continuing advocating for patients and psychiatrists.

j. Area 5 Dep Rep: Hannah Scott, MD

Hannah is a Child and Adolescent Fellow at LSUHSC Shreveport. She wants to practice C&A psychiatry in a university setting. Her husband is also a physician, and they prefer to stay in Louisiana after training.

k. Area 6 Dep Rep: Alexis Seegan, MD

Alexis is a PGY4 at UC Irvine. She is working on increasing resident involvement in CA. CPA has an annual conference in September, and along with her Dep Rep, she was able to convince CPA to waive the resident registration fees at our council meeting, and hoping to plan some resident events there.

l. Area 6 Dep Rep: Jonathan Serrano, MD

Jonathan is a PGY3 at UC Irvine, and is happy to be elected as the Area RFM Dep Rep. He is looking forward to participating more in the Assembly and in his own area.

m. Area 7 Rep: Kelly Jones Thomas, MD

Kelly is a PGY-4 at Tripler Army Medical Center. She is interested in pursuing general adult psychiatry, and her interests lie in addictions and geriatric psychiatry. Outside of psychiatry, she is a wife, mother and huge movie buff, and she loves spending time with her family hiking in Hawaii.

n. Area 7 Dep Rep: Robert Mendenhall, MD

Robert is a PGY3 at the University of Nevada School of Medicine and has a special interest in psychiatric neuroscience.

o. ACORF Mentor: Elie Aoun, MD

Elie is a PGY4 at Brown University and served last year as the Area 1 RFM Rep. This year, he joins ACORF as the mentor after having written several APs over his last couple years. His interest is in Addiction Psychiatry.

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Council on Addiction Psychiatry
Summary of Activities

- A grant was received from the Robert Wood Johnson Foundation's Smoking Cessation Leadership Center that supported the near-term efforts of the council's Workgroup on Tobacco Use Disorders. The group is chaired by chaired Douglas Ziedonis, MD and includes experts in tobacco use disorder, integrated care, resident education, community psychiatry, and child-adolescent psychiatry. Through a series of conference calls, members worked closely with APA Administration liaisons to (1) prepare an organizational plan to help reduce tobacco use among individuals with mental illness and/or addiction; (2) develop and field a pilot survey to assess current psychiatric practice; (3) compile a variety of resources , including reimbursement information; (4) prepare a Position Statement on Tobacco Use Disorders; (5) plan and present an Annual Meeting Workshop; and (6) present a July 14 webinar on Tobacco and Substance Use Disorders.

  Among the many strategies outlined in the organizational plan is the development of a champions program that will recruit a cadre of opinion leaders (i.e., "TUD champions") who are prominent in the field of psychiatry to mentor, train, and coach other psychiatrists into becoming opinion leaders around the country and in various healthcare systems. The APA has previously developed initiatives consistent with academic detailing strategies successfully used by the Veterans Health Administration, including online resources and didactic and interactive webinars. In addition to replicating these activities, the APA can help advocate for tobacco cessation needs by partnering with state psychiatric societies, linking with state quit lines to promote referrals, and collaborating with state departments of health and Veterans Integrated Service Networks.

- The National Institute on Drug Abuse (NIDA) will present the featured research track at the 2016 APA Annual Meeting. The track is being planned by NIDA's leadership and will feature symposia and lectures.

- Council's leadership and administration liaison are active participants in an AMA Task Force to Reduce Opioid Abuse. The group's approximately 30 members include representatives of State medical associations, as well as medical specialty associations. Thus far, the group has developed and publicly released two statements: (1) Help save lives – increase access to naloxone and (2) Opioid abuse is a public health crisis. Is your state's Prescription Drug Monitoring Program (PDMP) up to par? Additional messaging will be released in the coming months. A report reflecting the group's recommendations will be presented to the AMA Board in November.

- With the financial support of the National Institute on Drug Abuse, the Council on Addiction Psychiatry and Council on Medical Education will identify, evaluate, and make widely available curriculum on substance use disorders that can be used to guide and augment the didactics curriculum of general psychiatry residency training programs in accordance with ACGME program requirements. A workgroup of key medical education influencers will be established, comprised of representatives of APA's Council on Addiction Psychiatry, Council on Medical Education and Life Long Learning, Resident Fellow Members of the APA, American Association of Directors of Psychiatry Residency Training, Accreditation Council for

Graduate Medical Education (ACGME) members of the Residency Review Committee and others, and the American Academy of Addiction Psychiatry. This group of experts in substance use disorders and medical education will identify and assess the scope and quality of existing open-source SUD curriculum, design and implement mechanisms to make the curriculum available to all residency training programs, execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors, identify gaps in the existing curriculum, with the goal of developing curriculum to address them in a future initiative, and develop and implement mechanisms to evaluate the project.

- APA continues to present webinars once or twice a month on behalf of the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT). They offer free continuing medical education credit and attract large numbers of participants. All webinars are recorded and available at http://education.psychiatry.org and www.psychiatry.org/pcssmatwebinars. The program's dedicated website is www.pcssmat.org

- The Providers' Clinical Support System for Opioid Therapies (PCSS-O) is a SAMHSA-funded initiative that includes 13 partner organizations, among them APA, American Academy of Addiction Psychiatry (lead), American Medical Association, American Academy of Neurology, American Academy of Pediatrics, American Academy of Pain Medicine, and the American Dental Association. APA contributes to the program by presenting webinars and developing online clinical case vignettes with self-assessment. The focus of the program is the appropriate use of opioids to treat chronic pain and the recognition and treatment of opioid use disorder. The dedicated website is www.pcss-o.org

- The council frequently provides consultation to APA's Division of Government Relations regarding proposed legislative and regulatory initiatives that address the epidemic of prescription drug and heroin addiction and increased access to medication assisted treatment.

- The Council is updated several position statements for JRC, Assembly, and Board approval.

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS
ASSEMBLY REPORT, OCTOBER 2015

Barry B. Perlman, M.D., Chairperson

The Council on Advocacy and Government Relations was established in May 2009, as part of the reorganization of APA councils and components. The Council was consolidated to include the charges of the Council on Advocacy and Public Policy, the former Committee on Government Relations, and the former Committee on Mental Health Care for Veterans and Military Personnel and their Families. The Council also absorbed some of the charges of the former Council on Social Issues and Public Psychiatry. The Committee on Advocacy and Litigation Funding was retained as a corresponding committee.

The Council continues to serve as the APA's coordinating body for all legislative and regulatory activities involving the federal and state governments. Activities include analyzing problems and anticipating needs for policies and planning strategies; actively collaborating with allied groups with shared goals to progressively move towards improved quality of care; and working with agencies that set policy on funding, access and quality of psychiatric services at the federal, state, and local level to affect legislation, regulations, and guidelines.

Comprehensive Mental Health Reform

Through the end of the year momentum will continue to build for Congressional action to enact meaningful reform to the federal government's management and financial support of MH/SUD services. On June 4, 2015, Representative Tim Murphy (R-PA), Chairman of the powerful House Energy and Commerce Subcommittee on Oversight and Investigations, and Representative Eddie Bernice Johnson (D-TX), introduced a refined version of their CMHR legislation – the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646). Over the past year, APA has strengthened its relationship with Representative Murphy affording APA the opportunity to stand with Congressman Murphy in championing comprehensive mental health reform. On August 5, 2015, Senators Bill Cassidy, M.D. (R-LA) and Christopher Murphy (D-CT) introduced a strikingly similar comprehensive reform bill – the Mental Health Reform Act of 2015 (S. 1945) that already has several bipartisan cosponsors. These bills include a number of important provisions that align with APA policy priorities, such as clinical leadership in the coordination and oversight of federal mental health resources, addressing the psychiatric workforce shortage, promoting stronger mental health parity enforcement, increased funding for important mental health research, and the protection of coverage of psychiatric medications.

Both bills are currently under consideration by the leadership of key House and Senate Committees – with the APA Administration deeply involved. APA is engaging with relevant members of Congress through direct lobbying and grassroots contact, as well as third party stakeholders, in order to drive APA's agenda forward through enactment of bipartisan comprehensive mental health reform. APA Administration has worked closely with the Council for political and policy feedback regarding comprehensive mental health reform since the effort began over two years ago.

Health Insurance Mergers

As a result of proposed major health insurance company mergers and acquisitions, in July the Council with a unanimous vote crafted a resolution to present to the Assembly Executive Committee. The measure recommended the APA assess and advocate accordingly regarding the proposed insurance company mergers. With support of the AEC, the resolution quickly moved through the Board of Trustees gaining support for the APA Administration to prepare a letter to the antitrust regulators focusing on access to clinically appropriate psychiatric care. In September, APA submitted a letter to the antitrust regulators at the Department

of Justice (with a copy to the Federal Trade Commission) expressing APA's concerns about the proposed insurance company mergers (Anthem-Cigna, Aetna-Humana, and Centene-HealthNet).

This issue has drawn considerable Congressional attention. In response, the U.S. House and Senate Judiciary Committees will be holding several hearings on insurance industry consolidation. APA is continuing to work collaboratively with the American Medical Association and other medical specialty organizations to raise our concerns with the Congressional members and their staff. CAGR has advised APA Government Relations staff throughout this process. We anticipate more movement on this in the future as federal review of the proposed mergers unfolds.

Scope of Practice

Since the 2015 opening session of the state legislatures, the APA Administration has worked closely with the Council and APA membership to contain the expansive and inappropriate scope of practice measures sought by psychologists. Nationwide, legislation has been introduced that would allow psychologists to gain prescriptive authority while "short-cutting" the education and training necessary to maintain patient safety. As a result of the passage of a prescriptive authority bill in Illinois in 2014, the American Psychological Association has intensified their efforts to gain such authority in many states. In response to the efforts, the APA Administration continues to work with the Council and APA Leadership in providing policy, lobbying, and media support to our members and DB/SAs in order to defeat these bills.

CALF Grants

Originally created in 2002, and re-established in 2009, the Committee on Advocacy and Litigation Funding is charged with reviewing requests, typically from district branches and state associations, for financial support of projects that involve legislation, litigation, and advocacy. The committee serves as a mechanism to review requests, usually from District Branches and State Associations, for financial support of projects involving legislation, litigation, and advocacy; of making recommendations regarding funding through the Council on Advocacy and Government Relations and the Joint Reference Committee to the Board of Trustees; and of proposing coordinated activity by other APA components, District Branches, and State Associations.

With increased legislative activity, the Council has worked with the APA Administration in ensuring support to eligible and approved DB/SAs as they seek to bolster their advocacy apparatus.

APA*PAC*

The APA Political Action Committee (APAPAC) is governed by a Board of Directors that is composed of 13 APA members. Chaired by Charles Price, M.D., APAPAC is the bipartisan political voice of the APA and enables APA to invigorate its patient and professional advocacy activities by supporting candidates for federal office. The APAPAC works to ensure the election of Members of Congress who share mutual principles and goals with APA and who stand up for psychiatry's position during the legislative process. Another extremely important role of the APAPAC is to educate other Members of Congress as to why they should support positions vital to our patients and our profession.

The APAPAC works to ensure the election of Members of Congress who share mutual principles and goals with APA. The APAPAC will continue to work to increase participation. With an average participation rate of just 4.5% since 2008, APAPAC will focus on raising this percentage in 2015. This participation rate ranks among the lowest of all medical specialty PACs, and increasing the number is vital to the PAC's future success. APAPAC's goal for individual contributors in 2015 is 1,670, which would be a 15% increase in participation and bring the participation rate above 5%. As of September 23, 2015, APAPAC has received contributions from 1,156 individual donors (69% of the 1,670 goal).

Summation

The Council on Advocacy and Government Relations, in conjunction with the Department of Government Relations, provides valuable expertise on a number of critical issues impacting APA membership. Opportunities and challenges to advancing the legislative goals of the APA will continue into 2015. APA is well-positioned to work with leadership on both sides of the aisle, particularly in the committees most relevant to our legislative agenda. As dynamic issues related to the practice of psychiatry have emerged and evolved over the last year, the members of the Council have served as key advisers to the Department of Government Relations and the Board of Trustees on pressing national priorities impacting psychiatrists and their patients.

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Assembly
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Council on Children, Adolescents and Their Families
Report to the Assembly

- The council met on September 11, 2015, during the September Components Meetings where Joseph V. Penn, MD, CCHP, FAPA, was welcomed as the new chairperson. The principal topics discussed at the meeting were the impact of environmental toxins on neurodevelopment and behavior, mental health leave in colleges, and the ABPN proposed changes to subspecialty certification requirements. Work groups were established to develop council's feedback to APA leadership on those topics. Given the date of the meeting, a moment of silence was held in memory of the 9/11 tragedy.

- Teen suicide, foster care systems in crisis, providing guidance to adult psychiatrists who treat adults with autism, and gender dysphoria in youth have been identified as key focus areas for the council within the coming year. Several council subcommittees have been established to develop action plans to address these issues. In addition, the council will embark upon a collaboration with the Council on Minority Mental Health and Health Disparities on efforts around at-risk minority youth, particularly those in the juvenile justice system.

- The council awaits the nearly completed *Parent Medication Guide Autism Spectrum Disorder*, a joint initiative of American Academy of Child and Adolescent Psychiatry and APA. Council member Louis Kraus, MD, is a member of the guide's writing team. The council will be among several APA entities to review the final document before APA's formal endorsement.

- Council member Jean Thomas, MD, is leading an effort to form an APA Caucus on Infancy and Early Childhood to promote communication and networking among APA members who share deep concern about the health of all children and recognize the need to identify and treat children as early as possible. Letters of support from members are being collected.

- The council will hold its next conference call in early November and at regular intervals going forward.

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Council on Communications

1. APA President Renée Binder visited the council and spoke about the APEX awards. In her remarks to the council, Dr. Binder introduced the APEX Awards, which are intended to recognize people doing "great work" on behalf of mental health.

   The council members later revisited the subject. Key points from their discussion:

   - Celebrities who were authentic to the cause of mental health were floated as honorees or key note speakers.
   - The council agreed that it would be more powerful for someone to share their own story about an experience with mental illness, rather than an actor who had merely offered a portrayal.

   The APEX discussion then evolved into a talk on the overall Communications Council's awards process and whether it should be overhauled. Communications Chief Jason Young said that decision lives with the council. The council agreed to form a working group to reevaluate the awards process, led by Vice-Chair Dr. John Luo.

2. Mr. Young delivered a presentation on APAs eblast campaigns. He noted:
   - Email is not free, but has tremendous value, possibly up to $2 million/year.
   - Emails have financial and non-financial value in that they can generate revenue, drive membership renewals, boost advocacy, etc.
   - Due to the large number of recent opt-outs, APA is unable to communicate via email with ¼ of its members. If the trend continued, by 2018, the APA would be able to communicate with less than half of its members.
   - The top three subjects that resulted in opt-outs were IPS, the Partnership for Workplace Mental Health, and APA Job Central. Detailed figures on these subjects and their opt-out rates are available in the meeting minutes.

3. Mr. Young gave an update on APA re-branding efforts:
   - The brand is now ~90% implemented, up from approx. 72% during the July call.
   - Young demonstrated the difference between old, fractured branding efforts by different orgs within the APA. He noted it was reasonable for someone to assume that they were looking at logos for 20+ different organizations rather than different components of one body.

   Amanda Davis, Deputy Director of Corporate Communications and Public Affairs, presented on efforts to license the APA brand to DBs and SAs. Council members were surprised that this was

a free service, and expressed unanimous approval. A few council members implied that they would bring this service in front of their home DB or SA. Ms. Davis noted that there has been a swell in interest in the new brand among DBs and SAs since it was introduced at the annual meeting, particularly in the last 3 months.

4. The council had a lengthy discussion on the scope of practice issue, during which the following issues were raised:
    - The perception that access to care is a bigger issue than safety of care available in USA
    - Public awareness of collaborative care, and the need for APA to be able to prove collaboration with facts
    - How aggressive the APA plans to get with its messaging against scope of care bills. Jason Young stated that there are parts of the higher tier toolkits that address the link between psychologists and torture.
    - Ways for council members to help on this issue. These included participating in social media; writing letters to the editor; standing with patients, other like-minded physician groups and politicians; and educating colleagues.
    - Toolkits which will serve as rapid response kits for DBs and state associations. Toolkits will also allow DBs and SAs to act proactively against scope of practice legislation.

5. Mr. Young gave a presentation on the need for the council to help APA develop communications policies. He noted:
    - Even several months after the re-branding, entities within APA continue to produce their own logos, newsletters, social media accounts, etc.
    - Young stressed a need for the council to support the chain of command
    - The council agreed to form a task force aimed at drafting communications policies and protecting APA media assets such as email, led by Drs. Ayana Jordan and Lara Cox.

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Council on Geriatric Psychiatry

The Council focuses on the special needs of older adults and thus stands at the interface of psychiatry with other medical specialties. It recognizes that integration of care is vital to the well-being of our patients. The council accomplishes its goals by initiatives related to education, research and clinical care in geriatric psychiatry.

Guideline on the Use of Antipsychotics to treat agitation and psychosis in patients with dementia: The Council reviewed the guidelines and provided feedback to the Practice Guideline Steering Committee. The Council was impressed by the effort made by the Guidelines group to create a document built on the foundation of the existing evidence, adherent to IOM rules, and useful to clinicians. The group has made a couple of suggestions for the Steering committee to consider including in the guidelines.

Council is working on the following position statements:

- Position statement on Role of Psychiatrists in Assessing Driving Ability: The draft statement was also reviewed by the Council on Psychiatry and Law.
- Role of Psychiatrists in Long-term Care Settings- The JRC asked the Council to review an old position statement on Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia. The Council has suggested retiring this position statement. The group strongly supports the importance of mental health needs in the long-term care (LTC) setting and has proposed to develop an updated position statement. The new statement will focus on the specific role of the psychiatrist in systems where LTC services are provided in interprofessional models where the psychiatrist is most often in a consultative, collaborative or supervisory role
- The Use of Antipsychotic Medications for the Treatment of Behavioral Disturbances in Persons with Dementia – The Council had put a hold on working on this statement since the members were waiting for the Practice Guidelines to come out. Now in light of the new guidelines, the Council will resume its work and will complete the statement in next two months.
- Palliative Care: The Council members participated in a joint meeting with the Council on Psych and Law to discuss the End-Of-Life Care issues after 1pm. At the end of the meeting, it was decided that the Council on Geriatric Psychiatry will work with the Council on Psychosomatic Medicine to develop a resource document on Role of Psychiatrists in End-of- Life care. Both the councils are working to put a workgroup together.

Long Term Care – CMS's new proposed regulation:
The Centers for Medicare and Medicaid services recently released a comprehensive overhaul of long term care facility requirements. This is the first amendment of its scale and scope in nearly 20 years, and the proposed regulations outline a slew of new quality and ethics rules for facilities that participate in the Medicare and Medicaid program. Among many other provisions, the proposed rule touches on staffing adequacy and training, psychotropic medication administration and oversight, the discharge process, and a variety of lifestyle issues. The Council reviewed the document and provided feedback to the Department of Government Relations.

ABPN Proposed Changes to Subspecialty Certification Requirements: ABPN is proposing a policy change which would require those who hold subspecialty board certification to also maintain general psychiatry certification. The Council discussed this proposal and conducted a poll. The verdict was divided. Out of 12 presented members, 3 leaned in favor of requiring general MOC and rest leaned in favor of not requiring it. Everyone admitted to have divided sentiments.

Geriatric Award Nominations: The Council is responsible for selecting the recipients of the Jack Weinberg Award in Geriatric Psychiatry and the Hartford-Jeste Award for Future Leaders in Geriatric Psychiatry. Recently the Council reviewed and selected nominees for both the awards. These names will be sent to the JRC for the Board's approval.

Collaboration with the Work Group on Telepsychiatry: The Council members have agreed to work with the Workgroup on telepsychiatry to develop geriatric psychiatry contents for the APA members. The Council will put a workgroup together to get started on this project.

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Assembly
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Report of the
Council on Healthcare Systems and Financing
Harsh K. Trivedi, MD, MBA, Chair

At the time of this writing the Council on Healthcare Systems and Financing is formulating its workplan for the next 12 to 18 months for submission to the JRC for review. The workplan is focused on the strategic priorities of the APA Board of Trustees (BOT) (adopted March 2015) and the recommendations of the BOT Workgroup on Health Reform. This plan should be finalized by the time the Assembly meets and details about it can be obtained from OHSF administration (Sam Muszynski or Becky Yowell).

The key focus of the Council since the Assembly last met in May has been:

1. Review and analysis of
    a. The proposed parity rules for Medicaid Managed Care,
    b. The proposed ruled which would establish new requirements for Medicaid managed care generally,
    c. The proposed rule on the 2016 Medicare physician fee schedule with special emphasis on CMS' proposal to move toward coverage for the Collaborative Care Model (CoCM) for beneficiaries with behavioral health conditions.
2. Review and preliminary analysis of what the SGR reform legislation means for psychiatrists in terms of options for participation and feasibility of alternative payment methods.
3. Collaborating with other medical professional associations on recognition of Medicare coverage for the interprofessional consultation codes, improvement for coverage of telepsychiatry, and increased recognition of cognitive work essential for appropriate clinical care.
4. Working with the administration to develop alignment of advocacy priorities with community psychiatry.
5. Development or revising essential APA position statements of import to APA advocacy efforts. (Care for the SPMI population, principles of collaborative care, ER boarding, off label prescribing)
6. Reviewing with APA staff its various efforts on increasing oversight and enforcement of the Federal parity laws including engagement of employers (as purchasers of health insurance) on the issue of payment equity and network adequacy for psychiatry.

See Attachment 1 for an update on Assembly action items

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.2	Developing an Access to Care Toolkit (ASMMAY1512.C) The action paper asks: 1. That an Access to Care Tool Kit be developed and maintained by the Council on Healthcare Systems and Financing to include relevant Action Papers, Position Statements, Guidelines, model or sample state legislation, survey instruments and a repository of related legal actions from states. The Tool Kit should include links to the Parity Tool Kit and other related resources and to be easily downloadable to members. 2. The availability of the Tool Kit and its components should be publicized in APA News, and to District Branches and State Organizations through the Federal Legislative Representative Network and the Office of Ethics and District Branch/State Association Relations.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing.	Council on Healthcare Systems and Financing Report to JRC: January 2016	The Council reviewed the three access to care related items at their fall meeting. The Council supported the actions and will incorporate this work into its workplan. It was felt that the survey would provide data that will be necessary to advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will be the project lead.
6.3	Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D) The action paper asks that a compendium of Action Papers and Position Statements relating to access to care be included in an easily downloadable Access to Care Tool Kit to be developed and maintained by the Office of Health Care Systems and Financing.			
6.4	Access to Care Survey (ASMMAY1512.E) The action paper asks that one or more patient centered Access to Care Surveys, such as the Area 6 Access to Care Survey, be included in an Access to Care Toolkit, to be developed and maintained by the Council on Health Care Systems and Financing.			

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.5	Level of Service Intensity Instrument (ASMMAY1512.F) The action paper asks: 1. Within six months the APA Administration will research what level of care/intensity of service tools are available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. 2. This data will be presented to the Councils on Quality Care and Healthcare Systems and Financing to determine whether APA should: a. Endorse a specific tool or set of criteria, or; b. Propose development of such a tool by APA 3. That the Councils will report their recommendations to the Joint Reference Committee the following year.	The Joint Reference Committee referred items #1 and #2 to the Office of Healthcare Systems and Financing and items #2 and #3 to the Council on Healthcare Systems and Financing.	Office of Healthcare Systems and Financing Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	APA staff have begun to compile information on the various level of care criteria (i.e. LOCUS, CANS, ANSA, Interqual/Milliman) to see what is currently available. This is an important issue as it is tied to medical necessity decision making and there are many parity issues inherent in this. CHSF thinks that this task is a very large undertaking and likely involves expertise from several APA councils and perhaps from experts who are not currently on an APA component. CHSF recommends that if this project is to be accomplished due consideration needs to be given to creating a special APA workgroup to do this.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.6	Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G) The action paper asks: That the Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance -paneled psychiatrists (and patients of psychiatrists who have opted out of third party payers excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.	The Joint Reference Committee referred the action paper to the Council on Quality Care [LEAD], and the Council on Healthcare Systems and Financing and requested a report in October 2015. The councils are asked to determine what the appropriate scope or universe would be to implement this paper and if legislation might be needed. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Council on Quality Care [LEAD] Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	The Council discussed the paper and suggests that it be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that this be refer to CAGR for input as well.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.7	Removing Barriers to Providing Compassionate Care to Victim of Sexual Assault (ASMMAY1512.H) The action paper asks that: 1. The APA develop a Position Statement and a Resource Document regarding the psychiatric morbidity associated with sexual assault, including the psychological difficulties attendant to sexual assault evidence procurement and the failure of acting upon such evidence; 2. The relevant component of the APA work with the American Association for Emergency Psychiatry to ascertain that the emergency treatment of sexual assault victims, including that the administration of sexual assault evidence assessment kits, be coupled with provision of information about access to mental health treatment resources; 3. The relevant component of the APA liaise with the entities responsible for analyzing sexual assault victim evidence kits and acting upon their results in order to educate those entities to the psychiatric morbidity of their failing to do so, and to be available to assist those entities in their efforts to obtain adequate funding by providing them with information about the psychiatric morbidity associated with sexual assault; 4. The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault.	The Joint Reference Committee referred the action paper to the Council on Minority Mental Health and Health Disparities (LEAD), Council on Quality Care, Council on Healthcare Systems and Financing and the Council on Psychiatry and Law. The councils were asked to provide feedback and comment on the feasibility of the action paper and to whom the APA would advocate. The JRC noted that the Council on Minority Mental Health and Health Disparities is currently developing a position statement on rape and human trafficking. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Council on Minority Mental Health and Health Disparities [LEAD] Council on Quality Care Council on Healthcare Systems and Financing Council on Psychiatry and Law Report to JRC: January 2016	The CHSF discussed item 4 at their September meeting. There was general consensus that an individual's health insurance provides coverage for mental health services. There is no evidence to show that benefits/coverage for these services do not already exist. Absent specific data to the contrary the CHSF has no basis for further recommendations. CHSF does not feel it is the appropriate Council to deal with this request.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.13	Emergency Department Boarding of Individuals with Psychiatric Disorders (ASMMAY1512.S) The action paper asks: That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding.	The Joint Reference Committee referred the action paper to the Council on Psychosomatic Medicine (LEAD), the Council on Healthcare Systems and Financing, the Council on Advocacy and Government Relations and the Council on Psychiatry and Law. A progress report was requested for October 2015. The Council on Psychosomatic Medicine is asked to develop a position statement with input from the other councils, and once the input has been received and incorporated into the draft statement, the proposed statement should be forwarded to the JRC.	Council on Psychosomatic Medicine [LEAD] Council on Healthcare Systems and Financing Council on Advocacy and Government Relations Council on Psychiatry and Law Report to JRC: October 2015 (Due October 2, 2015)	The CHSF is in the process of reviewing the draft position statement and will provide comments back to the Council on Psychosomatic Medicine. Dr. McLeer is the lead reviewer.

Attachment 1

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.15	Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U) The action paper asks: That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act. That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments, That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services. That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing [LEAD], the Division of Government Affairs, the Department of Healthcare Systems and Financing and APA Legal Counsel. All feedback and comments on this referral should be contained within the lead's report to the JRC	Council on Healthcare Systems and Financing [LEAD] Division of Government Affairs Department of Healthcare Systems and Financing APA General Counsel. Report to the JRC: January 2016	The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns raised within the VA system.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.17	Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W) The action paper asks: That the APA delegation to the AMA House of Delegates present a motion in that body that calls on the AMA to establish a process for providing the public with separate percentages of the GDP corresponding to actual health care provision and to ancillary, administrative-management-type economic activities that have been linked to health care.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to develop a motion for the APA AMA Delegation to present to the AMA.	Council on Healthcare Systems and Financing Report to the JRC: January 2016	CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar is being spent on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
8.B.4	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by Their Physicians [JRCOCT148.G.9] The Council on Advocacy and Government Relations was asked by the Council on Healthcare Systems and Financing (CHSF) to review a draft revision of the 2007 APA position statement, "Patient Access to Treatments Prescribed by Their Physicians," which addresses off-label use. The position statement under review is modeled after an AMA statement, since modified. As requested by CHSF, the Council discussed the suggested language affirming a physician's authority to use off-label drug products and medical devices. The Council recommends to the Council on Healthcare Systems and Financing to retain the more detailed 2007 off-label position statement without revisions.	The Joint Reference Committee requested that the Council on Healthcare Systems and Finance to obtain feedback from all councils as originally noted and make a recommendation to the JRC on the disposition of the position statement in October 2015.	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due October 2, 2015)	The CHSF was advised of the CAGR recommendation to maintain the existing position statement. A subsequent discussion with CAGR resulted in CAGR endorsing our support for the revised statement. It was reiterated that members of the CHSF thought that the original statement combined too many issues, and lacked clarity for that reason. The Councils on Government Relations and Research support the revised position statement as proposed by the CHSF. The Council on Children has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was necessary.
8.G.3	Referral Update Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A]	The Joint Reference Committee thanked the Council for the update and requested an updated report in October 2015.	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's workplan for the next 12 months.

Attachment 1

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
8.G.4	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers [ASMNOV1412.D] The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing and the Council on Psychiatry and Law and its Work Group on Mental Illness and Criminal Justice. The Council on Healthcare Systems and Financing was asked to determine if the compensation issues raised in the action paper are covered in other APA documents and to identify current statistics on this question. There are no current APA position statements that speak to the issue of compensation. OHSF has begun to identify preliminary data on salary/income (see the chart within the Council's report) and will share this information with the Council on a future conference call.	The Joint Reference Committee thanked the Council for the update.		The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers but also the Indian Health Service, VA, and other federal programs. General consensus that this is an issue in other areas as well. CHSF does not think there are any current APA position statements that speak to the issue of compensation. The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back on what kinds of salary income data we are able to discover.

Council on International Psychiatry

The Council on International Psychiatry is focused on increasing international membership by working cross-collaboratively with the governance of the APA, including the Assembly, other Councils and the Administration, to identify and develop benefits that support the education and training of psychiatrists inside and outside the United States.

Education & Training

The Council is currently focused on developing a comprehensive strategy to address the strengthening of health systems outside the United States by supporting the education and training of international psychiatrists.

The Council is also engaged in the development of a comprehensive presentation on the training of psychiatrists in the United States as global mental health investigators, implementers, and collaborators in order to identify best practices. This presentation follows the successful collaboration between Council members and the APA's Caucus on Global Mental Health and Psychiatry, which features and international composition, on the workshop "US and Low and Middle Income Countries Models of Education and Training on Global Mental Health" at the 2015 APA Annual Meeting.

The Council recognized and supported the submission of multiple symposiums at the 2015 Annual Meeting including "Challenges and Opportunities for Global Mental Health" which reviewed epidemiological issues of global mental health and opportunities for training and research and "Global Mental Health" which focused on the global burden of mental health and substance use disorders.

The Council is focused on developing opportunities for the exchange of knowledge and experiences between psychiatrists inside and outside the United States, including international medical graduate psychiatrists in the United States. To support this goal, the Council is in the process of identifying individuals and organizations inside and outside the United States to collaborate with to investigate issues that can address the global burden of mental health and substance use disorders through the education and training of psychiatrists. Additionally, the Council is reviewing global mental health opportunities offered by psychiatry training programs in the United States in order to determine their level of impact.

Membership

The Council has tracked a 26% rate of growth in international membership over the past year to over 2,000 international members from over 100 countries. The Council works closely with the APA Membership Committee on various international membership initiatives including the recent review and approval of an international resident fellow membership category and a pilot project offering international group membership discounts to international psychiatric organizations. The Council is also currently discussing opportunities to enhance the recognition and recruitment of international attendees at APA meetings.

Assembly Action Papers

While the Council is focused on increasing international membership through education and relationship building, it is also engaged in the review and development of APA policy, including Assembly Action Papers.

Parity in Permanent Licensure Policy: The Council discussed the Action Paper during a conference call and again during their annual in-person September meeting. While the Council was in general support of the Action Paper, it was communicated to the author that the term "parity" may not be the most appropriate term in this context and that alternate terms, such as "equity" or "equality", should be taken into consideration as effective substitutes.

The Impact of Global Climate Change on Mental Health: The Council is in the process of reviewing the Action Paper after being assigned it, along with several other reviewing components, by the Joint Reference Committee. However, the initial review of the Action Paper at their annual in-person September meeting generated a brief discussion regarding the investigation of increased suicide rates in Arctic populations impacted by climate change. A greater understanding of this issue could focus on the impact of global climate change on mental health in minority, under-represented and under-served populations in geographically Arctic areas such as Alaska and the Northwest territories of Canada. It was noted that this may be a potential issue for discussion with the Assembly Caucus of American Indian, Alaska Native and Native Hawaiian Psychiatrists.

ATTACHMENT 1: Council Charge

The charge of the Council on International Psychiatry is as follows:

The purpose of the Council is to facilitate understanding of problems facing international psychiatrists and their patients. It will do so by focusing on international membership in the APA, and through increased membership in the APA, avail all members of the opportunities in education, advocacy, prevention and clinical care that membership in the APA provides.

1. *The Council works in collaboration with the Membership Committee to recruit international members.*
2. *The Council ensures APA policies and positions on international issues are current and appropriate.*
3. *The Council, working in collaboration with the Council on Research, provides recommendations and strategies to enhance the scientific base of international psychiatric care and global mental health.*
4. *The Council identifies opportunities for partnership with other organizations to foster the creation of financially self-sustaining international programs that will benefit all members of the APA and their patients.*
5. *The Council will strive to establish mutually beneficial relationships between the APA and other internationally focused psychiatric organizations. The Council may facilitate collaborative development of clinical, research, training, and forensic guidelines by these various organizations, including the APA, for use by psychiatrists globally, with appropriate modifications for specific countries or regions. The Council may facilitate publication of news about these organizations and their activities in Psychiatric News.*
6. *The Council promotes engagement to enhance shared learning and leadership to achieve participation of all APA members.*

The Council members are experts with experience in global mental health and who are broadly representative (geographically and culturally) of the APA international body. The Council has a standard council composition. APA members who have membership in international organizations may be appointed as corresponding members and serve as liaisons to their international organizations. The Council will utilize freely available electronic communication technology to interact and coordinate with organizations and individuals outside of the United States in lieu of international travel. No APA funds will be budgeted nor used for travel outside the United States by members of this council for the work of this council.

ATTACHMENT 2: 2015-2016 Council Composition

The 2015-2016 composition of the Council on International Psychiatry is as follows:

Chairperson	Michelle Riba, MD, MS	Ann Arbor, MI
Vice Chairperson	Dilip Jeste, MD	La Jolla, CA
Member	David Baron, DO	Altadena, CA
Member	Anne Becker, MD, PhD	Boston, MA
Member (Assembly)	Ken Busch, MD	Chicago, IL
Member	James Griffith, MD	Washington, DC
Member	Nalini Juthani, MD	Scarsdale, NY
Member	Samuel Okpaku, MD, PhD	Nashville, TN
Member	Edmond Pi, MD	La Habra Heights, CA
Member (ECP)	Uyen-Khanh Quang Dang, MD, MS	San Francisco, CA
Member	Pedro Ruiz, MD	Miami, FL
Member	Allan Tasman, MD	Louisville, KY
Corresponding Member	Bibhav Acharya, MD	San Francisco, CA
Corresponding Member	John S. McIntyre, MD	Rochester, NY
Corresponding Member	Solomon Rataemane, MD	Pretoria, South Africa
Corresponding Member	Giuseppe Raviola, MD	Boston, MA
Corresponding Member	Eliot Sorel, MD	Washington, DC
Consultant	Mounir Soliman, MD, MBA	La Jolla, CA
Consultant	Jagannathan Srinivasaraghavan, MD	Marion, IL
Fellow (American Leadership-2nd Year)	Michael Morse, MD	Washington, DC
Fellow (American Leadership-2nd Year)	Rachel Winer, MD	Palo Alto, CA
Fellow (Diversity Leadership-1st Year)	Nakita Natala, MD	Ypsilanti, MI
Fellow (Diversity Leadership-1st Year)	Jennifer Severe, MD	West Springfield, MA
Fellow (Diversity Leadership-2nd Year)	Suni Jani, MD, MPH	Houston, TX
Fellow (Diversity Leadership-2nd Year)	Vera Tate, MD	Atlanta, GA
Fellow (Public Psychiatry-2nd Year)	Christopher White, MD	Moss Beach, CA
Fellow (SAMHSA-1st Year)	Josepha Iluonakhamhe, MD	Somerville, MA
Fellow (SAMHSA -1st Year)	Dyani Loo, MD	Albuquerque, NM
Fellow (SAMHSA -1st Year)	Aleema Sabur, MD, MPH	Brentwood, TN

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COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

The Council's purview covers issues affecting the continuum of medical education in psychiatry – from undergraduate medical education to lifelong learning and professional development of practicing physicians. The Council is a convening body for the allied educational organizations including PsychSIGN, AADPRT, ADMSEP, AAP and the ABPN.

SUMMARY

The Council on Medical Education and Lifelong Learning met during the Fall Components Meeting on September 11th in Crystal City, Virginia. The Council organized its agenda into discrete sections to focus on issues related to UME, GME, CME, and MOC. Key issues discussed included:

ABPN Policy Discussion

The Council had a robust discussion regarding ABPN's current requirement that individuals be required to maintain general certification in order to maintain subspecialty certification. The Council voted to approve the following statement:

> *We support the general certification requirement. We support the importance of maintaining current standards. We support ABPNs efforts to make exams as flexible and affordable as possible.*

BOT Workgroup on Training and Education Report

The Council reviewed the 20 recommended action steps in the BOT Workgroup on Training and Education Report. The Council was pleased with the overall implementation progress of the Division of Education.

#IAmPsychiatry YouTube Campaign

The Council reviewed the success of the recently launched I Am Psychiatry social media contest sponsored by the APA (lead), ADMSEP, AADPRT, and PsychSign. They would like to see this content continue in future years as a way to humanize psychiatry and focus on destimgamatization of the field.

National Substance Abuse Curriculum Curation and Dissemination

The Council reviewed and discussed the implementation of a recent award from NIDA to the APA to develop a toolkit of curricular resources for educators. An editorial board of members from CMELL and the Council on Addictions will work together to review existing substance abuse curriculum. and evaluate the scope and quality of what is out there. CMELL members Ashley Curry (fellow) and Jose Vito (member) have agreed to represent CMELL in this project.

Telepsychiatry

The Council is supportive of efforts by Jay Shore to develop a Telepsychiatry 101 toolkit. The Council encouraged Dr. Shore to think about the various target audiences within the context of their

developmental sophistication as related to technology. The Council considered the idea of advocating for a telepsychiatry milestone with RRC, but suggested that there may need to be some model programs first. The Council discussed the value of Donald Hilty's AADPRT model curriculum on this topic and potential synergies.

Mentorship of Fellows

The selection committees for the APA fellowships report up to CMELL. Dr. Francis Lu approached the committee to ask if CMELL would consider broadening the charge of the selection committees to include the responsibility of also assigning mentors to the fellows. The Council was supportive of this idea and is working through the JRC to amend the charters of the selection committees to include this task.

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Council on Minority Mental Health and Health Disparities
Report to the Assembly

The council met on September 12, 2015, during the September Components Meetings (SCM). Francis Lu, MD, conducted the meeting on behalf of the chairperson, Christina Mangurian, MD, who was unable to attend. Following are meeting highlights.

- To facilitate council members knowing each other, member biographies were distributed before the meeting. Based on that information, Dr. Lu constructed a seating chart to intermingle resident fellows with other council members based on interests and geographic location. Table cards with names were placed at each chair. These innovations helped increase group cohesiveness.

- Jay Shore, MD, from the Board Work Group on Telepsychiatry, presented an update of the activities of the Work Group. The council formed a subcommittee to provide input to the Work Group about cultural competence and translation issues.

- Council discussed potential Annual Meeting council submissions. There was a follow-up discussion of the May meeting concerning violent police interactions with African American men.

- Work groups were formed to respond to recent JRC referrals on:
    - Removing barriers to providing compassionate care to victims of sexual assault
    - Creation of a position statement on the impact of global climate change on mental health
    - How to train psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities

  Additional work groups were formed on:
    - At-risk children and adolescents (a collaboration with the Council on Children, Adolescents and Their Families)
    - Recruitment and retention of psychiatrists from minority and underrepresented groups
    - Revision of position statements on diversity and affirmative action

- Ranna Parekh, MD, director of the APA Division of Diversity and Health Equity, gave highlights of recent division activities, including the day-long orientation session at the SCM for all recipients of APA resident fellowships. She also promoted the ongoing *Conversation on Diversity and Health Equity with APA Members* event scheduled at the IPS, where APA members discuss their perspectives to help APA better serve members, their patients, and their communities.

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Council on Psychiatry and the Law
Steven Kenny Hoge, M.D., Chairperson

The Council on Psychiatry and Law met during the September Components Meeting in Arlington, VA. The Council heard updates from a range of its committees and workgroups including the Workgroup on Location of Civil Commitment Hearings, Workgroup on Confidentiality and Probation/Parole, Workgroup on College and University Mental Health and the Sex Predator Commitment Laws Workgroup.

The Council on Psychiatry and Law had a joint meeting with the Committee on Judicial Action and the Council on Geriatric Psychiatry on "Physician Assistance with Dying". There were several guest speakers including Dr. Dan Larriviere, a neurologist, Dr. Linda Ganzini, Dr. Bob Roca, and Dr. Joanne Lynn. The group had a lively discussion and decided to develop a resource document. A workgroup was formed by the Council on Psychiatry and Law.

The Council on Psychiatry and Law has been working on:

1. PROPOSED POSITION STATEMENT AND RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT – The Council has developed a proposed position paper and a resource document on Involuntary Outpatient Commitment. The resource document is being reviewed by the Joint Reference Committee (JRC) in October and the JRC is bringing the proposed position paper forward to the Assembly for consideration at this meeting. (more information is available in your packet)

2. The Council has been working on several position papers and resource documents and the following are being sent to the Joint Reference Committee in October for consideration:

    a) PROPOSED POSITION STATEMENT ON COLLEGE AND UNIVERSITY MENTAL HEALTH AND RESOURCE DOCUMENT ON COLLEGE MENTAL HEALTH AND CONFIDENTIALITY
    b) PROPOSED STATEMENT ON TRIAL AND SENTENCING OF JUVENILES IN THE CRIMINAL JUSTICE SYSTEM

3. APA GUIDELINES ON PSYCHIATRIC SERVICES IN CORRECTIONAL FACILITIES, 3RD EDITION - The Workgroup on Persons with Mental Illness and Criminal Justice, a subset workgroup of the Council, has worked with the American Psychiatric Publishing, Inc. (APPI) to have the updated the "APA Guidelines Psychiatric Services in Correctional Facilities" printed. The book is now available for purchase through APPI.

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Report to the Assembly
Council on Psychosomatic Medicine
David Gitlin, MD, Chair

Executive Summary

The Council on Psychosomatic Medicine (CPM) focuses on psychiatric care of persons who are medically ill and/or pregnant and works at the interface of psychiatry with all other medical, obstetrical and surgical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being and healing of patients and that full membership in the house of medicine is essential for our profession.

The Council is mission-driven and prioritizes activities around the updated charge set forth by the APA Board of trustees in 2015. Since the May meeting, Council members have strengthened working relationships with the Council on Healthcare Systems and Financing and its' Workgroup on Integrated Care; the Council on Advocacy and Government Relations; the Council on Psychiatry and the Law; the Council on Geriatrc Psychiatry; and the Academy of Psychosomatic Medicine. The Council recently completed a report, *Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model,* requested by the Council on Healthcare Systems and Financing, on the roles and responsibilities of psychiatrists; continues to submit abstracts for psychiatric and primary medical meetings for sessions designed to address the educational needs of psychiatrists who treat patients with complex comorbidities; and is currently encouraging the development of resource documents on member areas of expertise, (eg bariatric surgery). Finally, the Council continues to advocate for the enhancement of training in psychosomatic medicine and recruitment of residents into fellowship.

Action Item Update

- Action Item 8K, 8.K.1:
  The Council has asked the Joint Reference Committee to recommend that the Board of Trustees approve the completed report on identification of the roles and responsibilities of psychiatrists:
  Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model

Referral Updates

- Position statement development: Emergency Department Boarding of Individuals with Psychiatric Disorders (Item 6.13). Kim Nordstrom, MD, lead author, completed the draft position statement. The Council reviewed the document, suggested revisions and it was revised. The position statement is being reviewed by Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law and awaiting revisions. The position statement will be sent to the JRC for review in January.
- Revision of Position Statement: Principles of End-of-Life Care for Psychiatry. (Item 8.E.3) The CPM and the Council on Geriatric Psychiatry have created a small work group to collaborate on re-drafting the position statement.

Attachments:

Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model.

REPORT | 2015

DISSEMINATION OF INTEGRATED CARE WITHIN ADULT PRIMARY CARE SETTINGS

THE COLLABORATIVE CARE MODEL

AMERICAN PSYCHIATRIC ASSOCIATION
ACADEMY OF PSYCHOSOMATIC MEDICINE

I. EXECUTIVE SUMMARY

The integration of behavioral health and general medical services has been the focus of intensive resources, planning and education efforts for at least a decade. Significant, high-quality scientific health services research spanning three decades has identified one model, in particular, as being effective and efficient in delivering improved outcomes for a population of patients with behavioral health disorders seen in primary care settings, while also controlling costs and improving access and satisfaction with care. Known as the Collaborative Care Model, it separates itself from other attempts to integrate behavioral health services through its wide adaptation and steady reliance on consistent principles of chronic care delivery, as well as attention to accountability and quality improvement.

Over time, through many large-scale adaptations encompassing thousands of patients, expert consensus has identified four essential elements of Collaborative Care. These include the provision of care that is 1) team-driven, 2) population-focused, 3) measurement-guided and 4) evidence-based. A Collaborative Care team is multidisciplinary, shares roles and tasks, and together is responsible for the health outcomes of their patients. As a whole, the team is focused on the entirety of their patient population, regardless of the patient's current level of engagement in treatment. The team is equipped with tools to help manage their population of patients efficiently, often conceptualized as a disease registry. Together, this team utilizes measurement-guided patient-centered outcomes to guide the delivery of evidence-based care in order to achieve "treat-to-target" clinical goals for each patient. These core processes, in aggregate, allow each team to be held accountable to the care they provide, and improve upon their processes of care to achieve better outcomes in cost savings, satisfaction, access to care and health for the patients and systems they serve.

Each of these core elements can be adapted to a variety of community settings, and this report highlights the background, eligibility requirements, adaptation of the essential elements, accountability and quality improvement efforts in five of the largest Collaborative Care implementations to date from the persons directly involved in their implementation. Lessons learned from these early adopter programs provide invaluable insights for systems seeking quality evidence-based "integrated care" solutions.

The American Psychiatric Association and the Academy of Psychosomatic Medicine, jointly represented in authorship of this report, are dedicated to advancing the scientific understanding of evidence-based integrated care by outlining the current state of knowledge in this complex field and advocating for productive dialogue surrounding these models through the publication of this report.

ACKNOWLEDGEMENTS, DISCLOSURES

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Disclosures

James Rundell, MD is a paid consultant for Quartet, LLC. A company providing informatics services to health care plans to facilitate integrated care in their networks.

The remaining contributors report no relevant financial disclosures.

Acknowledgements

The workgroup members wish to express sincere thanks to the Academy of Psychosomatic Medicine and staff at the American Psychiatric Association for their instrumental support throughout the creation of this manuscript.

This report is dedicated in loving memory to the spirit and passion of Dr. Wayne Katon, whose body of scientific evidence and character lives on.

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Council on Quality Care
Report to the Assembly
Grayson Norquist, MD, Chair

Registry Workgroup: A workgroup under the direction of the Council on Quality Care and made up of members with expertise in the areas of quality care, health systems finance, and research met several times by conference call and one in-person meeting between May and December 2014. A recommendation report on how the APA should approach a society led registry has been developed and was presented to the Board of Trustees in July 2015. As a result of this presentation, the Board of Trustees has requested a Business Case be developed and shared at the December 2015 meeting.

Practice Guidelines: The full set of the Practice Guidelines on Psychiatric Evaluations of Adults, third edition were published on PsychiatryOnline as an online book and in print on August 1, 2015. An executive summary of the guidelines was also published in August. A number of promotional, marketing and social media efforts began in August after the publication was released. Staff is exploring the development of complementary tools to improve accessibility of the guidelines for psychiatrists, other clinicians, patients, the public, and other interested stakeholders (e.g., media, insurance companies).

The draft guideline on the use antipsychotics to treat agitation and psychosis in patients with dementia was open for public comment on July 31, 2015. The link to view and comment on the draft was widely disseminated to stakeholders both internal and external to APA, and was highlighted in Psychiatric News Update as well as APA President Dr. Binder's column in Psychiatric News. The Committee has reached out directly to the Council on Geriatric Psychiatry to solicit their feedback, and reached out to Assembly leadership in order to address any potential major concerns prior to the November 2015 Assembly meeting and vote. The public comment period ended on September 19, 2015, at which time the Guideline Writing Group reviewed the feedback and made changes as necessary.

Committee on Health Information Technology: The CMHIT is presently developing a set of requirements for the APA web site that would be the basis for an EHR and HIT Apps review process, including specified functionality and requisite data fields that would be a part of a database.

AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

October 9, 2015

To: APA Assembly

From: Grayson S. Norquist, M.D., Chair, APA Council on Quality Care
Michael J. Vergare, M.D., Chair, APA Steering Committee on Practice Guidelines
Victor L. Reus, M.D., Chair, Guideline Writing Group

Re: Approval of New APA Clinical Practice Guideline

The Council on Quality Care and the Steering Committee on Practice Guidelines invite the Assembly to approve the new APA Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia.

The Guideline was developed following the APA guideline development process that was adopted in 2011 to align with the Institute of Medicine's recommendations for trustworthy clinical practice guidelines. It was developed by a guideline writing group chaired by Victor Reus, M.D., and by a systematic review group led by Laura Fochtmann, M.D. The Assembly was involved in multiple steps of the development process, including nomination and participation of experts in an opinion survey that informed guideline recommendations and participation in public review of the draft guideline. Multiple comments were received on the guideline draft and included input from several APA Councils and the Alzheimer's Association. This feedback was used to fine-tune and strengthen the fifteen guideline statements and the accompanying guideline text. As a reference, the sections of the document that address guideline statements, rationale, benefits, harms and implementation can be found on pages 8-31.

Under the new guideline development process, all recommendations were determined by the work group using a modified Delphi method with blinded, iterative voting. In recognition of this systematic process, the Assembly is now asked for a "yes or no" approval of this guideline.

Pending approval by the Assembly and approval by the APA Board of Trustees in December, publication of the guideline is anticipated in the first half of 2016.

Will the Assembly vote to approve the APA Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia, with the understanding that the APA Board of Trustees will be asked in December to vote final approval for publication?

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The Council on Research
Dwight Evans, M.D., Chairperson

Action Items
There are currently no action items for the Assembly's consideration.

Referral Updates
The Council was asked to provide an update on the following Joint Reference Committee referral:

> Referral Item Number: JRCOCT148.G.22
> Title: Current Health Services Literature on Integrated Care Models
> Action: Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Office of Research to review the current health services literature on integrated care models, including physician-led and non-physician-led models, and summarize and organize this review in such a way that it can be used by APA administrative staff and members for integrated care education and advocacy?
> Response: The Division of Research has completed this report, which is being reviewed by the Council on Research. The summary of findings will be included in the final report to the JRC on October 2.

Informational Update
The Council brings the following Information Item:

1. The Council has made minor modifications to the position statement on atypical antipsychotic medications, which was sent back to the Council by the Joint Reference Committee for lack of compliance with formatting requirements.

September 24, 2015

To: APA Assembly

From: Carolyn B. Robinowitz, MD, Sr. Delegate, APA AMA Delegation, and Chair, AMA Section Council on Psychiatry

Re: Update on the Activities of the APA AMA Delegation/AMA Section Council on Psychiatry

Thank you for the opportunity to update you on the activities of the APA AMA Delegation and the Section Council on Psychiatry. As this report is being written, we are preparing for the 2015 Interim Meeting of the AMA House of Delegates, November 14 through 17. The focus of the Interim Meeting each year is on advocacy both for the profession and for patients. More information on its content will be available by the time of the Assembly meeting. The following is a brief summary of the significant activities of the delegation since our last report to the Assembly.

The major focus for which we worked and celebrated during the AMA Annual Meeting in June (Summary Attachment 1-4) was the re-election of Patrice Harris, MD to a second four-year term on the AMA Board of Trustees. Not only did Dr. Harris receive the largest number of votes of any candidate in this highly contested election, but she then was unanimously elected by her colleagues on the Board to the position of Chair-Elect of the AMA BOT. This second and remarkable victory reflected the Board members' respect of and admiration for her leadership. It also documented our successful implementation of a long term strategic plan begun in December 2000 under the wise direction of Dr. Joseph T. English. The goals of the plan included: greater recognition of and respect for psychiatrists and psychiatric issues; the election and appointment of psychiatrists to AMA leadership positions (e.g., councils and committees), and the support of the AMA for public policy and other issues related to clinical care such as parity, workforce, access, stigma and discrimination. For psychiatrists to achieve these goals required a longer range plan—keeping our eyes on the prize—while recognizing that AMA's operations and time table differ from those of APA, and learning to work well in AMA's organizational culture.

The Section Council's successes lead to future challenges. Not only must we mount a strong and successful campaign for Dr. Jack McIntyre in his quest for a seat on the AMA Board of Trustees in 2016 (Attachment 5), but we also must engage in activities that promote our next decade of success—identifying, mentoring, and promoting the next generation of psychiatrist leaders. At the AMA, it can take considerable time to gain the trust and approval of members of the House; that process is an important one, but it has contributed to a slant towards older leaders. In recent years, the House has looked for "younger" leadership (i.e., those in their forties or fifties) who have gained that trust and approval through time spent as resident/fellow delegates and/or Young Physicians. Thus, we are working with APA leadership to identify and appoint younger psychiatrists, including residents, to the delegation and to mentor them with the goal of their becoming the new leaders. In addition, work is already under way to expand our interactions and alliances with current young physician leaders in the House at the November AMA Interim Meeting —leaders representing state societies as well as the broad range of specialty organizations, in addition to continued work to strengthen the positive relationships with other specialty and state medical societies that have developed over the past four

years. In that process, we rely on the many psychiatrists to attend AMA meetings representing state medical societies as well as other groups such as medical schools, international medical graduates, minorities, etc.

We continue to encourage members of the Section Council on Psychiatry as well as other psychiatrists to become active within the AMA at their state and local level. Jerry Halverson and Ray Hsiao have both risen through their state organizations to serve as president of the Wisconsin and Washington state medical societies respectively, extending the influence of psychiatry. As you may recall from the address to the Assembly in May by Dr. David Barbe, past-chair of the AMA Board of Trustees, these relationships are critical as we work together on behalf of the field of medicine and our patients.

Attachment 1

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

The major focus for which we worked and celebrated was the re-election of Patrice Harris, MD (Attachment 2) to a second four-year term on the AMA Board of Trustees. Not only did Dr. Harris receive the largest number of votes of any candidate in this highly contested election, but she then was unanimously elected by her colleagues on the Board to the position of Chair-Elect of the AMA BOT. This second and remarkable victory reflected the Board members' respect of and admiration for her leadership. It also documented our successful implementation of a long term strategic plan begun in December 2000 under the wise direction of Dr. Joseph T. English. The goals of the plan included: greater recognition of and respect for psychiatrists and psychiatric issues; the election and appointment of psychiatrists to AMA leadership positions (e.g., councils and committees), and the support of the AMA for public policy and other issues related to clinical care such as parity, workforce, access, stigma and discrimination. For psychiatrists to achieve these goals required a longer range plan—keeping our eyes on the prize—while recognizing that AMA's operations and time table differ from those of APA, and learning to work well in AMA's organizational culture.

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

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

Attachment 3 lists the members of the AMA Psychiatric Caucus. The caucus includes all psychiatrists who attend the AMA House of Delegates Meetings as delegates or alternate delegates on behalf of their specialty, state or an AMA section (e.g., Minority Affairs Section).

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

Attachment 4 provides more information about these reports as well as a list of reports and resolutions of more general interest. For the full listing of the preliminary actions go to http://www.ama-assn.org/sub/meeting/reportsresolutions.html (login required) and review the reference committee reports.

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

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

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

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

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

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

Communications Report for AMA HOD

Once again this year we were very active on Facebook and Twitter at the AMA HOD in Chicago. Posts featured APA members at work in the House of Delegates, in reference committee hearings, and during section council meetings. Communications staff also assisted with preparing Patrice Harris, MD for her presentation for re-election to the Board of Trustees and with preparing campaign support letters to voting members of the house. Tweets from the APA Twitter account were re-tweeted by actress Patty Duke (on transgender in the military) and AMA President Dr. Robert Wah (congratulations to AAGP). Formal interviews for the APA Website were conducted with Drs. Levin and Harris.

NEWS RELEASE

AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

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

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

The Board of Trustees is an elected body of 21 physicians who guide the AMA as it sets standards and policy for the medical profession. "I am thrilled that Dr. Harris will serve as Chair-Elect on the AMA Board," said APA President Renee Binder, M.D. "The APA Board of Trustees is looking forward to working with her as both groups strive to improve and advance the practice of medicine."

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

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

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

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

Members of the AMA Psychiatric Caucus

Jeffrey	Akaka, MD	APA
Barnes	Alicia	APA
Thomas	Allen, MD	MedChi
Allan	Anderson, MD	AAGP
Daniel	Anzia, MD	APA
Perry	Bach, MD	OMSS
Alicia	Barnes, MD	APA
Jenny	Boyer, MD, JD	OK Med Soc
Don	Brada, MD	APA
Stephen	Brown, MD	WY Med Soc
Ken	Certa, MD	APA
Clarence	Chou, MD	WI Med Soc
Frank	Clark, MD	Min Affairs Sec
Frank	Dowling, MD	MSSNY
David	Fassler, MD	AACAP
Semyon	Faynboym, MD	APA
Shaan-Chirag	Gandhi	Med Student Sec
Stuart	Gitlow, MD, MPH	ASAM (CSAPH)
Sidney	Gold, MD	CA Med Assoc
Jeff	Goldsmith, MD	
Ryan	Hall, MD	AAPL
Jerry	Halverson, MD	APA
Patrice	Harris, MD	AMA BOT
Dionne	Hart, MD	Min Affairs Sec
Alfred	Herzog, MD	CT State Med Soc
Sharon	Hirsch, MD	AACAP - Sec Council Mbr
Ray	Hsiao, MD	APA
Brian	Hurley, MD	GLBT Section
Louis	Kraus, MD	AACAP
Jeremy	Lazarus, MD	AMA Past President
Saul	Levin, MD, MPH	APA
Maria	Lymberis, MD	CA Med Assoc
Jack	McIntyre, MD	APA
Michael	Miller, MD	WI Med Soc
Louis	Moench, MD	
Sean	Moran, MD	APA
Clifford	Moy, MD	TX Med Assoc (CLRPD)
Myo	Myint, MD	LA State Medical Soc
Paul	O'Leary, MD	APA
Jennifer	Piel, MD	AAPL

Charles	Rainey, MD	WI Med Soc
Nyapati	Rao, MD	Am Assoc of Phys of Indian Origin
Claudia	Reardon, MD	WI Med Soc
Carolyn	Robinowitz, MD	APA
James	Sabin, MD	CEJA
Louis	Sanchez, MD	FSPHP
Barbara	Schneidman, MD	APA - Sec Council Mbr
Joseph	Schwartz. MD	CA Med Assoc
Leslie	Secrest, MD	TX Med Assoc
Katy	Skimming, MD	
Bruce	Smoller, MD	MedChi
Vanessa	Stan, MD	RFS
Lee	Stevens, MD	LA State Med Soc
Bollepalli	Subbarao, MD	CT State Med Soc
Shastri	Swaminathan, MD	IL State Med Soc
Sandra	Swantek, MD	AAGP
Harsh	Trivedi, MD	APA
Bud	Vanna, MD	AACAP
Barry	Wall, MD	AAPL
John	Wernert, MD	APA
Paul	Wick, MD	APA
Alik	Widge, MD, PhD	CLRPD
Theodore	Zanker, MD	CT State Med Soc

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

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
			behavioral health care services into primary care settings.
A	RES 111 RES 112 RES 114 RES 130	Evaluate Vouchers Program for Veterans to Purchase to Purchase Private Health Insurance Improving Timely Access to Quality Healthcare for America's Veterans An HSA Card will Give Veterans Better, Faster Health Care Ensuring Enhanced Delivery of Health Care to our Nation's Veterans	**ADOPTION of Substitute Resolution 111 in lieu of Resolutions 112, 114 and 130** ACCESS TO HEALTH CARE FOR VETERANS RESOLVED, That our AMA continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system. (New HOD Policy); and be it further RESOLVED, That our AMA monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system. (New HOD Policy); and be it further RESOLVED, That our AMA call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans. (New HOD Policy); and be it further RESOLVED, That our AMA advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. (New HOD Policy); and be it further RESOLVED, That our AMA advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans. (New HOD Policy); and be it further RESOLVED, That our AMA support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans. (New HOD Policy)
A	RES 116	Study the Impact of the ACA Medicaid Expansion	**ADOPTED AS AMENDED** RESOLVED, That our American Medical Association use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low- income adults as specified by the Affordable Care Act to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population ~~as opposed to those who are otherwise insured~~, (b) the quality of health care services provided to those who are part of the Medicaid expansion population ~~as opposed to those who are otherwise insured~~, (c) the adequacy of provider payments for the services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use (Directive to Take Action); and be it further RESOLVED, That our AMA provide this report to the HOD at the 2016 Annual Meeting. (Directive to Take Action)
A	RES 106 RES 117 RES 124 RES 125 RES 127	Controlling the Skyrocketing Costs of Generic Prescription Drugs Pricing of Generic Drugs Reducing Prescription Drug Prices	**ADOPTION of Substitute Resolution 106 in lieu of Resolutions 117, 124, 125 and 127** RESOLVED, That our American Medical Association work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs (New HOD Policy); and be it further RESOLVED, That our AMA advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients (New HOD Policy); and be it further

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

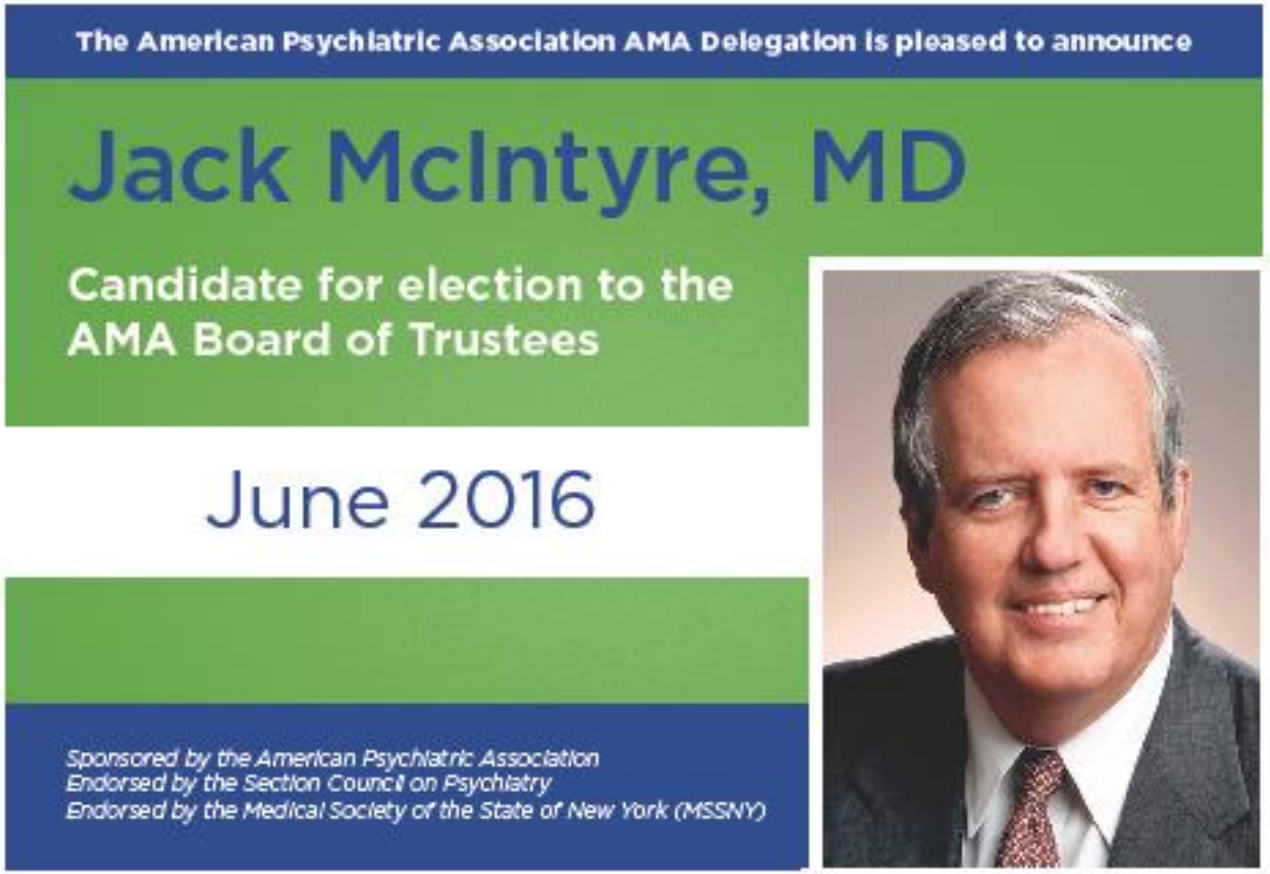
Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
		Interstate Medical Licensure Compact	
C	CME 05	Competency and the Aging Physician	**ADOPTED AS AMENDED with change in title** ASSURING SAFE AND EFFECTIVE CARE FOR PATIENTS BY SENIOR/LATE CAREER PHYSICIANS The Council on Medical Education recommends that the following recommendations be adopted, and that the remainder of the report be filed. 1.That our American Medical Association (AMA) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior ~~aging~~/late career physicians remain able to provide safe and effective care for patients. (Directive to Take Action) 2. That our AMA convene ~~encourage~~ organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior ~~aging~~/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (Directive to Take Action) 3. That our AMA rescind Policy D-275.959, Competency and the Aging Physician, since this directive has been accomplished through this report. (Rescind HOD Policy)
C	CME 10	Aligning the Evaluation of Physicians Across the Medical Education Continuum	**ADOPTED** The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed. 1. That our American Medical Association (AMA) support the concept that evaluation of physicians as they progress along the medical education continuum should include the following: a. Assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and b. Use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum. (New HOD Policy) 2. That our AMA encourage study of competency-based progression within and between medical school and residency. a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school. b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency. (Directive to Take Action) 3. That our AMA encourage research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum. (Directive to Take Action) 4. That our AMA encourage ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice. (Directive to Take Action)
C	RES 301	Alerting Physicians to Deadlines for Maintenance of Certification	**ADOPTED** RESOLVED, That our American Medical Association continue to work with the American Board of Medical Specialties (ABMS) to ensure that

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
			physicians are clearly informed of the maintenance of certification requirements for their specific board and the timelines for accomplishing those requirements (Directive to Take Action); and RESOLVED, That our AMA encourage the ABMS and its member boards to develop a system to actively alert physicians to the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification. (Directive to Take Action)
C	RES 302	Re-Evaluating Knowledge Assessment in Maintenance of Certification	**ADOPTED** RESOLVED, That our American Medical Association work with the American Board of Medical Specialties to streamline and improve the Cognitive Expertise (Part III) component of Maintenance of Certification, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination. (Directive to Take Action)
C	RES 304	Addressing the Increasing Number of Unmatched Medical Students	**ADOPTED AS AMENDED** RESOLVED, That our American Medical Association study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match (Directive to Take Action); and be it further RESOLVED, that our AMA discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions. (Directive to Take Action)
C	RES 309	Maintenance of Certification	**REFERRED** RESOLVED, That our American Medical Association advocate for a moratorium on the maintenance of certification requirements of all medical and surgical specialties until it has been reliably shown that these programs significantly improve patient care. (Directive to Take Action)
D	CSAPH 03	Concussion and Youth Sports	**ADOPTED AS AMENDED** The Council on Science and Public Health recommends that the following recommendations be adopted in lieu of Resolutions 401, 410, and 412-A-14 and the remainder of the report be filed. 1. That Policies H-470.959 "Return to Play after Suspected Concussion" and H-470.966 "Harmful Practices for Child Athletes" be amended by substitution to read as follows: REDUCING THE RISK OF CONCUSSION AND OTHER INJURIES IN YOUTH SPORTS (1) Our AMA promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other ~~physical~~ sports-related activity without the written approval of a ~~licensed~~ physician (MD or DO) or a designated member of the physician-led care team ~~licensed health care professional, whose scope of practice includes being~~ who has been

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
			properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) ~~and health care professionals~~ or the designated member of the physician-led care team should be mindful of the potential for other occult injuries. (2) Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; ~~and~~ (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual. (3) Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; and (c) promote educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers. (Modify Current HOD Policy 2. That Policies H-10.965 "Mild Traumatic Brain Injury Awareness," H-470.957 "Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention," and D-470.997 "Sports Injury Reduction" be amended by substitution to read as follows: REDUCTION OF SPORTS-RELATED INJURY AND CONCUSSION Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients. (Modify Current HOD Policy) 3. That the following policies be reaffirmed: H-10.982 Injury Prevention; H-470.956 Injuries in Cheerleading; H-470.958 Head Injury Prevention in Hockey; H-470.960 Soccer Injuries; H-470.963 Boxing Safety; H-470.967 Safety in Youth Baseball and Softball; H-470.971 Athletic Pre-participation Examinations for Adolescents; H-470.974 Athletic Helmets; H-470.984 Brain Injury in Boxing; H-470.995 Athletic (Sports) Medicine (Reaffirm HOD Policy)

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
D D	RES 412 RES 419	Regulation of Electronic Cigarettes Taxation of Tobacco Products	**ADOPTED AMENDED Policies H-495.987 and H-495.972 in lieu of Resolutions 412 and 419; REAFFIRMED Policy H-495.973** H-495.987 Taxation of All Tobacco ~~Taxes~~ Products and Electronic Nicotine Delivery Systems (ENDS) (1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to ~~pass~~ increased federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage tobacco use; (2) An increase in federal, state, and local excise taxes for ~~tobacco~~ such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating ~~the tobacco~~ such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education. H-495.972 Electronic Cigarettes, Vaping, and Health: 2014 Update 1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes.
D D	RES 421 RES 424	Raising the Minimum Legal Age to Purchase Tobacco Products to 21 Child-Proof Packages for E-Cigarette Liquid Refills	**ADOPTED AMENDED Policy H-495.986 in lieu Resolutions 421 and 424; REAFFIRMED Policies H-495.973, H-490.909 and H-495.972** H.495.986 ~~Tobacco Product~~ Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes Our AMA (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors.
D	RES 425	Ban on Powdered Alcohol Distribution and Sale	**REFERRED** RESOLVED, That our American Medical Association adopt policy urging the ban of the distribution and sale of powdered alcohol (New HOD Policy); and be it further RESOLVED, That our AMA lobby Congress and the Administration to ban by law or regulation the distribution and sale of powdered alcohol in the U.S. (Directive to Take Action)
E	BOT 14	Risk Evaluation and Mitigation Strategies for Methadone	**ADOPTED** The Board of Trustees recommends that the following statement be adopted and the remainder of the report be filed: That Policy D-120.985, "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone," be

Cmte*	Item	Title / Recommendations or Resolves	AMA House of Delegates Action
			reaffirmed in lieu of Resolution 512-A-14. (Reaffirm HOD Policy)
E	Joint CMS-CSAPH	Coverage for Chronic Pain Management	**ADOPTED AS AMENDED** The Councils recommend that the following recommendations be adopted in lieu of Resolution 112-A-14, and that the remainder of the report be filed 1. That our American Medical Association advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. (New HOD Policy). 2. That our AMA support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. (New HOD Policy) 3. That our AMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process. (New HOD Policy)
E	RES 517	Recreational Use and Abuse of Prescription Drugs	**ADOPTED Substitute Resolution 517 as AMENDED** ADDRESSING RECREATIONAL MISUSE AND DIVERSION OF CONTROLLED SUBSTANCES RESOLVED, That our American Medical Association, in conjunction with other Federation members, ~~and~~ key public and private stakeholders, and pharmaceutical manufacturers, pursue and intensify collaborative efforts involving a public health approach in order to: 1) reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; 2) increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and 3) reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
E	Res 518	Increasing Access to Care for Patients with Opioid Use Disorders	**Existing AMA policy was REAFFIRMED in lieu Resolution 518 (via reaffirmation consent calendar)** H-95.979 Curtailing Prescription Drug Abuse While Preserving Therapeutic Use -Recommendations for Drug Control Policy H-120.960 Protection for Physicians Who Prescribe Pain Medication H-95.990 Drug Abuse Related to Prescribing Practices H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs D-180.998 Insurance Parity for Mental Health and Psychiatry D-120.953 Treatment of Opioid Dependence
F	Res 607	Preventing Violent Acts Against Health Care Providers	**ADOPTED AS AMENDED** RESOLVED, that our American Medical Association work with other appropriate organizations, ~~as appropriate,~~ to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, and that our AMA widely disseminate the results of this study.


The American Psychiatric Association AMA Delegation is pleased to announce
Jack McIntyre, MD
Candidate for election to the
AMA Board of Trustees
June 2016
Sponsored by the American Psychiatric Association
Endorsed by the Section Council on Psychiatry
Endorsed by the Medical Society of the State of New York (MSSNY)

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Work Group on Access to Care
Report for Assembly, Fall 2015

In a conference call on 9/2/15 members were surveyed on emergent issues, potential action papers and next steps.

1. Medicaid Expansion continues to be an issue: 4.3 million citizens being deprived of access to Medicaid insurance in the 20 states which have opted out of Medicaid expansion. Action: Joe Mawhinney and Jim Fleming will co-author an Action Paper for the Fall Assembly meeting asking the APA to provide support and advocacy to DB and State Government Affairs efforts to influence state governments (APA state Legislative Affairs infrastructure being developed to extend APA Advocacy and Government Affairs efforts to the State level).

2. Access to stimulant medication in Florida reported to be a clinical problem. Causes to be further explored (pharmacy or insurance problem?).

3. Medicare Access to TMS unavailable in Florida due to low reimbursement. In Delaware although a commercial carrier covers TMS, it is not covered by the same insurance carrier's Medicaid contract.

4. In Delaware, electronic prescribing mandated but highly inconsistent and inefficient in practice.

5. General concerns reported regarding incarcerated patients' access to care; case management, transitional care. Query made re decriminalization and prison reform bill by Senator John Cornyn, R Texas.

6. Other "at risk" populations discussed for potential Access to Care Initiatives: Developmentally Disabled, Medi-Medi (dual diagnosis), persons with persistent or recurrent mental illness by all health insurances (public and commercial); increasing problems with access to medications; continuity of medications; access to appropriate intensity and levels of care.

7. Parity!!! Coleen Coyle, APA Counsel is collecting vignettes on parity violation for the Department of Labor.

   Work Group members were advised of a survey developed by the Council on Health Care Systems and Financing to evaluate formulary, PBM and prior authorization problems. All work group members are asked to survey their constituents and identify future initiatives to address access to care concerns.

   Joe Mawhinney, MD
   Area 6 Representative
   Chair Access to Care Work Group

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Report of the Assembly Work Group on Maintenance of Certification (MOC)

Since the last assembly, the most significant change made by ABPN is that they dropped all Part 4 requirements for MOC except the chart review and the peer and patient feedback sections are now optional.

- The opinion of the MOC Work Group in some recent email discussions and a conference call is that we would like to see the ABPN consider making the recertification examination a learning experience by having it become open book and give immediate feedback including references on answers. These are the opinions expressed by members of the MOC work group and have been forwarded to Dr. Martin.

- We also would like to see it be possible for psychiatrist who are certified in general psychiatry as well as a subspecialty be allowed to choose whether or not they wish to recertify in general psychiatry but not make it necessary to do so to keep the subspecialty certification. It is already ABPN policy that child and adolescent psychiatrists can choose whether or not they wish to recertify in general but are not required to do so to keep their certification in child and adolescent psychiatry.

- We are pleased with the simplification of Part 4, but would like to see the process become much more streamlined. The other issue of note is that the ABMS has not yet released its final actions or decisions with regard to the American Board of Internal Medicine's action to drop Part 4 altogether. Once that action is announced, it may have great implications on what our Board may or may not do.

- Fees for initial board certification continue to be of concern and focus of discussion as they hit people at a time when they have not yet entered a period of a more sustainable income.

- Finally, there have been some concerns expressed about the use of board certification for credentialing by insurance companies and hospital systems and the fear that failure to maintain board certification could result in being dropped from panels or medical staffs. Given work shortages in our field, it would be problematic for patients to have fewer psychiatrists practicing able quit because he do not wish to bother with board certification.

The MOC Work Group will meet at the upcoming Assembly in October.

Bob Batterson, M.D.
Work Group Chair

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Area I Council Semi-Annual Report
September 30, 2015

The Area I Council met on September 19, in Toronto, Ontario. Recent concerns of the Council have included the following:

Parity between psychiatry and other medical specialties, with regard to access to services and payment for them, remains problematic throughout the New England states. In preparation for the Fall Area I Council meeting, members were asked to discuss areas of greatest concern for the members in their district branches. Parity was identified as the most serious problem, with the burden of pre-authorization requirements, by private and public insurers, the primary problem in routine clinical practice. Members regard this as a form of parity violation in some cases; e.g., though physicians in most medical specialties are required to obtain insurance pre-authorization for payment for certain medications, the "fail first" algorithms and other restrictive requirements for psychiatry seem particularly extreme. A portion of the Fall Meeting was spent in brainstorming about pre-authorization and related problems. A list of specific examples that may represent parity violations was compiled for potential use by the APA legal counsel.

Though pre-authorization and other practice restrictions are more prevalent in the United States than Canada, appropriate valuation of psychiatric services is problematic in Canada as well. Representatives of the Ontario District Branch reported that they have recently been notified of an impending 4.45% reduction in fees for service. This is reportedly an adjustment based on projected utilization of services within the Province, and was imposed unilaterally by the government, without collaboration, negotiation or discussion with the Ontario Medical Association. This is seen by many as another example of the de-valuation of psychiatrist and other physician services, figuratively and literally. [A CBC news report shortly after the Fall Meeting included the following: *The New Democrats said the government needs to recognize that doctors should be properly compensated for the care they provide. "This government is bound and determined to paint every single physician in this province as money hungry and opportunistic, and this is wrong," said NDP health critic France Gelinas.*]

Access to psychiatric services and payment for them remain intertwined problems in a variety of settings. Integrated, collaborative care models that include psychiatrists in oversight or team leader roles have demonstrated efficacy in improving outcomes in treatment of a variety of psychiatric illnesses in primary care; however, in order to achieve widespread adoption, means of securing adequate payment for clinical services by psychiatrists that do not include a face-to-face component is imperative. Karen Sanders, MS, APA Director of Integrated Care, reported that APA is involved in these negotiations, such as with the Center for Medicare and Medicaid Services, and will be consulting with our Canadian Representatives regarding indirect service remuneration in the provincial plans. Massachusetts has started an access program for child psychiatry services that will need to navigate these difficulties.

People in need of psychiatric services who are in situations of heightened vulnerability, such as incarceration, homelessness, or experiencing severe and persistent illness, continue to bear the brunt of the financial and organizational dysfunctions that limit access to adequate psychiatric care. Ongoing shortages of psychiatric hospital capacity and excessive emergency department wait times remain problematic throughout the Area. Vermont has added psychiatric hospital beds during the last several years, but is still in the lowest quintile in the United States with regard to psychiatric inpatient capacity. Repeated incarceration of persons with serious psychiatric illness is an area of particular concern in New Hampshire. Connecticut psychiatrists are combatting new state policies that make access to homeless shelters more difficult. Some of our members have observed that the lack of parity in psychiatric remuneration, and excessive administrative burdens placed on psychiatric practice, reflect the public policy disregard for persons experiencing psychiatric illness, especially the most vulnerable.

The members of the Area I Council remain committed to ongoing improvement of communication within and between our constituent groups, and to fostering the further development of the organization. Members of ACORF are building on the work of the last few years in outreach to residency programs and publicity of resident/fellow events. The restructured Assembly, including the enhanced recognition of smaller district branches (two Representatives, no Deputy Representatives) and ACROSS groups is particularly welcomed by the members of the Area I Council. Area I includes primarily small to medium district branches, and is enriched by substantial ACROSS representation on the Area Council. The Area I Council promotes diversity in its leadership and in membership recruitment. We were saddened by the departure from the Council of Brian T. Benton, M.D., Area I Representative to the AEC, who retired after the 2015 Annual Meeting due to poor health. Dr. Benton had served the Council for many years, first as Representative from the American Indian, Alaska Native, Native Hawaiian Caucus, later as Area I Deputy Representative, and finally as Representative and chairman of the Area I Council. He was welcomed to the Fall Area I Council Meeting, by phone, as an honored guest.

Respectfully submitted,

A Evan Eyler, M.D., M.P.H, Area I Representative
Manuel N Pacheco, M.D., Area I Deputy Representative

Area 3 Report

Member Services:

- Established an Area 3 Committee on Member Services (COMS) in recognition that the APA is a member organization and that its highest priority is to serve its members – The COMS shall be chaired by Dr Bill Greenberg, Area 3 Dep Rep, to emphasize the importance of this committee and its function. It will draw on the member services expertise of the NJ DB Executive Director Patricia DeCotiis, Esq, who shall be an *ex officio* member. There shall be ACROSS, DB, ECP, RFM and M/UR representation. Its function shall be to: 1) track the ongoing member services and initiatives to benefit members of the Area 3 DBs, the Assembly Committee of Early Career Psychiatrists, the Assembly Committee of Representatives of Minority/Underrepresented Groups, the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS), the Assembly Committee of Resident-Fellow Member Representatives (ACORF), including but not limited to providing services for members, recruitment and retention efforts, engagement of members, leadership development, and mentoring, 2. coordinate communication and sharing amongst Area 3, about member services programs of Area 3 DBs and information regarding their effectiveness, 3. communicate and coordinate with the APA Chief of Membership & RFM/ECP Officer. The COMS shall study: 1) Decreased involvement or termination of membership when members transition from RFMs to ECPs and 2) Role of Area 3 in mentoring, and produce written reports on its findings and recommendations on each of these matters.

- Maryland Psychiatric Society will offer a DB specific MOC educational activity funded in part by Area 3 as a follow-up to the highly successful area-wide MOC training that served the members of Area 3. This program has the potential to be adopted by other Area 3 DBs.

Diversity: Area 3 DBs considered diversity in electing new representatives to the Assembly. There is diversity amongst the members of the Area 3 Council.

Advocacy: 1) Delaware: Bills on advanced practice nursing, telemedicine, school training for suicide prevention, naloxone access in schools and establishing a behavioral and mental health task force 2) Maryland: *Amicus curiae* Allmond v. DHMH to oppose that involuntary medication administration to committed patients is unconstitutional and addressing barriers to psychiatrists participating in Medicaid. 3) NJ: Integrated collaborative care and opposing psychologist prescribing privileges, 4) Pennsylvania: Expansion of nurse practitioner scope of practice

Education:

- The Area 3 Work Group on the Affordable Care Act/Health Insurance Exchanges is considering a 2016 Conference.

- The Area 3 DBs and Subspecialty Organizations continue to provide excellent CME activities.

Standards, Quality of Care and Health Economics: Reminded the Area 3 Council and DBs about the open comment period for the APA Practice Guideline on "Use of Antipsychotics to Treat Agitation and Psychosis in Patients with Dementia"

Strength of Area 3 and the Area 3 Council

- Dr Napoli assumed the position of Area 3 Representative.
- Dr Greenberg assumed the position of Area 3 Deputy Representative.
- Special email "Welcome" was sent to the new Area 3 members including the new presidents of the DBs
- Registered the new members, including the DB presidents, as members of "Welcome to Area 3," the Area 3 Website
- Used "Assembly Fast Facts," one page information sheets in a FAQ format, for orientation of the new members
- Held regular fall meeting on September 20 at Sheppard Pratt, Towson, MD and welcomed new members
- Elected Reena Thomas, MD of the NJ DB to fill the ECP Dep Rep vacancy.
- In process of forming an Area 3 AHWG on Projects
- Introduced a standardized template for Area 3 reports that highlights member services and incorporates the new APA strategic priorities. "Advocacy," "Education," and "Standards, Quality of Care and Health Economics" pertain to "Advancing Psychiatry." "Supporting Research" is under "Standards, Quality of Care and Health Economics."
  [Note: This report uses the template.]

- New members will shadow the Area 3 senior members, who are assigned to the Assembly Reference Committees, in order for the senior members to train and mentor the new members.

Respectfully submitted, Joseph C Napoli, MD, DLFAPA, Area 3 Rep

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Area 6 Report to the Assembly

Area 6 met in Dana Point, California, at the end of September, in conjunction with our annual educational meeting. Our council meeting was attended by 45-50 participants, including the chairs of our state committees and DB presidents and president-elects in addition to our Assembly representation. We were also happy to have with us much of the leadership of the APA including our own Californian APA President Rene Binder, APA CEO and Medical Director Saul Levin, APA Assembly Speaker Glenn Martin, and chief of APA Membership, John Fanning. At our annual meeting this year we are instituting a meeting time for seven newly established caucuses and are looking forward to the ideas and energy that may come out of these meetings. Our annual meeting attendance is increased by 30% this year, including increased attendance by our residents. We are looking at other ways to get our younger members involved and will have a task force looking at how to support their attendance at CPA activities. We also have a new website – check it out at www.calpsych.org !

Our president summarized that CPA is working with the state on ensuring parity with health care insurance, on issues surrounding children in foster care and the prescribing of psychiatric medications that has flared in the media, and on revisions to our involuntary hold laws. We are monitoring issues with integrated care and the need for adequate psychiatric input into these systems. We are looking forward to focusing on the issue of the incarceration of the mentally ill in the upcoming year. We also had an aid in dying bill in the legislature this year that made it to the governor's desk, which had considerable input from the CPA.

Our Trustee, the APA President, APA Assembly Speaker and the APA CEO all updated us on APA activities, which should be well covered and more up-to-date in the current Assembly materials. Steve Koh is working with the APA to increase our power in Federal Advocacy. We discussed and supported the action papers on psychiatric bed registry and increasing ACA participation that will be coming to this Assembly meeting from California authors. We received a Federal Legislative update from our representative Melinda Young.

We accepted a slate of Catherine Moore and Robert McCarron for CPA President and Robert Cabaj and Mary Ann Schaepper for CPA Treasurer. We reviewed some of the 95 resolutions that will be coming to our state House of Delegates meeting in October and took positions to support Housing First initiatives, support rebuilding Public Health infrastructure, support increased screening for peer bullying, support limitations on the use of long-term solitary confinement, and oppose that there must be a face-to-face encounter prior to initiation of telemedicine as well as oppose that

California recognize alternative methods to be "board certified" outside the ABMS programs.

We have expressed our concerns at the state level regarding the insurance mergers that are occurring. We added to our policy platforms support for Healthy Communities. Laura's Law, our assisted outpatient treatment law, has continued to expand into many counties. We endorsed exploring sponsorship of legislation for next year of Laura's Law (it expires this year), to establish a psychiatric bed registry in California, to secure health benefits for inmates prior to release into the community, and to establish a peer review process for group homes and foster youth facilities.

Our committees remain quite active. The Judicial Action Committee is working on coordinating better with APA judicial efforts, they are actively looking at 5 cases right now including psychotherapist patient confidentiality, access by the Medical Board to CURES prescribing records of physicians without patient permission, considering involvement with the APA in a case regarding mental health parity involving coverage of mental health in the UC system, and a whistleblower case involving a psychiatrist working at San Quentin prison system. The Child and Adolescent Committee is active in the very politically charged issues nationwide that relate to the prescription of psychotropic agents to children in the foster care system. In addition, it is becoming evident statewide that schools are not providing the federally mandated mental health services to students, and the committee is working with the media and the state legislature to establish a focus on this problem. We heard reports from our Resident and Early Career representatives and discussed their ongoing attempts to increase involvement at this level. The Public Psychiatry Committee has four large ongoing areas they are tracking including changes in 5150 (our involuntary hold) laws, progress in implementation of Laura's Law (our assisted outpatient treatment law), health care reform with medicaid expansion and integration of care, and the changes in relationship between correctional systems and public health systems. The State Facility Task Force continues to fight administrative attempts to eliminate or circumvent organized medical staffs in their facilities (the latest was an attempt to enforce standard bylaws on all of the facilities), look at how to deal with high vacancy rates, and block attempts to inappropriately expand the roles of psychologists in these facilities. The Integrated Care Committee is working on a Primary Care conference to be held in Sacramento in January, a mini-certificate program with UC Davis, a survey of training directors regarding integrated care training in residency, and money from royalties on a recent book will go to help with resident and ECP activities. The PAC has a reception at the annual meeting, and all council members were encouraged to donate to the state PAC.

Respectfully submitted
Joe Mawhinney and Barbara Weissman, Area 6 reps.

American Psychiatric Association
Area 7 Meeting Portland, Oregon
August 8-9, 2015

Attending

Glenn Martin, MD Speaker
Matthew Sturm, APA Staff
Area 7 Trustee: Jeff Akaka, MD, Area 7 Trustee
Area 7 Rep: Craig Zarling, MD
Area 7 Dep Rep: Charles Price, MD
RFM: Kelly Jones, MD Rep, Robert Mendenhall, MD Dep Rep
ECP: Joshua Sonkiss, MD Rep, Jason Collison, MD Dep Rep
MUR: Linda Nahulu, MD, American Indian/Alaska/Native Hawaiian Psychiatrists Rep, Chair MUR
Alaska: Alexander von Hofften, MD, Rep
Arizona: Payam Sadr, MD Rep, Gurjot (Reena) Marwah, MD Rep
Colorado: Charolette (Charlie) Lippolis, DO Rep
Hawaii: Leslie Gise, MD Rep, Iqbal (Ike) Ahmed, MD Rep
Idaho: Zach Morairty, MD Rep
Montana: Joan Green, MD Rep
Nevada: Dodge Slagle, MD Rep, Phil Malinas, MD Rep
New Mexico: Brooke Parish, MD Rep
Oregon: Annette Matthews, MD Rep, Amela Blekic, MD Rep
Utah: Jason Hunziker, MD Rep
Washington: Matthew Layton, MD Rep
Western Canada: Adeyinka (Yinka) Marcus, MD Rep, Ian Forbes, MD Rep
Wyoming: Stephen Brown, MD Rep, O'Ann Fredstrom, MD Rep

Guests:
Kirsten Pickard, DB Exec. Alaska
Gerald Block, MD Oregon

Not able to attend
John Pappenheim, MD, Rep Alaska
Alexis Giese, MD, Rep Colorado
Stamatios Dentino, MD, Rep Utah
Adel Gabriel, MD, Rep Western Canada
Nicole Thurston, MD, Rep Idaho
Krista David, MD, Rep Montana
Ruben Sutter, MD Dep Rep New Mexico

Brian Waiblinger, MD Rep Washington
Open seat, Rep Washington
Mary Roessel, MD, MUR Dep Rep, American Indian/Alaska/Native Hawaiian Psychiatrists
Kimberly Nordstrom, MD, Rep ACROSS American Association of Emergency Psychiatrists
Dan Anzia, MD, Speaker-Elect Assembly
Theresa Miskimen, MD, Recorder Assembly

Dr. Zarling opened the Council with a motion to approve the Minutes of the last meeting which was approved.

Dr. Zarling discussed the AEC meeting July 24-26 in Montreal, Quebec, Canada. Included were Leadership reports. The Speaker (Glenn Martin) discussed BoT highlights, APA/SAMHSA, and fellows involvement in the Assembly. The Speaker-Elect (Dan Anzia) discussed the Practice Guidelines review of elderly and antipsychotics, and the DSM Assembly Committee to report to Procedures. The Medical Director (Saul Levin) reported a 4.4% growth in membership, with International growth at 26%, Dues paying growth at 3.1%, ECP growth at 2.3%, and RFM growth at 4.6%. He also discussed the hiring of Phil Wang as Director of the Division of Research coming from being the Deputy Director of NIMH, David Keen as CFO having been the Finance Director of the American Federation of Federal Employees, and Brian Smith as Director of State Government Affairs. He aso discussed the BoT decision to lease the top three floors of a development at the WARF for three years with an option to purchase in 2020. This would be an anchor property. He discussed the strategic priorities: advancing psychiatry in the health system, support research, education, and diversity. Under comunications a new website soft launch in September 2015, ICD-10 instructions in October and including a psychopharmacology section in the newsletter. Under Advocacy the Murphy Bill (HR 2646) was reintroduced which included inducements in the workforce, and annual parity compliance reporting among other things. The recent insurance company mergers are concerning and are being looked at by CAGR and the AEC among others. The reviving of the State Legislative Advocacy Conference will be in October, 4 field Reps will be hired to support DB legislative work, and well as the hiring of Brian Smith as Director.
The Assembly workgroup on MUR issues was discussed by Linda Nahulu (Chair of MUR). And the Assembly is asked to be mindful of disverity in it's many forms when electing Representatives to the Assembly. Assembly workgroups kept were Access to Care, MOC, Membership, other OTHERS were retired or combined to work to optimize the Reference Committee process. A new President's Award for the highest percent of members of a DB voting in the annual elections. The Action Paper deadline was noted to be September 10th.

Report of the Speaker (Glenn Martin). He discussed APA strategic priorities and the importance of Area 7 in the Assembly and the APA with acknowledgement of the challenges that geography and sparcely populated states brings to our organization and that the restructuring of the Assembly, in part, reflected this. He noted that September 19th was the deadline for comments on the Practice Guideline. He discussed the JRC and BoT disposition of the various Action Papers. He discussed several strategies to increase the effectiveness of Reference Committees. The Areas are being seen as very important and a survey of the Areas activities may be a step in securig more funding for the Areas. An increase in technology is being looked at for Assembly business including wireless and video conferencing. There is a group being conveined CONVENED to

work on this. There was discussion on integrating the Area Trustees into the Areas. The Assembly DSM Committee was approved. The BoT approved procedures for making changes to the DSM. DSM-5 may be slowed in changing due to several technical reasons except for essential content. He discussed several workgroups including Access to Care, a Matrix workgroup, a workgroup on Assembly/Foundation Initiatives, The Foundation is looking for new funding streams. MUR issues included a lack of consistency within the groups, there may develop a few necessary criteria for caucus inclusion. A small group will work on this which includes Dr. Nahulu, Coleen Cole COLLEEN COYLE and an administrator. Regarding Assembly organization it was mentioned that the Area selection of members of the Nominating Committee follow the Procedure Code which calls for election not appointment. Voting by Strength was discussed looking at electronic voting versus paper ballots and how this might change dynamics in the Assembly. Reference Committees will be reconfigured in the Assembly to better reflect areas of focus, increase usser USER friendliness, and increase efficiency. There is an attempt to clarify Action Paper situation. The maker will move the paper after which time the maker loses control to the Assembly. Then the Reference Committee gives their commentary and moves from there. If the Reference Committee motion and the Astion Paper fails, then there will be an entertainment of the original Action Paper. The Council on Advocacy and Government Relations is concerned about the recent consolidtion of health insurance companies. Expect costumes, imagination, and innovation at the Holloween Assembly which will meet at the Onmi Sheraton. The Assembly is earlier than usual this year due to scheduling and economic considerations. It is expected the Assembly will move to a later date in November next year. Assembly members on a Council will be responsible for presenting the Council opinions to the Assembly.

Dr. Zarling discussed mentorship. He encouraged new Area Council members to partner up with members that had been on the Area Council for some time.

Matt Sturm gave a report from the APA staff and from his position in the Department of Government Relations. Dr Wang joined the APA as the new Director of Research. The Fall Component meeting will be September 9 – 12. The Assembly will meet the end of October this year. The State Government Relations infrastructure will be upgraded to include four regional coordinators. A State Government Relations Director was hired, Brian Smith (bsmith@psych.org) who will bolster the work being done by Janice Brannon and Pamela Thornton. They will staff the State Advocacy Conference. It was noted that Alaska is in a transition state and needs help soon. The Tim Murphy Bill was discussed as well as the insurance company mergers.

The Awards Committee brought the Old Business of Chuck Burgess receiving the 2015 Bill Richards Award. Lex von Hafften eloquently laid out the case for ratifying the tentative decision of the Spring Assembly. The vote was delayed until this meeting to give other DBs an opportunity to advance other candidates. The selection of Chuck Burgess of Alaska to receive the 2015 Bill Richards Award was approved by the Area Council. Lex von Hafften stated that he would personally present the Award to Dr. Burgess as he is in very poor health. Matt Sturm gave the Certificate to Dr. von Hafften to present to Dr. Burgess in a timely manner.

Dr. Hunziker reported that the Procedures Committee will be reviewing the Area Council Procedural codes. A copy of the Area 7 Procedural Code was distributed eletronically to the members for comment and suggestions. Dr. Hunziker is the point person on reviewing the by-laws of the Area Council.

Dr. Zarling reported that the $5,000 fund of the Area Council Corporation has been resolved. It was acknowledged the inordinate amount of time and dedication that Dr. Zarling expended in making this happen. Dr. von Hafften moved that the Area 7 Council Corporation be desolved DISOLVED. The fund was started in the late 1980's with a Rep from Colorado and a Rep from Alaska. The motion was approved.

Rules Committee – no news

Nominating Committee – Drs. Price and Parish asked for the Council members to send any names that should be considered for the Assembly Officers to them.

Public and Community Psychiatry – Dr. Gise. No report.

Follow-up from the May Council meeting. Psychiatric Boarding was being reviewed by Psych and the Law and CAGR. 12.B Civil Commitment Hearings was sent to JRC and referred to Psych and the Law and CAGR

APAPAC – Dr. Price. The rollout of APA-CAN was discussed. This is an initiative to pair up every member of the House and Senate with an APA member. Also the initiative to follow the lead of the Assembly Executive Committee and have 100% of Area 7 contribute to the APAPAC. Area 7 is one of the leading Areas in this effort to date.

Dr. Zarling asked if there were any Action Papers from members of Area 7 in the formative stages. Nothing current. ECP author is asking APA to work with ADPERT AADPRT to increase buprenorphine training in Residency.

Dr. Jerald Block, a member of the Oregon DB and a guest of the Area Council, spoke on the concen of the security of EMR psychiatry notes. Concerns about access and liability, inpatient versus outpatient, affecting outcome among other points. Dr. Zarling will send a note to leadership about the Area concerns on this matter.

MUR Report – Dr. Nahulu. Dr. Rao is unable to assume the Chair so Dr. Nahulu was elected to Chair. Discussed MUR BoT/Assembly issues. There are 7 caucuses with variable inclusion/exclusion criteria. The MURs support diversity, in its many forms, in national offices. The MUR Committee is looking to strengthen MUR engagement at the DB level as well as increasing membership and increasing the acivity of MUR members in the APA.

RFM- Dr. Jones. The RFMs had two meeting. MEETINGS Discussed were voter turnout for the Federal NATIONAL APA elections. They want to increase interest in participating in this process from an RFM perspective. They may put forth an Action Paper sugesting a dues reduction if there is duel membership in the AMA. They are looking at the equality of licensues

for IMGs as well. The RFM Trustte TRUSTEE is the editor for the Resident Column in Psych News.

Area VII Trustee Report to Area VII.
Highlights of the APA Board of Trustees Meeting
July 11-12, 2015
Arlington, Virginia

Greetings Area VII. This report is on some of the highlights of the business covered at the July 11-12, 2015 APA BOT meeting.

Everyone as usual introduced themselves and their conflicts of interest. New high level staff were introduced, including new Director of Political Affairs (APAPAC) Ashley Mild.

Legal Briefing – We were all reminded of our Fiduciary Responsibility to the APA: Not just a legal duty but a statutory duty to the entire membership. Views are heard but not represented. (Ie: Although I was elected by Area 7, just like every other Board Member, I represent ALL APA members).
Duty of Care: must be informed or ask questions, and vote must be in the interest of the APA
Duty of Loyalty: Put APA first. Must disclosed conflicts of interest, which may include more than just money, and recuse oneself if cannot vote independently of conflict. Don't blindside APA if aware of an issue that will affect it. Confidentiality. One voice. Dissent must be recorded in the minutes.
Duty of Obedience: Must follow all federal, state laws and APA bylaws. Must know our Bylaws and Procedural Code. The other apa got in big trouble for not obeying the law in the best interests of their members. Statutory duties include fiduciary ones.
Insurance covers unintentional breaches or mistakes, but will not cover you for fraud, or willful mistakes.

President's Report:
Telepsychiatry Committee will present at IPS.
Patrice Harris was elected to Chair Elect of the BOT of the AMA (the path to the Presidency).
Affordable Care Act affirmed by the Supreme Court.
Marquee Event of the APA is well on its way: A "Stepping Up" Summit April 17-19, 2016, Mayflower Hotel, is an APA-APAF event bringing together 350 of the nation's thought leaders on mental illness in those incarcerated: Psychiatrists, Judges, Police, etc. APEX (American Psychiatric Excellence Awards) will be given out: (In Public Policy-a politician, In Public Education-a journalist, in Raising Awareness-a Celebrity, in Local Leadership & Community based Advocacy).

NYT Article July 11, 2015 on the leadership of the American Psychological Association shielding the torture perpetrated by the DOD DoD written by Steve Reisen has received a great deal of media attention. Steve Sharfstein alerted us from England, of an inaccuracy in the editorial of it, which through the efforts of our media team was corrected within hours on the

online version, and through which we remain on good terms with the NYT.

APA Headquarters Move: Our lease on the Arlington building is up in 2017. In March, the BOT voted to consider the purchase of a building in Washington DC.
We are now in the optimal position of having an opportunity to lease for 2 years a building in DC for less than what we are paying for our current space in Arlington, with an option to extend the lease or to buy at the end of those 2 years, 4 years from now. The BOT voted to go ahead with purchasing a 2 year lease on the DC property.

Finance and Budget: The BOT voted on modest fee increases on CME courses in all categories for the 2016 IPS (with residents allowed a resident member discount at the time of registration if they claim or join membership), modest increases in fees for the IPS, and modest increases in the registration fees for the 2016 annual meeting.
BOT voted to approve a 2 year pilot project of discounts for groups that bring in new members, both international groups as well as domestic groups like hospital systems.

CEO Report: DSM 5 Includes the ICD 10 codes, so educate your colleagues about the benefit of DSM 5 in coping with the ICD 10 use requirement starting in October. New APA logo is being very well received. If speaking on behalf of APA, please contact Jason Young about incorporating our logo in your slide set. Annual Meeting in Toronto very successful with 10,800 attendees. Membership continues to grow overall, with very robust growth in International membership. Legislation: Confirmation of the constitutionality of the ACA includes wins for psychiatry and mental health care. Congressmen Murphy and Johnson are re-introducing their mental health bill that includes measures with great promise for improving the mental health of the patients we serve.

Registries: If you can't measure it, you can't improve it. Numerous entities (congress, payors, patients) are now demanding concrete measures of improvement. What is clear is that if we don't establish our own standards of measurable improvement in medicine, than THEN others will, and that specialties that have adopted them (Ophthalmologists, Neurologists) are showing measurable improvements in the outcomes of their patients through establishing registries. Although numerous challenges exist, including cost, and perhaps more concerns for psychiatry about confidentiality, the BOT voted to have the APA administration develop a business plan to explore how we might create registries for quality improvement for psychiatrists.

DSM Steering Committee: The BOT voted to approve
1) the "Format for Submissions of Proposed Changes to the DSM"
2) the Creation of six DSM Review Committees
3) several corrections to DSM 5 that were needed

Communications:
Website Transformation Project
All content will flow through a single point of contact to ensure relevance, appropriateness and audience focused placement.
The Team that has been assembled to work on it have collectively built over 70 websites.
Soft launch late August/early September, but it will not be heavily promoted till 2 weeks later to

correct glitches.
Features/Goals:
Audience focus (Psychiatrists, Residents and Medical Students, Patients and Families) then by topic, and not by component/department
3 Click navigation max
Mobile compatible

In closing, it continues to be a great privilege to serve as your Area VII Trustee this year on the APA BOT. On every matter brought before the Board I have voted in the same manner as always: What decision is in the best interest of each and every one of us. Thank you for your support of my efforts on your behalf.

As always, please don't hesitate to contact me at jakaka@gmail.com, or on my cell at 1-808-341-3472.

Aloha, best wishes, and safe travels to Portland in August.

Respectfully submitted,

Jeffrey Akaka, MD
Area VII Trustee
Board of Trustees, American Psychiatric Association

District Branch reports were received and discussed and follows:

RFM REPORT

- We've had two meetings thus far, primarily introductory.
- APA Elections
    - Voter turnout for residents is very low with less than 10% of residents voting.
    - Have discussed ideas as to how to increase this turnout, including involving e-mailing chief residents in all the residency programs encouraging participation. However, feedback from the chief residents is that residents feel largely disconnected from the APA, so we've been discussing ways to improve this with discussions in very early stages.
- RFM Representative Selection
    - Currently, each area elects RFM representatives using different procedures, and some of the areas typically appoint residents from the same programs/states.
    - Reviewing these procedures to see if there is away A WAY to increase exposure for residents in less represented programs/states/district. May suggest new appointment procedures in some areas.
- Action Papers
    - Buprenorphine training- Make certification for buprenorphine prescribing a part of residency.
    - Decreased dues- Proposal for a lower dues rate for residents in both the APA and AMA to encourage membership.

    - Addicts can sue providers- Earlier this summer the West Virginia Supreme Court ruled that addicts could sue their doctors and pharmacists for their addictions, highlighting over-prescribing and lack of prevention of doctor shopping. Requesting APA put forth a statement warning of the possible harmful implications of this.
- Psychiatric News "Resident Forum"
    - Our current RFM Trustee is the editor of this column and put out that he looking for submissions from residents for this column, which is printed biweekly.
    - Submissions can be sent to mshahmd@gmail.com and are reviewed in the order they're received.

Submitted by Kelly Jones, MD RFM Rep

Area VII Council
American Psychiatric Association
Alaska Psychiatric Association
Report: August 8, 2015

District Branch Well Being
Membership continues in the low 60s. Finances are stable. The district branch does not have a lobbyist. Currently all executive positions are filled. Dr. John Pappenheim is the new Assembly Representative. The district branch has a new website and is updating the bylaws.

Annual CME Meeting
The 22st annual CME meeting was held April 10-12 at the Hotel Alyeska in Girdwood. The meeting was a success. Dr. Saul Levin gave a presentation on assertive community treatment and assisted outpatient treatment. Dr. Levin presented Dr. SR Thorward the 2014 Area VII Bill Richards Award.

Medicaid Expansion
The Alaska legislature was unable to agree on the 2016 capital budget or operating budget during regular session. The 2016 budgets passed during special session. The legislature did not bring bills regarding Medicaid expansion to the House or Senate for a floor vote. Last month Governor Walker announced moving forward with Medicaid expansion despite lack of legislative leadership support.

Workforce
Since 2012 Alaska has focused on student loan repayment and direct incentives to fill high priority, hard to fill, health profession vacancies including psychiatrists. Funding for psychiatric resident training ended last June. The Psychiatry Workforce Committee (formerly the Alaska Psychiatry Residency Development Steering Committee) has no leadership.

Marijuana
Alaska is developing a process to regulate and to try and profit from the sale of marijuana.

William W. "Bill" Richards Award

The district branch nominates Charles Burgess MD MSW for the Bill Richards Award. Dr. Burgess joined the APA in October 1989. During the 1990s he was Chief of Service at Providence Alaska Medical Center. He did inpatient, outpatient, CL, and community education and outreach. About 15 years ago he moved to Homer, Alaska. He was the psychiatrist for the southern Kenai Peninsula and the Kachemak Bay serving remote and isolated communities. He interfaced with clinics, critical access hospitals, schools, libraries, and courts. Dr. Burgess was Public Affairs representative for the district branch. He met with legislators, state administrators, community leaders, and the media. In 2009 he was diagnosed with glioblastoma multiforme. He stepped down in 2014.

Respectfully submitted,
Alexander von Hafften, M.D.
Assembly Representative,
Alaska Psychiatric Association

Arizona Psychiatric Society (APS) Report for Area Council, August 2015 Legislative issues:

1 Scope of Practice – Psychologists did not file for prescribing authority in the Sunrise process for 2014-2015. Despite concerns for the Sunrise process in Arizona, the leadership of the Arizona Psychological Association have reported to the APS Lobbyist that they will honor the process and any future filings will continue to honor the Sunrise process. The Society has not heard any confirming word that there will be a filing in this cycle, and will know for certain on the September 1st filing deadline.

2 Budget – The original projected Arizona budget had a 5% provider cut for Medicare projected in order to balance the budget. Thanks to the better financial performance of the budget, and strong lobbying efforts by all physician groups on the topic, that provider cut has been waved off. Arizona lags behind most of the US on financial recovery and its budget had a large projected shortfall as a result.

3 Lobbyist- A full time lobbyist, Joe Abate Esq; is funded by APS membership dues and represents the APS.

4 State DB PAC- There is no DB PAC

District Branch Activities: The Annual Spring Meeting was held on April 18, 2015 at the Scottsdale Resort & Conference Center. Participants were eligible for 8 hours of Category 1 CME Credit (accredited through joint providership with the APA). Course registration was free for AZ DB members with a discounted fee of $150 for collaborating society/ArMA/AACAP members and $250 for non-members (which fee could be applied towards APS dues if the attendee joins the APA within 60 days of the meeting). This meeting had over 130 participants in attendance. The Friday evening social and awards reception was sponsored by the American Professional Agency, Inc. Because of higher than normal resort fees, the meeting came out at a loss to the Society, although Exhibitor income remained steady from the prior year. Planning is underway for the 2016 Annual Meeting.

The Society applied for and was awarded an APA expedited grant. A Committee has been formed with ECP leadership to create an event that will have a focus on ECP engagement but will invite all members to participate.

Some Society leadership has expressed an interest in an update on ICD-10 for the Fall.

Membership Status: Membership holds steady. The current number of dropped members is at 28 and efforts are continuing to be made to pursue the reinstatement of those members. Continued efforts on engaging residents in Arizona are being supported by in-person presentations in the Fall.

Financial status: The DB remains in stable condition financially. The APS Lobbyist requested a raise, but after review and analysis, the DB did not approve the raise request. If lobbyist fees rise in the future, it could require considering a dues increase, which the DB does not want to have to enact upon its members.

Management and work structure: Part-time Executive Director is employed through ArMA, the state medical association. The contact with ArMA has been updated, and APS is now being billed for photocopies and postage and the administrative fee was raised by $135 per month in light of the increased volume of work over the past two years being provided by ArMA.

Physician Leadership: The Executive Officers of the Society move up the ladder from Secretary to President and then serve three more terms as Past President. Officers were elected at the Spring Annual Meeting. Dr. Roland Segal moved up to President. President-Elect Gurjot Marwah would normally serve as Deputy Representative pursuant to Arizona Bylaws. As a result of the Assembly restructure, Dr. Marwah will serve as the second Assembly Representative, and a Bylaw amendment will be prepared so that Arizona Bylaws reflect the new Assembly representation. Arizona elected Dr. Payam Sadr (Past President of APS) as its first Assembly Representative, to serve a two-year term from 2015 to 2017. We are very thankful to Dr. Jay Bastani for his service as Assembly Representative from 2011 to 2015. He has agreed to serve as our Ethics Chair.

Rebranding. After reviewing the presentation materials from the APA, the Arizona Executive Council voted to retain its brand but to pursue some updates to make it more cohesive in appearance with the APA brand in terms of type font, appearance, and color.

State News: In May of 2015, the Centers for Medicare and Medicaid Services completed an inspection of the Arizona State Hospital and the report of their findings found several deficiencies. Arizona put a new leadership team in place, and they've been busy putting together a plan of action to address and improve all of the areas identified in the CMS report. In July, CMS notified ASH that their corrective plan has been accepted.

As a streamlining measure, legislation was enacted that transfers the roles and responsibilities of the Division of Behavioral Health over to AHCCCS. This is part of the administrative simplification plan proposed by the Governor. The switch becomes effective July 1, 2016.

Reported earlier, the University of Arizona Health Network (UAHN) and the University of Arizona (UA) completed their merger with Banner Health, creating a statewide health care organization and a comprehensive new model for academic medicine. The related transition of 6,300 employees working at UAHN's two hospitals, the health plan and the medical group into Banner will create Arizona's largest private employer with more than 37,000 employees.

Psychiatric Training Program: The training programs in the State remain unchanged. The Tucson Psychiatry Residency programs under Dr. Ole Thienhaus leadership have facilitated the increased participation of Tucson members. The MIHS Psychiatry Residency Program under Dr. Carol Olson has the largest membership, having attained Silver Level, 100% Club Status in 2014.

Specific Member Concerns re: APA: Building and developing the membership of APS, with the support of the APA, continue to be a specific concern and focus.

Respectfully submitted,

Payam M. Sadr, MD, FAPA Gurjot K. Marwah, MD Arizona Assembly Representative
President-Elect and Arizona Assembly Representative

Colorado Psychiatric Society
August 2015 District Branch Report

Office Staffing
At the end of May, CPS bid a fond farewell to Laura Michaels, the CPS Executive Director of over 20 years and welcomed Associate Director Anna Weaver-Hayes into the position.

Website/Database
CPS conducted a major outreach to members to update CPS Membership Directory and searchable online membership database available in the password-protected Members Only section of our website. We added new sections such as population served, specialties and a checkbox for whether or not members are accepting new patients.

2015 Spring Meeting
Multiple members received awards at the Spring Meeting and Dr. Patrick Fox presented, "The Times, They are a Changin': State and National Developments and Trends in Behavioral Health Care Delivery." Dr. Fox is the Chief Medical Officer for the Colorado Department of Human Services and Acting Director for the Office of Behavioral Health and he educated attendees on new initiatives by the State and Federal Government that affect psychiatry.

Mental Health Stories
There is no better way to counter stigma than to tell stories that include examples of effective diagnosis, treatment, empathy and support from family, friends, employers and a therapeutic community. The Mental Health Stories project was born out of this observation in 2012 as a partnership between the Public Information and Education Committee of CPS and the CHARG Resource Center. The project is in its fourth year now and wanted to broaden its impact by inviting Peer Specialists to play an active role in the contest. In June, a dynamic group of Peer Specialists joined CPS and CHARG members and staff to discuss how to encourage more entries and update the prompt and entry form.

Financial
CPS continues to be financially solvent.

Legislative
Key bills of interest to CPS before the 2015 Colorado legislature included:

HB 1029 – Healthcare Delivery Via Telemedicine Statewide – On 2/19, the Senate Health and Human Services Committee amended, approved and referred this bill to the Senate Floor for 2nd Reading. The bill removes the population restrictions regarding the delivery of in person health care and precludes a health plan from requiring in person care when tele-health care is appropriate. The Committee added an amendment that "tele-health will not be used when a provider determines that it is not appropriate or when a covered person chooses not to receive

care through tele-health". Colorado Assembly Representative Dr. Charlie Lippolis testified in support of the bill on behalf of CPS.

HB 1135 – Terminally Ill Individuals End of Life Decisions – On February 6th, the House Public Health Committee took over 11 hours of testimony. The bill did not move forward. CPS did not take a position in support or opposition of the bill, but we did work with the sponsors and the Colorado Psychological Association on an amendment to strike the word "counseling" and replace it with "capacity assessment" as that more accurately describes would actually be done by the psychiatrist or licensed psychologist who does the evaluation.

Summer Activities:

CPS members had the opportunity to meet with U.S. House Representative Diana DeGette at her office near Capitol Hill on June 8th, 2015 to discuss issues of concern to CPS and APA and to learn more about her current legislative interests. Liz Lowdermilk MD, CPS President-Elect, and legislative committee members Patrick Fox MD, George Kalousek MD and Jennifer Hagman MD, along with CPS executive director Anna Weaver-Hayes, MA, and Debbie Wagner, our CPS lobbyist, attended the meeting. Congresswoman DeGette was quite welcoming and interested in the issues of concern to us. She is in the lead role on the 21st Century Cares Act, which addresses many health care issues including NIMH funding and improving access to promising interventions (https://degette.house.gov/21stCenturyCures). This act recently passed overwhelmingly in the House with bipartisan support and now heads to the Senate.

CPS partnered with the Colorado Medical Society and the Colorado Academy of Family Physicians to provide feedback on the definition of experience to the Colorado State Board of Nursing in response to Stakeholder Discussion about SB15-197 Concerning the Prescriptive Authority of Advanced Practice Nurse.

In a victory for CPS and for science, the Colorado Board of Health voted 6-2 to refrain from adding PTSD to the list of medical conditions for which marijuana can be prescribed. CPS successfully presented the position that medical marijuana policy and practice should not be altered until research has been conducted demonstrating safety and efficacy. Dr. Doris Gundersen testified that due to lack of solid empirical evidence and the ethical obligation of to do no harm, CPS cannot currently support the use of marijuana in the treatment of PTSD. Dr. Gundersen was quoted on the front page of the Denver Post, interviewed by 9news and CPS Legislative Co-Chair Jennifer Hagman was also interviewed on the topic by 7news.

Submitted by Charlie Lippolis, DO, Rep. Colorado

HPMA Report to AC7 – Leslie Hartley Gise MD, APA Assembly Rep
Mission: Helping Hawai'i's Psychiatrists Provide the Highest Quality Care
Membership: 178, up 6% from 12 mo ago, 18 on Drop List.
Outreach: 2 members are reaching out to private practice psychiatrists to attend meetings
Monthly Meetings: 10-17 attending, much improved over the past few years. Hot topics,
Ethics, Cognitively Impaired Physicians, Buprenorphine, Recreational Marijuana, Network Adequacy

Remote meeting access: Monthly membership meetings are available via GoToMeeting. We have a new administrative assistant to help with remote connections.
Educational/recruitment dinner 3/5/25 for ECPs/MITs - "Pharmacogenomics in Psychiatry"
NAMI: Book signing event and discussion by HPMA member 3/19/15, introduced by President of NAMI HI, of novel by woman born in HI who grew up with 2 schizophrenic parents, Terri Morgan, The Genetic Lottery 3/19/15
Social: End-of-year lunch 4/19/15
APA DB Membership Committee Meeting - After the meeting in Toronto, HPMA filed the requested report to Susan Kuper (APA Membership) about our outreach project.
Diversity: We are the diversity capital of the US.
Website: The HPMA website is really good. Possible update of HPMA logo with new APA logo.
Referrals: APA has a database for referrals, http://finder.psychiatry.org
Staff: SBI has added new staff, administrative assistant and client services coordinator
Legislative:
State Advocacy Conference: 2 members will attend in FL 10/2015
Scope: A state senator did not schedule a hearing for the crash course prescribing bill
2 members wrote a letter to the editor of the Honolulu newspaper "Psychiatrists Not Psychologists Should Prescribe Medications"
MH Access: The state House introduced a resolution for a MH Task Force with an auditor to study workforce, standards and improve access but it was not funded, so deferred.
DB Innovative Grant: Outreach to Hilo and Kona on the Big Island, community presentations in Libraries, May 2015.
Finance: $83,000, drop from using grant money.
RFM Dep Rep: Trisa Danz substituted for the substitute in Toronto on extremely short notice. Dr Gise personally thanked all the faculty and staff who covered for her.
Communications and Public Affairs:
Torture: The relationship between the American Psychological and torture blew up in the media. Pat DeLeon is a HI psychologist who could not get into medical school three times. He was on the staff of our very powerful former US Senator and started the crash course prescribing movement. In 2000 he became President of the American Psychological and directed their staff on policy and dominated their governance on political affairs. After American Psychological members filed a class action lawsuit accusing him of fraud the American Psychological established a $9 million fund to pay members who were misled into paying for lobbying. De Leon helped set up the CIA torture program in 2001-2004, and got the American Psychological to change their ethics code to allow it. For over 25 years he strongly encouraged and closely coordinated relationships between the American Psychological and the Department of Defense. APA banned psychiatrists' participation in interrogation of detainees in 2004. DeLeon is Distinguished Professor, Uniformed Services University in nursing, medicine and pharmacy and at UH in nursing, law, and pharmacy, and member of the Institute of Medicine. American Psychological continues to honor graduate students with the Patrick H DeLeon Prize.

Idaho District Branch Report – August 2015

Membership Status

- Membership remains stable with a total in the mid-60s.

Financial Status

- While the District Branch's financial status has stabilized, it continues to be an ongoing concern that requires diligence going forward. The membership dues for the DB were increased in 2015 to ensure the financial viability of the branch. Fellow and Distinguished Fellow dues were raised from $100 to $125 annually.

Education

2015 Annual Conference: The 2015 Annual Conference was held April 24-25 in Boise. The topic of the conference was Integrating Behavioral Health and Primary Care: Collaborative Care Principles and Practice presented by Anna Ratzliff, MD, PhD from the University of Washington, Department of Psychiatry and Behavioral Sciences. The annual business meeting was held in conjunction with the CME conference. There were 30 registrants and the evaluations were very positive.

Planning has begun for the 2016 Conference which will be held April 22-23, 2016 and the topic will be Evidence-Based Psychiatry.

Legislative Issues: The 2015 Idaho legislative session was notable as the Idaho Psychological Association brought forth a bill seeking prescribing authority - SB1060. The bill was introduced in the Senate and heard by the Health and Welfare Committee. It was forwarded to the Senate with a "do pass" recommendation. It was then was voted on by the Senate and passed by a vote of 26-8-0. The bill next went to the House of Representatives Health and Welfare Committee. The chairman of that committee elected not to have a hearing on the bill and it went no further. It is notable that the chairman of the Health and Welfare Committee is a physician who had voiced opposition to the bill from the start.

The Idaho Psychology Association received substantial funding from the American Psychological Association to move the bill. At the Senate Health and Welfare Committee hearing, Marlin Hoover, PhD, a prescribing psychologist from New Mexico along with a prescribing psychologist from the US Public Health Service testified. The proponents stressed access to care (noting long waiting times to see psychiatrists) and that this wasn't a patient safety issue as no reported cases of patient harm by prescribing psychologists have been reported.

The Idaho Psychiatric Association believes that support from the medical community at large will be a key factor in defeating potential legislation going forward. We drafted a resolution that was presented to the Idaho Medical Association House of Delegates at the IMA Annual Meeting in July. The resolution establishes IMA policy opposing prescriptive authority for Idaho psychologists and directs the IMA to support our efforts to inform, educate and lobby against the granting of prescriptive authority for Idaho psychologists. The resolution was adopted.

In order to successfully counter the efforts of the Idaho Psychology Association in the 2016 Legislature, the IPA has applied for a CALF grant from the APA. This will allow us to contract with a lobbyist to execute an educational/informational campaign directed at legislators to educate them about medical training vs social science education and lobby during the legislative

session to accomplish our goal of defeating further legislative efforts to allow psychologists prescription privileges.

The IPA would like to thank our colleagues in Area 7 for sharing much-needed resources and support as we face this challenging legislative issue.

Other Updates
An IPA member recently completed a site visit to St. Luke's Behavioral Health Clinic in Twin Falls. The clinic is a semifinalist for the APA's Psychiatric Services Achievement Award.

Two IPA members will be attending the APA's State Advocacy Meeting in October.

Respectfully submitted

Zachary Morairty, MD, Area VII Representative

ECP Report to the Area 7 Council August 9,2015

Submitted by Joshua Sonkiss

The ECP committee does not meet for the first three months after the Annual Meeting, so there is nothing to be reported.

Montana DB Report to the Area 7 Council August 6,2015

Submitted by Joan Green

Montana now has an Executive Director who is quite active in passing messages, working on membership and applying for grants. We have applied for 3 grants and have received $7600 so far with a third grant pending. Membership is fairly stable. We are working on calling Doctors that are about to be dropped.

We are working on ways to offer CME to MT Psychiatrists and to generate some income.

Not much else to report, looking forward to seeing everyone in Portland.

Submitted by Joan Green, MD Rep. Montana

Nevada Psychiatric Association

District Branch Report to Area VII Council
August 8-9, 2015

Portland, Oregon

NPA Management: We held our annual one-day retreat for DB leaders in July to discuss long-term planning and goals, get a presentation from our new website designer, plan our budget and discuss updates to our constitution and bylaws among other things.

Membership Status: Our membership is stable. The drop list from the APA was reviewed by our executive council and all those on the list still in our state were called.

Financial Status: Our financial status is stable. We regularly evaluate our financial priorities, balancing savings with DB needs, member needs, community needs and advocacy.

Member Services: We have Northern (primarily Reno) and Southern Branches (Las Vegas), and each meet monthly. The Northern Branch had it's July meeting at the DB President Elect's home and included a reception for incoming residents. This was well attended and will hopefully strengthen our bonds with our northern university and it's residents. In addition, gifts of books or software were given to all first-year residents in our state.

Community Activities:

We allocated money to help fund a NAMI program that pays for dental care for the mentally ill.

Legislative and High-Profile Activities:

Our legislative session ended with the passing of a Tarasoff bill, an expansion of who can involuntarily detain mentally ill people and who can release them, and a requirement for suicide prevention CME.

Submitted by Phil Malinas, MD Rep. Nevada

New Mexico, DB 67 - Highlights
Update for Area 7 – August 8, 2015 Meeting

Community Activities & Member Services:

The Psychiatric Medical Association of New Mexico (PMANM) held a training/ seminar on May 2, 2015 for all NM mental health providers. The seminar was well received and included speakers who were key physicians who had expertise on the topics of: Resident training, Health Reform, Affordable Care Act Requirements & ICD-10 training. PMANM once again promoted The Roadrunner Food Bank and collected 30 pounds of food and $135.00.

The next membership meeting is scheduled for September 2, 2015 at the New Mexico Medical Society. The topic will be "Medicinal Marijuana – Pros and Cons". Invitations will go out to all mental health providers in New Mexico. Since there is so much to cover on the topic, it was decided that there will be two separate meetings – Part A - Scope of Utilization of Marijuana for

Medical Purposes, scheduled for September. Part B will cover the Legalization/Decriminalization aspect of Marijuana, which will be scheduled later in the year.

The meeting in September will focus on the psychiatric aspect of marijuana; including, cancer, glaucoma and palliative care. The speakers will include experts in the field and will be a roundtable forum having speakers that are both pro and con. PMANM is working on bringing in an expert from Colorado to discuss the experience of marijuana legalization in that state. The goal of the meeting is to have a fair and informative debate on the marijuana issues in New Mexico. It is also important to let everyone know that the topics discussed, are not necessarily the views of PMANM

Three new members joined the executive council. Dr. Pamela Arenella, new Councilor Member, Dr. Dany BouRaad and Dr. Sammie Moss will represent PMANM as the new Resident Representatives. We welcome them!

New Mexico welcomes a new Assembly Representative, Dr. Reuben Sutter. Unfortunately, he will not be available to make it to the Portland meeting in August.

PMANM sent out invitations to members who were chosen from an APA list, eligible to apply for Distinguished Fellowship status. Applications were reviewed in May by the Executive Council. Three applicants; Dr, Cynthia Geppert; Dr. John Evaldson, and Dr. Kathryn Fraser's applications were approved by the Council and forwarded to APA for final consideration.

PMANM will continue to collaborate with Mesilla Valley Hospital in Las Cruces to reach the psychiatrists in the southern part of the state. Dr. Parish travelled to Las Cruces to train on ICD-10, DSM5 and Ethics and Cultural Competency Training at Mesilla Valley Hospital on July 10, 2015.

The Executive Council is working with three PMANM members who are working on a Position Paper regarding "Central American Asylum Seeking Children & Families in need of International Protection". Drs. DeLuca, Larroque and Leckman have proposed that the paper be introduced at the Assembly. Before the paper can be brought to APA, the council did make recommendations on the position paper regarding the detention of children and mother. A conference call will be held on August 18, for more discussion regarding the needed changes.

<u>Financial Status:</u>

The Financial status of the district branch continues to be healthy. Our annual expenditures have been kept low and consistent.

PMANM received an expedited grant from APA for $2,678.57, which will be used for membership recruitment and retention, membership/resident training and CME. We are grateful to APA for their generosity.

Legislative Update:

The Scope of Practice Act was introduced in the 2015 legislative session and was passed by both the House and the Senate. Once it got to the Governor's desk, it was pocket vetoed. The sponsor of the bill is Representative Terry McMillan (who is also a NM physician in Las Cruces) is in the process of re-writing the legislation and will plan on re-introducing at the 2016 Legislative Session.

Senator Papen's bill on Assisted Outpatient Treatment Act did not pass.

The Medicaid Bill regarding the accused fraud did not pass.

There was earlier discussion that the psychologists were going to pursue legislation regarding prescribing authority during the 2015 legislative session. John Anderson, PMANM's legal counsel, heard through the grapevine that the psychologists did not pursue dropping the bill this year, and may be waiting to see what transpires with HB-122 - The Scope of practice Act. This act would require that any proposed changes to the scope of practice of a health provider be systematically analyzed, researched and vetted before those proposed changes can come before the legislature.

PMANM applied for the 2015 CALF grant and was awarded $14,000.00 to help with efforts of stopping any legislation regarding psychologists pursuing prescribing authority during the 2015 and 2016 legislative session.

Dr. Brooke Parish and Dr. Kristine Sowar will attend the Legislative Advocacy Meeting on October 23-25 in Hollywood Florida.

Membership Status:

Membership status has remained steady throughout the past couple years. Membership is at 177. Transfers in and out of the state have balanced out. There were 6 members on the drop list in 2015. PMANM will focus on reaching out to the residents, and will also reach out to psychiatrists who are not members in the outlaying counties. Members of the executive council plan to travel to different parts of the state to hold casual gatherings in a roundtable forum with members and nonmembers alike to better communicate the benefits of PMANM and APA and find out what their issues are and how they can be addressed. The first visit is scheduled in late summer.

Coalition Building

Richard Gonzales, MD with the NMPA has collaborated with PMANM and other professional organizations in discussing a plan to help support HSD through on-going planning and problem solving regarding the behavioral health system, and addressing the problems of the Medicaid system. So far, out of the two meetings, all organizations have come up with important topics for discussion. The next meeting is scheduled for August 15, 2015 for everyone involved to come together more strategic planning.

Physician Leadership – Resident Training "Beyond Residency":

Resident membership continues to grow at a successful rate. Two residents signed up to be Resident Representatives for the Executive Council. The next 'Beyond Residency' is scheduled for September 30, 2015 at the medical school at UNM. PMANM will reach out to those residents who are not APA/PMANM members.

Respectfully submitted

Brooke Parish, MD
Area VII Representative

Area VII Council
Oregon District Branch Report

Membership

Membership remains around 400, the Membership Committee has started developing different strategies to increase the numbers, including looking into North Carolina Psychiatric Association, the DB that received District Branch Best Practices Award for their successful efforts to improve retention among DB members.
The membership committee has a new staff person who is also working on qualifying members for distinguished fellowship and fellowship.

Financial Status

During the Presidency year led by Dr. Annette Mathews our DB was under significant financial pressure with the question if even some of vital functions could remain. Dr. Mathews was able to work successfully with Executive Council members and the Executive Director and through multiple steps and actions improve our financial status.
Currently the association is meeting all of its expenses on time. We have been able to build back our reserve and legal funds, even though we have not reached the goal yet we are on the right truck.

Legislation

Our Legislation Committee continues to be very active, Dr. Daniel Dick, the committee chair, prepared a report for our Area meeting.

Session concluded in early July-many of the issues OPPA was monitoring were tabled until 2016-2017. The interim will be used to work on issues surrounding civil commitment issues, payment reform, and prescription drug coverage of mental health drugs.

The brief list of bills that OPPA watched/weighed-in and their outcome:

HB3347 (PASSED): The original text of this bill made multiple changes to the references in statute of gravely disabled. The bill was amended after receiving significant opposition and the version that passed expands the "person with mental illness" definition to include "unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm" language.

HB3427 (DID NOT PASS): The bill originally created a tiered payment system for insurance companies when reimbursing for mental health services. Physicians would have been at 100%, psychologists at 95%, and social workers and therapists at 80%. OPPA was supportive of this concept, which was introduced by the Social Workers. The psychologists however opposed the bill and the language was replaced with task force requirements. The psychologists continued to oppose the bill, even as a task force, and sources indicate that there will be similar bills to the original version of 3427 introduced next session.

SB132 (DID NOT PASS): The would have expanded the crime of assault in third degree to include physical injury to health care provider in hospital. The bill was sent to the Senate Health Care Committee where it was amended to define health care provider as a person who provides or assists in providing health care services in hospital. The bill had a subsequent referral to Judiciary so after it passed out of the Health Care Committee, it had a hearing in the Senate Judiciary Committee and never moved out to the Senate floor.

HB2222 (DID NOT PASS): Provides that Oregon State Hospital may not procure psychiatric treatment for patients at hospital by number of physicians employed by or contracting with Oregon Health and Science University that is in excess of 25 percent of total number of physicians who provide psychiatric treatment at hospital. This bill was referred to Ways and Means where it died.

HB2307 (PASSED): Prohibits mental health care professionals and social health professionals from practicing conversion therapy if recipient of conversion therapy is under 18 years of age.

HB2948 (PASSED): The bill clarifies additional conditions under which a healthcare provider may disclose protected health information for an individual being treated for mental illness, without obtaining an authorization from the individual or a personal representative. The final version of the bill ensured that the provider not only had protection if they choose to disclose but also that they would not face liability concerns for choosing not to disclose. The legislation was cited as the Susanna Blake Gabay Act.

District Branch Activities

<u>CME Accreditation</u>

During our March meeting I reported that the Institutional Accreditation Committee (IAC) of the Oregon Medical Association (OMA) completed its accreditation survey of the Oregon Psychiatric Physicians Association continuing medical education (CME) program and on February 9, the OMA IAC placed the Oregon Psychiatric Physicians Association's program on Probation.

We have been working with OMA since, one of the OMA requests was that OPPA sends representatives for continuing medical education workshop requiring thousands of dollars to be paid in fees.

Since then there has been a change in staff at the Oregon Medical Association including a resignation of the staff person that handles accreditations.
OPPA continues to be under probationary status until a report is due in August. The program committee and the Executive Director are working on the report, but, by consensus, the council decided to
postpone sending representatives to Chicago for a continuing medical education workshop given the financial burden that would place on the Association.

The progress report detailing the planned necessary steps and actions is required by August 9, 2015.

Performance Evaluations
The Association has initiated staff and the council performance evaluation process, the forms that will be in use are approved by APA and are now official Guidelines of the Association.

Staff Evaluation Process (attached)
Council Self-Assessment (attached)

Advocacy Days
The first OPPA Advocacy Day on April 16th , 2015 was successful. OPPA has been working on HPSP law (Health Professionals Services Program) among other things.
The legislative committee chair, Dr. Daniel Dick, has been engaging members in training as well and he is planning to attend the APA State Legislature workshop with one of our psychiatry residents in October 2015.

CME

28th Annual Fall CME Conference of the Oregon Psychiatric Physicians Association
Resilience: How We Sweat the Big Stuff
September 17-20, 2015 @ Historic Ashland Armory - Ashland, Oregon (information attached)

Respectfully submitted, Amela Blekic, MD Oregon Representative

Utah District Branch Report

Utah Psychiatric Association:

Current members: 147

Psychiatrists in Utah: 340 approximately

This includes retired, residents, and practicing

2015 Rates: $95 – GM 1st, 2nd, 3rd yr in practice

$185 – GM full member

$185 – Distinguished Fellow

$70 – Life members 1 – 5 yrs (multiple categories) (2/3 of full rate)

$61 – Life members 6 - 10 yrs (multiple categories) (1/3 of full rate)

2016 Rates: $95 – GM 1st, 2nd, 3rd yr in practice

$190 – GM full member

$190 – Distinguished Fellow

$127 – Life members 1 – 5 yrs (multiple categories) (2/3 of full rate)

$63 – Life members 6 - 10 yrs (multiple categories) (1/3 of full rate)

Matthew Moench is the current President of the UPA. Paul Carlson is the President elect. Stamatios Dentino is Utahs second Rep to the APA assembly.

Utah Health care:
-New Tax on physicians being decided Tuesday. Because of the short fall of funds to cover the gap of 96,000 patients left without coverage by the decision to not expand Medicaid, Utah government leadership has decided that physician should pay for that short fall. This amounts to over $1000 per physician for year. They will increase the licensing fees as a way to get around calling this a tax.
-New program providing social workers acting as consultants in the University of Utah community clinics. Part of this program includes using a web based system to bring patients, primary care providers and psychiatrist together for more rapid psychiatric consultation.

Optum healthcare (Medicaid provider):

-New Medical director of Optum is a physician known to us in Utah for many years. That means he won't last very long in the Job.

-We have successfully argued denial of inpatient care days before a judge to receive payment from optum.

University of Utah:

-Finally got our new chairman, Jon-Kar Zubieta from University of Michigan.

-shortfall of social worker and nurses at the University.

Submitted by Jason Hunziker, MD, Rep. Utah

Washington State DB 33 – Update for Area 7 Meeting – Portland
8/8-9/2015

Washington State Supreme Court Activity

Psychiatric bed shortage – Ruling said we were approximately 300 beds short statewide. New beds have been created on the West side, but we have had major additional bed losses on the East side due to a shortage of psychiatrists. Applications for a new 100 bed facility in Spokane are being processed for a Certificate of Need from the Department of Health. The earliest this facility would open would be late 2017 and how it will be staffed is still a good question. It will likely require a combination of psychiatrists, psychiatry residents and nurse practitioners. Financial resources were made available by the Governor to start the process and the legislature just approved more mental health funding throughout the system after a double-overtime session that ended the last day of June.

Untimely competency evaluations – Ruling said the State is out-of-compliance with the 7-day requirement, which legally requires competency evaluations to be conducted within a week of the request. Delays have been extensive, often well over 60 days.

DeMeerleer Case – WSPA is joining with our state medical association (WSMA) on an amicus brief in this case that involves a Spokane psychiatrist and a question of fact about a general duty to protect the public from violent acts patients commit, even if the patient did not make specific threats toward an individual and even if the violent act is committed weeks or months later.

Legislative Issues

A mandatory training law for licensed healthcare providers in suicide prevention passed unanimously in the Washington State legislature last year. This includes all licensed physicians. WSPA's Secretary Jeff Sung will be providing the required 6-hour Category 1 continuing medical education program that will fulfill the statutory requirements. This will be a one-time training, whereas the original bill would have required recurrent training.

Legislation passed this year that allows family members to appeal directly to a judge if a designated mental health professional makes a decision not to detain someone to a more restrictive involuntary inpatient setting.

Membership

As of the end of May 2015, WSPA had 558 total members. This was an increase from 527 in April, likely related to our annual Spring CME event at which we offer a registration discount for members. We have approached several members about serving as our third District Branch Representative to the APA Assembly, but no takers yet.

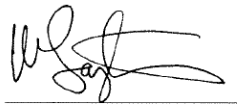
Psychiatry Graduate Medical Education

We now have three psychiatry residents in our new 4-year psychiatry residency program in Spokane. Coincidentally, all 7hospital psychiatrists resigned in June, so we have been scrambling to juggle rotations to keep their educational experience foremost. At this point 5 of the 7 have decided to stay, but we will see a reduction in available beds (12 adult/12 child-adolescent compared to 46 and 24). The remaining psychiatrists have also said they will not take residents or medical students.

Finances

WSPA is financially doing very well at this point in 2015. This allowed our Executive Council to approve a contribution of $2,500 to the joint amicus brief discussed above. We do not expect any particular challenges or shortfalls in the near future.

Respectfully submitted,



Matthew E. Layton, M.D., Ph.D. Rep. Washington State
layton@wsu.edu

Western Canada District Branch Report

APA Area 7
Portland, August 8-9, 2015

Membership

Since June, 2015 there has been an increase in membership of 18, bringing the total to 508. The breakdown by province is: British Columbia 262, Alberta 152, Manitoba 50, Saskatchewan 42. NWT and Yukon both 0.

Our WCDB Annual Meeting is held in conjunction with the APA Annual Conference, this year at the Royal York in Toronto. It is at that meeting that our executive members are elected.

Finances

With the gradual increase in enrollment our accounts have been stable. We have been able to encourage the various local branches to organize events primarily related to psychiatry and/or APA membership recruitment, advocacy and awareness.

WCDB Activities

- The WCDB applied for an APA innovative grant on August 1st. The proposal is to host an educational evening with a keynote speaker (TBD) in Vancouver in March 2016, for purposes of recruiting new members and to cultivate and retain existing members. Four Resident-Fellow members (one from each province) will be engaged by competing for a stipend which will offset the costs of attending the meeting.
- The 4th APA Movie Night will be held in Vancouver on October 21. The branch will also be entering this activity into the APA's Best Practice Award competition, in November 2015
- Winnipeg co-presidents Dr. Tyler Oswald and Dr. Anita Chorazyczewski are planning and education evening this Fall in Winnipeg. A DSM 5 presentation given there earlier in the year was well received and did help to generate more interest in the local branch.
- Likely there will be a Psychiatry Resident's Research night in November 2015, a very popular annual event
- Our annual WCDB newsletter 'Catharsis' will be published in the Fall 2015.

Professional Activities/ Legislation

There has been a nationwide debate concerning ' MD assisted dying', previously known as MD assisted suicide, an issue which has relevance to psychiatrists in a number of ways. Since the Supreme Court struck down the Criminal Code absolute prohibition on assisted dying, late last year, the Canadian Medical Association (CMA) has been working quickly to engage physicians in the development of guidelines to address the matter. New legislation from the Federal Government is expected to be in the works, after the Supreme Court set out only broad parameters. The CMA has been soliciting input from all physicians with the results of their survey available in the near future.

Cannabis continues to be an important topic for psychiatrists and other physicians. There is widespread dispensing of marijuana now especially in BC. The CMA has expressed great concern that prescribing is rather loosely regulated and the medicine has scarce scientific evidence for its use. In fact there is little precedence for this situation; with little exception new drugs go through rigorous trials before being allowed on the market. So the profession is doing its best to catch up to a rapidly changing reality in this regard. Provincial regulatory agencies have noted their concern about the sometimes exorbitant fees for the prescribing cannabis, where education and counseling is sometimes included with the visit, and will continue to formulate practice guidelines. Vancouver, for example, has numerous cannabis dispensaries but it should be noted the drug has not been generally legalized anywhere in Canada.
Also of concern is the use of the various edible medicinal cannabis products, also not Health Canada approved , which might pose a greater risk of overdose or abuse.

Psychiatrist Compensation

Significant variability from province to province; for Western Canada the highest fees in Alberta. In BC there have been a series of negotiations with respect to the fees paid by Worksafe BC (the worker's compensation board), The Insurance Corp. of BC (government automobile insurer) and

the Forensic Psychiatric Service, all of which fall outside the main Fee Guide that applies to the majority of MDs. There is a new fee item proposed for Transcranial Magnetic Stimulation as this treatment gains more widespread use for an increasing number of indications.

Respectfully submitted,

Ian Forbes MD FRCPC
WCDB Representative

WYOMING ASSOCIATION OF PSYCHIATRIC PHYSICIANS
AREA VII REPORT
Portland, Oregon
August 2015

The executive committee continues to meet at least monthly on phone calls with fairly active participation with President Jason Collison.

A major legislative focus again has been on the court detention and commitment process. Different counties handle the assessment of a patient for a hold or detention. Cheyenne and Casper utilize psychiatrists who oversee the process with consultation with the professionals providing the assessment. Other counties with psychiatric units also involve psychiatrists in the process. A number of the smaller populated counties utilize various mental health professionals to decide on placing a hold without necessarily any involvement of a psychiatrist. Many of the community counseling centers are advocating that they become the assessment team and determine whether patients be placed on a hold and have a hearing for either a 10 day detention or commitment. The Wyoming Association of Psychiatric Physicians support involvement of psychiatric physicians.

One of the drivers for change is the growing cost to the state for paying for treatment at facilities for court ordered treatment. The Wyoming State Hospital (WSH) is always full with a waiting list for committed patients from other facilities. The WSH pays for their treatment at those facilities. Wyoming is looking at building a bigger state hospital and also similarly building onto the Wyoming Resource Center (for those with developmental disabilities). Also Wyoming has in much of the state limited residential services for the persistently mentally ill and limited resources in place to assertively manage this population either before or quickly after an acute psychiatric hospitalization. There is also not an outpatient commitment law. These issues and others are likely to enter into many of the legislative decisions.

The WAPP had a very limited annual meeting this year for a number of reasons. The members who are active continue to be a small core. Wyoming Medical Society serves as WAPP's executive director.

There were concerns about scope of practice issues involving psychologists last year that did not materialize. It is early and unknown if that will be an issue this year.

Sincerely, Stephen Brown, M.D. Rep. Wyoming
Child and Adolescent Psychiatrist
Distinguished Fellow of APA
2417 East 15th Street
Casper, Wyoming 82609
Office 307-234-3638

The Area Council attempts to set the time and date for the Spring meeting at the Fall/Summer meeting and the time and date for the Summer/Fall meeting at the Spring meeting.

Spring meeting will be in the Phoenix/Scottsdale are March 5th and 6th. Arizona Reps will help to suggest venues and Dr. Marwah has graceously offered to host the Saturday evening dinner at her house.

The August meeting is scheduled for Denver/Boulder, Colorado. Probably August 13th and 14th thought the date is not yet firm.

The Area 7 Council was adjourned at 11:10am on Sunday.

Respectfully submitted,

Charles Price, M.D.
Deputy Rep. Area VII

Item 2015A2 12.A
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Access to Care Provided by the Department of Veterans Affairs

WHEREAS:
Whereas, The Department of Veterans Affairs' (VA) mandate, as first articulated by President Lincoln, in his Second Inaugural Address, is to:

> "Care for him who shall have borne the battle and for his widow, and his orphan."

Whereas, with these words, rendered more than a century ago, President Lincoln affirmed the government's obligation to care for those injured during war and to provide for the families of those who perish~~ed~~ on the battlefield,

Whereas, veteran access to Psychiatric Care~~,~~ continues to be inadequate, according to the August 2015[2] and September 2015[1] Inspector General of the Department of Veterans Affairs reports, and the listings of vacancies in USAJOBS.GOV for available psychiatrist positions.

Whereas, many long-time employed VA psychiatrists, under the current pay structure, are often paid less than new hires based on personal knowledge and survey data from the VA Caucus members.

Whereas, new hires with loan repayment obligations have limited access to receiving loan forgiveness based on length of employment with the VA compared to those employed by other federal agencies.

BE IT RESOLVED:
That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans.

That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans.

That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to fund~~s~~ mental health care and suicide prevention programs within the VA.

AUTHORS:
Harold Ginzburg, M.D., J.D., M.P.H., Representative, Oklahoma Psychiatric Physicians Association
Jenny L. Boyer, M.D., J.D., Ph.D., Immediate Past Speaker

ESTIMATED COST:
Author: $2,940
APA: $4,106.67

ESTIMATED SAVINGS: none
ESTIMATED REVENUE GENERATED: More psychiatrists working for the VA would mean more potential members of APA and VA Caucus.

ENDORSED BY: Area 5

KEY WORDS: Department of Veterans Affairs, Access to Care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations

REFERENCES:

1. Report No. 15-03063-511, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, September 1, 2015.
2. Report 13-03917-487, OIG Report, *Audit of VHA's Efforts To Improve Veteran's Access to Outpatient Psychiatrists August 25, 2015.*

Item 2015A2 12.B
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Directions to the Area Nominating Committees

WHEREAS:
1] The Procedure Code of the Assembly states:

"c. Nomination of Trustees. The Area Nominating Committee shall select as candidates for the office of Trustee three voting members of the American Psychiatric Association residing in the Area who are not members of the APA Nominating Committee. Two of these candidates shall be designated as nominees and the third as an alternate. The names of those selected shall be reported to the Area Council at which time the names of two candidates and an alternate shall be forwarded to the chair of the Nominating Committee of the American Psychiatric Association by September 1."

2] The APA Members appointed to Area Nominating Committees should not have tight limits set on their nomination decisions. They should be free to decide what is best for their Area as to nominations.

BE IT RESOLVED:
Areas should have the latitude to nominate more than two candidates.

The Procedures Committee should be asked to change the language accordingly.

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society RogerPeele@aol.com

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society, August, 2015

KEY WORDS: Area Trustees

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Sent to Assembly Committee on Procedures

Item 2015A2 12.C
Assembly
October 30-November 1, 2015

ACTION PAPER
FAILED

TITLE: New Names for Psychiatric Conditions

WHEREAS:

1] With DSM-5, we limited our coding to exact codes from ICD-10-CM one hundred percent of the time, but we selected exact names from ICD-10-CM only ten percent of the time. Ninety percent of the names of DSM-5 conditions have names at least somewhat different than ICD-10-CM's.

2] Thus, those using DSM-5 are often using a vocabulary different than the rest of medicine. This was reflected in the medical literature where a year after DSM-5 was published, PubMed showed "dementia" listed 7217 times in 2014 and "neurocognitive" listed 1846 times in 2014. It ill serves psychiatry to unnecessarily have an idiosyncratic vocabulary from the rest of medicine. We need to seem as similar to the rest of medicine as we possible can.

3] In order to address these differences in names, some billers have developed cross-walks that may not be accurate as to the condition, such as cross-walking Hoarding Disorder to Obsessive Compulsive Disorder, which DSM-5 says is different from Obsessive-compulsive disorder, page 251-252.

4] It can confusing to non-psychiatrists as to why two names for a condition.

5] DSM-5 reflects the fact that the APA often comes up with a superior term for a condition.

6] The author of the ICD-CMs in the United States is the National Center for Health Statistics [NCHS].

7] The APA has not had a habit of going to NCHS with proposed improvements in nomenclature prior of publishing an edition of the DSM.

BE IT RESOLVED:

1] To reduce the confusions presently as to nomenclature when billing, the APA should champion the need to bill only using codes, not nomenclature

2] The APA should have a process of developing improvements in the nomenclature of psychiatric conditions that promptly reflects developments in psychiatry, is not limited to DSM publication dates.

3] The APA should promptly suggest improvements in nomenclature to the NCHS.

4] Future DSMs should reflect nomenclature approved by the NCHS.

AUTHORS:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society RogerPeele@aol.com
Mahrokh Shayanpour, M.D., APA Member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society, August, 2015

KEY WORDS: DSM

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.D
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Prior Authorization

WHEREAS:
1] Prior authorization can be time-consuming.

2] Clinicians should be reimbursed for time-consuming tasks that are required to treat the patient.

BE IT RESOLVED:
The APA should explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization.

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society RogerPeele@aol.com

ENDORSED BY: Washington Psychiatric Society, September, 2015

KEY WORDS: Prior Authorization

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Sent to Committee on Reimbursement for Psychiatric Care

Item 2015A2 12.E
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product

WHEREAS:
The APA has excellent, evidence-based practice guidelines that are authoritative, detailed, and lengthy; and

The format of the practice guidelines do not lend themselves to being used routinely in everyday practice at the average pace of care; and

Primary care practitioners and other non-psychiatrists, as well as psychiatrists, would greatly benefit from leveraging the clinical information about a specific patient that lives within various electronic tools to query a computable version of the entire set of practice guidelines to guide their clinical decision making; and

Developing such a clinical decision support product would require a combination of subject matter experts, technology experts, and knowledge representation experts, which would be a significant investment; and

Numerous universities, electronic health record vendors, registries, health information exchanges, payer, and other entities would be potential customers who would be interested in licensing an APA-developed CDS Product, with significant revenue potential; and

Users of such a product, including primary care providers, would be able to review a tailored list of treatment options for a given patient, based on the data known about the patient, ranked based on the strength of the evidence and indicating what missing data could have an impact on treatment options; and

Such a product could be very useful in developing new research, in providing CME opportunities, and simplify maintenance of certification and licensure requirements.

BE IT RESOLVED:
That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and

That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.

AUTHOR:
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ESTIMATED COST:
Author: $5,577.95
APA: $1,700

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: Unknown at this time, but potentially on the order of millions annually when fully built out.

ENDORSED BY:

KEY WORDS: practice guidelines, clinical decision support, learning systems, electronic health records, personalized medicine, information technology

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT:
The Committee on Mental Health IT supports this concept.

The Council on Quality Care discussed the concept during the Fall Component meeting and voiced vigorous support. Dr. Phillip Wang, the new Director of Research, also agreed that this was a worthwhile endeavor to explore and pursue. The author will pursue additional review by all other relevant components in time for consideration by the Assembly.

Item 2015A2 12.F
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Payer Coverage for Prescriptions from Nonparticipating Prescribers

WHEREAS:
The AMA has adopted a policy that opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it; and

Managed care has led to a reduction in the level of participation of psychiatrists in insurance, including commercial, Medicare and Medicaid; and

A significant number of solo or small practice psychiatrists who do not participate in an insurance plan continue to provide ongoing treatment to patients with insurance, at the request of the patient; and

Some payers are implementing policies that prohibit payment for prescriptions ordered by non-participating psychiatrists. This is occurring with Medicaid within a number of states now; and

For example, Maryland Medicaid has announced that as of December 1, 2015, they will not pay for prescriptions written by nonparticipating prescribers, There is concern that these policies may later spread to Medicare and commercial payers; and

If this prohibition proceeds, patients receiving care from non-participating physicians must disrupt their relationship with their long-standing psychiatrist and find one of the few participating psychiatrists to prescribe medications; and

If this prohibition proceeds, psychiatrists who work in jails or prisons (who are not participating physicians) and who provide prescriptions upon release to their patients will not have their prescriptions filled, resulting in risk of unnecessary relapse and re-arrest.

BE IT RESOLVED:
That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and

That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and

That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and

That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.

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ESTIMATED COST:
Author: $0
APA: $12,339.18

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Medicaid, prescriptions, insurance, nonparticipating, network

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.G
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: APA Support for NIMH Funding of Clinical Research

WHEREAS:
Whereas the NIMH has dramatically shifted its research focus to translational neuroscience to the exclusion of clinical research;

Whereas optimal clinical trials of drugs and therapies are conducted by investigators free of potential bias from funding source (e.g., NIMH funded drug trials are preferable to industry funded trials);

Whereas full implementation of mental health parity means there will be an increasing need for evidence supporting the efficacy of clinical treatments for the disorders real patients present with;

Whereas additional clinical trials research is needed because under-resourced and minority communities have been underrepresented in clinical trials, leaving these communities disproportionately affected by the NIMH policy change;

Whereas the APA has already supported the recommendation of the 2015 Institute of Medicine report on Psychosocial Interventions for Mental and Substance Use Disorders that explicitly calls for more research into psychosocial treatments and their effective core elements;
Whereas improving patient care requires commitment to the development and testing of clinical treatment methods;

Whereas future grant support for randomized controlled trials from the NIMH is crucial to demonstrating the efficacy of clinical treatments for particular treatment populations;

Whereas an optimal and comprehensive national research strategy for mental health must include clinical approaches, in addition to a basic science search for brain mechanisms;

BE IT RESOLVED:
That the APA shall:

1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget.
2. The APA will advocate the implementation of the recommendations of the White Paper.

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ESTIMATED COST:
Author: $3,717.95
APA: $2,701.74

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Research, NIMH, RDoC criteria, clinical trials

APA STRATEGIC PRIORITES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT: Comments from members of the Council on Research for comments led to revision of the action paper before submission.

Item 2015A2 12.H
Assembly
October 30-November 1, 2015

ACTION PAPER
Referred to Council on Healthcare Systems and Financing

TITLE: Is It Ethical For A Psychiatrist to Serve as a Utilization Management Reviewer When Review Standards Fail to Comply With Parity?

WHEREAS:
Whereas the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or parity law) is the law of the land;

Whereas the MHPAEA requires that treatment for mental and substance use disorders be covered without quantitative or non-quantitative limitations that are more stringent than those applied for medical and surgical care;

Whereas multiple class action lawsuits have been filed and are in process that allege that some major insurance companies use review standards that are patently out of compliance with parity (e.g., standards that exclude reimbursement for treatment of patients with personality disorders when these are treatable DSM disorders with a practice guideline and established morbidity and mortality, or that end coverage of treatment for patients with substance use disorders who continue to use substances during treatment when this would not be done for a diabetic patient who failed to follow a diet, or when arbitrary annual caps on numbers of sessions are imposed);

Whereas ethical practice by psychiatrists is of paramount importance to good clinical care;

Whereas ethical practice has a profound effect on how the field of psychiatry is viewed by the public;

Whereas public consciousness and concern are growing about flagrant abuses of the parity law, as evidenced by two recent segments on the above referenced class action lawsuits on the CBS show *60 Minutes* and two on NPR *(All Things Considered* and *On Point)*;

BE IT RESOLVED:
That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting.

The Ethics Committee review will specifically address at least the following questions:

1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law?

2) If an insurance company policy or the review standards that guide a psychiatrist reviewer's decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer?

3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law?

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ESTIMATED COST:
Author: $340
APA: $840-$2,100

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Parity, Ethics, Utilization Review

APA STRATEGIC PRIORITES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Copy sent to Council on Healthcare Systems and Financing on August 17, 2015. No feedback received at point of submission of action paper on September 13, 2015.

Item 2015A2 12.I
Assembly
October 30-November 1, 2015

FINAL
ACTION PAPER

TITLE: Strengthening the Role of Residency Training to Improve Access to Buprenorphine

WHEREAS:

1. One of the APA's Strategic Priorities is educating members, patients, families, the public and other practitioners about mental disorders and evidence-based treatment options, and
2. Opioid use disorders (OUD) are reaching epidemic proportions in the United States **(past year heroin use has increased by 34% from 681,000 to 914,000 in the past year)**, resulting in significant mortality and morbidity, and a significant overall societal cost.
3. Buprenorphine is an effective maintenance treatment for opioid use disorders and included as on the World Health Organization's list of essential medications.
4. 3% of physicians in the United States are licensed to prescribe Buprenorphine, and less than a third of Buprenorphine providers are psychiatrists.
5. The number of Buprenorphine providers in many areas falls below the patient demand for such services, and patients often find themselves unable to locate a Buprenorphine provider. Methadone maintenance is often unavailable or logistically difficult (e.g., some states only have one or two licensed methadone treatment programs and federal law requires daily visits to the methadone clinic for the first 90 days of treatment). This can contribute to continued illicit drug use and increased risk of overdose and its sequelae, including death.
6. Most residency training programs do not require their trainees to complete the Buprenorphine waiver training and waiver certification paperwork; this represents a critical missed opportunity to train tomorrow's psychiatrists to meet the demands of the growing OUD epidemic and provide services for a growing underserved patient population.
7. Many psychiatrists do not feel comfortable treating psychiatric patients with co-occurring substance use disorders. This exacerbates the vulnerability of this underserved population.
8. The APA Position Statement on "Residency Training Needs in Addiction Psychiatry for the General Psychiatrist" approved in 2014 was supported by background information that "Appropriately dosed Buprenorphine is superior to placebo in diminishing illicit opiate use and treatment retention. All psychiatry residents should receive appropriate didactic training to obtain the DATA 2000 waiver to prescribe Buprenorphine and sufficient clinical supervision to assure competency in managing patients on Buprenorphine maintenance."

BE IT RESOLVED:
That the APA liaise with ACGME/Residency Review Committee (RRC) to promote Buprenorphine training during general adult psychiatric residency training.

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ESTIMATED COST:
Author: $680
APA: $2,058.46

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Assembly Committee of Residents and Fellows, New Jersey Psychiatric Association, Area 3 Council, Area 1 Council

KEY WORDS: Buprenorphine, Opioid Use Disorders, Access to Care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry, Council on Medical Education and Lifelong Learning

References:
Drug Alcohol Depend. 2006 Feb 1; 81(2):103-7. Epub 2005 Jul 14.

Barriers to Primary Care Physicians Prescribing Buprenorphine Eliza Hutchinson, BA; Mary Catlin, BSN, MPH; C. Holly A. Andrilla, MS; LauraMae, Baldwin, MD, MPH; Roger A. Rosenblatt, MD, MPH, MFR Ann Fam Med. 2014;12(2):128133.

Substance Abuse and Mental Health Services Administration, Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings, Page 120, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf

Item 2015A2 12.J
Assembly
October 30-November 1, 2015

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: Need to Gather Information on Physician Health Program (PHP) Performance

WHEREAS:
Physician Health Programs (PHPs) were established a resource to improve the health of medical professionals when substance use and/or other mental issues emerge and are a personal concern and/or a concern of Medical Boards, hospitals and other health entities may affect the physician's ability to work or provide quality medical care.

The Federation of State Physician Health Programs (FSPHP) advocates that PHPs have specific and consistent standards, language, and definitions nationwide so as to promote timely and appropriate identification, treatment, and monitoring.

The current quality, appropriateness and adherence to FSPHP recommendations for PHPs may vary from state to state. For example, in some states, PHPs require evaluation in centers that have not gone through quality assurance studies to determine the quality and consistency of care, or proper use of diagnostic criteria as set out by the DSM. Some referrals are made despite objection to the diagnosis from the subject physician and without subsequent access to a second opinion regarding diagnosis and/or determination of severity of the condition or its potential danger to patient care. And some evaluation centers have a predetermined length of stay of 30 or more days based on the assessment of the PHP, but without access to a second opinion.

Complaints in the past few years have arisen that, despite FSPHP recommendations or state statutes, some PHPs neither vet nor investigate anonymous or even identified complaints and deem such complaints to be valid and true.

Additionally, some PHPs:
Some PHPs deny the physician client due process rights including knowing the allegations against him or her, the ability to confront one's accuser, the right to present witnesses on one's behalf, the right to cross examine those who have furnished negative information against the physician, and the right to receive a copy of the proceedings, all in violation of the Health Care Quality Improvement Act (HCQIA).

Classify major depression, bipolar disorder, and adjustment disorder as conditions that mandate psychiatric inpatient hospitalization despite lack of safety concerns and severity of the condition.

Mandate "contracts" between the physician and the PHP that extend for 3-5 years, regardless of the condition identified and/or intensity of the condition.

The APA currently does not have an identifiable group or body within its organizational structure to address physician needs, health and resources.
BE IT RESOLVED:
That the APA delegation to the AMA ask the AMA to investigate the performance of PHPs and the need for oversight, response to complaints by physicians, and what other areas the AMA and APA deem important.

That the appropriate body within the APA structure study the need for an APA Committee, Task Force, or Work Group on Physician Health and Physician Health Programs and make recommendations for improvement in the current process.

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ESTIMATED COST:
Author: $850
APA: $1,837.95

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: medical license, physician health programs, PHP, substance use disorder

APA STRATEGIC PRIORITIES:
Supporting Research: Supporting research to advance treatment and the best possible clinical care, as well as to inform credible quality standards, and leading the development, refinement ad evaluation of appropriate quality measures.

Education: Educating patients, families and the public and other practitioners about mental disorders and evidence-based treatment options.

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.K
Assembly
October 30-Novembe 1, 2015

ACTION PAPER
FINAL

TITLE: Equality in Permanent Licensure Policy

WHEREAS:
Prior to an International Medical Graduate entering an ACGME-accredited residency training program, a rigorous credentialing process by the Educational Commission for Foreign Medical Graduates (ECFMG) is required to assess the mastery of medical school basic science curriculum as well as the clinical knowledge and skills of each physician, which must match, if not exceed, the mastery standards required of US medical grads.

The ACGME reviews and accredits graduate medical education (residency and fellowship) and the institutions that sponsor them in the United States with the mission of assessing and advancing the quality of resident physicians' education through accreditation. Length of time and quality in residency training, as established by ACGME accreditation, rather than location of prior medical school education, should be the determining factor in granting a permanent medical license.

Each state has its own regulations for obtaining a permanent medical license and all require a specific amount of time in an ACGME-accredited residency before a medical license can be approved. Currently, 37 States require U.S. residency-trained International Medical Graduates to spend more time in the same ACGME-accredited training programs than their US medical grad counterparts prior to obtaining permanent licensure.

The Association of American Medical Colleges (AAMC) predicts a workforce shortage of between 46,000 and 90,000 physicians by 2025*, largely created by passage of the Affordable Care Act. Action is required *now* to address this anticipated workforce shortage. A more timely entrance into the workforce of trained residents from ACGME-accredited residencies, will increase the workforce. Training programs are being relied on more to provide care for underserved populations via funding from State or County, and often there are licensure requirements. This places limits on training and also stretching the already stretched resources of training programs

Position statements from national professional associations such as the APA, the AMA, the Residency Review Committees (RRC), and the Federation of State Medical Boards (FSMB) can influence state policies.

BE IT RESOLVED:
That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards.

That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.

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ESTIMATED COST:
Author: $ 16,613.85
APA: $5,185.64

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Nebraska Psychiatric Society, Assembly Committee of Early Career Psychiatrists, Assembly Committee of Resident Fellow members (ACORF)

KEY WORDS: medical license, licensure, international medical graduates, residency requirement, state medical board

APA STRATEGIC PRIORITIES:
Advancing Psychiatry: Advancing the integration of psychiatry as delivery system evolves a central role in all care settings, full implementation, enforcement or parity, assistance to members in practice with new technologies, reimbursement, and building and safeguarding the workforce.

Diversity: Supporting and increasing diversity within the APA, serving the needs of evolving, diverse, underrepresented and underserved patient populations, and working to end disparities in mental healthcare.

REVIEWED BY RELEVANT APA COMPONENT:
Council on International Psychiatry
Council on Medical Education and Lifelong Learning
Council on Advocacy and Government Relations
APA delegation to the AMA

Item 2015A2 12.L
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Partial Hospital Training in Psychiatry Residency

WHEREAS:

1. Partial Hospital Programs (PHP's) are effective and bridge the gap in the continuum of care between inpatient and outpatient psychiatric treatment;
2. PHP's have been increasingly recognized and provided in psychiatric hospital settings across the country, particularly in light of shortened inpatient stays and need to further stabilize mentally ill patients and prevent relapses;
3. PHP's offer a unique clinical and educational experience in terms of daily intensive group therapies encompassing diverse themes and approaches supplemented by individual and family/couples therapy and close medication monitoring, all occurring over 4-6 weeks that allows observation of a patient's rapid bio-psycho-social progress in a short span of time;
4. The Accreditation Council for Graduate Medical Education (ACGME) does not formally recognize PHP experience under Curriculum Organization and Resident Experiences for psychiatry residency (Section 4. A. 6) but states in the Question and Answer Section that PHP would not fulfill the minimum six month requirement for inpatient; however, rotations in day treatment programs will be counted as part of the 16-month maximum allowed for inpatient psychiatry.
5. A majority of psychiatry residencies do not provide PHP rotations and are not aware of this valuable educational experience;
6. Many graduating residents are entering psychiatric hospital settings and are asked to work in PHP's although they have had no training in PHP;

BE IT RESOLVED:
That the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.

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ESTIMATED COST:
Author: $0
APA: $65.64

ESTIMATED SAVINGS: Immeasurable gains in clinical knowledge and skill

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Partial hospital, Psychiatric residency

APA STRATEGIC PRIORITIES: Advancing psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
APA Council on Medical Education and Lifelong Learning- Comments:
"The Council thinks PHP rotations are important but residencies operate within the rules set by the ACGME-RRC. APA can however play a role as an advocate to ACGME through the liaison to the RRC and continue to stress the importance of PHP training in residency. While the ACGME has removed PHP requirement specifically, they have also lowered the number of required inpatient months from 9 to 6. The Council believes that this presents an opportunity for residency programs to continue to offer PHP rotations."

Item 2015A2 12.M
Assembly
October 30-November 1, 2015

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: Addressing the Shortage of Psychiatrists

WHEREAS:

1) There is a serious nation-wide shortage of psychiatrists which is anticipated to only get worse since 55% of psychiatrists are over 55 (1). A recent publication cited by the APA's Psychiatric New Alerts noted that, in Wisconsin, for example, most counties have no more than 1 psychiatrist for every 30,000 people, and the situation with child psychiatrists is even worse. (2)
2) The average cost of tuition and fees for a first year medical student in 2012-2013 (U.S. News and World Report) was $47,000-$50,000. Medical students are generally saddled with tremendous debt upon graduation which presents an economic burden and which influences choice and location of specialty (generally opting for more lucrative specialties in more urban areas). Additionally, many potential medical students are opting for less expensive programs, such as those for physician assistant.
3) The only resources for assistance in funding medical school expenses currently posted on the APA website or identified by the Council on Medical Education and Lifelong Learning are the federally-funded National Health Service, the NIH research loan repayment program, and state loan programs. The NHS scholarships and loan repayment programs are limited to primary care, the NIH program is only for research, and the state programs are not specific to psychiatry. Vermont's, for example, is only for family practice. So these do not address the specific shortage of psychiatrists.
4) In the tenor of the rabbinic teaching, "If I am not for myself, who will be for me.....and if not now, when," it is important for the APA to take action toward remediating this shortage.

BE IT RESOLVED:

1. That the Assembly and the Board of Trustees create a task force, or designate an APA component to create such a task force, to investigate the feasibility of the establishment of a foundation for the purpose of providing scholarship funds to qualified students who will commit themselves to completing a psychiatry residency and who will promise to practice as a psychiatrist for a defined number of years in an underserved area. The task force will report its findings to the Assembly and the Board of Trustees at the 2016 Annual Meeting.

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ESTIMATED COST:
Author: $1,295.69
APA:

ESTIMATED REVENUE GENERATED: None

ESTIMATED SAVINGS: None

ENDORSED BY:

KEY WORDS: psychiatrist, shortage, scholarship

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Medical Education & Lifelong Learning

REFERENCES:

(1) NIMH website, cited in Psychiatric News Alerts 2/10/14
(2) Milwaukee Journal Sentinel 8/9/15, cited in Psychiatric News Alerts 8/10/15.

Item 2015A2 12.N
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Advocating for Medicaid Expansion

WHEREAS:
The Affordable Care Act (ACA), passed by the US Congress in 2010 provides provisions for federal financing for states which expands eligibility for Medicaid coverage to include those with incomes up to 133% of the poverty level, 20 states still have not accepted the federal offer to expand Medicaid in their states;

Millions of Americans who do not have access to other forms of health insurance due to inability to afford private plans or lack of employer-provided insurance are forced to either forego medical and psychiatric care or attempt to access urgent or emergency care settings, leading to adverse medical outcomes and increased mortality rates. At the same time, hospitals are forced to absorb the cost of uncompensated care, in some cases causing closures which further exacerbate the access to care problems;

Expansion of Medicaid would result in increased access to care including access to critical medications for seriously and persistently mentally ill individuals. This is likely to reduce incarceration rates for minor offenses in this population, a serious and pervasive problem in the U.S. and a problem which the APA leadership, including current President Renée Binder, MD has begun to formally address (1);

It has been assumed until recently that the only way for a state to expand Medicaid is through legislative action, however in late August, a judge in Alaska blocked an effort by the state legislature to prevent the governor from accepting the federal money to expand Medicaid. This suggests another avenue for advocacy in addition to that of legislative action;

Both the APA and AMA have endorsed the ACA including Medicaid expansion but no formal advocacy effort on the state level has been undertaken by the APA;

While expansion of Medicaid will undoubtedly improve access to care for many individuals, low physician participation in the program could exacerbate access to care problems for some people who currently have Medicaid insurance but find it difficult to find a provider, thus incentive measures to encourage more physician participation in the program are needed.

BE IT RESOLVED:
That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion (2);

That a status report and recommendations be made to the Assembly at the May 2016 meeting.

AUTHORS:
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ESTIMATED COST:
Author: $ 3,123.85
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Medicaid Expansion

APA STRATEGIC GOALS: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
Council on Healthcare Systems and Financing: this Council strongly supported the intent of this action paper and recommended several changes which were all incorporated into the current (final) draft.

Council on Advocacy and Government Relations: this Council did not support the action paper in its original form and cited "resistance" in some state legislatures to Medicaid expansion and "heated discussions/debates" in these settings. (This Council did not have an opportunity to review the updated (final) draft prior to the deadline for Action Papers)

REFERENCES:
1. "Stepping Up to Address Our Nation's Shame". Psychiatric News, June 17, 2015 (Vol 50, No 14).
2. "Work Force Initiative", Assembly Action Paper, passed November 2012.

Item 2015A2 12.O
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Systems to Coordinate Psychiatric Inpatient Bed Availability

WHEREAS:
Whereas, in many areas of our country availability of psychiatric inpatient beds to accommodate psychiatric emergencies is inadequate or severely limited.

Whereas, regrettably patients languish in general hospital emergency rooms for hours or days after being placed on a "hold"--receiving minimal specialized treatment often further complicating their mental and physical status rendering later treatment more difficult and problematic.

Whereas, there have been efforts to devise online systems of bed registration and availability involving participating programs [Virginia Acute Psychiatric and CSB Bed Registry, Patient Valet, Maryland Institute for Emergency Medical Services Systems (MIEMSS), Minnesota Department of Human Services and Minnesota Hospital Association mental health service locator web site] in local communities and regions which can be easily accessed by emergency room staff, medical surgical staff and community providers.

Whereas a strategic approach to the bed crisis must involve prevention, early diagnosis and treatment intervention, enhanced outpatient services, and provision of additional acute beds, the establishment of registry models can be a significant immediate step in improving timely access.

BE IT RESOLVED:
That the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.

AUTHORS:
Richard Granese, M.D., Representative, Orange County Psychiatric Society
Barton Blinder, M.D., APA Member

ESTIMATED COST:
AUTHOR: $0
APA: $367.59

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Orange County Psychiatric Society

KEY WORDS: Psychiatric Emergency, Access to Care, Bed Registry

APA STRATEGIC PRIORITIES: Supporting Research

REVIEWED BY RELEVANT APA COMPONENTS: Council on Quality Care, Work Group on Access to Care, Council on Advocacy and Government Relations

Item 2015A2 12.P
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Making Access to Treatment for Erectile Disorder Available Under Medicare

WHEREAS:
Whereas Erectile Disorder (302.72 [F52.21]) is included as a psychiatric disorder under the DSM5 when the dysfunction is not better explained by a nonsexual mental disorder, severe relationship distress, other significant stressor, the effect of a substance/medication or another medical condition and that access to a full array of evidenced based treatments are not available under Medicare.

Whereas there is an increasing likelihood of Erectile Disorder with advancing age. (By age 70, 67% of men experience some degree of Erectile Disorder.)

Whereas those with diabetes mellitus, hypertension, multiple sclerosis and many other medically diagnosed illnesses have a higher probability of experiencing Erectile Disorder than age matched controls.

Whereas treatment of prostate cancer whether by surgery and/ or radiation therapy and/ or hormone therapy as well as those undergoing bladder, rectal and other surgeries have a high probability of experiencing Erectile Disorder.

Whereas those treated for prostate surgery and other cancers or for diagnoses requiring bladder, rectal and other surgeries are highly likely to be insured by Medicare.

Whereas, due to Congressional prohibition, Medicare does not pay for PDE5 inhibitors, the penile pump, injectable medications, etc. but does pay for costly corrective surgery.

Whereas psychiatrists are aware that the consequences of Erectile Disorder may be depression, anxiety, diminished self-worth and quality of life, as well as significantly impacting the relation between the patient and his partner

Whereas the FEHB does include payment for PDE5 inhibitors, etc. (Representatives who oppose such coverage assert that the federal government should not have taxpayers paying for 'lifestyle' treatments. However, the federal government does pay for such care for its employees including Members of Congress.)

BE IT RESOLVED:
That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner.

That the Council on Advocacy and Government Relations and the Council on Healthcare Systems and Financing advocate, along with other professional societies and advocacy groups, for legislation to allow access to the full array of medications, mechanical therapies, and other treatments for Erectile Disorder which are currently excluded from coverage under Medicare.

AUTHORS:
Seeth Vivek, M.D., Representative, Area 2
Barry B. Perlman, M.D., APA Member
Jeffrey A Borenstein, M.D., Deputy Representative, Area 2

ESTIMATED COST:
Author: $689.23 per annum
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY:

KEY WORDS: Medicare, Erectile Disorder, insurance benefits, human sexuality

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.Q
Assembly
October 30-November 1, 2015

ACTION PAPER
NOT MOVED BY THE AUTHOR

TITLE: Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Section Organizations

WHEREAS:
The Assembly approved a limited time waver for current Subspecialty and Section Organizations who do not fulfill the membership requirements, to give time for them to reach the required number of psychiatric members, to continue to have Assembly representation.

There are Subspecialty and Section organizations without current Assembly representation, because they do not fulfill the required number of psychiatric members to qualify at this time.

Allowing these organizations to be included, would enhance the membership representation in the Assembly and will enrich the breath of the Assembly by allowing additional perspectives to be heard and considered.

BE IT RESOLVED:
That the Assembly asks the Committee on Procedures to make recommendations for lowering the initial psychiatric membership qualification requirement for established subspecialty and section organizations, applying for the first time to be represented in the Assembly and sets up a reasonable extended time waiver for them to be able to reach the final minimum required membership count.

AUTHORS:
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Jose M Cañive, M.D., APA Member
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Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $1,263

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Hispanic Psychiatrists

KEY WORDS:

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.R
Assembly
October 30-November 1, 2015

ACTION PAPER
Referred to the Joint Reference Committee

TITLE: Senior Life Psychiatrist Seat on the Board of Trustees (BOT)

WHEREAS:
There will be an ever increasing number of older members in the APA. (Life expectancy in the USA went from 69.77 years in 1960 to 78.74 years in 2012. The median age of an APA member in 1996 was 52 years old; the percentage of psychiatrists practicing in the USA in 2010 over the age of 55 was 57% of all psychiatrists.)

There is no seat on the BOT specifically designated for a Life member of APA. ("Senior" is defined here as having reached "life status" membership in the APA. (The APA defines life status as: age plus total years of membership equal 95.)

There is not necessarily at any given time a Senior member on the Board.

There are seats designated for younger APA members, e.g., Resident-Fellow Trustee, ECP Trustee.

The Life Psychiatrist Trustee could be elected by the Life Members of the APA.

BE IT RESOLVED:
1. Create a Senior Psychiatrist seat on the BOT.
2. The Senior Psychiatrist Trustee would be elected by the Life Members.

AUTHORS:
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Jack W. Bonner, M.D., Representative, Senior Psychiatrists Jwb2@att.net

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: BOT Trustee, Life Member, Senior Psychiatrist

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity
REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.S
Assembly
October 30-November 1, 2015

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: Need for Position-Specific Email Addresses for Leadership Roles in the APA

WHEREAS:
Communication between our APA's national-level elected and appointed leaders and the general membership has been identified as a significant problem for the organization

For full engagement in the APA, it is essential that members be able to readily contact their representatives at the Assembly, Board, Council, and Committee level

The average member may not be aware of the name of the individual who is currently occupying any given leadership role

Many individuals in leadership are reluctant to have their personal or business email addresses made publicly available on the APA website, as evidenced by a recently defeated action paper on the issue

The individuals occupying elected and appointed leadership positions change on a regular basis, while the names of the positions do not change

Position specific email addresses has been successfully utilized by PsychSIGN since 2007, using position-specific gmail addresses for each member of the national board

It would appear more professional for the email addresses associated with leadership roles to be associated with the psych.org domain, but it would be prohibitively expensive and time-consuming to create a personal account for each individual who is elected or appointed to leadership

BE IT RESOLVED:
That the APA create a position-specific email address for each national-level leadership role (e.g. APAPresident@psych.org), that is intended to be used for official APA business only and to be passed down to each succeeding individual who occupies the role.

AUTHORS:
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Matthew Kruse, M.D., RFM Deputy Representative, Area 4
Elie Aoun, M.D., ACORF Mentor

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: ACORF

KEY WORDS: communication, email, supporting volunteers within the organization

APA STRATEGIC PRIORITIES:
Education: Educating patients, families and the public and other practitioners about mental disorders and evidence-based treatment options.

REVIEWED BY RELEVANT APA COMPONENT:

Item 2015A2 12.T
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Election of Assembly Officers

WHEREAS:
Whereas: The Assembly currently provides matrix representation that combines both geographic and special interest representation,

Whereas: The Assembly officers, the Speaker-elect and Recorder, are elected on a geographic basis which gives district branch representatives a total of over 30,000 votes, and gives the ECP, RFM, MUR, ACROSS, and AEC representatives less than 70 votes total,

Whereas: The RFM, ECP, MUR, ACROSS, and AEC representatives constitute nearly a third of all representatives in the Assembly,

Whereas: The Assembly officers represent and serve all Assembly representatives equally;

BE IT RESOLVED:
That the Assembly Procedural Code be rewritten to make the election of Assembly officers based on a majority vote with each voting member of the Assembly casting one vote.

AUTHORS:
David Scasta, M.D., Representative, Association of Gay and Lesbian Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Assembly Committee of Resident-Fellow Member Representatives, Assembly Committee of Early Career Psychiatrists, Assembly Committee of Minority and Under Represented Groups, Assembly Committee of Representatives of Subspecialties and Sections, Area 3 Council

KEY WORDS: Voting for Assembly Officers

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Procedures Committee

Item 2015A2 14.A
Assembly
October 30-November 1, 2015

Joint Reference Committee
Additional Report to the Assembly
October/November 2015

Action: Revised Position Statement on Telemedicine in Psychiatry

Will the Assembly approve the revised position statement *Telemedicine in Psychiatry*, and if approved, forward it to the Board of Trustees for consideration?

The Joint Reference Committee requests that this action be placed on the Assembly's agenda as new business. Passage of this revised policy is urgent due to the need to move forward with a current policy (rather than maintaining the current position statement dated 1995) to advance our federal and state policy and legislative strategies for providing solutions for access to mental health care.

REVISED POSITION STATEMENT:

Position Statement on Telemedicine in Psychiatry

Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality.

CURRENT POSITION STATEMENT:

Position Statement on the Ethical Use of Telemedicine (1995)

The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality.